



Iowa Certified Community Behavioral Health Clinics (CCBHC) Final Report

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OVERVIEW

In October 2015, the Iowa Department of Human Services was awarded a one-year planning grant from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). The aim of this grant is to assist Iowa in improving the behavioral health of its citizens through high-quality, coordinated, community-based mental health and substance use disorder services. These services are to be built upon evidence-based practices and are designed to integrate physical health services. Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the Iowa CCBHC project.

As a part of the CCBHC Planning Grant, grantees are required to report on agency level indicators aggregated on a quarterly basis. These indicators are called Infrastructure, Health Promotion and Prevention (IPP) measures. This report presents results from July 1, 2016 to September 30, 2016.

Eleven of the twelve members of the Iowa CCBHC Stakeholder Advisory Committee were e-mailed a survey to collect information for the Performance Assessment Measures. (One of the members of the CCBHC Stakeholder Advisory Committee is the Director of the Consortium, and as such was not included in the data collection process). The Consortium received two surveys from the Iowa CCBHC Stakeholder Advisory Committee members yielding a response rate of 18.2%. However, Advisory Committee members forwarded the survey to other agencies yielding two additional surveys. In sum, four surveys were collected. The data for seven of the eight Performance Measures reflect these four surveys.

Common themes arising from key interviews conducted with executive officers of each Certified Community Behavioral Health Clinic between August 29, 2016 and September 8, 2016 are also discussed in this report. Key informants were asked to discuss their role with the CCBHC Planning Grant thus far, and to communicate anticipated challenges, assets, and strategies to overcome barriers throughout the Demonstration Program should the State of Iowa be chosen to receive funding.



Lastly, this report contains responses from the Community Conversations held in each CCBHC catchment area between August 29, 2016 and September 6, 2016.

INFRASTRUCTURE DEVELOPMENT, PREVENTION & MENTAL HEALTH PROMOTION (IPP) INDICATORS

Data for the Fourth Quarter IPP Indicators represent the following four agencies:

Abbe Center for Community Mental Health
Iowa Association of Community Providers
Iowa Primary Care Association
Seasons Center for Behavioral Health

Table 1 lists the indicator acronym, indicator and reported frequency of each indicator for the four agencies.

Table 1. Fourth Quarter IPP Indicators

Indicator Acronym	Indicator	N Agencies = 4
PD1	The number of policy changes completed as a result of the grant.	3
WD1	The number of organizations or communities implementing mental health/substance use-related training programs as a result of the grant.	1
WD3	The number of people newly credentialed/certified to provide mental health/substance use-related practices/activities that are consistent with the goals of the grant.	0
F2	The number of financial policy changes completed as a result of the grant.	0
OC1	The number of organizational changes made to support improvement of mental health/substance-use related practices/activities that are consistent with the goals of the grant.	11
PC2	The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.	72
A3	The number of communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery data as a result of the grant.	1
A4	The number and percentage of work group/advisory group/council members who are consumers/family members.	2/12 (16.7%)

Progress towards Annual Performance Goals

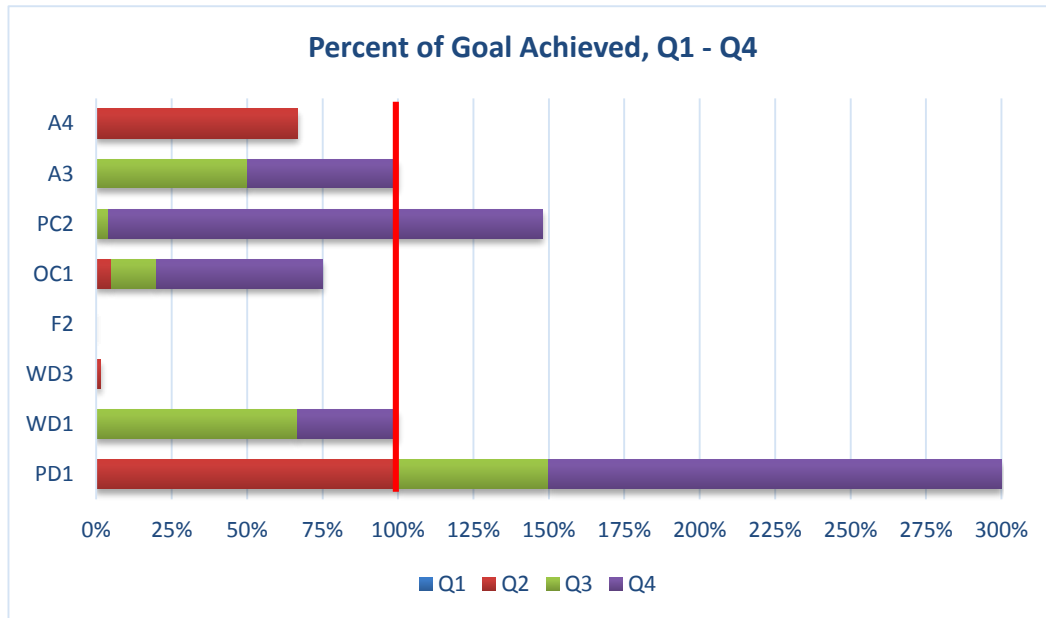
The following figure illustrates the proportion of the Annual Goals that have been met during the year-long planning grant phase quarter. Four of the eight goals have been met or exceeded throughout the four quarters of the CCBHC Planning Grant. Six policy changes have been reported (PD1), which is triple the goal amount of two policy changes throughout the year. In addition, agencies exceeded the goal of collaborating with fifty organizations (PC2) by 48%.



The goal of two communities establishing management information/information technology system links across multiple agencies (A3) was also met. Lastly, agencies met the goal of implementing three mental health or substance used-related practices/activities (WD1) that are consistent with the goals of the CCBHC initiative.

Agencies came close to meeting the goal of twenty organizational changes (OC1) throughout the planning year with fifteen reported changes resulting in 75% of the goal met. The goal of one-quarter of advisory council members who are consumers or family members of consumers (A4) was not met; however, one in six advisory council members were consumers or family members throughout three quarters of the grant year. The goal of two organizations reporting financial policy change (F2) was not met since agencies frequently reported that they would not make financial policy changes until the State of Iowa was chosen to receive the two-year Demonstration Program funds. Lastly, only three people were newly credentialed or certified (WD3) throughout the duration of the planning grant phase. Several agency staff had been trained; however, agencies have reported that the duration of this grant was often not long enough for trainees to receive accreditation or certification.

Figure 1. Percent of Goal Achieved, by IPP Indicator (Quarter 1 to Quarter 4)



Qualitative Data

All questions of the CCBHC Planning Grant Survey were open-ended. The following data result from agencies' responses to the open-ended questions. Results include brief summaries of agency responses by IPP Indicator and verbatim general comments.



PD1: The Number of Policy Changes Completed As a Result of the Grant

Abbe Center for Community Mental Health

Job Description Review: Agency has implemented policy to review and update job descriptions as significant changes in job duties occur through transitioning to a CCBHC.

Treatment Environment: New policies developed to make the treatment environment, including physical spaces in the center, more supportive of the recovery process.

