

Mental Health Systems Improvement in Iowa:

A Report to the Legislature and Governor

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January 31, 2008

Memorandum

To: Attached Distribution List

From: Allen Parks, EdD, MPH, Administrator/Director, Division of Mental Health and Disability Services, Iowa Department of Human Services

Date: January 28, 2008

Subject: Division Recommendations and Comments on Mental Health Systems Improvement Workgroups Report

Copy: Kevin W. Concannon, Director – Iowa Department of Human Services

Per last year's Appropriation Bill (S909), the Legislature directed the Department of Human Services, Mental Health and Disability Services to convene workgroups, prepare a report of the workgroups, request review by the MHMRDDBI Commission of the report of the workgroups and comment to the Legislature and the Governor on or before January 31, 2008 on major findings and recommendations.

Attached to this email please find the *Mental Health and Disability Services Recommendations and Comments on the Report of the Workgroups on Mental Health Systems Improvement* (MHDS Report). Also attached are the following APPENDICES:

- A: Overview and Statement of Need for MHDS Information Systems
- B: Framework for a State Mental Health Authority position paper
- C: Draft Amendments to Ch. 230A – Community Mental Health Centers
- D: Draft Emergency Mental Health Crisis Response Services Code
- E: Draft Emergency Mental Health Crisis Response Services Request for Proposals
- F: Draft Community Mental Health Centers Act
- G: Co-Occurring Disorders Policy Academy Charter
- H: Behavioral Health Workforce Vision
- I: Behavioral Health Workforce Data
- J: MHDS Legislative Proposals
- K: Evidence-Based Practices
- L: Workforce Development Proposal
- M: A View of the Data
- N: Community Mental Health Center and Central Point of Coordination Survey Data
- O: Recommendations from the Workgroups and Steering Committee on Mental Health Systems Improvement

We would be pleased to discuss further with you the Division's Comments and Recommendations as well as the Appendices and specifically legislative proposals contained herein.

This past year the MHDS requested, and obtained approval of the two legislative proposals contained in APPENDIX J, from the Human Services Council. These two proposals are currently in development with legislative staff in LSB 5362 DP Emergency Mental Health Crisis Services and LSB DP 5355 Children's Mental Health Services. The MHDS is also seeking funding of a Mental Health and Disability Services

Training Institute (APPENDIX L) through reallocation of a portion of what is currently referred to as “psych papers” funds.

I would like to once again express my appreciation to the consumers, family members, advocates, providers, Human Services Council, all of the workgroups, steering committee members, Co-occurring Disorders Policy Academy, Acute Mental Health Task Force, Children’s Oversight Committee, Mental Health Planning Council, members of the MHRDDBI Commission, our partnership agencies and various technical advisors for their patience and ongoing assistance. This report is a culmination of hundreds of people over nearly a year and scores of workgroup, steering committee, task force, and other stakeholder meetings. It has been a pleasure to work with all of the individuals involved who have the shared vision of building and improving, step by step, the Iowa mental health system. Thanks to one and all.

Sincerely,

Allen W. Parks, EdD, MPH
Administrator/Director
Division of Mental Health and Disability Services
Iowa Department of Human Services

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Recommendations and Comments from the Department of Human Services, Division of Mental Health and Disability Services on the *Report of Workgroups on Mental Health Systems Improvement*

Establishment of Workgroups:

As directed by the Iowa Legislature's 2007 HF909, and in order to build upon the partnership between the state and counties in providing mental health and disability services in the state, the Iowa Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS) established six workgroups for planning and recommendation purposes and engaged equal proportions representing the Department, counties, and service providers. Statewide associations representing counties and community providers appointed county and provider representatives to the workgroups. In addition, each workgroup included a representative of the MHMRDDBI Commission, the Mental Health Planning Council, consumers, and a statewide advocacy organization. Per HF909, workgroups were established for discussion and recommendations in each of the following areas:

- Alternative Distribution Formula,
- Community Mental Health Center Plan,
- Core Mental Health Services,
- Evidence-based Practices,
- Co-occurring Disorders, and
- Accreditation

Formulation of recommendations was to lead to comprehensive plan items. The workgroups met during the summer and fall of 2007. In order to draft a report of the workgroups, MHDS requested that each of the workgroups elect two members from each work group to participate in a steering committee to meet after the workgroups had met and in order to prepare a report for the Commission, the DHS Director, the Legislature and the Governor.

Explanation of the Documents:

Following over fifty meetings that involved over 100 stakeholders, the workgroup-elected steering committee members, MHDS and DHS staff, and technical advisor expert consultants prepared the *Report on the Workgroups on Mental Health Systems Improvements*. The *Report on The Workgroups* was distributed to the MHRMRDDBI Commission in the months of September through December 2007. In several Commission meetings, workgroup representatives and Steering Committee representatives verbally presented summary findings to the Commission. A written draft report was submitted to the Commission in December 2007. The comments and distribution of documents were reflected in the minutes of the Commission's meetings. Although not required in FH909, the Commission held a public hearing on the *Report of the Workgroups*. On December 13, 2007, the Commission's hearing was held, and verbal and written testimony was offered at a number of locations around the state.

This document, along with the *Report of the Workgroups and Steering Committee on Mental Health Systems Improvements*, and a number of additional documents prepared by MHDS are included with this submission to the Legislature and Governor's office. This document summarizes key recommendations from the *Report of the Workgroups*, prioritizes them, and additional information is provided by the MHDS to begin to design a comprehensive plan. The MHDS is offering this compendium based on a belief in the need for the integration of the key

recommendations of the workgroups since standing alone, no one set of recommendations from any individual workgroup would provide sufficient information to develop a comprehensive plan.

Each section in the following describes the purpose and scope of the Workgroup and the key recommendations from MHDS. Where indicated, explanations are also listed and APPENDICES containing supporting documents are referenced.

Alternative Distribution Formula

This Workgroup required that the Department submit a final report to the chairpersons and ranking members of the General Assembly's committees on Human Resources and the Joint Appropriations subcommittee on Health and Human Services, and to associated legislative staff, and the Governor's office on or before January 31, 2008.

The legislation requested that the Workgroup identify alternative formulas for distributing mental health, mental retardation, and developmental disabilities allowed growth factor adjustment funding to counties. The alternative formulas were to provide methodologies that, as compared to the current methodologies, more readily understood and better reflect the needs for services, respond to utilization patterns, acknowledge historical county spending, and address disparities in funding and service availability. The formulas should serve to strengthen the partnership between the Department and counties in the state's services system. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS does not support the majority of the recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee pertaining to Alternative Distribution Formula.

Explanation: During the course of workgroup meetings, several factors became evident:

1. The workgroups lacked adequate county information about the utilization of services to accurately model various funding mechanisms.
2. It was likely that the scope of the workgroup was too narrow and failed to account for major structural changes needed in the overall approach to funding all mental health and disability services and this could not be addressed within the scope of addressing only allowed growth factors.
3. Other issues, such as state and local taxation policy, global concepts of funding health care, and other large-scope issues often were discussed but outside of the scope of the Workgroup.
4. MHDS recommendations to contain the scope to the legislative mandate were resisted by some workgroup and steering committee members during the project process.
5. The development of case rate models (a core recommendation of the workgroup) could not be accurately prepared due to #1 above.
6. As a result of some of these factors, the MHDS has prepared a statement on Information Systems.
7. The global issue of funding the mental health and disability service system continues to be problematic and technical expertise on taxation models needs to study and make recommendations on this in the future.

**For further information, see:
APPENDIX A Information Systems**

Community Mental Health Centers

The plan shall be submitted to the Governor and General Assembly on or before January 31, 2008. The workgroup should prepare a phased plan for increasing state responsibility for and oversight of mental health services provided by community mental health centers and the providers approved to fill the role of a center. The plan shall provide for an initial implementation date of July 1, 2008. Proposed administrative rules and legislation to amend chapter 230A as necessary to implement the core services beginning July 1, 2008 should be reviewed. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Develop Emergency Mental Health Crisis Response Services in response to a major systems need.
2. Develop Children's Mental Health Services, as they are non-existent in many counties.
3. Develop School Mental Health Services with the CMHCs throughout the state to offer mental health expertise to families and students.
4. Begin to regionalize CMHCs through funding multi-CMHC projects to serve low-incidence populations (those that are typically high cost programs to individual counties) through collaborative operation of services.
5. Address significant behavioral health workforce issues in all regions of the state.
6. Review the current rate of payment for mental health services to determine if the current rate covers the actual cost of service provision. Included in this also should be a review of the rates for substance abuse and co-occurring mental illness and substance abuse disorders services.
7. Establish the State Mental Health Authority (SMHA) as the statewide policy-making entity for required core safety net services and establish that the CMHCs are primary providers of those services.
8. Establish the SMHA as the statewide oversight entity of other mental health services and service providers (i.e., accrediting body).
9. Determine the role, relationship, and responsibilities of the SMHA and the counties regarding financing and managing the public mental health system:
 - a. Endorse that the SMHA is responsible for funding services identified as required core "Safety Net" services (i.e., non-federal portion of Medicaid; Emergency Services, funding for uninsured/underinsured),
 - b. Endorse that the SMHA is responsible for the financing of the non-federal portion of all other community level mental health services funded through Medicaid.
 - c. Ensure that individual counties are responsible for funding other mental health services based on local need as identified in the *County Management Plan*. This should include responsibility for other local service needs for children.
 - d. Delineate in greater detail the contents and requirements for reporting to the SMHA by counties in their County Management Plans.
10. The non-federal portion of community level mental health services remain with one entity and become the responsibility of the SMHA.

Note: There was considerable discussion in the workgroup about delineation of financial responsibilities for payment for the non-federal portion of mental health services funded through Medicaid being split between the state and the counties. State responsibility for financing the non-federal portion of some Medicaid funded mental health services (i.e., required core Safety Net services) and County responsibility for financing other Medicaid funded mental health services can result in competing interests, influence service provision based on funding responsibilities rather than clinical need, and/or result in other unintended consequences that can negatively impact service access and provision for adults, youth, and their families.

11. Revise *Chapter 230A: Community Mental Health Centers* to enhance the state's role in oversight, funding, and support of CMHCs.

12. Revise *Chapter 24* to:
 - a. Establish minimum standards for accreditation of CMHCs as an agency with responsibility for required core safety net services.
 - b. Establish standards for accreditation of emergency mental health crisis response services.
 - c. Change accreditation of other mental health service providers. Focus on accreditation standards for services rather than providers (i.e., providers would then need to meet standards for a service to provide that service).
13. Revise, amend, or develop other related areas of Iowa Code and/or Administrative Code to be consistent with Mental Health Systems Improvement recommendations.
 - a. Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Reps, Commission, IME, etc.).
 - b. Include language clarifying the role of the SMHA.
 - c. Assess accreditation process of other MH service providers (i.e., accreditation by individual service or by provider entity). Incorporate necessary changes as it relates to changes, additions of Medicaid services.
 - d. Utilize the support and expertise of others such as consultants and legislative staff.
 - e. Ensure accreditation standards for mental health service providers and related mental health service standards (i.e., Habilitation Services, Remedial Services, and Psychosocial Rehabilitation, Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations.
 - f. In collaboration with the Judicial System, include an assessment and recommend revisions to code related to voluntary and involuntary psychiatric commitments (Ch. 229).
14. Convene a workgroup or task force of representative stakeholders to analyze larger funding issues such as the amount of funding needed for safety net services that address the financing for uninsured, underinsured, and uncompensated care.
 - a. Assess how current county/state funding is being utilized for uncompensated care (i.e., determine what is being matched to Medicaid, what is not, etc.).
 - b. Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what segments? Where are responsibilities shared?).
 - c. Determine if there is existing funding that can be leveraged for Medicaid services.
 - d. Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy-in program for people with disabilities.
 - e. Assess the pros, cons, and unintended consequences related to funding responsibilities and financing mechanisms.
 - f. Utilize a financing model that supports the service needs of consumers and youth, removes cons and other unintended negative consequences, promotes collaboration (and eliminates cost shifting) across responsible parties, and contributes to the successful implementation of Mental Health Systems Improvement.
 - g. Coordinate the findings of this group with MHDS and IME regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.
15. DHS establish a multi-agency workgroup with MHDS and IME to revise the Medicaid State Plan and the various Medicaid service options related to mental health so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:
 - a. Add/revise services that support the financing of core required Safety Net services (i.e., Emergency Mental Health Crisis Response Services, Intensive Case Management Services, Peer Support and Parent Support).

