

ACUTE CARE TASK FORCE:
Iowa's Mental Health Acute Care Service System
Recommendations for system planning

PURPOSE:

The Acute Care Task Force was established to conduct a cross-system review of Iowa's mental health system and to make recommendation for expanded and enhanced services.

MAJOR ISSUE:

There is a critical need in Iowa for the development of community-based services as an alternative to the current reliance on institutions for mental health care. A key step in the development of community-based services is to change the administration of funds for Iowans with mental illness, intellectual and developmental disabilities. There are current disparities in funding for supportive services delivered across the state.

TRANSFORMATION NEEDED:

Iowa is in the process of transforming its mental health system to a recovery-oriented approach based on individual and family needs of Iowans. This is a long term plan with the goal to shift philosophy from triage to recovery. The recovery-oriented approach embraces SAMHSA's National Recovery-oriented Consensus Statement with the following principles:

- Self-direction or choice
- Individualized and person-centered
- Strengths based
- Responsibility
- Respect for self and society
- Empowerment, including needs, wants and goals
- Holistic components including: community, housing, spirituality, etc.
- Non-linear recovery
- Peer support
- Hope

ORGANIZATION OF THE ACUTE CARE TASK FORCE:

Under the direction and coordination of the Division of Mental Health and Disability Services in the Department of Human Services, the Acute Care Task Force shared leadership among numerous statewide stakeholders.

The following committees were established to carry out the overall goals of the Acute Care Task Force and each committee had expertise at the systems, program and clinical levels.

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ACUTE CARE SYSTEM OVERVIEW:

The Acute Care Task Force completed an Acute Care System Map (Attachment A). The map depicts how the majority of Iowans access acute mental health and substance abuse services. It may not apply to all regions and communities; however, the map is fairly representative of the statewide system. The most widely used access point in Iowa is the hospital emergency room. Some hospitals operate inpatient psychiatric units however, the majority does not. In Iowa the use of emergency rooms is primarily due to the lack of alternative mental health and substance abuse acute care services, both secure and non-secure, with integrated continuing care options.

The Acute Care Task Force analyzed data of people accessing services at each setting in the system, including restrictive settings, such as jails. Through the mapping overview, it is clear that Iowa's acute mental health system has been created by default and not by design. When a system is created by default, the system will have gaps and pitfalls with the end result that people will not have access to a comprehensive acute care system.

OVERALL GOAL AND STRATEGIES OF THE ACUTE CARE TASK FORCE:

Goal: Develop acute care recommendations for a system that is recovery-oriented and promotes an accountable and seamless public-private system with access to care, expansion of acute care services and data-driven outcomes.

Strategies:

- To establish committees composed of key public and private behavioral healthcare stakeholders in Iowa.
- To develop Mental Health System Acute Care recommendations that can be integrated with all other behavioral healthcare planning initiatives, such as the Olmstead Plan, the combined Mental Health and Disabilities State Plan.

Goal: To examine current and future policies, rules, legislation and financial options that support contemporary crisis and acute mental health systems.

Strategies:

- To update (Chapter 229/230A) or promulgate new crisis mental health and co-occurring capable rules.
- To conduct a cross-systems financial analysis of acute care services.
- To identify barriers and opportunities to providing co-occurring mental health and substance abuse services.
- To develop Public-Private-State-County partnerships in securing funding for service delivery.
- To develop legislation and budget requests for a full array of long-term cross-systems services
- To maximize Medicaid, Medicare, federal grants, local initiatives and private revenues supporting the system.

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- To identify federal American Recovery Act or other funds that will support the acute care system (short term, housing, employment, renovation funds, etc.)

Goal: To research, plan and implement system processes and program models that are evidenced-based or best practices in mental health acute care.

