Iowa Department of Human Services

Complex Service Needs Workgroup Report

December 15, 2017

Executive Summary

The 2017 Iowa Acts, Chapter 109, Section 17 directed the Department of Human Services (Department) to convene a stakeholder workgroup to: *"…make recommendations relating to the delivery of, access to, and coordination and continuity of mental health, disability, and substance use disorder services and supports for individuals with mental health, disability, and substance use disorder needs, particularly for individuals with complex mental health, disability, and substance use disorder needs."*

The Complex Service Needs Workgroup recommends expanding and improving Iowa's mental health and substance use disorder services array to fill gaps for individuals with the most complex service needs by developing and implementing in strategic locations throughout Iowa:

- Six (6) access centers
- Twenty-two (22) Assertive Community Treatment teams
- A full array of mental health crisis response and sub-acute residential services
- Intensive residential service homes to serve a minimum of 120 individuals
- Tertiary care psychiatric hospitals including the mental health institutes and other hospitals

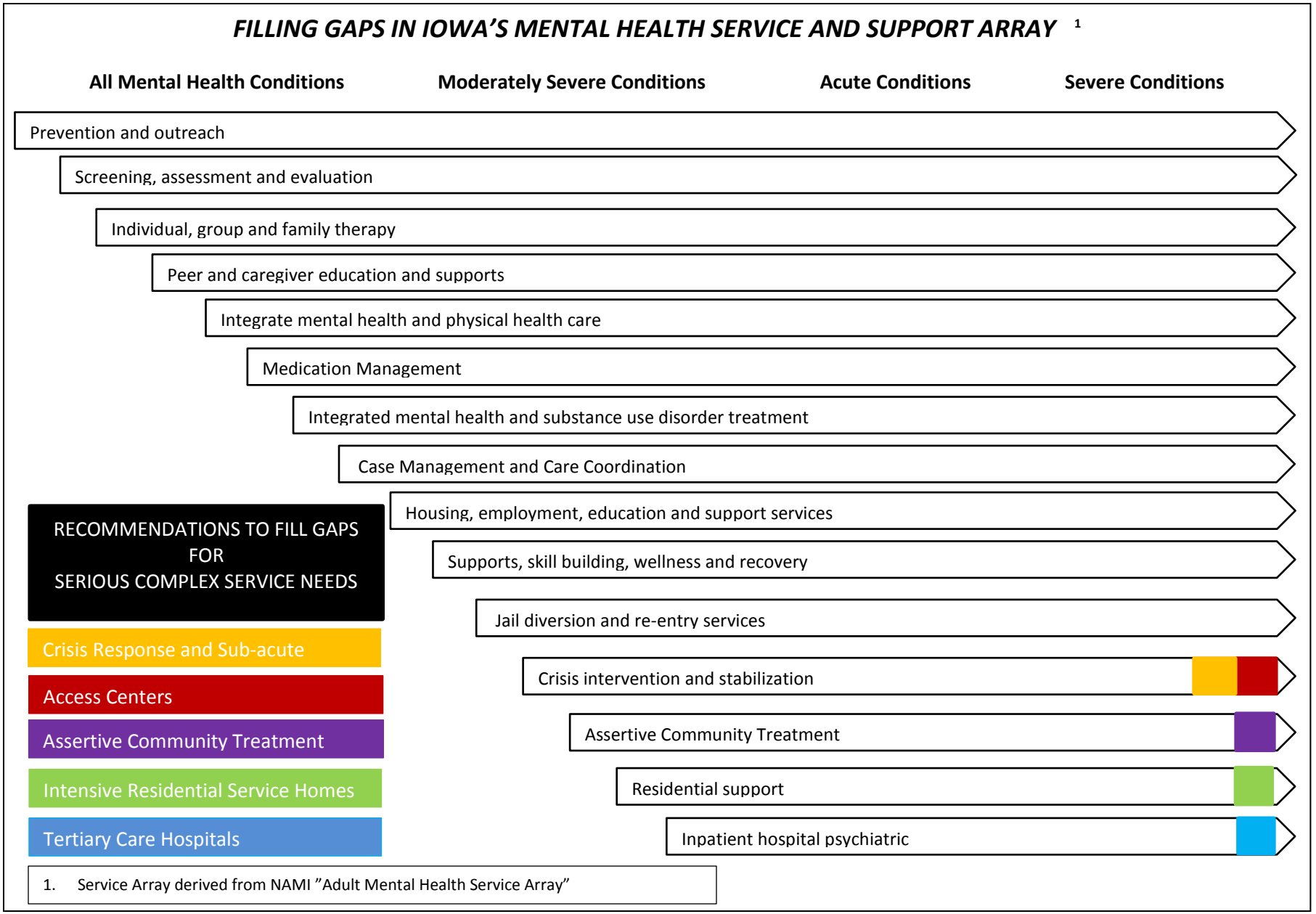
The Workgroup also recommends the following legislative action:

