ARC 4207C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to mental health and disability services regions

The Human Services Department hereby amends Chapter 25, "Disability Services Management," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 225C.6 and 2018 Iowa Acts, House File 2456.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 225C.6 and 2018 Iowa Acts, House File 2456.

Purpose and Summary

These amendments implement 2018 Iowa Acts, House File 2456, which requires the mental health and disability services regions to initiate new core services, expand the core services that the regions currently provide, meet new access standards for these services, and include the service changes in their services, budget planning, and reporting by a specified date. The regions must also collaborate to ensure that core services are available in minimum numbers strategically located throughout the state.

These amendments also establish new and revised service standards for providers of comprehensive crisis services, subacute mental health services, and intensive mental health services.

Finally, these amendments provide for a broader and more accessible statewide array of crisis and intensive mental health services to individuals with severe and persistent mental illness and to other individuals experiencing a mental health or substance use crisis.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on August 15, 2018, as **ARC 3942C**. An Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on October 10, 2018, as **ARC 4044C**. A public hearing was held on November 14, 2018, at 2:30 p.m. at Polk County River Place, Rooms 1 and 1A, 2309 Euclid Avenue, Des Moines, Iowa.

Eighteen individuals attended the public hearing; seven individuals presented 12 oral statements. Additionally, two individuals submitted their comments in writing.

The Department received 326 comments from 25 individuals in addition to the comments provided during the public hearing. A consolidated comment and response document detailing changes to the amendments as the result of comments received and the Department's responses to those comments is available on the Department's website at www.dhs.iowa.gov.

The following changes were made to the amendments published under Notice of Intended Action. Changes to the proposed amendments are shown by subject area.

I. DEFINITIONS.

1. In the definition of "access center," the words "for adults with serious mental health conditions or substance use disorders" were changed to "for individuals experiencing a mental health or substance use crisis" to clarify that no diagnosis is necessary for a person to enter an access center for screening and assessment.

2. The definition of "ACT full-size team" was removed as unnecessary because the term was eliminated from Chapter 25.

3. The definition of "ACT population" was removed as unnecessary because the term was eliminated from Chapter 25.

4. The definition of "ACT small-size team" was removed as unnecessary because the term was eliminated from Chapter 25.

5. The definition of "care coordination" was revised to refer to transition planning in addition to service and discharge planning.

6. A definition of "face-to-face" that refers to the definition of "face-to-face" in rule 441—24.20(225C) was added. This definition relates to the use of telehealth in service delivery.

7. The definition of "intensive residential service homes" was revised to describe the individuals served as "individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions."

8. A definition for "medical assistance program" was added. The definition cross-references the definition of the same term in Iowa Code section 249A.2. This definition relates to the paragraph on regional coordination.

9. The definition for "medically stable" was removed as unnecessary because the term was eliminated from Chapter 25.

10. In the definition of "multi-occurring conditions," the term "substance-related disorder" was replaced with the term "substance use disorder" for consistency.

11. The words "in-person, or telehealth" were deleted from the definition of "prescreening assessment" as redundant since those words are included in the definition of "face-to-face."

12. The definition of "severe and persistent mental illness" was changed to replace "substance-related disorders" with "substance use disorders" for consistency and to replace the reference to "principal mental health disorder" with "primary mental health disorder," as more appropriate in this context.

13. The definition of "subacute mental health services" was revised to include the words "and includes both subacute facility-based services and subacute community-based services" to clarify that "subacute mental health services" refers inclusively to both types of subacute services.

14. The definition of "substance-related disorder" was removed as unnecessary because the term was eliminated from the chapter.

15. A definition for "substance use disorder" was added. The definition cross-references the definition of the same term in Iowa Department of Public Health (IDPH) rule 641—155.1(125,135).

16. Where appropriate, references to "substance abuse" were changed to "substance use," and all references to "substance-related disorder" were changed to "substance use disorder" for consistency within this chapter and with IDPH rules.

17. For consistency, references to "serious mental illness" were replaced with references to "severe and persistent mental illness" throughout, except where a more inclusive population is intended, such as in reference to experience working with individuals with "mental illness" (as in staff qualifications) or in reference to individuals "experiencing a mental health . . . crisis."

II. ACCESS STANDARDS.

1. Paragraph 25.4(2)"b," the access standard for crisis stabilization community-based services (CSCBS), has been changed to clarify that the 120-minute time frame for receiving face-to-face contact begins after the individual has been determined to need the service. The paragraph now reads as follows:

"b. Crisis stabilization community-based services. An individual who has been determined to need CSCBS shall receive face-to-face contact from the CSCBS provider within 120 minutes from the time of referral."

2. Paragraph 25.4(2)"c," the access standard for crisis stabilization residential services (CSRS), has been changed to clarify that the 120-minute time frame for receiving CSRS begins after the individual has been determined to need the service. The distance access standard has also been changed from 100 miles to 120 miles to allow more flexibility in reaching individuals in rural areas or near regional boundaries. The paragraph now reads as follows:

"c. Crisis stabilization residential services. An individual who has been determined to need CSRS shall receive CSRS within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual."

3. Paragraph 25.4(2)"e," the access standard for 23-hour observation and holding, has been changed to clarify that the 120-minute time frame for observation and holding begins after the individual has been determined to need the service. The distance access standard has also been changed from 100 miles to 120 miles to allow more flexibility in reaching individuals in rural areas or near regional boundaries. The paragraph now reads as follows:

"e. Twenty-three-hour observation and holding. An individual who has been determined to need 23-hour observation and holding shall receive 23-hour observation and holding within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual."

4. Subrule 25.4(4), the access standard for subacute facility-based mental health services, has been revised to change the distance access standard from 100 miles to 120 miles to allow more flexibility in reaching individuals in rural areas or near regional boundaries.

5. Subparagraph (2) of paragraph 25.4(9)"a," the access standard for assertive community treatment (ACT), has been revised to read as follows:

"(2) A sufficient number of ACT teams shall be available to serve the number of individuals in the region who are eligible for ACT services. As a guideline for planning purposes, the ACT-eligible population is estimated to be about 0.06 percent of the adult population of the region. The region may identify multiple geographic areas within the region for ACT team coverage. Regions may work with one or more other regions to identify geographic areas for ACT team coverage."

This revision clarifies that the 0.06 percent figure is a guideline rather than a requirement and that the region is responsible for having a sufficient number of ACT teams to serve its ACT-eligible population.

6. Subparagraph (2) of paragraph 25.4(9)"b," the access standard for access centers, has been revised to increase the distance access standard from 100 miles to 120 miles and the time access standard from 90 minutes to 120 minutes to allow more flexibility in reaching individuals in rural areas or near regional boundaries.

III. ACCESS CENTERS.

1. The words "the purpose of an access center is to serve individuals with a serious mental health condition or substance use disorder who are otherwise medically stable" in the introductory paragraph of subrule 25.6(1) were changed to "the purpose of an access center is to serve individuals experiencing a mental health or substance use crisis" to clarify that no diagnosis is necessary for a person to enter an access center for screening and assessment. The term "medically stable" was eliminated to clarify that the criteria are intended to be a reasonable-person determination rather than a formal clinical judgment.

2. The words "with the support of the medical assistance program" were added to subparagraph 25.6(1)"a"(1) so that the subparagraph now reads:

"(1) Regions shall work collaboratively to develop a minimum of six access centers strategically located throughout the state, with the support of the medical assistance program."

This revision was made to clarify that the medical assistance program will support the regional development of access centers.

3. Subparagraph 25.6(1)"b"(5) was revised to read:

"(5) An access center shall provide services on a no reject, no eject basis to individuals who meet service eligibility criteria."

