

Application for Federal Assistance SF-424

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): * Other (Specify):
* 3. Date Received: 06/15/2011		4. Applicant Identifier:
5a. Federal Entity Identifier: 		5b. Federal Award Identifier:
State Use Only:		
6. Date Received by State:	7. State Application Identifier:	
8. APPLICANT INFORMATION:		
* a. Legal Name: State of Iowa - *Iowa Department of Public Health		
* b. Employer/Taxpayer Identification Number (EIN/TIN): 42-6004571		* c. Organizational DUNS: 8083459200000
d. Address:		
* Street1: Street2: * City: County/Parish: * State: Province: * Country: * Zip / Postal Code:	321 East 12th Street Des Moines Polk IA: Iowa USA: UNITED STATES 50319-0075	
e. Organizational Unit:		
Department Name: Iowa Dept. of Public Health	Division Name: Behavioral Health	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: Mr.	* First Name: Lonnie	
Middle Name: 		
* Last Name: Cleland		
Suffix: 		
Title: Program Planner 3		
Organizational Affiliation: Iowa Department of Public Health		
* Telephone Number: 515-281-3763	Fax Number: 	
* Email: lonnie.cleland@idph.iowa.gov		

Application for Federal Assistance SF-424*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Substance Abuse & Mental Health Services Adminis.

11. Catalog of Federal Domestic Assistance Number:

93.243

CFDA Title:

Substance Abuse and Mental Health Services_Projects of Regional and National Significance

*** 12. Funding Opportunity Number:**

TI-11-002

* Title:

Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):*** 15. Descriptive Title of Applicant's Project:**

Iowa Recovery Health Information Technology (IRHIT)

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424**16. Congressional Districts Of:*** a. Applicant b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:* a. Start Date: * b. End Date: **18. Estimated Funding (\$):**

* a. Federal	<input type="text" value="279,400.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="279,400.00"/>

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- a. This application was made available to the State under the Executive Order 12372 Process for review on .
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)** Yes No

If "Yes", provide explanation and attach

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 21B, Section 1001)

 ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:Prefix: * First Name: Middle Name: * Last Name: Suffix: * Title: * Telephone Number: Fax Number: * Email: * Signature of Authorized Representative: * Date Signed:

Iowa Recovery Health Information Treatment Abstract

The Iowa Department of Public Health (IDPH) proposes to expand and enhance the Iowa's substance abuse treatment services by enabling IDPH-funded agencies to include web-based communication tools as a method of providing treatment services to rural adults in need of intensive outpatient (IOP) treatment. The Iowa Recovery Health Information Technology (IRHIT) project will be implemented at 23 IDPH-funded agencies during the three year life of the project. Over the project's life, IRHIT will serve a minimum of 1,970 clients; 470 in the first year and 1,500 in the two succeeding years.

IRHIT services will use an online portal to implement and support clinically appropriate, evidence-based practices. It will promote the integration of anonymous screenings and directed clinical interventions such as secure individual and group chats, email, treatment planning, web videos, and educational libraries. This will ensure a broader and more comprehensive approach to substance abuse treatment for rural clients.

IRHIT Goals and Outcomes

1. IRHIT will increase the number of rural adults assessed and retained in treatment that are in need of IOP and continuing care levels of care.
 - a. Increase the number of rural clients served in IOP services by 15%.
 - b. Increase rural IOP retention rates from 22.6% to 32.6%
 - c. Increase the rates of family involvement from 9.2% to 20%
2. Contracted providers will implement a planned IRHIT project.
 - a. Create policies and procedures to expand IRHIT online services to rural clients
 - b. Provide IRHIT clients real-time access to evidence-based counseling services, education and clinical evaluation tools, and client-initiated treatment plan management.
 - c. Provide client family members web-based libraries
3. IDPH will implement and sustain diffusion of enhanced IRHIT: first year – 9 agencies, second year – 7 agencies, third year – final 7 agencies.
 - a. IDPH will fund .3 FTE at each contracted agency (first year)
 - b. IDPH will provide training to providers in services enabled by HIT.
 - c. IDPH will disseminate innovative and best practices to service delivery network.
 - d. IDPH will hold yearly learning collaborative meetings and monthly phone conferences
 - e. IDPH will organize a collaborative committee composed of stakeholder representatives.

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BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Iowa Recovery Health Information Technology	93.243	\$ []	\$ []	\$ 279,400.00	\$ []	\$ 279,400.00
2.						
3.						
4.						
5. Totals		\$ []	\$ []	\$ 279,400.00	\$ []	\$ 279,400.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) Iowa Recovery Health Information Technology	(2) N/A	(3) N/A	(4)	
a. Personnel	\$ 26,391.00	\$	\$	\$	\$ 26,391.00
b. Fringe Benefits	7,917.00				7,917.00
c. Travel	2,920.00				2,920.00
d. Equipment	0.00				
e. Supplies	420.00				420.00
f. Contractual	218,400.00				218,400.00
g. Construction	0.00				
h. Other	14,260.00				14,260.00
i. Total Direct Charges (sum of 6a-6h)	270,308.00				\$ 270,308.00
j. Indirect Charges	9,092.00				\$ 9,092.00
k. TOTALS (sum of 6i and 6j)	\$ 279,400.00	\$	\$	\$	\$ 279,400.00
7. Program Income	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$

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SECTION C - NON-FEDERAL RESOURCES					
(a) Grant Program		(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	Iowa Recovery Health Information Technology	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)		\$	\$	\$	\$
SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 279,400.00	\$ 69,850.00	\$ 69,850.00	\$ 69,850.00	\$ 69,850.00
14. Non-Federal	\$				
15. TOTAL (sum of lines 13 and 14)	\$ 279,400.00	\$ 69,850.00	\$ 69,850.00	\$ 69,850.00	\$ 69,850.00
SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT					
(a) Grant Program		FUTURE FUNDING PERIODS (YEARS)			
		(b) First	(c) Second	(d) Third	(e) Fourth
16.	Iowa Recovery Health Information Technology	\$ 279,400.00	\$ 279,400.00	\$ 279,400.00	\$ 0.00
17.					
18.					
19.					
20. TOTAL (sum of lines 16 - 19)	\$ 279,400.00	\$ 279,400.00	\$ 279,400.00	\$ 279,400.00	\$
SECTION F - OTHER BUDGET INFORMATION					
21. Direct Charges:	270308	22. Indirect Charges:	9092		
23. Remarks:					

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Section A: Statement of Need

The Iowa Department of Public Health, Division of Behavioral Health is requesting funding to expand and enhance Iowa's distance treatment efforts to include substance abuse treatment health information technology to adult rural residents in need of intensive outpatient substance abuse treatment (IOP). Iowa currently utilizes web-based health information technology to identify and reach out to problem gamblers and their families, providing relevant problem gambling information, prevention and treatment services.

A1: DEMOGRAPHIC INFORMATION

The 2010 U.S. Census Bureau describes Iowa as a predominately rural state with a population of 3,046,355 in 99 counties. Eighty-nine counties have populations of 50,000 or less while 45 counties have populations of 10,000 or less. Only nine Iowa counties have populations of 65,000 or more. Most counties are rural with populations that range from 5,000-20,000. The state's population is evenly divided between males (49.3%) and females (50.7%). The median age is 38.2 years, and 61.6% of the population (1,849,573 persons) falls between 18 and 65 years. Whites (non-Hispanic) represent 90.2% of the population, Hispanics 4.1% African Americans 2.5%, Asians 1.6%, and American Indians .3%. Multiple races are reported at 1.5%.¹

Statewide, cultural minorities represent 8.5% of the population. While the Hispanic/Latino population represents 4.1% of the population, this proportion increases to over 9% in some rural towns in the central and western region of Iowa. Latinos represent 5.2% of the treatment admissions in Iowa but are over-represented in the Operating While Intoxicated (OWI) justice-referred treatment programs. African Americans comprise 2.5% of Iowa's population, but they represent 6.9% of the substance abuse treatment admissions. Census and projected demographic data provided by the Iowa Data Center describe a Native American population that has reached 10,000 and is concentrated in the northern and western regions of the state. Sioux City, (in western Iowa) holds the largest Native American population. Half of Native American children live with both parents, half are in single-parent homes.

Every year Iowa's substance abuse assessment and treatment efforts reach almost 46,000 Iowans. Seventeen thousand of these persons receive services funded by IDPH. Another 8,700 are funded by the Iowa Plan for Medicaid. Iowa's State Prevention Framework/ State Incentive Grant program (*Strategic Plan*) provides baseline data for alcohol use for adults and youth in the state. Data provided by the National Survey on Drug Use and Health (NSDUH) from 2006-2008 allows Iowa to view state prevalence data within age and regional cohorts. In 2006-07, of persons 12 and older, 52.6% had consumed at least one alcoholic drink in the past 30 days [2006-07 NSDUH].² NSDUH data estimates that 27.5% of Iowans 12 years old and older had consumed more than 5 drinks of alcohol in one sitting during the past month. This is significantly higher than the national rate of 23.1%. The Strategic Plan reported that Iowan's perceive less risk than national rates regarding binge drinking.

¹ U.S. Census, Quick Facts – State Level Data

² SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008

The problems associated with alcohol use and harmful use (binge drinking, heavy drinking and dependency) are well understood and challenge Iowa to adopt integrated efforts in health promotion and disease prevention. The expansion of health information technology into substance abuse treatment by agencies already using distance treatment HIT as an intervention strategy integrates well into Iowa's plan to reach and retain greater numbers of its citizens in substance abuse treatment services. As outlined in more detail in Section C, Iowa Recovery Health Information Technology (IRHIT) will expand existing IOP curricula and evidence-based practices to a web-based platform while maintaining the practices fidelity, validity and effectiveness.

While some observers might presume that internet access would be a problem for rural Iowans, that is not the case. In its January 28, 2008 report titled "Assessing High-Speed Internet Access in the State of Iowa: Sixth Assessment," the Iowa Utilities Board (IUB) reported that nearly 94 percent of both rural and non-rural Iowa communities now have access to high-speed Internet service from at least one provider. Of Iowa's rural communities, 925 out of 963, or 96.1 percent, currently have high-speed Internet access. That compares to barely 50% percent of both rural and non-rural communities in the Utility Board's May 2002 report.³ It appears that most rural substance abuse treatment recipients have ready access to the internet and would be able to participate in expanded web-based substance abuse treatment services were it available.

Iowa Department of Public Health-funded substance abuse treatment is provided by 23 agencies through block grant funding. These agencies are overseen by the Iowa Department of Public Health (IDPH) as the single state authority (SSA) for the Substance Abuse Prevention and Treatment block grant and associated state appropriations. All 23 agencies are contracted with Magellan Behavioral Health (State of Iowa managed care contractor), to provide IDPH-funded treatment. All agencies contracted with Magellan for IDPH-funded services are reimbursed in equal monthly disbursements through annual capitated agreements. Rural adults assessed as in need of IOP services can access IOP treatment services at one of these 23 IDPH-funded agencies that is the contracted provider for the region where the client's county of residence lies. These 23 agencies provide services to all of Iowa's 99 counties.

A2: NATURE OF THE PROBLEM AND EXTENT OF THE NEED

Prevalence data derived from the 2008 NSDUH shows that 19.5% of Iowa's adult population of over 2,000,000 is in need of substance abuse treatment. Of the estimated 218,000 Iowans in need of treatment, 58% or over 127,000 reside in rural counties. Of these 218,000 in need of treatment, Iowa's substance abuse providers were able to identify and admit 23,127; just a bit more than 10% of those in need.⁴

County Pop ≥18	Total Admissions	Number of Iowans with Alcohol dependence or abuse	Number of Iowans Needing alcohol treatment but not receiving	Number of Iowans Needing Drug Treatment but not receiving
2,294,701	23,127	195,050	185,871	32,126

³ Iowa Utilities Board, Assessing High-Speed Internet Access in the State of Iowa: Sixth Assessment, January 2008.

⁴ SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008

Clients access the system through licensed treatment agencies that constitute Iowa's clinical gateways. Screening and assessment is provided throughout the treatment system. For those that elect treatment, assessment drives a level of care determination by which appropriate treatment is planned. Clinical decision making is based on nationally-accepted American Society of Addiction Medicine Patient Placement Criteria Second Revised Edition (ASAM PPC-2R) criteria and use of patient placement criteria, standardized screening and sequential assessment protocols are used when making decisions regarding level of care decisions. IOP is an ASAM-defined level of care that requires at least 9 hours of client/treatment contact each week.

