Iowa Department of Human Services

Mental Health and Disability Services Redesign Progress Report

December 1, 2016

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Executive Summary

The purpose of this report is to review and report progress on the implementation of the adult mental health and disability services redesign and identify any challenges faced in achieving the goals of the redesign as required by HF 2460 Section 89. (Appendix A) HF 2460 directs the Department to review and report on the following:

- Governance, management, and administration;
- The implementation of best practices including evidence-based best practices;
- The availability of, access to, and provision of initial core services and additional core services to and for required core service populations and additional core service populations; and
- The financial stability and fiscal viability of the redesign.

Improving the MHDS system has been an on-going journey. The MHDS Redesign has moved the MHDS system several positive steps in this journey. However, much has occurred that was not envisioned when the Redesign legislation was passed that affects the MHDS system as a whole. Therefore, this report takes the opportunity to review the current environment in which the MHDS system operates, the challenges it is facing, and describe the next steps the Department will take to further improve the public MHDS system as a whole.

The Department based its findings and recommendations in this report on data and information collected from the MHDS Regions for the MHDS Regional Dashboard; Medicaid claims data; hospital inpatient psychiatric bed tracking system data; reports from MHDS advocacy groups; discussions with the DHS Council, MHDS Regional Chief Executive Officers, MHDS Commission, and Mental Health Planning Council; experience at the Department's facilities; and experience from monitoring individual situations brought to the Department's attention.

Key findings for MHDS Regions:

- Fourteen (14) MHDS Regions (Appendix B) have been successfully established with only a few concerns such as: a small number of MHDS Regions do not maintain continuity of leadership because they annually rotate the chief executive officer (CEO) among county staff, a few MHDS Regions do not combine county funds for common use (i.e., pooling), and several MHDS Region service areas include too few residents to operate effectively and efficiently.
- MHDS Regions are generally providing core services that meet access standards to the core populations. In a few instances some standards are not being met and core services are not consistent in quality and quantity across the state. (Appendix D)

- Some MHDS Regions are providing optional core plus services: comprehensive crisis services, jail diversion, and civil commitment prescreening. These optional services are a significant improvement, but, since these are not required services, they are not consistently available statewide. (Appendix E)
- Some progress is being made developing evidence based practices, but much more progress is needed. (Appendix F)
- Most MHDS Regions have sufficient MHDS levy authority and fund balances to operate at current service levels for several years.
- Some MHDS Regions report that current MHDS levy limits create the perception that some counties are subsidizing others. This is reportedly causing friction among some MHDS Region member counties and inhibits pooling of funds. If the role and responsibility of the MHDS Region is further expanded as indicated in the recommendations below, additional funding may be needed in the future. (Appendix G)
- The Department believes there is sufficient funding authority for MHDS Regions and views the perceived friction as primarily a tax policy question.

Key Findings for the MHDS System

- A small number of individuals (i.e., less than 1%) with a mental illness, intellectual disability, or co-occurring substance use disorder that also have severe multiple complex needs are underserved, precariously served, or served in higher levels of care than they need. Inadequately serving these individuals has led some to the misperception there is a crisis in the MHDS system. Instead, what is needed are more intensive effective supports and treatment that meet the needs of those most challenging to serve, including 24 hour 7 day a week residential services.
- The MHDS system lacks clarity regarding what entity or entities are responsible and accountable for ensuring that individuals with the most severe mutliple complex needs are effectively and efficiently served.
- Most MHDS providers do not have the capacity or capability to effectively serve individuals with severe multiple complex needs. This lack of capacity has led to the misperception that more public inpatient psychiatric hospital, state resource center, and psychiatric medical institution for children beds are needed. Instead what is needed is a more complete and effective continuum of services to meet individuals' needs, especially those with the most severe and complex needs.
- There is no point of responsibility and accountability for the provision of critical non-clinical social services, such as housing and transportation, which are necessary for individuals with a severe mental illness or an intellectual disability to live successfully in the community.

- MHDS Regions and the Managed Care Organizations (MCOs) have not yet worked collaboratively to achieve statewide outcomes and goals that will improve the MHDS system. This lack of organized effort has led to the belief that the MHDS system is broken. Instead what is needed is to coordinate the efforts of the MHDS Regions and the MCOs.
- Sufficient funding exists for the MHDS system to successfully address the most significant MHDS issues by building a more effective and efficient continuum of services that achieves better outcomes for the individuals that are served.

Recommendations:

To strengthen the effectiveness and efficiency of the MHDS Regions, the Department recommends the following:

- MHDS Regions should: have a minimum number of county residents in each region, pool county funding, and maintain continuity in their leadership.
- MHDS Regions and MCOs should identify funding for the provision of all Core and Core Plus services to individuals with a mental illness or an intellectual disability.
- MHDS Regions should continue building the community service system by planning for the provision of critical, non-clinical social services, such as, but not limited to, housing and transportation.
- The MHDS Regions' responsibility and authority for effectively and efficiently serving individuals that are the most difficult to serve should be clarified.

To address the most pressing statewide MHDS system and behavioral health need (i.e., a complete and effective array of supports, treatment and care for individuals that are the most difficult to serve) the Department will:

- Immediately convene a workgroup that includes MHDS Regions, MCOs, and other key stakeholders to identify effective services for individuals with severe multiple complex needs and report recommendations for the provision of the identified services.

Progress of the Implementation of the Adult Mental Health and Disability Services Redesign

Mental Health and Disability Services Regional Service System Governance, Management, and Administration

Fourteen (14) MHDS Regions have been formed and are operating under the direction of governing boards made up of county supervisors from the Regions' member counties. (Appendix B) The governing boards are responsible for the management of

the MHDS Regions and the expenditure of the Regions' funds. The MHDS Regions have established local points of contact for services, and the MHDS Regions have also formed advisory committees of advocates, consumers, family members, and providers to advise the governing boards.