This revision was made to clarify that "no reject, no eject" does not waive service eligibility criteria.

4. A new subparagraph 25.6(1)"b"(7) was added and reads as follows:

"(7) An access center shall provide all required services listed in 25.6(1)*'d'* in a coordinated manner. An access center may provide coordinated services in one or more locations."

The purpose of the new language is to clarify that access center services must be coordinated but that the services are not all required to be located in the same physical place.

5. Subparagraph (1) of paragraph 25.6(1)"c," eligibility for access center services, was changed so that the subparagraph no longer refers to "an adult in need of services or treatment related to a serious mental health condition or a substance use disorder" and instead reads as follows:

“(1) The individual is in need of screening, assessment, services or treatment related to a mental health or substance use crisis.”

This revision was made (1) to allow access centers the flexibility to serve individuals under the age of 18 when deemed appropriate and (2) to clarify that no diagnosis is required for an individual to enter an access center for screening or assessment.

6. Subparagraph 25.6(1)“c”(2) was changed to read as follows:

“(2) The individual shows no obvious sign of illness or injury indicating a need for immediate medical attention.”

This revision was made to eliminate the term “medically stable” and to clarify that this is a reasonable-person determination, not a formal clinical judgment.

7. In subparagraph (1) of paragraph 25.6(1)“d,” access center services, the words “immediate intake assessment and screening for multi-occurring conditions, including but not limited to suicide risk, brain injury, and drug and alcohol use” were changed to “immediate intake assessment and screening that includes but is not limited to mental and physical health conditions, suicide risk, brain injury, and substance use” to specifically add “mental and physical health conditions” as part of the screening to indicate that all aspects of the person’s condition and needs are to be addressed and to replace “drug and alcohol use” with “substance use” for consistency. Also, the words “crisis evaluation may serve as an intake assessment” were changed to “crisis evaluation that includes all the required screenings may serve as an intake assessment” to clarify that the screenings must be part of any assessment performed.

8. In subparagraph 25.6(1)“d”(7), the words “medically necessary physical health services” were changed to “physical health care services as indicated by a health screening” (1) to remove the reference to “medically necessary” to avoid confusion with determinations of “medical necessity” and (2) to add “as indicated by a health screening” to make the wording more consistent with the revised wording described above.

9. In subparagraph 25.6(1)“d”(8), the phrase “as defined in rule 441—25.1(331)” relating to “care coordination” was deleted as unnecessary.

10. In subparagraph 25.6(1)“d”(9), intellectual and developmental disability services were added to the list of services requiring service navigation and linkage to more clearly cover the range of multi-occurring conditions. The subparagraph now reads as follows:

“(9) Service navigation and linkage to needed services including housing, employment, shelter services, intellectual and developmental disability services, and brain injury services, with warm handoffs to other service providers.”

IV. ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES.

1. Subparagraph (1) of paragraph 25.6(2)“a,” regional coordination of ACT services, was revised to eliminate references to ACT full-size and small-size teams and now reads:

“(1) Each region shall determine the number of ACT teams needed to serve the ACT-eligible population of the region.”

This revision was made to simplify the ACT team standards and allow more flexibility in determining the team size and number of teams needed.

2. Subparagraph 25.6(2)“a”(2) was revised (1) to remove references to “meeting” fidelity criteria because there is a range of fidelity scores that may be acceptable and (2) to require fidelity reviews and reporting of fidelity scores on a regular schedule, as follows: an initial review during the first 12 months of operation, an annual review during the second and third years of operation, a biennial review thereafter for teams with satisfactory reviews, and an annual review for any team with an unsatisfactory review. The subparagraph was also revised to indicate that the results of the ACT team fidelity reviews shall be included in the region’s annual report.

3. Paragraph 25.6(2)“b,” ACT team composition, has been simplified to require each ACT team to have a minimum of six members. The six members are required to include each of eight areas of competency. One member may fill more than one area of competency. This change establishes a minimum size for all teams and allows for larger teams to be used when necessary to meet the needs of the individuals being served.

4. In subparagraph 25.6(2)“c”(1), psychiatrist staff qualifications, all references to a board-certified psychiatrist have been changed to include both board-certified psychiatrists and psychiatrists who are eligible for board certification to allow greater flexibility in securing the services of psychiatrists on ACT teams. This change was also made in subparagraph 25.6(2)“b”(1) for consistency.

5. Paragraph “1” of subparagraph 25.6(2)“c”(4), team leader staff qualifications, has been revised to read:

“1. Has a master’s degree in a mental health field, including but not limited to nursing, social work, mental health counseling, psychiatric rehabilitation, or psychology.”

The revised wording allows for greater flexibility in hiring ACT team leaders.

6. Paragraph 25.6(2)“c”(4)“2” has been revised to remove the reference to “clinician” and now reads:

“2. Is actively involved in direct contact with individuals being served by the team.”

This revision clarifies that the team leader need not be a licensed clinician but must be active in the delivery of ACT services to individuals and cannot serve a solely administrative function.

7. Under subparagraph 25.6(2)“c”(6), mental health professional qualifications, language was added to include occupational therapists licensed pursuant to 645—Chapter 206 in the list of types of licensed professionals who may qualify to serve as a mental health professional on an ACT team.

8. Under subparagraph 25.6(2)“c”(9), peer support specialist qualifications, language was added to allow peer support specialists on ACT teams up to six months after the date of hire to complete their peer support training.

9. Employment specialist qualifications were inadvertently omitted from the noticed rules. The qualifications have been added herein as new subparagraph 25.6(2)“c”(10); the subsequent subparagraph was renumbered accordingly.

10. In subparagraph (2) of paragraph 25.6(2)“e,” ACT team standards, the words “provide 24-hour services for the psychiatric needs of the individual” were changed to “ensure that services for the psychiatric needs of the individual are available 24 hours a day” to clarify that the standard is to have service availability at all times, not to have continuous services 24 hours a day.

11. The end of subparagraph 25.6(2)“e”(7) was revised to read: “The number of team contacts per individual served shall average at least three per week per individual when calculated across all individuals served by the team. Contacts may be weekly, daily, or more frequent. The frequency of contacts is determined by the needs of the individual.”

These revisions are intended to clarify that the team has flexibility in determining how often to schedule contacts based on needs of the individuals being served, which may change over time. The frequency of contacts is averaged for all individuals served by the team.

12. Subparagraph 25.6(2)“e”(9) was revised to clarify that the team must ensure that treatment, rehabilitation, and support activities are available 24 hours a day, 7 days a week but that it is not required to provide continuous 24-hour services.

13. Paragraph 25.6(2)“f,” staff-to-client ratio, was revised to establish one minimum ratio for all teams, regardless of size. The paragraph now reads:

“*f. Staff-to-client ratio.* ACT teams shall maintain a ratio of at least one full-time or full-time equivalent staff person to every ten individuals served. The ACT team staff-to-client ratios do not include the psychiatrist, advanced nurse practitioner, or physician assistant practicing under the supervision of a psychiatrist.”

The language setting a 1-to-8 ratio for teams that serve up to 48 individuals and a 1-to-10 ratio for teams that serve more than 48 individuals has been removed for simplicity and to allow for greater flexibility.

14. Subparagraph (2) of paragraph 25.6(2)“g,” eligibility criteria for ACT services, has been revised to add “personality disorder” to the list of primary diagnoses that are not eligible for ACT services, because ACT has not been found to be an effective treatment for individuals with personality disorder.

