V. Report of the Adult Mental Health Workgroup

A. Introduction

The Mental Health Workgroup met five times between August and October. A sub-committee met one time to discuss standardized level of functioning assessments and reported back to the full Workgroup at the October 4 meeting.

As required by Senate File 525, the Workgroup discussed a range of topics including eligibility, outcomes and performance measures, Core Services, and workforce development issues necessary to deliver a system of comprehensive, evidence-based services to Iowans. Added consideration was given to additional content areas such as multi-occurring conditions, older adults, cultural diversity and competence, and the need for Iowa to serve people in the most integrated settings possible (*Olmstead*).

This report summarizes the recommendations from the Mental Health Workgroup. Recommendations in this report were informed by comments made in the public comments session following each meeting. The Workgroup generally agreed on most issues, and the report notes areas where there was lack of consensus.

Within the context of these recommendations, the Workgroup offers two overarching issues critical to the success of the redesign process. First, mental illness is a leading cause of disability in this country. Upwards of 761,588 Iowans (25% of the population) will have a diagnosable mental illness over the course of a year, and 182,781 (6% of the population) has a serious mental illness[1]. In addition, on average, people with mental illness die 25 years sooner than the general population largely attributed to co-morbid diabetes, hypertension and other medical conditions[2]. The prevalence of mental illness throughout the population and its significant socio-economic impact to individuals, government and private industry across sectors (e.g. healthcare, criminal justice, lost productivity) make it a key public health issue that this country faces. According to Iowa's 2010 National Outcomes Measures (NOMS) 2010 report, 96,430 individuals were served in Iowa's public adult and children's mental health system[3].

While not all people with a mental illness need or will seek treatment, access to services is most typically reliant on the availability of services. Accordingly, the Workgroup premises its recommendations on the need to maintain, and, when possible, expand funding in order to ensure the success of this redesign process.

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1 Based upon 2010 Census data and generally accepted prevalence rates.

2 National Association of State Mental Health Program Directors. (2006). *Morbidity and mortality in people with serious mental illness.* http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

3 http://www.samhsa.gov/dataoutcomes/urs/2010/Iowa.pdf

Furthermore, this redesign process as conceptualized will only be partially complete until such time that there is alignment across all systems, including primary healthcare, so that people with mental illness can have access to coordinated mental health, substance use and primary care necessary to promote whole health, and that the private insurance industry is held accountable for ensuring access to a range of effective mental health services.

B. Multi-Occurring Conditions[4]

The Workgroup discussed multi-occurring conditions in the context of Iowa's system and how best to build a multi-occurring capable system. The Workgroup presumes that multi-occurring conditions are part of each of the recommendations in this report, and encourages any action on these recommendations by the legislature, DHS or any other agency consider the effect on individuals with multi-occurring conditions.

In its discussion, the Workgroup utilized a position statement submitted by Drs. Kenneth Minkoff and Christie Cline[5], nationally recognized experts in the field of multi-occurring conditions. The position statement defined multi-occurring disorders as:

> "An individual with multi-occurring conditions is defined as any person of any age with ANY combination of any MH condition (including trauma) and/or developmental or cognitive disability (including Brain Injury) and/or any Substance abuse condition, including gambling and nicotine dependence, whether or not they have already been diagnosed."

There was consensus that there must be active consideration of co-occurring and multi-occurring conditions across all functions of the system and within all services provided within core service domains. Accordingly, the Workgroup supported the following statement excerpted from the position paper:

> "For individuals and families seeking services in Iowa, multi-occurring issues should be the expectation, not the exception. We need to design a system in the State in which all services are organized to welcome, inspire and provide integrated services to individuals and families

4 The terms "co-occurring" and "dual diagnosis" often refer to individuals with two diagnoses such as a mental illness and substance use disorder or an intellectual disability and mental illness. The use of "multi-occurring" expands on this concept that a person may have two or more co-existing conditions that need to be addressed simultaneously, and that systems must develop the capability to serve and/or coordinate care for those with multi-occurring conditions.

5 Minkoff, Kenneth & Cline, Christie. (2011). *Assuring a system of care designed to serve individuals and families with multi-occurring conditions and disabilities, and other complex needs; A guide for universal implementation*. Prepared for the Iowa Mental Health and Disability Redesign. http://www.dhs.iowa.gov/docs/Co-occurringPositionStatementandGuidanceDocument_10-13-2011.pdf

with multi-occurring conditions and disabilities, and other complex needs. Therefore, we recommend that as part of addressing the elements of each workgroup's charge (e.g. eligibility, core services, workforce, accreditation, performance measurement/quality management), Iowans should expect all agencies and programs in the State that provide mental health, intellectual/developmental disabilities, brain injury and substance abuse services to commit to work as partners, both statewide and in regional systems, to develop "multi-occurring capability" within their existing resources and according to their stated missions, by continuously improving their ability to address the needs of individuals and families with multi-occurring issues and disabilities."

This includes, but is not limited to, state agencies working together on regulatory standards and financing, eligibility for services, service delivery models, workforce development initiatives, and outcomes measurement and evaluation. Like many other issues discussed in the redesign process, working with individuals with multi-occurring conditions requires the involvement of multiple stakeholders at various levels.

The Workgroup particularly encouraged DHS and the Iowa Department of Public Health (IDPH) to continue to work collaboratively together. The Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) are committed to a statewide system of care for Iowans with complex concerns, including but not limited to, disabilities, mental health issues, and substance use disorders. Related efforts over the past several years have involved consumers, clients, family members, providers, policy-makers, consultants, county and state staff, and other stakeholders in varied venues ranging from public forums and listening posts to planning groups and trainings. As a result, Iowa has a strong base of educated and committed individuals who are contributing in ways specific to their individual or organizational mission to a comprehensive system of care that supports people working toward personal recovery. The following joint statement from DHS and IDPH is consistent with the intent of addressing multi-occurring conditions:

"Over time, all Iowa disability, mental health, and substance use disorder services – and all State processes that support such services – will become recovery-oriented and capable of meeting the complex needs of individuals and families."