- Require mental health and disability services (MHDS) regions to establish, implement, and maintain the following services as required core services[1] in partnership with managed care organizations (MCOs) in strategic locations throughout Iowa:
    - Access centers
    - Assertive Community Treatment
    - Comprehensive crisis and sub-acute services
    - Intensive residential service homes
- Direct the Department to establish a single set of provider qualifications and access standards that are used for Chapter 24 accreditation, Iowa Medicaid Enterprise for Medicaid enrollment, MHDS Region standards, and MCO utilization review standards
- Direct the Department to establish access standards that allow and encourage multiple MHDS Regions to strategically locate and share intensive, specialized services among and between MHDS Regions to best serve Iowans in the most efficient manner possible
- Eliminate the Iowa code that limits the number of sub-acute care facility beds
- The 2018 Legislative Interim Committee on MHDS funding fiscal viability should consider this report in its deliberations.

The Workgroup recommends the Department of Human Services and Public Health (Departments) review this report with the Courts and seek their support for the recommendations. The Departments will seek agreement with the Courts to discuss how Iowa Code 125 and 229 could be amended to make the best use of these changes and include pre-commitment screening.

[1] "Core Services" are those services MHDS Regions are required to develop, implement, and maintain.

FILLING GAPS IN IOWA'S MENTAL HEALTH SERVICE AND SUPPORT ARRAY [1]



1. Service Array derived from NAMI "Adult Mental Health Service Array"

Introduction

The Department of Human Services (Department) convened the Complex Service Needs Workgroup (Workgroup) made up of diverse members that included: Department of Public Health (IDPH), advocates, community providers, hospital providers, law enforcement, mental health and disability services (MHDS) regions, and Department of Corrections. (Appendix A) The Workgroup conducted its work during six open public meetings on August 22, October 10, November 2, November 21, November 28, and December 12, 2017 and several subcommittee meetings. Public comment was heard at each Workgroup meeting. In its deliberations, the Workgroup discussed previous similar efforts related to its task. (Appendix B)

Recommendations

Providing individuals with severe, complex mental health or substance use disorder needs the right services by the right provider at the right time.

The following recommendations are intentionally not listed in priority order. Instead they are listed in alphabetical order. No single recommendation provides the solution to fill the gaps in services for individuals with serious complex service needs. The Workgroup recommends they be considered as a package to be added to Iowa's existing array of mental health and substance use disorder services.

These recommendations are based on the expectation that:

- MHDS Regions fund required services not reimbursable by Medicaid or services required by and provided to eligible individuals that are not enrolled in Medicaid; and
- MCOs fund services covered by Medicaid provided by a Medicaid enrolled contracted provider to a member that has demonstrated the need for the service.
- MHDS Regions and MCOs work cooperatively and collaboratively to successfully implement these recommendations.

Designate and/or develop six (6) access centers in strategic geographic locations throughout Iowa by the end of 2019.

Access centers are specially organized and designated crisis residential/sub-acute services that provide immediate, short-term assessment and treatment services to individuals that do not require inpatient psychiatric hospital level of care, but need significant amounts of support and services not immediately available in the individual's home or other available community-based setting such as non-designated crisis residential or sub-acute services.