15. Subparagraph 25.6(2)“g”(3) has been revised to clarify that an individual may meet eligibility criteria if the individual has either “one or both” of the following: (1) A pattern of repeated treatment failures during the previous 12 months, including at least two psychiatric hospitalizations or psychiatric

care delivered at least twice in an emergency department, at an access center, or by a mobile crisis team; or (2) the need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

16. Paragraph "4" of subparagraph 25.6(2)"g"(4) has been revised for clarity to read:

"4. Lives independently in the community or demonstrates a capacity and desire to live independently in the community."

17. Paragraph "1" of subparagraph 25.6(2)"h"(1), ACT service initial assessment and treatment planning, has been revised for clarity and to eliminate repetitive language. It now reads:

"1. An assessment of the individual shall be completed within 30 days of admission that includes psychiatric history, medical history, educational history, employment, substance use, problems with activities of daily living, social interests, and family relationships."

V. 23-HOUR OBSERVATION AND HOLDING.

In subrule 25.6(4), the language of the purpose statement has been revised to describe the care as provided "in a safe and secure, medically staffed treatment environment." This change brought the language into closer alignment with provisions in 441—Chapter 24 for this service and eliminated the phrase "psychiatrically supervised" as unnecessarily prescriptive.

VI. SUBACUTE MENTAL HEALTH SERVICES.

Subparagraph 25.6(7)"b"(2) was revised to clarify that subacute mental health services in a community-based setting are the same as ACT services. The subparagraph now reads as follows:

"(2) Subacute mental health services in a community-based setting are the same as assertive community treatment (ACT) services provided as described in subrule 25.6(2)."

VII. INTENSIVE RESIDENTIAL SERVICES.

1. Subparagraph (1) of paragraph 25.6(8)"a," regional coordination, was changed to include the phrase "with the support of the medical assistance program" to clarify that the medical assistance program will support the regional development of intensive residential services.

2. In subparagraph (1) of paragraph 25.6(8)"b," intensive residential services standards, the language requiring a provider to be in good standing with all Iowa Medicaid managed care organizations (MCOs) was eliminated to clarify that intensive residential service providers are not required to contract with all MCOs.

3. Subparagraph 25.6(8)"b"(6) was revised to require that coordination for the individual be provided for "other services and supports" as well as for "clinical mental health and physical health treatment."

4. Subparagraph 25.6(8)"b"(7) was revised to indicate that "all" behavioral health services provided to individuals shall be overseen by a mental health professional; to add that any cognitive or physical rehabilitation plans are to be included in the plans the mental health professional must consult on and review; and to improve clarity.

5. Subparagraph (2) of paragraph 25.6(8)"c," eligibility criteria for admission to intensive residential services, was revised for clarity to read:

"(2) The individual is approved by the Iowa Medicaid enterprise or Medicaid managed care organization, as appropriate, for the highest rate of home-based habilitation or the highest rate of home- and community-based services intellectual disability waiver supported community living service. Reimbursement rates for intensive residential services shall be equal to or greater than the established fees for those services. Regional reimbursement rates for non-Medicaid individuals receiving intensive residential services shall be negotiated by the region and the provider and shall be no less than the minimum Medicaid rate."

These revisions were made to eliminate reference to "fee schedule" and "floor rate" for the purpose of aligning the language with currently used Medicaid terms.

6. The words "or continued" were added to paragraph "5" of subparagraph 25.6(8)"c"(3) to clarify that individuals who are doing well in intensive residential services should not be discharged if the level of supports the individuals are receiving continues to be needed to maintain their level of functioning.

VIII. ANNUAL SERVICE AND BUDGET PLAN; ANNUAL REPORTS.

1. The words “shall be included” were added to the introductory paragraph of 25.18(2)“d” to make it parallel to the other paragraphs in the subrule.

2. In paragraph “4” of rule 441—25.20(331), the reporting language for regions with relation to ACT teams has been revised to reflect changes made in subparagraph 25.6(2)“a”(2) to the fidelity review requirements for ACT teams. The revised paragraph reads as follows:

“4. Documentation that each regionally designated ACT team has been evaluated for program fidelity, including a peer review as required by subrule 25.6(2), and documentation of each team’s most recent fidelity score.”

Adoption of Rule Making

This rule making was adopted by the Mental Health and Disability Services Commission on December 6, 2018.

Fiscal Impact

This rule making has a fiscal impact to the State of Iowa of $100,000 annually or $500,000 over five years. The fiscal impact statement containing a detailed discussion of assumptions and how estimates were derived is available from the Department upon request.

Jobs Impact

These amendments are not expected to have a significant impact on private-sector jobs and employment opportunities in Iowa. However, the introduction of new and expanded services may provide a small number of new jobs or opportunities for job change or advancement.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on March 1, 2019.

The following rule-making actions are adopted:

ITEM 1. Amend **441—Chapter 25**, chapter preamble, as follows:

This chapter provides for definitions of regional core services~~,~~; access ~~and~~ standards; implementation dates; practice standards~~,~~; reporting of regional expenditures~~,~~; development and submission of regional management plans~~,~~; data collection~~,~~; applications for funding as they relate to regional service systems for individuals with mental illness, intellectual disabilities, developmental disabilities, or brain injury~~,~~; and submission of data for Medicaid offset calculations.

ITEM 2. Amend **441—Chapter 25**, Division I title, as follows:

REGIONAL ~~CORE~~ SERVICES

ITEM 3. Amend rule **441—25.1(331)**, definitions of "Assertive community treatment," "Case manager" and "Home and vehicle modification," as follows:

"Assertive community treatment" or *"ACT"* means a program of comprehensive outpatient services consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration, provided in the community and directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of individuals with severe and persistent mental ~~disorders~~ illness and individuals with complex ~~symptomatology~~ symptomology who require multiple mental health and supportive services to live in the community ~~consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration~~.

"Case manager" means a person who has completed specified and required training to provide case management through the medical assistance program ~~or the Iowa Behavioral Health Care Plan~~.

"Home and vehicle modification" means a service that provides physical modifications to the home or vehicle that directly address the medical health or remedial needs of the individual and that are necessary to provide for the health, welfare, and safety of the ~~member~~ individual and to increase or maintain independence.

ITEM 4. Adopt the following **new** definitions of "Access center," "Adult," "Brain injury," "Care coordination," "Comprehensive assessment," "Crisis assessment," "Crisis intervention plan," "Crisis screening," "Crisis stabilization community-based services," "Crisis stabilization residential services," "Emergency detention," "Face-to-face," "HCBS," "Homeless," "Intake assessment," "Intensive residential service homes," "Medical assistance program," "Mobile response," "Multi-occurring conditions," "No reject, no eject," "Precariously housed," "Prescreening assessment," "Region," "Severe and persistent mental illness," "Subacute mental health services," "Substance use disorder," "Twenty-four-hour crisis response," "Twenty-three-hour observation and holding," and "Warm handoff," in rule **441—25.1(331)**:

"Access center" means the coordinated provision of intake assessment, screening for multi-occurring conditions, care coordination, crisis stabilization residential services, subacute mental health services, and substance abuse treatment for individuals experiencing a mental health or substance use crisis who do not need inpatient psychiatric hospital treatment, but who do need significant amounts of supports and services not available in other home- and community-based settings.

"Adult" means the same as defined in 441—subrule 78.27(1).

"Brain injury" means the same as defined in rule 441—83.81(249A).

"Care coordination" means facilitating communication and ensuring provision of services among multiple professionals and service providers, the individual, and family members or other natural supports when designated by the individual, and ensuring the individual has the information necessary to actively participate in service and discharge or transition planning.

"Comprehensive assessment" means the same as "crisis assessment" defined in rule 441—24.20(225C) for individuals being referred to crisis stabilization residential services and means the same as "assessment" defined in rule 481—71.2(135G) for individuals being referred to subacute mental health services.

