Iowa's Integration Project
Year 1 Evaluation

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Legal Disclaimer

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Executive Summary

Background

Iowa's Integration Project is funded by the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant. The Iowa Department of Public Health (IDPH) was awarded a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) in September 2018. The purpose of the project is to improve primary and behavioral health outcomes for individuals with substance use disorders.

Iowa's Integration Project proposed to meet PIPBHC requirements through the following goals:

1. Promote integrated health care services through a bidirectional model utilizing an Integrated Care Team approach;
2. Support the improvement of integrated health care services provided to individuals with substance use disorder (SUD), serious mental illness (SMI), and co-occurring health conditions;
3. Increase the number of integrated health care services provided to individuals with SUD, SMI, and co-occurring health conditions;
4. Implement an innovative and comprehensive care team approach between the Iowa Army National Guard (IAANG) and co-located substance use/mental health community providers.

Methods

Data was gathered from several sources: 1) Intake Notification Forms; 2) Discharge Notification Forms; 3) National Outcome Measures (NOMs) instrument at admission, discharge, and six-months post admission (follow-up) from SAMHSA's Performance Accountability and Reporting System (SPARS); 4) SUD Interview Guide; 5) Federally Qualified Health Center (FQHC) Interview Guide; 6) Monthly forms completed by treatment providers; 7) Client Success Stories.

Key Findings

- Eighty (80) clients were admitted between March 20, 2019 and September 29, 2019.
- The majority of clients were males (64%), White (91%), non-Hispanic or Latino (89%), and between the ages of 25-44 (67%).
- Over half (60%) of clients reported smoking daily or almost daily.
- Fifty-five percent (55%) had prehypertension or hypertension.
- Eighty-three percent (83%) were overweight or obese.
- Nearly half (44%) of clients identified as being unemployed but looking for work.
- Sixty-five percent (65%) of clients had a secondary behavioral health diagnosis, and almost one-third (31%) had a tertiary diagnosis.
- Organizations spent over $25,000 on recovery support services, of which two-thirds were spent on NOMs coordination and clothing/hygiene.
- Most staff have a basic understanding of integration, but there is room for improvement.

Recommendations

Due to the limited number of follow-ups and discharges completed in Year 1, recommendations are based on baseline data, monthly tracking forms, and the SUD interview guide. As the PIPBHC grant continues to collect more data, future evaluations will be able to use follow-up and discharge data to inform recommendations.

- **Explore ways to increase access to a more diverse client population to address and reduce health disparities.** The majority of clients are males (64%), White (91%), non-Hispanic or Latino (89%), and between the ages of 25-44 (67%).
- **Offer education on people experiencing homelessness and how they may benefit from services.** Almost every organization identified people experiencing homelessness as a special population with unmet primary health needs.
- **Enhance efforts to address tobacco use and obesity.** Over half (60%) of clients reported smoking daily or almost daily, had prehypertension or hypertension (55%), and were overweight or obese (83%). Throughout the first year of the grant, no organizations reported tobacco cessation programs, and minimal activities related to health/wellness were reported.
- **Connect clients with resources on job training or employment opportunities.** Nearly half (44%) of clients identified as being unemployed but looking for work.
- **Connect clients with a primary care provider.** Out of the total number of unique individuals seen at the SUD treatment organizations, nearly one-third do not have a primary care provider.
- **Diversify recovery support services spending.** Organizations spent over $25,000 on recovery support services, of which two-thirds were spent on NOMs coordination and clothing/hygiene. Additional funds can be used for services such as gas cards, wellness, or education.
- **Explore ways to improve SBIRT implementation and tracking,** such as increasing SBIRT training and communications between organizations and staff.
- **Offer educational opportunities to organization staff to further their understanding of integrated care.** The SUD interview guide revealed that staff’s understanding of integration varies, and there is room for additional education.

List of Acronyms

CADS……Center for Alcohol and Drug Services, Inc.

CHC……Community Health Care, Inc.

CMHS……Center for Mental Health Services

FQHC……Federally Qualified Health Center

HOM……House of Mercy

IAANG……Iowa Army National Guard

ICD-10-CM……International Statistical Classification of Diseases, 10th revision, Clinical Modification

IDPH …… Iowa Department of Public Health

JRC……Jackson Recovery Centers

NOMs……National Outcome Measures

PHC…… Primary Health Care, Inc.

Prelude……Prelude Behavioral Services

RSS……Recovery Support Services

SAMHSA……Substance Abuse and Mental Health Services Administration

SBIRT……Screening, Brief Intervention and Referral to Treatment

SCHC……Siouxland Community Health Center

SMI……Serious Mental Illness

SPARS……SAMHSA's Performance Accountability and Reporting System

SUD……Substance Use Disorder

UCS……UCS Healthcare

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Iowa Department of Public Health (IDPH) a five-year grant for Promoting Integration of Primary and Behavioral Health Care (PIPBHC) in September 2018. The purpose of PIPBHC is to promote full integration and collaboration in clinical practice between primary and behavioral healthcare to serve individuals with substance use disorders.

As explained in the application submitted by IDPH for the initial funding opportunity, awards to primary and behavioral healthcare programs would be made to the organizations that participated in the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, funded by SAMHSA from 2012-2017. The organizations participating are three substance use disorder (SUD) treatment providers: Center for Alcohol and Drug Services, Inc. (CADS), Prelude Behavioral Services (Prelude), and Jackson Recovery Centers (JRC). All three SUD treatment organizations partner with the Federally Qualified Health Center (FQHC) in their respective regions to further integrate primary and behavioral healthcare practices and building upon the foundation of SBIRT implementation. The FQHC's involved in the PIPBHC grant with the SUD treatment organizations are Community Health Care, Inc. (CHC), Primary Health Care, Inc. (PHC), and Siouxland Community Health Center (SCHC). Iowa's Integration Project also includes a special project focusing on a community of high need, the Iowa Army National Guard (IAANG). This statewide project co-locates SUD treatment providers from two SUD treatment organizations (House of Mercy (HOM) and UCS Healthcare (UCS)) at the IAANG to further integration of primary and behavioral healthcare for Iowa's soldiers. Appendix A displays the partnerships described within this section.

The objectives of this evaluation report were to:

- Assess the degree to which the project goals and objectives proposed in the grant application were met for year one (September 30, 2018 to September 29, 2019).
- Provide an evaluation of data for clients admitted, beginning March 20, 2019.
- Explore the level of integrated care at each SUD treatment organization and FQHC.

Program Goals and Objectives

The purpose of the PIPBHC grants outlined in the initial funding opportunity are to: 1) promote full integration and collaboration in clinical practice between primary and behavioral healthcare; 2) support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); and (3) 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 proposed to meet PIPBHC grant requirements through the following goals:

Goal 1: Promote integrated health care services through a bidirectional model utilizing an Integrated Care Team approach.

Goal 2: Support the improvement of integrated health care services provided to individuals with SUD, SMI, and co-occurring health conditions.

Goal 3: Increase the number of integrated health care services provided to individuals with SUD, SMI, and co-occurring health conditions.

Goal 4: Implement an innovative and comprehensive care team approach between the Iowa Army National Guard (IAANG) and co-located substance use/mental health community providers.

Appendix B lists corresponding objectives for each goal.

Methods

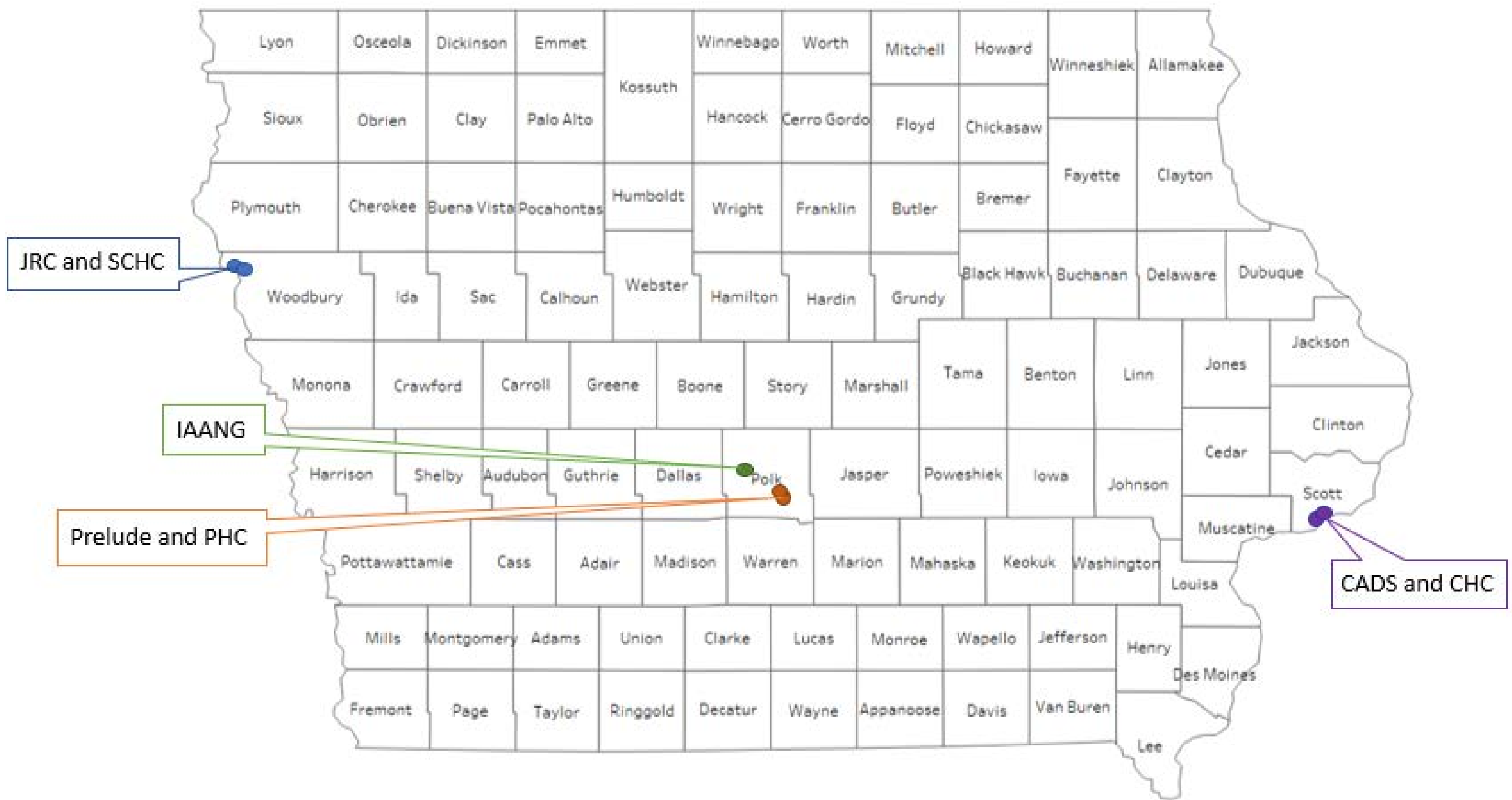
This report presents results for Iowa's Integration Project from September 30, 2018 to September 29, 2019. The IDPH established contracts in March 2019 and during this time, all of the organizations involved had significant changes within their programs, including infrastructure, administration, and staffing. These changes created a significant delay in implementation of the project, with client admissions ultimately beginning on March 20, 2019.