Access centers should:

- Serve individuals that have a serious mental health and/or substance use disorder need that:
    - Are medically stable;
    - Do not need inpatient psychiatric hospital level of care; and
    - Do not have alternative, safe, effective services immediately available to them;
- Serve individuals with serious mental illness or substance use disorder on a no eject, no reject basis;
- Accept and serve individuals court ordered for mental health or substance use disorder treatment;
- Be Chapter 24 accredited as a mental health crisis residential provider and licensed as a mental health sub-acute provider;
- Be Chapter 155 licensed as a substance use disorder treatment program or have a cooperative agreement with and immediate access to licensed substance use disorder treatment services or medical care that incorporates withdrawal management;
- Provide person-centered mental health and substance use disorder assessments by appropriately licensed/credentialed professionals and peer support services based on a comprehensive assessment;
- Provide or arrange to provide necessary physical health services; and
- Ensure short stays by providing individuals care coordination that provides successful navigation and warm handoffs to the next service provider, and linkages to needed services such as housing, employment, shelters, etc.

MHDS Regions should be required to develop, implement, and maintain Access Center services as a core service in strategic areas throughout Iowa.

The Department should be required to establish Access Center designation criteria and access standards that allow and encourage multiple MHDS Regions to strategically locate and share this intensive level service. The Department should also clarify whether or not crisis residential service settings can accept court commitments.

MCOs and the MHDS Regions, in consultation with local law enforcement, should jointly select, develop, and implement six (6) access centers strategically located throughout Iowa by December 2019.

MHDS Regions should provide start-up funds for the establishment of the jointly selected access centers.

MCOs should offer contracts to the jointly selected access centers to provide Medicaid reimbursable services. MCOs should reimburse the access centers at the floor rate for covered Medicaid services the centers are enrolled to provide to Medicaid members that have a demonstrated need for the service.

MHDS Regions should be required to provide additional funding for non-Medicaid services (e.g., room, board, transportation, and reasonable operational vacancies).

Story – How Access Centers Can Work
Naomi, a woman in her late 20s, told her boyfriend she was tired of living and was going to overdose. Her boyfriend hid her medications and called for help. Police with specialized mental health training responded to the call. They found the boyfriend and head for the bedroom where Naomi was sitting on her bed.

Naomi tells police that she is OK and that she overreacted to a Halloween joke. The police don't believe her story and after asking more questions learn that she struggles with alcohol, had attempted suicide before, and takes psychiatric medication. The police tell Naomi that they don't think she is feeling well and they want to help.

Naomi tells them that she's tired of living, is estranged from her family, and is drinking again after several years of sobriety. The police build rapport and she agrees to pursue treatment, even as she's saying, "I don't want to go." As police watch carefully, she packs a small bag and walks to a patrol car waiting outside.

Once she is medically cleared at the emergency room, a decision is made that she doesn't have an acute psychiatric crisis and she is stating she does not want to hurt herself anymore so the physician determines inpatient hospital treatment is not needed. However, she cannot safely go home, so the physician obtains a court commitment to the Access Center. There she is watched closely, kept safe, provided preliminary treatment, and connected with treatment and support services as soon as possible. In two days she is heading home with follow up appointments and someone monitoring to make sure she stays engaged in treatment.

The number of Assertive Community Treatment (ACT) teams should be expanded so that a total of twenty-two (22) ACT teams are available in strategic locations throughout Iowa by the end of SFY19.

ACT provides interdisciplinary team-based individualized, flexible treatment and supports to individuals with mental illness in their home and community, 24 hours a day, seven days a week, 365 days a year. ACT team members are trained in the areas of psychiatry, social work, nursing, substance use disorder treatment, and vocational rehabilitation. Individuals served usually have schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder (manic-depressive illness); or are experiencing significant disability from other mental illnesses and are not helped by outpatient treatment models.

Currently, Iowa has ten (10) ACT programs currently operating and one (1) under development.

Program	**Counties Served**
Operating	
• Abbe Center ACT	Linn
• Berryhill	Webster, Hamilton
• Eyerly Ball – 2 (incl. FACT[2])	Polk
• Heartland Family Services	Pottawatomie
• University of Iowa IMPACT	Johnson, Cedar
• RHD	Blackhawk
• RHD	Marion, Monroe, Lucas, Wayne, Clarke, Decatur, Ringgold
• Seasons Center	Lyon, Osceola, Dickinson, O'Brien, Clay, Palo Alto, Buena Vista
• Vera French	Scott
Under Development	
• Eyerly Ball	Boone, Story

