Iowa

UNIFORM APPLICATION
FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/30/2019 12.16.32 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year	2020
End Year	2021

State DUNS Number

Number	808345920
Expiration Date	

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

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

II. Contact Person for the Grantee of the Block Grant

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

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	9/30/2019 12:13:58 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	michele
Last Name	tilotta
Telephone	515-242-6333
Fax	
Email Address	michele.tilotta@idph.iowa.gov

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

Footnotes:

state expenditure years is not fillable line

State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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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.
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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.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act 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 182 by:

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

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

Footnotes:

KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

September 16, 2019

Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E201
Rockville, MD 20857

To Whom it May Concern:

As the Governor of the State of Iowa, for the duration of my tenure, I delegate authority to DeAnn Decker, Interim Division Director of the Division of Behavioral Health, in the Department of Public Health, to sign funding agreements and certifications, provide assurances of compliance to the Secretary, and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment Block Grant until such time this delegation of authority is rescinded.

Sincerely,

Kim Reynolds
Governor of Iowa

STATE CAPITOL DES MOINES, IOWA 50319 515.281.5211 FAX 515.725.3527 WWW.GOVERNOR.IOWA.GOV

State Information

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

Fiscal Year 2020

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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act 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 182 by:

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: Iowa

Name of Chief Executive Officer (CEO) or Designee: DeAnn Decker

Signature of CEO or Designee[1]: DeAnn M. Decker

Title: Interim Division Director Bureau Chief of Substance Abuse

Date Signed: 8/23/19

mm/dd/yyyy

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

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

Footnotes:

Approved by OMB No. 0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

[B]
a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

[A]
a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

[A]
a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____

date of last report

4. Name and Address of Reporting Entity:

[X] Prime [ ] Subawardee

Tier _____, if known: _____

State of Iowa
Department of Public Health
321 E. 12th Street
Des Moines Iowa
50319-0075

Congressional District, *if known:* 4C

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

SAMHSA

7. Federal Program Name/Description:

CFDA Number, *if applicable:* 93.959

8. Federal Action Number, if known:

9. Award Amount, if known:

$

10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*

NA

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

N/A

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: DeAnn M. Decker

Print Name: DeAnn M Decker

Title: Bureau Chief of Substance Abuse

Telephone No.: 515-281-0928 **Date:** 8/23/19

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature:

Date:

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

Footnotes:

uploaded under assurances and governor delegation section

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

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

Footnotes:

Organizational background of the Iowa Department of Public Health

The Iowa Department of Public Health (IDPH) is the parent organization to the Division of Behavioral Health, the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant (SABG). IDPH's mission is "Protecting and Improving the Health of Iowans."

In addition to the Division of Behavioral Health, IDPH has four other divisions operating under its authority:

- Acute Disease Prevention, Emergency Response, and Environmental Health
- Administration and Professional Licensure
- Health Promotion and Chronic Disease Prevention
- Tobacco Use Prevention and Control

IDPH Division Directors report to the IDPH Department Director, who reports directly to the Governor. The Department Director is appointed by the Governor and selects the Department's Division Directors.

In addition to the five operating divisions, IDPH also houses four professional boards:

- Dental Board
- Board of Medicine
- Board of Nursing
- Board of Pharmacy

As the parent organization, IDPH provides budgeting, fiscal management, information technology, and planning support to the professional boards.

Advisory Body to the Iowa Department of Public Health

The State Board of Health is the policy-making body for IDPH and has advisory responsibilities for IDPH activities, including the SABG. The State Board of Health has the powers and duties to adopt, promulgate, amend and repeal rules and regulations, and advises or makes recommendations to the Governor, the General Assembly, and the IDPH Director. The State Board of Health Substance Abuse and Gambling Treatment Program Committee reviews and acts on IDPH recommendations for the regulation of treatment programs. The SSA participates in the monthly Substance Abuse and Gambling Treatment Program Committee meetings to provide policy-level information and seek input on substance use services. The SSA makes reports to the full State Board of Health at their bi-monthly meetings, as requested.

The Division of Behavioral Health is comprised of two bureaus and three offices, staffed by 60.7 full-time equivalents. These bureaus and offices provide significant strengths to the collaborative work of the department and on behalf of multiple funders.

Division of Behavioral Health Single State Agency (SSA)

The IDPH Behavioral Health Division Director is selected by and serves as directed by the IDPH Director. DeAnn Decker has served as the IDPH Interim Behavioral Health Division Director and SSA since January 2019. A new Division Director, Jeff Kerber, was hired and will begin his responsibilities at IDPH on October 3, 2019.

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 assure alignment of tobacco efforts. A designee of the SSA attends the quarterly Tobacco Commission Meetings and participates in tobacco workgroups as needed and/or requested. 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 Bureaus and offices in the Division of Behavioral Health are:

- Bureau of HIV, Sexually Transmitted Diseases, and Hepatitis
- Bureau of Substance Abuse
- Office of Disability, Injury, and Violence Prevention
- Office of Gambling Treatment and Prevention
- Office of Medical Cannabidiol

Bureau of HIV, Sexually Transmitted Diseases, and Hepatitis

The Bureau of HIV (Human immunodeficiency virus), STD (sexually transmitted diseases), and Hepatitis is part of the Division of Behavioral Health and works to reduce the impact of communicable diseases in Iowa and to eliminate the morbidity associated with these diseases. Prevention and care services target chlamydia, syphilis, gonorrhea, HIV/AIDS, and hepatitis A, B, and C. Programs within the bureau guide community-based prevention planning, monitor current infectious disease trends, prevent transmission of infectious diseases, provide hepatitis A and B immunizations for adults, provide early detection and treatment for infected persons, and ensure access to health care persons in Iowa. Staff from the Sexually Transmitted Disease (STD), HIV/AIDS, and Adult Viral Hepatitis Prevention Programs partner with local public health departments, private health care agencies, disease prevention specialists, and community-based organizations to interrupt the disease transmission process and provide access to testing, treatment, immunizations, and prevention programs.

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, 2018, there were 2,872 Iowans who were diagnosed with HIV and living in Iowa. There were 116 Iowans newly diagnosed in 2018. 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. Males are disproportionately impacted by HIV in Iowa. There are about four males diagnosed for every female. For more information and reports: http://www.idph.iowa.gov/hivstdhep

Bureau of Substance Abuse

The Bureau of Substance Abuse is part of the Division of Behavioral Health, in the Iowa Department of Public Health. The Bureau focuses on and provides oversight for all aspects related to substance abuse prevention and treatment services in Iowa, in addition to injury prevention program.

The bureau actively works to address Prevention and Treatment needs by providing a focus for training efforts, identifying and securing available grant funding, monitoring grant compliance, and regulating licensure for treatment programs

Division of Behavioral Health SSA duties, including the SABG, are implemented through the Bureau of Substance Abuse. Additional grants, projects, and programs supported by the bureau include, but are not limited to:

- AmeriCorps Mentoring Program
- Capacity Coach and Capacity Coach Support Services
- Children's Mental Health Services
- Comprehensive Substance Abuse Primary Prevention (SAMHSA SABG)
- Community Coalitions
- County Substance Abuse Prevention
- Data systems -Prevention and Treatment
- Iowa Partnerships for Success (SAMHSA)
- Iowa Youth Survey
- Medication Assisted Treatment
- Opioid Treatment Programs
- Overdose Data to Action (CDC)
- Promoting the Integration of Primary and Behavioral Health Care
- Residential Treatment for Pregnant and Postpartum Women (SAMHSA - PPW)
- State Epidemiological Workgroup (SEW)
- State Funding-Support of Suicide
- Strategic Prevention Framework for Prescription Drugs (SAMHSA SPF-Rx)

- State Targeted Response to the Opioid Crisis Grant (STR)
- State Opioid Response Grant (SOR)
- State Youth Treatment Implementation Grant (SAMHSA - SYT-I)
- Substance Abuse Prevention Ethics Training
- Substance Abuse Prevention Skills Training
- Training and workforce development
- Treatment program licensure and regulation
- Youth Mentoring
- Youth Substance Abuse Prevention Services
- Women and Children's Programs (SAMHSA SABG)
- Yourlifeiowa.org (statewide resource and crisis response helpline)
- Zero Suicide Grant

Current data reflects:

- Iowa has experienced a 38% increase in methamphetamine treatment admissions over the past four years
- Adults aged 25-44 had the highest rates of methamphetamine-related treatment admissions
- Iowa youth report using methamphetamine at rates near zero (1 percent or less statewide for all grades on the last several Iowa Youth Surveys)
- Among all adult Iowans, 21.2% reported at least one binge drinking episode in the last 30 days
- Over 190,000 Iowans have a substance use disorder (National Survey on Drug Use and Health) and over 29,000 adult Iowans have a gambling disorder
- About 78,700 Iowans aged 12 or older (3%) report the use of illicit drugs in the past 30 days
- During fiscal year 2018, of those Iowans admitted for substance use disorder treatment, 38.4% identified alcohol, 28.6% identified methamphetamine, 24.1% identified marijuana, and 7.4% identified opioids as their primary substance use problem
- In Iowa, about 15,000 adolescents aged 12-17 (6.3%) per year in 2013-2014 reported using illicit drugs within the month of being surveyed
- In a sample of 12-25 year-olds admitted to treatment in Iowa, co-occurring substance use and mental health disorder rates are 50%
- Rural Iowans reported Methamphetamine as the primary drug of choice 34% in admissions compared to 29% in Urban Iowans
- Rural Iowans reported Opioids as the primary drug of choice in 4.6% of admissions compared to 9.1% for Urban Iowans
- Alcohol remains the number 1 drug of choice for adult males (42.5%) followed by methamphetamine (26.1%)
- The number one drug of choice for adult females admitted into treatment is methamphetamine (39.4%) and for adolescent females, marijuana (70.7%)
- In CY2018:
    - 44,500 Iowans were served by 102 licensed substance use disorder treatment providers
    - 44,600 substance use disorder assessments were completed

- 27,576 (18 and older) and 1,807 (age 12-17) admissions completed
- Location:
  - Rural 39.4%
  - Urban 58.4%
- Admitted patients by level of care:
  - Outpatient: 22,339 Iowans received individuals services
  - Intensive Outpatient: 6,306 Iowans received services
  - Residential: 5,598 Iowans received services
  - Gender:
    - 62.9% Male
    - 36.4% Female
    - .7% other

For more information regarding the Bureau of Substance Abuse visit: http://idph.iowa.gov/substance-abuse/programs

Office of Disability, Injury and Violence Prevention

Disability

Disability Status in Iowa presents information on the prevalence of Iowans with disabilities and comorbidity conditions. The American Community Survey (ACS), an ongoing survey of the U.S Census Bureau survey, defines disability as an affirmative response to one of six questions listed below:

- Is this person deaf or does he/she have serious difficulty hearing?
- Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?
- Because of a physical, mental or emotional condition, does this person have serious difficulty concentrating, remembering or making decisions?
- Does this person have serious difficulty walking or climbing stairs?
- Does this person have difficulty dressing or bathing?
- Because of a physical, mental or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

Disability affects all Iowans regardless of race/ethnicity and socio-economic status. Many Iowa residents with disabilities have lower educational attainment, higher rates of unemployment and lower earnings from work than their counterparts without disabilities. Iowans with disabilities are more likely to experience problems with weight, limited physical activity, comorbidity conditions such as arthritis, diabetes, coronary heart disease and stroke, and fair or poor health.

From 2008-2014, Iowans aged 75 and older had the highest rate (46 percent) of disability. People aged 21-64 had the lowest rates of disabilities compared to people under the age of 20, 65-74, and 75 and older. Among Iowans with disabilities, 61 percent of females and 53 percent of males had one single disability. For people with two disability types, the rates were similar for both

males (22 percent) and females (21 percent). Males were more likely to have a disability at a younger age compared to their female counterparts. Native Americans or Alaska Natives had the highest rate of disability followed by blacks, with whites, Hispanics and Asians at lower rates. Iowans with disabilities were more likely to be separated, divorced or widowed. In addition, they were less likely to have graduate school education than Iowans without disability. Iowa veterans were more likely to report a disability compared to their non-veteran counterparts.

The Iowa Department of Public Health (IDPH) was awarded a five-year, $300,000 annually, grant from the Centers for Disease Control and Prevention (CDC). Iowa was one of 19 states to be awarded funding through the "Improving the Health of People with Mobility Limitations and Intellectual Disabilities through State-based Public Health Programs" grant.
The purpose of the grant is to promote and maximize health, prevent chronic disease, and increase the quality of life among Iowans with disabilities. Grant funding from the CDC will support the following activities, with an emphasis on improving the health of Iowans with disabilities through increased physical activity, better nutrition and healthy weight:

- Improve Iowa public health system capacity
- Build healthy, inclusive Iowa communities
- Develop Iowa disability service organization capacity
- Increase Iowa healthcare provider knowledge and accessibility

For more information and reports:
http://idph.iowa.gov/disability-injury-violence-prevention/disability-health

Injury
Injuries are a major public health concern that affects the lives of all Iowans, regardless of age, race, gender, or size of county. Unintentional injuries are the leading cause of death for Iowans between the ages of 1 and 34, while suicides and/or homicides also rank among the top 5 leading causes of death for Iowans between the ages of 1 and 54. Unintentional injury is the 5th leading cause of death for all Iowans, with over 1,500 injury deaths occurring on average each year (from 2002- 2006) in Iowa. Injuries also lead to more than 17,000 hospitalizations in Iowa each year and more than 250,000 emergency department (ED) visits. Suicides are the third leading cause of injury death after motor vehicle traffic and falls in Iowa; the rate of suicide (11.1/100,000) in Iowa is higher than the national average of 10.9/100,000. Homicide rates in Iowa (1.9/100,000) are lower than the national average (5.9/100,000), but are still the second leading cause of injury death for children under age 5 and in the top four causes of injury death in teens and young adults aged 15-44. Injury death rates increase with age, with rates by far the highest in seniors (85+). For every female who dies due to injuries in Iowa, two males will die due to injuries, regardless of age group. Overall injury charges from hospitals, for inpatient and outpatient services, amounted to a 5-year average of $300 million per year, which still underestimates the real cost of injury to the State of Iowa. Further, untold numbers of Iowans do not seek medical care for many of the injuries they may incur. Because injuries are preventable, they lead to unnecessary medical costs, economic losses, reduced productivity, and immense physical and emotional strain.

IDPH strives to address the burden of injury on the public health by disseminating information about injury deaths and hospitalizations and promoting programs directed at preventing both intentional and unintentional injuries. In 2008, IDPH and the University of Iowa Injury Prevention Research Center partnered to produce the first comprehensive report on injury in Iowa. This report, The Burden of Injury in Iowa (2002-2006), is intended to provide information on the burden of injury in Iowa to assist communities, health practitioners, and state and local policymakers in developing strategies and policies to reduce injuries in the state.

For more information and reports:
http://idph.iowa.gov/disability-injury-violence-prevention/injury-prevention

Violence Prevention

The IDPH Violence Prevention services include the Iowa Violent Death Reporting System (IAVDRS), Sexual Violence Prevention services, Violence Against Women and Suicide Prevention.

The Iowa Domestic Abuse Death Review Team was established in 2000 to identify the causes and manner of deaths resulting from domestic abuse in Iowa. It is established by statute in the *Code of Iowa*, Chapter 135.108-135.112. Team members are appointed by the Director of the Department of Public Health for a term of three years, and they meet up to six times per year to review cases of homicide and suicide resulting from domestic violence. In a biannual report, case data is presented to identify contributing factors to the deaths and form the basis for recommendations for the prevention of future domestic abuse-related deaths. For reports and information: http://idph.iowa.gov/disability-injury-violence-prevention/domestic-abuse-review

The sexual violence prevention program of the Iowa Department of Public Health uses public health strategies to prevent sexual violence in Iowa. Sexual violence refers to sexual behavior that occurs between people where consent is not obtained or freely given. Not all sexual violence includes physical contact between the individuals; it also may occur in the form of sexual harassment, threats, taking nude photos or sending them via email or text messages. Unwanted sexual touch may range from groping or fondling to rape.

The program collaborates with community prevention partners to:

- gather data on the incidence of sexual violence in Iowa,
- develop strategies for preventing first-time victimization and perpetration of sexual violence,
- administer federal and state sexual violence prevention funds, and
- support the work of state and local agencies and organizations in their efforts to end sexual violence.

The program is funded by the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention. The Iowa Department of Public Health contracts with the Iowa Coalition Against Sexual Assault to conduct community prevention and education

activities.

Sexual violence is a serious and costly public health problem in Iowa. In addition to its emotional toll, sexual violence causes substantial financial damage to the victims, their families, and society as whole. Injuries from sexual violence result in large expenditures by our systems of health care, law enforcement, criminal justice, and welfare. More important, acts of sexual violence lead to even greater costs that arise from lost productivity and the inability of victims and families to continue with activities of daily life. In 2009, an estimated 55,340 individuals experienced sexual violence in Iowa. Of these, nearly three of every four were female and one in ten was under age 18. At least 595 victims were raped or sexually assaulted while incarcerated. There were nearly 39,000 rape incidents in 2009, with some victims subject to multiple rapes.

For more reports and information:
http://idph.iowa.gov/Portals/1/Files/InjuryViolence/sv_cost_brief.pdf

Traumatic Brain Injury Program

The Brain Injury Services Program works to improve the lives of Iowans living with brain injuries by linking those individuals and their families to needed information, services, and supports as well as training service providers and other professionals on how to best work with people who have sustained a brain injury. The Advisory Council on Brain Injuries are members appointed annually by the Governor of Iowa. Appointed members are typically appointed to serve two-year terms, beginning in July. The council is made up of members who are survivors of brain injury, family members of individuals who have experienced a brain injury, and/or professionals working in a field related to brain injury services. In addition to appointed members, representation from various state agencies also comprise the council as non-voting members. The Advisory Council on Brain Injuries routinely produces a state plan which serves as guidance for brain injury services and prevention for Iowa and can be found at
http://idph.iowa.gov/Portals/1/userfiles/32/2018-2021%20state%20plan%20for%20brain%20injury.pdf

To better understand how brain injury impacts Iowans, the Brain Injury Services Program routinely conducts surveillance activities. Findings are published in fact sheets, surveillance reports, and/or data briefs. An estimated 17,000 TBIs occur in Iowa annually. Of those TBIs occurring each year, about 88 percent were emergency department visits, 9 percent were hospitalizations, and 3 percent were deaths. These numbers could have been a lot higher if the data for individuals receiving “other medical care or no care sought” were included (approximately 25 percent of all mild and moderate cases of TBI).

For more reports and information: http://idph.iowa.gov/brain-injuries/surveillance-and-reporting

Violence Against Women

Sexual violence is a serious and costly public health problem in Iowa. One in thirty-five Iowa women aged 18-44 will experience sexual violence. In addition to its emotional toll, sexual violence causes substantial financial damage to the victims, their families, and society as whole.

Injuries from sexual violence result in large expenditures by our systems of health care, law enforcement, criminal justice, and welfare. More important, acts of sexual violence lead to even greater costs that arise from lost productivity and the inability of victims and families to continue with activities of daily life.

The Public Health Approaches to Violence Against Women Program offers resources for health care providers to improve their responses to victims of intimate partner violence (IPV) and sexual assault. The program, under the direction of the violence prevention coordinator, collaborates to:

- assist with activities during Sexual Assault Awareness Month which is held during every April, and Domestic Violence Awareness Month held in October;
- arrange training and technical assistance to health care providers seeking to improve their facility's response to intimate partner violence and sexual assault.
- develop protocols, identify resources, and develop training materials for health care providers across the state;

While IPV is difficult to accurately measure, national surveys indicate that one in three women have experienced some form of intimate partner violence by a current or former partner at some point in their lives. While relatively few women report the abuse to law enforcement authorities, many are seen by health care providers, who have the opportunity to identify the abuse, provide education, and intervene before the abuse becomes fatal.

In Iowa all hospitals are required to have a protocol in place for identifying and intervening with patients who experience domestic violence (Iowa Administrative Code [481] 51.7(3).

To view the most recent National Intimate Partner and Sexual Violence Survey State Report:
https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf

For more reports and information:
http://idph.iowa.gov/disability-injury-violence-prevention/violence-against-women

Suicide Prevention

Suicide was the ninth leading cause of death in 2018 for all Iowans; second leading cause of death for ages 15-34, fourth leading cause for ages 35-54, eight leading cause for ages 55-64 and tenth leading cause of death for ages 65 & older. IDPH's suicide prevention program works with communities and related partners to provide information about signs and symptoms of depression and suicide, and develop suicide prevention strategies. On average, one person dies by suicide every 19 hours in the state. Preliminary data from 2018 indicates there were 482 deaths by suicide in Iowa.

The Iowa Department of Public Health’s suicide prevention program works with communities and related partners to provide information about signs and symptoms of depression and suicide, and develop suicide prevention strategies. IDPH leads the Iowa Suicide Prevention Planning Group and generates the state suicide prevention plan on a regular basis. The Planning Group is

comprised of state and local leaders active in suicide prevention, and welcomes members with lived experience.

Through the Integrated Provider Network (IPN) the Department's substance use disorder, prevention and problem gambling contractors, IPN contractors complete suicide screening for all participants who complete a substance use evaluation at intake. During the most recent Amerigroup retrospective review process, which focused on the review period from July 2018-December 2019, contractors were reviewed for use of screening tools; as well as technical assistance was provided. During this review the following key highlights were noted:

- The majority of contractors utilize the PHQ-9, others utilize screenings such as SAD Persons scale, suicide risk assessment, Columbia Suicide Severity Tool etc. This is standard protocol for all contractors and was found to be completed on all participant charts that were reviewed.
- Contractors continue to place significant focus on the increase of mental health staff on site as well as securing linkages to mental health providers in the community. IPN contractors continue to place emphasis on using the PHQ-9 or other screening tools to evaluate risk and need for additional mental health support as the participant progresses through their treatment episode
- Numerous contractors have noted completing the PHQ-9 at intake, mid-way through treatment and at discharge to ensure that suicidality and mental health risks are continually addressed
- Contractors are working to not only train staff, but have consultation staff available at all times either internally or with a contracted provider, to ensure that the individuals needs are addressed
- Contractors are increasingly completing detailed safety planning for participants who had a positive suicide screening and identified some level of risk for self-harm (current or past). As with many mental health providers, IPN contractors continue to place focus on being trauma informed, which includes clinical, office and leadership staff.

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

The IDPH Your Life Iowa program provides telephone hotline services, texting, and chatting support 24/7, 365 days per year for the state. The website http://yourlifeiowa.org/suicide also provides a live chat feature, depression screening quiz, suicide warning signs, help for family and friends, FAQ's about suicide, and how to practice self-care. The program is funded through State General Fund appropriations and federal funding; funded by IDPH under the Division of Behavioral Health.

For additional information, reports and the most recent Iowa Suicide Prevention Plan:
http://idph.iowa.gov/substance-abuse/suicide-prevention

Office of Gambling Treatment and Prevention

Within the IDPH Bureau of Substance Abuse, problem gambling prevention and treatment services are guided by a public health approach that considers biological, behavioral, economic and cultural determinants that influence gambling and health. This approach incorporates a balance of outreach, education, prevention, treatment, and recovery support efforts that together minimize gambling's potential negative impacts on individuals, families and communities, while recognizing gambling's availability, cultural acceptance and economic appeal.

Iowans seeking to gamble can choose from 19 casinos licensed by the Iowa Racing and Gaming Commission (IRGC): four tribal casinos; 2,400 lottery outlets; over 2,800 licensed social and charitable gambling options, amusement concession and bingo games; and approximately 5,500 registered amusement devices. As of August 15, 2019, a new law was passed and Iowans can now place wagers on approved sporting activities (Advanced Deposit Sports Wagering), including fantasy sports contents. Additionally, Iowans have access to a broad range of social media and smartphone gambling-like games and applications, as well as an expanding number of internet-based and other (often illegal) gaming. Gambling Treatment and Prevention services are provided by 19 contractors who provide services in all 99 counties.

1-800-BETS OFF and www.1800BETSOFF.org have been the point of entry for problem gambling information and services in Iowa. Almost 90% of adult Iowans are familiar with 1-800-BETS OFF and the services offered. Annually over 5,000 gambling related contacts (phone/chat) are answered and information, resources, and where applicable, referral to problem gambling treatment are provided. In October 2017, 1-800-BETS OFF and www.1800BETSOFF.org were integrated into the new Your Life Iowa integrated system for information and referral for problems related to gambling, alcohol, drugs, and suicide concerns.

In SFY 2016, IDPH funded the Gambling Attitudes and Behaviors: A 2015 Survey of Adult Iowans by the University of Northern Iowa Center for Social and Behavioral Research (UNI-CSBR). The survey was completed by a random sample of 1,825 adult Iowans, weighted to reflect the Iowa adult population. The survey provided the following information:

- Gambling rates among adult Iowans: 87.6% lifetime (ever), 68.1% during the past 12 months, and 39.1% during the past 30 days. It is estimated that almost 1.6 million adult Iowans gambled during the past 12 months
- Problem gambling prevalence among adult Iowans: 12% of adult Iowans reported experiencing at least one symptom associated with problem gambling during the past 12 months. More than 1 in 5 (22.6%) Iowans reported that they know a person with financial, physical, or emotional problems caused by gambling

Prevention strategies provide targeted information, education, and strategies on the risks and responsibilities of gambling and assistance for individuals at increased risk of problem gambling. Problem gambling prevention services are built on the SAMHSA CSAP six prevention strategies. In addition to information on the risks of gambling, responsible gambling education for adults is a

core component of the education services provided. In State Fiscal Year 2017, over 7,500 hours of prevention and education services were provided reaching over 67,000 Iowans.

Admission profiles of Gamblers admitted to Treatment in SFY2018 include:

- High school education or beyond 88.9%
- Caucasian 84.7%
- Ages 30-59 average age
- Report of tobacco use 54.6%
- Male-51.4%/Female 48.6%
- Alcohol use 36.1%
- Reported debt as a result of gambling at greater than $5,000
- Reported credit card debt greater than $5,000
- Reported bankruptcy or other defaults 13.9%
- Reported ever treated for a drinking/drug problem 54.2%
- Reported one or more gambling-related arrests 18.1%
- Over 2,200 Iowans have received treatment for problem gambling since July 1, 2011

The IDPH contracts with the University of Northern Iowa to monitor and analyze problem gambling treatment outcomes. Highlights include:

- Patients who received four or more services within 30 days from admission were associated with greater length of service and completion of treatment plans.
- Patients who participated in recovery support services and electronic therapy were associated with greater length of service and completed treatment plans.
- Patients who received four or more services were 75% less likely than those who received three or fewer services to meet criteria for Disordered Gambling six months after discharge.
- At discharge, patients reported significant improvement in several indicators compared to admission.
- 24 percent reported "dissatisfied with life" compared to 66% at admission.
- 25 percent reported being "late paying bills" compared to 50% at admission.
- Primary wagering prior to admission- 50.5% slots; followed by 19.4% use of lottery/scratch tickets, table games-18.1%, followed by sports, internet, video and other.

During the 2019 legislative session, many bills were introduced to legalize advanced deposit sports wagering and fantasy sports contests in Iowa. In the end, SF617 was passed by the legislature and signed into law by the Governor. . Additionally, SF632 was also passed and signed by the Governor, appropriating $300,000 to the Iowa Gambling Treatment Program within IDPH to enhance prevention and treatment efforts related to sports wagering.
For information and reports:
http://www.idph.iowa.gov/igtp/reports

Office of Medical Cannabidiol

The vision of the Office of Medical Cannabidiol (OMC) at the Iowa Department of Public Health is to have a high-quality, effective, and compliant medical cannabidiol program for Iowa

residents with serious medical conditions. The OMC works to balance a patient's need for access to treatment of their debilitating medical condition, with the requirement to ensure the safety and efficacy of the products.

Effective May 12, 2017, House File 524 established Iowa Code chapter 124E, the Medical Cannabidiol Act, expanding the use of medical cannabidiol to treat certain debilitating medical conditions. To qualify as a patient for Iowa's medical cannabidiol program, a patient must be able to prove permanent Iowa residency and provide physician certification of one of the following qualifying medical conditions:

- Cancer – if the illness or its treatment produces one or more of the following: severe or chronic pain, nausea or severe vomiting, cachexia or severe wasting
- Seizures
- Crohn's disease
- Untreatable pain - any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects
- Multiple Sclerosis with severe and persistent muscle spasms
- AIDS or HIV (as defined in Iowa Code, section 141A.1)
- Amyotrophic lateral sclerosis (ALS)
- Parkinson's disease
- Any terminal illness with a probable life expectancy of under one year – if the illness or its treatment produces one or more of the following: severe or chronic pain, nausea or severe vomiting, cachexia or severe wasting
- Ulcerative colitis
- Severe, pediatric autism with aggressive or self-injurious behaviors

The 2017 law allows use of medical cannabidiol delivered in a form recommended by the Medical Cannabidiol Board, approved by the Iowa Board of Medicine, and adopted by IDPH pursuant to rules. The 2017 Medical Cannabidiol Act also established a Medical Cannabidiol Board.

The Medical Cannabidiol Board convenes at least twice a year but no more than four times a year, to: Accept and review petitions to add medical conditions, medical treatments, or debilitating diseases to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial; make recommendations to remove or add debilitating medical conditions to the list of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial; work with IDPH regarding the requirements for licensure of medical cannabidiol manufacturers and dispensaries, including licensing procedures; advise IDPH regarding the location of medical cannabidiol manufacturers and dispensaries throughout the state; and make recommendations related to the form and quantity of allowable medical uses of cannabidiol.

For more information about Iowa's Medical Cannabidiol Program please go to:

https://www.idph.iowa.gov/omc

Notable Achievements and Strengths:

Integrated Provider Network (IPN)

- The Iowa Department of Public Health is the federally designated single state authority (SSA) on substance abuse, and is responsible for the development, implementation, and administration of the state's comprehensive substance abuse prevention and treatment service delivery system. Since 1995, administrative services related to IDPH-funded substance use disorder treatment had been part of Iowa's Medicaid managed care contracts either through Magellan of Iowa or Amerigroup, Inc. Provider contracts included contractual requirements for all IDPH funded services through state and federal appropriations including payment and SABG compliance requirements.
- In 2018, a competitive, 6-year, release for proposal process (RFP) was initiated to select a new provider network and provider facilities were selected. Beginning on January 1, 2019, the "IDPH-funded Provider Network" is now referred to as the Integrated Provider Network or IPN contractors. 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). Of the approximately 100 licensed substance abuse licensed facilities in Iowa, 20 contractors were competitively selected to provide prevention, treatment and problem gambling services to Iowans on a statewide basis. What once was three distinct RFP processes (Gambling Prevention and Treatment, Substance Abuse Prevention and Substance Abuse Treatment) is now one fully integrated system of care. This new integrated network is required to provide education, prevention, early intervention, treatment and recovery support services spread across 19 geographical regions. The Integrated Provider Network (IPN), supports substance use disorder assessment and treatment services for Iowans without insurance, Medicaid, or other payment resources.
- Beginning in January of 2019, the Bureau of Substance Abuse, assumed management of all aspects of the IPN and no longer contracts with a managed care organization. The IPN contractors must not only support an integrated provider network but are also responsible to:

    - Educate the public
    - Assess local needs
    - Understand state and national policy
    - Inform and collaborate with each other and with stakeholders
    - Reduce stigma
    - Prevent substance use and gambling problems
    - Intervene with at-risk or in-need persons and populations
    - Provide effective treatment, and

- Support early remission and long term recovery

- The Department established a 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.
- Goals were developed for the IPN to:
  - Establish and maintain a comprehensive and effective system of care for substance use and gambling problems through a statewide integrated network of services and providers.
  - Reduce substance use and gambling problems in Iowa through public education, evidence-based prevention, and early intervention services
  - Increase remission and recovery from substance use disorder and problem gambling through timely, accessible, ongoing, and effective treatment services
- IPN contractors conduct, support and participate in continuous quality improvement (CQI) activities that improve IPN services by identifying, implementing, and monitoring critical performance measures on an ongoing basis, based on valid and reliable data, and stakeholder input. IDPH is organizing IPN activities around NIATx concepts and other activities ,which are currently being implemented with contractors, include:
  - Access and Wait Time performance measures
  - Critical incident reports (See Appendix J.)
  - Data integrity reports
  - Engagement and retention performance measures
  - External review and evaluation
  - Outcome performance measures
  - Process "walk-throughs" and improvement projects
  - Retrospective review of service provision and contract compliance
  - Frequently asked question and answer documents
  - IPN mailbox dedicated site for submission of exception requests, questions, replies to questions, concerns, challenges, stakeholder feedback
  - Bi-Annual IPN director and key staff face to face day meetings focused on IPN and SABG priorities/requirements/other
  - Monthly IPN Director meetings with SSA and SSA staff

- The IDPH recently, through SABG Technical assistance funding, provided, and required all Prevention and Treatment IPN contractors to attend NIATx Change Leader Academy trainings and a coaching series focused on quality improvement and sustainability. Dates of coaching calls were July 10 & 24 and August 7th & 21st, 2019. Dates of the full day Change Leader Academy occurred June 26th & 27th, 2019.
- NIATx, founded in 2003 at the University of Wisconsin-Madison Center for Health Enhancement Systems Studies, is a CQI process designed for behavioral health settings. NIATx focuses on a learning collaborative model which incorporates a plan, do, study, act cycle (PDSA). The process focuses on making small changes within one of 4 AIMS (reduce no-shows, reduce wait times, increase continuation, increase admissions). IDPH worked with the NIATx contractor to tailor the principles to the prevention field. All IPN

contractors are required to complete a walk-through of a system/practice they want to focus on, pick an AIM, complete a PDSA cycle, select a change leader, complete a nominal group technique, and implement the project. IPN contractors have reviewed their projects through the on-going webinar series through the University of Wisconsin contractor and IDPH and are required to write up and submit their summaries to IDPH by September 13, 209. Ongoing work is expected through NIATx.

- In addition to NIATx as one means of CQI, in 2019, Amerigroup was contracted with IDPH to complete retrospective reviews, at 20 IDPH-funded substance use disorder treatment contractors. One facility had closed prior to the review process and two facilities did not respond to a request for retrospective review. The review period for contracts were July 2018-December 2018. A total of 158 IDPH funded participant files were reviewed. Of the 168 files reviewed; 81 files consisted of the Extended Outpatient Level of Care, 40 were Intensive Outpatient Level of Care, and 37 files were from Residential Level of Care. IDPH funded participant files were reviewed. All treatment covered services levels of care and performance measure covered services were reviewed. Amerigroup noted significant trends with providers, both successes and challenges. Some key highlights include:
    - Many facilities added Medication Assisted Treatment services to their service array
    - The application of ASAM criteria was applied correctly to all participants and levels of care recommendations
    - Interim Services provided, referrals made and contractors assisted with many referrals to ensure comprehensive care
    - Contractors understand priority placement confirmed with IV drug users and pregnant women
    - Contractors have added a care coordinator to their staff to assist solely with referring to residential programs across the state
    - Contractors have increased their use of dually-licensed clinical staff
    - Workforce development continues to be a challenge in the ability to recruit, hire and retain quality treatment staff. There continues to be a shortage of qualified staff across the state
    - Rural contractors have difficulty in providing services in satellite locations
    - Women and Children programs have expanded in the availability of services that are offered. Some contractors have increased residential beds for women and some have increased wellness activities
- The Department set funding allocation determined by state and service area population, historical and projected service utilization data for SFY2017 and 2018, historical funding information for SFY 2017 and 2018, projected funding information for SFY 2019 and 2020, SABG requirements and guidance and department requirements, goals and priorities. To view the RFP: http://idph.iowa.gov/Portals/1/userfiles/152/IPN%20RFP.pdf
- IDPH SSA staff monitor contractor performance against contract requirements through data and claims reporting and through narrative reports submitted. Reports also include monitoring of capacity and interim service provision for priority populations – Women and Children patients and persons who inject drugs.
- IDPH received technical assistance funding in October 2018 from SAMHSA. The funding

supported both treatment and prevention workforce trainings and efforts focused on the following:

- Prevention- Training to IPN network on: Life Skills, curriculum based support group, SPF/Environmental Strategies webinar series.
- Treatment- Contract for annual training to IPN on Confidentiality and 42CFR and Quality Improvement training and webinars which focused on NIATx principles

- The IPN contractors are required to provide Network Support, Prevention Services and Outpatient Treatment. Through the competitive RFP process, contractors could apply to provide optional services related to: Adult Residential Treatment, Juvenile Residential Treatment, Women and Children Treatment and Methadone Treatment.
  - ***Network Support***- Contractors participate in and conduct activities that support community collaboration and outreach, health promotion education, quality improvement, and workforce development. Under Network Support Covered Services; contractors must:
    - Collaboration and Community Outreach: Contractors conduct, support, and participate in collaboration and community outreach activities that establish the contractor as a primary resource for substance use and problem gambling issues in the Service Area and statewide. Contractors coordinate planning and service delivery in collaboration with IDPH, other contractors, subcontractors, and stakeholders, based on and aligned with community, service area, and state needs and strengths.
    - Needs Assessment: Contractors conduct, support, and participate in local and state needs assessment processes that support understanding of substance use and problem gambling needs, trends, and service gaps. Needs Assessment processes may include, but are not limited to:
      - Community Assessment Workbooks
      - Each county's Community Health Needs Assessment and Health Improvement Plan (CHNA HIP)
      - IDPH's Iowa Youth Survey
    - Health Promotion: Contractors conduct, support, and participate in health promotion activities that inform and educate Iowans on substance use and gambling problems. Health promotion also supports access to prevention, early intervention, treatment, and recovery support resources and services. Health Promotion activities may include, but are not limited to:
      - Contractor websites and social media presence
      - IDPH's YourLifeIowa and 1-800-BETS OFF helpline and website
      - IDPH's "A Matter of Substance" newsletter and other publications
      - IDPH's substance abuse prevention and treatment focused media campaigns
      - The IDPH website and social media platforms
      - Contractor and IDPH efforts directed to specific topics and issues
    - Data and Continuous Quality Improvement: Contractors conduct, support, and participate in continuous quality improvement (CQI) activities that improve Integrated Provider Network services by identifying,

implementing, and monitoring critical performance measures on an ongoing basis, based on valid and reliable data and stakeholder input.

IDPH organizes Integrated Provider Network CQI activities around NIATx concepts. CQI activities may include, but are not limited to:

- Access and wait time performance measures
- Critical incident reports
- Data integrity reports
- Engagement and retention performance measures
- External review and evaluation
- Outcome performance measures
- Process "walk-throughs" and improvement projects
- Retrospective review of service provision and contract compliance
- Satisfaction surveys
- Simulated phone calls or other requests for information or services

■ Workforce Development: Contractors conduct, support, and participate in workforce development activities that recruit, retain, and develop highly qualified staff to provide Integrated Provider Network services.

Workforce Development activities may include, but are not limited to, strategies to:

- Support recruitment and retention of qualified staff
- Enhance staff competency and performance
- Expand the roles of persons in recovery and family members/friends in planning and delivering services

■ Meetings, Trainings and Technical Assistance: Contractors conduct, support, and participate in meetings, trainings, and technical assistance activities that enhance, expand, and improve Integrated Provider Network services. Meetings, trainings, and technical assistance may be face-to-face or may be conducted through electronic means, as determined by IDPH.

Meetings, trainings and technical assistance may include, but are not limited to:

- CQI meetings (quarterly, face-to-face during the initial contract term)
- Governor's Conference on Substance Abuse (annual, face-to-face)
- Integrated Provider Network Roundtables (bi-annually, face-to-face during the initial contract term)
- Integrated Provider Network – Substance Use and Problem Gambling Services meetings and trainings
- Prevention Conference (as scheduled, face-to-face)
- Reporting requirements and processes (as scheduled)
- Technical assistance (as scheduled)
- Topic-specific trainings (as scheduled)
- Women and Children Roundtables (twice a year, face-to-face)

■ Other Core Services include:

- Care Coordination

- Care Coordination encompasses the broad range of patient-specific people, systems, and issues related to the patient's current situation and future recovery. These may include, but are not limited to, family members, referral sources, employers, schools, medical and mental health professionals, the child welfare system, the courts and criminal/juvenile justice systems, housing status, legal needs, and recovery support. Care Coordination includes use of electronic information and telecommunication technologies to support patients through check-in calls and texts.
- Crisis Counseling is a response to a crisis or emergency situation experienced by an individual, family member and/or significant others related to substance use disorders, such as:
  - Crisis Counseling services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The interventions shall be designed to de-escalate situations in which a risk to self, others, or property exists.
  - Crisis Counseling services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.
  - Crisis Counseling services with family members or friends using general counseling methods.
  - Crisis Counseling services can occur in person or over the phone.

- Early Intervention (based on ASAM Level 0.5)
  - Early Intervention may be provided to persons who have received an Initial Assessment but do not meet criteria for a substance use disorder. Individuals that previously received an Initial Assessment and do meet criteria for a substance use disorder may not be provided Early Intervention.
  - Early Intervention could be considered as an equivalent to SBIRT Brief Treatment, which is a more intensive intervention than a SBIRT Brief Intervention.
- Interim Services for Priority Populations funding
  - Interim Services are those minimum services which must be offered when priority populations cannot be admitted within required timeframes and would benefit from IPN funded services.

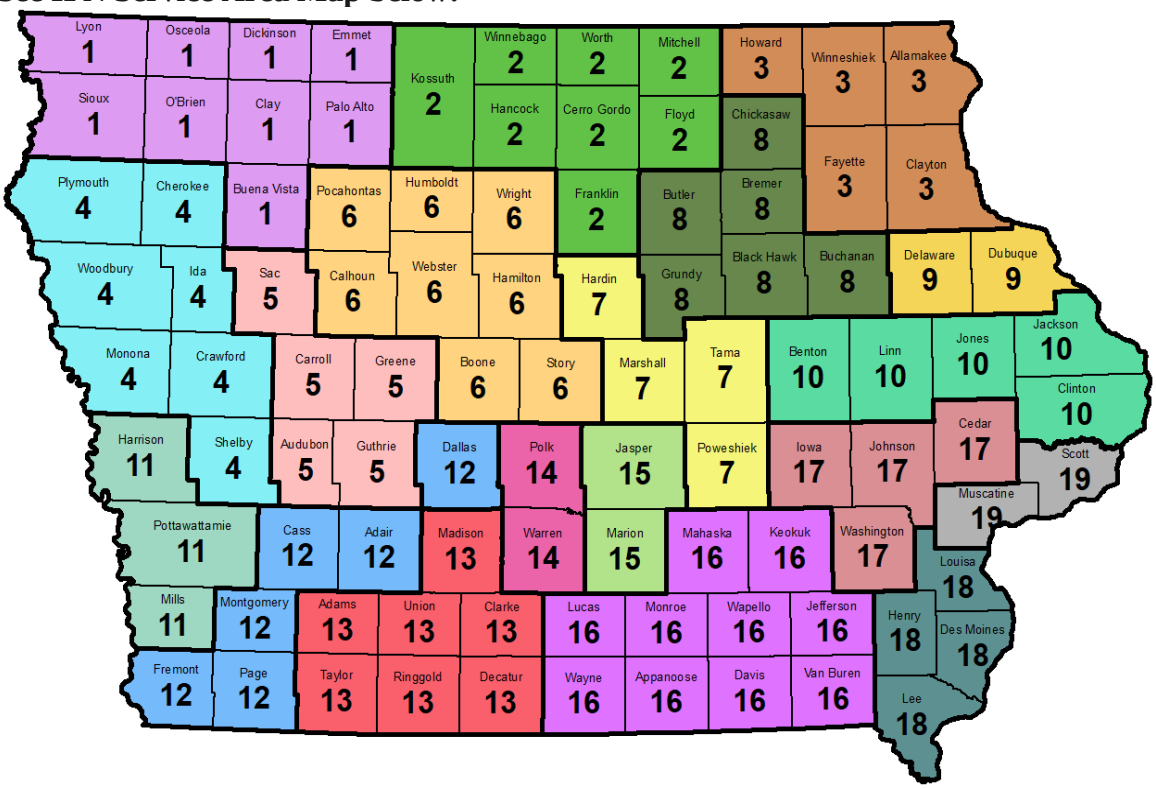
        - The purposes of these services are to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease.
    - Medication Assisted Treatment Medical Evaluation, Medical Care
        - Medical Evaluation means an assessment conducted by a physician or other licensed prescriber to determine the need for medication-assisted treatment and/or tobacco cessation services.
        - Medical Care means ongoing medical evaluation services provided by a licensed medical prescriber to assess appropriateness for continued medication-assisted treatment and/or tobacco cessation services.
        - Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of Alcohol Use Disorders, Opioid Use Disorders, and/or tobacco use
    - Medication Assisted Treatment Drug Testing
        - Drug Testing means routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen)
    - Screening, Brief Intervention and Referral to Treatment (SBIRT)
        - is an integrated, evidence-based approach that offers providers the tools to effectively and efficiently screen individuals for risky substance use and problem gambling
        - SBIRT services are to be provided by substance use and problem gambling treatment providers in a variety of locations outside of a treatment center. Examples include primary care settings, schools, and casinos
    - Transportation
        - Transportation means assistance in the form of gas cards or bus passes, given directly to the patient for the purpose of transportation to and from an activity related to the patient's treatment plan or recovery plan.
    - Other Covered Services for Persons who are not Patients
        - Family Education Services: Education on various topics related to substance use and problem gambling disorders, treatment and recovery, for family members and concerned persons of individuals in treatment.
- ***Prevention-*** Contractors must include the Institute of Medicine Prevention Classifications, the Strategic Prevention Framework, and the SAMHSA Prevention Services Categories within their awarded Service Area. IPN Prevention Contractors must plan and provide prevention services in coordination with stakeholders. Agencies must provide services that address the lifespan, with evidence-based

programs appropriate to different persons and populations. Prevention Priority Areas Alcohol, Tobacco, Marijuana, Prescription Medication Problem Gambling, and optional prevention services (Opioids, Methamphetamine or Suicide).

- ***Outpatient Treatment-*** General outpatient problem gambling and substance use disorder treatment for patients and for their families and Early Intervention services to persons and populations at high risk Iowa residents, at or below 200% of the Federal Poverty Level, who are not enrolled in Medicaid, are un- or under-insured, and have no other resources to pay for needed treatment. Certain treatment services during the gap period between enrollment in Medicaid and assignment to an MCO, and for residential treatment services that are not covered under the Iowa Health and Wellness Plan. Patients pay a copay for their treatment services based on a sliding fee scale. In addition to treating substance use disorders and problem gambling, contractors must also provide or assure provision of services to meet their patients' co-occurring medical and mental health needs. Contractors are required to use ASAM Criteria for clinical assessment and placement. For further discussion of treatment related to residential treatment, see discussion under priority populations "*Persons in need of substance abuse treatment*".

- For specific definitions and responsibilities of required service delivery requirements for each service, see:
  http://idph.iowa.gov/Portals/1/userfiles/152/IPN%20RFP.pdf
- The Bureau of Substance Abuse has developed multiple resource guides, set up an IPN Provider Mailbox, developed contractor manuals, attestation documents, and have, and continue to hold, extensive trainings and meetings to educate the IPN on contractual requirements including:
  - Claims processes and reporting procedures
  - ISMART Data user manuals (prevention and treatment)
  - Critical Incident Forms and processes
  - Exception Request Processes
  - IPN Provider Manual
  - IPN Prevention Services Orientation Guide
  - IPN Maps
  - IPN Strategic Prevention Framework Overview
  - Prevention Survey Overview
  - Prevention 101
  - Recovery Peer Coaching guidance
  - IPN meetings (topics related to SABG requirements, claims, reporting, data and quality improvement activities, problem gambling, prevention requirements, data reporting and collection, contractual responsibilities). For meetings and trainings see:http://idph.iowa.gov/substance-abuse/Integrated-Provider-Network/Meetings
  - Developed IPN documents and forms. See:
    http://idph.iowa.gov/substance-abuse/Integrated-Provider-Network/Documents

See IPN Service Area Map below:



Service Area	Contractor	Service Area	Contractor
1	Jackson Recovery Centers, Inc., Spencer Phone: 800-472-9018	13	Crossroads Behavioral Health Services, Creston (4) Phone: 641-782-8457
2	Prairie Ridge Integrated Behavioral Healthcare, Mason City (1) Phone: 866-429-2391	14	Broadlawns Medical Center, Des Moines Phone: 515-282-6610
3	Northeast Iowa Behavioral Health, Decorah (4) Phone: 800-400-8923		House of Mercy, Des Moines (1,3) Phone: 515-643-6500
4	Jackson Recovery Centers, Inc., Sioux City (1, 2, 3) Phone: 800-472-9018		Prelude Behavioral Services, Des Moines (1) Phone: 515-262-0349
5	Community Opportunities DBA New Opportunities, Carroll Phone: 712-792-9266		UCS Healthcare, Des Moines (4) Phone: 515-280-3860
6	Community and Family Resources (CFR), Fort Dodge (1, 2, 4) Phone: 866-801-0085	15	House of Mercy, Newton Phone: 641-792-0717
7	Substance Abuse Treatment Unit of Central Iowa, Marshalltown Phone: 641-752-5421		UCS Healthcare, Knoxville Phone: 515-280 -3860
8	Pathways Behavioral Services, Inc., Waterloo (1, 4) Phone: 319-235-6571	16	Southern Iowa Economic Development Association (SIEDA), Ottumwa (4) Phone: 800-622-8340
9	Substance Abuse Services Center (SASC), Dubuque Phone: 563-582-3784	17	Prelude Behavioral Services, Iowa City (1) Phone: 319-351-4357
10	Area Substance Abuse Council,Inc. (ASAC), Cedar Rapids (1, 2, 3, 4) Phone: 319-390-4611	18	Alcohol & Drug Dependency Services (ADDS), Burlington (1, 4) Phone: 319-753-6567
11	Heartland Family Service, Council Bluffs (1, 3) Phone: 712-322-1407	19	Center for Alcohol & Drug Services, Inc. (CADS), Davenport (1) Phone: 563-322-2667
12	Zion Recovery Services, Inc., Atlantic (1), Phone: 712-243-5091		Robert Young Center, Muscatine, Phone: 563-264-9409 (4)
Additional Specialized Treatment Statewide Services **(1) Adult Residential Treatment (2) Juvenile Residential Treatment (3) Women and Children Treatment (4) Methadone Treatment**			

Notable Achievements and Strengths (continued)

- The Bureau of Substance Abuse is currently developing a strategic plan to address priority goals and objectives for substance use and problem gambling prevention, treatment and recovery support. This five-year strategic plan is anticipated to be in effect in January 2020.
- IDPH has made progress to expand adolescent and young adult substance use services. The State Youth Treatment Implementation (SYT-I) grant awarded to the IDPH from September 29, 2015 - March 29, 2019 from SAMHSA provided funding to support infrastructure and services which were developed during the previous adolescent grant funded by SAMHSA (SAT-ED). Accomplishments include:
    - Implementation of two evidence-based practices, including Motivational Enhancement Therapy/Cognitive Behavioral Therapy and Multi-dimensional Family Therapy, and recovery support services to serve adolescents and transitional age youth ages 12-25 with substance use or co-occurring disorders.
    - Continuation of the EBP's by supporting training after the grant ended.
    - Enhancement of Iowa's substance use disorder treatment system by increasing the number of clinicians trained and workforce competency to provide evidence-based practices.
    - Establishment of an Adolescent Steering Committee to have a forum to address adolescent and transitional age youth treatment and recovery in Iowa, which will be sustained.
    - Expansion of Recovery Peer Coaching by training Recovery Peer Coaches and trainers and dissemination of a Recovery Peer Coaching fact sheet.
    - Expansion of partnerships with colleges and universities.

Legislation

- ***Complex Needs Legislation SF 504 and HF2456.*** 2017 Iowa Acts, Chapter 109 (SF504) directed the Department of Human Services to convene a stakeholder workgroup to *"make recommendations relating to the delivery of, access to, and coordination and continuity of mental health, disability, and substance use disorder services and supports for individuals with mental health, disability and substance use disorder needs, particularly for individuals with complex mental health, disability and substance use disorder needs"* As a result of the workgroup's recommendations, HF2456 was signed into law in March of 2018. This legislation requires access to an expanded array of mental health and substance use disorder services and supports for individuals with complex service needs. The legislation requires the Mental Health Regions to establish, implement, and maintain new core services which include; state-wide access centers (6 geographically located), crisis response, sub-acute care, and withdrawal management services. HF2456 also contained requirements for workgroups to convene and review mental health substance use disorder commitment processes and the role of tertiary care psychiatric hospitals. The SSA staff were involved in these joint workgroups and administrative rule development.
    - The Complex Needs legislation, also directed DHS to develop a single statewide twenty-four-hour crisis line providing information and referral, counseling, crisis service coordination and linkages to crisis screening and mental health services 24

hours a day. As a result, the Iowa Department of Public Health and the Iowa Department of Human Services are collaborating to bring mental health resources to Your Life Iowa. This collaboration and planning has taken place over the course of the last year and a "warm start" occurred July 1, 2019. Information regarding the Complex Services Needs Workgroup, Commitment Process Workgroup and other related information can be found at: https://dhs.iowa.gov/mhds/community-integration

- ***Children's Board and System Governor's Executive Order and HF 690***. In 2018, Governor Reynolds, Governor of Iowa, signed an Executive Order, establishing a children's behavioral health system and a children's behavioral health state board, which also requires certain children's behavioral core services. The Board was required to submit a plan to the Governor and General Assembly by November 15, 2018. This report recommended an array of core services which included the continuum of services from early intervention, prevention through treatment, recovery supports and community based supports. The report recommended that the Mental Health and Disability Service regions, under the DHS, be designated responsibility to develop the services, funding be identified to support the development of the services and administrative rules be developed. The report can be found at: https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board/executive-order-2-board

  In continuance of the Children's Board ongoing work, HF 690 was passed and signed into law in May, 2019. Within this legislation, the *"DHS and IDPH shall provide a single, statewide twenty-four hour crisis hotline that incorporates information for families of children with a serious emotional disturbance which may be provided through the expansion of the yourlifeiowa platform"*. Resources for the addition of the children's resources, to YLI, are currently led by the SSA staff and planning, development, and contractual work is currently underway. For more information on Your Life Iowa resources visit: https://www.yourlifeiowa.org/

  - YourLifeIowa (YLI), 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. Foundation 2 is accredited by the American Association of Suicidology for Crisis Intervention Service, Mobile Outreach and Online Emotional Support (chat and text support services) and has maintained accreditation for 29 years.

  HF 690 also required the establishment of the Children's System State Board (Children's Board), and designated the Children's Board as the single point of responsibility in establishing the implementation and management of the Children's System. The Board is Co-led by the DHS and Director of Education and is made of 17 voting members. The

Board, appointed by the Governor, is comprised of multiple organizations, family members, state agency directors (including the IDPH Director) law enforcement, medical providers, and education. The IDPH SSA staff has been involved in ongoing meetings, subcommittee meetings and providing guidance related to the prevention and substance use disorder needs of children involved in the system. For more information about the Children's Board visit:
https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board

- ***Reimbursement for Substance Use Disorder Services SF 2418***. The 2018 Iowa General Assembly directed the Iowa Department of Public Health (IDPH), SSA and SSA staff, to work with stakeholders to review reimbursement for substance use disorder services providers, as follows:
    - The department of public health [IDPH], in collaboration with the department of human services [DHS], shall engage a stakeholder workgroup to review reimbursement provisions applicable to substance use disorder services providers. The issues considered by the workgroup shall include but are not limited to:
        - the adequacy of reimbursement provisions, including for both outpatient and residential treatment,
        - whether it is appropriate to rebase reimbursement,
        - whether there is equity in reimbursement compared to the reimbursement methodologies used for providers of similar behavioral health services, and
        - access substance use disorder services providers including whether the designated number of community mental health centers is sufficient

The workgroup shall review the reports of previous workgroups including those authorized in 2014 Iowa Acts, chapter 1140, section 3, subsection 1, and shall report the workgroup's findings and recommendations to the general assembly on or before December 15, 2018. Workgroup findings included:

- Current substance use disorder reimbursement provisions are NOT ADEQUATE
- It is necessary to ADJUST (REBASE) reimbursement for substance use disorder treatment services
- There is NO EQUITY in reimbursement for substance use disorder treatment service providers compared to providers of similar behavioral health services
- ACCESS IS NOT SUFFICIENT to substance use disorder services providers
- The Workgroup did not make a determination on whether the designated number of community mental health centers is sufficient. Instead, the Workgroup determined that access to substance use disorder treatment providers is severely limited by the significantly lower Medicaid reimbursement rates paid to those providers, when compared to the Medicaid enhanced rates paid to community mental health centers for the same services.

Workgroup Recommendations to the Legislature

- Establish equity in Medicaid reimbursement for similar mental health and substance use disorder services and providers
- Direct DHS to establish the IDPH Integrated Provider Network as a Medicaid provider type, consistent with the Community Mental Health Center provider type, and grant DHS emergency rule-making authority to do so
- Direct DHS to reimburse the Integrated Provider Network provider type at the Medicaid Community Mental Health Center Enhanced Fee Schedule, effective no later than July 1, 2019.
- Adjust and assure adequate reimbursement for substance use disorder treatment services.
- Direct DHS and IDPH to study 1915(b)(3) service reimbursement for substance use disorder Intensive Outpatient and Residential treatment using a projected cost report agreed upon by DHS, IDPH, and the Integrated Provider Network, no later than March 1, 2019. Use the results of the study to recommend adjustments to 1915(b)(3) rates for the Integrated Provider Network service type for the 2020 State Fiscal Year.
- For this to be accomplished, Integrated Provider Network providers must provide projected cost report data to DHS by February 1, 2019.
- Appropriate funding to implement the recommended reimbursement adjustments for the 2020 State Fiscal Year.
- Direct DHS, in collaboration with IDPH and behavioral health services providers, to study Behavioral Health Service and 1915(b)(3) service reimbursement using the projected cost report agreed upon by DHS, IDPH, and the Integrated Provider Network, and use the results to recommend adjustments to the 1915(b)(3) and Behavioral Health Services Fee Schedule for the 2021 State Fiscal Year.
- For this to be accomplished, the study and recommendations must be completed by December 15, 2019.
- Appropriate funding to implement the recommended reimbursement adjustments for the 2021 State Fiscal Year.
- Direct DHS and IDPH to establish a plan for regular review of substance use disorder treatment reimbursement and provide information to the legislature for consideration of appropriating funding.
- If funding is appropriated, direct DHS to adjust Medicaid fee-for-service and 1915(b)(3) waiver reimbursement rates accordingly, and direct IDPH to review Integrated Provider Network service reimbursement rates.
- ASSURE ACCESS to substance use disorder treatment.
- Direct DHS to direct the Medicaid managed care organizations (MCOs) to review and revise pre-authorization requirements for medication-assisted treatment for opioid use disorders to support immediate initiation of needed treatment services, effective April 1, 2019.

In so doing, DHS should direct each MCO to:

- Request and consider input from IDPH.
- Request and consider input from medication-assisted treatment prescribers and providers.
- Consider and align with Center for Disease Control and other Federal guidelines, other States' approaches, "Medication First" models, and other nationally-accepted standards of care.
- Provide to DHS and IDPH a summary of each MCO's considerations and subsequent revisions to the pre-authorization requirements for medication-assisted treatment.
- Direct IDPH to establish a Substance Use Disorder Provider Panel, in collaboration with DHS, to review access to substance use disorder services and to identify and resolve barriers to access.
- Provider Panel members should include, at a minimum, representatives of hospital-affiliated substance use disorder treatment programs and the Integrated Provider Network.
- DHS is currently reviewing the cost reports of SSA IPN contractors.

- ***SF565- An Act relating to prior authorization for Medication Assisted Treatment (MAT).*** This bill requires DHS to adopt administrative rules to require that under both Medicaid fee-for-service and managed care administration, at least one form of medication-assisted treatment in specified categories shall be available to Medicaid member without prior authorization. Implementation of the law is pending rule-writing and approval by the Department of Human Services.

- ***HF766- Enhanced Delivery of Services***- New legislation that directs the Director of the DHS and the Director of the IDPH to develop recommendations for the enhanced delivery of co-occurring conditions. The directors shall examine the current service delivery system to:
    - Identify opportunities for reducing administrative burden on Departments and providers
    - Evaluate the use of an integrated helpline and website
    - improvements in data collection and sharing of outcomes
    - 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 to the Governor and the General Assembly by December 15, 2019. To date, the IDPH has held three planning meetings to date and is scheduling a joint *Co-Occurring Conditions Focus Group* meeting for October 2019 with DHS and other stakeholders. A final report will be submitted by December 15, 2019 as required.

IDPH Strengths

- The IDPH annually plans and funds the annual Governor's Conference on Substance Abuse providing educational opportunities to Iowa's workforce.
- IDPH Contracts with the Iowa State University Event Planning Group to implement

trainings on various topics and evidenced based practices to support the SUD IPN network.

- IDPH has collaborated extensively with the Department of Human Services (DHS) Adult, Child and Family Services, to review and plan implementation of the Family First Act. Family First effective July 1, 2020. The Family First Act was signed by President Trump in February 2019 which changes the way state child welfare services are administered and financed. SSA staff has been involved in review of evidence-based practices, submitting comments to the Children's Bureau, participating in planning meetings and survey processes and working collaboratively with partners at DHS
- Meet with Iowa Behavioral Health Association members on a monthly basis to obtain input, provide training, identify barriers and opportunities for collaboration and problem solve.
- IDPH provides opportunities for feedback through the Bureau Newsletter, meetings, Board of Health meetings, monthly IPN meetings between the SSA and IPN contractor directors, and other stakeholder meetings
- SSA staff ensure a full continuum of prevention, treatment and recovery support services are available statewide and have aligned geographical service areas for problem gambling, substance abuse prevention, and substance use disorder treatment.
- SSA staff have strong partnerships across prevention agencies, community coalitions, and treatment contractors, facilitating local and statewide meetings.
- SSA staff use evidence-based prevention practices that consider risk and protective factors, and have expanded prevention workforce development, including continued funding for "capacity coaches" and creating a training cadre for ongoing support of the Substance Abuse Prevention Skills Training and Prevention Ethics Training.
- The SSA staff participates in annual child welfare meetings and initiatives and participates in meetings associated with child welfare policy review on a regular basis.
- There are a total of 292 adult residential beds identified as dual substance abuse treatment beds and one Psychiatric Medical Institutes for Children (PMIC) to provide substance abuse treatment and mental health services for individuals up to age 21. Many IPN contractors and other licensed providers are increasing their co-occurring capability and provide services to individuals with complex needs. Of the 23 accredited Iowa Community Mental Health Centers (CMHC's) in Iowa, 14 are licensed substance use disorder service providers. PMIC's provide substance use disorder treatment and mental health services to individuals up to 21 years of age. The PMIC which provides SUD services, is located in the western part of the state and offer approximately 41 beds.
- Iowa has two Veterans Administration (VA) health centers located in Des Moines and Iowa City, Iowa. The VA provides comprehensive substance use disorder and mental health services to Iowa Veterans. The Central Iowa VA systems provides inpatient and outpatient substance use disorder services. SSA staff serve on the VA Stakeholders monthly meeting. In addition, Veterans are represented on the Mental Health Planning Council - a council attended by a SSA representative and a VA representative is engaged in the Suicide Planning efforts and meetings.
- SSA staff is a member of the planning committee meetings for the annual Public Health Conference
- SSA staff are involved in committee work related to Drug Endangered Children

(DEC). Coordination of efforts to identify, intervene and treat children endangered by caregiver drug use, manufacturing, and distribution. SSA staff participates in DEC meetings.

- SSA staff are involved in the Children's Justice Initiative which is dedicated to improving the lives and future prospects of children who pass through Iowa's dependency courts. The Children's Justice State Council is made up of representatives, appointed by the Supreme Court, from those organizations that are involved in the child welfare system or that might be impacted by systemic change resulting from initiative efforts, including representatives of state agencies with decision and/or policy-making authority: Attorney General, State Public Defender, Department of Education, State Mental Health Authority (SMHA), and SSA. A component of the Children's Justice work is participation on the statewide leadership team focused on collaborative work involving multiple stakeholders focused on using an evidence based screening tool (Dr. Chasnoff-4-P's Plus) for women and implementation of Dr. Chasnoff's screening, brief intervention and referral to treatment curriculum. The screening tool and curriculum is used at a variety of providers and the leadership team reviews statewide data and is focused on engaging more stakeholders to use this process. Since implementing the 4P's Plus program in 2015, Iowa has screened a total of 924 women. Of the women who disclosed their race, the majority identified as White (83.0%) and Black (7.4%). Of the women who disclosed their ethnicity, most were non-Hispanic (79.1%). Of the women who disclosed their payer source, the vast majority had Medicaid (61.2%). The average age of women screened was 26.59 (SD = 5.83), ranging from 14 to 46 years old. There were a total of 508 positive screens, or about 55.8% of the screens that were valid. There have been a total of 1,298 referrals made and 896 (69.0%) of those referrals were accepted.
- SSA staff is a member of the Children's Justice State Advisory Council. Membership represents stakeholders appointed by the Supreme Court to address issues in the child welfare system that might require legislative, funding, policy or statewide practice change. The Council refers issues to or makes recommendations to member organizations or develops multidisciplinary work groups to resolve issues that require joint solutions. Court process issues, even if multidisciplinary, would be referred to the Children's Justice Advisory Committee for action. SSA staff takes a leadership role within a subcommittee and plays an active role in the Council and provide guidance on substance use disorders.
- SSA staff provide contract management of the state-wide Child Protection Centers. Child Protection Centers (CPC) provide a comfortable, private, child-friendly setting that is both physically and psychologically safe for children who are victims of suspected abuse and neglect and their families. Specialists at each of the five centers work together in the investigation, treatment and prosecution of child abuse cases. Since 2004, Iowa legislators have appropriated funding to support CPCs that meet standards established by the National Children's Alliance (NCA). The SSA provides contract management for CPC centers and attends CPC meetings as needed.
- IDPH has a strong collaboration with the Iowa Board of Certification (IBC). The IBC is a professional credentialing organization for substance abuse counselors in Iowa. IBC is an ICRC entity. It is not affiliated with IDPH's professional licensing boards (e.g. social workers, marriage and family therapists, etc.)

- SSA staff have a collaborative relationship with the IDPH Tobacco Use Prevention and Control Division (TUPAC) and SSA staff attend the quarterly Tobacco Commission meetings. The SSA staff and TUPAC staff collaborate on SYNAR efforts and report development.
- The IDPH Director, SSA and Maternal Health Bureau staff, Iowa Medicaid Enterprise staff, and provider organizations (Maternal Health and IPN SUD) are participating in Promoting Innovation in State Maternal Child Health (MCH) Learning Community (PRISM). PRISM is an 18 month policy academy, supported by the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal & Child Health Programs (AMCHP). The goal of the PRISM Learning Community is to improve public health by building policy-making capacity and providing technical assistance in substance misuse and addiction and mental health, to benefit the maternal and child health population. The Iowa team attended a PRISM Policy Academy in February 2019 and has developed a plan to implement strategies to address cross training efforts, review Medicaid reimbursement for bundled services, providing evidence-based screening to women using the 4-P's, and to implement Project ECHO trainings for maternal and substance use disorder facilities in pilot counties.
- The IDPH Bureau of Family Health and Bureau of Substance Abuse are participating in an 18-month Child Safety Learning Collaborative cohort launched by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), in cooperation with the Children's Safety Network. This cohort (November 2018-April 2020) is designed to reduce fatal and serious injuries among infants, children, and adolescents. The two initiatives Iowa is addressing include bullying prevention and poisoning prevention which includes the prevention of prescription medication misuse/abuse.
- Collaboration with the Iowa Healthcare Collaborative

Partnerships

- One of the significant strengths IDPH has, in both treatment and prevention, is the broad array of partnerships which include:
    - Local Boards of Health
    - Alcohol Beverages Division
    - Community Coalitions
    - Community Colleges
    - County Boards of Supervisors
    - Department on Aging, Aging and Disability Resource Centers, Area Agencies on Aging
    - Department of Corrections
    - Department of Education, both public and private school districts
    - Department of Inspections and Appeals
    - Department of Human Rights
    - Department of Human Services regions
    - Department of Public Health programs and services, State Board of Health
    - Department of Public Safety
    - Department of Transportation

- IDPH Division of Tobacco Use and Control
- IDPH Bureau of Emergency and Trauma Services
- IDPH Bureau of HIV, Hepatitis, and STDs
- Governor's Office of Drug Control Policy
- Primary Care Providers
- Judicial Branch; including Children's Justice, Family Treatment Courts and Juvenile Justice
- Local public health agencies
- Iowa Collaboration for Youth Development
- Iowa Youth Advisory Council
- Iowa Boards of Pharmacy, Medicine, Nursing, and Dentistry
- Iowa Behavioral Health Association
- Iowa Army National Guard
- Iowa Veterans Administration
- Iowa Primary Care Association
- Iowa Healthcare Collaborative
- Iowa Harm Reduction Coalitions
- Iowa Medical Society
- Iowa State University Conference Planning and Management
- Law Enforcement Personnel including Sheriffs' Association and Police Chiefs' Association
- University of Iowa Health Care, Department of Pharmaceutical Care,
- UIHC Psychiatry and Internal Medicine
- Meskwaki Nation -Sac & Fox Tribe of the Mississippi in Iowa
- Midwest Counterdrug Training Center
- Iowa Regent Universities
- Iowa Hospital Association
- Iowa Poison Control Center
- Midwest High Intensity Drug Trafficking Area
- Iowa State Extension Partnerships in Prevention Science Institute
- Iowa Board of Certification
- Iowa Prevention & Treatment Supervisors Association
- Iowa Mentoring Partnership

Priority Populations

Pregnant Women and Women with Dependent Children

Through the IPN, four Women and Children IPN contractors were selected to provide women and children treatment and ancillary services statewide. Women and Children treatment must be readily accessible, comprehensive and appropriate to the persons seeking the services. Women and Children treatment must be available when needed, with minimal wait time. Women and Children contractors must provide all ancillary services and requirements under Code of Federal Regulations: 96.124, 96.126 and 96.131. Under the Women and Children Treatment set aside,

ancillary services and/or treatment specialized for women is provided for pregnant and parenting women and their dependent children. Other treatment funding may be funded by Medicaid if the client and/or their children have Medicaid (consistent with client enrollment). The women and children set aside is utilized as the payor of last resort.

