Preliminary Impact Statement

Department: **Elder Affairs**

REVIEW OF IMPACT ON YOUR DEPARTMENT FROM STATEWIDE DISASTERS

How has your department been affected by the disasters statewide?

Thirteen senior meal sites were impacted directly.

- Southeast AAA (1) -- Columbus Junction meal site is totally under water. They were able to empty the building before it flooded. The site did not prepare food onsite and served 6 people.
- Elderbridge AAA (6) -- Mason City Autumn Park most likely will be condemned; sites lost some food because of power outages. Gowrie lost freezer due to electrical storm.
- Northland AAA (1) -- Elkader meal site destroyed.
- Seneca AAA (1) -- Keosauqua is still under water.
- Hawkeye Valley AAA (1) -- Greene meal site destroyed and moved to new site; Iowa Falls site had water in basement- meal site still operational.
- Heritage AAA (3) -- Palo & Witwer meal sites are closed (ruined); New Horizons closed (totaled).

One Area Agency on Aging sustained severe damage.

- Aging Resources of Central Iowa (Des Moines) took on 4 feet of water in a flash flood June 5th, ruining carpet, walls, phones, and office equipment.

One Area Agency on Aging now has its largest contractor co-located with it.

- Heritage AAA (Cedar Rapids) has 17 employees from the Abbe, Inc working from its office in order to maintain basic nutrition and supportive services.

DEA redirected $20,000 to the affected AAAs.

How have the citizens you serve been impacted?

- Approx. 740 congregate meal participants had daily meal service interrupted; all now receiving meals at alternate temporary sites.
- Approx. 1400 home delivered meal participants had daily meal service interrupted; most received frozen meals or shelf-stable meals until regular service could resume.
- Based on FEMA application trends and county-level demographic data, approximately 94,000 Iowans over 60 are now in need of one or more of the following: housing, mental health, home care or other supportive service, clean-up, or case management services.

Best estimates on costs incurred to date. Include any concern on how the expenses may impact your fiscal year ’08 budget (ending 6.30.08)

- $20,000 redirected DEA funds.
- Approx. $3,000,000 in damaged and ruined meal site kitchens.
- No concerns about the impact on DEA's FY 08 budget. **However**, DEA will likely revert $250,000 to the Senior Living Trust Fund in unexpended Senior Living Program funds restricted to non-Medicaid case management (established in statute). This restriction must be removed in order to redirect current and future unexpended non-waiver case management funds to direct services, particularly where there are UNMET NEEDS.

MOVING FORWARD

What can your department do to help with recovery?

These item are in addition to the services that Area Agencis on Aging provide including, but not limited to:

- Ready-to-eat meals, home delivered meals, congregate meals and bottled water; temporary housing vouchers to prevent people from being placed in nursing homes; Chore Care to assist in the cleanup of damaged homes; Appliance replacement (washers/dryers); Personal Care items such as clothing, undergarments, soap, hair care, tooth brushes/paste shaving items; Durable medical equipment such as oxygen, supportive devices such as wheel chairs, canes, and walkers; Medical supplies for wound care, diabetes test kits etc.; Trained advocates for case management; Mental health counselors for on-going mental trauma experienced by constituents and staff; Home health and other medical and non-medical therapy; Funeral expenses; and, Family caregiver support and respite care.

Iowa's ADRC

- v The ADRC web-site LLL should be of tremendous value to the approximately 94,000 older adults impacted by the flood and their caregivers. This web site should also be a resource for those working with older adults within the DRC's. In Linn and Johnson Counties, options counselors will be available to assist in the recovery efforts.

NOTE: Additional funding would allow the expansion of options counseling into other hard hit counties.

National Family Caregiver Program:

- v The web site should be of value to caregivers and to those staffing the DRC's. Funding may be available to assist grandparents or older adults caring for a dependent child in need of services.

NOTE: Additional funding would allow for the purchase of additional direct services.

Legal Services:

DEA legal services development team and the Senior Legal Aid hotline has already seen an increase in contacts from Linn and Black Hawk counties on such matters and landlord-tenant disputes.

Elder Abuse Initiative:

- Where available, AAA's will be able to address issues related to abuse. In times of extreme stress and anxiety, elder abuse is likely to increase.

NOTE: Additional funding would be used to expand the elder abuse initiative into counties that do not currently have access, for example those in south central and south eastern Iowa.

Senior Internship Program:

- Additional federal funding would allow Senior Community Service Employment Program (SCSEP) workers to work additional hours throughout the year. In not for profits hit particularly hard by the flood, this may be of benefit.

Office of Substitute Decision Maker:

- There will be an increased need for this service and for public awareness related to powers of attorney, conservatorships, etc… This is particularly true as individuals displaced from their homes may need to seek alternate housing or facility based care.

Creative ideas to plan & implement recovery?

- Uncharted territory suggests more integration is need among health, human services, and housing services with FEMA, federal and state agencies. This is particularly needed in order to develop and deploy long-term housing, mental health, and community services for special needs populations.
- The State of Iowa needs a master calendar detailing phases of the recovery including target dates for tangible outcomes (no matter how big or small). That's important for planning, but also important psychologically. State and local leaders, as well as members of the public need to know that the recovery effort has traction and is moving rather than spinning its wheels.
- Targeted fundraising must be integrated with the Griswold commission. Donor-directed solicitation initiatives will maximize private fundraising. For example, I am preparing to raise funds from the National Council on Aging, AARP Foundation, and the National Association of State Units on Aging in order to support older Iowans with unmet needs. The same could happen with just about any sector of health and human services, infrastructure-related associations, and sectors of the economy.

Best estimate on long-term impacts affecting your department and/or the citizens you serve?

Mental Health:

- There will be a significant increase in mood disorders, anxiety disorders and adjustment disorders – 5 visits (brief solution focused therapy) would not be unreasonable, nor would 15% of the senior population impacted:94,000 x .15 x 5 x $225 cost/session = $15,862,500.00.

Housing:

- Of the roughly 25,000 FEMA applicants for housing assistance, nearly 40% are age 60 and older. There will need to be additional dollars for utility hookups, rent deposits, etc…

Services and Service Coordination:

- HVAAA has seen at 60% increase in case management and supportive services request of new clients (Waterloo and surrounding counties).
- AAAs estimates at least $14 million is needed to address unmet needs.

Transportation:

- There will most certainly be a need for additional funding as there will be an increased need to transport displaced individuals to and from medical appointments, grocery stores, etc… This will be particularly true in the Cedar Rapids area.

Nutrition:

- Damaged meal sites will need to be repaired and replaced. The cost will be substantial to replace physical plants, furnishings and lost program income. In addition, other costs, such as increased transportation costs and increased food costs (i.e. the floods are causing a spike in raw food prices).

Material Aid:

- This will probably be one of the largest categories of need and I'm not sure how we best calculate. Clearly, there will be a need for home modification; chore services (clean up of debris, sanitation, yard work, etc…).

Needs you may have for changes in Administrative Rules or Code?

- DEA will likely revert $250,000 to the Senior Living Trust Fund in unexpended

Senior Living Program funds restricted to non-Medicaid case management (established in statute). This restriction must be removed in order to redirect current and future unexpended non-waiver case management funds to direct services, particularly where there are UNMET NEEDS.

How can your agency help leverage and/or receive federal $$ assistance?

- DEA received a grant of $50,000 from the US Administration on Aging June 23 to help provide for: Ready-to-eat meals, home delivered meals, congregate meals and bottled water; temporary housing vouchers to prevent people from being placed in nursing homes; Chore Care to assist in the cleanup of damaged homes; Appliance replacement (washers/dryers); Personal Care items such as clothing, undergarments, soap, hair care, tooth brushes/paste shaving items; Durable medical equipment such as oxygen, supportive devices such as wheel chairs, canes, and walkers; Medical supplies for wound care, diabetes test kits etc.; Trained advocates for case management; Mental health counselors for on-going mental trauma experienced by constituents and staff; Home health and other medical and non-medical therapy; Funeral expenses; and, Family caregiver support and respite care.

- The US Administration on Aging is working very closely with DEA to prepare the federal aid request needed for older adults. The figures at the end of this report are continually reviewed by Regional AoA staff. In addition, AoA has provided formula-based spreadsheet used successfully by Texas after Katrina to assist Iowa DEA with its federal aid request.
- Iowa DEA is working with AoA to obtain FEMA material aid to begin repairing senior meal site kitchens
- Iowa DEA has applied and may well receive the names and contact information of FEMA applicants 60+ which will enable local AAAs to address individual unmet needs not covered by FEMA individual aid – the resulting documentation will help DEA build an evidence-base request for additional *long-term* federal funding.

BEST PRACTICES

Suggestions from your department, colleagues or other interested parties

- Twice/week conference calls with Area Agency on Aging directors providing updates and gathering data. These include guests from various aspects of the FEMA JFO, as well as guest from the US Administration on Aging. Constant communication with local aging services provides is essential and has helped them stay focused and effective.
- All AAAs in affected regions published disaster response and preparedness articles in this month's news letter.
- All AAAs have employees working in nearly all DRCs to assist older adults with the complicated FEMA application process.
- 3 AAAs canvassed shelters with fliers directing people to services for older

adults.

- Heritage AAA utilized the HPAA waiver to provide case management client lists to the NG prior to canvassing neighborhoods
- The US Administration on Aging send an experienced disaster specialist (been through 9 major disasters) from Florida to Iowa for 2 weeks to assist the DEA and affected AAAs with response, recovery and FEMA processes.
- DRCs, CRs, VAL reps, and Housing liaison tied directly into DEA and the affected AAAs.
- Implemented and EMAC agreement to recruit seven aging services professionals (from the FL Dept. of Elder Affairs) to serve as community responders in Cedar Rapids. These individuals are experienced in hurricane response and recovery efforts.
- US Administration on Aging team conducted supplemental field assessments for the Iowa DEA and *trained* local AAA employees on FEMA processes.

OTHER COMMENTS

Additional comments not addressed above

Canvassing Area Agencies on Aging and conducting our own projections the need for federal assistance for older Iowans will be substantial. Preliminary costs for the next 12 months follow:

DRAFT --IOWA AAA FEDERAL AID REQUEST TOTALS:

Home Repair and Clean Up:	$3,169,268.00
Direct Service and Service Coordination:	$1,640,576.00
Nutrition:	$100,390.00
Mental Health Services:	$212,949.00
Ongoing MH (94,000 x .15 x 5 x $225)	$15,862,500.00
Transportation:	$154,030.00
Legal assistance/outreach	$204,228.00
Home Relocation:	$311,250.00

Temporary Office Accomm.	$64,572.17
Kitchen Equipment replacement/ Meal Site Repair	$2,020,000.00
Follow Up Services	$165,058.00
Material Aid:	$100,000.00
SUBTOTAL (w/o MH)	$8,142,321.17
SUBTOTAL (w/ MH)	$24,004,821.17
Including estimates from the following affected Area Agencies on Aging: Aging Resources of Central Iowa, Hawkeye Valley AAA, Heritage AAA, Elderbridge AAA, Northland AAA, Seneca AAA, and SE Iowa AAA.	

State Data Center of Iowa and the Iowa Department of Elder Affairs

OLDER IOWANS: 2008

Older Americans Month originated with a presidential proclamation in May 1963 and has been proclaimed by presidents each year since. Last year, President Bush stated, "Older Americans teach us the timeless lessons of courage, sacrifice and love. By sharing their wisdom and experience, they serve as role models for future generations. During Older Americans Month, we pay tribute to our senior citizens and their contributions to our nation."

438,448

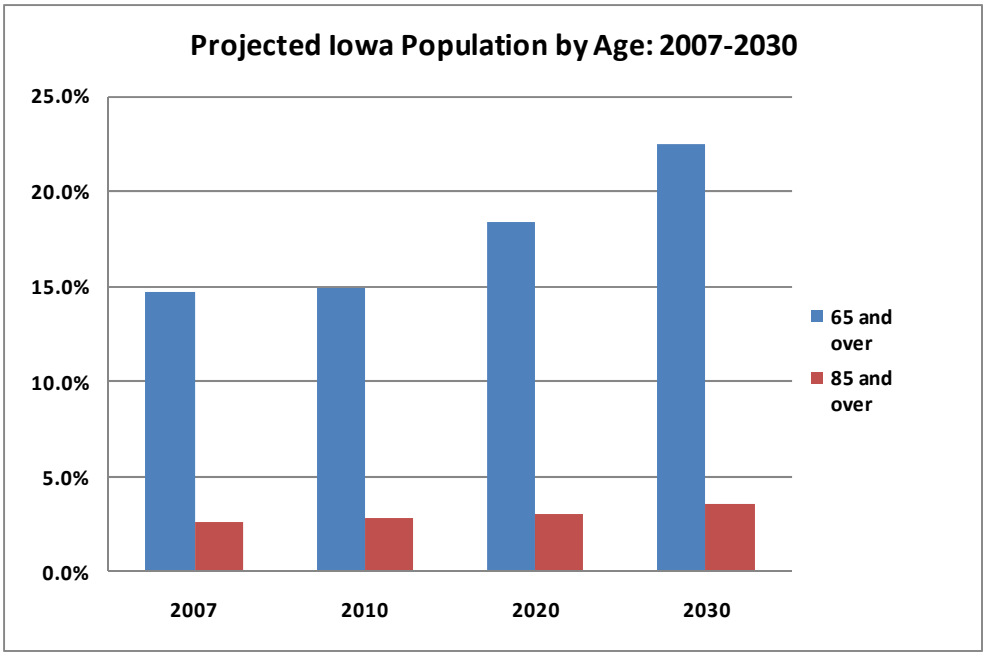
The estimated number of people age 65 and over in Iowa on July 1, 2007. This age group accounted for 14.7 percent of the total population. Between 2006 and 2007, the size of this age group increased by 3,190 people.

256,054

The estimated number of women age 65 and over in Iowa on July 1, 2007. This age group accounted for 58.4 percent of the total population 65 and over. The estimated number of women age 85 and over on July 1, 2007 was 53,970. This was 69.7 percent of this age group.

663,186

The projected population age 65 and older in Iowa in the year 2030. According to the U.S. Census Bureau, this age group will constitute 22.4 percent of the states's total population at that time. In 2000 Iowa ranked 4th in the percentage of population age 65 and older. In 2030 it is projected that Iowa will rank 12th.



Families and Children

62.9%

Percentage of people in Iowa age 65 and older in 2006 who were married.

14,436

The number of children under 18 who are being cared for by a grandparent in Iowa.

31.3%

Percentage of Iowans age 65 and older in 2006 who were widowed.