The following describes three areas in which Regions differ in their management and administration.

Role of the Chief Executive Officer

Twelve (12) MHDS Regions operate with a single chief executive officer (CEO). Single CEO models are where the CEO is selected by the governance board and does not change from year to year. MHDS Redesign envisioned a single CEO model, but did not require it to be used.

Two (2) MHDS Regions operate a multiple CEO model in which the CEO role may rotate between various participating county staff, usually former central point of coordination administrators. In this model county employed coordinators (points of contact) operate in an autonomous fashion from the MHDS Region.

The MHDS Region CEO's role is made more complicated because most of the staff that support the work of the MHDS Region are employees of counties and not employees of the Region. This makes directing their work and holding them accountable more difficult.

Pooling Funds

Pooling of funds is when all counties in the MHDS Region place their funds into a single account to be used to pay for services region wide. Pooling of funds allows the MHDS Region to take a unified, system wide management approach to service development and delivery. Ten (10) MHDS Regions pool their funds.

MHDS Redesign envisioned that MHDS Regions would pool their funding, but the final legislation did not require pooling.

Three (3) MHDS Regions place some of their funds in a single account. Only specifically identified services are funded with pooled funds while the remaining services are funded from member county accounts. Often expenditures from the account are monitored so that one county's funds are not used for residents of another county. This is referred to as "virtual pooling."

One (1) MHDS Region draws funds from member counties as the funds are needed to serve individuals that are residents of that county. This model meets requirements, but falls short of the more unified approaches of pooling or virtual pooling.

Failing to pool funds is a barrier to providing a unified regional service delivery system and fails to take advantage of the efficiencies and economies of scale that pooling of funds provides.

Various Sizes of MHDS Regions

MHDS Regions serve member counties with significantly different numbers of residents. (Appendix C) The Department believes that regions serving smaller numbers of residents cannot operate efficiently and effectively. The original MHDS Redesign Regionalization Workgroup identified the minimum number of residents an MHDS Region serves should be between 200,000 and 700,000[1]. The final MHDS Redesign legislation required MHDS Regions to include at least three counties, but it did not require a minimum number of residents be included in an MHDS Region. The Department recognizes that a region may potentially be too large geographically to be effectively managed. This too needs to be guarded against.

Availability of, Access to, and Provision of Initial Core Services for Required Core Populations

Iowa Code section 331.397 and 441 IAC 25.2 require MHDS Regions to provide a set of defined core services to a defined group of Iowans. Required core services and the access standards are found in Appendix D.

MHDS Regions must provide these services to adults with a mental illness or an intellectual disability. This is referred to as the "core population."

Appendix D also shows the extent to which MHDS Regions are providing access to required core services to the required core population as of September 30, 2016, as reported by the MHDS Region CEOs. While most MHDS Regions are providing core services that meet access standards, the quality and quantity of those services are uneven and vary depending on where the individual lives.

Availability of, Access to, and Provision of Core Plus Services and Services to Core Plus Populations

MHDS Regions that are providing core services to the required core population and have additional available funds may choose to expand to core plus services. Core plus services include services defined in Iowa Code section 331.397, subsection 6.

[1] Iowa Mental Health and Disability Services System Redesign Final Report dated December 9, 2011

Appendix E provides an overview of core plus services being provided as of September 30, 2016.

MHDS Regions that are providing core services to the required core population and have additional available funds may choose to expand services to core plus populations. Examples of core plus populations include:

- Individuals with developmental disabilities,
- Individuals with a brain injury,
- Children with a mental illness or intellectual disability.

Overall, with some isolated exceptions, MHDS Regions serve relatively few individuals in the core plus populations.

Implementation of Best Practices Including Evidenced Based Practices

Iowa Code Section 331.397 subsection 5, requires that MHDS Regions ensure access to providers of core services that demonstrate competencies in serving persons with co-occurring conditions, provide evidenced based practices, and trauma informed care. "Evidence based practices" (EBP) are practices that have consistent scientific evidence showing they improve individual outcomes.

441 IAC 25.4 requires that MHDS Regions develop access to specific EBPs listed in Appendix F.

These EBPs have the advantage of having research based fidelity standards that more objectively demonstrate whether or not the EBP is being delivered. Appendix F shows where the MHDS Regions have identified that they have providers working to implement the identified EBPs. MHDS Regions need to make more progress in developing and implementing EBPs in Iowa.

Financial Stability and Viability

Iowa Code 331.424A provides guidance and limitations on how much each MHDS Region member county is allowed to levy. Counties are limited in the amount of levy that they can raise for MHDS. MHDS Redesign funding was based on "equalization." Equalization means that each county has available the same amount of funding per resident of the county from either the MHDS levy or a combination of the MHDS levy and state general fund to support the MHDS Region. Iowa Code 426B identifies the statewide per capita expenditure target amount for regions to fund MHDS services as $47.28 per capita. Counties that were authorized to levy more than $47.28 are required to lower their levy to that amount. Counties that had limits below $47.28 per capita were to receive additional state general funds identified in a yearly appropriation to make up the difference between their maximum levy and the $47.28 per capita amount.

For SFY14 and SFY15 the state appropriated $30 million in funding to counties that had levy limits below $47.28 to provide “equalized” funding to MHDS Regions. As a result of added state funding in the early years and county levy authority, nearly all MHDS Regions have accumulated sizable fund balances. The legislature did not authorize a state general fund appropriation for equalization for SFY16 and SFY17.

The accumulation of fund balances have provided MHDS Regions sizable funds with which to operate, though fund balances should be considered one time funds. The Department has estimated that, assuming counties approve the current maximum MHDS levy and cost of MHDS Region services increases at 3% a year, nearly all MHDS Regions could operate without financial difficulty until SFY25. However, counties are not approving the maximum MHDS levy. The current SFY17 amount levied across all counties is $87.9 million compared to the current maximum allowed total of $114.6 million. If this lower levy rate continues, MHDS Region fund balances will be spent sooner than SFY25.

