Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

December 15, 2014

Michael Marshall
Secretary of the Senate
State Capitol Building
L O C A L

Carmine Boal
Chief Clerk of the House
State Capitol Building
L O C A L

Dear Mr. Marshall and Ms. Boal:

Enclosed please find the required report "Community Integration Workgroup For Adults with Serious Mental Illness Final Report".

This report was prepared pursuant to 2014 Iowa Acts, Chapter 1140, Section 72.

This report is also available on the Department of Human Services website at http://www.dhs.iowa.gov/Partners/Reports/LegislativeReports/LegisReports.html.

Sincerely,

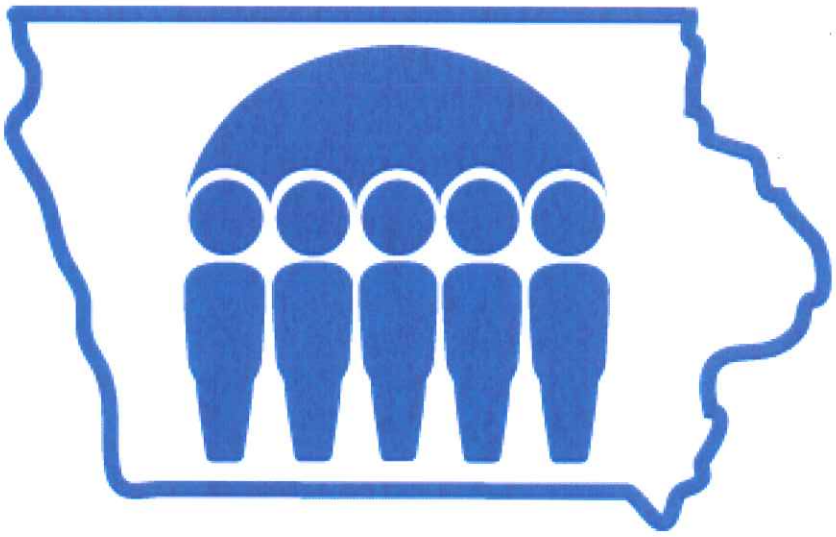
Jennifer Davis Harbison

Jennifer Davis Harbison
Policy Advisor

Enclosure

cc: Governor Terry E. Branstad
Senator Jack Hatch
Senator David Johnson
Representative David Heaton
Representative Lisa Heddens
Legislative Services Agency
Aaron Todd, Senate Majority Staff
Josh Bronsink, Senate Minority Staff
Carrie Malone, House Majority Staff
Zeke Furlong, House Minority Staff

Human Services



Community Integration Workgroup For Adults with Serious Mental Illness Final Report

December 15, 2014

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Recommendations:

1. High Intensity, flexible and responsive services should be available for those individuals with the most complex needs.

2. Housing assistance should be made available to support individuals with serious mental illness in integrated housing.

3. Mental Health services should be easily accessible and the system should be easy to navigate.

4. Authorization and reimbursement for services should be person-centered, based on best practices and outcomes, and should reasonably meet provider costs of doing business.

5. Providers should have the capacity to meet the co-occurring and multi-occurring needs of individuals with serious mental illness.

6. DHS, Magellan and the Regions should monitor performance indicators for individuals with serious mental illness, and use this data for decision making.

7. Regulations should ensure that programs and services are consistent with community integration requirements under Olmstead and Title II of the ADA.

8. Systems should support programs and services necessary for sustained recovery and engagement.

9. An entity should be assigned responsibility for improving the mental health workforce shortage.

10. DHS, the MHDS Regions and Magellan should engage the criminal justice system to minimize negative interactions between law enforcement and individuals with serious mental illness.

Executive Summary

2014 Iowa Acts, Chapter 1140, Section 72 established a study of community-based service options for persons with serious mental illness. The purpose of the study, as specified in Section 72, was to do the following:

> "...to study community-based placement options for persons with serious mental illness. The study shall consider both services currently available and services that should be developed to meet the needs of persons with serious mental illness. The system elements addressed by the study shall include but are not limited to regulatory, liability, and funding issues, and other barriers to maintaining current community-based services options and developing new options."[1]

The Community Integration Workgroup for Adults with Serious Mental Illness (Workgroup) was established to conduct this work and held three open public meetings on October 5, November 6 and November 20. Public comment was heard at each meeting. In its deliberations, the Workgroup discussed the previous work done by the 2011 Adult Mental Health Workgroup of the Mental Health & Disability Services (MHDS) Redesign Task Force. That 2011 Workgroup identified a series of recommendations that included the development of best practices and the need to serve persons with serious mental illness in more integrated settings consistent with Title II of the Americans with Disabilities Act (ADA) and the 1999 U.S. Supreme Court's *Olmstead* decision. Those recommendations formed the basis for Core and Core Plus services that are currently being implemented in Iowa.

The Workgroup identified several areas of progress in Iowa's system for individuals with serious mental illness, including regional administration of services and innovative Medicaid approaches designed to improve access to and coordination of care, such as Integrated Health Homes (IHH), 1915(i) Habilitation services, and the Balancing Incentives Program (BIP).