The Workgroup generally agreed that no new organized structure should be created to address co-occurring/multi-occurring conditions, but rather all component parts of the system must commit to addressing multi-occurring conditions within their scope of work. The group was clear that multi-occurring conditions are the expectation, not the exception, and silos that perpetuate barriers to a welcoming, holistic approach should continue to be broken down.

C. Eligibility - Adults

The Workgroup concluded that having two definitions in the Iowa code – Mental Illness and Chronic Mental Illness – were unnecessary. The definition of mental illness, as described below in "Diagnosis," and level of impairment should determine general eligibility, and clinical assessment and consumer choice should factor into eligibility for specific services rather than meeting a definition of "chronic mental illness".

Regarding Financial Eligibility, there was consensus in support of a co-payment and sliding fee scale as long as there is the ability at the provider level to waive the co-pay and adjust the sliding fee depending on individual circumstances. It was noted that the use of co-pays and sliding fee scales should not become a barrier to individuals who may be seeking treatment. Some members also suggested that if an individual's income increased that there should be a mechanism to ease them off of assistance rather than dropping them off immediately.

The Workgroup further recommends that DHS conduct an impact analysis on the number of people who could be served at 150% of the Federal Poverty Level (FPL) versus 200% of FPL. While it understands the limitations of available funding, the Workgroup felt that this analysis would support a more informed decision-making approach to the threshold that is ultimately applied.

It was noted that this eligibility criteria is for general eligibility for services in Iowa. Other insurance coverage (e.g. Medicaid, Medicare, other third party) will have unique eligibility criteria. In addition, people will receive specific services depending on certain criteria including level of functioning, severity of symptoms and other needs and by funding source (i.e. federal block grant). In any case, however, a person experiencing a crisis should receive appropriate services regardless of their situation.

Age: An individual must be 18 years or older.

Residency: An individual must be a Resident of the State of Iowa.

Financial Eligibility: An individual must have an income equal to or less than one 150% of the Federal Poverty Level, as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human services. A contracted provider shall apply a copayment requirement for a particular disability service to a person with an income equal to or less than 150% of FPL. The copayment amount shall be established with rules adopted by the commission applying uniform standards with respect to copayment requirements, including a waiver provision. A person with an income above 150% of FPL shall be eligible subject to a copayment or other cost-sharing arrangement subject to limitations adopted in rule by the commission. A person who is eligible for services must apply for and utilize other potential sources of insurance or financial coverage for services prior to using public funds. The Workgroup recommended that beginning July 1, 2014, savings resulting from the Affordable Care Act's

expansion of Medicaid and private insurance to currently uninsured individuals shall be reinvested to expand eligibility to 200% of the FPL.

Diagnosis: An individual must have or have had at any time during the past year a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable mental illness[6]. An individual will also be eligible for services in situations where criteria for a specific diagnosis have not yet been met, but the individual is experiencing functional impairment and psychological duress which substantially interferes with or limits one or more major life activities. An assessment of functioning must be documented in the clinical record.

Continuity of Services: It is expected that individuals will progress through treatment and services. Consumer preference and clinical assessment shall be considered in determining the appropriate programs and services available to an individual so as not to jeopardize the recovery of a consumer through premature discharge or termination.

Functional Assessment: Following the Workgroup meeting on September 9, 2011, a subcommittee met to discuss functional assessments and reported to the full Workgroup on October 10, 2011. The Workgroup recommends that a standardized functional assessment tool, such as the LOCUS, be used by all contracted providers who receive Medicaid and non-Medicaid, public funds for individuals needing an intensity of services beyond Outpatient treatment. Data from the functional assessment shall be available to DHS, IME and/or the regional entity responsible for managing service provision and payment for services as applicable. The tool should be administered at set intervals consistently across the regions, and more frequently as needed to support clinical decision making for levels of care.

The purpose of the standardized assessment includes the following:

- The tool can be used as an authorization for services to support the recommendation for a particular service. The Regional entity can verify that an assessment has been done and that the service a consumer is receiving or assigned to is consistent with the level of care identified in the assessment. For example, the tool may indicate a level of service equivalent to Outpatient Counseling. Thus, placement into Assertive Community Treatment (ACT) would be inappropriate and better utilized by a person in need of that level of service, unless a more detailed clinical assessment justifies the need for the more intensive level of care. The Workgroup felt strongly that an individual who is benefitting from a particular program or

6 The exclusion of substance use and developmental disorders is as a result of existing statutory requirements for the use of funding. The Workgroup recognized the limitations perpetuated by this criteria, and recommends that the legislature, DHS and IDPH work together to ensure that existing or potential statutes and regulations and restrictions on the use of resources do not create barriers to accessing services for those with mental illness, substance use disorders, developmental disorders and multi-occurring conditions.

service should be considered for continued stay in the program or service, despite the tool's recommendation, if consumer preference and clinical assessment justify continued stay.

- Aggregate data collected from the report can be used in a Dashboard Report by DHS, regional entities and the Iowa Plan to support outcomes. For example, progress or regression can be identified over time on an individual, regional and a statewide systems level.
- At a state level, aggregate functional assessment data would allow for analyses of levels of service across regions vs. expected need.
- Aggregate data can be used to inform policy makers and payers regarding the general need for particular levels of services. For example, if a region didn't have access to an ACT team, it would be expected that there would be more discrepancies between the functional assessment recommended and actual levels of care, with more patients being in residential settings. This would help support the development adequate array of services to match the needs in each region.

D. Outcome Assessment and Performance Measures

The workgroup felt strongly that outcomes should be clear and understandable to a wide variety of audiences. DHS, the Iowa Plan contractor and regional entities should be required to monitor and evaluate similar outcomes and performance indicators.