- b. Utilize Medicaid administrative funding to support the financing of core Safety Net services such as assessment, screening and already identified functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
 - c. Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other “typical” CMHC services can be provided in any community location.
 - d. Revise HAWK-I (S-CHIP) to include core required mental health safety net services and to offer a similar mental health benefit package as Medicaid.
 - e. Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, and Psych. Rehab. Services, Children’s Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.
16. In relation to Co-Occurring Disorders and in the context of the Co-Occurring Disorders Policy Academy, MHDS, CMHCs, IME, and IDPH should develop a concrete plan to work together to:
- a. Conduct an analysis of and work together to resolve administrative, policy, and funding related to the provision of services to persons with co-occurring disorders.
 - b. Resolve inconsistencies/remove barriers between funding streams for mental health and substance abuse services.
 - c. Work towards integrated funding for persons with co-occurring disorders.
 - d. Institute joint outcomes regarding service provisions for persons with co-occurring disorders.
 - e. Develop a data tracking system that can track and identify services provided to persons with co-occurring disorders across services systems (i.e., Mental Health Services, Substance Abuse Services, Inpatient Treatment, etc.). Implement this joint data tracking system within 3 years.
 - f. Complete a review of the rates paid for mental health versus substance abuse services to ensure that the rates are comparable to one another based on level of service, qualifications of staff, etc.

For further information, see:

- **APPENDIX B on State Mental Health Authority**
- **APPENDIX C on Ch. 230a Community Mental Health Center Revisions**
- **APPENDIX D Draft Emergency Mental Health Crisis Response Services Code**
- **APPENDIX E Draft Emergency Mental Health Crisis Response Services Request for Proposals**
- **APPENDIX F Draft Iowa CMHC Act**

Core Mental Health Services

The charge to this workgroup was to identify core mental health services to be offered in each area of the state by community mental health centers and core services agency providers. The core services are to be designed to address the needs of target populations identified by the workgroup, and the services may include but are not limited to emergency mental health crisis response services, school-based mental health services, short-term counseling, prescreening for those subject to involuntary treatment orders, and evidence-based practices.

The Report of The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following:

1. Ensure that lowans of all ages have access to a comprehensive array of core mental health services and that services can be accessed statewide.
2. Ensure emergency mental health crisis response services can be accessed anytime of the day or night (i.e., 24/7) throughout the state for anyone, any age experiencing a psychiatric crisis.
3. Ensure timely access to all core services (including psychiatry and emergency mental health crisis response services).
4. Standardize the target population definitions used for adults (i.e., Chronic Mental Illness is sometimes used, Serious Mental Illness is sometimes used) to specify who is eligible for what core services. Use the term Serious Mental Illness (SMI) and create a definition that is in keeping with the federal definition for SMI.
5. Create and implement a definition/targeted population of Serious Emotional Disturbance (SED) for youth that is in keeping with the federal definition for SED.
6. Create eligibility criteria for core services which:
 - a. Focuses on priority populations and determines service access by clinical eligibility/medical necessity and financial eligibility criteria (i.e., Outpatient and Emergency Services for anyone in need regardless of ability to pay; “Specialized CSS/CBS Services” for individuals experiencing SED/SMI).
 - b. Addresses barriers for people that hinder service access related to insurance limitations or having no insurance.
 - c. Ensures access to mental health services for people of all ages (i.e., includes children and older adults, is not limited to adults).
 - d. Addresses service delivery barriers for providers that results in achieving what is expected with service provision.
7. Ensure that youth experiencing SED and adults experiencing SMI have access to specialized services (i.e., the services that can be provided anywhere in the community) locally, in their own homes and their own communities.
8. Implement Intensive Case Management (ICM) services as a core service for both adults experiencing SMI and youth experiencing SED.
9. Utilize CMHCs as the public safety net with the responsibility to ensure the statewide availability of core services and 24/7 access to emergency mental health crisis services. Ensure that the new standard of care focuses on local availability, personal contact, and local coordination of services.
10. Address Behavioral Health Workforce Shortages in the following areas:
 - a. Psychiatry, Advanced Practice Nurses, Physician’s Assistants.
 - b. Other mental health professionals (i.e., doctoral-level Psychologists, Licensed Independent Clinical Social Workers and other licensed practitioners; BA and para-professional level staff).

- c. Develop an organized statewide program to recruit and retain mental health specialists.
- d. Look at other models to address the gap in psychiatry such as:
 - Telemedicine and consultation support to other prescribers
 - Specialized training in mental health for Primary Care Physicians (PCPs)
 - Utilization of other medical professionals (i.e., ARNPs, PAs, etc.) as “extenders” of psychiatrists.
 - Define an organized statewide program to recruit psychiatrists and other behavioral health workforce professionals where there are shortage areas.

11.Ensure the standard of care for mental health supports an integrated health model (e.g. co-location of related service providers; integration of mental health with primary care physicians).

12.Support the ongoing collaboration of an Acute Mental Health Care Task Force including relevant agencies (i.e., Providers, County Attorneys, Judges, Law Enforcement, Child Welfare, Schools, Hospitals, CPCs, consumers and family members) to review models and approaches in acute mental health services to determine how such services should be carried out in Iowa.

13.Develop training opportunities for all service providers of Co-Occurring Disorders.

14.Create a state level/statewide funding pool specifically for the purchase of medications for people who are uninsured/underinsured. Allow this funding stream to be utilized for lab testing, other services, etc. directly related to medication management. A statewide Medication Assistance Program with oversight and management by MHDS is recommended in order to secure additional resources such as:

- a. Resources related to administrative costs of managing Medication Assistance Programs.
- b. Prescription assistance programs with pharmaceutical companies (i.e., in kind contributions, reductions in purchasing, etc.).
- c. Federal funding or other resources to support the purchasing of medications.

15.Prevent any unfunded mandates. Ensure that adequate resources are dedicated to successfully implement required changes related to the redesign of the Iowa mental health system.

16.Address resource needs related to the uninsured, underinsured that lead to uncompensated care.

17.Identify approaches to deal with increasing levels of uncompensated care.

18.Ensure that any requirements for CMHCs and Inpatient facilities to have a letters of agreement with one another is not misinterpreted to mean CMHCs have financial responsibilities for the cost of inpatient care (and vice versa).

19.Ensure that the shift to community-based service provision is supported through all related processes across agencies.

Accreditation Standards

The Workgroup was to provide recommendations on accreditation changes associated with mental health systems improvement to the Governor and General Assembly on or before January 31, 2008. The charge was to identify standards for accreditation of core services agencies that are not a community mental health center but may serve as a provider approved to fill the role of a center. Such core services agencies could be approved to provide core mental health services for children and adults on a regional basis. The workgroup’s recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Name a CMHC accreditation task force to revise the Ch. 24 standards following the revision of Ch. 230a.

2. Develop new standards that support a fundamental Continuous Quality Improvement process similar to that seen by the Joint Commission on Accreditation of Healthcare Organizations to restore governance, administrative, and services sections and that more completely detail standards specific to CMHCs.
3. Restore community planning, consultation and education services to the definitions of mental health services.
4. Accreditation activities should ensure the following:
 - a. CMHCs establish and continuously monitor staff credentials and scope of practice provided to served consumers,
 - b. Staff improvement should continue to serve as an important standard establishing the staff development plan, organizational plans and resources, and
 - c. Supervision, consultation, and peer review be defined and incorporated within CMHCs continuous quality improvement system.
5. Provide MHDS Accreditation staff with standardized tools and processes, and accreditation standards should reflect and allow for service information to be recorded and accessed electronically.
6. Ensure that Accreditation standards provide for the development of outcome and process indicators on which continuous quality improvement occurs.

Co-Occurring Disorders

The Report of The Workgroups recommendations for this section can be found in APPENDIX O.

The MHDS supports the recommendations from the Co-Occurring Disorders Workgroup:

- a. Incorporate a vision statement for a comprehensive, continuous and integrated system of care for individuals with co-occurring disorders.
- b. Develop and use a charter document for Co-occurring disorders systems development and expansion.
- c. Continue collaboration with IDPH and active participation in a Co-Occurring Disorders Policy Academy.
- d. Ensure ongoing future consultation on co-occurring systems development work.
- e. Begin development of pilot, co-occurring projects around the states in collaboration with providers and CMHCs.
- f. Utilize various management tools developed through the Co-Occurring Policy Academy to facilitate the implementation of a Comprehensive, Continuous, and Integrated System of Care of Co-Occurring Disorders.

For further information, see:

- [APPENDIX G Co-Occurring Disorders Policy Academy Charter](#)

Evidence-based Practices

Legislation directed the MHDS to begin phased implementation of evidence-based practices for mental health services over a period of several years in order to provide a reasonable timeline for the implementation of evidence-based practices with mental health and disability services providers. The legislation directed the division to provide for implementation of two adult and two children evidence-based practices per year over a three-year period. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The Department supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Implement the three-year plan for rolling out EBPs for children and adults (see below for additional details).
2. The Department supports the definition of EBPs put forth by the Institute of Medicine in 2001 (i.e., EBP is the integration of best research evidence with clinical expertise and patient values (Sacket, et al, 2000; Institute of Medicine, 2001).
3. The Department recommends that training in the delineated EBPs be conducted through a newly created Mental Health and Disability Services Training Institute (MHDSTI) in collaboration with the Iowa Mental Health Consortium, the Center for Disabilities Development, and with expert technical assistance from the Annapolis Coalition.

The recommended EBPs are summarized below:

Children and Adolescents

Key Service Delivery Model:

SYSTEM OF CARE MODEL

- | | |
|---------|---|
| Year 1: | <ol style="list-style-type: none"> 1. School-based Mental Health Services 2. Intensive Case Management with Wraparound |
| Year 2: | <ol style="list-style-type: none"> 1. Parent Support, Education, and Training 2. In-Home and Community Based Services and Supports |
| Year 3: | <ol style="list-style-type: none"> 1. Functional Family Therapy 2. Integrated Dual Diagnosis Treatment of Co-Occurring Mental Illness and Substance Abuse Disorders |

Adults

Key Service Delivery Model:

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

- | | |
|---------|--|
| Year 1: | <ol style="list-style-type: none"> 1. Integrated treatment for Co-occurring Mental Illness and Substance Use Disorders 2. Peer Support |
| Year 2: | <ol style="list-style-type: none"> 1. Supported Employment 2. Illness Management and Recovery (including CBT) |
| Year 3: | <ol style="list-style-type: none"> 1. Assertive Community Treatment 2. Family Psychoeducation |

Comprehensive Training Program and MHDS Training Institute

The Legislature directed the MHDS to develop a comprehensive training program concerning practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa Consortium for Mental Health and mental health service providers. The Legislature directed the Division to consult with experts on behavioral health workforce development regarding implementation of the mental health and disability services training and the curriculum and training opportunities offered.

Beginning in the summer of 2007 the MHDS engaged the services of the *Annapolis Coalition*, leading national experts on training and behavioral health workforce development. The MHDS held a series of meetings with the Annapolis Coalition, the Iowa Consortium for Mental Health

and the Iowa Center for Disabilities Development in order to plan the development of a comprehensive training program per legislative direction. MHDS and the Annapolis Coalition held meetings with IDPH, and offered presentations with at MHMRDDBI Commission meetings, the Mental Health Planning Council, and a joint meeting of the Iowa Senate and House Human Resources Committees to discuss behavioral health workforce issues. The MHDS also recently worked with the Annapolis Coalition, the Consortium and Center for Disabilities Development and the Western Interstate Consortium of Higher Education (WICHE) to identify specific behavioral workforce needs with academia, in rural locations, and with primary healthcare providers. Most recently a proposal to develop a Mental Health and Disability Services Training Institute has been developed to address multiple issues of behavioral health workforce needs in Iowa.

THE CHALLENGE. There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically–effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services Administration’s “Toolkits”). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

A SOLUTION FOR IOWA. Any effort to address concerns about the quality or quantity of workers in the mental health and disabilities service system must have as its goal *sustainable, practical* approaches. The answers are not to be found solely among existing service providers, in our institutions of higher education, or in state government. What will serve Iowa’s citizens best is a structure that brings together the strengths of all of these communities with a heightened focus on real-world solutions to the on-going crisis of having a competent, committed workforce in place to support people with mental illnesses and intellectual and developmental disabilities.

THE NEW VISION. The vision of the proposed Mental Health and Disability Services Training Institute (MHDSTI) is to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others, and educate the workforce.

THE BUILDING BLOCKS. The implementation of the new vision for Iowa will build upon simple, practical approaches:

The creation of basic infrastructure to manage the process and the creation of a **Workforce Collaborative** to bring together the many skills, voices, and talents needed to implement sustainable change.

A series of tangible work products that address immediate and urgent needs in Iowa’s current mental health and disability service system:

- Strengthening the competences of line supervisors—the lynch pin in supporting change and improving quality is the quality of supervision.
- Strengthening the competencies of staff that work with children, adolescents and their families.
- Addressing the needs of our crisis and emergency services statewide.