Progress Notes. New policy adopted to increase accessibility of behavioral observation documentation by prohibiting the use of professional jargon.

WD1: The Number of Organizations or Communities Implementing Mental Health Related Training Programs As a Result of the Grant

Seasons Center for Behavioral Health

Veteran Behavioral Health Training Program: Agency has created new training program to educate staff on how to address veteran's unique behavioral health needs through trauma-informed care.

F2: The Number of Financing Policy Changes Completed As A Result of the Grant

Nothing new this quarter to report.

WD3: The Number of People Newly Credentialed/Certified to Provide Mental Health/Substance Use-Related Practices/Activities that are Consistent with the Goals of the Grant.

Abbe Center for Community Mental Health

“As a part of the planning grant, the Abbe Center as an agency obtained the licensure for SUD treatment provider. No new staff members obtained additional certification during this quarter. We did identify staff that would like to obtain their CADAC, however, that process for required training, supervision and mentoring takes longer than this grant period allowed.”



OC1: The Number of Organizational Changes Made to Support Improvement of Mental Health-Related Practices/Activities That Are Consistent With the Goals of the Grant

Abbe Center for Community Mental Health

Staff Development and Training Tracking System: New system at agency tracks employee training to assist in the development of staff training plans.

Tuberculosis Testing Initiative: All staff and practicum students working for a particular treatment site are tested for Tuberculosis to prevent spread of disease.

Creation of Executive Staff Position: Agency established a new Association Executive Director of Recovery Services position to assist in the training and development of a fuller array of services.

Medication Management Plan: New initiative designed to ensure proper administration, documentation, and storage of medication.

Referral System: Agency updated client referral system based on American Society of Addiction Medicine criteria containing an outline of the screening processes and client orientation to services.

Seasons Center for Behavioral Health

Intensive Psychiatric Rehabilitation: Intensive Psychiatric Rehabilitation services have been integrated into agency practices to better assist clients recovering from mental illness.

Respite Services: Agency has included respite services to care for children who need less intensive levels of care.

Co-Occurring Department: New Co-Occurring Department was developed to improve treatment of clients with substance use and mental health disorders.

Creation of Veteran's Service Specialist Position: Development of new Veteran Services Specialist Position to oversee training on veterans' mental health needs.

New Mental Health and Substance Use Disorder Staff: A Substance Use Disorder Peer Specialist, Psychiatrist, and nurse practitioner was hired to meet increased demand for services and to prepare for CCBHC demonstration.

New Clinic Manager Position: Agency has hired a new Clinic Manager who is responsible for ensuring ongoing appropriate and timely communication with primary care providers.



PC2: The Number of Organizations Collaborating/Coordinating/Sharing Resources with Other Organizations As a Result of the Grant

Abbe Center for Community Mental Health

DCO Agreements: Agency has worked with three organizations to define how resources will be shared to structure referral framework as DCOs become a part of the CCBHC array of services.

Community Listening Post: Three agencies shared time and information to discuss the how the presence of CCBHCs will impact community mental health, employment and integrated health home services.

Heartland Family Services

Community Listening Post: Eighteen agencies shared ideas and expectations of how CCBHC presence will impact existing education, health and correctional systems.

Seasons Center for Behavioral Health

Care Coordination Agreements: Twenty-seven agreements have been secured which outline inter-organizational commitments to aid in care coordination for Season's work as a CCBHC.

Community Discussion: Twenty-one agencies discussed how the presence of CCBHCs will impact community crisis, county health, education, corrections and hospital services.

A3: The Number of Communities that Establish Management Information/Information Technology System Links Across Multiple Agencies in Order to Share Service Population and Service Delivery Data as a Result of the Grant

Seasons Center for Behavioral Health

Sharing Information Across Providers: Agency has enhanced existing health information technology to share service population and service delivery data with key primary care providers in the community.

Data Collection and Reporting

Goals: Several data collection and reporting goals were put forth in the final quarter of the CCBHC Planning Grant including:

- Meet with data collection contractor
- Attend weekly SAMHSA data quality and measurement webinars
- Collect information for IPP indicators
- Conduct key informant interviews with CCBHC executive personnel



- Conduct a Community Needs Assessment Survey
- Conduct Community Listening Posts at each CCBHC Catchment area
- Assess CCBHC readiness to collect data
- Prepare data collection and reporting sections of the CCBHC Demonstration application

Progress: At the time of the completion of this report, all goals have been met with the exception of completing the data collection and reporting sections of the CCBHC Demonstration application.

Barriers: Several agencies felt that they were not ready to collect the data quality measures in the manner discussed in the SAMHSA webinars.

Efforts to Overcome Barriers: Project Directors used SAMHSA data collection templates in conjunction with a survey to assess CCBHC readiness to collect data quality measures.

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted with five executive officers of the newly Certified Community Behavioral Health Clinics. Two executive officers from each CCBHC were contacted to attempt an interview; however, one officer was not available within the time frame in which interviews were being conducted. The following section describes each key informant's role at their respective Certified Community Behavioral Health Clinic (CCBHC) including their official titles, job duties, tenure with the agency and anticipated role in the Demonstration Program should Iowa be chosen to receive the funds for the CCBHC Demonstration Program.

Abbe Center for Community Mental Health

Cindy Kaestner is a former executive director who assisted with writing the proposal to the state to become an accredited CCBHC. Cindy now works as a contractor to several agencies including Abbe Center for Community Mental Health. Abbe has not determined what role Cindy would have should the State of Iowa receive funding for the CCBHC Demonstration Program. However, Cindy expects that she will be working on aligning protocols and policies with CCBHC guidelines and navigating the financial aspects of the program.

Kathy Johnson now holds Cindy Kaestner's position as Executive Director. Kathy is responsible for overall clinical and financial operations. She has worked with Abbe Center for Community Mental Health for twenty-nine years and has held a variety of positions during her tenure with the agency. Kathy anticipates that she will be generally responsible for the CCBHC initiative during the CCBHC Demonstration Program.

Heartland Family Services

Shannon Mahnke is the Iowa Behavioral Health Director at Heartland Family Services. She oversees outpatient and residential services, and substance abuse, mental health and gambling treatment. She also oversees school based services, the child and family center and programs for victims of crime. Shannon has held this position for three years and has been at Heartland Family Services for twelve years. Prior to holding this position, Shannon was the program director for the woman and children residential program. At the time of the interview, Shannon's



specific role within Heartland during the Demonstration Program is undecided; however, she knows that she will have a large role in the initiative.

Seasons Center for Behavioral Health

Kim Scorza is the Seasons Center for Behavioral Health Chief Executive Officer. Kim focuses on the financial aspects of Seasons Center with specific emphasis on program development, program compliance and donations. Kim has held this position for seven years. Kim completed an agency internal audit to prepare for application as a CCBHC to the State of Iowa. Kim anticipates that during the CCBHC Demonstration Program she would be involved with hiring and communicating regularly with staff, stakeholders and community members.

