Iowa's Integration Project Year 2 Evaluation

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Protecting and Improving the Health of Iowans

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Legal Disclaimer

This project was supported by the Iowa Department of Public Health, Des Moines, IA. The contents are solely the responsibility of the authors and do not necessarily represent the official views of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Iowa Department of Public Health, Division of Behavioral Health or the University of Iowa.

Table of Contents

List of Tables and Figures v
Executive Summary 1
Introduction 1
Methods 1
Key Findings and Recommendations 1
List of Acronyms 3
Introduction 4
Overview 4
Methods 4
Organizations 5
Evaluation Methods and Measures 6
Results 6
Program Implementation 6
Goal 1: Promote integrated health care services through a bidirectional model utilizing an Integrated Care Team approach. 7
Goal 2: To support the improvement of integrated health care services provided to individuals with SUD, SMI and co-occurring health conditions. 7
Goal 3: To increase the number of integrated health care services provided to individuals with SUD, SMI and co-occurring health conditions. 9
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. 14
Process Evaluation 15
Barriers to Integrated Care 15
Promotion of Integrated Care 15
Stakeholder Involvement 16
Regarding stakeholder involvement, we specifically wanted to know how have stakeholders shaped processes surrounding consumer experience, access and quality of care and program sustainability and scalability. 16
Outcome Evaluation 16
Length of Stay 16
Overall Health 17
Physical Health 17
Behavioral Health 18

Appendix A – Iowa’s Integration Project 21
Appendix B – Success Stories 22
Appendix C – Recovery Support Services 24

List of Tables and Figures

List of Figures

Figure 1 Map of Iowa's Integration Project Organizations 5
Figure 2 Admissions by Partnerships 9
Figure 3 Prescreening and Screening Progress 12
Figure 4 Recovery Support Services, FFY2020 14

List of Tables

Table 1 SBIRT by Year 8
Table 2 Client Characteristics 10
Table 3 SBIRT at the IAANG 14

Executive Summary

Introduction

Year 2 of Iowa's Integration Project occurred during two major events, the COVID-19 pandemic and the August 2020 Derecho. These challenges brought many barriers including, but not limited to: quickly and efficiently adjusting service delivery by virtual means; identifying options for services not applicable to virtual means (i.e. physical health indicator data collection); adjusting to the ever changing environments and regulations; coping with potential and actual health risks to staff and clients; developing flexible and adequate policies and procedures; and dealing with the unavoidable side effects of a pandemic, such as staff turnover. Despite the pandemic and natural disaster, Iowa's Integration Project organizations remained resilient and strived to provide the best care to Iowans.

This report describes the Year 2 Evaluation of Iowa's Integration Project, which is funded by the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant. The Iowa Department of Public Health (IDPH) was awarded this five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) on September 30, 2018. The purpose of Iowa's Integration Project is to improve primary and behavioral health outcomes for individuals with substance use disorders.

Methods

The Year 2 Evaluation of Iowa's Integration Project had three main components, each designed to answer the corresponding research questions:

1. Program Implementation: Did Iowa's Integration Project meet the goals and objectives written in the application?
2. Process Evaluation: Is it possible to integrate primary health and substance use disorder (SUD) services between a Federally Qualified Health Center (FQHC) and SUD organization?
3. Outcome Evaluation: Does the integration of primary care and SUD lead to improvements in physical and behavioral health of the population served?

To answer these questions, data were gathered from several sources: 1) Intake Notification Forms; 2) Discharge Notification Forms; 3) National Outcome Measures (NOMs) instrument at admission, discharge, and six-month post admission (reassessment) from SAMHSA's Performance Accountability and Reporting System (SPARS); 4) Monthly forms completed by treatment providers; 5) Client Success Stories.

Key Findings and Recommendations

- **Explore opportunities to diversify client admissions.** Iowa's Integration Project admitted 168 clients out of the proposed 175. Most clients admitted in Year 2 were male (67%), White (79%), non-Hispanic or Latino (93%), and between the ages of 26-44 (64%).
- **Continue implementing Screening, Brief Intervention and Referral to Treatment (SBIRT).** SBIRT implementation is on track to meet the target number of prescreenings and screenings with 50% of prescreenings and nearly 80% of screenings being completed.
- **Share data with organizations about their physical health indicators. Organizations can then use this data to inform health promotion activities they are offering to PIPBHC clients.** The

percentage of normal blood pressure readings decreased from 32% at baseline to 24% at 6-month reassessment. The percentage of clients who are obese increased from 42% at baseline to 46% at 6-month reassessment. The percentage of clients with prehypertension decreased from 45% at baseline to 30% at 6-month reassessment.

- **Work with and encourage organizations to collect PHI data at each reassessment.** The number of missing physical health indicators increased considerably at the 6-month reassessment for each physical health category. While this can be attributed to the COVID-19 pandemic and derecho, more data is needed in order to draw conclusions about changes in physical health throughout the grant.
- **Encourage organizations to increase tobacco cessation programs and education about alcohol consumption.** The percentage of tobacco use and alcohol use changed minimally from baseline to 6-month reassessment.
- **Explore and expand ways to educate clients about job opportunities.** Forty percent (40%) of admitted clients reported they were unemployed, but looking for work.

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

Overview

Year 2 of Iowa's Integration Project occurred during two major events, the COVID-19 pandemic and the August 2020 Derecho. These challenges brought many barriers including, but not limited to: quickly and efficiently adjusting service delivery by virtual means; identifying options for services not applicable to virtual means (i.e. physical health indicator data collection); adjusting to the ever changing environments and regulations; coping with potential and actual health risks to staff and clients; developing flexible and adequate policies and procedures; and dealing with the unavoidable side effects of a pandemic, such as staff turnover. Despite the pandemic and natural disaster, Iowa's Integration Project organizations remained resilient and fought to provide the best care to Iowans.

This report describes the year 2 evaluation of Iowa's Integration Project. This project is part of the Substance Abuse and Mental Health Services Administration's (SAMHSA) five-year grant for Promoting Integration of Primary and Behavioral Health Care (PIPBHC). The Iowa Department of Public Health (IDPH) was awarded this grant in September 2018 with a purpose to promote full integration and collaboration in clinical practice between primary and behavioral healthcare to serve individuals with substance use disorders.

Awards to primary and behavioral healthcare programs were granted to organizations that participated in the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, funded by SAMHSA from 2012-2017. The organizations awarded funds 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 a Federally Qualified Health Center (FQHC) in their respective region to further integrate primary and behavioral healthcare practices and build upon the foundation of SBIRT implementation. The three FQHC's awarded funds 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.