- Building capacity to serve people with co-occurring conditions, such as mental illnesses and addictive disorders, or mental illnesses and developmental disorders.
- Improving the competencies of front line staff, which spend the most time with people receiving services, yet often receive the least training.
- Supporting consumers of services and their families to become more effective partners and care givers, and to engage them in training the rest of the workforce.
- Providing incentives to recruit and retain highly skilled professionals.

ACHIEVING SUCCESS. Many partners will be required to achieve success, but failure cannot be an option for Iowa. We have recognized the need, and it is within our capacity to move ahead quickly and effectively to make the new vision for our workforce a reality.

For further information, see:

- [APPENDIX H Workforce Vision](#)
- [APPENDIX I Workforce Data](#)

Comprehensive Plan

The Legislature directed MHDS to complete a written plan describing the key components of the state's mental health services system, including the services addressed in this subsection and those that are community-based, state institution-based, or regional or state-based.

This document contains a wide range of recommendations that should be considered integral to the phased rollout of an improvement plan. The Legislature directed that the plan should incorporate the community mental health center plan provisions. In addition, the MHDS was directed to complete a written plan for **“the Department to assume leadership and to assign and reassign significant financial responsibility for the components of the mental health services system in this state, including but not limited to the actions needed to implement the provisions of this subsection involving community mental health centers, core mental health services, core services agencies, co-occurring disorders, and evidence-based practices”**. We are pleased to present this document in support of that plan.

In its legislative proposals, submitted to the Governor in the Fall of 2007, the MHDS included recommendations for funding levels, payment methodologies for new emergency mental health crisis response, children's mental health and school mental health services. Per legislative direction, a more complete plan shall be submitted to the Governor and General Assembly on or before January 15, 2009. The Workgroups recommendations for this section can be found in APPENDIX O.

Presently, the MHDS recommends the following PHASED changes to be updated on or before January 15, 2009 in the following outline:

Phase I:

Develop and Implement

- Data infrastructure and capacity to monitor system utilization.
- CMHCs as lead agencies on the implementation of Emergency Mental Health Crisis Response Services through an RFP process via state “block grants”
- Children's Mental Health Services are designed and developed.
- School Mental Health Services are designed and developed
- Co-Occurring Disorders Programs and Services are piloted through the auspices of the Co-Occurring Disorders Policy Academy and MHDS technical advisors.

- MHDS develops and implements the Mental Health and Disability Services Training Institute through “state psychiatric papers” funds
- Functional Assessment and Outcomes Systems are developed and implement by MHDS in collaboration with CMHCs, MHIs, RCs and Juvenile facilities.
- Create necessary legislative, code, rules, and standards associated with phase changes.

Phase II:

Development and Implement:

- Acute Mental Health Task Force and in collaboration with counties, judicial system, law enforcement, health care systems and other major stakeholders update mental illness commitment procedures
- CMHC and Inpatient Program Information Network with Electronic Linkage with MHIs, RCs, and JJ facilities
- Establish MHDS as provider of Intensive Clinical Management Program
- Contract with a Pilot Regional Mental Health Authority
- Programs and Services for Individuals with Dual MH/MR disorders
- Create necessary legislative, code, rules, and standards associated with phase changes.

Phase III:

Develop and Implement:

- Early Intervention Programs
- Programs and Services for Persons with Autism Spectrum Disorders
- Programs and Services for Older Adults
- Create necessary legislative, code, rules, and standards associated with phase changes.

For further information, see:

- **APPENDIX J Legislative Proposals**
- **APPENDIX K Evidence-based Practices**
- **APPENDIX L Workforce Development Proposal**
- **APPENDIX M A Data View**
- **APPENDIX N CMHC and CPC Survey Responses**
- **APPENDIX O Recommendations from the Workgroups and Steering Committee**

Strengthening Iowa's Mental Health and Disability Services Workforce: Building and Sustaining Competencies

THE CHALLENGE. There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically-effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services "Toolkits"). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

A SOLUTION FOR IOWA. Any effort to address concerns about the quality or quantity of workers in the mental health and disabilities service system must have as its goal *sustainable, practical* approaches. The answers are not to be found solely among existing service providers, in our institutions of higher education, or in state government. What will serve Iowa's citizens best is a structure that brings together the strengths of all of these communities with a heightened focus on real-world solutions to the on-going crisis of having a competent, committed workforce in place to support people with mental illnesses and intellectual and developmental disabilities.

THE NEW VISION. The vision of the proposed Mental Health and Disability Services Center for Clinical Competence and Training Institute is to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

THE BUILDING BLOCKS. The implementation of the new vision for Iowa will build upon simple, practical approaches:

- The creation of a **Workforce Collaborative** to bring together the many skills, voices and talents needed to implement sustainable change.
- A series of tangible work products that address immediate and urgent needs in Iowa's current service system:
- Strengthening the competencies of line supervisors—the lynch pin in supporting change and improving quality is the quality of supervision.
- Strengthening the competencies of staff that work with children, adolescents and their families.
- Addressing the needs of our emergency mental health crisis services statewide.
- Building capacity to serve people with co-occurring conditions, such as mental illnesses and addictive disorders, or mental illnesses and developmental disorders.
- Improving the competencies of front line staff, which spend the most time with people receiving services, yet often receive the least training.

- Supporting consumers of services and their families to become more effective partners and care givers, and to engage them in training the rest of the workforce.
- Providing incentives to recruit and retain highly skilled professionals.

Iowa is in the process of transforming its publicly funded mental health system to a consumer and family-driven system that embraces prevention, resiliency, and recovery as guiding principles. Implementing that goal requires shedding old stereotypes of mental illness and replacing them with new attitudes and services that support people with mental illnesses. In the midst of this transition, the mental health system faces a crisis in providing appropriate mental health services to forensic clients. Without systematic and quality training as well as attention to effective strategies needed for implementation of new practices, the realization of Iowa's transformation goals could be compromised.

Center for Clinical Competence/Training Institute

1. Creating a Center of Clinical Competence

This initiative will require dedicated in-state staff and resources to ensure that all relevant partners are included, and that the efforts to develop Iowa's capacities are a constant focus of attention. For the initial year of this effort, we are proposing to hire a Project Director and an administrative assistant to manage all of the elements of the development process; the Project Director should be someone of demonstrated planning and organizing skills, with a good understanding of behavioral and other disabilities services, with additional expertise in the working with both academic and practice communities. In addition, funds are proposed for logistics support to convene meetings, publish reports, and to engage the services of needed consultants.

Total projected cost: \$200,000.00

2. Creating a Workforce Collaborative

Essential to the success of a statewide effort of this type is an infrastructure to identify and prioritize workforce problems, coordinate or implement interventions, and monitor outcomes. Perhaps most important, an infrastructure is necessary to link and leverage *existing* resources that are available within the state to strengthen its workforce. The functions of such an infrastructure would include, but not be limited to the following:

Leveraging existing resources by:

- Identifying and disseminating information about existing workforce development resources (clearinghouse function).
- Coordinating workforce development efforts among various public and private agencies to achieve efficiencies and reduce duplication of effort.

Linking Iowa's mental health and higher education systems in a coordinated effort to develop a pipeline of culturally diverse and appropriately trained mental health providers. This includes:

- Educating educators about current trends in service delivery as a strategy for fostering relevant curricula in the educational system
- Working with the mental health, higher education, licensing systems, and payers to improve career ladders in mental health within Iowa.

Assessing routinely the mental health workforce development needs within Iowa, including:

- The magnitude, characteristics, and causes, of recruitment and retention problems, including the impact of compensation and benefits

- The accessibility, relevance, and effectiveness of training and education resources/program.

Planning in the form of a biannual strategic plan on mental health workforce development and report on the status of this workforce will be conducted by the Collaborative.

Implementing interventions to strengthen the workforce.

Promoting employment of consumers, youth, and family members in the mental health workforce.

Disseminating best practices in workforce development to employers of the mental health workforce.

Advising Iowa's executive, legislative, and judicial branches on workforce issues and policy.

Applying for other potential sources of funds to support workforce development.

The structure of the Collaborative would include a General Membership, Executive Committee, Standing Councils, and ad hoc workgroups.

Persons in recovery, youth, and the parents of children and youth with emotional and mental problems would play a major role in all structures.

Technology, in the form of web-enabled conference calls, will be used for selected meetings to maximize efficiency, minimize time and travel-related meeting costs, and foster access for consumers and family members.

The collaborative can serve as the Advisory Council to the Institute, ensuring that the voices of key stakeholders are heard, and that all elements of the system are engaged in the selection, design, delivery and evaluation of the work of the Institute. The Collaborative sets the policy direction for the work of the Institute in strengthening Iowa's workforce.

The activities of the Collaborative would be the responsibility of the Project Director identified above in the Basic Infrastructure section; the Institute would staff the work of the Collaborative and provide its administrative home. Resources dedicated to this effort would include logistic support for meetings, development and dissemination of reports, and the services of content and process consultants to advise the process.

Total projected costs: \$100,000.00

Special Initiatives

The Center for Clinical Competence/Training Institute should sponsor a series of inter-related initiatives as soon as basic infrastructure is in place. Based on the assessment of the MHDS, the following five initiatives should be funded during the first year of the Institute's development. The first initiative (focusing on supervision) is cross cutting and provides the foundation on which the successful dissemination of evidence-based practices can be built and sustained. The remaining five areas focus on areas of urgent need in Iowa's system of care, and addressing them in a manner consistent with the vision of the Institute (using evidence-based methods, incorporating the best science available, etc.) will provide credibility for further elaboration of the work of the Center/Institute.

3. Supervision

A critical element in successful system transformation is intervention at the level of service supervisors. Training clinicians and other direct-care workers in evidence-based practices requires an informed support system; the lynchpin in such a support system is the front-line supervisor. In its national work, The Annapolis Coalition has determined that there has been significant erosion in the role of supervision in service delivery; this has been the case in Iowa as well. The pressure for billable hours has shifted the role of clinical supervision away from the content of service delivery and toward more administrative and financial duties. A concentrated effort to provide training in effective supervision is a necessary core step

in changing practice. Existing resources are inadequate to address the content of such training, much less to attend to the necessary policy and reimbursement strategies that will need to be developed to shift the system in the direction of evidence-based models.

The resources allocated here would provide for curriculum development and pilot implementation of supervisory training in the MHDS system of providers, as well as the development of relevant policy and protocol changes needed to ensure continuity in the dissemination of new models.

Projected total costs: \$100,000.00

4. Improved Services for Children, Adolescents and Their Families

This is already an identified high priority for Iowa MHDS, and this funding would ensure that there are resources available to the system to support dissemination of evidence-based strategies. Funds would provide for the engagement of experts in identified best practices and for implementation of training sessions and development of fidelity monitoring technologies to ensure that practices are implemented in a way that is consistent with the scientific findings that drive the practice.

Projected total costs: \$100,000.00

5. Improved Emergency Mental Health Crisis Services

Iowa's hospitals are struggling to meet the demands of persons with mental and developmental disorders in crisis, many of whom could be served both more effectively and in a more cost-effective manner by robust crisis and emergency mental health services, including such strategies as "Mental Health First Aid", peer supports, crisis prevention intervention, use of telephone "hotlines", and the like. Funding would provide for the engagement of key Iowa stakeholders, content experts in model design, and provision of basic training in new approaches to emergency mental health crisis services.

Projected total costs: \$100,000.00

6. Co-occurring Disorders

Iowa MHDS has identified co-occurring disorders (especially mental and substance-use disorders) as a high priority population that is currently un- or under-served. In addition, there are many individuals with co-occurring intellectual/development disorders and mental health/substance use disorders who are not receiving state of the art care. Funding would provide for statewide training on science-based interventions, and for the engagement of content experts for curriculum design and training delivery.

Projected total costs: \$100,000.00

7. Direct Care Workforce

Although there are efforts underway in Iowa to address the needs of the direct care workforce in the development disabilities area, more effort is needed there. According to the University of Iowa Center for Disabilities and Development, there is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. These efforts need to be expanded to begin to reach the direct care workforce in other areas of the MHDS service system, as well. Funding would provide for development of cross-disciplinary competencies, curriculum development, and training implementation for direct care workers in all MHDS service agencies.

Projected costs: \$100,000.00

8. Consumer and Family Training

Self-directed care is a cornerstone of contemporary practice, which has been recognized in the development disabilities field for some time, and is a hallmark of recovery- and resilience-oriented systems of care for people with mental and substance use conditions. While often given lip service,

consumers and families will not be able to engage in effective management and leadership of their recovery plans without training, education and supports. Funding will provide for the use of existing training models (e.g., NAMI's "Family-to-Family" and "Provider Education" tools, the Certified Peer Specialist training models, etc.) or the development of curricula specific to the needs and desires of Iowa's consumer communities.