Site Descriptions

Figure 1 displays the geographic location of the organizations providing services for Iowa's Integration Project across the state. JRC and SCHC are located on Iowa's western border in Sioux City, Iowa. Sioux City is the fourth largest city in Iowa with a population of 82,396[1]. Prelude, PHC, and the IAANG are centrally located near Des Moines, Iowa. Des Moines, the capital and largest city in Iowa, has a population of 216,853 residents[2]. CADS and CHC are located on Iowa's eastern border, in Davenport, Iowa. Davenport is the third largest city in Iowa with a population of 102,085 residents[3].

[1] U.S. Census Bureau. (2018). *QuickFacts: Sioux City, Iowa*. Retrieved from http://quickfacts.census.gov.
[2] U.S. Census Bureau. (2018). *QuickFacts: Des Moines, Iowa*. Retrieved from http://quickfacts.census.gov.
[3] U.S. Census Bureau. (2018). *QuickFacts: Davenport, Iowa*. Retrieved from http://quickfacts.census.gov.

Figure 1 Map of Iowa's Integration Project Organizations



Client Eligibility

Eligibility for admission into Iowa's Integration Project included that an individual must meet the following criteria:

1. Eighteen (18) years or older
2. Resident of the state of Iowa
3. Received a diagnosis for a substance use disorder and meet one of the two following criteria:
    a. Has or is at risk of a chronic physical health condition and/or
    b. Has received a diagnosis of a serious mental illness (serious mental illness is defined by someone over 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities).
4. Client is at or below 200% of the current Federal Poverty Guidelines.

Data Collection

Data was gathered from March 20, 2019 through September 29, 2019 from a variety of sources including:

1. **Intake and Discharge Notification Forms.** The intake and discharge notification forms were developed by IDPH to collect client-level data on functional outcomes. These forms were administered by project staff during the NOMs baseline or discharge interview. Functional outcomes included participation in supportive housing or independent living programs, criminal justice involvement, attendance in social & rehabilitative programs, participation in job training opportunities, satisfactory performance in work settings, attendance at scheduled medical and behavioral health appointments, and compliance with prescribed medication regimes.
2. **National Outcome Measures (NOMs) instrument at baseline, reassessment, and discharge from SAMHSA’s Performance Accountability and Reporting System (SPARS).** SAMHSA’s NOMs tool is a standardized questionnaire that gathers client-level data at baseline, quarterly reassessment, six-month reassessment, and discharge interviews. In total, 80 baseline, thirteen quarterly reassessments, one six-month reassessment, and three discharges were collected. Due to the low number of reassessments and discharges, only baseline NOMs data is included in this evaluation. PIPBHC grantees were also required to complete a program-specific section of NOMs, which tracks physical health indicator (PHI) data. PHI data reported includes height, weight, blood pressure, plasma glucose/HgbA1c, and cholesterol. These data were used as biomarkers for obesity, hypertension, diabetes, and hypercholesterolemia.
3. **FQHC and SUD Interview Guides.** The Iowa Primary Care Association (IPCA) developed and administered interview guides to FQHC’s across the state of Iowa to determine their level of integrated care in March 2019. IDPH was able to adapt the FQHC interview guide for SUD organizations to gather similar data in October 2019. Together, both the FQHC and SUD interview guides provided IDPH with baseline data on the level of integrated care for Iowa’s Integration Project organizations.
4. **Monthly forms completed by treatment providers.** IDPH developed monthly tracking forms to collect data on staff training, recovery support services (RSS), SBIRT implementation, and Integrated Care Team activities, which included mental health prevention and promotion.
5. **Client Success Stories.** Iowa’s Integration Project organizations submitted client success stories to IDPH and are included throughout this report.

Client Recruitment

This section provides an overview on the clients admitted into Iowa's Integration Project.

Admissions

Between March 20, 2019 and September 29, 2019, Iowa's Integration Project served 80 clients across the state. Targeted, actual, and monthly admissions counts are discussed below.

Intake Coverage

Iowa's Integration Project proposed to provide services to 175 unduplicated individuals annually, with each of the three main project sites partnered with an FQHC serving 50 clients annually, and the IAANG serving 25 clients annually. Staff capacity led to a delay in client admissions, and therefore, Iowa's Integration Project only admitted 46% of the targeted number of clients. Figure 2 shows the number of clients admitted into Iowa's Integration Project compared to the target number of clients.

Figure 2 Total Admissions for FY19

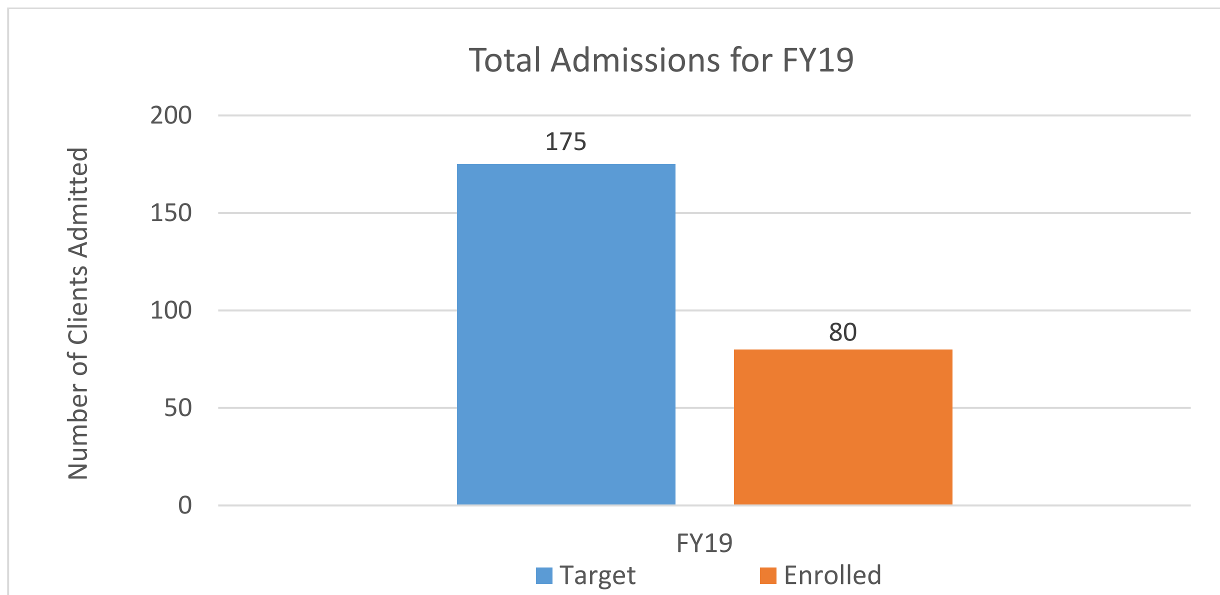
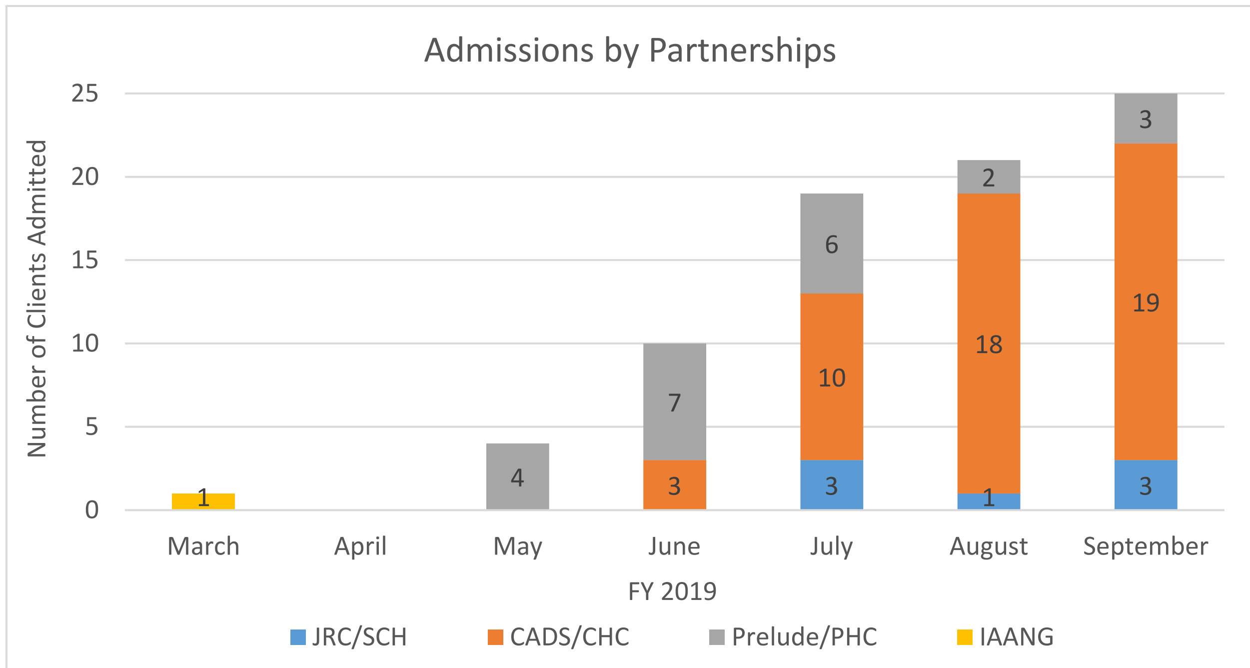


Figure 3 illustrates admissions by each partnership. Starting in May, admissions increased each month, reaching a high of 25 clients in September. IAANG was the first organization to admit a client; however, they were only able to admit one client during the first year due to significant deployments and limited drill weekends. JRC and SCHC started admitting clients in July, and admitted a total of 7 clients within the first year. Prelude and PHC started admitting clients in May, and admitted 22 clients within the first year. CADS and CHC started admitting clients in June, and were the only partnership to achieve the goal of 50 client admissions for FY19.

Figure 3 Admissions by Partnership



Baseline Client Characteristics

Table 1 displays baseline characteristics of the 80 clients admitted in Iowa's Integration Project between March 20, 2019 and September, 29 2019. The median age of all clients is 38 years. The age group 35-44 years had the highest number of clients (37%) with 25-34 years being the second highest (30%). Overall, most clients were male (64%), White/Caucasian (91%) and non-Hispanic or Latino (89%). Forty-one percent (41%) of clients reported graduating 12th grade/receiving a high school diploma, followed closely by completing some college or university (31%). Nearly half (44%) identified as being unemployed but looking for work, followed by being employed full-time (21%).