EDUCATION

78.3%

Percent of people age 65 and older in 2006 with at least a high school diploma. The percent of all Iowans age 25 and over with at least a high school diploma was 88.9%.

13.8%

Percentage of the population age 65 and older in 2006 who had earned a bachelor's degree or higher education. The percent of all Iowans age 25 and over who had earned a bachelor's degree or higher was 24.0%.

VOTING

83.5%

Percentage of Iowans age 65 and older registered to vote in the 2004 presidential election, the highest rate of any age group. 76.8 percent of people in this age group reported actually casting a ballot.

21.4%

Percent of the votes cast by citizens age 65 and older in the 2004 election.

MIGRATION

98.8%

Percent of Iowans age 65 and over who either stayed in their own home or moved within the state between 2005 and 2006. This can be compared to 96.6% for the state as a whole.

75.9%

Percent of Iowans age 65 and over in 2006 who were born in Iowa. The percent of all Iowans born in the state was 72.3%.

5,127

The number of people age 65 and over who moved into the state of Iowa between 2005 and 2006. This represented only 5.2% of all the people who moved into the state during that time.

Living Arrangements

29.6%

Percent of Iowans age 65 and over who lived alone in 2006.

INCOME AND POVERTY

$28,544

Median 2006 income of households with householders 65 and over. The median income for all households in Iowa in 2006 was $44,491.

8.7%

Poverty rate for people 65 and older in 2006, compared to 11.0% for all Iowans.

419,018

The number of 2006 social security beneficiaries aged 65 or older in Iowa. This group collected $424,138,000 total monthly benefits.

Data provided by the Social Security Administration publication "OASDI Beneficiaries by State and County"

http://www.ssa.gov/policy/docs/statcomps/

Coming to America

8,565

The number of Iowans in 2006 age 65 and over who are foreign born.

COUNTIES AND CITIES

44,917

The number of people age 65 and over in Polk County, making it the largest population of this age group in any county in 2006.

23.6%

The percent of total population in Ringgold county who are age 65 and over in 2006. Other Iowa counties with a high percentage in this age group are Sac (22.7%), Monona (22.6%), Pocahontas (22.6%) and Adair (22%).

28.0%

Over a quarter of Iowans age 65 and over in 2005 lived in Polk, Linn, Scott, Black Hawk and Dubuque counties.

75

The number of Iowa counties with a decrease in the population age 65 and over between 2000 and 2006.

24,559

The number of people age 65 and over in Des Moines, making it largest population of this age group in any Iowa city in 2000.

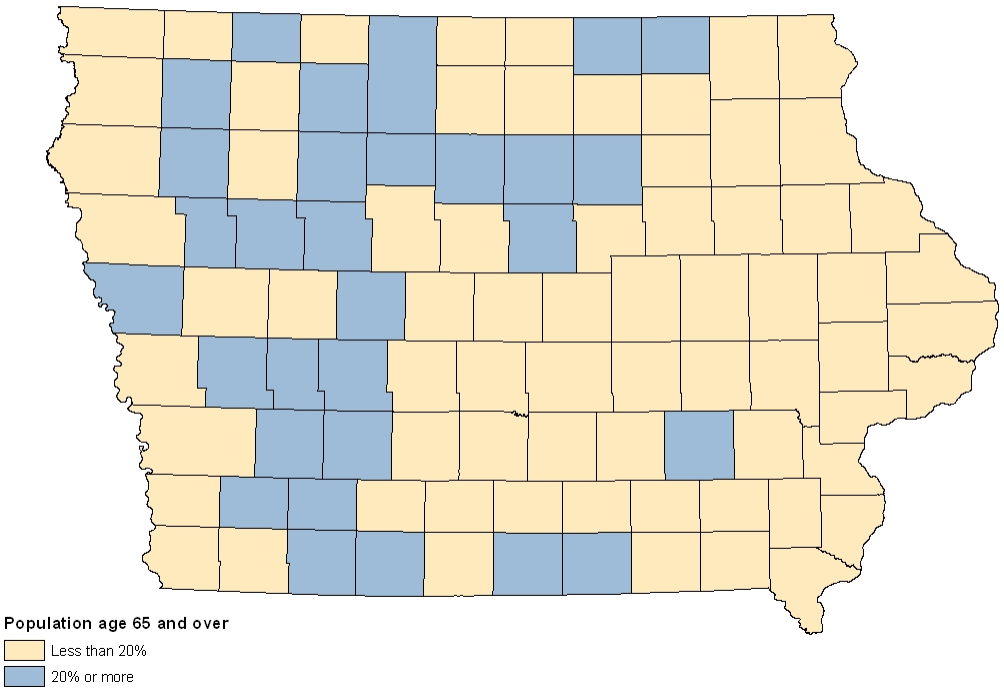
90.9%

The percent of total population in Beaconsfield who were age 65 and over in 2000. Other Iowa cities with a high percentage in this age group were Athelstan (55.6%), Berkley (45.8%), Elk Horn (42.4%) and Littleport (42.3%).

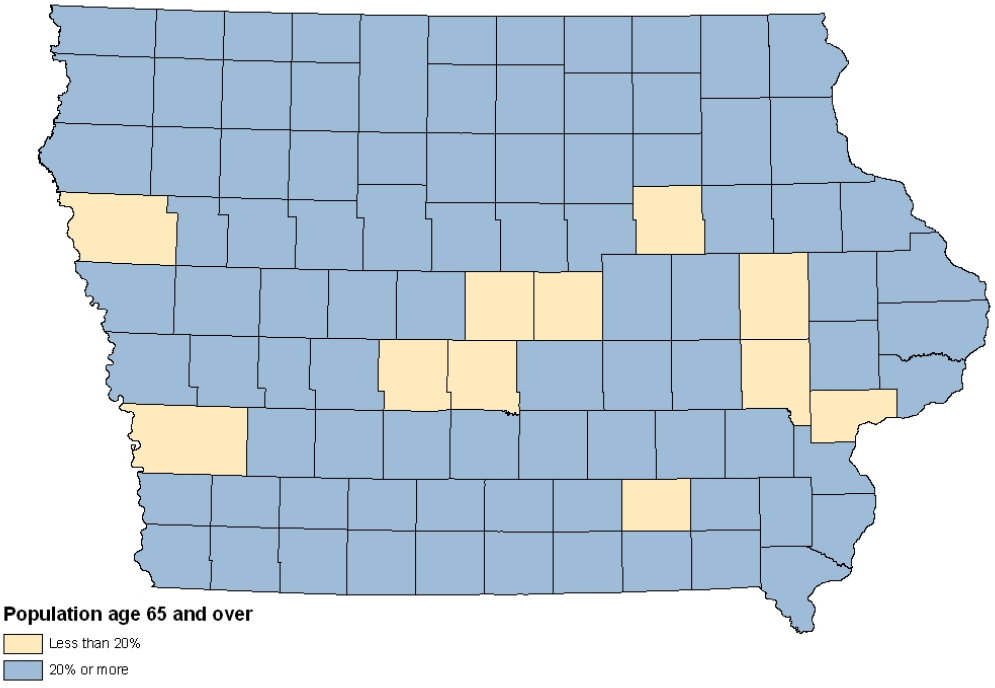
21.0%

The percent of the total population age 65 and over in 2000 who lived in Des Moines, Cedar Rapids, Davenport, Sioux City and Waterloo.

2000



2030



88

The number of Iowa counties in 2030 in which at least 20% of the residents will be age 65 and over according to Woods & Pool Economics, Inc. In 2000 that number was 30.

State Data Center of Iowa a program of the State Library of Iowa

Miller Building
1112 E. Grand
Des Moines, Iowa 50319
Phone: 800-248-4483
Fax: 515-242-6543
Email: census@lib.state.ia.us

We're on the web!
www.iowadatacenter.org
www.state.ia.us/elderaffairs

Iowa Department of Elder Affairs

Jessie M. Parker Building
510 E 12th Street, Suite 2
Des Moines, IA 50319
Phone: 800-532-3213
Fax: 515-725-3300
Email:
Danika.Rosales@iowa.gov

Data Source (unless otherwise noted) :
U.S. Census Bureau,
U.S. Decennial Census 1970,1980,1990 and 2000
American Community Survey, 2006
Photos by:
the U.S. Census Bureau

EMPLOYMENT

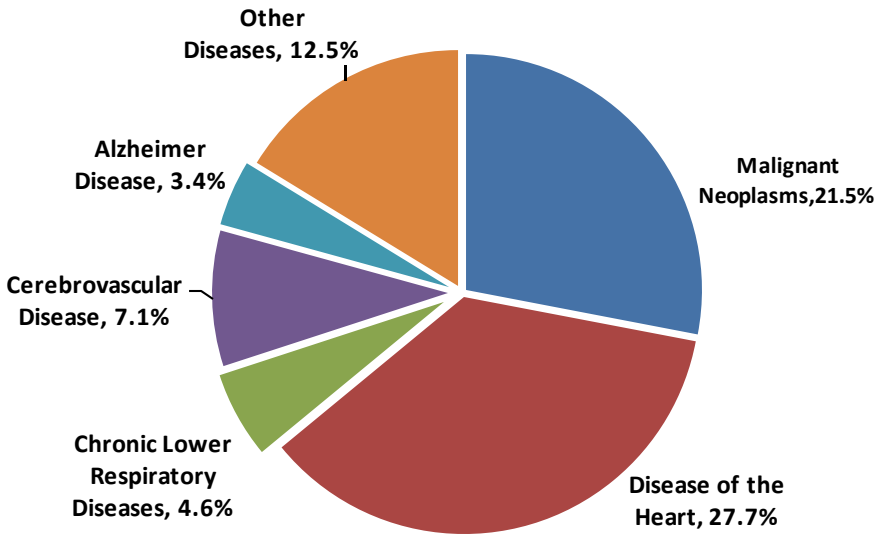
77,856
Number of Iowans age 65 and older in 2006 who are in the labor force.

3.4%
The unemployment rate in 2006 for Iowans age 65 and over.

Serving Our Nation
107,280
Estimated number of people in 2006 age 65 and older in Iowa who are military veterans.

VITAL STATS

Leading Causes of Death for Iowans Age 65 and Over: 2006



DISABILITY

146,398
The number of Iowans in 2006 age 65 and over with at least one type of disability.

36.8%
The percent of Iowa veterans age 65 and over with a disability.

At a Glance

Type of Disability:
Population 65 and over

	2006
Sensory	60,196
Physical	104,683
Mental	35,120
Self-care	27,308
Go-outside-home	49,112

Leading causes of death for all Iowans: 2006

Disease of the heart—26.2%
Malignant Neoplasms-23.2%
Cerebrovascular-6.3%
Chronic lower respiratory-6.1%
Unintentional injuries-4.2%
Influenza and Pneumonia-2.8
Other-31.2%

Public Health Preparedness

Thomas Newton, Director
Iowa Department of Public Health

PROTECT IOWA HEALTH

1

Introduction and Overview

- Role of public health in a disaster
- Preparedness phase
- Response phase
- Recovery phase
- After action reports and improvements

2

Role of Public Health in a Disaster

- **Promote and Protect the Health of Iowans**
  - Disease prevention and control (infectious, environmental, chronic)
  - Access to health care
  - Environmental health
  - Community health
  - Behavioral health
  - Injury prevention
  - Resource coordination and management

3

Response to Floods 2008

- **Disease Prevention & Control**
  - Outbreaks of infectious disease rare after tornados and floods
  - Personnel protective measures
  - Immunization
  - Call center at IDPH
- **Access to Health Care**
  - Maintenance of hospital critical infrastructure
  - Evacuation of hospital and transfer of patients
  - Deployment of instate DMAT members to staff mobile health care facility and shelters

4

Response Phase

- **Environmental Health**
  - Clean drinking water, sampling
  - Safe food
  - Air quality, carbon monoxide
  - Sanitation standards
- **Community Health**
  - Assessments and public health teams responded to six counties

5

Response Phase

- **Behavioral Health**
  - Public information and education
  - Collaboration with Department of Human Services and Critical Incident Stress Management (CISM) Team
  - Special needs facility displaced, found alternate housing
- **Injury Prevention**
  - Surveillance – hospitals, clinics

6

Response Phase

- **Resource Coordination & Management**
  - Staffing at the State Emergency Operations Center (SEOC) and IDPH's Emergency Coordination Center (ECC)
  - Incident Management Structure
  - Communication and Alerting – Health Alert Network (HAN), 800 MHz radios
  - Regularly scheduled conference calls with affected counties

7

Response Phase

- **Resource Coordination and Management cont….**
  - Deployment of Mobile Health Care Facility (MHCF) and in-state Public Health Response Teams
  - Emergency Management Assistance Compact (EMAC) – Florida, North Carolina
  - Moved vaccines, human resources, medical patients
  - Fact sheets, media, public education
  - Incident action plans

8

Recovery Phase

- **Disease and Injury Prevention & Control**
  - Continued public information and education
  - PPE for debri removal and clean-up
  - Ongoing immunization work
  - Vector surveillance (mosquito) and abatement
  - Carcass removal, health risks
- **Community Health**
  - Ongoing technical assistance

9

Recovery Phase

- **Environmental Health**
  - Sanitation & safety for cleanup workers and citizens
  - Ongoing water sampling
  - Ongoing air quality monitoring
  - “Healthy home” recommendations
  - Continued collaboration with federal, state, and local partners

10

Recovery Phase

- **Access to Health Care**
  - Focused effort to place citizens from shelters in longer term housing
- **Behavioral Health**
  - Focused prevention interventions to reduce stress
  - Public information and education regarding stress, general well being, substance abuse

11

Recovery Phase

- **Resource Management & Coordination**
  - Deployment of on-site technical assistance as needed
  - Formulating after action follow-up and improvement plans
  - Downsizing incident management structure, focus on returning to business “normal”

12

The Way Forward

- Public messaging: accurate, timely, and consistent
- Sheltering: mass care vs. medically fragile and special needs
- Workforce availability, assistance at both local and state level

13

The Way Forward

- Disease and injury prevention and control
  - Mosquito surveillance and abatement
  - Public messaging
- Environmental health
  - Mold, well water testing, air quality, debris removal
- Community health
  - Follow-up on community health needs assessments