Projected costs: \$100,000.00

9. Professional recruitment strategies

Iowa has experienced chronic shortages at the highest end of the workforce: psychiatrists, psychologists, master's level licensed social workers and advanced practice nurses. Under this special initiative, Iowa will establish a pool of dollars to offer financial incentives (stipends, loan forgiveness, supplements) to individuals in the high-need categories who are willing to help meet the skills deficits, especially in our rural and frontier communities. We will select those strategies that have been demonstrated to provide results, and match them to candidates who seem most likely to contribute to our system over time. Consumers seeking services in programs for those with chronic and persistent mental illness will benefit from the recruitment, placement and retention of up to eight psychiatrists, doctoral level psychologists or nurse practitioners with mental health specialization. Once placed in programs serving the chronically and persistently mentally ill, these practitioners will provide professional mental health services to Iowans that do not receive the services now.

Projected costs: \$200,000.00

Building on Existing Strengths

Iowa is fortunate to have in place existing structures that can support and enhance the development of the Institute. Chief among these are the Iowa Mental Health Consortium and the University of Iowa Center for Disabilities and Development. These two entities will play a significant role in the development and functioning of the new Institute, and their current work will be amplified and enhanced by the new structure. In addition to their work, there are several proposed federal efforts (specifically related to telemedicine and to enhanced recruitment and retention strategies for hard-to-find specialists) that would significantly broaden the impact of the proposed Institute.

Summary of Projected Expenditures:

- 1. Creating a Center for Clinical Competence \$150,000**
- 2. Behavioral Health Workforce Collaborative \$100,000**
- 3. Supervision of the Behavioral Health Workforce \$100,000**
- 4. Improved Services for Children, Adolescents and Families \$100,000**
- 5. Improved Emergency Mental Health Crisis Services \$100,000**
- 6. Co-Occurring Disorders \$100,000**
- 7. Direct Care Behavioral Health Workforce \$100,000**
- 8. Consumer and Family Training \$100,000**
- 9. Professional Recruitment Strategies \$200,000**

Appendix A:

Overview and Statement of Need - Mental Health and Disability Services Information Systems

Overview

According to the *President New Freedom Commission on Mental Health*:

Information technology is now available to support integrating electronic health record systems. Integrated systems can promote high quality, coordinated services by helping psychiatrists and other physicians, psychologists, social workers, nurses, and other health and human service providers communicate vital health information clearly, confidentially, and when it is needed.

The Institute of Medicine, the National Committee on Vital and Health Statistics, and the National Quality Forum have all proposed widely implementing a paperless, interoperable communications and information technology infrastructure as a way to improve and integrate the Nation's health care system. Mental health can lead this change.

Already, the Federal government is working to establish guidelines and standards to more effectively transmit, communicate, and protect health information. For example, by agreeing to use the same health messaging standards, pharmaceutical codes, imaging standards, and laboratory test names, the country is one giant step closer to speaking a common language and providing better patient care - thus leading the way to a more integrated health care system.

Consumers and families must be assured that their privacy and the confidentiality of their health information are well protected. If health care systems do not make substantial, front-end, ongoing investments to protect privacy, electronic health information systems are doomed to fail. Existing Federal regulations that balance privacy protections and the need for shared information within the health system, such as the Health Insurance Portability and Accountability Act (HIPAA), must be constantly re-examined to ensure that they adequately address both provider and consumer needs.

If health care systems do not make substantial, front-end, ongoing investments to protect privacy, electronic health information systems are doomed to fail.

With the explosion of scientific advances, new treatments, breakthroughs in promoting health, and medical information, all providers must have high-speed electronic access to the latest evidence-based practice guidelines, best practice models, ongoing clinical trials, scientific research, and other health information.

Studies show that electronic health records improve quality, accountability, and cost-effectiveness of health care services. Enhancing communication between informed consumers and health care professionals improves their discussions about treatment

options and more knowledgeable decisions. Health care providers, including those in the mental health field, urgently need universal access to real-time, computer-based health records. Successful models of person-centered, integrated, comprehensive electronic health records already exist, such as the Department of Veterans Affairs' (VA) health record system.

The Commission recommends that HHS and VA lead a public-private effort to create and promote use of software for Internet access to privacy-protected, personal health information that consumers maintain and control. Consumers and families must be involved in designing, evaluating, and implementing the system that would enable them to personalize their records. The software and training should enable consumers to personalize their health information record through links to key portions of their health records, local consumer support groups, self-care trackers, advance directives, and directories of local service providers located in or near their own ZIP Codes. This personal health information system should include the following elements:

- Electronic copies of key portions of individual health information, including records from health care providers, laboratories, and pharmacies; personal health trackers; and advance directives, care reminders, and self-entered health information;
- Access to Internet assessment services and health information sources so that they can build a personalized health information library;
- Interface with a wide range of services and programs, including prescription, appointment scheduling and reminders, medication refills, participation in consumer and support groups, and alerts to new research findings and projects;
- Availability to the general public, consumers, and families; and
- Universal design to ensure access for people with sensory perceptual and physical disabilities and availability in a broad range of multilingual formats.”

Mental Health Information System Defined

“A mental health information system is a system for action: it should exist not simply for the purpose of gathering data, but also for enabling well-informed decision-making in all aspects of the mental health system.”

From: World Health Organization, Mental health information systems. (Mental Health Policy and Service Guidance Package, 2005)

“Knowledge and understanding about mental health and mental illness are essential for the public. The general public needs accurate and current information if there is to be community responsibility for the mentally ill and community provisions for mental health.”

From: Robert H. Felix, M.D., “Evolution of Community Mental Health Concepts” presented at the Annual Meeting of the American Psychiatric Association in 1956.

Major Reasons for a MHIS

Information is crucial for decision-making at all levels of the mental health system.

- Policy-makers need information to make the best use of scarce resources,
- Planners for the design of more efficient and effective services,
- Managers for the monitoring and evaluation of services, and
- Clinicians to provide appropriate, good quality, evidence-based care.

In the context of limited resources, increasing decentralization and changes to the financing of mental health care, the quality of such data is becoming even more important.

MHIS Q & A

- What is a mental health information system?
- What are the main stages of an MHIS?
- From where should information be collected?
- What types of information should be collected?
- Benefits of an MHIS

What is a MHIS?

A mental health information system (MHIS) is a system for collecting, processing, analyzing, disseminating and using information about a mental health service and the mental health needs of the population it serves.

The MHIS aims to improve the effectiveness and efficiency of the mental health service and ensure more equitable delivery by enabling managers and service providers to make more informed decisions for improving the quality of care.

In short, an MHIS is a system for action: it exists not simply for the purpose of gathering data, but also for enabling decision-making in all aspects of the mental health system.

From where should information be collected?

Information should be collected from a variety of different mental health services. To make this possible, the appropriate systems need to be in place within these services.

The WHO has developed a model for an optimal mix of mental health services – the WHO “pyramid framework” –, which can be used to help organize the place of collection as well as the type of information that needs to be collected.

Types of Information

Planners need to consider each level of the service organization pyramid when deciding what information is required. Different types of information need to be processed at different levels within the MHIS, and it is important to consider the practicalities of how one level relates to another.

To help planners make these decisions, it is necessary to distinguish between the different types of information needed:

- Episode-level information is required to manage an individual episode of service contact – some refer to mental health vital signs, functional assessments, or outcomes measures;
- Case-level information is required to care for an individual service user;
- Facility-level information is required to manage the specific service facility (whether the facility is a specialist institution, a mental health unit in a general hospital, a community mental health team, or a primary health care (PHC) clinic); and
- Systems-level information is required to develop a policy and plan for the mental health system as a whole.

Benefits of MHIS

Information systems are an essential planning tool:

- they are a way of providing accurate, consistent information about a mental health service;
- they assist with coherent planning; and
- they are essential for policy implementation and evaluation.

Information systems are also a service delivery tool to assist service providers with recording and monitoring the needs of individual service users; they provide a means of reporting the interventions that are used, and can be linked to the ongoing improvement of service quality.

Information systems improve effectiveness by enabling the measurement of indicators explicitly determined by the policy framework of the mental health service.

They also enable effective monitoring of the clinical interventions that are used and they improve efficiency by measuring how well a service is using its resources.

As a tool for measuring need and coverage, the MHIS addresses a central challenge facing the mental health service, namely, providing equitable care with scarce resources.

APPENDIX B

Framework for a State Mental Health Authority

(Adapted from the National Association of State Mental Health Program Directors
*POSITION STATEMENT ON A FRAMEWORK FOR COMPREHENSIVE STATE MENTAL
HEALTH SYSTEM*)

Values and Principles Essential To a Comprehensive State Mental Health System

The creation of a Comprehensive State Mental Health *Plan* is a first step toward the ultimate goal of creating “Comprehensive State Mental *System*.” Although states must plan more broadly, transforming mental health care requires implementing the plan and coordinating and integrating relevant services and supports. Only such deep and broad action will create what will be from the perspective of the consumer and family a single effective, transparent, and navigable system. Although comprehensive state mental health systems will vary significantly from state to state according to their unique characteristics, all systems should be rooted in shared values. They should:

- Provide convenient access to a comprehensive array of consumer- and family-centered services and supports in the least restrictive community-based settings appropriate for the consumer.
- Recognize and promote recovery and resiliency as expected outcomes for all consumers.
- Promote policies and practices that achieve for consumers the earliest possible detection of mental health problems and early intervention.
- Ensure that all health care programs address mental health with the same urgency as physical health and that the policies of all programs that serve adults and children with mental disorders – e.g., child welfare, Medicaid, education, housing, criminal and juvenile justice, substance abuse treatment, and employment services – consider their specialized mental health needs.
- Emphasize efficiency, effectiveness, and performance improvement; base resource allocation and planning on well-measured outcomes; minimize administrative costs; and promote evidence-based and promising practices.

System Characteristics

Building on this foundation, a successful comprehensive state system will share several common characteristics:

- First, developing an effective system must begin with the recognition that most of the resources that fund services for people with mental health needs come from federal and state programs outside the jurisdiction of the state mental health authority (SMHA). In most cases, these programs are not designed as “mental health programs” at all. Therefore, fundamental to planning the system will be establishing relationships and coordinating policy development and implementation activities among the applicable state agencies. This is the case in Iowa where a large percentage of mental health dollars come through the federal Medicaid program.

When devising a comprehensive state system, Iowa must strive to involve all agencies that deliver, fund, or administer services and supports used or needed by people with a mental illness and/or their families. Many factors, however, will determine the planning process, such as the state’s fiscal health, organizational structure, political structure (e.g.,

the role of local government in financing and managing mental health services), and the status of its policy agenda and priorities. Thus, states will plan and implement their comprehensive state systems at their own pace and in a manner that fits their unique circumstances. Iowa's unique county-managed mental health system provides challenges in the development of a consistent, statewide system.

- Second, Iowa needs to ensure that other stakeholders play an active role in the process. This is most important with respect to the people the system is designed to serve. Consumers (including youth as well as adults) and family members and their advocacy organizations must be involved in all levels of the decision-making process, including the development, management, and oversight of the comprehensive system. In addition, counties and local governments are responsible for the direct delivery and management of mental health care delivery, their representatives need to be actively engaged in the planning process. Other important sectors include private providers and payors.
- Third, Iowa's success in transforming its mental health system will be significantly affected by the roles the governor and legislature plays in the process. The Final Report of the New Freedom Commission states that "the Office of the Governor should coordinate each [comprehensive state mental health] plan." It will be critical to have the support of the chief executive officer and the legislature if we are to succeed. The governor has the unique authority to convene the relevant state agency heads and hold them accountable for their performance. States that have begun the comprehensive system planning process know the value of having the governor's attention and participation of the legislature

APPENDIX C:

Draft Amendments to: CHAPTER 230A COMMUNITY MENTAL HEALTH CENTERS

230A.1 ESTABLISHMENT AND SUPPORT OF COMMUNITY MENTAL HEALTH CENTERS.

~~A county or affiliated counties, by action of the board or boards of supervisors, with approval of~~ The administrator of the division of mental health and disability services of the department of human services, may establish a community mental health center under this chapter ~~to serve the county or counties.~~ This section does not limit the authority of the board or boards of supervisors of any county or group of counties to continue to expend money to support operation of the center, and to form agreements with the board of supervisors of any additional county for that county to join in supporting and receiving services from or through the center.

[C66, 71, 73, § 230.24; C75, 77, 79, 81, S81, § 230A.1; 81 Acts, ch 78, § 20, 41, ch 117, § 1029]

83 Acts, ch 123, § 87, 209; 94 Acts, ch 1170, §40; 98 Acts, ch 1181, §1; 2006 Acts, ch 1115, §26

Referred to in § 230A.2, 230A.3, 230A.14, 230A.15, 230A.16

230A.2 SERVICES OFFERED.