Strategies:

- To identify a comprehensive array of acute care services that support crisis or acute care including:
 - Array of Jail Diversion Services and community collaboration
 - Assessment Centers (walk-in crisis response, pre-admission medical and psychosocial screening, Community Mental Health Center or non-hospital emergency room settings)
 - Children’s System of Care, Wraparound crisis stabilization, in-home based
 - Crisis care coordination/care management
 - Crisis Hotline Response 24/7
 - Crisis Stabilization units for Voluntary Admissions; “Living Room” type model with Professional/Peer Specialist Staffing
 - Drop-in Center; Clubhouse Models, Peer support services
 - Expansion of school-based mental health supports
 - Future consideration: Crisis Stabilization units for involuntary admissions; Short-term residential (secure) treatment in-state capacity (children/adolescents), Secure detoxification and/or co-occurring models
 - Mental Health First Aide
 - Mobile Crisis Response Teams (Urban/Rural models)
 - Other innovations: Iowa-based or national best practices.
 - Psychiatric emergency room models
 - Psychiatric inpatient
 - Transportation options (law enforcement and providers)
- Conduct research on effective state, national or international crisis or acute care services (i.e. data, articles, technical assistance centers, websites, etc.)
- Determine differential cost models for acute care services.
- Ensure that all mental health acute care providers are co-occurring capable over time.
- Inclusion of consumers and families in the design, development and evaluation of services.
- Review statewide clinical quality improvement practices, training, technical assistance and evaluation plans.
- Utilize logic models or other mapping tools in the assessment, design and installation of best practices in the existing system.
- Develop a partnership with law enforcement and the judiciary to implement *appropriate* jail diversion strategies, such as police-based Crisis Intervention Teams (CIT: Memphis Model); Court based programs and in-jail screening, treatment and discharge planning.
- Determine the need for traumatic brain injury (longer-term care) treatment capacity in-state.

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- Develop a statewide Mental Health Acute Care training program for providers, judges, clerk of courts, advocates, qualified assessors, etc.

Goal: To gather and analyze cross-systems data that informs planning, decision making, implementation and evaluation of acute mental health care services. (Non-identifying data in the public planning process)

Strategies:

- To gather aggregate data on mental health petitions across the state.
- To analyze voluntary and involuntary referrals to emergency rooms and community mental health settings or “document the need” based on current service array and capacity.
- To gather and analyze voluntary and involuntary admissions and lengths of stay on inpatient psychiatric units.
- To analyze the payer mix of people admitted to inpatient psychiatric settings (i.e. Indigent, Medicaid, Medicare, private pay, etc.)
- Develop a future state/county requirement for centralized data collection repository from all agencies, including hospitals, managed care firms and Community Mental Health Centers or substance abuse providers delivering acute care services.
- Utilize the expertise and evaluation capabilities of Iowa’s Universities.
- Use local or regional data as a planning and problem solving tool.
- Improve clinical data sharing between systems relative to treatment concerns, consumer consents, advance directives, transfers and establish inter-agency memorandums of agreement as a tool to sharing information. (I.e. HIPAA)
- Use data to determine system outcomes and inform the Mental Health Systems Acute Care Task Force.
- Continue to utilize MHDS on-line “Share Point” as a communication tool for data, best practices and Acute Care Task Force information.

REVIEW OF DATA

The Acute Care Task Force reviewed data related to many areas of acute mental health service delivery and funding in Iowa. Some of the key findings are noted below:

- *Iowa Judicial Branch:* Since 2005, mental health and substance abuse applications for commitments in Iowa have increased 10% for adults.
- *Iowa Judicial Branch:* Since 2005, mental health and substance abuse applications for commitments in Iowa have increased 114% for children.
- *Iowa Hospital Association and the Department of Human Services:* Iowa has over 800 psychiatric inpatient beds across the state; many of those beds are occupied by people unable to be discharged to a less intense level of service.