Last legislative session the MHDS Regions and the Iowa State Association of Counties (ISAC) reported that the inequities resulting from the limits on the MHDS levies is causing strain in MHDS Region member county relationships. Counties with higher MHDS levy limits perceive they are subsidizing counties that have lower MHDS levy limits. (Appendix G) This perceived inequity is causing friction within some MHDS Region member counties. The MHDS Regions and ISAC asked the legislature to address this inequity by granting the counties the authority to raise the MHDS levy to address the current funding inequity among counties.

MHDS System Review

Current Context

When reviewing information for this report the Department concluded it would be most helpful to provide a broader view of the MHDS system beyond the MHDS Regions. Since MHDS Redesign was enacted in 2012 the following changes have occurred that were not envisioned when MHDS Redesign was passed that have significantly affected the MHDS system. Some of these changes are described below.

State Change Financing

Total state and county spending for mental health and disability services is expected to be about $2 billion for SFY13 through SFY17. About $1.5 billion of this amount is state general funds. About $1.4 billion of the general funds were primarily used for the non-federal share of Medicaid for mental health and disability services that resulted when

the state took over the financial responsibility for the non-federal share of Medicaid from the counties and the MHDS Regions.

Medicaid Expansion

Beginning January 2014, the Iowa Health and Wellness Plan (IHAWP) expanded comprehensive health care coverage to about 145,000 Iowans. This expansion primarily benefited single adult low income males and is of particular assistance for those needing behavioral health services. In addition, some of these newly covered individuals that have a serious mental health or disability condition can now be eligible for the more comprehensive Medicaid program coverage.[2] As of January 2016 IHAWP was expending about $67 million per year on behavioral health services (i.e., mental health and substance use disorder services) and served about 35,360 individuals whose services were previously the responsibility of the MHDS Regions. As a result, the number of Iowans receiving services funded by the MHDS Regions has declined significantly in recent years, as shown in the following chart:

Unduplicated Number of Individuals Whose Services were Funded by MHDS Regions		
Population	**SFY13**	**SFY15**
Individuals with Mental Illness	32,943	17,227
Individuals with Intellectual Disability	3,635	2,538
TOTAL	36,578	19,765

Managed Care Implementation

In April 2016 Iowa implemented the IA Health Link, a comprehensive managed care program for Medicaid managed by three MCOs under contract with the Department. Iowa's transition to managed care marks a major change in the management approach to Medicaid. The three MCOs are expected to be more than payers of service. They are required to improve member outcomes through increased and improved care management and coordination, and the use of health care transformation practices that result in more effective and efficient service delivery. MCOs operate within highly comprehensive contracts that include extensive Departmental oversight. This new approach is expected to significantly improve the health and wellbeing of MCO members including those with mental illness or disabilities.

Health Care Transformation

Health care management is moving beyond the principles of MHDS Redesign – regional management, local service delivery, and statewide standards – to new health care transformation practices with greater promise of progress and success. Health care transformation is the trend to move away from the traditional patient/provider/payer

[2] The process called being determined medically exempt provides more expansive regular Medicaid coverage for individuals with the most severe disabilities.

model to a model that uses proven practices to improve patient outcomes including: population management, social determinants of health, and value based purchasing.

The MCOs are required to use value based purchasing and are being encouraged to use the other practices to improve member outcomes and achieve greater efficiency. MHDS Regions are not required to use these practices. This means providers must operate in two different worlds: one world that is moving forward with payment for outcomes and incentives for performance, and the other world that operates using older, less efficient payment for volume of service. If MHDS Regions do not use these new practices they will be left behind and they will not be equipped to operate in the new, emerging managed health environment.

Program Initiatives

Iowa has adopted several key program initiatives designed to increase and improve MHDS program policy approaches such as:

- *The Home and Community Based Services (HCBS) settings rules* required by the Centers for Medicare and Medicaid Services to ensure individuals are living community integrated lives;
- *Increased reimbursement for supported employment* to encourage individuals with mental illness or other disabilities to gain and keep integrated employment;
- *Integrated Health Homes* to improve care coordination for individuals with serious mental illness and improve health care outcomes;
- *Systems of Care* to improve the mental health and wellbeing of children with a serious emotional disturbance and their families;
- *Certified Community Behavioral Health Clinics* to develop community mental health provider capacity to better serve individuals with a serious mental illness;
- *Hospital inpatient bed tracking system* to improve the efficiency of locating available inpatient psychiatric hospital beds for individuals that need them;
- *Autism Support Program* to provide proven and effective services for children with autism for families that cannot afford to pay for them;

In addition to these intiatives, the *Children's Mental Health and Wellbeing Workgroup* is implementing two projects, one on children's crisis services and the other on learning labs for children and family wellbeing. The workgroup is developing a proposal to continue building a children's system that will focus on prevention. This next step will help design regional collaborative interagency approaches to prevention that will improve child and family wellbeing.

Perceptions

The MHDS service system is a developing system that has both strengths and weaknesses. For example, due to the IHAWP and MHDS Regions, every low income Iowan needing MHDS services has an entity responsible to pay for their needed services. More low income Iowans than ever before are receiving publicly funded mental health and developmental disability services.

However, a small number of individuals with severe and multiple complex needs are inadequately served. Tragic events have occurred that could potentially have been avoided with better and more comprehensive services.

Funds available for the MHDS Regions are substantial and can support expansion of services for years into the future, but much of that funding is from one time fund balances that are being slowly depleted and continuing to rely on fund balances is unsustainable.