A community mental health center established or operating as authorized by section 230A.1 may offer to residents of the county or counties it serves ~~any or all of the mental health services defined in~~ Sections XXXX of this document.

~~by the mental health, mental retardation, developmental disabilities, and brain injury commission in the state mental health plan.~~

[C75, 77, 79, 81, § 230A.2; 82 Acts, ch 1117, § 3]

94 Acts, ch 1170, §41; 2004 Acts, ch 1090, §9

Referred to in § 230A.10, 230A.12, 230A.14

230A.3 FORMS OF ORGANIZATION.

Each community mental health center established or continued in operation as authorized by section 230A.1 shall be organized and administered in accordance with one of the following alternative forms:

1. Direct establishment of the center by the ~~department of human services, division of mental health and disability services~~ ~~county or counties supporting it~~ and administration of the center by an elected board of trustees, pursuant to sections 230A.4 to 230A.11.

~~2. Establishment of the center by a nonprofit corporation providing services to the county or counties on the basis of an agreement with the board or boards of supervisors, pursuant to sections 230A.12 and 230A.13.~~

~~[C75, 77, 79, 81, § 230A.3]~~

~~98 Acts, ch 1181, §2, 5; 99 Acts, ch 96, §25~~

~~Referred to in § 230A.12~~

230A.4 TRUSTEES -- QUALIFICATIONS -- MANNER OF SELECTION.

When the department of human services, division of mental health and disability services the board or boards of supervisors of a county or affiliated counties decides to directly establish a community mental health center under this chapter, the supervisors, acting jointly in the case of affiliated counties, shall appoina a board of community mental health center trustees to serve until the next succeeding general election. The board of trustees shall consist of at least seven members each of whom shall be a resident of the county or one of the counties served by the center. An employee of the center is not eligible for the office of community mental health center trustee. At the first general election following establishment of the center, all members of the board of trustees shall be elected. They shall assume office on the second day of the following January which is not a Sunday or legal holiday, and shall at once divide themselves by lot into three classes of as nearly equal size as possible. The first class shall serve for terms of two years, the second class for terms of four years, and the third class for terms of six years. Thereafter, a member shall be elected to the board of trustees for a term of six years at each general election to succeed each member whose term will expire in the following year.

[C75, 77, 79, 81, S81, § 230A.4; 81 Acts, ch 117, § 1030]

Referred to in § 230A.3, 331.321

230A.5 ELECTION OF TRUSTEES.

The election of community mental health center trustees shall take place at the general election on ballots which shall not reflect a nominee's political affiliation. Nomination shall be made by petition in accordance with chapter 45. The petition form shall be furnished by the county commissioner of elections, signed by eligible electors of the county or affiliated counties equal in number to one percent of the vote cast therein for president of the United States or governor, as the case may be, in the last previous general election, and shall be filed with the county commissioner of elections. A plurality shall be sufficient to elect community mental health center trustees, and no primary election for that office shall be held.

[C75, 77, 79, 81, § 230A.5]

91 Acts, ch 129, §23

Referred to in § 230A.3, 230A.16

230A.6 VACANCIES.

Vacancies on the community mental health center board of trustees shall be filled by appointment in accordance with sections 69.11 and 69.12, by the remaining trustees, except that if the offices of more than half of the members of the board are vacant at any one time the vacancies shall be filled by the administrator, division of mental health and disability services. board of supervisors or boards of supervisors acting jointly in the case of affiliated counties. The office of any trustee who is absent from four consecutive regular board meetings, without prior excuse, may be declared vacant by the board of trustees and filled in accordance with this section.

[C75, 77, 79, 81, § 230A.6]

Referred to in § 230A.3, 230A.16, 331.321

230A.7 ORGANIZATION -- MEETINGS -- QUORUM.

The members of the board of community mental health center trustees shall qualify by taking the usual oath of office within ten days after their appointment or prior to the beginning of the term to which they were elected, as the case may be. At the initial meeting following appointment of a board of trustees or of a majority of the

members of a board, and at the first meeting in January after each biennial general election, the board shall organize by election of one of the trustees as chairperson, one as secretary and one as treasurer. The secretary and treasurer shall each file with the chairperson a surety bond in a penal sum set by the board of trustees and with sureties approved by the board for the use and benefit of the center, the reasonable cost of which shall be paid from the operating funds of the center. No other members of the board shall be required to post bond. The board shall meet at least once each month. One half plus one of the members of the board shall constitute a quorum.

[C75, 77, 79, 81, § 230A.7]

Referred to in § 230A.3

230A.8 DUTIES OF SECRETARY.

1. The secretary shall report to the ~~county auditor and treasurer~~ the names of the chairperson, secretary and treasurer of the community mental health center board of trustees as soon as practicable after each has qualified.

2. The secretary shall keep a complete record of all proceedings of the board of trustees.

3. The secretary shall draw warrants on the funds of the center, which shall be countersigned by the chairperson of the board of trustees, after claims are certified by the board.

4. The secretary shall file with the board of trustees, on or before the tenth day of each month, a complete statement of all receipts and disbursements from the center's funds during the preceding month and the balance remaining on hand at the close of the month.

[C75, 77, 79, 81, § 230A.8]

Referred to in § 230A.3, 230A.9

230A.9 DUTIES OF TREASURER.

1. The treasurer of the community mental health center shall receive the funds made available to the center ~~by the county or counties it serves, and any other funds which may be made available to the center,~~ and shall disburse the center's funds upon warrants drawn as required by section 230A.8, subsection 3.

2. The treasurer shall keep an accurate account of all receipts and disbursements and shall register all orders drawn and reported to the treasurer by the secretary, showing the number, date, to whom drawn, the purpose and amount.

3. At intervals specified by the ~~county board of supervisors,~~ not less often than once each ninety days, the ~~county treasurer of each county served by the center shall notify the chairperson of the center's board of trustees of all amounts due the center from the county which have not previously been paid over to the treasurer of the center. The chairperson shall then file a claim for payment as specified in section 331.504, subsection 7, sections 331.506, and 331.554. Section 331.504, subsection 8 notwithstanding, the claims shall not include information which in any manner identifies an individual who is receiving or has received treatment at the center.~~

[C75, 77, 79, 81, S81, § 230A.9; 81 Acts, ch 117, § 1209]

Referred to in § 230A.3

230A.10 POWERS AND DUTIES OF TRUSTEES.

The community mental health center board of trustees shall:

1. Have authority to adopt bylaws and rules for its own guidance and for the government of the center.

2. Employ a director and staff for the center, fix their compensation, and have control over the director and staff.
3. Designate at least one of the trustees to visit and review the operation of the center at least once each month.
4. Procure and pay premiums on insurance policies required for the prudent management of the center, including but not limited to public liability, professional malpractice liability, workers' compensation and vehicle liability, any of which may include as additional insureds the board of trustees and employees of the center.
5. ~~Establish, with approval of the board or joint boards of supervisors of the county or counties served by the center, standards to be followed in determining whether and to what extent persons seeking services from the center shall be considered able to pay the cost of the services received.~~
6. ~~Establish, with approval of the board or joint boards of supervisors of the county or counties served by the center, policies regarding whether the services of the center will be made available to persons who are not residents of the county or counties served by the center, and if so upon what terms.~~
7. Purchase or lease a site for the center, and provide and equip suitable quarters for the center.
8. Prepare and approve plans and specifications for all center buildings and equipment, and advertise for bids as required by law ~~for county~~ buildings before making any contract for the construction of any building or purchase of equipment.
9. File with the ~~board of supervisors~~ within thirty days after the close of each budget year, a report covering their proceedings with reference to the center and a statement of all receipts and expenditures during the preceding budget year.
10. Accept property by gift, devise, bequest or otherwise; and, if the board deems it advisable, may, at public sale, sell or exchange any property so accepted upon a concurring vote of a majority of all members of the board of trustees, and apply the proceeds thereof, or property received in exchange therefor, to the purposes enumerated in subsection 7, or to purchase equipment.
11. ~~There shall be published quarterly in each of the official newspapers of the county as selected by the board of supervisors pursuant to section 349.1 the schedule of bills allowed and there shall be published annually in such newspapers the schedule of salaries paid by job classification and category, but not by listing names of individual employees. The names, addresses, salaries and job classification of all employees paid in whole or in part from public funds shall be a public record and open to inspection at reasonable times as designated by the board of trustees.~~
12. Recruit, promote, accept and use local financial support for the community mental health center from private sources such as community service funds, business, industrial and private foundations, voluntary agencies and other lawful sources.
13. Accept and expend state and federal funds available directly to the community mental health center for all or any part of the cost of any service the center is authorized to provide.
14. Enter into a contract with an affiliate, which may be an individual or a public or private group, agency, or corporation, organized and operating on either a profit or a nonprofit basis, for any of the services described in section 230A.2, to be provided by the affiliate to residents of the county or counties served by the

community mental health center who are patients or clients of the center and are referred by the center to the affiliate for service.

[C75, 77, 79, 81, § 230A.10]

83 Acts, ch 101, § 41

Referred to in § 230A.3

230A.11 TRUSTEES -- REIMBURSEMENT -- RESTRICTIONS.

1. No community mental health center trustee shall receive any compensation for services in that office, but the trustee shall be reimbursed for actual and necessary personal expenses incurred in the performance of the trustee's duties. An itemized and verified statement of any such expenses may be filed with the secretary of the board of trustees, and shall be allowed upon approval by the board.

2. No trustee shall have, directly or indirectly, any pecuniary interest in the purchase or sale of any commodities or supplies procured for or disposed of by the center.

[C75, 77, 79, 81, § 230A.11]

Referred to in § 230A.3

230A.12 CENTER ORGANIZED AS NONPROFIT CORPORATION -- AGREEMENT WITH COUNTY.

Each community mental health center established or continued in operation pursuant to section 230A.3 shall be organized under the Iowa nonprofit corporation Act appearing as chapter 504A, Code and Code Supplement 2003, except that a community mental health center organized after January 1, 2005, and a community mental health center continued in operation after July 1, 2005, shall be organized under the revised Iowa nonprofit corporation Act appearing as chapter 504, and except that a community mental health center organized under former chapter 504 prior to July 1, 1974, and existing under the provisions of chapter 504, Code 1989, shall not be required by this chapter to adopt the Iowa nonprofit corporation Act or the revised Iowa nonprofit corporation Act if it is not otherwise required to do so by law. The board of directors of each such community mental health center shall enter into an agreement with the county or affiliated counties which are to be served by the center, which agreement shall include but need not be limited to the period of time for which the agreement is to be in force, what services the center is to provide for residents of the county or counties to be served, standards the center is to follow in determining whether and to what extent persons seeking services from the center shall be considered able to pay the cost of the services received, and policies regarding availability of the center's services to persons who are not residents of the county or counties served by the center. The board of directors, in addition to exercising the powers of the board of directors of a nonprofit corporation, may:

1. Recruit, promote, accept and use local financial support for the community mental health center from private sources such as community service funds, business, industrial and private foundations, voluntary agencies, and other lawful sources.

2. Accept and expend state and federal funds available directly to the community mental health center for all or any part of the cost of any service the center is authorized to provide.

3. Enter into a contract with an affiliate, which may be an individual or a public or private group, agency or corporation, organized and operating on either a profit or a nonprofit basis, for any of the services described in section 230A.2, to be provided by the affiliate to residents of the county or counties served by the community mental health center who are patients or clients of the

center and are referred by the center to the affiliate for service.

[C75, 77, 79, 81, § 230A.12]

83 Acts, ch 101, § 42; 98 Acts, ch 1181, §3; 2003 Acts, ch 108, §44; 2004 Acts, ch 1049, §182, 192

Referred to in § 225C.15, 230A.3

230A.13 ANNUAL BUDGET.

The board of directors of each community mental health center which is organized as a nonprofit corporation shall prepare an annual budget for the center and, when satisfied with the budget, submit it to the ~~auditor or auditors of the county or affiliated counties served by the center,~~ at the time and in the manner prescribed by ~~chapter 24.~~ The budget shall be subject to review by and approval of the board of supervisors of the county which is served by the center or, in the case of a center serving affiliated counties, by the board of supervisors of each county, acting separately, to the extent the budget is to be financed by taxes levied by that county or by funds allocated to that county by the state which the county may by law use to help support the center.

Release of administrative and diagnostic information, as defined in section 228.1, and demographic information necessary for aggregated reporting to meet the data requirements established by the department of human services, division of mental health and disability services, relating to an individual who receives services from a community mental health center ~~through the applicable central point of coordination process,~~ may be made a condition of support of that center by ~~any county under this section.~~

[C75, 77, 79, 81, § 230A.13]

83 Acts, ch 101, § 43; 96 Acts, ch 1183, § 27; 2004 Acts, ch 1090, §33; 2006 Acts, ch 1115, §27

Referred to in § 228.6, 230A.3

230A.14 SUPPORT OF CENTER -- FEDERAL FUNDS.

