Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Addictions Services System Transition

Division of Behavioral Health

***Strategic Plan* for Substance Abuse and Problem Gambling Prevention, Treatment, and Recovery Support: 2011-2014**

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Strategic Plan for Substance Abuse and Problem Gambling Prevention, Treatment, and Recovery Support: 2011-2014

The Iowa Department of Public Health (IDPH) is charged in Iowa code to establish and maintain treatment, intervention, education, and prevention programs as necessary or desirable in accordance with the comprehensive substance abuse program. Substance abuse programming is part of the IDPH Division of Behavioral Health. The Division is the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment (SAPT) Block Grant administered by SAMHSA, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services. The Division is responsible to disperse and administer state or federal funds or other monies allocated to the department related to substance abuse and problem gambling prevention, treatment, and recovery support services.

Purpose of the Strategic Plan:

- The purpose of the strategic plan is to guide IDPH's addictions services system transition.
- The plan will guide substance abuse and problem gambling service system decision-making and policy development at both the state and provider levels.
- The plan is a "living document" and it is anticipated that it will undergo changes as service system transition efforts move forward.

Overview of Addictions Service System Transition:

In 2009, the Iowa Department of Public Health Division of Behavioral Health (IDPH) initiated a transition to a comprehensive and integrated recovery-oriented system of care for addictive disorders, built on coordination and collaboration across substance abuse and problem gambling prevention and treatment.

Key system transition elements include:

- program licensure standards
- practitioner credentialing
- workforce development and training
- client/family leadership
- geographic service areas
- local collaboration
- funding/funding methodologies
- crisis services and wraparound supports
- data systems
- outcome/performance measures

Currently separate IDPH contracts for substance abuse comprehensive prevention, substance abuse treatment, and problem gambling prevention and treatment will all end June 30, 2014. IDPH anticipates release in 2013 of an integrated Request for Proposals (RFP) for local contractors who will together assure coordinated provision of addiction services – problem gambling and substance abuse prevention and treatment and associated recovery support services – in designated geographic service areas statewide, effective July 1, 2014.

In this transition, IDPH continues to envision places where people with substance use and gambling problems can go for essential care if they are low income, lack health insurance, or have minimal benefit coverage. IDPH funding has provided critical points of access for substance abuse and problem gambling treatment, referred to collectively as the addictions "safety net" infrastructure. This infrastructure exists to assure the availability of effective treatment in local communities for those without other financial resources. Money alone cannot assure access, there must be a place, designated and recognized as the safety net, to serve as the focal point for essential care in a community. The safety net infrastructure must be in place in each geographic area.

The addictions system of care is based in recovery-oriented system of care (ROSC) principles, encompassing community partners, prevention organizations, the recovery community, treatment providers, and other state and local stakeholders, as well as IDPH.

Overview of Planning Process:

In December 2010, the Division of Behavioral Health initiated work on a strategic plan for substance abuse and problem gambling services. Such a plan is required by the SAMHSA SAPT Block Grant and is part of the on-going follow-up to the Division's December's 2009 "system alignment" report to the Iowa State legislature wherein the addiction service system transition was first described.

Between December 2010 and August 2011, 13 in-person meetings were held with Division of Behavioral Health staff related to service system transition. The meetings were facilitated by a SAMHSA-funded technical assistance consultant who worked with Division staff to:

1. draft six discussion papers related to the key system transition elements
2. discuss each draft and revise as needed
3. post each discussion draft on IDPH's website for 15 to 30 days for review and comment by stakeholders

4. review stakeholder comments received in response to each discussion draft and revise each discussion draft, as indicated
5. post each revised discussion paper in final form, and
6. draft a strategic plan based on consideration of all the discussion and input to-date.

Stakeholders were notified of the discussion papers through the Division's "A Matter of Substance" newsletter that goes out to more than 700 agencies/individuals statewide. In addition, Division staff talked with providers and service contractors as well as with stakeholder associations who, in turn, notified their members. Sixteen different Division staff participated in the service system transition meetings, including the Division Director, the Substance Abuse Bureau Chief, the Access to Recovery program manager, the Office of Problem Gambling program manager and the Strategic Prevention Framework program manager, as well as staff representing block grant coordination, the Culturally Competent Programs project, data and information management, Jail-Based Treatment, Opioid Treatment, substance abuse prevention, substance abuse treatment, and treatment program licensure/regulation.

Overview of Discussion Papers:
The following discussion papers were developed and posted for input:

- Medicaid and Health (Affordable) Insurance Exchange Covered Benefits
- Recovery-Oriented System of Care (ROSC)
- Service System Transition
- Licensure Standards
- Geographic Service Areas
- Practitioner Credentialing, Performance Measurement, and Funding Methodology

Final versions of all discussion papers are posted at http://www.idph.state.ia.us/bh/sa_rosc_papers.asp. A summary of the input received in response to the discussion drafts begins on page 15.

Information and Resources Used:

- *Access to Recovery Approaches to ROSC*
- *Description of a Good and Modern Addictions and Mental Health Service System* (SAMHSA)
- *Guiding Principles and Elements of ROSC*
- *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014*

- IDPH Addendum to Block Grant Application
- Information from other states on program licensure
- Information from other states on practitioner credentialing
- Input from programs and individuals
- 2009 Institute of Medicine (IOM) report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People*
- *Olmstead Plan for Mental Health and Disability Services: State Plan Framework (2011-2015)*
- *DHS Olmstead Action Agenda for First 18 Months: 1/1/11 through 6/30/12*

Next Steps:
The Division utilized the discussion papers and the input received in the development of this draft strategic plan. Further input will be obtained as the transition to a comprehensive and integrated resiliency/recovery-oriented system of care moves forward. In addition, every effort will be made to align IDPH's addictions service system transition with the Iowa Department of Human Services' 2011 Olmstead Plan and planned Mental Health Redesign.