The Workgroup also identified challenges and barriers to serving individuals with serious mental illness in integrated community settings. Among these include the need for more intensive services for individuals with serious mental illness; the need for more rental assistance so that housing is affordable; the shortage of a trained and available workforce; and the need to work better with law enforcement and the criminal justice system.

Since the mental health and disability services system redesign efforts are still in the early stages of implementation, the Workgroup developed recommendations that it felt augment these efforts. There was recognition that many of the requirements established by the legislature following the redesign process, for example, the availability of crisis services, will take some time to develop. The recommendations made in this report are consistent with those requirements and are intended to add support. Recommendations cover ten areas, each containing more specific recommendations, and include the following:

1. High Intensity, flexible and responsive services should be available for those individuals with the most complex needs.
2. Housing assistance should be made available to support individuals with serious mental illness in integrated housing.

[1] See Appendix A for the exact Budget language.

3. Mental Health services should be easily accessible and the system should be easy to navigate.
4. Authorization and reimbursement for services should be person-centered, based on best practices and outcomes, and should reasonably meet provider costs of doing business.
5. Providers should have the capacity to meet the co-occurring and multi-occurring needs of individuals with serious mental illness.
6. Department of Human Services (DHS), Magellan (Iowa Medicaid contractor for the mental health managed care program also known as the Iowa Plan for Behavioral Health), and the MHDS Regions (Regions) should monitor performance indicators for individuals with serious mental illness, and use this data for decision making.
7. Regulations should ensure that programs and services are consistent with community integration requirements under *Olmstead* and Title II of the ADA.
8. Systems should support programs and services necessary for sustained recovery and engagement.
9. An entity should be assigned the responsibility for improving the mental health workforce shortage.
10. DHS, the Regions and Magellan should engage the criminal justice system to minimize negative interactions between law enforcement and individuals with serious mental illness.

Introduction

Section 72 of the Iowa Budget Act of 2014 established a study of community-based service options for individuals with serious mental illness. The purpose of the study, as specified in Section 72, was to do the following:

> "...to study community-based placement options for persons with serious mental illness. The study shall consider both services currently available and services that should be developed to meet the needs of persons with serious mental illness. The system elements addressed by the study shall include but are not limited to regulatory, liability, and funding issues, and other barriers to maintaining current community-based services options and developing new options."[2]

Workgroup was organized by DHS consistent with the legislation. The Workgroup met on three occasions in October and November.[3] Workgroup meetings were open to the public and notice of the meeting dates, location and time were posted on the Iowa DHS website in advance of each meeting. Stakeholders were invited to offer comment and recommendations at each meeting and that feedback was considered by the Workgroup members in making the recommendations in this report. The report was also informed by the previous work of the Adult Mental Health Workgroup of the MHDS Redesign in 2011, as well as other recent workgroups that have addressed related issues (e.g. Outcomes and Performance Measures Workgroup; AMOS Mental Health Workforce Workgroup). The Mental Health section, including the 2011 Workgroup's recommendations, can be found on the DHS website at http://dhs.iowa.gov/mhds-redesign/reports.

[2] See Appendix A for the exact Budget language.
[3] See Appendix B for Workgroup membership.

National Context and Iowa Redesign

Nationally, states are working to strengthen community-based services infrastructure in order to promote recovery, reduce the need for more costly crisis-oriented and institutional settings, and facilitate community integration. States however are challenged by a confluence of issues that affect how this is accomplished. Below are some of the key federal and state factors that influence the ability of states to develop their community-based services.

A. Federal Policy

Olmstead and Title II of the Americans with Disabilities Act (ADA)

Many states are utilizing *Olmstead* as leverage for the development of integrated, community-based services and housing. The *Olmstead* decision affirmed the right of individuals with disabilities to live in the least restrictive, most integrated settings suitable to their needs, and articulated the obligation of state and local government to ensure that this occurs. States that do not have actionable plans are vulnerable to litigation, and several states, in fact, have entered into settlement agreements with the U.S. Department of Justice (DOJ), the federal enforcement arm of the ADA and *Olmstead*, and state Protection and Advocacy (P&A) groups resulting in significant expansion of community-based services.

However, states are challenged to develop services and settings that are consistent with the principles of integration. Many state and county services are traditional, legacy systems. That is, systems that are heavily reliant on settings that have institutional qualities such as hospitals, nursing homes, and board and care type facilities that may not produce positive outcomes or be consistent with the principles of integration defined by, for example, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) or the DOJ. In this context, systems have had to move away from existing program and housing models toward those that are more integrated.

Medicaid Policy

Similarly, Medicaid policy has an emphasis on supporting individuals with disabilities in integrated settings. Most recently, the federal Centers for Medicare and Medicaid Services (CMS) published a final rule (January 2014) on Home and Community Based Services (HCBS). This rule applies to 1915(c) waiver and 1915 (i) state plan services, both of which are used in Iowa, and describes the types of services and settings that Medicaid will allow its funds to be used for. The rule applies to residential, day program and vocational settings, and is forcing states to modify how and where they allow Medicaid HCBS funding.