The number of staffed operating inpatient psychiatric hospital beds in Iowa has grown from 721 beds in January 2016 to 744 beds in August 2016. Iowa has one of the few inpatient psychiatric hospital bed tracking systems in the nation. Over the last 12 months, the psychiatric hospitals reported an average of 72 vacant beds per day through the bed tracking system. Yet Iowa has fewer state mental health institute beds per capita than most other states.

Iowa is 47th in the nation with regard to psychiatrists per capita, but Iowa has a robust advanced nurse practitioner program and emerging telehealth system. In addition, the governor has announced the establishment of three new psychiatric residency programs in Iowa.

Some look at this information and conclude Iowa's MHDS system is in crisis and failing Iowans with mental illness or disabilities, their families, and their communities. Others see this information as a reflection of a robust, thriving, and growing MHDS system. In reality Iowa has a healthy and progressive public mental health and disability system with some challenges that need to be addressed.

Challenges to the MHDS System

Need to Increase and Improve Service Capability and Capacity

Less than 1 percent of Iowans have a serious mental illness, severe intellectual disability, or co-occurring substance use disorder and serious multiple complex needs. These include, but are not limited to, individuals that can be aggressive, have a serious mental illness and a serious substance use disorder, and/or a serious criminal offense.

Across the nation these individuals are often safely, appropriately, and successfully served in intensive integrated service settings that have a combination of 24 hour, seven day a week staffing supervision and guidance, and extensive professional treatment and oversight. Iowa needs to increase the number of and statewide access to effective and efficient services such as these.

At the direction of the legislature a workgroup was formed in 2014 to address the intensive services needed for adults with serious mental illness to live successfully in the community. No substantive changes resulted from the report. The top five recommendations from the 2014 report include:

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.

The 2014 report also found that non-clinical social services that are not identified as core or core plus services are needed such as supported housing, financial assistance for safe, decent, affordable housing, comprehensive peer support, and non-Medicaid funded transportation. Since the report was issued it has become clear that increased capacity is needed across the entire array of MHDS services to successfully serve individuals with the most severe and multiple complex needs.

Many service providers lack the capacity to successfully and effectively serve Iowans with the most serious service needs. Too many individuals are discharged from community placement when their needs exceed the providers' capability. These individuals are far too often admitted to in-patient psychiatric hospitals and, when they are ready to be discharged, have nowhere to go because of a lack of community-based providers with the capacity to successfully serve them.

Example
John is 48 years old and has an intellectual disability and autism. He lives with 3 roommates and is on the intellectual disability waiver. He has been physically and verbally aggressive to staff and roommates resulting in his arrest. John has been admitted to the hospital for inpatient psychiatric services multiple times. When he was last admitted to the hospital his waiver provider discharged him from services. This is the third waiver provider who has discharged him due to his behaviors. John has now been in the hospital for 4 weeks and is stable and ready for discharge, but has no where to go. Before these recent episodes John has proven he could live successfully with intensive home and community based services provided by well trained and supported providers that follow John's behavior plan designed by a Board Certified Behavior Analyst.

At least 10 percent of all in-patient psychiatric hospital beds are vacant every day. However these inpatient psychiatric hospital programs often do not accept patients, not because there is a lack of beds, but because the hospital believes the individuals are too difficult for them to serve. Some demand the development of more state or publicly operated psychiatric hospital beds with longer lengths of stay. This would mean community hospital beds would remain vacant and individuals would be placed in the most restrictive, most expensive service option when they could be effectively served in a more modern, effective, and efficient service.

Example
Ann is 30 years old diagnosed with bi-polar disorder and substance use disorder. Her recent behavior has been erratic and unpredictable. Inpatient psychiatric services are being sought for her due to her hurting herself. Recently, she has had a history of multiple hospitalizations with long lengths of stay, aggression towards hospital staff and property, failure to comply with medication and other treatments. She has also been evicted from her apartment. Ann was taken to a local rural emergency department by the sheriff. The emergency department has not been able to find a community inpatient psychiatric hospital admission even by calling hospitals that show bed availability in the psychiatric hospital bed tracking system. Several years ago, before she was allowed to become non-compliant with her treatment, Ann was living successfully in a small home she shared with others while receiving 24 hour 7 day a week habilitation services and care coordination from an integrated health home. It is believed she could be successful again if she could have a brief stay in a hospital to stabilze, good discharge planning, and intensive habilitation and other mental health services.

MHDS Regions are not required to address the needs of individuals with severe multiple complex needs. While some MHDS Regions have voluntarily expanded into "core plus" services, such as comprehensive crisis services and jail diversion, others have not. Failure to require all MHDS Regions to provide these services has created a new inequity in services across the state. MCO funding has not yet been secured for crisis services to help ensure the fiscal viability of these programs.

Alternative sub-acute services have been slow to develop. Smaller, more integrated 24 hour "habilitation homes" are slow to replace large residential care facilities that cannot be funded by Medicaid and are being less frequently funded by MHDS Regions.

Each individual MCO is required to have a provider network sufficient to achieve measurable outcomes of service access and community integrated service delivery. However, the MCOs are not required to work jointly in developing a needed statewide service capacity to meet the needs of individuals with the most severe, complex and co-occurring needs.

An effort is needed to require both the MCOs and the MHDS Regions to collaborate to develop intensive service options across the state to more effectively and efficiently serve the less than 1 percent of Iowans with mental illness or disabilities or co-occurring substance use disorder and severe multiple complex needs.

Substance use disorder (SUD) treatment is not closely connected with the MHDS Region service systems. So, while at least 35 percent of all individuals with a serious mental illness have co-occurring substance use disorder, there is no formal required coordination of these service delivery systems. In addition, we are faced with an emerging opioid epidemic that requires a coordinated response by many different government entities at all levels. Therefore, the Department must collaborate with the Iowa Department of Public Health to include SUD treatment as part of this coordination effort.