A revised strategic plan, likely with additional, specific action steps, will be posted and widely distributed for stakeholder and public comment.

Overall Goal of the Planning Process:
By July 1, 2014, substance abuse and problem gambling prevention, treatment, and recovery support services will form a comprehensive and integrated resiliency/recovery-oriented system of care for addictive disorders.

Medicaid and Health (Affordable) Insurance Exchange Covered Benefits

To provide a continuum of quality and effective substance abuse and problem gambling prevention, treatment and support services that meet the full range of needs, including age, gender, and cultural considerations.

Objective: Ensure that the Medicaid expansion and Health (Affordable) Insurance Exchange addictions benefit packages support resiliency and recovery and emphasize cost-effective, evidence-based, best practice approaches, with specific consideration of service delivery to rural areas and to traditionally un-served and underserved populations.

Action Step	Responsible Person	Timeline
Include continuing care, detoxification, distance treatment, medication assisted treatment, nicotine dependence counseling/nicotine replacement therapy, and recovery peer coaching as covered benefits.	Kathy Stone, Division Director	November 2011
Work with provider associations on understanding the importance of the benefit package.	Kathy Stone, Division Director	November 2011
Monitor minimum benefit discussions at the federal and state levels.	Kathy Stone, Division Director	Ongoing
Work with the Iowa Medicaid Enterprise and Insurance Division to include addiction services as covered benefits and addictions services organizations and practitioners as eligible providers, including as medical home providers.	Kathy Stone, Division Director	December 2011
Monitor covered population discussions at the federal and state levels, with specific consideration of corrections/criminal justice clients and returning service members/National Guard.	Kevin Gabbert, Program Manager - Access to Recovery	Ongoing
Monitor the inclusion of gambling diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM5) and problem gambling services minimum benefit discussions at the federal and state levels.	Mark Vander Linden, Program Manager - Office of Problem Gambling Treatment/Prevention	Ongoing

Resiliency/Recovery-Oriented System of Care (ROSC)

Iowa's definition of ROSC: ROSC supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems and problem gambling. A ROSC offers a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery.

Objective: Disseminate concepts and provide opportunities for people to learn about ROSC principles and connection to an effective addictions safety-net service system.

Action Step	Responsible Person	Timeline
Establish and participate in monthly conference calls with programs who have received ROSC training, sponsored by IDPH and the Prairielands Technology Transfer Center (ATTC).	Kathy Stone, Division Director Mark Vander Linden, Program Manager - Office of Problem Gambling Treatment/Prevention Prairielands ATTC	Ongoing from October 2011
Conduct additional prevention-specific ROSC discussions and expand resiliency principles.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Julie Hibben, Linda McGinnis, and Debbie Synhorst, Prevention Consultants	Ongoing from November 2011
Provide ROSC training at meetings, workshops and conferences, including 2011 Annual Prevention Symposium and 2012 Annual Governor's Conference on Substance Abuse.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment	Ongoing November 2011 April 2012
Provide the ROSC preparedness survey, ROSC 101 webinars, and general ROSC trainings to programs.	Prairielands ATTC	January 2012 February 2012 Ongoing
Consider potential linkages with Federally Qualified Health Centers or health homes to support a ROSC environment.	Eric Preuss, Iowa Plan Program Manager	Ongoing

Accreditation/Licensure – Treatment

As of July 1, 2011, IDPH has licensed 115 problem gambling and/or substance abuse treatment programs, either through direct licensure or through deemed status based on their accreditation by a nationally recognized credentialing organization. Of the 115, 29 (25%) are nationally accredited. Four additional licensed programs are considering national accreditation. Most of the programs currently accredited by a national organization are affiliated with a hospital, or are opioid treatment programs required to be accredited by the federal government, or are part of large comprehensive treatment programs. Eight or 32% of the 23 treatment programs funded by the Division of Behavioral Health/SSA are nationally accredited. (For the purposes of this document, licensure refers to treatment program licensure by IDPH, not individual practitioner credentialing.)

As noted in SAMHSA's Strategic Initiatives **"**mental and substance use disorders often occur together as well as with general medical conditions, such as diabetes or heart disease." To best serve substance abuse clients with co-occurring mental health problems, IDPH is working with the Department of Human Services (DHS) to align IDPH substance abuse program licensure and DHS mental health service accreditation and eliminate the need for separate credentialing for mental health services provided by a qualified substance abuse treatment program.

Objective: Ensure availability of quality, qualified substance abuse and problem gambling treatment services in Iowa.

Action Step	**Responsible Person**	**Timeline**
Establish a committee with representatives of licensed programs to consider licensure standards revision and associated Iowa code changes, including expansion of deemed status.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Jeff Gronstal, Cindy Kelly, Bob Kerksieck, Program Licensure Surveyors	December 2011 – September 2012
Review Commission on Accreditation of Rehabilitation Facilities (CARF) and other accreditations to identify standards linked to quality improvement and cultural competency for consideration in licensure revision.	Jeff Gronstal, Cindy Kelly, Bob Kerksieck, Program Licensure Surveyors	January 2012
Consider licensure revisions related to ROSC principles and DHS mental health redesign, including alignment of IDPH program licensure standards with DHS mental health services certification	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Jeff Gronstal, Cindy Kelly, Bob Kerksieck, Program Licensure Surveyors	July 2012
Submit revised licensure standards to the State Board of Health and follow the Administrative Rules process.	Jeff Gronstal, Cindy Kelly, Bob Kerksieck, Program Licensure Surveyors	November 2012

Accreditation/Licensure – Prevention

As stated in *Leading Change: A Plan for SAMHSA's Roles and Actions*, "Mental and substance use disorders have a powerful effect on the health of individuals and on the Nation's social, economic, and health-related problems. Mental and substance use disorders are among the top conditions for disability, burden of disease, and cost to families, employers, and publicly funded health systems. Excessive alcohol use and illicit drug use are linked directly to increased burden from chronic disease, diabetes, and cardiovascular problems."