In addition, Medicaid has established other mechanisms, such as the Health Homes state plan option and BIP to assist states in rebalancing systems from long term care-based approaches toward more cost effective community based options.

In addition, Medicaid's long standing policy known as the Institutions for Mental Disease (IMD) exclusion prohibits the use of Medicaid funds for individuals between the ages of 22 - 64 in settings of more than 16 beds where more than 50% of the residents have a mental disorder. As states grapple with how to fund services, the IMD exclusion serves as a financial disincentive to states relying on institutional settings. To the extent possible, states are pursuing the

development of more integrated, community based options as a way to reduce the state financial burden and to generate federal financial participation in funding services.

Healthcare Reform

While states are implementing healthcare reform measures and the Affordable Care Act (ACA) differently, they are generally seeing more individuals covered by health insurance and are enacting various measures to improve access to care and reduce costs. Many states, including Iowa, are working on healthcare integration strategies that decrease costs and improve access to primary care for individuals with mental illness and other disabilities.

B. State Issues

While every state is unique, there are common issues across states that affect the ability of persons with serious mental illness to live successfully in integrated community settings. Several of these issues were identified in the Workgroup and are briefly discussed below.

State and Local Resources:

The availability of resources to fund community-based services is a significant challenge for states. Despite the fact that states are spending fewer dollars in state psychiatric hospitals in recent years,[4] a significant amount of funding is still dedicated to state hospitals, nursing facilities, and other congregate residential programs for the minority of individuals needing services. Complicating this is that there is little evidence to suggest that these costly settings produce positive outcomes.

Further, state systems are still recovering from the last economic recession. Between 2009 and 2012, state mental health systems lost approximately $4.5 billion due to budget cuts.[5] These cuts placed additional strain on arguably underfunded systems, and resulted in decreased access to services in most states.

In addition to mental health services, many of the resources needed in states are for non-traditional types of supports. Among these include the need for rental assistance for supportive housing, transportation and supported employment. Several states are establishing or expanding state funded rental assistance programs to support the affordable housing needs of persons with serious mental illness, including those that have entered into *Olmstead* settlement agreements. A 2014 report produced by the Technical Assistance Collaborative identifies the state funded rental assistance programs across the United States.[6]

Most states are utilizing managed care approaches to authorize, deliver and pay for care. As states have gained experience with managed care, they are moving away from fee-for-services reimbursement mechanisms to case-based, outcomes-oriented reimbursement.

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[4] NASMHPD Research Institute. FY 2010 State Mental Health Revenues and Expenditures. http://www.nri-inc.org/#!reports-by-year/cm1j

[5] NASMHPD Research Institute. The Impact of the State Fiscal Crisis on State Mental Health Systems. March 2012. http://media.wix.com/ugd/186708_c2fd199b2a9f4d04818b889b93c3a884.pdf

[6] TAC. *State Funded Housing Assistance Programs.* (2014). http://www.tacinc.org/knowledge-resources/publications/reports/state-funded-housing-assistance-report/

Access and related challenges:

States with large rural and frontier geography often struggle to ensure access to and the availability of evidence-based services. There are several reasons for this. The lower density of people and services makes access to services a challenge. Additionally, fewer people often mean less workforce and infrastructure.

The availability of a trained, multidisciplinary workforce is also a major challenge for states. This is particularly troublesome in rural states where the workforce simply does not exist to meet demand. Consequently, states have had to utilize alternate approaches (e.g. telepsychiatry) and workforce (e.g. primary care professionals) to meet demand.

While the availability of quality, evidence-based services are critical, so too is the availability of affordable housing, transportation services and employment. In fact, the lack of affordable housing is cited as a primary barrier to individuals with disabilities living in integrated community settings.[7] A lack of transportation also impacts the ability of individuals to get to mental health and primary care appointments, as well as basic obligations ranging from employment, childcare, and other community necessities. In addition, limited access to employment and employment supports impacts the ability of individuals with serious mental illness to participate in the community in a meaningful way.

Iowa Redesign

In 2011, the Iowa Legislature, DHS and other State agencies, and numerous stakeholders engaged in the mental health and disability service system redesign. Considerable time was devoted by the Mental Health Task Force during the 2011 MHDS Redesign work to discussion about the development of community-based services. Much of the work of that Task Force three years ago is still relevant today. The Task Force made several recommendations, and Senate File 2315 of 2012 statutorily established a set of minimum Core Services that must be provided in Iowa, and further specified several specific practices that must be implemented. These services are generally consistent with those described by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in the document, *A Description of a Good and Modern Addictions and Mental Health Service System.*

In addition, Senate File 2315 specified additional services (i.e. Core Plus) that should be available depending on resource availability. The legislature also established that a Region shall ensure that access is available to providers of Core Services that demonstrate competencies necessary for all of the following: serving individuals with co-occurring conditions; providing evidence-based services; and providing trauma-informed care that recognize the presence of trauma symptoms in individuals receiving services. Table 1 below shows the Core and Core Plus Services authorized in Senate File 2315.