Under the IPN contractual agreement, Women and Children Treatment contractors, at a minimum, must:

- Determine a person's need for Women and Children Treatment and manage the services provided
- Eligibility includes: Iowa residents who are pregnant women and women with children, including women who have custody of their children and women seeking custody
- Women and Children funding is the payor of last resort. If the patient and/or the patient's children are enrolled in Medicaid or with another payor, and Medicaid or other payor covers the patient's licensed program services and/or any of the patient's or children's enhanced treatment/ancillary services, the Contractor shall not use Integrated Provider Network funding to pay for those covered services. IPN funding can pay for substance use disorder residential licensed program services that are not covered services under the Iowa Health and Wellness Plan and during the gap period between enrollment in Medicaid and assignment to a managed care organization (MCO) because of B3 services requirements
- Provide Women and Children Treatment in compliance with clinical appropriateness and the Department's guidance
- Provide Women and Children Treatment services in accordance with each person's assessed needs
    - If a patient needs a Licensed Program Service the Contractor does not provide, the Contractor must assure that the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
- Screen patients and children for medical and mental health conditions and directly provide or assure provision of needed medical and mental health services.
    - If a person has a medical or mental health condition the Contractor is not staffed to address, the Contractor must assure the patient's needs are met by a qualified provider and closely coordinate ongoing services with the patient and the referred provider
    - If a person has a medical or mental health condition that is covered by another provider or payor, the Contractor must closely coordinate ongoing services with the patient and that provider/payor
- Monitor a patient's progress on an ongoing basis, modifying the level of care and frequency of service in accordance with the person's evolving needs.
- Establish a "disease management" approach that includes engagement with patients over time, beyond a traditional acute care and discharge service delivery model
- Assure patients have access to the broad range of crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate remission and engage person in long term recovery in ways appropriate to each person

- Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the Contractor
- Provide substance use disorder treatment services ordered through a court action when the services ordered meet the ASAM Criteria and the court orders treatment with the Contractor.
- Contractors must have processes in place to serve "walk-in" and persons in crisis
- Contractors hours of operation for residential Women and Children Treatment must be 24 hours a day, seven days a week, 365 days a year, and must include weekend services
- Contractors must provide residential Women and Children Treatment in a residential facility setting that admits women patients only, and their dependent children.

During the most recent Amerigroup retrospective review process, which focused on the review period from July 2018- December 2018, contractors utilizing Women and Children services were reviewed. During this review the following key highlights were noted:

- Addition of residential beds for women and increase in the access to wellness services within those programs
- Many programs have increased their wellness services such as on site fitness centers and mediations rooms
- Expansion of medical care and more inclusive services for mental health, employment support and parenting
- Contractors continue to work closely with MCOs, DHS, community stakeholders and others involved in utilization of Women and Children programs
    - Contractors have noted that there continues to be ongoing discussion and work done with DHS and the MCOs primarily regarding length of stay. One provider noted they have seen a decline in DHS referrals due to shorter length of stay for women which can compound their reunification plans. However, they continue to work closely with their local DHS to find ways in which they can still assist and provide residential care to those women which may include longer stays in lower levels of care etc.
- Many contractors are offering mental health services for children who are living with their mother in their programming and this has been beneficial to have on-site in many locations. Mental health services are often coupled with parenting classes and support for improving long term outcomes for women to regain and sustain custody of their children
- Some contractors have found success in hiring care coordination staff to assist with the additional needs of women and their children who are in these programs. This allows for greater time and focus on the ancillary needs by the care coordinator and allows the clinical staff to focus on the clinical needs of the participant.
- Providers have noted that there continues to be ongoing discussion and work done with DHS and the MCOs primarily regarding length of stay. One provider noted they have seen a decline in DHS referrals due to short length of stays for women which can compound their reunification plans.
- IDPH convenes Women and Children Provider Roundtables two times a year. Women and Children providers, IDPH staff and other stakeholders share best practices and updates about services. The roundtables generally include SSA activities and grants, and

SABG compliance. During SFY18, a presentation was made to the Women and Children providers on the SABG requirements for contractors receiving funding for the women's set aside and requirements related to charitable choice was reviewed. In 2018, IDPH funded providers provided Women and Children provided required ancillary services per narrative reporting to IDPH.

- The primary substances most often reported by women admitted to Women and Children program during SFY 2018 were Methamphetamine (55.2%); alcohol (17.4%); Marijuana (16.8%); Opioids (7%), and Cocaine/Crack (2.6%). Women and Children programs provided specialized treatment and ancillary services to 889 women during State Fiscal Year 2018.

Injecting Drug Users and Persons at risk for TB - IPN Contractors who provide substance abuse treatment services must meet SABG requirements and provide services to individuals who seek treatment to persons who inject drugs and to individuals related to the tuberculosis requirement. During the 2018 retrospective review process, all IPN providers were able to demonstrate and provide necessary policies for implementation of the TB requirements and interim services provisions. According to IDPH most recent data, 28,350 were admitted during SFY 2018 of which 2,604 Admissions had a primary/secondary/tertiary route of administration of IV injection in the last 30 days.

Tuberculosis (TB) remains a major health problem globally, in the U.S. and in Iowa, killing an estimated 1.3 million people annually. Despite this statistic, TB morbidity rates are declining in the U.S. and around the world. In Iowa, TB case rates remain relatively stable due to the influx of immigrants and refugees from areas of the world where TB is prevalent. Vigilance is required to properly treat and cure patients to prevent treatment relapse, treatment failure or the development of acquired drug resistant TB. Declines in funding, delayed diagnosis and challenging clinical case management still plague TB control efforts in the United States.

The number of TB cases in Iowa, as in the rest of the U.S., has significantly declined since the discovery of antibiotics that kill the TB bacilli. Despite drugs that can cure TB disease, TB remains a significant public health issue in Iowa and the rest of the country. The 2017 TB case rate for Iowa is 1.5 cases per 100,000 persons. This is significantly lower than the 2017 national average of 2.8 cases per 100,000 persons. Iowa owes its low TB case rate in part to proficient contact investigations, healthcare providers observance of treatment guidelines, adherence to DOT for active disease cases and the provision of medication for LTBI to more than 1,100 Iowan's annually.

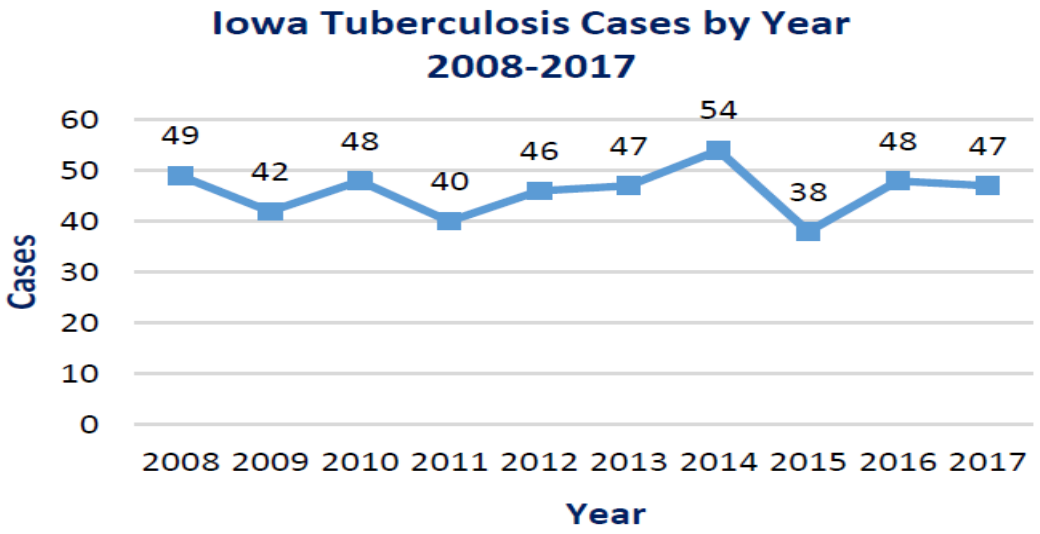
The IDPH is the state agency which is responsible for TB Control. The TB Control Program is comprised of two full time employees: the Program Manager and the Nurse Consultant. The program provides direct oversight of cases afflicted with latent tuberculosis infection (LTBI) and TB disease from admission to discharge in the TB Control Program. This includes consultation with physicians, nurses, local public health agencies (LPHAs) and other healthcare providers regarding TB transmission, pathogenesis, treatment, signs and symptoms, infection control

practices and contact investigations. The purpose and scope of responsibilities is defined by the core functions of the TB Control Program which include:

- Disease consultation and education
- Investigation of active or suspect TB cases
- Case management of LTBI and active TB cases
- Administration of Iowa's TB Medication Program
- Data management and analysis
- Administration and finance

The Iowa TB programs provides medication for all latent TB, suspected, and confirmed cases of TB disease at no cost for individuals residing within the state of Iowa. The most recent 2017 Annual Report for Iowa Tuberculosis Control, indicates that 47 cases of TB were reported in Iowa in 2017. (IDPH TB Control Program Annual Report.) During the last decade, Iowa has averaged 46 cases of TB each year. For further information, reporting requirements, resources, and reports see: https://idph.iowa.gov/immtb/tb and https://idph.iowa.gov/immtb/tb/reporting

Graph below shows number of Iowa TB Cases per Year 2008 - 2017



IPN contractors, who were recently awarded a contract with IDPH, are required to sign an annual attestation regarding meeting all required SABG requirements. Within IPN contracts, IPN Contractors are required to meet SABG TB and Persons who inject drugs requirements including: timeliness standards, capacity notification requirements, outreach efforts, providing or making services available to TB clients (including screening, counseling, education, referral to medical providers, as needed, and reporting to the Bureau of TB any active TB cases (within 1 day) and interim service provisions. Screening and services for persons with tuberculosis are provided directly by IPN funded contractors or through interagency collaborative agreements with other local agencies. In the case of an individual in need of such treatment who is denied admission by a provider on the basis of the lack of capacity to admit the individual, the provider will refer the individual to another contractor for tuberculosis services. Each provider implements infection

control procedures and protocols to address TB and other communicable diseases. IDPH is currently moving from a narrative reporting function, from IPN contractors to incorporate tracking of SABG requirements through the reporting of data to the Departments new data reporting system (Iowa Behavioral Health Reporting System - IBHRS) that will launch in July 2020.

Through the licensure process, and under Iowa Administrative Code Chapter 155, screening for health care workers and residents at substance use disorder and problem gambling treatment program facilities must conduct a risk assessment to determine the risk classification of the facility and to identify appropriate screening criteria. The screening criteria are consistent with those of the U.S. Centers for Disease Control and Prevention (CDC), TB Elimination Division, as outlined in the MMWR December 30, 2005/Vol. 54/No. RR-17, "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005."[ARC 1926C, IAB 4/1/15, effective 5/6/15].

Through licensure and/or IPN, providers/contractors are required to test for TB in the following populations:

- all residents in residential, inpatient, and half-way house facilities
- outpatient clients who are injecting drug users or are persons in close relationships with injecting drug users
- any other client who may be at high risk for TB, such as those with unexplained persistent cough or the homeless

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

Native Americans/American Indians

Although this is not a population of focus under the SABG, coordination of care with Native Americans/American Indians is a priority of the Department.

There is only one federally recognized tribe within Iowa, the Sac & Fox of the Mississippi in Iowa (locally known as the Meskwaki Nation). Due to the very small size of the population, the health services for the Meskwaki people are all provided in one health center. The new Medical Director for IDPH has developed a relationship with the director of the health center and IDPH SSA staff collaborates with them on several health topics of interest. In order to track and coordinate the services and communications with the tribe, IDPH established a point of contact team that includes

a staff person from the Bureau of Substance Abuse.

The Meskwaki have a SUD treatment center within their health center, and several IDPH SSA staff have provided technical assistance and access to training for SUD prevention and treatment topics over the last several years. Tribal Opioid Response (TOR) opioid funding was acquired by the tribe in fall of 2018 after encouragement and consultation from IDPH SSA staff to apply for the funding. The Meskwaki TOR efforts are focused on prevention services targeting youth. Additional efforts focused on recovery supports are being explored for potential funding through the State Opioid Response (SOR) funds.

Individuals in Need of Substance Abuse Prevention

The needs assessment process for SSA substance abuse prevention is based on and informed by the Iowa Epidemiological Profile which is reviewed and discussed regularly by the State Epidemiological Workgroup. Approximately fifty indicators were included in the 2016 Iowa Epidemiological Profile and builds upon previous profiles which included intervening variables associated with substance use. Mental health and suicide data were also added to the 2016 Profile. The Epidemiological Profile provides direction to the prevention services provided through IDPH funded prevention grants as well as focuses training needs on specific substances. IDPH funded prevention providers are required to complete a needs assessment through a County Assessment Workbook or through a grant application process which is updated regularly yearly or as data are available.

Prevention SABG Set Aside Contracts

IDPH directs 20% of the SABG and certain State legislative appropriations to 18 community-based agencies through the Integrated Provider Network (IPN) contracts. Contractors were determined through a competitive Request for Proposals (RFP) process. The RFP explicitly referenced the Strategic Prevention Framework (SPF) model and was built around SPF principles. The 18 unique contractors serve 19 different prevention service areas, each generally covering 2-10 counties, and collectively encompassing all 99 Iowa counties. The contracts support alcohol, tobacco and other drug abuse prevention services to all counties in Iowa, twelve months of each contract year.

IPN prevention contractors provide services through the lifespan and may be directed to all ages and populations not in need of direct treatment services. IPN prevention services maintain and advance public health activities, essential services, core public health functions, and strong relationships with community partners.

The objectives of IPN prevention contracts are to:

- Provide primary substance abuse prevention in all 99 Iowa counties
- Utilize the Strategic Prevention Framework to drive all prevention services
- Implement evidence-based programs, practices and policies

- Provide culturally competent/responsive services
- Assist in developing substance abuse community coalition capacity
- Sustain positive outcomes related to prevention services
- Evaluate services based on common outcomes
- Provide services that do not duplicate or overlap other prevention services with the same target population

In State Fiscal Year 2018, IPN prevention agencies provided 28,422 direct service hours to 199,137 individuals.

Iowa's IPN prevention services are based on a multi-strategic approach, encompassing all six primary prevention strategies, that aims strategies at multiple populations including youth, adults, high risk individuals, community coalitions, and workplaces. All contracted providers have to address five priority areas.

Prevention programs use the six prevention strategies, as appropriate to each result area, and follow CSAP evidence-based program definitions.

Early Intervention Efforts

- **Iowa Prevention of Opioid Misuse in Women Program** is a three year (08/01/2017-06/30/2020) grant awarded to the Iowa Department of Public Health Division of Behavioral Health (IDPH) by the Department of Health and Human Services (DHHS) - Office on Women's Health (OWH). The purpose of this program is to expand the prevention strategies that support the decrease of opioid misuse in women.

Discretionary, State, County, and other Prevention Grants/Contracts

AmeriCorps Substance Abuse Prevention Program
The focus of the AmeriCorps Mentoring program, which started in October 2015, was on the Healthy Futures objective for the Corporation for National and Community Service. Members are in schools, human service-oriented agencies, public health and mentoring programs including Big Brothers and Big Sisters. In September 2017 and 2018, the IDPH AmeriCorps Substance Abuse Prevention Program began focusing on mentoring and preventing opioid and prescription drug misuse within the Capacity Building Objective. The IDPH AmeriCorps Substance Abuse Prevention Program is now in its fourth program year. IDPH receives funding from Sunday Sales to fund community service organizations that host AmeriCorps members. The amount of funding received by each organization is determined by how many members the host site requests. The IDPH AmeriCorps Substance Abuse Prevention Program supports Mentoring and Substance Abuse Prevention agencies throughout the state of Iowa. Members serving at these sites across the state provides education to Iowa community members (including youth) on substance abuse, particularly opioid and prescription drug abuse; build capacity of organizations who need to broaden understanding of opioid and prescription drug abuse; and form coalitions and partners to address the growing crisis. At the end of this program year, AmeriCorps members will increase

community education, knowledge, and awareness on prescription drug and opioid abuse and enhance program capacity and sustainability of substance abuse prevention programs, mentoring programs, and recovery community organizations. In addition, AmeriCorps members recruit volunteers who will be engaged in hours of service serving their communities. As of August 1, 2019, AmeriCorps members recruited 2,143 volunteers that volunteered 5,971 hours to serve youth in their communities throughout Iowa.

Community Coalition Contracts

Funded by a State legislative appropriation to IDPH, Community Coalition contracts support local environmental substance abuse prevention strategies to reduce underage use of alcohol and/or adult binge drinking. Applicants can apply for $5,000 to $10,000 per year, with one grant awarded per coalition.

Community Coalition objectives include:

- Implementation of a coalition action plan that includes alcohol, tobacco, and other drugs (ATOD) prevention as a priority issue
- Use of environmental strategies to address underage alcohol use and/or adult binge drinking
- Establishing a coalition comprised of grass root volunteers representing many sectors of the community
- During FY18, IDPH funded eight substance abuse prevention coalitions.

County Contracts

Funded by State of Iowa Sunday Beer and Liquor Permit Revenue, County Substance Abuse Prevention Services grants are available each year through a Request for Bid. The grants require a 3:1 county funding match. Services may include any type of substance abuse prevention programming for any age group. Per Iowa code, county contracts state "To encourage substance abuse education and prevention efforts and to insure that such efforts are coordinated to provide a high quality of services without unnecessary duplication." Each county applies for up to $10k to provide specific services each year to meet local needs and with locally matched 3:1 funding. In FY19, 23 counties applied for funds that varied from $1,500-10,000 and approximately 85% of services were targeting youth under age 18. These funds allow counties to expand on local priorities and increase support for community, school, or other prevention efforts. In State Fiscal Year 2020, 21 of Iowa's 99 counties requested and received funding, ranging from $1,000 to the maximum of $10,000.

Overdose Data to Action

IDPH received the Centers for Disease Control and Prevention Overdose Data to Action grant in September 2019. The three-year grant aims to decrease all drug morbidity and mortality by strengthening relationships between critical surveillance and prevention partners and increasing the use of data to inform and evaluate prevention initiatives. The grant purpose is to provide high quality, comprehensive, and timely data on overdose morbidity and mortality to lead to better understanding of the drug overdose crisis in Iowa and inform more effective prevention efforts.

Funding is provided annually for three-years to support: increased use of findings from data sources (i.e., Prescription Drug Monitoring Program (PDMP), ED, mortality) to inform and target prevention efforts; increased real-time response to overdose "outbreaks" by offering prevention and treatment services; increased prevention interventions in six highest burden counties; and increase stakeholder collaboration.

Strategic Prevention Framework for Prescription Drugs Grant

The Strategic Prevention Framework for Prescription Drugs grant is a five year (2016-2021) $1,858,080 grant awarded by SAMHSA CSAP to help reduce the misuse of prescription drugs for youth ages 12-17 and young adults 18-25. The purpose of the grant is to raise community awareness about the dangers of sharing and misusing medications as well as work with pharmaceutical and medical communities to address the risks of overprescribing.

Through 2021, three highest need counties identified through an RFP process use the data-driven Strategic Prevention Framework (SPF) model to help increase the effectiveness of evidence-based prevention outcomes. To accomplish this, each county implements four prevention strategies vetted through an evidence-based workgroup, the State Epidemiological Workgroup and the Prevention Partnerships Advisory Council. Two of the strategies are required include the Prescription Drugs Are Still Drugs media campaign created by the Strategic Prevention Framework for Prescription Drugs grant, and also the distribution of the CDC's Guidelines for Prescribing Opioids for Chronic Pain and SAMHSA's Opioid Overdose Prevention Toolkit. The remaining two strategies are selected by community coalitions implementing the SPF process.

The goals of the grant:

- Decrease by 5% the number of 11th grade youth reporting misuse of prescription medications based on the 2016 Iowa Youth Survey as baseline for the misuse of prescription medication.
- Promote the CDC Guideline for Prescribing Opioids for Chronic Pain within 80% of primary care clinics and among 80% of pre-professional programs across the state of Iowa.
- Maximize the use of the Iowa Prescription Monitoring Program (PMP). Increase registration of controlled substance prescribers from 42% (2016 baseline) to 90%. Increase registration of pharmacists from 83% (2016 baseline) to 90%.

Youth Substance Abuse Prevention Services Contracts

IDPH receives funding from the Iowa State Appropriations General Fund for two grants, Prevention Through Mentoring and Youth Development. Prevention Through Mentoring promotes creation and support of community youth mentoring programs that support the state's goal of primary prevention of use and abuse of alcohol, tobacco and other drugs. Youth Development provides evidence based substance abuse prevention programming for youth that includes out of school youth development and opportunities for character development, youth development and leadership. Funded by State legislative appropriations to IDPH, this grant focuses on youth development and youth mentoring services, explained below: The Prevention through Mentoring grant is awarded to seven different certified mentoring programs. The purpose is to promote the

creation of and support community youth mentoring programs that support the state's goals of primary prevention of use and abuse of alcohol, tobacco, and other drugs. Communities may be geographical or may be groups such as churches, schools or colleges, after-school programs, workplaces, etc. Programs will follow the 'Elements of Effective Practices' established by the National Mentoring Partnership. In SFY18, there were a total of 487 mentor matches. The Youth Development grant is awarded to seven different agencies serving youth. The purpose is to provide evidence-based substance abuse prevention programming for youth (ages 5-18) that includes out-of-school youth development and opportunities for character development, youth development, and leadership. In SFY18, a total of 1,285 youth were served with evidence-based substance abuse prevention programs.

Youth Development

Youth Development supports evidence-based programming to reduce alcohol, tobacco, and other drug use in children, and provides specific out-of-school youth development/leadership opportunities in funded communities. In State Fiscal Year 2018, seven local agencies provided youth development programming serving a total of 1,285 youth.

Prevention through Mentoring

Prevention Through Mentoring contracts:

- Establish mentoring programs that prevent alcohol, tobacco, and other drug use by youth
- Promote relationship-building and social skills
- Encourage students to complete school
- Decrease dropout rates

Using the Elements of Effective Mentoring Practice, the seven funded agencies provided mentoring matches for 487 Iowa youth in State Fiscal Year 2018.

Additional SSA Substance Abuse Primary Prevention Activities, Health Promotion Activities, Evaluation Outcomes, Iowa Youth Survey, Epi Workgroup, and Data System.

State Epidemiological Workgroup (SEW)

In 2006, the Iowa Department of Public Health (IDPH) received funding from the federal Department of Health and Human Services, Substance Abuse and Mental Health Administration's Center for Substance Abuse Prevention for a State Epidemiological Workgroup (SEW). IDPH's Division of Behavioral Health, Bureau of Substance Abuse, administers the funding and activities of the SEW. The SEW initiates processes to establish the Strategic Prevention Framework as the basis for ongoing state substance abuse prevention (and treatment) needs and outcomes monitoring. The SEW process involves forming an epidemiological team to assess, analyze, interpret, and communicate data about Iowa substance consumption patterns and consequences.

The major products resulting from the SEW's work are:

- The state epidemiological profile with yearly updates (which includes Iowa Youth Survey data)
- Community/county profiles in three locations
- System planning to accommodate the ongoing lead and collection of data for monitoring prevention and treatment outcomes
- Data gap analysis and plan
- National Outcome Measures Reporting

During the summer and fall of 2006, a separate Data Task Group (DTG) was formed to identify, analyze, and select indicators to include in the Iowa epidemiological profile. This smaller DTG was a sub-group of the SEW with additional members recruited from an existing Iowa Collaboration for Youth Development data committee. The DTG forwarded findings and recommendations to the SEW, which made final decisions about which data to include in the epidemiological profile.

The DTG included individuals with extensive experience in using specific state- and federal-level data collection processes and data sets. DTG representatives included:

- Department of Human Rights, Division of Criminal and Juvenile Justice Planning
- Governor's Traffic Safety Bureau
- Iowa Consortium
- Iowa Department of Education
- Iowa Department of Public Health
- Iowa Department of Public Safety

Among the approximately 300 possible indicators, available in an appendix on the State Epidemiological Website the Data Task Group (DTG) identified potential data sources for each and determined the quality and characteristics of the datasets. Criteria for choosing the best indicators for the profile were later developed.

The SEW emphasized including applicable National Outcome Measures (NOM) in the identified indicators. The following criteria were used in the selection process:

- Data available at State (Iowa) level
- Sample includes all geographic areas
- Sample includes age range
- Data collected at least every two years
- Measures directly related or strongly associated with Alcohol, Tobacco, and Other Drugs (ATOD) use
- Data pertain to consumption or consequence; and
- Datasets have adequate sample size

Additional criteria were applied where similar indicators existed:

- Historical data available
- Data available at local level
- Limited redundancy between indicators; and

- Alignment with consequence data

Approximately 45 indicators were included in the 2007 Iowa Epidemiological Profile, and an additional six new indicators were added to the 2008 Profile. The 2009 Profile also introduced mapping for the major consumption and consequence indicators showing their distribution across Iowa's 99 counties. The magnitude of the indicators dictated the priorities chosen in the Strategic Prevention Framework State Incentive Grant application (SPF SIG). After receiving the SPF SIG Cooperative Agreement, the 2010 Profile introduced the analysis of mortality and hospital discharge data. Using Internal Classification of Diseases (ICD) 9th and 10th revision, conditions attributed to alcohol, tobacco, and drugs were identified and computed to generate rates. The 2012 Profile introduced Synar data, which assessed how tobacco outlets are compliant to the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. The Synar amendment prohibits the sale or distribution of tobacco products to individuals under the age of 18.

The 2016 Profile builds upon previous profiles and includes new data including intervening variables associated with substance use. Mental health, suicide data, and recommendations were also added to the 2016 Profile. The 2018 Epidemiological Profile highlights data regarding over-the-counter medications, opioid-related hospitalizations, and opioid-related deaths. State and national maps were presented to provide visual presentations of the various substances.

From 2016-2017, several SEW members either retired or changed jobs. For that reason, new members were added to the SEW. For instance, members from the following organizations were added to the SEW:

- Area Substance Abuse Council
- Department of Commerce, Alcohol and Beverage Division
- Governor's Office of Drug Control Policy
- Iowa Department of Human Services
- Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning
- Jones County Substance Abuse Coalition
- Iowa Hospital Association
- State of Iowa Youth Advisory Council
- University of Iowa
- University of Northern Iowa

Various reports/data briefs/epi profiles have been completed as a result of this workgroup. For more information on the Epi Workgroup, to see data reports and meeting minutes see: http://idph.iowa.gov/substance-abuse/epidemiological-workgroup

Workforce Development Trainings:

- Conducted a Primary Prevention Workforce Survey in April 2013. The Iowa Prevention Workforce Development Task Force reviewed and approved the list of prevention workforce competencies that were included in the survey. The report discusses results

from a workforce development survey administered to people working in prevention in Iowa. More than 219 people – from coalition volunteers to coalition coordinators and from just hired to 20-year veterans of prevention – responded to parts of the survey.

- Prevention Trainings include:
    - Substance Abuse Prevention Skills Training, Prevention Ethics for Certification and Prevention Ethics for Recertification provided for the substance abuse prevention field, hosted in collaboration with the Midwest Counterdrug Training Center
        - https://counterdrugtraining.com/default.aspx/MenuItemID/316/MenuSubID/34/
    - Monthly Prevention Webinar series hosted the first Friday of each month on a variety of prevention-related topics
        - https://yourlifeiowa.org/prevention-training
    - Sixteen prevention-focused webinars took place from January 1, 2019 through June 30, 2019 to provide foundational trainings to Integrated Provider Network (IPN) prevention agencies.

Workforce Development Resources and Materials:
In order to support the work of substance abuse prevention professionals, the Iowa Department of Public Health has developed the following:

- A Five-Year Substance Abuse Prevention Strategic Plan that focuses on the areas of workforce development, evidence-based programs, policies and practices, quality improvement, statewide education efforts and opioids.
- A Prevention Guide which outlines Iowa's approach to prevention services. This resource is intended to inform all prevention efforts throughout the state.
- An I-SMART User Manual to assist prevention agencies when entering prevention services in the approved data portal.
- Two separate Prevention Services Orientation Guides to help inform primary prevention efforts throughout the state. The initial guide informed prevention services for the timeframe of January 1, 2019 through June 30, 2019. The second guide covered prevention services for the timeframe of July 1, 2019 through June 30, 2020.

Iowa Youth Survey:
From October 1, 2018 through November 9, 2018, the Iowa Department of Public Health (IDPH) collaborated with schools in Iowa to conduct the 2018 Iowa Youth Survey (IYS). The 2018 IYS is the seventeenth in a series of surveys that have been completed every two or three years since 1975. The survey is conducted with students in grades 6, 8, and 11 attending Iowa public and private schools. The IYS includes questions about students' behaviors, attitudes, and beliefs, as well as their perceptions of peer, family, school, neighborhood, and community environments. The 2018 IYS questionnaire can be found here.

The 2018 Iowa Youth Survey (IYS) State of Iowa report is designed to help state-level planners, community agencies, and school personnel identify youth development needs, implement

relevant, targeted interventions, and assess outcomes. IYS data can assist in providing a better understanding of students in Iowa and their needs. It can also help to assess the strengths and challenges of schools, families, and communities from the young person's perspective. In addition, IYS data help the state obtain funding for a wide variety of programs and services. The Iowa Youth Survey has proven to be a valuable resource in youth needs assessment, program development, implementation, and outcome evaluation. The 2018 Iowa Youth Survey was conducted via the internet and completed by students online through an electronic survey tool (Survey Monkey) administered by the Iowa Department of Public Health.

Iowa Youth Survey reports can also help Iowa's schools, area education agencies, and counties assess their relative strengths and weaknesses. In addition to the State of Iowa report, multiple population-specific IYS reports are also publicly available. For more information, please check the IYS website: www.iowayouthsurvey.iowa.gov for the availability of County, Iowa Area Education Agency (AEA), Judicial District, and Iowa Department of Public Health Substance Abuse Prevention Service Area reports. The total percentages provided in these additional reports, as well as the breakdowns by grade level and gender, can be compared with the respective State of Iowa report percentages to view similarities and differences by region or population.

A total of 70,451 validated records were received from students across the state. Data in this report assumes each record represents one student. Validated records were received from 69,091 students attending public school districts, and 1,360 students attending non-public schools. Records were identified from 225 of Iowa's 330 public school districts (68.2%) and from 13 of the 170 non-public schools (7.6%).

Trends out of the Iowa Youth Survey from 2012 to 2018 include:

- Past 30 day alcohol use has decreased for 11th graders from 2012 to 2018. From 2016 to 2018, there was a significant increase among 8th grade students. Students continue to report that adults in their community feel it would be wrong for students to drink alcohol, with more than 84% of all students reporting so in 2018.
- Binge drinking in the past 30 days has decreased for 8th and 11th grade students, and remained near 1% for sixth grade students since 2012. This decrease is reflected for 11th grade students for both males and females.
- Marijuana use by all grades has remained consistent from 2012 to 2016, with less than 5% of all participating students reporting marijuana use in the past 30 days. All grades showed a significant increase in the percentage of students from 2016 to 2018 that reported that smoking marijuana would make them more popular. This may predict a future increase in reported marijuana use on future Iowa Youth Surveys.
- Illicit drug use, other than marijuana, continue to be reported at very low levels for all grades.

Data System and outcomes:
In early 2015, Iowa implemented a prevention module within its I-SMART data collection system. I-SMART, Iowa's version of WITS, was already in use by Iowa substance use disorder and problem gambling treatment and prevention programs. The I-SMART system enables IDPH, substance use disorder treatment programs, community-based service providers, and others to collect and report the numbers and types of primary substance abuse prevention services delivered. I-SMART prevention is a web-based tool that supports a uniform method of collecting group-level process data. Prevention providers enter work plans and information into I-SMART about the services they provide in their communities on an ongoing basis. The aggregate data in the database makes it possible to explore the extent to which organizations are implementing various types of programs and to see which general populations are being served. Providers can enter, store, and retrieve data and generate data exports using predefined and user-selected criteria.

The Iowa Consortium for Substance Abuse Research and Evaluation is contracted by the SSA to administer Qualtrics. Prevention contractors use Qualtrics for pre/post survey data from recurring educational programs.

- ***Qualtrics*** is a web-based system used to collect and report individual-level survey data. This web-based evaluation tool provides a structure and framework for collecting prevention process data. This system allows questionnaires to be built interactively, the set of respondents to be defined and data to be collected. Qualtrics further assists evaluation efforts by performing basic statistical reporting and providing detailed data downloads that allows evaluation staff to perform more exhaustive statistical analysis.

Evaluation of SFY2016 Comprehensive Prevention services:
The Iowa Consortium for Substance Abuse Research and Evaluation is contracted by the SSA to provide a comprehensive evaluation report. The evaluation report was completed in March 2019. The evaluation report employed a matched pre-post design, whereby a pre-test survey was administered when a participant entered the mentoring program and at the end of each project year (post-test) for all programs. The survey asked questions of middle and high school youth about past 30-day use of alcohol, binge drinking, cigarettes, and marijuana.

Cumulative results were reported for each state fiscal year (SFY16 through SFY18), and individual program results are also reported for each state fiscal year for programs with 50 or more matched surveys. The overall percentage change was reported for each year and each program, where a positive percentage change (+) indicated an increase in use, and a negative change (-) indicated a decrease in use.

A parallel survey conducted is the Iowa Youth Survey (IYS), a biennial survey of Iowa's students (grades 6, 8, and 11) which includes the collection of information on attitudes and use of substances. The IYS data revealed changes due to maturation of the youth through the different grade levels. For convenience, 2016 and 2018 IYS results appeared in the tables of this report as a general population benchmark. This comparison included all grades who participated in the

IYS, as the Comprehensive Prevention participants range from 9th through 12th grades. While the time span between pre-test and post-test for some prevention programs presented in the report was less than one year, the IYS average yearly change served as a general point of reference when examining the program outcomes rather than comparing to zero, or no change. It is important to note that youth who participated in Comprehensive Prevention programming may also have completed the IYS. Examples of these results, include but are not limited to:

Cumulative Years Alcohol Use, Binge Drinking, Marijuana Use and Cigarette Use in Past 30-Day Use, Comprehensive Prevention Survey Respondents

Program	N	Alcohol Use Difference	Binge Drinking Difference	Marijuana Use Difference	Cigarette Use Difference
2016 Iowa Youth Survey	52,560	2	1	1	1
LifeSkills Training	5,162	-0.97	0.14	0.12	-0.15
Project ALERT	3,689	-0.62	-0.03	0.14	-0.16
Too Good for Drugs	1,610	0.5	-0.25	-0.12	0
Prime for Life Non-Diversion	736	-7.07	-1.36	-4.62	-2.31
Project Northland	514	1.95	0.78	0.58	0.19
Project Towards No Drug Abuse	302	-0.33	2.96	2.96	1.98
Brain Power	220	1.36	0.46	-0.46	0.46
Diversion	179	-2.79	1.12	0	0
Curriculum-Based Support Group	158	0.63	1.9	3.16	1.27
Juvenile Education Groups	83	0	2.41	-1.19	1.19
All Stars	75	-4	-2.67	0	0

The evaluation concludes:

- LifeSkills Training showed a significant percentage point decrease (-0.97) in alcohol use for all years combined. LifeSkills is a middle and high school substance abuse prevention program to prevent teenage drug, tobacco, and alcohol use and abuse and violence and other risk behaviors.
- Prime for Life Non-Diversion showed a significant percentage point decrease in alcohol use (-7.07), binge drinking (-1.36), cigarette use (-4.62), and marijuana use (-2.31) for all years combined. Prime for Life is an evidence-based program specifically designed for people who might be making high-risk choices. This group contains universal, selective, and indicated audiences. Universal audiences are youth without any known increased risk factors and may only need risk reduction information. Selective audiences are those that might have signs of increased risk of substance use problems and would benefit from the program. Indicated groups are those who are already making high-risk alcohol or drug choices and who may be showing signs of problems.
- Project Towards No Drug Abuse showed a significant percentage point increase in cigarette use for all years combined (+2.96). This program targets high school-age youth by focusing on motivation factors, skills, and decision-making that predict tobacco, alcohol, other drug use, and violence-related behaviors.

For further information on the comprehensive prevention evaluation, please see report uploaded in attachments.

Individuals in Need of Substance Abuse Treatment

One of IDPH's priorities is direct services to Iowans through treatment covered services. Iowans have available a wide range of substance use disorder services. Many private insurance plans offer specific benefits for their members that may cover certain types of treatment. The public substance use disorder services system is decentralized and multi-faceted, with responsibility spread across multiple government agencies. In addition, external advocacy and stakeholder groups make important contributions to the system. Public substance abuse services are funded from state, federal, and private sources that encompass such diverse but related areas as criminal justice, child development and welfare, education, employment, housing, mental health, physical health, and public safety, as well as general substance use disorder prevention, treatment, and recovery support. Iowa's SSA assures an accessible, comprehensive, coordinated, and effective safety-net system of care for the broad range of substance-related issues faced by Iowans, through both statewide resources and specific local services.

IDPH SSA staff license and regulates approximately 100 substance use disorder and problem gambling treatment programs. On-site inspections are conducted with recommendations on the length and type of license reported to the State Board of Health Substance Abuse/Program Gambling Program Licensure Committee for action.

The Department shall offer the following program licenses:

- A substance use disorder assessment and OWI evaluation only

- A substance use disorder treatment program license
- A problem gambling license
- A substance use disorder and problem gambling treatment program license.

SSA licensure staff provides technical assistance to programs in the general areas of clinical services, program administration, and overall compliance with licensure standards.

Licenses can be issued for an initial 270 days or for one, two, or three years. Licenses may be granted under deemed status to organizations accredited by the Joint Commission, CARF, or COA. IDPH issued 83 licenses in 2016. One license was denied.

IPN/SSA Funded Substance Abuse Services:
All Treatment Covered Services are reported to the IDPH I-SMART/Central Data Repository (CDR) via established processes. 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

IPN/SSA-funded contractors form a limited provider panel, selected through a competitive request for proposals process that assures access through outpatient geographic services areas and statewide residential services. Providers must be not-for-profit, licensed substance abuse treatment programs. A limited number of Iowa hospitals have inpatient substance abuse treatment units and/or outpatient treatment programs. Hospitals may provide inpatient medical detoxification services. Any licensed prescriber can provide outpatient/ambulatory detox. Programs are increasingly seeking national accreditation, such as CARF (Commission on Accreditation of Rehabilitation Services), COA (Council on Accreditation) and the Joint Commission. National accreditation supports insurance reimbursement eligibility. In addition, in compliance with IDPH program licensure standards, providers must integrate culturally- and environmentally-specific customs and beliefs of a given population into assessment and treatment planning.

IPN/SSA-funded substance abuse treatment services follow SABG requirements:

- Meeting required set asides
- Services for women and pregnant women, including time frames for women requesting and in need of treatment and interim services if program is at capacity.

- Services to injecting drug users, including: time frames for individuals requesting and in need of treatment and interim services if program at capacity
- Use of outreach services
- Tuberculosis services
- Resident of Iowa with income at or below 200% of the federal poverty guidelines who is not insured or for whom third party payment is not available to pay for services and who seeks substance use disorder services funded by IDPH. Cannot be an Iowa Medicaid member eligible for Medicaid funded substance use disorder services. May be an Iowa Health and Wellness Plan member due to restrictions to available substance use disorder services.
- Priority in treatment:
  - Given to those clients with the greatest clinical need
  - Given to substance abuse that results in the highest personal and social cost
  - Ranked priority for admissions to treatment:
    1) Pregnant women injecting drug users
    2) Pregnant substance abusers
    3) Persons who inject drugs
    4) All others

IDPH program licensure standards and provider contracting require use of the American Society of Addiction Medicine (ASAM) Criteria for all treatment clinical decisions, regardless of payor. IDPH-funded treatment services are self-managed by providers. The ASAM Criteria six clinical dimensions assure comprehensive assessment and treatment planning and are consistent with the integration of mental and physical health conditions into substance use disorder treatment:

1. Acute Intoxication/Withdrawal Potential (includes Physical Health)
2. Biomedical Conditions/Complications (Physical Health)
3. Emotional/Behavioral/Cognitive Conditions/Complications (Mental Health)
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem Potential
6. Recovery/Living Environment.

All licensed substance use disorder programs report service utilization and treatment information to IDPH's Central Data Repository (CDR).

- IDPH's Central Data Repository (CDR) launched in July 2011. Licensed treatment programs have the option of using the historical I-SMART clinical record and reporting system to enter and report required data to IDPH and the CDR or may use their electronic health records to report required data to IDPH directly to the CDR. A growing number of licensed programs have chosen to report directly to the CDR from their own clinical record system via a file transfer site process.

IPN-funded services have been described by stakeholders as an efficient and effective statewide system of care, organized around:

- Regional service areas
- Uniform eligibility criteria

- Standardized core services
- National practice standards for admissions, level of care transitions, and discharges
- Capitated funding and contractual performance measures

The IPN/SSA funded services also support services categorized as: Care Coordination, Medical Evaluations and Medical Care, Medication, Recovery Peer Coaching, Transporation, Early Intervention, Suicide Screening, and Outreach, Quality Improvement and Workforce Development initiatives as previously noted.

IPN funding may be used to pay for treatment covered services that are not covered under the Iowa Health and Wellness Plan, specifically, residential treatment. The ACA was enacted in Iowa as the Iowa Health and Wellness Plan. Iowa's plan included co-pays, coinsurance, and deductible requirements. The 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. The Iowa Health and Wellness Plan does not provide coverage for Substance Disorder residential treatment.

- The Iowa Health and Wellness Plan includes three options:
  - *The Iowa Wellness Plan* for Iowans with income up to/including 100% of the Federal Poverty Level (FPL) and medically exempt individuals with income up to/including 133% of the FPL through Medicaid managed care.
  - *Marketplace Choice Plan* for non-medically exempt individuals with income 101-133% of the FPL, through premium assistance to enroll in qualified health plans in the health insurance marketplace; and
  - *Health Insurance Premium Payment Program* which provides premium assistance for individuals with income up to/including 133% of the FPL who have access to cost-effective employer-sponsored insurance coverage.

IPN funding may also be used to pay for treatment covered services that are not covered during the gap period between enrollment in Medicaid and assignment to a managed care organization (MCO) because of B3 services requirements. All IDPH funding requirements, including, but not limited to, IDPH Participant eligibility, apply. Providers must actively support enrollment in Medicaid. Retrospective reviews, as previously completed by Magellan of Iowa and Amerigroup Inc. (last 2019), will be completed by IDPH staff beginning in 2020. These site on-site retrospective reviews of provider records assess for clinical appropriateness, quality assurance, and fiscal and contract compliance.

A population of individuals in need of treatment are individuals seeking SUD treatment for Methamphetamine Abuse. From 2014-2017, there was a 38 percent increase in methamphetamine treatment admissions in Iowa. Similarly, the Iowa Department of Public Health (IDPH) reports there was an eight-fold increase in Iowa deaths related to amphetamines, which includes methamphetamine. Methamphetamine is now the second most reported drug by adults at admission to treatment, moving ahead of marijuana for the first time. Alcohol remains number one for adults, while marijuana remains the number one drug of choice for juveniles. The IDPH has focused extensive resources on addressing the Methamphetamine issues in Iowa communities.

This effort brought awareness to Iowans while providing resources to available prevention and treatment services. In 2018, the Bureau of Substance Abuse formed an internal committee to begin strategic planning on the rise in Methamphetamine. Some of these initiatives included; development of strategies including health promotion activities, data profiles, and infographics aimed at prevention, treatment and women. IDPH ran media campaigns in the summer of 2019 and have worked with IPN contractors, both treatment and prevention, to complete webinars focused on gathering data and for IDPH SSA staff to educate on current Iowa data. In 2019, IDPH required IPN contractors to complete community needs assessment workbooks to guide community/stakeholder planning. IDPH SSA staff is presenting public health information at several conferences in 2019 including a family planning council conference and at the National Conference on Methamphetamines and Stimulants in Miami, Florida in November. A statewide Methamphetamine conference is currently being planned for December 3, 2019 to bring national experts to Iowa to educate treatment and prevention professionals on Methamphetamine and the contamination with Opioids. For treatment and prevention resources on Methamphetamine visit: https://yourlifeiowa.org/drugs/methamphetamine

Opioid Initiatives and Iowa Data

The Iowa Department of Public Health (IDPH) has collaborated with state, local and private partners to address opioid related problems in Iowa and to serve this population in need of treatment. Statewide, Iowans have implemented coordinated, multi-sector efforts that have led to increased awareness, access to resources and improvements in care. IDPH receives the following appropriations/grants that support Iowa's opioid initiatives:

- Iowa General Fund Appropriation
- SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG)
- SAMHSA Opioid State Targeted Response Grant (STR)
- SAMHSA State Opioid Response Grant (SOR)
- SAMHSA Strategic Prevention Framework – Prescription Drugs Grant (SPF-Rx)
- Bureau of Justice Assistance – Harold Rogers Prescription Drug Monitoring Grant
- CDC Opioid Overdose Crisis Cooperative Agreement for Emergency Response
- SAMHSA Prevention of Opioid Misuse in Women (POMW)
- SAMHSA First Responders Comprehensive Addiction and Recovery Act (FR-CARA)

Previously thought to be an issue only in major U.S. cities or more populated states, the use of opioids (which includes heroin and prescription pain relievers) has become a problem of epidemic proportions in more rural areas of the country. While alcohol, methamphetamines and marijuana remain the primary substances misused in Iowa, in the last decade significant increases have occurred in the number of Iowans identifying opioids as their drug of choice at the time of admission to treatment – and in the number of deaths related to opioids. Initial data show these efforts are making positive impacts in Iowa communities to prevent and reduce the negative consequences.

Preliminary data from the IDPH Bureau of Health Statistics indicate a reduction in the number of deaths related to opioids in 2018. In 2018, there were 137 deaths related to opioids – a 33% decrease from 2017 (206). While these numbers have been circulated previously as provisional,

the numbers are not considered final until the national vital statistics file is closed. The number of healthcare professionals eligible to prescribe buprenorphine (a form of medication-assisted treatment for opioid use disorders) has increased from 31 in 2015, to 160 in 2019 and Iowa has increased the number of sites capable of dispensing methadone (another form of medication-assisted treatment) from eight locations in 2015, to 20 locations current/planned, by mid-2019.

The number of Iowans under the age of 40 diagnosed with chronic hepatitis C virus (HCV) increased steadily from 2000 through 2016, decreased significantly in 2017, but increased again in 2018 according to preliminary data. Hepatitis C virus (HCV) is transmitted primarily through the sharing of injection drug equipment. Iowans under the age of 40 who are diagnosed with chronic hepatitis C represent a population that may be transmitting the virus. Diagnosis is important, as hepatitis C is curable. In 2018, Iowans under the age of 40 represented 27 percent of all Iowans diagnosed with chronic HCV, a proportion that has steadily increased. IDPH will continue to expand the availability of testing, which has increased substantially over the past four years.

In October 2017, IDPH presented to the Opioid Epidemic Evaluation Study Committee as part of a larger update to state legislators on the impact of opioids in Iowa. In addition to IDPH, presenters included representatives from other state agencies and from law enforcement, healthcare, education, harm reduction and funders. To convey public health concerns about opioid misuse in the state, IDPH developed a State of Iowa Opioid Initiatives Report Card, listing proven approaches adopted by other states to combat the nationwide opioid epidemic. The Report Card format provides a way to evaluate Iowa's efforts in addressing opioid misuse and identify opportunities for improvement.

When the Opioid Report Card was first developed, Iowa met only three of the 10 recommended measures. By enacting HF 2377 in 2018, the General Assembly adopted four additional measures (*), reinforcing Iowa's commitment to combat opioid misuse in the state, and improve – and save – the lives of Iowans. As for the three measures Iowa has not implemented:

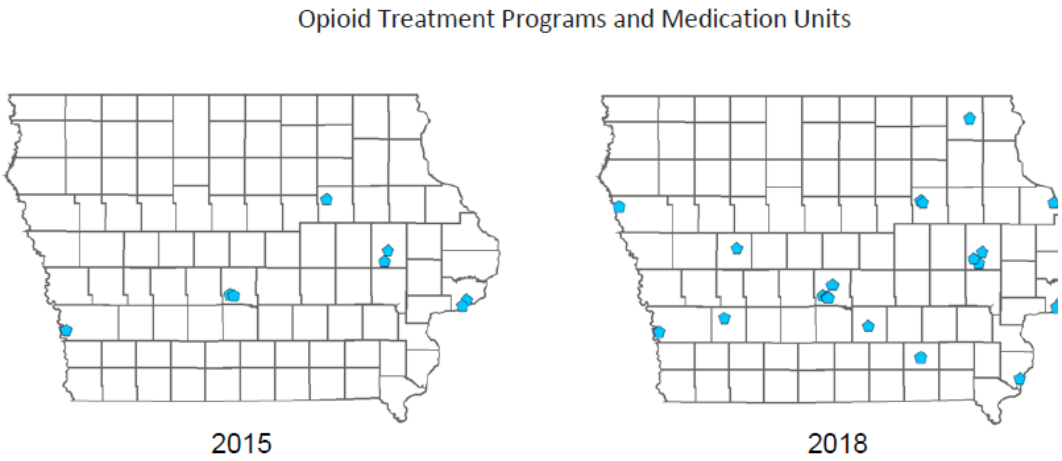
- X1 While the state has not pursued prescribing limits, several related efforts have taken place in Iowa, including: national pharmacy chains refusing to fill prescriptions for specific extended release, long acting opioids; insurers limiting the number of days of an opioid prescription that can be filled; and the Board of Pharmacy initiating Prescriber Activity Reports (PARs) as a part of the prescription monitoring program, intended to provide health care professionals with relevant and accurate information to constructively assist his/her prescribing of controlled substances.
- X2 Although there are no legally operated syringe service programs currently in Iowa, the topic has been increasingly discussed at the state level and legislation was introduced in 2019 which did not pass.
- X3 At this time, Iowa does not have dedicated state funding for naloxone. However, IDPH has consistently made use of federal grant funding for this purpose.

State of Iowa Opioid Initiatives Report Card		
Measure	**Yes**	**No**
1. State has a Prescription Monitoring Program	✓	
2. Prescribers are required to use the Prescription Monitoring Program	✓*	
3. Prescription Monitoring Program has 24-hour upload from pharmacies	✓*	
4. State utilizes prescription limits for opioids		X[1]
5. State has a Syringe Services Program		X[2]
6. State has a Good Samaritan Law	✓*	
7. State has Expanded Naloxone Access	✓	
8. State has dedicated funding for Naloxone		X[3]
9. State has Medicaid coverage for all forms of medication assisted treatment	✓	
10. State requires training on CDC Guideline for Prescribing Opioids for Chronic Pain	✓*	

✓* Indicates a measure that was not Iowa law prior to the passage of HF 2377 in 2018.

Other strategies IDPH is implementing to combat the Opioid Epidemic include:

- Iowa has expanded the number of OTPs – including satellite "Medication Unit" locations to seven OTPs, with a combined total of 20 locations in 14 counties planned by mid-2019.



- IDPH's Strategic Prevention Framework for Prescription Drugs (SPF Rx) federal grant supported the development of a youth-focused statewide media campaign to help reduce misuse or non-medical use of prescription drugs. The campaign began running in targeted communities in June 2017. After conducting foundational research with 12- to 25-year-olds, IDPH determined youth needed to understand that there are real health consequences associated with sharing or abusing prescription drugs. To get that message out, IDPH developed the "Prescription Drugs Are Still Drugs" health promotion campaign for radio, TV, billboards and social media.
- Development of a monthly Opioid Newsletter that is distributed to stakeholders and partners. Newsletters can be found: http://idph.iowa.gov/substance-abuse/opioid-update
- An example of the above noted media messaging, a YouTube video, can be viewed here: https://www.youtube.com/watch?v=u9rUDWmFNIk&feature=youtu.be
- IDPH's State Targeted Response federal grant has played a valuable role in expanding MAT. Through STR grant activities, including community needs assessments and strategic planning, 16 of the 23 local programs in IDPH's treatment provider network used STR funding to enhance or expand MAT services. In the first year of the STR grant, 118 more Iowans received MAT as part of their treatment experience than in the previous year. Over the course of both years of STR funding, over 500 Iowans received treatment and/or recovery support services.
- The Iowa Board of Pharmacy Prescription Monitoring Program (PMP) is a vital tool in understanding opioid prescribing and reducing the risk of patients developing an opioid use disorder. Prior to 2018's HF 2377, provider utilization of the PMP was voluntary, meaning a prescriber could choose whether or not to use the system to verify a patient's

prescribing history. Left as an option, less than one-third of prescribers in Iowa registered to use the PMP, and even fewer used it. As a result of HF 2377, prescribers will be required to register and use the PMP at designated intervals. At the time of this report, PMP registration for prescribers that have a current and active Controlled Substances Act (CSA) registration had increased to 86 percent. While the requirement to use the PMP is a major step forward, the PMP in operation at the time the law was passed existed on an outdated platform and did not support needed functionality. Through several of its federal grants, IDPH made funding available to the Board of Pharmacy to obtain a new PMP platform. Launched in April 2018, the new PMP not only provides improved functionality, it allows for easier development of reports useful in understanding prescribing patterns in the state.

- IDPH has worked with other state agencies and stakeholders to prevent opioid overdose by providing access to naloxone, the medication that temporarily reverses an opioid overdose, allowing the person to receive life-saving medical care. Made possible by federal grant funds, examples of IDPH naloxone distribution efforts include:
    - 1,300 kits provided to emergency departments across the state for distribution to individuals being released from the hospital following treatment for opioid overdose. Research has shown that such individuals are at high risk of dying of an overdose within one year.
    - 400 kits to the Department of Public Safety to equip every staff member.
    - 450 kits to the Department of Corrections for individuals being released from a correctional setting who have a history of opioid misuse.
    - 350 kits to the IDPH Bureau of Emergency and Trauma Services for distribution to EMS providers.
- On November 3, 2016, then IDPH Medical Director, Dr. Patricia Quinlisk, issued a statewide standing order allowing individuals to purchase naloxone from a pharmacy. That initial order has been renewed through September 21, 2019, by current IDPH Medical Director, Dr. Caitlin Pedati. Note: While the standing order has broadened access to overdose reversal medication, the cost for an individual to purchase a kit from a pharmacy under the standing order, without having insurance coverage, is approximately $150.
- On June 29, 2018, IDPH, the Iowa Board of Pharmacy and the Iowa Pharmacy Association held the first Narcan Access Day in Iowa. Through this collaborative effort, over 1,500 free Narcan nasal spray kits were dispensed to “persons in a position to assist” through more than 360 participating pharmacies across the state. IDPH purchased the kits using federal grant funds at the reduced “public interest” price offered by the manufacturer of $75 per kit.
- On July 1, 2018, IDPH Director Gerd Clabaugh designated suspected and confirmed opioid overdoses requiring administration of naloxone as reportable conditions in Iowa. This means Iowa hospitals, primarily Emergency Departments, are required to report all suspected and confirmed cases of opioid overdose requiring administration of naloxone, to IDPH’s designated data collection site within three days of administration. This temporary order supports timely understanding and response to potential overdose outbreaks and helps direct prevention efforts. As of mid-December 2018, over 540 opioid overdoses (both fatal and non-fatal) requiring naloxone administration have been reported by hospitals in Iowa. This information has been used by IDPH to target intervention activities

with two counties

- To assist communities, IDPH adapted the assessment workbook developed though the Iowa Partnerships for Success and Strategic Prevention Framework-Rx federal grants. Community organizers completed the workbooks, which allowed stakeholders to determine what was most needed in their communities and create strategic plans to address those identified needs. Some of the results to date include:
    - 118 people received MAT-related medical evaluation/assessment.
    - More than 1,300 people participated in naloxone training that included distribution of naloxone.
    - More than 2,100 Iowans – health care providers, mental health and substance use disorder professionals and staff, and other interested community members – received information on opioid topics from treatment providers across the state.
- IDPH developed an informational campaign focused on the Good Samaritan law passed as part of 2018's HF 2377. The Good Samaritan law encourages those who witness a drug overdose to stay and call 911, rather than leaving the scene out of fear of prosecution. Generally, overdose bystanders, defined as "overdose reporters" under the law, will not be arrested, charged or prosecuted for possession of a controlled substance, delivery of a controlled substance or possession of drug paraphernalia, if they make a good faith effort to seek medical assistance for an overdose patient. The Good Samaritan law protects overdose reporters if they:
    - Are the first person to seek medical assistance for
    - the overdose victim
    - Provide their contact information to emergency
    - personnel
    - Remain on the scene until assistance is provided
    - Cooperate with emergency personnel

- IDPH staff conducted more than 25 presentations in 2018 on opioid related topics, to multiple stakeholders
- To assist providers in understanding alternatives to opioids, IDPH sponsored the Approaches to Pain Management Symposium on October 30, 2018. With nearly 100 people in attendance, the symposium provided an overview of a range of non-pharmacological approaches to addressing pain in addition to, or as an alternative to, the use of opioids. Presentation topics included a national perspective on approaches to pain management, chiropractic care, mindfulness-based stress reduction, physical therapy, acupuncture and alternative medicine, yoga therapy, nutrition and physical activity, and interventional orthopedics
- UCS Healthcare, a medication-assisted treatment (MAT) provider based in Des Moines, has partnered with the Bureau of HIV, STD, and Hepatitis on a demonstration project to integrate and routinize HIV and HCV testing in a MAT setting. IDPH staff provided training on the fundamentals of HIV and Hepatitis for UCS clinic staff in March 2018. From March to September, UCS Healthcare administered 146 HCV tests at their Des Moines office, with a 31 percent positivity rate. The results of this demonstration project has been very promising and will contribute to additional strategic discussions around

integration of testing in similar settings.

- IDPH used its federal State Targeted Response (STR) grant to fund community needs assessment and strategic planning to support local communities to become "opioid-informed," defined as a community where stakeholders:
    - Are aware of current opioid-related risks and problems in their communities
    - Prioritize education, prevention, treatment and recovery from opioid use disorders; and
    - Agree to implement a plan of action to address both the current opioid crisis and underlying factors that may contribute to the crisis

Recovery Support Services (RSS)

IDPH provides Recovery Support Services through the IPN and through discretionary grant funding, including the following:

The IPN funding provides RSS services through:

Recovery Peer Coaching,

Recovery Peer Coaching: The Iowa Department of Public Health has defined Recovery Peer Coaching as face-to-face meetings between an individual and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective. The Recovery Peer Coach must complete a standardized training program of recovery peer coaching, peer facilitation or peer support that is acceptable to the Iowa Department of Public Health. Acceptable training would include completed training in the Connecticut Community for Addiction Recovery (CCAR) model or training based on the Georgia Model of Peer Support. For anyone not trained using the CCAR model, 3 additional hours of substance use disorder specific education is required. In addition to the training, a Recovery Peer Coach must be a person with lived experience with a substance use disorder, has been in recovery for a minimum of 12 months, and is willing to share those experiences.

History of Recovery Peer Coaching: In November 2007, Iowa was awarded the Access to Recovery (ATR) II grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). As part of the ATR program, Iowa introduced Recovery Peer Coaching as a service to compliment Iowa's Recovery Oriented System of Care. With help from Altarum, the CSAT technical assistance contractor, Iowa brought the Connecticut Community for Addiction Recovery (CCAR) to Iowa in November 2008 to assist in the ongoing development and implementation of Recovery Peer Coaching. Using their established curriculum, CCAR provided training to over 30 coaches, representing 20 agencies, and provided additional training for 10 individuals to be trained as a "train the trainer." Since that initial training, Iowa has conducted additional Recovery Coaching Academy's to form a group of nearly 100 coaches. In February 2019 additional trainings were conducted with funding provided by three SAMHSA grants, State Youth Treatment Implementation (SYT-I), State Opioid Response (SOR) and Residential Treatment for Pregnant and Postpartum Women (PPW). The trainings and total trained in each model include: Recovery Coaching Academy - 25, TOT – 12; Recovery Coaching

Academy for Young Adults – 14, TOT – 7; and Ethical Considerations for Recovery Coaches – 17, TOT – 8. As a result, Recovery Peer Coach Trainers that participated in the February 2019 training coordinated a training in their community in August 2019. An additional Recovery Coaching Academy is planned for September 2019 and is funded by SAMHSA grants, including the Substance Abuse Block Grant technical assistance funding and PPW.

Historically, Iowa Medicaid reimbursed Peer Support services, through the Medicaid State Plan B3 services; and the definition of training included language for only training through the Georgia Model of Peer Support. These Peer Support services required serving individuals with either a primary mental health diagnosis and/or co-occurring mental health and substance use disorder diagnosis. Individuals with a primary substance use disorder were not eligible for Iowa Medicaid reimbursement. In April 2016, Iowa modernized its Medicaid Program to a proactive, patient-centered approach. This approach included requirements for recovery peer coaching to become a billable Medicaid service. MCOs, DHS and IDPH have collaborated to promote policy which supports parallel training. IDPH collaborated with the Iowa Behavioral Health Association (IBHA), an association of mental health and substance use disorder providers, and the MCO's to develop and implement consistent Recovery Peer Coaching Criteria and Utilization Management Guidelines. IDPH and DHS have reviewed the curriculum content for the U of I sponsored peer support training and the CCAR curriculum promoted by IDPH. Iowa Medicaid will accept either version of the training with an additional 6 hours of specialized training either in substance use disorders or mental health. The CCAR curriculum is now recognized by Iowa Medicaid, under the B3 service description, and the Department of Human Services; the state agency which has oversight of Iowa Medicaid and IDPH Recovery Peer Coaching is now Medicaid eligible for billing under Medicaid reimbursement and is an optional RSS for IPN funding if the individual is not Medicaid eligible.

Care Coordination: Care Coordination is a new IPN service added within the January 2019 RFP. Contractors may bill care coordination when services are provided during the month. The Licensure Standards define Care Coordination as "the collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services, both internal and external to the program, to meet patient needs, using communication and available resources to promote quality care and effective outcomes." Care Coordination services are provided to active patients. The following criteria is noted in the IPN Provider Manual:

- For Care Coordination billing purposes, a patient must receive at least one Licensed Program Service from the contractor during the month
- Care Coordination encompasses the broad range of patient-specific people, systems, and issues related to the patient's current situation and future recovery. These may include, but are not limited to, family members, referral sources, employers, schools, medical and mental health professionals, the child welfare system, the courts and criminal/juvenile justice systems, housing status, legal needs, and recovery support
- Care Coordination is generally conducted by contractor staff, outside of patient counseling sessions
- Care Coordination includes use of electronic information and telecommunication technologies to support patients through check-in calls and texts.

For the first six-months of 2019, IDPH reimbursed IPN providers for 8,797 units of Care Coordination (where a patient had at least 1 treatment service during the month).

Transportation: Transportation is a new IPN RSS added within the January 2019 RFP. Transportation means assistance in the form of gas cards or bus passes, given directly to the patient for the purpose of transportation to and from an activity related to the patient's treatment plan or recovery plan.

Data available since January 1, 2019 indicates that $745 in transportation was provided.

Other RSS:

Recovery Month: SAMHSA has promoted *National Recovery Month* each September since 1989 to honor prevention, treatment, and recovery service providers; educate others about how behavioral health services help individuals live healthy, rewarding lives; and applaud those in recovery. Starting in 2013, individual communities were offered funding for local recovery month events. In 2018, IDPH funded 13 organizations across the state to provide local recovery month activities. Some of the local activities included recovery themed painting classes, Annual Recovery and Wellness run/walk, recovery month carnival and recovery bike ride.

Treatment and Prevention discretionary grants which also support recovery support services (RSS)

Opioid State Treatment Response (STR) STR was funded by SAMHSA CSAT from May 1, 2017 to April 30, 2019. A 12 month no-cost extension was also approved, extending several efforts through April 30, 2020. The focus of this project was to build community capacity for a successful community response to the opioid crisis through the following goals: Build an enhanced, statewide infrastructure to address opioid misuse in Iowa; Increase awareness of opioid risks through statewide prevention efforts and; Increase the use of medication assisted treatment and other evidence-based practices in Iowa. STR helped Iowa to increase prevention, treatment and recovery services for individuals with an opioid use disorder, and to help develop more opioid informed communities. Through this funding, IDPH is able to support several initiatives, which includes:

- Helping communities develop opioid-specific needs assessments and strategic plans
- Training over 8,500 Iowans on naloxone administration
- Expanding availability of medication assisted treatment through Medication Units
- Providing treatment and recovery support services to over 500 Iowans
- Supporting PMP enhancements through the Board of Pharmacy

Residential Treatment for Pregnant and Postpartum Women: IDPH was awarded a PPW grant on September 30, 2015 to implement through September 29, 2018. The IDPH PPW program goals are to expand and enhance the continuum of care for pregnant and postpartum women in residential treatment and to increase the capacity of residential programs to provide services to the

family unit. Iowa was provided with a No Cost Extension approval in September of 2018 to continue providing services to pregnant and postpartum women in Iowa for a year until September 29, 2019.The program was originally implemented at three and expanded to the four IDPH-funded residential women and children treatment programs. The purpose of the PPW grant is to offer comprehensive treatment and recovery services that support each woman's self-determined personal recovery plan.

Each of the four programs utilize a Women's Coordinator to implement a care coordination approach to provide clinically appropriate evidence based practices. The primary focus for the fourth and final year was improve and increase the number of services received by the partners, fathers and family members of the women enrolled. As of July 31, 2019 the Iowa PPW grant has provided services to 441 pregnant and postpartum women. Each of the pregnant and postpartum women and their families enrolled in Iowa PPW receive Recovery Support Services that includes support for Supplemental Needs such as funding education opportunities, gas cards for recovery activities, supporting sober living activities and funding basic clothing and hygiene needs.

State Opioid Response Grant: IDPH received the State Opioid Response (SOR) grant from September 30, 2018 to September 29, 2020 to further expand the capacity of the existing regional substance use disorder prevention and treatment provider network with a focus on increasing access to opioid use disorder treatment including FDA-approved medications for all Iowans in need. Funding is provided to the IPN network for implementation of opioid efforts, building on the capacity improvements of the State Targeted Response (STR) grants. The network providers joined with local stakeholders to update the opioid-specific Community Assessment Workbooks as well as Strategic Action Plans to become opioid-informed communities. The goals on both the local and state levels include: increasing access to Medication Assisted Treatment (MAT) in both rural and urban areas, increasing awareness of the risks involved in opioid misuse, and increasing both knowledge and availability of naloxone.

State Youth Treatment Implementation Grant (SYT-I): SYT-I is funded by SAMHSA and awarded to IDPH from September 30, 2015 - March 29, 2019. This project supported efforts to expand and enhance evidence-based practices and recovery support services that are utilized in substance abuse treatment for adolescents and transitional aged youth (TAY) ages 12-25. Four substance use disorder treatment providers in Iowa received training to implement Motivational Enhancement Therapy/Cognitive Behavioral Therapy 5 (MET/CBT 5) and Multidimensional Family Therapy (MDFT), along with an array of Recovery Support Services (RSS) to compliment treatment. Nearly 450 youth ages 12-25 were served in the grant with either treatment modality and were offered RSS. Total expenditures for RSS was $45,498. Analysis shows receiving RSS was associated with success as reported by The Consortium for Substance Abuse Research and Evaluation in the SYT-I, Year Three, Final Report (2019).

Iowa Prevention of Opioid Misuse in Women Program is a three year (08/01/2017-06/30/2020) grant awarded to the Iowa Department of Public Health Division of Behavioral Health (IDPH) by the Department of Health and Human Services (DHHS) - Office on Women's Health (OWH). The purpose of this program is to expand the prevention strategies that support the decrease of opioid

misuse in women. The Iowa Department of Public will expand prevention strategies through two approaches including (1) Screening, Brief Intervention, and Referral to Treatment (SBIRT) trainings to community service professionals who provide services to women and (2) development and implementation of a digital media campaign to increase awareness on the risks of opioid misuse for women. During the first two years of the grant provided a total of 10 trainings across the state of Iowa to over 400 community service providers. Additionally, during the 2nd year, IDPH's media campaign for this grant created 4,123,890 impressions and had a click through rate of .08%. This resulted in the campaign sending over 2,500 Iowans to the Your Life Iowa website landing page for this grant.

Promoting the Integration of Primary and Behavioral Health Care: Iowa's *Promoting the Integration of Primary and Behavioral Health Care (PIPBHC)* grant is a five-year project awarded to the Iowa Department of Public Health Division of Behavioral Health (IDPH) by the Substance Abuse and Mental Health Services Administration- Center for Mental Health Services (SAMHSA-CMHS). The purpose of this project is to:

- promote full integration and collaboration in clinical practice between primary and behavioral health care
- support the improvement of integrated care models for primary and behavioral health care to improve overall wellness and physical health status of adults with serious mental illness (SMI) and adults with substance use disorders (SUD)
- promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases
- Iowa's Integration Project will accomplish these objectives through the utilization of a person-centered integrated care team approach to address the whole person's health and wellness for 875 people throughout the five years of the grant.