Objective: Ensure quality, qualified substance abuse and problem gambling prevention services in Iowa. (For the purposes of this document, licensure refers to program licensure by IDPH, not individual practitioner credentialing.)

Action Step	**Responsible Person**	**Timeline**
Establish a committee representing prevention contractors and stakeholders to consider licensure standards and any associated Iowa code changes.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Julie Hibben, Linda McGinnis, and Debbie Synhorst, Prevention Consultants	December 2011 – September 2012
Review prevention credentialing standards in other states and related to national healthcare reform.	Julie Hibben, Linda McGinnis, and Debbie Synhorst, Prevention Consultants	January 2012
Consider licensure revisions related to ROSC principles and DHS mental health redesign.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Julie Hibben, Linda McGinnis, and Debbie Synhorst, Prevention Consultants	July 2012
Submit licensure standards to the State Board of Health and follow the Administrative Rules process.	Jeff Gronstal, Cindy Kelly, Bob Kerksieck, Program Licensure Surveyors	November 2012

Workforce and Training Issues

All have to work in collaboration to develop strategies for creating learning models to ensure the workforce has the information, technical assistance and culturally-relevant training to effectively implement improved practices.

Objective: Promote and maintain a competent and diverse behavioral health care provider's workforce

Action Step	Responsible Person	Timeline
Develop the 2011-2012 training and workforce development calendar, focusing on general prevention and treatment issues and evidence-based practices and supporting cultural competency.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Training Resources	October 2011
Consider benefits of aligning prevention training with the core areas of the Community Health Education Specialists national model.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Michele Tilotta, Project Coordinator - Access to Recovery Training Resources	November 2012
Work with DHS/Medicaid and Magellan to better align mental health peer support and IDPH recovery coach training requirements and service descriptions.	Kevin Gabbert, Program Manager - Access to Recovery Michele Tilotta, Project Coordinator - Access to Recovery	January 2012
Develop training for physical health providers on brief screening for substance abuse and problem gambling issues.	DeAnn Decker, Bureau Chief Michele Tilotta, Project Coordinator	March 2012
Continue to disseminate public health information statewide.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Mark Vander Linden, Program Manager - Office of Problem Gambling Treatment/Prevention Iowa Substance Abuse Information Center	Ongoing

Service Areas

The current designated geographical service areas for problem gambling prevention/treatment, substance abuse prevention, and substance abuse treatment are different throughout the state. While changes have been made to service areas over the years, most of the changes were associated with factors like program closings or organizational mergers rather than consideration of the infrastructure of the service system as a whole. IDPH recognizes that multiple contracts may be inefficient for both IDPH and contractors and may be ineffective in supporting a full continuum of care at the local level. This is true whether a single program or organization holds the contracts in a local area or if different programs/organizations hold different contracts.

Objective: Align geographic service areas to support a full continuum of care and safety-net infrastructure through coordinated provision of problem gambling and substance abuse prevention, treatment, and recovery support services.

Action Step	Responsible Person	Timeline
Continue stakeholder discussions regarding alignment of geographic service areas and how local programs can collaboratively provide services within and across service areas.	Kathy Stone, Division Director	July 2012
Assess potential prevention, treatment and recovery supports service system capacity issues related to parity and state and federal health care reform legislation.	Kathy Stone, Division Director	July 2012
Ensure a full continuum of prevention, treatment, and recovery support services in geographic service areas and statewide.	Kathy Stone, Division Director	July 2013
Decrease the contractual burden on contractors.	Kathy Stone, Division Director	July 2014

Performance Indicators/Outcome Measures

Over the past several years, the NIATx principles of access, engagement and outcomes have been utilized in substance abuse and problem gambling prevention and treatment. These principles are consistent with the resiliency/recovery-oriented system of care approach, as well as health care reform and will be incorporated into performance measures aligned across all programs.

The Quality and Performance Management section of the *"Description of a Good and Modern Addiction and Mental Health Services System"*, states that "quality improvement through the use of outcomes and performance measures are a cornerstone of the Accountable Care Act (ACA). A renewed focus on quality will also help payer's link performance improvement and payment while moving away from the current incentives to provide more care without evidence of improved outcomes."

Objective: Develop performance and outcome measures that define and support a good system of care.

Action Step	Responsible Person	Timeline
Research national standards, including the National Behavioral Health Quality Framework, to begin development of statewide outcomes.	Lonnie Cleland, Program Planner - Jail-Based Treatment Eric Preuss, Iowa Plan Program Manager	November 2011
Consult with contractors to consider prevention and treatment outcome measures and timelines.	Kathy Stone, Division Director	January 2012
Identify data needed for outcome measures and determine if the data currently exist, the cost of collecting and analyzing the data, and available funding.	Lonnie Cleland, Program Planner - Jail-Based Treatment Eric Preuss, Iowa Plan Program Manager	January 2013
Determine contractual performance measures and associated financial incentives.	Kathy Stone, Division Director DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Eric Preuss, Iowa Plan Program Manager	July 2014

Funding Methods/Methodologies

The *"Description of a Good and Modern Addiction and Mental Health Services System"* notes that "funding strategies must be sufficiently flexible to promote efficiency, control costs, and pay for performance. Healthcare payment reform is intended to align quality and cost and reinforce desired client and system outcomes. If services are to be integrated, the good and modern system must either blend or braid funds in support of comprehensive service provision for consumers, youth and families."