Table 1: Iowa Core Services

Core Service Domains	Core Services (Including but not limited to all of the following)
Treatment designed to ameliorate a person's condition	• Assessment and evaluation.

[7] Martone, Kevin. *The Impact of Failed Housing Policy on the Public Behavioral Health System.* Psychiatric Services. March 2014. Vol. 65 No. 3.

	• Mental health outpatient therapy. • Medication prescribing and management. • Mental health inpatient treatment.
Basic crisis response provisions	• Twenty-four-hour access to crisis response. • Evaluation. • Personal emergency response system.
Support for community living	• Home health aide. • Home and vehicle modifications. • Respite. • Supportive community living.
Support for employment	• Day habilitation. • Job development. • Supported employment. • Prevocational services.
Recovery services	• Family support. • Peer support.
Service coordination including coordinating physical health and primary care	• Case management. • Health homes.
Additional Core Service Domains (Core Plus)	**Core Plus Services** (Including but not limited to all of the following)
Comprehensive facility and community-based crisis services	• Twenty-four-hour crisis hotline. • Mobile response. • Twenty-three-hour crisis observation and holding, and crisis stabilization facility and community-based services. • Crisis residential services.
Sub-acute services provided in facility and community-based settings	
Justice system-involved services	• Jail diversion. • Crisis intervention training. • Civil commitment prescreening.
Advances in the use of evidence-based treatment	• Positive behavior support. • Assertive community treatment. • Peer self-help drop-in centers.

Findings

Workgroup members recognized that the system is in transition in several areas, including the implementation of Regions and Core and Core Plus services, implementation of IHHs changes to authorization and reimbursement of services by Magellan, the development of a No Wrong Door/Single Entry Point (NWD/SEP) approach to benefit and services eligibility through BIP, and the implementation of health insurance expansion through the Iowa Health and Wellness Plan and the ACA.

Workgroup members generally support the intent of these efforts to improve access to the types of services that are of sufficient quality, flexibility and intensity to support individuals ready to move from institutional to more integrated settings or those most at risk of becoming institutionalized, homeless, or incarcerated. Understanding that these system reform efforts need time to develop, the Workgroup considered how the system supports the community integration needs of individuals with serious mental illness in this context. It is important to note that several Workgroup members support the Core and Core Plus services established by the legislature and pointed out that the Regions are working in a positive manner to establish the regional systems. Several Workgroup members suggested that the Core Plus services should also be required considering they are recognized as important services in mental health systems.

The Workgroup identified the following issues that form the basis of recommendations in this report. Positive developments and areas of progress in Iowa's system for individuals with serious mental illness include:

1. Implementation of the Regions and regional structure;
2. Synergy of resources at the Regional level;
3. Implementation of Core and Core Plus services;
4. Innovative Medicaid approaches designed to improve access to and coordination of care, including IHHs, 1915(i) Habilitation services, and the Balancing Incentives Program;
5. Increased insurance coverage through the Iowa Health and Wellness Plan and the Affordable Care Act, including coverage of mental health services;
6. A state funded rental assistance program for individuals covered by the Medicaid 1915(c) waiver administered by the Iowa Finance Authority (IFA) that could be a model for individuals with serious mental illness;
7. Launch of the free Iowa affordable housing locator, www.iowahousingsearch.org, in November 2013, funded by IFA.
8. Pockets of innovation throughout Iowa in services such as Assertive Community Treatment and Forensic Assertive Community Treatment, peer delivered services, Crisis Intervention Team (CIT) training, Mental Health Courts, and supportive housing.

The Workgroup also identified various challenges and barriers to serving individuals with serious mental illness in integrated community settings. The Workgroup felt that funding limitations, the inability of funding streams to coordinate funding, and regulations should not be barriers to access services. Among the challenges and barriers identified by the Workgroup include:

1. Insufficient capacity and coordination of systems to meet the community needs of those with the most complex conditions;

