

To: Subacute Mental Health Care Services Interim Study Committee (J)

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From: Michael Flaum, MD, Emeritus Professor of Psychiatry, University of Iowa Carver College of Medicine; Facilitator, Johnson County System of Care group

Date: 1/5/26

RE: For your consideration on Subacute Mental Health Care Services

Thank you for your work in this important area. Your decisions will likely have broad-ranging impact on the mental health system in Iowa. As such, I urge the committee to take the following points into consideration prior to reaching any closure:

1. There is no standard or widely used definition of “Subacute Care” as it applies to mental health care in the US. The term Subacute Care was only introduced to Iowa Administrative code in 2012 – and the way it was defined did not address the intended need. How your committee chooses to define “Subacute Mental Health Care services” is critical.
2. An effective and efficient mental health system requires a basic array of services; if one or more critical components of that array is missing, the capacity of other components of the service array can be profoundly negatively impacted.

3. “Subacute care”, **as defined below**, had existed in Iowa’s service array up until 2001, provided through the Mental Health Institutes. That level of care was eliminated in 2001, with far-reaching negative impact ever since, affecting acute psychiatric inpatient units, emergency rooms, jails, and homeless shelters ever since.
4. There are feasible and financially sound opportunities to fill this gap that are likely to have a similarly far-reaching positive impact on those services.

This is admittedly complex. I will do my best to briefly elaborate on these issues below, and would be happy to provide more detail to the committee at any time.

First, by way of introduction, while I’ve spent most of my professional career at the University of Iowa, my comments are not on behalf of the University or University of Iowa Hospitals and Clinics. They are based on my own extensive experience, both in terms of direct service provision and systems implementation at the local, state and national levels. Between 1999 – 2013, I directed the Iowa Consortium for Mental Health (ICMH), which served as an academic liaison to the publicly funded mental health system in Iowa. The ICMH was funded through Iowa’s federal Mental Health Block Grant program.

In the early 2000’s, as a part of Iowa’s Olmstead plan, the ICMH focused on ways to evaluate the array of mental health services in Iowa, specifically looking at regional variability. We introduced the Level of Care Utilization System (LOCUS), which is the most widely used method to track the match between individual needs for mental health services with the appropriate level of service intensity¹. I have since served in a leadership role in the organization that developed that tool, the American Association for Community Psychiatry, and I am part of the team that works with systems around the country implementing this tool.

The LOCUS does not use the term “subacute” care, nor does any other system of categorizing mental health service intensity that I am aware of. Rather, the LOCUS defines 6 levels of service intensity ranging from the least to most intensive. Each level is described in terms of three domains: Care environment, clinical services, and support services.

¹ Toward A National Standard for Service Intensity Assessment and Planning for Mental Health Care. <https://www.thenationalcouncil.org/resources/service-intensity-assessment-and-planning/> Downloaded 1/5/26

The most intensive level, level 6 almost always takes place in psychiatric inpatient units within hospitals. Two sublevels are identified, (6A and 6B) which vary on expected length of stay and the frequency of need for medical decision making. **Level 6A is exemplified by acute inpatient units**, typically with expected lengths of stay on the order of a few days to a few weeks. In addition to optimizing the safety of individuals who may present a danger to themselves or others, they provide thorough evaluation and diagnoses, leading to the development and initial implementation of treatment plans, typically requiring medical decision making on a daily basis. They have the full array of clinical and support services.

The large majority of individuals admitted to these level 6A acute inpatient units can be stabilized within the first one to two weeks to the extent that they can be stepped down to lower intensity services: Those may be to a Level 5 setting such as a residential care facility; a level 4 service such as a partial hospital program, a level 3 service such as an intensive outpatient program, or most often to level 2 services which typically take place in an outpatient clinic.

However, there are individuals who continue to require the safety and support of a service intensity level 6 beyond the first few weeks following admission. These may be people who cannot yet be safely served in a setting from which they could freely wander away – either because of lack of insight, cognitive capacity or other issues – and require ongoing treatment of psychiatric and/or medical issues in a safe environment.

Data from UIHC, shown below, consistently finds that about 80% of all admissions to adult inpatient psychiatry units can be stepped down to a lower level of care within the first few weeks after admission. But what happens to the remaining 20%?