Literature on ACT estimates that .06% of the adult population or 51% of adults with a Serious Mental Illness could benefit from ACT services.[3] Following these estimates, eleven (11) more ACT programs should be developed in strategically located areas throughout Iowa. Based on population, consideration should be given to the following areas:

- Dubuque
- Sioux City – 2 Teams
- Mason City
- Waterloo – 2nd Team
- Davenport/Bettendorf – 2nd Team
- Des Moines – 3rd Team
- Ottumwa - Southeast Iowa
- Rural West Central Iowa
- Rural Northeast Iowa, e.g. Manchester/Independence (Already initially in development)
- Southeast Iowa, e.g., Burlington/Ft. Madison/Keokuk

The Department should be required to establish uniform, statewide accreditation standards for ACT based on national accreditation standards by July 1, 2018. The statewide standards should require that ACT teams meet fidelity to nationally recognized standards as determined by an independent review of each team that includes peer review. The Department should make allowance for nationally recognized small team standards. MCOs' utilization management requirements should not exceed the Department's established standards.

[2] FACT is an adaptation of assertive community treatment (ACT) for persons involved with the criminal justice system. All ACT should be capable of addressing issues related to criminal justice.
[3] Cuddeback G, Morrissey J, Meyer P. Psychiatric Services 57:1803-1806, 2006

MHDS Regions should be required to develop, implement, and maintain ACT as a core service in strategic areas throughout Iowa.

By April 1, 2018, MCOs and MHDS Regions should jointly agree on:

- The strategically located geographic areas in which additional ACT teams should be developed considering at least the following criteria:
    - The recommended list of locations above,
    - A review of known individuals with diagnoses that benefit from ACT,
    - Hospital inpatient psychiatric readmission rates,
    - Interest and readiness of the provider and community partners to form ACT,
    - Availability of psychiatric providers (MD, ARNP, PA) interested in the model,
- How independent review of fidelity to established standards will be accomplished.

MHDS Regions should be required to provide start-up funding to the jointly selected ACT teams that are not yet developed including assistance in achieving fidelity to practice standards and technical assistance.

MCOs should offer contracts to the jointly selected ACT teams. MCOs should reimburse at the floor rate ACT teams enrolled in Medicaid that provide services to Medicaid covered members that have a demonstrated need for ACT.

MHDS Regions should be required to ensure efficiently and effectively operated ACT teams remain viable including providing funding for general operations following guidance provided by the Department. (Note: Balance billing will not be allowed)

The Department should review ACT Medicaid reimbursement rates and, if appropriate, a recommendation to adjust reimbursement rates should be presented to the Governor and Legislature prior to the 2019 session. The Governor and Legislature may consider the recommendation and, if appropriations are approved, MCO per member per month rates should be established based on the approved appropriation to allow for adjustments to ACT reimbursement.

The Department should work with the University of Iowa to provide specific data that demonstrates ACT's effectiveness.

<u>Story – How ACT can work</u>

Steve is a 52 year old gentleman with schizoaffective disorder and polysubstance abuse that does not take his prescribed medications regularly. During these times, he acts on his paranoia in sometimes dangerous ways. He has a legal history for trespass, disorderly conduct, and assault while psychotic. He has been homeless and has experienced frostbite at least once during these periods. He has been hospitalized three times in the last two years and has been in residential care twice, once for three months and once for six months. Upon discharge from residential care he typically decompensates and experiences paranoia. He accuses his

physicians and care providers of various things such as stealing his money and has burned bridges with many care providers.

Steve was referred to ACT. ACT arranged for a payee service to assure his bills were paid. The Team stopped by his apartment daily to provide medications and to monitor his symptoms. The Team spends a good deal of time with Steve hearing his grievances and helping him with immediate needs such as furnishing his apartment and getting access to food stamps and other benefits. The Team helped him avert evictions and helped him to communicate more effectively with his payee and his landlord. The Team attended appointments with him. Over a period of months his consistent use of his mental health medications helped him to become less paranoid. He was willing to see a primary care physician to treat his hypertension and high cholesterol. He began engaging in problem solving with the Team when his paranoia reappeared. They accompanied him to the grocery store, laundry, another public places to learn to use these new skills. Steve has had no hospitalizations or arrests since beginning ACT. He is considering a part time job. He is still smoking, but uses illegal drugs less frequently. The ACT team sees him five days a week in his home.