The demographics and client characteristics of those referred to Iowa's treatment system illustrate both the system's reach and challenges. Iowa's substance abuse treatment system services a majority of males for whom the largest source of referral is the criminal justice system. In FY 2010, criminal justice referrals represented more than 60% of treatment admissions to state-funded treatment agencies.

The majority of Iowans entering the substance abuse system, through any referral agent report alcohol as their substance of choice. Marijuana, (most frequently identified by adolescents) ranks second. Methamphetamine use is again growing and has knocked cocaine from the "top three" substances of choice.

Substance abuse providers report admissions, services, discharges and follow-ups through the Iowa Service Management and Reporting Tool (I-SMART). I-SMART data also includes basic demographic information, substances of abuse, referral sources, psychiatric problems, employments status, treatment length and other data. IDPH has a core set of covered services statewide that encompasses a 24-hour helpline and treatment locator, assessment, evaluation and referral locator, outpatient and intensive outpatient treatment, and two levels of sub-acute residential treatment. Clinical decision making is based on nationally-accepted American Society of Addiction Medicine Patient Placement Criteria Second Revised Edition (ASAM PPC-2R) criteria and use of patient placement criteria, standardized screening and sequential assessment protocols are used when making decisions regarding level of care decisions.

In rural Iowa, entrance to treatment and recovery support service systems is impeded by a lack of understanding of treatment, the support process and the benefits that may be extended to them. For drug-using parents, cultural minorities, new immigrants, non-English speaking persons, and Native Americans, there may be resistance to entering "government services". Potential clients may be disinclined to seek treatment if they have previous treatment failures, are concerned about legal issues or have child welfare involvement or can be intimidated by a treatment system that requires excessive paperwork or participating face-to-face with a group of other clients.

A baseline data review from Iowa's I-SMART/SARS data system indicate that Iowa's outpatient services need to reduce the time between initial contact and first appointment for treatment. The number of individuals lost after initial contact is a documented barrier to client access—nearly 43% recommended for treatment were not admitted to treatment services. Iowa's data shows that clients who access treatment within two days of assessment and referral tend to stay in treatment longer than clients accessing treatment services at 30 and 60 days. Retention issues are

apparent statewide. Only 50% of admitted clients completed or substantially completed treatment after admission. Over 30% of the clients left against the advice of the agency. The longer clients stay in treatment, the greater percentage of those completing treatment: For those completing 28 days, 65.2% completed; for those retained in treatment 56 days the completion rate was 68.4%.

According to data from Iowa's substance abuse database (I-SMART), in calendar years 2008, 2009 and 2010, Iowa's 23 state-funded agencies discharged 12,275 clients from IOP services. Of these, 49.8% were discharged as having not completed their treatment plans.

Year	2008	2009	2010	Total
IOP Unsuccessful	1,518	1,618	2,987	6,123
IOP Successful	1,472	1,810	2,870	6,152
Total	2,990	3,428	5,857	12,275

Barriers in rural Iowa to successful treatment completion include childcare, transportation and admission wait time. Childcare and transportation are vitally important in rural Iowa where persons often receive treatment and support services in communities away from their home communities. For clients referred to IOP treatment, wait times for admission to treatment services can exceed one week. Clients admitted to IOP are required to attend substance abuse treatment at least 9 hours a week, requiring 3-4 trips to a treatment agency each week, these structural barriers translate into inconsistent attendance, no-shows, lack of family participation, multiple unsuccessful treatment episodes, and frustrated agencies, clinicians, clients, family members and referral sources.

Demonstrated cultural competence in substance abuse treatment

IDPH requires integration of cultural competency into the network of substance abuse treatment providers. Agencies participating in the IRHIT rollout have demonstrated clear competencies in serving ethnic minorities, persons who are poor, victims of trauma, and those who are sexual minorities. These agencies are among the most developed in the state.

Since 2007, Iowa has been focusing on improving the cultural competence of Iowa's providers by:

- increasing substance abuse treatment options for racially and ethnically diverse populations;
- providing best practices or tried treatment methods and document program outcomes so Iowa treatment providers may adopt culturally competent treatment methods;
- identifying barriers to participants accessing treatment and work with community wrap-around services to assist clients with barriers in order to participate in and complete treatment services;
- maintaining contact and support services with clients for six months;
- documenting and providing program outcomes by working with the Iowa Consortium for Substance Abuse Research and Evaluation;
- disseminating information about the project including, but not limited to, programming, lessons learned, community involvement, and outcomes as requested; and

- training substance abuse treatment staff to work more effectively with target populations.

Primary prevention services are also provided by IDPH and include youth mentoring, youth development, safe and drug free schools, comprehensive prevention, and mentoring. The prevention system supports universal, selective and indicated preventative interventions that are culturally competent and specific to the cultures of need. All IDPH prevention grants have cultural competence written into them as a matter of course.

Other funding sources available for intervention and treatment services that specifically require providers to demonstrate cultural competence include:

- Iowa's State Prevention Framework-State Incentive Grant program, (SPF-SIG) was funded in 2009, for \$2,135 million per year up to 5 years, and will compliment SBIRT services in the goals of prevention and progression of substance abuse, and building prevention capacity and infrastructure at the state and community-levels,
- The Prevention Block Grant (\$3.9 million) provides funds for the Comprehensive Substance Abuse Prevention is to provide alcohol, tobacco and other drug (ATOD) abuse prevention services to all counties in Iowa in the twenty-three service areas.
- Iowa's Access to Recovery grant, initially funded in 2007, for \$3.3 million per year up to 5 years, was recently awarded a second project grant through the ATR III project initiative. ATR is a statewide grant and provides care coordination, recovery support services and access to treatment services for more than 2,500 persons annually. Access to Recovery is active in the Iowa National Guard at Camp Dodge. ATR redefines treatment and recovery within the context of client choice and expands the continuum of care.⁵

None of the above funding sources, whether prevention or treatment, enables clients to access or receive services using health information technology.

Section B: Proposed Evidence-Based Service/Practice

B1: PURPOSE OF THE PROJECT

Statement of Purpose: The Iowa Department of Public Health proposes to expand and enhance Iowa's ability to reach, engage and retain rural clients who are in need of intensive outpatient (IOP) services through the use of treatment-focused health information technology. IRHIT is designed to add health information technology to Iowa's already well-developed and closely-monitored statewide recovery-oriented system of care. As discussed further in Section C, IRHIT will utilize online screening and assessment tools, treatment-based homework assignments, treatment plans managed collaboratively by client and clinician, online individual and group chats, online outcomes rating scales, and both client and family-focused educational libraries to provide easy and flexible services to rural IOP clients.

Iowa's proposed plan and approach in implementing this project is a direct response to the needs of the clients, potential clients and the needs of the current system. This plan will build upon the current distance treatment services the IDPH Office of Gambling Programs implemented in

⁵ Iowa Department of Public Health, Bureau of Substance Abuse, Access to Recovery Resource website

2009. Iowa will expand and enhance the current substance abuse treatment delivery system by enabling clients who, in the past, would have dropped out of treatment because of distance barriers and lack of services in their community. One of the largest challenges yet greatest opportunities of this grant proposal is the development of a strong web-based component to Iowa's service delivery system. Iowa's overall strategy will enhance the ability to reach and retain rural clients whose involvement in IOP levels of care are restricted by travel, time and community resource deficits.

Culturally competent service delivery: IDPH is purposeful in its efforts to utilize IRHIT web-based services to support clinically appropriate, culturally competent evidence-based practices. These practices promote the appropriate use of substance use screenings, client assessments and interventions within IOP levels of care in community-based settings. IRHIT will promote the integration of online evidence-based interventions within licensed substance abuse treatment agencies to ensure a more comprehensive approach to substance abuse intervention and continuing care services. This project will eventually assist all rural Iowans in maximizing the use of proven substance abuse treatment techniques to improve client and family health outcomes.

IRHIT is being developed and will be implemented in a method consistent with the following underlying the principles.

- All clients and family members of clients have an equal right to access to assessment and recovery services;
- no program, method of treatment, or service deliver method is "always right" for every client;
- client choice is denied if systems of care are not holistic and do not honor the cultural, parental, family, economic and logistical needs of the individual,
- clients' recovery is jeopardized when these needs are ignored; and,
- multiple gateways and modalities enhance client access and retention in treatment and strengthen client commitment to recovery as clients are exposed to greater opportunity for success.

Increasing Capacity through Expanded Clinical Services:

Iowa's IRHIT targets rural adults in need of IOP substance abuse treatment services. In CY2010, 5,857 or 31% of the client population admitted to outpatient services were admitted to provider agency IOP services.

New web-based clinical assessment and treatment modalities will increase access to services for a projected 470 individuals in the first year, and 750 persons in each of years two and three. Based on the targeted population data, the Iowa Department of Public Health estimates the first year treatment and assessment services will include:

- 1800 anonymous screenings via provider agency websites for substance use disorders
- Web-based IOP treatment services for 575 persons
- Web-based continuing care services for 250 persons will receive

Through the implementation of IRHIT, Iowa's treatment capacity will be increased in the following ways:

- Expanding services to provide anonymous online assessments and substance use disorder educational materials will enable more potential clients to access confidential assessments through publicly supported services. This will allow each agency to provide assessments to rural residents and family members without requiring that they drive long distances to access assessment services. IRHIT proposes to change the manner in which treatment and recovery is offered to Iowa's clients. Currently, lack of supports or lack of education about supports for such basics as transportation and child-care discourages clients that otherwise would enter the treatment system. While Iowa's in-need populations have been helped enormously by Iowa's Access to Recovery (ATR) program, we know that ATR cannot reach all in-need Iowans. Iowa believes that new clients, whether substance users or client family members, will engage with existing assessment and treatment services and commit to a personal choice of recovery because of access to web-based services focused on specific education and treatment needs.
- Providing enhanced intensive outpatient treatment and continuing care services particularly in remote, rural regions of the state will provide increased capacity in IDPH-funded providers. New web-based treatment options consisting of; real-time treatment plan updates; motivational interview-based individual and group chats; Matrix model online homework assignments geared towards intensive outpatient treatment; online libraries of documents and videos enabling clients and their families to receive educational and treatment services at a distance; will be at all clients' fingertips. All of these online methods will include not only the ability to accommodate Spanish-speaking client service delivery, but also the ability to tailor components to other underserved populations as they become recognized by providers. New online treatment options that will be enabled in Iowa include the ability to provide bi-lingual treatment and support for Hispanics that can include Spanish-speaking support groups, family involvement, and substance abuse assessments and treatment.

Web-based services are not meant to supplant face-to-face services. They are instead designed to be used as adjuncts to existing services that will allow greater flexibility for providers and greater autonomy for clients. Clients with distance, childcare and other barriers to attendance can build web-based services into their treatment plans to cut down the number of face-to-face services needed.

Goals and Objectives

1. In collaboration with IDPH, contracted providers will increase the number of rural adults assessed and retained in treatment that are in need of intensive outpatient and continuing care levels of care through the use of expanded health information technology.
 - a. Over the next three years, IRHIT will increase the number of rural clients served in IOP services by participating IDPH-funded providers by 15%. Each provider will increase the number of rural IOP clients served by their agency by 10% in year one with a 15% increase in succeeding two years.
 - b. IRHIT will increase the IOP retention rates for clients with 4 or more sessions with IDPH-funded providers from 22.6% to 32.6% over the life of the project.

- c. IRHIT will increase the rates of family involvement from 9.2% to 20%
2. IDPH-funded providers will expand and enhance the substance abuse treatment services offered by agencies by implementing a planned IRHIT project.
 - a. Providers will create appropriate policies and procedures to expand IRHIT online services to clients in need of substance abuse treatment services.
 - b. Providers will enhance their web-based services to provide substance abuse IRHIT clients with real-time access to evidence-based counseling services, education and clinical evaluation tools, and client-initiated treatment plan management.
 - c. Providers will expand and enhance services to client family members by providing web-based libraries containing family-based education as well as treatment services including access to counseling, web-based education and clinical evaluation tools, and client-initiated treatment plan management as appropriate.
3. IDPH will implement and sustain diffusion of enhanced HIT to the 23 IDPH-funded substance abuse treatment agencies: first year – 9 agencies, second year – 7 agencies, third year – final 7 agencies.
 - a. IDPH will fund .3 FTE at each contracted agency to enable providers to defray initial personnel costs related to agency coordination.
 - b. IDPH will provide training to providers in expanded and enhanced services enabled by HIT.
 - c. IDPH will utilize NIATx process improvement principles and aims to disseminate innovative and best practices to service delivery network.
 - d. IDPH will hold yearly state-wide learning collaborative meetings and monthly webinar/phone conferences to disseminate lessons learned and best practices to engage consumers, providers, funders and community members; meetings are to ensure that substance abuse treatment services offered through IRHIT are appropriate, client-focused, and easily accessible.
 - e. IDPH will organize a collaborative committee composed of stakeholder representatives including the targeted population.
 - i. Collaborative partners will provide guidance on the values, beliefs, culture, and socioeconomic factors of individuals in their communities.
 - ii. Collaborative partners will identify and review barriers to treatment and assist the providers in utilization of the IRHIT in a manner appropriate to the community.