14

The Way Forward

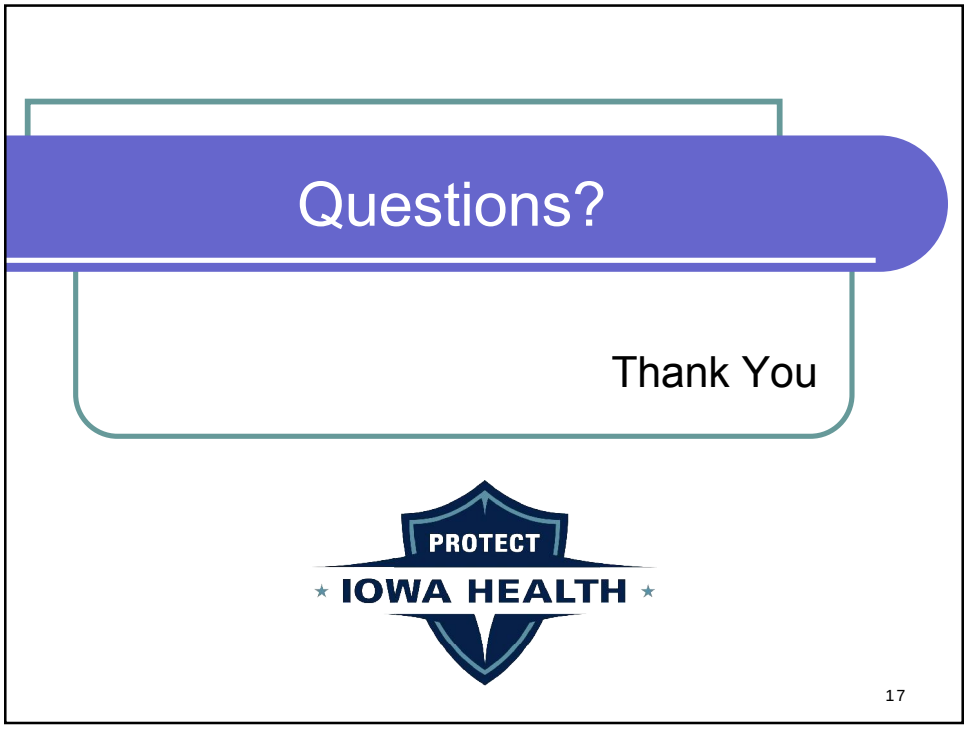
- Behavior health
  - CISM involvement and stress reduction
  - Substance abuse prevention
- Resource coordination and management
  - Addressing current preparedness activities while recovering from disaster – meeting performance expectations
  - Coordination of After-Action-Report (AAR) with local, state, and federal partners
  - Develop and implement improvement plan

15

Severe Weather Response – 2008 Summary

- Review handout

16


Questions?
Thank You
PROTECT
IOWA HEALTH
17

Iowa Department of Public Health
Response to Severe Weather – 2008

* Summary of Facts *

- 77 Department staff directly involved with response
  - Staffing at State Emergency Operations Center (SEOC) 24/7 for 4 weeks
  - IDPH Emergency Coordination Center (ECC) 24/7 for 6 weeks
  - Public Health Nursing staff at emergency shelters
  - On-site technical assistance to local public health agencies

- 55 Medical volunteers from 5 in-state Disaster Medical Assistance Teams (DMAT) deployed to 2 counties to assist with medical care to displaced residents

- Volunteers from private business deployed as Logistical Support Response Team (LSRT) to assist with set-up and operations of the Mobile Health Care Faculties (MHCF)

- 11 Environmental Health Response Teams (EHRT) comprised of 21 Environmental Health specialists deployed to 6 counties to assist with community assessments
  - Tested 50 out of 200 sandpoint wells in high risk areas, county continues testing, however water quality better than expected for a normal year

- 9 Public Health Response Teams comprised of 27 Public Health specialists deployed to 5 counties to assist with community assessments

- 26 Environmental Health and Public Health specialist from Florida and North Carolina deployed to Iowa to provide assistance through the Emergency Management Assistance Compact (EMAC)

- 200 plus displaced residents were cared for in 2 emergency shelters in Cedar Rapids for 3 weeks
  - Medical care provided by DMAT members and Public Health Nurses

- Mobile Health Care Facility (MHCF) deployed to Black Hawk County
  - Self contained facility (electricity, heat, AC, showers, toilets, etc.)
  - 6 interconnected structures erected
  - Ability to provide care for up to 50 patients

- 183 patients evacuated from one flood affected hospital
  - Patients transferred to 22 different hospitals across Iowa
  - 27 volunteer ambulances from 14 communities
  - 10 military ambulances (Humvee)
  - All patients evacuated in under 8 hours

- 38,520 doses of tetanus vaccine provided over 4 weeks
  - 16,170 doses of tetanus vaccine provided for entire year in 2007

- Vector control: mosquito trapping done by local officials and ISU Medical Entomology Department late June and early July
  - Flood water mosquitoes abundant, however these mosquitoes usually do not usually transmit WNV
  - 7 sentinel chicken flocks stationed in Black Hawk, Dubuque, Linn, Polk, Pottawattamie, Scott, and Woodbury (routine for WNV program). Mosquito testing (by way of trapping) occurs in same seven counties plus Story County every week
  - Iowa has one confirmed case of WNV, last year there were a total of 30 confirmed human cases
  - Initial trapping of mosquitoes was required prior to applying for FEMA reimbursement for surveillance and control measures. This was done in five counties; this requirement has now been waived.

Iowa Department of Public Health
Division of Behavioral Health

Frequently Asked Questions About Coping with Stress After a Disaster

Overview: Recent storms and rainfall have caused flooding throughout Iowa. Certain communities have also been impacted by tornados. While the immediate crisis will stabilize, many Iowans face long hours of clean-up and disaster recovery. This fact sheet answers questions about how to cope with emotional stress related to disaster and disaster recovery.

What should I know about disaster and stress?
No one who witnesses a disaster is untouched by it. In the middle of the crisis, it's normal to be anxious about your safety and the safety of your family and friends. It is also normal to be worried about your property. As the crisis passes and recovery begins, you may begin to wonder about the impact on work or school and the community around you and on your daily activities. You may face many frustrations as you try to get things back to normal. It is important to believe that you will get through this. It helps if you follow a few basic tips to manage your stress.

What should I do to take care of myself and support others?
Different people react in different ways -- there is no one right way to feel or to respond to disaster! Taking care of yourself is the right thing to do for yourself and for those who count on you. Here are things to do:

- Watch out for emotional exhaustion or strain. Signs may include:
  - general anxiety or nervousness
  - feeling numb or having difficulty communicating thoughts/feelings
  - confusion or difficulty concentrating
  - limited attention span
  - becoming easily frustrated or irritable
  - feeling depressed or crying easily
  - poor work performance
  - physical problems like increased heart rate/blood pressure, headaches, stomach problems, or cold/flu symptoms

- Spend time with family and friends. If your normal supports are not available, do not hesitate to turn to:
  - community health centers
  - mental health organizations
  - substance abuse counselors
  - 12-Step or other self help groups
  - your church, mosque, synagogue, or clergy

- Resume a normal sleep schedule as quickly as possible. Get plenty of rest and take frequent rest breaks before exhaustion builds up.

- Pay attention to any change in your use of alcohol and/or drugs. Avoid increasing your use. Continue to take prescription medications as prescribed.

- Set priorities for clean-up and recovery. Pace yourself to avoid physical or mental exhaustion.

- Take advantage of disaster relief programs and services in your community. Learn as much as you can!

Iowa Department of Public Health
Division of Environmental Health

Frequently Asked Questions About Cleaning Flooded Basements

Overview: Recent storms and rainfall have caused flooding throughout Iowa. As residents clean out their flood-damaged homes, the Iowa Department of Public Health has received many questions. This fact sheet answers those questions and others related to basement clean-up after a flooding event.

What should I do before entering a flooded basement?

1. Turn off the electricity, preferable at the meter. If you cannot safely turn it off, contact your utility company to have it disconnected.
2. Turn off all gas valves.
3. Check outside cellar walls for possible cave-ins, structural damage, or other hazards.
4. Open doors and windows, or use blowers to force fresh air into the basement. Gas may be trapped inside your home.
5. Wear rubber gloves when handling materials that have been in floodwater.
6. Get a tetanus shot if necessary.

What should I know before pumping water out of my basement?

Do not use an electric pump powered by your own electrical system. Instead, use a gas-powered pump or one connected to an outside line.

More damage may be done by pumping water from the basement too soon or too quickly than from letting the floodwater remain. Water in the basement helps brace the walls against the extra pressure of water-logged soil outside. If water is pumped out too soon, walls may be pushed up or collapse.

To help prevent structural damage, pump water out of your basement in stages. Remove about one-third of the water each day. This will prevent structural damage or collapsing of basement walls due to unequal pressure.

What about the clean-up process?

- Shovel out any mud and debris while it is still moist.
- Hose down walls and remove as much silt as possible before it dries.
- Floors and walls may need sanitizing, particularly if sewage has entered the basement.
- Scrub walls and floors with a mild bleach and water solution (one tablespoon of bleach to one quart of water). Allow the area to dry completely.
- In homes without basements, the area below the floor may be completely filled with mud. Remove the mud as soon as possible to avoid rotting joists or foundation wood.

Iowa Department of Public Health
Bureau of Disease Prevention and Immunization

Tetanus

During times of flooding people are often reminded to receive a booster dose of tetanus- containing vaccine even though flooding is not shown to be a risk for tetanus. Tetanus infection (lockjaw) can occur with a wound which breaks the surface of the skin; in particular, puncture wounds or deep cuts can result in infection. There are two types of vaccine that are routinely used for a tetanus booster dose: tetanus diphtheria (Td) or tetanus, diphtheria, pertussis (Tdap) vaccine.

Prior to the administration of Td/Tdap vaccine, the individual's vaccination history should be reviewed.

- Screen the patient for a primary series (3 doses) of tetanus, diphtheria containing vaccine. A booster dose of Td vaccine should be given every 10 years. Tdap is approved for a single dose at this time (e.g., it should not be used for all the doses of Td). Tdap vaccine is licensed for individuals from 10 through 64 years of age.
- If an injury occurs, the following is recommended:
  Persons with wounds that are neither clean nor minor, and who have had 0–2 prior doses of tetanus toxoid or have an uncertain history of prior doses should receive tetanus immune globulin (TIG) as well as Td toxoid. Early doses of toxoid may not induce immunity, but only prime the immune system. The TIG provides temporary immunity by directly providing antitoxin. This ensures that protective levels of antitoxin are achieved even if an immune response has not yet occurred.

Tetanus Wound Management

	Clean, minor wounds		All other wounds	
Vaccination History	Td*	TIG	Td*	TIG
Unknown or less than 3 doses	Yes	No	Yes	Yes
3 or more doses	No†	No	No**	No

* Tdap may be substituted for Td if the person has not previously received Tdap and is 10 years or older
† Yes, if more than 10 years since last dose
** Yes, if more than 5 years since last dose

Hepatitis A

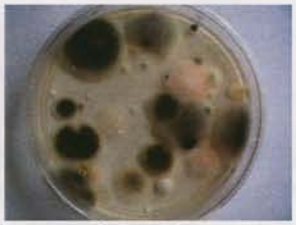
Hepatitis A outbreaks have not been associated with floods and vaccination is not recommended. Hepatitis A is transmitted by consuming food or water that has been contaminated by feces.

Iowa Department of Public Health
Division of Environmental Health

Frequently Asked Questions about Mold

Overview: Mold is a natural part of the outdoor environment. Mold is present in outdoor air at some level throughout the year. In order for mold to grow indoors, there must be a significant source of water, moisture or humidity. Mold is found through simple visual inspection. Once a mold problem is identified, the first step to solving the problem is to get rid of the moisture. Once the moisture problem is solved, the mold can be cleaned or removed. Homeowners can use a mild household detergent and water solution to clean mold off of non-porous surfaces. For porous surfaces, it is recommended that items are removed, discarded and replaced.

What are the health effects from exposure to mold?



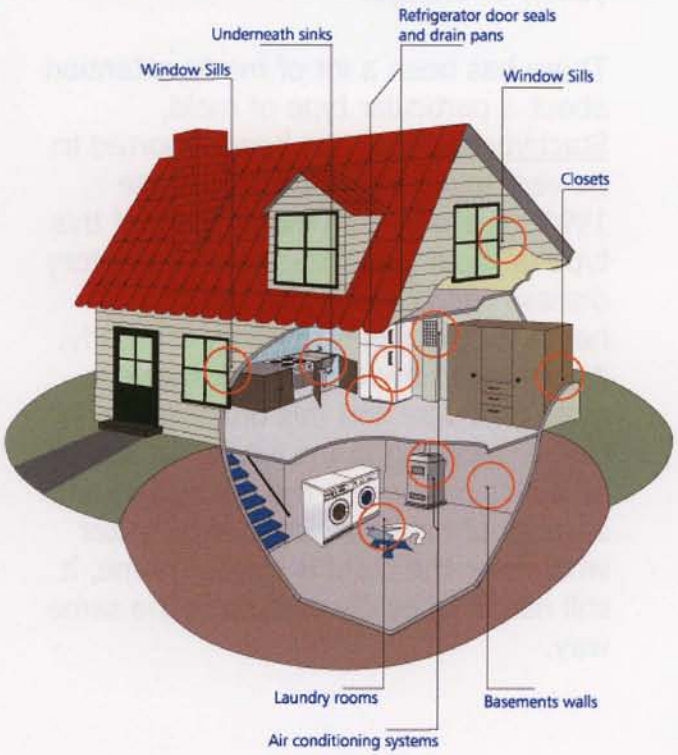
In general, mold only causes an allergic reaction. Symptoms of an allergic reaction are itchy or watery eyes, runny nose, sinus drainage, respiratory discomfort and cough. According to the Centers for Disease Control and Prevention, about 50% of the population of the United States is allergic to mold. If you are NOT allergic to mold, there will be NO health effects from exposure. If you ARE allergic to mold, your reaction depends on the sensitivity of your allergy.

How do I know if I have a mold problem?

Mold problems are ALWAYS caused by a moisture or water problem. It does no good to clean up the mold, if you haven't solved the water issue first. Environmental professionals "inspect" for mold through simple visual examination. There is no special state of Iowa training or certification for mold inspectors.

Where should I look for mold?

Most homeowners can tell if they have a mold issue in their home. Simply look for mold in places where there may be water issues (under sinks, in laundry rooms, kitchens, bathrooms, where a roof has leaked, in the basement, etc.) Very simply, if you see mold in your home, you have mold. If you don't see mold in your home, you probably don't have mold.



I have mold in my home and I want to have it tested, what should I do?

The Iowa Department of Public Health does **NOT** recommend testing for mold for several reasons:

1. Mold is a natural part of our environment.
2. Mold is present at some level in outdoor air throughout the year.
3. It is very difficult, even for professionals, to get meaningful test results for mold.
4. Mold testing is very costly.
5. There are no regulatory levels or guidelines for comparing results.

There is black mold in my home, What if it is the toxic kind you see on TV?