Table 1 Client Demographics

Client Characteristics	***n* (%)**
Age (median)	38
18-25	* (*)
25-34	24 (30)
35-44	30 (37)
45-54	15 (19)
55-64	7 (9)
65+	* (*)
Gender	
Male	51 (64)

Female	29 (36)
Race	
White/Caucasian	73 (91)
Black/African American	* (*)
Asian	* (*)
Native Hawaiian/other Pacific Islander	* (*)
Alaska Native	0 (0)
American Indian	* (*)
Other	* (*)
Ethnicity	
Hispanic or Latino	9 (11)
Non-Hispanic or Latino	71 (89)
Education	
Less than 12th Grade	9 (11)
12th Grade/High school diploma/GED	33 (41)
VOC/Tech diploma	6 (8)
Some college or university	25 (31)
Bachelor's degree (BA,BS)	7 (9)
Employment	
Full-time	17 (21)
Part-time	10 (12)
Unemployed, looking for work	35 (44)
Unemployed, disabled	* (*)
Unemployed, not looking for work	10 (13)
Other	* (*)

**Totals of 1-5 are suppressed*

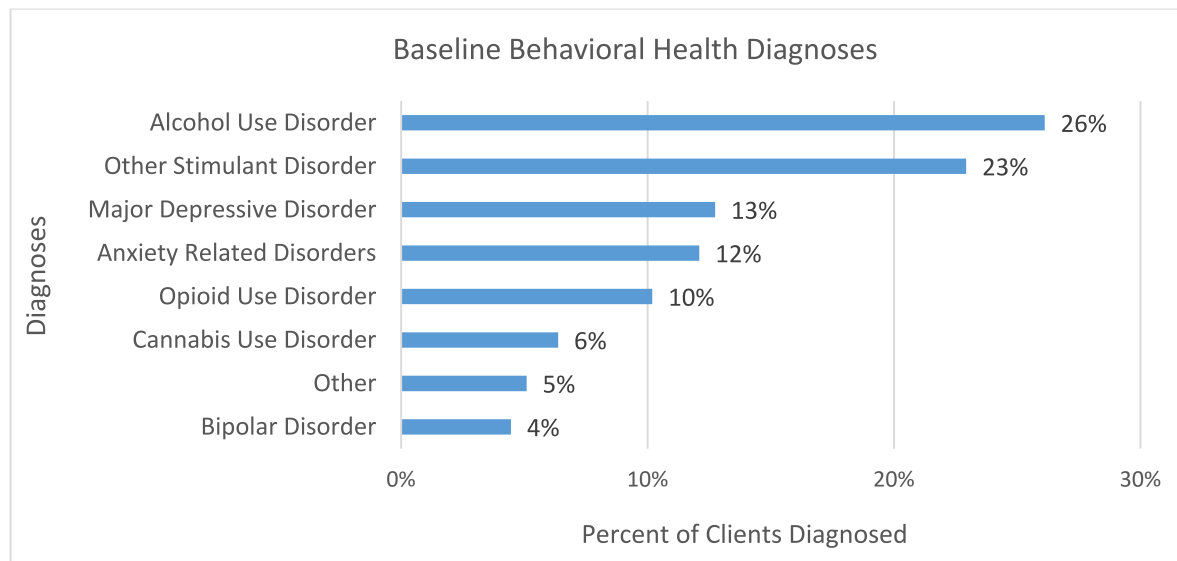
Success Story:

- What was the turning point at which you chose to begin your path to recovery: *"January 2018 I totaled my car after being up for 7 days on meth. The following day I went to Riverside on my own and checked myself in."*
- What do you want to share with others about your recovery: *"It has not been easy and don't expect it to be. Learn to ask for help."*
- Describe what healthy changes you made regarding your use of alcohol or drugs? *"I don't use and I stay connected to all of my support and keep myself involved with lots of recovery based classes and groups."*
- How is your life better today as a result of reducing or eliminating your use of drugs or alcohol? *"I am financially balanced. My relationship with my family is great. I have a career working with those who struggle with addiction. Life is much better."*
    - Male receiving services through SUD provider, part of the Integrated Care Team

Baseline Behavioral Health

Figure 4 displays clients' primary, secondary, and tertiary behavioral health diagnoses reported using ICD-10-CM codes by program staff. Diagnoses are collected in SPARS during the NOMs baseline interview. A list of the ICD-10-CM codes collected in SPARS is included in Appendix C. The most common behavioral health diagnosis was alcohol use disorder (25%), followed closely by other stimulant disorder (23%). The third most common behavioral health diagnosis was major depressive disorder (13%), followed closely by anxiety-related disorders (12%), and opioid use disorder (10%).

Figure 4 Baseline Behavioral Health Diagnoses



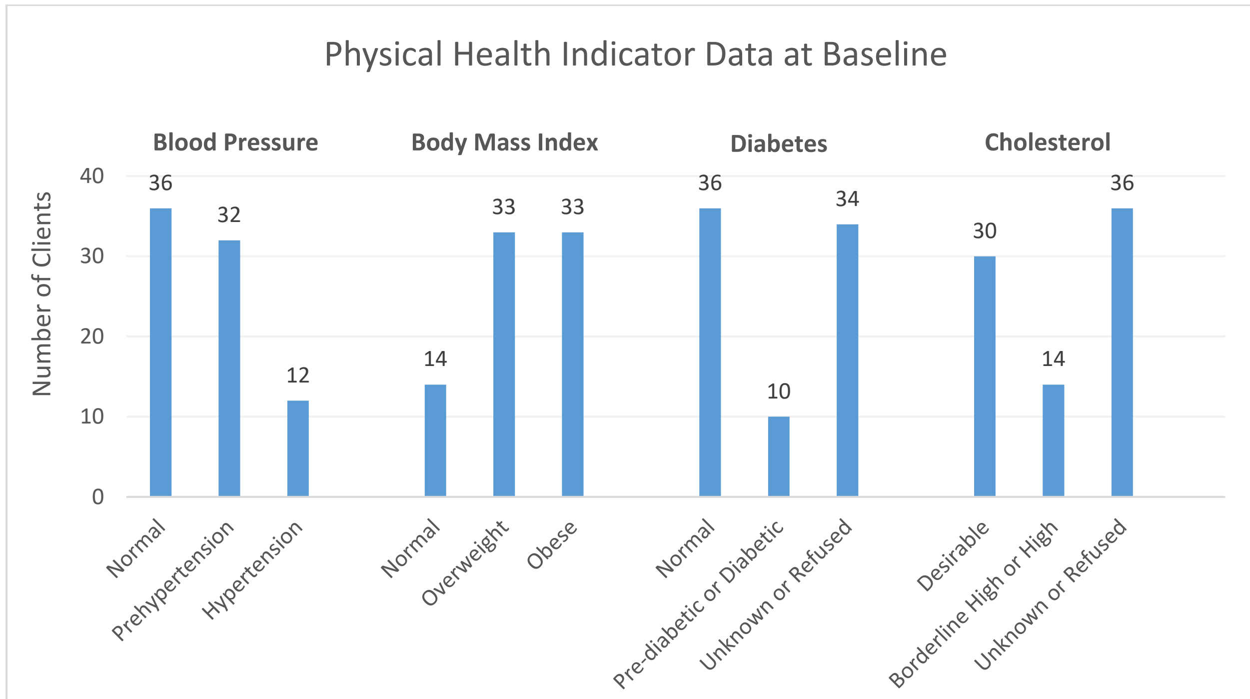
**Totals of 5 or fewer are suppressed*

Baseline Physical Health

Figure 5 displays clients' physical health indicator data collected for the NOMs baseline interview. Over half of clients (55%) had prehypertension or hypertension, while 45% had normal blood pressure. Sixty-six clients (83%) were either overweight or obese and fourteen clients (17%) had a normal BMI. Thirty-six clients (45%) had normal HgbA1c or fasting plasma glucose levels. Ten clients (13%) were pre-diabetic or diabetic. Thirty-four clients (43%) either refused or had unknown HgbA1c or fasting plasma

glucose levels. Thirty clients (38%) had desirable cholesterol levels. Fourteen clients (18%) had borderline high or high cholesterol levels, leaving 36 clients (45%) who refused or have unknown levels.

Figure 5 Physical Health Indictor Data at Baseline



**Totals of 5 or fewer are suppressed*

Baseline Functional Outcomes

Fifty clients (63%) participated in supportive housing or independent living. Forty-four clients (55%) were involved with the criminal justice system at the time data was collected. Seventy-two clients (90%) were attending social and rehabilitative programs at the time of the NOMs baseline interview. Only twelve clients (15%) were participating in job training opportunities at the time of baseline interview. Thirty-eight clients (48%) reported they are currently working, and of those currently working, 25 clients (66%) reported satisfactory performance in their current work setting. Only seven clients (9%) had been hospitalized in the 30 days before the interview. Seventy-eight clients (98%) were always, or almost always, attending scheduled medical and behavioral health appointments. Seventy-five clients (94%) were always, or almost always, compliant with prescribed medication regimes. Figures 6 and 7 display functional outcomes reported during each client's baseline interview.

Figure 6 Functional Outcomes

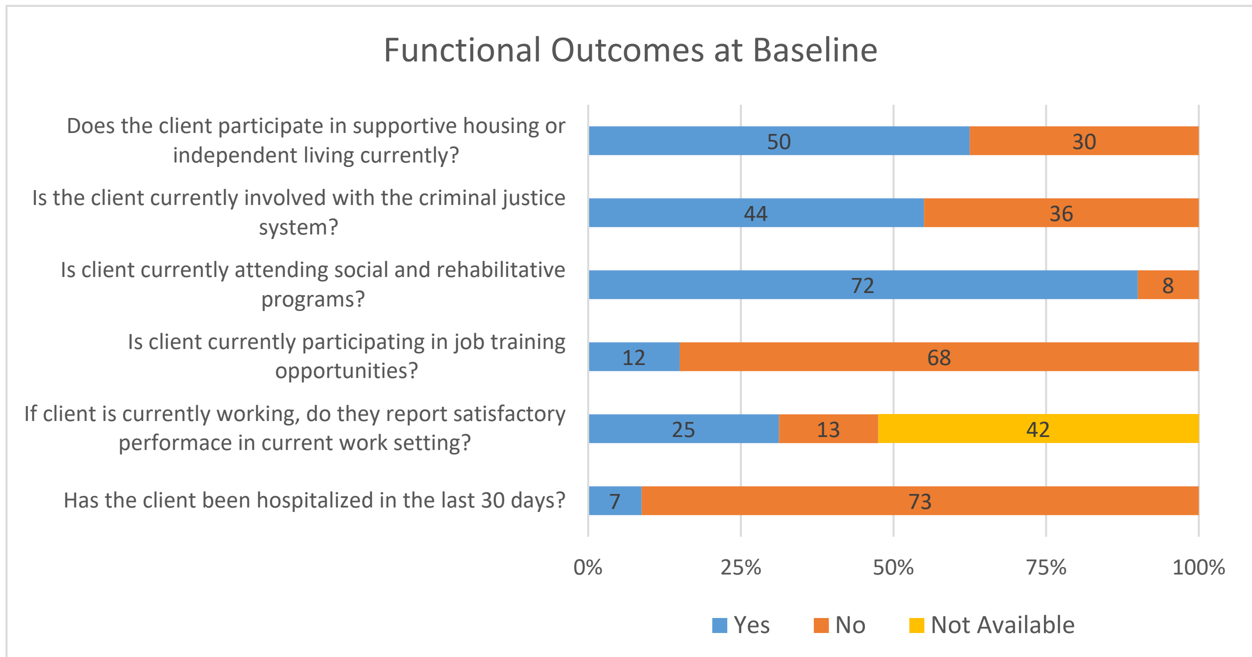
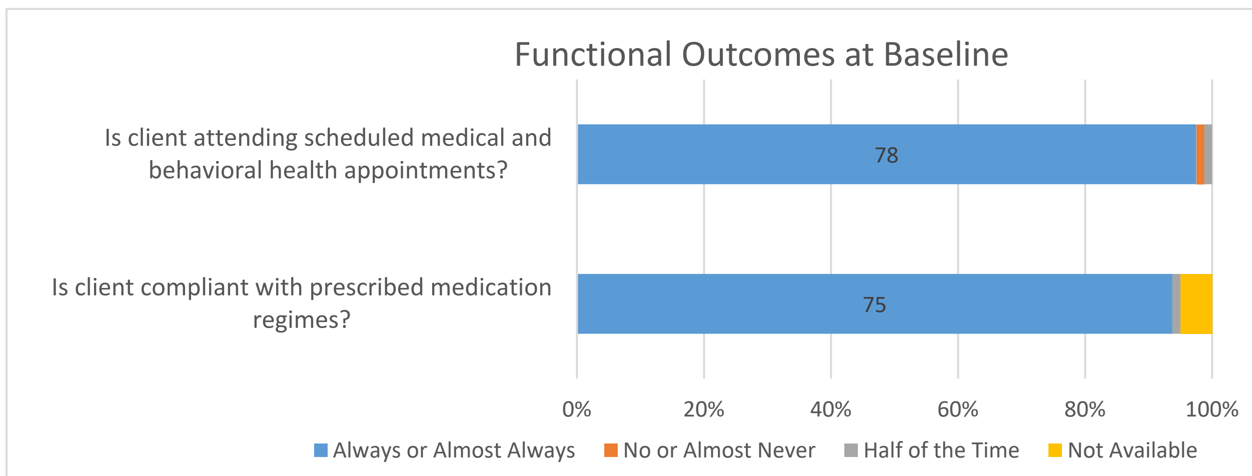