Objective: Develop a uniform cost structure that is aligned with and adequately supports all services in the geographic service area.

Action Step	Responsible Person	Timeline
Work with providers and payers regarding billing multiple services in one day.	Eric Preuss, Iowa Plan Program Manager	November 2011
Monitor state and federal health care reform, federal block grant funding, and Iowa mental health redesign for implications for addictions services.	Kathy Stone, Division Director	Ongoing
Review all separate State appropriations for substance abuse prevention and consider requests for changes in appropriations and associated code language.	Kathy Stone, Division Director	July 2012
Consider options for directing prevention services to high-risk populations and for billing for certain prevention services.	DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment	July 2012
Develop a competitive RFP for problem gambling and substance abuse prevention and treatment contracts that supports effective delivery of all services within designated geographic service area and statewide.	Kathy Stone, Division Director DeAnn Decker, Bureau Chief - Substance Abuse Prevention/Treatment Mark Vander Linden, Program Manager - Office of Problem Gambling Treatment/Prevention	December 2012

Practitioner Credentialing for Prevention and Treatment

The workforce section of SAMHSA's *"Description of a Good and Modern Addiction and Mental Health Services System"* notes the following: "The modern system must have experienced and competent organizations and staff that can deliver the services. Licensure requirements need to evolve and certification requirements strengthened for those professions that do not require formal licensure." Some states have moved from counselor certification to professional licensure to better meet insurance and Medicaid requirements. As health care reform moves forward, Iowa needs to determine what type of credentialing for substance abuse and problem gambling counselors and prevention specialists, is most advantageous for the field in terms of access and funding.

Objective: Assure that gambling and substance abuse credential is reimbursable with Medicaid and other insurances.

Action Step	Responsible Person	Timeline
Meet with the IDPH Bureau of Professional Licensure to understand the requirements for establishing a substance abuse practitioner licensing board.	Kevin Gabbert, Program Manager - Access to Recovery	November 2011
Consult with professional licensure boards to understand requirements for substance abuse agencies as practice settings for supervision of Licensed Independent Social Worker (LISW) and other professionals.	Kevin Gabbert, Program Manager - Access to Recovery	November 2011
Research other states' practices and policies for credentialing prevention practitioners.	Debbie Synhorst, Prevention Consultant	November 2011
Research National Commission for Health Education credentialing.	Michele Tilotta, Project Coordinator - Access to Recovery	November 2011
Meet with the University of Iowa regarding the certified health education specialist curriculum and program.	Linda McGinnis, Prevention Consultant	November 2011
Establish a committee to consider licensure of substance abuse and problem gambling prevention and treatment practitioners.	Kathy Stone, Division Director Chemical Dependency Treatment Programs of Iowa Iowa Behavioral Health Association Iowa Board of Certification Iowa Substance Abuse Supervisors Association	July 2012
Align credentialing efforts with state and federal healthcare reform.	Kathy Stone, Division Director	Ongoing

Summary of Feedback Received

Benefit Design

- Use outcomes as a measure of success
- Appreciate that substance abuse prevention is a covered benefit, but a challenge is that prevention services are conducted through coalitions and they are unlicensed efforts and not under the direct supervision of licensed substance abuse treatment providers. I would support developing licensure for prevention
- Classifications not previously funded will need definitions, criteria for eligibility, staff credentials and defined billing codes.
- Cost reimbursement is essential especially since the chronic population has higher rates of no shows and cancellations which leave the provider no way to cover cost
- What is the extent that states will have control over the scope and rates for levels of care and services offered?
- If residential is not covered there needs to be a housing option
- Don't let the change destroy good, basic addiction treatment
- Recovery coaching needs to be a reimbursed service if it is going to expand and grow in Iowa
- Coverage for significant others is important
- If a covered diagnosis is required how will that be handled for prevention?
- Can a substance abuse assessment in a non-medical facility fall under SBIRT?
- Tele-Health Distance Prevention should be covered
- Independent and non-biased substance abuse assessments need to be an integral part of the continuum
- Add inpatient detoxification, psychiatric services, nicotine dependence and nicotine replacement therapy
- Ensure all behavioral health plans are on par with major medical plans and Mental Health Parity and Addiction Equity Act requirements

ROSC

- Movement to a ROSC system of care is a huge undertaking when our funding and clinical processes reflect an acute care model. IDPH can support ROSC implementation by finding a way to fund peer recovery coaches beyond the ATR model.
- Having prevention as a part of ROSC is great, the challenge will be how to fund it
- ROSC is a theoretical model which makes sense, but it seems to be defined by bureaucrats when the core of the model is cooperation, collaboration and partnership

- If addiction is to be defined as a chronic disease then utilizing harm reduction outcomes seems to be in conflict
- Model needs to have definitions
- Need to study systems of care models like "impaired physician treatment model" and the Iowa in Jail treatment model and take lessons from them as a ROSC model is developed
- Medication assisted therapy needs to focus on necessary life style changes too
- Physicians need to be trained in using medications to treat addicted individuals
- Dollars should be prioritized for treatment
- Stigma is powerful in the community
- Have organized conversations around ROSC
- Professional and non-professional level staffing needs and differences should be addressed
- Ethnicity, cultural competency and awareness needs should be addressed

Service System Transition

Health Information – Agency

- Internet sources such as IDPH, Center for Disease Control (CDC) SAMHSA, the ATTC network, CADCA, Training Resources, local public health office, NIATx, and a variety of gambling information sites.
- Information newsletters delivered to my e-mail account, television programs and newspapers.
- Webinars, conferences – both state, regional, and national.
- Networking with other program directors.
- Key informants
- Social networks
- Information about health issues is acquired from an inconsistent mix of local, state, federal, and private health resources with mixed results which often require excessive staff time
- Health care information and education services should be easily and quickly accessible.