2. Few high-intensity, "high touch" services to meet the needs of individuals with serious mental illness. There are only six ACT teams in Iowa. Individuals with SMI should be able to receive non-emergency based services on nights and weekends.
3. A system that is difficult to access and navigate;
4. Over-reliance on hospital and congregate residential settings;
5. Lack of rental assistance and integrated, affordable housing such as individual apartments and small, shared living situations. This also causes backup in transitional living arrangements for individuals who could live in more integrated settings;
6. Too many individuals are discharged from inpatient settings to homelessness or homeless settings (e.g. homeless shelters);
7. Local Public Housing Authorities have not established preferences for disabilities and homelessness;
8. Lack of non-emergency medical and other transportation and employment opportunities;
9. Provider concerns that reimbursement does not meet the cost of doing business;
10. Limitations to Medicaid services, including delays in or gaps in Medicaid coverage due to burdensome documentation requirements and processing (i.e. eligibility for Habilitation services could take 6 – 8 weeks) and concerns about the ability of Integrated Health Homes providers to coordinate care given current caseload ratios and reimbursement;
11. Funding not allocated or dedicated for non-Medicaid reimbursable non-Core or Core Plus services and supports such as housing assistance and transportation;
12. Co-pays, deductibles and limited coverage of services most needed by persons with serious mental illness established by several private insurance plans through the Affordable Care Act limit access to mental health services and shift the burden to the public system. As a result, some Regions have stepped in to cover these costs to ensure access to services.[8]
13. Access problems due to significant workforce shortages, especially psychiatrists;
14. Insufficient number of police officers trained in the Crisis Intervention Team (CIT) model;
15. Lack of funding and/or system coordination to start up new services;
16. Insufficient system capacity and coordination to meet the co-occurring (i.e. mental illness and substance use disorders) and multi-occurring (i.e. mental illness and other disabilities such as intellectual/developmental disabilities or acquired brain injuries) needs of individuals.
17. Lack of coordination with the criminal justice and judicial system, ranging from local law enforcement to the courts.
18. While the Workgroup acknowledged that the charge to the group was focused on adults with serious mental illness, it identified the need for continuing development of a system of care for children and adolescents that can identify and intervene early thereby reducing the likelihood of people developing a reliance on more costly, deep-end mental health services.

Recommendations

The Workgroup identified ten recommendations essential to serving individuals with SMI in integrated community settings. Since the mental health and disability services system redesign efforts are still in the early stages of implementation, the Workgroup developed recommendations that it felt augment these efforts.

[8] Workgroup members noted that this issue is less relevant to most individuals with serious mental illness who tend to have Medicaid coverage.

Olmstead and Title II of the ADA is the overriding framework for a comprehensive system of services and supports to meet the community integration mandate for persons with SMI and other disabilities. This overarching recommendation suggests that all regulations, programs and funding that guide and implement services and supports for people with SMI and other disabilities that are administered by Iowa state agencies, Regions and insurers are consistent with Olmstead and Title II of the ADA. The recommendations in this report support this principle.

1. High Intensity, flexible and responsive services should be available for those individuals with the most complex needs.

A. Assertive Community Treatment and other intensive services:

i. Individuals with the most challenging behaviors and needs should have access to intensive services that meet individual needs, are flexible, and responsive. Individuals with SMI should be able to receive non-emergency based services on nights and weekends. Assertive Community Treatment (ACT) teams are an effective, evidence-based model designed to serve individuals with serious mental illness with the complex needs. Iowa should ensure that there is sufficient access to ACT teams throughout the State, including in rural areas. Programs will likely be utilized by individuals with and without Medicaid coverage, and should be reimbursed jointly by Medicaid and regional funds. Regions could utilize regional funding to start up and establish ACT teams. As ACT teams are implemented, teams should begin billing Medicaid for eligible services. This enables the region to re-allocate the non-Medicaid funding to establish additional teams in the region, or for other related purposes. ACT teams that serve targeted populations such as justice-system involved individuals or individuals with severe behavioral challenges should also be explored. Eyerly Ball Community Mental Health Services, Des Moines, for example, runs a Forensic Assertive Community Treatment Team (FACT).

ii. Steps should be taken to ensure that ACT and other EBPs are provided consistent with established fidelity standards.[9] Several states require fidelity to the model in order to be reimbursed by Medicaid.

iii. In addition, the Workgroup acknowledged the effectiveness of the Systems Training for Emotional Predictability and Problem Solving (STEPPS)[10] model that is being used by some providers in Iowa for individuals with other challenging behaviors, such as Borderline Personality Disorder. The Workgroup recommends that this service continue to be supported.

B. Habilitation and other community support services:

i. Magellan and the Regions should ensure effective use of Habilitation, community support services, or supported community living to meet the needs of individuals with a

[9] Several states use the Dartmouth Assertive Community Treatment Scale (DACTS) to assess fidelity to the ACT model.
[10] SAMHSA National Registry of Evidence-based Programs and Practices. http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=243

serious mental illness in community settings. These services should be delivered as part of a person-centered plan in coordination with appropriate clinical mental health services. This could include development of basic adult mental health training for direct support professionals to ensure a basic level of knowledge across providers for individuals providing direct services.

ii. Magellan, DHS and providers should develop processes to assure that resources are used for those who have the highest need at the time that the person needs them. Some individuals need more intensive support than what is currently reimbursed through ACT, and consideration must be given to ensure that caseload sizes are reasonable to meet actual needs. Consequently, consideration should be given to increasing the availability of ACT staffing to meet these needs, or adding habilitative services if appropriate. However, caution should be exercised since this could have an unintended consequence of creating care coordination issues if multiple providers become involved.

iii. Workgroup members identified that there are pockets of innovative services across the state but there is difficulty bringing services to scale. DHS, Magellan, and the regions should work together to identify programs that are successfully supporting individuals with SMI in the community, and identify how those programs could be replicated.

iv. Magellan and DHS should work to streamline the eligibility and authorization process for 1915(i) Habilitation services in order to make access to services timelier.