Opioid Treatment Programs: Iowa funds one IPN contractor for opioid treatment dosing services. UCS Healthcare, headquartered in Des Moines, has three Opioid Treatment Programs in Iowa. In addition to these OTP sites, UCS also operates nine Medication Units across the state. These programs provide opioid detoxification and maintenance treatment services to individuals assessed as in need of such services but without means to pay. Providers participate in the IDPH Iowa Central Registry and apply for take home medication exceptions through the CSAT exception extranet. For the first 6 months of CY 2019, 14,288 doses of Methadone were provided. Programs are monitored through the IDPH Opioids Initiative Director and Data team.

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 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. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States 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, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

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

Footnotes:

BG App 2020-2021
Planning Step II- Needs and Gaps

State 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 is the capital city. The State of Iowa had an estimated population of 3,130,869 in 2016 (U.S. Census, 2017). Iowa borders two great American rivers, the Mississippi and the Missouri on its east and west sides, thus making it part of the Lewis and Clark Expedition.

According to the 2016 U.S. Census estimate, 90.4 percent of Iowans are White, non-Hispanic, 5.7 percent Hispanic or Latino, 3.6 percent African American or Black, 2.4 percent Asian, 0.3 percent American Indian and Alaska Native, and 0.1 percent Native Hawaiian and other Pacific Islander. More than 90 percent of Iowans have a high school diploma or higher, and 28 percent have a bachelor's degree or higher.

Iowa Population by Sex, Age, Race/Ethnicity, and Urban and Rural Designation, U.S. Census Bureau, 2016

Sex	Percent
Female	50.3
Male	49.7
Age (in years)	
<1 (infancy)	1.2
1 – 14 (childhood)	18.1
15 – 24 (adolescence/ young adulthood)	14.3
25 – 44 (early working age)	24.3
45 – 64 (older working age)	25.7
65+ (older adult)	16.4
Race/Ethnicity	
White	87
Hispanic or Latino	5.8
Black or African American	4.2
Asian	2.7
American Indian and Alaska Native	0.3
Urban and Rural Designation	
Urban	64.3
Rural	35.7

Discussion of Needs/Gaps/Unmet Needs in Prevention and Treatment System

Iowa is a rural state with many of the same social and substance use disorder issues as other rural states: the decline of rural life resulting from the disappearance of the family farm, subsequent decaying of the infrastructure of small towns, isolated communities, growing

dependence on the gaming industry, and other needs. Iowa is among the small number of states not dominated by a major metropolitan area. It is comprised of rural areas, small towns, and small cities — the population in Iowa is markedly older than most states, moderately educated, and less likely to include minority group members. Consideration of Iowa's unique population is important in comparing state or local data with national data.

The Iowa legislature has been forthcoming on policy to prevent substance use disorder and related deaths. Several policy proposals at the state and local level have been enacted to address alcohol (Keg registration, 21 only proposition), tobacco ($1 tax raise in 2006, Iowa Smoke-Free Air Act), illicit drugs (e.g., methamphetamine with Pseudoephedrine Control Law), and most recently, access to Naloxone (expanding availability beyond medical and emergency personnel to persons in a position to assist, and allowing dispensing through a Standing Order). However, it is important to understand that the burden of substance use disorder requires continuous efforts to reduce the consequences of substance use among Iowans of all ages.

Iowa is one of the states with the highest prevalence of binge drinking and alcohol use (i.e., past 30 days). Iowans surveyed have significantly higher levels of alcohol use acceptance, binge drinking, and lower perception of risk than other states. The results from the data also demonstrate significantly increased use of Methamphetamine admissions (specifically increased Methamphetamine diagnosis for pregnant and parenting women), increased alcohol related fatalities, high rates of binge drinking, increased use of e-cigarettes, increased rates of suicidal ideation among 18-25 year olds and the percentage of students who reported having a plan to kill themselves within the past year increased by 53.0%. All reported data/unmet needs are illustrated in the Iowa Health Barometer Report, the Iowa Youth Survey data, and the Epidemiological Profile by BRFSS and NSDUH data.

Iowa also continues to address substance use disorder prevention and treatment efforts related to prescription drug misuse and opioid addiction. Strategies focusing on the need to increase access to medication assisted treatment (MAT) and to increase the number of MAT providers is a priority area for IDPH. Iowa's goals will focus on strategic planning with the Integrated Provider Network/SSA funded providers to build capacity and competency of this workforce in relationship to meeting these goals.

Role of the State Epidemiological Workgroup (SEW)

In 2006, the Iowa Department of Public Health (IDPH) received funding from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention, for a **State Epidemiological Outcomes Workgroup** (SEOW; name changed later to the **State Epidemiological Workgroup** (SEW)).

The IDPH Division of Behavioral Health, the Single State Authority for substance abuse prevention and treatment, administers the funds and activities of the SEW. Through the SEW, Iowa initiated a systematic process to identify and analyze substance use and abuse epidemiology statewide. The resulting epidemiological profiles of substance use helped assess substance use issues and prioritize prevention services and treatment. Statewide

profiles were divided into sections to summarize data by consumption patterns and consequences of use of various substances. The SEW Workgroup directs and reviews substance related data, develops the Epi Profile, every 2 years, providing input into data related decision making and leads work related to the SABG priorities/goals..

The Epidemiological Profile can be used to:

- Guide actions for substance abuse problems in Iowa
- Measure the burden of substance abuse problems
- Monitor trends in the burden of substance abuse, including the detection of substance abuse epidemic in Iowa
- Prioritize the allocation of substance abuse resources, and
- Provide a basis for substance abuse epidemiology.

The SSA Data Manager leads the SEW meetings which occur on a quarterly basis and several SSA staff are involved in SEW quarterly meetings. For more information/reports/resources/data related to the SEW, please see step I under Prevention or see http://idph.iowa.gov/substance-abuse/epidemiological-workgroup

IDPH Epidemiological Profile Key findings 2018 Report

The *2018 Epidemiological Profile* provides a comprehensive overview of the prevalence of substance use, mortality, and morbidity in Iowa. Within the SEW, underage alcohol use and adult binge drinking have been selected as priorities for substance use prevention efforts. Most recently, the *Iowa Partnerships for Success* project focuses on addressing underage drinking and youth binge drinking among Iowans ages 12 to 20.

The Epidemiological Profile serves as a tool to assess, collect, and evaluate substance use disorder and consequences affecting Iowans. The SEW process provides an avenue for SEW members, data managers, and stakeholders to consolidate surveillance data to examine the various health, social, and economic factors in Iowa. Based on this Epidemiological Profile, the following recommendations are made to ensure continuous efforts to reduce substance use problems in Iowa:

- Identify, collect and analyze new data related to substance consumption and consequence
- Analyze and evaluate relevant data systems for long-term use
- Identify indicators needing improvement or expansion of the surveillance
- Increase efforts to identify and collect data specifically among college students in Iowa.

Key Findings in the 2018 Epidemiological Profile:

Alcohol

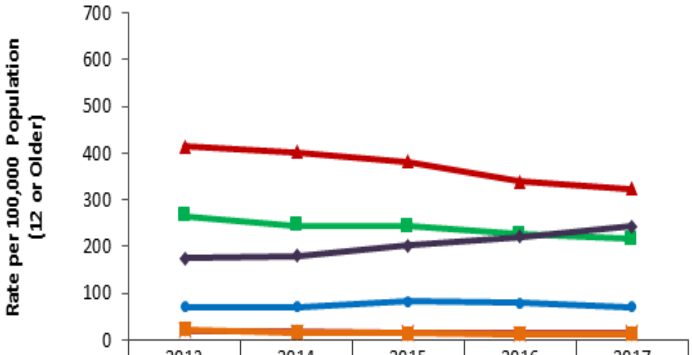
- ***Adult Consumption***
  - Alcohol remains the most reported primary substance of choice for treatment admission; however, the data shows a gradual decrease from 2013 to 2017 (414 per 100,000 to 323 per 100,000; IDPH, 2017)
  - Alcohol-related treatment admission was higher among adults aged 24-44

compared to other age groups

- Black or African American aged 18 or older had the highest rates of alcohol-related treatment admissions compared to Hispanic or Latino and White in the same age group
- The percentage of treatment admissions indicating alcohol as the primary substance of choice was higher among Iowans with bachelor's degree and higher compared to the other educational levels
- The percentage of Iowans reporting alcohol use in the past 30 days remained stable since 2007
- Alcohol use in the past 30 days is higher among Iowans compared to the national rate
- Among Iowa's six regions, Northeast Iowa had the highest alcohol use in the past 30 days; percentages range from 59.2 – 63.4 percent (NSDUH, 2016)
- Iowa men engaged in binge drinking at nearly twice the rate among women
- Iowans aged 18-24 had the highest percentage of binge drinking compared to other age groups

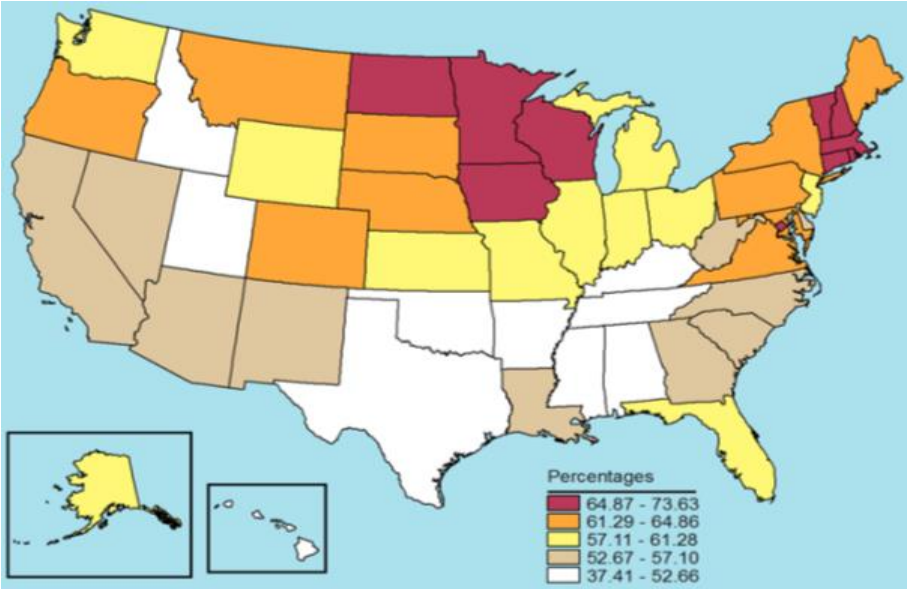
Alcohol is the substance most frequently used by Iowa adults and youth. The total number of substance use disorder treatment admissions decreased 7 percent from 2013 to 2017 (i.e., 29,873 to 27,780), indicating fewer Iowans received treatment in 2017. Alcohol remains the most reported substance at treatment admission albeit at a decreasing rate (2013 admissions 414 per 100,000; 2017 admissions 323 per 100,000; Figure 1). Methamphetamine was the second most-cited drug of choice noted on 2017 treatment admission (i.e., 244 per 100,000), followed by marijuana (i.e., 217 per 100,000 population), and opioids (i.e., 71 per 100,000 population; Figure 1).

Rate of Treatment Admission Primary Substance of Choice by Substance Type, Iowans 10 years of age and older, IDPH, 2013-2017



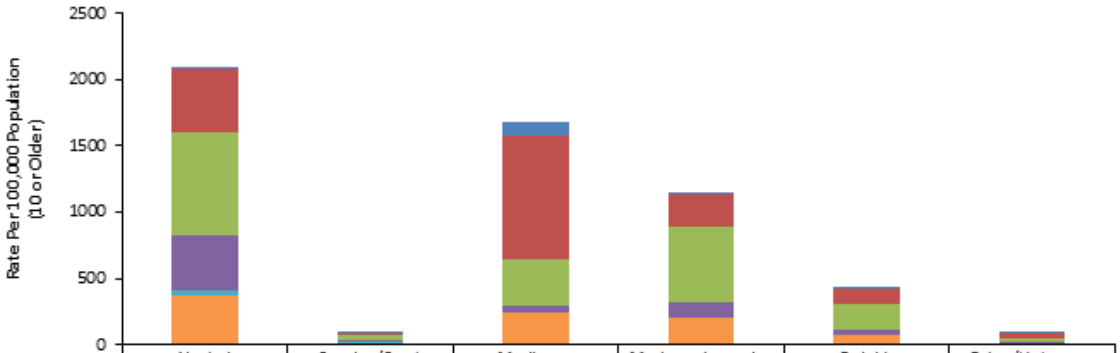
	2013	2014	2015	2016	2017
Alcohol	414	403	381	339	323
Cocaine/Crack	19	18	16	14	16
Marijuana	265	245	244	227	217
Methamphetamine	175	180	202	221	244
Opioids	71	70	82	79	71
Other/Unknown	23	15	14	12	12

Alcohol use in the past 30 days for individuals aged 18-25 is particularly alarming. The below table illustrates the frequency distribution of the percentages of those surveyed reporting alcohol use in the past 30 days. States are categorized into five groups based on the magnitude of their percentages; **Iowa was one of the states in the highest group** for alcohol use in the past 30 days.



The illustration below shows the average rate of people aged 10 or older reporting primary substance of choice at treatment admission. The average rates are based on combined 2013-2017 treatment admission data from Iowa Service Management and Reporting Tool (I-SMART). The 2013-2017 data indicated that the average annual percentage of treatment admissions for marijuana was highest among people aged 15 to 24 (929 per 100,000 population) compared to other age groups (Figure 2). The annual percentage of treatment admissions for alcohol was highest among people 24 to 44 (769 per 100,000 population) followed by people aged 15 to 24 (483 per 100,000 population) and 45 to 65 (419 per 100,000 population). Overall, among all ages in Iowa, alcohol (372 per 100,000 population) was the primary substance of choice followed by marijuana (239 per 100,000 population) and methamphetamine (204 per 100,000 population).

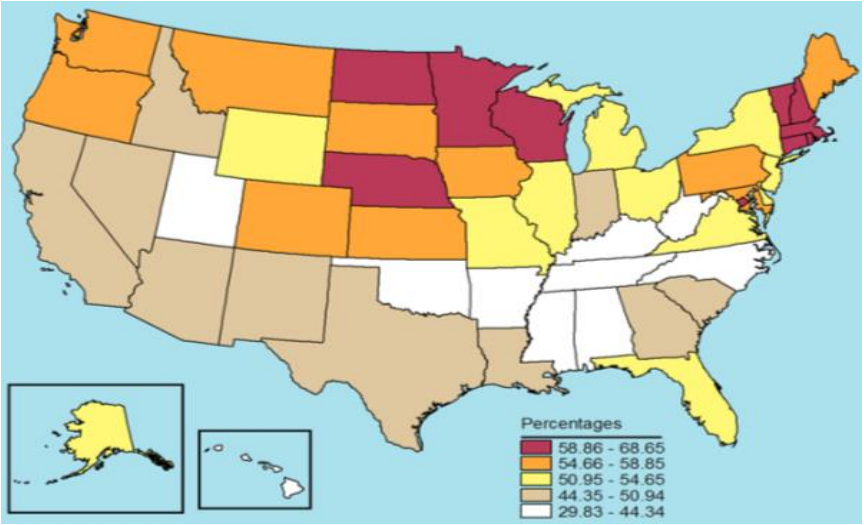
Average Rate of Primary Substance of Choice for Treatment Admission by Substance Type Age, IDPH, 2013-2017



	Alcohol	Cocaine/Crack	Marijuana	Methamphetamine	Opioids	Other/Unknown
10-14	15	0	113	2	2	4
15-24	483	12	929	253	118	42
24-44	769	34	348	568	191	30
45-65	419	25	55	115	41	7
65+	41	1	1	2	3	0
All Ages	372	17	239	204	74	15

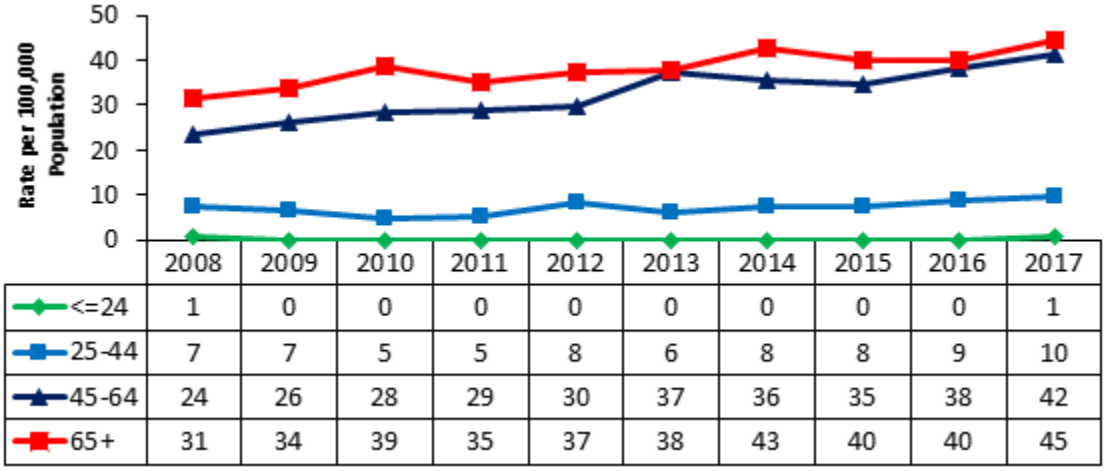
Alcohol data regarding past 30 Day use, aged 12 or Older, NSDUH, 2015-2016 illustrates the percentage of people aged 12 or older reporting alcohol use in the past 30 days. The color legend illustrates the frequency distribution of the percentages of those surveyed reporting alcohol use in the past 30 days in the United States. States are combined into five groups based on the magnitude of alcohol use percentages; Iowa was categorized in the **second highest group nationally.** The states with the highest percentages of those surveyed reporting alcohol use in the past 30 days are in the upper Midwest and New England.

The graph below demonstrates the states magnitude of alcohol use percentages:



According to the World Health Organization (2018), three million deaths occur globally each year because of the harmful use of alcohol. In the U.S. in 2010, an estimated 70,000 people died from alcohol use, making alcohol the third leading cause of premature deaths. The first and second leading causes of preventable factors causing premature deaths in the U.S. were diet/inactivity (400,000) and tobacco use (350,000), respectively. Alcohol-involved deaths are a public health concern in Iowa. These deaths significantly increased over the past decade in Iowa. In 2017, 650 Iowans died from alcohol-involved causes such as acute poisoning, chronic diseases, injury and perinatal causes. Iowa alcohol-involved death rates increases with age, and is two times higher among males and alcohol-involved deaths are prevalent among Iowans aged 45 to 64, and 65 or older.

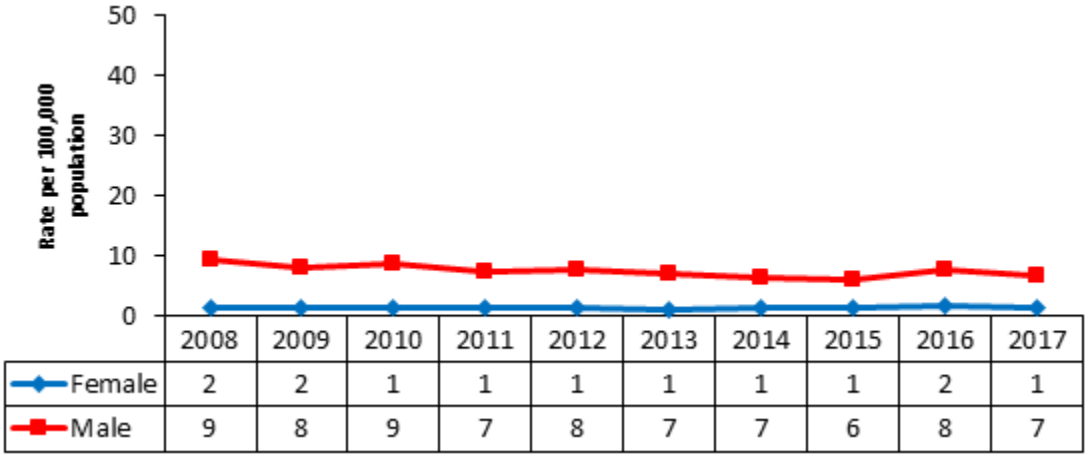
The graph below demonstrates the Alcohol-Involved Deaths by Age, IDPH



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
<=24	1	0	0	0	0	0	0	0	0	1
25-44	7	7	5	5	8	6	8	8	9	10
45-64	24	26	28	29	30	37	36	35	38	42
65+	31	34	39	35	37	38	43	40	40	45

From 2008 to 2017, alcohol-involved deaths increased by 45% among Iowans aged 65 or older, and 75% among Iowans aged 45 to 64. In 2017, the rate of alcohol- involved deaths was 45 per 100,000 population for Iowans aged 65 or older, and 42 per 100,000 population for Iowans aged 45 to 64. In 2017, there were 330 deaths from motor vehicle crash in Iowa. Of these 330 crash deaths, 88 (27%) involved at least one driver with a Blood Alcohol Concentration (BAC) of .08 g/dL or higher, which is above the legal intoxication level. Alcohol-involved motor vehicle crash deaths were higher among alcohol-impaired males compared to their female counterparts. In 2017, the rate of alcohol-involved motor vehicle crash deaths was 7 per 100,000 population for males and 1 per 100,000 for females.

Fatality Rate Involving Alcohol-Impaired Driving Crashes by Sex

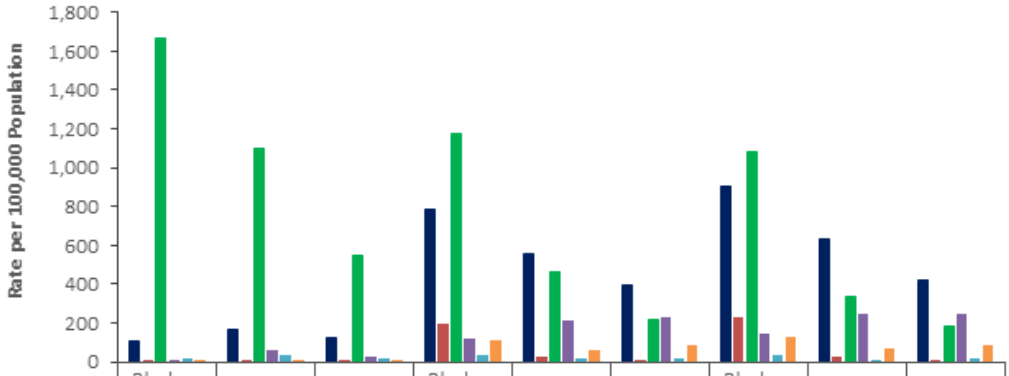


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Female	2	2	1	1	1	1	1	1	2	1
Male	9	8	9	7	8	7	7	6	8	7

The illustration below shows the annual average rate of primary substance of choice for treatment admission among three different age groups (i.e., 12 to 17, 12 or Older, and 18 or older) by race/ethnicity. From 2013-2017, the rate of marijuana treatment admission was significantly higher among Black or African Americans 12 to 17 years old. Among

Iowans aged 18 or older, alcohol was the primary substance of choice at treatment admission for Black or African Americans, Hispanic or Latinos, and White.

Rate of Primary Substance of Choice for Treatment Admission by Substance Type, Race/Ethnicity, IDPH, 2013-2017



	12-17			12+			18+		
	Black or African American	Hispanic or Latino	White	Black or African American	Hispanic or Latino	White	Black or African American	Hispanic or Latino	White
Alcohol	108	168	121	782	553	391	908	630	418
Cocaine/Crack	4	7	2	194	24	11	230	27	12
Marijuana	1,666	1,095	545	1,172	466	218	1,078	339	186
Methamphetamine	9	61	31	121	213	231	142	243	251
Other/Unknown	18	33	21	32	16	17	34	12	16
Opioids	4	5	10	112	58	82	132	69	89

- ***Youth Consumption -Alcohol***
  - Alcohol use in the past 30 days and binge drinking among Iowa youth continue to decline for all grade levels (Grades 6, 8, 11)
  - From 1999 to 2016, alcohol use in the past 30 days decreased by 65 percent and binge drinking decreased by 75 percent among all grade levels
  - From 2002 to 2016, perceived alcohol availability for all grade levels declined by 21 percent

<u>Tobacco</u>

- ***Youth/Adult Consumption***
  - Iowans with less than a high school education had the highest rate of cigarette use in the past 30 days compared to other educational levels
  - Cigarette use in the past 30 days decreased by 12 percent in Iowa
  - In 2016, 5 percent of youth in all grade levels (i.e., Grades 6, 8, 11) reported e-cigarette use in the past 30 days
  - According to the 2018 Iowa Youth Survey, 23% of 11th grade students, 8% of eighth grade students and 2% of sixth grade students currently use

e-cigarettes. The long-term health consequences for youth using these products are unknown.

The below table illustrates the percentage of youth reporting e-cigarette use in the past 30 days by grade. In 2014, an e-cigarette use question was added to the Iowa Youth Survey (IYS). The question is: "In the past 30 days, on how many days have you used electronic cigarettes or e-cigarettes (battery-powered cigarettes)?" In 2016, the IYS e-cigarette question revised to: "In the past 30 days, on how many days have you used e-cigarettes (vape-pens, hookah-pens, e-hookahs, e-cigars, e-pipes, personal vaporizers or mods)?" It is important to acknowledge that changes made to the context of the survey question could lead to different responses for the 2014 and 2016 IYS results. The table below demonstrates these data demonstrating increased use in all grades surveyed and the distribution between male and female usage.

Past 30 Day E-Cigarette Use among Youth by Grade & Sex, IYS, 2016-2018

Grade	**2016**	**2018**
6th	**1%**	**2%**
8th	**3%**	**8%**
11th	**9%**	**23%**
All Grades	**5%**	**11%**
Sex		
Male	**7%**	**11%**
Female	**5%**	**10%**

Vaping

- ***Youth/Adult Consumption***
    - Cases of severe respiratory illness associated with vaping continue to be reported across the U.S. and in Iowa. Nationwide, the Centers for Disease Control and Prevention has reported 805 cases and 12 deaths
    - Nationally, most cases have reported the use of vaping and e-cigarette products containing THC; however, vaping products and devices that do not contain THC have also been reported among affected states. Case numbers will likely continue to increase as this investigation continues.
    - In Iowa, there have been 23 reported cases and no deaths. Of the 23 Iowa cases, ages range from 17 to 60, 18 have reported the use of THC
    - Mirroring national statistics, most of the cases (78%) have been male.
    - All Iowa cases have recovered.

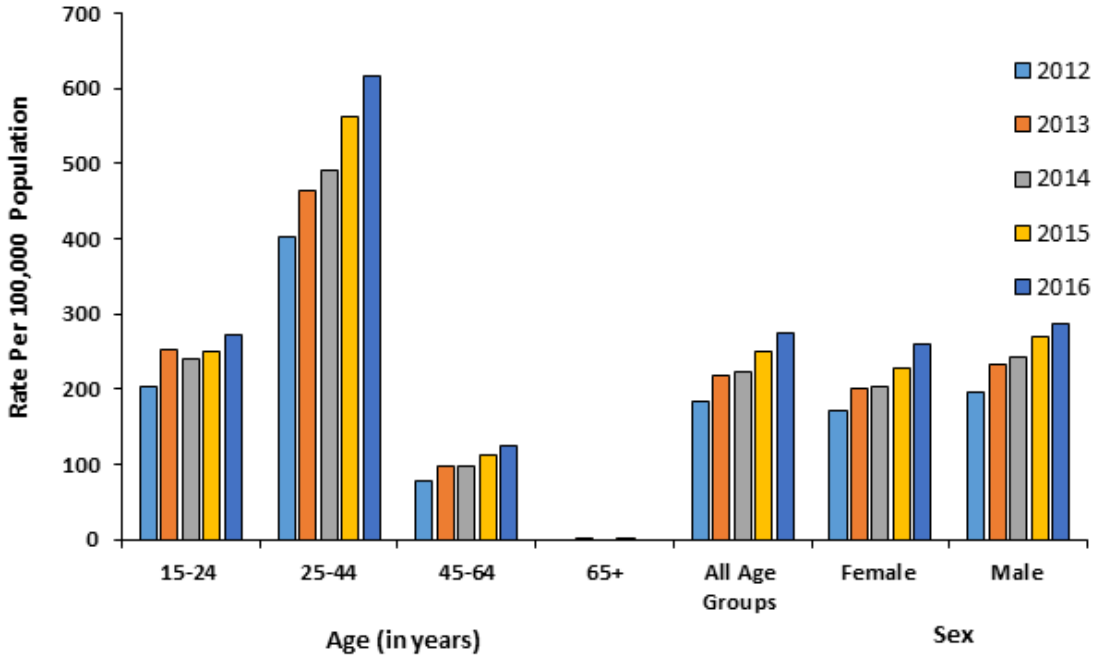
Marijuana and Illicit Drugs

- ***Adult Consumption***
    - Marijuana use in the past 30 days fluctuated between 5 – 6 percent for Iowans aged 12 or older from 2007 to 2014.
    - Compared to other states, Iowa was among those states with the lowest marijuana and cocaine use in the past 30 days.
    - Cocaine use in the past 30 days was higher among Iowans aged 18-25 compared to other age groups.
    - **Methamphetamine-related treatment admissions doubled since 2012** and the rates were higher for males than females; however, the primary and secondary diagnosis for admissions of women related to Methamphetamine have significantly increased.

The rate of methamphetamine-related treatment admissions in Iowa has nearly doubled since 2012. In 2016, more than 6,900 Iowans were admitted for methamphetamine use disorder treatment. The methamphetamine-related treatment admission rate increased from 183.4 per 100,000 population in 2012 to 273.9 per 100,000 population in 2016. Iowans aged 25 to 44 had the highest rates of methamphetamine-related treatment admissions compared to other age groups. Rates were higher for males than females. Among males, the rate increased from 195 per 100,000 population in 2012 to 288 in 2016. Among females, the rate increased from 172 per 100,000 population in 2012 to 260 in 2016.

IDPH has also noted upward trends of women using methamphetamine. Iowa's data reflects significant increases in admissions related to methamphetamine use disorder (MUD) by women in years that are more recent. Treatment admissions in Iowa for use of methamphetamine has increased by 38% in Iowa from 2014 to 2017, which corresponds with an eightfold increase in MUD-related deaths during the same period. Within Iowa, fewer pregnant women with SUD enter treatment (3.8%) than in the rest of the nation (4.2%). The most frequently reported substances used by women in Iowa admitted for SUD treatment include methamphetamines (48.2%), alcohol (23.7%), and marijuana (17.1%). In addition, in 2016 the rates of amphetamine-related Emergency Department visits were higher for females than for males. Pregnant women report MUD use at a higher rate (58.9%) than others (48.2%) do The analysis includes actual counts of the primary and secondary substances reported by unique individuals. The below chart illustrates a critical need/gap in Iowa:

Methamphetamine Treatment Admissions Rate by Age and Sex, 2012-2016



- **Youth Consumption**
  - Illicit drug use in the past 30 days was less than or equal to 2 percent for all grade levels (IYS, 2016)
  - In 2016, 85 percent of youth in all grade levels reported that their peers believed illicit drug use was Very Wrong - Wrong
  - Males had a lower perception of self-harm due to illicit drug use compared to females
  - Iowa youth who reported marijuana use before age 13 also continued to decrease since 2002

<u>Over the Counter and Prescription Medications</u>

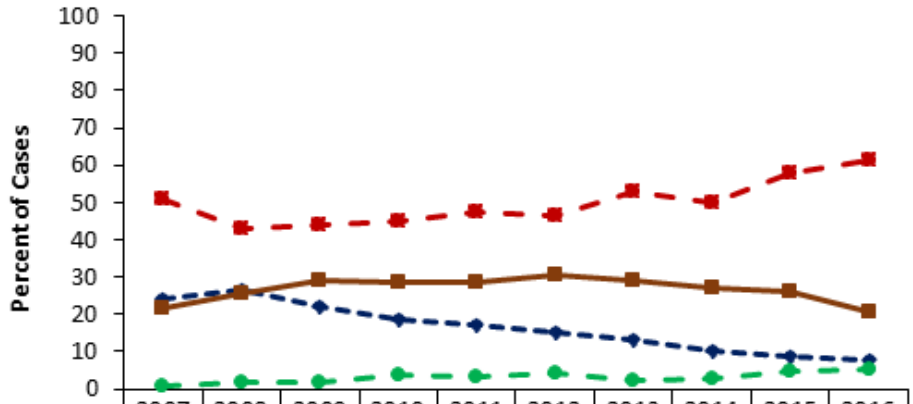
- ***Youth/Adult Consumption***
  - In Iowa, prescription medication misuse in the past year has remained relatively stable since 2007.
  - Opioid-related poisoning emergency department visits were higher among females compared to males.
  - Opioid-related deaths were higher among Iowans aged 25-44 compared to other age groups; opioid-related hospitalizations were higher among Iowans aged 45-64.
  - All drug-related emergency department visits were higher among Iowans aged 25 and younger.

- Marijuana use in the past 30 days fluctuated between 5 – 6 percent for Iowans aged 12 or older from 2007 to 2014.
- Although women had higher rates of all drug-related emergency department visits and hospitalizations, males had a higher rate of all drug-related deaths.
- Based on the IYS data, from 2005 to 2016, the rate of over the counter medication misuse in the past 30 days decreased 25 percent for all grades (6th, 8th, and 11th grade).

- ***Legal Consequences***
  - The rate of prison admissions in which methamphetamine was cited as primary drug of choice increased 20 percent in the past 10 years.
  - Marijuana was the second drug cited as primary drug of choice at prison admissions.
  - The rate of prison admissions in which opioids was cited as primary drug of choice increased 400 percent since 2007, from 1 percent to 5 percent.

The table below illustrates the percentage of prison incarceration by drug type. The data includes offenders who were newly admitted to prison with a most serious drug offense (Iowa Correctional Offender Network (ICON; 2016)). These drugs are identified as having the most significant harm to the users including, in order from most to least harmful, crack, heroin, methamphetamine, and cocaine ICON, 2016). The 2007-2016 ICON data demonstrate that upon prison incarceration, Iowa offenders reported methamphetamine as primary drug of choice more frequently than opioids, marijuana, and cocaine/crack. Between 2007 and 2016, the rate of prison admissions in which methamphetamine was cited as the primary drug of choice increased 20 percent, from 51 percent (2007) to 61 percent (2016). Since 2007, the rate for opioids as the primary drug of choice increased 400 percent, from 1 percent (2007) to 5 percent (2016). The rate in which marijuana was cited as the primary drug of choice upon incarceration has fluctuated over the past decade; however, cocaine/crack noted as the primary drug of choice decreased by 67 percent, from 24 percent (2007) to 8 percent (2016).

Prison Incarcerations by Primary Drug of Choice, ICON, 2007-2016

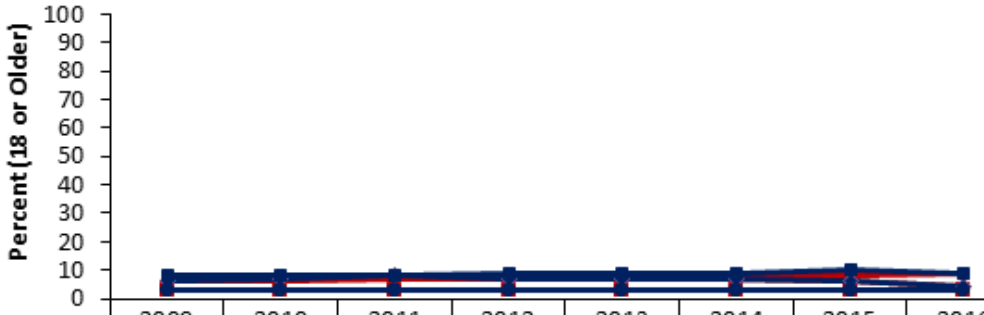


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Methamphetamine	51	43	44	45	47	46	53	50	58	61
Cocaine/Crack	24	27	22	19	17	15	13	10	9	8
Marijuana	22	25	29	28	28	30	29	27	26	21
Opioids	1	2	2	4	4	4	3	3	5	5

- ***Mental Health***
  - Between 2009 and 2016, Iowans aged 18 to 25 with major depressive episodes in the past year increased 38 percent.

The below table illustrates the percentage of Iowans aged 18 or older who reported "Serious thoughts of suicide" in the past year. The 2016 NSDUH data estimated approximately 96,019 (4 percent) of Iowa adults aged 18 or older reported serious thoughts of suicide in the past year. In the same time period, the percentage of adults aged 18 to 25 had the highest rate (9 percent) of serious thoughts of suicide in the past year, which is similar to the national rate. Overall, there was no significant difference in serious thoughts of suicide between adults 18 or older and 26 or older in the past year statewide or nationally.

Past Year Serious Thoughts of Suicide among Adults by Age: Iowa and the U.S. NSDUH, 2009-2016



	2009	2010	2011	2012	2013	2014	2015	2016
Iowa - 18+	6	7	8	7	7	7	6	4
Iowa - 18-25	6	6	7	7	7	8	8	9
Iowa - 26+	3	3	3	3	3	3	3	3
U.S. - 18+	6	7	8	7	7	7	6	4
U.S. - 18-25	8	8	8	9	9	9	10	9
U.S. - 26+	3	3	3	3	3	3	3	3

<u>Iowa Behavioral Health Barometer Report</u>

According to the Behavioral Health Barometer: Iowa, Volume 5 Report, indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services, provides an annual update on a series of data sets that focus on substance use and mental health (collectively referred to as behavioral health) in Iowa. This report highlights those data:

- **Youth Substance Use**
  - ***Cigarette Use***
    - Among youth aged 12–17 in Iowa, the annual average percentage of cigarette use in the past month **decreased** between 2002–2005 and 2014–2017.
    - During 2014–2017, the annual average prevalence of past-month cigarette use in Iowa was 4.4% (or 11,000), similar to both the regional average (5.3%) and the national average (3.9%)
  - ***Marijuana Use***
    - Among youth aged 12–17 in Iowa, the annual average percentage of marijuana use in the past month did **not significantly change** between 2002–2005 and 2014–2017.
    - During 2014–2017, the annual average prevalence of past-month marijuana use in Iowa was 4.9% (or 12,000), similar to the regional average (5.2%) but lower than the national average (6.8%).

- ***Alcohol Use***
    - Among youth aged 12–17 in Iowa, the annual average percentage of alcohol use in the past month **decreased** between 2002–2005 and 2014–2017.
    - During 2014–2017, the annual average prevalence of past-month alcohol use in Iowa was 8.9% (or 22,000), similar to both the regional average (10.1%) and the national average (10.1%).

- ***Initiation of Substance Abuse***
    - Among youth aged 12–17 in Iowa, during 2013–2017, an annual average of 9.7% (or 24,000) used alcohol for the first time in their lives, similar to both the regional average (9.6%) and the national average (9.4%).
    - In Iowa, 3.6% (or 9,000) used marijuana for the first time in their lives, similar to the regional average (4.4%) but lower than the national average (4.8%).
    - In Iowa, 3.9% (or 10,000) used cigarettes for the first time in their lives, similar to both the regional average (3.5%) and the national average (3.1%).
- ***Youth Mental Health-Depression***
    - Among youth aged 12–17 in Iowa, the annual average percentage with a major depressive episode (MDE) in the past year **increased** between 2004–2008 and 2013–2017.
    - During 2013–2017, the annual average prevalence of past-year MDE in Iowa was 12.6% (or 30,000), similar to both the regional average (12.7%) and the national average (12.1%).
- ***Youth Mental Health-Depression Care***
    - Among youth aged 12–17 in Iowa during 2013–2017 with a MDE in the past year, an annual average of 46.7% (or 14,000) received depression care in the past year, similar to both the regional average (43.0%) and the national average (40.3%).
- ***Young Adult Binge Drinking- Ages 18-25***
    - Among young adults aged 18–25 in Iowa, during 2015-2017, the annual average prevalence of past-month binge alcohol use was 47.6% (or 171,000), **higher** than both the regional average (41.8%) and the national average (38.1%).
- ***Young Adult Mental Health- Serious Suicidal Ideation-Ages 18-25***
    - Among young adults aged 18–25 in Iowa, the annual average percentage with serious thoughts of suicide in the past year **increased** between 2008–2012 and 2013–2017.
    - During 2013–2017, the annual average prevalence of past-year serious thoughts of suicide in Iowa was 9.3% (or 33,000), similar to both the regional average (8.5%) and the national average (8.5%)

- 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 has increased 2.2% since the 2016 survey. For more information on the Iowa Youth Survey: http://www.iowayouthsurvey.iowa.gov/images/2018_State/IYS%202018%20State%20Report.pdf

- ***Iowa Youth Survey Results- Serious Suicidal Ideation***
  - From 2012 to 2018, the percentage of students who reported having a plan to kill themselves within the past year increased by 53.0%. One in ten students taking the Iowa Youth Survey in 2018 reported they had a plan to kill themselves in the past twelve months. From 2012 to 2018, the percent of 6th grade students who reported having a plan to kill themselves within the past year increased by 71.1%.
- ***Substance Use, Misuse and Use: Ages 12 and Older***
  - Among young adults aged 18–25 in Iowa, during 2015-2017, the annual average prevalence of past-month binge alcohol use was 47.6% (or 171,000), **higher** than both the regional average (41.8%) and the national average (38.1%).
- ***Substance Use- Heroin: Ages 12 and Older***
  - Among people aged 12 or older in Iowa, the annual average percentage of heroin use in the past year did not significantly change between 2002–2005 and 2014–2017
  - During 2014–2017, the annual average prevalence of past-year heroin use in Iowa was 0.03% (or 1,000), lower than both the regional average (0.15%) and the national average (0.33%)
- ***Substance Use- Opioid Use Disorder: Ages 12 and Older***
  - Among people aged 12 or older in Iowa, during 2015–2017, 0.4% (or 12,000) had opioid use disorder in the past year, similar to both the regional average (0.6%) and the national average (0.8%)
- ***Substance Use- Alcohol Use Disorder: Ages 12 and Older***
  - Among people aged 12 or older in Iowa, the annual average percentage of alcohol use disorder in the past year decreased between 2002–2005 and 2014–2017.
  - During 2014–2017, the annual average prevalence of past-year alcohol use disorder in Iowa was 7.0% (or 183,000), **higher** than both the regional average (6.0%) and the national average (5.8%)
- ***Substance Use Disorder: Opioid Treatment (Medication Assisted Treatment)***
  - In a single-day count on March 31, 2017, 1,200 people in Iowa were receiving methadone in opioid treatment programs as part of their substance use treatment – an **increase** from 623 people in 2013

- ***Substance Use Disorder: Opioid Treatment (Medication Assisted Treatment)***
    - In a single-day count on March 31, 2017, 1,200 people in Iowa were receiving methadone in opioid treatment programs as part of their substance use treatment – an **increase** from 623 people in 2013.

The Iowa Health Barometer Report may be found at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Iowa-BH-BarometerVolume5.pdf

Goals and plans to address gaps/challenges as reflected in above data:

Prevention:

Expand the capacity of the IPN Primary Prevention Workforce to target increased rates of Underage and Binge Drinking-Plan to Address: IDPH will work with the State Epidemiological Workgroup, Integrated Provider Network (IPN) Primary Prevention contractors, and discretionary grant contractors to address these issues. Contractors must meet required goals that reduce consumption of alcohol by persons under age 21 and reduce binge consumption of alcohol. These strategies include:

- IDPH is currently conducting three IPN Prevention Regional Trainings on the Strategic Prevention Framework to discuss the Assessment and Capacity steps, which will inform future prevention strategies.
- IDPH is supporting ongoing evidence-based programming through online and in-person trainings, during year one, to support IPN prevention agencies in their efforts to address underage alcohol use and binge drinking.
- Alcohol is a required prevention priority area that all funded agencies must address throughout the project period of the grant. Prevention strategies focusing on alcohol and currently include but are not limited to the following:
    - Evidence-based programming such as Life Skills, Project Alert, Curriculum Based Support Group, and Prime for Life;
    - Drivers education focusing on the risks and harms of underage drinking;
    - Health Promotion efforts such as the "What Do You Throw Away" underage drinking media campaign;
    - Responsible Beverage Server Training for liquor license establishments utilizing the Training for Intervention Procedures evidence-based program;
    - Providing technical assistance and support to local community coalitions to discuss the importance and benefits of alternative activities;

- Share information with IPN prevention contractors, throughout years one and two, on the best practices gained through services provided in the Strategic Prevention Framework - State Incentive Grant and the Partnership for Success Grant.
- Attend quarterly State Epidemiological Workgroup - Prevention Partnerships Advisory Council (SEWPPAC) meetings to discuss underage drinking and binge drinking data throughout the state.
- Youth Substance Abuse Prevention Service (YSAPS) Grant funded agencies provide Youth Development and Prevention through Mentoring services. Prevention efforts work to address behavioral health topics primarily focusing on substance misuse prevention efforts.

Expand the capacity of IDPH, the IPN Primary Prevention Workforce, and other stakeholders to develop strategies for Alcohol Related Deaths-Plan to Address:

- Creation of an IDPH alcohol-related death workgroup with collaborators from across the department and a variety of state agencies to ensure continuation of recommended prevention strategies and policies and to share information about this important topic
- Creation of an alcohol and older adults media campaign to help adults understand the risks of alcohol use on an aging body
- Promotion of specific prevention programs and policies to address this priority issue.

Increase IPN workforce competency in Zero Suicide: Youth and Young Adult Mental Health- Serious Suicidal Ideation Increase-Plan to Address:

- The majority of contractors utilize the PHQ-9, with the few others utilizing screenings such as SAD Persons scale, suicide risk assessment, Columbia Suicide Severity Tool etc. IDPH will require ALL IPN providers to implement an evidenced based screening tool for suicide/depression screening and to repeat screening as needed throughout the treatment episode. IDPH will explore the use of requiring one specific screening
- IDPH will educate the IPN contractors about co-occurring disorders, data and the required focus to either provide mental health related services or utilize care coordination to provide warm handoffs and secure linkages to mental health providers in the community
- IDPH will provide training on the Zero Suicide framework to all IPN contractors by the end of the fourth project year of the SAMHSA grant. Approximately half of the providers will be trained via the Zero Suicide Academy by September 2020
- IDPH will continue to provide education to IPN. IDPH will work with contractors to complete detailed safety planning for participants who had a positive suicide screening and identified some level of risk for self-harm (current or past)
- Transitionary times are times when people who are at-risk for suicide are at greater risk. Knowing this, IDPH through the Zero Suicide Iowa project, will be offering patients who may be at risk for suicide follow-up calls as they transition out of residential SUD treatment. These calls will be provided by the IDPH Your Life Iowa contractor and will occur up to three times within the first 14 days of

discharge.

Expand Competency of workforce to develop strategies related to the increase in E-Cigarette/Vaping in Iowans-Plan to Address: The Iowa Department of Public Health (IDPH) now offers a special program for teens who want to quit using tobacco, including e-cigarettes. IDPH is one of nine states collaborating with Quitline provider National Jewish Health to offer the teen-focused tobacco cessation program.

The new *My Life, My Quit* program includes educational materials designed for teens and created through focus groups with teens, subject matter experts and community stakeholders. Teens can text or call a toll-free number (855-891-9989) dedicated for teens, or they can visit mylifemyquit.com for real-time coaching. Through the program, teens work with a coach who listens and understands their unique needs, provides personalized support, and helps them build a quit plan to become free from nicotine. *My Life, My Quit* provides youth access to tailored resources for quitting, including:

- Free and confidential help from a quit coach specially trained to listen to teens, help teens navigate social situations that involve tobacco or vaping, and find healthy ways to cope with stress
- Five coaching sessions via live text messaging or by phone on a dedicated toll-free number (855-891-9989) or online chat
- Simplified online and mobile program registration to get teens to a coach quicker
- Dedicated teen website at mylifemyquit.com with online enrollment, live chat with a coach, information about vaping and tobacco, and activities to support quitting and stress relief
- On-going text messages for encouragement throughout the quit process
- Certificate of program completion

In addition to the Quitline, the IDPH Bureau of Substance Abuse and the Division of Tobacco Use Prevention and Control are collaborating to:

- Align prevention efforts across CDC and SAMHSA funding to ensure duplication of effort is not occurring
- Share consistent tobacco prevention language, messaging and evidence-based practices with contractors through meetings and webinars
- Share information about the Strategic Prevention Framework with Division of Tobacco Use Prevention and Control staff and contractors
- The Iowa Department of Public Health Medical Director is providing education through multiple channels and communicating with multiple health providers. A release to the public on September 27, 2019 contained the following instructions "*Iowans should not use vaping and e-cigarette products since the cause of this outbreak is not yet clear and the long-term health impacts of these products are unknown. Patients with a history of vaping who are experiencing breathing problems should seek medical care. Health care providers should ask patients with respiratory illness about the use of vaping and e-cigarette products. Health care providers are asked to report severe respiratory illness in patients with a history of*

vaping or e-cigarette use to the Iowa Department of Public Health (1-800-362-2736)".

- *To learn more, visit https://idph.iowa.gov/ehi/lung-disease-vaping. Weekly Iowa case counts may be found on this page.*

Treatment:

Expand access to MAT services and Increase MAT Prescribers related to Prescription Misuse/Opioid Use/Medication Assisted Treatment Needs-Plan to Address: The IPN contractors are building capacity to address the needs of Iowans with opioid and other polysubstance use disorders to increase accessibility of Medication Assisted Treatment and to decrease infectious disease. For opioid-involved patients, Iowans access to traditional methadone and daily dosing is limited because of distance and the rural nature of the state. Therefore, a critical gap in Iowa is the need to have more Medication Assisted Treatment (MAT) providers. IDPH has worked collaboratively with other partners to begin to address the shortage of providers and has increased the number of Buprenorphine providers over the last four years from 31 to 160 physicians. These providers are certified to prescribe buprenorphine; however many of them are not active providers and some of these providers choose not to be listed on the Buprenorphine SAMHSA locator. Within the next two years, IDPH is working on goals to expand Medication Assisted Treatment access and prescribers for opioid use and will increase the number of Buprenorphine prescribers from 160 currently to 194 within two years.

Strategies by IDPH to increase access to MAT services and to increase the number of prescribers include:

- The SOR and STR efforts to expand access to MAT are increasing the capacity of the SUD treatment programs as they establish new services, partnerships and coordination with other community-based medical providers. Each treatment program engaged local stakeholders in or to complete a community needs assessment relevant to the opioid-related conditions and resources in their particular community. Action plans were established to most effectively utilize the opportunities afforded by the STR/SOR funding priorities. Treatment programs increase capacity for MAT access through multiple efforts including internal, client-level, community-level, and some regional or policy-level efforts. Ongoing treatment staff trainings to educate the workforce on updated research and knowledge about treatments of OUD is key to continue improving the competency and understanding of counselors and staff who interact directly with clients. Service coordination to include MAT access for clients through telehealth, onsite services, and/or community partnerships is another important area of growth to assure that waivered prescribers in their communities have the support and communication with the treatment agency to encourage them to provide MAT medicines.
- Collaboration with IDPH's Bureau of HIV, STD and Hepatitis to expand education, screening, care coordination, risk reduction intervention and

counseling for Iowa MAT clients. IDPH has hired a substance abuse/HIV coordinator to link needed services. The Bureau of HIV, STD, and Hepatitis contracts with 10 local public health agencies and community-based organizations (located in the most populous counties of Iowa) to provide opportunities for high-risk and disproportionately impacted populations to test for HIV, STD (chlamydia, gonorrhea, and syphilis), and hepatitis B and C. Sites also offer immunizations for hepatitis A and B to high-risk adults who have never been vaccinated. Staff at these counseling, testing, and referral (CTR) sites provide counseling to help initiate behavior change to avoid infection or if the client is infected, to prevent transmission to others. They also refer clients to additional prevention programs, medical care, and services, like substance abuse treatment.

- IDPH works with the Board of Pharmacy in the enhancement of and data analysis from the Prescription Drug Monitoring Program.
- IDPH has developed an IDPH Medication Assisted Treatment Webpage at http://idph.iowa.gov/mat. In addition to specific information about the grant, the web page provides information about what to do in the event of an overdose, signs of opioid withdrawal, and links to the SAMHSA Overdose Toolkit and the CDC Guidelines for Prescribing Opioids.
- IDPH has developed an Opioid Overdose Recognition and Response brochure, which has been distributed to over 15,000 stakeholders and is available per request. Available at: http://www.idph.iowa.gov/mat
- IDPH has put in place a statewide standing order for administration of Naloxone. Pharmacies, statewide, have stocked naloxone per the standing orders.
- IDPH created educational materials about the Good Samaritan law that include flyers, information cards, and short educational videos available on the YourLifeIowa website for both law enforcement and the general public to increase understanding and awareness of the law, and encouraging people to call 911 in case of opioid overdose.
- IDPH developed a Heroin and Opioid Fact Sheet and is currently posted on the IDPH website and is distributed and updated as needed.
- To assist providers in understanding alternatives to opioids, IDPH sponsored the Approaches to Pain Management Symposium on October 30, 2018. With nearly 100 people in attendance, the symposium provided an overview of a range of non-pharmacological approaches to addressing pain in addition to, or as an alternative to, the use of opioids. Presentation topics included a national perspective on approaches to pain management, chiropractic care, mindfulness-based stress reduction, physical therapy, acupuncture and alternative medicine, yoga therapy, nutrition and physical activity, and interventional orthopedics. IDPH is hosting a Poly Substance Abuse Conference in December/2019 focusing on Opioids and Methamphetamine.
- IDPH has worked with other state agencies and stakeholders to prevent opioid overdose by providing access to naloxone, the medication that

temporarily reverses an opioid overdose, allowing the person to receive life-saving medical care. Made possible by federal grant funds, examples of IDPH naloxone distribution efforts include:

- 1,300 kits provided to emergency departments across the state for distribution to individuals being released from the hospital following treatment for opioid overdose. Research has shown that such individuals are at high risk of dying of an overdose within one year.
- 400 kits to the Department of Public Safety to equip every staff member.
- 450 kits to the Department of Corrections for individuals being released from a correctional setting who have a history of opioid misuse.
- 350 kits to the IDPH Bureau of Emergency and Trauma Services for distribution to EMS providers.
- 2,400 kits were distributed to law enforcement in Iowa that volunteered to receive the kits.

- IDPH is offering MAT as a funded Recovery Support Services through various discretionary grants such as STR, and SOR grants. The purpose of the grant is to raise community awareness about the dangers of sharing and misusing medications as well as work with pharmaceutical and medical communities to address the risks of overprescribing.
- The SPF-RX grant collaborates with the MAT program grantees on the development of a statewide opioid media campaign and has organized a statewide evidenced-based practice work group to review and approve the suggested/planned strategies
- IDPH competitively procured the Integrated Provider Network for Methadone providers as part of the integrated RFP, which was effective January 2019. United Community Services, the selected Methadone OTP, has expanded the number of OTPs – including satellite "Medication Unit" locations to three OTPs, with a combined 12 locations with 3 more planned by late 2019. The expansion will increase access to MAT services across the state.
- Beyond those directly funded by IDPH, Iowa healthcare providers include an additional four OTPs and many clinics/health systems that employ buprenorphine-waivered providers, such as the VA, University of Iowa Hospitals and Clinics, county or critical access hospitals, mental health providers and private practice groups.

Increase Competency of New IPN to Develop Strategies to work with individuals with Primary or Secondary Diagnosis of Methamphetamine-Plan to Address: A population of individuals in need of treatment are individuals seeking SUD treatment for Methamphetamine use. From 2014-2017, there was a 38 percent increase in methamphetamine treatment admissions in Iowa. Similarly, the Iowa Department of Public Health (IDPH) reports there was an eight-fold increase in Iowa deaths related to amphetamines, which includes methamphetamine. Methamphetamine is now the second

most reported drug by adults at admission to treatment, moving ahead of marijuana for the first time. Methamphetamine, in particular, is of concern to pregnant and parenting women.

The IDPH has focused extensive resources on addressing the Methamphetamine issues in Iowa communities. This effort brought awareness to Iowans while providing resources to available prevention and treatment services. In 2018, the Bureau of Substance Abuse formed an internal committee to begin strategic planning related to the increase in Methamphetamine.

IDPH has developed the following strategies to address the critical need for treatment and prevention services to individuals with a methamphetamine diagnosis including:

- Health promotion activities, data profiles, and infographics aimed at prevention, treatment and specific information directed to women.
- IDPH ran media campaigns in the summer of 2019 and have worked with IPN contractors, both treatment and prevention, to complete webinars focused on gathering data.
- IDPH SSA staff have provided education to the IPN contractors regarding current Iowa data.
- In 2019, IDPH required IPN contractors to complete community needs assessment (CAW) workbooks to guide community/stakeholder planning. A draft CAW, based on the SPF process, submitted to IDPH by contractors, and strategies are currently being addressed to further utilize the CAW within the framework of the SPF.
- IDPH SSA staff is presenting public health information on methamphetamine at several conferences in 2019 including a Family Planning Council Conference and; are keynote speakers at the National Conference on Methamphetamines and Stimulants in Miami, Florida in November/2019. SSA staff will bring back data and information; will be shared with IPN contractors and SSA staff.
- A statewide methamphetamine conference, currently being planned for December 3, 2019, will bring national experts to Iowa to educate treatment and prevention professionals on methamphetamine and the contamination with opioids. For treatment and prevention resources on methamphetamine visit: https://yourlifeiowa.org/drugs/methamphetamine

Priority Populations-Treatment

Expand Competency of New IPN Workforce for Persons who are Injecting Drug Users-History and Plan to Address:

Through 2018, Provider contracts required outreach to injecting drug users and included access standards for priority admission to treatment. Iowans seeking and in need of substance use disorder treatment for injecting drug use must be admitted no later than 14 days after the initial request is received or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim

services are made available to the individual not later than 48 hours after such request. Contractual requirements with the Integrated Provider Network contractors indicate to admit clients to treatment within 48 hours of making the request for admission.

Interim services to persons who inject drugs include counseling and education about HIV and TB, the risks of transmission to sexual partners and infants, the relationship between injecting drug use and communicable diseases, and steps that will be taken to ensure that HIV transmission does not occur. Referral for HIV and/or TB treatment services is made as necessary. An AIDS Education Component shall be provided to treatment clients. The component shall include information regarding optional AIDS virus testing. Pre- and post-test counseling will be made available to clients to be tested for the virus.

During 2018, IPN contractors were required to notify Amerigroup when they reached 90% of capacity to admit an injecting drug user. Contractors established waiting lists for individuals awaiting treatment for injecting drug use, including those receiving interim services. Amerigroup, the MCO, ensured that contractors providing services to IDPH participants who were intravenous (IV) drug users performed outreach activities.

Prior to the IPN RFP, effective January 1, 2019, the IDPH funded network reported activities through quarterly and monthly reporting, to IDPH and Amerigroup. Amerigroup and IDPH met on a regular basis to review provider data and reporting and request provider action plans as indicated. The providers encouraged individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. During 2018, Amerigroup completed retrospective reviews, which documented provider understanding and compliance with SABG requirements.

In January 2019, as described in Step I, IDPH released a new competitive RFP and selected a new provider network, the *Integrated Provider Network* (IPN). IDPH no longer contracted with Amerigroup for ASO functions and all administrative oversight of the IPN, is the responsibility of the IDPH, Bureau of Substance Abuse. Upon the award of contracts, the IPN contractors signed an attestation to comply with SABG requirements. Through the direction of the Interim Division Director, IDPH is currently putting in place new strategies for meeting these requirements and is focusing on developing the capacity of the new IPN to provide services to this priority population including:

- Initial and annual attestation to SABG requirements
- New contractor training in January 2019 on SABG requirements
- Ongoing annual training of requirements to contractors
- In-depth training on requirements at the Iowa Behavioral Health Provider Association Meetings to contractors
- SSA and contractor director meetings to review requirements
- Transition from a narrative reporting function to reporting through Iowagrants.gov in 2019
- Further building capacity within Iowa's data system and central data repository to implement required data elements to by July 2020
- IDPH will continue to monitor provider capacity for persons who inject drugs. IDPH will review data reporting definitions, review ability for how

data are tracked within Iowa's data reporting system and review if revisions are needed in providing a data subscription to providers to better track their specific wait times/interim services
- IDPH is currently working with the system developer FEI to make these changes in the data system

Pregnant and Parenting Women-Expand Competency of New IPN Workforce and Develop Strategies for Increased Admissions related to Primary or Secondary Methamphetamine Admissions-Plan to Address:

Through 2018, Amerigroup confirmed compliance with IDPH funded providers in meeting all Women and Children SABG requirements through the retrospective review process. Provider contracts specified required access standards, including priority admission status, for pregnant and parenting women seeking substance use disorder treatment. These periods included admission within 48 hours of making the request for admission; or 120 days after the date of such request if a program did not have the capacity to admit the individual on the date of such request and if interim services were made available to the individual not later than 48 hours after such request. If, after notifying Amerigroup, the admission to treatment was not made within 48 hours, interim services were to be provided. The provider established a wait list, which included interim services. For pregnant women, this also included a requirement for prenatal care, and referral and education about the effects of alcohol and drug use on the fetus. Providers reported information to Amerigroup through monthly reporting to Amerigroup and IDPH and compliance monitored during the retrospective review process conducted by Amerigroup in 2018. Amerigroup found Women and Children contractors to comply with these requirements and expressed understanding of regulations.

In January 2019, as described in Step I, IDPH released a new competitive RFP, selected a new provider network, the Integrated Provider Network (IPN), and selected four contractors to provide Women and Children services under SAMHSA's Women's Set-Aside funding. These services include: ancillary services, treatment, and recovery support services. The Women and Children contractors provide all levels of care, including residential care for women with their dependent children. Services are provided statewide and Iowans have a choice as to where they seek services.

As IDPH is no longer contracting with Amerigroup for ASO functions effective January 1, 2019, all administrative oversight of the IPN, is the responsibility of the IDPH, Bureau of Substance Abuse. Upon the award of contracts, the IPN contractors signed an attestation to comply with SABG requirements related to the Women's Set Aside requirements. Through the direction of the Interim Division Director, IDPH is currently putting in place new strategies for meeting these requirements and is focusing on developing the capacity of the new IPN to provide services to this priority population including:

- Initial and annual attestation to the Women and Children SABG requirements
- New contractor training in January 2019 on requirements
- Ongoing annual training of requirements to contractors

- In-depth planned trainings on requirements at the Iowa Behavioral Health Provider Association Meetings with SUD directors
- SSA and contractor director meetings to review requirements
- Transition from a narrative reporting function to reporting through Iowa's data system and the Central Depository to collect all required data elements by July 2020
- Building capacity within Iowa's data system and central data repository to review and monitor required data elements will be completed by July 2020.
- IDPH will continue to monitor provider capacity for women and children's services. IDPH is currently reviewing data reporting definitions, reviewing how data will be tracked within Iowa's data reporting system, and review if revisions are needed in providing a data subscription to providers to better track their specific wait times/interim services
- IDPH is currently working with the system developer FEI to make these changes in the data system
- IDPH will also focus education efforts to IDPH funded providers regarding SABG requirements and provide specific follow up for data collection, monitoring and follow-up
- IDPH SSA staff are implementing retrospective reviews in October/2019 and will validate and monitor provider capacity, interim services documentation and documentation of ancillary, treatment and recovery support services at each IPN Women and Children Program

Additional Strategies to address the Women and Children increase in Methamphetamine admissions includes:

- IDPH will review data and monitor on an ongoing basis to monitor data trends
- IDPH will refer to SEW workgroup to analyze this data further and provide recommendations for further strategies
- IDPH has provided education and data to Women and Children IPN contractors and held meetings with IPN providers to explore gaps/challenges/evidence-based practice and needs to further support treatment efforts. The IPN contractors provided feedback about the need for further training in Matrix and Living in Balance and Contingency Management training (Evidence-Based Models). In addition, contractors requested assistance with further recovery support needs such as assistance with transportation and other wrap around services.
- IDPH is inviting the Women and Children contractors to participate in a series of Stimulant/Methamphetamine specific Project Echo trainings to occur later in 2019 sponsored by the Addiction Technology Transfer Center
- IDPH is providing shared training opportunities to Women and Children contractors through the PRISM Policy Academy participants; and including maternal health providers.

Expand workforce capacity of the IPN network to effectively serve individuals in need of screening, treatment or referral for individuals with Tuberculosis (TB) - History and Plan to Address:

Through 2018, SABG requirements related to TB Screening and services for persons with tuberculosis were provided directly by IDPH-funded providers or through interagency collaborative agreements with other local agencies. In the case of an individual in need of such treatment denied admission by a provider based on the lack of capacity to admit the individual, the provider referred the individual to another provider of tuberculosis services. Each provider was required to implement infection control procedures and protocols to address TB and other communicable diseases.

Effective January 2019, as described in Step I, IDPH released a new competitive RFP and selected a new provider network, the *Integrated Provider Network* (IPN). IDPH no longer contracts with Amerigroup for ASO functions and provides all administrative oversight of the IPN, under the Bureau of Substance Abuse. Upon the award of contracts, the IPN contractors signed an attestation to comply with SABG requirements related to TB SABG regulations. Through the direction of the Interim Division Director, IDPH is currently putting in place new strategies for meeting these requirements and is focusing on developing the capacity of the new IPN to provide services to this priority population including:

- Initial and annual attestation to the TB SABG requirements
- New contractor training in January 2019 on SABG requirements
- Ongoing annual training of requirements to contractors
- In-depth planned trainings on requirements at the Iowa Behavioral Health Provider Association Meetings to contractor directors
- SSA and provider director meetings to review requirements
- Transition from a narrative reporting function to monitoring through the retrospective review process beginning in October 2019.
- IDPH will also focus education efforts to IPN contractors regarding SABG requirements and provide specific follow up for data collection, monitoring and follow-up
- IDPH SSA staff are implementing retrospective reviews in October/2019 and will validate and monitor documentation related to TB regulations through the retrospective review process.

Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Programs, Chapter 155, outlines procedures for conducting tuberculosis screening for health care workers and residents at substance use disorder and problem gambling treatment program facilities. Facilities conduct an annual risk assessment to determine risk classification of the facility and to identify appropriate screening criteria. The screening criteria are consistent with those of the U.S. Centers for Disease Control and Prevention (CDC). Licensure staff, upon inspection, review compliance for adherence to standards. All program staff must have a TB baseline screening prior to employment at a licensed substance abuse treatment facility.

Additionally, all licensed substance abuse programs are required to have screening procedures to evaluate residents of residential, inpatient, and halfway house facilities.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?
Please indicate areas of technical assistance needed related to this section.

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Footnotes:

BG Application 2020-2021
Section 11
Quality and Data Collection Readiness Narrative

1. **Describe the state's approach to data collection and reporting systems and how it can be improved and result in better client level data and outcomes. Both Prevention and Treatment Systems. Please note primary prevention will not be client level, but should be population level measures such as NSDUH. Indicate collaboration with other community partners, planning groups and the public about the Block Grant and how this assists in the development of improved data collection and outcomes.**

Iowa Substance Use Disorder Treatment Data Reporting

The IDPH Division of Behavioral Health collects patient level data from licensed substance use disorder treatment agencies to meet state and federal data (TEDS, etc.) reporting requirements.

The Central Data Repository (CDR) is Iowa's data warehouse (Microsoft Sequel Server 2008) of substance use disorder treatment data. Client level data (Client Profile, Crisis, Placement Screening, Admission, Discharge, Service and Follow-up) is collected from approximately 100 licensed substance use disorder treatment programs.

IDPH monitors and uses these data to assist in decision making regarding system trends (utilization, demographic, drug of choice, level of care, etc.), system/network improvements (access, engagement, retention, continuation, quality of life, etc.) and health equity.

Data Reporting Methods

Licensed substance use disorder treatment programs have two options to submit patient level data electronically to the CDR:

- Secure File Transfer Protocol (SFTP): Licensed substance use disorder treatment agencies that currently use or are planning to procure an EHR/EMR (Electronic Health Record or Electronic Medical Record), may submit patient level data per the CDR Vendor Submission Guide (http://www.idph.iowa.gov/ismart/repository).
- I-SMART (Iowa Service Management and Reporting Tool): Licensed substance use disorder treatment Agencies that don't currently have an EHR/EMR or whose EHR/EMR does not currently meet the CDR Vendor Submission Guide, may choose to submit data via data entry in I-SMART.

Data Integrity

Each month, IDPH conducts Data Integrity checks to ensure that data reported are complete and accurate. Data Integrity Reports are sent via encrypted mail on the 17th of the month. Agencies are expected to review their individual reports and to make the corrections noted by the 15th of the following month. Examples of data integrity checks include identifying when an admission has occurred without any associated services, inaccurate data such as “pregnant” and “male” reported for a single patient, etc.

Help Desk

IDPH offers a Help Desk to answer questions and provide assistance on data reporting requirements and the data system. The Help Desk can be reached via phone email.

Help Desk hours are M-F from 9-3 (excluding holidays). Help Desk calls are automatically answered with messages transcribed and sent to the help desk email.