Christina Eggink-Postma is the Vice President of Program Coordination and Compliance at Seasons Center for Behavioral Health. Christina has held the position for less than one year. Prior to this position she was a Program Coordinator at Seasons Center for approximately three years. Christina works with agencies on new program start up and ongoing compliance for accreditation for existing programs. Should Iowa be chosen to participate in the Demonstration Program, Christina believes that she will be involved with the initial roll out of the initial changes that come with doing business as a CCBHC with a focus on ensuring compliance with CCBHC criteria.

What financial benefits and challenges did key informants anticipate will result from CCBHC certification?

Table 1 presents the advantages and challenges agencies anticipate that will result from CCBHC certification during the demonstration program should the State of Iowa be chosen to receive funding. Interviewees at all agencies anticipated that certification as CCBHC will result in the ability of their organizations to improve their current care coordination efforts. Financially, respondents indicated that being certified as a CCBHC will allow the agency to receive a higher reimbursement rate for care coordination services. There is an expectation to receive funding for care coordination services that they are already providing but are currently unable to bill. Being certified as a CCBHC and participating in the Demonstration Program will allow agencies to have care coordination services built into their fee schedule. Interviewees reported that the funds received from the Demonstration Program will allow agencies to hire more employees. A larger staff is key to providing the level of care required by CCBHC guidelines. Increasing staff will allow agencies to ensure that they have employees dedicated to aspects of the CCBHC program without having to be pulled from other job duties. Interviewees indicated that increased funding will allow them to pay their staff a wage that is more commensurate to experience and expertise. Higher wages will also allow agencies to retain current employees and to attract new employees with credentials required by CCBHC guidelines.

“The financial consequences of getting cost reports correct are substantial.”

Informants specified several challenges that they expect to encounter during the Demonstration Program and have already encountered in the planning phase of the CCBHC grant. The most salient challenge interviewees spoke of was creating the cost reports for the state application for being certified as a CCBHC. Predicting the cost of services that they have not yet implemented and have no “historical data” for was the primary difficulty discussed in creating these cost reports. Many interviewees stated that producing a cost report that is even slightly imprecise



could “financially ruin” their organization. In addition, there were concerns that there would not be any opportunity to adjust the cost report after submission. Another concern respondents voiced was about the amount of funds spent on start-up costs to initiate new evidence-based programs. Currently, some agencies are using their own funds to hire new staff and train new and existing staff to provide new mental health and substance use disorder services. In some cases, agencies will not be able to continue offering these new services if the funding for the Demonstration Program is not received. Lastly, some interviewees voiced concern that increased collaboration between the state and CCBHCs when developing the Prospective Payment System would have results in an improved Demonstration Program application and more informed CCBHCs.

Table 1. Anticipated Financial Advantages and Challenges for Demonstration Program

Advantages	Challenges
<ul style="list-style-type: none"> • Higher reimbursement rate • Bill for care coordination services • Hire more staff • Pay staff commensurate wages 	<ul style="list-style-type: none"> • Predicting future service costs • Start-up costs • PPS collaboration

What are the biggest challenges CCBHCs foresee throughout the two-year Demonstration Program? How can your agencies overcome these challenges?

Table 2 summarizes key informants’ commonly cited barriers to successfully completing the CCBHC Demonstration Program along with anticipated strategies to overcome barriers. Interviewees were most concerned with staffing, receiving appropriate reimbursement through managed care organizations, and collecting the CCBHC required quality measures in a timely and comprehensive manner.

“In the past we were able to fill a nursing position in 30 days, but today it takes 4 months to fill the same position”

Staffing. Issues with staffing were more salient among Seasons Center for Behavioral Health and Heartland Family Services as they serve a large rural population. Respondents claim that the statewide health care provider shortage has hit these areas particularly hard. Low wages have made it increasingly difficult to find employees with appropriate credentials. Agencies indicate that they cannot offer a competitive wage to their employees, and that many people in the health care fields such as

licensed social workers are working in entirely different fields where there are higher wages. Interviewees expected that their ability to hire appropriate staff will improve once they are able to offer higher wages to oncoming employees through funding through the CCBHC Demonstration Program. However, agencies will need to offer higher wages to all current staff as well.

Strategies to overcome staffing barriers include developing internal workforce development teams whose primary focus is to attract new employees and retain existing staff. Interviewees who are in the process of hiring staff or have recently hired new staff mention using new recruitment and retention techniques. Such techniques include using social media sites to post job openings, hiring recruiters to find prospective employees, and offering benefits such as employee resource groups that focus on employee self-care to retain employees. Another



strategy is to contract out work when agencies do not have the staff to complete a task. For example, one agency contracts with a company that provides tele-health services.

Managed Care Organizations (MCOs).

Interviewees expressed a generous amount of concern in working with Managed Care Organizations (MCOs). Agencies explained that in the past, it has been a “huge undertaking” to ensure that claims are paid correctly. Often times, their claims were not being reimbursed correctly or there was a considerable amount of delay in receiving reimbursement for services. Respondents believed that these issues will be compounded when working as a CCBHC since they will have to bill for both CCBHC and non-CCBHC services. This is believed to result in a situation in which MCOs and CCBHCs have to navigate dual systems for each patient. Some interviewees expressed concern that there may not be enough time to obtain prior authorization from MCOs to get new services added to contracts. One agency does not work with MCOs and is concerned that operating as a CCBHC will require them to work with one of these organizations. Lastly, respondents indicated that there will be a considerable learning curve in teaching staff new billing codes.

“How confusing is it going to be that on any given patient there can be a CCBHC service and a non-CCBHC service?”

Strategies to overcome the barriers associated with working with Managed Care Organizations include testing the claims process well before agencies begin using encounter codes. This will give agencies time to troubleshoot any problems that they may not currently foresee and identify comprehensive solutions to billing problems. In the event that reimbursement for services or obtaining prior authorization from MCOs is exceptionally delayed, one respondent indicated that the agency would resolve the problem by contacting more senior staff within the managed care organization and, if necessary, communicating with the legislature. Interviewees requested more communication with IDPH and DHS to ensure that there are agreements on units of services, encounter definitions and payment methodologies.

Quality Measures. At least one interviewee from each agency anticipated that collecting the CCBHC quality measures will present a challenge to their organization. Interviewees communicated that, although they had attended the required SAMHSA data and measures webinars, they were still unclear as to how to collect the data appropriately and comprehensively. Interviewees had additional concerns regarding working with their software vendors. All agencies will need to build new data collection measures into their Electronic Health Records which require that agencies pay their software vendors more money. There is a concern that the software vendor will not make the necessary changes to the Electronic Health Record in a timeframe that allows them to meet CCBHC data deadlines. Finally, there is also concern that additional time and effort will be needed to train staff to collect data in a way that meets CCBHC guidelines.

Since agencies have had to comply with standardized data collection methods in the past, interviewees cite looking at past experiences as one of the best strategies to overcome and issues with data collection. One agency will continue to contract out data collection to a nearby university during the Demonstration Program. Other interviewees indicated that the agency would have conversations with internal staff with experience in data compliance and optimizing data collection systems.