Methods

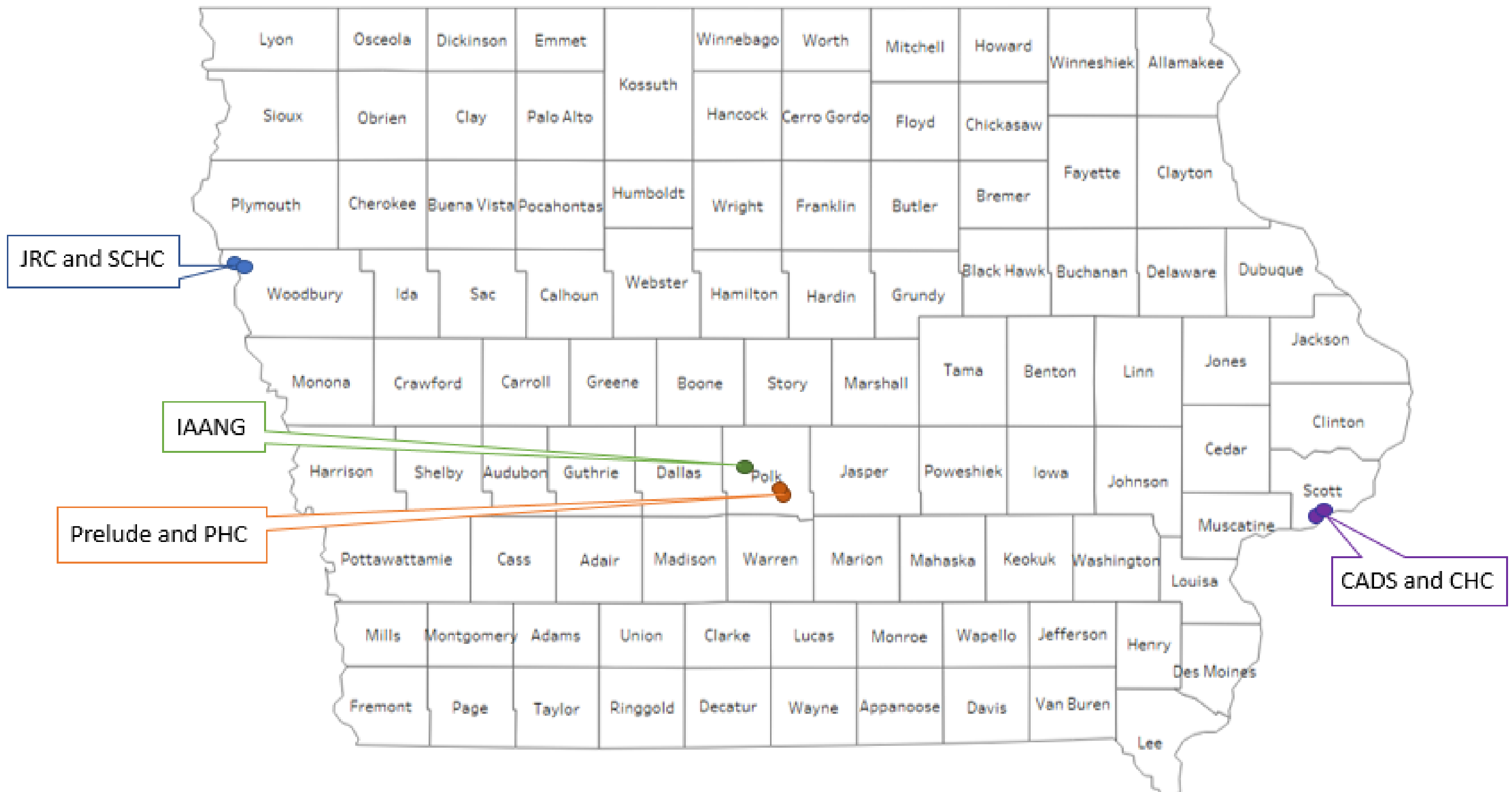
This section provides an overview of the organizations involved with Iowa's Integration Project and the measures used to answer these three research questions:

1. Program Implementation: Did Iowa's Integration Project meet the goals and objectives written in the application?
2. Process Evaluation: Is it possible to integrate primary health and SUD services between a Federally Qualified Health Center (FQHC) and SUD organization?
3. Outcome Evaluation: Does the integration of primary health and SUD lead to improvements in physical and behavioral health of the population served?

Organizations

Figure 1 displays the geographic location of the organizations providing services for Iowa's Integration Project across the state.

Figure 1 Map of Iowa's Integration Project Organizations



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].

In order to admit clients into Iowa's Integration Project, organizations had to ensure clients met the following eligibility requirements:

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:

[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.

   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.

Evaluation Methods and Measures

Data was gathered from September 30, 2019 through September 29, 2020 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 diagnoses (SUD, mental health, and physical health) and functional outcomes. These forms were administered by project staff during the NOMs baseline and 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, 168 baseline, 160 three-month reassessments, 118 six-month reassessments, 60 nine-month reassessments, 30 twelve-month reassessments, 4 fifteen-month reassessments, and 87 discharges were collected. 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. **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.
4. **Client Success Stories.** Iowa's Integration Project organizations submitted client success stories to IDPH and are included in Appendix B.

Results

Program Implementation

In this section, we looked to answer the question; *did Iowa's Integration Project meet the goals and objectives written in the application?*

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

Objective 1: Iowa will co-locate a substance use disorder treatment/mental health professional at a Federally Qualified Health Center (FQHC) to enhance behavioral health services.

- ✓ **Iowa's Integration Project met this objective.** During the first half of Year 2, each of the partnerships (Integrated Care Teams (ICT) and the special project with the IAANG) obtained full staffing of all the positions. Since that time, due to COVID-19, one partnership has struggled with maintaining staff in the SUD treatment counselor position that is co-located at the FQHC.

Objective 2: 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.

- ✓ **Iowa's Integration Project met this objective.** During the first half of Year 2, each of the partnerships (Integrated Care Teams (ICT) and the special project with the IAANG) obtained full staffing of all the positions. Since that time, due to COVID-19 one partnership has struggled with maintaining medical staffing (physician, ARNP, nurse) within the SUD treatment program.

Objective 3: 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.

- ✓ **Iowa's Integration Project met this objective.** However, due to the COVID-19 pandemic, IDPH worked with partnerships to alter expectations for the type of provider, explore how to restructure roles within the ICT and identify short-term solutions for meeting PIPBHC program requirements during the uncertain times.