B2: EVIDENCE-BASED PRACTICES OF CHOICE IN IRHIT

Discussion of proposed evidence-based Assessment and Treatment practices

- Matrix model of intensive outpatient substance abuse treatment: IRHIT providers currently use the Matrix model of intensive outpatient substance abuse treatment as the preferred evidence-based practice for IOP. Matrix will also be utilized as the preferred online tool for IRHIT services. This therapeutic approach has been selected because it

provides effective clinical tools that are adaptable across cohorts and clinical needs. The Matrix Model is a 16 week evidence-based treatment approach consisting of education groups, individual counseling, social support groups, relapse prevention groups, and urine and breath testing.⁶ This model enables clients and family members to learn about addiction and relapse in a setting that fosters respect and positive relationships. This model is especially amenable to web-based use as it provides clients with homework assignments and a didactic component, in addition to enabling clinicians to manage larger groups of people efficiently and effectively.

IRHIT providers will utilize the Matrix Model components as online adjuncts and in many cases, as a substitute for face-to-face client and clinician interactions. Within the Matrix Model, clinicians will use the following evidence-based practices to deliver model web-based services to rural clients.

- Motivational Interviewing (MI) is a core evidence-based practice for IRHIT. Although not a new practice, the principles of motivational interviewing are consistent with strongly held values of cultural competency and client and patient self-determination. According to Dr. William Miller, Motivational Interviewing uses an empathetic approach to increase readiness for change, resulting in ambivalence about change.

Motivational Interviewing principles include empathetic listening; heightening client awareness by reflecting discrepancy between clients' goals or values and current behavior; validating clients by accepting client reports as "their truth" and avoiding confrontation; adjusting to client resistance; and supporting self-efficacy and optimism.⁷ Motivational interviewing, when skillfully practiced, easily adapts to racial and ethnic cohorts for the interviewer's adherence to empathy and self-efficacy, and demonstrates respect and sensitivity across cultures. In Iowa, Substance Abuse Treatment providers continue to receive extensive training in MI and have developed the Motivational Interviewing Network of Trainers (MINT) which are qualified to provide MI training.

- Cognitive Behavioral Therapy (CBT) is another practical clinical choice for Iowa's IRHIT substance abuse network. Iowa's IDPH-funded provider clinicians have been trained extensively in this model. It is particularly adaptable for persons with a range of affective disorders ranging from anxiety and depression to PTSD.⁸ This practice has been demonstrated as effective across age cohorts and has particular application to assist those with late life depression.⁹

The demonstrated success of the Matrix Model, MI and CBT, coupled with Iowa's readiness in having highly trained Matrix-using substance abuse professionals, are the primary reasons for selecting these practices for the IRHIT project application. The only adaptations planned involve placing the forms used by the Matrix Model online for clinician and client use. These have

⁶ Rawson, Richard and McCann, Michael, The Matrix Model of Intensive Outpatient Treatment, *Hazelden*, Center City, MN.

⁷ U.S. Department Of Health And Human Services, Substance Abuse and Mental Health Services Administration, Brief Interventions and Brief Therapies for Substance Abuse, TIP 34 (1999)

⁸ Deacon, Brett J. and Jonathan Abramowitz, Cognitive and Behavioral Treatments for Anxiety Disorders: A Review of Meta-analytic Findings, *Journal of Clinical Psychology*, Vol 60 (4) 429-441 (2004)

⁹ University of Washington, IMPACT – Evidence Based Depression Care, Toolkit, <http://impact-uw.org/tools/>

typically been given to client in hard copy during face-to-face sessions. Matrix Model publisher, Hazelden, has an online version that each provider will use as the basis for IOP web-based treatment.

B3: EVIDENCE THAT THESE PRACTICES ARE EFFECTIVE WITH POPULATION OF FOCUS

The Matrix Model has been researched and shown effective for adults and adolescents, for both genders, and for several ethnic groups. Matrix has been studied in numerous racial and ethnic populations including African American, Asian and Latino groups. The developers have also created client handouts for American Indians and Alaskan Natives. It has been proven to be useful in treating opioid and alcohol abuse and dependence.

Each of the identified evidence-based practices; the Matrix Model for IOP, Motivational Interviewing and Cognitive Behavioral Therapy are reported in practice and research to improve client outcomes in terms of substance use reduction and abstinence. CBT is also particularly useful in managing co-occurring substance use, depression and other mental illnesses. Furthermore, MI and CBT are complimentary as each of these practices works within a change stage framework to enhance self efficacy and to motivate positive behavioral change.¹⁰

A significant number of meta-analyses have been published detailing the use and significance of MI over a broad range of age cohorts experiencing a range of problems including alcohol and drug use/ use, mental health issues, and tobacco reliance. Motivational interviewing is found to be a cost effective method for reducing use or inducing persons to change behaviors. In their 2006 meta-analysis, Vasilaki, Hosier and Cox found motivational interviewing effective in moderating heavy drinking for patients with low-dependency or for others that were resistant or inappropriate for treatment. The authors reiterated the need to consider factors such as age, gender, employment status, marital status, mental health, initial expectations, and readiness to change.¹¹

Culturally competent treatment practices:

Culturally competent treatment improves clients' chances of getting better in treatment. Clients are powerfully affected by the cultural context, treatment modality and setting, and therapist to whom one is assigned. Miller and Willoughby in their literature review stated: "Clients' 'resistance' or 'denial' appears to be an interpersonal phenomenon strongly influenced by the therapist, and counseling styles that increase client resistance and produce little change, whereas empathic styles that minimize resistance are associated with relatively rapid change. People who faithfully do *something* to recover (even something that should not "work," like taking placebo medication) show better improvement. When people exercise control over their own treatment (such as choosing their approach to change), they fare better. People sometimes show dramatic and sudden bursts of change, usually outside the context of therapy, that are associated with

¹⁰ Center for Substance Abuse Treatment. *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*. Treatment Improvement Protocol (TIP) Series 48. DHHS Publication No. (SMA) 08-4353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

¹¹ Vasilaki EI, Hosier SG, & Cox WM. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. *Alcohol and Alcoholism*, 41, 328-35. 206

broad and enduring transformation. A letter or a phone call can make a substantial difference in the course of treatment.”¹²

IRHIT’s use of the Matrix Model including Motivational Interviewing and Cognitive Behavioral Therapy techniques in both face-to-face and online therapy sessions along with other online clinical and educational resources, will allow rural clients of diverse backgrounds to benefit from an even larger toolkit of strategies than Iowa’s agencies now provide. It will also give them access to a broader range of therapist style, culture and experience by breaking down barriers such as time and distance.

B4: EVIDENCE THAT PRACTICES ARE APPROPRIATE FOR THE OUTCOMES

The expected client outcomes of IRHIT’s evidence-based clinical practices include:

- IRHIT will increase the IOP retention rates for IDPH-funded providers’ clients with 4 or more sessions from 22.6% to 32.6% over the life of the project.
- IRHIT will increase the rates of family involvement from 9.2% to 20%.
- Increase the number of rural clients served in IOP services by participating IDPH-funded providers by 15%. Each provider will increase the number of rural IOP clients served by their agency by 10% in year one with a 15% increase in next two succeeding years.

As discussed in section B3, the evidence-based practices of choice are research-based and proven effective with the target populations. Because IRHIT will utilize these practices as web-based tools with a focus on integrating higher numbers of family members into the treatment process, IDPH believes distance, childcare and cultural barriers will be minimized. Both clients and family members can access an educational library, complete and submit home work, chat with counselors, and receive other services that previously were limited by travel and time considerations and allow access a broader array of tools and resources at each client or family member’s individual pace.

Iowa has extensive experience with process improvement, having been a three year grantee in the CSAT-funded Strengthening Treatment Access and Retention-State Initiative (STAR-SI) May want to include all of Iowa’s involvement with NIATx in addition to STAR-SI. During this project Iowa’s 23 IDPH-funded substance abuse treatment agencies focused on improving wait times, increasing the number of sessions in the first 30 days and increasing treatment stays for outpatient clients. Since the STAR-SI project, Iowa has moved process improvement efforts into the fields of both gambling treatment and substance abuse prevention.

IRHIT will use the skills gained by IDPH and state-licensed providers through previous process improvement efforts to manage and collaborate to bring online services to rural IOP clients. The IRHIT project director is currently a NIATx-trained state coach and was also the state change leader for Iowa’s STAR-SI initiative. As such, he will bring that process improvement skill set to managing the day-to-day process of implementing successful web-based treatment processes.

¹² Miller WR, Willoughby KV, (1997) *Bringing Excellence to Substance Abuse Services in Rural and Frontier America*. Treatment Assistance Publication (TAP) Series 20. DHHS Publication No. (SMA) 97-3134. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

B5: INFORMATION SUPPORTING SELECTION OF INTERVENTIONS FOR POPULATION OF FOCUS

As discussed previously in this section, Iowa has chosen the Matrix Model and Motivational Interviewing and Cognitive Behavioral Therapy because of their proven effectiveness with IRHIT's target population. The intervention of choice utilizes specific provider websites that will function as communication portals for clients, family members and counselors. These communication portals developed by Iowa Solutions (Section C) will enable counselors to communicate with clients and family members via secure chat, email and instant messaging. It will also enable counselors and clients to update client treatment plans for use in the client health record.

Iowa's Gambling Distance Treatment Services (GDTs) has been using a similar communication portal since 2009. GDTs has used the portal to allow all state-funded gambling treatment providers to integrate distance treatment approaches into their gambling treatment programs. The web-based communication portal has enabled Iowa to employ a broader array of gambling interventions than are typically available with a more traditional face-to-face treatment approach. This approach has already brought broader possibilities for success to Iowa.

Using web-based interventions through secure portals encourages and supports Iowa's continuing focus on innovative practices at the prevention and treatment levels. This approach to client/agency interactions demands that provider agencies devise new ways to recruit, orient and deliver treatment services to clients of all backgrounds. By enhancing the broader treatment system, this intervention creates a foundation that will eventually break down existing barriers to successful treatment based on distance and culture. Clients can be matched with culturally specific counselors based on expertise, rather than treatment region. Indeed, IRHIT demands innovative approaches to larger system planning. This is an opportunity that IDPH is taking with the implementation of IRHIT by encouraging:

- a focus on process
- flexibility in clinical practice as it exposes providers to broader client bases
- innovative thinkers to participate in Iowa's planning processes
- strong leadership with vision to participate
- clinicians to become more broadly educated as client bases expand to new include populations clinicians may not have interacted with before IRHIT.

B6: ADAPTATION OR MODIFICATION FOR PRACTICE

Because the Matrix Model with MI and CBT has already been developed for electronic use, none of the model will need to be adapted for web-based use. However, IRHIT is proposing to use the GAIN Short Screener (GAIN-SS) and the GAIN Treatment Satisfaction Index (TxSI) as the pre-treatment screeners, on-going treatment assessment tools, and discharge ratings tools of choice.

- The GAIN Short Screener (GAIN-SS) is designed primarily to achieve three purposes. First, it will serve as a screener in general populations to quickly and accurately identify clients who might have one or more behavioral health disorders (e.g., internalizing or externalizing psychiatric disorders, substance use disorders, or crime or violence problems). This use can suggest the need for referral to some part of the behavioral health treatment system. IRHIT will employ the GAIN to allow persons online to do an anonymous assessment and, if desired, to contact providers online to arrange

appointments or seek more information. Second, “estimates of need from the GAIN-SS can be used as a common metric across multiple systems or remote staff (e.g., employee assistance program with multiple contractors) and as a denominator for quality assurance on the extent to which the rate of diagnoses/referrals are consistent with the estimated mix of problems from the GAIN-SS. Such measures of quality assurance can be used for one-on-one supervision or performance-based contracting.”¹³ Third, IRHIT will use it to assess behavioral health change over time.