Data System Enhancements

Several recent enhancements have been made to the treatment data systems used in Iowa. These include updating the GPRA to meet new expectations and development of the Opioid Treatment Program (OTP) Registry. The Department is currently working with a vendor to create the next generation system called the Iowa Behavioral Health Reporting System (IBHRS). This data warehouse model will collect integrated data across SUD, problem gambling, and mental health. IBHRS streamlines the data collected, includes robust validation rules and checks to improve data reporting accuracy/quality, and includes previously unreported Treatment Episode Data Set (TEDS) elements.

Iowa Substance Abuse Prevention Data Reporting

Iowa uses the Prevention Domain within I-SMART to report substance abuse and problem gambling prevention data. I-SMART is also in use by the state’s substance use disorder treatment and problem gambling treatment programs. Currently the I-SMART Prevention Domain collects population (group) level data which meets Block Grant Substance Abuse Prevention reporting requirements.

Data Integrity

Each month, IDPH conducts Data Integrity checks to ensure that data reported are complete and accurate. Data Integrity Reports are distributed monthly. Agencies are expected to review their individual reports and to make the corrections noted by the 15th of the following month. Examples of data integrity checks include comparing the Strategy IOM to the IOM Classification, duration minutes are entered as directed, recurring programs have the required number of sessions, etc.

Data System Enhancements

During FFY19, enhancements to the Prevention Domain were developed and launched. The enhancements included a new prevention data reporting module that will reduce data entry errors, increase reporting capability, and improve data quality. Through one-time and session-based prevention strategies, the module continues to collect group-level data to meet the SABG reporting requirements.

Iowa plans to implement a competitive process to procure an integrated data system to improve data quality and the reporting process. These plans are just beginning, with decisions coming soon on how to integrate systems and which systems to integrate. For example, the data system may integrate substance use disorder treatment and substance abuse prevention data, or integrate substance abuse prevention individual-level and group-level data.

Technical Assistance

None needed at this time

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Expand the capacity of the IPN Primary Prevention Workforce to target increased rates of Underage and Binge Drinking

Priority Type: SAP

Population(s): PP

Goal of the priority area:

By year two, the underage drinking rate of 8th graders will be reduced by at least one percentage point as documented by the Iowa Youth Survey (2020 -2022)

Objective:

IDPH will identify and implement strategies to reduce binge-drinking in youth under the age of 18 and young adults up to age 24

Strategies to attain the objective:

IDPH is supporting ongoing evidence-based programming through online and in-person trainings, to support IPN prevention agencies in their efforts to address underage alcohol use and binge drinking.
IDPH is requiring all IPN contractors to focus on Alcohol as a required prevention priority.IDPH is currently conducting three IPN Prevention Regional Trainings on the Strategic Prevention Framework to discuss the Assessment and Capacity steps which will inform future prevention strategies.
IDPH is supporting ongoing evidence-based programming through online and in-person trainings, during year one, to support IPN prevention agencies in their efforts to address underage alcohol use and binge drinking.
Alcohol is a required prevention priority area that all funded agencies must address throughout the project period of the grant. Prevention strategies focusing on alcohol and currently include but are not limited to the following:
Evidence-based programming such as LifeSkills, Project Alert, Curriculum Based Support Group, and Prime for Life;
Drivers education focusing on the risks and harms of underage drinking;
Health Promotion efforts such as the “What Do You Throw Away” underage drinking media campaign;
Responsible Beverage Server Training for liquor license establishments utilizing the Training for Intervention Procedures evidence-based program;
Providing technical assistance and support to local community coalitions to discuss the importance and benefits of alternative activities;

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reuced the drinking rate of 8th grade students by one percentage point

Baseline Measurement: Iowa youth survey

First-year target/outcome measurement: 8.9%

Second-year target/outcome measurement: 7.9%

Data Source:

Iowa Youth Survey 2020-2022

Description of Data:

Data collected evey two years in survey administered in school setting

Data issues/caveats that affect outcome measures::

Data not available until 2021 as data survey administered every two years with data collection and analysis following that collection of data.

Priority #: 2

Priority Area: Increase IPN workforce competency in Zero Suicide: Youth and Young Adult Mental Health- Serious Suicidal Ideation Increase-Plan to Address:

Priority Type: SAP

Population(s): PP

Goal of the priority area:

IDPH will increase the competency of the IPN network to implement Zero Suicide strategies

Objective:

IPN contractors will increase competency in assessing and developing policies and skills in the Zero Suicide Framework

Strategies to attain the objective:

The majority of contractors utilize the PHQ-9, with the few others utilizing screenings such as SAD Persons scale, suicide risk assessment, Columbia Suicide Severity Tool etc. IDPH will require ALL IPN providers to implement an evidenced based screening tool for sucide/depression screening and to repeat screening as needed throughout the treatment episode. IDPH will explore the use of requiring one specific screening
IDPH will educate the IPN contractors about co-occurring disorders, data and the required focus to either provide mental health related services or utilize care coordination to provide warm handoffs and secure linkages to mental health providers in the community.IDPH will provide training on the Zero Suicide framework to all IPN contractors.IDPH will continue to provide education to IPN. IDPH will work with contractors to complete detailed safety planning for participants who had a positive suicide screening and identified some level of risk for self-harm (current or past). IDPH through the Zero Suicide Iowa project, will be offering patients who may be at risk for suicide follow-up calls as they transition out of residential SUD treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase workforce competency in Zero Suicide

Baseline Measurement: By the end the the Zero Suicide Project, contractors will utilze screening, have training in Zero Suicide, will demonstrate competency in zero suicide safety planning and will have follow-up processess in place

First-year target/outcome measurement: By the end of year one, IDPH will review screening tools and ensure all IPN providers are assessing for depression and suicide

Second-year target/outcome measurement: By 2020, approximately half of the IPN contractors will have attended the Zero Suicide Academy

Data Source:

Retro Reviews, Zero Suicide Academy Trainings

Description of Data:

Documentation of Screening tools utilized in Retrospective Reviews; Zero Suicide Attendance logs

Data issues/caveats that affect outcome measures::

incomplete attendance logs ; need for increased technical assistance

Priority #: 3

Priority Area: Expansion of MAT services including Access to MAT physicians

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Increase access to Medication Assisted Treatment Services and Increase Medication Assisted Treatment Prescribers

Objective:

Build capacity of the IPN network to build capacity to address the needs of Iowans with opioid use disorders and individuals with polysubstance

abuse; including persons who inject drugs who are at higher risk for infectious disease.

Strategies to attain the objective:

Collaboration with IDPH's Bureau of HIV, STD and Hepatitis to expand education, screening, care coordination, risk reduction intervention and counseling for Iowa MAT clients. IDPH has hired a substance abuse/HIV coordinator to link needed services. The Bureau of HIV, STD, and Hepatitis contracts with 10 local public health agencies and community-based organizations (located in the most populous counties of Iowa) to provide opportunities for high-risk and disproportionately impacted populations to test for HIV, STD (chlamydia, gonorrhea, and syphilis), and hepatitis B and C. Sites also offer immunizations for hepatitis A and B to high-risk adults who have never been vaccinated. Staff at these counseling, testing, and referral (CTR) sites provide counseling to help initiate behavior change to avoid infection or if the client is infected, to prevent transmission to others. They also refer clients to additional prevention programs, medical care, and services, like substance abuse treatment.
IDPH is participating in the State Prescription Abuse Work group and works with the Board of Pharmacy's Prescription Drug Monitoring Program.IDPH has put in place a statewide standing order for administration of Naloxone. Pharmacies, state-wide, have stocked naloxone per the standing orders.IDPH has worked with other state agencies and stakeholders to prevent opioid overdose by providing access to naloxone, the medication that temporarily reverses an opioid overdose, allowing the person to receive life-saving medical care.IDPH is offering MAT as a funded Recovery Support Services through various discretionary grants such as STR, and SOR grantsIDPH competitively procured the Integrated Provider Network for Methadone providers as part of the integrated RFP which was effective January 2019. United Community Services, the selected Methadone OTP, has expanded the number of OTPs – including satellite "Medication Unit" locations to three OTPs, with a combined total of 12 locations with 3 more planned by late 2019. The expansion will increase access to MAT services across the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Iowan's will have Increased access to MAT providers: number of physicians prescribing Buprenorphine

Baseline Measurement: Expansion of Medication Units to provide Methadone and Buprenorphine

First-year target/outcome measurement: 3 additional Medication units by end of 2019

Second-year target/outcome measurement: Increase in number of prescribers from 160 to 194 by end of year two

Data Source:

SAMHSA registry and State data for number of Medication Units prescribing MAT

Description of Data:

SAMHSA Prescriber Registry and tracking of State MAT clinics

Data issues/caveats that affect outcome measures::

increased costs, workforce, accurate documentation in SAMHSA prescriber registry, dedication of additional resources

Priority #: 4

Priority Area: Expand Competency of New IPN Workforce and Develop Strategies for Increased Admissions related to Primary or Secondary Methamphetamine Admissions

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Expand capacity of IPN Women and Children workforce to effectively identify and treat women and women with dependent children who have a primary or secondary diagnosis of Methamphetamine

Objective:

IDPH will collaborate with SEW workgroup to analyze data and make recommendations for focus

Strategies to attain the objective:

IDPH will review data and monitor on an ongoing basis to monitor data trends-quarterly. IDPH is inviting the Women and Children contractors to participate in a series of Stimulant/Methamphetamine specific Project Echo trainings to occur later in 2019 sponsored by the Addiction Technology

Transfer Center. IDPH is providing shared training opportunities to Women and Children contractors through the PRISM Policy Academy participants; and including maternal health providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase workforce competency in treating women with stimulant disorders

Baseline Measurement: IDPH has held educational meetings with contractors to review current data/trends/treatment options

First-year target/outcome measurement: 100% of Women and Children Contractors will participate in series of Project Echo trainings on Stimulant disorders by end of 2020

Second-year target/outcome measurement: 100% of Women and Children Contractors will attend a Polysubstance Summit to be held by end of 2019.

Data Source:

Project Echo Trainings logs and attendance records at summit

Description of Data:

attendance log records

Data issues/caveats that affect outcome measures::

environmental factors such as weather conditions to attend face to face trainings, workforce development issues which could impact attendance

Priority #: 5

Priority Area: Expand workforce capacity of the IPN network to effectively serve individuals in need of screening, treatment or referral for individuals with Tuberculosis (TB)

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase capacity of IPN to effectively serve persons in need of screening, treatment or referral for persons with TB

Objective:

Increase workforce strategies related to screening, collaboration with partners, and providing treatment services

Strategies to attain the objective:

IDPH is requiring all IPN contracts to annual attest to following SABG TB requirements, annual training on TB requirements, In-depth planned trainingings on requirements at the Iowa Behavioral Health Provider Association Meetings to contractor directors
SSA and provider director meetings to review requirements
Transition from a narrative reporting function to monitoring through the retrospective review process. beginning in October 2019.
IDPH will also focus education efforts to IPN contractors regarding SABG requirements and provide specific follow up for data collection, monitoring and follow-up. Monitor additional requirements through licensure process

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: IPN capacity will be increased to provide SABG requirments related to persons with TB or have screening process and referral processes in place

Baseline Measurement: Number of IPN providers with screening processes and referral processes in place

First-year target/outcome measurement: IDPH will provide training to all IPN contractors by end of year one

Second-year target/outcome measurement: IDPH will complete retrospective reviews on 100% of IPN contractors to monitor compliance

Data Source:

Training attendance logs and retrospective reviews

Description of Data:

attendance at required trainings for converyance and monitoring cllnical records and policy at retrospective reviews

Data issues/caveats that affect outcome measures::

lack of understanding of regulations, lack of workforce to collaborate, workforce development issues

Priority #: 6

Priority Area: Expand the capacity of the IPN Primary Prevention Workforce to target alcohol-related deaths with adults

Priority Type: SAP

Population(s): PP

Goal of the priority area:

IDPH will increase the capacity of the IPN Primary Prevention Workforce to address alcohol-related deaths through identified evidence-based strategies.

Objective:

IPN Primary Prevention contractors will increase competency in effective evidence-based programs, policies and practices to address alcohol-related deaths.

Strategies to attain the objective:

IDPH has created a workgroup to discuss alcohol-related deaths and create a plan to address this issue including dissemination of data briefs, collaboration within IDPH divisions and other state agencies, researching and recommending evidence-based programs, practices and policies that most effectively address this priority issue. This information will be shared with IPN Primary Prevention contractors through a variety of means including resource sharing, trainings, guidance documents, etc.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase capacity of IPN Primary Prevention contractors address alcohol-related deaths

Baseline Measurement: By year two, IPN Primary Prevention contractors will know of three evidence-based strategies to address this priority, received at least two trainings and implemented one strategy to address this priority issue.

First-year target/outcome measurement: By the end of year one, IDPH staff will identify and approve at least three evidence-based strategies to address alcohol-related deaths in collaboration with the Alcohol-Related Deaths Workgroup and the Evidence-Based Practices Workgroup

Second-year target/outcome measurement: by the end of year two, 100% of IPN Primary Prevention contractors will be implementing one identified strategy to address alcohol-related deaths

Data Source:

I-SMART Prevention System, Alcohol-Related Deaths Workgroup Meeting minutes

Description of Data:

Evidence-based strategy implemented by contractors, documentation of workgroup decisions and approved resources

Data issues/caveats that affect outcome measures::

Data not entered not entered into I-SMART fully, meeting notes being misplaced

Priority #: 7

Priority Area: Expand Competency of workforce to develop strategies related to the increase in E-Cigarette/Vaping in Iowans

Priority Type:

Population(s): PP

Goal of the priority area:

Increase competency of the IPN Primary Prevention contractors to align prevention efforts related to tobacco efforts and associated increase in vaping/e-cigarette use by Iowans

Objective:

Monitor E-Cigarette and Vaping use in Iowans

Strategies to attain the objective:

Collaborate and develop shared strategies with Division of Tobacco Use Prevention and Control, collaborate with IDPH Medical Director in providing education through multiple channels and communication with partners, monitor Iowa data related to vaping illness, promote use of mylifemyquit.com for connecting teens to dedicated teen website,

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Monitor Iowans use of vapor products and obtain baseline. Refer to SEW Workgroup for data analysis and recommendtaions

Baseline Measurement: In Iowa, there have been 23 reported cases and no deaths. Of the 23 Iowa cases, ages range from 17 to 60, 18 have reported the use of THC

First-year target/outcome measurement: 23 Iowa cases

Second-year target/outcome measurement: IDPH will monitor data trends, collaborate with CDC and FDA, inform health providers and public on vaping and e-cigarette product information

Data Source:

Reported respiratory illness in Iowa to IDPH/CDC

Description of Data:

Iowa Department of Public Health data at https://idph.iowa.gov/ehi/lung-disease-vaping

Data issues/caveats that affect outcome measures::

cause of outbreak not yet clear and long-term health impacts of these products are unknown. Reliance on health care providers to ask patients with respiratory illness about use of vaping and e-cigarette products and reliance on health care providers to report respiratory illness in patients with a history of vaping or -e-cigarette use to the IDPH.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	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
1. Substance Abuse Prevention* and Treatment	$9,313,488		$0	$10,922,980	$33,917,814	$0	$0
a. Pregnant Women and Women with Dependent Children**	$1,390,939		$0	$0	$0	$0	$0
b. All Other	$7,922,549		$0	$10,922,980	$33,917,814	$0	$0
2. Primary Prevention	$3,123,696		$0	$2,042,120	$3,438,786	$0	$0
a. Substance Abuse Primary Prevention	$0		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$654,589		$0	$4,905,820	$1,690,006	$0	$0
10. Total	**$13,091,773**	**$0**	**$0**	**$17,870,920**	**$39,046,606**	**$0**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	354	410
2. Women with Dependent Children	4788	6121
3. Individuals with a co-occurring M/SUD	13358	16021
4. Persons who inject drugs	226	262
5. Persons experiencing homelessness	23968	28930

Please provide an explanation for any data cells for which the state does not have a data source.
"Notes: • Report filters for Admission activity date during the report period with unduplicated patient and admission counts. Total Admissions represents the total unduplicated count of patients and admissions. • Women with Dependent Children ireports those women with childrend age 17 or less (birth, adopted or step children) • Individuals with co-occurring M/SUD reports those admissions where a patient reported a MH problem or in the clinician's opinion the patient displayed signs of depression, anxiety or other mental health problems. • Persons who inject drugs reports those admissions where a patient reports IV Drug use in the past 30 days (Primary, Secondary, Tertiary) from report /Repository/IDPH/DATA REQUESTS/Drug Use by IV Method. • Persons experiencing homelessness reports those admissions where the Client Address Line 1 is like ""homeless"". Per I-SMART data entry user guide, agencies may enter the address where a homeless person is currently staying (which would be the agency), or enter ""homeless."""
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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$9,313,488
2 . Primary Substance Abuse Prevention	$3,123,696
3 . Early Intervention Services for HIV**	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	$654,589
6. Total	**$13,091,773**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020** **SA Block Grant Award**
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$0**
Total SABG Award*		**$13,091,773**
Planned Primary Prevention Percentage		**0.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Iowa will plan and report activities utilizing IOM categories.

No Block Grant funds will be used for Section 1926-Tobacco. No substance abuse funds will be used for activities targeting individuals or subgroups.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$2,029,367
Universal Indirect	$104,524
Selective	$200,560
Indicated	$90,701
Column Total	**$2,425,152**
Total SABG Award*	**$13,091,773**
Planned Primary Prevention Percentage	**18.52 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures
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Footnotes:
Of the amount of primary prevention funds shown on Table 4, Row 2, it is anticipated $698,544 will be expended for Non-Direct-Services/System Development for SABG Prevention (Table 6).

Iowa -

Table 4, Row 2 - $3,123,696

Table 5b - $2,425,152
Table 6 - $698,544
TOTAL: $3,123,696

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☑
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☑
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☑
Underserved Racial and Ethnic Minorities	☐

Footnotes:

Planning Tables

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

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	**A. SABG Treatment**	**B. SABG Prevention**	**C. SABG Combined***
1. Information Systems	$840,644	$335,344	
2. Infrastructure Support	$450,000		
3. Partnerships, community outreach, and needs assessment	$240,022	$22,049	$93,044
4. Planning Council Activities (MHBG required, SABG optional)	$13,072		
5. Quality Assurance and Improvement	$266,734	$8,977	
6. Research and Evaluation	$462,324	$123,480	
7. Training and Education	$208,694	$208,694	
8. Total	**$2,481,490**	**$698,544**	**$93,044**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.
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Footnotes:

Of the amount of primary prevention funds shown on Table 4, Row 2, it is anticipated $698,544 will be expended for Non-Direct-Services/System Development for SABG Prevention (Table 6).

Iowa -

Table 4, Row 2 - $3,123,696

Table 5b - $2,425,152
Table 6 - $698,544
TOTAL: $3,123,696

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.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

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[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **http://www.samhsa.gov/co-occurring/**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **http://www.samhsa.gov/health-disparities/strategic-initiatives**

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

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

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[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[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.

The IDPH integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorder or makes arrangements for services if not available at the SUD program. The state of Iowa has many legislative initiatives currently occurring regarding co-occurring disorders, complex needs, children's behavioral health services,, access to MAT, review of reimbursement rates for SUD providers, providing a single statewide twenty-four hour hotline and crisis response system, establishing access centers around the state, reviewing and aligning mental health and SUD commitment processes, and others. Most recently, HF766- Enhanced Delivery of Services is new legislation that directs the Director of the DHS and the Director of the IDPH to develop recommendations for the enhanced delivery of co-occurring conditions. The directors shall examine the current service delivery system to:
Identify opportunities for reducing administrative burden on Departments and providers
Evaluate the use of an integrated helpline and website
improvements in data collection and sharing of outcomes
create a structure for ongoing collaboration
For details regarding this co-occurring legislation and work, please see Planning Step One;; legislation.
Additionally, through the IPN, IDPH contractors support co-occurring clients through the vast service array of levels of care, early intervention services, crisis calls, expansion of Medication Units across the state, collaborations with a variety of stakeholders, provides recovery support services, establishment of on-site primary care providers. For details, please see Step One IPN network services. Additionally, the IDPH supports integration efforts with every discretionary grant including the Primary Health Care Integration grant, youth and women specific grants, and the STR and SOR grants. For details, please see Planning Step One.

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

The state, through the IPN and legislative priorities, are moving towards an integrated system of care for individuals and families with co-occurring. Through the IDPH, a variety of initiatives are currently focused on integration. Some of these legislative initiatives which focus on this include: the Complex Needs Legislation, the establishment of a Children's System and state-wide Governor appointed Children's Board, through prioritizing integration through discretionary grants, by providing reimbursement for recovery support services through the IPN and other grants, through the reimbursement workgroup (review of funding for SUD providers) and most recently the legislation focused on the Directors of the Mental Health Authority and the Substance Abuse Authority to review and develop recommendations for the enhanced delivery of services related to co-occurring conditions. For details; please see Planning Step One

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? (•) Yes ( ) No

b) and Medicaid? (•) Yes ( ) No

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

IDPH is responsible for monitoring all contractual requirements for the IPN. This is completed by contracting, claims submission and review, monitoring of contracts, retrospective reviews, data integrity reviews and system development, technical assistance , etc.

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?

Continued reductions in Length of Stay at residential facilities with newer Managed Care Organizations new to state. Continued barriers related to authorization processes- longer times to authorize, shorter LOS, difficulty in understanding and authorizing levels of care to the ASAM criteria by MCO's.

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

The SSA has worked, in recent past, with the MCO's, Dr. David Mee-Lee (ASAM), and the Iowa Behavioral Health Association to review barriers, and provide education needed.

Please indicate areas of technical assistance needed related to this section

None at this time

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

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] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.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 focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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Footnotes:

Environmental Factors and Plan

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?

The IDPH has established a new provider network, the IPN, effective January 1, 2019. Through this network of contractors, new processes, extensive training, contractual requirements, attestation forms, and the expansion of the IDPH data system (and new data manuals and training) has significantly increased the competency of the IPN to meet stator and regulatory requirements. For further details on requirements, please see Planning Step One.

Please indicate areas of technical assistance needed related to this section

None

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Footnotes:

BG Application 2020-2021
Section 11
Quality and Data Collection Readiness Narrative

1. **Describe the state's approach to data collection and reporting systems and how it can be improved and result in better client level data and outcomes. Both Prevention and Treatment Systems. Please note primary prevention will not be client level, but should be population level measures such as NSDUH. Indicate collaboration with other community partners, planning groups and the public about the Block Grant and how this assists in the development of improved data collection and outcomes.**

Iowa Substance Use Disorder Treatment Data Reporting

The IDPH Division of Behavioral Health collects patient level data from licensed substance use disorder treatment agencies to meet state and federal data (TEDS, etc.) reporting requirements.

The Central Data Repository (CDR) is Iowa's data warehouse (Microsoft Sequel Server 2008) of substance use disorder treatment data. Client level data (Client Profile, Crisis, Placement Screening, Admission, Discharge, Service and Follow-up) is collected from approximately 100 licensed substance use disorder treatment programs.

IDPH monitors and uses these data to assist in decision making regarding system trends (utilization, demographic, drug of choice, level of care, etc.), system/network improvements (access, engagement, retention, continuation, quality of life, etc.) and health equity.

Data Reporting Methods

Licensed substance use disorder treatment programs have two options to submit patient level data electronically to the CDR:

- Secure File Transfer Protocol (SFTP): Licensed substance use disorder treatment agencies that currently use or are planning to procure an EHR/EMR (Electronic Health Record or Electronic Medical Record), may submit patient level data per the CDR Vendor Submission Guide (http://www.idph.iowa.gov/ismart/repository).
- I-SMART (Iowa Service Management and Reporting Tool): Licensed substance use disorder treatment Agencies that don't currently have an EHR/EMR or whose EHR/EMR does not currently meet the CDR Vendor Submission Guide, may choose to submit data via data entry in I-SMART.

Data Integrity

Each month, IDPH conducts Data Integrity checks to ensure that data reported are complete and accurate. Data Integrity Reports are sent via encrypted mail on the 17th of the month. Agencies are expected to review their individual reports and to make the corrections noted by the 15th of the following month. Examples of data integrity checks include identifying when an admission has occurred without any associated services, inaccurate data such as “pregnant” and “male” reported for a single patient, etc.

Help Desk

IDPH offers a Help Desk to answer questions and provide assistance on data reporting requirements and the data system. The Help Desk can be reached via phone email.

Help Desk hours are M-F from 9-3 (excluding holidays). Help Desk calls are automatically answered with messages transcribed and sent to the help desk email.

Data System Enhancements

Several recent enhancements have been made to the treatment data systems used in Iowa. These include updating the GPRA to meet new expectations and development of the Opioid Treatment Program (OTP) Registry. The Department is currently working with a vendor to create the next generation system called the Iowa Behavioral Health Reporting System (IBHRS). This data warehouse model will collect integrated data across SUD, problem gambling, and mental health. IBHRS streamlines the data collected, includes robust validation rules and checks to improve data reporting accuracy/quality, and includes previously unreported Treatment Episode Data Set (TEDS) elements.

Iowa Substance Abuse Prevention Data Reporting

Iowa uses the Prevention Domain within I-SMART to report substance abuse and problem gambling prevention data. I-SMART is also in use by the state’s substance use disorder treatment and problem gambling treatment programs. Currently the I-SMART Prevention Domain collects population (group) level data which meets Block Grant Substance Abuse Prevention reporting requirements.

Data Integrity

Each month, IDPH conducts Data Integrity checks to ensure that data reported are complete and accurate. Data Integrity Reports are distributed monthly. Agencies are expected to review their individual reports and to make the corrections noted by the 15th of the following month. Examples of data integrity checks include comparing the Strategy IOM to the IOM Classification, duration minutes are entered as directed, recurring programs have the required number of sessions, etc.

Data System Enhancements

During FFY19, enhancements to the Prevention Domain were developed and launched. The enhancements included a new prevention data reporting module that will reduce data entry errors, increase reporting capability, and improve data quality. Through one-time and session-based prevention strategies, the module continues to collect group-level data to meet the SABG reporting requirements.

Iowa plans to implement a competitive process to procure an integrated data system to improve data quality and the reporting process. These plans are just beginning, with decisions coming soon on how to integrate systems and which systems to integrate. For example, the data system may integrate substance use disorder treatment and substance abuse prevention data, or integrate substance abuse prevention individual-level and group-level data.

Technical Assistance

None needed at this time

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Please respond to the following items

Assessment

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

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

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

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

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

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

- [ ] Archival indicators (Please list)

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

IDPH reviews a variety of data indicators in determining priority issues for contractors to focus on with the Prevention Set Aside funding. We also utilize an Iowa Epidemiological Profile that is updated every two years to assist with this process.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Capacity Building

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

If yes, please describe

The Iowa Board of Certification (IBC) credentials prevention and treatment professionals in addictions and other behavioral health fields by promoting adherence to competency and ethical standards. IBC certifies and recertifies professionals in a variety of substance use disorder fields. For prevention, IBC supports a Prevention Specialist Certification and an Advanced Prevention Specialist Certification. Information about the certification requirements can be found at https://www.iowabc.org/cps.

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

If yes, please describe mechanism used

IDPH oversees several training systems which support training and technical assistance to prevention professionals including a Substance Abuse Prevention Training Team which provides foundational prevention trainings for Iowa's prevention field. IDPH also contracts with five Capacity Coaches to provide coaching services to contractors utilized the Strategic Prevention Framework process. In addition, IDPH contracts with Iowa State University to organize and support statewide training efforts including the Governor's Conference on Substance Abuse, grant contractor meetings and other trainings as determined by contractor need throughout each contract year.

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

If yes, please describe mechanism used

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

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

Planning

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

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

See attached.

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

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

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

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

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

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

There are two evidence-based strategy approval categories supported by the Evidence-Based Practice Workgroup (EBPW) which include:

1. Pre-approved by the EBPW: Pre-approved EBPs consist of those strategies designed to impact the priority, for which strong and well-documented evidence of effectiveness is available. These EBPs have been recommended by federal agencies, substance abuse prevention organizations, and/or are strongly supported by peer-reviewed literature.

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

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

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

• The intervention is based on a theory of change that is documented in a clear logic or conceptual model;
• The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
• The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; AND

The approval request will be reviewed and deemed appropriate by a panel of the Evidence-Based Practice Workgroup members who are informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions; local prevention practitioners; and key community leaders as appropriate. If the strategy is not approved an appeal process will be made available with a panel of out-of- state experts.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

Implementation

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

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

SAMHSA and IDPH created media campaigns on the priority issues, speaking engagements and health fairs/health promotions.

b) Education:

Classroom and/or small group sessions, parenting programs, supports groups for the selective population, evidence-based programs as reviewed and approved through the Evidence-Based Practices Workgroup (list can be provided).

c) Alternatives:

Technical assistance to community organizations and coalitions providing alternative activities.

d) Problem Identification and Referral:

Diversion programs for youth and young adults.

e) Community-Based Processes:

Technical assistance to community organizations and coalitions, training.

f) Environmental:

Promoting the establishment or review of alcohol, tobacco and drug use; policies in schools, colleges and workplaces,

procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies. Environmental strategies reviewed and approved by the Evidence-Based Practices Workgroup (list can be provided).

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

If yes, please describe

IDPH monitors prevention services through a variety of means including annual site visits, work plan review, data system review, and fidelity processes. The IDPH Prevention Team has created a new process to cross check all IDPH administered prevention funding to ensure there is no duplication in service, including IPN funding. IDPH is reviewing additional ways to ensure no duplication is happening through SABG and non-IDPH administered prevention funding.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

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

See attached.

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

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

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

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

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

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use
- [x] Binge use
- [x] Perception of harm

c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Comprehensive Prevention

THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

FY16 Through FY18
Cumulative Evaluation Report

With Funds Provided by:
Iowa Department of Public Health,
Division of Behavioral Health,
Bureau of Substance Abuse

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THE IOWA CONSORTIUM
FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

Comprehensive Prevention

Cumulative Evaluation Report
March 2019

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Principal Investigator

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OVERVIEW

Evaluation Design

The evaluation employs a matched pre-post design, whereby a pre-test survey is administered when a participant enters the mentoring program and at the end of each project year (post-test) for all programs. The survey asks questions of middle and high school youth about past 30-day use of alcohol, binge drinking, cigarettes, and marijuana.

Cumulative results are reported for each state fiscal year (SFY16 through SFY18), and individual program results are also reported for each state fiscal year for programs with 50 or more matched surveys. The overall percentage change is reported for each year and each program, where a positive percentage change (+) indicates an increase in use, and a negative change (-) indicates a decrease in use.

A parallel survey conducted is the Iowa Youth Survey (IYS), a biennial survey of Iowa's students (grades 6, 8, and 11) which includes the collection of information on attitudes and use of substances. The IYS data reveal changes due to maturation of the youth through the different grade levels. For convenience, the 2016 and 2018 IYS results appear in the tables of results in this report as a general population benchmark.

This comparison includes all grades who participated in the IYS, as the Comprehensive Prevention participants range from 9th through 12th grades. While the time span between pre-test and post-test for some prevention programs presented here is less than one year, the IYS average yearly change serves as a general point of reference when examining the program outcomes rather than comparing to zero, or no change. It is important to note that youth who participated in Comprehensive Prevention programming may also have completed the IYS.

Methodology

Anonymous codes are used to match before and after surveys. The number of matched surveys for each program is presented in the column titled "N." Each column of results presents the difference score between the pre-test and post-test. For each program, all valid pairs of responses for each question are used to calculate the difference score (i.e., the response percentage for the post-test minus the pre-test). For example, a -10.0 difference means a reduction of 10 percentage points from pre-test to post-test.

OUTCOMES

Table 1: Cumulative Years Alcohol Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

Program	N	Alcohol Use Difference
2016 Iowa Youth Survey	52,560	+2.00
LifeSkills Training	5,162	-0.97
Project ALERT	3,689	-0.62
Too Good for Drugs	1,610	+0.50
Prime for Life Non-Diversion	736	-7.07
Project Northland	514	+1.95
Project Towards No Drug Abuse	302	-0.33
Brain Power	220	+1.36
Diversion	179	-2.79
Curriculum-Based Support Group	158	+0.63
Juvenile Education Groups	83	0.00
All Stars	75	-4.00

Table 2: Cumulative Years Binge Drinking Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

Program	N	Binge Drinking Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	5,167	+0.14
Project ALERT	3,684	-0.03
Too Good for Drugs	1,607	-0.25
Prime for Life Non-Diversion	737	-1.36
Project Northland	515	+0.78
Project Towards No Drug Abuse	304	+2.96
Brain Power	218	+0.46
Diversion	178	+1.12
Curriculum-Based Support Group	158	+1.90
Juvenile Education Groups	83	+2.41
All Stars	75	-2.67

Table 3: Cumulative Years Cigarette Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

Program	N	Cigarette Use Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	5,171	+0.12
Project ALERT	3,688	+0.14
Too Good for Drugs	1,605	-0.12
Prime for Life Non-Diversion	736	-4.62
Project Northland	515	+0.58
Project Towards No Drug Abuse	304	+2.96
Brain Power	218	-0.46
Diversion	178	0.00
Curriculum-Based Support Group	158	+3.16
Juvenile Education Groups	84	-1.19
All Stars	75	0.00

Table 4: Cumulative Years Marijuana Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

Program	N	Marijuana Use Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	5,167	-0.15
Project ALERT	3,683	-0.16
Too Good for Drugs	1,603	0.00
Prime for Life Non-Diversion	736	-2.31
Project Northland	515	+0.19
Project Towards No Drug Abuse	303	+1.98
Brain Power	218	+0.46
Diversion	177	0.00
Curriculum-Based Support Group	157	+1.27
Juvenile Education Groups	84	+1.19
All Stars	75	0.00

Table 5: FY16 Alcohol Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY16 Programs	N	Alcohol Use Difference
2016 Iowa Youth Survey	52,560	+2.00
LifeSkills Training	1,409	+0.64
Project ALERT	1,220	-0.90
Too Good for Drugs	519	+2.31
Project Northland	145	+2.76
Project Towards No Drug Abuse	101	+11.88
Brain Power	64	+1.56
Diversion	60	+3.33

Table 6: FY16 Binge Drinking Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY16 Programs	N	Binge Drinking Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	1,409	+0.35
Project ALERT	1,218	-0.57
Too Good for Drugs	519	0.00
Project Northland	146	+2.05
Project Towards No Drug Abuse	101	+9.90
Brain Power	64	0.00
Diversion	59	+8.47

Table 7: FY16 Cigarette Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY16 Programs	N	Cigarette Use Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	1,412	+0.42
Project ALERT	1,219	-0.33
Too Good for Drugs	518	-0.19
Project Northland	146	0.00
Project Towards No Drug Abuse	101	+8.91
Brain Power	64	-3.12
Diversion	59	+3.39

Table 8: FY16 Marijuana Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY16 Programs	N	Marijuana Use Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	1,411	-0.50
Project ALERT	1,217	-0.41
Too Good for Drugs	518	-0.58
Project Northland	146	+0.68
Project Towards No Drug Abuse	101	+6.93
Brain Power	64	0.00
Diversion	59	+6.78

Table 9: FY17 Alcohol Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY17 Programs	N	Alcohol Use Difference
2016 Iowa Youth Survey	52,560	+2.00
LifeSkills Training	1,177	-2.12
Project ALERT	1,111	-0.72
Too Good for Drugs	346	-1.45
Prime for Life Non-Diversion	263	-11.41
Project Towards No Drug Abuse	164	-6.10
Project Northland	130	0.00
Diversion	77	-5.19
Brain Power	58	+1.72

Table 10: FY17 Binge Drinking Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY17 Programs	N	Binge Drinking Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	1,178	-0.76
Project ALERT	1,108	+0.36
Too Good for Drugs	348	+0.29
Prime for Life Non-Diversion	263	-2.28
Project Towards No Drug Abuse	166	0.00
Project Northland	130	+0.77
Diversion	77	-5.19
Brain Power	56	0.00

Table 11: FY17 Cigarette Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY17 Programs	N	Cigarette Use Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	1,179	-0.59
Project ALERT	1,110	+0.63
Too Good for Drugs	344	+0.29
Prime for Life Non-Diversion	262	-1.91
Project Towards No Drug Abuse	166	0.00
Project Northland	130	+1.54
Diversion	77	-2.60
Brain Power	56	0.00

Table 12: FY17 Marijuana Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY17 Programs	N	Marijuana Use Difference
2016 Iowa Youth Survey	52,560	+1.00
LifeSkills Training	1,178	-0.17
Project ALERT	1,108	-0.18
Too Good for Drugs	346	-0.29
Prime for Life Non-Diversion	262	-2.29
Project Towards No Drug Abuse	165	0.00
Project Northland	130	0.00
Diversion	76	-5.26
Brain Power	56	0.00

Table 13: FY18 Alcohol Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY18 Programs	N	Alcohol Use Difference
2018 Iowa Youth Survey	49,215	+1.00
LifeSkills Training	2,576	-1.32
Project ALERT	1,358	-0.29
Too Good for Drugs	745	0.13
Prime for Life Non-Diversion	427	-5.15
Project Northland	239	2.51
Brain Power	98	1.02
Curriculum-Based Support Group	73	0.00

Table 14: FY18 Binge Drinking Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY18 Programs	N	Binge Drinking Difference
2018 Iowa Youth Survey	49,215	+0.48
LifeSkills Training	2,850	0.43
Project ALERT	1,358	0.15
Too Good for Drugs	740	-0.68
Prime for Life Non-Diversion	428	-1.17
Project Northland	239	0.00
Brain Power	98	1.02
Curriculum-Based Support Group	74	-1.35

Table 15: FY18 Cigarette Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY18 Programs	N	Cigarette Use Difference
2018 Iowa Youth Survey	49,215	+0.14
LifeSkills Training	2,850	0.27
Project ALERT	1,359	0.15
Too Good for Drugs	743	-0.27
Prime for Life Non-Diversion	428	-6.54
Project Northland	239	0.42
Brain Power	98	1.02
Curriculum-Based Support Group	74	0.00

Table 16: FY18 Marijuana Use Change in Past 30-Day Use: Comprehensive Prevention Survey Respondents

FY18 Programs	N	Marijuana Use Difference
2018 Iowa Youth Survey	49,215	+0.48
LifeSkills Training	2,578	0.04
Project ALERT	1,358	0.07
Too Good for Drugs	739	0.54
Prime for Life Non-Diversion	428	-2.80
Project Northland	239	0.00
Brain Power	98	1.02
Curriculum-Based Support Group	74	-1.35

CONCLUSION

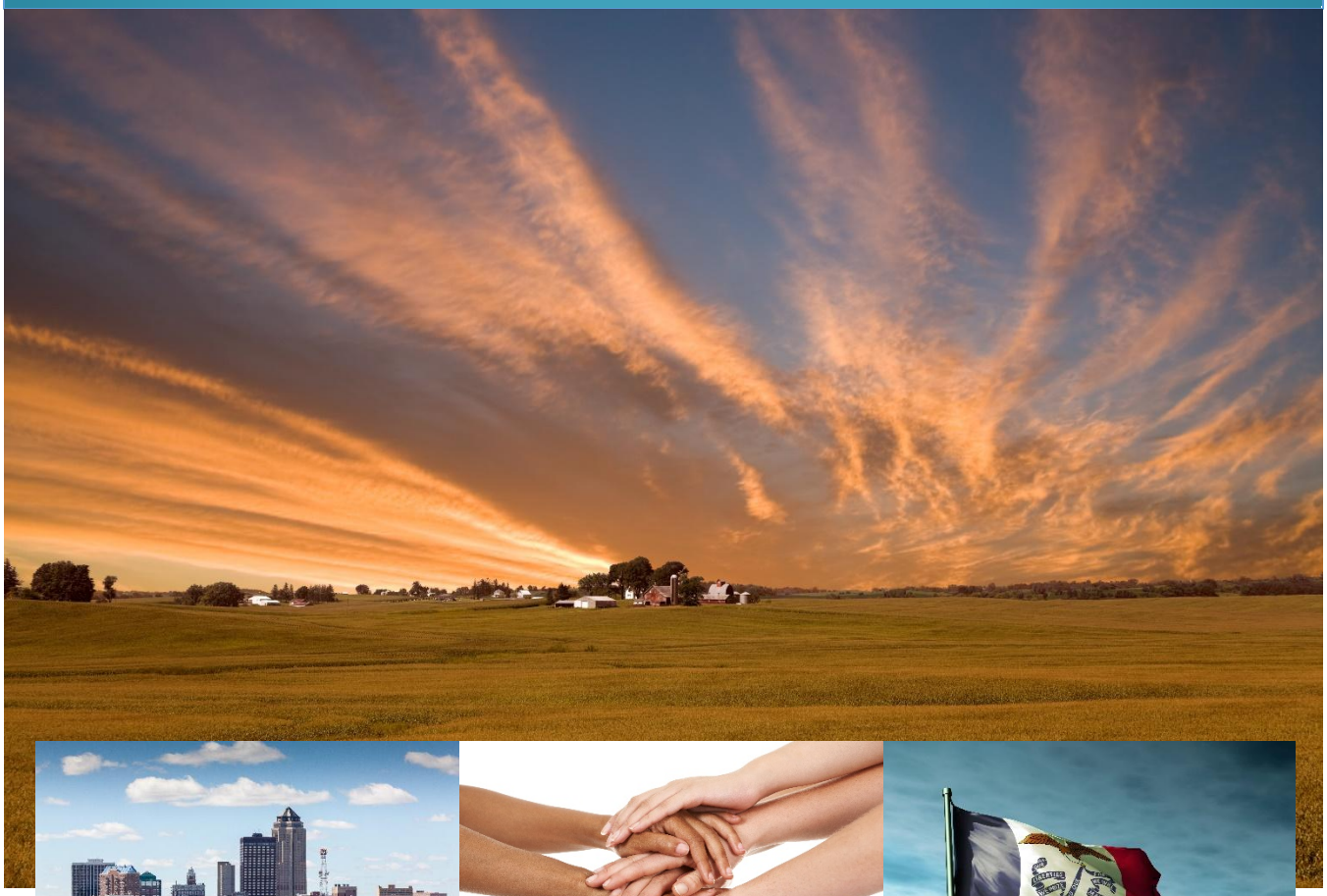
- LifeSkills Training showed a significant percentage point decrease (-0.97) in alcohol use for all years combined. LifeSkills is a middle and high school substance abuse prevention program to prevent teenage drug, tobacco, and alcohol use and abuse and violence and other risk behaviors.[1]

- Prime for Life Non-Diversion showed a significant percentage point decrease in alcohol use (-7.07), binge drinking (-1.36), cigarette use (-4.62), and marijuana use (-2.31) for all years combined. Prime for Life is an evidence-based program specifically designed for people who might be making high-risk choices. This group contains universal, selective, and indicated audiences. Universal audiences are youth without any known increased risk factors and may only need risk reduction information. Selective audiences are those that might have signs of increased risk of substance use problems and would benefit from the program. Indicated groups are those who are already making high-risk alcohol or drug choices and who may be showing signs of problems.[2]

- Project Towards No Drug Abuse showed a significant percentage point increase in cigarette use for all years combined (+2.96). This program targets high school-age youth by focusing on motivation factors, skills, and decision-making that predict tobacco, alcohol, other drug use, and violence-related behaviors.[3]

- Due to differences across programs in target populations, implementation processes, and intervention fidelity, comparisons across programs are not reliable.

[1] Retrieved from https://www.lifeskillstraining.com/
[2] Retrieved from https://www.primeforlife.org/
[3] Retrieved from https://tnd.usc.edu/



Five-Year Substance Abuse Prevention Strategic Plan for the State of Iowa

Iowa Department of Public Health
Division of Behavioral Health
Bureau of Substance Abuse

2018 – 2022

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Introduction

The Iowa Department of Public Health (IDPH) Bureau of Substance Abuse, within the Division of Behavioral Health, leads substance abuse prevention and substance use disorder treatment and recovery support services in Iowa. In addition to overseeing State- and SAMHSA Block Grant-funded prevention and treatment services statewide, the Bureau seeks and implements other federal grant funding to expand the scope of Iowa's prevention-specific efforts

Currently, IDPH manages three federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants intended to prevent substance misuse and abuse in Iowa:

Strategic Prevention Framework of Iowa

- the Partnerships for Success grant,
- the Strategic Prevention Framework for Prescription Drugs grant, and
- the prevention set a side portion of the Substance Abuse Prevention and Treatment Block Grant, often referred to as the Comprehensive Substance Abuse Prevention grant.

In 2014, Iowa was awarded the five-year Partnerships for Success (PFS) grant to help reduce underage drinking and underage binge drinking, and to strengthen prevention capacity at the state level. Through a Request for Proposal (RFP) process, PFS awarded contracts to 12 highest-need counties. PFS is based on the premise that changes at the community level will lead to measurable changes at the state level. Through collaboration, states and their PFS-funded communities of high need can overcome challenges associated with substance misuse.

In 2016, IDPH was awarded the five-year Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant. The purpose of SPF RX is to raise awareness about the dangers of sharing medications among youth ages 12-17 and adults 18-25, work with pharmaceutical and medical communities to address the risks of over-prescribing to young adults, and raise community awareness and implement evidence-based environmental strategies to address prescription drug misuse with schools, communities, parents, prescribers, and patients. Through an RFP process, three counties were awarded SPF Rx grant contracts.

IDPH directs at least 20 percent of the Substance Abuse Prevention and Treatment Block Grant (SABG) along with State General Fund appropriations to 18 community-based agencies through Comprehensive Substance Abuse Prevention (CSAP) contracts awarded by a RFP process. The 18 contractors are organized into 23 geographic prevention service areas, each generally covering up to 10 counties, and together encompassing all 99 Iowa counties. CSAP contracts support alcohol, tobacco, and other drug abuse prevention services statewide. CSAP services may be directed to all ages and populations who are not in need of substance use disorder treatment. CSAP services maintain and advance public health activities, essential services, core public health functions, and strong relationships with community partners.

IDPH established a committee in the summer of 2017 to inform the content of this strategic plan. In addition to IDPH staff, committee members included representatives from the Governor's Office of Drug Control Policy, the Iowa Department of Education, the Iowa Department of Human Services, and the Iowa Department of Public Safety, along with community-based prevention and treatment service providers from across the state.

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The Problem

In August 2017, IDPH reviewed available data sets pertaining to substance-related consequences and substance use/misuse among Iowans. Appendix A to this report includes the full Data Brief prepared for consideration by planning committee members. The facts and figures presented within the Data Brief were used to inform context for the creation of the resulting plan featured in this document. Sources of information included but were not limited to the Behavioral Risk Factor Surveillance System (BRFSS), CDC's National Center for Health Statistics and National Vital Statistics System (NCHS/NVSS), County Health Rankings, the Agency for Healthcare Research and Quality, the Iowa Youth Survey (managed by IDPH), the National Survey on Drug Use and Health (NSDUH), and SAMHSA's Treatment Episode Data Set (TEDS). The data highlighted several areas of opportunity.

- The rate of alcohol-related mortality per 100,000 population in Iowa has increased slightly since 2010, similar to national rates (Death Certificate Data: NCHS/NVSS).
- Current alcohol use among Iowans 18+ is higher than the national average with a widening gap in recent years (BRFSS).
- Binge drinking among Iowans 18+ remains relatively steady yet above the national average.
- The percentage of persons aged 18 or older reporting current cigarette use has decreased since 2013 (down from 19.5% to 18% in 2015).
- While the rate of illicit opioids-related overdoses (including heroin) per 100,000 population is relatively low compared to alcohol-related mortality in Iowa, the trend is increasing over time alongside U.S. rates (Death Certificate Data: NCHS/NVSS).
- The perceived risk associated from using alcohol, marijuana, and cigarettes among adults aged 12 or older has remained relatively unchanged since 2008 (NSDUH).
- The percentage of adults aged 12 or older reporting dependence on or abuse of alcohol has decreased since 2008 from nearly 9% to approximately 6% as of 2014 (NSDUH). Self-reported incidence of illicit drug dependence over the same time frame remains unchanged.
- The top four primary substances abused by Iowans (as per TEDS, 2016) include 1) amphetamines, 2) marijuana, 3) alcohol only, and 4) alcohol with other substances. Of those, there has been a noticeable increase in admissions among those using amphetamines as their primary substance from 2014 (19.8% of total treatment admissions) to 2016 (25.3% of total treatment admissions).
- The age at time of treatment admission among individuals being admitted for marijuana abuse peaks among younger adults. Higher incidence of treatment for alcohol abuse happens among middle-aged Iowans (age 26 to 50). Amphetamine abuse happens most often among 21-35 year olds.
- Opioid pain relievers, such as oxycodone or hydrocodone, contributed to 43 (14 percent) of the 297 drug overdose deaths in 2015

In addition to the data brief provided, evidence-based strategies and the collective experience of the team assembled informed this strategic plan. IDPH gathered subject-matter experts from across the state to participate and contribute in the strategic plan development and implementation. The framework of the planning effort was to create one strategic plan that encompasses all grant driven efforts.

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Target Population/Area of Focus

The target population for the PFS grant is underage youth 13-20; SPF Rx grant is youth 12-17 and young adults 18-25, and the Comprehensive Substance Abuse Prevention grant is not limited to a particular audience. Beyond this, the planning team was careful to acknowledge several population subgroups that the prevention efforts were not intended to impact. These subgroups included individuals with cancer or chronic debilitating pain, or those managing end of life. Rather, in the case of prescription opioid abuse, the focus is on individuals whose pain management needs may not require the utilization of drugs that could put a person at risk for addiction issues. There was also acknowledgement that much was to be learned regarding effective pain management balanced with responsible prescribing practices. The planning team also acknowledged and holds professional respect for each of the disciplines involved in this continuum, which ensures a collaborative effort is embraced for the citizens of Iowa potentially at risk of all substance abuse issues.

Guiding Principles

The guiding principles outlined below provides a framework and ground rules of how the plan will be executed by IDPH and its partners.

We will…

- continually strive to bridge the continuum of care between prevention and treatment so it is a seamless bridge for Iowans in need of those services.
- be open and receptive to the evolution of substance abuse prevention and key influencers in that continuum, and continually engage those sectors in the overall aims of this plain.
- reflect the diversity of our state through materials, education, and messaging that are culturally inclusive and responsive to both providers and patients, regardless of their ethnicity or scope of practice.
- leverage all resources – private, not-for-profit, and state – to coordinate a comprehensive approach so as not to duplicate efforts and make best use of resources available for this work.
- ensure our efforts are measurable so we can assess our impact, and redirect resources if an activity does not generate the desired outcomes.
- hold one another accountable for completing the work, and be transparent in our communications to demonstrate that accountability to one another and among stakeholders, including but not limited to the Prevention Partnership Advisory Council[1].
- focus first on activities that increase capacity of communities to prevent substance use disorder through education and public awareness.
- recognize responsible prescribing and monitoring practices.
- recognize responsible sales and use of legal substances.

[1] The Prevention Partnerships Advisory Council is a multi-disciplinary team representing state and local agencies. The council is responsible for providing strategic and operational recommendations for the implementation of all steps of the Strategic Prevention Framework process including assessment, capacity, planning, implementation and evaluation as well as cultural competency and sustainability.

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Program Structure

IDPH's substance abuse prevention strategic plan follows the Strategic Prevention Framework (SPF) model and is guided by the principles of the cultural competence and sustainability throughout all five steps of the process.

Assessment

At the state and community level, the assessment process supports community surveillance of substance use and behavioral health through ongoing epidemiological data review which encompasses the services of the State Epidemiological Workgroup (SEW) and the Prevention Partnerships Advisory Council. Highest-need areas and gaps were identified using several indicators, including the Prescription Monitoring Program (PMP) data and analysis through the SEW. The SEW oversaw development of the *County Assessment Workbook* which is designed to be used by community grantees to determine risk and protective factors within their areas.

Capacity

PFS, SPF Rx, and the Comprehensive Substance Abuse Prevention grants all utilize stakeholders within but not limited to the Prevention Partnerships Advisory Council, the SEW, Iowa Workforce Development, the Governor's Office of Drug Control, Department of Human Rights, law enforcement, community coalitions, community-based prevention and/or treatment agencies, Iowa Poison Control, Department of Public Safety, colleges and universities, Iowa Board of Pharmacy, Iowa Pharmacy Association, youth, and medical professionals.

Community grantees are required to complete the IDPH-provided *County Assessment Workbook* and utilize the document to review the prevention services in their respective communities to establish connections that help plan, implement and sustain strategy outcomes. As a support, community grantees through SPF Rx and Partnerships for Success use a Capacity Coach to help adhere to their capacity-building needs. Capacity-building is a continuous process for all, including IDPH's Prevention Partnerships Advisory Council, which actively recruits stakeholders who represent needed sectors.

Planning

The strategic planning process began by recruiting Short-Term Action Teams (STAT) to assist in analyzing data from the SEW. These action teams (Evidence Based Practices, Workforce Development, Continuous Quality Improvement, and PMP/Public Education) were determined by the SPF Rx, IPFS, and CSAP grants project directors. Planning consisted of two in-person meetings and several web-based meetings for each STAT. During these meetings the STAT members analyzed data, determined plan objectives, action items, timelines and persons/departments responsible. Local grantees in each of the counties were provided a Strategic Planning Template, logic model example, rubric, training and technical assistance. These resources will continue to guide the community grantees and their coalitions through the SPF process.

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Implementation

Implementation of the strategies determined within this strategic plan will provide Iowan's access to effective prevention services and produce measurable outcomes. Resources and persons responsible have been allocated to implement strategy action steps throughout the next several years. *SAMHSA's Opioid Overdose Prescription Toolkit* and *CDC's Guideline for Prescribing Opioids for Chronic Pain* are part of the public education plan and are a strategy requirement for SPF Rx grantees. The Comprehensive Substance Abuse Prevention grantees will also assist in the comprehensive public education plan by promoting the SAMHSA and CDC resources throughout its 23 prevention agencies through the State Targeted Response to the Opioid Crisis grant.

Evaluation

Members of the SEW have been tasked with determining the feasibility of the data measures for each strategy. The SEW will also oversee creation of a Prevention Evaluation Plan that will encompass all substance abuse prevention grants funded through IDPH. At the community grantee level, a required Evaluation Plan Template along with training in completing the document will be provided. Once established, the project director, along with the evaluator and each community grantee will monitor the action steps, indicators and outcomes of the strategies. Additionally, data at the county level will be tracked using the Kansas University Community Check Box system, I-SMART Prevention System, quarterly progress reports, and SAMHSA's SPARS system. Evaluation will encompass every SPF step and will address any gaps and behavioral health disparities. Once a disparity has been identified, the STAT members will regroup, review the data, and determine the best course of action. At the community grantee level, coalitions will meet to determine how to proceed with guidance from the state, if needed.

Cultural Competency

Cultural competence has been an important component of the IDPH programs for at least 15 years, addressed in the first State Incentive Grant funded in 2001. All PFS grantees are trained in Culturally and Linguistically Appropriate Services (CLAS) and it is part of standard operating procedures and it is also a requirement in the SPF Rx grant. The STAT members were tasked with keeping CLAS standards a priority in implementing strategies. Recruiting, supporting and promoting a diverse governance, leadership and workforce; offering language assistance; and continuous improvement are all closely related to eliminating health disparities. Data collection and analysis with assistance from the SEW and the Prevention Partnerships Advisory Council will improve the design of the CLAS, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Sustainability

The strategies determined by the STAT members were designed with sustainable objectives. The Prevention Partnerships Advisory Council will continue to monitor and provide guidance to IDPH throughout the SPF process on the strategies implemented. On the local level, community grantees are charged with selecting strategies that are sustainable once funding ends and are provided with a Sustainability Plan Template to submit to IDPH project directors for approval. Sustainability focused services and the action steps taken are recorded through quarterly progress reports.

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Partners

IDPH commits to ensuring that productive and value-added partnerships with all pertinent stakeholders involved with substance abuse prevention at the local, state, and national levels are established and maintained as part of this collaborative work. These partnerships in health, law enforcement, child welfare, educational systems, among others will operate on the guiding principles defined above and commit to taking action within their agencies and organizations to best of their abilities and to the extent of their available resources.

Key partners include but are not limited to:

- Alliance of Coalitions for Change
- Allies for Substance Abuse Prevention
- Ames Police Department
- Area Substance Abuse Council
- Community Youth Concepts
- Des Moines Area Community College
- Department of Human Rights
- Department of Public Safety
- Governor's Office of Drug Control Policy
- Helping Services for Youth and Families
- Iowa Board of Pharmacy
- Iowa Department of Public Health
- Iowa Poison Control Center
- Iowa State University
- New Opportunities, Inc.
- Prairie Ridge Integrated Behavioral Healthcare
- Youth and Shelter Services

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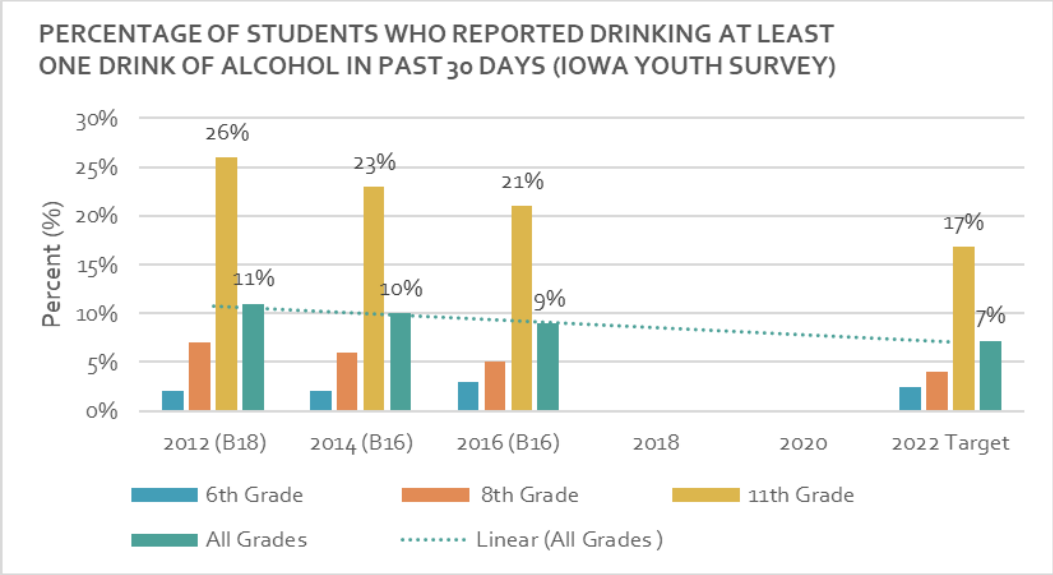
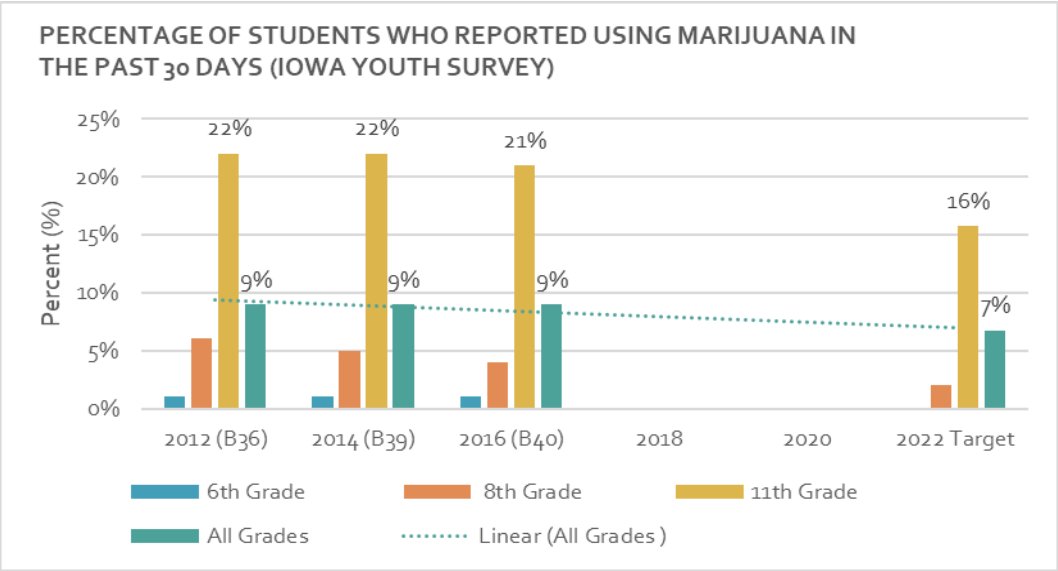
Performance Indicators & Targets

The following substance use/misuse metrics will be monitored to assess impact of the implemented strategies, in addition to specified metrics in the strategies as applicable.

Decrease underage drinking from 11% (baseline 2012) to 7% or fewer youth reporting alcohol consumption. State rate in 2016 of 3% for 6th graders, 5% for 8th graders, and 21% for 11th graders (B16, Iowa Youth Survey).



Decrease marijuana use from 9% (baseline 2012) to 7% or fewer youth reporting its use. Measured by the Iowa Youth Survey. The 2016 IYS shows 1%, 2%, and 10% for 6th, 8th, and 11th graders, respectively (B41).



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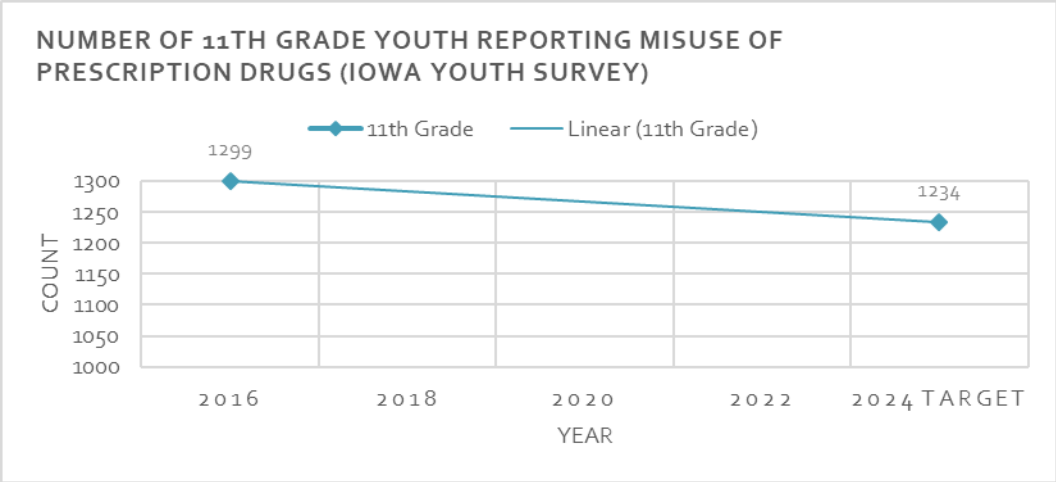
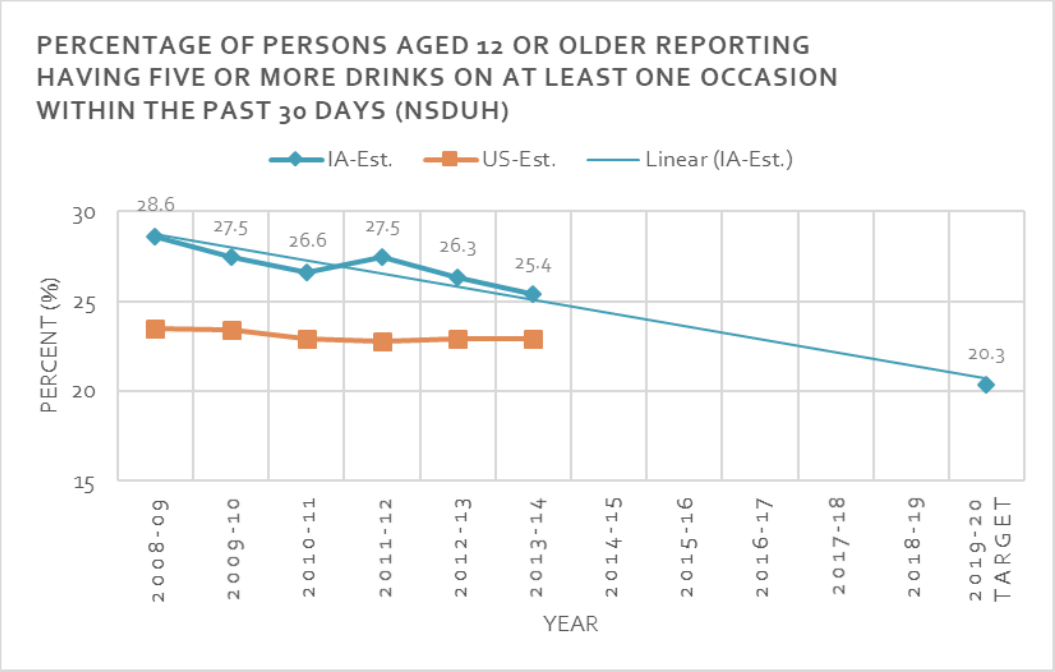
Decrease by 5% the number of 11th grade youth reporting misuse of prescription medications. Reduce by 5% (n=65) the current numbers of 11th grade youth (n=1,299) reporting prescription medication misuse as measured on the IYS. The 2016 IYS shows 1,299 11th, graders reported (B45) using prescription medications that were not prescribed to them by their doctor or using prescription medications that were prescribed to them by a doctor different from the directions (B46).



Decrease in binge drinking among adults from 28.6% (baseline 2008-09) to 20.3% (2019-20 reported data). Measured by NSDUH. Behavioral Health Barometer, Iowa reports that 18.1% of individuals aged 12-20 in Iowa engaged in binge drinking within the past month, higher than the national rate of 14.0%. NSDUH 2013-14 reports binge rate at 25.36 for Iowans 12+, 47.04 for 18-25 year-olds.



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Work Plan

Strategies for Evidence Based Practices

1. **Develop a resource guide of substance abuse prevention best practices, programs, and policies that are evidence-based or evidence-informed as defined by IDPH. Distribute completed resource guide by FY2020 Q1.**

Action Steps	**Anticipated Completion**	**Funding Source(s)**	**Lead Agency *and Partner(s)***
Expand membership of the Evidence-Based Practice Workgroup.	FY2018 Q2	IDPH	Lead: IDPH
Investigate evidence-based practice prevention programs for each substance.	FY2019 Q3	IDPH	Lead: EBP Workgroup
Create a guideline document and update annually.	FY2020 Q1 FY2021 Q1 FY2022 Q1	IDPH	Lead: EBP Workgroup
Post guidelines on IDPH website.	FY2020 Q1	IDPH	Lead: EBP Workgroup

2. **Develop a template of questions around substance use/misuse to be used in community needs assessments across Iowa. Distribute questions by FY2020 Q1.**

Action Steps	**Anticipated Completion**	**Funding Source(s)**	**Lead Agency *and Partner(s)***
Research existing questions used in needs assessments or similar studies.	FY2018 Q3	IDPH / Comp	Lead: EBP Workgroup
Gather and share county completed workbooks on IDPH website.	FY2019 Q3	IDPH / Comp	Lead: EBP Workgroup
Create and test questions and adjust based on feedback.	FY2019 Q4	IDPH / Comp	Lead: EBP Workgroup
Work with the State Epidemiological Workgroup and others to create an Assessment template.	FY2019 Q2	TBD	Lead: IDPH
Roll out to all prevention agencies to use as they complete a county assessment with the target of 75% of organizations completing by FY2021.	FY 2020Q2	IDPH / Comp	Lead: EBP Workgroup

3. **Develop and launch a toolkit by FY2020 Q3 for communities to use when advocating for public policy change in the prevention of substance abuse.**

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Action Steps	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
Outline desired objectives and requirements of toolkit.	FY2018 4Q	TBD	Lead: EBP Workgroup
Reach out to SAMHSA technical assistance providers and other subject matter experts to attain similar toolkits. Determine if there are existing toolkits that meet objectives and are easy to follow and implement.	FY2018 4Q	TBD	Lead: EBP Workgroup
Adopt/adapt policy change toolkit.	FY2019 2Q	TBD	Lead: EBP Workgroup
Test toolkit in three communities and adjust based on feedback.	FY2020 2Q	TBD	Lead: EBP Workgroup
Post toolkit on IDPH website.	FY2020 3Q	TBD	Lead: EBP Workgroup

Strategies for Continuous Quality Improvement

4. Increase awareness of the established *Iowa Substance Abuse Prevention Practices & Resource Guide* (Strategy 1), and encourage collaboration between block grant providers through regional meetings held annually.

Action Steps	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
Host regional meeting with block grant providers at least two times during grant period.	FY2018 Q4 FY2020 Q4	TBD	Lead: IDPH
Host two collaborative meetings at the Governor's Conference on Substance Abuse during grant period specific to prevention professionals and/or host break-out sessions.	FY2019 Q3 FY2021 Q3	TBD	Lead: IDPH

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5. Adapt the NIATx™ or similar model to offer providers effective ways to plan for, institute, and measure improvements in prevention services across Iowa. Pilot model in 2020 and evaluate systemic sustainability.