Figure 7 Functional Outcomes Continued



Screening, Brief Intervention and Referral to Treatment (SBIRT)

In total, Iowa's Integration Project completed 23,726 prescreenings, 2,346 screenings, 325 brief interventions, 124 brief treatments, and provided 146 referrals to treatment. IDPH was close to the target number of prescreenings for year one (28,000), with nearly 24,000 completed. However, IDPH fell short of the target number of 26,000 screenings per year, with 2,346 screenings completed. In addition to SBIRT, IDPH collected information on the number of clients receiving an assessment and the number of clients agreeing to an assessment; however, these numbers are not included because multiple

organizations did not have the resources to track and report that information in the first year of grant implementation. The following table displays SBIRT services by month and organization.

Table 2 SBIRT Tracking

SBIRT Tracking						
Month	**Site**	**Prescreenings**	**Screenings**	**Brief Intervention**	**Brief Treatment**	**Referral to Treatment**
April	CHC	116	21	0	0	0
	IAANG	375	150	21	13	*
	PHC	3156	56	0	9	20
	SCHC	1554	30	0	0	0
May	CHC	348	114	26	12	10
	IAANG	195	96	5	0	0
	PHC	1691	36	0	11	11
	SCHC	1535	35	*	0	0
June	CHC	279	74	25	*	14
	IAANG	86	45	*	*	0
	PHC	1565	31	0	0	0
	SCHC	1359	32	*	*	0
July	CHC	250	90	28	6	17
	IAANG	6	6	6	*	*
	PHC	1690	29	0	0	0
	SCHC	1402	24	*	*	0
August	CHC	434	229	114	16	34
	IAANG	489	305	24	3	*
	PHC	1408	42	0	0	0
	SCHC	1551	21	*	6	2
September	CHC	333	144	40	12	32
	IAANG	1016	681	21	11	*
	PHC	1430	30	0	0	0
	SCHC	1458	25	*	8	*
Total		23,726	2,346	325	124	146

**Totals of 1-5 are suppressed*

Interview Guide

To better understand the current level of integrated services available for clients at each organization, IDPH partnered with the Iowa Primary Care Association (IPCA) to develop and collect interview guides. Prior to the partnership, the IPCA collected interview guides from FQHC's across the state of Iowa to determine levels of integrated care within FQHC's across the state. IDPH was able to adapt the FQHC interview guide for SUD organizations to gather similar information. These combined data provided IDPH with baseline data of integrated care for this project. The below paragraphs summarize key findings from these guides.

FQHC Interview Guides

In the FQHC interview guides, the IPCA collected a history of behavioral health services from PHC and SCHC, which are included below. CHC did not complete the interview guide implemented by IPCA, therefore the history of behavioral health is unknown for their organization.

SCHC began hiring outpatient therapists in response to long wait-times and low referral success at area mental health organizations. Case managers function as "health coaches" and can be paged into a room to assess behavioral health needs and perform brief interventions. Case managers may refer patients to licensed independent social workers (LISW) or psychiatric nurse practitioner. SCHC is using the PIPBHC grant funding to co-locate a nurse case manager and SUD counselor from the SUD facility.

In 2008, PHC received consultations and submitted a HRSA expansion grant to begin mental health services. They proceeded to co-locate a physician assistant and Licensed Independent Social Worker (LISW) onsite. In 2011, they visited a clinic in Madison, WI and were inspired to turn their therapists into behavioral health consultants, beginning a process toward integrated primary care behavioral health. In the following years, PHC continued to use grant funding to hire BHCs and visited integration leaders to learn more about warm handoffs and brief interventions.

Table 3 displays the type of staff and how many full time employees (FTEs) are available by each FQHC. A snapshot of behavioral health at the FQHC's is provided in Appendix E.

Table 3 FQHC Staffing

	CHC	PHC	SCHC
Type of Staff	**FTEs**	**FTEs**	**FTEs**
Primary Care Providers	12.4	35	24.5
Psychiatric Nurse Practitioner	2	1.3	1
RN/BSN	-	-	1
Behavioral Health Specialists/Clinicians	2	8.8	-
LCSW/LISW/MSW	1	8	2
LMHC	3	-	-
Therapist	-	1.5	-
LMFT	-	0.5	-
Case Managers	-	-	4

Family Support Workers	-	6	-

SUD Interview Guides

The SUD interview guides collected a self-reported history of both mental health and primary health services from CADS, JRC, Prelude, and the IAANG, which are included below.

At CADS, primary health care services and mental health services involve health & physicals done by an advanced registered nurse practitioner (ARNP) and physician for admissions into programs. Clinical staff (counselors, nursing, ARNPs, doctor) inquire about biomedical conditions and mental health conditions and symptoms, and coordinate care to other providers as appropriate. CADS has made efforts with integrated care in conjunction with Community Health Care. CADS also works to link clients to their provider of choice, including connecting clients with the Unity Point Health continuum of services.

In 2007, JRC hired a local physician to be the medical director and formally began planning an integrated care model in 2010 when the Affordable Care Act was passed. In January 2014, they collaborated with the FQHC to open an outpatient primary care clinic embedded in our outpatient SUD treatment program. JRC's residential programs have on-site healthcare services provided by nurse practitioners and include, well-child, initial history and physical examinations, and routine care for illnesses, in addition to embedded psychiatric evaluation and medication management, when needed. In regards to mental health, JRC have always had a focus on the co-morbidity of substance use and mental health. All patients in residential treatment programs receive psychiatric screening as part of their initial history and physical.

Prelude has historically screened for mental health needs and suicide concerns and has employed licensed mental health providers who can provide integrated SUD/MH services. Integrated care has advanced in the last few years with a new electronic health record that allowed them to use a master assessment tool which incorporates both MH and SUD material. Prelude has worked closely with Primary Health Care (PHC) for approximately 5 years. Prior to PIPBHC, Prelude and PHC were struggling to maintain collaboration due to physical proximity and lack of coordination. In the first year of PIPBHC, PHC and Prelude grew their collaborative relationship and established roles as well as additional policies and procedures that furthered integrated care at each program. PIPBHC allowed Prelude to place staff onsite at PHC and jumpstarted the collaboration. Prelude is able to draw labs, prescribe medications, collect physical health data, obtain medical records from previous providers, review lab results with patients, some care coordination, collaborate with other medical providers, and refer to outside medical providers as needed.

The IAANG is a special project within Iowa's Integration Project, where two SUD treatment programs co-locate an SUD treatment professional at the main base in Johnston, Iowa. Mental health services were barely existent at the IAANG 5 years ago. Now, a behavioral health department screens guard members for anxiety, depression, and trauma during physical health assessment (PHA's) events. While therapy is not provided at the IAANG, they can provide referrals into the community. The IAANG's goal with primary health is to assess the readiness of guard members. Periodic health assessments (PHA's), which are similar to a physical, are completed every year. The guard also requires physical training (PT) tests to be done by units. PT tests are completed twice a year for full-time members and yearly for part-time members and consist of a two-mile run, sit-ups, and push-ups. The IAANG cannot treat any medical

condition and instead refer out to the community. If a condition needs treated, a medical profile is created for that guard member and they have one year to treat the condition.

The SUD interview guides also collected self-reported data from CADS, JRC, Prelude, and the IAANG on patient population, data collection, screenings, provider and staff engagement, and on-site providers. The below sections provide a summary of key findings.

Patient Population

- Out of the total number of unique individuals seen at the SUD treatment organizations, an estimated 3,900 do not have a primary care provider.
- Each organization identified people experiencing homelessness as a special population with unmet primary health needs.
- SUD treatment organizations served nearly 2,000 individuals with multiple chronic conditions.
- The most prevalent mental health diagnoses reported were depression and anxiety and the most prevalent SUD diagnosis was alcohol.
- An estimated 1,800 individuals had an opioid or benzodiazepine prescription at admission.

Data Collection

- All organizations collect individual-level data, record the names of primary care providers, and use an electronic health record.
- Dates of the last primary care visit and recorded past-year hospitalizations were not collected by each organization.

Screenings

- All organizations screen for trauma, depression, anxiety, and PTSD.
- Physical health screenings varied by each organization and general health measures are not always collected.

Provider and Staff Engagement

- Most staff have a basic understanding of integration, but there is room for improvement.
- The level of experience and background of a staff member affects their level of comfort working with a member of the primary care team.

Each SUD treatment provider has a Psychiatrist, Social Workers, and Master's degree level staff available. Additional staff varies based on each organization and is displayed in Table 4.