A full array of mental health crisis response and sub-acute residential services should be developed in strategic locations by the end of SFY19.

Mental health crisis and sub-acute services include:

- Crisis assessment - face-to-face clinical interview to determine an individual's current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan.
- Crisis screening - process to determine what crisis response service is appropriate to effectively resolve the presenting crisis.
- Crisis stabilization community-based services (CSCBS) - short-term community-based services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis
- Crisis stabilization residential services (CSRS) - short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis
- Mobile response - a mental health service which provides on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. (Note: The Department should adjust access standards to mobile response to address Iowa's rural communities.)
- Single statewide twenty-four-hour crisis line - a crisis line providing information and referral, counseling, crisis service coordination, and linkages to crisis screening and mental health services 24 hours a day. (Consider building on the IDPH YourLifeIowa platform)

- Twenty-three-hour observation and holding - a level of care provided for up to 23 hours in a secure and protected, medically staffed, psychiatrically supervised treatment environment.
- Warm line - a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis. (Consider building on the IDPH YourLifeIowa platform)
- Sub-acute services - a comprehensive set of wraparound services for individuals who have had or are at imminent risk of having acute or crisis mental health symptoms that threatens removal of the individual from their home and community, but do not need acute inpatient care.

MHDS Regions should be required to develop, implement, and maintain the full array of crisis services as core services in strategic areas throughout Iowa. MHDS Regions should be required to provide funding for their initial start-up.

MHDS Regions and MCOs should jointly agree on which sub-acute facilities are designated in strategic geographic locations throughout Iowa.

MCOs should offer contracts to all mental health crisis service providers and jointly designated sub-acute facilities. MCOs should reimburse at the floor rate Medicaid enrolled mental health crisis and sub-acute providers for services provided to Medicaid covered members that have a demonstrated need for the service.

MHDS Regions should be required to provide ongoing funding for services that are not reimbursed by Medicaid (e.g., services to individuals not enrolled in Medicaid, warm lines, etc.)

The statutory limit of 75 publicly funded sub-acute beds should be eliminated. Iowa Code Section 135G.6 (b) (2) states…

"…The department of human services shall not give approval to an application which would cause the number of publicly funded subacute care facility beds licensed under this chapter to exceed seventy-five beds."

The Department should review crisis and sub-acute services' Medicaid reimbursement rates and, if appropriate, a recommendation to adjust reimbursement rates should be presented to the Governor and Legislature prior to the 2019 session. The Governor and Legislature may consider the recommendation and, if appropriations are approved, MCO per member per month rates should be established based on the approved appropriation to allow for adjustments to crisis and subacute services' reimbursement.

Intensive residential service homes (IRSHs) capable of serving a statewide total of one hundred twenty (120) individuals should be designated and/or developed in strategic locations by the end of SFY19.

Individuals served in IRSHs are adults that have a diagnosis of mental illness and may also have an accompanying co-occurring diagnosis of developmental/intellectual disability and/or substance use disorder. The individuals' functional assessment – an analysis of daily living skills that takes into consideration the strengths, stated needs, and level and kind of disability of the individual using the service - reflect that the individuals have a serious and persistent mental illness including:

- Having a diagnosis of a serious mental illness (e.g., schizophrenia, schizoaffective disorder, major depression, bipolar disorder, or other serious psychiatric disorder);
- Having three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;
- Needing 24-hour supervised, monitored and focused treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;
- Not being responsive to an adequate trial of active treatment at a less intensive level of care;
- Being at risk of significant functional deterioration if intensive residential services are not received; and
- Having one or more of the following:
    - Three psychiatric hospitalizations in 6 months
    - Greater than 30 medically unnecessary psychiatric hospital days
    - Greater than 90 psychiatric hospital days per one stay
    - Three emergency room visits related to a serious psychiatric diagnosis in 6 months
    - Residing in State Resource Center with a serious psychiatric diagnosis
    - Being served out-of-state due to unavailability of mental health residential services in Iowa
    - In jail due to a serious psychiatric diagnosis or, being released from jail or prison with a serious psychiatric diagnosis
    - Being precariously housed or homeless