Action Steps	**Anticipated Completion**	**Funding Source(s)**	**Lead Agency** ***and Partner(s)***
Define guidelines for evidence-based strategies to provide guidance to prevention services in the field / linkages to Workforce Development workgroup.	FY2020 Q3	TBD	Lead: Continuous Quality Improvement Workgroup
Define strategies for local-level fidelity monitoring to strengthen the prevention services in the field and, in turn, better support individuals going through a prevention program. ▪ Examine compliance rates and identify any barriers to program completion. ▪ Leverage the NIATx model to offer providers effective ways to plan for, institute, and measure improvements in prevention services. ▪ Incentivize/support at the state level to ensure programs are implemented statewide.	FY2021 Q1	TBD	Lead: Continuous Quality Improvement Workgroup
Collect evaluation data for each program. Collect baseline data in FY2020 and then annually thereafter. Based on evaluation, update resource guide of substance abuse prevention best practices that are evidence-based or evidence-informed.	Baseline: FY2020 Q4 FY2021Q4 FY2021Q4	TBD	Lead: Continuous Quality Improvement Workgroup; IDPH Funded Prevention Agencies

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Strategies for Prevention Education

6. Leverage *Your Life Iowa* to better connect Iowans with prevention resources.

Action Steps	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
Develop and promote a public awareness campaign to encourage individuals to seek assistance and support using tools managed by *Your Life Iowa*.	FY2018 Q4	TBD	Lead: IDPH
Finalize content and prompts for call center use to encourage outreach to the phone, text, and chat resources available through *Your Life Iowa*.	FY2018 Q4	TBD	Lead: IDPH
Establish enhanced protocols that include warm hand-offs and follow-up calls to individuals and family/friends to ensure referral connections to resources are established when appropriate.	FY2019 Q4	TBD	Lead: IDPH

7. Inform and engage youth on the dangers of substance misuse through community-based awareness training and supporting media campaign by the end of 2019. Repeat activities by the end of 2021.

	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
Identify models that can be adopted/adapted for youth, leveraging information gathered as part of Strategy 1.	FY2018 Q2	TBD	Lead: IDPH
Identify and engage partners.	FY2018 Q2	TBD	Lead: IDPH Partners: Prevention Resource Centers, AC4C, health teachers, school resource officers, etc.
Define outcome metrics to determine education/training effectiveness.	FY2018 Q4	TBD	Lead: IDPH
Implement trainings and/or engage students on the dangers of substance use through existing community-based organizations and partnerships.	FY2019 Q3 Repeat 2021	TBD	Lead: IDPH Partners: Prevention Resource Centers and others TBD
Adapt the "Bottle Cap" campaign (IDPH-led/SPF SIG funded underage drinking campaign) and "Prescription Drugs Are Still Drugs" (IDPH-led SPF Rx funded campaign) to address the dangers of substance misuse; define requirements and the development of creative materials.	FY2019 Q2 Repeat 2021	TBD	Lead: IDPH

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Strategies for Workforce Development

8. Define needs, identify gaps and craft a plan to address subject matter training for all experience levels of prevention professionals. Finalize training framework by the end of 2018.

Action Steps	**Anticipated Completion**	**Funding Source(s)**	**Lead Agency *and Partner(s)***
Define workforce characteristics/prevention as a profession. Research as needed.	FY2018 Q2	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Outline the skill sets required for prevention professionals based on prevention frameworks used in Iowa.	FY2018 Q2	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Assess what subjects / courses are needed for each experience level (prospective, new, and current staff).	FY2018 Q2	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Define criteria for training resources (e.g. in-state, those developed by a national accrediting body).	FY2018 Q2	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
List existing training resources and courses that address each skillset and experience level.	FY2018 Q2	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Reach out to other prevention domain professionals for training materials and potential collaboration.	FY2018 Q2	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Define framework for training based on assessment findings; identify partners, required resources, and delivery methods that best meet the need.	FY2018 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC

9. Diversify the field of prevention professionals to reflect the population of Iowa through recruitment and retention strategies.

Action Steps	**Anticipated Completion**	**Funding Source(s)**	**Lead Agency *and Partner(s)***
Connect with *Iowa Workforce Development* to promote prevention professions.	FY2018 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup
Build a workforce pipeline through outreach to university programs.	FY2018 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, Vocational

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Action Steps	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
			Development, Dept of Education
Develop staff retention strategies for prevention agencies. Roll out to agencies by year-end 2018.	FY2018 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup

10. Identify an onboarding model for prevention professionals by 2020 to ensure basic competencies are met across all IDPH-recognized primary prevention strategies.

Action Steps	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
Outline the skill sets required for prevention professionals based on prevention frameworks used in Iowa. Determine what competencies IDPH will recognize for each strategy framework.	FY2019 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Identify tools, including fidelity measures when applicable, to be used by IDPH funded agencies to increase competency in each strategy. Determine process by which fidelity will be assessed and roles/responsibilities to conduct those assessments.	FY2020 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup
Schedule meetings with colleges, agencies and others to ensure basic competencies are included in curriculum/programs for pre-professional training.	FY2020 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Identify and recommend an assessment tool to determine if prevention professionals have met skillset criteria. Recommend how to administer assessments and define plan for interventions if individual needs additional skill-building.	FY2020 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC

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11. Foster and encourage partnerships between prevention professionals and community stakeholders (e.g. youth serving organizations, faith leaders, local law enforcement, health care, educators) across the state to ensure consistent practices are applied.

Action Steps	**Anticipated Completion**	**Funding Source(s)**	**Lead Agency *and Partner(s)***
Identify and list secondary prevention professions that need a basic understanding of prevention topics or concepts.	FY2020 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Meet with leaders at the state and community level who can collaborate to set up consistent training to professionals across the state.	FY2020 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Create presentation/education materials and test on pilot audience.	FY2020 Q1	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Schedule and deliver presentations/education.	FY2021 Q1	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Evaluate presentation and adjust based on feedback. Determine if referrals are increasing.	FY2021 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC
Investigate and determine if work group should launch a marketing campaign highlighting the prevention field.	FY2022 Q4	TBD	Lead: IDPH Partners: Workforce Workgroup, IBC

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Special Focus Area – FY18 to FY22

Strategies to Reduce Opioid Use Disorder

12. Maximize the use of the Iowa Prescription Monitoring Program (PMP). Increase registration of controlled substance prescribers from 42% (2016 baseline) to 90% (2020 goal). Increase registration of pharmacists from 83% (2016 baseline) to 90% (2020 goal).

Action Steps	Anticipated Completion	Funding Source(s)	Lead Agency *and Partner(s)*
Identify a template provider report card to feature PMP data (e.g., number of top prescriptions, number of professionals enrolled.)	FY2018 Q3	TBD	Lead: Iowa Board of Pharmacy
Craft and deploy strategies to leverage the report card as a constructive community tool.	FY2019 Q1	TBD	Lead: Iowa Board of Pharmacy
Identify ways in which the Iowa Board of Pharmacy can help the Iowa Pharmacy Association and other partners in promotion of the PMP to increase registration and utilization of the tools.	FY2019 Q4	TBD	Lead: Iowa Board of Pharmacy; Iowa Pharmacy Association; Professional Healthcare Associations; IDPH
Assess PMP utilization and impact.	Baseline: FY2018 Q4 Follow up: FY2020 Q4	TBD	Lead: Iowa Board of Pharmacy Partners: IDPH

13. Promote the *CDC Guideline for Prescribing Opioids for Chronic Pain* within 80% of primary care clinics and among 80% of pre-professional programs across the State of Iowa by the end of FY2022.

Action Steps	Timeline	Funding Source(s)	Lead Agency *and Partner(s)*
Identify partners that can provide access to the target audience through conferences and education venues.	FY2018 Q2	IDPH / SPF Rx	Lead: IDPH
Work with Iowa's Opioid-STR team and prevention agencies to offer training.	FY2018 Q2 Ongoing	IDPH / STR IDPH / SPF Rx	Lead: Iowa Legislature Professional Boards – MD/DO, Nursing, Dentistry

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Action Steps	Timeline	Funding Source(s)	Lead Agency *and Partner(s)*
Work with medical schools, advanced practice nursing, dentistry, and physician assistant programs to ensure graduates demonstrate understanding of: CDC opioid prescribing guidelines, recognition of addiction, alternative pain therapies, counseling, and referral to treatment processes/resources.	FY2019 Q2	TBD	Lead: Professional Boards and Associations – MD/DO, Nursing, Dentistry
Develop and deliver continuing education for primary care prescribers regarding guidelines, alternative pain therapies and other relevant topics.	FY2020 Q2	TBD	Lead: Professional Boards and Associations – MD/DO, Nursing, Dentistry
Work with healthcare professionals to recommend alternative pain therapies.	FY2018 Q2 forward	TBD	Lead: Professional associations

14. Advocate for *Iowa Prescription Drug Take Backs* at the local level by supporting the creation of new permanent collection sites, in partnership with the Iowa Governor's Office of Drug Control Policy, and provide public education on "Take Back Events" annually.

Action Steps	Timeline	Funding Source(s)	Lead Agency *and Partner(s)*
Support coalitions in promotion of take-back program in the community, particularly in promoting awareness of established "Take Back Kiosks" across Iowa and promotion of national take-back days.	Ongoing	TBD	Lead: Iowa Pharmacy Board, AC4C, ODCP, pharmacies, law enforcement
Increase disposal options for take-back programs. - Research disposal options - Share options with take-back hosts. - Assess if more sites are needed.	FY2018 Q4 FY2020 Q4 FY2022 Q4	TBD	Iowa Pharmacy Board, AC4C, ODCP

15. In coordination with the SPF Rx Public Education Plan, educate the public about the dangers of prescription opioids and reduce stigma of accessing resources.

Action Steps	Timeline	Funding Source(s)	Lead Agency *and Partner(s)*
Distribute the SPF Rx Media Campaign "Prescription Drugs Are Still Drugs." Assess efficacy through pre- and post-surveys.	May 31, 2017-September 2021	SPF Rx	SPF Rx Project Director and Evaluator

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Action Steps	**Timeline**	**Funding Source(s)**	**Lead Agency *and Partner(s)***
Distribute Iowa Prescription Drug Epidemiological Profile update to all statewide coalitions via the AC4C coalition stakeholders, IDPH website, and Matter of Substance IDPH newsletter announcement.	October 2017-August 31, 2021		SEW, Project Director, AC4C Director
Complete County Assessment Workbook with SPF Rx-awarded counties to help determine the strategies to be applied. Results will be shared with coalitions in their counties and distributed in town hall meetings, hospitals, libraries.	October 1, 2017-April 27, 2018	SPF Rx	SPF Rx County Coordinator, SPF Project Director, Evaluator
Collaborate with Iowa Board of Pharmacy, Iowa Pharmacy Association, and IDPH for PMP marketing pieces targeted to 1) medical providers and 2) patients.	August 2017 – February 2018	SPF Rx	SPF Project Director, IBP & IPA Liaison, OSTR Project Director
Collaborate with Opioid State Targeted Response grantee in distributing combined SPF Rx PMP marketing pieces throughout 23 catchment areas in Iowa.	September 2017-August 2021	SPF Rx	OSTR and SPF Rx Project Director, County Coordinators
Collaborate with Iowa's Opioid-STR team in distributing the Opioid Overdose Recognition and Response brochure; begin with SPF Rx-awarded counties.	October 2017-August 2021	SPF Rx	OSTR and SPF Rx Project Director, SPF Rx County Coordinators
Distribute SAMHSA's Opioid Overdose Toolkit at the Governor's Conference on Substance Abuse Prevention. Distribute CDC's Guideline for Prescribing Opioids for Chronic Pain.	April 2018, April 2019, April 2020, April 2021	SPF Rx	Project Director
Post SPF Rx media campaign materials and PMP Comprehensive presentation on AC4C website and IDPH website.	September 2017	SPF Rx	Project Director, AC4C Director
Submit press release media campaign during Opioid Prevention Week.	September 2017	SPF Rx	Project Director, OSTR Director
Submit SPF Rx grantee press releases in their counties announcing they were awarded the SPF Rx grant and again for each of the strategies they implement and their status throughout the grant.	October 2017-September 2021	SPF Rx	SPF Rx County Coordinators
Submit press release announcing evaluation and progress for each year of the SPF Rx grant.	November 2017-October 2021	SPF Rx	SPF Rx Project Director

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Implementation Timeline

Calendar Year	***2018***				***2019***				***2020***				***2021***				***2022***			
Quarters	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*4*
1. Develop EBP Resource Guide	■	■	■	■	■	■	■													
1. Distribute/Update EBP Resource Guide									■				■				■			
2. Identify/review complete Assessments	■	■	■																	
2. Develop Assessment questions			■	■	■	■	■	■												
2. Distribute Assessment templates									■	■										
2. Ongoing data capture/monitoring		■				■				■				■				■		
3. Develop public policy change toolkit				■	■	■	■	■	■											
3. Test toolkit										■										
3. Launch toolkit on IDPH website											■									
4. Host regional/collaborative meetings				■			■					■			■					
5. Define CQI model & guidelines									■	■	■									
5. Define process for fidelity monitoring										■	■	■	■							
5. Support CQI model implementation												■	■							
5. CQI program evaluation												■				■				■
6. Develop public awareness campaign		■	■	■																
6. Promote public awareness campaign				■																
6. Establish follow-up protocols					■	■	■	■												
7. Identify model for youth engagement	■	■																		
7. Identify/engage partners for training	■	■																		
7. Define outcome metrics			■	■																
7. Implement youth trainings							■								■					
7. Adapt/implement media campaign			■	■	■	■	■							■	■					
8. Outline workforce skills & training	■	■																		
8. Define training framework			■	■																
9. Promote prevention professions		■	■	■																
9. Outreach to university programs		■	■	■																
9. Develop workforce retention strategies			■	■																
10. Define onboarding skill sets required					■	■	■	■												
10. Identify tools, fidelity measures									■	■	■	■								
10. Outreach to university programs							■	■	■	■	■	■								
10. Onboarding assessment											■	■				■				■
11. Identify secondary prevention sources										■	■	■								
11. Community meetings/collaboration											■	■								
11. Create/test presentation materials												■	■							
11. Schedule/deliver presentations													■	■						
11. Evaluate/adjust based on feedback														■	■	■				
11. Evaluate marketing campaign need																		■	■	■
12. Design provider report card/PMP data			■																	

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Calendar Year	***2018***				***2019***				***2020***				***2021***				***2022***			
Quarters	***1***	***2***	***3***	***4***	***1***	***2***	***3***	***4***	***1***	***2***	***3***	***4***	***1***	***2***	***3***	***4***	***1***	***2***	***3***	***4***
12. Craft/deploy strategies, report card				■	■															
12. Promote PMP/increase registration						■	■	■												
12. Assess PMP utilization				■				■				■				■				■
13. Identify partners to promote guideline		■																		
13. Offer training/communication		■	■	■	■	■														
13. Outreach to medical schools					■	■														
13. Develop/deliver education to PCPs							■	■	■	■										
14. Promote "Take Back Kiosks"	■	■	■	■			■		■		■		■		■		■		■	
14. Research/share disposal options				■								■								■
15. Distribute SPF Rx Media Campaign	■	■	■	■	■	■	■	■	■	■	■	■	■	■						
15. Distribute Epidemiological Profile	■	■	■	■	■	■	■	■	■	■	■	■	■	■						
15. Complete County Assess. Workbook	■	■																		
15. Collaborate w/PMP marketing plan	■																			
15. Distribute PMP marketing materials	■	■	■	■	■	■	■	■	■	■	■	■	■	■						
15. Distribute guidelines/regional mtgs.		■				■				■				■						
15. Press releases with SPF Rx program	■	■	■	■	■	■	■	■	■	■	■	■	■	■						

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Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ( ) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare ( ) Yes (●) No

d) Inclusion of recovery support services ( ) Yes (●) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? ( ) Yes (●) No

g) Providing employment assistance ( ) Yes (●) No

h) Providing transportation to and from services ( ) Yes (●) No

i) Educational assistance ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Through the IPN, four Women and Children IPN contractors were selected to provide women and children treatment and ancillary services statewide. Women and Children treatment must be readily accessible, comprehensive and appropriate to the persons seeking the services. Women and Children treatment must be available when needed, with minimal wait time. Women and Children contractors must provide all ancillary services and requirements under Code of Federal Regulations: 96.124, 96.126 and 96.131. Under the Women and Children Treatment set aside, ancillary services and/or treatment specialized for women is provided for pregnant and parenting women and their dependent children. Other treatment funding may be funded by Medicaid if the client and/or their children have medicaid (consistent with client enrollment). The women and children set aside is utilized as the payor of last resort.

Under the IPN contractual agreement, Women and Children Treatment contractors, at a minimum, must:
Determine a person's need for Women and Children Treatment and manage the services provided
Eligibility includes: Iowa residents who are pregnant women and women with children, including women who have custody of their children and women seeking custody
Women and Children funding is the payor of last resort. If the patient and/or the patient's children are enrolled in Medicaid or with another payor, and Medicaid or other payor covers the patient's licensed program services and/or any of the patient's or children's enhanced treatment/ancillary services, the Contractor shall not use Integrated Provider Network funding to pay for those covered services. IPN funding can pay for substance use disorder residential licensed program services that are not covered services under the Iowa Health and Wellness Plan and during the gap period between enrollment in Medicaid and assignment to a managed care organization (MCO) because of B3 services requirements
Provide Women and Children Treatment in compliance with clinical appropriateness and the Department's guidance
Provide Women and Children Treatment services in accordance with each person's assessed needs
If a patient needs a Licensed Program Service the Contractor does not provide, the Contractor must assure that the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
Screen patients and children for medical and mental health conditions and directly provide or assure provision of needed medical and mental health services.
? If a person has a medical or mental health condition the Contractor is not staffed to address, the Contractor must assure the patient's needs are met by a qualified provider and closely coordinate ongoing services with the patient and the referred provider

? If a person has a medical or mental health condition that is covered by
another provider or payor, the Contractor must closely coordinate
ongoing services with the patient and that provider/payor
Monitor a patient's progress on an ongoing basis, modifying the level of care and frequency of service in accordance with the person's evolving needs.
Establish a "disease management" approach that includes engagement with patients over time, beyond a traditional acute care and discharge service delivery model
Assure patients have access to the broad range of crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate memission and engage person in long term recovery in ways appropriate to each person
Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the Contractor
Provide substance use disorder treatment services ordered through a court action when the services ordered meet the ASAM Criteria and the court orders treatment with the Contractor.
Contractors must have processes in place to serve "walk-in" and persons in crisis
Contractors hours of operation for residential Women and Children Treatment must be 24 hours a day, seven days a week, 365 days a year, and must include weekend services
Contractors must provide residential Women and Children Treatment in a residential facility setting that admits women patients only, and their dependent children.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs — ( ) Yes (●) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — (●) Yes ( ) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

IPN Contractors who provide substance abuse treatment services must meet SABG requirements and provide services to individuals who seek treatment to persons who inject drugs and to individuals related to the tuberculosis requirement. During the 2018 retrospective review process, all IPN providers were able to demonstrate and provide necessary policies for implementation of the TB requirements and interim services provisions. According to IDPH most recent data, 28,350 were admitted during SFY 2018 of which 2,604 Admissions had a primary/secondary/tertiary route of administration of IV injection in the last 30 days. IPN contractors, who were recently awarded a contract with IDPH, are required to sign an annual attestation regarding meeting all required SABG requirements. Within IPN contracts, IPN Contractors are required to meet SABG TB and Persons who inject drugs requirements including: timeliness standards, capacity notification requirements, outreach efforts, providing or making services available to TB clients (including screening, counseling, education, referral to medical providers, as needed, and reporting to the Bureau of TB any active TB cases (within 1 day) and interim service provisions. Screening and services for persons with tuberculosis are provided directly by IPN funded contractors or through interagency collaborative agreements with other local agencies. In the case of an individual in need of such treatment who is denied admission by a provider on the basis of the lack of capacity to admit the individual, the provider will refer the individual to another contractor for tuberculosis services. Each provider implements infection control procedures and protocols to address TB and other communicable diseases. IDPH is currently moving from a narrative reporting function, from IPN contractors to incorporate tracking of SABG requirements through the reporting of data to the Departments new data reporting system (Iowa Behavioral Health Reporting System - IBHRS) that will launch in July 2020.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — ( ) Yes (●) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — ( ) Yes (●) No
- **c)** Established co-located SUD professionals within FQHCs — ( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

IPN Contractors who provide substance abuse treatment services must meet SABG requirements and provide services to individuals who seek treatment to persons who inject drugs and to individuals related to the tuberculosis requirement. During the 2018 retrospective review process, all IPN providers were able to demonstrate and provide necessary policies for implementation of the

TB requirements and interim services provisions. According to IDPH most recent data, 28,350 were admitted during SFY 2018 of which 2,604 Admissions had a primary/secondary/tertiary route of administration of IV injection in the last 30 days. The IDPH is the state agency which is responsible for TB Control. The TB Control Program is comprised of two full time employees: the Program Manager and the Nurse Consultant. The program provides direct oversight of cases afflicted with latent tuberculosis infection (LTBI) and TB disease from admission to discharge in the TB Control Program. This includes consultation with physicians, nurses, local public health agencies (LPHAs) and other healthcare providers regarding TB transmission, pathogenesis, treatment, signs and symptoms, infection control practices and contact investigations. The purpose and scope of responsibilities is defined by the core functions of the TB Control Program which include:
Disease consultation and education
Investigation of active or suspect TB cases
Case management of LTBI and active TB cases
Administration of Iowa's TB Medication Program
Data management and analysis
Administration and finance

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ( ) Yes ( ) No

b) Establishment or expansion of tele-health and social media support services ( ) Yes ( ) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ( ) Yes ( ) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ( ) Yes (●) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ( ) Yes (●) No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ( ) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — ( ) Yes (●) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ( ) Yes (●) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

1

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) [ ] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No
- **b)** Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

- **a)** Recent trends in substance use disorders in the state ◉ Yes ○ No
- **b)** Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No
- **c)** Preformance-based accountability ◉ Yes ○ No
- **d)** Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No
- **b)** Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No
- **c)** Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No
- **d)** State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

- **a)** Prevention TTC? ◉ Yes ○ No
- **b)** Mental Health TTC? ○ Yes ◉ No
- **c)** Addiction TTC? ◉ Yes ○ No
- **d)** State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

- **a)** Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

- **a)** Tuberculosis ○ Yes ◉ No
- **b)** Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

- **a)** Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No
- **b)** Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.legis.iowa.gov/docs/aco/chapter/641.155.pdf
Licensure link
https://www.legis.iowa.gov/docs/ico/chapter/125.pdf Chapter 125

Footnotes:

Iowa is not an HIV designated state

IDPH Substance Use and Problem Gambling Services
Integrated Provider Network

Integrated Provider Network Provider Manual

July 2019

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Based on Integrated Provider Network feedback and IDPH review, changes have been made to the IPN Provider Manual that will take effect September 1, 2019. Please note that changes to the IPN Provider Manual are indicated by bold and underlined text throughout the document.

I. Introduction

The Iowa Department of Public Health (IDPH) Substance Use and Problem Gambling Services Integrated Provider Network (Integrated Provider Network) is a statewide, community-based, resiliency- and recovery-oriented system of care for substance use and problem gambling services. IDPH selected Integrated Provider Network contractors in 2018, through a competitive request for proposal process that evaluated applicant capability and experience to:

- Educate the public
- Assess local needs
- Understand state and national policy
- Inform and collaborate with each other and with stakeholders
- Reduce stigma
- Prevent substance use and gambling problems
- Intervene with at-risk or in-need persons and populations
- Provide effective treatment, and
- Support early remission and long term recovery.

Contractors, as IDPH's representatives, are responsible for the substance use and problem gambling "health" of Iowans and of Iowa communities statewide.

A. Provider Manual

Contractors must provide Integrated Provider Network services in accordance with applicable laws and requirements, and with the Integrated Provider Network contract.

The Integrated Provider Network Provider Manual (Provider Manual) is part of the contract between IDPH and each contractor for provision of Integrated Provider Network services. The Provider Manual is intended to provide contractors with general information about contract requirements, and with specific details and instructions, where indicated. If Provider Manual language differs from contract language, the contract language prevails.

Certain information in the Provider Manual is in ***bold italics*** or is bulleted or is in a text box, to draw the reader's attention.

The Provider Manual includes information for all Integrated Provider Network service types.

All contractors provide Required Services:
Network Support, Prevention Services, and Outpatient Treatment.

Certain contractors also provide one or more Optional Services:
Adult Residential Treatment, Juvenile Residential Treatment,
Women and Children Treatment, and Methadone Treatment

The Provider Manual is organized into nine sections, followed by Appendices A. through L. Sections I. and II. contain general information applicable to many or all service types. Sections III. through IX. are specific to each service type.

The Provider Manual will be published for each contract period. Revisions and updates will be published as either a numbered and dated ***Integrated Provider Network Provider Manual Release*** or a revised Provider Manual, as determined by IDPH. Contractors are responsible for monitoring IDPH Provider Manual communications and for compliance with revisions and updates as they are published. IDPH will endeavor to give contractors 30 days notice of any Provider Manual revision that adds a requirement to contractors.

Integrated Provider Network Mailbox
Contractors may direct general questions about the Provider Manual and requests for exceptions, as allowed per the contract and as described in the Provider Manual, to the Integrated Provider Network email mailbox at IPN@idph.iowa.gov.

Use the ***Integrated Provider Network Exception Request Form*** in ***Appendix L*** to request an exception.

IDPH will review and respond to questions and exception requests in a timely manner. IDPH will document a contractor's approved exception request in the Grant Tracking system.

B. Goals

Through the Integrated Provider Network, contractors assist IDPH to protect and improve the health of Iowans by meeting the following three goals:

1. **Establish and maintain a comprehensive and effective system of care** for substance use and gambling problems through a statewide, integrated network of services and providers.

2. **Reduce substance use and gambling problems** through public education, evidence-based prevention, and early intervention services.

3. **Increase remission and recovery from substance use disorders and problem gambling** through timely, accessible, ongoing, and effective treatment services.

C. Lead Staff

Lead staff identified in each contractor's application serve as IDPH's contacts for Network Support services and participate in Network Support and other contract monitoring activities. Required Lead staff roles are listed below. Each contractor must have designated Lead staff for Network Support, Prevention Services, and Outpatient Treatment. Contractors providing Adult Residential Treatment, Juvenile Residential Treatment, Women and Children Treatment, and Methadone Treatment must also have designated Lead staff for those service types. ***Contractor staff may fill more than one Lead staff role.***

- Network Support Lead
- Prevention Services Lead
- Prevention Services Data/QI Lead

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- Outpatient Treatment Substance Use Disorder Lead
- Outpatient Treatment Problem Gambling Lead
- Outpatient Treatment Data/QI Lead
- Adult Residential Treatment Lead
- Adult Residential Treatment Data/QI Lead
- Juvenile Residential Treatment Lead
- Juvenile Residential Treatment Data/QI Lead
- Women and Children Treatment Lead
- Women and Children Treatment Data/QI Lead
- Methadone Treatment Lead
- Methadone Treatment Data/QI Lead

IDPH Lead staff for Integrated Provider Network purposes are:

- **DeAnn Decker – Substance Abuse Bureau Chief**
- **Julie Hibben – IPN Co-Lead (Prevention)**
- **Kevin Gabbert – IPN Co-Lead (Treatment)**

II. Overview

A. Service Delivery Areas

IDPH established service areas for delivery of Network Support, Prevention Services, and Outpatient Treatment and reserves the right to revise service areas to meet IDPH goals. (See ***Appendix K - Map of Integrated Provider Network Service Areas and Providers***.)

Contractors that provide one or more Optional Services -- Adult Residential Treatment, Juvenile Residential Treatment, Women and Children Treatment, and Methadone Treatment -- provide such services statewide.

Integrated Provider Network services are offered collaboratively in each service area and statewide.

B. Hours of Operation and Service Locations

Contractors provide Integrated Provider Network services in Iowa. ***Contractors may request an exception from IDPH to participate in services outside of Iowa*** but must receive IDPH approval prior to implementation.

Hours of operation and service location requirements specific to a service type are listed in that service type section.

Contractors provide treatment Covered Services in person or through telehealth. Treatment Covered Services that can be provided through telehealth are listed in each treatment service type section.

- Per 2018 House File 2305, "Telehealth" means the delivery of health care services through the use of interactive audio and video. "Telehealth" does not include the delivery of health care services through an audio-only telephone, electronic mail message, or facsimile transmission. Health care services that are delivered by telehealth must be appropriate and delivered in accordance with applicable law and generally accepted health care practices and standards prevailing at the time the health care services are provided …"

C. Service Recipient Eligibility Requirements

Network Support and Prevention Services

All Iowa residents may participate in and receive Network Support and Prevention Services.

Treatment Services

Treatment services are intended to support Iowa residents who are not eligible for Medicaid, do not have insurance, and do not have access to other resources to pay for needed Covered Services.

Contractors must apply all available funding from third party payors prior to determining a patient's eligibility for contract funding and must assure services are paid by the correct payor.

- An individual patient may have different payors for different treatment services. For example, a patient may receive medical care through an insurance health plan or at a Federally Qualified Health Center (FQHC), but may not have coverage for substance use disorder Licensed Program Services. In this example, medical care would be paid by the health plan or

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the FQHC, and the substance use disorder treatment Licensed Program Services could be paid by contract funding.

Iowa residents who meet the requirements below are eligible to receive treatment Licensed Program Services for Patients and Other Covered Services for Patients and may receive such services from the contractor(s) of their choice.

Contractors must determine and document a person's eligibility for treatment services.

Iowa residents who seek Licensed Program Services for Patients and Other Covered Services for Patients must meet the following financial eligibility requirements:

- Income at or below 200% of the Federal poverty guidelines as published by the U.S. Department of Health and Human Services, and
- Not insured, or third party payment is not available to pay for the services.
  - Contract funding can pay for Licensed Program Services that are not covered during the gap period between enrollment in Medicaid and assignment to a managed care organization because of Medicaid (b)(3) services requirements.
  - Contract funding can pay for substance use disorder residential Licensed Program Services for Patients that are not covered under the Iowa Health and Wellness Plan.
  - **For patients seeking problem gambling treatment services, the following may also be taken into consideration:**
    - **Burden of gambling related debt reduces the patient income to or below 200% of the Federal Poverty Level**
    - **Patient is without other financial resources to pay for the problem gambling treatment service(s)**

Contractors must actively support enrollment in Medicaid by Medicaid eligible persons.

- Time spent complying with managed care organization (MCO), insurer, or other payor requirements or processes is not covered by contract funding. Such requirements are specific to each payor and each health plan, and are funded under the contractor's agreement with that payor/health plan. Refusal by a patient's MCO, insurer, or other payor to authorize a service covered by that payor, or the denial of a covered service claim by an MCO, insurer, or other payor, does not make that patient eligible for contract funding and does not make that service payable under contract funding.

Any additional service recipient eligibility requirements specific to a service type are listed in that service type section.

D. Performance Measures

Contractors must submit accurate, complete, and timely Data Reporting, Claims Reimbursement reports, and Claims Reimbursement Support Documentation. IDPH reviews submissions and issues payments for services when contractor reports are accurate, as determined by IDPH.

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If IDPH determines a contractor's submitted reports are not timely, are inaccurate, or are incomplete for multiple occurrences, or if IDPH determines such errors and omissions are severe, IDPH will require the contractor to create and submit a corrective action plan. Contractors must request and receive approval of the corrective action plan from IDPH prior to implementation.

IDPH will deduct funding from a corresponding month's claim reimbursement amount, if IDPH determines a contractor's reports:

- Are submitted late, without IDPH pre-approval of an acceptable delay, or
- Have severe errors or omissions, or
- Are not compliant with the IDPH-approved corrective action plan.

IDPH may develop additional performance measures in collaboration with contractors, through the Network Support - Data and Continuous Quality Improvement covered service.

E. Documentation

Contractors must clearly and accurately document Integrated Provider Network services in their records, and must clearly and accurately report Integrated Provider Network services in the IDPH Grant Tracking system and data systems.

Contractors must document provision of Integrated Provider Network services in a manner sufficient to support their billing and IDPH monitoring.

IDPH requires periodic reporting of compliance with contractor work plans, provision of services, and incurred expenses.

- Any additional data and reporting requirements specific to a service type are listed in that service type section.

F. Reports

Contractors must complete and submit the reports listed below. IDPH reserves the right to add to or change reports and submission requirements, as determined necessary.

Report	Reporting Method/Type	Frequency/Date Due
1. Claims Reimbursement	IowaGrants Claim Component	See Contract Article X - Payments
2. Claims Reimbursement Support Documentation – Claim Spreadsheet, Claim Detail, Claim Progress Report	IowaGrants Claim Component	Monthly no later than 30th day of following month
3. Critical Incident Report	Via e-mail to: IPN@idph.iowa.gov	Within 24 hours of Contractor becoming aware of the incident
4. Data Reporting - Prevention	I-SMART and Qualtrics	Monthly no later than 15th day of following month

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5. Data Reporting - Treatment	I-SMART and/or CDR	Monthly no later than 15th day of following month
6. Quarterly Progress Report	IowaGrants Progress Report Component	Quarterly no later than 30th day of following quarter
7. SABG Certification Form	Submitted with Application	At application and annually
8. Sliding Fee Scale	IowaGrants Progress Report Component	At application for IDPH approval and annually
9. Subcontract Draft	IowaGrants Subcontract Documents	Submitted with contract for IDPH approval prior to execution
10. Work Plan - Network Support	IowaGrants Correspondence	Annual submission for IDPH approval
11. Work Plan - Prevention Services Expectations	IowaGrants Correspondence	December 31, 2019 for IDPH approval
12. Work Plan - Prevention Services	IowaGrants Correspondence	Annual submission for IDPH approval

1. Claims Reimbursement

Submit claims for reimbursement to IDPH once a month by completing the Claim Form in the Iowa Grants.

- **For Network Support and Prevention Services**, enter the total amount requested for each service type and enter the amount for each applicable line item for each service type.
- **For Outpatient Treatment, Adult Residential Treatment, Juvenile Residential Treatment, Women and Children Treatment, and Methadone Treatment**, enter the total amount requested for each service type.

Note: Contractors may submit the claim for a month at any time during the next month, up to the 30th day of that next month. IDPH will review claims and determine payment after all Claims Reimbursement Support Documentation is received and the contractor's data is available for review by IDPH in IDPH's data systems.

2. Claims Reimbursement Support Documentation

For Outpatient Treatment, Adult Residential Treatment, Juvenile Residential Treatment, Women and Children Treatment, and Methadone Treatment, upload the Claims Reimbursement Support Documentation in the Iowa Grants system. Claims Reimbursement Support Documentation includes:

- Claim Spreadsheet
- Claim Summary

3. Critical Incident Report

Critical Incidents are events that occur while a patient or other person is participating in or receiving Integrated Provider Network services that negatively affect that person or another person or the contractor. Submit Critical Incident Reports as directed on ***Appendix J - Critical***

Incident Report Form.

4. Data Reporting - Prevention

Requirements for reporting Prevention Services are in ***Section IV***.

5. Data Reporting - Treatment

Requirements for reporting treatment services are in each service type section, ***Sections V. through IX***.

6. Progress Report

Progress Reports are to be submitted on a quarterly basis. The reporting quarters are:

- July 1 through September 30
- October 1 through December 31
- January 1 through March 31
- April 1 through June 30

IDPH will release the quarterly report form to Contractors by the end of the first reporting quarter (September 30, 2019).

7. SABG Certification Form

Contractors and subcontractors that provide substance abuse Prevention Services and substance use disorder treatment Licensed Program Services must meet SAMHSA Substance Abuse Prevention and Treatment Block Grant requirements. See ***Appendix A - SABG Certification Form***.

8. Sliding Fee Scale

Treatment services must be available to patients based on a sliding fee scale that considers patient income and family size, as stated in the federal Poverty Guidelines at https://aspe.hhs.gov/poverty-guidelines.

Contractors may charge patients a co-pay for certain treatment covered services, based on application of the sliding fee scale. Contractors retain such co-pays.

- Co-pay requirements specific to a service type are listed in that service type section.

In implementing their IDPH-approved sliding fee scales, contractors must implement and maintain documentation of patient co-pay procedures and policies and retain documentation of co-pays and associated patient income and family size.

9. Subcontract

Draft subcontracts were submitted with contractor contracts, for IDPH approval.

Changes to subcontracts for Prevention Services and Outpatient Treatment Licensed Program Services require IDPH prior approval.

Subcontracts, including subcontracts for other Covered Services such as MAT – Medical Evaluation, are handled in accordance with contract General Conditions.

10. Work Plan - Network Support

Contractors will be given instructions on updating and submitting a work plan for network support services each contract year.

11. Work Plan - Prevention Services Expectations

Per RFP requirement, contractors will need to become compliant with the Prevention Organization Expectations within the first year of the project (listed on page 46 of the RFP). Contractors will be responsible for submitting documentation to show compliance with these expectation as noted on page 45 of the RFP. Additional guidance will be provided by September 2019.

12. Work Plan - Prevention Services

Contractors will be given instructions on updating and submitting a work plan for prevention services each contract year.

G. Available Funds

The sources of funding for Integrated Provider Network services are both State and Federal funds. State funds are those appropriated to IDPH for specific programming through State of Iowa appropriations. Federal funds are those received through the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Payor of Last Resort

Integrated Provider Network funds are considered payment of last resort.

Payment in Full

Contract funding, inclusive of allowable patient copays, is payment in full for the Integrated Provider Network services provided.

- The actual total work conducted and services provided in a contract period may exceed contract funding. Contractors must continue to provide Integrated Provider Network services, even if contract funds are depleted.

H. Budget

The budgets listed for each service type in each contractor's contract are separate budgets. Contractors cannot interchange funds between service types without request to IDPH and execution by IDPH of a contract amendment.

- Substance Abuse Prevention and Treatment Block Grant unallowable expenditures are specified in ***Appendix A - SABG Certification Form***.

I. Payment

Contractors complete and submit claims for reimbursement of services rendered.

For Network Support and Prevention Services, IDPH provides line item budget contractual payments on the basis of reimbursement of actual expenses.

For Outpatient Treatment, Adult Residential Treatment, Juvenile Residential Treatment, Women and Children Treatment, and Methadone Treatment, IDPH provides unit cost budget contractual payments on the basis of reimbursement of Covered Services unit rates. The rate sheets for each service type are in ***Appendices E. through I***.

IDPH will not reimburse travel amounts in excess of limits established by the Iowa Department of Administrative Services.

- Instate maximum allowable amounts for food are $12.00/breakfast, $15.00/lunch and $29.00/dinner; lodging maximum $98.00 plus taxes per night and mileage maximum of $0.39 per mile.

- Out of state maximum allowable amounts for meals are available upon request. There is no restriction on airfare or lodging but the incurred expenditures are to be reasonable.

Except as allowed in the contract, contractors must submit all claims to IDPH by August 10 for all services performed in the preceding state fiscal year, which ends on June 30. Final payment may be withheld until all contractually required reports have been received and accepted by IDPH. At the end of the contract period, unobligated contract amount funds revert to IDPH.

J. Additional Contract Requirements

1. Contractors must assure linkage with the local board of health in each county where services are provided.

2. Work plan revisions must be approved by IDPH prior to implementation. Requests for work plan revisions must be received by IDPH on or before March 31, 2020.

3. Contractors must be an Iowa non-profit/not-for-profit organization and must be licensed and qualified to provide contracted services throughout the project period.

4. Contractors must assure any subcontractor providing Prevention Services or Treatment Licensed Program Services for Patients is an Iowa non-profit/not-for-profit organization and is licensed and qualified for the subcontracted services throughout the project period.

5. Contractors must assure the contractor and any subcontractor providing Prevention Services or Treatment Licensed Program Services for Patients comply with the requirements specified in the ***Appendix A - SABG Certification Form***.

6. Contractors must assure the contractor and any subcontractor providing Prevention Services or Treatment Licensed Program Services for Patients orient new staff to contract services and requirements; ***Appendix A - SABG Certification Form***; and Confidentiality of Protected Health Information in accordance with 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including disciplinary action for inappropriate disclosures or breaches.

7. Contractors must assure the contractor and any subcontractor providing Prevention Services or Treatment Licensed Program Services for Patients train staff each year on contract services and

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requirements; ***Appendix A - SABG Certification Form***; and Confidentiality of Protected Health Information in accordance with 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including disciplinary action for inappropriate disclosures or breaches.

8. Contractors must notify IDPH in writing within 10 working days of any change of Lead staff.

9. Contractors must receive prior approval from IDPH to change or terminate a subcontract for Prevention Services or Outpatient Treatment Licensed Program Services for Patients.

10. Contractors must assure staffing and staff qualifications are sufficient to implement contract services. No single staff person may exceed 1.0 FTE across the contract.

11. IDPH may change contract conditions if there are changes in Federal or State law.

12. IDPH may change the contract if IDPH receives additional funding or requirements through other State or Federal awards for services that relate to Integrated Provider Network goals and services, and IDPH requires contractors to provide the related services through the Integrated Provider Network contract.

13. **Contractors may submit questions and exception requests regarding IPN service delivery and policies via the IPN Help Desk at ipn@idph.iowa.gov. IDPH intends to respond to questions and requests within 15 calendar days, however some responses may involve lengthier processes that delay the intended response deadline.**

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III. Network Support

A. Service Delivery Requirements

Contractors directly provide Network Support services that are comprehensive and integrated in their service areas and statewide.

At a minimum, contractors must:

- Participate in IDPH's management approach for implementing, promoting, monitoring, evaluating, and improving Integrated Provider Network services.
- Coordinate and assure provision of all Required Services in the service area.
- If contracted for Optional Services, integrate provision of Required Services and contracted Optional Services.
- Work with IDPH to coordinate and assure provision of Integrated Provider Network services statewide.
- Provide services based on assessed need and address the complex needs of the people served, including, but not limited to, substance use and problem gambling, general medical and mental health conditions, and related family, legal, and other concerns that can hinder remission and recovery.
- Serve as local- and state-level resources for substance use and problem gambling services in Iowa.
- Conduct outreach to assure that Integrated Provider Network services are known to the communities served.
- Assure that Integrated Provider Network services are readily accessible, comprehensive, flexible, and appropriate to the persons participating in or receiving services.

Contractors must acknowledge IDPH and SABG funding on websites, materials, campaigns, and other communications or platforms that reference Integrated Provider Network services, using the following citation:

"[Contractor] is part of the IDPH Integrated Provider Network, with services funded by the Iowa Department of Public Health and the U.S. Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration."

B. Covered Services Requirements

Contractors provide each of the following Network Support Covered Services for their service areas:

1. Collaboration and Community Outreach

Contractors conduct, support, and participate in collaboration and community outreach activities that establish the contractor as a primary resource for substance use and problem gambling issues in the Service Area and statewide.

Contractors coordinate planning and service delivery in collaboration with IDPH, other contractors, subcontractors, and stakeholders, based on and aligned with community, service area, and state needs and strengths.

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Stakeholders may include, but are not limited to:

- Local Boards of Health
- Community coalitions
- County Boards of Supervisors
- Department on Aging, Aging and Disability Resource Centers, Area Agencies on Aging
- Department of Corrections, judicial districts
- Department of Education, school districts and non-public schools
- Department of Human Services, child welfare, Medicaid managed care, Mental Health and Disability Services regions
- Department of Public Health programs and services, State Board of Health
- Department of Public Safety, local law enforcement, emergency response
- Elected officials, policy-makers
- Hospitals, other healthcare providers
- Judicial Branch, drug courts, family treatment courts, juvenile justice
- Mental health services providers
- Local public health agencies, HIV prevention and care centers
- Service Area residents and Iowans statewide

2. Needs Assessment

Contractors conduct, support, and participate in local and state needs assessment processes that support understanding of substance use and problem gambling needs, trends, and service gaps. Needs Assessment processes may include, but are not limited to:

- Community Assessment Workbooks
- Each county's Community Health Needs Assessment and Health Improvement Plan (CHNA HIP)
- IDPH's Iowa Youth Survey

3. Health Promotion

Contractors conduct, support, and participate in health promotion activities that inform and educate Iowans on substance use and gambling problems. Health promotion also supports access to prevention, early intervention, treatment, and recovery support resources and services.

Health Promotion activities may include, but are not limited to:

- Contractor websites and social media presence
- IDPH's YourLifeIowa and 1-800-BETS OFF helpline and website
- IDPH's "A Matter of Substance" newsletter and other publications
- IDPH's substance abuse prevention and treatment focused media campaigns
- The IDPH website and social media platforms
- Contractor and IDPH efforts directed to specific topics and issues

Contractors must request prior approval from IDPH for the use of other health promotion materials or campaigns for Integrated Provider Network purposes.

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4. Data and Continuous Quality Improvement

Contractors conduct, support, and participate in continuous quality improvement (CQI) activities that improve Integrated Provider Network services by identifying, implementing, and monitoring critical performance measures on an ongoing basis, based on valid and reliable data and stakeholder input.

IDPH organizes Integrated Provider Network CQI activities around NIATx concepts. (See ***Appendix C***.)

CQI activities may include, but are not limited to:

- Access and wait time performance measures
- Critical incident reports (***See Appendix J***.)
- Data integrity reports
- Engagement and retention performance measures
- External review and evaluation
- Funding source monitoring
- Provider Manual review
- Outcome performance measures
- Process "walk-throughs" and improvement projects
- Retrospective review of service provision and contract compliance
- Satisfaction surveys
- Simulated phone calls or other requests for information or services

5. Workforce Development

Contractors conduct, support, and participate in workforce development activities that recruit, retain, and develop highly qualified staff to provide Integrated Provider Network services.

Workforce Development activities may include, but are not limited to, strategies to:

- Support recruitment and retention of qualified staff
- Enhance staff competency and performance
- Expand the roles of persons in recovery and family members/friends in planning and delivering services

6. Meetings, Trainings, and Technical Assistance

Contractors conduct, support, and participate in meetings, trainings, and technical assistance activities that enhance, expand, and improve Integrated Provider Network services. Meetings, trainings, and technical assistance may be face-to-face or may be conducted through electronic means, as determined by IDPH.

Meetings, trainings and technical assistance may include, but are not limited to:

- CQI meetings (quarterly, face-to-face during the initial contract term)
- Governor's Conference on Substance Abuse (annual, face-to-face)
- Integrated Provider Network Roundtables (quarterly, face-to-face during the initial contract term)

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- Prevention Conference (as scheduled, face-to-face)
- Reporting requirements and processes (as scheduled)
- Technical assistance (as scheduled)
- Topic-specific trainings (as scheduled)
- Women and Children Roundtables (twice a year, face-to-face)

C. Budget Requirements

The Network Support budget is a line item budget, reimbursed on actual direct cost expenditures per budget line category. Allowed budget line categories for Network Support are:

- Salary and Fringe Benefits
- Equipment
- Other
- Indirect or Administrative Cost

Contractors experiencing under-utilization of their Outpatient Treatment Covered Services budget can submit a request to IDPH through Iowa Grants correspondence to redirect up to 10% of their total Outpatient Treatment Covered Services budget for local health promotion and outreach activities under Network Support. Requests must include an updated Network Support Work Plan that includes the scope and expected outcome of each proposed activity.

D. Fees

Contractors cannot charge participants a fee for Network Support Covered Services.

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IV. Prevention Services

A. Service Delivery Requirements

Contractors assure provision of Prevention Services in their service areas that meet the assessed needs of the service area. Contractors provide these services directly or through a subcontractor.

Contractors comply with the definition of prevention in IAC 641—155 Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Program: "activities aimed at minimizing the use of potentially addictive substances, lowering risk in at-risk individuals, or minimizing potential adverse consequences of substance use or gambling."

At a minimum, contractors must provide Prevention Services that comply with the Institute of Medicine Prevention Classifications, the Strategic Prevention Framework, and the SAMHSA Prevention Service Categories, described below.

Contractors plan and provide Prevention Services in coordination with stakeholders.

Contractors provide Prevention Services that address the lifespan, with evidence-based programs appropriate to different persons and populations.

Contractors address the following Prevention Services priorities:

- Alcohol
- Marijuana
- Prescription medications
- Problem Gambling
- Tobacco

Additional Prevention Services priorities may include, but may not be limited to, methamphetamines, opioids, and suicide, as well as other priorities mutually determined by IDPH and contractors, based on data and identified need.

1. Institute of Medicine Classifications

The Institute of Medicine (IOM) classifications for classifying prevention services focus on populations with different levels of risk.

a. *Universal* services are targeted to the general public or to a whole population group that has not been identified on the basis of individual risk. Universal is split into two categories:
   - *Universal Direct* interventions directly serve an identifiable group of participants.
   - *Universal Indirect* interventions support population-based programs and environmental strategies.

b. *Selective* services are targeted to individuals or to a subgroup of the population whose risk of developing a disorder is significantly higher than average.

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c. *Indicated* services are targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing a disorder, or having biological markers indicating predisposition for a disorder but not yet meeting diagnostic levels.

2. Strategic Prevention Framework

SAMHSA's Strategic Prevention Framework (SPF) is a five-step planning process, with two guiding principles. Contractors document use of the SPF process in developing and delivering Prevention Services Covered Services to address at least one of the Prevention Services priorities in the Service Area during each contract term. The SPF steps are:

a. The *Assess* step, which helps define the problem or issue a project needs to tackle, and includes collection of data to:
- Understand a population's needs
- Review the resources that are required and available
- Identify the readiness of the community to address prevention needs and service gaps.

b. The *Build Capacity* step mobilizes human, organizational, and financial resources to meet project goals. Training and education to promote readiness are also critical.

c. The *Plan* step involves creation of a comprehensive plan with goals, objectives, and strategies to meet the prevention needs of the community. Organizations select logic models and evidence-based programs and policies, and determine costs and resources needed for effective implementation.

d. The *Implement* step focuses on carrying out the prevention plan and identifying and overcoming potential barriers. During implementation, organizations detail the evidence-based programs and policies to be undertaken, develop specific timelines, and decide on ongoing program evaluation needs.

e. The *Evaluate* step helps organizations recognize what they have done well and what areas need improvement. Evaluation measures the impact of programs and practices to understand their effectiveness and any need for change. Evaluation influences future planning and can impact sustainability, because evaluation can show sponsors that resources are being used wisely.

The SPF guiding principles are:

a. *Cultural Competence*, which is the process of communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social, and linguistic backgrounds. Becoming culturally competent requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice.

b. *Sustainability* is the process through which a prevention system becomes a norm and is integrated into ongoing operations. Sustainability ensures prevention processes are established, partnerships are strengthened, positive prevention outcomes are

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maintained, and financial and other resources are secured over the long term.

3. SAMHSA Prevention Strategies Categories

Contractors report Prevention Services Covered Services to IDPH in accordance with the SAMHSA Prevention Services Categories:

a. *Direct/Indirect Services* - Prevention Services are delivered directly and indirectly. ***Direct services are preferred.*** Direct services are face-to-face contact between prevention staff and participants through curricula delivery, educational activities, and awareness activities. Indirect services are delivered through social media, websites, printed media, etc.

b. *Session-Based Services* - Session-based prevention services are a pre-planned series of structured program lessons and/or activities. Session-based services are intended to inform, educate, develop skills, and identify/refer individuals who may be at risk for a substance use disorder or problem gambling. Session-based prevention services must have an anticipated measurable outcome, measured via a pre/post-test survey design. Session-based services must be evidence-based programs listed on a national registry approved by IDPH and focus on outcomes directly related to substance abuse. (See Appendix C.)

c. *One-Time Services* - One-time prevention services are single activities intended to inform general and specific populations about substance use or problem gambling. IDPH will provide direction on allowable one-time services. ***IDPH plans to limit one-time services to Information Dissemination or Environmental strategies*** which may include but may not be limited to:

- Responsible Beverage Service Training using the Training for Intervention Procedures (TIPS), which can include TIPS for Gaming
- Driver's Education classes
- Minor in Possession diversion classes
- Workplace training and workplace policy change
- Responsible Gaming
- Self-Exclusion Tool Kit
- Gambling in the Workplace

d. *Evidence-Based Programs, Policies, and Practices* - "Evidence-based" refers to approaches to prevention that are validated by documented evidence. Prevention Services evidence-based programs must be specific to substance abuse or problem gambling. Contractors plan and provide Prevention Services in coordination with stakeholders. Contractors provide Prevention Services that address the lifespan, with evidence-based programs appropriate to different persons and populations.

B. Hours of Operation and Service Locations

Contractors provide Prevention Services in their service areas.

Contractors have sufficient Prevention Services locations and hours of operation to support access for all residents in each county in their service areas.

Contractors provide Prevention Services in person or through electronic means or written communications, with direct face-to-face services preferred.

Contractors offer Prevention Services in each county in their service area. ***Contractors may request an exception from IDPH if there is a need to deviate from this expectation*** and must receive approval prior to implementation**.**

Contractors cannot limit Prevention Services to the school year and cannot limit Prevention Services locations to schools.

C. Evidence-Based Practices and Standards of Care

Contractors provide Prevention Services that are evidence-based programs that have outcomes directly related to substance abuse and/or problem gambling.

IDPH has accepted certain registries as resources for Prevention Services Programs:

- Blueprints for Healthy Youth Development (model programs)
- National Institute of Drug Abuse Red Book (model programs)
- Evidence-Based Practices Resource Center
- Stacked Deck

To implement a Prevention Services program not listed in an approved registry, ***contractors must request an exception from IDPH.***

IDPH established Prevention Organization Expectations for Prevention Services staff and services. Contractors must work with IDPH to become fully compliant during the contract term. (See ***Appendix D - Prevention Organization Expectations***.)

D. Service Recipient Eligibility Requirements

Contractors cannot provide Prevention Services to persons identified as in need of substance use disorder or problem gambling treatment or those receiving treatment. This includes providing early intervention services such as pre-screening, screening and SBIRT.

E. Covered Services Requirements

Prevention Services Covered Services are based on the six SAMHSA Primary Prevention Strategies. Prevention Services prevent or reduce use and abuse of alcohol, tobacco, and other drugs, and prevent or reduce problem gambling.

Contractors provide or assure provision of the following Prevention Services Covered Services in their service areas:

1. Information Dissemination

Information Dissemination provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction, as well as problem gambling, and the effects on individuals, families and communities. It also provides awareness and knowledge of available prevention programs and services. Information Dissemination is characterized by

one-way communication from the source to the audience, with limited contact between the two.

2. Education

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

3. Alternatives

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

4. Problem Identification and Referral

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

5. Community-Based Process

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

6. Environmental

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

F. Budget Requirements

The Prevention Services budget is a line item budget, reimbursed on actual direct cost expenditures per budget line category. Budget line categories for Prevention Services are:

- Salary and Fringe Benefits
- Subcontract
- Equipment
- Other
- Indirect or Administrative Cost

Fees

Contractors cannot charge participants a fee for Prevention Services Covered Services. ***Contractors may request an exception from IDPH if there is a need to deviate from this expectation.***

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G. Data and Reporting Requirements

Contractors specifically document use of the IOM classifications, the SPF steps, and the SAMHSA Prevention Services Categories.

Contractors report certain Prevention Services information and data through IDPH's data systems as outlined below and in ***Appendix B***. The data systems include:

- Iowa Service Management and Reporting Tool (I-SMART)
  - Substance abuse and problem gambling prevention data
- Qualtrics
  - Substance abuse and problem gambling prevention outcomes data

Contractors report Prevention Services outcomes data to the web-based Qualtrics data collection system using a pre-post survey design, including survey instruments and guidelines provided by IDPH.

Contractors report additional Prevention Services data to the I-SMART data collection system as directed by IDPH.

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V. Outpatient Treatment

A. Service Delivery Requirements

Contractors assure provision of Outpatient Treatment services that meet the assessed needs of the service area. Contractors provide these services directly or through a subcontractor.

Contractors provide Outpatient Treatment services that are readily accessible, comprehensive, appropriate to the persons seeking the services, flexible to meet the evolving needs of patients and service recipients, and effective. Outpatient Treatment services are available when needed, with minimal wait time.

At a minimum, contractors must:

- Determine a person's need for Outpatient Treatment services and manage the services provided.
- Provide Outpatient Treatment services in compliance with clinical appropriateness and IDPH requirements and guidance.
- Provide Outpatient Treatment services to patients in accordance with each patient's assessed needs.
- If a patient needs a Licensed Program Service a contractor does not provide, the contractor must assure that the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
- Screen patients for medical and mental health conditions and directly provide or assure provision of needed medical and mental health services.
- If a patient has a medical or mental health condition a contractor is not staffed to address, the contractor must refer the patient to a qualified provider and closely coordinate ongoing services with the patient and that provider.
- If a patient has a medical or mental health condition that is covered by another provider or payor, the contractor must closely coordinate ongoing services with the patient and that provider/payor.
- Monitor a patient's progress on an ongoing basis, modifying the level of care and frequency of services in accordance with the person's evolving needs.
- Establish a "disease management" approach that engages with patients over time.
- Assure that patients have access to crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate remission and engage persons in long term recovery in ways appropriate to each person.
- Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the contractor.
- Provide substance use disorder treatment services ordered through a court action when the services ordered meet The ASAM Criteria, and the court orders treatment with the contractor.
    - Contractors work with the courts to examine the appropriateness of court-ordered placements and identify specific appropriate alternatives for the courts to consider, as indicated.

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B. Hours of Operation and Service Locations

Contractors provide Outpatient Treatment services in their service areas.

Contractors have sufficient Outpatient Treatment locations and hours of operation to support access for all residents in each county of their service areas. Hours of operation for Outpatient Treatment include evening and weekend times.

Contractors schedule Outpatient Treatment services with minimal wait time for the patient.

Contractors assure timely and effective response to service requests, both during and outside their normal business hours, including response to referrals from the Your Life Iowa and 1-800-BETS OFF helplines and websites.

Contractors accommodate requests for services in addition to scheduled Outpatient Treatment Covered Services, related to a patient's emerging needs or worsening condition. Contractors have processes in place to serve "walk-ins" and persons in crisis. Same day services, when requested, are the goal.

Outpatient Treatment Covered Services that may be provided by telehealth are Initial Assessment, Medical Evaluation, and Medical Care. Contractors may request an exception from IDPH if there is a need to deviate from this expectation and must receive approval prior to implementation.

C. Evidence-Based Practices and Standards of Care

Contractors provide Outpatient Treatment Licensed Program Services in accordance with IAC 641—155 Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Programs. Contractors provide Outpatient Treatment Other Covered Services in accordance with IDPH requirements and guidance.

D. Service Recipient Eligibility Requirements

See Section II.C.

Iowa residency is the sole eligibility requirement for Early Intervention.

E. Covered Services Requirements

Outpatient Treatment Covered Services include Licensed Program Services for Patients, Other Covered Services for Patients, and Other Covered Services for Persons who are not Patients.

1. Licensed Program Services for Patients

Contractors provide or assure provision of each Licensed Program Service to patients, sufficient to meet the assessed needs of each patient. Services are provided in accordance with IAC 641—155 Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Programs and should be provided by qualified clinical treatment staff.

a. Outpatient (based on ASAM Level 1)

- **Initial Assessment**

- An Initial Assessment must be sufficient to determine the existence of a substance use disorder or a gambling problem and to identify medical and mental health risks or conditions, including assessment of suicide risk.
  - If the Initial Assessment identifies a need for services a contractor does not provide, the contractor must closely coordinate referral to qualified provider.
  - If the Initial Assessment identifies a gambling problem, contractors provide or arrange for any needed education on financial management and credit counseling.
  - If the Initial Assessment identifies a medical and/or mental health risk or condition, contractors provide or arrange for provision of any needed medical and/or mental health evaluation or services.

- **Individual and Group Counseling**
  - Individual and Group Counseling include mental health counseling.
    - Mental health counseling must be related to general mental health risks and/or conditions that often co-occur with a primary diagnosis of substance use disorder or problem gambling, and with remission and recovery.

b. Intensive Outpatient (based on ASAM Level 2.1)

c. Partial Hospitalization (based on ASAM Level 2.5)

For Intensive Outpatient and Partial Hospitalization, mental health services are provided in an integrated manner with other treatment services and are included in the service reimbursement rate.

2. Other Covered Services for Patients

Contractors provide Other Covered Services for Patients, sufficient to meet the assessed needs of each patient.

a. Care Coordination

The Licensure Standards define Care Coordination as "the collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services, both internal and external to the program, to meet patient needs, using communication and available resources to promote quality care and effective outcomes."

- Care Coordination fosters long term engagement and ongoing remission/recovery support.
- Care Coordination services are provided to active patients.
  - For Care Coordination billing purposes, a patient must receive at least one Licensed Program Service from the contractor during the month.
- Care Coordination encompasses the broad range of patient-specific people, systems, and issues related to the patient's current situation and

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future recovery. These may include, but are not limited to, family members, referral sources, employers, schools, medical and mental health professionals, the child welfare system, the courts and criminal/juvenile justice systems, housing status, legal needs, and recovery support.

- Care Coordination is generally conducted by contractor staff, outside of patient counseling sessions.
- Care Coordination includes use of electronic information and telecommunication technologies to support patients through check-in calls and texts.
  - Contractors providing check-in calls and texts must have policies and procedures that assure safety, privacy, and confidentiality.

b. Crisis Counseling

A response to a crisis or emergency situation experienced by an individual, family member and/or significant others related to substance use disorders, such as:

- **Crisis Counseling services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The interventions shall be designed to de-escalate situations in which a risk to self, others, or property exists.**
- **Crisis Counseling services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.**
- **Crisis Counseling services with family members or friends using general counseling methods.**
- **Crisis Counseling services can occur in person or over the phone.**
  - **Routine requests for information or calls or inquiries handled by non-clinical staff do not qualify as Early Intervention crisis counseling.**
- **Crisis Counseling services are intended for individuals, family members and/or significant others not currently enrolled in services.**

c. Early Intervention (based on ASAM Level 0.5)

The ASAM criteria level of care which explores and addresses problems or risk factors that appear to be related to an addictive disorder and which helps the individual recognize potential harmful consequences.

- **Early Intervention may be provided to persons who have received an Initial Assessment but do not meet criteria for a substance use disorder. Individuals that previously received an Initial Assessment and do meet criteria for a substance use disorder may not be provided Early Intervention.**
- **Early Intervention could be considered as an equivalent to SBIRT Brief Treatment, which is a more intensive intervention than a SBIRT Brief Intervention.**
- **Early Intervention may be provided using the SAMHSA Integrated Change Therapy/Brief Treatment Model or a similar model acceptable to**

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IDPH.

- **Although ASAM recognizes impaired driving programs as an example of Early Intervention, IPN funding may not be used for this purpose.**

d. Interim Services for Priority Populations (pregnant women and individuals who inject drugs that are seeking treatment)

- **Interim Services are those minimum services which must be offered when priority populations cannot be admitted within required timeframes and would benefit from IPN funded services.**
- **The purposes of these services are to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease.**
- **At a minimum, interim services include counseling and education about: HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.**
- **The program must offer interim services within 48 hours to pregnant women who cannot be admitted because of capacity.**
- **For individuals who inject drugs, the program must offer interim services not later than 14 days of making the request.**

e. MAT – Medical Evaluation

Medical Evaluation means an assessment conducted by a physician or other licensed prescriber to determine the need for medication-assisted treatment and/or tobacco cessation services.

f. MAT – Medical Care

Medical Care means ongoing medical evaluation services provided by a licensed medical prescriber to assess appropriateness for continued medication-assisted treatment and/or tobacco cessation services.

- **Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of Alcohol Use Disorders, Opioid Use Disorders, and/or tobacco use.**
- **Medical Care does not include routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen) or conducting other medical tests.**

g. MAT – Medication

Medication means medicine(s) ordered by the Medical Evaluation for MAT and/or tobacco cessation.

h. MAT – Drug Testing

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Drug Testing means routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen).

i. Recovery Peer Coaching

Recovery Peer Coaching means individual face-to-face meetings between a patient and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective.

j. Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an integrated, evidence-based approach that offers providers the tools to effectively and efficiently screen individuals for risky substance use and problem gambling (see *Appendix B - Links to IDPH Substance Use and Problem Gambling Resources*).

- **SBIRT stands for Screening, Brief Intervention and Referral to Treatment and refers to the following processes:**
  - **Screening: Universal screening for quickly assessing use and severity of substance use and problem gambling.**
  - **Brief Intervention: Brief motivational and awareness-raising intervention given to individuals determined to be at risk for problematic substance use and gambling.**
  - **Referral to Treatment: Referrals to specialty care for individuals at high risk for a substance use or problem gambling disorder.**
- **SBIRT Screening services may occur in a group setting, but any services beyond Screening must be provided on an individual basis.**
- **A service historically offered as part of the SBIRT process has been Brief Treatment. Although Brief Treatment can be a referred service, it is now funded as Early Intervention for Patients.**
- **SBIRT services are to be provided by substance use and problem gambling treatment providers in a variety of locations outside of a treatment center. Examples include primary care settings, schools, and casinos.**

k. Transportation

Transportation means assistance in the form of gas cards or bus passes, given directly to the patient for the purpose of transportation to and from an activity related to the patient's treatment plan or recovery plan.

3. Other Covered Services for Persons who are not Patients

a. Family Education Services

Education on various topics related to substance use and problem gambling disorders, treatment and recovery, for family members and concerned persons of individuals in treatment.

F. Budget Requirements

Contractors provide a mix of Outpatient Treatment Licensed Program Services for Patients, Other Covered Services for Patients, and Other Covered Services for Persons who are not Patients. ***The majority of funding is expected to be expended on Licensed Program Services for Patients.***

Rates
See ***Appendix E - Outpatient Treatment Rates***.

Fees
Contractors **shall** implement a co-pay for the following Outpatient Treatment Licensed Program Services:

- Outpatient
- Intensive Outpatient
- Partial Hospitalization

Contractors **may** implement a co-pay for the following Outpatient Treatment Other Covered Services:

- **Early Intervention**
- **MAT – Medical Evaluation**
- **MAT – Medical Care**
- **MAT – Medication**
- **MAT – Drug Testing**
- Recovery Peer Coaching

Contractors **shall not** implement a co-pay for the following Outpatient Treatment Other Covered Services:

- Care Coordination
- **Crisis Counseling**
- **Family Education Services**
- **Interim Services**
- **Screening, Brief Intervention and Referral to Treatment (SBIRT)**
- Transportation

G. Data and Reporting Requirements

Contractors document provision of Licensed Program Services for Patients in accordance with the Licensure Standards. Contractors document provision of Other Covered Services for Patients in each patient's record. Contractors have procedures in place to document provision of Other Covered Services for Persons who are not Patients.

Contractors report certain Outpatient Treatment service information and data through IDPH's data systems, as outlined below and in ***Appendix B***. The data systems include:

- Central Data Repository (CDR)
  - Substance use disorder treatment services data
- Iowa Service Management and Reporting Tool (I-SMART)
  - Substance use disorder and problem gambling treatment services data

Contractors report Licensed Program Services data to the CDR and/or I-SMART data systems, in accordance with IDPH guidelines.

- In reporting Licensed Program Services data, contractors must specify the correct payor for each encounter at the time the encounter is provided. A patient may have a different payor for different services. For example, Integrated Provider Network funding may be the payor for Licensed Program Services and another payor may be responsible for certain other Covered Services, such as medical care. Further, the payor for some services may change during a patient's treatment episode. If the payor changes, contractors must update reporting to specify the correct payor for each encounter.

For services utilizing a unit rate reimbursement, IPN providers should submit data as follows:

- **Report "Duration" in 30 minute increments, rounded to the nearest 30 minute level, e.g. 30, 60, 90, 120. For example: If the session is 44 minutes you would round to 30 minutes. If the session is 45 minutes you would round to 60 minutes.**
- **Report "Duration Type" as "Minutes"**
- **Report "Session/Unit" as "1"**

For Intensive Outpatient and Partial Hospitalization:

- **Report "Duration" as "1"**
- **Report "Duration Type" as "Days"**
- **Report "Encounter Type" as "24 Hours Service"**
- **Report "Session/Unit" as "1"**

To support appropriate patient engagement in ongoing treatment services that support recovery, IDPH has suspended the 60-day administrative discharge requirement for Contractors, for the duration of the project period.

Mental health services are reported as treatment service data in accordance with IDPH requirements and guidelines.

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VI. Adult Residential Treatment

A. Service Delivery Requirements

For Adult Residential Treatment, "adult" generally refers to persons age 18 and older.

Contractors provide Adult Residential Treatment statewide. Contractors directly provide Adult Residential Treatment Licensed Program Services for Patients.

Contractors provide Adult Residential Treatment services that are readily accessible, comprehensive, appropriate to the persons seeking the services, flexible to meet the evolving needs of patients, and effective. Adult Residential Treatment must be available when needed, with minimal wait time.

At a minimum, contractors must:

- Determine a person's need for Adult Residential Treatment and manage the services provided.
- Provide Adult Residential Treatment in compliance with clinical appropriateness and IDPH requirements and guidance.
- Provide Adult Residential Treatment to patients in accordance with each patient's assessed needs.
  - If a patient needs a Licensed Program Service a contractor does not provide, the contractor must assure that the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
- Screen patients for medical and mental health conditions and directly provide or assure provision of needed medical and mental health services.
  - If a patient has a medical or mental health condition a contractor is not staffed to address, the contractor must refer the patient to a qualified provider and closely coordinate ongoing services with the patient and that provider.
  - If a patient has a medical or mental health condition that is covered by another provider or payor, the contractor must closely coordinate ongoing services with the patient and that provider/payor
- Monitor a patient's progress on an ongoing basis, modifying the level of care and frequency of services in accordance with the person's evolving needs.
- Establish a "disease management" approach that engages with patients over time.
- Assure that patients have access to crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate remission and engage persons in long term recovery in ways appropriate to each person.
- Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the contractor.
- Provide substance use disorder treatment services ordered through a court action when the services ordered meet The ASAM Criteria, and the court orders treatment with the contractor.
  - Contractors will work with the courts to examine the appropriateness of court-ordered placements and identify specific appropriate alternatives for the courts to consider, as indicated.

B. Hours of Operation and Service Locations

Hours of operation for Adult Residential Treatment are 24 hours a day, seven days a week, 365 days

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a year, and include weekend programming.

Contractors schedule Adult Residential Treatment with minimal wait time for the patient.