There are thousands of different types of mold in the environment that come in a variety of colors. Just because a mold is black does not mean that it is any more or less toxic than mold that is green, blue, yellow or orange.

There has been a lot of media attention about a particular type of mold, Stachybotrys that has been reported to be very toxic. In the middle to late 1990's there was an indication that this type of mold was linked to a respiratory disease called acute idiopathic hemorrhagic airway disease. Currently, it is believed there is no link between mold exposure and this disease, which causes bleeding in the lungs. In reality, all molds may cause the same type and severity of health reaction. No matter what color the mold is in your home, it still needs to be cleaned up in the same way.

I've identified the area covered in mold, how do I clean it up?

It depends on the type of material that the mold is growing on. If the material is **non-porous** (it **will not** absorb water) such as a concrete, tile or vinyl flooring, plastic patio furniture, plastic toys, tub surrounds, paneling, molding, etc., use a mild household detergent solution to wipe away the mold. If it is a **porous** surface (it **will** absorb water) such as drywall, carpeting, furniture, bedding, clothing, stuffed animals, books, etc., remove, discard, and replace the items or surfaces the mold is growing on.

What if the mold is trapped behind a wall, in a crawl space or in the attic?

In order for there to be mold behind a wall, in a crawl space or attic, there would have to be a water, moisture, or humidity problem to feed the mold. Most likely if the mold is behind the walls or in the attic, you are not being exposed to it, so there should not be a problem. If the water problem persists in the area, the mold will eventually work its way through the wall, ceiling, or floor and become obvious.

The best way to check for mold is through visual inspection, or looking for it. If there is access to an area behind the wall or in the attic, use a flashlight to look for the mold. If not, the only way to determine if there is mold would be to cut a hole and look. This is typically not recommended.

For More information contact:

Sara Colboth, Health Educator
Iowa Department of Public Health at
(515) 281-5894

Iowa Department of Public Health
Division of Environmental Health

Return Home Safely!

Safety Recommendations for Returning to your Home after a Flood

Follow the directions of your local authorities when preparing to return home. DO NOT return home until local authorities tell you it is OK to re-enter your property.

Do not enter homes and buildings until you are sure there is no structural damage.

Remove mold and debris from your home or building before allowing children, older adults, pregnant women, persons who are sick, and pets to reenter.

Turn the power off before entering a flooded home or building. Never turn power off or on if you are standing in water.

If you smell gas, or hear the sound of escaping gas, leave the building immediately. Do not use cell phones, matches, lighters, or electrical equipment inside the building. Call emergency officials for help and wait for clearance before reentering.

Open all windows and doors as soon as you enter the building. Then exit the building and do not reenter until it has aired out for 30 minutes.

Gas generators and pressure washers give off deadly gases you cannot smell or see. NEVER operate gas generators or pressure washers inside a house, garage or other enclosed areas; or near doors, windows, air conditioning units, or vents. If you feel sick or dizzy, go outside to fresh air immediately.

Dry out buildings as soon as possible. Open windows and doors and use fans or dehumidifiers to remove moisture.

Use fans to dry out buildings after cleaning. Put fans in windows blowing out so mold won't spread inside the building.

Never mix household cleaners. Mixing bleach and ammonia generates toxic fumes that can make you sick.

Throw away wet materials that can't be thoroughly cleaned and dried, such as fabric furniture, mattresses, carpeting, stuffed animals and baby toys.

Remove standing water in buildings as soon as possible. Limit your contact with flood water and avoid any direct contact with gasoline contaminated water. Gasoline on skin may cause rashes.

Limit your exposure to mold. Wear an N-95 respirator, goggles, rubber gloves, and rubber boots while working in wet and moldy areas. N-95 respirators are masks that cover the nose and mouth and filter particles in air, including mold and dust. They can be bought at local hardware stores.


N-95 Respirator

Molds can produce mold spores. Breathing mold spores can cause coughing, congestion, runny nose, burning eyes, headaches, sneezing, sore throat, and can make breathing problems, like asthma, worse. Children, pregnant women, the elderly and people with weak immune systems may be more sensitive to mold. Talk to your doctor about any health concerns you may have.


N-95 Respirator

Wash your hands and remove your clothes before removing your mask and goggles.

Keep all cleaning products locked, out of site and out of reach of children. In case of poisoning call the Poison Control Center at 1-800-222-1222 immediately.

Iowa Department of Human Services
Division of Mental Health and Disability Services

Mental Health Presentation to Rebuild Iowa Task Force

Urbandale Public Library

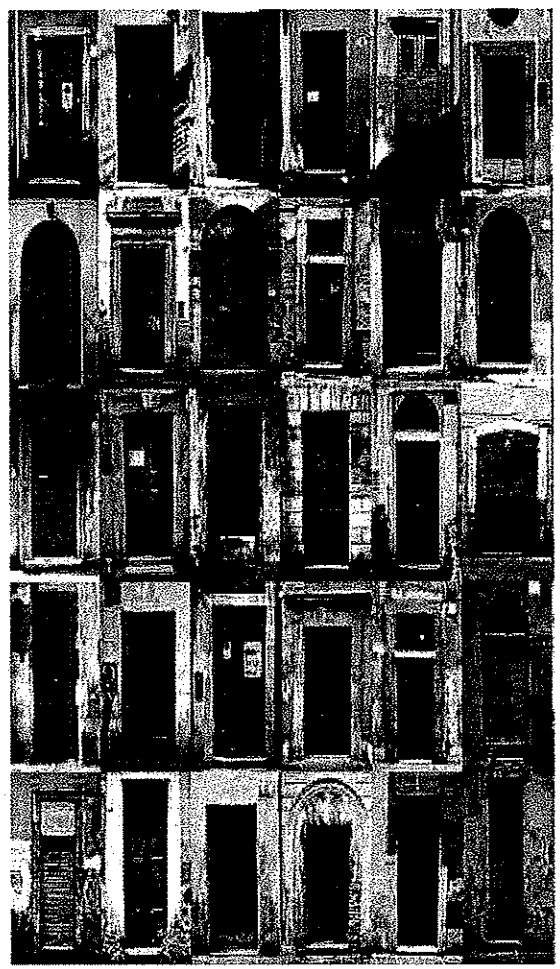
August 6, 2008

Meeting Handouts

Allen Parks, EdD, MPH
Administrator/Director
Mental Health & Disability Services Division

515-281-0377
email: aparks@dhs.state.ia.us

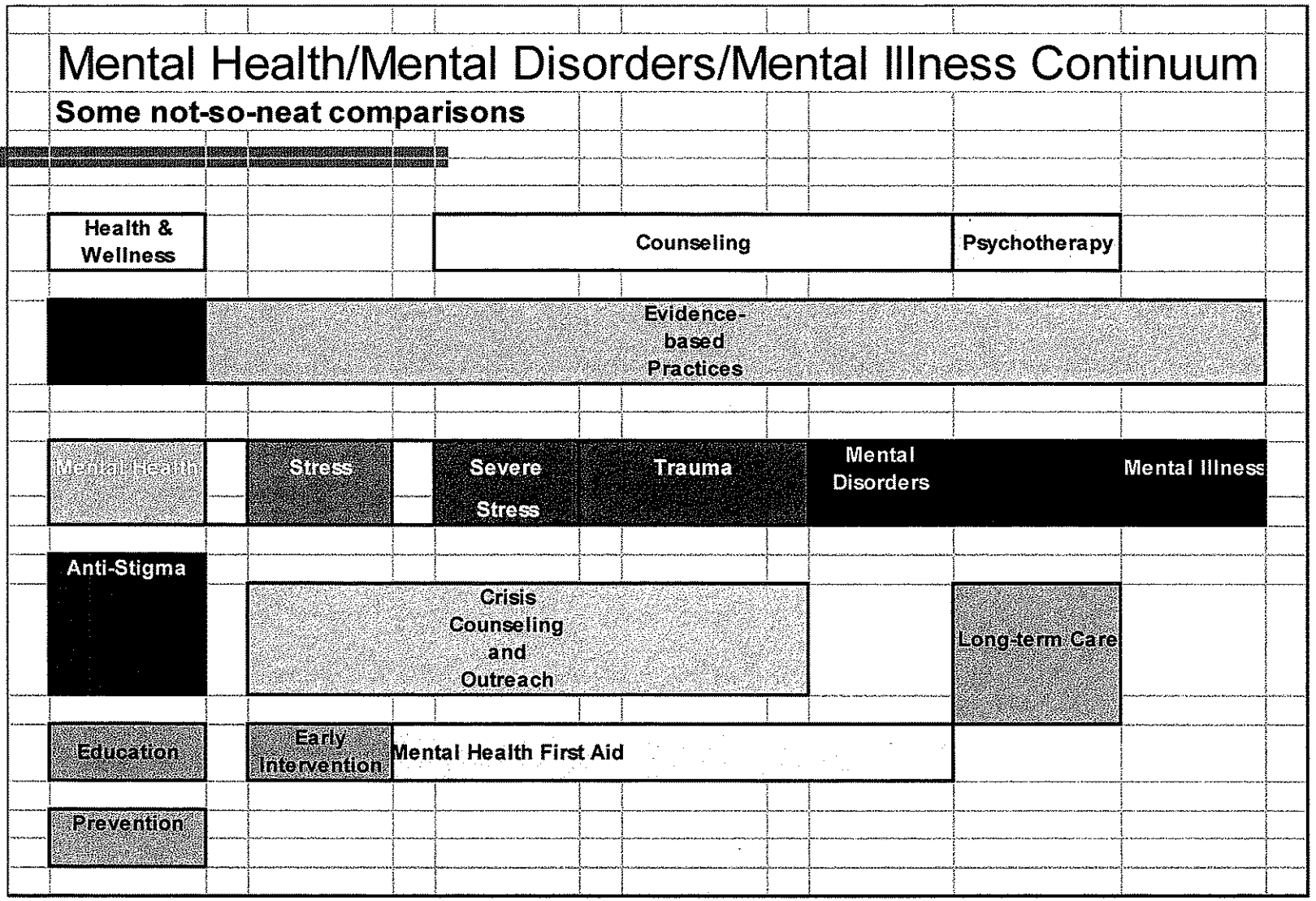
Iowan's should not have to enter multiple doors to find effective treatment



The safe and effective management of mental health emergencies is a very important component of a comprehensive system of services to individuals with mental illness and their families. Often, this is the point of entry to treatment, and frequently, it is a time of distress and turmoil. Good quality care at this point prepares a path for recovery and constitutes a critical opportunity to effect both immediate and long term benefits.

Mental Health/Mental Disorders/Mental Illness Continuum

Some not-so-neat comparisons



KEY CONCEPTS on Disaster Mental Health

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma-individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Most people do not see themselves as needing mental health services following disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

Response "Phases"

- Phase 1: Pre-disaster
  - Fear and Uncertainty
- Phase 2: Impact
  - Intense Emotional Reactions
- Phase 3: Heroic Phase
  - High level of activity with a low level of productivity
- Phase 4: Honeymoon
  - Dramatic shift in emotion
- Phase 5: Disillusionment
  - Stark contrast to honeymoon
- Phase 6: Reconstruction
    - Overall feeling of Recovery

Crisis Counseling Program

- The following are excerpts from *Federal Emergency Management Agency Crisis Counseling Assistance and Training Program Guidance Version 1.1*
- The Crisis Counseling Program (CCP) consists of two grant programs, the ISP and the RSP. The ISP provides funding for up to 60 days after the date of Presidential disaster declaration; while the RSP provides funding for up to 9 months from the date the RSP is awarded. The CCP may be a year or longer in duration if it includes an RSP in addition to an ISP. Many other disaster relief resources may have terminated services before the CCP. This is another aspect of the program that sets it apart from other approaches to disaster work.
- The ISP application is due 14 days after the date of the Presidential disaster declaration. The RSP application and ISP extension request are due 60 days after the declaration date and are followed by a Federal grant application review period, during which the ISP can be extended until a decision is made on approval of the RSP application.

MHFA

- Like CPR training helps a non-medical professional assist an individual following a heart attack, Mental Health First Aid training helps an individual who doesn't have clinical training assist someone experiencing a mental health crisis. In both situations, the goal is to help support an individual until appropriate professional help arrives.
- Mental Health First-Aiders learn a single strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying and contacting appropriate professional help. Trainees learn to apply this strategy in a variety of situations, such as helping someone through a panic attack, engaging with someone who may be suicidal, supporting a person experiencing psychosis and helping an individual who has overdosed.
- An important component of the Mental Health First Aid training is that trainees practice the intervention strategy rather than just learn about it. This simple experience can make it easier to actually apply the knowledge in a real-life situation.

Who uses EMHCS?

- Everyone – not just the chronically mentally ill.
- Anyone who goes into crisis (including vulnerable "first episode" consumers).
- Children, adults, older adults.
- Insured, under-insured, uninsured.

Mental Health First Aid Information Sheet

Overview

The root of most stigmas is generally fear. The stigma surrounding mental illnesses in America is no different: fear of not understanding the problem, fear of doing or saying the "wrong" thing, and fear of not knowing what to do when someone needs help.

Mental Health First Aid is a 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it makes people feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness.

History and Background

Mental Health First Aid was created by Professor Tony Jorm, a respected mental health literacy professor, and Betty Kitchener, a nurse specializing in health education. The program is auspiced at the ORYGEN Research Center at the University of Melbourne, Australia.

The Department of Human Services, Mental Health and Disability Services Division are collaborating with the National Council of Community Behavioral Healthcare to help bring Mental Health First Aid to Iowa due to the strong evidence supporting the program. Four detailed studies have been completed in Australia and nearly a dozen journal articles published on Mental Health First Aid's impact on mental health literacy. One trial of 301 randomized participants found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. Unexpectedly, the study also found that Mental Health First Aid improved the mental health of the participants themselves. Findings from the other studies have echoed these outcomes.

To date, Mental Health First Aid has been replicated in England, Scotland, Canada, Hong Kong, Ireland, and Singapore. In our collaborative effort with the National Council, we truly value the supporting evidence and strive to achieve fidelity to the original Mental Health First Aid program developed in Australia. In the future, we hope that Mental Health First Aid will become as common as CPR and First Aid training. It has the potential to reduce stigma, improve mental health literacy, and empower individuals — the benefits are limitless!

About the Program

The goal of Mental Health First Aid is to increase mental health literacy. Mental Health First Aiders learn a 5-step process to assess a situation, select and implement appropriate interventions, and help the individual in crisis connect with appropriate care. Participants learn the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis and addiction; engage in experiential activities that build understanding of the impact of illness; and learn information about evidence-supported treatment programs.