Objective 4: 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.

- ✗ **Iowa's Integration Project did not meet this objective.** The ICT within Iowa's Integration Project identified periods of paused admission into the grant because of COVID-19, the timeframes of which varied across partnerships from March through June. Despite paused admissions, Iowa's Integration Project admitted a total of 168 individuals by September 29, 2020, seven individuals short of the 175 Year 2 goal for client admissions.

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

Objective 1: Iowa will implement evidence based practices (Motivational Interviewing, SBIRT, Recovery Peer Coaching, and Brief Treatment), to address behavioral health in primary care settings.

- ✓ **Iowa's Integration Project met this objective.** Organizations continue to utilize Motivational Interviewing that was offered in Year 1 and will be offered again in Year 3 of the grant. The Recovery Peer Coaching has been enthusiastically embraced by the PIPBHC grantees. Many organizations have looked into hiring a second coach, as their current coach has been overwhelmed with the amount of care needed. The PIPBHC Integrated Care Teams have found

that Peer Recovery Coaches offer an important contact for those with complex needs and SUD, as this role is better positioned to obtain client trust and support clients in navigating between systems. Despite the overwhelmingly positive experience of offering this service to clients, most third party payers do not reimburse and the managed care organizations offer limited reimbursement. In regards to SBIRT services, IDPH continues to monitor and track these numbers each month. Table 1 shows the overall numbers of SBIRT services that have been offered by year.

Table 1 SBIRT by Year

	Prescreening	Screening	Brief Intervention	Brief Treatment	Referral to Treatment
FFY 2019	23,726	2,346	325	124	146
FFY 2020	46,090	5,550	642	197	196
Total	69,816	7,896	967	321	342

Objective 2: Iowa will implement general health screenings and align physical health practices with the goals of the Million Hearts Initiative® into the continuum of care at the SUD treatment programs.

- ✓ **Iowa's Integration Project met this objective.** All of the FQHC's participating in Iowa's PIPBHC grant also participate in Million Hearts® 2022, a national initiative to prevent 1 million heart attacks and strokes within 5 years.

Objective 3: Iowa will develop a Policy Steering Advisory Committee (PSAC) 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 PSAC 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.

- ✓ **Iowa's Integration Project met this objective.** IDPH had scheduled the first meeting for the PSAC in FY20, and due to COVID-19 had to delay from the planned date of March 18, 2020, to September 28, 2020. Despite the delay, the PSAC was able to begin a successful collaboration in September 2020 that led to: the identification of the committee chair from a statewide organization with experience in policies and barriers to care; the identification of barriers to integrated care for people with SUD/SMI in Iowa; and the foundations of a guiding document that will provide actions to address the barriers identified at multiple structural levels across Iowa. A second PSAC meeting was held in December 2020 and the third PSAC meeting is scheduled for March 2021.

Objective 4: Iowa will host Knowledge Transfer trainings for all providers (FQHC, SUD treatment program) to enhance bidirectional understanding of health care practices.

- ✓ **Iowa's Integration Project met this objective.** IDPH implemented a Knowledge Transfer Training between one partnership to enhance bi-directional understanding of healthcare practices in Year 1 of the grant. Knowledge Transfer Trainings for all three partnerships will be implemented

in April – June 2021. The IAANG partnership will implement an Immersion training that will be offered to all PIPBHC staff in July or August 2021.

Objective 5: Complete all objectives of EHR Stage 2 Modification by September 29, 2022.

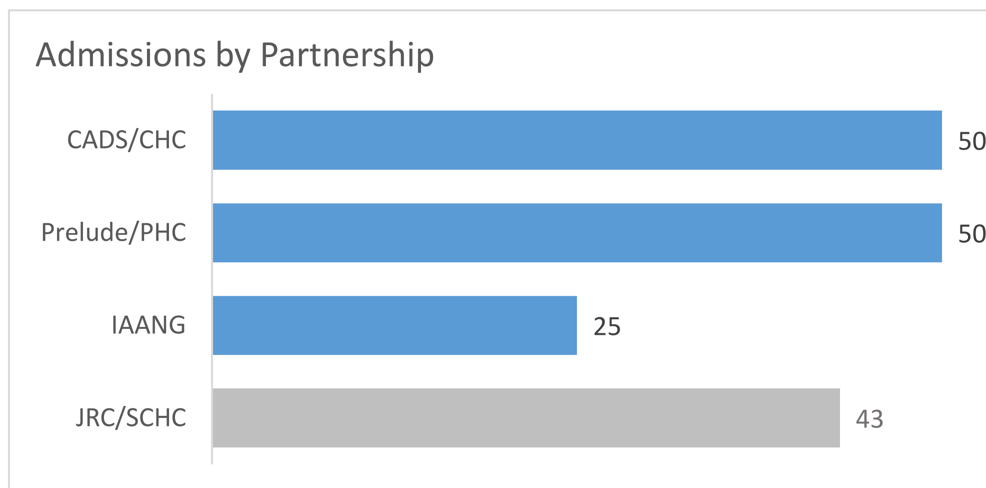
- **This objective is not application to Iowa's Integration Project.** Prior to beginning implementation of this grant, the FQHC's in Iowa all achieved Stage 2 Modifications for their Electronic Health/Medical Records and had various attestation to the factors included in Stage 2 Modification. During Year 1, it was identified that the completion of Stage 2 Modifications was not appropriate for SUD treatment programs.

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

Objective 1: Iowa will provide integrated health services to 175 clients within the Iowa Integration Project.

- **Iowa's Integration Project did not meet this objective.** Between September 30, 2019 and September 29, 2020, only 168 of the proposed 175 clients were admitted into the project. The three partnerships are required to serve 50 clients annually, while the special project at the IAANG is required to serve 25. JRC and SCHC was the only partnership that did not meet their required admission numbers. Figure 2 displays admissions by partnership during FFY20.