Designated Collaborative Organizations (DCOs). Two of the three CCBHCs will be utilizing DCOs to provide care that they do not offer within their organization. Interviewees reported some barriers in communicating with DCO staff. One respondent indicated that their agency is receiving some “push back” from staff at one DCO. In this case, the DCO staff does not wish to have an outside organization inform them of how to manage their agency. Another interviewee indicated that there have been issues with approving an agreement form between their agency and a DCO. The management at this DCO has expressed concern that accepting funding from the CCBHC Demonstration Program will put their own funding in jeopardy. The management at this particular DCO fears that the regions who fund crisis services will cost shift since they will assume that the CCBHC will cover the crisis management services.

Both interviewees cited new communication strategies as a method to overcome barriers to entering a mutually beneficial partnership with DCOs during the Demonstration Program.

Table 2. Anticipated Barriers and Strategies to Overcome Barriers for Demonstration Program

Barriers	Strategies to Overcome Barriers
Staffing	<ul style="list-style-type: none"> ○ Internal workforce development teams ○ New recruitment and retention strategies ○ Utilize tele-health services
Managed Care Organizations (MCOs)	<ul style="list-style-type: none"> ○ Complete test run of claims processing system ○ Communicate with IDPH and DHS
Quality Measures	<ul style="list-style-type: none"> ○ Problem solve with internal staff ○ Contract with external organizations
Designated Collaborative Organizations (DCOs)	<ul style="list-style-type: none"> ○ New communication strategies

What do you foresee as the biggest asset to your success throughout the two-year Demonstration Program?

Interviewees focused on three assets that will be detrimental to the success of CCBHCs during the Demonstration Program should the State of Iowa be chosen to receive funding: staff, experience, and existing partnerships with other agencies.

“The biggest asset we have is the people. We have folks that will take this on.”

Staff. Nearly all interviewees identified staff as the biggest asset to the success of their agency throughout the two-year Demonstration Program. Respondents indicated that their staff are willing to take on new challenges, are great problem solvers and provide a high level of quality services. Additionally, interviewees claimed that staff are supportive of each other which creates an environment of collaboration. Lastly, interviewees pointed out that staff are in regular



communication with clients to obtain feedback on how to improve patient care and treatment outcomes.

History of Innovation. Informants looked to their past experiences with implementing innovative evidence-based practices as an asset to assist them undertaking the CCBHC initiative. These agencies have implemented a variety of services including Integrated Health Homes, Access to Recovery, Peer Support and Wellness Support. The lessons learned from managing these services will assist agencies with developing additional services under the CCBHC initiative and ensuring that existing services comply with CCBHC criteria.

Existing Partnerships. Interviewees recognized existing partnerships with other organizations as a key asset to being successful throughout the two-year Demonstration Program. Some interviewees envisioned such partnerships will allow them to improve their care coordination throughout the CCBHC program by sharing information across entities in a timely manner. Thus, the CCBHC will be aware of the type of social services such as housing, food security and employment clients are receiving or are in need of to create a comprehensive plan for recovery. Another interviewee indicated that existing partnerships will allow the CCBHC initiative to take on a more “multi-disciplinary approach” that will make room for diverse perspectives on treatment. Lastly, one respondent suggested that the CCBHC initiative will strengthen existing bonds with other agencies as they work together to improve existing services.

How aware are agency staff and the community of the CCBHC initiative?

Staff Awareness. Interviewees indicated that there is a core group of agency employees who are very aware of the CCBHC initiative. These individuals have worked together to create the application to the State to become a CCBHC and are continuously working together to ensure CCBHC readiness. This core group of employees then inform the non-core group of staff that make up the majority of the agency. Among these non-core employees, the CCBHC initiative has yet to severely impact their daily job duties. However, the core CCBHC staff routinely route pertinent CCBHC-related information to the non-core group via monthly e-mails, presentations and staff meetings. Some non-core employees are more aware of the CCBHC initiative than others due to some agencies needing to integrate substance use disorder and mental health services that were previously unavailable at their agency. Generally, interviewees claimed that non-core employees know that the CCBHC program involves care coordination for a larger spectrum of clients that would include adding supplementary services and closely monitoring evidence based practices.

Community Awareness. Respondents cited a need to improve communication about the CCBHC initiative to the community. One interviewee responded that they had received letters of support from twenty-five organizations throughout the community, but that they had no communication with these organizations following these letters. Two interviewees suggested that more community outreach is needed to raise community awareness of the additional services that they now offer as a CCBHC. For example, now agencies offer mental health *and* substance use disorder services for adults as well as children. In general, interviewees claimed that although behavioral health providers in their catchment area were familiar with the CCBHC initiative, social service organizations such as those that provide housing and employment services were not familiar with the program. Several respondents suggested that the community discussions assisted in communicating *some* CCBHC-related information to these organizations.



COMMUNITY CONVERSATIONS

Community conversations for the CCBHC project occurred between August 29 and September 6, 2016 in all three of the respective CCBHC communities. Professionals and consumers of services were invited to give input into what they saw were the biggest concerns within their communities. The comments given at these meetings have been collated into areas of concern by each CCBHC and are listed in the following section.

Abbe Center for Community Mental Health

There were three main areas of concern that came up in the conversations regarding Abbe Center and the services that will be provided through the CCBHC. These main areas of concern include: access, care coordination and staffing. Under each main area of concern, there is a sub-category of specific concerns and the specific documented comment that was made at these community meetings.

Access

Access to Services

- *I have had trouble with follow through with the IHH. I think there needs to be easier access to the IHH.*
- *The same day access program is great. I haven't had any trouble seeing someone when I need to.*
- *I haven't had any problems with IHH. When I call my person she always gets back to me. We have a monthly meeting and she is easy to schedule with. We get together and meet for 40- 45 minutes and it feels really good to me.*
- *One of the main strengths of this area is a high population of both "normies" and consumers. Environmentally and geographically this is an accessible center, I think that it is highly congruent with what you are asking to do.*
- *If a consumer identifies as having SUD issues, but not MH issues can they still come to the clinic here? Answer: (Lori Hancock-Muck) Yes and the beauty of this is that before this grant Abbe wasn't licensed to do SUD, but as of September they will be.*
- *And it is still about consumer choice. A person can still choose to get their SUD services somewhere else but Abbe has to coordinate with that agency.*
- *I think the core group is really good, but I sometimes feel intimidated to go to it because of where I am personally with my MI. I have problems with alcohol, plus depression, plus COPD. When I do go it is really good for me. Like she said we aren't having ASAC come in anymore which is good and bad. They didn't seem really into it or sincere about it, but I think the people she has now are really sincere. But within this community here I think there are probably a lot of people who have SUD issues but don't want to admit it. That group on Friday is a small group, and people you see all the time, and it is really nice to just be able to talk about it.*