Health Information – General Public

- The general public gets information in the same way as the agencies
- Public often gets more targeted information from their children's schools, from the workplace, etc
- Family physicians are a source of information when ill
- When people are in crisis, they may call a helpline – though I'm not sure they always know where to call.
- Public Health offices, local media sources, local treatment agency, clergy, public library

- Stakeholders have even a more difficult time finding and accessing the information and service they need.
- Health care information and education services should be easily and quickly accessible.
- People should be able to subscribe to health information newsletters delivered to their e-mail accounts or other social media.
- People should be able to get information from Twitter
- Any methods that get information into the hands of people quickly are most effective.
- Websites and trainings seem to be the most effective
- IDPH, SAMHSA, my state/national provider organizations and other national level websites
- Mayo Clinic website
- The internet to get most of my information

Health Information – Other

- Information needs to be readily available, websites up to date, accurate, informative and consistent
- Iowa needs to have public health campaigns each year with messages delivered in a variety of media and geared toward all segments of the population.
- The use of public dollars for help lines is an ineffective and expensive strategy

Merging of Funding Streams

- Universal prevention efforts are best supported by merging funding streams – since the messages at that level ought to be comprehensive and aimed at reducing health risks in general and targeted at the whole community.
- Indicated prevention efforts should be funded by not merging funding streams but rather funding specialized programs/personnel that are specifically trained to address early symptoms and behaviors.
- Selective prevention efforts could be done with merged funding streams, but there should be core populations identified with uniformity in messages and delivery.

Coalitions

- Coalitions should not be led by agency professionals. They should be led by non-agency professionals
- Coalitions should meet when the community is available
- Coalitions are often spontaneously organized around a specific concern or issue – but disband when the issue has been addressed. People in today's communities rarely want to sign on for a coalition that goes on forever.
- Prevention agencies should serve as resources for community coalitions – not lead the coalitions.
- One unique quality of coalitions is that they tend to be a mighty group of passionate volunteers.

- There are unique strengths and unique weakness of coalitions that need to be identified. Strengths are multiple: 1. Energy and passion generated by people close to the problems(s) 2. Coordination of services 3) Local oversight for accountability 4) local buy in to defined solutions/outcomes, and 5) higher likelihood of sustainability of outcomes.
- Challenges are: rise and fall of coalition energy, inconsistent leadership, leadership dominated by one person with the coalition becoming one person's vision, and the messiness of local jealousies and territorial feuds. It is difficult to keep the coalition a "community" effort. They often favor the "professional class" who are already invested in the issues.
- When coalitions become 501C3's to take local donations they then begin to develop an agency profile with the financial needs and obligations of nonprofits. At this point they cease to be coalitions.

Prevention Services

- Most populations engaging in risky behaviors engage in multiple kinds of risky behavior and there are clear indicators that some of the same strategies can effectively prevent many social and health problems.
- Incentivize groups to join together and integrate the delivery. When prevention is viewed as a community health partner it only makes sense to have staff who can deliver a wider spectrum of services based upon data and unique needs of the community and the individuals in the community.
- Looking a risk and protective factors is one principal that can span many prevention services.
- Evidence based programming often results in impacts to multiple areas of risk.
- A barrier, tough, to greater cooperation between programs is funding contracts that discourage shared programming. Blinded funding streams with shared work plans would eliminate this problem.
- Expand formal training in prevention, either as certificate programs or degrees with practical experience. But make the training available to whole geographic area of Iowa, not just on one side of the state. Consider the national model of Community Health Education Specialists with training specific to the core areas. Move to training
- Assistance and training in billable services for prevention
- The prevention certifications are not broad enough to cover all mental, emotional, and behavioral issues. This will be important to address if prevention specialists are to practice within a medical home environment. Move to credentialing

Partnership between Prevention and Treatment Organizations

- Prevention and treatment need to be in the same agency. Treatment agencies are serving populations with significant health problems. Their families and children are at great risk and should have the benefit of selected and indicated preventions activities funded by the state

- Prevention and treatment agencies should educate one another on philosophies and everyday work duties and value each other's role
- Specialty Treatment (substance abuse and mental health), prevention and primary care can work well in partnership under a unified plan driven by policy, frame work, and funding. Leadership at the state level should get the different groups together to design a white paper on how it could work. This might be a project that the University of Iowa could help facilitate.
- Funds for services should be allowed to flow back and forth between treatment and prevention to help fund movement of staff between the 2 areas
- Cut down on all the different reporting systems
- Ongoing discussions to figure this out

Licensing or Accreditation and Ensuring Quality Services for all Iowans

Quality Services

- Ensure a level playing field
- Safeguard the health of all Iowans, regardless of where they choose to receive services.
- The issue is to ensure quality of care. There should be one standard across all programs independent of funding.
- Private providers, assessment only providers need to be included in the decision making process so access to services for Iowans are not decreased.
- A significant financial barrier would apply to small and medium sized agencies that do not have the resources or ability to pay for national accreditation.
- Programs need to make their own decision if national accreditation would result in additional 3rd party reimbursement.