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- *Iowa Ombudsmans Office CPC Survey:* There is no standard procedure for locating at bed for court-committed individuals. Many counties ask parents and family members to search for an available psychiatric bed across the state. Central Point of Coordination personnel, Clerks of Court, County auditors, magistrates, sheriff department personnel, Community Mental Health Center staff and hospital staff are utilized to locate beds.
- *Magellan Behavioral Health:* Since 2005, Magellan paid \$32 million dollars for people on psychiatric units who no longer met medical necessity to be on the inpatient unit (over 6,000 patients authorizing more than 46,000 days)
- *Iowa Department of Corrections:* Over 40% of people in Iowa prisons have a mental illness or co-occurring mental illness and substance abuse diagnosis.
- *Iowa Department of Human Services:* Throughout the year there are 150 youth in out of state placement, the majority who have serious emotional disabilities.
- *Annie Casey Foundation:* Iowa is the 2nd highest in the nation for out-of-home placement of youth (2006). Approximately thirty percent (30%) of youth in out-of-home foster care come into custody for mental health service reasons, not safety and protection.
- *Iowa Department of Public Health:* Suicide is the 3rd highest cause of death across the nation for adolescents. In Iowa, suicide is the 2nd highest cause of death for adolescents.
- *DHS Acute Care Task Force Crisis Services Survey to Central Point of Coordinators, May 2009:* The array of crisis services available to Iowans is minimal and is not dispersed equitably across the state.
- *Iowa Sheriffs Association Survey from DHS Acute Care Taskforce, 2009:* Sheriff Departments across the state do not have standard assessment tools for assessing the mental health and substance abuse needs of detainees.
- *Iowa Hospital Association, Behavioral Health Affiliate Survey:* Less than 50% of emergency rooms surveyed have access to a behavioral health nurse or social worker to assist with behavioral health patient evaluations and level of care decisions.
- *Eyerly-Ball Mental Health Center, MCRT data, 2008):* When local Community Mental Health Centers assessment services are utilized at the Clerk of Court office for persons who have commitment applications filed, over 95% are diverted from psychiatric admission.

RESEARCH AND REVIEW:

Significant research, including literature reviews, expert information solicitation regarding various topical areas, Medicaid/Magellan and county funding data, service unit analysis, surveys to Central

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Point Coordinators and sheriff's departments was conducted to better understand Iowa's acute care service delivery system. The literature and data was utilized by the Acute Care Task Force to inform and guide recommendations for additional analysis and decisions regarding recommendations. The

ACUTE CARE TASK FORCE RECOMMENDATIONS:

The Acute Care Task Force chose seven priorities from a lengthy list of needs for recommendation to create a state-of-the-art acute care mental health system in Iowa.

The complete documents provided by the seven priority subgroups are attached in the Appendix C.

ADULTS AND CHILD AND ADOLESCENT CRISIS STABILIZATION SERVICES

Adult Crisis Stabilization Centers provide 24-hour access to shelter, food, social support, and comprehensive treatment services for persons experiencing a mental health crisis who are voluntarily seeking assistance and do not need inpatient hospitalization.

- Services are typically provided in a small, comfortable setting, these centers typically do not serve more than 10 people at a time.
- Treatment includes intensive discharge planning which links the consumer to natural supports and community resources needed for ongoing recovery.
- Crisis stabilization centers typically cost a fraction of inpatient hospital care.
- Crisis stabilization centers are staffed by a multidisciplinary team and may include a psychiatrist, psychiatric nurses, peer support specialists, and social workers and/or mental health counselors.
- Services often include significant peer provided care and support.
- Crisis stabilization units are recovery focused and co-occurring capable.
- Average length of stay is two weeks or less.

Youth and Adolescents Crisis Stabilization Services for provide 24-hour access to a continuum of crisis services that include:

- A) Mobile crisis outreach services that are provided in the home, school, and community to de-escalate interpersonal, community and intra-familial tension that is frequently the antecedent condition that typically underlies high-risk behaviors in children/youth.
- B) Community-based stabilization center is available to provide the children/youth with needed shelter if the situation cannot be de-escalated to a safe level. The family is a critical partner in this process and should participate in the crisis stabilization services to the fullest extent possible, including receiving services at the center with their child. The Crisis Stabilization Services Center (CSSC), in addition to providing a safe and welcoming environment that de-escalates interpersonal, family and community tension, allows the child/youth and family to access a professional team that facilitates a multi-faceted mental health assessment that evaluates the therapeutic needs of the child/youth and assists the family in accessing needed

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services. Discharge planning is also an integral part of this service, with the crisis stabilization worker facilitating smooth transitions back to the home, school, and community.