- The GAIN Treatment Satisfaction Index (TxSI) is a stand-alone instrument used to measure early engagement and participant satisfaction with treatment. It is a fourteen-item index using a 5-point agreement scale (1 = strongly disagree to 5 = strongly agree). The TxSI was developed as part of the Global Appraisal of Individual Needs (GAIN; Dennis, 2002).¹⁴ The participant completes the TxSI, rating their satisfaction with the staff at their current treatment. The participants give their responses to the items based only on the treatment they are currently receiving. Participants in aftercare can respond based on their thoughts about aftercare. One very unique aspect of the tool is that both the therapist and family members can complete the TxSI. Both therapist and family member ratings are based on their perceptions of how the participant would rate each item, not their own perceptions. IRHIT will always encourage completion by the client.

These screening tools will be adapted for web-based use by IRHIT’s web contractor, Iowa Solutions.

B7: EXPLANATION OF EVIDENCE-BASED PRACTICE OF CHOICE

IRHIT will use the Matrix Model exclusively because of its already wide-spread use with both rural and urban substance abuse treatment clients in Iowa. On July 1, 2007, The Iowa Department of Public Health received an appropriation from the general fund of the state of Iowa legislature (House File 471) to provide culturally competent substance abuse treatment. The Matrix Model was the model of choice for this project. The objectives of the Culturally Competent Substance Abuse Treatment Pilot Projects were to:

- increase substance abuse treatment options for racially and ethnically diverse populations;
- provide best practices or tried treatment methods and document program outcomes so Iowa treatment providers may adopt culturally competent treatment methods;
- identify barriers to participants accessing treatment and work with community wrap around services to assist clients with barriers in order to participate in and complete treatment services;
- maintain contact and support services with clients for (6) months;
- document and provide program outcomes by working with the Iowa Consortium for Substance Abuse Research and Evaluation;
- disseminate information about the pilot project including but not limited to: programming, lessons learned, community involvement, and outcomes as requested; and

¹³ Dennis, M. L., Feeney, T., Stevens, L. H., & Bedoya, L. (2006). *Global Appraisal of Individual Needs–Short Screener (GAIN-SS): Administration and Scoring Manual for the GAIN-SS Version 2.0.1*. Bloomington, IL: Chestnut Health Systems.

¹⁴ Dennis, M. L., White, M. K., Titus, J. C., & Unsicker, J. (2006). *Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures, version 5*. Bloomington, IL: Chestnut Health Systems.

- train substance abuse treatment staff to work more effectively with the target population.

The use of the Matrix Model as the model of choice for IDPH's cultural competency project makes it an easy selection as IRHIT practice given the rural IOP target population is made up of several underserved demographics.

The selection and subsequent implementation of Motivational Interviewing (MI) was part of a statewide process to implement evidenced-based practices in Iowa that began in 2004. The MI Network project was part of a statewide commitment by substance abuse stakeholders to enhance the quality of substance abuse treatment in Iowa. The state's managed care contractor, Magellan Behavioral Health initially led the MI training process by supporting training for more than 50 substance abuse professionals, representing 15 different agencies. Motivational Interviewing is nationally accepted treatment approach for helping clients move through the stages of change and find internal motivation for change.

B8: DESCRIPTION OF IRHIT'S APPROPRIATENESS FOR THE TARGET POPULATION

The Matrix Model will address the following issues in the population(s) of focus, while retaining fidelity to the chosen practice. As discussed previously, the model has been shown to maintain fidelity in each of these areas.

- Demographics: race, ethnicity, religion, gender, age, geography, and socioeconomic status – the model is sensitive to each of these areas.
- Language and literacy: the model is available in Spanish and is written at a fifth grade level.
- Sexual identity: sexual orientation and gender identity – Motivational interviewing within the matrix model values clients without regard to orientation or identity
- Disability: IRHIT using the Matrix Model will diminish the barriers created by disability such as distance, transportation and hearing and vision deficits.

The Matrix Model is a research and evidence-based model that has both web-based and culturally specific components.

B9: LOGIC MODEL

IRHIT LOGIC MODEL

Resources (Inputs)	Program Components (Activities)	Outputs/ Measures	Outcomes (Goals)
<p>System Level Resources: Providers, Stakeholder , IDPH staff Collaborative Committee (8 hours/year):</p> <p>IRHIT Project Level and Service Delivery Staff Resources Project Director (.3 FTE) Epidemiologist (.05 FTE) Iowa Plan Program Manager (.05 FTE) Provider coordination (.3 FTE*9 sites)</p>	<p>Review and Modify operations to include web-based provider processes Collaborative: Assessment of continuing cultural competence and development of IRHIT model, professional education and collaborative sharing of information by all stakeholders</p> <p>Screening: All clients accessing selected Idph-funded providers; GAIN-SS and TxSI become a part of patient intake and health update.</p> <p>Provider staff provide motivation to use IRHIT for selected Matrix Model sessions; GAIN-SS and TxSI used for monthly behavioral health assessment.</p> <p>Matrix model with MI and CBT used with IRHIT to augment face-to-face sessions for high-risk clients; used as complement for lower risk clients with fewer face-to-face sessions needed.</p>	<p>IDPH block grant funding will be open to support IRHIT in web-based treatment.</p> <p>Number of treatment community members aware of IRHIT as a treatment modality used at provider agencies.</p> <p>Number providers using IRHIT as a primary IOP treatment practice.</p> <p>Number and % of IDPH-funded clients who are:</p> <ul style="list-style-type: none"> - Screened (GAIN, TxSI) - Receive Matrix Model treatment using IRHIT - Collaborating with providers and family members on Tx Plan development and maintenance; - Receiving monthly behavioral health assessments using GAIN; - Receiving educational materials through IRHIT; - Enter treatment; - Complete treatment; - Report positive outcomes at discharge and post treatment. 	<p>Increased # of IDPH-funded providers implementing web-based SA treatment services supported by IDPH funding.</p> <p>Increased # of community and family members that report using IRHIT web-based services as a treatment and collaboration tool.</p> <p>Increased # of patients screened at the pre-treatment level;</p> <p>Increased # of rural clients served in IOP services by participating IDPH-funded providers</p> <p>Increased # of clients who are retained in services for 4 or more sessions.</p> <p>Increased # of clients reporting involvement of family members in treatment process.</p>

Section C: Proposed Implementation Approach

C1: IDPH EXPERIENCE USING HEALTH INFORMATION TECHNOLOGY FOR TREATING SUBSTANCE USE DISORDERS.

Substance Abuse: In 2004, IDPH began developing the Iowa-Service Management and Reporting Tool (I-SMART). It was completed and implemented in 2006 and is now a required system for all state-licensed substance abuse treatment agencies that report data to IDPH Division of Behavioral Health.

The I-SMART system is a web-based client file and data reporting system that enables IDPH Division of Behavioral Health and the licensed providers it supports to share software that supports substance abuse treatment information management. Using a web-based tool allows agencies to take a more collaborative, technical approach to meeting the needs of substance abuse and gambling treatment consumers and their programs. By keeping client records online, agencies are able to share data with one another electronically in a secure environment. This facilitates not only quicker service for the consumer should he or she change providers, but also allows agencies to cut costs associated with a paper record keeping system. Since its implementation, I-SMART's goals have been to:

- improve treatment by giving practitioners better access to tools for assessing, planning, tracking, and monitoring client treatment information,
- facilitate cooperation and collaboration across treatment providers by enabling the sharing of client treatment information within the constraints of individual privacy regulations,
- advance the standardization and quality of treatment data to provide the best available treatment information for managing and monitoring system outcomes,
- reduce the amount of treatment funding diverted to cover the costs of administering the system by promoting the sharing, and
- help substance abuse treatment providers meet key regulatory and reporting requirements with minimal burden and disruption

The I-SMART application modules are designed for persons working in an environment that integrates data collection and data use processes across the clinician/counselor – provider – state agency continuum that makes up the substance abuse and gambling treatment systems. Some modules (or actions within modules) can be completed by provider administrative staff, some by treatment professionals, and some by provider clerical staff.

Gambling: The Iowa Department of Public Health (IDPH) Iowa Gambling Treatment Program began offering distance treatment as an approved service type for individual, family, and group counseling on July 1, 2008. The Iowa Distance Treatment Program for Problem Gamblers targets problem gamblers that may have significant access barriers to traditional face-to-face treatment – such as transportation difficulties, physical impairment, motivational impairment, or work/family responsibilities – that would preclude them from attending treatment in a traditional setting in their local community. Distance treatment uses a variety of tools including web-based chats, telephone, and email. Beginning July 1, 2011, Iowa's Office of Gambling Treatment and

Prevention licensed programs will begin using the I-SMART system for both provider client file management and data reporting.

IDPH E-Health initiative: The Iowa Department of Public Health has formed Iowa e-Health, a collaboration of consumers, health care providers, insurers, state government, and health care purchasers, to build the Iowa Health Information Exchange (HIE) and encourage Iowa providers to use electronic health records (EHRs).

The Iowa HIE will allow health care providers to access vital patient health information no matter where the patient has been seen in Iowa. Iowa HIE will act as a “hub” that connects different EHRs throughout the state allowing patient information to flow between providers in a secure and confidential way. Health information will be exchanged quickly and accurately through the Iowa HIE.

Initially, the types of information that will be exchanged through the Iowa HIE include:

- secure provider to provider messaging
- continuity of care document (summary of a patient record)
- clinical lab results
- immunization list
- medication history

IDPH was initially challenged by the “culture shock” experienced by providers who had been using data systems that resided on their desk top computers and were used to report data once a month by mail using floppy disks or paper forms. The move to a web-based tool, while simple in description, was a challenge to users who had little and often no experience using the internet. Simple processes such as a website secured with user ids, passwords and pins became a barrier to timely data submission. These barriers have since melted away with the experience agency users have gained. IDPH has always had a “hands on”, customer-focused approach to helping providers with new processes. It was this customer focus centered on rapid personal responses to agency problems that helped correct these problems.

C2: IDPH CURRENT CAPACITY IN HIT

IDPH currently provides those licensed agencies that so desire use of the I-SMART system as their client file management system. The system developer, FEI Inc., reports that the WITS system upon which Iowa’s system is built will have all components in place to meet certification in December 2011. At this time, several IDPH-funded agencies have certified systems in place and are using them to report data into the IDPH central data repository (CDR). The CDR is used in turn to store data for reporting to Magellan (IDPH’s contracted Medicaid and block grant funds manager), the Iowa Consortium for Substance Abuse Research and Evaluation, and SAMHSA’s Treatment Episode Data Set contractor.

The use of a CDR greatly enhances IDPH’s ability to manage data as all I-SMART data is reported in real time. This enables IDPH to provide legislative, research and provider partners with up-to-date information.

C3: DESCRIPTION OF HOW IRHIT WILL BE USED TO REACH TARGET POPULATION.

In the project's first year, IRHIT will be implemented at up to nine IDPH-funded agencies currently licensed to deliver both gambling and substance abuse treatment services. These nine agencies are currently providing web-based distance treatment as part of the Iowa Office of Gambling Treatment's Distance Treatment initiative. Iowa's remaining 14 IDPH-funded treatment agencies will be phased-in over the next two years of the project; seven in each of the second and third project years. The IRHIT project will enable these 23 IDPH-funded substance abuse treatment agencies to reach and retain an additional 20% of clients and family members in the project's three year span. Over the three years, IRHIT will serve a minimum of 1,970 clients; 470 in the first year and, 1,500 in the two succeeding years.

IRHIT services will use a web-based approach to implement and support clinically appropriate, culturally competent evidence-based practices to promote the use of anonymous substance use screenings, online client assessments and interventions within the IOP levels of care. Iowa's IRHIT will promote the integration of these practices within licensed substance abuse treatment agencies as a way to ensure a more comprehensive approach to substance abuse assessment, intervention and continuing care services. This project will eventually assist all rural Iowans in maximizing the use of proven substance abuse treatment techniques to improve client and family health outcomes.

IRHIT is being developed and will be implemented in a method consistent with the following underlying the principles. All clients and family members of clients have an equal right to access to assessment and recovery services; no program, method of treatment, or service deliver method is "always right" for every client; client choice is denied if systems of care are not holistic and do not honor the parental, family, economic and logistical needs of the individual (clients' recovery is jeopardized when these needs are ignored); and, multiple gateways and modalities enhance client access and retention in treatment and strengthen client commitment to recovery as clients are exposed to greater opportunity for success.

When prospective participants contact a participating provider, agency personnel will inform them of the treatment services, including optional involvement in a web-based treatment approach. If potential clients are interested in the web-based option, the staff will give them a brief overview of the project and conduct a brief interview to determine their accessibility to online services. If the staff deems the client appropriate, and the client consents to services, the staff will enroll the individuals in the project at that point. At that point, they will begin receiving web-based services as determined appropriate in discussion between the client and counselor.