Management structure

While successful in many ways, the MHDS Regions operate autonomously and do not coordinate in providing a comprehensive statewide approach. MHDS Regions are making efforts to work more closely together and with the Department. Consensus is emerging from these efforts such as the need for comprehensive crisis services, jail diversion services, sub-acute services, and developing capacity to serve individuals that have difficult complex needs. However, the Department has not been given responsibility and authority to work with MHDS Regions to manage and operate a statewide MHDS system.

Both the MHDS Regions and MCOs face similar challenges to adequately serve broad population groups effectively and efficiently. However, each of these separately managed entities are developing, providing, and funding these efforts in each of their own unique ways. In addition, MHDS Regions are locally managed and inwardly focused and serve far fewer non-Medicaid funded services than in the past. MHDS Regions have not established a role for themselves in Medicaid funded services.

Both the MHDS Regions and the MCOs are working voluntarily with the Department to collaborate on initiatives such as braided funding for crisis services, uniform quality of life outcome measures, and coordinated approaches to better serving individuals with difficult, complex needs. However, these efforts are singular and isolated. Each of the

MHDS Regions and MCOs operates autonomously. Nothing requires the MHDS Regions or the MCOs to operate cooperatively and collaboratively on statewide goals and outcomes. The individual parts of these public MHDS systems do not operate as a coordinated system of service delivery that is easily understood and used by Iowans that need them. The Department needs responsibility and authority to require the both MCOs and the MHDS Regions to collaborate to develop and operate a unified system of MHDS service delivery.

Finally, since the MHDS Regions are only required to manage services for adults, no semblance of a children's system exists.

Workforce Challenges

Iowa has a serious MHDS workforce shortage and does not have a comprehensive plan to address it. Iowa ranks 47th in the nation in the per capita number of psychiatrists. Limits exist for what trained mid-level practitioners can do, especially in hospitals. In addition the governor has announced the establishment of three new psychiatric residency programs in Iowa. Similar challenges are faced with behavioral health and disability professionals. Direct care professionals are difficult to find, turnover is high, and adequate training is insufficient. Additionally, Iowa has very few training sites for Board Certified Behavior Analysts.

Recommendations

To strengthen the effectiveness and efficiency of the MHDS Regions, the Department recommends the following:

- MHDS Regions should: have a minimum number of county residents in each region, pool county funding, and maintain continuity in their leadership.
- MHDS Regions and MCOs should identify funding for the provision of all Core and Core Plus services to individuals with a mental illness or an intellectual disability.
- MHDS Regions should continue building the community service system by planning for the provision of critical, non-clinical social services, such as, but not limited to, housing and transportation.
- The MHDS Regions' responsibility and authority for effectively and efficiently serving individuals that are the most difficult to serve should be clarified.

To address the most pressing statewide MHDS system and behavioral health need (i.e., a complete and effective array of supports, treatment and care for individuals that are the most difficult to serve) the Department will:

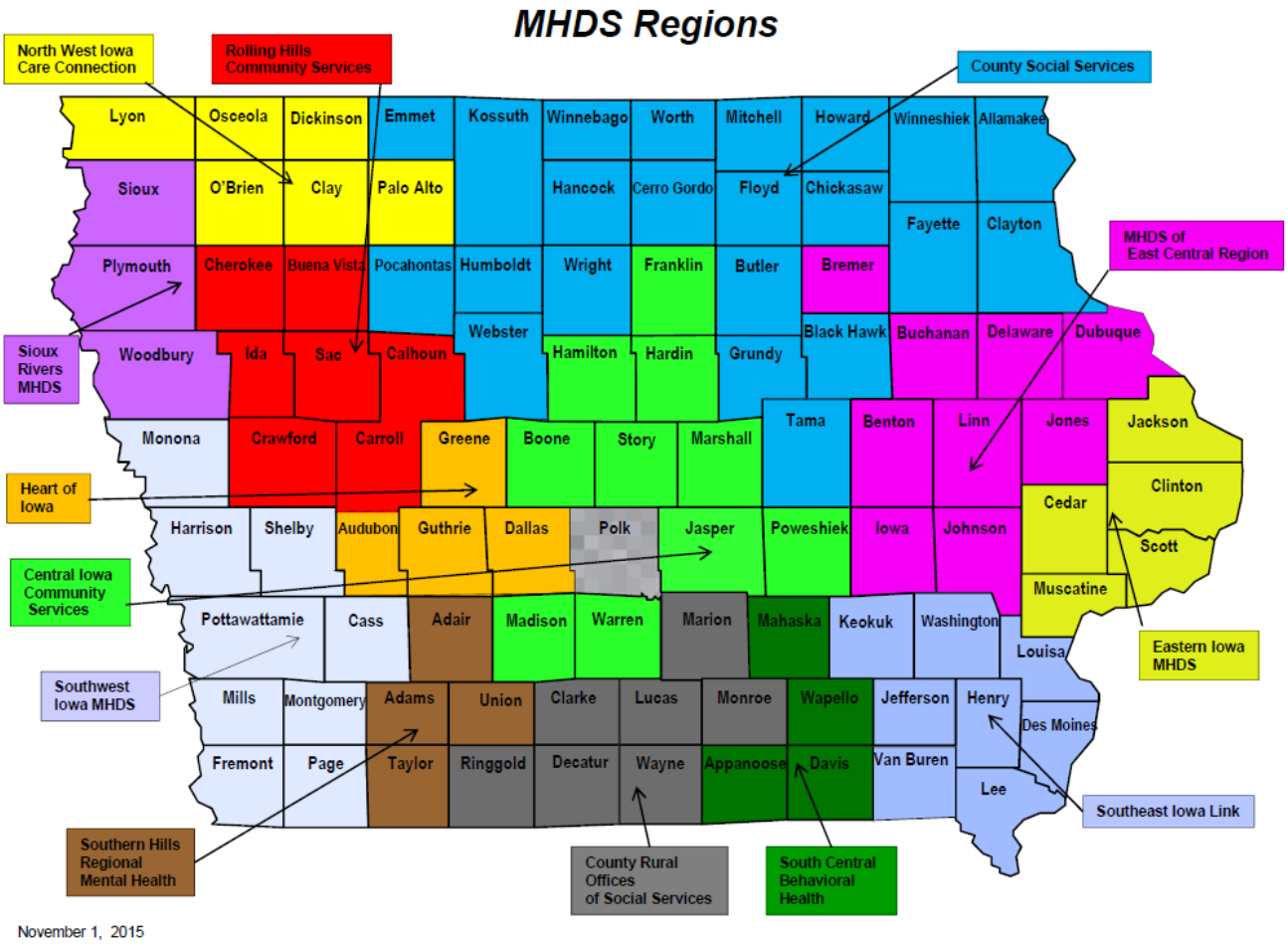
- Immediately convene a workgroup that includes MHDS Regions, MCOs, and other key stakeholders to identify effective services for individuals with severe multiple complex needs and report recommendations for the provision of those identified services.