Like CPR training helps a non-medical professional assist an individual following a heart attack, Mental Health First Aid training helps an individual who doesn't have clinical training assist

someone experiencing a mental health crisis. In both situations, the goal is to help support an individual until appropriate professional help arrives. Mental Health First Aiders learn a single strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying and contacting appropriate professional help. Trainees learn to apply this strategy in a variety of situations, such as helping someone through a panic attack, engaging with someone who may be suicidal, supporting a person experiencing psychosis and helping an individual who has overdosed. An important component of the Mental Health First Aid training is that trainees practice the intervention strategy rather than just learn about it. This simple experience can make it easier to actually apply the knowledge in a real-life situation.

Bringing Mental Health First Aid to Your Community

The Mental Health and Disability Services Division intends to work with a range of provider organizations to bring Mental Health First Aid to Iowa, and is starting participation in an Instructor Certification Program. This weeklong program will enable the attendees to facilitate the 12-hour training in local communities and organizations.

Instructors must complete an application to participate in the Instructor Certification Program. Each applicant is assessed as indicating a sufficient level of expertise on the following six selection criteria:

1. Good knowledge of mental disorders and their treatment.
2. Personal or professional experience with people with mental health problems.
3. Favorable attitudes towards people with mental health problems.
4. Good teaching and communication skills
5. Good background knowledge of mental health and community services.
6. Good interpersonal skills.

For sites that participate in the Instructor Certification Program, the MHDS and the National Council will provide ongoing technical assistance in program planning and implementation, marketing, funding and other core components critical to the sustainability of Mental Health First Aid in communities. In addition, we will provide trained sites with new research and updated materials, module supplements targeted to a variety of audiences, and best practices from other Mental Health First Aid sites across the country and around the world. Perhaps most importantly, we are also developing evaluation processes to allow sites to benchmark and track program outcomes.

Note: Adapted from materials produced by the *National Council for Community Behavioral Healthcare*

July 1, 2008

Iowa Department of Human Services
Mental Health and Disability Services Division

MENTAL HEALTH FIRST AID
FREQUENTLY ASKED QUESTIONS

GENERAL INFORMATION

Q: What is Mental Health First Aid?

A: Mental Health First Aid is a 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy — helping the public identify, understand and respond to signs of mental illness.

Q: How many days does it take to complete the Mental Health First Aid program?

A: The Mental Health First Aid program runs 12 hours. It was originally conducted as four 3-hour sessions, but can also be conducted over a two-day period.

Q: What do Mental Health First Aid training participants learn?

A: The goal of Mental Health First Aid is to increase mental health literacy. Mental Health First Aiders learn a 5-step process that teaches them to assess a situation, select and implement appropriate interventions, and help the individual in crisis connect with appropriate care. Participants are also introduced to the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis and addiction; engage in experiential activities that build understanding of the impact of illness; and learn information about evidence-supported treatment programs.

Q: What types of crisis interventions are covered?

A: Like CPR training helps a non-medical professional assist an individual following a heart attack, Mental Health First Aid training helps an individual who doesn't have clinical training assist someone experiencing a mental health crisis, such as contemplating suicide. In both situations, the goal is to help support an individual *until appropriate professional* help arrives. Mental Health First Aiders learn a single strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying and contacting appropriate professional help. Trainees are taught how to apply this strategy in a variety of situations, such as helping someone through a panic attack or with an acute stress reaction, engaging with someone who may be suicidal, supporting a person experiencing psychosis and helping an individual who has overdosed. An important component of the Mental Health First Aid training is the opportunity to practice the intervention strategy rather than just learn about it. This simple experience can make it easier to actually apply the knowledge in a real-life situation.

Q: Where did Mental Health First Aid start?

A: Mental Health First Aid was created by Professor Tony Jorm, a respected mental health literacy professor, and Betty Kitchener, a nurse specializing in health education. The program is auspiced at the ORYGEN Research Center at the University of Melbourne, Australia. (www.mhfa.com.au)

Q: Who is the target audience for Mental Health First Aid?

A: Mental Health First Aid is targeted to a variety of audiences: friends and family of individuals with mental illness or addiction, professionals (such as police officers, human resource directors and primary care workers), school and college leadership, faith communities or anyone interested in learning more about mental illness and addiction. The training venues will also vary as Mental Health First Aid program sites reach out to Chambers of Commerce, professional associations, hospitals, nursing homes, Rotary Clubs, PTAs, social clubs and other groups who make up the fabric of a community.

Q: Is there evidence to support the effectiveness of the program?

A: Yes, in fact, evidence is the very reason the National Council selected this particular program. So far in Australia, four detailed studies have been completed and nearly a dozen journal articles published on Mental Health First Aid's impact on mental health literacy. One trial of 301 randomized participants found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. Unexpectedly, the study also found that Mental Health First Aid improved the mental health of the participants themselves. Findings from the other studies have echoed these outcomes.

For further evidence supporting the implementation of Mental Health First Aid, please see the Evaluation section of the Australian Mental Health First Aid website. http://www.mhfa.com.au/evaluation.shtml

Q: Has Mental Health First Aid been replicated in other countries?

A: Yes. To date, it has been replicated in England, Scotland, Canada, Hong Kong, Ireland, and Singapore.

Q: How do I find a Mental Health First Aid Training near me?

A: As of May 2008 seven sites in six states launched the Mental Health First Aid program in their communities. We will add information about new trainings as they are scheduled.

NATIONAL COUNCIL

Q: What role is the National Council playing in bringing Mental Health First Aid to the U.S.?

A: The National Council adapted the Mental Health First Aid program for U.S. audiences. We have graduated our first class of 14 instructors who are certified to teach the 12-hour Mental Health First Aid program. These instructors hail from seven behavioral health organizations in six states. We expect to conduct several more instructor certification trainings in 2008, and plan to average 4-6 such trainings per year beginning in 2009. In addition to adapting the core program and certifying instructors, the National Council will also be developing specialized training materials for a variety of audiences, providing ongoing technical assistance to Mental Health First Aid program sites, and partnering with local, state and national organizations to expand the reach of this important and innovative program.

Q: What is the National Council's long-term vision for Mental Health First Aid?

A: In the next ten years, we hope that Mental Health First Aid will become as common as CPR and First Aid training. Mental Health First Aid has the potential to reduce stigma, improve mental health literacy, and empower individuals-the benefits are limitless!

INSTRUCTOR CERTIFICATION PROGRAM

Q: Do I have to be a member of the National Council to participate in Mental Health First Aid?

A: National Council member organizations are natural partners to roll out Mental Health First Aid in communities across the country. However, the leads may vary from community to community, so we do not require National Council membership in order to participate in the program. For example, the state division of mental health and disability services in Iowa has taken the lead in managing the program, while a consortium of organizations may partner in another. In most communities, we anticipate that member organizations will lead the roll out or at least be part of the planning process, but spreading Mental Health First Aid is going to rely largely on partnerships no matter what the model.

Q: Who are the instructors?

A: Instructors are identified by the organization that is launching Mental Health First Aid in the community. Most often, instructors will be staff from behavioral health provider organizations, local/state mental health authorities, or mental health/addictions advocacy organizations. In some cases, the organization may tap partner organizations or identify volunteer leaders to conduct the programs. In all cases, the instructors must be affiliated with a Mental Health First Aid program site and meet general criteria around knowledge of mental health/addictions and ability to communicate and transfer knowledge effectively.

Q: How often will the National Council and MHDS offer Instructor Certification Programs?

A: In 2008, we plan to offer at least three Instructor Certification Programs in Iowa.

Q: Which organizations participated in the first Instructor Certification Program?

A: The inaugural Mental Health First Aid sites are: Denver Mental Health Center (CO), Seminole Community Mental Health Center (FL), Community Counseling Centers of Chicago (IL), North Central Behavioral Health Services (IL), **Iowa MHDS** (IA), Bert Nash Community Mental Health Center (KS), and Gateway Healthcare (RI).

Q: Once I am certified as a Mental Health First Aid Instructor, can I train others to be instructors?

A: No, the weeklong Instructor Certification Program qualifies participants to conduct the 12-hour basic training.

Q: Will the National Council provide technical assistance to sites that participate in the Instructor Certification Program?

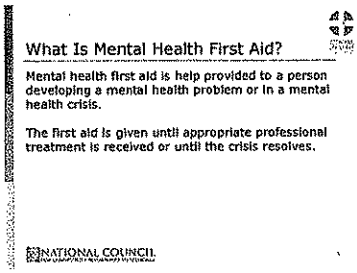
A: Yes. The National Council will provide ongoing technical assistance in program planning and implementation, marketing, funding and other core components critical to the sustainability of Mental Health First Aid in communities. In addition, through MHDS we will provide trained sites with new research and updated materials, module supplements targeted to a variety of audiences, and best practices from other Mental Health First Aid sites across the country and around the world. Perhaps most importantly, we are also developing evaluation processes to allow sites to benchmark and track program outcomes.

Mental Health First Aid in Iowa

Iowa Department of Human Services
Mental Health & Disability Services Division
July 2008

Why didn't we think of this sooner??

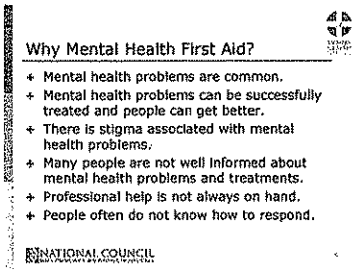
What is Mental Health First Aid?



Role of DHS/MHDS

- MHDS has, per agreement with National Council for Community Behavioral Healthcare, agreed to maintain oversight of the MHFA in the State of Iowa.
  - All MHFA training occurs under the umbrella of MHDS/DHS.
  - All certification in Iowa in MHFA is through training organized by MHDS/DHS
  - MHDS/DHS agrees to maintain fidelity of training approach.
  - MHDS/DHS serves on National Scientific Advisory Board (with NCCBH and SAMHSA) on MHFA studies.

Why?



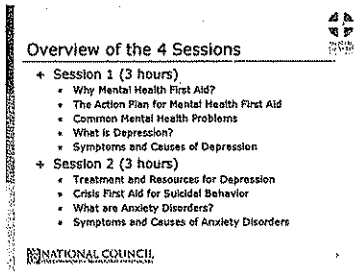
Key Features and Benefits

- Mental Health First Aid is a training program for members of the public in how to support someone in a mental health crisis situation or who is developing a mental disorder. The program has solid evidence for its effectiveness from randomized controlled trials and qualitative studies.
- It increases knowledge, reduces stigma and, most importantly, increases supportive actions.
- It even improves the mental health of first-aiders. Mental Health First Aid training can assist in early intervention and in the on-going community support of people with mental illnesses.
- It is useful for people employed in areas which involve increased contact with mental health issues and for carers of people with mental illnesses.
- It is recommended that Mental Health First Aid training becomes a prerequisite for practice in certain occupations which involved increased contact with people having mental health problems, such as teachers and police.

Similar to "other first aid"

- First aid training is widespread throughout the world to give members of the public skills to help an injured person before medical help arrives. However, first aid courses typically teach little or nothing about helping people with mental health issues. This is curious given how common these problems are. Most first-aiders would never get a chance to use their CPR skills, but they would have a good chance of having close contact with someone in a mental health crisis.

Overview of Basic MHFA Training



Overview (cont.)

Overview of the 4 Sessions (cont'd)

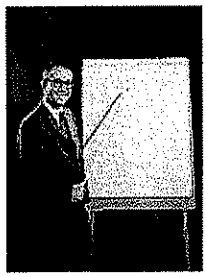
+ Session 3 (3 hours)
  - Treatment and Resources for Anxiety Disorders
  - Crisis First Aid for Panic Attacks
  - Crisis First Aid for Acute Stress Reaction
  - What are Psychotic Disorders?
  - Symptoms and Causes of Psychotic Disorders
+ Session 4 (3 hours)
  - Treatment and Resources for Psychosis
  - Crisis First Aid for Acute Psychosis
  - What is Substance Use Disorder?
  - Symptoms, Causes, Treatment and Resources
  - Crisis First Aid for Overdose

NATIONAL COUNCIL

Organization of the Basic Training

- The MHFA basic course is a 12-hour course that is usually run over 4, 3-hour sessions. At the end of the course, participants receive a Mental Health First Aid certificate. The course can be taken by any member of the public. Most participants choose to do the course for one of three reasons:
  - their work involves people contact,
  - they have someone close who is affected by a mental health problem, or
  - they see it as their duty as a citizen to learn first aid skills.
- We emphasize that the course is not therapy and that it is not a substitute for getting professional help. However, it is useful for people who may have experienced a mental health problem but are currently functioning reasonably well.
- We also emphasize to participants that the course does not qualify them to be a counselor, just as a conventional first aid course does not qualify someone to be a doctor or a nurse. Its role is to promote first aid—the initial help that is given before professional help is sought.

"To be good is noble,
but to teach others how to be good is nobler, and less trouble."
- Mark Twain

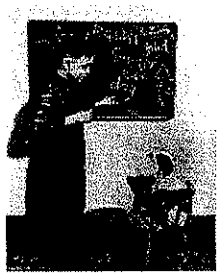


Training Content

- The course teaches the symptoms, causes and evidenced- based treatments for the common mental health problems of depression, anxiety disorders, psychosis and substance use disorder. It also addresses the possible crisis situations arising from these mental health problems and steps to help. The crisis situations include a person who is feeling suicidal; a person having a panic attack; a person who has had a recent traumatic experience; a person who is acutely psychotic and perceived to be threatening violence; and a person who has overdosed.
- Although crises are dramatic consequences of mental health problems, it is better to intervene early before such crises develop. We therefore emphasize in the course the need for early intervention for mental disorders as they are developing.

Instructor Requirements

Train the Trainers



Mental Health First Aid Materials

To give participants information that they can take away from the course, the NCCBH developed a *Mental Health First Aid Manual* (based on the work of Kitchener & Jorm, 2002a). The manual gives information about the major types of mental disorders, the best types of help available, local resources, and how to apply the steps of Mental Health First Aid to various situations.

There is also a Mental Health First Aid web site which is very easy to navigate. Basic mental health first aid information is available, along with information about the 12-hr Mental Health First Aid course and the 5-day Mental Health First Aid Instructor Training Course. Instructors are able to advertise the courses they are conducting.