Any client involved in IRHIT for IOP services will use IRHIT as an adjunct to face-to-face services unless it is determined that they are physically unable or their lack of resources makes it impossible for them to attend any provider-site sessions. IRHIT clients will be expected to attend at least one hour per week on site unless otherwise agreed upon by the client and counselor.

Providers will continuously evaluate clinical appropriateness for IRHIT services. If providers determine that the clients are more appropriate for treatment as usual or a different level of care,

they will refer those clients to the clinical program that best meets their needs. Providers will monitor these referred clients until they engage in such services.

C4: EHR SOFTWARE

IDPH is not proposing the introduction or use of electronic health records as part of the project resulting from funds acquired through this grant application.

C5: FACTORS INFLUENCING THE EXPANSION AND ENHANCEMENT OF HIT

The following factors will influence expansion and enhancement of HIT.

- Organizational factors: Prior to the implementation of “live” services, each provider will participate in an agency-wide walkthrough including the use of IRHIT for communication with clients. IDPH-funded agencies are familiar with this concept as each of them has participated in past STAR-SI process improvement projects in which walkthroughs were an important first step. The walkthrough will identify any process problems, “bottlenecks” in work flow, and barriers to rapid implementation and client service process.
- Provider training and competence: Iowa’s providers are generally well experienced in the use of the Matrix Model, Motivational Interviewing and Cognitive Behavioral Therapy. Contracted agencies will be expected to use experienced and well-trained counselors for IRHIT. Providers will be trained in the use of the IRHIT portal, assessment tools and the anonymous screening tool at the project’s kick-off learning collaborative meeting.
- Relationships between provider staff and clients: Providers will be expected to train all prospective clients and family members in the use of the IRHIT portal and its tools. Prior to training each client and family members will be assessed for the appropriateness of IRHIT in their treatment plan. Services and training will be provided based on this assessment.
- Technical factors requiring additional staff or consultants: None are anticipated. The project director is well-versed in the use of online tools. The portal developer will be contracted to provide technical support following implementation.
- Financial factors: IDPH is making funding available for the provision of online substance abuse treatment services in the same manner as face-to-face sessions have been previously funded. It is expected that this funding will offset any sustainability issues following the award’s funding period.

C6: METHOD OF IMPLEMENTATION

IRHIT will be implemented by IDPH and will use project funds in conjunction with other available funding to provide IRHIT services. Project funds provided through this proposed grant award are considered “seed money” to offset start-up and initial IRHIT implementation costs until provider behavioral health care resources can support the project. Infrastructure support, notably training provided by IDPH and Iowa Solutions, will advance through combined project funds and existing training state staff resources. To ensure that IRHIT training is expanded broadly throughout behavioral health, IDPH will invite all state-licensed providers to attend the kickoff learning collaborative meeting. For this essential training function, IDPH will dedicate .4 FTE in project director, data analysis and epidemiological in-kind contributions.

IRHIT will initially be supported through project award funds. Project funds will be directed to substance abuse provider partners. Project funds directed to providers will support one project coordinator in each agency. These coordinators will be responsible for GPRA data submission, provider staff training following the initial IDPH-supported trainings, IDPH-required reports and the day-to-day on-site project monitoring. Clinical staff will provide IRHIT assessment and treatment services. Each contracted provider will support IDPH in completing face-to-face GPRA interviews for the follow up sample.

As substance abuse online treatment costs shift to other patient related revenues, providers will be supported in developing self-sustaining IRHIT program activities. Revenues currently available for face-to-face alcohol and drug treatment services through block grant funding will support the new treatment approaches driving the IRHIT process. IDPH and the SSA has committed to providing treatment funding for IRHIT on an equal footing with face-to-face services. Rural IOP clients will require stable and intensive treatment resources. Clients that require additional levels of care will be referred to the appropriate services where they may use IRHIT services if the provider determines it is appropriate. Specific steps and responsibilities in the implementation process are outlined in the project timeline (C11).

C7: SCREENING, ASSESSMENT AND TRACKING

Each prospective client will have access to an anonymous online screening tool and email contact with provider agencies prior to making any decision to attend treatment. This screening tool will be used as a method of enabling clients to better manage their own behavioral health care as they can assess themselves and make a “low-pressure” decision on their care. Should they decide to attend a more complete face-to-face assessment at a provider, they will be assessed according to ASAM levels of care and recommendations made.

Each client participating in IRHIT will complete a monthly GAIN-SS assessment to determine the presence or level of substance/mental health disorders. These assessments will be used as part of the IRHIT on-going project evaluation discussed in Section E. The TxSI will be used to determine clients’ satisfaction with services. This will inform IDPH and each provider about any ongoing challenges to the treatment process.

As part of the program design, individuals who are required to complete a Government Performance and Results Act (GPRA) intake, discharge and follow-up, will be provided an incentive to meet their prevention or treatment goal. Individuals will receive a twenty- dollar gift card for completion of the GPRA follow up interview.

Client data will also be entered into the I-SMART data system. This will allow IDPH, providers and partners to track trends in both IRHIT and the larger treatment data system.

Information gathered during the ongoing client assessment process will be used to inform each client’s substance abuse treatment plan. The IRHIT will also give clients and counselors a toll with which to communicate about and to modify the treatment plan. Should clients be found in

need of more extensive mental health care, they will be referred to appropriate services based on each client's needs at that time.

C8: MESSAGING SYSTEMS TO ENGAGE CLIENTS IN TREATMENT

IRHIT at its foundation is a communication tool that can be used in a variety of ways. Not only will IRHIT allow clients and counselors to use real-time chat for both individual and group therapy, but it will also be enabled for smart phone usage; thereby lowering barriers of distance, employment, transportation and family responsibility. Agencies that use the I-SMART system as a client file management tool, have found that clients often are fascinated by the systems use for assessment and managing treatment plans. Anecdotal reports from counselors show successful results turning the monitor to the client during sessions to both lower anxiety and to engage them.

IDPH anticipates the same results with the IRHIT system; especially in the area of treatment plan management and online individual and group chats. Each client will have the ability to access a number of learning tools including treatment plans uploaded to the secure site by counselors. That will enable the client to edit the treatment plan by checking off completed objectives, commenting on various aspects of their plan and then uploading the edited version to the counselor using the secure IRHIT system. Family members that were previously limited by time, distance and in some cases, deteriorating relationships with the client will be able to access educational and treatment tools using IRHIT. Group therapy via secure chat is also a possibility and appears to have possibilities in engaging younger clients who may not have resources to travel.

C9: HOME-BASED MONITORING TOOLS

More and more, observers are becoming aware that client-based ratings of health and well being are often more important than clinician ratings.¹⁵ IRHIT will use the Treatment Satisfaction Index (TxSI) as an online home-based tool. Clients, family members and therapists if need be can rate the client's experience in treatment. This tool will enable IDPH, the provider, the clinician, the client and family members to rate perceptions of client satisfaction with services. Clients will also be able to do the monthly GAIN-SS to monitor their own behavioral health progress during treatment. Both IDPH and providers in collaboration with client representatives will be able to introduce other tools to IRHIT as the project continues. The tools of choice will be based on client, clinician, provider and IDPH needs to provide a more complete treatment, behavioral health monitoring, and educational experience.

C10: CONSENT FOR SERVICES AND SPECIAL CONDITIONS

Per current state licensure regulations, clients are to sign a Consent to Services form and appropriate release of information when admitted into treatment. Specific instruction to providers on obtaining patient consent for IRHIT services and release of information in support of web-based treatment or referral for web-based treatment will be specifically addressed through training. IDPH recognizes the rights of each client to his or her health record. However,

¹⁵ Miller, S.D., Duncan, B.L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2(2), 91-100.

IRHIT's web portal does not constitute a health record, but, rather a communication tool used by counselors, clients, and family members to enhance and improve the clients' the treatment experiences and to improve the delivery of services.

C11: Implementation Timeline

IOWA IRHIT TIMELINE		3 YEAR TIMELINE			
Activities	Responsible staff or Agent	Target Milestones (Assumes 10/1 start)	Q1	Q2	Q3
At notice of award, assign Lonnie Cleland as project director	Kathy Stone, DeAnn Decker	10/1/2011			
Finalize contracts with providers for IRHIT implementation. Require providers to use developed privacy notices and consents.	Lonnie Cleland, supported by IDPH Division of Behavioral Health administration.		Contracts finalized 10/1/2011	Contracts finalized 10/1/2012	Contracts finalized 10/1/2012
Develop Collaborative plan that prioritizes IRHIT provider and community learning goals, identifies community client leaders , and sustainability plan	Providers and IDPH staff	11/15/2011	11/15/2011 Yearly collaborative meeting	11/15/2012 Yearly collaborative meeting	11/15/2013 Yearly collaborative meeting
Identify SA Provider treatment coordinators that will be assigned to IRHIT project.	SA Provider Executive Directors;	11/15/2011	11/15/2011	10/31/2012	10/31/13
Provide pre-implementation training for providers on GAIN-SS, TxSI, and Treatment Planning using IRHIT web portal	Project Director, Provider Coordinators, Iowa Solutions	1/31/12	Beginning 12/15/2011	On-going	On-going
Initiate walkthrough IRHIT implementation at provider sites; incorporate client advisers, IDPH staff and provider exec. directors into the walkthrough	Project Director, Executive Directors, Client advisors	1/31/12	1/31/2012 Yearly process walk-through	1/31/13 Yearly process walk-through	1/31/14 Yearly process walk-through
Conduct pre-implementation webinar trainings in GGRA reporting and patient consent	Project Director	1/31/12	Refresher trainings at each yearly collaborative meetings	Refresher trainings at each yearly collaborative meetings	Refresher trainings at each yearly collaborative meetings
Initiate IRHIT Services at 9 IDPH-funded provider agencies	Project Director, Provider Executive Directors, Provider Coordinators	2/1/12	2/1/2012		
Initiate IRHIT services at 7 IDPH-funded provider agencies	Project Director, Provider Executive Directors,	11/1/2012		11/1/2012	

	Provider Coordinators				
Initiate IRHIT services at 7 IDPH-funded provider agencies	Project Director, Provider Executive Directors, Provider Coordinators	11/1/2013			11/1/2013
Providers train clients and family members in use of IRHIT web portal.	Project Director, Project Coordinators	2/1/2012	On-going	On-going	On-going
Begin monitoring evaluation and schedule site visits to provider sites as needed.	Project Director, Project Epidemiologist	2/1/2012	On-going	On-going	On-going
Enhance website to provide new educational materials to clients and families	Project Director, Providers, Iowa Solutions	2/1/2012	On-going	On-going	On-going
Collection of process and outcome data	Project Epidemiologist, Project Director	2/28/2012	On-going	On-going	On-going
Collection of outcomes data	Project Epidemiologist	7/31/12	7/31/12	3/31/13 9/30/13	3/31/14 9/30/14
Collection of Process Data through interviews with clients and providers	Project director, Project Epidemiologist, Providers, Clients, Community	7/31/12	7/31/12	3/31/13 9/30/13	3/31/14 9/30/14
Project reports to SAMHSA	Project Director		Semi-annual	Semi-annual	Semi-annual and Final

C12: NUMBER OF INDIVIDUALS SERVED OVER THE LIFE OF THE GRANT, TYPES AND NUMBER OF SERVICES

IDPH anticipates IRHIT will serve the following numbers of individuals over the 3 year life of the project.

- Individuals served: 1970 admitted IOP clients, 3600 anonymous assessments, and 2000 family members.
- Types of services provided: Online anonymous assessments, secure Individual and Group Therapy chats, secure online GAIN-SS and TxSI assessments for monthly client health assessments, secure online Treatment Plan management by clients and counselors, library of educational files for both client and family member use.
- Number of services provided will be determined by the number of clients and the services accessed by each.

C13: IMBEDDING OF SERVICES INTO CURRENT SERVICE DELIVERY SYSTEM

As discussed in Sections B:6 and B:7, Iowa has chosen to use the Matrix Model, Motivational Interviewing and Cognitive Behavioral Therapy as the modalities of choice. No services new to providers in the treatment of rural IOP clients are being proposed by IRHIT. Instead IRHIT is enabling providers and clients a new way to communicate and deliver services within the context

of an already existing level of care. These services will be embedded into the current service delivery system by encouraging providers to use web-based services as one means of meeting their requirements to receive IDPH funding.

C14: IDENTIFICATION OF PROVIDER AGENCIES

IDPH-funded substance abuse treatment providers will be the primary organizations participating in the IRHIT project. IDPH anticipates all 23 agencies will eventually use IRHIT to some extent. Year one's participating agencies will include all agencies that provide both gambling and substance abuse treatment services. Once contracted, provider agencies will invite community stakeholders to participate in the cultural and community building activities specific to each agency. IDPH will provide letters of support from community stakeholders specific to each provider along with a plan to include them in the planning process once the award notice is received.