Access to Transportation

- *Disagree that the transportation is good. I think for a metro area our transportation stinks. For people to come to certain things none of the services will pay for transportation aside from the bus. (echoed by several people).*
- *People who can't pay for a bus pass have an even harder time. Comment: If they lie and say they are coming to see a peer support specialist it's paid for, but you don't want to encourage people to do that.*
- *We used to use TMS, but now whoever your MCO is if you call them and you have two medical appointments per month you could qualify for a bus pass. They don't count things like Club 520. Some MCOs won't send the 31-day pass, but mine does as long as I have two appointments per month. So I make sure all of my appointments are on the bus routes.*
- *I go to dialysis 2 times a week, and if I take the bus pass I can't get other forms of transportation paid even though the bus doesn't run during some of my appointment times.*
- *I have lived in smaller places that have better transportation systems. It is the worst of anywhere I have ever lived.*
- *For as bad as it is in town, it is even worse if you live outside of the metro area. Comment: And they got rid of transfers. The bus needs to run a lot more. Not everyone works 8-5pm.*

Hours of Operation

- *With this project serving the whole county it has to be looked at. It puts a damper on evening hours too because it's harder to get transportation in the evenings.*
- *A good thing about Abbe is that they have a psychiatrist who works on Saturdays and for me that is very convenient.*
- *This all ties into transportation and staff. Abbe only works from 8-5pm. Other organizations don't have set times; they can work evenings or weekends. Here they need to scramble to get a car, but at Optima they can use their own car. Also they need more staff. 1 staff person to 32 people is ridiculous. And we only get them for an hour. What can you do in an hour? I can't even do my laundry. We need more everything - more staff, more hours, more access. Life happens, I get a phone call, I forgot about an appointment I have tomorrow and my care worker is busy. If I don't have a bus pass that month I have to cancel that appointment.*

Care Coordination

Difficulty with forms

- *With DHS I had a problem. You get your food stamps and they send you a form supposedly but sometimes people never get it, and then they drop your food stamps and medical but you never even got the form. So you have to do all this paperwork to get it turned back on. You do all of this paperwork all the time, and I understand that's important, but I was in the hospital for 8 weeks and my benefits got shut off and there*



are other people I know who said they didn't get their form and I know that's happened to me too. I don't have a computer so I can't do it online. There has to be something better though.

- *I am concerned too because I see forms that say they have to be completed in 6 days and returned, but I know some people need help filling those things out but might not be able to get an appointment with their IHH worker in enough time and their benefits get shut off because of it.*
- *They could send those forms out earlier, I know sometimes I just don't have time to help someone if they get a form and it is due tomorrow.*
- *One idea for people who have an IHH worker is if they are going to contact a consumer they could also send a notice to their IHH worker. So they know this person needs to turn the form in and they might need some help doing it.*
- *Sometimes there are people who don't have family and say they have to have a colonoscopy or something and don't have people to stay with them for 24 hours. There has to be a solution to that; even someone to be with them during the procedure. People aren't going to those appointments and they are getting cancer.*
- *Like me I got my gallbladder out and was all alone for the recovery. It was hard.*
- *We can't make appointments more than 10 days in advance, but you can't get in to see your doctor if you call within 10 days. It's impossible. So if you are having an issue there is no consistency. I had surgery and wanted to see my doctor but was told I couldn't see him again in 4 months.*
- *I have a general comment about all of the services here. Club 520 is great, so are IPR and Life Skills. One problem I run into is consumers who aren't already seeing people here don't know about all of the stuff they offer. I am in a group at Horizon's and people who aren't involved in Abbe have no idea about all of the services. There should be a way for the general public to know about the services here. More publicity.*

Follow-up and Discharge Planning

- *How will this project help with following up with people after hospitalization? It's one of the requirements that the clinics have to have really tight plans with the hospitals in the area. We know sometimes people do fall through the cracks, especially if they aren't already connected. The CCBHC has a lot of responsibility around that.*
- *Yes it is part of the CCBHC but we have already been working on that issue. If you have been up on the unit you might be familiar with our staff person who goes there so that connection is established and people come to the follow up appointments. Before we started we were finding that 75% of people weren't doing that follow through after discharge.*
- *Is that coordination just for mental health or medical services too? If there is a behavioral health consult we would expect it. I think there would have to be a way for the hospital to flag that there was a behavioral health issue.*



- *I've been in the hospital for health reasons, not mental health, but wasn't getting those services because I was seen as a health patient not a mental health patient. But I needed both.*
- *That is part of the focus here. Clinics have to make sure all of your health is coordinated- mental and physical. SUD- Abbe is close to being licensed with IDPH.*

Staffing

- *I facilitated a co-occurring group for five years and my issue was when ASAC restructured their services my group was gone. Is this going to help build that back up? Is there going to be a better dual diagnosis program built out of this? There is a need for peer facilitated group focused on co-occurring populations. There is also need for greater training. Just because I have lived experience doesn't mean I can always make the group go the way it needs to go. I also think there is a need for the trainings to be in other places than Des Moines.*
- *One thing this project does is say we want mental health and substance use disorder services side by side. We want staff to have experience in both. We know that no one is just one diagnosis; we are all more than that. And many people have co-occurring health issues across multiple domains. We hope doing it this way is going to lead to better outcomes.*
- *At a national level a lot of people have gone away from the term "dual" diagnosis- they call it multi-complex because there might not just be two, but whatever the need is let's address it all.*
- *Good point. We have a co-occurring group here that is a strength and if you can build on that it would be good. It would be good to solicit all kinds of input too. There is a huge AA population here. I have spoken with CPCs and treatment people and they are highly interested in this process and willing to help support in a lot of ways. Unfortunately, the SUD community isn't well represented here today, so don't overlook them.*
- *Probably outside of this, I know you aren't providing inpatient services, but the SUD community identifies that as a high need. Should be communicated to the state that the detox facilities at hospitals are lacking.*
- *How is this going to work with drug court? I went through drug court 10 years ago and it helped me get to where I am today. Answer: (Laura Larkin) This program should be working with any program like that.*



Heartland Family Services

There were two main areas of concern that came up in the conversations regarding Seasons Center and the services that will be provided through the CCBHC. These main areas of concern include: care coordination and staffing. Under each main area of concern, there is a sub-category of specific concerns and the specific documented

Care Coordination

Crisis Intervention

- *I am a nurse case manager at the ER and we find that most patients with these types of high need are coming after hours and on the weekends. There is a need for both crisis and regular mental health services, ER doctors are not trained to deal with a lot of the psych needs they encounter, and the staff is older so their training was a while ago. Also the majority of my patients come in after hours when people are least equipped. Also come to ER for prescription refills. We see an ambulance bring the same person in 3-4 times after hours in a week. Face to face contact is big. If I can have contact with them in the ER it is much better than trying to follow up later.*
- *The volume on the front lines in terms of fire department and medics is an issue. MH and SUD calls have dramatically increased over the past few years. A low estimate for MH would be 6.5% of our call volume- above stroke, but below chest pain. That's just the patients we absolutely know are having MH issues. SUD around 5%, but again a low estimate.*
- *We haven't even seen the wave of opioid abuse that we know is coming too.*
- *Why do you think there has been an increase in those types of calls? I have lived in this area my whole life, I know most of these people. I think it is more accepted, whereas it used to be more hidden when I first started nursing in the 80s. People are more willing to talk about who they buy from, where they get it, etc.*
- *In Harrison County we completed the needs assessment we do every five years and did a survey and a lot of outreach. It's still a convenience sample, but MH and SUD issues came out 2nd and 3rd on the survey, and when we went out and looked at secondary data both of those popped up again. Lots of hospitalizations for MH across the lifespan. It's recognized as an issue by the community, and reflected in the data.*
- *What kind of crisis situations are people calling about? OD, violence, threatening violence, or suicide. We have naloxone on the ambulances now.*
- *I am concerned about parents who already seem to have a full array of services in line, BHIS etc., but seem to hit the end of their rope and whatever crisis supports should be there aren't so parents end up bringing them to the ER but they are turned away. Whatever the solution to that is isn't strong enough or meaningful enough. The response needs to be more than what it is- more responsive, more on the spot. Crisis response needs to be emphasized or it won't feel like much has changed. Different for children than it is for adults, in terms of what that parent might need; there is a need for more specialized care.*