"Crisis assessment" means the same as defined in rule 441—24.20(225C).

"Crisis intervention plan" means the same as defined in rule 441—24.1(225C).

"Crisis screening" means a brief assessment to make a determination of the presenting problem and referral to the appropriate level of care.

"Crisis stabilization community-based services" or *"CSCBS"* means the same as defined in rule 441—24.20(225C).

"Crisis stabilization residential services" or *"CSRS"* means the same as defined in rule 441—24.20(225C).

"Emergency detention" means the same as "immediately detained" as described in Iowa Code section 229.22(1).

"Face-to-face" means the same as defined in rule 441—24.20(225C).

"HCBS" means home- and community-based services as defined in rule 441—78.27(249A).

"Homeless" means the same as "homeless person" defined in rule 441—25.11(331).

"Intake assessment" means the process used with an individual to collect information related to the individual's history, needs, strengths, and abilities for the purpose of determining the individual's need for comprehensive assessment, appropriate services or referral.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours a day, 7 days a week, 365 days a year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in subrule 25.6(8).

"Medical assistance program" means the same as defined in Iowa Code section 249A.2.

"Mobile response" means the same as defined in rule 441—24.20(225C).

"Multi-occurring conditions" means a diagnosis of a severe and persistent mental illness occurring along with one or more of the following: a physical health condition, a substance use disorder, an intellectual or developmental disability, or a brain injury.

"No reject, no eject" means that an individual who otherwise meets the eligibility criteria for a service shall not be denied access to that service or discharged from that service based on the severity or complexity of that individual's mental health and multi-occurring needs.

"Precariously housed" means that a person does not have a permanent household and is living day-to-day in a motel, in a vehicle, with family or friends, or in some other temporary location.

"Prescreening assessment" means a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition.

"Region" means a mental health and disability service region that operates as the "'regional administrator' or 'regional administrative entity'" as defined in rule 441—25.11(331).

"Severe and persistent mental illness" or *"SPMI"* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that: (1) the individual does not have the resources or skills necessary to maintain function in the home or community environment without assistance or support; (2) the individual's judgment, impulse control, or cognitive perceptual abilities are compromised; (3) the individual exhibits significant impairment in social, interpersonal, or familial functioning; and (4) the individual has a documented mental health diagnosis. For this purpose, a "mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Subacute mental health services" means the same as defined in Iowa Code section 225C.6(4)*"c"* and includes both subacute facility-based services and subacute community-based services.

"Substance use disorder" means the same as defined in rule 641—155.1(125,135).

"Twenty-four-hour crisis response" means the same as defined in rule 441—24.20(225C).

"Twenty-three-hour observation and holding" means the same as defined in rule 441—24.20(225C).

"Warm handoff" means an approach to care transitions in which a health care provider uses face-to-face or telephone contact to directly link individuals being treated to other providers or specialists.

ITEM 5. Rescind subrule 25.2(3) and adopt the following **new** subrule in lieu thereof:

25.2(3) The region shall ensure that the following services are available in the region:

a. Access centers.
b. Assertive community treatment.
c. Assessment and evaluation.
d. Case management.
e. Crisis evaluation.
f. Crisis stabilization community-based services.
g. Crisis stabilization residential services.
h. Day habilitation.
i. Family support.
j. Health homes.
k. Home and vehicle modification.
l. Home health aide.
m. Intensive residential service homes.
n. Job development.
o. Medication prescribing and management.
p. Mental health inpatient treatment.
q. Mental health outpatient treatment.
r. Mobile response.
s. Peer support.
t. Personal emergency response system.
u. Prevocational services.
v. Respite.
w. Subacute mental health services.
x. Supported employment.
y. Supportive community living.
z. Twenty-four-hour access to crisis response.
aa. Twenty-three-hour crisis observation and holding.

Regions may fund or provide other services in addition to the required core services consistent with requirements set forth in subrules 25.2(4) and 25.2(5).

ITEM 6. Amend subrule 25.2(5), introductory paragraph, as follows:

25.2(5) A regional service system may provide funding for other appropriate services or ~~other~~ support. In considering whether to provide such funding, a region may consider the following criteria:

ITEM 7. Rescind rule 441—25.3(331) and adopt the following **new** rule in lieu thereof:

441—25.3(331) Implementation dates.

25.3(1) Regions shall implement the following core services effective July 1, 2014:

a. Assessment and evaluation.
b. Case management.
c. Crisis evaluation.
d. Day habilitation.
e. Family support.
f. Health homes.
g. Home and vehicle modification.
h. Home health aide.
i. Job development.
j. Medication prescribing and management.
k. Mental health inpatient therapy.
l. Mental health outpatient therapy.
m. Peer support.

n. Personal emergency response system.
o. Prevocational services.
p. Respite.
q. Supported employment.
r. Supportive community living.
s. Twenty-four-hour access to crisis response.

25.3(2) Regions shall implement the following intensive mental health core services on or before July 1, 2021, provided that federal matching funds are available under the Iowa health and wellness plan pursuant to Iowa Code chapter 249N:

a. Access centers.
b. Assertive community treatment.
c. Crisis stabilization community-based services.
d. Crisis stabilization residential services.
e. Intensive residential service homes.
f. Mobile response.
g. Subacute mental health services provided in facility and community-based settings.
h. Twenty-three-hour crisis observation and holding.

ITEM 8. Rescind rule 441—25.4(331) and adopt the following **new** rule in lieu thereof:

441—25.4(331) Access standards. Regions shall meet the following access standards:

25.4(1) A sufficient provider network which shall include:

a. A community mental health center or federally qualified health center that provides psychiatric and outpatient mental health services in the region.

b. A hospital with an inpatient psychiatric unit or state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant.

25.4(2) Crisis services shall be available 24 hours per day, 7 days per week, 365 days per year for mental health and disability-related emergencies. A region may make arrangements with one or more other regions to meet the required access standards.

a. Basic crisis response.

(1) Twenty-four-hour crisis response. An individual shall have immediate access to crisis response services by means of telephone, electronic, or face-to-face communication.

(2) Crisis evaluation. An individual shall have immediate access to a crisis screening and will have a crisis assessment by a licensed mental health professional within 24 hours of referral.

b. Crisis stabilization community-based services. An individual who has been determined to need CSCBS shall receive face-to-face contact from the CSCBS provider within 120 minutes from the time of referral.

c. Crisis stabilization residential services. An individual who has been determined to need CSRS shall receive CSRS within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

d. Mobile response. An individual in need of mobile response services shall have face-to-face contact with mobile crisis staff within 60 minutes of dispatch.

e. Twenty-three-hour observation and holding. An individual who has been determined to need 23-hour observation and holding shall receive 23-hour observation and holding within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

25.4(3) The region shall provide the following treatment services:

a. Outpatient.

(1) Emergency: During an emergency, outpatient services shall be initiated to an individual within 15 minutes of telephone contact.

(2) Urgent: Outpatient services shall be provided to an individual within one hour of presentation or 24 hours of telephone contact.

(3) Routine: Outpatient services shall be provided to an individual within four weeks of request for appointment.

(4) Distance: Outpatient services shall be offered within 30 miles for an individual residing in an urban community and 45 miles for an individual residing in a rural community.

b. Inpatient.

(1) An individual in need of emergency inpatient services shall receive treatment within 24 hours.

(2) Inpatient services shall be available within reasonably close proximity to the region.

c. Assessment and evaluation. An individual who has received inpatient services shall be assessed and evaluated within four weeks.

25.4(4) Subacute facility-based mental health services. An individual shall receive subacute facility-based mental health services within 24 hours of referral. The service shall be located within 120 miles of the residence of the individual.