Table 4 SUD Treatment Organizations Staffing

	CADS		JRC		Prelude		IAANG	
Type of Staff	**N**	**FTEs**	**N**	**FTEs**	**N**	**FTEs**	**N**	**FTEs**
MD/DO	-	-	1	0.2	-	-	1	0.5
MD/DO - Psychiatry	2	2	2	(2 PRN)	1	1	1	0.5
APRN	-	-	4	3 (1 PRN)	-	-	-	-
APRN – Psychiatry	2	2	3	2 (1 PRN)	1	1	-	-
RN/BSN	6	4 (2 PRN)	14	14	10	8.4	-	-

PhD/PsyD	-	-	1	1	-	-	1	0.5
LCSW/LISW/MSW	1	1	5	5	3	2.4	3	1.5
LMHC	-	-	6	6	8	8	2	2
MA/MS	5	5	15	15	9	9	1	1
BA/BS	24	24	53	53	17	16.5	-	-
Other:	2	2	12	12	3	2.9	9	7

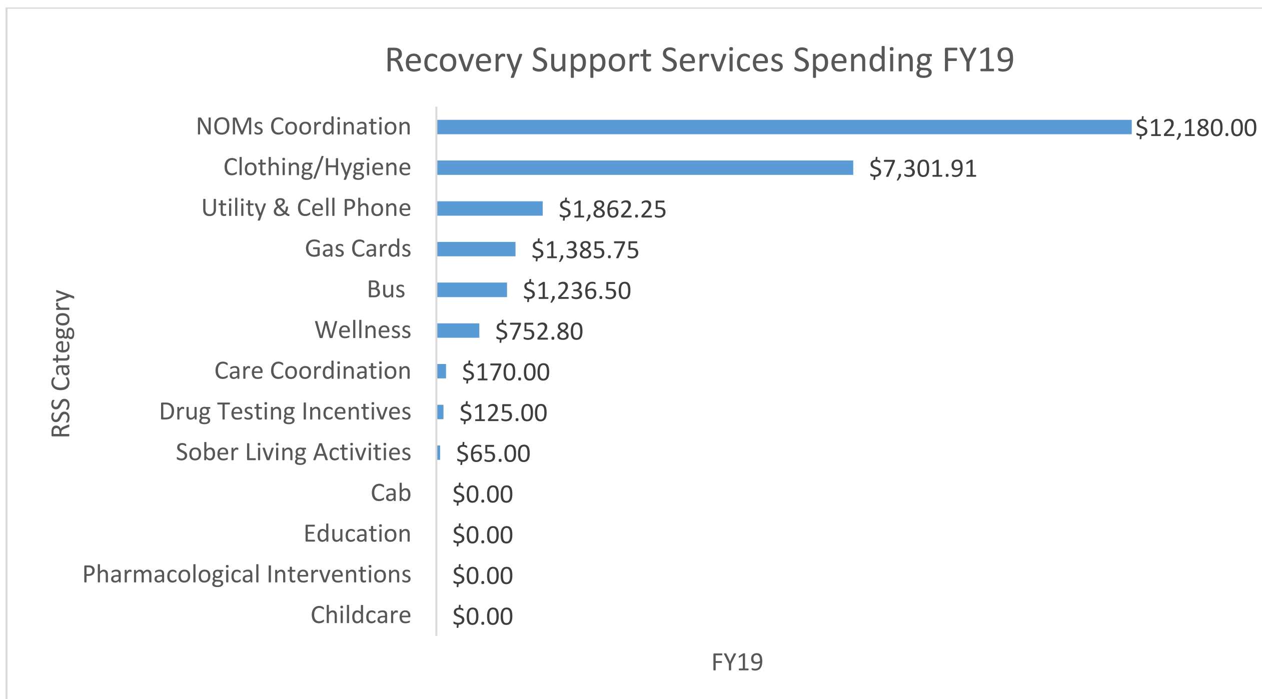
Client Retention

The following section presents services and practices implemented by Iowa's Integration Project organizations to retain and engage clients in treatment through the use of Recovery Support Services (RSS).

Recovery Support Services

Iowa's Integration Project allows RSS to support personalized recovery plans and promote client engagement in treatment. Figure 5 displays the amounts billed to Iowa's Integration Project by category for FY19. There are 13 categories of RSS: NOM's Coordination (with Intake, Follow-up and Discharge Interviews), Supplemental Needs (Clothing and Hygiene, Education, Utility Assistance, Wellness), Sober Living Activities, and Transportation (Bus, Cab, Gas Cards). A total of $25,075.71 was spent for all clients. NOMs Coordination was the largest amount spent at $12,180.00, followed by Clothing and Hygiene at $7,301.91. A list of available RSS and descriptions for each category is included in Appendix D.

Figure 5 Recovery Support Services Spending by Category



**As of May 2020, RSS have been revised per SAMHSA guidelines*

Client Outcomes

Iowa's Integration Project organizations completed thirteen quarterly reassessments, one 6-month reassessment, and three administrative discharges in the first year (FY19). Of the three administrative discharges, two were due to client death. Due to the low amount of data available from the reassessments and discharges completed, client outcomes were not analyzed for FY19. Client outcomes will be closely monitored in FY20 and reported in the year 2 evaluation.

Success Story:
"A 42 year old male patient who was at Prelude's SA treatment program and referred to the Wellness Center to be seen. The patient was at Prelude for treatment of polysubstance abuse. Patient's BMI was 42.07. Blood pressure readings when seen at the Wellness Center were 148/90 & 151/97. The patient related he had been having left anterior upper chest pain and right arm numbness. He mentioned his cholesterol and blood sugar had not been checked. Patient has a family history of arteriosclerotic cardiovascular disease, diabetes, and other conditions. We ordered a lipid panel and a HgbA1c; and requested patient's blood pressure be monitored at Prelude. Lipid panel results were received and revealed high triglycerides (413. Normal levels < 150) and an elevated non-LDL cholesterol of 146 (normal, < 130). We referred the patient to Iowa Heart for evaluation, in view of multiple risk factors and symptoms. Our Nurse Care Manager coordinated the referral and the patient was seen by Iowa Heart on Friday, October 25. Iowa Heart records are pending receipt at PHC as of this writing, but we have received the EKG report showing what is called a "prolonged QT interval". This can be caused by amphetamines and cocaine in particular, and this abnormality can lead to fatal arrhythmias."

- Doctor at FQHC, part of the Integrated Care Team

Conclusion

Despite the delay in the project implementation, a wide array of services were able to be provided to help enhance integrated healthcare across the state to individuals with substance use disorders. Below are the responses to questions based on Iowa's Integration Project proposed goals and objectives.

Goal 1: Promote integrated health care services through a bidirectional model utilizing an Integrated Care Team approach.

- Did Iowa co-locate a SUD treatment/mental health (MH) professional at each FQHC?
  - *Answer:* **Partially.** A mental health professional was co-located between most organizations, but establishing partnerships and staff turnover impacted implementation progress.
- Did Iowa provide a nurse care manager at each FQHC to work in tandem with the on-site SUD/MH professional?
  - *Answer:* **Yes.** A nurse care manager was located at each FQHC to work alongside the SUD/MH professional.
- Did Iowa enhance on-site physical health and care coordination services at the SUD treatment program?
  - *Answer:* **Partially.** By the end of FY19, each partnership was meeting weekly between the Integrated Care Team to improve care coordination and client outcomes. Only one SUD treatment provider was providing health/wellness activities to SUD clients regularly.

Goal 2: Support the improvement of integrated health care services provided to individuals with SUD, SMI and co-occurring health conditions.

- Did Iowa will implement evidenced based practices to address behavioral health in primary care settings?
  - *Answer:* **Yes.** IDPH completed a Training Plan for Year 1, and also completed a motivational interviewing needs assessment in May of 2019. IDPH implemented training for the following evidence-based practices in FY19: Motivational Interviewing (the series included three separate trainings, beginner, intermediate and advanced and 1x1 training); Recovery Peer Coaching; and Screening, Brief Intervention and Referral to Treatment. IDPH also implemented a Knowledge Transfer Training between two organizations to enhance bi-directional understanding of healthcare practices.
- Did Iowa implement general health screenings and align physical health practices with the goals of the Million Hearts® Initiative?
  - *Answer:* **Yes.** All of the FQHC's participating in Iowa's Integration Project also participate in Million Hearts® 2022.
- Did Iowa develop a Policy Steering Advisory Committee (PSAC)?
  - *Answer:* **No.** IDPH received notice of award in August of 2018, more than a year after the initial application was submitted. The delay in award impacted implementation of the first year, the primary focus was to ensure that formation of each ICT and clients admissions, so the formation of the PSAC was delayed. As of the time of this report, IDPH has begun planning meetings for the implementation of the PSAC, the initial PSAC meeting is tentatively scheduled for February/March 2020.
- Did Iowa host Knowledge Transfer trainings for all providers?

- *Answer:* **Partially.** Knowledge Transfer trainings were identified in the initial application to occur between each partnership and due to the timing/staffing limitations within the organizations CADS and CHC were the only partnership able to plan/complete the KT training.

Goal 3: To increase the number of integrated health care services provided to individuals with SUD, SMI and co-occurring health conditions.

- Did Iowa provide integrated care services to 175 people?
  - *Answer*: **No.** As mentioned previously, the NOA was provided to IDPH in August of 2018, which led to delayed implementation of Iowa's Integration Project. As a result, only 80 clients were admitted into the grant.
- Did Iowa increase outreach and awareness of integrated health care practices through the provision of 140,000 substance use pre-screenings and 130,000 substance use screenings to individuals?
  - *Answer:* **Partially.** The amount of prescreenings and screenings proposed in the above objective reflect the total amount proposed for the 5-year grant period. IDPH was close to the target number of prescreenings for year one, as 23,726 were completed (target is around 28,000/year). However, IDPH fell short of the target number of 26,000 screenings per year, with 2,346 screenings completed within FY19.
- Did Iowa improve outcomes for Iowans with substance use disorders measured by fewer ER visits and inpatient hospitalizations for chronic conditions post initial screening?
  - *Answer:* **Unknown.** Due to the low numbers of reassessments and discharges completed in year one, only baseline data was used for evaluation. This objective will be closely monitored and tracked during FY20.
- Did Iowa increase prevention and health promotion activities, recovery supports and wellness programs to adults with a substance use disorder and/or a mental health condition?
  - *Answer:* **Yes.** Ten prevention activities, reaching over 1200 participants, six health promotion activities, reaching nearly 350 participants, and twenty-five wellness visits or group activities were implemented by SUD treatment organizations and FQHCs. Additionally, over $25,000 was spent on Recovery Support Services.

Goal 4: Implement an innovative and comprehensive care team approach between the Iowa Army National Guard (IAANG) and co-located substance use/mental health community providers.

- Did Iowa utilize (SBIRT) with 1,250 Soldiers annually?
  - *Answer:* **Yes.** The IAANG completed 2,167 prescreenings, 1,283 screenings, 81 brief interventions, 32 brief treatments, and 4 referrals to treatment in FY19.
- Did Iowa coordinate medical screenings (fitness tests, preventative health screenings) between the IAANG Nurse Care Managers and the co-located SUD professionals and implement services (tobacco cessation, wellness groups)?
  - *Answer:* **Partially.** The co-located SUD professionals at the IAANG coordinated medical screenings and lab work for PIPBHC clients. The IAANG team reported several wellness activities implemented in Year 1 with 8 soldiers. Limitations experienced by the IAANG team included significant deployments and limited drill weekends, which affected access to soldiers for screening and service provision.
- Did Iowa provide comprehensive coordination of psychiatric screenings (GADS-7, PHQ-9, PC-PTSD) between the IAANG Psychological Health Consultants and the co-located substance use disorder professionals and assist with referrals as needed by Guard Command?

- *Answer:* **Yes.** The co-located SUD professionals at the IAANG coordinated psychiatric screenings between the IAANG Psychological Health Consultants and assisted with referrals.