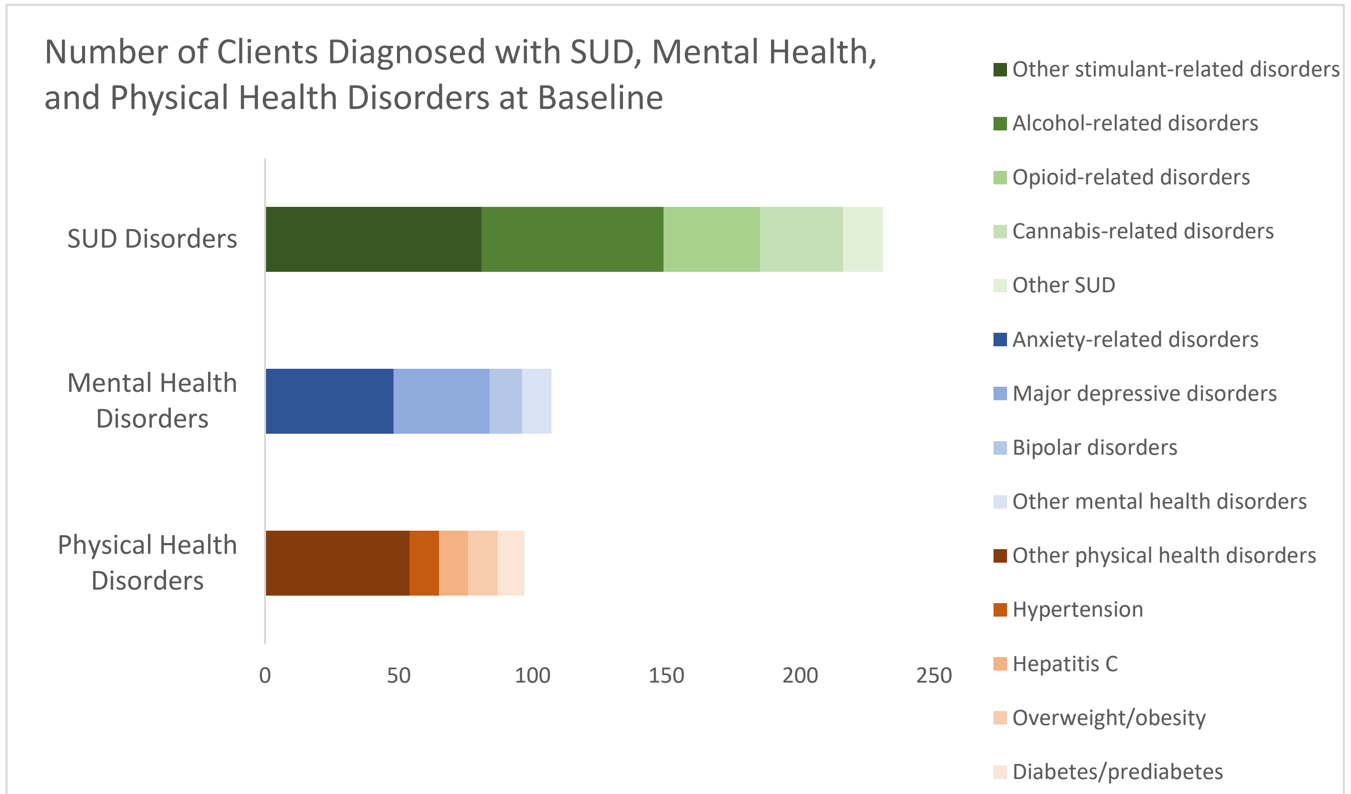
Figure 2 Admissions by Partnerships



Of the 168 admitted clients, 92 had a co-occurring SUD and serious mental illness (SMI) diagnosis, 14 had a co-occurring SUD and Physical Health diagnosis, and 62 had a co-occurring SUD, SMI, and Physical Health diagnosis. Other stimulant-related disorders was the most common SUD disorder (35%), followed by alcohol-related disorders (29%). Anxiety-related disorders was the most common mental health disorder (45%) and major depressive disorder was the second most common (34%). Slightly more than half (56%) of physical health disorders were categorized as other due to low numbers and IDPH's suppression guidelines. Figure 3

displays clients' diagnoses for substance use, mental health, and physical health captured during the baseline NOMS interview.

Figure 3 Number of Clients Diagnosed with SUD, Mental Health, and Physical Health Disorders at Baseline



The median age of all clients was 37 years. Overall, most clients were male (67%), White (79%), non-Hispanic or Latino (93%), and between the ages of 26-44 (64%). Sixty-three (38%) of clients reported graduating 12th grade/receiving a high school diploma/GED, and sixty (36%) reported completing some college or university. Table 2 provides a breakdown of client characteristics.

Table 2 Client Characteristics

Client Characteristics	#	%
Age (median)	**37**	
18-25	29	17.3
26-34	56	33.3
35-44	51	30.4
45-54	23	13.7
55-64	9	5.4
65+	0	0.0
Gender		
Male	112	66.7

Female	56	33.3
Race		
White	132	78.6
Black	10	6.0
American Indian	10	6.0
Asian	0	0.0
Multi-Racial	6	6.0
Native Hawaiian or Other Pacific Islander	*	*
Alaska Native	*	*
None of the Above	9	5.4
Ethnicity		
Non-Hispanic or Latino	156	92.9
Hispanic or Latino	11	6.5
Missing	1	0.6
Education		
Less than 12th Grade	20	11.9
12th Grade/High School Diploma/GED	63	37.5
VOC/Tech Diploma	8	4.8
Some College or University	60	35.7
Bachelor's Degree (BA/BS)	10	6.0
Graduate Work/Graduate Degree	7	4.2
Employment		
Full-time	25	14.9
Part-time	11	6.5
Unemployed, looking for work	67	39.9
Unemployed, volunteer work	32	19.0
Unemployed, not looking for work	27	16.1
Other	6	3.6

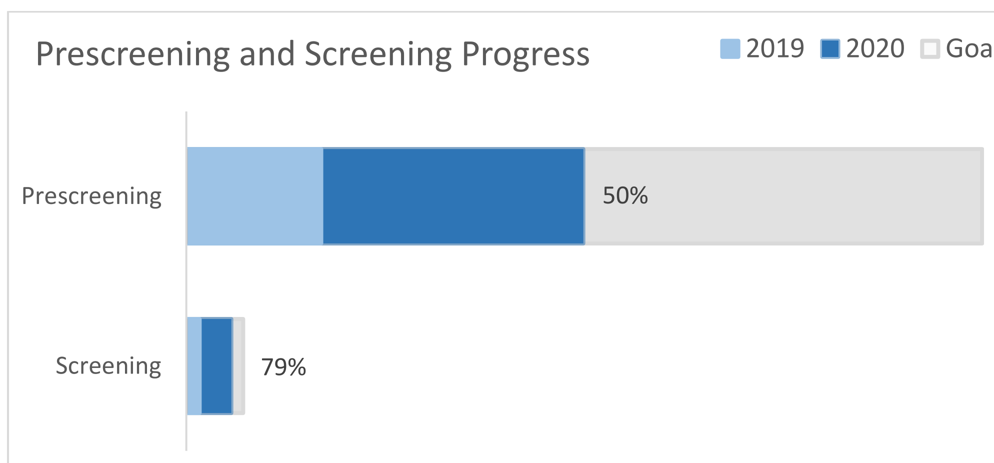
**Totals of 1-5 may be suppressed*

Objective 2: Iowa will increase outreach and awareness of integrated health care practices through the provision of 140,000 substance use pre-screenings and 10,000 (previously 130,000) substance use screenings to individuals.