25.4(5) Support for community living. The first appointment shall occur within four weeks of the individual's request of support for community living.

25.4(6) Support for employment. The initial referral shall take place within 60 days of the individual's request of support for employment.

25.4(7) Recovery services. An individual receiving recovery services shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

25.4(8) Service coordination.

a. An individual receiving service coordination shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

b. An individual shall receive service coordination within ten days of the initial request for such service or being discharged from an inpatient facility.

25.4(9) The region shall make the following intensive mental health services available. A region may make arrangements with one or more other regions to meet the required access standards.

a. Assertive community treatment.

(1) A minimum of 22 ACT teams shall be operational statewide.

(2) A sufficient number of ACT teams shall be available to serve the number of individuals in the region who are eligible for ACT services. As a guideline for planning purposes, the ACT-eligible population is estimated to be about 0.06 percent of the adult population of the region. The region may identify multiple geographic areas within the region for ACT team coverage. Regions may work with one or more other regions to identify geographic areas for ACT team coverage.

b. Access centers.

(1) A minimum of six access centers shall be operational statewide.

(2) An access center shall be located within 120 miles of the residence of the individual or be available within 120 minutes from the time of the determination that the individual needs access center services.

c. Intensive residential services.

(1) A minimum of 120 intensive residential service beds shall be available statewide.

(2) An individual receiving intensive residential services shall have the service available within two hours of the individual's residence.

(3) An individual shall be admitted to intensive residential services within four weeks from referral.

25.4(10) The following limitations apply to home and vehicle modification for an individual receiving mental health and disability services:

a. A lifetime limit equal to that established for the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

b. A provider reimbursement payment will be no lower than that provided through the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

ITEM 9. Adopt the following **new** rule 441—25.5(331):

441—25.5(331) Practices. A region shall ensure that access is available to providers of core services that demonstrate the following competencies:

25.5(1) Regions shall have service providers that are trained to provide effective services to individuals with multi-occurring conditions. Training for serving individuals with multi-occurring conditions provided by the region shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the regional service system management plan.

25.5(2) Regions shall have service providers that are trained to provide effective trauma-informed care. Trauma-informed care training provided by the region shall be recognized by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the regional service system management plan.

25.5(3) Regions must have evidence-based practices that the region has independently verified as meeting established fidelity to evidence-based service models including, but not limited to, assertive community treatment or strengths-based case management; integrated treatment of co-occurring substance use and mental health disorders; supported employment; family psychoeducation; illness management and recovery; and permanent supportive housing.

ITEM 10. Adopt the following **new** rule 441—25.6(331):

441—25.6(331) Intensive mental health services. The purpose of intensive mental health services is to provide a continuum of services and supports to individuals with complex mental health and multi-occurring conditions who need a high level of intensive and specialized support to attain stability in health, housing, and employment and to work toward recovery.

25.6(1) *Access centers.* The purpose of an access center is to serve individuals experiencing a mental health or substance use crisis who are not in need of an inpatient psychiatric level of care and who do not have alternative, safe, effective services immediately available.

a. Regional coordination. Each region shall designate at least one access center provider and ensure that access center services are available to the residents of the region consistent with subrule 25.4(9).

(1) Regions shall work collaboratively to develop a minimum of six access centers strategically located throughout the state, with the support of the medical assistance program.

(2) Access centers may be shared by two or more regions.

(3) Each region shall establish methods to provide for reimbursement of a region when a non-Medicaid-eligible resident of another region utilizes an access center or other non-Medicaid-covered services located in that region.

b. Access center standards. A designated access center shall meet all of the following criteria:

(1) An access center shall have no residential facility-based setting with more than 16 beds.

(2) An access center provider shall be accredited to provide crisis stabilization residential services pursuant to 441—Chapter 24.

(3) An access center provider shall be licensed to provide subacute mental health services as described in rule 441—77.56(249A).

(4) An access center provider shall be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a cooperative agreement with and immediate access to licensed substance abuse treatment services or medical care that incorporates withdrawal management.

(5) An access center shall provide services on a no reject, no eject basis to individuals who meet service eligibility criteria.

(6) An access center shall accept and serve eligible individuals who are court-ordered to participate in mental health or substance use disorder treatment.

(7) An access center shall provide all required services listed in 25.6(1)*"d"* in a coordinated manner. An access center may provide coordinated services in one or more locations.

c. Eligibility for access center services. To be eligible to receive access center services, an individual shall meet all of the following criteria:

(1) The individual is in need of screening, assessment, services or treatment related to a mental health or substance use crisis.

(2) The individual shows no obvious signs of illness or injury indicating a need for immediate medical attention.

(3) The individual has been determined not to need an inpatient psychiatric hospital level of care.

(4) The individual does not have immediate access to alternative, safe, and effective services.

d. Access center services. An access center shall provide or arrange for the provision of all of the following:

(1) Immediate intake assessment and screening that includes but is not limited to mental and physical health conditions, suicide risk, brain injury, and substance use. A crisis evaluation that includes all required screenings may serve as an intake assessment.

(2) Comprehensive person-centered mental health assessments by appropriately licensed or credentialed professionals, as indicated by the intake assessment.

(3) Comprehensive person-centered substance use disorder assessments by appropriately licensed or credentialed professionals, as indicated by the intake assessment.

(4) Peer support services, as indicated by a comprehensive assessment.

(5) Mental health treatment, as indicated by a comprehensive assessment.

(6) Substance use treatment, as indicated by a comprehensive assessment.

(7) Physical health care services as indicated by a health screening.

(8) Care coordination.

(9) Service navigation and linkage to needed services including housing, employment, shelter services, intellectual and developmental disability services, and brain injury services, with warm handoffs to other service providers.

25.6(2) *Assertive community treatment (ACT) services.* The purpose of assertive community treatment is to serve individuals with the most severe and persistent mental illness conditions and functional impairments. ACT services provide a set of comprehensive, integrated, intensive outpatient services delivered by a multidisciplinary team under the supervision of a psychiatrist, an advanced registered nurse practitioner, or a physician assistant under the supervision of a psychiatrist. An ACT program shall designate an individual to be responsible for administration of the program and with the authority to sign documents and receive payments on behalf of the program.

a. Regional coordination. Each region shall designate at least one ACT provider and ensure that ACT services are available to the residents of the region consistent with subrule 25.4(9). Regions may work collaboratively with other regions when an ACT team is serving more than one region.

(1) Each region shall determine the number and size of ACT teams needed to serve the ACT-eligible population in that region.

(2) Each region shall verify that all ACT programs operating in the region have periodic fidelity reviews consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration (SAMHSA). Each ACT program shall have a fidelity review, including a peer review, on the following schedule:

1. Within the first 12 months of operation.
2. Annually during each of the second and third years of operation.
3. Biennially thereafter for teams with satisfactory fidelity reviews. Teams with unsatisfactory reviews shall be reviewed again after one year.

Results of the ACT team fidelity reviews shall be included in the region's annual report.

b. ACT team composition. Each ACT team shall include a minimum of six members and must include a member qualified to fill each of the eight following roles. One team member may fill more than one role if all other qualifications are met.

(1) A psychiatrist, an advanced registered nurse practitioner, or a physician assistant under the supervision of a psychiatrist who is board-certified or eligible for board certification.

(2) A team leader.

(3) A registered nurse.

(4) A mental health professional.

(5) A substance abuse treatment provider.

(6) A community support specialist.

(7) A peer support specialist.