Contractors assure timely and effective response to service requests, both during and outside their normal business hours, including response to referrals from the Your Life Iowa helpline and website.

Contractors accommodate requests for services in addition to scheduled Adult Residential Treatment Covered Services, related to a patient's emerging needs or worsening condition, with minimal wait time. Contractors have processes in place to serve "walk-ins" and persons in crisis. Same day services, when requested, are the goal.

Adult Residential Treatment Covered Services that may be provided by telehealth are Medical Evaluation and Medical Care. Contractors may request an exception from IDPH if there is a need to deviate from this expectation and must receive approval prior to implementation.

C. Evidence-Based Practices and Standards of Care

Contractors provide Adult Residential Treatment Licensed Program Services in accordance with the Licensure Standards. Contractors provide Adult Residential Treatment Other Covered Services in accordance with IDPH requirements and guidance.

D. Service Recipient Eligibility Requirements

See Section II.C.

E. Covered Services Requirements

Adult Residential Treatment Covered Services include Licensed Program Services for Patients, Other Covered Services for Patients, and Other Covered Services for Persons who are not Patients.

1. Licensed Program Services for Patients

Contractors provide one or more Licensed Program Services for Patients to adults statewide, sufficient to meet the assessed needs of each patient.

a. Clinically Managed Low-Intensity Residential (based on ASAM Level 3.1)
b. Clinically Managed Medium-Intensity Residential (based on ASAM Level 3.3)
c. Clinically Managed High-Intensity Residential (based on ASAM Level 3.5)
d. Medically Monitored Inpatient (based on ASAM Level 3.7)

Due to the comorbidity of substance use and problem gambling disorders, IDPH supports the provision of services that can address both disorders simultaneously. This includes the provision of Early Intervention specific to Problem Gambling, and Problem Gambling treatment, for individuals residing in a substance use disorder residential treatment level of care. Therefore these services can be provided as an outpatient service for patients at 3.1 or higher level of care, as long as the services are separate and distinct. This means that Early Intervention and Problem Gambling treatment services cannot supplant the required 30-50 hours of substance use disorder treatment per week.

e. Outpatient (based on ASAM Level 1) to address Problem Gambling

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These additional services should be submitted in I-SMART in the Problem Gambling domain.

Mental health services are provided in an integrated manner and are included in the reimbursement rates for Licensed Program Services for Patients.

2. Other Covered Services for Patients

Contractors provide or assure provision of Other Covered Services for Patients, sufficient to meet the assessed needs of each patient.

a. Early Intervention (based on ASAM Level 0.5) to address Problem Gambling
The ASAM criteria level of care which explores and addresses problems or risk factors that appear to be related to a gambling disorder and which helps the individual recognize potential harmful consequences.

- **Early Intervention may be provided to persons who have received an Initial Assessment but do not meet criteria for a problem gambling disorder. Individuals that previously received an Initial Assessment and do meet criteria for a problem gambling disorder may not be provided Early Intervention.**
- **Early Intervention could be considered as an equivalent to SBIRT Brief Treatment, which is a more intensive intervention than a SBIRT Brief Intervention.**
- **Early Intervention may be provided using the SAMHSA Integrated Change Therapy/Brief Treatment Model or a similar model acceptable to IDPH.**

b. MAT – Medical Evaluation
Medical Evaluation means an assessment conducted by a physician or other licensed prescriber to determine the need for medication-assisted treatment and/or tobacco cessation services.

c. MAT – Medical Care
Medical Care means ongoing medical evaluation services provided by a licensed medical prescriber to assess appropriateness for continued medication-assisted treatment and tobacco cessation services.

- **Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of Alcohol Use Disorders, Opioid Use Disorders, and/or tobacco use.**
- **Medical Care does not include routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen) or conducting other medical tests.**

d. MAT – Medication
Medication means medicine(s) ordered by the Medical Evaluation for MAT and/or tobacco cessation.

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e. MAT – Drug Testing
Drug Testing means routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen).

f. Recovery Peer Coaching
Recovery Peer Coaching means individual face-to-face meetings between a patient and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective.

3. Other Covered Services for Persons who are not Patients
Contractors provide the following Other Covered Service for Persons who are not Patients:

a. Family Education Services
Education on various topics related to substance use and problem gambling disorders, treatment and recovery, for family members and concerned persons of individuals in treatment.

F. Budget Requirements

Contractors provide a mix of Adult Residential Treatment Licensed Program Services for Patients, Other Covered Services for Patients, and Other Covered Services for Persons who are not Patients. ***The majority of funding is expected to be expended on Licensed Program Services for Patients.***

Rates
See ***Appendix F - Adult Residential Treatment Rates***.

Fees
Contractors **shall** implement a co-pay for the following Adult Residential Treatment Licensed Program Services for Patients:

- Clinically Managed Low-Intensity Residential
- Clinically Managed Medium-Intensity Residential
- Clinically Managed High-Intensity Residential
- Medically Monitored Inpatient

Contractors **may** implement a co-pay for the following Adult Residential Treatment Other Covered Services for Patients:

- **Early Intervention – Problem Gambling**
- **MAT – Medical Evaluation**
- **MAT – Medical Care**
- **MAT – Medication**
- **MAT – Drug Testing**
- **Recovery Peer Coaching**

Contractors **shall not** implement a co-pay for the following Other Covered Services for Persons who are not Patients:

- **Family Education Services**

G. Data and Reporting Requirements

Contractors document provision of Licensed Program Services for Patients in accordance with the Licensure Standards. Contractors document provision of Other Covered Services for Patients in each patient's record. Contractors have procedures in place to document provision of Other Covered Services for Persons who are not Patients.

Contractors report treatment service information and data through IDPH's data systems, as outlined in ***Appendix B***. The data systems include:

- Central Data Repository (CDR)
  - Substance use disorder treatment services data

- Iowa Service Management and Reporting Tool (I-SMART)
  - Substance use disorder treatment services data

Contractors report Licensed Program Services data using the CDR and/or I-SMART data systems, in accordance with IDPH requirements and guidelines.

- In reporting Licensed Program Services data, contractors must specify the correct payor for each encounter at the time the encounter is provided. A patient may have a different payor for different services. For example, Integrated Provider Network funding may be the payor for Licensed Program Services and another payor may be responsible for certain other Covered Services, such as medical care. Further, the payor for some services may change during a patient's treatment encounter. For example, Integrated Provider Network funding may be the payor for residential Licensed Program Services and the Iowa Health and Wellness Plan may be the payor for Outpatient Licensed Program Services. To specify the correct payor for each encounter, contractors must update the primary payment source as needed during the patient's full treatment episode.

For services utilizing a unit rate reimbursement, IPN providers should report data as follows:

- **Report "Duration" in 30 minute increments, rounded to the nearest 30 minute level, e.g. 30, 60, 90, 120. For example: If the session is 44 minutes you would round to 30 minutes. If the session is 45 minutes you would round to 60 minutes.**
- **Report "Duration Type" as "Minutes"**
- **Report "Session/Unit" as "1"**

For Residential and Inpatient levels of care, IPN providers should report data as follows:

- **Report "Duration" as "1"**
- **Report "Duration Type" as "Days"**
- **Report "Encounter Type" as "24 Hours Service"**
- **Report "Session/Unit" as "1"**

To support appropriate patient engagement in ongoing treatment services that support recovery, IDPH has suspended the 60-day administrative discharge requirement for Contractors, for the duration of the project period.

Mental health services are reported as treatment service data in accordance with IDPH requirements and guidelines.

VII. Juvenile Residential Treatment

A. Service Delivery Requirements

For Juvenile Residential Treatment, "juvenile" generally refers to persons under age 18.

Contractors provide Juvenile Residential Treatment statewide. Contractors directly provide the Juvenile Residential Treatment Licensed Program Service for Patients.

Contractors provide Juvenile Residential Treatment services that are readily accessible, comprehensive, appropriate to the persons seeking the services, flexible to meet the evolving needs of patients, and effective. Juvenile Residential Treatment must be available when needed, with minimal wait time.

At a minimum, contractors must:

- Determine a person's need for Juvenile Residential Treatment and manage the services provided.
- Provide Juvenile Residential Treatment in compliance with clinical appropriateness and IDPH guidance.
- Provide Juvenile Residential Treatment in accordance with each patient's assessed needs.
  - If a patient needs a Licensed Program Service the contractor does not provide, the contractor must assure that the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
- Screen patients for medical and mental health conditions and directly provide or assure provision of needed medical and mental health services.
  - If a patient has a medical or mental health condition the contractor is not staffed to address, the contractor must assure the patient's needs are met by a qualified provider and closely coordinate ongoing services with the patient and that provider.
  - If a patient has a medical or mental health condition that is covered by another provider or payor, the contractor must closely coordinate ongoing services with the patient and that provider/payor
- Monitor a patient's progress on an ongoing basis, modifying the level of care and frequency of services in accordance with the person's evolving needs.
- Establish a "disease management" approach that includes engagement with patients over time.
- Assure that patients have access to crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate remission and engage persons in long term recovery in ways appropriate to each person.
- Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the contractor.

B. Hours of Operation and Service Locations

Contractors provide Juvenile Residential Treatment in the state of Iowa.

Hours of operation for Juvenile Residential Treatment are 24 hours a day, seven days a week, 365 days a year, and include weekend programming.

Contractors schedule Juvenile Residential Treatment with minimal wait time for the patient.

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Contractors assure timely and effective response to service requests, both during and outside their normal business hours, including response to referrals from the Your Life Iowa helpline and website.

Contractors accommodate requests for services in addition to scheduled Juvenile Residential Treatment Covered Services, related to a patient's emerging needs or worsening condition, with minimal wait time. Contractors have processes in place to serve "walk-ins" and persons in crisis. Same day services, when requested, are the goal.

Juvenile Residential Treatment Covered Services that may be provided by telehealth are Medical Evaluation and Medical Care. Contractors may request an exception from IDPH if there is a need to deviate from this expectation and must receive approval prior to implementation.

Contractors must provide Juvenile Residential Treatment in a residential facility setting that admits juvenile patients only.

C. Evidence-Based Practices and Standards of Care

Contractors provide the Juvenile Residential Treatment Licensed Program Service in accordance with the Licensure Standards. Contractors provide Juvenile Residential Treatment Other Covered Services in accordance with IDPH requirements and guidance.

D. Service Recipient Eligibility Requirements

See Section II.C.

E. Covered Services Requirements

Juvenile Residential Treatment Covered Services include Licensed Program Services for Patients, Other Covered Services for Patients, and Other Covered Services for Persons who are not Patients.

1. Licensed Program Service for Patients

Contractors must provide the following Licensed Program Service for Patients to juveniles statewide, sufficient to meet the assessed needs of each patient.

a. Clinically Managed High-Intensity Residential (based on ASAM Level 3.5)

2. Other Covered Services for Patients

Contractors provide or assure provision of Other Covered Services for Patients, sufficient to meet the assessed needs of each patient.

a. MAT – Medical Evaluation

Medical Evaluation means an assessment conducted by a physician or other licensed prescriber to determine the need for medication-assisted treatment and/or tobacco cessation services.

b. MAT – Medical Care

Medical Care means ongoing medical evaluation services provided by a licensed medical prescriber to assess appropriateness for continued medication-assisted treatment and/or tobacco cessation services.

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- **Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of Alcohol Use Disorders, Opioid Use Disorders, and/or tobacco use.**
- **Medical Care does not include routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen) or conducting other medical tests.**

c. MAT – Medication
Medication means medicine(s) ordered by the Medical Evaluation for MAT and/or tobacco cessation.

d. MAT – Drug Testing
Drug Testing means routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen).

e. Recovery Peer Coaching
Recovery Peer Coaching means individual face-to-face meetings between a patient and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective.

3. Other Covered Services for Persons who are not Patients

a. Family Education Services
Education on various topics related to substance use and problem gambling disorders, treatment and recovery, for family members and concerned persons of individuals in treatment.

F. Budget Requirements

Contractors provide a mix of Juvenile Residential Treatment Licensed Program Services for Patients, Other Covered Services for Patients, and Other Covered Services for Persons who are not Patients. ***The majority of funding is expected to be expended on Licensed Program Service for Patients.***

Rates
See ***Appendix G - Juvenile Residential Treatment Rates***.

Fees
Contractors **shall** implement a co-pay for the Juvenile Residential Treatment Licensed Program Service:

- Clinically Managed High-Intensity Residential

Contractors **may** implement a co-pay for the following Juvenile Residential Treatment Other Covered Services:

- **MAT – Medical Evaluation**
- **MAT – Medical Care**

- **MAT – Medication**
- **MAT – Drug Testing**
- **Recovery Peer Coaching**

Contractors **shall not** implement a co-pay for the following Other Covered Services for Persons who are not Patients:

- **Family Education Services**

G. Data and Reporting Requirements

Contractors document provision of Licensed Program Services for Patients in accordance with the Licensure Standards. Contractors document provision of Other Covered Services for Patients in each patient's record. Contractors have procedures in place to document provision of Other Covered Services for Persons who are not Patients.

Contractors report treatment service information and data through IDPH's data systems, as outlined below and in ***Appendix B***. The data systems include:

- Central Data Repository (CDR)
  - Substance use disorder treatment services data
- Iowa Service Management and Reporting Tool (I-SMART)
  - Substance use disorder treatment services data

Contractors report Licensed Program Service data using the CDR and/or I-SMART data systems, in accordance with IDPH guidelines.

- In reporting Licensed Program Service data, contractors must specify the correct payor for each encounter at the time the encounter is provided. A patient may have a different payor for different services. For example, Integrated Provider Network funding may be the payor for Licensed Program Services and another payor may be responsible for certain other Covered Services, such as medical care. Further, the payor for some services may change during a patient's treatment encounter. For example, Integrated Provider Network funding may be the payor for residential Licensed Program Services and the Iowa Health and Wellness Plan may be the payor for Outpatient Licensed Program Services. To specify the correct payor for each encounter, contractors must update the primary payment source as needed during the patient's full treatment episode.

For services utilizing a unit rate reimbursement, IPN providers should report data as follows:

- **Report "Duration" in 30 minute increments, rounded to the nearest 30 minute level, e.g. 30, 60, 90, 120. For example: If the session is 44 minutes you would round to 30 minutes. If the session is 45 minutes you would round to 60 minutes.**
- **Report "Duration Type" as "Minutes"**
- **Report "Session/Unit" as 1**

For Residential levels of care, IPN providers should report data as follows:

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- **Report "Duration" as "1"**
- **Report "Duration Type" as "Days"**
- **Report "Encounter Type" as "24 Hours Service"**
- **Report "Session/Unit" as "1"**

To support appropriate patient engagement in ongoing treatment services that support recovery, IDPH has suspended the 60-day administrative discharge requirement for Contractors, for the duration of the project period.

Mental health services are reported as treatment service data in accordance with IDPH requirements and guidelines.

VIII. Women and Children Treatment

A. Service Delivery Requirements

Contractors provide Women and Children Treatment statewide. Contractors directly provide Women and Children Treatment Licensed Program Services for Patients.

Contractors provide Women and Children Treatment services that are readily accessible, comprehensive, appropriate to the persons seeking the services, flexible to meet the evolving needs of women patients and their children, and effective. Women and Children Treatment are available when needed, with minimal wait time.

At a minimum, contractors must:

- Determine a woman's need for Women and Children Treatment and manage the services provided.
- Provide Women and Children Treatment in compliance with clinical appropriateness and IDPH guidance.
- Provide Women and Children Treatment services in accordance with each person's assessed needs.
    - If a patient needs a Licensed Program Service a contractor does not provide, the contractor must assure that the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
- Screen patients and children for medical and mental health conditions and directly provide or assure provision of needed medical and mental health services.
    - If a person has a medical or mental health condition the contractor is not staffed to address, the contractor must assure the patient's needs are met by a qualified provider and closely coordinate ongoing services with the patient and that provider.
    - If a person has a medical or mental health condition that is covered by another provider or payor, the contractor must closely coordinate ongoing services with the patient and that provider/payor
- Monitor a patient's progress on an ongoing basis, modifying the level of care and frequency of services in accordance with the person's evolving needs.
- Establish a "disease management" approach that includes engagement with patients over time.
- Assure that patients have access to crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate remission and engage persons in long term recovery in ways appropriate to each person.
- Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the contractor.
- Provide substance use disorder treatment services ordered through a court action when the services ordered meet The ASAM Criteria, and the court orders treatment.
    - Contractors will work with the courts to examine the appropriateness of court-ordered placements and identify specific appropriate alternatives for the courts to consider, as indicated.

B. Hours of Operation and Service Locations

Hours of operation for outpatient Women and Children Treatment include evening and weekend times. Hours of operation for residential Women and Children Treatment are 24 hours a day, seven

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days a week, 365 days a year, and include weekend programming.

Contractors schedule Women and Children Treatment with minimal wait time for the patient.

Contractors assure timely and effective response to service requests, both during and outside their normal business hours, including response to referrals from the Your Life Iowa helpline and website.

Contractors accommodate requests for services in addition to scheduled Women and Children Treatment Covered Services, related to a patient's emerging needs or worsening condition, with minimal wait time. Contractors have processes in place to serve "walk-ins" and persons in crisis. Same day services, when requested, are the goal.

Women and Children Treatment Covered Services that may be provided by telehealth are Initial Assessment, Medical Evaluation, and Medical Care. Contractors may request an exception from IDPH if there is a need to deviate from this expectation and must receive approval prior to implementation.

Contractors must provide residential Women and Children Treatment in a residential facility setting that admits women patients only and their dependent children.

C. Evidence-Based Practices and Standards of Care

Contractors provide Women and Children Treatment Licensed Program Services for Patients in accordance with the Licensure Standards. Contractors provide Women and Children Treatment Enhanced Treatment/Ancillary Support Services for Patients and their Children in accordance with IDPH requirements and guidance.

Contractors must meet SABG requirements and related SAMHSA guidance, as provided by IDPH. (See ***Appendix A - SABG Certification Form***.)

D. Service Recipient Eligibility Requirements

See Section II.C.

Iowa residents who are pregnant women and women with children, including women who have custody of their children and women seeking custody, are eligible to receive Women and Children Treatment.

Contractors must make Enhanced Treatment/Ancillary Support Services available to all eligible women and their children.

- If Medicaid or another payor pays for the patient's Licensed Program Services, no additional eligibility requirements must be met.
- If Women and Children Treatment funding pays for the patient's Licensed Program Services, the patient must also meet the eligibility requirements outlined below.

If the patient and/or the patient's children are enrolled in Medicaid or with another payor, and Medicaid or the other payor covers the patient's Licensed Program Services and/or any of the patient's or children's Enhanced Treatment/Ancillary Support Services, contractors cannot use

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contract funding to pay for those Covered Services.

If the patient and/or the patient's children are not enrolled in Medicaid or with another payor, or if Medicaid or the other payor does not cover the patient's Licensed Program Services and/or any of the patient's or children's Enhanced Treatment/Ancillary Support Services, and no other payor exists for those services, contractors can use contract funding to pay for those Covered Services.

E. Covered Services Requirements

Women and Children Treatment Covered Services include Licensed Program Services for Patients and Enhanced Treatment/Ancillary Support Services for Patients and their Children.

1. Licensed Program Services for Patients

Contractors provide Licensed Program Services to women patients statewide, sufficient to meet the assessed needs of the patient.

Contractors provide one or more residential/inpatient Licensed Program Services and also provide Outpatient and Intensive Outpatient Licensed Program Services.

a. Outpatient (based on ASAM Level 1)

- **Initial Assessment**
  - An Initial Assessment must be sufficient to determine the existence of a substance use disorder or a gambling problem and to identify medical and mental health risks or conditions, including assessment of suicide risk.
    - If the Initial Assessment identifies a need for services a contractor does not provide, the contractor must closely coordinate referral to an appropriate provider.
    - If the Initial Assessment identifies a gambling problem, the contractor must provide or arrange for any needed education on financial management and credit counseling.
    - If the Initial Assessment identifies a medical and/or mental health risk or condition, the contractor must provide or arrange for provision of any needed medical and/or mental health evaluation or services.
- **Individual and Group Counseling**
  - Individual and Group Counseling include mental health counseling.
    - Mental health counseling provided under contract funding must be related to general mental health risks and/or conditions that often co-occur with a primary diagnosis of substance use disorder, and with remission and recovery.

b. Intensive Outpatient (based on ASAM Level 2.1)
c. Partial Hospitalization (based on ASAM Level 2.5)
d. Clinically Managed Low-Intensity Residential (based on ASAM Level 3.1)
e. Clinically Managed Medium-Intensity Residential (based on ASAM Level 3.3)
f. Clinically Managed High-Intensity Residential (based on ASAM Level 3.5)
g. Medically Monitored Inpatient (based on ASAM Level 3.7)

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For Intensive Outpatient, Partial Hospitalization, all residential services, and Medically Monitored Inpatient, mental health services are provided in an integrated manner and are included in the service reimbursement rate.

2. Enhanced Treatment/Ancillary Support Services for Patients and their Children

Contractors provide or assure provision of Enhanced Treatment/Ancillary Support Services to women patients and their children, sufficient to meet the assessed needs of each patient and child.

- Primary medical care for women who are receiving substance abuse services including prenatal care and, while women are receiving such treatment, child care.
- Primary pediatric care for their children, including immunizations.
- Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting and child care while the women are receiving these services.
- Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
- Sufficient case management and transportation services to ensure that women and their children have access to the services needed during the course of treatment.
- Comprehensive services including case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments; employment and training programs; education and special education programs; drug-free housing for women and their children; prenatal care and other health care services; therapeutic day care for children; Head Start; and other early childhood programs.

F. Budget Requirements

Contractors provide a mix of Women and Children Treatment Licensed Program Services for Patients and Enhanced Treatment/Ancillary Support Services for Patients and their Children. Women and Children Treatment Enhanced Treatment/Ancillary Support Services are funded 100% by the SABG.

Rates

See ***Appendix H - Women and Children Treatment Rates***.

Fees

Contractors **shall** implement a co-pay for Women and Children Treatment Licensed Program Services:

- Outpatient
- Intensive Outpatient
- Partial Hospitalization
- Clinically Managed Low-Intensity Residential
- Clinically Managed Medium-Intensity Residential
- Clinically Managed High-Intensity Residential
- Medically Monitored Inpatient

Contractors **shall not** implement a co-pay for:

- Enhanced Treatment/Ancillary Support Services

G. Data and Reporting Requirements

Contractors document provision of Licensed Program Services for Patients in accordance with the Licensure Standards. Contractors document provision of Enhanced Treatment/Ancillary Support Services for Patients and their Children in the patient record.

Contractors report treatment service information and data through IDPH's data systems, as outlined below and in ***Appendix B***. The data systems include:

- Central Data Repository (CDR)
  - Substance use disorder treatment services data
- Iowa Service Management and Reporting Tool (I-SMART)
  - Substance use disorder and problem gambling treatment services data

Contractors report Licensed Program Services data using the CDR and/or I-SMART data systems, in accordance with IDPH guidelines.

- In reporting Licensed Program Services data, contractors must specify the correct payor for each encounter at the time the encounter is provided. A patient may have a different payor for different services. For example, Integrated Provider Network funding may be the payor for Licensed Program Services and another payor may be responsible for certain other Covered Services, such as medical care. Further, the payor for some services may change during a patient's treatment encounter. For example, Integrated Provider Network funding may be the payor for residential Licensed Program Services and the Iowa Health and Wellness Plan may be the payor for Outpatient Licensed Program Services. To specify the correct payor for each encounter, contractors must update the primary payment source as needed during the patient's full treatment episode.

For services utilizing a unit rate reimbursement, IPN providers should report data as follows:

- **Report "Duration" in 30 minute increments, rounded to the nearest 30 minute level, e.g. 30, 60, 90, 120. For example: If the session is 44 minutes you would round to 30 minutes. If the session is 45 minutes you would round to 60 minutes.**
- **Report "Duration Type" as "Minutes".**
- **Report "Session/Unit" as 1.**

For Intensive Outpatient, Partial Hospitalization, Residential and Inpatient levels of care, IPN providers should report data as follows:

- **Report "Duration" as "1"**
- **Report "Duration Type: as "Days"**
- **Report Encounter Type as "24 Hours Service"**
- **Report "Session/Unit" as "1"**

To support appropriate patient engagement in ongoing treatment services that support recovery, IDPH has suspended the 60-day administrative discharge requirement for Contractors, for the duration of the project period.

Mental health services are reported as treatment service data in accordance with IDPH requirements and guidelines.

Contractors report Women and Children Treatment Licensed Program Services and certain Enhanced Treatment/Ancillary Support Services using the "Women and Children/Magellan Special Initiative" Code/Description.

IX. Methadone Treatment

A. Service Delivery Requirements

Contractors provide Methadone Treatment statewide. Contractors directly provide the Methadone Treatment Covered Service for Patients.

Contractors continuously meet the following requirements throughout the project period:

1. Accredited as an opioid treatment program in accordance with IAC 641—155.35, and
2. Accredited as an opioid treatment program in accordance with IAC 641—155.35, and
3. Licensed to provide and continuously provide following substance use disorder Licensed Program Services in Iowa:
  a. Outpatient
  b. Opioid Treatment Services.

At a minimum, contractors must:

- Determine a person's need for Methadone Treatment and manage the services provided.
- Provide Methadone Treatment in compliance with clinical appropriateness and IDPH requirements and guidance.
- Provide Methadone Treatment in accordance with each patient's assessed needs.
  - If a patient needs a Licensed Program Service the contractor does not provide, the contractor must assure the patient's needs are met by a qualified provider and closely coordinate the patient's successful referral.
- Monitor a patient's progress on an ongoing basis, modifying services in accordance with the patient's evolving needs
- Establish a "disease management" approach that includes engagement with patients over time.
- Assure that patients have access to crisis services, residential treatment, intensive services and supports, and less intensive and extended services and supports that facilitate remission and engage persons in long term recovery in ways appropriate to each patient.
- Have processes in place to outreach to and follow-up with persons who do not keep appointments, and patients who leave treatment prior to discharge by the contractor.

B. Hours of Operation and Service Locations

Contractors schedule Methadone Treatment with minimal wait time for the patient.

Contractors assure timely and effective response to service requests, both during and outside their normal business hours, including response to referrals from the Your Life Iowa helpline and website.

C. Evidence-Based Practices and Standards of Care

Contractors provide Methadone Administration in an organized manner consistent with and in compliance with all applicable federal, state and local regulations pertaining to the provision of these services, including those of the Food and Drug Administration (FDA), the Drug Enforcement Administration (DEA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and State of Iowa Specific Standards for Opioid Treatment Programs (IAC 641—155.35).

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Contractors have policies and procedures regarding therapeutic methadone dosage that are consistent with SAMHSA Center for Substance Abuse Treatment Guidelines for the Accreditation of Opioid Treatment Programs and TIP 43, Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.

D. Service Recipient Eligibility Requirements
See Section II.C.

E. Covered Services Requirements
Methadone Treatment Covered Services include one Covered Service for Patients.

1. Covered Service for Patients
Contractors provide the following Covered Service to persons with opioid use disorders, sufficient to meet the assessed needs of each person.

a. Methadone Administration

Contractors assure Methadone Treatment patients also receive treatment Licensed Program Services from the contractor or from another licensed and qualified program.

Contractors meet Medicaid requirements for providing Medication Assisted Treatment/Recovery to persons with an Opioid Use Disorder, and bill Medicaid for methadone provided to Medicaid members.

Licensed Program Services provided to Methadone Treatment patients are reported, billed, and reimbursed separately from Methadone Administration.

F. Budget Requirements
Contractors provide one Covered Service for Patients.

Rate
See ***Appendix I - Methadone Treatment Rate***.

Fees
Contractors **shall** implement a co-pay for the Methadone Treatment Covered Service:

- Methadone Administration

G. Data and Reporting Requirements
Contractors document provision of Methadone Treatment in accordance with IDPH requirements.

Contractors must report treatment service information and data through IDPH's data systems, as outlined below and in ***Appendix B***. Data systems include:

- I-SMART Opioid Treatment Program Registry
  - Methadone Treatment data

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APPENDIX A - SABG Certification Form

Contractors and subcontractors providing substance abuse Prevention Services and substance use disorder treatment Licensed Program Services must comply with the SABG requirements outlined below. Complete SABG requirements are at: https://tinyurl.com/y73q4wor

Substance Abuse Prevention and Treatment Block Grant (SABG) Requirements *Note: References to patients or to persons receiving treatment services apply to substance use disorder treatment patients only.*
1. Non-Supplanting Requirement (45 C.F.R 96.135 (a) (4)) Federal funds made available shall not be used to supplement and increase the level of state, local and other non-federal funds that would in the absence of such federal funds be made available for the programs and activities for which funds are provided and will in no event take the place of state, local and other non-federal funds.
2. Payment Schedule (96.137) When using SABG funds for 96.124, 96.127 and 96.128, SABG funded entities must make every reasonable effort to: Collect reimbursement for costs of providing services to patients through other programs or private insurance and secure payments from patients or clients in accordance with their ability to pay.
3. Statewide Assessment of Needs (96.133) The state is required to submit to the Secretary an Assessment of Need in the State for authorized activities, both by locality and the State in general. Providers are required to participate in the annual survey and data collection process.
4. Priority in Admission Status (45 C.F.R 96.131) Priority in admission to substance use disorder treatment shall be given to patients with the greatest clinical need, as follows: • Pregnant women who inject drugs • Pregnant women who abuse substances in other ways • Other Individuals who inject drugs • All others
5. Treatment and Interim Services for Pregnant Women (45 C.F.R . 96.131) a. Priority admission must be offered to pregnant women, either through immediate admission or priority placement on a waiting list. Interim services must be provided to pregnant women on a waiting list. If there is insufficient capacity to provide interim services, IDPH must be notified immediately to assist in the coordination of the provision of interim services (within 48 business hours). b. Preference in admission must be given to pregnant women who seek or are referred for and would benefit from SABG funded treatment services. All providers who serve women and who receive SABG funds must provide preference as outlined above and meet the following: • Publicizes that pregnant women receive preference in admission. • Refers pregnant women to IDPH when the program has insufficient capacity to provide services to any such pregnant women who seek services. • Makes available interim services within 48 hours to pregnant women who cannot be admitted due to lack of capacity. • Provide the following interim services: ○ counseling and education about HIV and tuberculosis about the risks of needle-sharing, risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV transmission does not occur,

- referral for HIV and TB services,
- counseling on the effects of alcohol and drug use on the fetus, referrals for prenatal care.

- Documentation of all required elements including documentation of pregnant women capacity, interim services offered, provided and referred.

6. Capacity of Treatment for Persons who Inject Drugs and Interim Services (45 CFR 96.126)

a. Priority admission must be offered to persons who inject drugs, either through immediate admission or priority placement on a waiting list, to persons who inject drugs. Interim services are provided to individuals for intravenous substance abuse on the waiting list.

b. Assure that each individual who requests and is in need of treatment for intravenous drug use is admitted to a program of such treatment not later than:
   - 14 days after making the request for admission,
   - 120 days if the program has no capacity to admit the individual on the date of the request; and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance use disorder treatment program. Programs must report to IDPH when bed capacity reaches 90% and must document such notification including date and outcome of contact with IDPH and interim services or referrals made, within seven (7) days.

Notification must be provided to IDPH within seven (7) days of reaching 90% treatment capacity.

c. Provide the following interim services:
   - counseling and education about HIV and tuberculosis about the risks of needle-sharing,
   - risks of transmission to sexual partners and infants and steps that can be taken to ensure that HIV transmission does not occur,
   - referral for HIV and TB services,
   - counseling on the effects of alcohol and drug use on the fetus-for pregnant women,
   - referrals for prenatal care-for pregnant women.

d. Establish a waiting list that includes a unique client identifier for each injecting drug abuser seeking treatment, including patients receiving interim services.

e. Ensures that outreach efforts include the following:
   - selecting, training and supervising outreach workers,
   - contacting, communicating and following-up with high-risk substance abuser as well as their associates and neighbors (within constraints of 45 CFR Parts 160 and 164 Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2),
   - promoting awareness among persons who inject drugs to the relationship between injecting drug abuse and communicable diseases such as HIV, TB, etc. to encourage the individuals to enter treatment,
   - recommending steps that can be taken to ensure that HIV transmission does not occur.

f. A mechanism to maintain contact with individuals awaiting admission must be in place or established. maintain documentation of all counseling and education provided, Interim Services provided and/or referrals made, dates of services/referrals, providers referred to, and wait list information in the patient's health record and report to IDPH as requested.

g. Remove persons awaiting treatment for intravenous substance use off the waiting list only when one of the following conditions occur: such persons cannot be located for admission into treatment or such persons refuse treatment.

7. Coordination of Prevention and Treatment Activities (45 CFR 96.132(c))

Coordinate treatment services with the provision of other appropriate services (including health, social, correctional and criminal justice, education, vocational rehabilitation, and employment services) to ensure clients have access to a full array of services.

8. Wait List Requirement (Office for Treatment Improvement-1992)

a. Uniform Waiting List is defined as a document that:
   - Identifies individuals who are seeking treatment when appropriate treatment slots are not available
   - is a log/roster that the program maintains when service capacity has been reached
   - identifies individuals who are actively seeking treatment and who meet eligibility criteria

b. Maintain a wait list that:
   - Is a written log/roster that documents when service capacity has been reached, and identifies individuals who are actively seeking treatment and who meet eligibility criteria for admission.
   - Contains the screening mechanism used and location of the program.
   - Contains the patient name and contact information (mailing address, telephone number, and other contact information).
   - States disposition, including how and when the person was informed of the disposition, the recommended resource and how the recommendation was made.
   - Describes follow-up contact with the referral agency.
   - Includes priority categories: Pregnant Women and Persons Who Inject Drugs.

9. AIDS Education Component (45 CFR 96.121)

Provide an AIDS Education Component to treatment patients. The component shall include information regarding optional AIDS virus testing. Pre- and post-test counseling will be made available to patients to be tested for the virus. Maintain documentation of such education and counseling.

10. Non discrimination (42 USC 300x–57)

a. For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], on the basis of handicap under section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794], on the basis of sex under title IX of the Education Amendments of 1972 [20 U.S.C. 1681 et seq.], or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], providers and activities funded in whole or in part with MHBG or SABG funds shall be considered to be providers and activities receiving Federal financial assistance.

b. No person shall on the ground of sex (including, in the case of a woman, on the ground that the woman is pregnant), or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available through the MHBG or SABG.

11. Religious Discrimination Prohibition/Charitable Choice (42 CFR 54a)

If a provider of service is a religious organization as defined in 42 CFR Part 54 and Part 54A (Charitable Choice Regulations), the provider may not discriminate against a patient on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. Patients who object to a provider's religious character have the right to referral to another provider and providers will post or otherwise assure notice of such right as follows: "If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance use disorder services to which you have no religious objections." The referral and receipt of alternative service must occur within a reasonable period of time after such a request. The alternative provider must be

accessible to the patient and have the capacity to provide substance use disorder treatment services. The services provided by the alternative provider must be of value not less than the value of the services the patient would have received from the Provider. The Provider must document such objection, alternative service made or referral provided.

12. Collection of Treatment Episode Data Set (TEDS) Data (42 US 290aa-4)
Collect and submit to the Department all TEDS data on admission and discharge ages 12 and older.

13. Confidentiality of Protected Health Information (45 CFR 96.132 (e))
Establish a process to protect the privacy and confidentiality of patient records and information, including proportionate disciplinary action for inappropriate disclosures or breaches and ensuring all staff shall receive annual training in accordance with 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act of 1996.

14. Continuing Education (45 CFR 96.132)
Ensure that continuing education is made available to employees of the facility who provide treatment and prevention services.

15. Requirements Regarding Tuberculosis (42 USC 300x-24, 96.127 and 96.121)

a. The provider directly, or through arrangements with other public or nonprofit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:
   - Counseling the individual with respect to TB
   - Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual
   - Appropriate medical evaluation and treatment for individuals infected by mycobacteria TB
b. For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services.
c. The provider has implemented infection control procedures that are consistent with those established by IDPH to prevent the transmission of TB and that address the following:
   - Screening patients and identifying those individuals who are infected or at high risk of becoming infected
   - Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2
   - Case management activities to ensure that individuals receive such services
d. The provider reports all individuals with active TB as required by State law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2. To report a case of TB in Iowa, call the TB Control Program 800-362-2736.

16. Coordination of Prevention and Treatment Activities (45 CFR 96.132(c)
Coordinate treatment services with the provision of other appropriate services (including health, social, correctional and criminal justice, education, vocational rehabilitation, and employment services) to ensure clients have access to a full array of services.

17. Smoking Prohibition (Pro-Children Act of 1994 (Act), Public Law 103-227, Iowa Smokefree Air Act)
The provider shall demonstrate that it prohibits smoking in any facilities owned, leased, or contracted for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal providers.

18. Unallowable Expenditures (45 CFR, 96.135, 96.137)
SABG funding cannot be expended for the purposes listed below:

- Purchase of land or construction of building or improvements thereon
- Purchase of major medical equipment
- Providing individuals with hypodermic needles or syringes
- Any salary in excess of Level II of the federal senior executive service pay scale.
- Inpatient hospital services
- Satisfying the requirement for expenditures of non-Federal funds as a condition for the receipt of Federal funds
- Providing financial assistance to any entity other than a public or nonprofit entity
- Cash payments to intended recipients of health services
- Providing treatment services in penal or correctional institutions of the state

Substance Abuse Prevention - Additional Unallowable Expenditures:

- Purchase of Naloxone
- Strategies to enforce alcohol, tobacco, or drug (ATOD) policies (compliance checks, party patrols, shoulder taps, etc.)
- Services to enforce ATOD state laws
- Services that support Screening, Brief Intervention and Referral to Treatment (SBIRT), including promotion of SBIRT and screening
- Services that support mental health promotion and mental disorder prevention strategies
- Meal costs that are unrelated to program participant involvement in evidence-based program implementation
- Purchase of gift cards

19. Sliding Fee Scale Requirement

Treatment services must be available to patients based on a sliding fee scale that considers patient income and family size as stated in the Poverty Guidelines at https://aspe.hhs.gov/poverty-guidelines.

Contractors must implement and maintain documentation of patient co-pay procedures/policies and retain documentation of co-pays-and associated patient income and family size.

20. Single State Audit (2 CFR 200.501)

The provider shall adhere to the following requirements:

a. If the provider expends $750,000 or more in federal financial assistance during the provider's fiscal year, an independent financial and compliance audit must be completed by a Certified Public Accounting firm under the auspices of 2 CFR 200 Uniform Administrative Requirements for Federal Awards–Single State Audit. The provider must submit a copy of the audit report to IDPH. The provider must also submit a data collection form and reporting package to the Federal Audit annually to: https://harvester.census.gov/facweb
b. If the provider is a non-Federal entity that expends less than $750,000 during the provider's fiscal year, the provider must retain records to support expenditures, and the provider will make those records available for review or audit by appropriate officials of the Substance Abuse and Mental Health Services Administration (SAMHSA), the state, and the General Accounting Office.
c. If the 2 CFR 200 audit report includes findings or questioned costs, the provider must develop and implement a corrective action plan that addresses the audit findings and recommendations contained therein. The provider must submit the corrective action plan to IDPH.

The provider must retain records to support expenditures and make those records available for review or audit by appropriate officials of SAMHSA, the awarding agency, the General Accounting Office and/or their representatives.

21. Salary limitation States and subrecipients cannot use the block grants to pay salaries more than level II of the federal senior executive service pay scale.
22. Prohibitions regarding receipt of funds (42 USC 300x–56) The provider understands the following as conditions regarding receipt of SABG funds: a. Persons associated with the provider shall not knowingly and willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made from the SABG. b. Persons associated with the provider with knowledge of the occurrence of any event affecting the initial or continued right of the person to receive any payments from a grant made from the MHBG or SABG shall not conceal or fail to disclose any such event with an intent to fraudulently secure such payment either in a greater amount than is due or when no such amount is due. Any person who violates any prohibition established in this section shall for each violation be fined in accordance with federal law or imprisoned for not more than 5 years, or both.
23. Prohibition on Using Funds for Lobbying (Title 31, United States Code, Section 1352) • The provider must not use federal funds to lobby the Executive or Legislative Branches of the State or Federal Government in connection with the MHBG or SABG. • If the provider receives federal funds in excess of $100,000, it must disclose whether and how much it uses any non-federal funds for lobbying.
24. Government-wide Debarment and Suspension (Non-procurement) (13 CFR 400.109) The provider agrees to participate in the government-wide exclusion of suspended or debarred personnel and has policies to that effect.
25. Peer Review Process (42 USC 300x-53, SABG 96.136) • The provider agrees to participate, if selected, in the Independent Peer Review conducted by the State. The provider agrees to permit and cooperate with federal investigations into the use of the SABG. • The provider must submit such data and reports as required by the state to meet block grant reporting requirements.
Additional Substance Abuse Prevention and Treatment Block Grant Requirements **Pregnant Women and Women with Dependent Children (45 CFR 96.124)** *Note: References to patients or to women receiving services apply to Women and Children patients only.*
1. Ensure that women receiving services funded by Women and Children funding have no other financial means to obtain treatment and the funding is the payment of last resort. The program will document such in the patient record.
2. Ensure that the family is treated as a unit and admits both women and their children, as appropriate.
3. Ensure that the services in 2.02B.3. a. (3) are provided or arranged by the program and are documented in each patient's record. Providers must maintain a tracking mechanism to report each service to the Department upon request.
4. Establish a Memoranda of Understanding with other service providers to arrange for services in 2.02B.3. a. (3) that the program does not provide.

By signing, I attest that my organization and all employees of my organization will know, understand, and comply with federal Substance Abuse Prevention and Treatment Block Grant requirements.

If my organization provides Women and Children Treatment, I further attest that my organization and all employees will comply with the additional requirements for Pregnant Women and Women with Dependent Children.

I attest that I have the authority to sign on behalf of the contractor or subcontractor organization.

Organization Name:

Signature of Authorized Individual:

Typed Name of Signatory:

Title of Signatory:

Date Signed:

APPENDIX B - Links to IDPH Substance Use and Problem Gambling Resources

- IDPH General Conditions: http://idph.iowa.gov/finance/funding-opportunities/general-conditions
- Federal Guidelines for Opioid Treatment Programs: https://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf
- Iowa Gambling Treatment Program: http://www.idph.iowa.gov/igtp
- I-SMART and CDR: https://www.idph.iowa.gov/ismart
- SBIRT Iowa: http://idph.iowa.gov/sbirt
- Substance Abuse Prevention and Treatment Block Grant: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1cd9b9d45c5713f41740207f1f4c5010&mc=true&n=pt45.1.96&r=PART&ty=HTML#sp45.1.96.l
- Your Life Iowa: https://yourlifeiowa.org

APPENDIX C - Links to Evidence-Based and Best Practices

- Blueprints for Healthy Youth Development http://www.blueprintsprograms.com/
- National Institute of Drug Abuse Red Book https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf
- NIATx Model https://niatx.net/Content/ContentPage.aspx?PNID=1&NID=8
- SAMHSA Evidence-Based Practices Resource Center https://www.samhsa.gov/ebp-resource-center
- Stacked Deck https://www.hazelden.org/HAZ_MEDIA/7931_stackeddeck.pdf
- Strategic Prevention Framework http://www.samhsa.gov/spf

APPENDIX D - Prevention Organization Expectations

PREVENTION ORGANIZATION EXPECTATIONS
1. Policies and Procedures Manual (based on IAC 155.21(4)) Maintain and implement written policies and procedures manual that documents the Contractor's prevention services. Describe the prevention services and related activities, specify the policies and procedures to be followed, and govern all prevention staff. a. The manual shall have a table of contents. Revisions to the manual shall be entered with the date and with the name and title of the staff person making the revisions.
2. Staff Development and Training (based on IAC 155.21(5)) Policies and procedures shall establish a staff development and training plan that encompasses all prevention staff and all prevention services, considers the professional continuing education requirements of certified staff, and is available to all prevention staff. a. Designate a staff person responsible for the staff development and training plan. b. The staff person responsible for the staff development and training plan shall conduct an annual needs assessment. The staff development and training plan shall describe orientation of new staff which includes an overview of the Contractor's organization, prevention services, and confidentiality.
3. Data Reporting (based on IAC 155.21(6)) Policies and procedures shall describe how the Contractor reports data to IDPH in accordance with IDPH requirements and processes.
4. Fiscal Management (based on IAC 155.21(7)) Policies and procedures shall ensure proper fiscal management.
5. Personnel (based on IAC 155.21(8)) The Contractor shall have personnel policies and procedures. a. Personnel policies and procedures shall address: • Recruitment and selection of staff • Wage and salary administration • Promotions • Employee benefits • Working hours • Vacation and sick leave • Lines of authority • Rules of conduct • Disciplinary actions and termination • Methods for handling cases of inappropriate service delivery • Work performance appraisal • Staff accidents and safety • Staff grievances • Prohibition of sexual harassment • Implementation of the Americans with Disabilities Act • Implementation of the Drug-Free Workplace Act • Use of social media • Implementation of equal employment opportunity

1. Each position and staff person will have a written job description that describes the duties of each position and staff and the qualifications required for each position.
   - A staff person providing prevention services shall be qualified to provide prevention services by meeting at least one of the following conditions:
     - Be certified as a prevention specialist by the Iowa Board of Certification or other organization as approved by IDPH.
     - A staff person employed to provide prevention services on and after January 1, 2019 who is not certified as a prevention specialist shall be deemed qualified while the person is in the process of being certified as a prevention specialist. Such staff must meet the requirements of the certification process, must be supervised or mentored by a certified prevention specialist, must participate in Substance Abuse Prevention Skills Training within one year of hire, must receive a minimum of three hours of ethics training within three months of hire, and must be certified as a prevention specialist within 18 months of hire.
     - A staff person employed as the prevention supervisor or lead staff must be certified as a prevention specialist by a national or state organization approved by IDPH by June 30, 2020.
   - A review or all job descriptions will happen annually and whenever there is a change in a position's duties or required qualifications.
   - Job descriptions will be in the personnel section of the policies and procedures manual.
2. Written evaluation of job performance with each staff person will happen at least annually. The evaluation shall include the opportunity for the staff person to comment.
3. Personnel record on each staff person will be maintained. The record shall contain:
   - Verification of training, experience, qualifications, and professional credentials
   - Job performance evaluations
   - Incident reports
   - Disciplinary action taken
   - Documentation of review of and agreement to adhere to confidentiality laws and regulations. This review and agreement shall occur prior to the staff person's assumption of duties.
4. Personnel policies and procedures shall ensure confidentiality of personnel records and shall specify staff authorized to have access to personnel information.
5. Notification will be made to IDPH in writing within ten days of being informed that a staff person has been sanctioned or disciplined by a certifying body. Such notice shall include the sanction or discipline order.

6. Child Abuse, Dependent Adult Abuse, and Criminal Background Checks (based on IAC 155.21(9))

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

- Any mistreatment, neglect, or abuse of children and dependent adults is prohibited and shall be reported and enforcement procedures shall be enacted. Alleged violations shall

be reported immediately to the Contractor's executive director and appropriate Department of Human Services personnel. Policies and procedures on reporting alleged violations shall be in compliance with sub-rule 155.21(10). A staff person found to be in violation of Iowa Code sections 232.67 through 232.70, as substantiated by a Department of Human Services investigation, shall be subject to the Contractor's policies concerning termination.
7. Service Records (based on IAC 155.21(10)) Policies and procedures shall describe compilation, storage, and dissemination of service records.
8. Quality Improvement (based on IAC 155.21(20)) Policies and procedures shall describe a written quality improvement plan that encompasses all prevention services and related Contractor operations.
9. Safety (based on IAC 155.21(21)) Policies and procedures shall ensure that physical facilities are clean and safe. A written plan will be in place and will be followed in the event of fire or tornado. The plan shall be conspicuously displayed at the Contractor's facility.

APPENDIX E - Outpatient Treatment Rates

UNIT RATES – OUTPATIENT TREATMENT		
Covered Service: Licensed Program Services for Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Outpatient Initial Assessment – OWI Evaluation	Limited to one per patient / per Contractor / per treatment episode*	$125.00
Outpatient Initial Assessment	**Limited to one per patient / per Contractor / per treatment episode***	**$165.00**
Outpatient Individual Counseling	**Per patient / per 30 minute unit**	**$65.00**
Outpatient Group Counseling	**Per patient / per 30 minute unit**	**$35.00**
Intensive Outpatient (IOP)/ Partial Hospitalization Individual Counseling	**Per patient / per 30 minute unit (for IOP a maximum of two units can be billed per 7-day period)**	**$65.00**
Intensive Outpatient (IOP) / Partial Hospitalization Group Counseling	**Per patient / per day (for IOP a maximum of three units can be billed per 7-day period)**	**$150.00**
Covered Service: Other Covered Services for Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Care Coordination	Per patient / per month	$75.00
Crisis Counseling	**Per patient / per 30 minute unit**	**$65.00**
Early Intervention – Individual Counseling	**Per patient / per 30 minute unit**	**$65.00**
Early Intervention – Group Counseling	**Per patient / per 30 minute unit**	**$35.00**
Interim Services	**Per patient / per 30 minute unit**	**$65.00**
MAT – Medical Evaluation**	**Limited to one per patient / per treatment episode***	**$275.00**
MAT – Medical Care**	**Per patient / per day**	**$50.00**
MAT – Drug Testing**	**Per patient / per test (maximum of 12 tests per year)**	**$10.00**
MAT – Medication**	**Limited to $100 per month (maximum of $300 per patient / per treatment episode)***	**Actual Cost**
Recovery Peer Coaching	**Per patient / per 30 minute unit**	**$30.00**
SBIRT	**Per 30 minute unit**	**$35.00**

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Transportation	Limited to $20 per month (maximum of $60 per patient / per treatment episode)*	Actual Cost
Covered Service: Other Covered Services for Persons who are not Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Family Education Services – Individual and Group	**Per 30 minute unit**	**$55.00**

* **A treatment episode is defined as the period of service between the beginning of a treatment service for a drug or alcohol [or gambling] problem (admission) and the termination of services for the prescribed treatment plan (discharge). Source: Treatment Episode Data Set (TEDS) State Instruction Manual Admission Data With National Outcomes Measures (NOMS)**

** **Indicates services available only to substance use disorder clients.**

APPENDIX F - Adult Residential Treatment Rates

UNIT RATES – ADULT RESIDENTIAL TREATMENT		
Covered Service: Licensed Program Services for Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Clinically Managed Low-Intensity Residential*	Per day	$80.00
Clinically Managed Medium-Intensity Residential*	Per day	$200.00
Clinically Managed High-Intensity Residential*	Per day	$275.00
Medically Monitored Inpatient*	Per day	$350.00
Individual Counseling – Problem Gambling**	**Per patient / per 30 minute unit**	**$65.00**
Group Counseling – Problem Gambling**	**Per patient / per 30 minute unit**	**$35.00**
Covered Service: Other Covered Services for Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Early Intervention – Individual Counseling Problem Gambling**	**Per patient / per 30 minute unit**	**$65.00**
Early Intervention – Group Counseling Problem Gambling**	**Per patient / per 30 minute unit**	**$35.00**
MAT – Medical Evaluation*	**Limited to one per patient / per treatment episode*****	**$275.00**
MAT – Medical Care*	**Per patient / per day**	**$50.00**
MAT – Drug Testing*	**Per patient / per test (maximum of 12 tests per year)**	**$10.00**
MAT – Medication*	**Limited to $100 per month (maximum of $300 per patient / per treatment episode)*****	**Actual Cost**
Recovery Peer Coaching	**Per patient / per 30 minute unit (maximum of 4 units per treatment episode)*****	**$30.00**
Covered Service: Other Covered Services for Persons who are not Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Family Education Services – Individual and Group	**Per 30 minute unit**	**$55.00**

* **Indicates services available only to substance use disorder clients.**

** **Indicates services available only to problem gambling clients (These are services provided to clients in a residential treatment setting but are to be billed as outpatient services).**

*** A treatment episode is defined as the period of service between the beginning of a treatment service for a drug or alcohol [or gambling] problem (admission) and the termination of services for the prescribed treatment plan (discharge). Source: Treatment Episode Data Set (TEDS) State Instruction Manual Admission Data With National Outcomes Measures (NOMS)

APPENDIX G - Juvenile Residential Treatment Rates

UNIT RATES – JUVENILE RESIDENTIAL TREATMENT		
Covered Service: Licensed Program Services for Patients		
Service Type	**Unit Description**	**Unit Cost**
Clinically Managed High-Intensity Residential	Per day	$275.00
Covered Service: Other Covered Services for Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
MAT – Medical Evaluation	**Limited to one per patient / per treatment episode***	**$275.00**
MAT – Medical Care	**Per patient / per day**	**$50.00**
MAT – Drug Testing	**Per patient / per test (maximum of 12 tests per year)**	**$10.00**
MAT – Medication	**Limited to $100 per month (maximum of $300 per patient / per treatment episode)***	**Actual Cost**
Recovery Peer Coaching	**Per patient / per 30 minute unit (maximum of 4 units per treatment episode)***	**$30.00**
Covered Service: Other Covered Services for Persons who are not Patients – Substance Use Disorder / Problem Gambling		
Service Type	**Unit Description**	**Unit Cost**
Family Education Services – Individual and Group	**Per 30 minute unit**	**$55.00**

* A treatment episode is defined as the period of service between the beginning of a treatment service for a drug or alcohol [or gambling] problem (admission) and the termination of services for the prescribed treatment plan (discharge). Source: Treatment Episode Data Set (TEDS) State Instruction Manual Admission Data With National Outcomes Measures (NOMS)

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APPENDIX H - Women and Children Treatment Rates

UNIT RATES – WOMEN AND CHILDREN TREATMENT		
Women and Children Treatment: Outpatient – Licensed Program Services for Patients		
Service Type	**Unit Description**	**Unit Cost**
Outpatient Initial Assessment – OWI Evaluation	Limited to one per patient / per Contractor / per treatment episode*	$125.00
Outpatient Initial Assessment	**Limited to one per patient / per Contractor / per treatment episode***	**$165.00**
Outpatient Individual Counseling	**Per patient / per 30 minute unit**	**$65.00**
Outpatient Group Counseling	**Per patient / per 30 minute unit**	**$35.00**
Intensive Outpatient (IOP) / Partial Hospitalization Individual Counseling	**Per patient / per 30 minute unit (for IOP a maximum of two units can be billed per 7-day period)**	**$65.00**
Intensive Outpatient (IOP) / Partial Hospitalization Group Counseling	**Per patient / per day (for IOP a maximum of three units can be billed per 7-day period)**	**$150.00**
Women and Children Treatment: Residential – Licensed Program Services for Patients		
Service Type	**Unit Description**	**Unit Cost**
Clinically Managed Low-Intensity Residential	Per day	$80.00
Clinically Managed Medium-Intensity Residential	Per day	$200.00
Clinically Managed High-Intensity Residential	Per day	$275.00
Medically Monitored Inpatient	Per day	$350.00
Women and Children Treatment: Enhanced Treatment / Ancillary Support Services for Patients / Children		
Service Type	**Unit Description**	**Unit Cost**
Outpatient Case Rate	Half Month (1-14 days)	$140.00
Outpatient Case Rate	Full Month (15+ days)	$310.00
Residential Case Rate – Facility does not admit children	Half Month (1-14 calendar days)	$140.00
Residential Case Rate – Facility does not admit children	Full Month (15+ calendar days)	$310.00

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Residential Case Rate – Women Patients Only Facility does admit children	Half Month (1-14 calendar days)	$1,400.00
Residential Case Rate – Women Patients Only Facility does admit children	Full Month (15+ calendar days)	$3,100.00

* A treatment episode is defined as the period of service between the beginning of a treatment service for a drug or alcohol [or gambling] problem (admission) and the termination of services for the prescribed treatment plan (discharge). Source: Treatment Episode Data Set (TEDS) State Instruction Manual Admission Data With National Outcomes Measures (NOMS)

APPENDIX I - Methadone Treatment Rate

UNIT RATES – METHADONE TREATMENT		
Methadone Treatment: Covered Service for Patients		
Service Type	**Unit Description**	**Unit Cost**
Methadone Administration	Per dose	$12.00

APPENDIX J - Critical Incident Report

IOWA DEPARTMENT OF PUBLIC HEALTH - INTEGRATED PROVIDER NETWORK

CRITICAL INCIDENT REPORT

Submit this form to the Integrated Provider Network email mailbox at **IPN@idph.iowa.gov,** Attention: Critical Incident, within *24 business hours of when the incident occurred or when the organization was informed of the incident.*

Retain a copy of the form in the patient's file.

Date:
Name/Title of Individual Completing Form:
Contractor Organization Name:
Address: City: Phone: Email::
Location of Incident:

PATIENT or PERSON INVOLVED IN INCIDENT
Patient ISMART#:
If incident involves a person who is not a patient, name that person here:

☐ Male ☐ Female Age:

List any other involved party (i.e. patient, family member, visitor, staff, member, etc.):

Specify service being provided or treatment level of care:

DATE OF INCIDENT: **TIME OF INCIDENT:** ☐ a.m. ☐ p.m.
The incident was: ☐ Witnessed ☐ Discovered

TYPE OF INCIDENT:
- ☐ Death - Specify (i.e. car accident, heart attack, overdose, suicide, etc.):
- ☐ Suicide attempt
- ☐ Self-injury
- ☐ Assault/abuse of others or allegation thereof (Report child abuse pursuant to Iowa Code section 232.67 through 232.70 and dependent adult abuse pursuant to Iowa Code section 235B.3)
- ☐ Medication error (wrong dosage, wrong medication, wrong time, unauthorized administration)
- ☐ Unauthorized departure from a 24-hour facility pursuant to a court order
- ☐ Behavior that requires the intervention of law enforcement
- ☐ Behavior that results in physical injury to the patient or another person that requires treatment by a medical professional, emergency room visit, or admission to a hospital
- ☐ Condition that requires emergency medical treatment
- ☐ Condition that requires emergency mental health treatment
- ☐ Other dangerous behavior
- ☐ Other

Brief description of incident:

Follow-up actions taken by Contractor (i.e. patient admitted to hospital, counseling/referral provided to family, revised policies/procedures):

Resolution as a result of follow-up action:

Signature of Individual Completing Form:

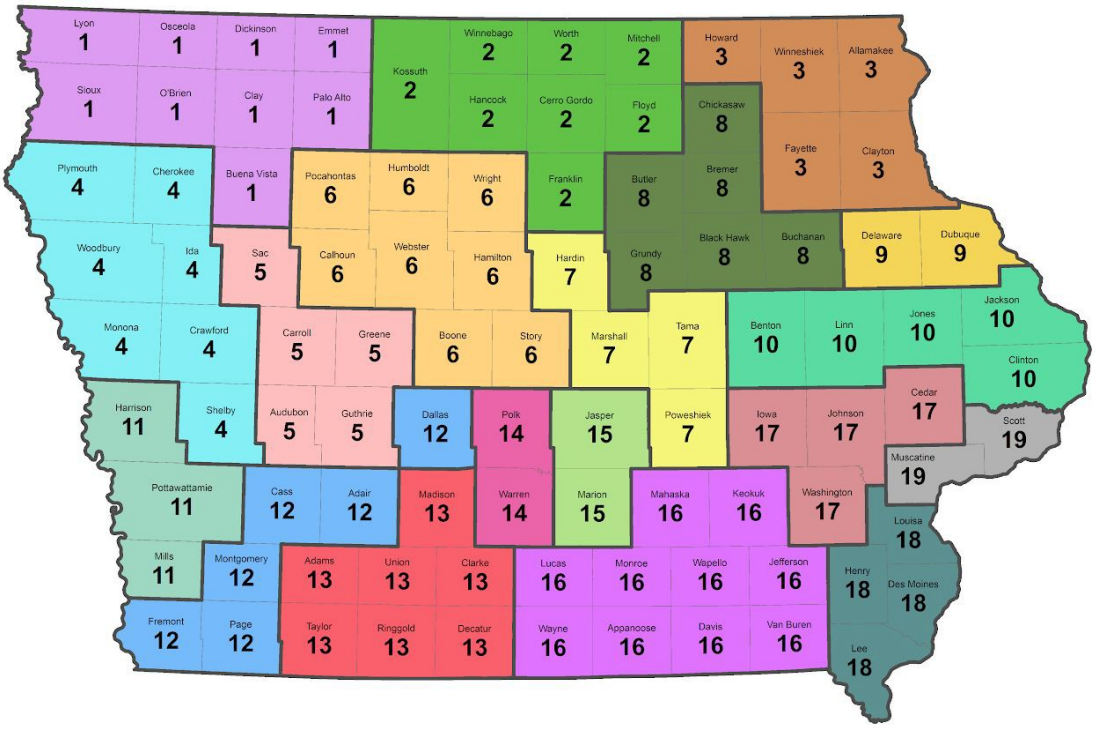
Date Signed:

Date and Time emailed to IDPH:

APPENDIX K - Map - Integrated Provider Network Contractors

Services Areas - Network Support, Prevention Services, and Outpatient Treatment

Statewide - (1) = Adult Residential Treatment, (2) = Juvenile Residential Treatment, (3) = Women and Children Treatment, (4) = Methadone Treatment



Service Area	Contractor	Service Area	Contractor
1	Jackson Recovery Centers, Inc.	13	Crossroads Behavioral Health Services
2	Prairie Ridge Integrated Behavioral Healthcare (1)	14	Broadlawns Medical Center
3	Northeast Iowa Mental Health Center		House of Mercy (1,3)
4	Jackson Recovery Centers, Inc. (1, 2, 3)		Prelude Behavioral Services (1)
5	Community Opportunities DBA New Opportunities		United Community Services (4)
6	Community and Family Resources (1, 2)	15	House of Mercy (1, 3)
7	Substance Abuse Treatment Unit of Central Iowa		United Community Services
8	Pathways Behavioral Services, Inc. (1)	16	Southern Iowa Economic Development Association
9	Substance Abuse Services Center	17	Prelude Behavioral Services (1)
10	Area Substance Abuse Council, Inc. (1, 2, 3)	18	Alcohol & Drug Dependency Services (1)
11	Heartland Family Service (1, 3)	19	Center for Alcohol & Drug Services, Inc. (1)
12	Zion Recovery Services, Inc (1)		New Horizons

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APPENDIX L - Integrated Provider Network Exception Request Form

Integrated Provider Network
Exception Request Form

Email to IPN@idph.iowa.gov
Do not include any protected health information.

Date Requested:	Contractor Organization:
Check service type: □ Network Support □ Prevention Services □ Outpatient Treatment □ Adult Residential Treatment □ Juvenile Residential Treatment □ Women and Children Treatment □ Methadone Treatment	Contractor Staff Name:
Contractor Telephone:	Contractor Email:

State the requested exception. Cite the related contract requirement. Explain how the request supports Integrated Provider Network goals and requirements.
IDPH ONLY: ☐ Approved ☐ Denied Notes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ 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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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds? ○ Yes ○ No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ○ Yes ○ No

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

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

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?

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

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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.

IDPH is not the mental health authority

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

Recovery Support Services (RSS)
IDPH provides Recovery Support Services through the IPN and through discretionary grant funding. The IPN funding provides RSS services through Recovery Peer Coaching, transportation, Care Coordination. Discretionary grant funding is also used to provide multiple recovery support services as indicated in Planning Step 1.

Recovery Peer Coaching: The Iowa Department of Public Health has defined Recovery Peer Coaching as face-to-face meetings between an individual and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective. The Recovery Peer Coach must complete a standardized training program of recovery peer coaching, peer facilitation or peer support that is acceptable to the Iowa Department of Public Health. Acceptable training would include completed training in the Connecticut Community for Addiction Recovery (CCAR) model or training based on the Georgia Model of Peer Support. For anyone not trained using the CCAR model, 3 additional hours of substance use disorder specific education is required. In addition to the training, a Recovery Peer Coach must be a person with lived experience with a substance use disorder, has been in recovery for a minimum of 12 months, and is willing to share those experiences.Care Coordination: Care Coordination is a new IPN service added within the January 2019 RFP.
Contractors may bill care coordination when services are provided during the month. The Licensure Standards define Care Coordination as “the collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services, both internal and external to the program, to meet patient needs, using communication and available resources to promote quality care and effective outcomes.” Care Coordination services are provided to active patients. The following criteria is noted in the IPN Provider Manual:
? For Care Coordination billing purposes, a patient must receive at least one Licensed Program Service from the contractor during the month
? Care Coordination encompasses the broad range of patient-specific people, systems, and issues related to the patient’s current situation and future recovery. These may include, but are not limited to, family members, referral sources, employers, schools, medical and mental health professionals, the child welfare system, the courts and criminal/juvenile justice systems, housing status, legal needs, and recovery support
? Care Coordination is generally conducted by contractor staff, outside of patient counseling sessions
? Care Coordination includes use of electronic information and telecommunication technologies to support patients through check-in calls and texts.
For the first six-months of 2019, IDPH reimbursed IPN providers for 8,797 units of Care Coordination (where a patient had at least 1 treatment service during the month).
Transportation: Transportation is a new IPN RSS added within the January 2019 RFP.
Transportation means assistance in the form of gas cards or bus passes, given directly to the patient for the purpose of transportation to and from an activity related to the patient’s treatment plan or recovery plan. Data available since January 1, 2019 indicates that $745 in transportation was provided.
Recovery Month activities are also a priority of the IDPH. Beginning in 2013, individual communities were offered funding for local recovery month events. In 2018, IDPH funded 13 organizations across the state to provide local recovery month activities. Some of the local activities included recovery themed painting classes, Annual Recovery and Wellness run/walk, recovery month carnival and recovery bike ride.

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

New IPN providers are able to provide RSS and services to Iowans are greatly enhanced with the addition of these services. Recovery Month funding to IPN providers is a priority and IPN providers are able to fund local community events based on their needs and the needs of those they serve.

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

None required

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

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

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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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.)

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:

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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: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:
Not required for SABG

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Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
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 or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Not required for SABG

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:

http://www.idph.iowa.gov/block-grant

c) Other (e.g. public service announcements, print media) (•) Yes ( ) No

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

Footnotes:

A Matter of Substance

A Publication of the IDPH
Bureau of Substance Abuse

April 2019
Quarterly Publication
Bureau of
Substance Abuse

IDPH • Lucas State Office Building • 321 East 12th St., Des Moines, IA 50319 • www.idph.iowa.gov

April is Alcohol Awareness Month

The theme this year:

Help for Today, Hope for Tomorrow

April is Alcohol Awareness Month and the Iowa Department of Public Health wants to remind you there is "Help for Today, Hope for Tomorrow." Visit the Your Life Iowa webpage to gather prevention resources, learn how alcohol impacts Iowans, and find local prevention and treatment professionals near you. Visit: Your Life Iowa.

To help you plan and develop your own 2019 Alcohol Awareness Month events, Facing Addiction with National Council on Alcoholism and Drug Dependence (NCADD) have prepared an Organizer's Guide which you can download as a PDF or you can download their new Alcohol Awareness Month Social Media Kit.

Alcohol Facts and Statistics
(from the National Institute on Alcohol Abuse and Alcoholism)

Prevalence of Drinking:

✓According to the 2015 National Survey on Drug Use and Health (NSDUH), 86.4 percent of people ages 18 or older reported that they drank alcohol at some point in their lifetime; 70.1 percent reported that they drank in the past year; 56.0 percent reported that they drank in the past month.

Alcohol-Related Deaths:

✓In 2014, alcohol-impaired driving fatalities accounted for 9,967 deaths (31 percent of overall driving fatalities)

Consequences of Underage Alcohol Use:

✓Research indicates that alcohol use during the teenage years could interfere with normal adolescent brain development and increase the risk of developing AUD. In addition, underage drinking contributes to a range of acute consequences, including injuries, sexual assaults, and even deaths—including those from car crashes.

Alcohol and the Human Body:

✓Drinking alcohol increases the risk of cancers of the mouth, esophagus, pharynx, larynx, liver, and breast.

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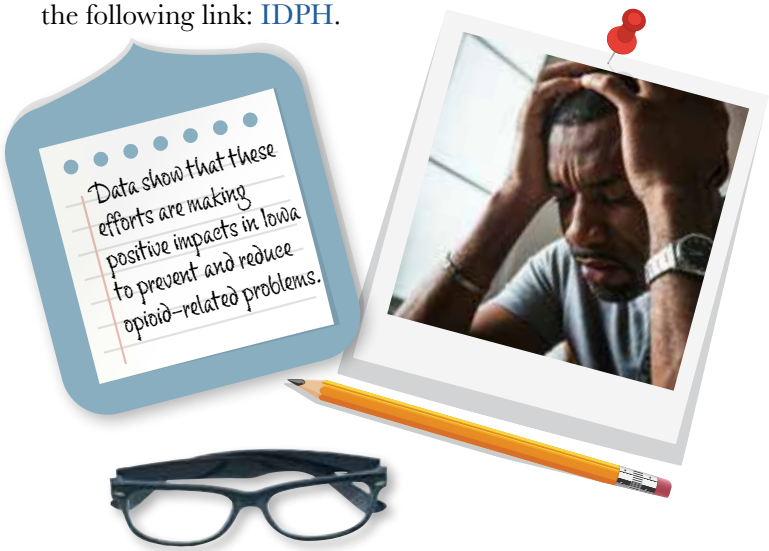
IDPH Releases New Report: Iowa's Opioid Crisis – An Update

The Iowa Department of Public Health (IDPH) has collaborated with state, local and private partners to address opioid use problems in Iowa. Statewide, Iowans have implemented coordinated, multi-sector efforts that have led to increased awareness, access to resources and improvements in care. Initial data show these efforts are making positive impacts in Iowa communities to prevent and reduce the negative consequences of opioid-related problems, but work still needs done.