IRSH are specially developed and/or designated residential services that provide intensive, 24 hour, seven day a week, 365 day a year, coordinated supported community living services for individuals with the most intensive serious and persistent mental illness described above. Since the skills required to serve each sub-group of individuals dramatically differs, IRSH should serve a homogeneous group of individuals (e.g., individuals that have similar characteristics such as only an serious and persistent mental illness or a serious and persistent mental illness with intellectual disability, or serious and persistent mental illness with substance use disorder, etc.) IRSH services and supports should:

- Be enrolled with Iowa Medicaid Enterprise as a 1915i home and community based (HCBS) habilitation waiver and/or intellectual disability HCBS waiver supported community living provider
- Have adequate staffing that includes:
    - Appropriate specialty training including applied behavior analysis as appropriate;
    - Adequate direct care staffing ratios (e.g., no more than 2½ individuals served per staff on duty) with opportunities for lower staffing ratios based on demonstrated need; and
    - Swift access to additional staffing if serious incidents occur; and
    - Adequate pay and paid time off commensurate with the increased intensity of the services provided.
- Coordinate with the individuals' clinical mental health and physical health treatment including:
    - Ensuring treatment plans are developed by a comprehensive interdisciplinary team selected by the individual that develops and implements the individual's person-centered plan;
    - Ensuring access to active medication management and outpatient therapy, including evidence based therapy approaches;
    - Establishing a fully coordinated care plan that includes instructions on how to most effectively interact with the individuals served in home and in the community;
    - Accessing Assertive Community Treatment (ACT) services if there is a demonstrated need[4]; and
    - Developing a thorough Wellness Recovery Action Plan (WRAP) as appropriate.
- Be Chapter 155 licensed as a substance use disorder treatment program or have a cooperative agreement with and timely access to licensed substance use disorder treatment services for those it serves with a demonstrated need;
- Accept court ordered commitments;
- Have a high tolerance for serious behavioral issues; and
- Not eject or reject individuals referred to them based on the severity of the individuals' mental health and/or co-occurring needs.

IRSHs are the individuals' home. So, IRSHs should preferably be small (e.g., 4 individuals or less) and located in typical neighborhood settings to maximize community integration and natural supports[5]. Larger capacity IRSHs should be rare. In no case should an IRSH be larger than 16 beds.

[4] Recommend Iowa Administrative Code be revised to state that, when there is a demonstrated need, ACT can be provided simultaneously with 1915i Habilitation services.

[5] Housing options need to be compliant with Principles of the Olmstead Ruling, Centers for Medicare and Medicaid (CMS) Settings Rules, and the 16 bed limit related to the CMS institutions for mental disease rules.

The individual's length of stay in the program should be determined on an individual basis using person-centered planning and objective utilization review criteria with the goal to live in the most integrated setting practicable. The individual's status related to housing should be based on the individual's expected length of stay. Individuals expected to stay longer in the home should have the protections of a landlord tenant relationship. Individuals expected to stay shorter periods should not be hampered from moving by a long term lease.

In addition to IRSH, individuals should have opportunities for employment, vocational development, or other valued activities outside of the home such as day habilitation and vocational services.

MCOs and MHDS Regions should jointly select where IRSHs will be located by July 2018. Existing 1915i "habilitation homes" or Intellectual Disability HCBS Waiver supported community living providers that meet IRSH criteria should be considered for selection. MCOs and MHDS Regions should mutually agree on additional IRSH to be developed in strategic geographic locations. MCOs and MHDS Regions should work with the state mental health institutes, Broadlawns, and the University of Iowa Hospital and Clinics, or other interested hospitals with inpatient psychiatric programs to operate or affiliate with one IRSH each as an integral part of their mental health services.

MHDS Regions should be required to develop, implement, and maintain IRSHs as a core service in strategic areas throughout Iowa. MHDS Regions should be required to provide start-up funding for jointly selected IRSHs that are not yet operating.

MCOs should offer contracts to jointly selected IRSHs. MCOs should reimburse IRSHs for the covered Medicaid services the IRSH is enrolled with Medicaid to provide (e.g., home-based habilitation or supported community living) to Medicaid covered members that have a demonstrated need for the service. The mutually agreed upon contracts should include objective utilization review criteria. MCOs shall manage IRSHs to meeting individuals' needs consistent with the requirements of the Americans with Disabilities Act and the principles of the Supreme Court Olmstead decision.