Recommendations

Analysis of both quantitative and qualitative data revealed several areas of Iowa's Integration Project that can help improve client outcome for Year 2.

- **To address and reduce health disparities, organizations should explore strategies for increasing access to behavioral health services for diverse client populations.** The majority of clients are males (64%), White (91%), non-Hispanic or Latino (89%), and between the ages of 25-44 (67%).
- **Offer education on people experiencing homelessness and how they may benefit from services.** Almost every organization identified people experiencing homelessness as a special population with unmet primary health needs.
- **Enhance efforts to address tobacco use and obesity.** Over half (60%) of clients reported smoking daily or almost daily, had prehypertension or hypertension (55%), and were overweight or obese (83%). Throughout the first year of the grant, no organizations reported tobacco cessation programs and minimal activities related to health/wellness were reported.
- **Connect clients with resources on job training or employment opportunities.** Nearly half (44%) of clients identified as being unemployed, but looking for work.
- **Connect clients with a primary care provider.** Out of the total number of unique individuals seen at the SUD treatment organizations, nearly one-third do not have a primary care provider.
- **Diversify recovery support services spending.** Organizations spent over $25,000 on Recovery Support Services, of which two-thirds were spent on Care Coordination with NOMs Interviews and Supplemental Needs (Clothing/Hygiene). Additional funds can be used for services such as gas cards wellness, or education.
- **Explore ways to improve SBIRT implementation and tracking**. Initial discussions have begun with the IDPH team to develop an SBIRT interview guide to identify strategies for improvement, such as providing diversified training in SBIRT and identifying discrepancies in communications regarding SBIRT services.
- **Offer educational opportunities to organization staff to further their understanding of integrated care.** The SUD interview guide revealed that staff's understanding of integration varies and there is room for additional education.

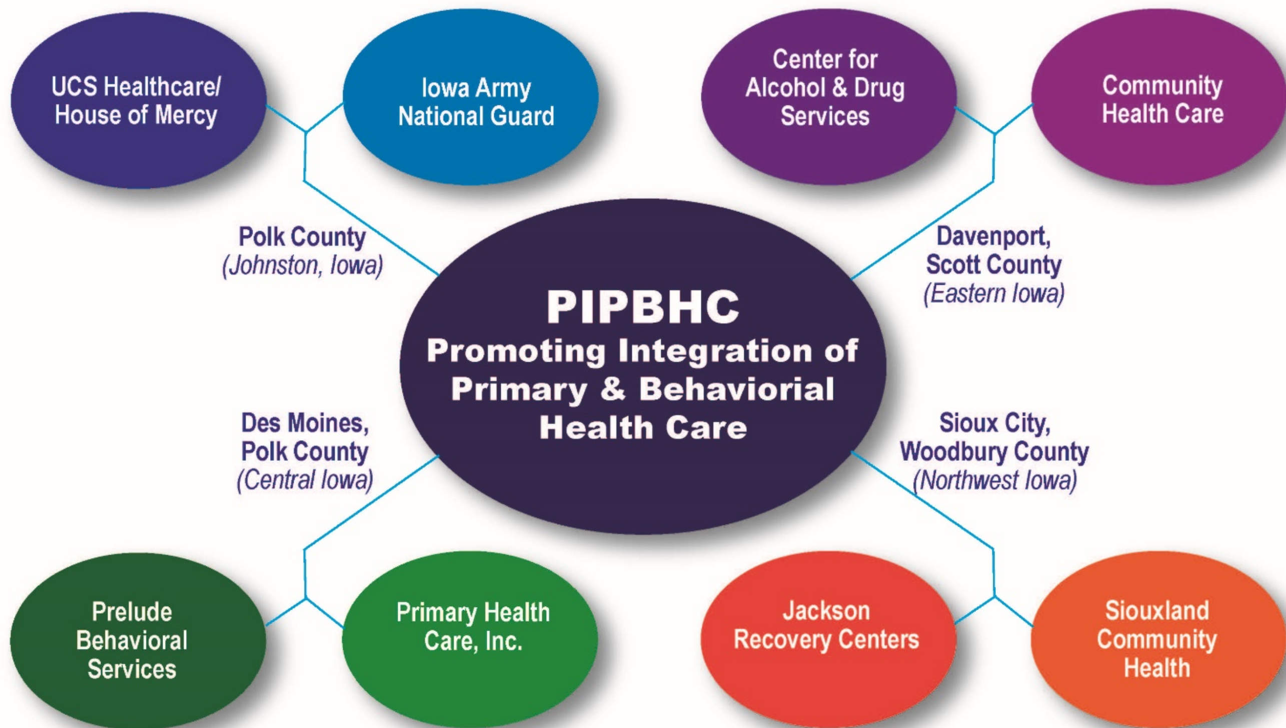
Bibliography

U.S. Census Bureau. (2018). *State & county Quick Facts: Davenport, Iowa.* Retrieved from http://quickfacts.census.gov

U.S. Census Bureau. (2018). *State & county Quick Facts: Des Moines, Iowa.* Retrieved from http://quickfacts.census.gov

U.S. Census Bureau. (2018). *State & county Quick Facts: Sioux City, Iowa.* Retrieved from http://quickfacts.census.gov

Appendix A – Iowa's Integration Project



Purpose:

1. To promote integration and collaboration in clinical practice between primary and behavioral healthcare.

2. Support the improvement of integrated care models for primary care and behavioral healthcare to improve overall wellness.

3. 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.

November 2018

Appendix B – Goals and Objectives

Goal and Objectives:

The overarching goal of Iowa's Integration Project is to improve primary and behavioral health outcomes for individuals with substance use disorders. Iowa PIPBHC will accomplish this through the four primary goals and corresponding measurable objectives described below:

1. Promote integrated health care services through a bidirectional model utilizing an Integrated Care Team approach.
    a. Iowa will co-locate a substance use disorder treatment/mental health professional at a Federally Qualified Health Center (FQHC) to enhance behavioral health services.
    b. Iowa will provide a nurse care manager to provide comprehensive care management services at each partnering FQHC to work in tandem with the on-site SUD treatment professional.
    c. Iowa will enhance on-site physical health and care coordination services at the SUD treatment program through the hiring and training of a nurse care manager, care coordinator and a peer support specialist to further integrated services.
    d. Iowa will provide integrated care services; screening, diagnosis, prevention and treatment of mental and substance use disorders, and co-occurring physical health conditions for 175 people annually.
2. To support the improvement of integrated health care services provided to individuals with SUD, SMI and co-occurring health conditions.
    a. Iowa will implement evidenced based practices (Motivational Interviewing, SBIRT, Recovery Peer Coaching, and Brief Treatment), to address behavioral health in primary care settings.
    b. Iowa will implement general health screenings and align physical health practices with the goals of the Million Hearts Initiative29 into the continuum of care at the SUD treatment programs.
    c. Iowa will develop a Policy Steering Committee to provide project oversight; modify policies to remove barriers to integrated care; create guidelines for consistent integrated care practices for screening, diagnosis and service delivery. Additionally, the PCSC will monitor EBP fidelity and continuous quality improvement; guide and improve consumer experience and the quality of care; and ensure program sustainability and scalability of grant activities.
    d. Iowa will host Knowledge Transfer trainings for all providers (FQHC, SUD treatment program) to enhance bidirectional understanding of health care practices.
    e. Complete all objectives of EHR Stage 2 Modification by September 29, 2022.
3. To increase the number of integrated health care services provided to individuals with SUD, SMI and co-occurring health conditions.
    a. Iowa will provide integrated health services to 175 clients with the Iowa Integration Project.
    b. Iowa will increase outreach and awareness of integrated health care practices through the provision of 140,000 substance use pre-screenings and 130,000 substance use screenings to individuals.
    c. Iowa will improve outcomes for Iowans with substance use disorders measured by fewer ER visits and inpatient hospitalizations for chronic conditions post initial screening.

   d. Iowa will increase prevention and health promotion activities, recovery supports and wellness programs to adults with a substance use disorder and/or a mental health condition.

4. Implement an innovative and comprehensive care team approach between the Iowa Army National Guard (IAANG) and co-located substance use/mental health community providers.
   a. Iowa will utilize Screening, Brief Intervention and Referral to Treatment (SBIRT) evidenced based practices with 1,250 Soldiers annually.
   b. Iowa will coordinate medical screenings (fitness tests, preventative health screenings) between the IAANG Nurse Care Managers and the co-located SUD professionals and implement services (tobacco cessation, wellness groups).
   c. Iowa will provide comprehensive coordination of psychiatric screenings (GADS-7, PHQ-9, PC-PTSD) between the IAANG Psychological Health Consultants and the co-located substance use disorder professionals and assist with referrals as needed by Guard Command.

Appendix C – ICD-10-CM Codes

DSM-5 Diagnoses and New ICD-10-CM Codes

As Ordered in the DSM-5 Classification

Disorder	DSM-5 Recommended ICD-10-CM Code for use through September 30, 2017	DSM-5 Recommended ICD-10-CM Code for use beginning October 1, 2017
Avoidant/Restrictive Food Intake Disorder	F50.89	F50.82
Alcohol Use Disorder, Mild	F10.10	F10.10
Alcohol Use Disorder, Mild, In early or sustained remission	F10.10	F10.11
Alcohol Use Disorder, Moderate	F10.20	F10.20
Alcohol Use Disorder, Moderate, In early or sustained remission	F10.20	F10.21
Alcohol Use Disorder, Severe	F10.20	F10.20
Alcohol Use Disorder, Severe, In early or sustained remission	F10.20	F10.21
Cannabis Use Disorder, Mild	F12.10	F12.10
Cannabis Use Disorder, Mild, In early or sustained remission	F12.10	F12.11
Cannabis Use Disorder, Moderate	F12.20	F12.20
Cannabis Use Disorder, Moderate, In early or sustained remission	F12.20	F12.21
Cannabis Use Disorder, Severe	F12.20	F12.20
Cannabis Use Disorder, Severe, In early or sustained remission	F12.20	F12.21
Phencyclidine Use Disorder, Mild	F16.10	F16.10
Phencyclidine Use Disorder, Mild, In early or sustained remission	F16.10	F16.11
Phencyclidine Use Disorder, Moderate	F16.20	F16.20
Phencyclidine Use Disorder, Moderate, In early or sustained remission	F16.20	F16.21
Phencyclidine Use Disorder, Severe	F16.20	F16.20
Phencyclidine Use Disorder, Severe, In early or sustained remission	F16.20	F16.21
Other Hallucinogen Use Disorder, Mild	F16.10	F16.10
Other Hallucinogen Use Disorder, Mild, In early or sustained remission	F16.10	F16.11
Other Hallucinogen Use Disorder, Moderate	F16.20	F16.20
Other Hallucinogen Use Disorder, Moderate, In early or sustained remission	F16.20	F16.21
Other Hallucinogen Use Disorder, Severe	F16.20	F16.20
Other Hallucinogen Use Disorder, Severe, In early or sustained remission	F16.20	F16.21
Inhalant Use Disorder, Mild	F18.10	F18.10
Inhalant Use Disorder, Mild, In early or sustained remission	F18.10	F18.11
Inhalant Use Disorder, Moderate	F18.20	F18.20
Inhalant Use Disorder, Moderate, In early or sustained remission	F18.20	F18.21
Inhalant Use Disorder, Severe	F18.20	F18.20