✓ **Iowa's Integration Project is on track to meet this objective.** All three FQHC's and the special project at the IAANG continue to implement SBIRT and are on track for implementing the proposed number of pre-screenings to the population served. The initial estimate of 130,000 screenings was based off a different project and is now estimated for the five years at 10,000. With the new adjustment, nearly 80% of the target number of screenings have been completed.

Figure 2 shows Iowa's progress towards prescreenings and screenings from the first two years of the grant.

Figure 4 Prescreening and Screening Progress



Objective 3: Iowa will improve outcomes for Iowans with substance use disorders measured by fewer ER visits and inpatient hospitalizations for chronic conditions post initial screening.

✓ **Iowa's Integration Project met this objective.** To answer this objective, data was pulled from Intake Notification Forms, Discharge Notification Forms, and NOMs baseline, 6-month, and discharge data. At baseline, Iowa's Integration Project reported nearly 30 client visits to a hospital and 85 days spent in the hospital. At 6-month reassessment, we saw these numbers decrease to only 7 client visits and 16 days were spent in the hospital. Unfortunately, these numbers increased slightly at discharge to 10 client visits and 62 days in the hospital. More data is needed to draw a conclusion to this objective.

	Baseline *(n=168)*		**6-month *(n=118)***		**Discharge *(n=87)***	
	# Client Visits**	# of days in Hospital	# Client Visits**	# of days in Hospital	# Clients Visits**	# of days in Hospital
Been to the Emergency Room Visit for Physical Health Care	10	13	*	7	0	0
Hospitalized for Physical Health Care	*	15	0	0	*	19
Hospitalized for Mental Health Care	7	39	*	9	*	31
Hospitalized for Substance Use***	*	18	N/A	N/A	*	12
Total	28	85	7	16	10	62

**Totals of 5 or fewer may be suppressed*
***Responses were from the 30 days prior to the interview. In addition, the number of client visits is not a unique number as a client may have visited more than once and for more than one reason.*

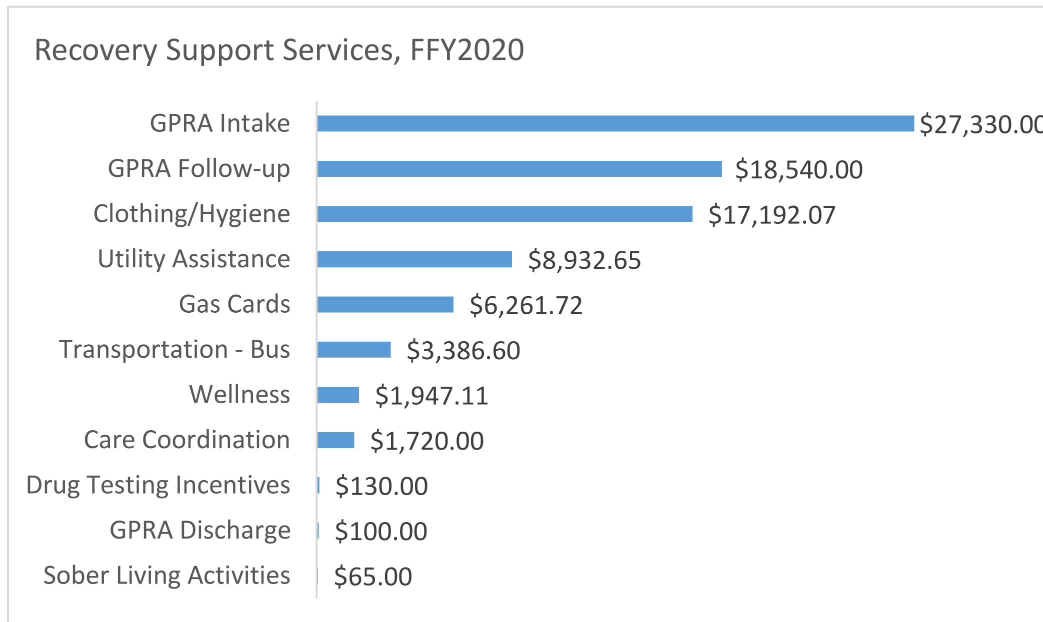
****Hospitalized for Substance Use was only collected on the Intake and Discharge Notification Form. This number is unknown at 6-month* reassessment*.*

Objective 4: 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.

- ✓ **Iowa's Integration Project met this objective.** The following describes all health promotion and wellness activities reported by Iowa's Integration Project in FFY2020. HIV and AIDS awareness and STD prevention, treatment and awareness was conducted across the state to over 450 participants, with one organization testing an additional 168 individuals. Over 350 participants received education on heart health and the Million Hearts Initiative. Wellness programs focusing on the importance of physical health, women's health and fitness, and general education reached nearly 600 participants. One agency hosted a women's health fair on vape education and addiction that reached 316 participants. Additional smoking and vaping education, including the Great American Smoke Out, lung cancer awareness, and hazards of smoking and vaping reached over 500 participants. Limited diabetes education was reported, reaching only 21 participants. Mental health awareness activities, including WRAP and Crisis Plans, minority mental health awareness, SUD and mental health awareness, and mental health stress management reached 230 participants. Suicide Awareness and Crisis Hotline education reached 360 participants, while PTSD and trauma informed care reached nearly 200 participants. One organization planned a domestic violence awareness table and was able to reach 350 participants. Recovery and return to use education and prevention reached 88 participants, and specific overdose awareness education reached 200. COVID-19 education focused on mental health and stress management, education of alternative recovery meeting options, and general education and prevention reaching 65 participants. Unfortunately, many planned health promotion activities and wellness programs were cancelled, starting in March 2020, due to the COVID-19 pandemic.