Recommendation: The group suggested that outcomes be measured in at least the following core service domains:

CORE SERVICE DOMAINS	
Acute Care and Crisis Intervention Services	Recovery Supports
Mental Health Treatment	Family Supports
Mental Health Prevention	Health and Primary Care Services
Community Living	Justice Involved Service
Employment	Workforce Development[7]

Recommendation: Outcomes and Performance Measures Committee: Due to the limited time available, the Workgroup was unable to recommend detail regarding the specific outcomes and performance measures the system should work on. The Workgroup did agree that the Vision and Principles identified earlier in this report (Section III) provide a sound foundation for the specific development of outcomes and performance measures.

7 Workforce Development was added to the Outcomes list because of the serious workforce issues confronting Iowa.

Therefore, the Workgroup further recommends that an Outcomes and Performance Measures Committee be established to continue and finalize this work beyond the Redesign process. The first responsibility of the committee should be to recommend specific outcomes and performance measures to be measured consistently across the system. To the extent possible, there should also be consistency across disability groups. This Committee should also include an evaluation of current data collection requirements that should be eliminated because they may be administratively burdensome or have little relevance to outcomes or other reporting requirements (e.g. legislature, federal block grants). A summary of the various data elements that are currently captured by DHS or other entities is attached.

The committee should be composed of DHS employees and stakeholders with expertise in quality improvement, including representatives from the Iowa Plan, the *Olmstead* workgroup, regional entities, University of Iowa, consumers and family members, and the provider community.

Once the outcome and performance measures are established, the MHDS Commission and Department should monitor, evaluate and report the progress toward system outcomes on at least an annual basis as well as any recommendations for improvement or modification.

Recommendation: Data collection must be tied to outcomes. Data must also have relevance to each of the players in the system, including the Department, the Medicaid contractor, the Regional Entities, and providers. Data with little or no relevance to the system should be phased out. The Workgroup noted that much data is collected in the system, but the general consensus is that it is not used to guide decision making.

Recommendation: Contributing to this is the lack of capacity at DHS due to relatively small numbers of staff. DHS is in need of additional staff resources if it is to be able to perform a satisfactory role in monitoring outcomes and the overall effectiveness of the system. Sufficient staffing for this function must also be considered in the development of the regional entities.

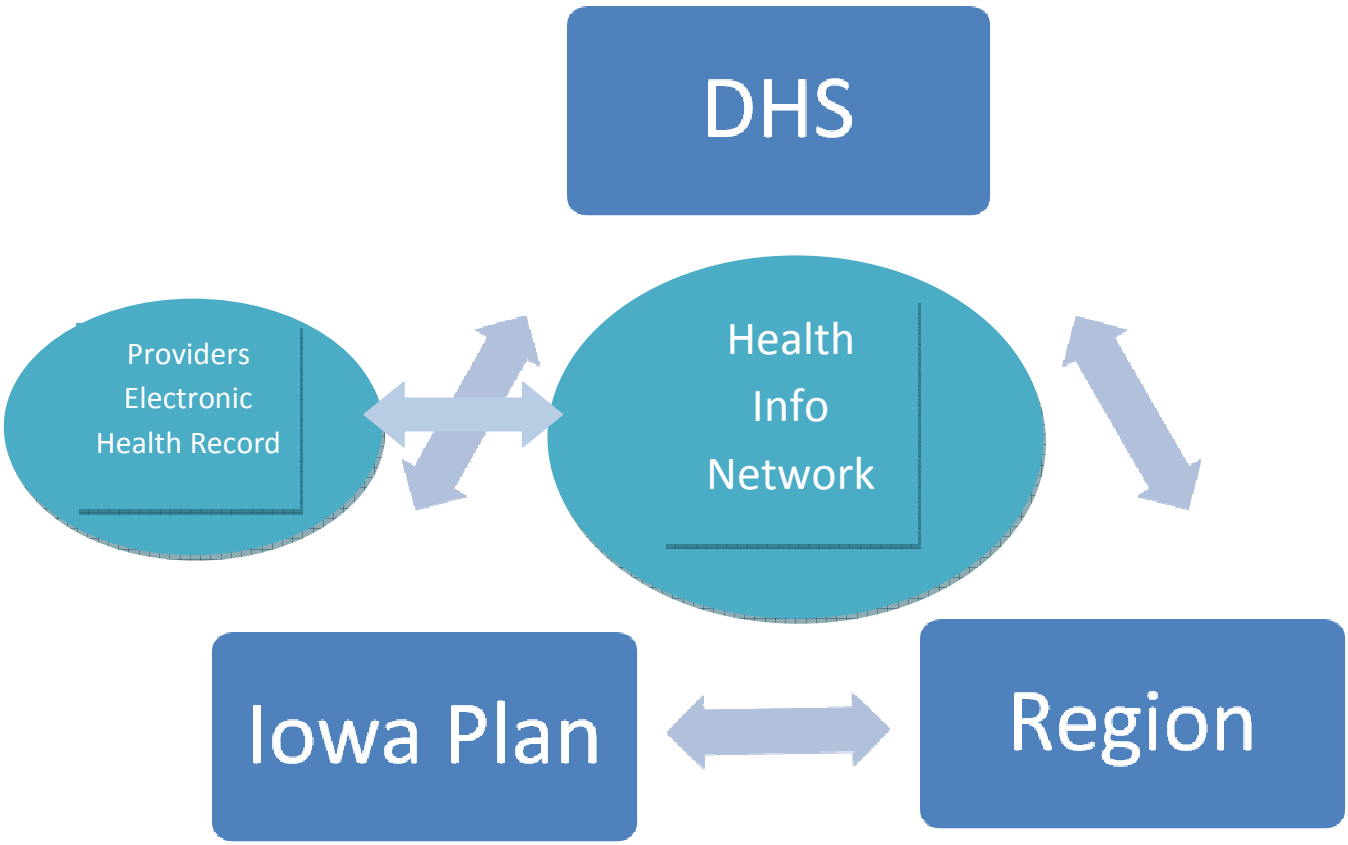
Recommendation: There was discussion regarding whether data for performance indicators should be handled by DHS or by the Iowa Plan contractor and regions. The Workgroup felt that a singular repository at the State level is desirable though much of the data will flow through the regions and the Iowa Plan contractor as a first step in the process. DHS currently is able to access data about Medicaid recipients. Ability to access similar data on a timely basis about non-Medicaid services, including but not limited to dashboard reports, is also necessary to provide clarity of services delivered in the state as a whole.