Changes go in effect October 1, 2017

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Inhalant Use Disorder, Severe, In early or sustained remission	F18.20	F18.21
Opioid Use Disorder, Mild	F11.10	F11.10
Opioid Use Disorder, Mild, In early or sustained remission	F11.10	F11.11
Opioid Use Disorder, Moderate	F11.20	F11.20
Opioid Use Disorder, Moderate, In early or sustained remission	F11.20	F11.21
Opioid Use Disorder, Severe	F11.20	F11.20
Opioid Use Disorder, Severe, In early or sustained remission	F11.20	F11.21
Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild	F13.10	F13.10
Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild, In early or sustained remission	F13.10	F13.11
Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate	F13.20	F13.20
Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate, In early or sustained remission	F13.20	F13.21
Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe	F13.20	F13.20
Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe, In early or sustained remission	F13.20	F13.21
Amphetamine-type Substance Use Disorder, Mild	F15.10	F15.10
Amphetamine-type Substance Use Disorder, Mild, In early or sustained remission	F15.10	F15.11
Amphetamine-type Substance Use Disorder, Moderate	F15.20	F15.20
Amphetamine-type Substance Use Disorder, Moderate, In early or sustained remission	F15.20	F15.21
Amphetamine-type Substance Use Disorder, Severe	F15.20	F15.20
Amphetamine-type Substance Use Disorder, Severe, In early or sustained remission	F15.20	F15.21
Cocaine Use Disorder, Mild	F14.10	F14.10
Cocaine Use Disorder, Mild, In early or sustained remission	F14.10	F14.11
Cocaine Use Disorder, Moderate	F14.20	F14.20
Cocaine Use Disorder, Moderate, In early or sustained remission	F14.20	F14.21
Cocaine Use Disorder, Severe	F14.20	F14.20
Cocaine Use Disorder, Severe, In early or sustained remission	F14.20	F14.21
Other or Unspecified Stimulant Use Disorder, Mild	F15.10	F15.10
Other or Unspecified Stimulant Use Disorder, Mild, In early or sustained remission	F15.10	F15.11
Other or Unspecified Stimulant Use Disorder, Moderate	F15.20	F15.20
Other or Unspecified Stimulant Use Disorder, Moderate, In early or sustained remission	F15.20	F15.21
Other or Unspecified Stimulant Use Disorder, Severe	F15.20	F15.20
Other or Unspecified Stimulant Use Disorder, Severe, In early or sustained remission	F15.20	F15.21
Tobacco Use Disorder, Moderate	F17.200	F17.200
Tobacco Use Disorder, Moderate, In early or sustained remission	F17.200	F17.201
Tobacco Use Disorder, Severe	F17.200	F17.200

Changes go in effect October 1, 2017

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Tobacco Use Disorder, Severe, In early or sustained remission	F17.200	F17.201
Other (or Unknown) Substance Use Disorder, Mild	F19.10	F19.10
Other (or Unknown) Substance Use Disorder, Mild, In early or sustained remission	F19.10	F19.11
Other (or Unknown) Substance Use Disorder, Moderate	F19.20	F19.20
Other (or Unknown) Substance Use Disorder, Moderate, In early or sustained remission	F19.20	F19.21
Other (or Unknown) Substance Use Disorder, Severe	F19.20	F19.20
Other (or Unknown) Substance Use Disorder, Severe, In early or sustained remission	F19.20	F19.21

Changes go in effect October 1, 2017

Appendix D – Recovery Support Services Descriptions

Iowa's Integration Project **Promoting the Integration of Primary and Behavioral Health Care (PIPBHC)**
Recovery Support Service Type/Definition All PIPBHC RSS utilized must be funded as the payor of last resort.
Care Coordination with NOM's (GPRA) Intake (Unit = 1 meeting – Unit rate $150) One time, face-to-face meeting with client, conducted at admission to review client participation in PIPBHC covered services and to complete NOM's Intake Interviews Includes: • completing the NOM's Intake Interview and entering the data into the SAMHSA data system • documenting the service in the provider's records
Care Coordination with NOM's (GPRA) Discharge (Unit = 1 meeting – Unit rate $50) One time, face-to-face meeting with client, conducted at discharge to review client participation in PIPBHC covered services and to complete NOM's Discharge Interviews Includes: • completing the NOM's Discharge Interview and entering the data into SAMHSA data system • documenting the service in the provider's records
Care Coordination with NOM's (GPRA) Follow-Up (Unit = 1 meeting – Unit rate $180) One time, face-to-face/telephonic meeting with client, conducted at NOM's follow-up to review client participation in PIPBHC covered services and to complete NOM's Follow-Up Interview. Includes: • completing the NOM's Follow-Up Interview and entering the data into SAMHSA data system • documenting the service and delivery of the gift card to the individual in the client's record • providing the individual $30 dollar incentive gift card (gift card dollars are inclusive in the rate)
Care Coordination (Unit = 15 min – Rate = $10) Maximum 10 sessions This service is available to assist in coordinating PIPBHC Recovery Support Services with the client, conducted at Intake, Follow-Up and Discharge, to assess satisfaction with PIPBHC and to complete recovery support service coordination related to PIPBHC RSS.
Child Care (Unit = 1 hour – Unit Rate = $15.00) Maximum $300 Childcare, for children (under 14 years of age) of the clients admitted into the PIPBHC grant, while the client is engaged in PIPBHC covered service.

If the individual in the PIPBHC program has a child and is not present in the building, the person delivering the service must be employed by an organization licensed by or registered with the Iowa Department of Human Services (DHS) to provide childcare in compliance with Iowa Code, Chapter 237A. If the individual in the PIPBHC program has a child is present in the building receiving PIPBHC covered services, the provider is not required to be licensed according to DHS. The provider must complete criminal and child abuse record checks for each employee or volunteer that provides the childcare. Employees and volunteers who examine, attend, counsel or treat children must receive, at a minimum, 2 hours of mandatory child abuse training as approved by the Iowa Department of Public Health (Iowa Code, Chapter 232). Includes: • documenting each service in the individual records • tracking services billed
Drug Testing Incentives **$5 for three consecutive negative screens** **$10 for six consecutive negative screens** **$15 for nine consecutive negative screens** **$20 for twelve consecutive negative screens** Clients are to receive incentive gift cards based on the number of consecutive negative drug test screens, and the increased unit reimbursement should go to the client in the form of a gift card administered by the provider as follows: • $5 gift card after 3 consecutive negative screens • $10 gift card after 6 consecutive negative screens • $15 gift card after 9 consecutive negative screens • $20 gift card after 12 consecutive negative screens Upon completion of 12 consecutive negative screens, incentives are to be discontinued. Should a client receive a positive drug screen during involvement in the incentive programming for Drug Testing, incentives are to be discontinued.
Pharmacological Interventions (Unit Rate = $1) Maximum $100 Assistance provided to clients ages 18 and over to purchase prescription pharmacological medications used only for the treatment of substance use disorders, only including: • Acamprosate • Antabuse • Naltrexone (oral) • Buprenorphine (Suboxone)

If costs for this service are higher than the maximum amount of funding allowed per month, the provider of this service can collect the remaining amount owed from the PIPBHC client. Payment must be made to the vendor directly by the treatment provider.

Includes:
- documentation of adherence to medical protocols
- documentation of medication prescription and/or pharmacy receipt
- documenting client receipt of goods or services
- documenting each service in the provider's records

Sober Living Activities- (Unit Rate = $1) Maximum = $250

This service provides funding for PIPBHC clients to participate in recreational or social events that support healthy living choices. Examples include:

- recovery conferences or educational opportunities to support attendance at recovery based seminars/events
- organized community recovery events
- wellness activities such as fitness memberships,

These fees should be individualized to the person/event. The agency should make purchases directly on behalf of the individual.

Includes:
- documenting each service in the individual records
- tracking services billed

Supplemental Need- Clothing/Hygiene (Unit Rate = $1) Maximum $250

Assistance provided to clients to purchase clothing and personal hygiene products.

Clothing:
This service includes clothing to be used for employment, coats, gloves, education, and other recovery-related needs. Clothing vouchers may be issued in segments as related to agency policy or client need.

Personal Hygiene:
This service includes hygiene products related to individual daily needs, including soap, shampoo, toothpaste, deodorant, shaving needs, feminine hygiene, and dental products. This service does not include perfume, cologne, nail polish, nail polish remover, make-up, hair color, electric razors, cleaning supplies or other purchases as designated by the care coordination provider. Products containing alcohol are strongly discouraged.

The treatment provider directly reimburses the vendor and obtains a receipt documenting payment. No funding may go directly to the client.

Includes:

- documenting the distribution of funding in each client record,
- documenting each service in the client's record

Supplemental Needs- Education - (Unit Rate = 1 unit = $1) Maximum - $200

This service provides assistance to clients for the purpose of completing or continuing education. This service may be used for GED coursework and testing, English as a second language classes (ESL), apprentice programs, trade school fees or supplies, or educational materials, books and tuition at a secondary educational institution. This service may also be used to purchase materials (textbooks, books and manuals to support recovery based learning and necessary supplies required for the vocational/educational program (requires submission of exception request for vocational programs)

Includes:
- documenting each service in the individual records
- tracking services billed

Supplemental Needs - Gas Cards (Unit Rate = 1 gas card – Unit rate = $1) Maximum = $600

This service provides transportation assistance in the form of gas cards, to be given directly to the client, for the purpose of transportation to and from an activity to support the client recovery; including recovery events and treatment. Individual must submit an itemized receipt for the purchase of gas.

- Prior to the distribution of additional gas cards, individuals must provide a receipt for the use of the previous gas card. Failure to provide a receipt for gas cards used may result in the loss of any future gas card distribution. Only the purchase of gas will be reimbursed and receipts should not contain documentation of any other purchase. Individuals will need to turn in a receipt to the PIPBHC staff prior to a new card being issued. In the event that a client purchases unallowable items, PIPBHC staff should submit an exception request prior to providing any additional RSS to the client.

Includes:
- documenting each service in the individual records
- tracking services billed

Supplemental Needs-Wellness (Unit Rate = $1) Maximum $250

Assistance provided to clients for the purchase of items or services that support improved health of client. This may include an eye exam or the purchase of eyeglasses/contact lenses, fitness memberships, smoking cessation, or nutritional counseling.

This service does not cover costs associated with treatment for general medical/health related issues or services that may be obtained through another source with no charge (ex: Iowa Quitline).

The provider pays directly for the item or service, obtains a receipt documenting payment, and documents the service in the medical record. PIPBHC staff is responsible for ensuring that RSS funds are utilized as a last resort for funding.

Includes:
- documenting the distribution of funding
- documenting each service in the provider's records

Supplemental Needs – Utility Assistance/Cellular Phone Service (Unit Rate = $1) Maximum = $200

Assistance provided to the client to assist with costs of utilities/deposits (electricity, gas, water) that assist in establishing or maintaining their residence, or current cellular phone service.