(8) An employment specialist.

c. Staff qualifications. ACT team members shall meet the following qualifications:

(1) Psychiatrist. A psychiatrist on the team shall be a person who meets all of the following criteria:

1. Is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).

2. Is licensed in Iowa pursuant to 653—Chapter 9.

3. Is certified or is eligible to be certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry.

4. Has experience working with persons with severe and persistent mental illness.

5. Provides a minimum of 16 hours per week of psychiatrist time for every 50 ACT clients.

(2) Advanced registered nurse practitioner. An advanced registered nurse practitioner on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 655—Chapter 7.

2. Has a mental health certification.

3. Has experience working with persons with severe and persistent mental illness.

4. Provides a minimum of 16 hours per week of advanced registered nurse practitioner time for every 50 ACT clients.

(3) Physician assistant. A physician assistant on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 645—Chapter 326.

2. Has experience working with persons with severe and persistent mental illness.

3. Is practicing under the supervision of a psychiatrist who is board-certified or eligible for board certification.

4. Provides a minimum of 16 hours per week of physician assistant time for every 50 ACT clients.

(4) Team leader. A team leader shall be a person on the team who meets all of the following criteria:

1. Has a master's degree in a mental health field, including but not limited to nursing, social work, mental health counseling, psychiatric rehabilitation, or psychology.

2. Is actively involved in direct contact with individuals being served by the team.

3. Is a full-time staff member whose responsibilities are limited to the ACT team and who serves as the clinical and administrative supervisor of the team.

(5) Registered nurse. A registered nurse on the team shall be a person who meets all of the following criteria:

1. Is licensed as a registered nurse pursuant to 655—Chapter 3.

2. Has experience working with persons with severe and persistent mental illness.

(6) Mental health professional. A mental health professional on the team shall be a person who meets all of the following criteria:

1. Is a mental health counselor or marital and family therapist licensed pursuant to 645—Chapter 31; a social worker licensed as a master or independent social worker pursuant to 645—Chapter 280; or an occupational therapist licensed pursuant to 645—Chapter 206.

2. Has experience working with persons with severe and persistent mental illness.

(7) Substance abuse treatment professional. A substance abuse treatment professional on the team shall be a person who meets all of the following criteria:

1. Is an appropriately credentialed counselor pursuant to 641—subparagraph 155.21(8)*"b"*(1).

2. Has at least three years of experience working with persons with substance use disorders.

(8) Community support specialist. A community support specialist on the team shall be a person who meets all of the following criteria:

1. Has a bachelor's degree with at least 30 semester hours or equivalent quarter hours in a human services field, including but not limited to sociology, social work, counseling, psychology, or human services.

2. Has experience working with persons with severe and persistent mental illness.

(9) Peer support specialist. A peer support specialist on the team shall be a person who meets all of the following criteria:

1. Has been diagnosed with a severe and persistent mental illness.

2. Has met all requirements of the Appalachian Consulting Group Peer Support Training Model by no later than six months after the date of hire.

(10) Employment specialist. An employment specialist on the team shall be a person who meets all of the following criteria:

1. Has experience working with persons with severe and persistent mental illness.

2. Meets one of the following:

- Has a bachelor's degree with at least 30 semester hours or equivalent quarter hours in a human services field, including but not limited to sociology, social work, counseling, or psychology, and completes at least 12 hours of employment services training within six months of the date of hire.
- Has a high school diploma or equivalent, has at least one year of specialized vocational training or supervised experience in vocational and related services, including but not limited to supported employment, job coaching, supported community living, or habilitation, and completes at least 12 hours of employment services training within six months of the date of hire.

(11) Psychologist. A psychologist on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 645—Chapter 240.

2. Has experience working with persons with a severe and persistent mental illness.

d. ACT provider standards. Organizations seeking regional designation as an ACT provider shall meet the following criteria at initial application and annually thereafter. A designated ACT provider shall:

(1) Develop and maintain written ACT-specific admission policies and procedures, including but not limited to a gradual rate of admission and program eligibility requirements.

(2) Develop and maintain written ACT-specific discharge policies and procedures. Discharge criteria shall include but are not limited to the following:

1. An individual reaches individually established goals for discharge, and the individual and program staff mutually agree to the termination of services; or

2. An individual requests discharge, demonstrates the ability to function in all major role areas without ongoing assistance from the program and without significant relapse when services are withdrawn, and the program staff agree to the termination of services; or

3. An individual moves outside the geographic area of the team's responsibility. In such cases, the team shall arrange for transfer of responsibility for mental health services to an ACT program or another provider wherever the individual is relocating, and the team shall maintain contact with the individual until the service transfer is implemented; or

4. An individual declines or refuses services and requests discharge despite the team's best efforts to develop an acceptable treatment plan with the individual.

(3) Documentation of discharges. Documentation shall include:

1. The reason(s) for discharge as stated by both the individual and the team.

2. A summary of the individual's biopsychosocial status at the time of discharge.

3. A written final evaluation summary of the individual's progress toward the goals in the treatment plan.

4. A plan developed in conjunction with the individual for follow-up treatment after discharge.

5. The signature of each of the following:

- The individual, or documentation of why the individual's signature was not obtained.
- The service coordinator.
- The team leader.
- The psychiatrist, advanced registered nurse practitioner, or physician assistant under the supervision of a board-certified psychiatrist.

e. ACT team standards. All designated ACT teams shall:

(1) Participate in all of the individual's mental health services.

(2) Ensure that services for the psychiatric needs of the individual are available 24 hours a day.

(3) Develop a specific treatment plan based on the assessment of needs and including goals and actions to address the individual's medical, social, educational, and other needs.

(4) Make referrals to services and related activities to assist the individual with the individual's assessed needs.

(5) Monitor and perform follow-up activities necessary to ensure that the treatment plan is carried out and that the individual has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

(6) Hold team meetings at least four times a week to facilitate ACT services and briefly review the status of the individual with other members of the team.

(7) Have the capacity to provide multiple contacts a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in a living situation or employment, or having significant ongoing problems in daily living. All members of the team share responsibility for addressing the needs of all individuals. The number of team contacts per individual served shall average at least three per week per individual when calculated across all individuals served by the team. Contacts may be weekly, daily, or more frequent. The frequency of contacts is determined by the needs of the individual.

(8) Have the capacity to rapidly increase service intensity to an individual when the individual's status requires it or the individual requests it.

(9) Ensure that treatment, rehabilitation, and support activities are available 24 hours a day, 7 days a week, 365 days a year, including nights, weekends, and holidays. If there are insufficient numbers of staff to operate an after-hours on-call system, staff shall provide crisis response during regular work hours and arrange coverage for all other hours through a reliable crisis response service.

(10) Provide no more than 20 percent of service contacts in office-based settings.

f. Staff-to-client ratio. ACT teams shall maintain a ratio of at least one full-time or full-time equivalent staff person to every ten individuals served. The ACT team staff-to-client ratios do not include the psychiatrist, advanced nurse practitioner, or physician assistant practicing under the supervision of a psychiatrist.

g. Eligibility criteria for ACT services. To be eligible to receive ACT services, the individual shall meet all of the following criteria:

(1) Is at least 17 years of age.

(2) Has a severe and persistent mental illness or complex mental health symptomology. Individuals with a primary diagnosis of substance use disorder, developmental disability, personality disorder, or organic disorder are not eligible for ACT services.

(3) Is in need of a consistent team of professionals and multiple mental health and support services to live independently in the community and reduce hospitalizations, as evidenced by one or both of the following:

1. A pattern of repeated treatment failures during the previous 12 months, including at least two psychiatric hospitalizations or psychiatric care delivered at least twice in an emergency department, at an access center, or by a mobile crisis team; or

2. The need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

(4) Presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the individual's functioning and assist the individual in achieving or maintaining independent community living. Specifically, the individual:

1. Is medically stable;

2. Does not require a level of care that includes more intensive medical monitoring;

3. Presents a low risk to self, others, or property, with treatment and support; and

4. Lives independently in the community or demonstrates a capacity and desire to live independently in the community.

h. ACT services. ACT teams shall provide the following services:

(1) Initial assessment and treatment planning.