The new report was prepared in order to provide a comprehensive update on Iowa specific measures, IDPH efforts and an overview of funding the state has received to address opioid misuse. To read the report, please click on the following link: IDPH.



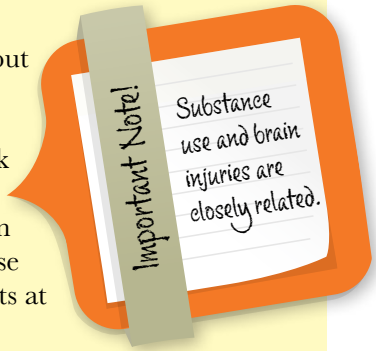
Iowa Brain Injury Advisory Council Recommends Brain Injury Screening

In February 2019, the Iowa Governor's Advisory Council on Brain Injuries made a recommendation that Iowa broadly adopt The Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID) and the Lifetime History of Traumatic Brain Injury (from the OSU TBI-ID) and other Acquired Brain Injuries as screening tools for obtaining a person's lifetime history of brain injury. The OSU TBI-ID has proven useful in many settings, including mental health and substance use treatment.

Substance use and brain injuries are closely related. Up to two-thirds of people with TBI have a history of alcohol abuse or risky drinking. Between 30 to 50 percent of people with TBI were injured while they were drunk and about one-third were under the influence of other drugs (Bombardier, 2011). By implementing use of the OSU TBI-ID, agencies will have a screening tool that is useful for determining which clients may need additional support or a modified approach to their treatment due to a disability related to their brain injury.

These forms, as well as other brain injury resources are available for download at https://yourlifeiowa.org/resources#general-topics.

Interested in learning more about meeting the complex needs of individuals with brain injury in substance use treatment? Check out the breakout session at the Iowa Governor's Conference on Substance Abuse, Substance Use Disorders and Cognitive Deficits at 2:30 PM on Tuesday, April 16.



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Take Note

Staff Spotlight

Monica Goedken is honored to serve as the Violence Prevention Coordinator with IDPH in our Office of Disability, Injury and Violence Prevention. In this position, Goedken provides training and technical assistance, works with Rape Prevention Education programs, Sexual Violence Prevention, Violence Against Women Act funds and collaborates on multi-disciplinary state initiatives.

Her professional background is in crisis response and advocacy for individuals experiencing interpersonal violence or coping with the impacts of past exposure. She was formerly with the Iowa Coalition Against Domestic Violence. Goedken has served as an expert witness, taught "seeking safety" at the Iowa Correctional Institute for Women, hosted support groups, managed an AmeriCorps program, mentored/supervised volunteers and interns, provided technical assistance and training to victim advocates, organized approaches for program development, and championed volunteer initiatives. Additionally, Goedken has worked in an emergency shelter setting, taught preschool for Headstart, and provided respite care for children with intellectual and cognitive disabilities.

Goedken received a bachelor's in Child, Adult and Family Services from ISU and a Master of Public Administration from Drake.

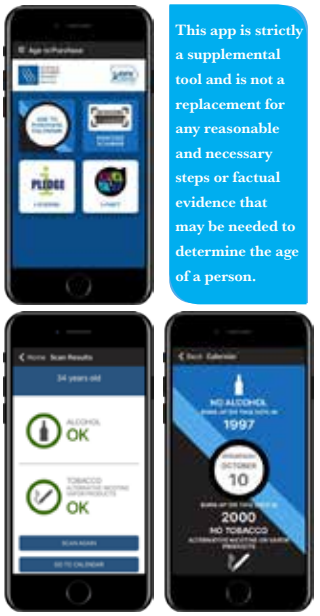
She is the proud momma of two lovely tiny humans. Her down time is filled with hikes, building forts, baking, bike rides, the gym, hammock lounging, laundry, playing flashlight hide and seek, and let's be real…smelling candles at Target. She hosts an annual kayaking trip with her girlfriends. Life is short; let's laugh it out and enjoy the ride!

ALCOHOLIC BEVERAGES DIVISION State of Iowa

Stephen Larson, Administrator

Iowa ABD Age to Purchase Mobile App

What is it?
The Iowa ABD Age to Purchase App allows users to scan driver's licenses with their smartphone. No personal information of the customer is stored on the device. The built-in scanning function uses the camera feature on the device to scan the barcode on the driver's license to quickly help determining age and validity. The app also gives users access to a view similar to the desktop calendars previously issued by ABD.



This app is strictly a supplemental tool and is not a replacement for any reasonable and necessary steps or factual evidence that may be needed to determine the age of a person.

Who should use it?
Anyone that is looking for assistance in determining the age of customers while selling or serving alcohol, tobacco, alternative nicotine, or vapor products should use this app.

Additional Features
The app also contains links to ABD's two online training programs, P-PACT and I-PLEDGE, which help teach responsible selling and serving of alcohol, tobacco, alternative nicotine, and vapor products.

The Iowa ABD Age to Purchase App is available to download for free from the App Store and Google Play Store.
App Store: https://itunes.apple.com/us/app/iowa-abd-age-to-purchae/id1437250743?ls=1&mt=8
Google Play Store: https://play.google.com/store/apps/details?id=gov.iowaabd.agetopurchase

Substance-Related Data Publicly Available

The Bureau of Substance Abuse is excited to announce that the first installment of substance-related data are now publicly available on the IDPH Data Portal at https://tracking.idph.iowa.gov/. These data are opioid, methamphetamine and alcohol-related deaths. The bureau continues to work to bring more substance-related data to the IDPH Data Portal, with quarterly releases planned for the remainder of 2019.

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Iowa Youth Survey: Suicide Risk and E-Cigarette Use Climbing; Alcohol Use Declines

The Iowa Department of Public Health's (IDPH) 2018 Iowa Youth Survey (IYS) shows in general, underage drinking continues to decline. Alcohol use among Iowa 11th graders was down from 26.4 percent in 2012 to 20.4 percent in 2018. Binge drinking fell from 19.2 percent in 2012 to 12.0 percent in 2018. An exception to the overall decline came among eighth graders, who reported a significant increase in drinking from 2016 to 2018, from 5.4 percent in 2016 to 7.3 percent in 2018 - a level not seen since 2012.

In multiple questions on suicide, Iowa youth reported increasing rates from previous surveys. Overall, the percentage of students who reported having a plan to kill themselves increased by 53 percent from 2012 to 2018. One in 10 students reported having a plan and 1 in 20 reported a suicide attempt within the past year.

Tobacco use appears similar to other substance use, remaining stable or declining from previous surveys. The exception to this is e-cigarettes. Almost one-quarter of 11th grade students (23 percent) reported use of e-cigarettes in the past month on the 2018 IYS, along with 8 percent of eighth graders and 2 percent of sixth graders.

"The Iowa Youth Survey gives us a glimpse into the lives of our young people," said IDPH IYS coordinator Pat McGovern. "While the answers represent a moment in time and do not give a complete view of the pre-teen and teenage mindset, they do give us a glimpse into their actions and beliefs. This enables us to tailor our programming and services in the most effective ways."

In 2018, 70,451 students representing 68 percent of Iowa's 330 public school districts participated in the IYS. The 2018 IYS is the 17th in a series of surveys that have been completed every two or three years since 1975. The survey is conducted with Iowa public and private students in grades 6, 8, and 11. The IYS includes questions about students' behaviors, attitudes and beliefs, as well as their perceptions of peer, family, school, neighborhood and community environments. The Iowa Consortium for Substance Abuse Research and Evaluation generates the IYS reports. To view the 2018 report and other information about the IYS, visit www.iowayouthsurvey.iowa.gov/.

Licensure Standards FAQ

Please submit any licensure questions to SUD.PG.License@idph.iowa.gov.

I am a licensed mental health counselor and a certified alcohol and drug counselor. Do I need to be licensed to provide substance abuse treatment?

An individual in private practice, independent from a program that is required to be licensed, is allowed to provide substance use disorder treatment services (Iowa Code section 125.13). The exception to this is when an individual is seeking a substance use disorder evaluation following a charge of operating a motor vehicle while intoxicated (OWI) under Iowa Code chapter 321J. For these purposes, the individual seeking an OWI evaluation and/or treatment, must have these services conducted at a substance use disorder treatment program licensed by the department.

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A Matter of Substance

A Publication of the IDPH Bureau of Substance Abuse

Please Read!

Syringe Services

The topic of syringe services programs (SSPs) has been gaining more and more attention as legislators in both the Iowa House and Senate consider revisions to the state drug paraphernalia law (Section 124.414) to allow for the delivery of sterile syringes to prevent transmission of HIV and hepatitis C. In bills introduced by the Senate Committee on Judiciary and House Representative Michael Bergan, legislators are proposing that the Iowa Department of Public Health, in collaboration with the Department of Public Safety and the Governor's Office of Drug Control Policy, establish a pilot syringe services program. The five-year pilot program would conclude December 1, 2025, to allow public health experts and legislators an opportunity to determine the program's efficacy in reducing new HIV and hepatitis C infections, and opioid overdoses.

If the Legislature and Governor Reynolds approve the proposed measures, Iowa will join 39 states and the District of Columbia in allowing SSPs to operate legally in the jurisdiction. Studies have observed that SSPs provide significant health improvements and cost savings to communities by preventing the transmission of infectious disease, improving opioid overdose response, and providing low-barrier access to substance use disorder treatment. Studies have also found that SSPs positively impact communities in many ways, including:

- ✓ A reduction in the incidence of HIV and HCV among people who inject drugs;
- ✓ A reduction in the number of improperly discarded needles in streets and parks;
- ✓ A reduction in costly emergency room visits by individuals suffering from injection-related complications (e.g., abscesses);
- ✓ A reduction in needle-stick injuries among law enforcement and other first responders; and
- ✓ An increase in substance use disorder treatment access.

SSPs are often the first "point of contact" for many vulnerable populations. Once engaged in services at an SSP, individuals may become re-integrated into their communities and utilize other services, including testing, immunizations, family planning and prenatal care, and referrals for social, behavioral and substance use services.

If you have questions or concerns regarding the potential implementation of syringe services programs, please reach out to HIV & Substance Use Coordinator Joe Caldwell at joe.caldwell@idph.iowa.gov.

What is "Resilience?"

Strengths-Based Batterer Intervention: A New Paradigm in Ending family Violence

A "Strengths and Resilience" based approach has a simple premise – identify what is going well, do more of it, and build on it. Strengths are positive factors, both in the individual and in the environment, which support healthy development. Resilience is the ability to "bounce back", to "recover" from adverse life experiences.

"Resilience is a mesh, not a substance. We are forced to knit ourselves, using the people and things we meet in our emotional and social environments." *Boris Cyrulnik*

A Strengths and Resilience based approach recognizes that each of us has a combination of risk factors and protective factors which shape our development. Some of them are within our control, and some beyond. Much attention has been given to the risk factors that have led to young men being over-represented among road crash fatalities, youth suicides, perpetrators of violence and many other negative statistics.

What has been given far less attention are the protective factors that mean most young men are not counted among those statistics, and most lead healthy and productive lives posing no risk to themselves or others.

Rather than having a problem based orientation and a risk focus, a Strengths and Resilience based approach seeks to understand and develop the factors that protect most young people. http://www.brave-project.org/strengthsandresilience.pdf

This is the fifth in a continuing series of commentaries about resilience, and how resiliency might support overall health and wellbeing.

Resilience is the ability to "bounce back", to "recover" from adverse life experiences.

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Rape Prevention and Education: Notice of Awards for Recipients Implementing Community-Level Strategies

Ten state health departments have been awarded additional funding through Category B of the recent funding opportunity, Rape Prevention and Education: Using the Best Available Evidence for Sexual Violence Prevention CDC-RFA-CE19-1902. CDC's Rape Prevention and Education (RPE) program aims to prevent sexual violence (SV) perpetration and victimization. Category B requires that recipients implement no less than 75% of their strategies at the community level, and no more than 25% at the individual or relationship level. Recipients were awarded through a competitive process to support state health departments with demonstrated capacity for additional community-level prevention strategy implementation and evaluation.

Funding recipients are:

- ✓ Colorado Department of Public Health and Environment
- ✓ State of Connecticut Department of Public Health
- ✓ Iowa Department of Public Health
- ✓ Minnesota Department of Health
- ✓ Missouri Department of Health and Human Services
- ✓ Montana Department of Public Health and Human Services
- ✓ New Jersey Department of Health
- ✓ Oregon Department of Human Services
- ✓ Rhode Island Department of Health
- ✓ Utah Department of Health

Sexual violence is a serious public health problem that affects millions of people each year. In the U.S., 44% of women and 25% of men experienced some form of contact sexual violence in their lifetime. These funding recipients will work with state and local partners, including sexual violence coalitions, non-governmental organizations, community-based organizations, local health departments, educational institutions and other stakeholders to prevent sexual violence. Their efforts will be informed by programs, practices and policies identified within DVP's STOP SV: A Technical Package to Prevent Sexual Violence, with emphasis on the focus areas of promoting social norms, teaching skills, creating protective environments, and providing opportunities to empower and support girls and women.

IPN Webpage Now Live

The Iowa Department of Public Health (IDPH) Substance Use and Problem Gambling Services Integrated Provider Network (Integrated Provider Network) is a statewide, community-based, resiliency- and recovery-oriented system of care for substance use and problem gambling services. IDPH selected Integrated Provider Network contractors in 2018, through a competitive request for proposal process that evaluated applicant capability and experience. Check out the updated Integrated Provider Networks webpage at: https://www.idph.iowa.gov/substance-abuse/Integrated-Provider-Network

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Please Read!

Adolescent Substance Use Webinar Recordings Now Available

The recordings and slides for the Adolescent Substance Use Webinar Series from February and March 2019 are now available here. The series consisted of four webinars, "A Toolkit for Adolescent Screening, Brief Intervention, Referral and Treatment" (Tracy McPherson, PhD), "Medication Assisted Treatment for Adolescents with Opioid Use Disorder" (Ned Presnall, MSW, LISW), "Understanding the Social and Biological Aspects of Adolescents and Substance Use Disorders" (Jason Burrow-Sanchez, PhD) and "Using the ASAM Criteria to Guide Assessment and Treatment of Youth" (Marc Fishman, PhD).

What is Collegiate Recovery and Why Should We Care?

On February 21, 2019, the Iowa Department of Public Health sponsored "What is Collegiate Recovery and Why Should We Care?" in Des Moines. Kennesaw State Assistant Dean of Student Affairs Teresa Wren Johnston and Association of Recovery in Higher Education Executive Director Timothy Rabolt presented information about the history and models of collegiate recovery. Providers and college representatives from across Iowa attended. A highlight of the training included a panel discussion featuring a student, clinician and others with lived and professional experience. Participants also engaged in roundtable discussions to identify action steps to complete following the training. For more information or questions, contact Cara.Weis@idph.iowa.gov.

Timothy Rabolt, Travis Goure (student); Teresa Wren Johnston, Cara Weis

Panelists Travis Goure, Timothy Rabolt, Jason Haglund (YSS) and Andrew Allen (YSS)

Recovery Peer Coaching Trainings

The Iowa Department of Public Health sponsored Recovery Peer Coaching trainings from February 21 – March 2, 2019. The trainings presented the curriculum developed by Connecticut Community for Addiction Recovery (CCAR). All trainings offered a Training of Trainers session. The trainings and total trained in each model include: Recovery Coaching Academy - 25, TOT – 12; Recovery Coaching Academy for Young Adults – 14, TOT – 7; and Ethical Considerations for Recovery Coaches – 17, TOT – 8. A Recovery Peer Coaching fact sheet can be found here. For more information or questions, contact Cara.Weis@idph.iowa.gov.

Participants at the Ethical Considerations for Recovery Coaches finish several days of Recovery Peer Coaching training. Included above are trainers Brenda Monforti (second row from the back, second from left) and Kevin McLaughlin (front right).

The trainings presented the curriculum developed by Connecticut Community for Addiction Recovery.

Marijuana Impact Report

The Midwest High Intensity Drug Trafficking Area (HIDTA) has just approved its Marijuana Impact Report. The purpose of this report is to examine the effects of marijuana legalization in other states in order to provide drug policy experts and law enforcement leaders with potential impacts and consequences for Midwestern states that are contemplating the legalization of "medical" and/or "recreational" marijuana. To read the report, please click on the following link: HIDTA Report

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Training Opportunities

The Iowa Department of Public Health has these training opportunities:

- ✓ **Overdose and Naloxone: Training of Trainers**
  - May 22 - Waterloo, register here
  - May 23 - Council Bluffs, register here

Midwest Counterdrug Training Center (MCTC)
7105 NW 70th Ave, Johnston

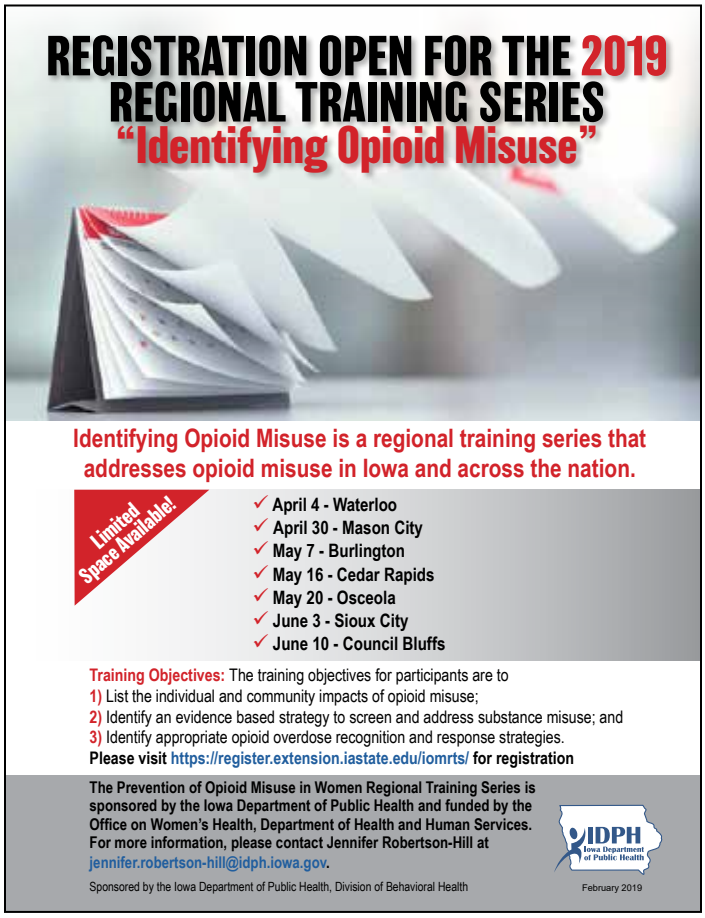
- ✓ **SAPST:**
  - June 26-27 and July 16-17 register here
- ✓ **Prevention Ethics for Certification:**
  - July 18 register here

Identifying Opioid Misuse, Regional Training Series

- ✓ **Burlington:** May 7 register here
- ✓ **Cedar Rapids:** May 16 register here
- ✓ **Sioux City:** June 3 register here

Governor's Conference on Substance Abuse

- ✓ April 16-17 register here



National Prescription Drug Take Back Day

April 27, 2019 – 10AM to 2PM

The National Prescription Drug Take Back Day aims to provide a safe, convenient, and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications. Click here for more information or to locate a collection site near you.

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Please Read!

Your Life Iowa and Blank Children's Hospital

Recently, Blank Children's Hospital/UnityPoint partnered with IDPH to raise awareness of the help and resources available through YourLifeIowa.org for youth and parents with questions about anxiety, depression, suicide and prescription drug safety. Two posters were created that are now featured at many UnityPoint clinics around the state.

This past fall, UnityPoint launched an online digital education course focused on safe and appropriate use of prescription medications (Prescription Drug Safety) for high school students. This program was piloted in several regions, and UnityPoint hopes to expand it across Iowa to assist in positively impacting the state's Drug Control Strategy goals. The course includes information about contacting Your Life Iowa for help, information and assistance regarding prescription drugs.

Thanks to UnityPoint for its efforts to protect and improve the health of Iowans!

Tools for Keeping Up-to-Date with the Iowa Legislature

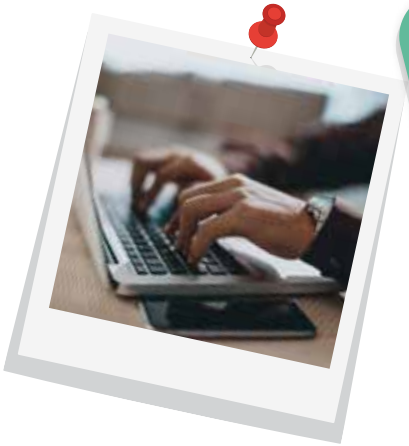
- ✓ Legislative Subscriptions offers a variety of subscriptions and tracking tools to watch and track bills.
- ✓ An instructional video called Subscription and Bills and Rules Watch can be viewed here.
- ✓ If you would like to know more about your legislators and the House and Senate leadership, click here.
- ✓ Details on committees are posted here.
- ✓ Learn what's happening in the chambers here.

More YourLifeIowa Updates

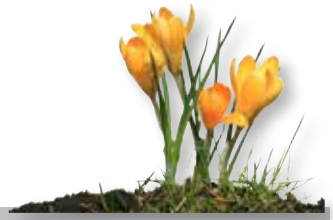
IDPH has been busy working on updates to YourLifeIowa.org. Over the past quarter, this included updating the Finder (facility locator) with newly-licensed programs, updating the list of facilities participating in the Integrated Provider Network, as well as those facilities offering Medication Assisted Treatment using the Advanced Finder.

Also, the first round of usability testing was completed and we are now working on several improvements to the navigating experience within YourLifeIowa.org. Additionally, a new Prevention module is being developed that will include a new landing page, calendar and media resource center. Look for these improvements to start rolling out later in April and May!

And finally, IDPH is collaborating with the Department of Human Services to position YourLifeIowa.org as the statewide resource for mental health and crisis services. This will include expanding phone, text and chat options, and the online resources and information available to all Iowans experiencing mental health related issues, problems or difficulties.



Look for these new improvements to start rolling out later in April or May!



For more information about the IDPH Bureau of Substance Abuse, visit http://idph.iowa.gov/bh. For questions related to *"A Matter of Substance,"* contact editors:

- ✓ Cara Weis: cara.weis@idph.iowa.gov
- ✓ Janet Nelson: janet.nelson@idph.iowa.gov
- ✓ Lori Hancock-Muck: lori.hancock-muck@idph.iowa.gov
- ✓ Colleen Bush, graphic designer: colleen.bush@idph.iowa.gov

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January 2019
Quarterly Publication
Bureau of Substance Abuse

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Integrated Provider Network

In August 2018, IDPH released a competitive Request for Proposals (RFP) to establish an IDPH Integrated Provider Network to deliver comprehensive and high quality substance use disorder and problem gambling prevention and treatment services in Iowa. The department's goals include:

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

On December 12, 2018 the Notice of Award was posted indicating the selected IDPH Integrated Provider Network (Network) contractors. Contracts were effective January 1, 2019. The Network brings together three previously separate service systems: Substance Abuse Prevention, Substance Use Disorder Treatment, and Problem Gambling Prevention and Treatment as directed in legislation beginning in 2009.

The IDPH Integrated Provider Network provides substance use and problem gambling education, prevention, early intervention, treatment and recovery support services statewide. Click here for the service area map. 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.

Questions about the Integrated Provider Network may be emailed to ipn@idph.iowa.gov.

Department News

Kathy Stone Retiring

The staff at IDPH would like to recognize the retirement of Kathy Stone, Director of the Division of Behavioral Health and the Single State Authority on Substance Abuse (SSA) for Iowa.

For more than 11 years Kathy has led the division's efforts to address substance misuse in Iowa. Under her leadership a variety of grants, efforts and approaches have been introduced, including: Access to Recovery (ATR), Screening, Brief Intervention and Referral to Treatment (SBIRT); Strategic Prevention Framework (SPF); Recovery Oriented Systems of Care (ROSC); and the new Integrated Provider Network (IPN). You don't have to look hard to see, Kathy has definitely left her mark on Iowa's substance use field. Kathy's last day at IDPH was December 31.

Congratulations Kathy – We'll miss you!

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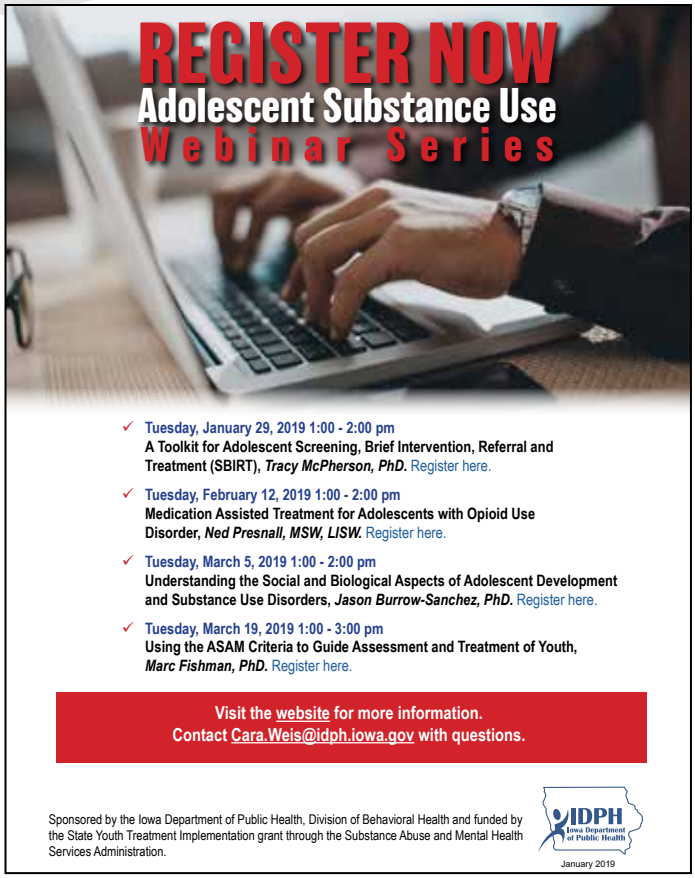

Multiple Pathways of Recovery

IDPH employees, Jennifer Robertson-Hill, Monica Wilke-Brown and Kevin Gabbert, attended the Multiple Pathways of Recovery Conference on October 24-26, 2018 in Punta Gorda, Florida. The conference, sponsored by Connecticut Community for Addiction Recovery, provided an opportunity to engage people across the country in discussions about the numerous pathways of recovery. Presentation topics focused on the value of integrating pathways to recovery and strategic approaches for doing so. Presentations educated participants about the ways people in recovery may be supported, such as therapeutic communities, fitness based programs, medication assisted recovery, shamanic healing and peer-run programs.

Agency Spotlight – ADDS

Alcohol and Drug Dependency Services of Southeast Iowa (ADDS) gambling treatment services started utilizing the Gambling Pathways Questionnaire (GPQ) in their admissions process almost two years ago. With this assessment, the counselor and patient identify and learn about the thought processes and behaviors that may occur when gambling, to assist in the treatment planning process. The GPQ provides a snapshot of eight areas that may interact with the gambling behaviors: mood pre- and post- problem gambling, childhood trauma, abuse and neglect, meaning motivation, stress-coping motivation, impulsivity, risk-taking, sexual risk-taking and antisocial traits/behaviors.

The GPQ takes about 10-15 minutes to fill out and can be given to the patient to complete; it takes approximately 5 minutes to score and provide feedback to the patient. The GPQ has been a useful tool for ADDS problem gambling treatment staff to personalize the patient's treatment planning to assist the patient in meeting their recovery goals. ADDS has found that the use of the eight domains as a guide, patient participation, retention, and meeting patient treatment expectations have increased. Additionally, the GPQ provides the counselor with specifics about the populations seeking problem gambling treatment services, including an average time frame of how long, based on a GPQ scoring, a patient may expect to engage in services.

The GPQ has been a beneficial "tool"in the tool belt for ADDS problem gambling treatment staff resulting in improved treatment planning. By identifying with each patient areas in their life that might otherwise have been overlooked, the GPQ has improved the ability of problem gambling treatment staff and patients to identify, discuss and provide feedback on the underlying reasons that led to the patient's problem gambling. Read more and find the GPQ here. For more information about how ADDS has integrated the GPQ into problem gambling treatment services, please contact, Nic Foss at ndfoss@addsiowa.org.

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Important Information!

Your Life Iowa and the Agricultural Community

IDPH is working on two fronts to assist the agricultural community in Iowa. On one front, representatives from Landus Cooperative reached out through a Contact Form on the Your Life Iowa website. This led to several discussions on how Your Life Iowa can assist Iowa farmers by providing support and assistance for concerns regarding substance use, problem gambling and suicide. This resulted in the use of the "Lean on Us" graphic in their October payroll stuffer.

This effort has included ensuring that Your Life Iowa staff (Foundation 2) understand agricultural-related issues and know what other resources are available. In March, IDPH will help facilitate at a Landus Cooperative event, a session for women in agriculture on behavioral health and how to access information and assistance.

The second front, with the newly procured Integrated Provider Network members in partnership with IDPH, will work on efforts to reach out to the agricultural community by engaging key community-based farm organizations in assessing local needs as it relates to substance use, problem gambling and suicide.

For more information, please contact Eric Preuss at eric.preuss@idph.iowa.gov.

Licensure Standards FAQ

Please submit any licensure questions to SUD.PG.License@idph.iowa.gov.

What is the purpose of the Substance Abuse and Problem Gambling Treatment Program Committee (Committee)?

The Committee was created in 2010 as part of the revisions made to Chapter 136 by House File 2183 (2010). The State Board of Health appointed a Substance Abuse and Problem Gambling Treatment Program Committee "to approve or deny applications for licensure received from substance abuse programs pursuant to chapter 125 and gambling treatment programs pursuant to chapter 135 and to perform any other function authorized by chapter 125 or 135 and delegated to the Committee." The Committee meets the second Wednesday of every month to review and act on IDPH recommendations on regulation of treatment programs. Committee members include Jay Hansen (Chairperson), Michael Wolnerman and Vickie Lewis. Past meeting agendas and minutes for the Substance Abuse and Problem Gambling Treatment Program Committee can be found at https://idph.iowa.gov/board-of-health/committee/meeting-info

For more information please contact Lori Hancock-Muck at lori.hancock-muck@idph.iowa.gov.

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Please Read!

Substance Use Impact on Public Health

Over the last five months, staff from the Bureau of HIV, STD, and Hepatitis have developed the Health Initiative for People Who Use Drugs. This initiative seeks to address a number of public health concerns surrounding substance use, such as:

- ✓ Outbreak potential of HIV and HCV
- ✓ Barriers to treatment for those using substances
- ✓ Prevention of substance use related harms
- ✓ Housing and employment limitations for people who use substances
- ✓ Access to public services for those who use substances

In an effort to address the wide variety of public health concerns stemming from substance use, the current Health Initiative for People Who Use Drugs operates on three levels of engagement: Micro-, Mezzo-, and Macro-.

At the Micro- level, the AmeriCorps VISTA Client Engagement Specialist is developing tools for engaging people who previously or currently use or inject drugs. This level seeks to better understand how people who use drugs access medical and social services and acquire feedback on the effectiveness or accessibility of services. At the Mezzo- level, the AmeriCorps VISTA Care and Prevention Support Specialist is developing resources on the intersections of HIV and Hepatitis C with various public and private sectors. At the Macro- level, a steering committee and workgroup structure have been established in order to facilitate a statewide discussion on public health and substance use between a variety of public and private sectors. Topics of discussion will revolve around community safety, structural determinants of health, linkage to care and drug user health.

If you would like more information on this initiative, to request capacity building assistance, or join a statewide workgroup, please email Richard Nesselroad, the AmeriCorps VISTA Systems Engagement Specialist.

Important Note!

Staff have developed the initiative to help address public health concerns.

What is "Resilience?"

The Social Ecological Model (or SEM) is a framework to understand the multiple levels of a social system in which a person exists and interacts. The SEM consists of four levels: individual, relationship, community and society. The SEM can help understand how personal and environmental factors affect behaviors and norms from the individual, to the community and societal levels. The risk and protective factors that exist within communities can impact the capacity of individuals to demonstrate resilience, and resilient individuals can strengthen a community's resilience when faced with adversity. Community resilience is defined by the RAND Corporation as "a measure of the sustained ability of a community to utilize available resources to respond to, withstand and recover from adverse situations." For more information on community resilience, please visit https://www.rand.org/topics/community-resilience.html.

This is the fourth in a continuing series of commentaries about resilience, and how resiliency might support overall health and wellbeing.

Resilient individuals can strengthen a community's resilience when faced with adversity.

Iowa Substance Abuse Brief

Did you know that in 2017, drugs - including prescription medications, illicit drugs, and over-the-counter medications - were the underlying cause of death for 77 percent of all poisoning deaths? Learn this and more in the recently released IDPH Iowa Substance Abuse Brief on Drug Overdose. Click here.

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Take Note

Ohio's Approach to Opioid Use

On October 8 and 9, Amanda McCurley, Program Director for the IDPH AmeriCorps Substance Abuse Prevention Program, visited the Ohio Association of County Behavioral Health Authorities (OACBHA) AmeriCorps VISTA Project in Columbus, Ohio that focuses on addressing Ohio's opioid epidemic. Amanda met with Liz Henrich, Associate Chief Executive Officer and Director of the VISTA Project, to discuss how the AmeriCorps members of OACBHA address the opioid epidemic. Most members serving in the OACBHA VISTA Project serve on county Alcohol, Drug Addiction and Mental Health (ADAMH) Boards to develop community outreach opportunities; research and write educational materials and papers related to opioid addiction, promising prevention approaches, treatment and recovery supports; build partnerships with other community organizations working to address the opioid epidemic by supporting the implementation of the County Hubs to combat opioid addiction; and conduct philanthropic research on potential supporters for community organizations working to address the opioid epidemic and participate in grant development and grant writing processes. Amanda also visited with three AmeriCorps members currently serving at different agencies in Columbus to discuss their service activities and service experience. Amanda was able to learn about legislation and policy in Ohio to address their opioid epidemic, and well-supported prevention efforts in Ohio such as the Good Behavior Game in Ohio community schools. During the visit Amanda also shared information about the Iowa Department of Public Health, the IDPH AmeriCorps Substance Abuse Prevention Program, and Iowa's current legislation and policies addressing the opioid crisis in Iowa. The visit provided a great opportunity for the two AmeriCorps programs to connect to share ideas, resources and information. Contact amanda.mccurley@idph.iowa.gov for more information.

Important Note!
The visit helped provide the opportunity to connect and share ideas and resources.

Save the Date

The Prevention of Opioid Misuse Regional Training series will begin in February 2019. This series is sponsored by the Iowa Prevention of Opioid Misuse in Women grant, funded by the Office of Women's Health, Department of Health and Human Services.

February 7 - Mason City
February 11 - Osceola
March 7 - Council Bluffs
April 4 - Waterloo
May 7 - Burlington
May 16 - Cedar Rapids
June 3 - Sioux City

Watch your in-box for registration details.

Grant Funds Integrated Care Team

The Iowa Department of Public Health was awarded a Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) grant by the Substance Abuse and Mental Health Services Administration - Center for Mental Health Services (SAMHSA-CMHS) for five years (09/30/2018-09/29/2023). IDPH will implement the grant with Iowa's Integration Project, a joint partnership between substance use disorder (SUD) treatment programs across the state and Federally Qualified Health Centers (FQHC's) in Polk, Scott and Woodbury counties, and at Camp Dodge, home to the Iowa Army National Guard. The purpose of this project is to provide an Integrated Care Team, co-located between the SUD treatment programs, the FQHCs and the Iowa Army National Guard. The Integrated Care Team will address areas of mental health, primary health care and SUD treatment services for adults with substance use disorders.

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Please Read!

Summit Addresses Stimulant Use

IDPH employees, Katie Bee, Michele Tilotta, and Cara Weis, attended the National Cocaine, Meth & Stimulant Summit (the Summit) on November 12-14, 2018, in Fort Lauderdale, Florida. The Summit, sponsored by The Institute for the Advancement of Behavioral Healthcare, provided an opportunity to engage stakeholders across the country in discussions about the cocaine, methamphetamine and stimulant epidemic. The information shared included topics focused on the changing patterns of stimulants, the rising challenge of psychostimulant use disorder in young adults, and High-Intensity Drug Trafficking Areas (HIDTA) program updates. One of the highlights was a keynote presentation from Jim Carroll, Deputy Director of the National Drug Control Policy Department, who addressed his agency's priorities addressing stimulants.

Some of the key takeaways from the conference included the following:

- ✓ Leading researchers and professionals suggest the current state of the nation is a poly-drug epidemic.
- ✓ Clinical professionals are in an ideal position to discuss with their clients why stimulants are dangerous, as well as address the trauma histories that often lead to substance use.
- ✓ The market is inundated with pure, low-cost and lethal methamphetamine.
- ✓ United States border agents are seizing 10 to 20 times the amounts they did a decade ago.
- ✓ Fentanyl contaminated methamphetamine and cocaine are on the rise.
- ✓ Stimulants include amphetamine, cocaine, methamphetamines and prescription medications for attention deficit hyperactivity disorder.
- ✓ In 2016, 667,000 people were current users of methamphetamine, 1.7 million were current misusers of stimulants, and 1.9 million were current users of cocaine (National Survey on Drug Use and Health).
- ✓ Cocaine or methamphetamine was involved in 18,000 of the more than 64,000 drug overdose deaths occurring in 2016 (Center for Disease Control).
- ✓ Through 2018, the United States will likely continue to experience the highest cocaine supply and usage levels in a decade (Drug Enforcement Administration).

And did you know in Iowa:

- ✓ Methamphetamine is now the second most reported drug by adults at admission to treatment, moving ahead of marijuana for the first time. Alcohol remains number one for adults, while marijuana remains the number one drug of choice for juveniles.
- ✓ From 2014-2017, there was a 38 percent increase in methamphetamine treatment admissions in Iowa. Similarly, the IDPH reports there was an eightfold increase in Iowa deaths related to amphetamines, which includes methamphetamine.

For more information on methamphetamine, visit yourlifeiowa.org.

Jim Carroll, Deputy Director, National Drug Control Policy

2014–2018 saw a 38% increase in methamphetamine treatment admissions in Iowa.

Methamphetamine Awareness Day Proclamation

Iowa Governor, Kim Reynolds signed a proclamation declaring November 30, 2018 Methamphetamine Awareness Day. A public proclamation signing was not scheduled. The proclamation is one way the Iowa Department of Public Health hopes to spread awareness of the increase in use of methamphetamine and other amphetamines in Iowa.

IDPH Methamphetamine Work Group members: Jennifer Robertson-Hill, Michele Tilotta, Pat McGovern, and Katie Bee

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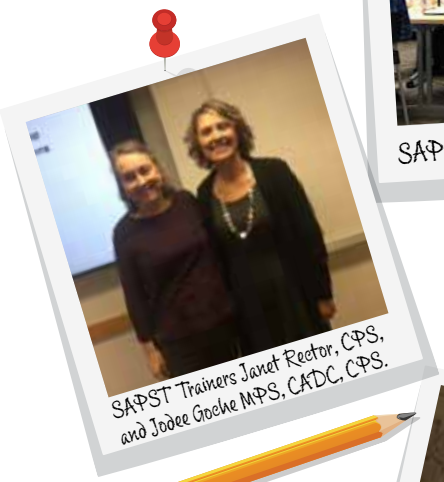
Important Information!

Training Opportunities

The Iowa Department of Public Health, in collaboration with Midwest Counterdrug Training Center (MCTC), provided Substance Abuse Prevention Skills Training (SAPST) on October 10-11 and November 7-8, 2018. SAPST training is a foundational course in substance abuse prevention for Iowa's entry-level prevention practitioners and professionals working in related fields. It is grounded in current research with a focus on the Substance Abuse Mental Health Services Administration's Strategic Prevention Framework (SPF), which is a five-step prevention model with two guiding principles in sustainability and cultural competency. SAPST provides knowledge and skills to implement effective, data-driven prevention programs, practices and policies to reduce behavioral health disparities and improve wellness.

The next trainings will take place March 6-7 and April 3-4, 2019. Participants can register at the MCTC website.

SAPST training participants



SAPST Trainers Janet Rector, CPS, and Jodee Goche MPS, CADC, CPS.

SAPST training participants

Annual Governor's Conference on Substance Abuse

The Iowa 42nd Annual Governor's Conference on Substance Abuse will be held April 16 and 17, 2019, at Veterans Memorial - Community Choice Credit Union Convention Center in Des Moines. Watch your inbox for a Call for Presentations with guidance on the opportunity to contribute content. The competitive presentation submission process will run December 21, 2018 - January 18, 2019. The Iowa Governor's Conference on Substance Abuse is sponsored by the Iowa Department of Public Health, Division of Behavioral Health.

Brain Injury Services Conference

The Brain Injury Alliance of Iowa is hosting its 27th Annual Best Practices in Brain Injury Services Conference February 28 through March 1, 2019, at the Sheraton in West Des Moines. This year's theme is **"Coming Together to Improve Outcomes: Weaving Best Practices into the Brain Injury Continuum of Care."** For more information, visit https://biai.member-clicks.net/2019-annual-conference-info-page.

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Please Read!

A Matter of Substance

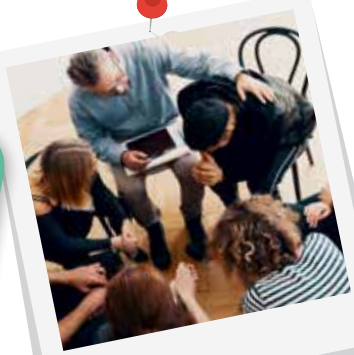
A Publication of the IDPH Bureau of Substance Abuse

New Suicide Prevention Project Launched

Across health and behavioral health care settings, there are many opportunities to identify and provide care to those at risk for suicide. Before that can happen, suicide prevention must first be seen as a core responsibility of health care. The Zero Suicide framework is defined by a system-wide, organizational commitment to safer suicide care in health and behavioral health care systems.

IDPH was awarded a five-year grant (9.30.18 - 9.29.23) by the Substance Abuse and Mental Health Services Administration to implement the Zero Suicide framework. The Zero Suicide Iowa project will be implemented with the Integrated Provider Network (IPN) to ensure that patients at prevention and treatment organizations receive services that are suicide safe. IPN providers will implement the Zero Suicide model with support from IDPH and in collaboration with the Iowa Suicide Prevention Planning Group and Foundation2 (manages Your Life Iowa for IDPH). Find the Zero Suicide overview form and the fact sheet here. Contact pat.mcgovern@idph.iowa.gov with questions.

In Iowa, suicide is the second leading cause of death for 25- to 44-year-olds.



Pain Management Approaches Highlighted

IDPH sponsored the Approaches to Pain Management Symposium at the Ron Pearson Conference Center in West Des Moines on October 30, 2018. With nearly 100 people in attendance, the symposium provided an overview of a range of non-pharmacological approaches to addressing pain, in addition or as an alternative to the use of opioids. Objectives of the symposium included the following:

1. The ability to identify seven approaches to pain management;
2. The ability to identify local resources in the state of Iowa for accessing alternative forms of pain management; and
3. The ability to identify the evidence and research that support the various approaches discussed.

Presentation topics included a national perspective on approaches to pain management, chiropractic care, mindfulness-based stress reduction, physical therapy, acupuncture and alternative medicine, yoga therapy, nutrition and physical activity, and interventional orthopedics.

The Approaches to Pain Management Symposium is a part of IDPH's opioid initiatives that supports prevention, treatment and recovery from substance use disorders. For more information about IDPH's opioid efforts, please contact Jennifer Robertson-Hill at jennifer.robertson-hill@idph.iowa.gov.

Matt Bravard, PT Director of Rehabilitation Therapies, Broadlawns Medical Center

Dr. Jennifer Sharpe Potter, PhD, MPH Associate Dean of Research, UT Health, San Antonio

Dr. Ole Olson, DC Optimal Health Sports & Family Chiropractic

Anne Cundiff, RD, LD, FAND and Andrew Salgado, CPT Registered Dietitian Nutritionist and Certified Personal Trainer, HyVee

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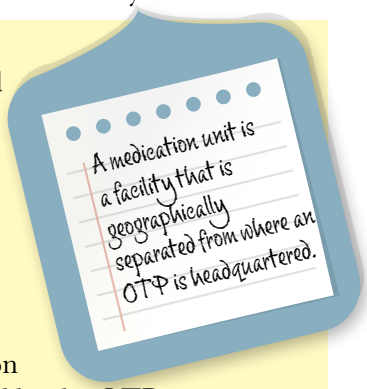
Take Note

Medication Units in Iowa

Once considered "resource poor" when it came to statewide availability of methadone as a form of medication-assisted treatment (MAT), Iowa has seen an increase in the number of locations offering this service through an alternative approach. Typically, a certified Opioid Treatment Program (OTP) can only provide methadone as a form of MAT. However, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), a certified OTP may establish what is known as a Medication Unit to administer or dispense medication therapy. As defined by SAMHSA:

A medication unit is a facility that is geographically separated from where an OTP is head-quartered. Medication-assisted treatment (MAT) professionals can administer medications, collect samples, and conduct drug testing and analysis from medication units. However, admission services and addiction counseling cannot be conducted by the OTP.



Medication units allow MAT patients to establish a routine and maintain a productive life. This can be especially helpful for people living in rural areas where the nearest OTP site may be 70 miles away or more. Even in major cities, medication units may be needed to help cut down on long wait times at busy OTP sites.

As an OTP with a long history of serving central Iowa, UCS Healthcare is working to expand MAT services to underserved areas of the state through establishment of medication units. These units are co-located within qualified licensed substance use disorder treatment programs that formally partner with UCS. According to Misty Angrick, Medical Services Director at UCS, "By co-locating services, rural communities will have an effective treatment process which combines the therapy services of the partnering agency with the medications provided by the medication unit. In this process we increase the access to life changing medications as well as individualized therapy, and promote recovery in those with an opioid use disorder."

Currently, UCS has medication units in Waterloo, Burlington and Ottumwa, in addition to two new OTP sites in Ankeny and Knoxville. Future medication unit locations include Carroll, Atlantic, Fort Dodge, Cedar Rapids, Osceola, Decorah, Ames and Clinton. For more information contact kevin.gabbert@idph.iowa.gov.

Register Now!

The Center for Addiction Recovery Training (CART) will offer three trainings for Recovery Peer Coaching in the Des Moines area! The curriculum was developed by the Connecticut Community for Addiction Recovery (CCAR), a national leader in recovery coaching.

- **February 18-22, 2019: Recovery Coaching Academy**
- **February 25-27, 2019: Recovery Coaching Academy for Young Adults**
  (two additional days of online coursework are also required for completion of this training)
- **February 28 - March 2, 2019: Ethical Considerations for Recovery Coaches**

Additional time will be added to each day for those interested in Training of Trainers.

Registration and more details about this training can be found here https://register.extension.iastate.edu/coachingacademy
Contact Cara.Weis@idph.iowa.gov with questions.

CART CCAR IDPH Iowa Department of Public Health

Sponsored by the Iowa Department of Public Health, Division of Behavioral Health

December 2018

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Transitional Age Youth Videos Now Available

The Iowa Department of Public Health, Criminal and Juvenile Justice Planning Division, and Achieving Maximum Potential, partnered to develop six videos addressing transitional age youth topics. Using a "Got Resources?" theme, the videos may serve as a valuable tool for youth, families and youth serving agencies. The videos provide guidance from a youth perspective for ways to access resources including: substance use and mental health (Got Help?), housing (Got Housing?), medication (Got Meds?), finances (Got Money?), support (Got People?) and education (Got School?). The videos and other resources can be found at a recently developed web page, Iowa Youth Resources. Contact cara.weis@idph.iowa.gov with questions.

National Survey on Drug Use & Health Coming

The National Survey on Drug Use and Health (NSDUH), sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), will again be conducted in Iowa during calendar year 2019. The NSDUH is an annual scientific, national survey. Each year the NSDUH provides up-to-date information on alcohol, tobacco, and drug use, mental health and other health-related issues across the country and Iowa. Randomly selected households will be sent a letter explaining the study and informing them that an interviewer will soon be visiting their household to ask if an eligible resident will voluntarily participate in the approximately one hour in-home interview. If selected, those completing the interview will receive a $30 cash incentive. State level estimates of substance use can be found at www.samhsa.gov/data/population-data-nsduh/.

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Take Note

Quarterly PMP Prescriber Activity Reports Coming Soon

The Iowa Prescription Monitoring Program (PMP) is vital to reducing and preventing prescription drug abuse and drug overdose. As a central depository of information on controlled substance prescribing and dispensing, a major role of the PMP is to make data available to authorized users. Beginning in late January 2019, as mandated by Iowa Code 124.554(3), Iowa PMP information will be disseminated to authorized users via Prescriber Activity Reports (PARs). The PAR provides a health care provider with a prescribing history summary, including their ranking compared to the median of prescribers within the same specialty. The PAR also includes a summary of each health care professional's prescribing history. The PAR is a tool that provides an opportunity for self-examination of a health care professional's practice as it relates to their prescribing of controlled substances. The intent of providing a health care professional with relevant and accurate information is to constructively assist his/her controlled substance prescribing practices. Informing health care professionals of their prescribing behaviors relative to their peers may provide insightful, concise data that may assist with treatment protocols. The PAR is not intended to be an indication that the prescriber or his/her patients have done something wrong and will be for the prescriber's information only.

PARs will be generated and distributed every quarter and sent only to health care professionals who have issued at least one Schedule II, III or IV controlled substance prescription during the previous six months. Each health care professional receives a PAR specific to their prescribing history. According to the Iowa Board of Pharmacy, there are nearly 18,000 registrants with authority to prescribe controlled substances in Iowa. The PAR categorizes each health care professional by specialty. The specialty group is determined using taxonomy codes maintained by the Centers for Medicare and Medicaid Services and the health care specialty selected during the process of registering for a PMP AWARxE user account.

The PAR will identify the following metrics for each prescriber:

- ✓ Opioid related patient and prescription volumes
- ✓ Top 3 medications prescribed
- ✓ Prescribing percentages based on daily Morphine Milligram Equivalents (MME) of opioid prescriptions
- ✓ Patient percentages based on opioid duration of therapy
- ✓ Prescribing volume based on total MME of selected opioids
- ✓ Anxiolytic/sedative/hypnotic prescribing
- ✓ Patient volumes exceeding multiple provider thresholds
- ✓ Patient volumes receiving dangerous combination therapy
- ✓ PMP Usage

There are nearly 18,000 registrants with authority to prescribe controlled substances in Iowa.

A Metrics Explanation document will accompany each PAR to assist prescribers to understand how to review and utilize the information. A PAR frequently asked questions (FAQ) document will be posted at pharmacy.iowa.gov/iowa-pmp-awarxe before dissemination of the first round of reports. The FAQ will be updated as more questions are received.

To register for an Iowa PMP AWARxE account visit iowa.pmpaware.net. Questions on Prescriber Activity Reports can be submitted by email to pmp@iowa.gov.

For more information about the IDPH Bureau of Substance Abuse, visit http://idph.iowa.gov/bh. For questions related to *"A Matter of Substance,"* contact editors:

- ✓ Cara Weis: cara.weis@idph.iowa.gov
- ✓ Janet Nelson: janet.nelson@idph.iowa.gov
- ✓ Lori Hancock-Muck: lori.hancock-muck@idph.iowa.gov
- ✓ Colleen Bush, graphic designer: colleen.bush@idph.iowa.gov

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July 2019
Quarterly Publication
Bureau of Substance Abuse

A Publication of the IDPH
Bureau of Substance Abuse

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Children's Mental Health Bill Signed

On May 1, 2019, Gov. Reynolds signed HF690, a bill that creates the first of its kind comprehensive Children's Mental Health System.

The legislation follows the priorities in a Strategic Plan submitted to the Governor and General Assembly by the Children's Behavioral Health System State Board and codifies the board which was established by Gov. Reynolds' Executive Order 2 in 2018. This legislation also establishes required core services for children, regional crisis stabilization, mobile response teams and 24-hour hotline access to services.

Important Note!
A more comprehensive bill for children's mental health was signed.

Strong show of support for childrens mental health bill

Substance Abuse Prevention Skills Training (SAPST)

The Iowa Department of Public Health, in collaboration with Midwest Counterdrug Training Center (MCTC), is offering the Substance Abuse Prevention Skills Training (SAPST) on October 2-3, 2019, with the second half on November 14-15, 2019.

The curriculum has the most current information available on evidence-based prevention practices with a focus on the Strategic Prevention Framework. SAPST will enable participants and agencies to gain the ability to enhance their efforts and design prevention programs that create real, long-term results. Register today to save your spot for this free training.

Governor's Conference on Substance Abuse

More than 500 people attended the 42nd Annual Governor's Conference on Substance Abuse April 16-17, 2019. With opening remarks by Governor Kim Reynolds and IDPH Director Gerd Clabaugh, the first day focused on what's "trending" in the fields of substance use disorder prevention and treatment. Day One presentations addressed brain injuries and substance use disorders, medical cannibidiol, electronic cigarettes and human trafficking. Day Two provided education on ethics in behavioral health fields and education on behavioral health medications, cultural humility, withdrawal management, special populations and problem gambling treatment. The large attendance included many programs and professions. Thank you to those who helped make this one of the most well attended and diversely represented events sponsored by the IDPH Division of Behavioral Health. We look forward to what we have planned next year!

Governor Kim Reynolds opens the conference

Claudia (not shown) and Rodrigo Garcia presented "Catch Me If You Can"

Alcohol-Involved Deaths Data Brief

IDPH recently released a data brief on alcohol-involved deaths. The number of alcohol-involved deaths has increased in Iowa from 388 in 2008 to 650 in 2017. You can find this information at: https://idph.iowa.gov/Portals/1/userfiles/133/May2019SubAbuse-BriefFinal_Alcohol%20Involved%20Deaths.pdf.

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Important Information!

A Matter of Substance

A Publication of the IDPH Bureau of Substance Abuse

IDPH Staff Attend Rx Drug Abuse and Heroin Summit in Atlanta

Staff from IDPH had the opportunity to attend the Rx Drug Abuse and Heroin Summit in Atlanta on April 22-25, 2019. For those unfamiliar with the conference, the Rx Summit is the largest national collaboration of professionals from local, state, and federal agencies, business, academia, treatment providers (including a few from Iowa), and allied communities impacted by prescription drug abuse and heroin use. Much like our own Governor's Conference on Substance Abuse, the summit includes various keynote speakers and specific topic breakout sessions. Notable speakers in past years have included President Barack Obama in 2016, Congressmen Patrick Kennedy and Newt Gingrich in 2017, and President Bill Clinton and Counselor to the President, Kellyanne Conway in 2018. This year was no exception, as President Donald Trump and First Lady Melania Trump addressed attendees.

As part of this year's summit, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) hosted two collaborative discussion meetings between federal partners and state alcohol and drug agencies.

Kevin Gabbert, Opioid Initiatives Director at IDPH (see picture), was part of the group that met with Dr. Nora Volkow, Director, National Institute on Drug Abuse (NIDA), and Dr. Debra Houry, Director, Center for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control. The meetings focused on topics such as increased access to medication-assisted treatment, the role of states regarding implementation of evidence-based practices, and how federal partners can help state prevention, treatment and recovery efforts.

The Rx Summit is the largest national collaboration of professionals from all aspects.

NIDA CDC meeting

Important Note!

All Iowa Youth Survey reports will be available July 7, 2019.

2018 IYS County Reports Available

2018 Iowa Youth Survey (IYS) county reports are available and may be accessed at http://www.iowayouthsurvey.iowa.gov/counties/county_2018.html. The county reports are based on the county of residence as reported by the students completing the survey. Additional reports, including by judicial district, area education agency and Integrated Provider Network (IPN) regions, will be posted to the IYS website by July 7, 2019. All substate reports are laid out similar to the state report and the data are useful for planning purposes, resource allocation, and to inform community discussions. If you have any questions about the Iowa Youth Survey, please e-mail IDPH at iowayouthsurvey@idph.iowa.gov.

New! Your Life Iowa Teen and Parent Campaign

In June 2019, IDPH sponsored a campaign to encourage teens and parents to contact or visit YourLifeIowa.org for help and support with drugs, alcohol, gambling and suicide. For this campaign, two new landing pages (Help for Teens and Help for Parents) were developed. Other promotional items included social posts on Facebook,Twitter and the IDPH homepage, and two YouTube videos (Teen Video and Parent Video). Posters will be available soon. Contact cara.weis@idph.iowa.gov with questions or to request posters.

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Take Note

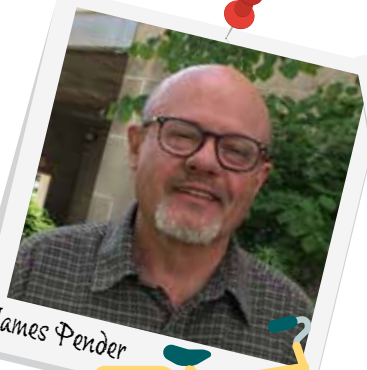
Staff Spotlight

Jim Pender joined IDPH in February 2019 as a community health consultant in the Office of Disability, Injury and Violence Prevention. Jim is the grant manager for the Administration on Community Living (ACL) Traumatic Brain Injury State Partnership Grant. Jim is responsible for supporting the program manager in the many IDPH initiatives that aim to prevent a brain injury or support the 27,000-plus Iowans who experience a brain injury every year.

Prior to IDPH, Jim spent 19 years at the Department of Human Services Bureau of Targeted Case Management as a social worker. While at DHS, Jim specialized in policy analysis and provided technical assistance to field staff serving Iowans on several home and community based waivers.

Jim graduated with his MSW from the University of Iowa, and is an avid Iowa Hawkeye and Minnesota Vikings fan. Jim and his wife are adoptive parents of five special needs children and reside in Windsor Heights.

In his spare time, Jim likes to ride his bike, work in his yard, and support his wife in mentoring refugees.

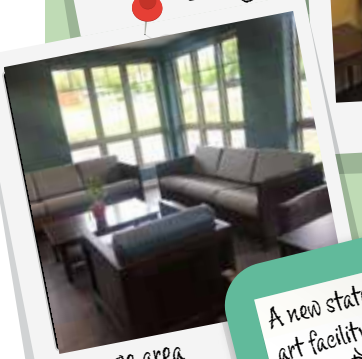

James Pender

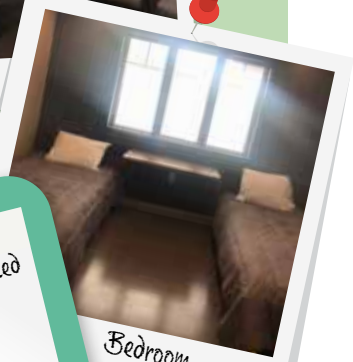
Community & Family Resources Grand Opening

On May 17, 2019, Community & Family Resources held the grand opening of its new state-of-the-art facility providing treatment services for mental health, substance use and gambling disorders. The facility has separate men's and women's residential wings, as well as an outpatient office, detoxification unit, adolescent residential unit, and a Medication Assisted Treatment clinic with UCS Healthcare.

Dining area

Lobby


Lounge area


Bedroom

A new state-of-the-art facility was opened in Fort Dodge for mental health, substance use and gambling disorders.

Prevention Media Campaigns

The Iowa Department of Public Health developed two prevention focused media campaigns to help raise awareness of the unintended risks of youth marijuana and adult methamphetamine use. During the month of June, these campaigns were promoted statewide using television commercials, radio spots, and online banner ads throughout Iowa. Materials from both campaigns are available for local implementation and these resources are available on the YourLifeIowa prevention media campaign site.

For more information about these resources or to view these campaigns, please visit Your Life Iowa at yourlifeiowa.org.

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Your Life Iowa–Mental Health Expansion

IDPH and DHS have been collaborating over the last six months in response to HF 2456, a behavioral health bill enacted at the conclusion of the 2018 Iowa Legislative Session. Efforts have focused on creation of a single statewide 24-hour crisis hotline, and information and resources for children with mental health disorders and their caregivers. IDPH received an appropriation for SFY 2020 to fund the children's mental health component for Your Life Iowa (YLI).

After evaluating options, Your Life Iowa was chosen to become the home of the single statewide resource (crisis hotline, online chat, text) for adult and children's mental health concerns. With a planned "soft launch" on July 1, 2019, YLI will be ready to take statewide crisis calls, text and online chats while transition plans are developed with each Mental Health and Disability Services (MHDS) region to transfer their crisis line services to YLI. In addition, DHS is busy working with IDPH to develop and launch new mental health content on YourLifeIowa.org. For more information on this project, contact eric.preuss@idph.iowa.gov.

Narcan Kits Sent Out

In early June, IDPH Bureau of Substance Abuse staff packed over 2,400 Narcan kits as part of the State Opioid Response grant efforts. The Narcan kits were distributed to law enforcement in Iowa that volunteered to receive the kits. Contact kevin.gabbert@idph.iowa.gov with questions.

Assembled kits ready to ship

IDPH Bureau of Substance Abuse staff

Licensure Standards FAQ

Please submit any licensure questions to SUD.PG.License@idph.iowa.gov.

We'd like to offer OWI evaluations at our licensed substance use disorder treatment program. Would our license allow for this?

Yes, licensed substance use disorder treatment programs can provide evaluations to those persons who are charged with operating a motor vehicle while intoxicated (OWI). Programs providing OWI evaluations are required to have additional policies and procedures to address the following standards:

641–155.25(1) A program conducting OWI evaluations on persons convicted of operating a motor vehicle while intoxicated (OWI) pursuant to Iowa Code section 321J.2 and on persons whose driver's license or nonresident operating privileges are revoked under Iowa Code chapter 321J shall do so in accordance with 641–Chapter 157.

641–155.25(2) The program shall make its fees public and shall inform potential patients of the fee at the time the assessment or evaluation is scheduled.

Programs shall charge no more than $125 for the cost of the screening and evaluation. The individual or the individual's insurance provider shall be responsible for the costs of the screening and evaluation. Programs shall seek reimbursement of the cost of screening, evaluation and treatment from an individual's insurance company or from Medicaid for individuals who are eligible or enrolled in Medicaid.

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A Matter of Substance

A Publication of the IDPH Bureau of Substance Abuse

Please Read!

5-2-1-0 Healthy Choices Count!

When working with youth at risk of, or having a substance use disorder, it is important to provide a whole health approach which includes reducing poor health habits while developing healthy habits. The 5-2-1-0 Healthy Choices Count! initiative is a nationally recognized evidence-based program that provides an easy way to engage and teach youth, parents, organizations and others about ways to increase healthy habits. The initiative promotes eating healthy foods, limiting screen time, participating in physical activity and limiting sugary beverages.

Resources and tools for 5-2-1-0 can be found on the Healthiest State Initiative website and includes information for a variety of settings, including parents and caregivers, and health care settings. Some of the resources specific to healthcare settings includes the Healthy Habit Toolkit, Motivational Interviewing Guide, Health Habits Talking Points, age-specific questionnaires and much more.

If you are a youth-serving provider, consider ways to incorporate the 5-2-1-0 initiative with youth and parents you serve. There are many ways providers can make connections between substance use and healthy habits; for example, talk to youth and parents about:

- ✓ Building healthy coping mechanisms
- ✓ Planning family interactions like eating a healthy meal together or participating in fun recreational activities
- ✓ How sleep and physical activity affects mood

For more information, contact erin.olson@idph.iowa.gov or cara.weis@idph.iowa.gov.

5 2 1 0
Healthy Choices Count!

What is "Resilience?"

Celebrating our Family Tree, an Exercise in Cognitive Resilience (the way we think about adversity)

Did you know that your genes are influenced by the lived experiences of your ancestors? Did you also know that our brains have the ability to heal?

Linking the study of epigenetics (nature) and neuroscience (nurture) on a basic level supports social science to recognize the behavioral and social implications of historical trauma. This expands the context for identifying protective factors we can celebrate/focus on from a public health approach within ourselves and our families.

Since adverse experiences alter the way we see the world, they also change how we internalize messages about ourselves and our families. We are continually shaping our perspective and pruning neural pathways in our brain.

Focusing on how we think about adversity can modify our cognitive response and even strengthen our coping capacity. How often do you respond to thoughts with compassion? Are you harsh with yourself when your behavior has negative health outcomes?

For instance, think about a behavior common across your family that is a symptom/outcome of adversity. Below is an example:

- ✓ **ADVERSITY: Food insecurity/poverty**
- ✓ **OUTCOME: Anxiety**
- ✓ **COPING/BEHAVIORAL RESPONSE: Eating disorder**

In this example we identified a behavior that is counter-productive to our overall health. While the behavior helps sooth mental health short-term, there are long-term implications. Begin with awareness and think broadly about this experience from a place of compassion. Was this coping strategy modeled within your family of origin? What other behavioral responses has your family practiced that were aligned with overall health? What ways do you celebrate your family's resilience to adversity?

An aspect of resilience is about normalizing our experiences as a collective society and being able to say, "I am doing the best I can today understanding that I am holding the lived experiences of my family, my community, and my ancestors."

This is the sixth in a continuing series of commentaries about resilience, and how resiliency might support overall health and wellbeing.

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Youth Grant Ends but Efforts Continue

The State Youth Treatment Implementation (SYT-I aka Families in Focus) grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) recently ended. SYT-I was awarded to IDPH from 2015-2019 and built upon accomplishments of the previous youth grant from 2012-2015. With both grants combined, IDPH funded substance use disorder (SUD) treatment providers, and key partners, have collaborated for nearly seven years!

The efforts include implementation of youth-specific state infrastructure development and evidence-based treatment and recovery support services for SUD or co-occurring mental health disorders. The funded SUD treatment providers were Heartland Family Service (Council Bluffs), Prelude Behavioral Services (Des Moines), Prairie Ridge Integrated Behavioral Healthcare (Mason City) and YSS (Ames).

Key accomplishments include:

- ✓ Implementation of two evidence-based practices and recovery support services for youth ages 12-25.
- ✓ Increase in number of clinicians trained to serve youth using evidence-based practices.
- ✓ Establishment of an Adolescent Steering Committee and subcommittees to have a forum for youth services and infrastructure (systems, workforce, financial, and linkages).
- ✓ Development of a media campaign targeting youth ages 12-25 to publicize Iowa's 24/7 helpline.
- ✓ Development of YourLifeIowa.Support text message service. This service will provide supportive, motivational messages related to drugs, alcohol, gambling and suicide. More information about this exciting new service will be coming soon!
- ✓ Expansion of Recovery Peer Coaching by training Recovery Peer Coaches and trainers and dissemination of a Recovery Peer Coaching fact sheet.
- ✓ Other webinars and trainings on various topics specific to youth and SUD such as evidence-based screening, assessment and treatment, adolescent development, and collegiate recovery.
- ✓ At a local level, the funded treatment providers in the grant report increased collaborative efforts with referral sources, that clinicians became experts in the field, and the overall ability to provide improved services to youth with SUD.

IDPH intends to continue efforts focused on youth substance use disorder treatment and recovery support services. Efforts may include continuation of the youth-specific committee and expansion of evidence-based practices and recovery support services when possible. For more information about SYT-I, visit the website or contact cara.weis@idph.iowa.gov.

IDPH TV Spot Receives Silver Award

The Iowa Department of Public Health's Overdose TV spot created for the Strategic Prevention Framework for Prescription Drugs grant received the Silver Award from the 36th Annual Healthcare Advertising Awards by the Healthcare Marketing Report.

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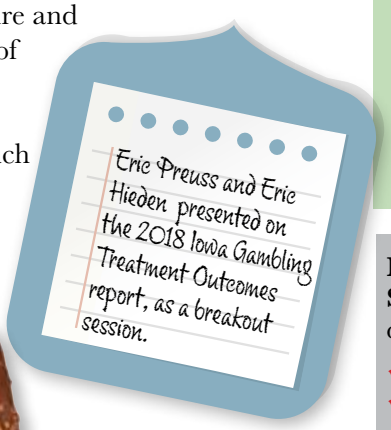
17th International Conference on Gambling and Risk Taking

The International Conference on Gambling & Risk Taking was held May 27-30, 2019, at Caesars Palace Hotel & Casino in, Las Vegas. Over 500 people (researchers, students, professors, industry representatives, professional gamblers, regulatory and government officials, and treatment/prevention providers) from 30+ countries attended, encouraging new ways of thinking, driving innovation and change, and providing interdisciplinary access to the world's brightest gambling minds.

Iowa Gambling Treatment Program Manager Eric Preuss and Eric Hieden of UNI-CSBR presented on the 2018 Iowa Gambling Treatment Outcomes report as part of the Treatment Programs: Outcomes breakout session. The presentation focused on a multi-level analysis of Iowa's gambling treatment programs, including utilization of services (including recovery support services and e-therapy), access, number of sessions in the first 30 days (engagement), length of stay (continuation), and the reduction of gambling and disordered gambling criteria. The key conclusion of the presentation was that longer length of stays in treatment was the only factor that could be linked to reduction in disordered gambling criteria.

The first conference in 1974 was organized by Dr. Bill Eadington — an innovative thinker and founding figure in gambling research. Held every three years — the conference has maintained its status as the largest, oldest, and most prestigious conference of its kind by always looking towards the future and remaining on the cutting-edge of gambling insights. The 2019 conference included over 280 presentations covering topics such as economics, public policy, mathematics, social sciences, psychology, prevention and treatment.