Utility Assistance:
Client must have documentation of denial from other sources for utility assistance and documentation of utility bill. Utility Assistance can be used for past due bills that are interfering in the client's ability to obtain housing. Utility bills must be in the client's name.

Cellular Phone Service:
- For clients using continuous monthly cellular service, payment is to be made directly to the cellular carrier by the treatment provider or through the purchase of a gift card specific to the cellular carrier by the agency.
- For clients using monthly minutes purchasing plans, payment is to be made by the treatment provider purchasing the additional minutes, and directly entered into the client's phone.

For clients using continuous monthly cellular service, a receipt documenting the use of the previous month's phone gift card must be provided. Failure to provide a receipt for phone gift cards used may result in the loss of all Supplemental Needs.

Includes:
- documenting the distribution of funding
- documenting each service in the provider's records
- maintaining copies of utility bills

Transportation – Bus (Unit Rate = Up to $100 per month) Maximum $100

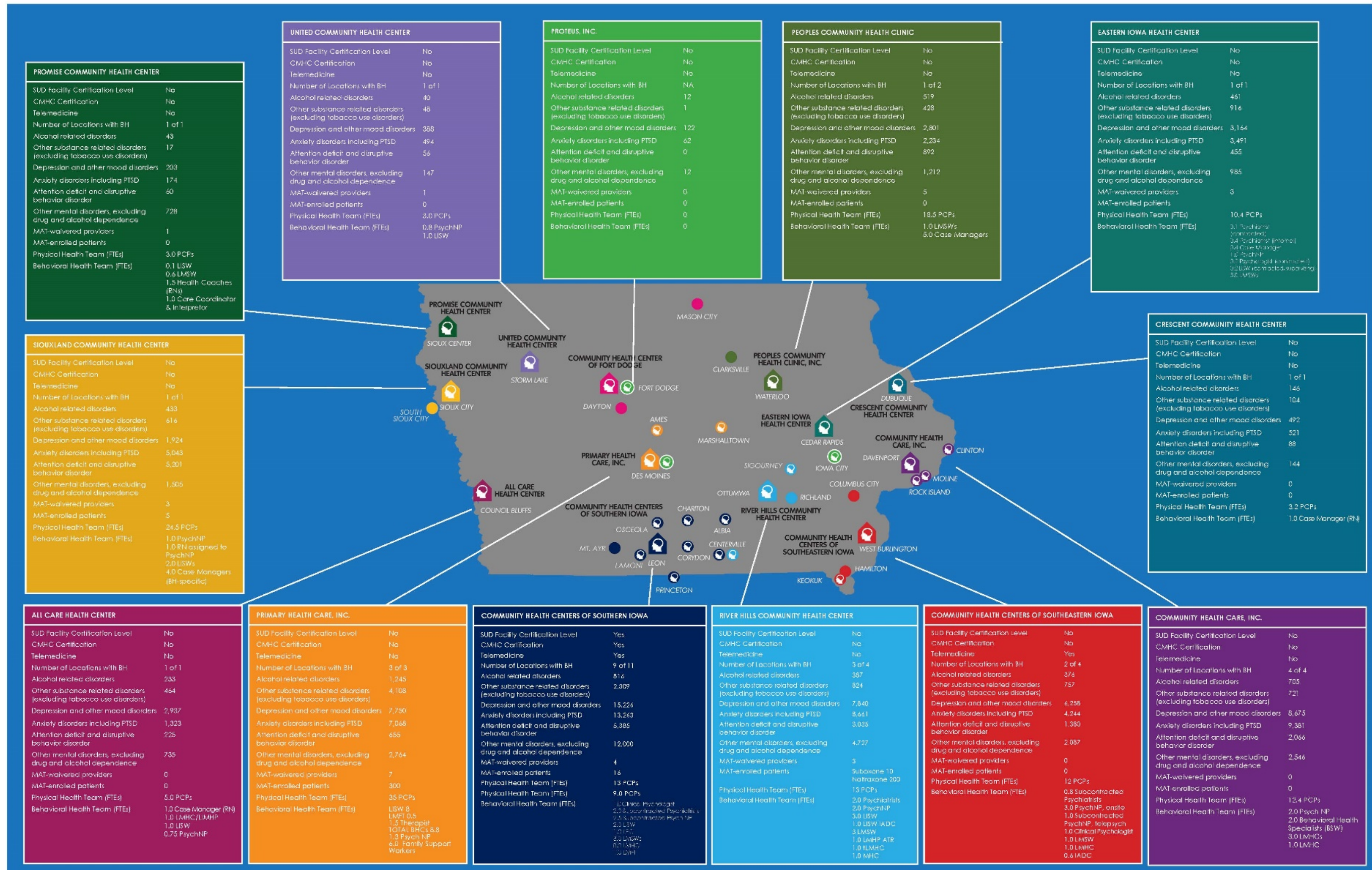
This service provides transportation by bus to and from an activity related to the client's recovery. (Taking the client to an AA meeting, to a session, from a session, etc.)

Transportation – Cab (Unit Rate = $1) Maximum $200

This service provides transportation by cab to and from an activity related to the client's recovery. (Taking the client to an AA meeting, to a session, from a session, etc.)

**As of May 2020, RSS have been revised per SAMHSA guidelines*

Appendix E – FQHC Behavioral Health Snapshot



IOWA'S COMMUNITY HEALTH CENTERS BEHAVIORAL HEALTH SNAPSHOT

ALL CARE HEALTH CENTER

All Care Health Center hired a part time therapist (LMHC) for co-located psychotherapy in 2017 and then a PsychNP for medication management in 2018. Most patients are scheduled with the therapist or the PsychNP by a case manager (RN), who occasionally receives a warm hand off from the PCP. The majority of case management is completed by phone with patients once they leave the clinic. Their therapist (LMHC) also doubles as a case manager sometimes. Recognizing that they have the components of both a PBHC and Collaborative Care Model, All Care Health Center is considering how to define the role of their care manager.

COMMUNITY HEALTH CARE, INC.

Community Health Care's behavioral health program is built on strong partnerships with the local mental health and SUD facilities. LMHCs and PsychNPs from the community behavioral health organization are sub-contracted by the health center and co-located at the health center's multiple sites. These co-located providers bill PPS under the health center and operate as part of the primary care team—receiving warm hand offs from PCPs. Through this partnership, Community Health Care took the opportunity to open up a walk-in services for behavioral health, which was not possible at the community partners at that time. Through PIPBHC, Community Health Care plans to enhance on-site SUD counseling services.

COMMUNITY HEALTH CENTERS OF SOUTHEASTERN IOWA

Community Health Centers of Southeastern Iowa (CHC/SEIA) began to co-locate behavioral health providers in 2014 in response to the disintegration of community health resources. Great Rivers hospital was closing its behavioral health division and CHCSE/IA and Great Rivers administration agreed to share a psychiatrist and clinical psychologist as a shared resource. In 2008, CHCSE/IA hired a PsychNP for medication management. CHCSE/IA proceeded to use the AIMS grant to co-locate a subcontracted SUD counselor from the local SUD agency (ADDS) and to begin telehealth services between its three sites. Through convergent evolution, CHCSE/IA has begun to use its PsychNPs as consultants for its PCPs, in an arrangement very similar to the Collaborative Care Model. Their PsychNP and BH leader provides ongoing didactic training to PCPs and staff.

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA

Community Health Centers of Southern Iowa's (CHCSI) behavioral health program began in 2006 when the Decatur County hospital dissolved its outpatient and residential mental health services. They hired and co-located a number of therapists from the hospital and then subsequently merged with the local CMHC in 2007. In 2008, CHCSI applied for and was awarded SUD licensure in Iowa. SUD licensure allowed CHCSI to do OWI evaluations, substance use assessment, and substance use-specific individual and group therapy. More recently, CHCSI built clinic space specific for telehealth services and used SUD-MH funding to build a training program for new CADCs. CHCSI plans to open an access center in November 2019. The interface between medical and behavioral health staff is a single "referral specialist" who schedules the patients with psych specialists or therapists.

CRESCENT COMMUNITY HEALTH CENTER

Crescent Community Health Center has pursued integration through long-term co-location from both a SUD facility and a CMHC. PCPs at Crescent Community Health Center prescribe MAT and patients receive MAT-counseling from the co-located SUD counselor. They are considering whether to build out internal counseling or psychiatric services. Whether or not it builds internal services, they are interested in improving its PHQ9, SBIRT, and PRAPARE workflows.

EASTERN IOWA HEALTH CENTER

Inspired by the IMPACT trial, Eastern Iowa Health Center hired a psychiatrist who consults with PCPs through a care manager in a Collaborative Care Model. The PCP or care manager may also refer patients to LMSWs or Psychologist for co-located psychotherapy. LMSWs are supervised by contracted LISW from the community.

PEOPLES COMMUNITY HEALTH CLINIC

Inspired by the Cherokee Health Systems model, Peoples Community Health Clinic's Case Managers receive referrals from PCPs and follow up with patients over the phone to coordinate referrals and encourage follow-up. Peoples Community Health Clinic also hired an LMSW who sometimes receives warm hand-offs and provides co-located psychotherapy.

PRIMARY HEALTH CARE, INC.

In 2008, Primary Health Care (PHC) received consultation from Neftali Serrano, in Madison, Wisconsin, and Jurgen Unutzer from Seattle, Washington and submitted a HRSA expansion grant to begin mental health services. PHC proceeded to co-locate a PA and LISW onsite. In 2011 they actually visited Serrano's clinic in Madison and were inspired to turn their therapists into behavioral health consultants, beginning a process toward integrated primary care behavioral health. In the following years, PHC continued to use grant funding to hire BHCs and visited Cherokee and other integration leaders to learn more about warm hand offs and brief interventions.

PROMISE COMMUNITY HEALTH CENTER

Promise Community Health Center has both an official, bilingual care coordinator as well as two nurse "health coaches" who perform unofficial care coordination roles while doing health education with families. In 2018, Promise Community Health Center hired an LMSW to provide co-located psychotherapy. The LMSW is supervised by a 0.1 FTE contracted LISW from the community.

RIVER HILLS COMMUNITY HEALTH CENTER

River Hills Community Health Center's behavioral health program began in 2013, when it hired three therapists from the local regional hospital (which was jettisoning behavioral health service lines after its purchase by a for-profit hospital system). Since that time, River Hill Community Health Center has continued to hire behavioral health staff, amassing 13 providers, including 2 PsychNPs, 1 contracted telePsychiatrist, and 1 on-site Psychiatrist.

SIOUXLAND COMMUNITY HEALTH CENTER

Siouxland Community Health Center began hiring outpatient therapists in response to long wait-times and low referral success at area mental health agencies. Case managers function as "health coaches" and can be paged into a room to assess behavioral health needs and perform brief interventions. Case Managers may refer patient to LISW or Psych nurse practitioner. Siouxland Community Health Center is using the PIPBHC grant funding to co-locate a nurse case manager and SUD counselor from the SUD facility.

UNITED COMMUNITY HEALTH CENTER

United Community Health Center hired a PsychNP in 2018 to perform medication management in consultation with primary care providers. They subsequently hired an LISW in Spring 2019 to begin co-located psychotherapy. Case managers perform some warm hand offs and schedule patients with behavioral specialists.