C. Transition to the Community:

Magellan and the Regions should ensure that there are established processes in place to ensure smooth and successful linkages for individuals who are being discharged back into the community. This includes:

i. Implementation of a standardized assessment process across payer sources.

ii. Require provider engagement prior to discharge. This includes detailed crisis plans developed by the person's interdisciplinary team, with strong collaboration between the discharging and admitting provider. Comprehensive, self-directed recovery and crisis planning, such as Wellness Recovery Action Plans (WRAP),[11] should be offered to individuals on a voluntary basis. Peer Support Specialists should be available to play a role during the pre- and post-discharge transition process, including facilitation of WRAP groups. Providers should work with individuals to assure that prescriptions provided at discharge are filled immediately.

iii. Develop processes that allow for services to begin immediately for a person entering a community placement. IHH or regional service coordination is important before, during, and after hospitalization. IHH is the lead entity for developing and coordinating community-based treatment plans for Medicaid-eligible individuals transitioning from residential/hospital services to community-based services. Additional training should be provided to support the IHH providers in this new role

[11] WRAP is an action planning process for individuals to design their own recovery plan, and is recognized nationally as a best practice. WRAP was developed by Mary Ellen Copeland and information can be found at: http://www.mentalhealthrecovery.com/about/overview.php

and to ensure that system partners understand the role of the IHH to provide care coordination across the service system.

iv. For individuals eligible for service coordination funded by the Region, the same training and service expectations should apply.

v. Reimbursement for pre-placement visits and related transition services and supports, including assistance finding and securing housing and peer support.

vi. Use of an Individual Housing Preferences questionnaire.

2. Housing assistance should be made available to support individuals with serious mental illness in integrated housing.

A. A funding model should be developed to assist individuals with SMI to access funds for housing assistance. Funds should only be used for safe, decent, integrated, and affordable, lease-based housing consistent with the Permanent Supportive Housing model. Funds should be prioritized for those with the most complex needs and who are most likely to be institutionalized, homeless or at-risk of homelessness or institutionalization. A process for prioritization should be led by DHS in partnership with IFA to ensure consistency for eligibility to rental assistance funds. Funding models for rental assistance should mirror federal rental assistance programs so that individuals receiving rental assistance can transition to federal rental assistance if/when they become eligible. Individuals receiving rental assistance should be required to apply for federal housing assistance programs when possible.

B. IFA currently administers a small, state funded rental assistance program for individuals who are eligible for 1915 (c) waiver services only. The regulation for the program should be reviewed and consideration should be given to expanding eligibility to individuals receiving 1915 (i) services or who otherwise may be determined to be a priority. Because of funding limitations, resources should be added to this program to accommodate persons with SMI. This is a more cost effective approach than paying for individuals in most institutional settings who can live in more integrated settings. DHS should lead the process, in coordination with IFA, to establish eligibility criteria.

C. IFA should lead a review of available rental housing resources in Iowa. This review should consider various federal and state resources at the State level and at local Public Housing Authorities (PHAs). The types of housing assistance identified and barriers and opportunities in securing them should be publicized to the disability community.

D. DHS and the Regions should work together to engage leadership at the local PHAs to establish local preferences for disabilities and homelessness. This could result in increased access to federal housing resources administered by the PHAs, such as Housing Choice Vouchers, project-based rental assistance, and HOME program Tenant Based Rental Assistance (TBRA).

E. DHS should work with the Iowa Council on Homelessness to ensure that coordinated planning and interventions are occurring.

3. Mental Health services should be easily accessible and the system should be easy to navigate.

A. DHS should continue to be involved in planning and implementation of the BIP effort to establish a NWD/SEP system. This planning and coordination will ensure that individuals gain access to the mental health or other services and supports they are seeking, and will minimize duplication of efforts across the Regions, Aging and Disability Resource Centers (ADRCs) and Magellan. The development of any written agreements between Regions, ADRCs and Magellan should clearly articulate respective roles and who has primary responsibility for certain issues.

B. Mental Health Crisis: It is likely that some individuals, particularly those who are not yet engaged in the mental health system, will access the ADRC system in psychiatric crisis. The State must ensure that this system access point, either through the 866 phone number or website, is capable of linking individuals to the nearest and appropriate crisis response services. Using 911 as the default mental health crisis referral is insufficient.

C. Mental health information and referral resources should be displayed more prominently on the ADRC website (www.lifelonglinks.org).

4. Authorization and reimbursement for services should be person-centered, based on best practices and outcomes, and should reasonably meet provider costs of doing business.

A. Authorization and reimbursement for services for individuals with serious mental illness should:

- Be based on clinical need;
- Be person-centered and driven, and consider individual choice;
- Be recovery focused;
- Be flexible, responsive and timely;
- Serve people in integrated settings;
- Reasonably meet provider costs of doing business;
- Be based on outcomes; and
- Provide provider incentives

B. Reimbursement for certified peer delivered services should be reviewed. Workgroup members reported that the reimbursement for peer delivered services is insufficient and does not meet the cost of utilizing peers. Magellan is currently working to address this concern.