MHDS Regions should be required to provide additional funding necessary for non-Medicaid funded services (e.g., room and board, reasonable vacancies, and transportation).

Story – How IRSH can work

John is 48 years old and has a serious and persistent mental illness and co-occurring intellectual disability and autism. He lives with 3 roommates and is on the Habilitation Waiver. He has been physically and verbally aggressive to staff and roommates resulting in his arrest. John has been admitted to the hospital for inpatient psychiatric services multiple times. When he was last admitted to the hospital his waiver provider discharged him from services. This is the third waiver provider who has discharged him due to his behaviors. John has been accepted by a service provider dedicated and specializing in serving individuals with serious

complex service needs. John is now succeeding because the home is specially designed to meet John's needs, the staff are specially trained, and there is access to intensive psychiatric services through ACT. His harmful behaviors are less frequent and he is positively engaged with staff and roommates. John has not had an inpatient hospital admission or run-ins with law enforcement for some time.

The role and responsibility of tertiary care[6] psychiatric hospitals within the array of intensive mental health services should be explicitly described and facilities designated in strategic locations by the end of SFY19.

Tertiary care psychiatric hospitals admit, care for, and treat individuals that other mental health care providers find too difficult to treat or too dangerous.[7] Tertiary care psychiatric hospitals should admit individuals on a no eject/no reject basis. Tertiary care psychiatric hospitals should be constantly seeking, developing, and implementing evidence-based, state-of- the-art practice and promising practice treatment approaches. Tertiary care psychiatric hospitals should be part of an array of well-defined routine and intensive mental health services. Tertiary care psychiatric hospitals should have strong linkages with the rest of the array of mental health services to ensure seamless and successful integration of individuals back into community settings including linkages to Access Centers.

Tertiary care psychiatric hospital roles and responsibilities should be clearly defined and should be complimentary to the roles and responsibilities of the full array of other mental health services, especially more intensive mental health services. Methods for referring and admitting individuals to tertiary care psychiatric hospitals should also be established including, but not limited to:

- Establishing admission criteria
- Describing the method for physician to physician consultation
- Describing how the tertiary care psychiatric hospital will decide whether or not to admit a patient
- Establishing a method for reconsidering admission decisions

Cherokee mental health institute and Independence mental health institute should be two of the designated tertiary hospitals. In addition, the Department and hospitals with inpatient psychiatric programs should agree upon and identify additional tertiary care psychiatric hospitals by July 2018.

[6] Tertiary Care is highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Marriam-Webster.com

[7] Substance of the description is from "The Vital Role of State Psychiatric Hospitals"; Joe Parks, M.D. Alan Q. Radke, M.D., M.P.H.; National Association of State Mental Health Program Directors; July 2014

A variety of funding options should be considered for state mental health institutes. Consideration should be given to the Department's cost containment proposal to allow state mental health institutes to retain 3rd party revenue to off-set the additional requirement for general funds. In addition, in the 2018 interim when the Legislature discusses sustainable funding for MHDS Regions, the amount MHDS Regions pay for mental health institute treatment for individuals that are their responsibility should be reviewed.

Impediments to fulfilling the tertiary care psychiatric hospital roles and responsibilities should be addressed including the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. EMTALA requires that a Medicare-participating hospital that has specialized capabilities, like a psychiatric hospital, must accept an appropriate transfer from another hospital of an individual with an unstabilized emergency medical condition who requires such specialized services. If an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities and the psychiatric hospital has capacity, it is obligated to accept an appropriate transfer of that individual. This transfer must occur regardless of whether the individual meets tertiary care psychiatric hospital admission criteria.

The extent to which tertiary care psychiatric hospitals provide forensic services is another challenge. Forensic services include competency evaluations to stand trial, competency restoration treatment, and treatment for individuals found not guilty due to mental illness[8]. Individuals in these categories tend to have very long lengths of stay and often may not meet tertiary care psychiatric hospital admission criteria. This essentially reduces the number of available beds at these facilities. The Workgroup recommends a thorough review regarding how forensic mental health services are currently provided and funded with the goal of recommending improved methods of serving these individuals.