Recommendation: An Iowa Health Information Network (IHIN) is currently under development state wide and will serve as Iowa's Health Information Exchange. While Electronic Health Records (EHR)are currently being adopted across health care systems, full implementation is still several years away. However, EHR's alone are not enough without the ability to aggregate and analyze the data. Therefore, EHR's should connect to the IHIN.

Any current or future state or regional IT systems (for example the current ISAC CNS system) should also connect to the IHIN. It was strongly recommended that mental health and disability services providers must be considered active partners throughout the development in the process as this has not been the case thus far.

A web-based system at the regional and provider level should also be developed that can support the seamless input and output of data through the IHIN. Data planning efforts need to incorporate HIPAA transaction standards and ICD-10 coding. This will ensure that data collection and coding are consistent and thus provide the ability to extract meaningful information.

A basic diagram for an integrated data delivery system is provided below and demonstrates that when an integrated electronic IHIN is developed with other electronic data feeding into that system, each of the component parts of a system can extract and utilize the data for its purposes.



E. Core Services

Recommendation: Core Service Domains: The Workgroup discussed "core services" over several meetings. The Workgroup generally felt that the continuum of services identified in the SAMHSA paper, *Description of a Good and Modern Addictions and Mental Health Service System*[8], is ideal, and considered its components during this process. While there is a need to fund evidence-based practices and other effective services within the system, the Workgroup was hesitant to develop an exhaustive list of core services that should be mandated.

The reasoning for this stems from the idea that, from a person-centered planning approach, different services may benefit consumers depending on their unique circumstances. Therefore, the Workgroup identified minimum Core Service Domains that should be mandated throughout the State. Within each Domain, a range of services can be provided depending on individual needs. There will likely be some variability in what services are funded and how they are delivered due to certain variables, such as rural versus suburban or urban communities. Nonetheless, each region, as well as the Iowa Plan, must ensure that a cadre of known effective services and evidence-based programs are available within each of the following Core Service Domains:

CORE SERVICE DOMAINS	
Acute Care and Crisis Intervention Services	Recovery Supports
Mental Health Treatment	Family Supports
Mental Health Prevention	Health and Primary Care Services
Community Living	Justice Involved Service
Employment	

Recommendation: As part of the discussions on core services, specific services were discussed. In addition to the development of a continuum of available, flexible services in each Domain in each region, the Workgroup does recommend the following services be created in each region. Each service should be capable of working with individuals who present with multi-occurring disabilities and those with more specialized needs (e.g. older adults). It is also recommended that services have adequate reimbursement to ensure financial viability necessary to achieve intended outcomes and fidelity to accepted models.

8 http://www.dhs.iowa.gov/docs/SAMHSA_ModernAddictions_8-22-11.pdf

1. Peer Run Self-help Centers: The use of peers in delivering services is recognized as an evidence- based practice in producing positive outcomes for consumers, and has a secondary gain of expanding the workforce necessary to meet the demand. Each region should establish one or more self-help centers. The self-help centers should be managed by a Consumer Program Manager at a gainful salary. The self-help center should consist of a governance structure that is composed of more than 50% consumers. The self-help center should also build in wellness and supported employment functions to the extent possible.

2. Crisis Services: Each region should have Psychiatric Emergency Services (PES) services that contain a range of crisis intervention and diversion services. PES services can be organized and administered by a single provider within a region or through a coordinated network of crisis response services as long as the core functions exist. When diversion is not possible, the PES will be responsible for facilitating inpatient hospitalization when necessary. The Acute Care Task Force Report (February 2010)[9] contains models that should be referenced for program development.

   - 24/7/365 crisis hotline. The hotline should be answered locally within a region. However, for ease of access to the general public, a single hotline number can be established that automatically bumps to the local area code that the individual in crisis is calling from so that it is answered by PES in close proximity to the caller.
   - Mobile Response: The PES must have 24/7/365 mobile response with the goals of, first, mitigating the crisis and diverting from inpatient hospitalization; second, facilitating inpatient hospitalization when civil commitment is necessary; and, third, ensuring linkage with the appropriate follow-up services. Mobile Response may be initiated by PES when a person calls, or may be requested by local police. In situations where Mobile Response is unavailable, a person may go to or be brought to the PES program for evaluation. The PES program should have capacity and/or access in the local emergency room, as well as, in non-hospital based settings.
   - 23-Hour Crisis Observation, Evaluation, Holding and Stabilization: These beds are used to provide assessment, extended observation, acute intervention, and continuity of care services under medical supervision and continuing nursing evaluation for up to one day to individuals in crisis and exhibiting acute psychiatric symptoms/impairments. Time spent in the bed is used to further evaluate the patient for the most appropriate level of care.
   - Crisis Residential: Each region should have short-term (0-7 days) crisis residential capacity in an unlocked setting. The purpose of this voluntary program is to help a person stabilize a psychiatric crisis and to avoid an unnecessary inpatient stay. Crisis residential programs may be staffed with consumers. Crisis Residential is for people

9 Iowa Acute Care Task Force Report (February 2010).
http://www.dhs.iowa.gov/docs/AcuteCareTaskForceRecommendations_FINAL_10-14-2011.pdf

who are experiencing an acute episode such that if this intervention is not in place, they would otherwise meet inpatient criteria. Crisis Residential services may be provided in a person's place of residence with intensive on-site, wraparound support or in a residence designed for this purpose. The residence should serve less than six people at any given point in time. If not directly managed by the PES program, it should work closely with the Crisis Residential program to ensure the efficient use of the beds. DHS should establish standards for Crisis Residential to ensure consistency across the State.