What gap is this filling in the current acute mental health care system?

Adult - There is a gap in serving the need of people whose crisis episodes are due to psychosocial stressors/events that can be better resolved through support and linking interventions (care coordination) than by medical interventions generally found on inpatient units. Crisis stabilization centers can provide an alternative to inpatient hospitalization for persons who are voluntarily seeking treatment and support to resolve a mental health crisis and do not need inpatient hospitalization. Small, welcoming home-like settings can provide respite for persons needing intensive support and linking to resources and can assist post-hospitalization for persons needing intensive assistance establishing community supports. This is an appropriate alternative for judges and law enforcement assisting persons with mental health needs to find help.

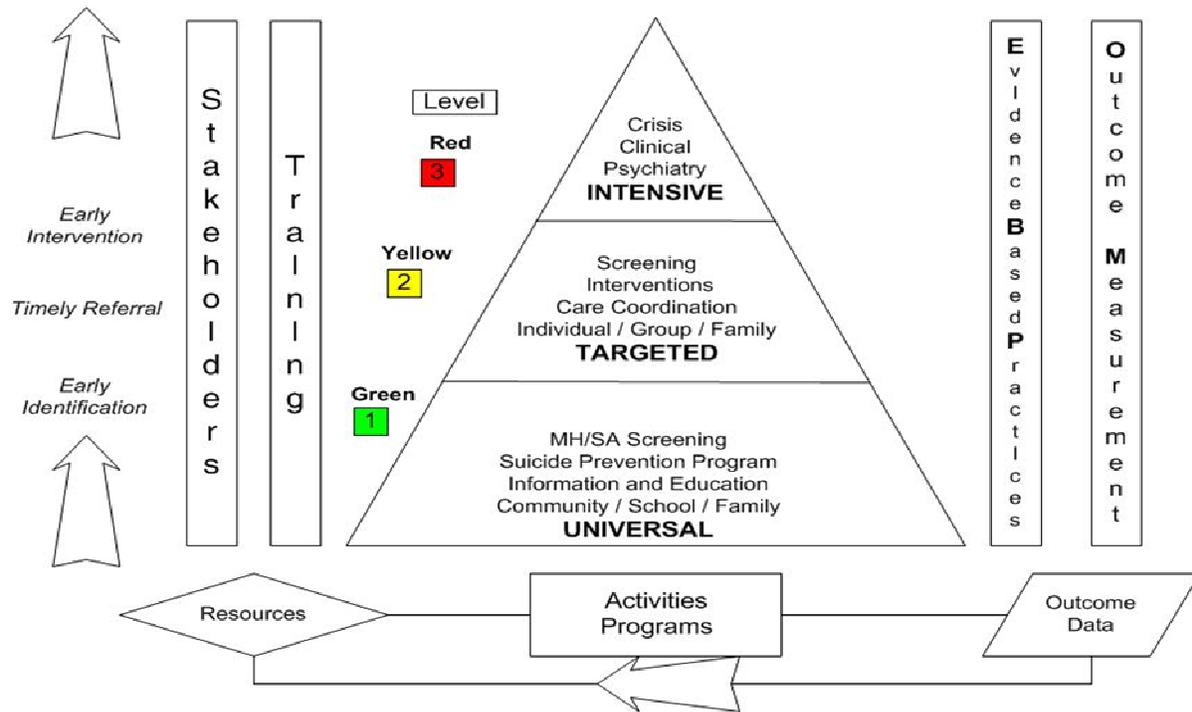
Youth and Adolescent - When hospitalization criteria are unmet or funding is unavailable, there is an absence of programming designed to provide minors with the opportunity to stabilize their emotional and behavioral situation unless the child/youth is court ordered into shelter or more restrictive services that are intended to consequence negative behaviors. The outpatient system is not designed or equipped to handle children/youth who are frequently in crisis and who may lack adequate support and services to manage their mental and behavioral health issues. Families are left with the option of seeking more restrictive options than may be needed for the situation due to the lack of crisis intervention and stabilization services. Crisis stabilization is a short-term intervention that isolates the youth from provoking stimuli and gives them the opportunity to develop insight and foresight to regain control of their future, while providing families the opportunity to receive support and assistance in improving the situation that led to the crisis.