Iowa's 23 IDPH-funded agencies are:

Alcohol and Drug Dependency Services	Heartland Family Service	SIEDA
Area Substance Abuse Council	House of Mercy	Substance Abuse Services Center
Broadlawns Medical Center	Jackson Recovery Centers	Substance Abuse Treatment Unit of Central Iowa
Center for Alcohol and Drug services	MECCA Services	Trinity-New Horizons
Community and Family Resources	New Opportunities	United Community Services
Compass Pointe	Northeast Iowa Behavioral Health	Youth and Shelter Services
Crossroads MHC	Pathways Behavioral Services	Zion Recovery Services
Employee and Family Resources	Prairie Ridge Addiction Treatment Services	

C15: DEMONSTRATION THAT NECESSARY GROUNDWORK FOR TIMELY IMPLEMENTATION HAS BEEN LAID.

Over the past year and continuing into the next three years, the Iowa Department of Public Health, Division of Behavioral Health (IDPH) is transitioning substance abuse service delivery to a comprehensive and integrated recovery-oriented system of care (ROSC) which includes the integration of gambling and substance abuse prevention and treatment services. This new system of care for clients with gambling, alcohol and other drug use disorders is being built on a foundation of collaboration and coordination between problem gambling prevention and treatment, substance abuse prevention and treatment and community partners including the customers of these services. The effectiveness of ROSC is dependent upon the partnership developed and nurtured by community partners, prevention and treatment providers, the recovery community and other stakeholders including IDPH.

The ROSC philosophy demands a new intervention paradigm. Iowa's previous service delivery system was built on a presumption that clients would and should seek services at physical locations where they would interact in structured treatment sessions with counselors whose skills were built and developed through face-to-face interactions. This paradigm can no longer be assumed to benefit Iowan's whose distance from these physical locations decreases the likelihood of engagement and successful completion of treatment.

Iowa's ATR initiative has expanded recovery services definitions to include community-based supports. The SBIRT project grant has proposed the inclusion of Federally Qualified Health Centers in the delivery of services. Iowa's Office of Gambling Treatment began distance treatment efforts in 2009.

Iowa's Office of Gambling Treatment and Prevention has laid the practical groundwork for the move to web-based substance abuse treatment services by making distance treatment services available to all 9 of the first year providers. The distance treatment portal will provide these agencies with a "leg up" for implementation.

C16: POTENTIAL BARRIERS TO SUCCESS AND STRATEGIES TO OVERCOME THEM.

Anticipated barriers include:

- Counselor Reluctance: Counselors sometimes show initial reluctance to implement new ideas. Having honed their skills in particular ways over, in some cases, many years, this is a natural response. Some may be reluctant to use new patient communication tools, information questionnaires and processes out of misinformation that it might be more work than they currently are doing. Our experience with the STAR-SI project has shown that process improvement is not always welcomed, at least initially
 - Resolution Strategy: However, STAR-SI also showed that clinician training is fundamental to both workforce development and acceptance of process improvement efforts. Professional training, education and involvement in the process as partners often moves opponents to become enthusiastic supporters. Iowa IRHIT will provide in-person and webinar trainings to first acquaint and then to train counselors in IRHIT's uses. IRHIT's project director will work directly with providers to educate and motivate clinicians.
- Client Reluctance: Many clients expect their counselors to manage the assessment and treatment process themselves. They might have little experience with a more self-directed approach that frames time away from face-to-face sessions as "time well spent." Lack of experience with web-based tools may be a concern as well as concerns about confidentiality.
 - Resolution Strategy: Just as personnel training, attitudes and tools are critical to alleviating counselor reluctance, so too are they important to lowering client reluctance. Motivational Interviewing, re-assurance, education about the nature of confidentiality, and clear instruction of the reasons for IRHIT are central to workforce development and will be included in all levels of professional training. IDPH believes a well informed and trained workforce will connect better with clients to alleviate many of the concerns clients might have.
- Lack of capacity and funding at IOP level of care for web-based services: Lack of capacity in substance abuse services generally applies to the higher levels of care such as IOP and residential treatment. IRHIT will address this lack of capacity by enabling clients to take part in the treatment process in where space and lack of physical space availability will not limit them. The lack of capacity to provide brief intervention, brief treatment or case management is most often driven by reimbursement models that reimburse for ASAM levels of care at I, II.1 and higher.

- Resolution Strategy: The IRHIT project will allow counselors to reach greater numbers of clients with more services in IOP level of care. Many rural clinics are not open every day and some may be open only once a week or less. IRHIT will provide clients with more opportunity to get the intensity of service they require.

C17: SUSTAINABILITY PLAN.

The sustainability plan includes a number of strategies.

- Financial Resources: Because the development cost of the IRHIT web portal is “front loaded,” developing reimbursement resources for clients using IRHIT will be less difficult than with some other projects. IDPH anticipates that once the three-year project period is complete that the cost of maintaining the web portal will be borne by the revenues generated from IOP reimbursements to providers. During the life of the grant, IDPH and providers will work to use the evaluation as a tool to inform other third party payers of the efficacy of IRHIT as a part of the treatment process. Obviously, sustaining IRHIT will require that programs break even on staff costs.
- Staffing and Efficiency Review: In order to demonstrate the efficacy of IRHIT, IDPH will ask providers to assist in doing yearly walkthroughs of the web portal and its use by both clients and clinicians. This process data will be shared within and outside of the sub-recipient community to motivate broad interest in the model and to show that IRHIT is cost efficient.
- Administrative Training and Workforce Development: Sustaining IRHIT in Iowa will require focused education for providers, clinicians, clients and their family members. This will require that providers continue the training, education and treatment processes begun during the IRHIT process and institutionalize them as policy and procedures for web-based services.

Section D: Staff and Organizational Experience

D1: CAPABILITY AND EXPERIENCE

As the designated Single State Authority (SSA) for substance abuse, the Iowa Department of Public Health (IDPH) is responsible for funding and licensing substance abuse treatment programs statewide. IDPH has extensive experience with similar projects, populations both rural and urban and with collecting GPRA data. IDPH is in year four of the Access to Recovery grant. During ATRII, IDPH reached a GPRA follow-up rate of 78% and was awarded performance incentives for exceeding grant thresholds. This speaks to IDPH being well versed in managing projects where the emphasis is on maintaining contact with disparate client populations.

IDPH is also in year three of a cultural competence grant which focuses on reducing barriers to treatment for cultural minorities. IDPH has contracted with treatment agencies to provide client centered community based, best/tried practice services that focus on a single targeted population. Providers have been supported by IDPH in consulting with community resources, developing community contacts and incorporating culturally competent treatment based on each targeted population’s culture and ethnicity.

Because 40% of Iowa's population lives in rural areas, Iowa's providers are well-versed in understanding and removing barriers and providing culturally competent services to these clients. The nine first year agencies all have boards of directors composed of community members who represent their agency and constituent best interests.

D2: STAFF POSITIONS

Project Director (.3 FTE): Lonnie Cleland, MSW, is a Program Planner for the Iowa Department of Public Health. He has been a Licensed Independent Social Worker in private practice, community mental health centers, and substance abuse assessments centers. He has extensive training and experience in the treatment of mental health and substance abuse disorders, domestic violence, couples and family therapy, mental health first aid and behavioral health disaster response. He has served as an adjunct faculty member with the University of Iowa, Graduate School of Social Work and as a supervisor of social work licensure candidates. He is past IDPH State Change Leader for the Strengthening Treatment Access and Retention-State Implementation (STAR-SI) grant. As State Change Leader, he was responsible for developing, facilitating and sustaining the process improvement efforts of substance abuse treatment agencies involved in the STAR-SI project. As lead trainer, primary help desk staff and member of I-SMART's development team, Mr. Cleland provides feedback to the application's developer on clinical treatment user and administrative issues related to the application's development. He has been involved in I-SMART's development as a data and clinical file system since 2004 and is cognizant of the many challenges of implementing an HIT system with substance abuse treatment provider. He will provide the day-to-day direction for the project and its providers. More detail of Mr. Cleland's duties is available in the IRHIT project implementation timeline.

Project Epidemiologist (.05 FTE): Dr. Ousmane Diallo, MD, MPH, is the epidemiologist hosted at the Division of Behavioral Health. He serves as the chair of State Epidemiological Workgroup (SEW) funded through the Strategic Prevention Framework State Incentive Grant (SPFSIG). He has led the publication of the state epidemiological profile and helped train locals to assess and identify priorities using epidemiological methods; build capacity and develop plans to address them; implement environmental strategies and evaluate impact and outcome. Dr. Diallo will conduct a baseline process evaluation (walk through) of the program implementation and propose any corrective measures if needed. He will also manage all project evaluation and GPRA data collection.

Iowa Plan Program Manager (.05 FTE): Eric Preuss, Iowa Plan Program Manager for the Division of Behavioral Health and under the supervision of the Division Director provides daily functional oversight to Department's statewide addictions management program. Five percent in-kind of Mr. Preuss' hours will be for assisting the program director and epidemiologist in the responsibilities of the project. No federal support is required. Existing funds will offset the cost of this position.

D3: DEMONSTRATED STAFF EXPERIENCE WITH THE POPULATION OF FOCUS

During the farm recession of the middle and late 1980's, Mr. Cleland organized and led several farmer and farm family support groups. The focus of the groups was on managing the devastating behavioral health consequences of the rural economic down turn. These experiences

coupled with the skills developed give him a unique view and skill set to direct this project integrating HIT into the treatment of rural Iowa's IOP clients. Additionally, Mr. Cleland led a state-wide NIATx process improvement effort where the goal was to increase client treatment admissions and retention and to decrease no-shows and wait times for services. This experience has provided an in-depth understanding of the barriers rural communities have in accessing much needed help.

D4: RESOURCES AVAILABLE FOR THE PROJECT

IRHIT proposes to enable web-based portals allowing clients and clinicians to communicate during the client's intensive outpatient treatment experience. Each provider agency has adequate computer resources and broadband internet access to easily manage the IT aspects of the project. Each provider also has a website devoted to informing the public about their philosophy and services. As part of Iowa's network of licensed agencies, each is required to be compliant with all state and federal laws related to equal access such as the Americans with Disabilities Act. IDPH believes the resources needed to adequately manage this project are in place.

Iowa's substance abuse providers are exceptionally well trained in clinical skills and practices including MI, and CBT. Throughout Iowa, cultural competency is prioritized in all aspects of the treatment experience. All agencies participating in this project have demonstrated clear competencies in serving ethnic minorities, persons who are poor, victims of trauma, and those who are sexual minorities. These agencies are among the most developed in the state.

Section E: Performance Assessment and Data

E1: DATA COLLECTION AND REPORTING

IDPH network of substance abuse providers have proven experience in National Outcome Measures (NOMS) and GPRA data collection. The IDPH system handles more than 45,000 treatment cases each year through the automated I-SMART (WITS) system. Twenty-two of the block grant providers have experience in collecting GPRA data and meeting performance expectations established by SAMHSA, in the ATR WITS system. For similar grant programs (ATR 1, 2, and 3) WITS users have experienced a near 100% data acceptance rate for GPRAAs submitted electronically. Changes (modifications or deletions) to the client interviews are also tracked in order to send appropriate transactions in the electronic data submission to SAMHSA. The GPRA data upload module is integrated as a back-end function within WITS to handle high-frequency electronic data submission to the CSAT repository and is currently set to upload automatically every night during the least active system usage times to minimize the impact to users.

For this project the GPRA reporting module information (baseline, follow-up and discharge) will be collected at the participating agency level by agency staff and then submitted to IDPH to be entered by the division epidemiologist via the Service Accountability Improvement System. IDPH is aware of the inefficiency of this method and plans to look for alternative ways to automate the collection and transmission of GPRA data as the grant progresses, either at the provider or state level.

Each client will be provided with a unique identification number (not based from the use of personal information) upon acceptance into the IRHIT program. IRHIT will be compliant with HIPAA and 42 CFR pt. 2. The site administrators and the epidemiologist will be able to monitor IRHIT activity including provider and client activity, number of sessions and duration, the status of each record, and individual errors for each record that will be corrected before submission.

In addition to the GPRA data collection, the IRHIT program will include the use of two additional tools for data collection that are evidence-based: the GAIN Short Screener (GAIN-SS) and Treatment Satisfaction Index (TxSI).