The board of ~~supervisors of any county served by a community mental health center established or continued in operation as authorized by section 230A.1~~ may expend money from ~~county funds or federal matching funds designated by the board of supervisors~~ for that purpose, without a vote of the electorate of the county, to pay the cost of any services described in section 230A.2 which are provided by the center or by an affiliate under contract with the center, or to pay the cost of or grant funds for establishing, reconstructing, remodeling, or improving any facility required for the center.

[C75, 77, 79, 81, § 230A.14]

83 Acts, ch 123, § 88, 209; 92 Acts, ch 1241, § 70

230A.15 COMPREHENSIVE COMMUNITY MENTAL HEALTH PROGRAM.

A community mental health ~~center established or operating as authorized by section 230A.1, or which a county or group of counties has agreed to establish or support pursuant to that section,~~ may with approval of the board or boards of supervisors of the county or ~~counties supporting or establishing the center,~~ shall undertake to provide a comprehensive community mental health program of **core mental health services for children, youth and adults as designated by the department of human services, division of mental health and disability services.** ~~for the county or counties. A center providing a comprehensive community mental health program shall, at a minimum, make available to residents of the county or counties it serves all of the comprehensive mental health services described in the state mental health plan.~~

~~[C75, 77, 79, 81, § 230A.15; 82 Acts, ch 1117, § 4]~~
230A.16 ESTABLISHMENT OF STANDARDS.

The administrator of the division of mental health and disability services of the department of human services shall recommend and the mental health, mental retardation, developmental disabilities, and brain injury commission shall adopt standards for community mental health centers, **core mental health services** and comprehensive community mental health programs, with the overall objective of ensuring that each center and each affiliate providing services under contract with a center furnishes high quality mental health services within a framework of accountability to the community it serves. The standards shall be in substantial conformity with those of the psychiatric committee of the joint commission on accreditation of health care organizations and other recognized national standards for evaluation of psychiatric facilities unless in the judgment of the administrator of the division of mental health and disability services, with approval of the mental health, mental retardation, developmental disabilities, and brain injury commission, there are sound reasons for departing from the standards. When recommending standards under this section, the administrator of the division shall designate an advisory committee representing boards of directors and professional staff of community mental health centers to assist in the formulation or revision of standards. At least a simple majority of the members of the advisory committee shall be lay representatives of community mental health center boards of directors. At least one member of the advisory committee shall be a member of a county board of supervisors. The standards recommended under this section shall include requirements that each community mental health center established or operating as authorized by section 230A.1 shall:

1. Maintain and make available to the public a written statement of the services it offers to residents of the county or counties it serves, and employ or contract for services with affiliates employing specified minimum numbers of professional personnel possessing specified appropriate credentials to assure that the services offered are furnished in a manner consistent with currently accepted professional standards in the field of mental health.

2. Unless it is governed by a board of trustees elected or selected under sections 230A.5 and 230A.6, be governed by a board of directors which adequately represents interested professions, consumers of the center's services, socioeconomic, cultural, and age groups, and various geographical areas in the county or counties served by the center.

3. Arrange for the financial condition and transactions of the community mental health center to be audited once each year by the auditor of state. However, in lieu of an audit by state accountants, the local governing body of a community mental health center organized under this chapter may contract with or employ certified public accountants to conduct the audit, pursuant to the applicable terms and conditions prescribed by sections 11.6 and 11.19 and audit format prescribed by the auditor of state. Copies of each audit shall be furnished by the accountant to the administrator of the division of mental health and disability services and the board of supervisors supporting the audited community mental health center.

4. Adopt and implement procedural rules ensuring that no member of the center's board of directors, or board of trustees receives from the center information which identifies or is intended to permit the members of the board to identify any person who is a client of

that center.

[C75, 77, 79, 81, S81, § 230A.16; 81 Acts, ch 78, § 20, 42]
89 Acts, ch 264, §6; 94 Acts, ch 1170, §42, 43; 2004 Acts, ch
1090, §10; 2006 Acts, ch 1115, §28, 29
Referred to in § 225C.4, 225C.6, 230A.18

NEW SECTION: QUALITY IMPROVEMENT

Each community mental health center shall develop a quality improvement program plan to be submitted to the administrator of the division of mental health and disability services. Such a plan shall include the following:

The community mental health center's policy and procedures related to quality improvement.

The description of the center's quality improvement committee, including membership.

An annual plan for the quality improvement program at the center including goals, objectives and performance measurement indicators.

Updates of the annual plan for the quality improvement program.

Modifications to the community mental health center's plan shall be submitted at least annually to the administrator of the division of mental health and disability services.

NEW SECTION: WORKFORCE DEVELOPMENT

NEW SECTION: MENTAL HEALTH BLOCK GRANT FUNDS

NEW SECTION: EVIDENCE BASED PRACTICES

NEW SECTION: FUNCTIONAL ASSESSMENTS

NEW SECTION: MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH

NEW SECTION: EMERGENCY MENTAL HEALTH SERVICES

NEW SECTION: CO-OCCURRING DISORDERS

Each community mental health center will develop, implement and monitor co-occurring mental health and substance abuse services and programs consistent with research-derived and consensus-derived principles that guide the implementation of the co-occurring disorders. The following principles will be supported by each community mental health center:

1. Dual diagnosis is an expectation, not an exception: Epidemiologic data defining the high prevalence of co-morbidity, along with clinical outcome data with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.
2. All co-occurring disorders are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level.
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting;

provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting. Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system different programs are designed to provide this balance in different ways. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change. Literature in both the addiction field and the mental health field has emphasized the concept of stages of change [26] or stages of treatment, and demonstrated the value of stage-wise treatment.

4. There is no single correct intervention for co occurring disorders; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements. This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. Clinical outcomes must also be individualized, based on similar parameters for individualizing treatment interventions. Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

NEW SECTION: FUNCTIONAL OUTCOMES

NEW SECTION: DATA REPORTING AND INFORMATION SYSTEMS

NEW SECTION: REIMBURSEMENT

230A.17 REVIEW AND EVALUATION.

The administrator of the division of mental health and disability services of the department of human services may review and evaluate any community mental health center and shall report evaluation findings to the ~~upon the recommendation of the~~ mental health, mental retardation, developmental disabilities, and brain injury commission. ~~and shall do so upon the written request of~~

~~the center's board of directors, its chief medical or administrative officer, or the board of supervisors of any county from which the center receives public funds. The cost of the review shall be paid by the division.~~

[C75, 77, 79, 81, S81, § 230A.17; 81 Acts, ch 78, § 20, 43]
94 Acts, ch 1170, §44; 2004 Acts, ch 1090, §11; 2006 Acts, ch 1115, §30

Referred to in § 225C.4, 230A.18
230A.18 REPORT OF REVIEW AND EVALUATION.

Upon completion of a review made pursuant to section 230A.17, the review shall be submitted to the board of directors and chief medical or administrative officer of the center. If the review concludes that the center fails to meet any of the standards established pursuant to section 230A.16, subsection 1, and that the response of the center to this finding is unsatisfactory, these conclusions shall be reported to the mental health, mental retardation, developmental disabilities, and brain injury commission which may forward the conclusions to the board of directors of the center and request an appropriate response within thirty days. If no response is received within thirty days, or if the response is unsatisfactory, the commission may call this fact to the attention of the board of supervisors of the county or counties served by the center, and in doing so shall indicate what corrective steps have been recommended to the center's board of directors.

[C75, 77, 79, 81, S81, § 230A.18; 81 Acts, ch 78, § 20, 44]
94 Acts, ch 1170, §45; 2004 Acts, ch 1090, § 12

Previous Chapter [230](#) Next Chapter [231](#)

APPENDIX D:

Draft Code for Emergency Mental Health Services

I. Authority, scope and purpose.

(1) This chapter is promulgated under the authority of _____ to establish standards and procedures for certification of mental health service programs. The persons who need those services are persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. The Department of Human Services contracts directly with Emergency Mental Health Services Providers for the operation of an emergency mental health program certified under this subchapter.

(2) This chapter applies to the department, to entities that request certification or are certified to provide emergency mental health services and to state-contracted agencies that request certification or are certified to provide emergency mental health services.

(3) This chapter relates only to the certification of programs providing emergency mental health services. It is not intended to regulate other mental health service programs or other emergency service programs.

II. Definitions.

In this chapter:

(1) "Certification" means the approval granted by the department an emergency mental health services program that meets the requirements of this chapter.

(2) "Client" means a person receiving emergency mental health services from a program.

(3) "Coordinated emergency mental health services plan" means a plan prepared by an emergency mental health services program to ensure that emergency mental health services will be available that are appropriate to the specific conditions and needs of the people of the counties in which the program operates.

(4) "County department" means a county department of human services.

(5) "Crisis" means a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual.

(6) "Crisis plan" means a plan prepared for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs.

- (7) "Department" means the Iowa Department of Human Services.
- (8) "Emergency mental health services" means a coordinated system of mental health services which provides an immediate response to assist a person experiencing a mental health crisis. An "Emergency Mental Health Services Provider" is defined as an organization certified by the Department of Human Services to provide emergency mental health services.
- (9) "Guardian" means the person or agency appointed by a court to act as the guardian of a person.
- (10) "Medical assistance" means the assistance program under 42 USC 1396.
- (11) "Medication administration" means the physical act of giving medication to a client by the prescribed route.
- (12) "Medication monitoring" means observation to determine and identify any beneficial or undesirable effects which could be related to taking psychotropic medications.
- (13) "Medically necessary" has the meaning prescribed under _____.
- (14) "Mental disorder" means a condition listed in the Diagnostic and Statistical Manual of Mental Disorders IV (4th edition), published by the American psychiatric association, or in the International Classification of Diseases, 9th edition, Clinical Modification, ICD-9-CM, Chapter 5, "Mental Disorders," published by the U.S. department of health and human services.
- (15) "Minor deficiency" means a determination by a representative of the department that while an aspect of the operation of the program or the conduct of the program's personnel deviates from the requirements of this chapter, the deviation does not substantially interfere with the delivery of effective treatment to clients, create a risk of harm to clients, violate the rights of clients created by this chapter or by other state or federal law, misrepresent the nature, amount or expense of services delivered or offered, or the qualifications of the personnel offering those services, or impede effective monitoring of the program by the department.
- (16) "Mobile crisis service" means a mental health service which provides immediate, on-site, in-person mental health service for individuals experiencing a mental health crisis.
- (17) "Parent" means a biological parent, a husband who has consented to the artificial insemination of his wife a male who is presumed to be the father, or has been adjudicated the child's father by final order or judgment of a court of competent jurisdiction in this state or another state, or an adoptive parent, but does not include a person whose parental rights have been terminated.
- (18) "Program" means an emergency mental health services program certified under this chapter.
- (19) "Psychotropic medication" means an antipsychotic, an antidepressant, lithium carbonate or a tranquilizer or any other drug used to treat, manage or control psychiatric symptoms or disordered behavior.

Note: Examples of drugs other than an antipsychotic or antidepressant, lithium carbonate or tranquilizer used to treat, manage or control psychiatric symptoms or disordered behavior include, but are not limited to, carbamazepine (Tegretol), which is typically used for control of

seizures but may be used to treat a bi-polar disorder, and propranolol (Inderal), which is typically used to control high blood pressure but may be used to treat explosive behavior or anxiety state.

(20) "Response plan" means the plan of action developed by program staff to assist a person experiencing a mental health crisis.

(21) "Stabilization services" means optional emergency mental health services which provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization.

(22) "Telephone services" means telephone response services to provide callers with immediate information, counseling, support and referral and to screen for situations which require in-person responses.

(23) "Walk-in services" means emergency mental health services provided at one or more locations in where a person can come and receive information and immediate, face-to-face counseling, support and referral.

III. Certification/Accreditation

(1) APPLICATION.

(a) An organization or entity (i.e., community mental health center, provider organization) seeking to have its emergency mental health services program certified or recertified under this chapter shall submit a written application to the department.

(b) The application shall contain information and supporting documents required by the department.

Note: For a copy of the application form, write to

(2) CERTIFICATION PROCESS.

(a) On receipt of an application for initial certification or renewal of certification, the department shall do all of the following:

1. Review the application and its supporting documents.
2. Designate a representative to conduct an on-site survey of the program, including interviewing program staff.

(b) The department's designated representative shall do all of the following:

1. Interview a representative sample of present or former participants in the program, if any, provided that the participants indicate a willingness to be contacted.
2. Review the results of any grievances or complaints filed against the program during the preceding period of certification.
3. Review a randomly selected, representative sample of client service records.
4. Review program policies and operational records, including the continuous quality improvement

plan and interview program staff to a degree sufficient to ensure that staff has knowledge of the administrative rules and standards of practice that may apply to the program and its participants.