Appendix A:

HF 2460 DIVISION XIX MENTAL HEALTH AND DISABILITY SERVICES REDESIGN PROGRESS REPORT Sec. 89 MENTAL HEALTH AND DISABILITY SERVICES REDESIGN PROGRESS REPORT

The Department of Human Services shall review and report progress on the implementation of the adult mental health and disability services redesign and shall identify any challenges faced in achieving the goals of the redesign. The progress report shall include but not be limited to information regarding the mental health and disability services regional service system including governance, management, and administration; the implementation of best practices including evidence-based best practices; the availability of, access to, and provision of initial core services and additional core services to and for required core service populations and additional core service populations; and the financial stability and fiscal viability of the redesign. The department shall submit its report with findings to the governor and the general assembly no later than November 15, 2016.

Appendix B:
MHDS Region Map



Appendix C:
Population Per MHDS Region

Region	2015 Population Estimate	Number of Counties in the Region
MHDS of the East Central Region (MHDS-ECR)	587,004	9
Polk County Health Services	467,711	1
County Social Services (CSS)	462,447	22
Central Iowa Community Services	326,018	10
Eastern Iowa MHDS Region	300,689	5
Southwest Iowa MHDS Region	189,780	9
Southeast Iowa Link (SEIL)	163,588	8
Sioux Rivers MHDS	162,519	3
Heart of Iowa Region	105,609	4
Rolling Hills Community Services Region	96,526	7
County Rural Offices of Social Services, CROSS	78,881	7
South Central Behavioral Health Region	78,795	4
Northwest Iowa Care Connection	74,634	6
Southern Hills Regional Mental Health	29,698	4
Statewide Totals	**3,123,899**	**99**

Appendix D:
Core Service Access Standards

Service Domain	Core Services Included	Access Standard
Domain: Treatment (Outpatient)	• Assessment & evaluation • Mental health therapy • Medication prescribing • Medication management	Emergency: during an emergency, outpatient services shall be initiated to an individual within 15 minutes of telephone contact
		Urgent: outpatient services shall be provided to an individual within one hour of presentation or 24 hours of telephone contact
		Routine: outpatient services shall be provided to an individual within 4 weeks of request for appointment
Domain: Treatment (Inpatient)	• Inpatient mental health	Emergency: an individual in need of emergency inpatient services shall receive treatment within 24 hours
		Proximity: Inpatient services shall be within a reasonably close proximity to the region (100 miles)
	• Assessment and evaluation after an individual has received inpatient services	Timeliness: an individual who has received inpatient services shall be assessed and evaluated within 4 weeks.
Domain: Basic Crisis Response	• 24 hour access to crisis response • Personal emergency response system	Timeliness: Access to crisis series, 24 hours a day, seven days a week, 365 days per year
	• Crisis evaluation	Timeliness: Crisis evaluation with 24 hours
Domain: Support for Community Living	• Home health aide • Respite • Home and vehicle modification • Supported community living	Timeliness: The first unit of service shall occur within 4 weeks of the individual's request of service.
Domain: Support for Employment	• Prevocational services • Day habilitation • Job development • Supported employment	Timeliness: The first unit of service shall occur within 4 weeks of the individual's request of service.
Domain: Recovery Services	• Family Support • Peer Support	Proximity: 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.
Domain: Service Coordination	• Case management • Health homes	Timeliness: An individual shall receive service coordination within 10 days of the initial request or

Service Domain	Core Services Included	Access Standard
		being discharged from an inpatient facility
		Proximity: 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 rural area to receive services

Dashboard Showing MHDS Regions Meeting Core Service Standards – September 30, 2016

Region	TREATMENT: Outpatient				TREATMENT: Inpatient		
	Timeliness Emergency	Timeliness Urgent	Timeliness Routine	Proximity	Timeliness Emergency	Timeliness Assessment/ Evaluation	Proximity
Central Iowa Community Services	Met	Met	Met	Met	Met	Met	Met
County Rural Offices of Social Services	Met	Met	Met	Met	Met	Met	Met
County Social Services	Met	Met	Met	Met	Met	Met	Met
Eastern Iowa MHDS Region	Met	Met	Met	Met	Met	Met	Met
Heart of Iowa Region	Met	Met	Met	Met	Met	Met	Met
MHDS of East Central Region	Met	Met	Unmet	Met	Met	Met	Met
Northwest Iowa Care Connections	Unmet	Met	Met	Met	Met	Met	Met
Polk County Health Services	Met	Met	Met	Met	Met	Met	Met
Rolling Hills Community Services Region	Met	Met	Met	Met	Met	Met	Met
Sioux Rivers MHDS	Met	Met	Met	Met	Met	Met	Met
South Central Behavioral Health Region	Met	Met	Met	Met	Met	Met	Met
Southeast Iowa Link	Met	Met	Met	Met	Unmet	Met	Unmet
Southern Hills Regional Mental Health	Met	Met	Met	Met	Met	Met	Unmet
Southwest Iowa MHDS Region	Met	Met	Met	Met	Met	Met	Met