- *Crisis line, get a lot of callers saying that it is taking a long time to get in - thankfully we do have the ability to collaborate on mobile crisis response through Heartland.*

Follow-up and Discharge Planning

- *What would you say you need? What is missing for people in this area? Things that exist that could be increased, rural v urban, etc.? **Timely follow up appointments after being discharged from the hospital.***
- *I hear that a lot, the time it takes to get somewhere initially for a psych or SUD evaluation, or getting services started quickly after a crisis.*
- *That's a barrier in Harrison County as well. Sometimes we call for an appointment and its three or four weeks out. You have the person committed to doing something that day, but they may feel differently in a few weeks so follow through with those appointments tends to be low.*
- *Communication, coordination of care needs to be a priority. There are a lot of providers seeing clients and it's hard to coordinate.*
- *We have a grant at the ER that made it so we can see certain things on our EMR that are being provided by community providers. Having the ability to find out what the community providers are doing is a very big plus for me, it helpful to see what is actually happening. Communication is big. It is called TAB, and was purchased through a grant and anyone who is involved with that patient we can see certain info. Our goal is to help the community as well- can share information even if I didn't see that person.*
- *Really nice to have someone on site at the hospital who is focusing on all of that.*
- *Extending hours of care coordination might be helpful. We used to have that, but the funding got cut.*

School Coordination

- *But what about people who could be in the future? People who could use some help before things get out of control? **We are fortunate to have a good relationship with Heartland Family Services and we are doing just that. Early identification, diagnosis, and treatment right in the schools for children and families. Getting those MH services in the schools is truly making a difference. Would love to see what we are doing increased, because it truly is making a difference- reducing 911 calls, law enforcement involvement, etc. And because we have licensed, well trained therapists working with our kids we are learning more about evidence based practices and that's helpful.***
- *As an example last year we were able to help schools staff with a crisis that probably prevented a much bigger crisis. It's been great to be part of the Lewis Central School District, and we are expanding into another school district because of all that success.*
- *There is a lot to be learned from sharing experiences. There are children in the schools whose parents are going through the same thing, and getting together in a group would really help on the front end. Seems to me there has been an increase on drug use, and there would be some value in getting together with people before they are in contact with*



us and the legal system. What people lack in general is a solid family unit- we can't necessarily replace that, but we could bring people together and acknowledge that and try to help.

- I hear people saying tobacco use is a huge problem from professionals in that field. I wanted to say that cessation/prevention could be something to focus on. Quit Line is free; and I have a lot of info on that.

Prison Population

- *In Douglas County/Omaha we have continuity of care when leaving prison.*
- *Southwest Iowa MH Program, there are two jail based MH coordinators, mainly in the Pottawattamie County Jail and we will be working with the other counties in the region as well. This started in July.*
- *There are some other projects in the county that overlap so you should be aware of those. Make sure you have the right partners.*

Staffing

More Training Opportunities

- *There are a lot of organizations in town that house people, but their staff are often low education, low skill, and/or young and they are working with the most vulnerable clients, and often end up calling the police, etc. So more training to the workforce is a big need.*
- *I think there is a need for more focus on evidence based practices. I think the people working with families and individuals have good intentions, but the interventions are not always evidence based or true MH/BH treatment. It is not enough to just refer, but want to refer to places that will work.*
- *There seems to be a gap in preventative care for people who are vulnerable to getting in trouble, even though we spend a lot of time on people who are truly in need right now.*
- *Trainings tend to be in Des Moines and I live and work in rural areas and it's hard for doctors and nurses to get away for trainings like that. It's been expressed that MAT is needed, but the question is how do you get that capacity built, providers comfortable doing it, not relying on having the psychiatrist available, etc.*
- *We hear that frequently and hope in the future to spread out the trainings. The physician training for MAT is currently available through webinar. It is a training for physicians, and there are not a lot of people signed up. We have 31 who can prescribe in our state, and not all of those even do prescribe. Federal legislation changed who can prescribe and how many patients they can prescribe to. New prescribers can only prescribe to a certain number in the first year, but that increases later.*
- *At the police department were trying to start an initiative a few months ago to have a more holistic approach to the people we meet on the street which seems to help. We have been looking at trends for opiates coming as well. One of the things touched on earlier I agree with, some of the group homes in town where staff don't have sufficient training and we do get called on a regular basis because people get out of control and*



the staff don't know how to handle it. And then the staff say they aren't going to take them back. They end up in the ER. There is a when they are there by court order we can't take custody of that program. Big training gap there.

Seasons Center for Behavioral Health

There were three main areas of concern that came up in the conversations regarding Seasons Center and the services that will be provided through the CCBHC. These main areas of concern include: care coordination, funding and cultural competency of staff. Under each main area of concern, there is a sub-category of specific concerns and the specific documented comment that was made at these community meetings.

Care Coordination

Homelessness:

- *We deal a lot with homelessness as a huge area of concern. A lot of shelters aren't shelters anymore- transitional living with program requirements, etc. Some people just need a place to be. Plus if they are homeless there are likely other things they need- transportation, meds, Medicaid, etc. It feels like we are giving up on people when we have to send them to a homeless shelter.*
- *We might try to set them up with IHH in whatever region they are going back to, but it's difficult to get them connected and keep track especially if they don't have a phone or an address.*
- *Any thoughts on what could make that better? Great homeless shelters. Sometimes the services are more than a person needs, or there are too many requirements. It feels like we are setting them up for failure. I think Sioux City is the nearest shelter to here too. Plus it gets complicated with the different regions funding people, where they go, etc.*
- *Our IHH director is seeing the same thing and it is becoming a growing problem. We have tried to work with other providers but there is no money attached to this population when they are homeless so there is no funding mechanism. Our IHH director spends a lot of time chasing people around. We had a sad situation with a family dropping a person who was just of age in our waiting room and asking us to deal with it. Didn't want to send him to a homeless shelter, we private paid for a hotel while our IHH team intensively wrapped him in services. It is a challenge. People are aware we've had some problems here with the Dream Center, which has been problematic for our folks. Better write that in our training plan, we definitely need help with that. Don't feel like with all we have going on we can operate a homeless shelter too.*
- *I think it is a problem that is going to take some partnering in order to solve, beyond just Seasons staff.*
- *We are trying to put together a difficult to serve group here, in addition to what the state is doing. Think we have a lot of resourceful people in this room.*
- *What does difficult to serve mean here? People who need 24 hour structure and support, could be housing, people who are very ill and don't do well with certain types of*



structure. So sporadic, you can't just know what type of supports people are going to need on a daily basis.