C. Now that there is experience with Integrated Health Homes (IHH) in Iowa, IME, Magellan and providers should review the assumptions used to determine caseload mix, caseload ratios, and reimbursement for IHH to ensure that the caseload size, mix and reimbursement are reflective of actual experience.

D. Regions, Magellan, DHS, and providers should meet to discuss the start-up and ongoing coverage of Core and Core Plus services, such as ACT, peer supports, supportive housing and crisis services. Implementation and sustained funding for these services requires the coordination of multiple funding sources and cannot be done in silos. In these discussions, priority services should be identified, along with short and longer term strategies to start and sustain these services.

5. Providers should have the capacity to meet the co-occurring and multi-occurring needs of individuals with serious mental illness.

A. Co-occurring Mental Illness and Addiction

DHS/Mental Health and Disability Services and IDPH/Division of Behavioral Health should continue to engage in active planning and coordination between the systems to ensure that individuals have access to services that can address their mental illness and substance use disorders. Providers should be encouraged to develop dual competencies, ranging from co-occurring capable to co-occurring enhanced, and minimally demonstrate the capacity to collaborate or coordinate services with specialty providers as needed. Since this will likely require providers to hold dual certification with DHS and IDPH, the two agencies should work to streamline the process for provider accreditation to minimize unnecessary or redundant paperwork, site review or other requirements.

B. Multi-occurring mental health and disability service capacity:

DHS should engage in active planning and coordination with the providers of HCBS waiver and Habilitation services to ensure that individuals with complex needs have access to services that address mental health needs while also accurately assessing and addressing other conditions such as brain injury, intellectual disability, other disabilities and primary health conditions. Providers should be encouraged to develop multiple competencies with the understanding that the ability to serve individuals with complex needs is the expectation and not the exception, and have the ability to coordinate care with other providers and systems. Gaps in the service system for individuals with complex needs should be identified and addressed.

6. DHS, Magellan and the Regions should monitor performance indicators for individuals with serious mental illness, and use this data for decision making.

DHS should identify and adopt a set of outcome measures to identify systemic issues for individuals with SMI who are in or at-risk of institutionalization or homelessness and have frequent emergency room and hospital visits. This data dashboard does not need to be extensive, but utilizes a few key measures that can inform the work of the regions and Magellan. Given the various changes that are occurring in the system (e.g. regionalization, changes to Medicaid authorization and reimbursement, and development of Core and Core Plus services) any significant positive or negative changes to the following, or other, outcome measures should trigger a more in depth analysis to understand the potential causes. Measures should include:

- discharges to homelessness and homeless settings (e.g. shelters)
- rate of institutionalization

- rate of homelessness
- rate of adults living in integrated housing
- rate of employment
- rate of inpatient hospitalization
- length of stay of individuals in inpatient settings
- rate of involuntary commitment applications

7. Regulations should ensure that programs and services are consistent with community integration requirements under Olmstead and Title II of the ADA.

A. Prior to admission to any residential program, an Individual Housing Preference questionnaire should be completed by the individual to inform the most appropriate community placement. This should be consistent with the State's efforts to implement the final HCBS rule published in early 2014. If the housing placement differs from the individual preference, a justification must be made identifying the attempts made to find housing consistent with the individual's preference.

B. DHS, DPH and the Department of Inspections and Appeals (DIA) should continue to streamline the credentialing and certification process to minimize unnecessary burden on providers. This may include aligning annual surveys, and conducting inspections or site reviews jointly and at the same time.

8. Systems should support programs and services necessary for sustained recovery and engagement.

A. Peers:

The Workgroup recognized the value of certified and volunteer peer support in helping individuals remain engaged in and sustain recovery.

- Trainings and ongoing implementation support should be available statewide on recognizing the value of peer delivered supports, developing local networks of peer support, maximizing the use of peers, and addressing the continued need for technical assistance to mental health providers on the effective use of peer-delivered services.

- In addition to the certified peer workforce, develop a network of volunteer peer-support that individuals and families can be referred to.

- A combination of home-based and self-help/drop-in center-based peer services should be available in Iowa.

- Individuals should be encouraged to develop comprehensive, self-directed recovery and crisis plans, such as WRAP plans.

B. Employment:

DHS should continue to strengthen coordination and collaboration with Iowa Workforce Development and Vocational Rehabilitation around Workforce Investment Act initiatives around employment for individuals with disabilities.

C. Transportation:

Non-emergency transportation services are crucial for access and engagement in treatment and recovery-oriented supports, and should be reimbursable. DHS, Magellan and the Regions should work together to review eligibility and authorization criteria to reimburse non-emergency transportation services when appropriate. Consideration should be given to coordination of transportation services so that there is clear assignment of which payer (e.g. Medicaid state plan or waiver services, Regions, others) is responsible for reimbursement depending on eligibility or other requirements.

D. Access and Availability of Continued Services:

Services should be flexible and responsive to changing needs. Individuals should have access to a range of supports during recovery and stability. Provider caseload sizes should be manageable so that individuals receive the level of support that is needed.