3. Sub-acute Services: The Workgroup felt that a range of sub-acute residential services should be available in each region as both a step-down and inpatient diversionary service. Sub-acute services should be defined as a residentially based service, either a) in the person's home; or b) in another residential setting. Sub-acute services have the ability to provide up to 24 hour on-site support with a range of psychiatric, substance use and medical treatment and support services. Eligible consumers should not require inpatient care, but their level of functioning is such that they require more intensive supports to remain in the community. Sub-acute services are intended to be temporary in nature with average length of stays up to 30 days with longer lengths of stay requiring authorization from the region. Sub-acute services are ideally in settings with fewer than six people. The Acute Care Task Force Report (February 2010) contains models that should be referenced for program development. However, the Workgroup did not reach consensus as to whether sub-acute facilities should have the ability to be locked or unlocked facilities. This issue should be explored further because it could have potential *Olmstead* and Medicaid reimbursement consequences. DHS should establish standards for Sub-acute Services to ensure consistency across the State.

4. Jail Diversion: Each county within a region should have access to a Jail Diversion program, such as a Crisis Intervention Team (CIT) based upon the principles in the Memphis, Tennessee CIT model. Several programs were studied for best practices including the jail diversion program in Bexar County, Texas as well as the program in Blackhawk County, Iowa. DHS should lead development of jail diversion in coordination with the Department of Corrections, local law enforcement and other stakeholders (e.g. Judiciary, consumer, NAMI). Using the Sequential Intercept Model, which is currently being used in Polk County, Iowa, jail diversion services should assist along the various points of intersection with the criminal justice system.

5. Assertive Community Treatment (ACT): Each region should have at least one ACT team that can serve Medicaid and non-Medicaid eligible individuals. Regulations that define the scope of ACT services should be established by DHS to ensure consistency throughout the state and fidelity to the ACT model. Some states, such as Texas, apply different standards to ACT teams depending on whether they are in rural or more urban

areas. ACT teams in rural areas can be expected to have smaller caseloads and spend more time traveling to see consumers.

6. Community Support Services/Supportive Community Living/Case Management: DHS should blend and consolidate these services into a single service that provides an array of flexible, recovery-oriented support and care/case management services delivered by a team of professionals, paraprofessionals and consumers, building off of a supportive housing model. By consolidating these services, duplicative, fragmented and competing services can be eliminated in lieu of a more coordinated approach to delivering services. Supporting an individual in their own residence, whether it is with family, a small shared living residence or their own home/apartment is cost effective, consistent with *Olmstead*, and desired by consumers. In this program, housing is not contingent upon receipt or compliance with services. This model often meets the needs of consumers who are very independent and those who are often difficult to serve in group settings, but can succeed in community living arrangements with intensive wraparound supports. DHS should establish standards for a Community Support Service/Supportive Housing service to ensure a level of consistency throughout Iowa. Any future modifications to the Targeted Case Management program should be considered in this consolidation.

7. Health Homes: Section 2703 of the Affordable Care Act (ACA) gives states the ability to submit a State Plan Amendment (SPA) to create Health Homes. CMS will pay for 90% of the costs of care management for the first two years. The Iowa Medicaid Enterprise (IME) should submit a SPA to develop Health Homes in each region of the state. Health Homes should be available to Medicaid and non-Medicaid individuals who fall into this category. Magellan currently has an integrated health home pilot underway. Health Homes are more a way of organizing service delivery rather than a new service.

8. Supported Employment and Supported Education: Obtaining gainful, meaningful employment is critical to a person's recovery and enables individuals to contribute to the system. Each region should establish these programs, and mechanisms to coordinate with the Iowa Departments of Labor and Education, and at the local level with employers, colleges and universities, should be established. The Workgroup did not recognize sheltered workshops as Supported Employment.

9. Family Support Services: Family psycho-education is considered a best practice. Regions should create mechanisms for families to receive support, skill building training and other supports to help cope with the illness of their loved one and to assist in their recovery.

Recommendation: Reimbursing evidence-based practices and services identified through a person-centered planning approach: The Workgroup recommends moving toward the availability of statewide evidence–based practices within each Domain and away from services that do not have an

evidence base. In addition to the Core Service Domains and specific services identified above, there are other services that are as important to an individual's recovery. These may include, for example, more traditional services like outpatient counseling as well as things like rental assistance, transportation, or homemaker services. The critical concept is that a successful system ensures that there is a foundation of core, evidence-based services and programs that deliver a cadre of flexible, individualized services.

Some services that may be important to an individual, based on a person-centered planning process, are not currently covered by Medicaid because of federal requirements or are not currently in the Medicaid state plan, but are important nevertheless. For instance, in a Community Support Services model, a service or function such as rental assistance or paying for food on an emergency basis may not be covered by Medicaid, but are worthy of reimbursement as compared with costly alternatives (e.g., homelessness). Therefore, Regions should have the flexibility to pay non-mandatory, yet essential, "services" as needed. Rather than include or exclude specific services that should be considered as reimbursable, the workgroup suggests that the following criteria be considered by regions when reimbursing for services:

1. A person-centered planning process should be utilized to justify the need for particular services.

2. The services should be recognized as having an evidence-base to support them.

3. Conversely, agencies should move away from providing those services for which the evidence base demonstrates that they do not yield the desired outcomes, i.e., move away from those services that appear to be ineffective.

The third recommendation is to examine the support provided to services that do not appear to be effective or supportive of Olmstead principles. A good example is the continued wide use of sheltered workshop for adults with mental illness versus supported employment. Accordingly, the Workgroup recommends that as regions are developed, they demonstrate a business plan for how they will implement evidence-based and best practices within each of the Domains over a five year period and reimburse services identified in individual service plans. The Workgroup felt this should be developed at a regional level due to the variability in regional makeup. Regional phase-in schedules should demonstrate how services that will yield the greatest return on investment will be phased in earlier in the process. The Workgroup also recommends that any expansion of new services should not be at the expense of current, effectively working programs.