Need for Better Crisis Intervention

- *Having a mobile crisis team is a part of this that we have never had before there are also three levels of care we have to provide for SUD detox and withdrawal. We will be working with hospitals on that- that's where our clients are currently ending up to get medically stable, and then often right back to where they came from and it's a big viscous cycle. We are hoping with mobile crisis that we will be able to get to those people quickly and help break that cycle. Also the team model we currently use with IHH we will be using with our SUD clients- so hopefully by doing that on the front end we will be able to help people get the support they need. We truly believe this is the best model of care for our clients. When we looked internally we found the same gaps in services that people are talking about with SUD, homelessness, etc. We served over 5100 people last year and it is heartbreaking to see that even though we are doing good work we don't have enough funding to serve everyone we want to serve. So if you have BC/BS but need intensive SUD supports that you aren't getting for whatever reason, we can provide that. We won't turn people away and keep them in that vicious cycle of being homeless or in and out of the hospital. It won't necessarily tackle housing because that's a big need in this area.*
- *Also these clinics can't just dump people in the hospital- they still have to coordinate their care and help them with whatever they might need to be successful in the community. It's an enhanced responsibility for their wellbeing.*

ACT Teams:

- *One aspect of Iowa's CCBHC proposal is ACT teams- we felt that was an important thing to include. The other two centers already have one, but we are providing some TA to Seasons from the University of Iowa.*
- *Having an ACT team to help people transition out of RCFs would be very helpful. We need to keep in mind that will be a growing population.*
- *Remember when Magellan did an ACT RFP 15 or so years ago. Included supported living as well as employment, are those still included?*
- *Yes still required. Definitely employment, and supported living but not to the point where it would be 24 hours or to the level of habilitation.*
- *How is Seasons planning on doing those aspects of ACT? Just had our first call last week in terms of how we can replicate it in a rural area. Think we will know more in the next several weeks in terms of how we will put it all together to make it work. Some of the things Laura said about having the hospital come to the person, can we do that with iPads, Skype, etc.? Figuring that out.*
- *Hope Haven provides services and are now focusing on integrated employment. Is it possible you would be looking to contract with us to support that?*
- *We want to keep our services more clinical based, so we are definitely wanting to partner with providers on that side of things.*



- *CROSS region is looking at doing rural ACT and also working with the UI on that. Looking forward to getting more information. They have the same issues we do, though maybe even more rural.*
- *We provide services in SW MN and have been fortunate to have a grant through MN VR using the IPS Dartmouth model of supported employment, it has been very effective for us. In my experience it hasn't been utilized as much in Iowa and would be something to look into.*
- *We really have to show that each of our clinics is structured to meet the needs of that area. We have been talking to Seasons about culturally competence in the areas they serve. How do they meet language needs, are the available/accessible when people need them, etc. Need to document those things.*
- *As changes are made at any of the agencies letting people know what those changes are ahead of time is important. If a client comes in unprepared for a session to happen over Skype that can be a really frightening situation. Let clients know what is going to happen so they can prepare, and definitely if it is going to be different than they might expect.*
- *Through t this we would be able to start an ACT team and that would involve going into the homes. We currently can do some transportation, but we are not a taxi company. Our IHH care coordinators occasionally provide transportation, but mainly their role is to help coordinate that with the patient.*

Children Services

- *We have struggled with children who don't fit into the right box- if they come into the system without the right diagnosis, or IEP, etc.- they fall through the cracks, and then by the time they get to high school the kids don't want that kind of support either. Need to identify those kids before they slip through the cracks and help them transition to adulthood. From a community standpoint there is a huge disconnect between mission work and whether the true needs of people are being met to regulatory standards. Anything my tax dollars are paying for should have a certain level of standards that are being upheld. That's a need we have as a state. If someone is going to go into a program that is court ordered, or receiving state money, there need to be standards. It's scary to think about that not existing, and if it did exist it seems like it would be easier to integrate care for the homeless people were talking about earlier into that mission.*
- *We really have a continuum when it comes to caring for kids. I sit on the workgroup that is looking at children's mental health issues around the state. It's really complicated getting all of these pieces together. It's so much more complicated when you are dealing with kids. I would say to tell parents to keep advocating. There is some momentum out there for children services and I think that people want some changes for MH care for children.*
- *I have one kid who is doing very well in the school system, and have another son who went through private school and got to HS without an IEP and has struggled a lot more.*



We aren't sure what is going to happen to him when he turns 21. It's really stressful for parents.

- *A lot of the work of the pediatric integrated health homes is helping parents advocate for IEPs, ask the right questions to get things going, etc. Help parents be stronger and more educated advocates for their children. Part of this grant is that IHH is going to be available for families and adults who qualify for IHH, even if they don't have Medicaid. Hopefully that will be beneficial to people. We hear all the time that parents don't know what they don't know.*

Schools

- *With the crisis behavioral health services, will they be able to go into the schools more? I say yes reluctantly because there are some schools that aren't open to having us come in. But for those that do though mobile crisis we can go into the schools and help deescalate behavioral crisis situations, connect the kid with other supports and care coordination, and work with the family. I think once other schools see that we are able to connect children with the correct level of care they will be more open to having us in. We currently have a therapist who goes on-site in Cherokee, and one who does other types of crisis work in the schools there. The schools have to make that decision on their own; we just hired Dr. Leah Clark, who is a BCBA and heading up autism services. She is helping in the schools, not just kids with autism, but other kids with behavioral needs who would benefit from careful behavioral planning.*
- *Sometimes even within a school system you will have one building who is all for it and another who isn't. Sometimes one administrator needs to see the positive impacts at the other schools- reduced expulsions, higher test scores, etc. and see that it isn't taking away from learning time and that it might be helping in other areas. We would say if this child has to leave school to go to therapy that also includes the drive time; they lose even more time than if we were able to do it right in the schools. And the therapists can see how the kid interacts at school and with other children. Some families aren't into the idea of therapy happening at school, so it is an individual choice.*

Veterans

- *Certainly the military has their own culture. What about accessing service for those populations? Do you feel competent serving those populations who might have issues with PTSD related to a recent or past employment? Do you think in your community you have the resources to do that?*
- *As far as I know the VA has some different counselors that go around to the different legion posts who do one-on-one and group services. And the VA has a hospital up in Sioux Falls where most of the vets go for their services.*
- *I think you just illustrated for us what we were talking about. For a lot of us in human services the VA is a place people go that is elsewhere, but you might not know how they qualify, what those services are, etc. This grant requires clinics to have strong relationships with the VAs in their area, which for Seasons is two VAs. So they do have to have a pretty strong relationship there. Some Veterans don't want to go to the VA, but they still need those services. If a person doesn't want to go to the VA, or if they are too far away, etc. The CCBHCs have to make sure they are providing those services*



and connecting them with the other services you just listed. It's part of their care coordination and their ability to serve those individuals.