Training Opportunities

The Iowa Department of Public Health has these training opportunities:

Webinar: Community Check Box Tools for Prevention

✓ July 12, 2019 from 10:00–11:00 a.m.
Access at this link: https://zoom.us/j/508824737.

Webinar: Quality Improvement - Is the Juice Worth the Squeeze? Why you should be interested in quality improvement.

✓ July 12, 2019 1:00–2:30 p.m. Register here.

Prevention Conference

✓ September 4, 2019
MCTC - Camp Dodge, Johnston. Registration coming soon - watch for it!

Webinar: Substance Abuse Prevention Ethics for Recertification

✓ October 10, 2019 from 9:00 a.m.–12:00 noon
To register and to learn more information, click here.

Substance Abuse Prevention Skills Training

✓ October 2-3 and
✓ November 14-15, 2019
Registration is free but mileage, meals and lodging are to be covered by each participant. In order for the training to count towards certification, participants will need to attend all four days within this course. To register and to learn more information, click here.

Substance Abuse Prevention Ethics for Certification

✓ November 13, 2019
Registration is free but mileage, meals and lodging are to be covered by each participant. In order for the training to count towards certification, participants will need to attend the full day of training. To register and to learn more information, click here.

For more information about the IDPH Bureau of Substance Abuse, visit http://idph.iowa.gov/bh. For questions related to *"A Matter of Substance,"* contact editors:

✓ Cara Weis: cara.weis@idph.iowa.gov
✓ Janet Nelson: janet.nelson@idph.iowa.gov
✓ Lori Hancock-Muck: lori.hancock-muck@idph.iowa.gov
✓ Colleen Bush, graphic designer: colleen.bush@idph.iowa.gov

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A Matter of Substance

A Publication of the IDPH
Bureau of Substance Abuse

October 2018
Quarterly Publication
Bureau of Substance Abuse

IDPH • Lucas State Office Building • 321 East 12th St., Des Moines, IA 50319 • www.idph.iowa.gov

Don't Run! Call 911!

In an effort to help save lives, IDPH has created flyers, Facebook ads, banner ads, postcard and pocket-sized ads, and educational videos for the general public and law enforcement to promote the Good Samaritan Law passed this last legislative session. The Good Samaritan Law encourages those who witness a drug overdose to stay and call 911, rather than running out of fear of prosecution. Generally, overdose witnesses, defined as "overdose reporters" under the law, will not be arrested, charged or prosecuted for possession of a controlled substance, delivery of a controlled substance or possession of drug paraphernalia, if the person makes a good faith effort to seek medical assistance for an overdose patient.

The Good Samaritan Law protects overdose reporters if they:

- ✓ are the first person to seek medical assistance for the overdose victim
- ✓ provide their contact information to emergency personnel
- ✓ remain on the scene until assistance is provided
- ✓ cooperate with emergency personnel

The Good Samaritan Law does not protect against arrest for open warrants and other crimes.

Details regarding Iowa's Good Samaritan Law can be found under Iowa Code Section 124.418.

Promotional materials on Iowa's Good Samaritan Law are available here. Printed versions of the materials will be available in the coming weeks and can be ordered by contacting Julie.Jones@idph.iowa.gov.

Generally, overdose reporters will not be charged if they seek medical assistance for an overdose patient.

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Staff Spotlight

Catherine J. Lillehoj, Ph.D.

Cathy Lillehoj joined the IDPH Bureau of Substance Abuse as a Management Analyst in July 2018. In her current role, Cathy is working with the Iowa Board of Pharmacy (BOP) on the Prescription Monitoring Program (PMP). In this capacity, Cathy assists the BOP in expanding access to data and reporting to support in-depth surveillance; helps design targeted training and education; and helps develop information to provide to funders. In addition, she will monitor the recently funded CDC opioid-related grant titled Iowa Public Health Emergency Response.

Prior to joining the Bureau of Substance Abuse, Cathy served as a Research Analyst in the IDPH Bureau of Nutrition and Physical Activity for over 11 years. In that position, she was the evaluator for the Iowa Nutrition Network (INN), a SNAP-Ed health promotion program that serves low-income populations, as well as the CDC-funded Health Promotion Chronic Disease Control Partnership project. During her tenure with the INN, she served as co-author of *Nutritional Risk among Congregate Meal Site Participants: Benefits of a Snap-Ed Program in the Journal of Nutrition in Gerontology and Geriatrics*. Publication of this article will help establish the evidence base for Fresh Conversations, a nutrition education program for older adults.

Prior to her work in public health, Cathy was at the Partnerships in Prevention Science Institute at Iowa State University. While at Iowa State, she was a member of the PROSPER team, a research initiative linking university-based prevention with the Cooperative Extension system and the public school system.

Cathy received her graduate education at Teachers College, Columbia University, and the City University of New York. She began her career at Cornell University Medical College serving as a research scientist evaluating the efficacy and effectiveness of the Life Skills Training program.

In her spare time, Cathy enjoys working with her husband, Carl, on restoring a historic home in Sherman Hill. After many years of restoration, the work still isn't complete but continues to present many challenging and time-consuming projects.

Teen Vaping an "Epidemic," Warns the FDA

The following article by Matthew Perrone/ Associated Press discusses the unprecedented rise in teen vaping which has led to a recent warning from the Food and Drug Administration. https://www.pbs.org/newshour/nation/fda-calls-teen-vaping-an-epidemic-weighs-bans-on-flavored-e-cigarettes.

There is an unprecedented rise in teen vaping.

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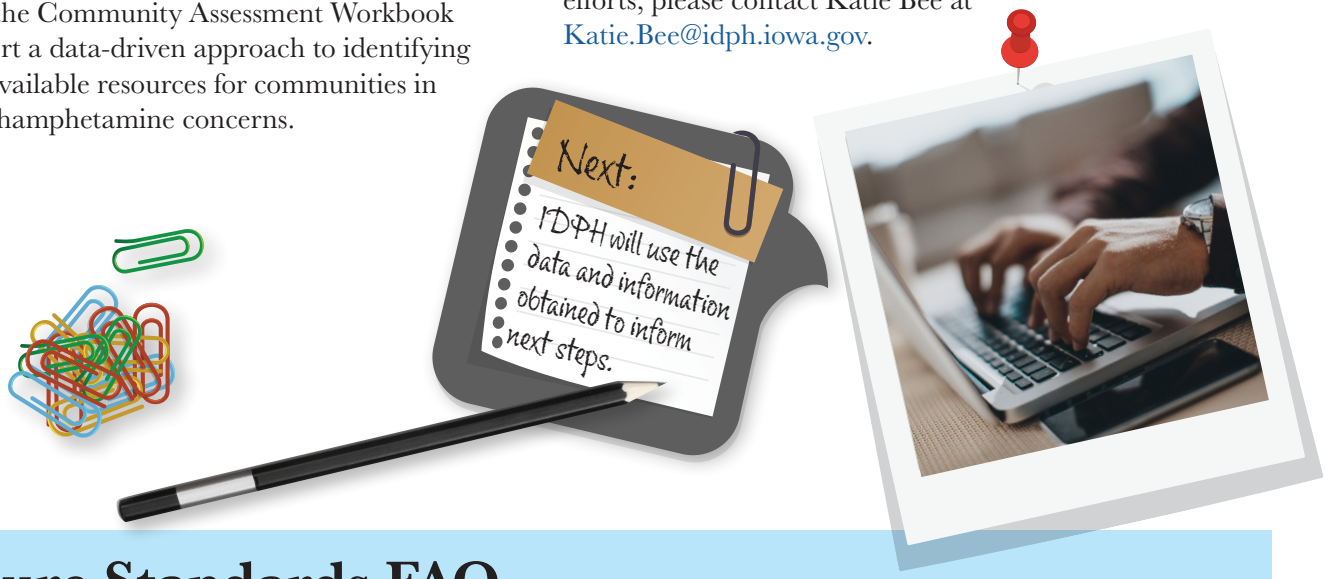
Important Information!

State Targeted Response
Taking the Lead in Understanding the Impacts of Methamphetamine in Iowa

In an effort to better understand the impact of methamphetamine in Iowa, IDPH Bureau of Substance Abuse staff worked with Iowa Opioid State Targeted Response (STR) contractors to complete Community Assessment Workbooks focused on methamphetamine in their communities. Contractors, representing all 99 Iowa counties, used the Community Assessment Workbook model to support a data-driven approach to identifying strengths and available resources for communities in addressing methamphetamine concerns.

The bureau's internal Methamphetamine Workgroup is currently reviewing Community Assessment Workbook findings. Once the review is completed, IDPH will use the data and information obtained to inform next steps.

For more information about IDPH's methamphetamine efforts, please contact Katie Bee at Katie.Bee@idph.iowa.gov.



Licensure Standards FAQ

Please submit any licensure questions to SUD.PG.License@idph.iowa.gov.

Our program is pursuing CARF accreditation. Will this allow us to be deemed status and what does deemed status allow?

Once a licensed program becomes accredited by a recognized national accreditation body, the program may apply for a deemed status license at the time of reapplication. The accreditation shall be for the same licensed program services for which the licensee is applying. The following national accreditation bodies are recognized for deemed status purposes:

a. The Joint Commission
b. The Council on Accreditation of Rehabilitation Facilities (CARF)
c. The Council on Accreditation of Children and Family Services (COA)
d. The American Osteopathic Association (AOA)

As part of the licensure reapplication process, a deemed status application shall include the following:

- The entire accreditation body survey or inspection report
- Certificate of accreditation
- Accreditation conditions
- Corrective action requirements and plans
- Deemed status application

A deemed status licensed program shall meet all requirements of 641-Chapter 155 Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Programs. The department may inspect deemed status programs if programs are not meeting requirements of Iowa Administrative Code 641-Chapter 155 or if the department receives a complaint against the program.

For more information on applying for licensure as a deemed status program, please contact Lori Hanock-Muck at Lori.Hancock-Muck@idph.iowa.gov.

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Please Read!

Iowa Youth Survey

The 2018 Iowa Youth Survey (IYS) is being administered in schools across the state, now through November 9. More than 255 school districts and non-public schools have registered to participate. County and school reports from these data will be available in March and April 2019. Please consider reaching out to your local schools to encourage them to administer the IYS and to identify ways in which you can work together to use IYS results.

These 2018 Iowa Youth Survey Talking Points were created by IDPH to aid in those discussions. Stressing the value of IYS data to community partners is important, as is talking about how community partners can support schools in ensuring students can succeed. Additional information about the 2018 IYS may be found on the 2018 IYS Announcements page. Send questions about the IYS to iowayouthsurvey@idph.iowa.gov.

Children's System State Board

The Children's Board is authorized by Governor Reynold's Executive Order 2 signed on April 23, 2018. The Children's System State Board (Children's Board) is the single point of responsibility in the development and implementation 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. Additional information, meeting schedules and listing of listening posts can be found at https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board. Further questions or comments may be directed to Michele Tilotta at Michele.Tilotta@idph.iowa.gov.

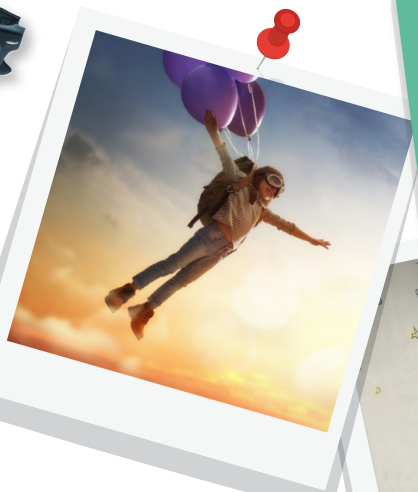
What is "resilience?"

Adverse Childhood Experiences, or ACEs, are traumatic or stressful events a person experiences before the age of 18. These experiences can include abuse, neglect, witnessing violence or growing up with family members experiencing mental health or substance use disorders. According to SAMHSA, "ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse."

One protective factor that can promote **resilience** (**the ability to thrive, adapt and cope despite experiencing adversity**) is having a supportive, responsive relationship with a caring adult.

More information about Iowans and ACEs and opportunities to respond to and prevent ACEs can be found in the Central Iowa ACEs 360 Coalition report, "Beyond ACEs: Building Hope and Resiliency in Iowa." https://www.iowaaces360.org/iowa-aces-research.html.

This is the third in a continuing series of commentaries about resilience, and how resiliency might support overall health and wellbeing.



Resilience is the ability to thrive, adapt and cope despite experiencing adversity.

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Take Note:

AmeriCorps 2018-2019 Program Year

Starting September 1, 2018, the IDPH AmeriCorps Substance Abuse Prevention Program will support up to 30 AmeriCorps members (15 full-time and 15 half-time) across the state to provide education to Iowa community members on substance abuse, particularly opioid and prescription drug abuse; build capacity of organizations to broaden understanding of opioid and prescription drug abuse; and form coalitions and partnerships to address the growing opioid crisis.

By the end of the first program year, AmeriCorps members will increase community education, knowledge and awareness on prescription drug and opioid abuse, and enhance program capacity and sustainability of substance abuse prevention programs, mentoring programs and recovery community organizations. In addition, AmeriCorps members will recruit 300 volunteers who will be engaged in 1100 hours of service.

The Bureau of Substance Abuse is excited to introduce the new **AmeriCorps Substance Abuse Prevention Program Coordinator – Helen Bisioulis**. Helen will be responsible for enhancing member experience and training throughout the AmeriCorps member service year.

For more information about how to host a member at your agency, please look under the Open Funding Opportunities in IowaGrants or reach out to Amanda McCurley at Amanda.Mccurley@idph.iowa.gov.

Important Note!

30 AmeriCorps members will be working in the state to educate on substance abuse.

Loan Repayment Program

The National Health Service Corps Loan Repayment program is now available for substance use disorder counselors and substance abuse programs in Health Professional Shortage Areas. More information can be found on the National Health Service Corps website at https://nhsc.hrsa.gov/nhsc-sites/index.html.

Changes for Iowa Consortium for Substance Abuse Research and Evaluation

The Iowa Consortium for Substance Abuse Research and Evaluation became part of the University of Iowa School of Social Work's National Resource Center for Family Centered Practice (NRC) on October 1. The NRC is a research, training and evaluation center with expertise that aligns with the Consortium's focus on evaluating substance use disorder prevention and intervention.

Dr. Miriam Landsman, associate professor in the School of Social Work and executive director of the NRC, and Dr. Brad Richardson, NRC Research Director and adjunct associate professor in the School of Social Work, are co-directing the Consortium. Landsman and Richardson have successfully carried out many research and evaluation projects, and are nationally known experts in research and evaluation. The Consortium's move coincides with the planned retirement of previous director Dr. Steve Arndt. During this transition year, Dr. Arndt is serving in a consulting capacity to the Consortium, while continuing his work as a biostatistician in the Department of Psychiatry.

The vision for the Consortium integrates understanding of substance use disorders and service systems, and improving the lives of Iowans. Drs. Landsman and Richardson look forward to working with state and local partners, and welcome inquiries at Miriam-Landsman@uiowa.edu and Brad-Richardson@uiowa.edu.

Iowa Consortium for Substance Abuse Research and Evaluation, 2662 Crosspark Rd. Coralville IA 52241-5000. http://iconsortium.subst-abuse.uiowa.edu/Staff.html.

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Please Read!

National Prevention Network Conference

The 31st Annual National Prevention Network (NPN) Conference was held August 28-30 in Boston, MA, and Iowa was represented by more than 25 attendees (pictured here)! The NPN Conference is the largest such event for prevention professionals in the world. The conference provides a forum for like-minded preventionists to gather and learn about the latest research, evidence-based practices and promising evaluation results in the substance misuse prevention field.

Iowa NPN conference attendees

Follow-up to 2018 Legislative Session

Here is a listing of ongoing work that may be of interest, related to actions taken during the 2018 Iowa General Assembly Legislative Session. All board and workgroup meetings are open to the public.

Substance Use Disorder Provider Reimbursement Workgroup

In Senate File 2418, the 2018 Legislature directed IDPH, in collaboration with DHS, to engage a stakeholder workgroup to ***"review reimbursement provisions to substance use disorder services providers,"*** including but not limited to, *adequacy of reimbursement, equity of reimbursement compared to reimbursement of similar services, and access to substance use disorder treatment services,* including whether the designated number of community mental health centers is sufficient. A report of workgroup findings and recommendations is due to the governor and Legislature by December 15. Contact Deanna Triplett at Deanna.Triplett@idph.iowa.gov with questions or comments or go to http://idph.iowa.gov/substance-abuse for more information.

Children's System State Board

The Children's Board is responsible for development and implementation of the Children's Mental Health System. Authorized by Governor Reynold's Executive Order 2, signed in April, the Children's Board, co-chaired by DHS Director Jerry Foxhoven and Department of Education Director Ryan Wise, has been meeting to draft a strategic plan. Director Gerd Clabaugh represents IDPH on the board, and Michele Tilotta, Bureau of Substance Abuse, has participated in related activities. ***Iowa Area Education Agencies are hosting regional listening posts in early October*** on behalf of the board. For more information, go to https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board.

Commitment Process Review Workgroup

House File 2456 directed DHS to convene a stakeholder workgroup to review the commitment process under *Iowa Code Chapters 125 (substance-related, currently under the authority of IDPH) and 229 (mental health, under the authority of DHS)*, and make recommendations for improvements in the process and amendments to law to increase efficiencies and more appropriately utilize the array of mental health and disability services available based on an individual's needs. The workgroup includes IDPH, judicial branch, Iowa Hospital Association, Iowa Medical Society, NAMI, Iowa State Sheriffs' and Deputies' Association, and Iowa Behavioral Health Association. The workgroup report with recommendations is due December 31. For more information, go to https://dhs.iowa.gov/mhds/community-integration. At that same link, you'll also find information on DHS' continuing work related to Complex Service Needs, including the Tertiary Care Psychiatric Hospitals Workgroup and administrative rules for Access Centers and Intensive Residential Service Homes.

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Important Information!

Training Schedules:

Substance Abuse Prevention Skills Training Dates (SAPST): November 7-8. Register at this link: https://counterdrugtraining.com/default.aspx?menu-itemid=220&menugroup=fy17&AspxAutoDetectCookie-Support=1.

November 2: Identifying and Utilizing Data Sources. Register here: https://zoom.us/webinar/register/WN_cP-ChIQkLRF-AO2E35t3WHg.

November 5, 2018, 1:30 - 3:00 p.m. ET. SAMHSA's Service Members, Veterans, and their Families Technical Assistance Center Presents: Asking This Critical Question Can Make a Difference: *"Have you or a loved one ever served in the military?"* Register here: https://goto.webcasts.com/starthere.jsp?ei=1211602&tp_key=0d605fca5c.

December 7: Trauma Informed Care/ Adverse Childhood Experiences (ACEs). Register here: https://zoom.us/webinar/register/WN_K7gwmM3sQnOoFg0zVARUag. For more information, please contact Clare Jones at Clare.Jones@idph.iowa.gov.

Youth and Recovery:

An Opportunity to Explore Prevention, Treatment and Recovery Strategies for Youth Ages 12-25

On September 27, 2018, 100 people attended IDPH's conference titled Youth and Recovery: An Opportunity to Explore Prevention, Treatment and Recovery Strategies for Youth Ages 12-25 in Ames. This one-day event informed attendees in various topics impacting youth and young adults. One highlight of the event was a very informative presentation by **Dr. Douglas Gentile on The Science of Gaming Disorders**. Dr. Gentile shared his research about gaming disorders and suggested use of a screening tool to identify symptoms of gaming disorders as part of a comprehensive approach to treatment.

Other topics included college-based recovery efforts in Iowa (**University of Iowa and Iowa State University/ YSS**), tobacco cessation in substance use disorder treatment (**American Lung Association**), recovery coaching (**Connecticut Community for Addiction Recovery**), and suicide/mental health awareness (**Frank King**, TheMentalHealthComedian.com).

For more information about the presenters please click here.

IDPH staff booth

Speakers at Youth & Recovery Conference

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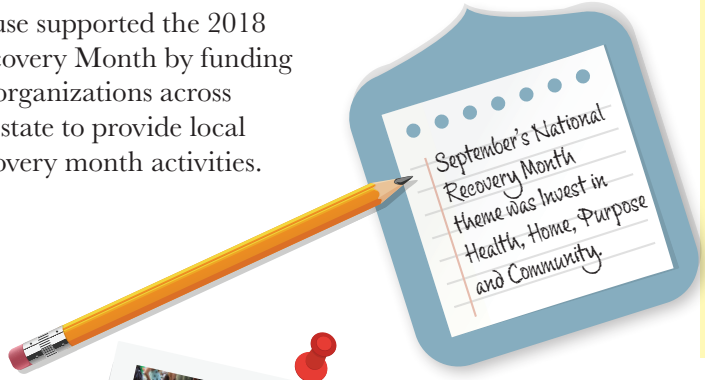
Local Recovery Month Activities

Every September, SAMHSA – the Substance Abuse and Mental Health Services Administration in the U.S Department of Health and Human Services – sponsors **National Recovery Month** to educate Americans about substance use treatment and mental health services. This observance promotes the belief that *behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental health and substance use disorders.*

Organizing an event for Recovery Month is an ideal way to celebrate the achievements of the recovery community, laud the contributions of treatment and service providers, and promote the message that recovery, in a broad range of forms, is possible. This year's National Recovery Month theme was *"Join the Voices for Recovery: Invest in Health, Home, Purpose, and Community."*

On September 28, 2018, Governor Kim Reynolds proclaimed September 2018 as Substance Abuse Recovery Month in Iowa. A public proclamation signing was not scheduled. IDPH's Bureau of Substance Abuse supported the 2018 Recovery Month by funding 13 organizations across the state to provide local recovery month activities.



These activities included:

- ✓ Substance-free movie night, showing "Anonymous People" ***(Alcohol and Drug Dependency Services of Southeast Iowa, Burlington)***
- ✓ Celebration of Recovery with recovery-themed painting class ***(Area Substance Abuse Council, Cedar Rapids)***
- ✓ 6th Annual Recovery & Wellness 5K run/walk ***(Community and Family Resources, Fort Dodge)***
- ✓ Substance use, Addiction and Recovery symposium ***(Compass Pointe, Spencer)***
- ✓ Recovery Rally ***(First Resources Corporation and SIEDA Behavioral Health, Ottumwa)***
- ✓ 8th Annual Hands Across the Bridge ***(Heartland Family Service, Council Bluffs)***
- ✓ Family Recovery Fun Night ***(Jackson Recovery Centers, Sioux City)***
- ✓ Art of Recovery Walk ***(Prelude Behavioral Services, Iowa City)***
- ✓ Pathways to Recovery Bike Ride ***(Substance Abuse Treatment Unit of Central Iowa, Marshalltown)***
- ✓ Recovery Month Carnival ***(Seasons Center for Behavioral Health, Spencer)***
- ✓ An Evening of Hope and Healing ***(YSS, Ames)***
- ✓ Family Fun Day ***(Zion Recovery Services, Atlantic)***

"Family Recovery Fun Night"

Jackson Recovery Centers

"Family Recovery Fun Night"

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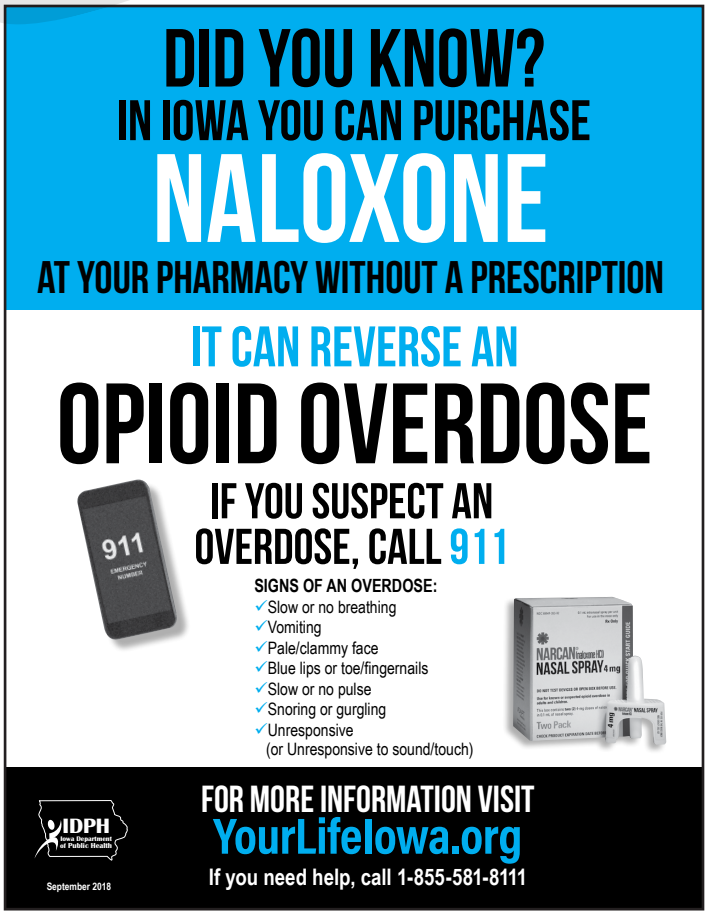

The Bureau of Substance Abuse developed a handout to educate the public on naloxone access. For more information, please visit YourLifeIowa.org. To order 8 ½" x 11" posters, contact Julie.Jones@idph.iowa.gov.

Substance Abuse Prevention and Treatment Block Grant Application and Reports

IDPH's Substance Abuse Prevention and Treatment Block Grant (SABG) application and report and Synar report will be posted for comment at http://idph.iowa.gov/block-grant.

You can also send comments directly to Michele Tilotta at Michele.Tilotta@idph.iowa.gov. ***Note:*** *Please include SABG Comments in the email subject line.*

ADDS and UCS Provide Opioid Use Disorder Treatment in SE Iowa

As Iowa treatment providers prepared to do their part in combating the nationwide opioid epidemic, many faced a significant lack of effective local resources. **Alcohol and Drug Dependency Services of Southeast Iowa** (**ADDS**) has joined other programs to implement evidence-based medication-assisted opioid use disorder treatment by partnering with Des Moines-based **United Community Services** (**UCS**). This unique partnership approach is organized around medication units. "Once UCS offered this opportunity to Iowa providers, we were very interested. In my mind, this equated directly to saving lives," said Nicolas Foss, associate director for treatment services at ADDS.

UCS partnered with ADDS to open a medication unit mini-clinic in Burlington on June 25, 2018. The medication unit was constructed within ADDS' existing Burlington location, allowing a physician and registered nurse to provide medication-assisted treatment (MAT) to ADDS clients. Available medications include methadone, buprenorphine and naltrexone. Individuals must be referred to UCS by ADDS, and must also receive counseling services from ADDS. The ADDS/UCS partnership is currently serving 21 individuals.

Contact ADDS at (**319**)-**753-6567** or go to www.addsiowa.org for information about ADDS services. The UCS Burlington location can be reached at (**319**)-**237-7210** or learn more at https://www.ucsonline.org/who-we-are.

For more information about the IDPH Bureau of Substance Abuse, visit http://idph.iowa.gov/bh. For questions related to *"A Matter of Substance,"* contact the editors:

- ✓ Cara Weis: Cara.Weis@idph.iowa.gov
- ✓ Janet Nelson: Janet.Nelson@idph.iowa.gov
- ✓ Lori Hancock-Muck: Lori.Hancock-Muck@idph.iowa.gov
- ✓ Colleen Bush, graphic designer: Colleen.Bush@idph.iowa.gov

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Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update for Wednesday, January 9, 2019

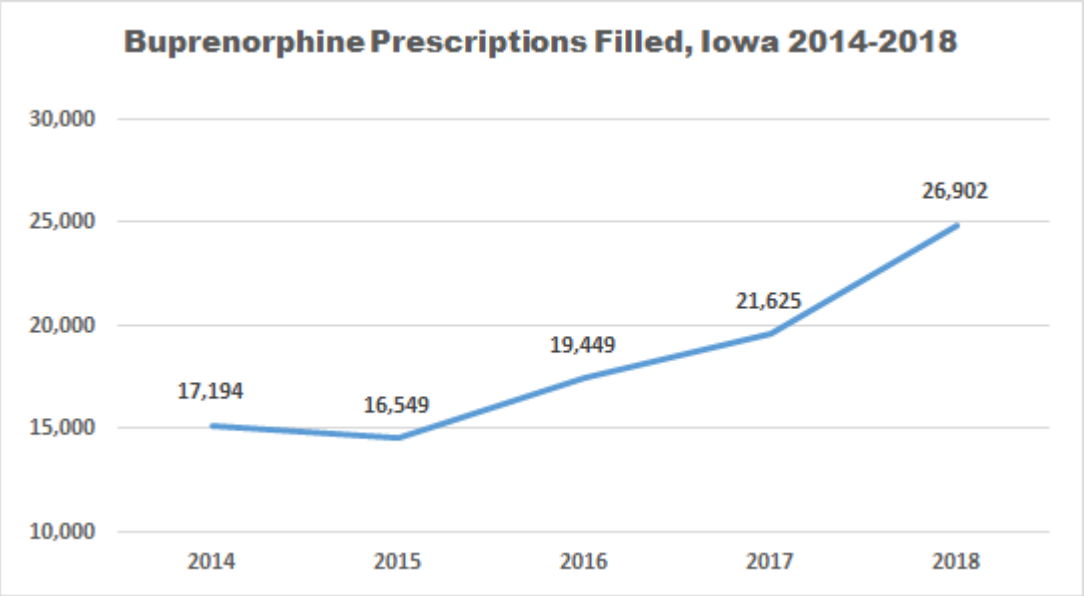
The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

In this issue:

- **Iowa News**
- **Department News**
- **Upcoming Trainings**

Iowa News

Buprenorphine Prescriptions Dispensed in Iowa Increase



Iowa Prescription Monitoring Program 2018

Data from Iowa's Prescription Monitoring Program indicate that since 2015, Buprenorphine (an FDA-approved form of medication-assisted treatment for an opioid use disorder) prescriptions dispensed have risen by more than 61 percent. This increase coincides with the rise in the number of Buprenorphine Waivered prescribers, which increased from 31 in 2015, to 115 in 2018, and to the expansion in service availability through new Opioid Treatment Programs and Medication Units across the state.

Hy-Vee Announces New Restrictions on Opioid Prescriptions

Hy-Vee no longer will allow its pharmacies to refill prescriptions of certain controlled substances more than 72 hours early without a doctor's authorization. The policy, effective January 1, 2019, pertains to refills for Schedule III and Schedule IV drugs or subsequent fills of a Schedule II prescription. "Our goal is to have as few unused opioids in the marketplace as possible," Hy-Vee Director of Public Relations Christina Gayman said.

To read the entire article, please click on the following link: The Gazette

Department News

AmeriCorps Update

IDPH currently has half-time, quarter-time, and minimal time member slots available in the IDPH AmeriCorps Substance Abuse Prevention Program. These positions are perfect for summer projects. Members can serve any amount of time from May 1, 2019, through November 30, 2019. As part of AmeriCorps, members can:

- Help with mentor and volunteer recruitment
- Enhance, improve, or commence program sustainability and growth
- Train volunteers and mentors and assist with curriculum development
- Enhance and improve parent and family engagement
- Assist and take lead on special projects and initiatives
- Plan, organize and facilitate community based education on substance abuse prevention
- Help establish recovery community organizations and other prevention programs throughout the state
- Create, enhance, and improve volunteer recruitment programs, policies and procedures

This program year, AmeriCorps members will be focusing their efforts on the opioid and prescription drug misuse epidemic within the state of Iowa. The IDPH AmeriCorps Substance Abuse Prevention Program will focus on theory of change around education, community engagement and capacity building. These three components together address the needs outlined and impact the long-term goal of reducing substance use, and addressing opioid and prescription drug abuse.

To learn more about AmeriCorps positions, please click on the following link: AmeriCorps. For more information on funding opportunities, please go to IowaGrants.Gov. The next application deadline is March 14, 2019.

Upcoming Trainings:

- **Second Annual Chicago Summit for Clinical Excellence on the Opioid Crisis**
  March 4-5, 2019.
  For more information, please click on the following link: Chicago.

- **NatCon19**
  March 25-27, 2019.
  For more information, please click on the following link: Nashville.

- **Governor's Conference on Substance Abuse**
  April 16-17, 2019
  For more information, please click on the following link: Des Moines.

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  For more information, please click on the following link: Atlanta.

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update for Wednesday, January 23, 2019

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In this issue:

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- **Opioid News**
- **Upcoming Trainings**

Department News

POMW Project Announces Upcoming Training Series

The Iowa Prevention of Opioid Misuse in Women (POMW) Project will be hosting a regional training series, focusing on opioid use in Iowa and strategies that support the decrease of opioid misuse in women. Specific training objectives include: 1) Identify individual and community impacts of opioid misuse; 2) Identify an evidence based strategy to screen and address substance misuse; 3) Identify appropriate opioid overdose recognition and response strategies.

The dates and locations for the trainings are:

- February 7 – **Mason City**
- February 11 – **Osceola**
- March 7 – **Council Bluffs**
- April 4 – **Waterloo**
- May 7 – **Burlington**
- May 16 – **Cedar Rapids**
- June 3 – **Sioux City**

The same content will be presented at each training. To register, please click on the following link: POMW. Cost for the training is $15.

Opioid News

Newest Opioid Training for Providers

The Centers for Disease Control and Prevention (CDC) has released the final three modules in the Applying CDC's Guideline for Prescribing Opioids interactive online training series for healthcare providers. The latest modules focus on, Opioid Use and Pregnancy, Motivational Interviewing, and Collaborative Patient-Provider Relationship in Opioid Clinical Decision Making. In these self-paced modules, providers will learn about opioid considerations in pregnancy, patient-centered communication practices and approaches to shared opioid decision-making. Each module includes clinical scenarios, knowledge feedback prompts, and a resource library to help enhance learning.

To learn more about the training series, please click on the following link: CDC

Opioid Prescribing Rates Higher in Nonmetropolitan Areas

According to a recent report in the CDC Morbidity and Mortality Weekly Report (MMWR), opioid prescribing rates in nonmetropolitan areas are higher when compared to areas that are more metropolitan. Using de-identified data from the Athenahealth electronic health record (EHR) system, opioid prescribing rates among 31,422 primary care providers in the United States were analyzed to evaluate trends from January 2014 to March 2017. This analysis assessed how prescribing practices varied among six urban-rural classification categories of counties, before and after the March 2016 release of CDC's *Guideline for Prescribing Opioids for Chronic Pain* (Guideline). Results showed:

- Higher rates of opioid-related deaths have been recorded in nonmetropolitan (rural) areas
- In 2017, 14 rural counties were among the 15 counties with the highest opioid prescribing rates.
- Patients in noncore (the most rural) counties had an 87% higher chance of receiving an opioid prescription compared with persons in large central metropolitan counties during the study period.

Across all six county groups, the odds of receiving an opioid prescription decreased significantly after March 2016.

To read the entire article, please click on the following link: CDC/MMWR

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Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
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Department News

IDPH Releases New Report: *Iowa's Opioid Crisis – An Update*

The Iowa Department of Public Health (IDPH) has collaborated with state, local and private partners to address opioid use problems in Iowa. Statewide, Iowans have implemented coordinated, multi-sector efforts that have led to increased awareness, access to resources and improvements in care. Initial data show these efforts are making positive impacts in Iowa communities to prevent and reduce the negative consequences of opioid-related problems, but work still needs done.

The following summary was prepared in order to provide a comprehensive update on Iowa-specific measures, IDPH efforts and an overview of funding the state has received to address opioid misuse. To read the report, please click on the following link: IDPH

Opioid News

ONDCP Releases National Drug Control Strategy

Last week the White House Office of National Drug Control Policy (ONDCP) released the 2019 National Drug Control Strategy, which establishes the President's priorities for addressing the challenge of drug trafficking and use. "Our number one goal is to save American lives, and this comprehensive plan reaffirms President Trump's commitment to addressing the opioid crisis aggressively and in partnership with our partners across the nation," said recently sworn-in ONDCP Director Jim Carroll.

To read the entire report, please click on the following link: ONDCP

NHSC Loan Repayment Application Deadline Approaching

To combat the nation's opioid crisis, the Health Resources and Services Administration (HRSA) launched the National Health Service Corps (NHSC) Substance Use Disorder Workforce Loan Repayment Program (SUD Workforce LRP). The program supports the recruitment and retention of health professionals needed in underserved areas to expand access to SUD treatment and prevent overdose deaths. The deadline for applications is February 21, 2019.

To learn more about qualifications and eligibility, please click on the following link: NHSC

Iowa News

Iowa Healthcare Collaborative Opioid Resources

To address opioid-related issues, the Iowa Healthcare Collaborative (IHC) has created several resources for Iowans. These include:

- The Pain Management Toolkit: Iowa's Guide to the Opioid Stewardship provides information on how to start and stop opioids, how to have difficult conversations, the use of benzodiazepines, and tools to utilize when a patient is taking opioids.
- The IHC Comfort Scale, which can be used in place of or in conjunction with the pain scale.
- The IHC Comfort Menu, which can be used to allow the patient to identify what will make them more comfortable.
- The IHC Comfort Treatment Plan, which can be used when a patient is discharged or started on a new opioid medication.

These resources can be found on the IHC website at https://www.ihconline.org/community-resources/ihc-comfort-resources/.

In addition to these resources, IHC has also created resource flyers for all 99 counties in Iowa, which include information on Medication Assisted Treatment locations, pharmacies that provide naloxone without a prescription and medication disposal locations in each county. These resource guides can be found on the IHC website at https://www.ihconline.org/community-resources/opioid-flyers/.

IHC is always looking for feedback on these resources and success stories when these resources are used. If you would like to share your feedback or story, please contact Shawna Law at laws@ihconline.org.

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Iowa Department of Public Health
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Department News

Two POMW Trainings Rescheduled

The Prevention of Opioid Misuse in Women regional training series has rescheduled two of the "Identifying Opioid Misuse" trainings due to weather conditions on the days of the trainings. The Mason City training was rescheduled to April 30 and the Osceola training was rescheduled to May 20. An additional training in Ames is being scheduled as well.

For more information on upcoming trainings, please click on the following link: POMW

Iowa News

Current Opioid Related Legislation

Several bills have been introduced this legislative session that involve opioid-related efforts. Some of these include:

House File 208
An act relating to substance use disorder prevention and treatment, including creating an excise tax on the gross receipts of certain controlled substances sold at wholesale and an opioid abuse prevention and treatment fund, making appropriations and providing penalties.

Senate File 122
An act relating to a prohibition against prior authorization for medication-assisted treatment (MAT) under the Medicaid program. The bill requires the Iowa Department of Human Services (DHS) adopt administrative rules to prohibit MAT prior authorization under either Medicaid fee-for-service or managed care administration.

Senate File 178
An act relating to the criminal offense of manufacturing, delivering, selling or possessing drug paraphernalia by exempting hypodermic needles or syringes delivered, sold or possessed through an approved needle exchange program.

Senate File 125
Similar to Senate File 178, this act not only proposes a revision to Iowa's drug paraphernalia law, but would also allow the Iowa Department of Public Health to create and administer a statewide needle exchange program, also known as a Syringe Services Program (SSP).

Opioid News

Study Examines Prevention of Prescription Opioid Misuse and Projected Overdose Deaths in the United States

Using data from the National Survey on Drug Use and Health (NSDUH), the Centers for Disease Control and Prevention (CDC) and published data, researchers developed a mathematical model to simulate the opioid overdose crisis in the United States from 2002 to 2025. The model was calibrated to reproduce observed trends of opioid misuse and opioid overdose deaths up to year 2015, and then used it to project outcomes from 2016 to 2025. Finally, researchers evaluated the effects of lowering the incidence of nonmedical opioid analgesic use on the projected number of opioid overdose deaths.

The results indicate that under current conditions, the opioid overdose crisis is likely to substantially worsen and that interventions such as prescription drug monitoring programs are unlikely to lead to major decreases in the number of deaths from opioid overdose in the near future. Given these findings, researchers suggest that policymakers will need to take a stronger and multipronged approach, such as improving access to treatment, expanding harm-reduction interventions and lowering exposure to illicit opioids, to curb the trajectory of the opioid overdose epidemic in the United States.

To read the entire study, please click on the following link: JAMA

California May Make Dent in Low Rates of Naloxone Co-Prescribing

A California alliance of health providers and consumers is trying to raise the public's awareness of a new state law designed to broaden access to the opioid overdose reversal drug naloxone.

The California Chronic Care Coalition, which conducts efforts to help improve the health of Californians with chronic conditions, believes the state's requirement that naloxone be offered at the same time as an opioid is prescribed will lead to significant strides in preventing fatal overdose. “And since many caregivers are family members, it is important to make them aware that this potentially life-saving emergency treatment will be more readily available when opioids are prescribed,” coalition president and CEO Liz Helms said in a news release last month.

Modern Healthcare reported in December that the U.S. Department of Health and Human Services (HHS) is urging more clinicians to prescribe naloxone. According to federal officials, less than 1 percent of patients who are prescribed opioids and are considered to be at high risk of an overdose are receiving the overdose reversal drug.

To read the entire article, please click on the following link: Addiction Professional

Upcoming Trainings:

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Department News

AmeriCorps Update

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- Help with mentor and volunteer recruitment
- Enhance, improve or commence program sustainability and growth
- Train volunteers and mentors, and assist with curriculum development
- Enhance and improve parent and family engagement
- Assist and take lead on special projects and initiatives
- Plan, organize and facilitate community based education on substance abuse prevention
- Help establish recovery community organizations and other prevention programs throughout the state
- Create, enhance, improve volunteer recruitment programs, policies and procedures

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The next application deadline is March 14, 2019.

To learn more about AmeriCorps positions, please click on the following link: AmeriCorps.
For more information on funding opportunities, please go to IowaGrants.Gov.

Reminder Regarding Treatment Licensure Revisions

Licensed substance use disorder treatment programs, which include opioid treatment programs, are required to provide the division with written notification prior to making a revision to an issued license. The written request shall be submitted to the division at least 30 days prior to any change of address, executive director, clinical oversight staff, facility or licensed program services. The division will determine if the requested revision can be approved or if the change is significant enough to require the submission of an application for license renewal by the licensee.

For more information regarding written requests, please contact Lori Hancock-Muck at lori.hancock-muck@idph.iowa.gov.

IDPH Receives ASTHO Funding Opportunity

The Association of State and Territorial Health Officials (ASTHO)'s Planning for National and State Viral Hepatitis Elimination Program awarded funds to the IDPH Bureau of HIV, STD and Hepatitis for an innovative project in partnership with the Bureau of Substance Abuse. The three main components of the project include gathering feedback from populations of Iowans who are disproportionately impacted by hepatitis C virus (people who inject drugs); implementing hepatitis C testing at substance use disorder treatment facilities; and providing patient navigation services to Iowans diagnosed with hepatitis C to improve linkage to medical care and treatment.

For more information regarding this funding opportunity, please contact Joe Caldwell at joe.caldwell@idph.iowa.gov.

Iowa News

Current Opioid Related Legislation

Several bills have been introduced this legislative session that involve opioid-related efforts. Some of those that are still active include:

House File 208
An act relating to substance use disorder prevention and treatment, including creating an excise tax on the gross receipts of certain controlled substances sold at wholesale and an opioid abuse prevention and treatment fund, making appropriations and providing penalties.

House File 580
An act relating to the establishment of a needle exchange pilot program by the Iowa Department of Public Health.

House Study Bill 200
An act relating to prior authorization for medication assisted treatment under the Medicaid program.

Senate File 122
An act relating to a prohibition against prior authorization for medication-assisted treatment under the Medicaid program.

Senate File 178
An act relating to the criminal offense of manufacturing, delivering, selling or possessing drug paraphernalia by exempting hypodermic needles or syringes delivered, sold or possessed through an approved needle exchange program.

Opioid News

ASAM Opioid Addiction Treatment Guide for Patients, Families and Friends

The American Society of Addiction Medicine (ASAM) has created a patient guide that provides information on assessment, treatment overview (including treatment plans, patient participation and counseling), and all the medications available to treatment opioid use and overdose. It also provides links to find a provider and support groups for patients and families.

This guide is a useful tool for clinicians to provide to their patients and their families, along with a resource for pharmacies and patient groups looking to inform people about their options to treat the challenging disease of addiction involving opioid use.

To access the guide, please click on the following link: ASAM

Upcoming Trainings

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- **Upcoming Trainings**

Iowa News

Recovery Stakeholders Learning Community Call: March 28

The Mid-America Addiction Technology Transfer Center (ATTC) and the Missouri Recovery Network have teamed up for a monthly Recovery Stakeholders Learning Community. The purpose of the Learning Community is to allow sharing of innovative recovery program ideas, successful advocacy efforts, available federal grants and other funding opportunities, as well as enable recovery stakeholders to get to know each other. Recovery stakeholders and other interested individuals within the four states of Iowa, Kansas, Missouri and Nebraska (SAMHSA Region 7) are welcome to participate.

The focus of this month's presentation is *Recovery Community Centers*. The session will be held at 12:30 p.m. (Central Time) via Zoom. For information on registering, please click on the following link: Mid-America ATTC

Current Opioid Related Legislation

Several bills have been introduced this legislative session that involve opioid-related efforts. While some did not make it past the first funnel week, others remain. Some of those that are still active include:

House File 580 – *Companion to SF 500, which is the successor to SF 178*
An act relating to the establishment of a needle exchange pilot program by the Iowa Department of Public Health.

House Study Bill 200 – *Passed committee, successor bill number is HF 623*
An act relating to prior authorization for medication assisted treatment under the Medicaid program.

Senate File 178 – *Passed committee, successor bill number is SF 500*
An act relating to the criminal offense of manufacturing, delivering, selling or possessing drug paraphernalia by exempting hypodermic needles or syringes delivered, sold or possessed through an approved needle exchange program.

IDPH will continue to provide updates as this session continues.

Department News

POMW Training: April 4

The next Prevention of Opioid Misuse in Women (POMW) "Identifying Opioid Misuse" regional training is scheduled for April 4, 2019, in Waterloo. The purpose of this program is to expand the prevention strategies that support the decrease of opioid misuse in women. Specific objectives of the training include:

- List the individual and community impacts of opioid misuse
- Identify an evidence-based strategy to screen and address substance misuse
- Identify appropriate opioid overdose recognition and response strategies

For more information about the training, please click on the following link: POMW

Opioid News

National Personal Training Institute – Opioid Recovery Project

The National Personal Training Institute is offering an online Certified Personal Trainer (CPT) course to those affected by the opioid epidemic. The initiative offers thousands of free scholarship opportunities (approx. $1.5 million total) to recovering opioid victims around the country. According to the Institute, personal training is a great bridge for recovering addicts. It not only gives them the benefits of exercise, but it will provide a wonderful career opportunity where they can ultimately give back as well.

For more information about the scholarship program, please click on the following link: CPT

HRSA Funding Opportunities

The Health Resources and Services Administration (HRSA) is accepting applications for the following funding opportunities.

- The Opioid Workforce Expansion Program (OWEP) for Professionals is intended to build upon existing HRSA investments to enhance community-based experiential training focused on Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD) for students preparing to become behavioral health professionals. The OWEP for Paraprofessionals NOFO funds this same training for peer support specialists and other types of behavioral health-related paraprofessionals.

  To learn more about this funding opportunity, please click on the following link: OWEP

- The Rural Communities Opioid Response Program-Implementation (RCORP-Implementation) is intended to enhance service delivery for substance use disorder, including opioid use disorder. Over the course of a three-year period of performance, grant recipients will implement a set of core prevention, treatment and recovery activities that align with the Department of Health and Human Services' Five-Point Strategy to Combat the Opioid Crisis.

  To learn more about this funding opportunity, please click on the following link: RCORP

MAT in the Criminal Justice System

The Substance Abuse and Mental Health Services Administration (SAMHSA) has prepared a brief that provides guidance to state governments on increasing the availability of evidence-based medication-assisted treatment (MAT) in criminal justice (CJ) settings. By including the criminal justice system as a path to treatment, states may see an increase in access to and retention in treatment, and lower rates of overdoses, re-offending and re-incarcerations. In this brief, states are provided an overview of the issue, the challenges to incorporating MAT, key considerations for establishing MAT in CJ settings, and existing standards/guidelines.

To read the entire brief, please click on the following link: SAMHSA

Upcoming Trainings

- **Governor's Conference on Substance Abuse**
  April 16-17, 2019
  For more information, please click on the following link: Des Moines.

- **National Rx Drug Abuse and Heroin Summit**
  April 22-25, 2019.
  For more information, please click on the following link: Atlanta.

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update for Wednesday, April 3, 2019

The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

In this issue:

- **Department News**
- **Iowa News**
- **Opioid News**
- **Upcoming Trainings**

Department News

POMW Training: April 30

The next Prevention of Opioid Misuse in Women (POMW) "Identifying Opioid Misuse" regional training is scheduled for April 30, 2019, in Mason City. The purpose of this program is to expand the prevention strategies that support the decrease of opioid misuse in women. Specific objectives of the training include:

- List the individual and community impacts of opioid misuse
- Identify an evidence-based strategy to screen and address substance misuse
- Identify appropriate opioid overdose recognition and response strategies

For more information about the training, please click on the following link: POMW

State Opioid Response (SOR) Grant Supplement

The State Opioid Response (SOR) grant will receive $2.3 million additional dollars allocated through the Substance Abuse and Mental Health Services Administration (SAMHSA). Additional funds will be used to support the evidence-based practices and strategies allowed and prioritized by SAMHSA and IDPH in the effort to address the opioid crisis.

Iowa News

Current Opioid Related Legislation

As the next funnel approaches, there are still a couple of opioid-related bills that are active. These include:

- House File 580 – *Companion to SF 500, which is the successor to SF 178*
  An act relating to the establishment of a needle exchange pilot program by the Iowa Department of Public Health.

- House Study Bill 200 – *Passed committee, successor bill number is HF 623*
  An act relating to prior authorization for medication assisted treatment under the Medicaid program.

IDPH will continue to provide updates as this session continues.

Opioid News

HRSA Funding Opportunities

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- The Opioid Workforce Expansion Program (OWEP) for Professionals is intended to build upon existing HRSA investments to enhance community-based experiential training focused on Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD) for students preparing to become behavioral health professionals. The OWEP for Paraprofessionals NOFO funds this same training for peer support specialists and other types of behavioral health-related paraprofessionals. **Due: May 7, 2019.**

  To learn more about this funding opportunity, please click on the following link: OWEP

- The Rural Communities Opioid Response Program-Implementation (RCORP-Implementation) is intended to enhance service delivery for substance use disorder, including opioid use disorder. Over the course of a three-year period of performance, grant recipients will implement a set of core prevention, treatment and recovery activities that align with the Department of Health and Human Services' Five-Point Strategy to Combat the Opioid Crisis. **Due: May 6, 2019.**

  To learn more about this funding opportunity, please click on the following link: RCORP

NIH to Test Experimental Drug to Curb Opioid Cravings

A clinical trial of an experimental drug designed to treat cravings associated with opioid use disorder (OUD) has begun in the National Institutes of Health Clinical Center. The Phase I trial in healthy adults will assess the safety of the experimental compound, ANS-6637, and how it is processed in the body when given with another drug that is processed by the same liver enzyme pathway. The NIH's National Institute of Allergy and Infectious Diseases (NIAID) is helping to conduct the trial, which is funded through NIH's Helping to End Addiction Long-Term (HEAL) Initiative, a comprehensive program to accelerate research efforts to stem the public health crisis of OUD.

Opioid use causes a surge of the neurotransmitter dopamine in the brain, and habitual use 'rewires' the brain's reward system, possibly generating irresistible cravings to both opioids and associated cues, like injecting equipment or drug use partners. ANS-6637 is being developed by Amygdala Neurosciences, Inc. Pre-clinical studies in animals suggest that the compound inhibits the dopamine surge that accompanies opioid use in persons with OUD, without impacting the background levels of dopamine required for normal brain functions.

To read more about the clinical trial, please click on the following link: NIH

Upcoming Trainings

- **Governor's Conference on Substance Abuse**
  April 16-17, 2019
  For more information, please click on the following link: Des Moines.

- **National Rx Drug Abuse and Heroin Summit**
  April 22-25, 2019.
  For more information, please click on the following link: Atlanta.

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update for Wednesday, May 1, 2019

The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

In this issue:

- **Department News**
- **Opioid News**

Department News

IDPH Sponsors Opioid Trainings

The Iowa Department of Public Health (IDPH) is sponsoring three upcoming opioid trainings:

- **POMW Training: May 7 and May 16**

  The next Prevention of Opioid Misuse in Women (POMW) "Identifying Opioid Misuse" regional trainings are scheduled for May 7, 2019, in Burlington, and May 16, 2019, in Cedar Rapids. The purpose of this program is to expand the prevention strategies that support the decrease of opioid misuse in women. Specific objectives of the training include:

  - List the individual and community impacts of opioid misuse
  - Identify an evidence-based strategy to screen and address substance misuse
  - Identify appropriate opioid overdose recognition and response strategies

  For more information about the training, please click on the following link: POMW

- **Implementing the CDC Guidelines for Opioid Prescribing**

  In 2016, the Centers for Disease Control and Prevention released the CDC Guideline on Prescribing Opioids for Chronic Pain. This training will assist participants in understanding and applying the guideline. Specific objectives of the training include:

  - Determine when initiation or continuation of opioids is indicated in the treatment of chronic pain
  - Evaluate and mitigate risk related to opioid use through dose limitations, clinical reassessment, and monitoring tools like the prescription drug monitoring program and urine drug testing
  - Identify quality measures applicable to clinical practices to assess implementation of the CDC guidelines

  Participants can choose to attend the in-person event at University of Iowa Hospitals and Clinics, or they participate via live webinar. For more information about the training, please click on the following link: CDC

Opioid News

FDA Approves First Generic Naloxone Nasal Spray

The U.S. Food and Drug Administration has granted final approval of the first generic naloxone hydrochloride nasal spray (commonly known as Narcan), a life-saving medication that can stop or reverse the effects of an opioid overdose. Teva Pharmaceuticals USA, Inc. has received final FDA approval to market generic naloxone nasal spray. At this time, there is no information available regarding when the new version of the medication will be available or the cost.

To learn more about the recent approval, please click on the following link: FDA

HRSA Funding Opportunities

The Health Resources and Services Administration (HRSA) is accepting applications for the following funding opportunities:

- The Opioid Workforce Expansion Program (OWEP) for Professionals is intended to build upon existing HRSA investments to enhance community-based experiential training focused on Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD) for students preparing to become behavioral health professionals. The OWEP for Paraprofessionals NOFO funds this same training for peer support specialists and other types of behavioral health-related paraprofessionals. **Due: May 7, 2019.**

  To learn more about this funding opportunity, please click on the following link: OWEP

- The Rural Communities Opioid Response Program-Implementation (RCORP-Implementation) is intended to enhance service delivery for substance use disorder, including opioid use disorder. Over the course of a three-year period of performance, grant recipients will implement a set of core prevention, treatment and recovery activities that align with the Department of Health and Human Services' Five-Point Strategy to Combat the Opioid Crisis. **Due: May 6, 2019.**

  To learn more about this funding opportunity, please click on the following link: RCORP

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update for Wednesday, May 15, 2019

The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

In this issue:

- **Department News**
- **Opioid News**
- **Iowa News**
- **Upcoming Trainings**

Department News

Naloxone for Law Enforcement Initiative

In an attempt to further reduce the number of opioid involved deaths in Iowa, IDPH sponsored an initiative to equip every interested law enforcement officer in the state with one (1) free naloxone (Narcan nasal) kit. Quite often law enforcement personnel are the first to a scene when a suspected overdose has occurred. Having the ability to administer naloxone without delay could mean the difference between life and death.

As a result of this initiative, *over 2,300 kits were requested by more than 140 law enforcement agencies* in Iowa. The kits have been ordered and once received by IDPH, will be shipped to the various agencies across the state. IDPH would like to thank the Iowa State Sheriffs' and Deputies' Association (ISSDA) and the Iowa Police Chiefs' Association (IPCA) for their help with this effort.

Opioid News

National Health Service Corps

Each year, HRSA's Bureau of Health Workforce accepts applications from eligible health care facilities throughout the United States and its territories to become National Health Service Corps (NHSC)-approved sites. As a reminder, the 2019 application is currently open and will close on May 30 at 11:59 p.m. ET.

Organizations are encouraged to apply for approval during this current cycle because this is the last opportunity ahead of the Fiscal Year 2020 NHSC Loan Repayment Program cycles. If you are not already an NHSC-approved site, review your eligibility requirements to be considered an NHSC-approved site before the May 30 deadline.

New facility types were recently added, which include: Opioid Treatment Programs (OTPs), Office Based Opioid Treatment (OBOTs) and Non-Opioid Substance Use Disorder Sites. The NHSC Rural Community Loan Repayment Program and the NHSC Substance Use Disorder (SUD) Workforce Loan Repayment Program are available to new and current staff as retention tools.

To learn more about the National Health Service Corps, please click on the following link: NHSC

ONDCP Releases Report on the President's Commission on Combatting Drug Addiction and the Opioid Crisis

The White House Office of National Drug Control Policy (ONDCP) released a report on the President's Commission on Combating Drug Addiction and the Opioid Crisis.

"From day one, our mission has been the same – to save more of our family members, friends, and neighbors dying from drug overdoses. Over the past year, the Trump Administration has made record investments and brought together the entire federal government to tackle America's addiction crisis. The President's Commission helped shape and inform the strategy we are implementing, and we have already begun to see significant progress because of these efforts," ONDCP Director James Carroll said.

The report outlines the progress the Trump Administration has made to curb addiction, and tackle drug demand and the opioid crisis through prevention, interdiction and treatment. To read the entire report, please click on the following link: ONDCP

Iowa News

DEA Brings in Record Number of Unused Pills during Drug Take Back Day

Americans nationwide did their part to drop off a record number of unused, unwanted or expired prescription medications during the DEA's 15th National Prescription Drug Take Back Day, at close to 6,000 sites across the country. Together with a record-setting amount of local, state and federal partners, DEA collected and destroyed close to one million pounds (nearly 475 tons) of potentially dangerous expired, unused and unwanted prescription drugs, making it the most successful event in DEA history. *With 135 collection sites in Iowa, the state collected 11,680 pounds of prescription medications.*

For more information on National Take Back Day results, please click on the following link: DEA

Upcoming Trainings

Implementing the CDC Guidelines for Opioid Prescribing: May 21

In 2016, the Centers for Disease Control and Prevention released the CDC Guidelines on Prescribing Opioids for Chronic Pain. The target audience of this webinar is doctors. This training will assist participants in understanding and applying the guideline. Specific objectives of the training include:

- Determine when initiation or continuation of opioids is indicated in the treatment of chronic pain
- Evaluate and mitigate risk related to opioid use through dose limitations, clinical reassessment, and monitoring tools like the prescription drug monitoring program and urine drug testing
- Identify quality measures applicable to clinical practices to assess implementation of the CDC guidelines

Participants can choose to attend the in-person event at University of Iowa Hospitals and Clinics, or they participate via live webinar. For more information about the training, please click on the following link: CDC

Training of Trainers: Opioid Overdose Education and Naloxone: May 22 or 23

As part of the State Opioid Response grant, IDPH is pleased to offer a free “training of trainers” on how to recognize and respond to an opioid overdose. The training will include an overview of an opioid use disorder; opioid overdose recognition and response; how to properly administer naloxone and manage overdose situations; and how to deliver overdose and naloxone education to others. Upon training completion, individuals will be able to train others in their community on how to recognize and respond to an opioid overdose.

- May 22, 2019 in Waterloo – The Isle Casino and Hotel
- May 23, 2019 in Council Bluffs – Hilton Garden Inn

For more information about the training, please click on the following link: IDPH

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update for Wednesday, May 29, 2019

The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

In this issue:

- **Department News**
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- **Upcoming Trainings**

Department News

POMW Trainings:

The Iowa Department of Public Health (IDPH) has scheduled three "Identifying Opioid Misuse" regional trainings. Upcoming dates and locations include:

- June 3: Sioux City
- June 10: Council Bluffs
- July 18: Ames

As part of the Prevention of Opioid Misuse in Women (POMW) project, the purpose of this program is to expand the prevention strategies that support the decrease of opioid misuse in women. Specific objectives of the training include:

- List the individual and community impacts of opioid misuse
- Identify an evidence-based strategy to screen and address substance misuse
- Identify appropriate opioid overdose recognition and response strategies

For more information about the June trainings, please click on the following link: June
For more information about the July training, please click on the following link: July

Opioid News

An Opioid Prescribing Interactive Online Training Series for Providers

An interactive online training series that supports providers in practicing safer and more effective opioid prescribing for chronic pain in primary care settings is now available! This series currently includes 11 modules that feature recommendations from the *CDC Guideline for Prescribing Opioids for Chronic Pain*. Providers can move through each module at their own pace while learning about important factors to consider when starting, continuing or stopping opioids. Each module offers free continuing education and includes clinical scenarios and tools, and a resource library to enhance learning.

To view the entire training series, please click on the following link: CDC

Upcoming Trainings

AATOD Conference: October 19-23, 2019 in Orlando, Florida

The 2019 American Association for the Treatment of Opioid Dependence, Inc. (AATOD) Conference will be held October 19-23, 2019, at Disney's Coronado Springs Resort in Orlando. The 2019 conference theme, "Out of the Shadows: Managing the Opioid Epidemic through the Continuum of Care" highlights the issues and challenges of medication assisted treatment in the context of the current opioid use/abuse epidemic.

The intent of the conference is to educate and promote acceptance and integration of MAT options by patients, families, clinicians, the medical system, judicial systems, government, policy makers, social service administrations and the general public. The conference works to disseminate innovative, evidence-based initiatives and treatment techniques to better serve patients and providers, improve program development and administration, promote integration across the continuum of care, and enhance patient outcomes to assist communities in developing an effective response to this crisis.

For more information on the conference, please click on the following link: AATOD

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update: August 2019

The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

In this issue:

- **Department News**
- **Opioid News**
- **Upcoming Trainings**

Department News

State Targeted Response (STR) Grant Coming to an End

Although Iowa is still a current recipient of the State Opioid Response (SOR) grant, the predecessor to this funding opportunity, known as the State Targeted Response (STR) grant, is ending. This SAMHSA-funded initiative has helped Iowa to increase prevention, treatment and recovery services for individuals with an opioid use disorder, and to help develop more opioid-informed communities. Through these funds, IDPH was able to support several initiatives, which included:

- Helping communities develop opioid-specific needs assessments and strategic plans
- Training over 8,500 Iowans on naloxone administration
- Expanding availability of medication assisted treatment through Medication Units
- Providing treatment and recovery support services to over 500 Iowans
- Supporting PMP enhancements through the Board of Pharmacy

As Iowa continues with the SOR grant, many of these activities will continue to be supported, as well as new initiatives. For more information on the State Opioid Response grant, please contact Monica Wilke-Brown at monica.wilke-brown@idph.iowa.gov.

Opioid News

New Jersey Authorizes Paramedics to Administer Buprenorphine

In a potential paradigm shift for addiction medicine, New Jersey's health commissioner authorized paramedics to administer the drug buprenorphine to patients almost immediately after reviving them from an opioid overdose.

Paramedics would offer patients the drug, often referred to by the brand name Suboxone, after their overdose had been reversed using the opioid antidote naloxone. The first-in-the-nation model has a two-fold purpose, health officials said: beyond treating the withdrawal symptoms that can result from a naloxone revival, administering buprenorphine on scene could serve as an immediate transition to longer-term treatment.

The bold program is without precedent in the U.S., but serves as a testament to many states' increasingly aggressive and innovative efforts to reduce drug overdose deaths. And, while the announcement came as a surprise to many addiction experts, most applauded the effort.

To learn more about this initiative, please click on the following link: STAT News

Secretary Azar Statement on 2018 Provisional Drug Overdose Death Data

Last month, the Centers for Disease Control and Prevention's National Center for Health Statistics released provisional counts of overdose deaths in the United States that showed a decline of 5.1% between 2017 and 2018. Health and Human Services Secretary Alex Azar issued the following statement:

"The latest provisional data on overdose deaths show that America's united efforts to curb opioid use disorder and addiction are working. Lives are being saved, and we're beginning to win the fight against this crisis." Secretary Azar went on to say, "While the declining trend of overdose deaths is an encouraging sign, by no means have we declared victory against the epidemic or addiction in general. This crisis developed over two decades and it will not be solved overnight."

To learn more about the provisional data released, please click on the following link: CDC

New Funding Opportunity to Support Women Affected by the Opioid Crisis

The U.S. Department of Health and Human Services – Office on Women's Health recently announced a new grant program to help women affected by the opioid crisis re-enter the workforce. The Re-Employment, Support, and Training for the Opioid Related Epidemic (RESTORE) grant will award $2.5 million to organizations that assist in providing coordinated, employment-focused services to women.

Applications are due August 23, 2019. For more information on this funding opportunity, please click on the following link: RESTORE

Upcoming Trainings

AATOD Conference: October 19-23, 2019, in Orlando, Florida

The 2019 American Association for the Treatment of Opioid Dependence, Inc. (AATOD) Conference will be held October 19-23, 2019, at Disney's Coronado Springs Resort in Orlando. The 2019 conference theme, "Out of the Shadows: Managing the Opioid Epidemic through the Continuum of Care," highlights the issues and challenges of medication assisted-treatment in the context of the current opioid use/abuse epidemic.

The intent of the conference is to educate and promote acceptance and integration of MAT options by patients, families, clinicians, the medical system, judicial systems, government, policy makers, social service administrations and the public. The conference works to disseminate innovative, evidence-based initiatives and treatment techniques to better serve patients and providers, improve program development and administration, promote integration across the continuum of care, and enhance patient outcomes to assist communities in developing an effective response to this crisis.

For more information on the conference, please click on the following link: AATOD

Iowa Department of Public Health
Division of Behavioral Health/Bureau of Substance Abuse
Opioid Update: September 2019

The Iowa Department of Public Health (IDPH) offers the Opioid Update to share information about opioid use and Iowa's efforts to address the national opioid epidemic. Please feel free to submit topics to Julie Jones at julie.jones@idph.iowa.gov.

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Department News

IDPH Receives 3-Year CDC Grant to Address Opioid Overdose

IDPH was recently awarded the Overdose Data to Action grant from the CDC. This competitively procured funding opportunity was the result of a collaborative approach that involved the IDPH Bureaus of Substance Abuse; HIV, STD and Hepatitis; and Health Statistics, as well as the Iowa Board of Pharmacy, State Office of the Medical Examiner, University of Iowa Injury Prevention Research Center and the Iowa Hospital Association.

The 3-year grant focuses on the complex and changing nature of the opioid overdose epidemic and highlights the need for an interdisciplinary, comprehensive and cohesive public health approach. These funds will support the state in obtaining high quality, more comprehensive, and timelier data on overdose morbidity and mortality, and use those data to inform prevention and response efforts. Iowa will receive $2.6 million per year of the grant.

For more information on the grant, please contact Julie Hibben at julie.hibben@idph.iowa.gov.

Opioid News

Still Not Enough Naloxone Where It's Most Needed

Despite a huge increase in naloxone prescribing in recent years, CDC researchers report in a published *Vital Signs* study that far too little naloxone is being dispensed in many areas of the country that need it the most.

According to the study, too few doctors are prescribing naloxone to patients receiving high-dose opioids or opioids plus benzodiazepines, or to those with a substance use disorder as recommended by *CDC's Guideline for Prescribing Opioids for Chronic Pain*. Nearly 9 million more naloxone prescriptions could have been dispensed in 2018 if every patient with a high-dose opioid prescription were offered naloxone.

Department of Health and Human Services Secretary Alex Azar said, "Giving people a chance to survive an opioid overdose and safely enter recovery is one of the five key pillars of our HHS strategy for ending the overdose epidemic." Azar went on to say that in light of the report, "there is much more all of us need to do to save lives."

To read the entire article, please click on the following link: CDC

Iowa News

Join the MAT ECHO…what?

The Extension for Community Healthcare Outcomes (ECHO) is a movement to de-monopolize knowledge and amplify local capacity to provide best practice care for underserved people all over the world. The Medication Assisted Treatment (MAT) ECHO is an interactive web-based program that provides essential guidelines and steps to implement and integrate a successful MAT program into an outpatient primary care setting. The MAT ECHO program aims to support healthcare teams to improve access for patients with opioid use disorder.

MAT ECHO sessions occur monthly on the second Friday via Zoom. These sessions are open at no charge, as they are supported by opioid grant funds. If you are interested in participating, please email ECHO@iowapca.org with the following information:

- Name
- Title
- Organization Name
- Email

To be clear, this is not the buprenorphine training needed to become a waivered prescriber. It is intended for those who have their waiver and are ready to start, or recently started providing services.

Trainings

CDC Guideline for Prescribing Opioids Trainings

Recently, IDPH and the Opioid Response Network (ORN) hosted four continuing education webinars on the CDC Guideline for Prescribing Opioids for Chronic Pain. Each training was designed specifically for a different healthcare provider population (nurses, dentists, pharmacists and physicians/physician assistants). In the event providers were unable to participate on the webinar, the presentations and materials can be found by clicking the following link: IDPH/ORN.

AATOD Conference: October 19-23, 2019, in Orlando, Florida

The 2019 American Association for the Treatment of Opioid Dependence, Inc. (AATOD) Conference will be held October 19-23, 2019, at Disney's Coronado Springs Resort in Orlando. The 2019 conference theme, "Out of the Shadows: Managing the Opioid Epidemic through the Continuum of Care," highlights the issues and challenges of medication assisted-treatment in the context of the current opioid use/abuse epidemic.

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For more information on the conference, please click on the following link: AATOD