F. *Olmstead* and System Rebalancing

Trends

Mental health systems across the country have historically been built upon an institutional, "get sick first" foundation. In the 19th century, many large state psychiatric hospitals were built and housed thousands of patients and employed thousands of individuals. At times, institutions played various roles including taking care of war veterans with "shell shock," family members from wealthy families who paid to have their loved ones taken care of, and the severely disabled. "Scientific" treatments evolved from hydrotherapy, lobotomies, dental and electric shock to the use of psychotropic medications, cognitive therapies, and other best practices known today aimed at recovery and preventing the need for inpatient treatment. Whereas the population of state institutions in the early to mid-20th century ranged in the hundred thousands, the census today is roughly 50,000 individuals nationally.

Note: Data in the following section is mostly excerpted and adapted from SAMHSA's *Funding and Characteristics of State Mental Health Agencies,* 2009 and 2007 editions[10/11].

In 2008, Iowa had approximately 150 adult residents in the state psychiatric hospitals at the start of the fiscal year. Patients per population (100k) were 6.8, as compared with a national average of 18. Average length of stay for adults was 53 days as compared with a national average of 170. Thus, the Mental Health Institute's in Iowa play more of an acute care role than in many other states. In addition, 80.7% of children and adolescents were involuntarily admitted in FY 11while those categorized as Adult Psych was 87.6%, and 70.4% for the Adult Dual program.

Most states use their state psychiatric hospitals to serve adults, elderly consumers, and forensic patients (e.g. those determined Not Guilty By Reason of Insanity, needing competency evaluation/restoration, or on detainer status). Patient demographics are increasingly toward treating those with forensic involvement or who require a longer inpatient stay and serving individuals without forensic status in community settings or local acute care inpatient settings as needed. Nationally, nearly one-third of all consumers in state hospitals were involuntarily criminally committed. Since 1993, state psychiatric hospital expenditures have increasingly been applied to forensic services. In 2006, 2% of Iowa's MHI population had a forensic status whereas the average across the country was 32%. Voluntary admissions into state hospital level settings are in decline, though Iowa has a relatively high number of voluntary admissions (21%) as compared with some states with fewer than 5% of admissions being voluntary (e.g. New Jersey, Mississippi, Montana, Nebraska, Nevada, New Hampshire, Tennessee, Utah,

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10 Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, Md: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

11 Substance Abuse and Mental Health Services Administration, *Funding and Characteristics of State Mental Health Agencies, 2009.* HHS Publication No. (SMA) 11-4655. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

and others). Several factors may contribute to this including geography in rural states and lack of funding for community-based alternatives.

As State Mental Health Authorities (SMHA) continue to reduce the size and presence of state psychiatric hospital beds and more frequently treat consumers in community-based treatment settings, funding for psychiatric hospitals continues to decline. In FY 2001, 63% of SMHA funds were devoted to community mental health systems. In FY 2007, SMHAs expended over 71% of their funds on community mental health services, whereas state psychiatric hospital inpatient services represented 27% of SMHA resources.

Nonetheless, the cost of operating state hospitals is mostly paid for by states and counties, and is expensive. The federal government, through CMS, continues to refrain from financial participation in large inpatient and community-based congregate care settings, known as Institutions for Mental Diseases (IMD). In 2008, the average expenditures, nationally, per patient day for civil status adults were $566.80, or roughly $207,000 annually. This number may actually be higher since many SMHAs do not account for fringe benefits in their cost estimates since these are often the responsibility of state Treasury departments.

In 2008, 26 SMHAs indicated that they either have closed, or are planning to reorganize, downsize, or close, a total of 44 state hospitals. Four states have closed a total of seven facilities in the past 2 years, and five states are currently planning to close one or more state psychiatric hospitals. Rather than eliminate state-operated inpatient psychiatric services altogether, many states are opting to reorganize their systems. Of the 26 SMHAs with plans to reorganize, the most frequently cited activities include closing hospital wards (58 percent), significantly reorganizing within one or more state hospitals (46 percent), downsizing one or more hospitals (42 percent), and consolidating two or more hospitals (23 percent). Eleven SMHAs are replacing old state psychiatric hospitals with new hospitals.

Olmstead

Several challenges emerge as states seek to redefine the roles of state psychiatric hospitals and other service providers, and rebalance the use of resources. There are many public opinions about what's best for consumers and where they should be served and economic and employment concerns for local communities. Paramount is the need to keep civil rights and fact based dialogue regarding the prudent use of taxpayer dollars at the forefront of all discussions. States, and in many instances, counties, will also continue to play a role in ensuring the availability of safety net services.

While the availability of inpatient treatment, both longer and shorter term, will be necessary in the foreseeable future, it is increasingly accepted that smaller, more integrated community-based settings over large congregate settings, both inpatient and community-based, are more preferable to consumers, produce better outcomes and are more economical to states. However, rebalancing systems is complex and requires changes in thinking, commitment to ensure civil rights of consumers, and creative funding strategies. Iowa will need to grapple with the design of its residential/housing

continuum, how it should be funded, and what role larger facilities should play in the mental health system.

What is clear is that states are increasingly facing litigation from the US Department of Justice and/or statewide protection and advocacy organizations, using the US Supreme Court *Olmstead* decision, to force development of smaller, more integrated housing and services options for people with mental illness and other disabilities. Though the Supreme Court decision was rendered in 1999, *Olmstead* efforts appear to have accelerated in the past few years. For example, New York lost a case last year for having too many people living in "adult homes,"[12] large board and care facilities that provided little treatment and community integration. New York also recently settled a lawsuit aimed at overutilization of nursing homes for people with mental illness, and is geared toward facilitating the movement of people into more integrated housing options[13]. Illinois recently settled a case where it was asserted by the Illinois ACLU and other advocacy organizations that they had too many people living in nursing homes[14].