Overview of T2

- Five full days in two major parts:
  - First two days = basic MHFA
  - Days 3 – 5 = Trainer Mentoring
  - Instructors: NCCBH developers/leaders of MHFA initiative
  - Trainers must meet requirements
    - Background
    - Commitment to conduct future training
    - Fidelity to use of materials and overall approach

Instructor Training

- Because the Instructor Training Course is only 5 days long, successful applicants need to meet the following criteria:
  - substantial knowledge about mental illness and treatments,
  - good teaching skills and "fire in the belly" to improve the mental health literacy of the community and to reduce the stigma surrounding mental illness.
- There are now over 450 instructors in Australia, covering all states and territories and hundreds in other countries. The interest in training as an instructor has been strongest in rural areas, both because of the shortage of mental health services in these areas and the greater concern to support others in the local community. Instructors usually work through an employer, a state area health service, a large employer (e.g. a university, government department), or work as fee-for-service private practitioners.

Teamwork

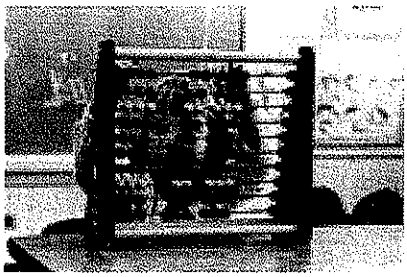
Expectations Post-Training

- Fidelity to training materials
- Fidelity to length of training
- Record-keeping
- Data reporting
- Sharing concerns with MHDS/DHS
- N of trainees

Data Collection

- Trainee Information
- Pre-test/Post-test
- Attitude Survey

Data collection is important



August 18, 2008 T2 Invitees
(note: 2 Trainers per Organization)

Proposed Year One T2 Calendar

- August 18, 2008 (n=24) – MHBG/TTI - funded
- December, 2008 (n=24) – EMHC funded – Primarily CMHCs with focus on EMHC providers
- January/February, 2009 (n=24) – ??Regents-Funded Training for University Invitees
- April, 2009 (n=24) – MHDS Funding
- Training Cost = $30,000/T2 session plus participant lodging, mileage, meals; Total cost for four (4) T2 = $160,000.00
- Duration = T2 is for 5 full days
- Trainer Organization = National Council Community Behavioral Healthcare

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- Potential of up to 96 trainers X 100 trained = 9696 individuals trained either as trainers or trainees of MHFA in one year.

Algee

You are Invited to Send Two Representatives from Your Organization

The Mental Health & Disability Services Division of the Iowa Department of Human Services invites you to recommend two staff members from your organization to participate in a weeklong training for Mental Health First Aid Instructors. We are requesting that you send two persons to receive the training as trainers as the depth and breadth of the training that is ultimately offered to individuals is best conducted with two trainers. We are also seeking your nomination of participants who have some training experience, mental health/substance abuse experience and who are willing to offer the MHFA training to others over the course of the next year.

Twelve organizations have been selected to participate in the first Iowa Mental Health First Aid Instructor training program. Each organization, if willing to participate, is required to send two staff members to the training. The two staff members will be expected to offer the two-day Mental Health First Aid program following completion of their training to other members of their organization and other groups. Participants also agree to **not** modify the training program manual, materials, or processes in order to maintain program integrity. Participants agree to submit to MHDS brief reports and participant information of trainings offered after the instructors have taken the training program and become Certified MHFA Instructors.

The program is for five (5) full days and starts Monday, August 18 and ends Friday, August 22.

The MHFA Train-the-Trainer program is the first-of-its-kind in Iowa and is sponsored by the Iowa Department of Human Services, Division of Mental Health & Disability Services in collaboration with the National Council on Community Behavioral Healthcare. There is no cost to organizations for participating in this training beyond their regular payment of staff salaries while they are attending the five days of training.

Participants will be offered the following:
1. Five days of training from National Council for Community Behavioral Healthcare trainers.
2. Five nights hotel lodging (if needed) at the training site.
3. Hot breakfast and buffet lunch for the training days.
4. Mileage reimbursement for travel to and from the training.

Participants will be responsible for their own dinner costs and hotel incidental room charges. Trainer manuals and handouts will be provided free of charge to program participants.

Attached is a description of the MHFA program and a FAQ about the Instructor Training.

Upon nomination by organizations, participants will be contacted and asked to provide additional information of their current work duties, clinical background and other basic demographic information. These forms will be emailed or mailed to nominated Instructors-in-Training prior to the Train the Trainer program. The preliminary agenda for the Train-the-Trainer program will be sent upon confirmation of participants.

The Instructor Training will be held at:

Valley West Inn
3535 Westown Parkway
West Des Moines, IA 50266
800.833.6755 (reservations) direct line 515.225.2524

Following is the link that will take you directly to the hotel website:

http://www.valleywestinn.com

Please email or phone Barbara Jean Funke at bfunke@dhs.state.ia.us or 515-281-7277 to RSVP the names and contact information of your two representatives by July 18, 2008. If you do not wish to participate in this exciting new program, please also let Barbara Jean know ASAP or at the latest by July 18.

We're looking forward your involvement in this training opportunity and the chance to spread mental health first aid throughout Iowa with you.

Sincerely,

Allen

Allen W. Parks, EdD, MPH
Administrator/Director
MHDS/DHS

Attachments

PS: You'll learn who the bear is from your trainers.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
SALLY TITUS, INTERIM DIRECTOR

August 13, 2008

Project Recovery Iowa
Crisis Counseling Outreach

Overview: Thousands of Iowans received crisis mental health counseling and information in the wake of severe storms and flooding. The Mental Health and Disabilities Services (MHDS) division of the Department of Human Services implemented a disaster response plan and secured federal grants to sharply expand service in the hardest hit counties. At the request of DHS, provider counseling agencies quickly, aggressively, and creatively offered service.

Summary of Crisis Service Provided:

- Within hours of both tragic tornados (Parkersburg May 25 and Little Sioux Scout Ranch June 11), counselors and other DHS response staff were on the scene.
- Within two weeks of the storms, the MHDS arranged for 16 de-fusion and debriefing sessions to help emergency responders cope with stress and the tragedy of storm victims.
- A single entry point for services was established for crisis mental health counseling and other DHS services. A call from anywhere in Iowa to the Iowa Concern Hotline will get access to an outreach counselor. The number is 1-800-447-1985.
- Project Recovery Iowa was established to provide additional outreach counselors in the 29 hardest-hit counties that qualified for federal grants sought by the DHS. Up to five in-person counseling sessions are provided at no cost.
- The results as reported through Aug. 7:
    - At least 5,800 people had brief contact with counselors at disaster recovery centers, churches, schools, or other places where people affected by the disaster were present.
    - Hundreds more received extended counseling services, many the result of door-to-door visits by counselors in hard hit areas.
    - More than 5,400 callers received assistance from counselors staffing the Iowa Concern Hotline (which is operated by Iowa State University Extension).
    - More than 2,400 people requested material to be sent to them in the mail.
    - More than 2,000 people heard counselors give presentations at meetings arranged by counselors or others.
    - Many thousands of flyers have been made available to churches, government offices, farm implement stores, county fairs and the State Fair, and local DHS offices.

Launching Project Recovery Iowa:

- With the crisis mental health response well underway, the MHDS advocated for and received $350,000 in FEMA grants to establish Project Recovery Iowa crisis mental health assistance for up to 60 days. The MHDS has applied for an additional grant of $4.6 million to carry the project an additional nine months. Twenty-nine counties qualified for federal assistance.
- The Iowa Concern Hotline was established as the statewide point of contact providing referrals to local counselors or limited assistance on the phone.

- Counseling in the 29 target counties is provided by eight provider agencies, many of whom expanded staff at the request of MHDS and began service well before the grants were approved.
- The provider agencies added 70 additional crisis response counselors insuring a wide-range of diversity. Counselors include teachers, farmers, social workers, ministers, and are representative of Iowa's rich cultural diversity.
- The DHS and the Recovery Iowa Office issued several news releases about crisis mental health, generating numerous radio interviews and dozens of news articles. An MHDS manager appeared twice on a public television show.
- Gov. Culver underscored the importance of crisis mental health with a visit to a provider agency in Waterloo.

Next steps in outreach:

- Create a web site accessible from the front page of the DHS website, dhs.iowa.gov.
- Approach high-profile officials to record public service announcements to urge flood survivors to seek crisis mental health counseling.
- Create op ed piece to introduce importance of seeking crisis mental health counseling.
- Target specific groups to disseminate information on crisis mental health counseling, including:
    - Faith based organizations
    - Schools
    - Health providers
    - Law enforcement

Examples of counselors and agencies going the extra mile:

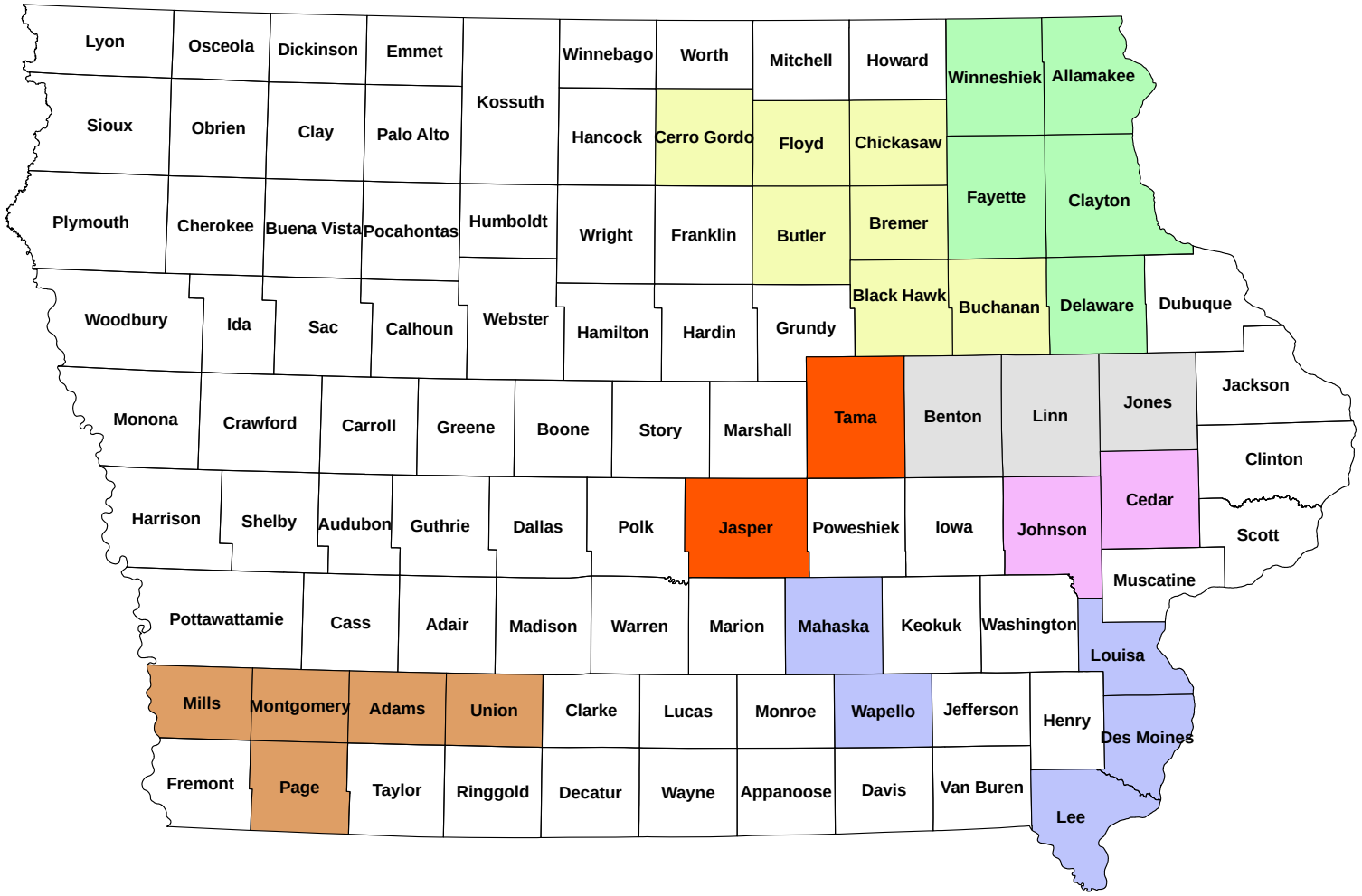
- Abbe Center of Cedar Rapids provided 24 hour disaster mental health / crisis counseling for two established 24-hour shelters for 12 days until the Red Cross took over, then returned when Red Cross officials said they did not have enough disaster mental health staff to provide the ongoing effort. The Abbe Center provided nearly 1,000 staff hours prior to the federal grant being accepted.
- Pathways Behavioral Services of Waterloo was on the scene almost immediately in the wake of the Parkersburg tornados. They, too, provided help without assurance of being reimbursed. To reach younger people, Pathways put their information on Facebook. They also worked with Parkersburg cheerleaders to distribute flyers in town, and they helped facilitate a "hope building" art project.
- Four Oaks, a Cedar Rapids based child welfare provider, entered into an agreement with DHS responding to the need for crisis shelter management when Red Cross announced they were ending shelter operation while 72 people were still in care.

What Services are Available?

- The overarching goal is to help people bring a sense of control to their lives, and to remind them that what is happening to them is normal in an abnormal disaster situation. Crisis counseling helps people understand their reactions, review their options, and link them with individuals or agencies that may assist them regain control of their lives.
- Services include:

- **Individual Crisis Counseling Services** assist disaster survivors in understanding their current situation and reactions, addressing their emotional support, and linking with other individuals and agencies that may be able to assist them. During individual services, crisis counselors are active listeners who provide emotional support.
- **Group Crisis Counseling Services** involves providing/facilitating support groups, meeting with citizens, working in classrooms with affected students, working with affected teachers and administrators after school, discussing disaster-related issues with families, assisting people in understanding their current situation and reactions, reviewing their options, addressing emotional support and linking with other individuals and agencies who may provide assistance.
- **Education Services** include the distribution or presentation of information on the project or crisis counseling-related topics. Educational information is provided through brochures, flyers posted in public areas, mailings, and training to human service personnel such as the clergy or teachers. Educational information is also provided to groups of people. The key difference between group education services and group crisis counseling services is that project staff present psycho-educational information to groups rather than facilitate the sharing of experiences between members of the group.
- **Referrals** are a key component of initial services. In most disasters, the majority of survivors have needs that can be met by short-term, relatively informal interventions. However, in some circumstances, some disaster survivors may need long-term, more formal mental health services that are beyond the scope of the immediate services plan. Survivors requiring longer-term, more formal mental health treatment are referred to an appropriate agency or licensed mental health professional. Some disaster recovery needs may be more physical, structural or economical in nature and addressing these issues is outside the scope of the DHS mental health crisis counseling services. In these instances, staff perform a key role in referring people to specific disaster services available through DHS, FEMA and other community groups. Individual crisis counseling services. During individual services, crisis counselors are active listeners who provide emotional support.