Region	BASIC CRISIS RESPONSE		SUPPORT FOR COMMUNITY LIVING	SUPPORT FOR EMPLOYMENT	RECOVERY SERVICES	SERVICE COORDINATION	
	Timeliness 24 Hour Access	Timeliness Assessment/ Evaluation	Timeliness	Timeliness	Proximity	Timeliness Routine	Proximity
Central Iowa Community Services	Met	Met	Met	Met	Met	Met	Met
County Rural Offices of Social Services	Met	Met	Met	Met	Met	Met	Met
County Social Services	Unmet	Unmet	Met	Met	Unmet	Met	Met
Eastern Iowa MHDS Region	Met	Met	Met	Met	Unmet	Met	Met
Heart of Iowa Region	Met	Met	Met	Met	Unmet	Met	Met
MHDS of East Central Region	Met	Met	Met	Met	Met	Met	Met
Northwest Iowa Care Connections	Met	Unmet	Met	Met	Met	Met	Met
Polk County Health Services	Met	Met	Met	Met	Met	Met	Met
Rolling Hills Community Services Region	Met	Met	Met	Met	Met	Met	Met
Sioux Rivers MHDS	Met	Met	Met	Met	Met	Met	Met
South Central Behavioral Health Region	Met	Met	Met	Met	Met	Met	Met
Southeast Iowa Link	Unmet	Met	Met	Met	Met	Met	Met
Southern Hills Regional Mental Health	Met	Met	Met	Met	Met	Met	Met
Southwest Iowa MHDS Region	Met	Met	Met	Met	Unmet	Met	Met

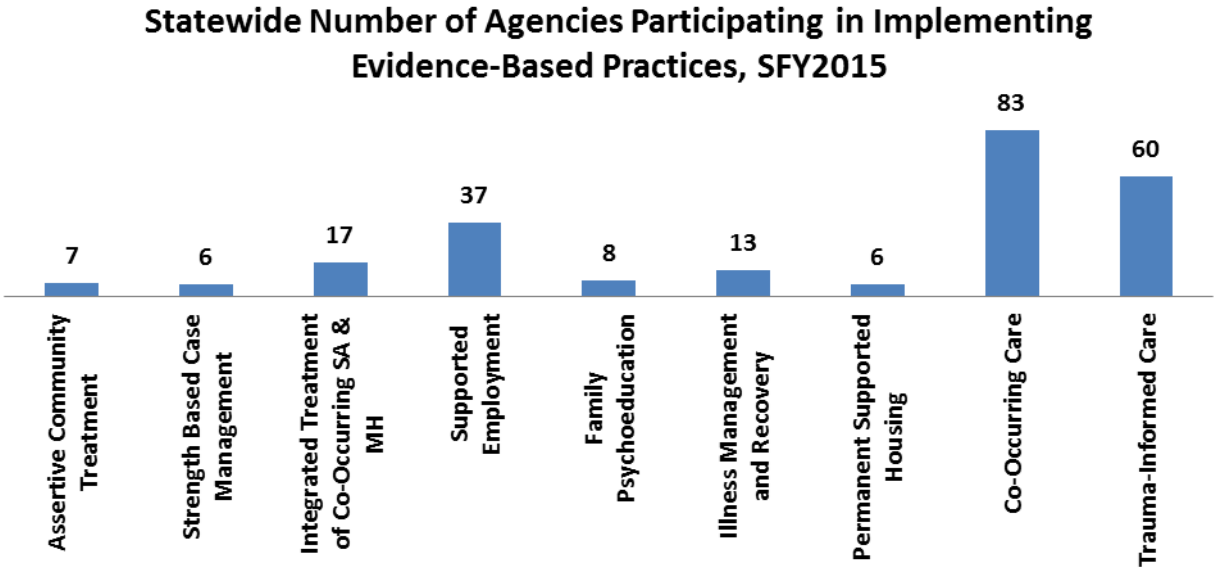
Appendix E:
Core Plus Services – 9/30/16

MHDS Region	24Hour Crisis Line	Mobile Response	23 Hour Crisis Observation & Holding	Crisis Stabilization/ Community	Crisis Stabilization/ Facility	Sub Acute	Jail Diversion	Crisis Intervention Training	Civil Commitment Prescreen
Central Iowa Community Services	X	X	X		X		X		X
County Rural Offices of Social Service	X							X	X
County Social Services	X		X		X		X	X	X
Eastern Iowa MHDS Region	X	X							X
Heart of Iowa Region	X	X			X		X		
MHDS of East Central Iowa Region	X	X			X		X		
Northwest Iowa Care Connection	X				X				
Polk County Health Services		X	X		X		X		X
Rolling Hills Community Services	X				X		X		X
Sioux Rivers MHDS	X		X		X		X	X	
South Central Behavioral Health					X		X	X	X
Southeast Iowa Link					X		X		X
Southern Hills Behavioral Health									X
Southwest Iowa MHDS	X	X			X		X	X	X

Appendix F:
Evidence Based Practices

EBPs have the following characteristics:

- Transparency: Both the criteria and the process of review are subject to peer-review.
- Research: Accumulated scientific evidence based on randomized controlled trials.
- Standardization: The practice's essential elements are clearly defined.
- Replication: More than one study and group of researchers have found positive effects.
- Fidelity Scale: A valid, reliable fidelity scale is used to verify that an intervention is being implemented in a manner consistent with the treatment model.
- Meaningful Outcomes: Consumers are shown to achieve meaningful outcomes.