As stated above, CMS continues to refrain from financial participation in large inpatient and community-based congregate care settings, known as Institutions for Mental Diseases (IMD), and is focusing its efforts on providing Medicaid reimbursement opportunities in smaller settings. Thus, states and counties remain the primary payer for larger settings whereas the federal government will participate financially in smaller settings enabling many states to serve more people at a fraction of the costs. CMS has developed various funding strategies to support community integration. Among these include the use of optional services such as the 1915(i) (Note: Iowa has a 1915(i) state plan option), rehabilitation option services, and Money Follows the Person. More recently, the care coordination features in the Health Homes option are likely to lead to positive outcomes. CMS will not reimburse for services provided in residential programs with more than 16 beds.[15]

While Iowa tends to have fewer patients per 100,000 residents in its Mental Health Institutes, its percentage of civilly committed and voluntary patients is higher than many other states, and its percentage of those with forensic involvement is lower than the national average. It should be anticipated that as those collectively involved in the mental health system (i.e. providers, courts and police) engage and divert people away from the criminal justice system to the mental health system, there could be added pressure for inpatient settings in lieu of corrections. This may ultimately present an issue of whether to add additional beds or redefine the target population served in the continuum of inpatient settings in Iowa.

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12 This case is under appeal.

13 *Joseph S. et al. v. Hogan*

14 Williams v. Quinn

15 There are some exceptions. CMS will pay for services for those under 21 or over 65 years of age. CMS may also pay for services if the facility has more than 16 beds, but less than 50% of the residents have a mental illness or substance use disorder.

Workgroup Discussion and Recommendations:

The Workgroup discussed *Olmstead* principles in several meetings and agrees that people should be served in the least restrictive, most integrated settings possible. By investing in services consistent with *Olmstead* principles, the system will be working to ensure that the civil rights of individuals with disabilities are protected, will have a greater return on its investments, and enable the State to rebalance or reallocate funds to fill gaps in services. This includes the recognition of serving people in smaller, non-congregate care settings and leveraging Medicaid to the extent possible. Examples of smaller settings include independent apartments and small shared living residences. This process will take time, and, ultimately, financial incentives should be built into rates or contracts to support this transition.

Within the continuum of inpatient care, the Workgroup discussed the role of the Mental Health Institutes, local inpatient treatment at acute care hospitals and non-inpatient, sub-acute settings. The Workgroup recommends that the legislature direct DHS to continually evaluate the inpatient continuum of services as the community system develops. The Workgroup agreed that there is a need for additional forensic inpatient capacity within the Mental Health Institutes and that as the need for long-term, civil commitment inpatient beds decreases as the community system strengthens, some beds can be re-purposed for individuals with mental illness and forensic circumstances. The Workgroup decided that the current construct of a forensic psychiatric hospital being located within the prison system should be transitioned to one that is located within the control of the mental health system.

The group agreed that, when needed, inpatient care should be delivered in local, acute care settings to the extent possible and that the Mental Health Institutes are more appropriate for patients who require longer term treatment. Local, acute care inpatient units are largely non-existent in Iowa for several reasons, mostly due to geographic and reimbursement issues for acute care hospitals. The Workgroup suggests that the legislature direct DHS to explore the expansion of local acute care, inpatient capacity, including a call for beds through a Certificate of Need process and suitable reimbursement for beds. The current number of operational beds at the Mental Health Institutes is needed and should not be decreased further without a corresponding increase in the number of psychiatric inpatient beds within local, acute care hospitals.

It was suggested that more beds are not necessarily needed in the system, but rather existing beds be used more efficiently. However, most members agreed there is a shortage of acute psychiatric inpatient beds and that consideration should be given to expanding beds now to meet immediate demand, even if on a transitional basis. This does not necessarily mean that new beds become permanent, and the system should be flexible enough to reallocate resources as the system evolves. As community-based alternatives become operational and demand for acute inpatient decreases, beds can be closed and funds reallocated to community services.

The Workgroup also recommends that DHS continue to evaluate the need for sub-acute services consistent with the recommendations in this report and the previous Acute Care Task Force Report. Within this discussion, there was discussion about the role of Residential Care Facilities (RCF) in the state. There is a wide variation in RCFs, including numbers served and services provided. Most RCFs are large (i.e. over 16 beds) and do not receive any Medicaid funding for services. The Workgroup recommends that DHS engage the Department of Inspections and Appeals and other stakeholders on defining the role of RCFs in the system and modifying licensing and inspection standards accordingly. The use of substance abuse residential services should also be considered for use as sub-acute care.

G. Supporting and Maintaining a Competent and Committed Workforce

The challenge of having a sufficient workforce is not unique to Iowa. Insufficient numbers of staff combined with existing staff whose knowledge and experience are inadequate to meet the needs of service recipients has created a national workforce crisis in behavioral health. For most mental health positions, there are severe workforce shortages, and nearly all of Iowa's counties are designated as shortage areas in Mental Health Care Health Professional Shortage Areas (HPSA)[16]. Iowa consistently ranks toward the bottom in terms of the availability of psychiatrists and psychologists. In 2000, Iowa ranked 47th among states in the number of psychiatrists per 100,000 people and 46th among states in the number of psychologists per 100,000 people[17]. The workforce crisis is especially profound in rural areas[18], and with children, youth and older adults, and on issues pertaining to co-occurring disorders, trauma-informed care, and cultural competence. The frequency of turnover in the workforce, often due low salaries and burnout, negatively impacts continuity and quality of care, and results in an added cost burden to providers who continually need to train new employees.

The Workgroup reviewed the Annapolis Coalition (2008) report, *Iowa Mental Health and Disability Services Workforce Review*[19], and the Department of Public Health's report (2006), *Iowa's Mental Health Workforce,* that addressed Iowa's workforce challenges. The reports highlight the need to develop recruitment and retention strategies (e.g. loan repayment programs, career ladders), work with higher

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16 Center for Health Workforce Planning, Bureau of Health Care Access, Iowa Department of Public Health 2006 Report, Iowa's Mental Health Workforce.

17 U.S. Department of Health and Human Services Bureau of Health Professions, 2000. The Iowa Health Workforce: Highlights from the Health Workforce Profile. Available at URL http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/iowa.htm.

18 More than 85% of the 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001), and they typically lack even a single professional working in the mental health disciplines.