B.) School-based Mental Health Services

General Description: The school based mental health model promoted by this task force is based on the public health model of three levels of intervention- primary prevention , secondary (early intervention), and tertiary (intensive) services. School-based mental health services would be available to all students with emotional, substance abuse and mental health needs. Additional consultation and support would be available to families to help them navigate the complex and sometimes frustrating mental health system of care. Educators would be provided with necessary education and support that will help them better understand their students' mental health needs and respond in a more effective manner.

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School-Based Mental Health Improvement Proposal Model



What gap is this filling in the current acute mental health care system?

Mental health services need to be readily available to children and families in a setting where children spend a significant amount of time, and where many behavioral and emotional issues occur. School based services provide a unique opportunity to address concerns in an environment that is convenient, more comfortable and decreases transportation issues and time away from school for appointments. Increased service provision, improved access to services, and care coordination would be available through schools, using a collaborative team approach to identify children at risk of mental health issues or in need of services, and provide/refer families to appropriate services. Schools and mental health providers would build cooperative relationships that would ensure seamless transition of referrals from schools to outside referral sources, and would maintain communication regarding ongoing needs and issues.

JAIL DIVERSION PROGRAM

Jail Diversion refers to programs that divert individuals with serious mental illness, and/or co-occurring mental health and substance use disorders away from jail and provide linkages to community-based treatment and support services.

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Jail Diversion programs:

- Screen detainees in the criminal justice system for the presence of a mental disorder
- Employ mental health professionals to evaluate detainees and work with the criminal justice system and the courts to develop community-based mental health plans for them
- Seek a disposition that is an alternative to prosecution; as a condition of reduction in charges; or satisfaction for the charges
- Decide upon a disposition and link the client to the community-based services

D.) Subacute Services

General Description: Subacute services are time-limited services which provide 24 hour comprehensive treatment services for individuals experiencing a mental health crisis who have received acute care in an inpatient setting, yet have not been adequately stabilized such that they can be discharged to their own home or other residency setting. This service is provided as part of a discharge plan to continue care from an inpatient unit. The objective of this service is to provide active treatment, ensure the safety of the person served and the safety of others, to allow time for stabilization, consultation and resource mobilization. Treatment includes intensive discharge planning which links the individual to community resources needed for ongoing stabilization and recovery in their own home and community.

What gap is this filling in the current acute mental health care system?

In Iowa, some individuals are not stabilized within the timeframe of the acute inpatient stay and cannot be safely discharged to their own home or other permanent residency situation. These individuals stay in the inpatient setting post medical necessity for acute hospitalization resulting in unnecessary costs to the individual/family, the inpatient facility, and any third party insurers (including Medicaid).

EXPANDED ROLE OF DESIGNATED COMMUNITY MENTAL HEALTH CENTERS

The community mental health center is viewed as a vital player in the provision of mental health and has a role in the delivery of acute mental health services for the communities they serve.

The Acute Care Task Force supported the proposed revision of the Iowa Code 230a which defined the role of the Community Mental Health Center. The proposed revisions defined an Access Center for a community, as a wide array of acute services, provided on a 24/7 basis. In addition, the Acute Care Task Force recommended fundamental changes in how Community Mental Health Centers are structured, financed, overseen and accredited statewide in order to allow for the a robust scope of services, including a mandated core safety net of services, to communities regardless of income, diagnosis or age.

Core safety net services suggested to be mandated include:

- 24/7 crisis emergency response
- 24/7 mobile response
- Screening Services

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- Liaison with inpatient/residential when consumer is admitted
- Crisis care coordination

What gap is this filling in the current acute mental health care system?