Appendix G:
Summary of Maximum County MHDS Levies

PER CAPITA AMOUNT BASED ON MAXIMUM MHDS LEVY

Region	County	2015 Pop Estimate	2018 Max Levy	Per Capita
Central Iowa Community Services	Boone	26,643	878,976	32.99
	Franklin	10,295	358,934	34.86
	Hamilton	15,190	718,183	47.28
	Hardin	17,367	821,112	47.28
	Jasper	36,827	1,741,181	47.28
	Madison	15,753	534,189	33.91
	Marshall	40,746	1,926,471	47.28
	Poweshiek	18,550	444,227	23.95
	Story	96,021	3,066,575	31.94
	Warren	48,626	1,084,011	22.29
		326,018	11,573,859	35.50
County Rural Offices of Social Services	Decatur	8,220	321,858	39.16
(CROSS)	Clarke	9,259	430,559	46.50
	Lucas	8,682	410,485	47.28
	Marion	33,294	1,089,896	32.74
	Monroe	7,973	340,278	42.68
	Ringgold	5,068	239,615	47.28
	Wayne	6,385	254,099	39.80
		78,881	3,086,790	39.13
County Social Services (CSS)	Allamakee	13,886	656,530	47.28
	Black Hawk	133,455	5,779,837	43.31
	Butler	14,915	389,899	26.14
	Cerro Gordo	43,017	2,033,844	47.28
	Chickasaw	12,097	571,946	47.28
	Clayton	17,644	834,208	47.28
	Emmet	9,769	461,878	47.28
	Fayette	20,257	773,024	38.16
	Floyd	15,960	610,064	38.22
	Grundy	12,435	530,188	42.64
	Hancock	10,974	518,851	47.28
	Howard	9,410	364,201	38.70
	Humboldt	9,555	451,760	47.28
	Kossuth	15,165	717,001	47.28
	Mitchell	10,832	512,137	47.28
	Pocahontas	7,008	331,338	47.28
	Tama	17,337	568,799	32.81
	Webster	37,071	1,752,717	47.28
	Winnebago	10,609	433,910	40.90
	Winneshiek	20,709	979,122	47.28
	Worth	7,569	357,862	47.28
	Wright	12,773	554,967	43.45
		462,447	20,184,083	43.65

Eastern Iowa MHDS Region	Cedar	18,340	867,115	47.28
	Clinton	47,768	2,258,471	47.28
	Jackson	19,444	787,145	40.48
	Muscatine	43,011	2,033,560	47.28
	Scott	172,126	3,308,032	19.22
		300,689	9,254,323	30.78
Heart of Iowa Region	Audubon	5,773	272,947	47.28
	Dallas	80,133	1,524,538	19.03
	Greene	9,027	426,797	47.28
	Guthrie	10,676	504,761	47.28
		105,609	2,729,043	25.84
MHDS of the East Central Region	Benton	25,658	908,642	35.41
(MHDS-ECR)	Bremer	24,722	1,168,856	47.28
	Buchanan	21,062	995,811	47.28
	Delaware	17,403	822,814	47.28
	Dubuque	97,125	4,592,070	47.28
	Iowa	16,401	729,235	44.46
	Johnson	144,251	3,138,395	21.76
	Jones	20,466	883,021	43.15
	Linn	219,916	8,195,141	37.26
		587,004	21,433,985	36.51
Northwest Iowa Care Connection	Clay	16,507	402,866	24.41
	Dickinson	17,111	412,509	24.11
	Lyon	11,745	248,113	21.12
	Obrien	13,984	570,532	40.80
	Osceola	6,154	195,225	31.72
	Palo Alto	9,133	431,808	47.28
		74,634	2,261,053	30.30
Polk County Health Services	Polk	467,711	14,439,175	30.87
Rolling Hills Community Services Region	Buena Vista	20,493	669,512	32.67
	Calhoun	9,818	431,560	43.96
	Carroll	20,498	969,145	47.28
	Cherokee	11,574	477,158	41.23
	Crawford	17,094	808,204	47.28
	Ida	7,028	300,889	42.81
	Sac	10,021	473,793	47.28
		96,526	4.130,261	42.79
Sioux Rivers MHDS	Plymouth	24,800	363,771	14.67
	Sioux	34,937	1,027,388	29.41
	Woodbury	102,782	3,564,086	34.68
		162,519	4,955,245	30.49
South Central Behavioral Health Region	Appanoose	12,529	592,371	47.28
	Davis	8,769	414,598	47.28
	Mahaska	22,324	1,055,479	47.28
	Wapello	35,173	1,662,979	47.28
		78,795	3,725,427	47.28

Southeast Iowa Link (SEIL)	Des Moines	40,055	1,751,030	43.72
	Henry	19,950	846,381	42.43
	Jefferson	17,555	607,300	34.59
	Keokuk	10,163	480,507	47.28
	Lee	35,089	1,659,008	47.28
	Louisa	11,185	528,827	47.28
	Van Buren	7,344	314,328	42.80
	Washington	22,247	781,141	35.11
		163,588	6,968,522	42.60
Southern Hills Regional Mental Health	Adair	7,228	309,066	42.76
	Adams	3,796	179,475	47.28
	Taylor	6,205	140,346	22.62
	Union	12,469	589,534	47.28
		29,698	1,218,421	41.03
Southwest Iowa MHDS Region	Cass	13,427	634,829	47.28
	Fremont	6,906	326,516	47.28
	Harrison	14,265	674,449	47.28
	Mills	14,844	609,781	41.08
	Monona	8,979	375,993	41.87
	Montgomery	10,234	369,740	36.13
	Page	15,527	652,027	41.99
	Pottawattamie	93,671	4,428,765	47.28
	Shelby	11,927	563,909	47.28
		189,780	8,636,009	45.51
Statewide Totals		3,123,899	114,596,196	36.68