E. Crisis, Jail Diversion, and Sub-acute Services:

Services should be available to support individuals in crisis in community settings whenever possible. Individuals should be diverted from unnecessary involvement with the justice system and the involuntary commitment process. New crisis programs being developed through the regions should provide support for individuals already involved with the MHDS system as well as new individuals. Reference should be made to the recently adopted Crisis rule (Effective 12/1/2014) and the pending rule for Sub-Acute Services (Effective 1/1/2015).

9. An entity should be assigned responsibility for improving the mental health workforce shortage.

The Workgroup recognized the work of previous and current workforce efforts that have occurred in Iowa and supports these efforts. Several of these workgroups have identified the need for a lead entity to address workforce competencies and shortages.
As part of this process, the Workgroup recognized peers, namely consumers and family members functioning in a service delivery role, as providers. Any reference made to providers in this report or other related workforce activities considers peers as part of the provider group. Furthermore, it is important to recognize that the workforce that comprises the mental health system consists of multidisciplinary professionals and para-professionals. Accordingly, any efforts to increase the workforce and improve expertise should address the respective disciplines and roles.

The Workgroup also recommends that any student loan forgiveness and tuition reimbursement programs should provide a preference for individuals pursuing work in the mental health field.

The existing A Mid-Iowa Organizing Strategy (AMOS) Mental Health Workforce Workgroup is currently preparing recommendations for the Iowa Legislature to consider.

10. DHS, the Regions and Magellan should engage the criminal justice system to minimize negative interactions between law enforcement and individuals with serious mental illness.

A. DHS should continue dialogue with the court system regarding the involuntary commitment process. Coordination between the new crisis services and the court system should also be addressed to encourage appropriate use of crisis services as a diversion from higher levels of care.

B. The Workgroup recommends that local systems engage in Sequential Intercept Model/Mapping to identify the points of engagement and gaps in the criminal justice system.[12] These local mapping and planning efforts should include local law enforcement and judicial branches. The Workgroup recommends that DHS reach out to statewide law enforcement groups, such as the Iowa State Sheriffs and Deputies Association, Iowa Police Chiefs Association, and Iowa Law Enforcement Academy, to request that they communicate with their local law enforcement agencies to participate in these local planning efforts.

[12] Griffin, Patty. SAMHSA GAINS Center. A Tool for Systems Transformation: Sequential Intercept Mapping. March 2013. http://gainscenter.samhsa.gov/cms-assets/documents/103893-516686.sim.pdf

Appendix A: Language Authorizing Workgroup

2014 Iowa Acts, Chapter 1140, Section 72: STUDY OF COMMUNITY-BASED SERVICE OPTIONS FOR PERSONS WITH SERIOUS MENTAL ILLNESS.

The department of human services shall engage representatives of the department of inspections and appeals, department on aging, the regional mental health and disability services system, the Iowa association of community providers, the Iowa behavioral health association, and other service providers, and other stakeholders to study community-based placement options for persons with serious mental illness. The study shall consider both services currently available and services that should be developed to meet the needs of persons with serious mental illness. The system elements addressed by the study shall include but are not limited to regulatory, liability, and funding issues, and other barriers to maintaining current community-based services options and developing new options. The results of the study, including findings and recommendations shall be reported on or before December 15, 2014, to the governor and the persons designated by this Act for submission of reports.

Appendix B: Community Integration Workgroup for Adults with Serious Mental Illness

Name	Agency	Job Title
Shults, Rick	Department of Human Services	Division Administrator
Bauer, Jen	Candeo	COO
Bigelow, John	Southwest Iowa MH Center	Executive Director
Bomhoff, Teresa	NAMI Greater Des Moines, AMOS, MH Planning Council	Parent Advocate
Brecht, Diane	Penn, Inc.	Executive Director
Dixon, Deb	Department of Inspections and Appeals	Program Coordinator for Licensed-only Facilities
Early, Jennifer	Iowa Lutheran Hospital	Director, Behavioral Health
Johnson, Steve	Magellan Behavioral Care of Iowa	Clinical Director
Kilgore, Earl	Broadlawns Medical Center	Director of Integrated Health Homes
Klein, June	Olmstead Consumer Task Force	Member
Miller, Steve	Peer Advocate	
Oltrogge, Marcia	Northeast Iowa Behavioral Health	Executive Director
Orent, Jason	Office of Consumer Affairs	Director
Rosonke, Terri	Iowa Finance Authority	Housing Iowa Development Specialist
Watson, Suzanne	Southwest Iowa MHDS Region	CEO
Wightman, Brent	Life Connections	Director of Veterans Peer Support
Sample, Joe	Iowa Department on Aging	Executive Director

Support Staff		
Armstrong, Theresa	DHS-Division of Mental Health and Disability Services	Bureau Chief
Larkin, Laura	DHS-Division of Mental Health and Disability Services	Executive Officer
Schulte, Renee	DHS-Division of Mental Health and Disability Services	Consultant
Martone, Kevin	Technical Assistance Collaborative	Facilitator