(c) The certification survey under [par. \(b\)](#) shall be used to determine the extent of the program's compliance with the standards specified in this chapter. Certification decisions shall be based on a reasonable assessment of the program. The indicators by which compliance with the standards is determined shall include all of the following:

1. Statements made by the applicant or the applicant's designated agent, administrative personnel and staff members.
2. Documentary evidence provided by the applicant.
3. Answers to questions concerning the implementation of program policies and procedures, as well as examples of implementation provided to assist the department in making a judgment regarding the applicant's compliance with the standards in this chapter.
4. On-site observations by surveyors from the department.
5. Reports by participants regarding the program's operations.
6. Information from complaints and grievances filed by persons served by the program.

(d) The applicant shall make available for review by the designated representative of the department all documentation necessary to establish whether the program is in compliance with the standards in this chapter, including the written policies and procedures of the program, work schedules of staff, program appointment records, credentials of staff and treatment records.

(e) The designated representative of the department who reviews the documents under [pars. \(a\) to \(d\)](#) and interviews participants under [par. \(b\) 1.](#) shall preserve the confidentiality of all participant information contained in records reviewed during the certification process, in compliance with department standards.

(3) ISSUANCE OF CERTIFICATION.

(a) Within 60 days after receiving a completed application for initial certification or renewal of certification, the department shall do one of the following:

1. Certify the program if all requirements for certification are met.
2. Provisionally certify the program if only minor deficiencies are found.
3. Deny certification if one or more major deficiencies are found.

(b)

1. If an application for certification is denied, the department shall provide the applicant reasons in writing for the denial and identify the requirements for certification which the program has not met.
2. A notice of denial shall state that the applicant has a right to request a hearing on that decision

under and a right to submit a plan to correct program deficiencies in order to begin or continue operation of the program.

(c)

1. Within 10 days after receiving a notice of denial under [par. \(a\)](#), an applicant may submit to the department a plan to correct program deficiencies.

2. The plan of correction shall indicate the date on which the applicant will have remedied the deficiencies of the program. Within 60 days after that date, the department shall determine whether the corrections have been made. If the corrections have been made, the department shall certify the program.

(d) The department may limit the initial certification of a program to a period of one year.

(4) CONTENT OF CERTIFICATION. Certification shall be issued only for the specific program named in the application and may not be transferred to another entity. An applicant shall notify the department of all changes of administration, location, program name, services offered or any other change that may affect compliance with this section, no later than the effective date of the change.

(5) DATE OF CERTIFICATION.

(a) The date of certification shall be the date that the department determines, by means of an on-site survey that an applicant is in compliance with this section.

(b) The department may change the date of certification if the department has made an error in the certification process. A date of certification which is adjusted under this paragraph may not be earlier than the date the written application under [sub. \(1\)](#) was submitted to the department.

(6) RENEWAL.

(a) Upon application and the successful completion of a recertification survey under [sub. \(2\) \(b\)](#), the department may renew the program's certification for a period of up to 3 years unless sooner suspended or revoked or unless a shorter period of time is specified under [sub. \(3\) \(d\)](#) at the time of approval.

(b) The department shall send written notice of expiration and an application for renewal of certification to a certified program at least 30 days prior to expiration of the certification. If the department does not receive an application for renewal of certification before the expiration date, the program's certification shall be terminated.

(c) Upon receipt of an application for renewal of certification, the department shall conduct a survey as provided in [sub. \(2\) \(b\)](#) to determine the extent to which the program continues to comply with the requirements of this chapter.

(7) FEE FOR CERTIFICATION. The department shall establish an annual fee structure for the certification and recertification processes.

(8) ACTIONS AGAINST A CERTIFIED PROGRAM. The department may terminate, suspend, or refuse to renew a program's certification after providing the program with prior written notice of the proposed action which shall include the reason for the proposed action and notice of opportunity for a hearing under [sub. \(12\)](#), whenever the department finds that any of the following has occurred:

- (a) A program staff member has had sexual contact, or sexual intercourse, as defined in state law with a client.
- (b) A staff member of the program requiring a professional license or certificate claimed to be licensed or certified when he or she was not, has had his or her license or certificate suspended or revoked, or has allowed his or her license or certificate to expire.
- (c) A program staff member has been convicted of a criminal offense related to the provision of or claiming reimbursement for services under the Medicare program under 42 CFR 430 to 456, or under this state's or any other state's medical assistance program or any other third party payer. In this paragraph, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.
- (d) A staff member has been convicted of a criminal offense related to the provision of care, treatment or services to a person who is mentally ill, developmentally disabled, alcoholic or drug dependent; or has been convicted of a crime against a child under state law.
- (e) The program has submitted, or caused to be submitted; statements for purposes of obtaining certification under this chapter which it knew or should have known to be false.
- (f) The program failed to maintain compliance with or is in substantial non-compliance with one or more of the requirements set forth in this section.
- (g) A program staff member signed billing or other documents as the provider of service when the service was not provided by the program staff member.
- (h) There is no documentary evidence in a client's services file that the client received services for which bills had been submitted to a third party payer.

(9) INSPECTIONS.

- (a) The department may make announced and unannounced inspections of the program to verify continuing compliance with this chapter or to investigate complaints received regarding the services provided by the program.
- (b) Inspections shall minimize any disruption to the normal functioning of the program.
- (c) If the department determines during an inspection that the program has one or more major deficiencies, or it finds that any of the conditions stated in [sub. \(8\)](#) or [\(11\)](#) exist; it may suspend or terminate the program's certification.
- (d) If the department determines during an inspection that the program has one or more minor deficiencies, it may issue a notice of deficiency to the program and offer the program provisional certification pursuant to [sub. \(10\)](#).
- (e) If the department terminates or suspends the certification of a program, the department shall provide the program with a written notice of the reasons for the suspension or termination and inform the program of its right to a hearing on the suspension or termination as provided under [sub. \(12\)](#).

(10) PROVISIONAL CERTIFICATION PENDING IMPLEMENTATION OF A PLAN OF CORRECTION.

(a) If, during a survey for renewal or an inspection, the department determines that minor deficiencies exist, the department shall issue a notice of deficiency to the program and offer the program a provisional certificate pending correction of the identified deficiencies.

(b) If a program wishes to continue operation after the issuance of a notice of deficiency under an offer for provisional certification, it shall, within 30 days of the receipt of the notice of deficiency, submit a plan of correction to the department identifying the specific steps which will be taken to remedy the deficiencies and the timeline in which these steps will be taken.

(c) If the department approves the plan of correction, it shall issue the program a provisional certificate for up to 60 days of operation, pending the accomplishment of the goals of the plan of correction.

(d) Prior to the expiration of the provisional certification, the department shall conduct an on-site inspection of the program to determine whether the proposed corrections have occurred.

(e) Following the on-site inspection, if the department determines that the goals of the approved plan of correction have been accomplished, it shall restore the program to full certification and withdraw the notice of deficiency.

(f) If the goals of the plan of correction have not been accomplished, the department may deny the application for renewal, suspend or terminate the program's certification or allow the program one extension of no more than 30 additional days to complete the plan of correction. If after this extension the program has still not remedied the identified deficiencies, the department shall deny the application for renewal, or suspend or terminate the certification.

(g) If the department denies the application for renewal or suspends or terminates the certification, the department shall provide the program with a written notice of the reasons for the action and inform the program of its right to a hearing under [sub. \(12\)](#).

(11) IMMEDIATE SUSPENSION.

(a) The department may immediately suspend the certification of a program or bar from practice in a certified program any program staff member, pending a hearing on the matter, if any of the following has occurred:

1. Any of the licenses, certificates or required local, state or federal approvals of the program or program staff member has been revoked, suspended or expired.
2. The health or safety of a client is in imminent danger because of knowing failure of the program or a program staff member to comply with requirements of this chapter or any other applicable local, state or federal statute or regulation.
3. A staff member of the program has had sexual contact, or sexual intercourse, as defined in state law with a client.
4. A staff member of the program has been convicted of client abuse under state law.

(b) The department shall provide written notice to the program or program staff member of the nature of the immediate suspension, the acts or conditions on which the suspension is based, any additional

remedies which the department will be seeking and information regarding the right of the program or the person under the suspension to a hearing pursuant to [sub. \(12\)](#).

(12) RIGHT TO A HEARING.

(a) In the event that the department denies, terminates, suspends or refuses to renew certification, or gives prior notice of its intent to do so, an applicant or program may request a hearing under.

(b) The request for a hearing shall be submitted in writing to and received by the department of administration's division of hearings and appeals within 30 days after the date on the notice required under [sub. \(3\)](#), [\(8\)](#), [\(9\)](#), [\(10\)](#) or [\(11\)](#).

(13) DISSEMINATION OF RESULTS. Upon completing action on an application for certification, staff of Human Services department responsible for certification shall provide a summary of the results of the process to the applicant program and to the Mental Health and Disability Services Division Administrator responsible for monitoring community mental health programs.

(14) VIOLATION AND FUTURE CERTIFICATION. A person with direct management responsibility for a program and all practitioners of a program who were knowingly involved in an act or acts which served as a basis for immediate termination shall be barred from providing service in a certified program for a period not to exceed 5 years. This applies to the following acts:

(a) Acts which result in termination of certification under _____

(b) Acts which result in conviction for a criminal offense related to services provided under _____ Stats.

(c) Acts involving an individual staff member who has terminated affiliation with a program and who removes or destroys participant records.

IV. Waivers.

(1) POLICY.

(a) Except as provided in [par. \(b\)](#), the department may grant a waiver of any requirement in this chapter when the department determines that granting the waiver would not diminish the effectiveness of the services provided by the program, violate the purposes of the program or adversely affect clients' health, safety or welfare, and one of the following applies:

1. Strict enforcement of a requirement would result in unreasonable hardship on the provider or on a participant.

2. An alternative to a rule, including a new concept, method, procedure or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better participant care or program management.

(b) The department may not grant a waiver of client confidentiality or rights or under other administrative rules, state statutes or federal regulations.

(2) APPLICATION. An application for a waiver under this section shall be made in writing to the department and shall specify all of the following:

- (a) The requirement to be waived.
- (b) The time period for which the waiver is requested.
- (c) Any alternative action which the program proposes.
- (d) The reason for the request.
- (e) Assurances that the requested waiver would meet the requirements of [sub. \(1\)](#).

(3) GRANT OR DENIAL.

(a) The department may require additional information from the program before acting on the request for a waiver.

(b) The department shall grant or deny each request for waiver in writing. Notice of denial shall contain the reasons for denial. If a notice of a denial is not issued within 60 days after the receipt of a completed request, the waiver shall be automatically approved.

(c) The department may impose any condition on the granting of a waiver which it deems necessary.

(d) The department may limit the duration of a waiver.

(e) No waiver may continue beyond the period of certification without a specific renewal of the waiver by the department.

(f) The department's decision to grant or deny a waiver shall be final.

SUBCHAPTER II — STANDARDS FOR BASIC EMERGENCY SERVICE PROGRAMS

I. Applicability.

(1) The Department of Human Services shall contract for the operation of all emergency mental health services programs.

II. Standards.

(1) GENERAL. A basic emergency service mental health program shall:

(a) Provide immediate evaluation and mental health care to persons experiencing a mental health crisis.

(b) Make emergency services available within the provider's mental health outpatient programs, mental health inpatient program or mental health day treatment program and shared with the other 2 programs.

(c) Be organized with assigned responsibility, staff and resources so that it is a clearly identifiable program.

(2) PERSONNEL.

(a) Only psychiatrists, psychologists, social workers and other mental health personnel who are qualified under state law _____ may be assigned to emergency duty. Staff qualified under this law may be included as part of a mobile crisis team if another team member is qualified.

(b) Telephone emergency service may be provided by volunteers after they are carefully selected for aptitude and after a period of orientation, with provision for in-service training and ongoing supervision.

(c) A regular staff member of the program shall be available to provide assistance to volunteers at all times.

(d) Medical, preferably psychiatric, consultation shall be available to all staff members at all times.

(3) PROGRAM OPERATION AND CONTENT.

(a) Emergency services shall be available 24 hours a day and 7 days a week.

(b) A program shall operate a 24-hour crisis telephone service staffed by mental health professionals or paraprofessionals, or by trained mental health volunteers backed up by mental health professionals. The crisis telephone service shall have a published telephone number, and that number shall be widely disseminated to community agencies and the public.

(c) A program shall provide face to face contact for crisis intervention. Face to face contact for crisis intervention may be provided as a function of the provider's outpatient program during regular hours of outpatient program operation, with an on-call system for face to face contact for crisis intervention at all other times. A program shall have the capability of making home visits or seeing patients at other off-headquarter locations, and shall have the resources to carry out on-site interventions when this is clinically desirable.