Project Recovery Iowa
Project Areas



Project Areas

- Non-Project County
- Abbe Center
- Backbone MHC
- MHC of Tama Co
- Mid-Eastern Iowa MHC
- Pathways Behavioral Services
- ResCare
- Waubonsie MHC

Source: DHS Division of MHDS
Created by DHS Bureau of Research and Statistics - August 05, 2008

Disaster Impact on Community and Migrant Health Centers

Provided by the Iowa/Nebraska Primary Care Association

Cedar Rapids – Linn Community Care's (LCC) main site, located adjacent to Mercy Hospital, was forced to close because of major flooding. To accommodate patients, LCC expanded operations at a much smaller clinic site co-located at St. Luke's Hospital. Although LCC was able to set up additional exam rooms at this site, they have not been able to reach pre-flood operational capacity and can only care for about 75% of their normal patient load. LCC is in the process of identifying a permanent solution.

Columbus Junction – Community Health Centers of Southeastern Iowa's (CHCSEIA) newest clinic site in Columbus Junction had only been operational since spring when flooding destroyed the clinic. The clinic was unable to see patients until July 11, when a mobile medical unit arrived in Columbus Junction. Dental visits resumed on July 15 when a mobile dental unit was established in the community. The limited number of exam rooms the mobile units provided are not meeting patient needs. The current clinic situation is less than ideal with the mobile units situated in an elementary school parking lot with one of the classrooms being used as a waiting room. CHCSEIA continues to identify a permanent solution.

Other Information – Staff at both LCC and CHCSEIA have expressed concern about their patients being able to access adequate behavioral health services.

The pharmacist for LCC indicated they were having trouble locating patients to provide them with their medications as so many people were displaced by the floods.

Primary Health Care, Inc., which is based in Des Moines, indicated their outreach program was impacted by the floods as portions of the homeless population they serve in the Des Moines were displaced by the floods (i.e. individuals living under bridges near the rivers).

Peoples Health Center, which is based in Waterloo, had to close their new health clinic in Clarksville for several days as there were no open roads into the town due to flooding.

Proteus Migrant Health Project's Iowa City administrative office was closed due to flooding, although care to patients does not seem to have been impacted as most care is provided in the fields.

Rebuild Iowa Task Force
Public Health and Health Care
Meeting Notes

August 6, 2008, 9:30 am – 4:30 pm
Urbandale Public Library
3520 86th Street, Urbandale, IA

Task Force Members Present:
Christopher Atchison, The University of Iowa Hygienic Lab, Iowa City
Douglas Beardsley, Johnson County Public Health, Iowa City
Greg Boattenhamer, Iowa Hospital Association, Des Moines
Steve Bolie, Area XIV Agency on Aging, Creston
John Dawson, Chariton Valley Planning and Development Council, Centerville
Representative Dave Heaton, Iowa General Assembly, Mount Pleasant
Patricia Heiden, Oaknoll Retirement Residence, Iowa City
Cheryll Jones, Child Health Specialty Clinic, Ottumwa
Terry LaBelle, Child Care Provider, Altoona
Kathy Lamb, YMCA, Cedar Rapids
Linda Langston, Linn County, Cedar Rapids
Linda Larkin, Agemark Assisted Living, Fort Madison
John Lundell, The University of Iowa College of Public Health, Iowa City
Alana Poage, Louisa County Public Health, Wapello
Kristin Powers, College of Natural Health, Ankeny
Senator Amanda Ragan, Iowa General Assembly, Mason City
Julie Schilling, Lee County Health Department, Fort Madison
Anne Strellner, St. Luke's Hospital, Cedar Rapids
Sally Titus, Iowa Department of Human Services (DHS), Des Moines
Dale Todd, Project Development, Cedar Rapids
Michael Trachta, Waverly Hospital, Waverly
Sharon Treinen, Retired, Ackley
Lisa Uhlenkamp, Iowa Health Care Association, West Des Moines

Resource Group Members Present:
Janet Buls, Hawkeye Valley Area Agency on Aging, Waterloo
Tracey Dormady, ISU Extension, Urbandale
Emma Edgington, Retired, Manchester
Carrie Fitzgerald, Child and Family Policy Center, Des Moines
Tricia Hoffman-Simanek, Shuttleworth & Ingersoll, Cedar Rapids
Jennifer Montgomery, The University of Iowa, Iowa City
Mike Rosmann, AgriWellness, Inc., Harlan
Virginia Wangerine, Iowa Nurses Association, Des Moines

Speakers:
Stacey Brown, Small Business Administration (SBA), Urbandale

Bill Gardam, Iowa Department of Human Services, Des Moines
Donna Harvey, Hawkeye Valley Area Agency on Aging, Waterloo
Karen Hyatt, Iowa Department of Human Services, Des Moines
Tom Mangum, Federal Emergency Management Agency (FEMA), Urbandale
John McCalley, Iowa Department of Elder Affairs, Des Moines
Tom Newton, Iowa Department of Public Health, Des Moines
Dr. Allen Parks, Iowa Department of Human Services, Des Moines

Observers:
Kris Bell, Senate Democratic Caucus
Anthony Carroll, AARP Iowa, Des Moines
Hanna DeGroot, Iowa Association of Counties, Des Moines
Kathleen Fitzgerald, FEMA
Patty Funaro, Legislative Services Agency, Des Moines
Heidi Goodman, Iowa Medical Society, Des Moines
Jennifer Jacobs, Des Moines Register, Des Moines
Mary Jones, Iowa Department of Public Health, Des Moines
Phil Kauffman, Legislative Services Agency, Des Moines
Neil Lawhead, US Department of HHS, Administration for Children and Families, Kansas City
Sue Lerdal, Legislative Services Agency, Des Moines
Lynh Patterson, Iowa Department of Public Health, Des Moines
Kris Powers, Iowa College of Natural Health, Ankeny
Marvin Schultz, Iowa Department of Human Services, Des Moines
Russ Trimble, Senate Republican Caucus, Des Moines
Brad Trow, House Republican Caucus, Des Moines
Kate Walton, Governor's Office, Des Moines
Zeke Furlong, House Democratic Caucus, Des Moines

Staff:
Sandra Lyles, Rebuild Iowa Office, Des Moines
Jon Neiderbach, Rebuild Iowa Office, Des Moines
Laura Riordan, Rebuild Iowa Office, Des Moines
Amelia Colwell, SPPG, Des Moines
Erin Drinnin, SPPG, Des Moines
Jennifer Furler, SPPG, Des Moines

Welcome and Introductions
Chair Linda Larkin welcomed the group and thanked them for their time and interest. Larkin discussed the significant public health and health care concerns that are present during disasters and recovery. Larkin outlined the goals of the day and informed the group that the Task Force recommendations developed during this meeting will inform a report due to the Commission on August 18. Larkin stated that there may be more meetings of this Task Force, depending on next steps identified by the Commission. Larkin asked the Task Force members and Resource Group members to introduce themselves.

Charge to the Task Force and Overview
Larkin directed the group to take breaks as needed and gave instructions on lunch. She pointed out the importance of focusing on public health and health care, as other task forces are addressing other issues. She introduced Jennifer Furler, who thanked the group for their efforts and time. Furler introduced Neiderbach, Lyles, Colwell, and Drinnin as Rebuild Iowa Office staff.

She said the Task Forces are likely to meet again after the short term reporting period. Furler noted the additional FEMA and SBA speakers not included on the original agenda, and shared the importance of the added expertise from the Resource Group. Furler said this is the only Task Force directly focused on people. She said that it will be essential to identify unmet needs and gaps between Task Forces. She said the result of the meeting will be a consensus report and asked the group to have an open conversation with one another.

Presentation of Information

Impact on Health and Human Services – Sally Titus, Iowa Department of Human Services

Larkin introduced Sally Titus, Acting Director of the Iowa Department of Human Services. Titus reminded the group to be aware of the need to assure that basic needs such as food, shelter, financial stability, physical health care, and mental health care are met. DHS does that on a daily basis throughout the year, but when there is a disaster, the agency takes on additional responsibilities, such as emergency shelters. The agency also administers federal disaster food stamps. They are able to provide one-time benefits to people who are higher income and affected by the disaster; 35,000 people were able to access food stamps, partly due to a waiver DHS received because of the flooding. DHS also administers a one-time grant program that is available for people who have been affected by the floods and administers an ongoing needs program. Between the state and FEMA programs, $100 million has been expended in the state so far. She reminded the group members of basic needs such as child care and food that have to be maintained regardless of affected offices and evacuated areas.

DHS learned some lessons from the floods of 1993 and 2008: organizations have to have a plan and need to adjust that plan as they go; there needs to be clear lines of communication and decision-making ability; and solid partnerships with public and private sector organizations, local governments, and the federal government are keys to success. Titus shared some of the challenges, including technology difficulties and food stamp cards not arriving on time. Task Force members described the leadership and hard work by DHS to bypass typical rules and regulations. Titus added that it is hard to predict the need for additional food stamps and eligibility for DHS programs as people's financial situations change. She said there is concern about a potential increase in child or older adult abuse, and about local areas' abilities to finance core mental health services with a loss of property taxes.

Titus introduced Dr. Allen Parks, Director of the Division of Mental and Health and Disabilities at DHS. Parks provided a brief overview of the division's role in disaster response related to crisis and mental health services. Although legislation passed during the 2008 session with funding for the crisis mental health system, the disasters happened before it was implemented. He said that people usually have their first encounter with the mental health system while they are in a crisis situation. Parks shared with the Task Force that the typical people who encounter mental health difficulties during a disaster are not the chronically mentally ill, as that population usually already has a support system in place and are aware of the contacts to make in a crisis situation. Parks described the incredible push and partnerships by mental health centers and local mental health providers to check in with mental health consumers and make sure needs are being met. Parks reviewed phases of response in a disaster, adding that the cycle can last for years.

Parks introduced Karen Hyatt who provided an overview of the crisis counseling program. Parks provided maps that indicate where currently active crisis counseling programs are located. Hyatt said there are eight project providers who are spearheading the crisis counseling

efforts, and over 100 outreach workers who work in collaboration with agencies in communities. There have been efforts to work with children, rural areas, older adults, and people with special needs. Hyatt said they do assessment, outreach, and referral, but not ongoing case management. The Immediate Service Program is initially for 60 days, and there were people on the ground on the second day after the disaster. DHS has applied for an additional nine months of funding to extend the work, which would end around the first anniversary of the first event.

The Department has used the Iowa Concern hotline as outreach to agricultural communities, and there are plans to conduct outreach with primary care and education providers. There is currently information about the program at school registration events. The Task Force discussed the importance of reaching out to rural health care providers to get the word out. Parks said that education, motivation, and collaboration are keys to mental health efforts. He said that a train-the-trainer program will be implemented on mental health first aid certification training, meant to reduce stigma.

Furler asked Hyatt and Parks to highlight any current gaps in meeting needs. Hyatt said that there is a gap with regard to current funding needs and long term costs for ongoing mental health services. Parks said that the nine-month federal funding will help with disaster response, but there is a need for an emergency response system in Iowa for mental health. Titus indicated that DHS is currently developing estimates for increased demand for mental health services. Parks said that the good news is that a funding stream for emergency mental health system is already in place. There was discussion about the need to fully fund the Department's request for the emergency mental health system.

There was discussion with Task Force members about the capacity of the workforce for crisis response, and Parks assured the group that it is currently sufficient. There was additional discussion about the evaluation component to current tracking data and assessing needs for the future. Hyatt added that the Department is expanding the evaluation tool to collect additional information not required by the federal government.

Impact on Services for Older Iowans – John McCalley, Iowa Department of Elder Affairs

Larkin introduced John McCalley, Director of the Iowa Department of Elder Affairs. He directed the group to a handout in the packet. McCalley thanked the group for the coordination between state agencies and reminded the group that Iowa has one of the highest populations of elderly in the country. He said that older adults tend to be on a fixed income and experience higher rates of poverty, leaving them more vulnerable to catastrophic events. Prior to the disasters, IDEA had maintained an Unmet Needs Report on behalf of older adults in Iowa. During any given month, 5,500 individuals found barriers to receiving services, due to gaps in funding and a shortage of providers in some areas. He drew the group's attention to some statistics related to FEMA applications. Initially, individuals 60 years of age and older represented a high proportion of the applicants for assistance, and now the numbers more accurately reflect Iowa's population make-up.

During the first few weeks of June, about 1,900 individuals in long term care facilities were evacuated temporarily, and most have been able to return. Nursing facilities have disaster plans in place; assisted living programs are not required to have emergency response plans in place. Thirteen kitchens that provide meals to 740 individuals had an interruption in service, most for less than one week. Aging Resources of Central Iowa sustained damage and is applying for FEMA assistance. The Area Agency on Aging in Cedar Rapids has relocated due to flooding. It is reasonable to estimate that 67,000 older adults have been impacted in some way through the disasters. The Department is looking for flexibility in the Senior Living Program to meet recovery

needs. The aging network response has been quick and pervasive, and they are a part of county and state emergency response centers.

McCalley said there is an enormous need for Home and Community Based Services for older adults, including information about these services. The Hawkeye Area Agency on Aging experienced over a 60% increase in requests for services, and the Heartland Area Agency on Aging saw a significantly larger increase in initial calls to the organization. Alerts from the Attorney General's Office have warned against financial abuse of older adults. There has been an increase in reports of dependent adult abuse and requests to Legal Aid. The Office of Substitute Decision Maker has experienced an overwhelming increase in calls. Collaboration between DHS and IDEA has been close and ongoing regarding mental health issues and older adults. IDEA has received an enormous level of support from other states and federal entities. Florida sent specialists to Iowa to help triage individuals in Cedar Rapids. FEMA is sharing information about individuals 65 and older who have applied for assistance, and contact is being made to those individuals from area agencies on aging.

The request from IDEA to the federal government will be for $22 million for the aging network. It is expensive and long term and requires a permanent connection to funding streams. He said that transportation systems will be stretched to the limit, especially as winter months approach. Nutrition services are the front line in terms of preventive services for health care for older adults, and they have already been stressed with the rise in food costs.

McCalley introduced Donna Harvey, Executive Director of the Hawkeye Valley Area Agency on Aging, who echoed that the IDEA has been flexible regarding local areas' responsibilities. She said that co-location and caregiving has put stress on families, with the lack of affordable housing. Harvey said that volunteers have found a lack of cooperation with residents to clean out houses and have worked through these issues. Rural issues are harder to assess because of hesitancy to ask for help. There has been an increase in requests for the home-delivered meal program, with fewer resources in donations. Harvey stressed that the flexibility provided through the Senior Living Trust has been crucial to meeting needs, including a significant need for shoes in the Parkersburg area. She said that the appeals process is overwhelming to older people. Harvey also addressed several additional issues, including lack of digital TV conversion, and this is the only way many people are connected. Food safety education has been important.