Revise Current Standards to Better Support ROSC and Quality Services

- More distinction between residential and outpatient treatment
- Change the requirement of 30 days no activity that the record must be closed
- Revise all related time frames to be more client centered
- Have specific rules related to levels of programs including a ROSC program
- Require providers to develop a menu or establish service agreements with recovery service providers for referral and coordination of care
- Require documentation to substantiate need for a particular recovery service

- Require documentation of follow-up to address monitoring, progress and completion of a particular recovery service/s. Reflect ROSC type language
- Some providers are licensed in multiple states and philosophical shift may put them in position of meeting multiple standards
- ROSC is an attitude change in how you do treatment. Does regulation equate with attitude change?
- Regulation for recovery support services should focus on ensuring that money is used for legitimate recovery support services and that proper audit trails exist.
- Decrease Intensive Outpatient (IOP) services to less than 9 hours per week.
- Find a way to keep the clinical files open to provide for the movement of clients in and out of the treatment agency without continually opening and closing cases.

Accreditation/Licensure – Prevention

- The standards need to be broad enough to go across urban and rural programs
- Prevention needs to be uniform across programs
- Uniformity is important, but can all state departments who provide prevention services come to an agreement on this?
- The nature and variety of prevention organizations might not lend itself to organization accreditation/licensure but individual provider and supervisor credentialing is recommended
- Regardless of different type of prevention services the credentialing process should be similar.
- Focus first on comprehensive prevention then open discussion about the other levels of prevention
- Look at work in other states
- Supportive of requiring accreditation/licensing for prevention. It raises the bar substantially for prevention.
- Need to distinguish between the different prevention programs in the standards.
- Licensure supported because it will lend credibility to prevention professionals working and collaborating with medical homes.

Accreditation/Licensure – Co-occurring

- National accreditation would address services in this area
- Utilize SF 525 as a mechanism to work through this area
- Going through one accreditation is better than many

Workforce and Training Issues

- Training for recovery coaches: time required, needing 2 trained facilitators, and not meeting the same requirements as recovery coaches for Medicaid
- Workforce and financial resources need to be addressed first
- Primary issue is the need to provide training to those who provide support
- Workforce issues in recovery support will be unique to the type of recovery support provider
- Review of standards for both prevention and treatment
- Competency for co-occurring workforce
- If problem gambling is considered a co-occurring disorder training is needed
- Confidentiality differences between substance abuse and gambling especially as it relates to adolescents
- Ongoing assessment skills to address co-occurring issues as they present
- Orientation to change in ROSC
- Role of physical health
- Assistance in organizing communities around a ROSC initiative
- Work force is a challenge in staffing rural offices
- Workforce recruitment and retention is critical. A good portion of the current workforce is aging out – and less people in recovery are coming in to the field. This makes the use of peer recovery coaches all the more important.
- Finding ways and $ to assist programs in better addressing the mental health needs of its clients – by helping programs recruit and retain licensed professionals – who can appropriately address the needs of client with co-occurring disorders.
- Prevention needs more training in NIATx
- Prevention needs to understand how they fit into ROSC
- Continue to support the use of NIATx process improvement methods.
- IDPH help provide resources for the training and curriculum of evidenced practice being implanted in prevention and treatment programs?

Service Areas

- Leave service areas alone due to the existing infrastructure, impact on clients, agency and community served
- Create regions of contiguous catchment areas clustered around MSA, making sure there is full continuum available in region
- Mandate collaborative efforts in contracts if multiple providers are vying for the contracts

- Award a single contract to the region with contractual requirements to collaborate, partner, create an Administrative Service Organization or something similar to ensure collaboration and services to the entire region
- Past contract ownership needs to disappear and be replaced with partnerships and collaborations that make the most efficient use of statewide infrastructure that provide the citizens the options and best care possible.
- Adjusting gambling and prevention boundaries to existing treatment boundaries would be more sensible, economically feasible
- Identify partners that are essential and require collaboration in the contracts
- Split state into tiers
- Unsure that streamlining of contracts will reduce overall cost of a unit of service. Streamlining of contracts might be more efficient for the state but more burdensome for local areas.
- Not all service areas are collaborative by nature. Contracts should lay out the expected outcomes for the service area and hold contractors accountable for the outcomes
- Treatment and prevention services should be well coordinated in a service area with a common vision and work plan
- To encourage good local access service areas should not be too geographically large
- People who can travel might choose mental health and addiction treatment outside their community to preserve confidentiality
- When service areas are too small the cost of administration goes up which would result in fewer dollars for clients
- Perhaps the number of contracts in each service area should be adjusted instead of the service areas
- Fewer service areas would increase the likelihood that strong, statewide messages supporting a comprehensive and integrated recovery-oriented system of care were provided to all Iowa residents.
- Shifting service areas could substantially disrupt the well trained workforce Iowa currently has
- Consider historical effectiveness when realigning service areas
- Medical hub is designed around specialty and tertiary care magnets as well as referral partners of primary care providers.
- Consider corporate capacity for change
- Access, quality and consumer satisfaction should be taken into consideration in this transformation
- Realigning service areas will jeopardize local funding.
- It is important to have well defined and stable service areas in order for an organization to offer practical, predictable and competent services to the citizens of such areas.
- Have conversation with those most directly impacted.
- Engage Iowa Behavioral Health Association (IBHA) in a conversation regarding service areas

- Improving the delivery of substance abuse services for residents of Iowa needs to be our collective goal.
- Consider connecting with the potential re-alignment of Community Mental Health Center (CMHC) regions
- Consider alignment with Federally Qualified Health Center's (FQHCs)
- Existing service areas should not be split, but combine whole existing areas with others