- GAIN-SS: The GAIN-SS contains 20 questions with a recency response set (past month, 2-12 months ago, 1+ years ago, never) that takes about 5 minutes to complete. IRHIT will provide a link (English and Spanish) on participating provider web pages that individuals seeking assistance can click on to anonymously complete the short screener and quickly receive confidential feedback on their need for assistance with 1 or more behavioral health disorders (internalizing/externalizing psychiatric disorders, substance abuse disorders, or crime/violence problems). Upon completion of the short screener, the individual will be given options to respond to the results by asking for additional information, scheduling an assessment, or talk to a professional. Upon full evaluation and acceptance into IRHIT, a baseline for the participant will be established, and each month a participant will be “assigned” to complete the GAIN-SS to monitor progress in treatment and the need to adjust treatment planning needs.
- TxSI: The TxSI¹⁶ contains sixteen questions (5 point Likert Scale) to measure how the individual is feeling about the treatment staff and programs they are participating in. Research has shown there is some connection for adults between client satisfaction of treatment services and positive client outcomes.¹⁷ The TxSI will be “assigned” by the participant’s counselor to be completed monthly during treatment and at discharge. An option will exist to “assign” family members participating in treatment to also complete the TxSI.

E2: DATA MANAGEMENT AND QUALITY IMPROVEMENT

Every 15th of the month, the epidemiologist will download from the IRHIT web portal the data to check for quality and develop detailed quality reports, which will assist in monitoring the types and frequencies of services by client demographics, age, gender, sex, ethnicity and race; social status such as veteran, employment; environmental influences; and type of treatment received. The analysis of the online short screener at baseline will allow generate a feedback to providers on the rate of agreement (using Kappa) between their recommendation and the GAIN-SS results. In addition, the epidemiologist will monitor the progress of a single client or at the group level as an outcome measure and also penetration and referral rates over time¹⁸. The TxSI results will be

¹⁶ Dennis, M.L., Titus, J.C., Hite, M.K., Unsicker, J.I., Hodgkins, D.V. (2002) Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures. Bloomington, IL: Chestnut Health Systems. [Online] Available at: www.chestnut.org/li.gain.

¹⁷ Tetzlaff, Brook T. and Jeffy H. Kahn, Godley, Susan and Mark; Diamond, Guy; Funk, Rodney. Working Alliance, Treatment Satisfaction, and Patterns of Post treatment Use among Adolescent Substance Abusers. Psychology of Addictive Behaviors (2005) Vol.19, no.2, 199-207.

¹⁸ Dennis, M. L., Feeney, T., Stevens, L. H., & Bedoya, L. (2006). Global Appraisal of Individual Needs—Short Screener (GAIN-SS): Administration and Scoring Manual for the GAIN-SS Version 2.0.1. Bloomington, IL: Chestnut Health Systems. Retrieved on [06/03/2011] from http://www.chestnut.org/LI/gain/GAIN_SS/index.html

monitored to identify key issues such as quality of the interface, acceptability of the methods, and barriers to compliance or non effectiveness of treatment. This information will be analyzed and real time feedback will be provided to department staff for resolution. The feedback will be disseminated to participating agencies either in face-to-face meetings, phone calls, or monthly conference calls and/or webinars. Opportunities for Improvement (OFI's) will be developed by each provider to address concerns, monitor progress, and assure continuous quality improvement.

E3: PERFORMANCE ASSESSMENT

The evaluation will be led by Dr. Ousmane Diallo, MD, MPH, the epidemiologist hosted at the division of Behavioral Health. He serves as the chair of State Epidemiological Workgroup (SEW) funded through the Strategic Prevention Framework State Incentive Grant (SPFSIG). He has led the publication of the state epidemiological profile and helped train locals to assess and identify priorities using epidemiological methods; build capacity and develop plans to address them; implement environmental strategies and evaluate impact and outcome. The epidemiologist will conduct a baseline process evaluation (walk through) of the program implementation and propose any corrective measures if needed.

The evaluation will involve the collection of process and outcome data. Provider and program-level process data will be collected every month through the online interface. Providers will be also asked to enter information, contact experience of every client they followed. It is expected that the level of commitment and care should not be different from face-to-face clients. Process and outcome data will be reported to the Project Director and to SAMHSA as required.

The process evaluation will encompass capturing both quantitative and qualitative data. The key partners and project leadership, in a participatory evaluation process, will provide insight into the processes and strategies that are successful and those that need improvement. Main process questions that will be addressed include but are not limited to the fidelity of implementation of the web-based application as measured against the original plan; barriers that were encountered in implementation and modifications that were required, reasons for changes in the original plan, results of the changes had on the implementation, planned services, and performance assessment. The epidemiologist and the project director will meet, either in focus group setting or informally, with providers and clients using either system to discuss their appreciation of the screening, and interventions. The results from those meetings will be used to adapt/tailor the web-based application to circumvent any issue that might limit the value of the service. The process evaluation will be useful in determining the lessons learned and recommendations for future projects and activities.

The outcome evaluation will address performance measures that meet and exceed SAMSHA guidance. The focus of the outcome review includes:

- The effect of the intervention on the rate of successful treatment completion,
 - Relapse rates
 - Duration of treatment (time to discharge)
-

- Client satisfaction
- Post Discharge Outcomes (Sustained Recovery)
- Program impact (cost effectiveness, increased admissions, counselor productivity, etc.)

Though not doing research in this project, the epidemiologist will identify key indicator of success and compare the Web-based treatment clients to the general treatment center client. The predictor of outcomes the programmatic level or client level will be assessed. Program factors that may influence success may be the quality of the service (the use of high speed internet, Smart-phone). At the individual level race/ethnicity, gender, age and socio-economic status (education level and income) may be modifiers of outcomes. To assess individual factors, including race, that may be associated with outcomes, regression analyses (stratified analysis, logistic, linear, Cox proportional hazards, as appropriate) will be performed to identify key demographics, and client characteristics which predict or are associated with client outcome measures.

Durability of intervention effects will be assessed at the six-month mark of the project. To assure that appropriate populations are being served and disparities are minimized, the project dropout rate (from screening to treatment ending) will be measured and compared for disparities among race/ethnic and sex groups.

The project team will adhere to all provisions of Title 42 of the Code of Federal Regulations, Part 2. All information and data will be treated as confidential information.

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Section G: Budget

A. Personnel:

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Program Cost	Federal Cost
(1) Project Director	Lonnie Cleland	\$74,819	.30	\$22,446	\$22,446
(2) Epidemiologist	Ousmane Diallo	\$78,901	.05	\$3,945	\$3,945
(3) Iowa Plan Program Manager	Eric Preuss	\$61,680	.05	\$3,084	\$0
			TOTAL	\$29,475	\$26,391

- (1) **Project Director – Lonnie Cleland**- has been selected to provide daily oversight of the grant and will be the project manager. Iowa requests federal support for this position
- (2) **Epidemiologist– Ousmane Diallo** – has been selected to monitor, evaluate, and report on the grant's performance and outcome measures. Iowa requests federal support for this position for data collection, performance measurement and performance assessment. Iowa requests federal support for this position.
- (3) **Iowa Plan Program Manager – Eric Preuss** - is the Iowa Plan Program Manager for the Division of Behavioral Health and under the supervision of the Division Director provides daily functional oversight to Department's statewide addictions management program. Five percent in-kind of Mr. Preuss' hours will be for assisting the program director and epidemiologist in the responsibilities of the project. No federal support is required. Existing funds will offset the cost of this position.

FEDERAL REQUEST FOR PERSONNEL: \$26,391

B. Fringe Benefits:

Component	Rate	Wage(s)	Cost
FICA	7.65%	\$26,391	\$2,019
Deferred Comp	.7%	\$26,391	\$185
Medical	14.5%	\$26,391	\$3,827
IPERS/Retirement	6.95%	\$26,391	\$1,834
LT/Disability	.2%	\$26,391	\$53
		TOTAL	\$7,917

Fringe is figured at the rate of 30% of salary. Full-time employee benefits include FICA, retirement, unemployment, workers compensation, medical and dental insurance, life insurance, and long-term disability insurance. Iowa requests federal support only for the benefits of the Project Director and Epidemiologist.

FEDERAL REQUEST FOR FRINGE:

\$7,917

C. Travel:

Purpose of Travel	Location	Item	Rate	Cost
(1) Grantee Conference	Washington, DC	Airfare	\$500/flight x 2 persons	\$1,000
		Hotel	\$220/night x 2 persons x 3 nights	\$1,320
		Per Diem (meals and incidentals)	\$50/day x 2 persons x 4 days (one travel day)	\$400
		Misc (parking and taxi)	\$100 x 2 persons	\$200
			TOTAL	\$2,920

- (1) Out-of-state travel includes the attendance of 2 individuals (Project Director and one other) at the mandatory out-of-state joint Grantee Conference. Airfare estimated @ \$500 per person = \$1,000, lodging @ \$220 per person for 3 nights = \$1,320, and \$50 per person for meals per diem (x 4 days which includes one travel day) = \$400. Miscellaneous cost for parking and taxi for 2 attendees = \$200.

FEDERAL REQUEST FOR TRAVEL:

\$2,920

D. Equipment:

FEDERAL REQUEST FOR EQUIPMENT:

\$0

E. Supplies:

Item(s)	Rate	Cost
(1) Training Materials	\$180 for 1 training	\$180
(2) Postage	\$10 x 12 months	\$120
(3) Copies	\$10 x 12 months	\$120
	TOTAL	\$420

Supplies include \$180 for training materials, i.e. foam boards, binders, training journals, etc. per year; \$120 for postage and \$120 for copies. Cost = \$420

FEDERAL REQUEST**\$ 420****F. Contracts:**

Name	Service	Rate	Cost
(1) Iowa Solutions	Web Portal Development, hosting, license fees and maintenance	N/A	\$56,400
(2) Project Partners (three cohorts)	Implementation and staff training costs	\$18,000 x 9 providers (.3 FTE including Fringes)	\$162,000
		TOTAL	\$218,400

- (1) **Iowa Solutions:** Iowa Solutions will provide Iowa with a centralized communication tool with each provider having a customized portal running on the backbone of RECOVERYATION.ORG. First year costs include the conversion of the current 9 distance treatment sites onto RECOVERYATION.ORG as Iowa's communication tool of choice. The program will provide Iowa and project site staff the ability to conduct the following web-based activities: anonymous initial screening, clinical sessions, treatment planning, individual and group chat, treatment progress, treatment assignments, family participation, client satisfaction, and program outcomes and evaluation.

The following is a description of the specific services that will be provided by Iowa Solutions:
Initial Configuration and Implementation of RECOVERYATION.ORG - \$30,060
(Infrastructure Development); *Licensing*: \$14,040 (9 core and 18 supplemental licenses);
Reporting, Performance /Outcome Management (9 provider licenses): \$10,800 (for data collection, performance measurement and performance assessment); *Training*: \$1,500.

Iowa Solutions Annual Cost - \$56,400

- (2) **Project Partners (three cohorts)** – The I-RHIT project in Iowa will provide for a .3 FTE (\$13,846 salary and \$4,154 for fringes) for each participating agency in their respective cohort to support the implementation of RECOVERYATION.ORG in their agency. These individuals will participate in the initial training, client training, GPRA data gathering requirements, attendance at monthly webinars and annual learning collaborative, and coordinate outreach efforts at each agency to increase participation in RECOVERYATION.ORG.

Project Partners Total Annual Cost - \$162,000

F. Total Contracts **\$218,400**

G. Construction: N/A

H. Other:

Item	Rate	Cost
(1) Curriculum - English	\$749 x 10 licenses	\$7,490
(2) Curriculum - Spanish	\$245 x 10 licenses	\$2,450
(3) Communications	\$60/ICN/Go-To Meeting x 12 mo.	\$720
(4) Telephone	\$40 x 12 Months	\$480
(5) License Fees	\$10 x 12 months	\$120
(6) Annual Learning Collaborative	\$1,000 per training	\$1,000
(7) GPRA Follow-up Incentive	Incentives of \$20 are planned for completion of GPRA Follow-up interview, (n=100) = \$2,000	\$2,000
	TOTAL	\$14,260

Other expenses:

- (1) **Curriculum - English** – I-RHIT will purchase The Matrix as the core evidenced practice to be used in RECOVERY.ORG as part of the core treatment library for participants and family members (10 Matrix Modules with DVD x \$749 each = \$7,490).
- (2) **Curriculum- Spanish** - I-RHIT will purchase the Spanish The Matrix as the core evidenced practice to be used in RECOVERY.ORG as part of the core treatment library for Spanish speaking participants and family members (10 Spanish Matrix Modules with DVD x \$245 each = \$2,450).
- (3) **Communications** – I-RHIT will schedule 12 monthly Go-To Meetings at a total of \$720
- (4) **Telephone** - include services for 1 staff at \$40 per month x 12 months = \$480.
- (5) **License Fees** – includes departmental charge for use of computer licensed software by I-RHIT totaling \$10 per month x 12 months = \$120
- (6) **Annual Learning Collaborative** - I-RHIT will schedule an annual learning collaborative which is required of all participating agencies to attend and share their implementation stories, successes, improvements, hurdles and barriers. Includes cost of room rental and learning collaborative materials totaling \$1,000.
- (7) **GPRA Follow-up Incentive** - \$20 gift cards will be given to all participants that successfully complete the GRPA follow-up time frame within 6 months of entry into the program (100 participants x \$20 gift card = \$2,000).