  In regards to Recovery Support Services (RSS), nearly $90,000 was spent in FFY2020. At the start of FFY2020, there were 13 categories of RSS: Care Coordination with NOMS (GPRA Intake, 6-month Reassessment and Discharge), Care Coordination, Child Care, Pharmacological Interventions, Sober Living Activities, Supplemental Needs (Clothing/Hygiene, Education, Gas Cards, Utility Assistance, Wellness), and Transportation (Bus, Cab). However, in May 2020, per SAMHSA guidelines, IDPH revised this list and no longer offered Pharmacological Interventions, Clothing/Hygiene, and Utility Assistance. Figure 4 displays the total amounts spent in each RSS category. A list of revised RSS and descriptions for each category is included in Appendix C.

Figure 5 Recovery Support Services, FFY2020



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.

Objective 1: Iowa will utilize Screening, Brief Intervention and Referral to Treatment (SBIRT) evidenced based practices with 1,250 Soldiers annually.

- ✓ **Iowa's Integration Project met this objective.** Table 3 shows the number of Soldiers served at the IAANG by fiscal year.

Table 3 SBIRT at the IAANG

	Prescreening	Screening	Brief Intervention	Brief Treatment	Referral to Treatment
FFY2019	2,167	1,283	81	32	*
FFY2020	5,734	3,754	118	47	*
Total	7,901	5,037	199	79	9

Objective 2: 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).

- ✓ **Iowa's Integration Project met this objective.** The IAANG provided four Physical Resilience Working Groups, a collaborative working group to coordinate well-being programs and fitness in support of soldier readiness and resilience and reached twenty participants. The IAANG also held four Prevention Working Groups, a collaborative working group focused on prevention in areas of suicide, substance use, sexual assault, and behavioral health in support of readiness and resilience, which reached forty-four participants.

Objective 3: 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.

- ✓ **Iowa's Integration Project met this objective.** Each of the twenty-five clients admitted into Iowa's Integration Project at the IAANG in Year 2 completed the GADS-7, PHQ-9, PC-PTSD, and ACES at their baseline interview.

Process Evaluation

In this section, we looked to answer the question; *is it possible to integrate primary health and SUD services between a FQHC and SUD treatment organization?* To answer this question, we looked at what were some barriers to integrated care, how grant activities promoted integrated care, and the role of stakeholders in shaping consumer experience and sustainability.

Barriers to Integrated Care

During the first half of Year 2, each of the partnerships integrated care team and the special project with the IAANG) obtained full staffing of all the positions. Since that time, due to COVID-19, one partnership has struggled with maintaining staff in the SUD treatment counselor position that is co-located at the FQHC, and one partnership has struggled maintaining medical staffing (physician, ARNP, nurse) within the SUD treatment program. The IDPH provided technical assistance during site visits (May - August 2020) with each of the programs to brainstorm strategies for these challenges. Additionally, Iowa's Integration Project encountered numerous challenges as a result of the COVID-19 pandemic. These challenges were mirrored in behavioral health organizations across the nation and included the following but were not limited to:

- quickly and efficiently adjusting service delivery by virtual means;
- identifying options for services not applicable to virtual means (i.e. physical health indicator data collection);
- adjusting to the ever changing environments and regulations;
- coping with potential and actual health risks to staff and clients;
- developing flexible and adequate policies and procedures;
- dealing with the unavoidable side effects of a pandemic (staff turnover, staff absences, staff mental and physical health needs, reported increase of symptomatology from individuals served, negative impacts on service delivery).

As a result of these barriers, Iowa's Integration Project saw two primary impacts. The ICT within Iowa's Integration Project identified periods of paused admission into the grant because of COVID-19, the timeframes of which varied across partnerships from March through June. Furthermore, as a result of COVID-19, Iowa's Integration Project did not host Knowledge Transfer training or the Military Immersion training, due to limited staff availability for training. Iowa provided technical assistance during site visits with each of the programs to brainstorm strategies for these challenges.

Promotion of Integrated Care

Despite the barriers mentioned, grant activities were still able to promote integrated care services. All of the SUD treatment programs utilize evidence-based practices and programs for prevention, treatment

and recovery throughout the full continuum of care. Collection of integrated care practices specific to wellness-related education and programming activities continued through Year 2 and each partnership reported health promotion and wellness programming and activities quarterly. Some of the activities include: Table events (Suicide Awareness/Crisis Hotline, Domestic Violence Awareness, Red Ribbon Week, National Recycling Day, PTSD awareness, Great American Smoke Out, SUD and Mental Health); Walks hosted by the program (Trauma Informed Trunk or Treat, Iowa's Healthiest State Initiative); Virtual groups (COVID-19 Education and Prevention, Skin Cancer Awareness) and in person groups (Garden/Nutrition, Stress Management, Donate Life, COVID-19 & Mental Health, Smoke Cessation, Physical Health and Wellness); and presentations and miscellaneous activities (March Kindness Bracket game, Escape the Vape escape room, Million Hearts Pledges, Million Hearts Initiative Cookbooks, Women's Health Fair, STD/STI flyers, Minority Mental Mental Health Awareness, Pay it Forward Bingo, AIDS Awareness Education, Overdose Awareness Education, Prevention Workgroups).

Stakeholder Involvement

Regarding stakeholder involvement, we specifically wanted to know how have stakeholders shaped processes surrounding consumer experience, access and quality of care and program sustainability and scalability.

Each of the integrated care teams explores consumer experience, access, and quality of care. These teams meet weekly to explore process improvement and staff cases of clients that are shared by the FQHC and SUD treatment programs. In conjunction with each of the integrated care teams, IDPH met consistently with each partnership to discuss client admission processes and how to improve services across the continuum of care for clients. Additionally, data collection and reporting tools were developed for interagency coordination to share data across provider organizations.

The development of the Policy Steering Advisory Committee (PSAC) at the end of Year 1 and at the beginning of Year 2 has aided in identifying sustainability approaches. The purpose of PSAC is to identify, define, and explore barriers and solutions for sustaining integrated care practices. The PSAC will further explore the barriers to sustainability of integrated care for complex clients and will focus on: identifying the integrated care practices that can be sustained post-grant; exploring methods to sustain those identified practices; and better meeting the needs of complex clients in Iowa through the provision of greater care integration.

Outcome Evaluation

In this section, we looked to answer the question; *does the integration of primary health and SUD lead to improvements in physical and behavioral health of the population served?* To answer this question, data from both FFY2019 and FFY2020 were used.