Performance Indicators or Outcome Measures Linked to Service Areas

- Service penetration could be a significant indicator of how well the catchment areas are drawn. Provider should be able to demonstrate admissions per population ratios are within defined parameters as well as other standard quality measures
- Units of service
- Days drug/alcohol free
- Client satisfaction with service
- Numbers of people served
- Prevention outcomes would come from assessment data
- Problem with outcome indicators is the cost of collecting/analyzing data. Function/cost should be assumed by IDPH
- IDPH through consultation with prevention and treatment providers should set the outcomes
- Data can be analyzed by region and measured against the targets
- A reasonable period of time should be allowed to impact those targets with benchmarking along the way
- Many resources were expended with NIATx and we should not lose those.
- Treatment programs should be accountable for decreasing wait times, increasing program completions, and decrease no shows.
- Performance indicators should be data driven and measurable
- The new performance measures with Magellan are good and a collaborative effort of both the funder and the service providers.
- Create one data tool for all of the various contracts to be reported through

Office in Each County

- Good to have presence in each county, but difficult to have daily access and not lose money in a rural office due to lower volume of clients
- It is not feasible for efficiency not fiscally responsible to have an office in each county
- Access should be assured by holding contractors to high standards and quarterly reporting

- Service locations should be based upon population and agreed upon travel radius.
- Performance targets should be outlined in contract that states desired outcomes and access standards.
- Programs should be required to keep data on home addresses and compare to admission per population ratio
- Patient satisfaction and referent satisfaction is another set of data to utilize
- Collaboration through sharing spaces in some counties provides access without having a separate office
- The more available and visible programs are the better the sense of care and service
- Some counties may need two service centers
- If an office is not in a rural small population area the county adjacent needs to have an office
- An 800 number should be provided to call the provider
- Distance treatment services need to be an option
- Governing boards should have representation from all counties in the service area
- Have the provider outline how they will remove barriers to client services
- It is advantageous to have an office in each county, especially in rural areas where public transportation options do not exist. More important for treatment services than prevention.
- Consider funding alternative service delivery, including technology, software, hardware and protocol for distance treatment

Measurement of Prevention Services

- Since changes in use rate may not be reflected until years later, prevention can be measured by the amount of effort provided to achieve an outcome, i.e. what steps were taken, how many contacts were made, which key stakeholders were involved.
- Since other providers are already implementing primary prevention strategies targeted to a general population, IDPH contracted prevention services should be targeted to high at risk groups and targeted for intervention services rather than primary prevention or environmental strategies. Then outcomes could be measured specific to individuals.
- Prevention service outcomes need to have a measurement that is consistent with the modality of service.
- The current system is time consuming and costly. However it is a reasonable process for measuring staff outputs.
- The notion of direct service hours for community prevention work as a contract measure is meaningless. However time invested in an activity does help define the level of dosage that is needed to achieve a result.
- A state sponsored work group to think this through would be useful.
- Prevention services need to be closely aligned with treatment services so there is truly a continuum of services in a community.

- Outcomes based only. Outcomes should be set and if not met without a documented reason why funding should be adjusted.
- Difficult to measure environmental changes since they take longer to meet. Might be able to use the SPF/SIG process.

Cultural Competency

- Measure the number of patients of minority backgrounds admitted and successfully discharged as well as patient satisfaction and referent satisfaction data.
- Compare the admission data to population data and make sure that targeted admissions per populations' ratios are reached.
- Require programs to create and submit Cultural competency plans which IDPH could evaluate and monitor.
- Provide trainings
- Require information on cultural competency efforts in reports
- Satisfaction surveys with groups receiving services
- Ask all stakeholders and consumers how it can be improved
- Broaden the definition of cultural competency so it is clearly understood that county to county variances can account for significant problems in communication and service provision. "Community competency" demands an understanding of the "culture" of each population center and the unique needs associated with each
- Multiple contracts within some service areas may address this more appropriately because of familiarity and trust.
- Training options, exchange of experiences, funds to assist with interpretation.
- Sustained training on this issue that goes beyond the urbanized definitions of diversity, ethnicity, and culture, and focuses on working with indigenous people and meaningful transformations from within their cultural perspective
- The governing board and staff should be reflective of the population of the service area whenever possible.
- Financial incentives to bring more minorities, bilingual individuals into the field
- Cultural competency should be a required training for providers.
- Cultural competency should be part of the provider's annual plan.

Current Contracts not Linked to Service Areas

- ATR needs to be tied to the contractor in the service area as the prime provider of ATR funds.
- Youth development, County contracts and all other prevention contracts should be added to the comprehensive prevention contract and the comp prevention contract part of the comprehensive contract to the chosen provider.

- Have all prevention money (gambling, tobacco and substance abuse) in one contract with appropriate outcomes set by the state. Also have reporting, data system the same.
- If contract is specific it might not need to be tied to a service area, but all interested can bid.
- County Contracts should have more uniform processes and expectations.
- To achieve optimal efficiency and effectiveness, it would be helpful to get all partners in a recovery-oriented system of care to provide the same services and messages as appropriate to the particular program type.
- The contracts should match a service area.
- These contracts fit well within current catchment areas and enhance work that is taking place.
- Small contracts are a hassle to administer and folding them into a larger funding stream would create a more efficient service.
- Linking all contracts to a service area is not possible. Not every service area has everything available. Not every client wants to receive ALL of their services in a particular service area
- Perhaps these specialized contracts should be linked to service areas. Doesn't every Iowan deserve the same access to services – no matter where they choose to live?