FEDERAL REQUEST **\$14,260**

TOTAL DIRECT CHARGES:
FEDERAL REQUEST \$270,308

INDIRECT CHARGES:
FEDERAL REQUEST
(26.5% of Wages/Fringes; .265 x \$34,308 = \$9,092) \$9,092

TOTAL:
FEDERAL REQUEST \$279,400

BUDGET SUMMARY:

Category	Year 1	Year 2*	Year 3*	Total Project Costs
Personnel	\$26,391	\$26,391	\$26,391	\$79,173
Fringe	\$7,917	\$7,917	\$7,917	\$23,751
Travel	\$2,920	\$2,920	\$2,920	\$8,760
Equipment	\$0	\$0	\$0	\$0
Supplies	\$420	\$420	\$420	\$1,260
Contractual	\$218,400	\$218,400	\$218,400	\$655,800
Other	\$14,260	\$14,260	\$14,260	\$42,780
Total Direct Charges	\$270,308	\$270,308	\$270,308	\$810,924
Indirect Charges	\$9,092	\$9,092	\$9,092	\$27,276
Total Project Costs	\$279,400	\$279,400	\$279,400	\$838,200

TOTAL PROJECT COSTS:
FEDERAL REQUEST \$279,400 – Year One
\$279,400 – Year Two
\$279,400 – Year Three

\$838,200 – Project Total

H: Biographies

Project Director

Lonnie Cleland, MSW, Program Planner for the Iowa Department of Public Health (IDPH) is responsible for three projects within the Bureau of Substance Abuse Prevention and Treatment. Mr. Cleland is the Project Coordinator for the Jail-Based Substance Abuse Treatment Project. The J-BT Project is charged with lowering offender recidivism rates by developing effective jail-based substance abuse/criminal thinking treatment programs as a first step in an extended offender treatment process.

Mr. Cleland is also one of the original members of the Iowa Service Management and Reporting Tool (I-SMART) development team. He currently serves as lead trainer, primary help desk staff and provides feedback to the application's developer on clinical and administrative issues related to the application's development.

Mr. Cleland is past State Change Leader for the Strengthening Treatment Access and Retention-State Implementation (STAR-SI) grant. As State Change Leader, he was responsible for developing, facilitating and sustaining the process improvement efforts of 23 substance abuse treatment agencies involved in the STAR-SI project. He also facilitated the state change team meetings at IDPH with a focus on supervising change and helping the state change team with implementation issues. He led the team to overcome barriers to implementation of change experiments, supervised measurement and compilation of data for the study and act phases of process improvement projects.

Prior to joining IDPH, he was a Licensed Independent Social Worker in private practice with extensive training and experience in the mental health and substance abuse treatment fields, domestic violence, couples and family therapy. He has worked in both rural and urban settings. Mr. Cleland has served as an adjunct faculty member with the University of Iowa, Graduate School of Social Work and as a supervisor of social work licensure candidates. Since joining IDPH, he has also served as Substance Abuse Reporting System's (SARS) Coordinator and as a Board Administrator for several licensure boards administered by the Department.

Job Description

Title: IRHIT Project Director

Description of Duties and Responsibilities

Summary: This position is responsible for administrative oversight of all aspects of the project. The Project Director will be instrumental in provider recruitment and planning, budget oversight, service development and delivery, training and implementation, quality improvement, adherence to grant requirements, and operations.

Duties:

- Responsible for working as lead IRHIT staff person
- Direct project design and implementation strategies
- Continually assess and refine system gaps
- Ensure IRHIT training and maintenance plans are implemented in all participating agencies
- Ensure coordination and management of all IRHIT project duties
- Direct collaboration with local, state and federal partners

- Ensures selection of collaborative members and responsible for ongoing planning, dissemination, executing, and reporting
- Develop and maintain processes to organize grant-monitoring activities; track grant requirements and maintain process to communicate non-compliance with providers
- Assist with provider press releases, conferences and social marketing if requested.
- Prepares all required SAMHSA reports, the division director and the project partners
- Develop a system for the dissemination of all data and evaluation reports
- Develop and maintain a strong technical assistance and training system for the state

Qualifications for Position

- Graduation from an accredited four-year college or university
- Experience equal to four years of full-time professional level work such as program administration, development, management or operations

Supervisory Relationships

- Reports directly to the Bureau Chief of the Bureau of Substance Abuse Prevention and Treatment

Skills and Knowledge Required

- Ability to establish program objectives or performance goals and to assess progress toward their achievement
- Ability to see problems, situations, or people from different perspectives
- Ability to solve problems with focus on efficiency in processes and outcomes
- Ability to develop and foster teamwork/create and maintain effective working relationships
- Ability to work collaboratively with IDPH staff and providers in a team approach
- Knowledge of Iowa's substance abuse treatment system
- Knowledge of substance abuse principles, theories and techniques
- Strong written and oral communication skills

Prior Experience Required

- Experience in data collection and analysis, grants/contract oversight and management
- Experience in broad-based planning processes and collaborative efforts
- Excellent oral and written communication skills
- Experience coordinating projects among multiple stakeholders

Personal Qualities Required

- Displays high standards of ethical conduct
- Excellent teamwork record
- Flexibility and adaptability to organizational changes

Travel Requirements

- Able to travel in and out of Iowa.

Salary Range

- \$13,800-27,000 (.3 FTE)

Work Hours

- 7:00-3:30

Project Epidemiologist

Ousmane Diallo, MD, MPH, will be funded at .05% FTE to serve as project epidemiologist. Dr. Diallo has coordinated Iowa's community health centers in disaster preparedness and mental health readiness. He developed comprehensive mental health competencies, including competencies for substance abuse, for health care workers in emergencies and disasters. Dr. Diallo has intensive experience in working with poor and socially disrupted communities, addressing the needs of refugees, seasonal migrants, and exploited children. He has worked in close partnerships with various non-governmental, religious, and international organizations in social mobilization, community empowerment, and grass-root organization design, implementation and evaluation. He has been active on the State Epidemiological Outcomes Workgroup since its inception in 2006.

Job Description

Title: Project Epidemiologist

Description of Duties and Responsibilities

Summary: The epidemiologist will conduct a baseline process evaluation (walk through) of the program implementation and propose any corrective measures if needed. He will oversee the collection of process and outcome data. Responsible for collection of provider and program-level process data through the online interface. Process and outcome data will be reported to the Project Director and to SAMHSA as required.

Duties:

- Work with all state staff, providers and stakeholders to identify innovative evidence-based practices and help sub-recipients to implement appropriate programs based on scientific and epidemiological knowledge.
- Work directly with the Project Director to provide technical assistance on an ongoing basis to sub-recipients in data collection methods and reporting procedures
- Assist in preparation of required reports and presentations on specific epidemiological data results

Qualifications for Position

- Master's Degree in Public Health, Statistics or Health Education and several years of experience in data analysis, statistics and interpretation of epidemiological disease/health data relevant to substance abuse and related problems.
- Knowledge of epidemiological research practices and procedures for the collection, analysis, evaluation, and validation of health/disease data sets; descriptive statistics, and theory; public health principles and health care delivery systems;

Supervisory Relationships

- Reports directly to the Bureau Chief of the Bureau of Substance Abuse Prevention and Treatment

Skills and Knowledge Required

- Knowledge of SAS and EPI information software.
- Ability to make presentations, use problem solving techniques, communicate effectively, analyze and interpret epidemiological data set, advise state, sub-state and community stakeholders on best epidemiological approach.
- Knowledge of trends in substance abuse, related mental health and other problems, as well as the risk, protective and other factors underlying these behaviors.

Prior Experience Required

- Experience in data collection and analysis, grants/contract oversight and management
- Excellent oral and written communication skills

Personal Qualities Required

- Displays high standards of ethical conduct
- Excellent teamwork record
- Flexibility and adaptability to organizational changes

Travel Requirements

- N/A

Salary Range

- .05 FTE

Work Hours

- 8:00-4:30

Iowa Plan Program Manager

Eric Preuss, ICAADC, CCS, LICDC is the Iowa Plan Program Manager for the Division of Behavioral Health and under the supervision of the Division Director provides daily functional oversight to Department's statewide addictions management program. Mr. Preuss leads the Division's collaboration with DHS/IME on oversight of IDPH/DHS Iowa Plan managed care program and contractor (Magellan) determining reporting requirements and processes; monitoring contractor and subcontractor performance and evaluating effectiveness of program activities.

Mr. Preuss oversees program surveillance and data/information analysis and dissemination efforts across multiple program information systems and databases and oversees the Division's problem gambling and substance abuse information systems and related supporting databases (ATR, Central Repository, GTRS, I-SMART, MDS, and SARS.)

Prior to joining IDPH, Mr. Preuss spent 20+ years as a counselor, educator, and leader in the areas of substance use disorder treatment and homelessness, most recently as the Special Projects and Quality Assurance Coordinator for a multi-county substance abuse and treatment program in north-central Iowa. He has a Master's degree in Alcohol & Drug Abuse Ministry from the Methodist Theological School in Ohio, received his undergraduate degree from Valparaiso University, and is a Licensed Independent Chemical Dependency Counselor (LICDC-Ohio), an IAADC (Advanced Alcohol and Drug Counselor) in Iowa and a CCS (Certified Clinical Supervisor) in Iowa.

Mr. Preuss has proven experience in collaborating, designing and implementing best practice substance use disorder treatment program models and comprehensive continuous quality improvement activities to positively affect staff performance and customer access, retention and continuation in treatment. He currently serves as a member of the Board of Directors for the Iowa Board of Certification.

Job Description**Title: Iowa Plan Program Manager****Description of Duties and Responsibilities**

Summary: This position is responsible for oversight of data systems and reporting involved in the project assisting the program director and epidemiologist in the responsibilities of the grant project.

Duties:

- Ensures selection of collaborative members and responsible for ongoing planning, dissemination, executing, and reporting
- Oversight of grant-monitoring activities, requirements and processes
- Assist program director in completing required SAMHSA reports, the division director and the project partners
- Assist in the development of a system for the dissemination of all data and evaluation reports
- Assist in provision of technical assistance and training system for the state
- Assist Epidemiologist in program data collection, monitoring, and evaluation

Qualifications for Position

- Graduation from an accredited four-year college or university
- Experience equal to four years of full-time professional level work such as program administration, development, management or operations

Supervisory Relationships

- Reports directly to the Director of the Division of Behavioral Health

Skills and Knowledge Required

- Ability to establish targeted goals, objectives and related activities and assess progress
- Knowledge of Division data systems, data management (collection, integrity, dissemination), and performance indicators
- Ability to develop and foster teamwork/create and maintain effective working relationships
- Ability to work collaboratively with IDPH staff and providers in a team approach
- Knowledge of Iowa's substance abuse treatment system
- Knowledge of substance abuse principles, theories and techniques
- Strong written and oral communication skills

Prior Experience Required

- Experience in continuous quality improvement process development, implementation and evaluation
- Experience in data collection and analysis, including proficiency in using Excel
- Experience in project/contract oversight and coordinating projects among multiple stakeholders.
- Excellent oral and written communication skills

Personal Qualities Required

- Detail oriented
- Displays high standards of ethical conduct and integrity
- Successful working independently and in team environment
- Flexibility and adaptability to organizational changes
- Effectively manages conflicting priorities to meet goals/objectives

Travel Requirements

- Able to travel in and out of Iowa.

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: (Agency)

on (Date)

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the

Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.

THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:

Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).

Handicapped Individuals – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).

Sex Discrimination – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).

Age Discrimination – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).

Debarment and Suspension – Title 2 CFR part 376.

Certification Regarding Drug-Free Workplace Requirements – Title 45 CFR part 82.

Certification Regarding Lobbying – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).

Environmental Tobacco Smoke – Public Law 103-227.

Program Fraud Civil Remedies Act (PFCRA)

HHS Checklist (08-2007)