19 Annapolis Coalition on the Behavioral Workforce and the Western Interstate Commission for Higher Education. (2008). Iowa *Mental Health and Disability Services Workforce Review*.

education to shape curricula, develop rural training opportunities, and work with primary care providers.

While the Workgroup did not specifically recommend any of the initiatives in the reports due to time constraints, it generally agreed with the content and makes the following two recommendations in order for there to be meaningful efforts in strengthening the capacity and capability of Iowa's mental health workforce. While more efficient use of staff, local training collaboratives, and the use of technology may serve to enhance the workforce, the Workgroup believes that sufficient progress cannot be made without an investment of resources to address the workforce crisis.

Recommendation: Creation of a standing Mental Health and Disability Workforce Development Group: Given the broad range of topics within workforce development, the Workgroup recommends that the legislature direct DHS to convene a standing Workforce Development group comprised of multiple stakeholders to address this multi-faceted issues. The group may consist of state agencies such as DHS, IDPH, Education, and Corrections, as well as regional entities, the Iowa Plan contractor, academia, providers, consumers, and families. The Workgroup was clear that unless this issue is given sufficient attention from both the legislative and executive branch of government, Iowa will continue to face a workforce crisis, and it could cripple system redesign efforts.

Recommendation: Development of a Peer Workforce: The Workgroup also discussed encouraging the development of a greater peer workforce. The use of peer-delivered services is considered a best practice approach, and the Workforce Development group that is convened should recommend ways to expand Iowa's peer workforce. Iowa does use Certified Peer Specialists and should continue to encourage the use of peers in the delivery of nearly all services. In Iowa, as in other states, peers remain a largely untapped resource. Consideration should be given to how to fund this workforce, as well as training, certificate and credentialing programs for peers that can be recognized by DHS, Medicaid and the Iowa Plan for allowing peer positions in programs. Training for peers, as well as supervisors and non-peer co-workers, should be funded to aid in the acceptance of the peer workforce and to help reduce burnout. The intent is not to replace professional or other paraprofessional staff, but to utilize the unique skills of peers as additional services.

Peers can be encouraged to enroll in traditional majors such as social work or psychology, and consideration should be given to the development of specialized certificate and degree programs. The University of Medicine and Dentistry in New Jersey, for example, offers certificates and an Associate's degree through PhD in Psychiatric Rehabilitation, and has many consumers enrolled. The State can also create its own or adopt national certificate curriculums/programs that can be used as recognized credentials to work in various programs. Some programs tailor the curriculum so that students, including peers, can become credentialed as Certified Psychiatric Rehabilitation Practitioners (CPRP), a rigorous, recovery-oriented credential.

H. Provider Qualifications and Monitoring

The Workgroup discussed accreditation, certification and licensure issues in the final meeting. Provider members felt that there is too much fragmentation between multiple agencies as it relates to this process, particularly in the areas of mental health and substance use provider oversight and monitoring. The group acknowledged the important role the State plays here in terms of ensuring that providers deliver safe and quality services to service recipients.

Recommendation: The Department of Human Services, the Department of Public Health and the Department of Inspections and Appeals should establish a process to streamline accreditation, certification and licensing standards and the inspection process in order to minimize unnecessary burdens on providers, reduce redundancy, and align the delivery of services. The use of deemed status by national accrediting bodies should be encouraged, but not required.

Recommendation: DHS and IDPH should continue their efforts to minimize the licensure and inspection burden to dually accredited/licensed providers that provide both mental health and substance abuse services.

Recommendation: The Department of Human Services and the Department of Inspections and Appeals should jointly review the standards and inspection process for Residential Care Facilities in order to more clearly delineate the roles, functions, available services, and client eligibility in these facilities. *Olmstead* implications should be considered in this process.

Recommendation: Consideration should be given to increasing the number of staff dedicated to provider oversight. The intent is not to increase the amount of work for providers, but to 1) have staff to work together on streamlining the accreditation, certification and licensure process across state departments; and 2) to ensure that the quality of monitoring is sufficient to ensure the availability of safe and quality services.

I. Transition Planning

The best approach is to incrementally implement portions of services within each service domain simultaneously in order to ensure greater access in more desirable services as the system rebalances. While a heavier investment in Acute Care and Crisis Services may be necessary early on, the expansion of non-crisis services, such as peer-delivered services, must quickly follow to ensure access for those who otherwise may have been admitted to an inpatient setting. Similarly, expanding jail diversion services requires that there be services accessible to those who are diverted. While it is critical to implement acute and crisis services to ensure a sound safety net, DHS should remain cognizant that people should have access to more recovery-oriented services in order to avoid the need for accessing the safety net in the first place.

In addition, the Workgroup felt that implementation of services must consider two issues. First, several desirable services do exist in Iowa but are not statewide. DHS should ensure that regions take current evidence-based practices to scale. Second, some services do not currently exist in Iowa at all, and DHS will need to work with regions to ensure these are operationalized. In both instances, DHS should ensure that there is consistency across the State in the development of regional systems, and that effectively working existing services are not sacrificed in order to implement new services as a result of the redesign process.

J. Community Mental Health Center Statutory Changes

In regards to Community Mental Health Centers, recommendations were made to amend Senate File 525.

Specifically, these include:

Section 230A.106, subsection 2, paragraph c, as enacted by 2011 Iowa Acts, Senate File 525, section 16, is amended to read as follows:

1. Page 17, c. Add the sentence: “An Assertive Community Treatment program may be offered as an alternative to the above services in section c.”

Section 230A.110, subsection 1, as enacted by 2011 Iowa Acts, Senate File 525, section 20, is amended to read as follows:

2. Page 19: Section 20, 1: Strike “and” and add “or” to the following sentence: “The standards adopted shall conform with federal standards applicable to community mental health centers and shall be in substantial conformity with the applicable behavioral health standards adopted by the joint commission, formerly known as the joint commission on accreditation of health care organizations, “or” other recognized national standards for evaluation of psychiatric facilities unless in the judgment of the division, with approval of the commission, there are sound reasons for departing from the standards."