1. An assessment of the individual shall be completed within 30 days of admission that includes psychiatric history, medical history, educational history, employment, substance use, problems with activities of daily living, social interests, and family relationships.

2. An individualized written treatment plan shall be developed based on the assessment. The treatment plan shall identify the necessary psychiatric rehabilitation treatment and support services, including all of the following:

- Treatment objectives and outcomes.
- The expected frequency and duration of each service.
- The location where the services will be provided.
- A crisis plan.
- The schedule for updates of the treatment plan.

(2) Evaluation and medication management.

1. The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the individual by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

2. Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant in response to the individual's complaints and symptoms. A psychiatric registered nurse assists in this management by making contact with the individual regarding medications and their effect on the individual's complaints and symptoms.

(3) Integrated therapy and counseling for mental health and substance abuse. Integrated therapy and counseling consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling may be provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

(4) Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by any team member.

(5) Community support. Community support may be provided by any team member and consists of the following activities focused on recovery and rehabilitation:

1. Personal and home skills training to assist the individual to develop and maintain skills for self-direction and coping with the living situation.

2. Community skills training to assist the individual in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

(6) Medication monitoring. Medication monitoring services shall be provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consists of:

1. Monitoring the individual's day-to-day functioning, medication compliance, and access to medications; and

2. Ensuring that the individual keeps appointments.

(7) Case management for treatment and service plan coordination. Case management consists of the development of an individualized treatment and service plan, including personalized goals and outcomes, to address the individual's medical symptoms and remedial functional impairments. Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the individual in gaining access to necessary medical, social, educational, and other services.

3. Assessing the individual to determine service needs by collecting relevant historical information through records and other information from relevant professionals and natural supports.

(8) Crisis response. Crisis response consists of direct assessment and treatment of the individual's urgent or crisis symptoms in the community by any team member, as appropriate.

(9) Work-related services. Work-related services may be provided by any team member. Services consist of assisting the individual in managing mental health symptoms as they relate to job performance and may include:

1. Collaborating with the individual to look for job situations of the individual's choice and creating strategies to manage situations that cause symptoms to increase.

2. Assisting the individual to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

3. Providing supports to maintain employment, such as crisis intervention related to employment.

4. Teaching communication, problem-solving, and safety skills.

5. Teaching personal skills, such as time management and appropriate grooming for employment.

(10) Peer support services. Peer support services are provided by a peer support specialist and include, but are not limited to, education and information, individual advocacy, and crisis response.

(11) Support services. All team members are responsible for providing support services. Services consist of assisting the individual in obtaining the basic necessities of daily life, including but not limited to:

1. Medical and dental services.

2. Safe, clean, and affordable housing.

3. Financial support.

4. Benefits counseling.

5. Social services.

6. Transportation.

7. Legal advocacy and representation.

(12) Education, support, and consultation to family members and other major supports of individuals. All team members are responsible for providing education, support, and consultation to family members and other major supports of individuals with the agreement or consent of the individual. Services include but are not limited to:

1. Individualized psychoeducation about the individual's illness and the role of the family and other significant people in the therapeutic process.

2. Intervention to restore contact, resolve conflicts, and maintain relationships with family or other significant people or both.

3. Ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family.

4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

5. Assistance to obtain necessary services for individuals with children, including but not limited to:

- Individual supportive counseling.
- Parenting training.
- Service coordination.
- Services to help the individual throughout pregnancy and the birth of a child.
- Services to help the individual fulfill parenting responsibilities and coordinate services for the child or children.
- Services to help the individual restore relationships with children who are not in the individual's custody.

25.6(3) *Mobile response.* The purpose of mobile response is to provide short-term individualized crisis stabilization, following a crisis screening or assessment, that is designed to restore the individual to a prior functional level. Mobile response services shall be provided as described in rule 441—24.36(225C).

25.6(4) *23-hour observation and holding.* The purpose of 23-hour observation and holding is to provide up to 23 hours of care in a safe and secure, medically staffed treatment environment. Twenty-three-hour observation and holding shall be provided as described in rule 441—24.37(225C).

25.6(5) *Crisis stabilization community-based services.* The purpose of crisis stabilization community-based services is to provide short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in the setting where the individual lives,

works, or recreates. Crisis stabilization community-based services shall be provided as described in rule 441—24.38(225C).

25.6(6) *Crisis stabilization residential services.* The purpose of crisis stabilization residential services is to provide a short-term alternative living arrangement in a setting of no more than 16 beds that is designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis. Crisis stabilization residential services shall be provided as described in rule 441—24.39(225C).

25.6(7) *Subacute mental health services.* The purpose of subacute mental health services is to provide a comprehensive set of wraparound services to individuals who have had or are at imminent risk of having acute or crisis mental health symptoms.

a. Regional coordination. Each region shall designate at least one subacute mental health service provider and ensure that subacute mental health services are available to the residents of the region consistent with subrule 25.4(4).

b. Subacute mental health services standards.

(1) Subacute mental health services in a facility-based setting shall be provided as described in Iowa Code chapter 135G and 481—Chapter 71.

(2) Subacute mental health services in a community-based setting are the same as assertive community treatment (ACT) services provided as described in subrule 25.6(2).

25.6(8) *Intensive residential services.* The purpose of intensive residential services is to serve individuals with the most intensive severe and persistent mental illness conditions who have functional impairments and may also have multi-occurring conditions. Intensive residential services provide intensive 24-hour supervision, behavioral health services, and other supportive services in a community-based residential setting.

a. Regional coordination. Each region shall designate at least one intensive residential services provider and ensure that intensive residential services are available to the residents of the region consistent with subrule 25.4(9).

(1) Regions shall work collaboratively to develop intensive residential services strategically located throughout the state with the capacity to serve a minimum of 120 individuals, with the support of the medical assistance program.

(2) Intensive residential services may be shared by two or more regions.

(3) Each region shall establish methods to provide for reimbursement of a region when the non-Medicaid-eligible resident of another region utilizes intensive residential services or other non-Medicaid-covered services located in that region.

b. Intensive residential services standards. An organization that seeks regional designation as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A designated intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) habilitation provider or an HCBS 1915(c) intellectual disability waiver supported community living provider in good standing with the Iowa Medicaid enterprise.

(2) Provide staffing 24 hours a day, 7 days a week, 365 days a year.

(3) Maintain a minimum staffing ratio of one staff to every two and one-half residents. Staffing ratios shall be responsive to the needs of the individuals served.

(4) Ensure that all staff members have the following minimum qualifications:

1. One year of experience working with individuals with a mental illness or multi-occurring conditions.
2. A high school diploma or equivalent.

(5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:

1. Applied behavioral analysis.
2. Autism spectrum disorders, diagnoses, symptomology and treatment.
3. Brain injury diagnoses, symptomology and treatment.

4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.

5. Motivational interviewing.

6. Psychiatric medications.

7. Substance use disorders and treatment.

8. Other diagnoses or conditions present in the population served.

(6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.

(7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.

(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services, including but not limited to ACT.

(9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.

(10) Accept and serve eligible individuals who are court-ordered to intensive residential services.

(11) Provide services to eligible individuals on a no reject, no eject basis.

(12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site.

(13) Be located in a neighborhood setting to maximize community integration and natural supports.

(14) Demonstrate specialization in serving individuals with an SPMI or multi-occurring conditions and serve individuals with similar conditions in the same site.

c. Eligibility criteria for admission to intensive residential services. To be eligible to receive intensive residential services, an individual shall meet all of the following criteria:

(1) The individual is an adult with a diagnosis of a severe and persistent mental illness or multi-occurring conditions.