Length of Stay

Among those admitted into Iowa's Integration Project, we looked at those who remain engaged in services and those who had been discharged. In order to do this, we used the total number of admissions into the grant. From FFY2019-FFY2020, Iowa's Integration Project has admitted 248 clients. Of those, 90 have been discharged and only 6 clients received a clinical discharge, or mutually agreed to the cessation of treatment. The remaining 84 discharged client interviews were not conducted for the following reasons: Sixty-four had no contact within 90 days of last encounter, thirteen withdrew from or

refused treatment, three were due to long term incarcerations, three were due to death, and one was clinically referred out. The average length of stay for the 90 discharged clients was 187 days. This is higher than the average length of stay in 2019 of 80.4 days reported by Iowa's Provider Network treatment facilities.

Overall Health

The percent of clients who reported their overall health as very good or excellent increased from 30% at baseline to 38% at 6-month reassessment. Table 4 shows the percent of client reported overall health at baseline and 6-month reassessment.

Table 4 Clients Reported Overall Health by Percent

	Baseline *N=248*	**6-month** *N=112*
Excellent	9.7	6.3
Very Good	19.4	31.3
Good	44.0	40.2
Fair	22.2	16.1
Poor	4.4	6.3

Physical Health

While client-reported overall health improved from baseline to 6-month reassessment, several physical health indicators did not improve. Physical health indicators that did not improved include the percentage of normal blood pressure readings, which decreased from 32% at baseline to 24% at 6-month reassessment, and the percentage of clients who are obese increased from 42% at baseline to 46% at 6-month reassessment. Physical health indicators that improved include the percentage of clients with prehypertension, which decreased from 45% at baseline to 30% at 6-month reassessment. Unfortunately, the number of missing physical health indicators increased drastically at 6-month reassessment for each category and more data is needed in order to draw conclusions about these indicators.

Table 5 Percent of Clients Physical Health Indicators

	Baseline (%) *N=248*	**6-month (%)** *N=112*
Blood Pressure		
Normal	32	24
Prehypertension	45	30
Hypertension	13	13
Missing	10	33
BMI		
Normal	20	14
Overweight	35	20
Obese	42	46

Missing	2	21
Diabetes		
Normal	59	8
Prediabetes	11	6
Diabetes	5	2
Missing	25	84
Cholesterol		
Desirable	50	11
Borderline/High	24	4
Missing	26	86

Behavioral Health

The percentage of clients who experienced no depression in the past 30 days increased from 37% at baseline to 52% at 6-month reassessment. Overall, the percentage of tobacco use and alcohol use changed minimally from baseline to 6-month reassessment. Daily or almost daily tobacco use increased from 54% at baseline to 57% at 6-month reassessment. Regarding alcohol use, the numbers did decrease from 6% at baseline to 2% at 6-month reassessment.

Table 6 Percent of Depression, Tobacco Use and Alcohol in the Past 30 Days

	Baseline (%) *N=248*	**6-month (%)** *N=112*
Depression		
None	37	52
Little	28	24
Some	22	15
Most	11	6
All	2	2
Missing	0	1
Tobacco Use		
Never	35	32
Once or Twice	7	4
Weekly	3	5
Daily or Almost Daily	54	57
Missing	1	1
Alcohol Use		
Never	80	79
Once or Twice	8	13
Weekly	6	7
Daily or Almost Daily	6	2

Conclusion

This evaluation assessed PIPBHC program implementation, processes and outcomes. Overall, Iowa’s Integration Project had many successes, such as building multidisciplinary integrated care teams, maintaining client admissions during a pandemic and natural disaster, and continuing to implement SBIRT across the state. This project also experienced several challenges, including working through pandemic and natural disaster, staff capacity during the pandemic, and collecting physical health indicator data. As mentioned earlier, the following recommendations are encouraged to continue to improve integrating services for Iowans:

- **Explore opportunities to diversify client admissions.** Most clients admitted in Year 2 were male (67%), White (79%), non-Hispanic or Latino (93%), and between the ages of 26-44 (64%).
- **Share data with organizations about their physical health indicators. Organizations can then use this data to inform health promotion activities they are offering to PIPBHC clients.** The percentage of normal blood pressure readings decreased from 32% at baseline to 24% at 6-month reassessment. The percentage of clients who are obese increased from 42% at baseline to 46% at 6-month reassessment. The percentage of clients with prehypertension decreased from 45% at baseline to 30% at 6-month reassessment.
- **Work with and encourage organizations to collect PHI data at each reassessment.** The number of missing physical health indicators increased considerably at the 6-month reassessment for each physical health category. More data are needed in order to draw conclusions about changes in physical health throughout the grant.
- **Encourage organizations to increase tobacco cessation programs and education about alcohol consumption.** The percentage of tobacco use and alcohol use changed minimally from baseline to 6-month reassessment.
- **Explore and expand ways to educate clients about job opportunities.** Forty percent (40%) of admitted clients reported they were unemployed, but looking for work.

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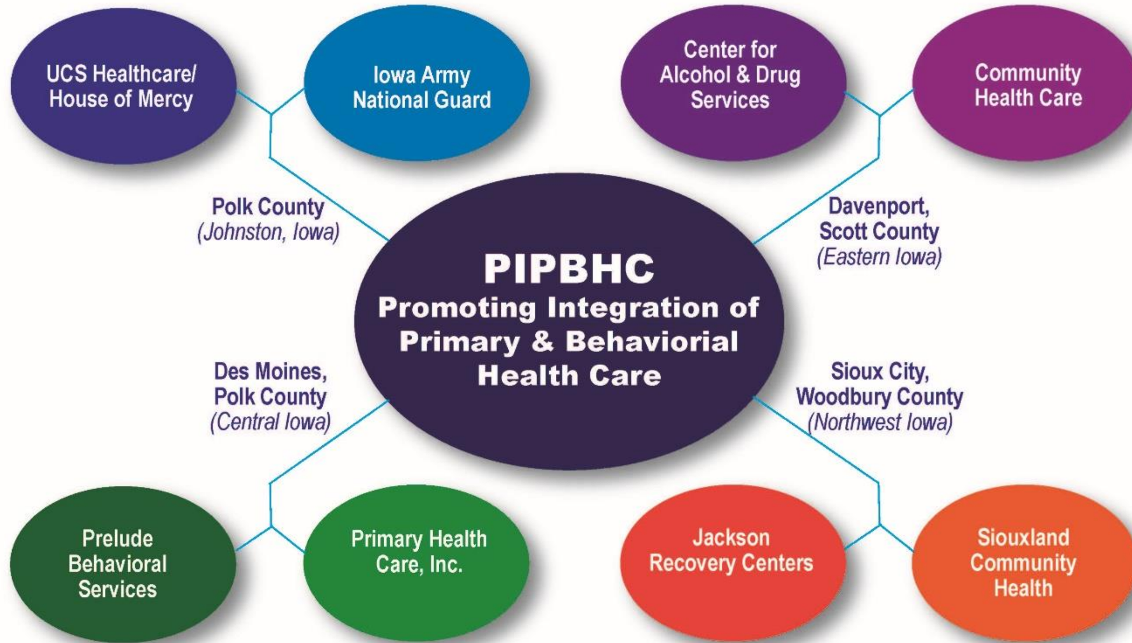
U.S. Census Bureau. (2018). *State & county Quick Facts: Sioux City, Iowa.* Retrieved from http://quickfacts.census.gov

Appendix A – Iowa's Integration Project



Appendix B – Success Stories

Success Story #1:

"We are sharing a success story from a larger perspective than that of an individual patient, by describing our success with a group of patients.