Funding

Redundant Services

- *I want to speak a little about PRA. We have been providing services under that model since 1988. We were one of the first providers to be certified to do that in Iowa. We provide those services in rural NW Iowa. In rural Iowa there aren't a lot of individuals who are served, and sometimes that causes some stress on the part of our admin because the dollars don't line up. A little concerned Seasons is starting their own PRA program, instead of possibly partnering with us. Similarly we have been providing peer support since the early 2000s, long history of recovery oriented services. Not sure if there is room in the region for both providers, so I just wanted to throw that out there.*
- *Thanks for that. Basically when we were looking at all of the requirements we had to ensure we had the ability to do all of this- we took the easy road by saying if we didn't work with a DCO we would be controlling the service, the quality measures, etc. If we worked with a DCO we wouldn't know who was providing it, when, or able to ensure the services were monitored and being checked etc. On site our staff can monitor people doing PRA down the hall internally. Not to say it will always be done that way, we can always evaluate that in the future. If it made sense to do a DCO we can thing about that, but we had a very short turnaround time for applying to this. It was a pretty intense application with a short turnaround. Easier for us to do it internally at this point in time.*
- *Again in rural Iowa it's important to make use of your available resources. Wish you would have reached out to us, we would have been happy to work with you and meet that need. We have been successful with that program for 18 years.*
- *My next question is how does this not compete with the regional services for the people who don't qualify for Medicaid? It seems duplicative. Hope Haven has been doing IPR since 1988 and it seems like the density of the people who we serve in those eight counties doesn't require two providers. Can we collaborate or anything?*
- *We also talked to Scott Witte about this and we will follow up with you and him on that. I would also say it's not just more of the same for us. There are services that have never been provided in this area- like SUD case management, ACT, etc. We do IHH for kids with SED and adults with SMI, but not people with SUD disorders. We seriously have people in our area who are losing their lives due to substance abuse. We have been seeing very good results on the IHH side with keeping people out of hospitals and that continuum of care. We see that as huge, and beyond more of the same.*
- *Going back to your question about the region, they will keep funding what they will fund, and Seasons will use that as appropriate, but there are people who fall outside of those guidelines. This is all about people getting the services they need when they need them. The clinics are required to meet routine, expedited, and emergency access standards which might be a little beyond what CMHCs are required to do. We would expect our clinics to work collaboratively with the regions and other providers. Even if Seasons provides a certain CCBHC service, choice is always in play and they can receive that*



service wherever they want. But regardless of where services are being accessed, Seasons has to coordinate that care.

How this works with Medicaid and MCOs?

- *Listening to what is supposed to happen with this grant I am having a hard time seeing how it is different from the things the MCOs are supposed to do.*
- *The difference is that the MCO services are for people who are Medicaid eligible. This builds on what is being provided through the MCOs, but they also have the requirement to provide these services to anyone who comes through their doors, not just those with Medicaid. And it requires IHH services to be expanded beyond those who are currently on Medicaid, and opens it up to anyone in the community who qualifies for the services. Medicaid still funds the services for those who qualify, but this opens it up more.*
- *I'll add that Seasons Center is responsible for all of the services being provided, and they will get a higher rate that includes the indirect rate of the services provided. They have also done several trainings on these specific EBPs, and beyond basic understanding there have been trainings beyond the basics, and they have to practice to fidelity so they have a level of expertise that is above what might be required of others.*
- *Simply- it is all of MCO, but more. And MCOs are really managing services, and this is more at the provider level. These clinics would still fall under the MCOs, but have to meet additional requirements.*
- *For someone who is uninsured they can receive services but it would be out of pocket? The clinic cannot turn people away for inability to pay, for people who are uninsured they can have a sliding fee scale to help people afford services.*

Training Needed for Staff

- *So this grant is going to help the clinic get better understanding of these services and they are going to get trained, not necessarily putting it back in the community.*
- *Yes this grant is paying for trainings, but those trainings were open to other providers across the state. Regardless of whether we get the next part of this grant, we have infused some training and capacity into the state providers.*

Cultural Competence of Staff

Staff Turnover

- *I serve Emmet and Palo Alto- think it is all about consistency. We have some clients we have had a hard time getting to go back to Seasons, but due to staff turnover especially in those two counties has been overwhelming recently.*
- *We are a loan repayment site and always have trouble recruiting and retaining people in those communities.*
- *Don't know what the answer to that is, but sometimes I can get new families to start and then they don't want to go back. It's frustrating.*



- *Also really looking at cultural competency and how clinics are meeting those requirements. Anything that makes that clinic more welcoming or a better experience for that person. Any comments on the CC needs or how they are/aren't being met in your areas?*
- *If you have bilingual staff, how do you work with people who are undocumented? First I tell people I am not the INS and neither is Seasons. I know we have several people who receive services who are undocumented. Do have an interpreter, Di Daniels, and also just hired a psychiatrist who is bilingual in the Sioux Center office. Have a bilingual child/adolescent psychiatrist here in Spencer. Also hired a bilingual psychiatrist who will be doing evening/weekend hours in Storm Lake. Trying to build capacity as best we can. Do have an intern who is bilingual and we are trying to recruit her as we speak. Definitely a need we are looking at.*
- *Do you think that is a need that isn't being met in your area? Yes for both SUD and MH. I think there are more and more people who are available to help, so that is good, but there is still a big need.*
- *Do you see that just in the Spanish speaking population or others as well? Mostly Spanish. There are other minority groups but it's definitely an issue with the Spanish speaking population because they are growing. But certainly the services are needed for all minority groups.*
- *Any specific groups? Guatemalan. Typically we see people at the hospital who are using Spanish as a second language anyway, and when you are doing that there can already be so many things that don't connect.*
- *Any other cultural barriers or issues aside from language? Things that make it hard for people to access services? Yes- we need more education on translation being more about just words. It's how we understand the world. Building relationships between groups in our community is important to gain that understanding. We have things come up a lot where they didn't go as well as we thought- maybe not because the words weren't spoken but because the cultural values or intent didn't come across.*
- *What about people who visual, hearing, or other disabilities? I personally haven't encountered that, but at the hospital we use video interpreting. Wouldn't know how to do that if someone needed additional accommodations so that is a need as well.*

Need for Bilingual Staff

- *I am a bilingual advocate and I cover Spencer and Storm Lake. Are there things in the grant that will target the LEP population? A lot of the people I work with don't feel comfortable with an interpreter, or would prefer a bilingual therapist.*
- *We have just contracted with a psych who is bilingual who will be doing evening and weekend hours. Also just got a grant to do bilingual trauma therapy in 19 counties. Very hard to reach bilingual therapists. There are very few. Trying to recruit a many people as we can. You are right it is a lot to ask people to tell their stories multiple times which is what we are asking this population to do. A lot of our immigrants have serious trauma.*



- *I am a bilingual family advocate, and I agree with Hannah on the need for education in the Hispanic community. A concern I have is that sometimes we have a client who is in need of housing but because they are either high or going through a withdrawal we are not allowed to house them. We honestly do not know what to do with them aside from dump them in a hospital. We want to be able to help but don't have any other options. We aren't staffed 24/7.*