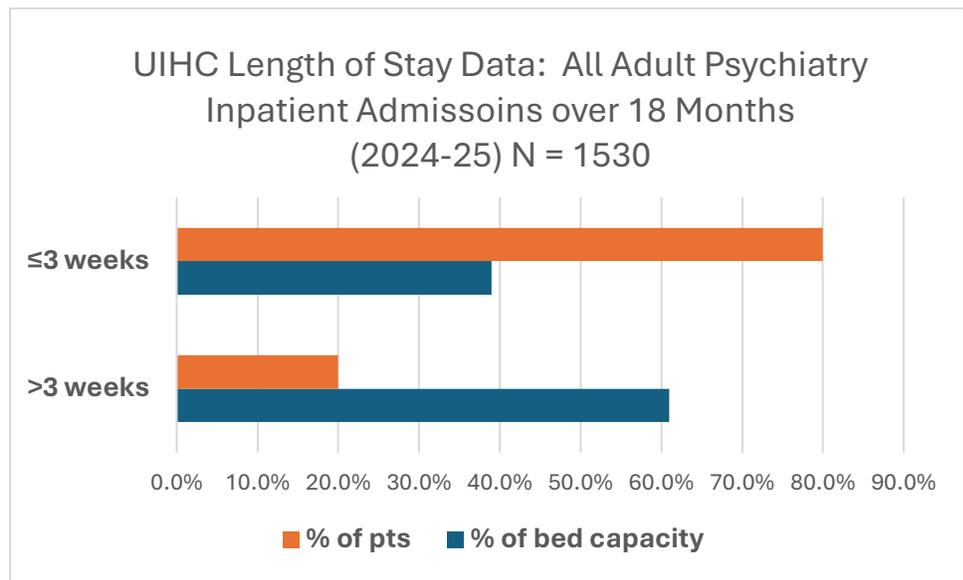
In Iowa, prior to 2001, most of those who were not yet ready for step down to level 5 or lower were transferred to one of the Mental Health Institutes (MHI's) for further stabilization and treatment. The MHI's had the full array of clinical and support services, similar to acute psychiatric units (level 6A), but they did not typically require medical decision making on a daily basis. Expected lengths of stays were typically several weeks to months. Each of the MHI's had both locked and open units, with most patients initially being admitted to a locked unit upon initial transfer and then moved to open units as they stabilized. **Both the locked and open units would be categorized as level 6B service intensity in light of expected length of stays and lower frequency of need for medical decision making.**

In 2001, in the context of one of a series of state financial crises, a decision was made by the Iowa Department of Human Services to decrease the capacity of the MHI's statewide by 40%. The decision of how to do so was given largely to the superintendents. They chose

to shut down the open units, and redefine the remaining locked units as level 6A, acute inpatient units. This is despite the fact that there were at the time more than six hundred acute inpatient beds (level 6A) in various secondary, tertiary and quaternary care hospitals around the state, and virtually NO level 6B beds.

Once the MHI's redefined their function as acute inpatient units, transfers to the MHI's from any of the other acute inpatient units in the state came to a near standstill, as they were now considered "lateral transfers". That is, it would be equivalent to transferring a patient from an acute inpatient psychiatric unit at UIHC to the same kind of unit in a Cedar Rapids or Des Moines hospital – a rare event that would require some specific reason (e.g., one hospital may not have the capacity to perform electro-convulsive treatment).

As someone who staffed acute inpatient units at UIHC for more than a decade prior to this change, and two decades after, I can report firsthand that the impact of the bottleneck this missing level of care created was dramatic from the start, and has persisted to this day. The reason is illustrated in the graphs below which show that **while more than 80% of patients admitted to those acute inpatient beds can be stepped down to lower level services within the first few weeks, the remaining <20% account for more than 60% of the overall bed capacity.** I.e., those outliers, who need longer term inpatient care, are getting that care in a tertiary or quaternary care acute inpatient unit, often for many months and in some cases, years. So practically, even though UIHC appears to have ~ one hundred acute adult inpatient beds, functionally, at any given time, it has less than forty.



As a part of my longstanding advocacy for the need to restore what I was calling at the time "Subacute Services" (referring to the lost level 6B services), I presented the same type of data analysis to the "MHI task force" of the 2009 Iowa legislature with remarkably similar

results. (In those data, which looked at all admissions across UIHC adult inpatient units over a 14-month period, 81% were able to be stepped down to level 5 or below within two weeks, and the remaining 19% accounted for 61% of the total bed capacity.)

I emphasized that the impact of this *functional* shortage (rather than an actual shortage) of acute inpatient beds had been:

- People who needed inpatient beds were being boarded in emergency rooms for days at a time and/or transferred to hospitals all over the state and far from their homes and loved ones.
- As there was constant pressure to open beds, people who needed inpatient services designed to stabilize them for more than a few weeks before gradually stepping them down are being prematurely discharged from acute inpatient units, too often to settings that are not adequately structured to meet their needs (including shelters or the street), resulting in frequent readmissions and/or other more negative and costly outcomes.