The Task Force discussed special needs sheltering, and McCalley recommended that the state accommodate this need by building this into the disaster response infrastructure. Additional discussion centered around how decisions will be made about rebuilding when a facility is located in a floodplain. This will be part of discussions with FEMA assistance as people seek to rebuild. Task Force members expressed concern about meeting people's health care needs, and it was suggested that the Legislature provide for expanded sites for the IowaCare program during disasters.

Overview of the Individual Assistance Program – Bill Gardam, Iowa Department of Human Services

Gardam reviewed the responsibility of DHS with shelters, and the recent agreement and process with Red Cross, including transition to full DHS responsibility when the Red Cross removed itself from that role. Gardam detailed the multiple partnerships that are being utilized with the Department of Public Health, the Department of Elder Affairs, Homeland Security and Emergency Management, Administration on Children and Families, and FEMA to coordinate all response, including shelter care. Local resources were key in making an effective transition from Red Cross to a local provider with DHS responsibility.

Gardam outlined the state and federal individual assistance programs. DHS operates the Iowa Individual Assistance Grant program. For that program, when there is a Governor's Disaster Declaration, individuals at or below 130 percent of the federal poverty level are eligible to receive grants up to a maximum amount of $3,318. When Presidential Disaster Declarations occur, then the federal Individual Assistance Program is available. For that program, individuals can receive up to $28,800. So far, approximately 165 grant applications for the state program have been received and checks are in the mail for those applications.

The federal Individual Assistance Program funds housing and other needs. As of August 5, 1,053 grants of $28,800 have been issued. Gardam described the process used for assessment of housing and other needs. For housing requests, 28,713 assessments have been completed, resulting in total funding of $104.4 million in housing assistance. For other needs, 7,000 assessments have been completed (of approximately 18,000 requests) and approximately $13 million distributed. Gardam described that there is a delay in processing other needs requests, because housing assessments take priority. DHS is currently processing about 300 claims daily. Gardman expressed that there has been a great partnership between FEMA and DHS.

There was discussion about child care homes needing immediate assistance with meeting regulations and not operating illegally. Gardam stated that DHS has been working to partner with groups and get certifications done quickly so that child care providers can continue to operate legally. DHS has been looking to other states, such as Mississippi, for best practices and lessons learned.

Impact on Public Health – Tom Newton, Iowa Department of Public Health

Newton addressed the Task Force by outlining the three phases of public health response in a disaster – preparedness phase, response phase, and recovery phase. Newton noted that the overall role of public health in a disaster is to promote and protect the health of Iowans through: disease prevention and control, access to health care, environmental health, community health, behavioral health, injury prevention, and resource coordination and management. Newton noted the concerns that are always evident about disease outbreaks during events such as this. Additionally, people have a lot of questions and concerns about immunizations. The Department distributed more than 38,000 tetanus shots. In response to health care needs, the Department conducted many evacuations and coordinated 22 ambulance services from 14 different communities to transport patients. They also deployed Disaster Medical Assistance Teams (DMAT) in response to special needs sheltering, and assigned over 55 medical professionals to staff those facilities. IDPH also set up a call center to answer all questions as they come in.

There are significant concerns about drinking water across the state. The Department has been working to get the word out to people and business owners about steps to take with food safety and injury prevention. Because of Iowa's involvement in the Emergency Management Assistance Compact, the state was able to get more than 27 people from Florida and North Carolina to assist with community-wide health assessments. The Department is working with substance abuse providers to identify issues.

There are more than 77 IDPH staff working at the state emergency operations center and the emergency coordination center. This is part of the incident management structure. Newton described some of the communication structures, such as the Health Alert Network (HAN), which allows the department to connect with local emergency management, public health, and health facilities to communicate about immediate issues and needs. The department operates a Mobile Health Care Facility, which can accommodate 50 beds.

Newton described the activities that are being conducted as part of the recovery phase. Vector surveillance and disease surveillance are being completed. The Department manages a lot of questions about mold, which is a significant concern in the state. IDPH is trying to get information out to people about how to identify issues in their homes, and informing providers about how to identify some of these issues. The Department is focused on public information and education about behavioral health and probable increases in substance abuse. The Department has supported special needs individuals through shelters and found alternate housing for displaced special needs individuals.

Director Newton reminded the group that staff members were redirected to disaster response from regular activities. Those other activities are not being done as thoroughly as expected, and conversations will have to take place with federal partners about not meeting some grant guidelines in a timely way because of the response. Newton also suggested the Task Force look at sheltering issues, especially for the medically needy.

There are long-term impacts, and it is important to do ongoing assessment with local public health agencies. The Task Force discussed disease and condition reporting. Hospitals are only required to report “reportable conditions,” and asthma for example, is not one of those conditions (but is a condition that could be a result of mold). However, there is syndrome surveillance that reports that kind of data. Planning for children and families in a disaster was also raised as an issue for consideration. In closing, Newton indicated that the Department will need additional funding for ongoing and follow-up activities, as well as some flexibility in funding to meet the demand.

Public Assistance Program – Tom Mangum, FEMA, and Stacey Brown, SBA

Tom Mangum, FEMA, reviewed the assistance available for Private Non Profit (PNP) organizations. Currently, 141 PNPs have applied for assistance, and 70 are now eligible. Mangum detailed the requirements for eligibility, including tax exempt status, ownership of the property or lease that gives responsibility of repairs to agency, and proof of insurance. Mangum reviewed the process for eligibility reviews, which includes site visits. If the organization conducts an essential government service, it is eligible for this assistance. Currently, we are still in the emergency timeframe, so funding is 90 percent federal and 10 percent state for emergency work. Emergency work was defined in more detail by Mangum, but includes things done before, during or immediately after the disaster, and funding turnaround is fairly quick. For non-critical or non-emergency work assistance, organizations must first apply for a loan from the Small Business Administration (SBA). Long-term repair assistance takes time to review and get in place. So far, FEMA has visited 23 sites, and there will be approximately $75 million distributed among the sites. Mangum distributed information with more detail about eligibility and services and activities covered by the PNP public assistance program.

Mangum introduced Stacey Brown from the Small Business Administration. Brown indicated that Mangum covered most of the information related to PNP public assistance and the role of the SBA. Brown noted that the SBA can now not only do physical damage loans to Private Non-Profits, but can also address economic and operations needs. SBA can provide loans to organizations in declared counties as well as contiguous counties. Most loans are at a four percent interest rate. Mangum pointed out the important partnership between SBA and FEMA, and noted that FEMA can also help with temporary relocation costs. There was discussion about the time lapse for non-critical funding; there is approximately two months between time of application and receipt of funds.

Issue Identification
Furler outlined the expectations for the afternoon to discuss and identify recovery issues, gaps, and recommendations (immediate and long term). An immediate recommendation was suggested: to waive Medicaid copayments for residents in disaster areas during and immediately after a disaster. There was discussion about the recommendation; Furler shared that it would be advantageous to prioritize recommendations, but most important is to recognize immediate and long term recommendations.

Infrastructure gaps were noted, and there was discussion about Iowa public health standards and a potential recommendation to endorse the standards. The group had a discussion about replacing buildings in an accessible way. The public health infrastructure was discussed, and the need to adequately fund public health. This would help address the fact that agencies provide public health services outside of their scope to ensure services were delivered. Furler noted that the Infrastructure Task Force is addressing physical infrastructure issues. It was suggested that state infrastructure needs would focus on technical assistance to counties. The group discussed the need to emphasize human needs.

Public health issues identified:
- Ongoing monitoring of air quality and water quality
- Disease and injury surveillance and communication, real time monitoring and coordinated review
- Monitoring increases in substance abuse, and other significant issues (such as adult and child abuse)
- Maintain communication infrastructure
- Collaboration and coordination

Mental health issues identified:
- Short and long term capacity (state and local)
    - providers and funding
- Focus on general population, not just chronically mentally ill
- Communication, education about points of entry into the system
- Collaboration and coordination
- Public education campaign to increase awareness of services available

There was discussion devoted to the mental health system and additional strain because of increasing mental health issues. Funding an emergency mental health system with crisis counseling was identified as an important issue. Additionally, disaster response team members' mental health should also be considered, and crisis counseling for first responders is not covered by FEMA. Because seeking and accessing mental health services is a significant part of the issue, there was discussion about an education campaign to inform people about their options. The Iowa Disaster Human Resource Council, convened by Homeland Security and Emergency Management, would be a helpful resource to assist with outreach. Task Force members discussed the difficulty of getting effective messaging to target populations, and identified a need for a variety of communication methods for public awareness campaigns.

Health care issues identified:
- Nutrition and meal services, and food safety
- Special needs populations: the chronically ill, older adults, people with disabilities
- Disaster plans in facilities
- Transportation infrastructure impact on health response and mobility

- Collaboration and coordination

Task Force members indicated that health care infrastructure needs should be included in discussion for 2009 priorities. Task Force members discussed the importance of transportation needs between counties for accessing health care services. It was suggested that IowaCare enrollees should be able to access any provider during times of disaster. The group emphasized the need for the health, mental health, and public health systems to collaborate.

Other basic and human needs issues identified:
- Infrastructure that supports quality of life for special needs populations, public health and health
- Case management services
- Appropriate and affordable housing
- Transportation
- Sheltering plans for people with special needs

General and cross-cutting issues identified:
- Continuity of services
- Coordination and cross training of responders
- Loss of local government revenue
- Financial support for expanded scope of services (i.e., hospitals that provide public health services and have not been funded)
    - private funding may be a solution

Gaps Identification and Prioritization
Furler defined gaps as state responsibilities that were not otherwise provided to meet needs. Director Newton reported that Iowa Department of Public Health is currently underfunded because of $1.5 million that was spent on immunizations. The Task Force members discussed gaps in health care coverage and mental health services access. There was discussion about providing communities more decision-making authority to respond to issues. The Task Force determined a need for collaboration, not just coordination and cooperation. It was pointed out that it is important to include atypical groups for information sharing, as well, such as city and county planners. The needs of child care providers in disaster response was discussed, and it was suggested that the issue also be addressed in the education Task Force. Accessible housing for displaced individuals with disabilities is an issue. Furler asked whether there were likely to be gaps in funding and services for health care, including Medicaid. Titus stated that it is difficult at this point to project growth for Medicaid services. In terms of public health needs, the Task Force indicated a gap in funding for disease surveillance. The group talked about the need to be aware of potential increases in domestic abuse and substance abuse. There was discussion about the lack of capacity of nonprofits to take on additional debt for recovery. One suggestion was subsidizing loans or buying down interest on those loans.

The following gaps were identified:
- Funding for vaccines
- Mental health response capacity
    - Disaster related health care for those who do not qualify for federal/state programs
    - Collaboration, planning and response, operations and funding
- Temporary assistance for child care providers
- Mobility transportation
- Accessible housing for special needs populations

- Programmatic funding shortfalls
- Capacity for local government resources to meet high demands
- Inability for nonprofits to take on additional debt

Recommendations
Drinnin provided a summary of recommendations discussed thus far. There was discussion about temporarily waiving Medicaid co-pays and moving that to an issue needing further exploration. Task Force members discussed flexibility in funding streams and policy to address gaps. There are some agencies that could, with some flexibility, reallocate funding to respond to disaster needs, but some agencies are unable to reallocate because of restrictions on funding. The group discussed the role of private fundraising efforts, such as Embrace Iowa, in addressing some of the needs. There was a discussion about the ability of local areas to raise revenue through taxes or other means.

It was suggested that the Iowa Rural Health Association could coordinate with Farm Bureau and the Department of Agriculture and Land Stewardship to decrease mental health stigma.

Public health is already beginning to see increases in the number of people accessing WIC. That is an example of a specific program that would need to be monitored to assess needs for increased capacity or funding. Furler said that mental health has arisen as a need across many of the Task Forces. The importance of public education was noted. There was also discussion about the significance of noting the needs of rural areas affected, not just the areas that have been highlighted in the news.

Immediate recommendations identified:
- Education and media plan, including all affected areas
- Disease surveillance – funding and infrastructure
- Recognition of the need for health and human services private, nonprofit physical infrastructure funding support (i.e. loan interest buy-downs)
- Senior Living Trust Fund flexibility- directed to client services
- Funding for immunizations
- Funding for emergency mental health services
- Communication to points of entry on mental health and utilize unusual and alternative partners (primary care providers, public health agencies, as well as regional planners and city/county points of entry)
- Support for nutrition, food safety, and food service recovery (for identified programs and populations, including elderly and WIC programs)
- Ongoing monitoring of critical public health and health program demands (child care, substance abuse, child and dependent adult abuse)
- Implement state public health standards
- Emergency health care services during the disaster

Long term recommendations identified:
- Build local and state response capacity (i.e., behavioral health disaster plan, shelter response teams)
- Special needs sheltering
- Disaster plans in facilities (specifically, assisted living facilities)
- Local government capacity to get resources to meet high demands
- Local and state public health standards

- Accountability for state and local level partners in coordinated planning and training for disaster planning
- Building public health infrastructure (public health nurses, community mental health centers, substance abuse, mental health services)
- Support for long term planning to enhance capacity and flexibility for county, local, and state disaster planning and response
- IowaCare eligibility flexibility during disaster (may need federal approval)
- Funding and policy flexibility among state agencies for disaster response
- Adequate funding for mental health and disability services through local government ability to generate resources
- Ongoing monitoring of critical public health and health program demands (child care, substance abuse, child and dependent adult abuse)
- Ongoing monitoring of air quality and water quality and environmental standards

Also mentioned:
- State mechanism to distribute disaster funds immediately

Needing further exploration:
- Temporary waiver of Medicaid co-pay in disaster areas, subsidized by state funding

Next Steps and Process for Completing 45-Day Report

Furler asked the group to agree to the recommendations by consensus and asked them to express concerns if they had them. Task Force members agreed to the recommendations listed. Furler explained the process for the report, with a draft report emailed to the Task Force to make sure thoughts were reflected honestly. There will need to be fast turnaround for feedback within less than 48 hours. Larkin thanked the Task Force and Resource Group for their input and said there will be opportunities for clarification on the report. Larkin said that there will be opportunities for listening sessions through Speak Up Iowa in different areas of the state and at the Iowa State Fair. The Red Oak session is August 11, Fort Dodge is August 12, and the Cedar Falls session is August 19.

The group adjourned at 4:25 p.m.