Additional Recommendations and Observations

In addition to the above recommendations, the Workgroup also recommends and takes note of the following:

- The Workgroup notes that, as these recommendations are implemented, there will be an opportunity to change and improve existing practices. Such changes will require education and effort for everyone supporting the mental health and SUD treatment system, including the courts. The Workgroup recommends that:
    - The Department of Human Services and the Department of Public Health arrange to educate judges regarding what changes can and should be made by the courts in the commitment process as these recommendations are implemented, and

[8] Iowa Code §812 and Iowa Ct. R. 2.22(8)

    - The Departments, representatives of the courts, and members of the Workgroup should develop recommendations for Iowa Code 125 and 229 including pre-commitment screening.
- The Department should convene a Task Force by July 2018 to develop and implement ACT teams and Systematic, Therapeutic, Assessment, Resources, and Treatment (START) Teams for individuals with co-occurring mental illness and intellectual/developmental disabilities.
- The Governor and Legislature should seek guidance from the Children's Mental Health and Well-being Advisory Committee for further development of a children's mental health and well-being system.
- The Workgroup takes notice that low reimbursement rates for substance use disorder residential treatment make it difficult to maintain capacity and workforce to serve patients with complex needs. (See December 2014 House File 2463 Report on adequacy and equity of reimbursement for substance use disorder treatment providers, submitted by IDPH.) The Department should review Medicaid substance use disorder residential treatment rates and, if appropriate, a recommendation to adjust reimbursement rates should be presented to the Governor and Legislature prior to the 2019 session. The Governor and Legislature may consider the recommendation and, if appropriations are approved, MCO reimbursement rates should be increased.
- The Workgroup takes notice of the challenges presented by the provision of forensic mental health evaluation and treatment. The Workgroup recommends that the Legislature direct the Department of Corrections in cooperation with the Department of Human Services to convene a Workgroup in the 2018 legislative interim to develop recommendations regarding how to more effectively and efficiently provide forensic mental health services.
- The Workgroup takes notice that individuals living with dementia represent another group of individuals with complex, difficult needs that are not being adequately met. The workgroup recommends that the Legislature consider recommendations from the December 15, 2017 joint report on dementia and work being undertaken by the Iowa Healthcare Association.
- The Workgroup takes notice that appropriately serving individuals with a history of sex offending adds a great deal of complexity, such as services are scarce, and the recommendations of the workgroup are unlikely to significantly resolve this issue and additional work is needed to address this issue.

Appendix A: Complex Service Needs Workgroup

Name	Agency
Rick Shults	Department of Human Services
Kathy Stone	Iowa Department of Public Health
Mary Ellen Barber	Family member of adult with SMI
Jerry Bartruff	Iowa Department of Corrections
Kevin Carroll	UnityPoint Behavioral Health
Jody Eaton	Central Iowa Community Services
Dr. Jerome Greenfield	Iowa Department of Corrections
Marc Hines	University of Iowa Hospital and Clinics
Chris Hoffman	Pathways Community Mental Health Center
Peggy Huppert	National Alliance on Mental Illness
Kathy Johnson	Abbe Center
Steve Johnson	Broadlawns Medical Center
David Lange	National Alliance on Mental Illness
Jeffrey Lipman	Polk County Magistrate
Bob Lincoln	County Social Services
Kim Murphy	Iowa Hospital Association
Marilyn Rhoten	CHI Health Behavioral Health
Jason Sandholt	Marion County Sheriff
Christina Schark	Southern Iowa Mental Health Center
Susan Seehase	Exceptional Persons, Inc
Dr. Jodi Tate	University of Iowa Hospital and Clinics
Tony Thompson	Black Hawk County Sheriff

Appendix B: Previous Work

Community Integration Workgroup for Adults with Serious Mental Illness Final Report
http://dhs.iowa.gov/sites/default/files/Community_Integration_Workgroup_for_Adults_with_SMI_Final_Report_12.15.2014.pdf

Getting Our ACT Together
https://dhs.iowa.gov/sites/default/files/ACTforIowaSept2011_09-15-2011.pdf

Mental Health and Disability Services Redesign Progress Report
http://dhs.iowa.gov/sites/default/files/MHDS_Redesign_Update_Report_Final_SFY17.pdf

IDPH House File 2463 Report – December 2014
https://www.legis.iowa.gov/docs/publications/DF/661296.pdf