The legislature responded to advocacy from a wide variety of stakeholders who were making similar points by introducing “Subacute Services” as a part of the 2012 Mental Health Redesign. Unfortunately, the way subacute was defined in Iowa Code was entirely inconsistent with the gap that I and others were advocating for. The most striking aspect of the inconsistency was the 10-day limit. It came as no surprise that these services never became a meaningful part of Iowa’s service array. Thankfully, the current study committee has the opportunity to redefine subacute services in a manner that can be transformative.

Summary: What can be done?

- 1) Clearly identify “Subacute Mental Health Services” as LOCUS level 6B, i.e., secure hospital or hospital-like settings with the full array of clinical and support services, but with expected lengths of stay measured in several weeks to a several months; and without the need for daily medical decision making; these are places where individuals’ psychiatric and medical needs can be addressed with the time that it may take to successfully prepare the person for a lower intensity level of care.
- 2) Recognize that the lack of a level 6B service intensity within Iowa’s system is a gap that is resulting in a functional shortage of acute inpatient beds, which in turn results in inefficient utilization of existing valuable services as well as poor (and at times tragic) outcomes.
- 3) One feasible way to fill this gap is to utilize the two remaining MHIs for this function, at least on the adult side. If the MHI’s served the level 6B function,

there would be more than adequate level 6A capacity across the state in existing units, and all of their adult beds could be used for 6B. There would still likely be a need to expand the MHI adult bed capacity – probably on the order of doubling the current adult capacity of 56. (See appendix)

Finally, I want to be clear that I am NOT recommending in any way, shape or form is a return to what may be thought of as “asylum”-like care, with expected lengths of stay measured in years or more without an expectation of recovery. In any population, there are likely going to be a very small number of people who will need ongoing level 6 care for more than a year (LOCUS level 6B), but with state-of-the-art recovery-oriented services, which the MHI’s should not only aspire to, but be resourced to be able to provide, they will be the exception. For those few who will likely require ongoing level 6 services, that much smaller gap in the existing array of services may need to be addressed in the future. For now, it is critical that the many individuals we know require level 6B services have the opportunity to benefit from them in the most appropriate, efficient and effective settings.

Thank you again for your attention to this critical issue. As I indicated in my opening, if I can provide any further information that may be helpful, please don’t hesitate to reach out.

Michael Flaum, MD
Emeritus Professor of Psychiatry
University of Iowa Carver College of Medicine
Immediate Past President, American Association for Community Psychiatry
Michael-flaum@uiowa.edu

Appendix: Bed capacity in Iowa's MHI's in the 21st Century

Mental Health Institute	2001* (*Ave. daily census)	2003	2014	2025	
				Adult	Child
Independence	152	95	40	20	36
Cherokee	70	60	24	36	0
Clarinda	70	55	35	0	0
Mt. Pleasant	74	39	40	0	0
				56	36
Total	366	249	139	92	

Addendum: I attended the meeting of the study committee on 1/6/25. After listening carefully to the discussion, I will add a few other points.

- 1) The fact that so few providers have chosen to operate subacute care since that level of care was introduced in Iowa Code in 2012, AND that the subacute beds that do exist have been un- or at least under-utilized is telling, and does NOT reflect the need for subacute care. Rather it reflects a mismatch between the need and the services that can feasibly be provided in these settings.
- 2) While the “10 day” length of stay is admittedly misunderstood as a hard and fast rule, the fact that patients would need to be reauthorized every 10 days is inconsistent with the kind and duration of services that are needed. It is unreasonable and inefficient to transfer a patient from an acute inpatient setting who has not stabilized over an initial stay of 2-3 weeks to another setting if the expectation is that the person may stabilize over the subsequent 10, or even 20 days. Most commonly, the need for subacute care capacity is for people who will likely require an additional ~1-6 months.
- 3) One critical issue that was raised in the discussion is that it is very difficult to create a financially viable staffing model that could provide the diverse services needed for good, recovery-oriented rehabilitative services in a facility that serves 16 people or less. That cap of 16 is driven by the IMD (Institute for Mental Disease) exclusion rule for Medicaid funding, i.e., if a facility had more than 16 people, more than half of whom are there for a mental disorder, it is considered an IMD, and is excluded from Medicaid funding. One way around this is through an IMD waiver, which could certainly be pursued, but an alternative is to locate subacute services within settings that are already designated as IMDs (and are accordingly funded through other sources). That is why the MHI’s - which are IMD’s, are well suited for this role in Iowa.