One of the key goals of PIPBHC is to assure the SUD patient/client receives not only good substance use care, but also good, coordinated medical care in general. We know that nationally this group does not always have the best medical care and suffers more long-term complications from that lack of care, as well as placing a larger burden on health care expenditures.

During the first two years of our program, we have uncovered at least six patients with untreated Hepatitis C, four of whom were unknown to be infected, and two of whom had been previously diagnosed but lost to follow-up. Currently four are now in treatment and two have been again lost to follow-up, though we still try to find them, and have not given up on them. One of these two is at least newly aware of his diagnosis.

Hepatitis C is now a treatable condition with a short duration of treatment and excellent results. This means that the long-term complications of liver failure, cirrhosis and organ transplant can be avoided. The cost of treatment is coming down, though still expensive, and we are usually able to get them covered by Medicaid due to Iowa's approval of the ACA expansion. It is at least theoretically possible that the cost of diagnosing and treating these patients will be totally covered by the savings from long-term complications.

Hepatitis C is just one example of how the PIPBHC model can impact care of individuals and the healthcare system itself, a sort of low-hanging fruit."

- SUD and FQHC Integrated Care Team

Success Story #2:

What was the turning point at which you chose to begin your path to recovery: *"When I wanted to die. Living was torture. I hated myself for who I had become and what I had done to my loved ones. I would look in the mirror and was disgusted with what I saw. I felt I was a waste of a life, so it was either die or surrender."*

What do you want to share with others about your recovery: *"I am not only in recovery from my drug addiction but from a life alcohol/abuse self hatred and feelings of unworthiness. My recovery began when gave up my control and full surrender of thoughts, actions, feelings and heart. My recovery is saturated with love as its foundation."*

Describe what healthy changes you made regarding your use of alcohol or drugs? *"My recovery demands 100% honest merit and all honesty with myself. I also surrendered myself who are on the same path as me. In my recovery serving and giving back has kept me humble and grateful."*

How is your life better today as a result of reducing or eliminating your use of drugs or alcohol? *"Not reducing. Complete elimination. I no longer wake up mad that I am not dead. I love my life now. I am for the first time in my life proud of who I am and that is something I never thought would happen ever"*

- Female, 40, receiving services through her Integrated Care Team

Success Story #3:

What was the turning point at which you chose to begin your path to recovery: *"During active addiction I lost my vehicle, got evicted from my home and lived in my dad's vehicle. I was borrowing, my kids had been removed from my care, I was pregnant, and went to jail for contempt. I knew I wasn't going to dig myself out of the mess I got myself into, alone. I stopped trying to fight against the system, and put faith into it. I surrendered!"*

What do you want to share with others about your recovery: *"In the beginning, I felt very overwhelmed, but I worked hard on improving my mental health with my provider and it made everything manageable. The harder I work on myself and my recovery, the better the results."*

Describe what healthy changes you made regarding your use of alcohol or drugs? *"I decided to attend inpatient treatment outside the Sioux City area. I cut ties with all the people I used with, improved relationships with my family, and made my mental health a top priority."*

How is your life better today as a result of reducing or eliminating your use of drugs or alcohol? *"I am so grateful for everything in my life, especially the things I took for granted. I am a better mother, and I like who I am today. I can take on whatever life throws my way, and will continue to improve my life while also helping others."*

- Female, 27, receiving services through her Integrated Care Team

Success Story #4:

What was the turning point at which you chose to begin your path to recovery: *"I am a soldier in the Iowa National Guard. I dropped hot for THC and got referred to the SBIRT program. I did the treatment weekend with Eric and Cassidy and that made me want to not give up on my military career."*

What do you want to share with others about your recovery: *"I have been able to save a lot of money, which allowed me to get a nicer home for myself and my girlfriend. My mind is clearer which has made it easier to deal with stress."*

Describe what healthy changes you made regarding your use of alcohol or drugs? *"I quit smoking marijuana completely, and cut down my drinking to one beer a night. I focus on time with my family and my job."*

How is your life better today as a result of reducing or eliminating your use of drugs or alcohol? *"I am about to get my rank back, I live in a nicer home, I am happier and my money goes to better things."*

- Male, 22, receiving services through his Integrated Care Team

Appendix C – Recovery Support Services

<table>
<tr><th>Iowa's Integration Project
Promoting the Integration of Primary and Behavioral Health Care (PIPBHC)</th></tr>
<tr><td>Recovery Support Service Type/Definition
All PIPBHC RSS utilized must be funded as the payor of last resort.</td></tr>
<tr><td></td></tr>
<tr><td>Care Coordination with NOM's Admission (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 Interviews

Includes:
• completing the NOM's Admission Interview and entering the data into the SAMHSA data system
• documenting the service in the provider's records</td></tr>
<tr><td>Care Coordination with NOM's 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 Interviews

Includes:
• completing the NOM's Discharge Interview and entering the data into SAMHSA data system
• documenting the service in the provider's records</td></tr>
<tr><td>Care Coordination with NOM's 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)</td></tr>
<tr><td>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.</td></tr>
<tr><td>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 is not present in the building, the person delivering the service must be, or 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.</td></tr>
</table>

1

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

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
- **$15 gift card after 12 consecutive negative screens**
- **$15 gift card after 15 consecutive negative screens**

Upon completion of 15 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.

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, school supplies, books and manuals to support recovery based learning and necessary supplies required for the vocational/educational program.)
Includes:
- documenting each service in the individual records
- tracking services billed

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

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

2

- 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 and the agency should make purchases directly on behalf of the individual.

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/and or family/support person on a weekly basis, 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. Individual will need to turn in a receipt to the PIPBHC staff prior to a new card being issued.

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 agency provider pays directly for the item or service directly, obtains a receipt documenting payment, and documents the service in the medical record.

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

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.)