COMMUNITY MENTAL HEALTH CENTER would serve an active role in the delivery of the mental health safety net service array rather than a passive or selective role. Currently, while COMMUNITY MENTAL HEALTH CENTERS are required to provide “emergency services”, this often takes the form of an answering service and a referral to a local emergency room, resulting in no meaningful interaction with individual in crisis and the COMMUNITY MENTAL HEALTH CENTER. This would create a statewide safety net of services with the COMMUNITY MENTAL HEALTH CENTER serving as the “hub” for these services.

F.) Psychiatric ER Screening

General Description: The Psychiatric Emergency Room (PER) is the term used to describe appropriate psychiatric assessment and care services are provided within an emergency room setting. In the emergency room, the psychiatric exam should be completed by a behavioral health nurse or another mental health professional, utilizing an acceptable psychiatric assessment tool. Access to a psychiatrist, or mental health-skilled ARNP for level of care determinations and medication consultations should be available either in person, via telephone or via telehealth services at all times. The psychiatric exam should be conducted in a safe environment, i.e. a “safe room”, commonly located apart from the main emergency room bed area.

What gap is this filling in the current acute mental health care system?

Because the ER is the first stop for many people in Iowa in need of mental health crisis services, having a designated psychiatric emergency room that is either part of the regular ER or an actual separate emergency department is critical. Currently, most local hospitals, especially in rural areas, do not have trained mental health professionals available to provide the appropriate assessment and care services for people with mental health needs. This results in an increase of unnecessary psychiatric admissions, incorrect diagnosis, inappropriate treatment recommendations and medication prescriptions. The final outcome is often delivery of substandard care that is more restrictive than necessary and costly. Having ER staff that are placed in the ER to provide appropriate assessment and intervention will result in better care and higher quality of life outcomes for people.

G.) Commitment Diversion/Chapter 229 Revisions

General Description: The practices and Iowa Code associated with Iowa’s mental health commitment is recognized to be in need of review and revision. Like other areas of focus, the commitment process looks different in the various communities across the state, largely because the Iowa Code 229 is often interpreted differently by those who are enforcing it. The subgroup working towards recommendations on behalf of the taskforce recommends short and long term goals for redefining commitment procedures in Iowa. Several short term goals have been recommended including statewide training for magistrates, increased utilization of clinical evaluations to determine need for hospitalization, identify procedures for release of people from psych units when evaluation does not require hospitalization.

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The long-term recommendation of the taskforce is for the creation of a mental health and judicial task force to build upon the recommendations made by the Iowa Supreme Court's Limited Jurisdiction Task Force and the Acute Care Taskforce to collaborate on recommended changes to Iowa Code Chapter 229 or other related Code and to recommend a plan for achieving systematic consistency across the state between county courts, providers, mental health administrators and policymakers. The recommendations are made so that ultimately a system is developed that provides innovation and consideration of the person in need as the central focus, is efficient and does not overuse the powers of courts and Iowa Code to "manage" the mental health needs of Iowans.

What gap is this filling in the current acute mental health care system?

There are several gaps due to inconsistent interpretations of Code and subsequent procedural variations across the state related to commitment of people with mental health needs. The trickle down effect is costly to the individual's wellbeing, as well as financially to those entities that cover the costs of commitments and related services (mental health advocate services, sheriff/other transport services, legal costs, facility costs etc). Clear, consistent Code and practices adopted by the involved stakeholders will possibly result in an increase in appropriate care for people, that is often less costly.

Next Steps...

The Acute Care Task Force was a premier demonstration of how Iowa stakeholders invested in the health and welfare of people with mental health needs can work in a positive, collaborative manner to accomplish needed goals.

The Task Force members recognize that the work conducted over the past two years is the tip of work necessary to be done in building a quality acute care mental health service system. However, there was consensus among members that careful, thoughtful *planning* was, and continues to be, a critical step to building the system that will produce sustained results . It is the expectation of the Acute Care Task Force members that the Iowa Department of Human Services will continue the collaborative facilitation of planning and development necessary to move the provided recommendations forward.

Each recommendation provided in this document requires ongoing planning and problem-solving at the both the macro and micro levels to determine a feasible strategic plan for roll-out. The Task Force advises the MHDS Division to continue to lead the efforts to roll-out these services and/or policies.