(2) The individual is approved by the Iowa Medicaid enterprise or Medicaid managed care organization, as appropriate, for the highest rate of home-based habilitation or the highest rate of home- and community-based services intellectual disability waiver supported community living service. Reimbursement rates for intensive residential services shall be equal to or greater than the established fees for those services. Regional reimbursement rates for non-Medicaid individuals receiving intensive residential services shall be negotiated by the region and the provider and shall be no less than the minimum Medicaid rate.

(3) The individual has had a standardized functional assessment and screening for multi-occurring conditions completed 30 days or less prior to application for intensive residential services, and the functional assessment and screening demonstrates that the individual:

1. Has a diagnosis that meets the criteria of severe and persistent mental illness as defined in rule 441—25.1(331);

2. Has three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;

3. Is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

4. Has exhibited a lack of progress or regression after an adequate trial of active treatment at a less intensive level of care;

5. Is at risk of significant functional deterioration if intensive residential services are not received or continued; and

6. Meets one or more of the following:

- Has a record of three or more psychiatric hospitalizations in the 12 months preceding application for intensive residential services.

- Has a record of more than 30 medically unnecessary psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of more than 90 psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of three or more emergency room visits related to a psychiatric diagnosis in the 12 months preceding application for intensive residential services.
- Is residing in a state resource center and has an SPMI.
- Is being served out of state due to the unavailability of medically necessary services in Iowa.
- Has an SPMI and is scheduled for release from a correctional facility or a county jail.
- Is homeless or precariously housed.

ITEM 11. Adopt the following **new** rule 441—25.7(331):

441—25.7(331) Non-core services. When a mental health and disability services region chooses to make the following non-core services available, the region shall ensure that such services meet the requirements of this rule.

25.7(1) *Prescreening assessments.* Prescreening assessments provided by the region or an entity contracting with the region shall meet the following requirements:

a. The prescreening assessment shall be provided in an emergency room or other crisis assessment setting within four hours of an emergency detention of an individual believed to be mentally ill to determine if inpatient psychiatric hospitalization is necessary.

b. The prescreening assessment shall be performed by a licensed physician or mental health professional who shall also provide ongoing consultations while the individual remains in the emergency room or other crisis assessment setting. The services provided by the consulting professional are intended to supplement, but do not replace, the services of the emergency room or other crisis setting staff.

c. The licensed physician or mental health professional shall submit appropriate documentation and reports to the emergency room or other crisis setting and the court as necessary.

d. The region or entity contracting with the region shall ensure the coordination of appropriate levels of care. Coordination may include but is not limited to:

(1) Securing an inpatient psychiatric bed when inpatient psychiatric hospitalization is needed.

(2) Utilizing community-based resources and services such as 23-hour observation and holding, crisis stabilization community-based or residential services, subacute facility-based mental health services or detoxification centers.

(3) Facilitating outpatient treatment appointments when inpatient psychiatric hospitalization is not needed.

25.7(2) *Transportation.* A service provider that is under contract with a region and transports individuals pursuant to an Iowa Code chapter 229 court order shall meet the following requirements:

a. The transport vehicle shall be secure such that the individual being transported cannot open doors or windows of the vehicle while it is moving.

b. Transportation staff shall complete a minimum of eight hours of training in mental health issues and crisis intervention in the first month of employment. After the initial training, each staff member shall complete a minimum of two hours of training annually.

ITEM 12. Amend **441—Chapter 25**, Division I, implementation sentence, as follows:

These rules are intended to implement Iowa Code chapter 331 and ~~2012 Iowa Acts, chapter 1120, section 15~~ 2018 Iowa Acts, House File 2456.

ITEM 13. Amend subrule 25.15(5), introductory paragraph, as follows:

25.15(5) *Eligibility for brain injury services.* An individual must comply with all of the following requirements to be eligible for brain injury services under the regional service system, if such services were provided to the same class of individuals by a county in the region prior to regional formation ~~and if funds are available to continue such services without limiting or reducing core services~~.

ITEM 14. Amend subrule 25.18(2) as follows:

25.18(2) The annual service and budget plan shall include but not be limited to:

a. and *b.* No change.

c. Crisis planning. ~~The plan for ensuring effective~~ A list of accredited crisis services available in the region for crisis prevention, response and resolution, including contact information for the agencies responsible, shall be included.

d. Intensive mental health services. Identification of the services designated by the region according to rule 441—25.6(331), including the provider name, contact information, and location of each of the following, shall be included:

(1) Access center(s).

(2) ACT services.

(3) Intensive residential services.

(4) Subacute mental health services.

~~*d.*~~ *e.* Scope of services. A description of the scope of services to be provided, a projection of need for the service, and the funding necessary to meet the need shall be included.

(1) and (2) No change.

~~*e.*~~ *f.* Budget and financing provisions for the next year. The provisions shall address how county, regional, state and other funding sources will be used to meet the service needs within the region.

~~*f.*~~ *g.* Financial forecasting measures. The plan shall describe the financial forecasting measures used in the identification of service need and funding necessary for services.

~~*g.*~~ *h.* The provider reimbursement provisions. The plan shall describe the types of reimbursement methods that will be used, including fee for service, compensating providers for a "system of care" approach, and use of nontraditional providers. A region also shall provide funding approaches that identify and incorporate all services and sources of funding used by the individuals receiving services, including the medical assistance program.

ITEM 15. Amend rule 441—25.19(331) as follows:

441—25.19(331) Annual service and budget plan approval. The annual service and budget plan shall be submitted each year by April 1~~, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014~~. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the regional annual service and budget plan in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for ~~the~~ a fiscal year beginning July 1~~, 2014,~~ shall remain in effect until June 30, ~~2015,~~ subject to amendment.

25.19(1) No change.

25.19(2) *Notification.* Except as specified in subrule 25.19(3), the director shall notify the region in writing of the decision on the plan by June 1~~, 2014~~ of each year. The decision shall specify that either:

a. and *b.* No change.

25.19(3) *Review of late submittals.* The director may review plans not submitted by April 1~~, 2014,~~ after all plans submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.19(4) and **25.19(5)** No change.

ITEM 16. Amend rule 441—25.20(331) as follows:

441—25.20(331) Annual report. The annual report shall describe the services provided, the cost of those services, the number of individuals served, and the outcomes achieved for the previous fiscal year. The annual report is due on December 1 following a completed fiscal year of implementing the annual service and budget plan. The initial report is due on December 1, 2015. The annual report shall include but not be limited to:

1. Services actually provided.
2. Actual numbers of individuals served.

3. Documentation that each regionally designated access center has met the service standards in subrule 25.6(1).

4. Documentation that each regionally designated ACT team has been evaluated for program fidelity, including a peer review as required by subrule 25.6(2), and documentation of each team's most recent fidelity score.

5. Documentation that each regionally designated subacute service has met the service standards in subrule 25.6(7).

6. Documentation that each regionally designated intensive residential service home or intensive residential service has met the service standards in subrule 25.6(8).

~~3.~~ 7. Moneys expended.

~~4.~~ 8. Outcomes achieved.

ITEM 17. Amend **441—Chapter 25**, Division VIII title, as follows:

~~CRITERIA FOR EXEMPTING COUNTIES FROM JOINING INTO REGIONS TO ADMINISTER MENTAL HEALTH AND DISABILITY SERVICES~~

ITEM 18. Rescind and reserve rule **441—25.91(331)**.

ITEM 19. Rescind **441—Chapter 25**, Division XI.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 1/2/19.