Financial issues

- Recovery support services need to have funding sources
- Financial resources for treating the co-occurring population
- Block grant funding is great because it helps to maintain the treatment infrastructure in Iowa. As local funding sources have become less, the block grant funding is important. However, for those agencies who continually "over-perform" on contract numbers – there should be a "profit-share" to reward good work.
- Fee for Service can be very stressful for staff. I honestly like supplementing block grant with fee-for-service contracts from other customers. It's a good mix.
- Medicaid funding is important and Iowa needs to make sure addiction providers and their services continue to be reimbursable.
- We need to explore Medicare funding for addiction programs – as our population ages, this will become more important.
- The more flexible the funding is to meet needs of clients would appear best.
- Funds should go "as far as possible" based on need and service criteria and outcomes and performance.
- Based on experience with ATR, it would appear that the voucher reimbursement system may be helpful as part of the larger funding scheme.

Practitioner Credentialing

- Our pay schedules and benefit packages are generally not competitive. We need to continue the workforce enhancement efforts as we've done in past years.
- Iowa's colleges need to make an effort to seriously teach about addictions and graduate those people who want to work in the addictions field.
- Licensure boards in Iowa need to recognize addiction agencies as appropriate supervision sites for those working toward licensure.
- Licensure boards need to consider using Internet and other technologies for providing supervision for those seeking licensure – as supervision is often difficult to find and expensive.
- Licensure boards need to become "consumer friendly" and provide assistance to those seeking professional licensure.
- Consideration needs to be given to maintaining certification for those who do not seek licensure
- Certification needs to be considered for peer recovery
- Identify grandfathering programs if we move from certification to
- Iowa needs to find payment streams for certified staff
- State or national practitioner certification and/or licensure must be recognized and accepted for reimbursement by Medicaid and third party payers of clinical and recovery services.
- Licensure is legislative with legal standing and weight. However credentialing is not, requiring licensure may provide some flexibility in terms of practitioner.
- Practitioner credentialing could be administered through the contracting process; however, may require enhanced monitoring.
- Accreditation could be an alternative to licensure; however, cost could be prohibitive to some providers or practitioners.
- Practitioner credentialing should ensure that it does not inhibit small and sole practitioners in complying with requirements.
- Strongly urge IDPH to move to practitioner licensure. We recognize that we need to move thoughtfully to credentialing status. It is critical that we protect non-degreed, recovering therapists, and make sure any new process at least "grandfathers" them.
- Support idea to make Iowa Board of Certification process recognized as licensure for substance abuse practitioners in Iowa.
- Encourage development of Masters Programs at the regent universities, specific to addiction programming, to help in the creation of a new Masters level independent addiction license.
- Consider offering incentives to provide educational opportunities for non-traditional students.
- Support another path to licensure and that is enacting legislation requiring insurance companies to reimburse practitioners at the level they are now.

Performance Measures

- The NIATx measures have served us well
- Number of patients accessing recovery services, retained versus discharged, number continued in recovery service(s) as per recovery plan
- Patient successfully continued participation in primary recovery support service per recovery plan over a specified period of time.
- Family support and participation over time and involvement in recovery support of recovering individual.
- Completion/attainment of agreed upon priority goals in recovery plan
- Post-discharge data including re-arrests, hospitalizations, and employment improvement.
- Do not like to see "abstinence" as an outcome measure as that may not be an appropriate/client-driven goal.
- Outcomes should include cross-referencing data bases rather than outcomes based solely on client reporting.
- Continued involvement in recovery support service over an expected period of time.
- Abstinence or no use for six months, one year, and over one year and six months following completion of primary recovery services.
- Family is actively supported through involvement in recovery support services of recovering family member.
- Client, consumer, and family satisfaction surveys could help measure outcomes progress.
- Be consistent with what is expected from our colleagues working in other chronic disease professions
- IDPH could monitor our performance just as they monitor other health care performance.

Incentives and Disincentives

- Incentives and disincentives need to be based on what the agency can control
- Incentives need to be achievable and data-driven.
- The specific criteria for determining incentives/disincentives need to be laid out from day 1.
- Contracts could include negotiated financial incentives for patients' attainment of each of the above listed important outcomes. Financial incentives could include a negotiated percentage bonus or disincentive compared to statewide averages or medians.

Other Issues

- Provide opportunities for distance treatment in substance abuse
- Quality improvement if state structure could look at substance abuse, mental health and primary health as a public health issue. Alignment can bring about enhanced services and impact stigma.
- Another area that would improve quality is working with the Iowa Department of Education and state and private colleges improving the training and degree opportunities in professions related – substance abuse, mental health, health education, and primary care with integrated training would provide quality improvement.
- Resources to pay adequate salaries, make loan forgiveness a universal opportunity to draw needed, talented candidates to the workforce will help with quality improvement.
- Contractor organizations need to remain fiscally viable. The organizations are one of the most effective ways to mentor incoming leaders and ensure ongoing quality in services.
- Contractor organizations role could shift to include dissemination of health information statewide – not just to their members but to other organizations and groups. I would prefer they are the ones in charge of training activities to insure quality and consistency in training. But their training focus needs to be regional and within programs. Training should be of significant duration to support skill-based change in programs – not just one shot training days.
- The Governor's Conference is aging and needs an infusion of out-of-state experts to get providers and line staff excited again.
- Contractor organizations are a great way to shift focuses in preparation for health care reform requirements such as electronic medical records.
- Support I-SMART in becoming an electronic health record. Some providers cannot create their own electronic health record system while others have the ability to do so. Both types of providers should be supported by the State in moving forward in electronic health records.
- Support the notion that public health information should come from local public health agencies.