(d) When appropriate, emergency service staff may transfer clients to other mental health programs.

(e) Services will be available to individuals of all ages.

SUBCHAPTER III — STANDARDS FOR EMERGENCY SERVICE PROGRAMS ELIGIBLE FOR MEDICAL ASSISTANCE PROGRAM OR OTHER THIRD PARTY REIMBURSEMENT

I. Applicability.

(1) The Department of Human Services may contract for the operation of an emergency mental health services program that is eligible for medical assistance program reimbursement or eligible for third-party payments.

(2) The Department of Human Services shall be the payer of last resort to organizations receiving medical assistance reimbursement, or other third party insurance providers. An annual reconciliation shall be provided to the Department by its emergency mental health providers for reimbursements received from Medicaid and other insurance providers.

(2) The Department of Human Services may retain a portion of the contractual amount for emergency mental health providers, as delineated in their contract, to offset any third party reimbursements obtained from (2) above.

II. Personnel.

(1) POLICIES.

(a) An emergency mental health services program shall have written personnel policies.

(b) A program shall maintain written documentation of employee qualifications and shall make that information available upon request for review by clients and their guardians or parents, where guardian or parent consent is required for treatment, and by the department.

(2) GENERAL QUALIFICATIONS.

(a) Each employee shall have the ability and emotional stability to carry out his or her assigned duties.

(b)

1. An applicant for employment shall provide references regarding professional abilities from at least 2 people and, if requested by the program, references or transcripts from any post secondary educational institution attended and employment history reports or recommendations from prior employers.

2. References and recommendations shall be documented either by letter or in a signed and dated record of a verbal contact.

(c) A program shall review and investigate application information carefully to determine whether employment of the individual is in the best interests of the program's clients. This shall include a check of relevant and available conviction records. Subject to _____ an individual may not have a conviction record.

(d) A program shall confirm an applicant's current professional licensure or certification if that licensure or certification is a condition of employment.

(3) QUALIFICATIONS OF CLINICAL STAFF.

(a) In this subsection, "supervised clinical experience" means a minimum of one hour per week of supervision by a mental health professional qualified under par. (b) 1. to 9., gained after the person being supervised has received a master's degree.

(b) Program staff retained to provide mental health crisis services shall meet the following minimum qualifications:

1. Psychiatrists shall be physicians licensed in Iowa to practice medicine and surgery and shall have completed 3 years of residency training in psychiatry or child psychiatry in a program approved by the accreditation council for graduate medical education and be either board-certified or eligible for certification by the American board of psychiatry and neurology.

2. Psychologists shall be licensed in Iowa, and shall be listed or meet the requirements for listing with the national register of health service providers in psychology or have a minimum of one year of supervised post-doctoral clinical experience related directly to the assessment and treatment of persons with mental disorders.

3. Psychology residents shall hold a doctoral degree in psychology and shall have successfully

completed 1500 hours of supervised clinical experience as documented by the Iowa psychology examining board.

4. Psychiatric residents shall hold a doctoral degree in medicine as a medical doctor or doctor of osteopathy and shall have successfully completed 1500 hours of supervised clinical experience as documented by the program director of a psychiatric residency program accredited by the accreditation council for graduate medical education.

5. Certified independent clinical social workers shall meet the qualifications established in Iowa and be certified by the examining board of social workers, marriage and family therapists and professional counselors.

6. Psychiatric nurses shall be licensed in Iowa as a registered nurse, have completed 3000 hours of supervised clinical experience and hold a master's degree in psychiatric mental health nursing from a graduate school of nursing accredited by the national league for nursing.

7. Professional counselors and marriage and family therapists shall meet the qualifications required established in Iowa, and be certified by the examining board of social workers, marriage and family therapists and professional counselors.

8. Master's level clinicians shall be persons with a master's degree and coursework in areas directly related to providing mental health services, including clinical psychology, psychology, school or educational psychology, rehabilitation psychology, counseling and guidance or counseling psychology. Master's level clinicians shall have 3000 hours of supervised clinical experience or be listed in the national registry of health care providers in clinical social work, the national association of social workers register of clinical social workers, the national academy of certified mental health counselors or the national register of health service providers in psychology.

9. Post-master's level clinician interns shall have obtained a master's degree as provided in [subd. 8.](#) and have completed 1500 hours of supervised clinical experience, documented as provided in [subd. 4.](#)

10. Physician assistants shall be certified and registered in Iowa and shall have had at least one year of experience working in a clinical mental health facility, or there shall be a specific plan for the person to acquire equivalent training and skills within 3 months after beginning employment.

11. Registered nurses shall be licensed in Iowa as a registered nurse, and shall have had training in psychiatric nursing and at least one year of experience working in a clinical mental health facility, or there shall be a specific plan for the person to acquire equivalent training and skills within 3 months after beginning employment.

12. Occupational therapists shall have obtained a bachelors degree and have completed a minimum of one year of experience working in a mental health clinical setting, and shall meet the requirements of the State of Iowa.

13. Certified social workers, certified advance practice social workers and certified independent social workers shall meet the qualifications established by the state of Iowa, and related administrative rules, and have received certification by the examining board of social workers, marriage and family therapists and professional counselors.

14. Other qualified mental health professionals shall have at least a bachelor's degree in a relevant area of education or human services and a minimum of one year of combined experience providing mental

health services, or work experience and training equivalent to a bachelor's degree including a minimum of 4 years of work experience providing mental health services.

15. Specialists in specific areas of therapeutic assistance, such as recreational and music therapists, shall have complied with the appropriate certification or registration procedures for their profession as required by state statute or administrative rule or the governing body regulating their profession, and shall have at least one year of experience in a mental health clinical setting.

16. Certified occupational therapy assistants shall have at least one year of experience in a mental health clinical setting and shall meet the requirements of the state of Iowa.

17. Licensed practical nurses shall be licensed in the state of Iowa as a licensed practical nurse and have had either training in psychiatric nursing or one year of experience working in a clinical mental health setting.

18. Mental health technicians shall be paraprofessionals who are employed on the basis of personal aptitude and life experience which demonstrates their ability to provide effective emergency mental health services.

19. Clinical students shall be students currently enrolled in an academic institution and working toward a degree in a professional area identified in this subsection who are providing services to the program under the supervision of a staff member meeting the qualifications under this subsection for that professional area.

(4) REQUIRED STAFF.

(a) *Program administrator.* A program shall designate a program administrator, or equivalently titled person, who shall have overall responsibility for the operation of the program and for compliance of the program with this chapter.

(b) *Clinical director.*

1. The program shall have on staff a clinical director or similarly titled person qualified under [sub. \(3\) \(b\) 1.](#) or [2.](#) who shall have responsibility for the mental health services provided by the program.

2. Either the clinical director or another person qualified under [sub. \(3\) \(b\) 1.](#) to [8.](#) who has been given authority to act on the director's behalf shall be available for consultation in person or by phone at all times the program is in operation.

(5) ADDITIONAL STAFF. A program shall have staff available that is qualified under [sub. \(3\) \(b\) 1.](#) to [19.](#) to meet the specific needs of the community as identified in the emergency mental health services program description.

(6) VOLUNTEERS. A program may use volunteers to support the activities of the program staff. Volunteers who work directly with clients of the program or their families shall be supervised at all times by a program staff member qualified under [sub. \(3\) \(b\) 1.](#) to [8.](#)

(7) CLINICAL SUPERVISION.

(a) Each program shall develop and implement a written policy for clinical supervision to ensure that:

1. The emergency mental health services being provided by the program are appropriate and being delivered in a manner most likely to result in positive outcomes for the program's clients.

2. The effectiveness and quality of service delivery and program operations are improved over time through the implementation of a continuous quality improvement process at the program and by applying what is learned from the supervision of staff under this section, the results of client satisfaction surveys, comments and suggestions offered by staff, clients, family members, other providers, members of the public and similar sources of information.

3. Professional staff has the training, competencies and experience needed to carry out the roles for which they have been retained, and receive the ongoing support, supervision and consultation they need in order to provide effective services for clients.

4. Any supervision necessary to enable professional staff to meet requirements for credentialing or ongoing certification is provided in compliance with those requirements.

(b) The clinical director is accountable for the quality of the services provided to participants and for maintaining appropriate supervision of staff and making appropriate consultation available for staff.

(c) Clinical supervision of individual program staff members includes direct review, assessment and feedback regarding each program staff member's delivery of emergency mental health services.

(d) Program staff providing emergency mental health services who have not had 3000 hours of supervised clinical experience, or who are not qualified under [sub. \(3\) \(b\) 1.](#) to [8.](#), receive a minimum of one hour of clinical supervision per week or for every 30 clock hours of face to face mental health services they provide.

(e) Program staff who have completed 3000 hours of supervised clinical experience and who are qualified under [sub. \(3\) \(b\) 1.](#) to [8.](#), participate in a minimum of one hour of peer clinical consultation per month or for every 120 clock hours of face-to-face mental health services they provide.

(f) Day to day clinical supervision and consultation for individual program staff is provided by mental health professionals qualified under [sub. \(3\) \(b\) 1.](#) to [8.](#)

(g) Clinical supervision is accomplished by one or more of the following means:

1. Individual sessions with the staff member to review cases, assess performance and let the staff member know how he or she is doing.

2. Individual side-by-side sessions in which the supervisor is present while the staff person provides emergency mental health services and in which the supervisor assesses, teaches and gives advice regarding the staff member's performance.

3. Group meetings to review and assess staff performance and provide staff advice or direction regarding specific situations or strategies.

4. Other professionally recognized methods of supervision, such as review using videotaped sessions and peer review, if the other methods are approved by the department and are specifically described in the written policies of the program.

(h) Clinical supervision provided for individual program staff is documented in writing.

(i) Peer clinical consultation is documented in either a regularly maintained program record or a personal diary of the mental health professional receiving the consultation.

(j) The clinical director is permitted to direct a staff person to participate in additional hours of supervision or consultation beyond the minimum identified in this section in order to ensure that clients of the program receive appropriate emergency mental health services.

(k) A mental health professional providing clinical supervision is permitted to deliver no more than 60 hours per week of face-to-face mental health services and supervision in any combination of clinical settings.

(8) ORIENTATION AND ONGOING TRAINING.

(a) *Orientation program.* Each program shall develop and implement a competency-based orientation program for all new staff and regularly scheduled volunteers. The orientation shall be designed to ensure that staff and volunteers know and understand all of the following:

1. Pertinent parts of this chapter.
2. The program's policies and procedures.
3. Job responsibilities for staff and volunteers in the program.
4. Applicable parts of relevant Iowa Code and any related administrative rules.
5. The provisions regarding confidentiality of treatment records.
6. The provisions regarding patient rights.
7. Basic mental health and psychopharmacology concepts applicable to crisis situations.
8. Techniques and procedures for assessing and responding to the emergency mental health service needs of persons who are suicidal, including suicide assessment, suicide management and prevention.
9. Techniques for assessing and responding to the emergency mental health service needs of persons who appear to have problems related to the abuse of alcohol or other drugs.
10. Techniques and procedures for providing non-violent crisis management for clients, including verbal de-escalation, methods for obtaining backup, and acceptable methods for self-protection and protection of the client and others in emergency situations.
11. Customer service training including but not limited to creating a welcoming environment in a mental health program, recognition of systems of care principles, and the implementation of co-occurring disorders services.

(b) *Orientation training requirement.*

1. Each newly hired staff person who has had less than 6 months of experience in providing emergency

mental health services shall complete a minimum of 40 hours of documented orientation training within 3 months after beginning work with the program.

2. Each newly hired staff person who has had 6 months or more of prior experience in providing emergency mental health service shall complete a minimum of 20 hours of documented orientation training within 3 months after beginning work with the program.

3. Each volunteer shall receive at least 40 hours of orientation training before working directly with clients or their families.

(c) *Ongoing training program.* Each program shall develop and implement an ongoing training program for all staff, which may include but is not limited to:

1. Time set aside for in-service training.
2. Presentations by community resource staff from other agencies.
3. Attendance at conferences and workshops.
4. Discussion and presentation of current principles and methods of providing emergency mental health services.

(d) *Ongoing training requirement.*

1. Each professional staff person shall participate in at least the required number of hours of annual documented training necessary to retain certification or licensure.

2. Staff shall receive at least 8 hours per year of in-service training on emergency mental health services, rules and procedures relevant to the operation of the program, compliance with state and federal regulations, cultural competency in mental health services and current issues in client's rights and services. Staffs who are shared with other community mental health programs may apply in-service hours received in those programs toward this requirement.

(e) *Training records.* A program shall maintain as part of its central administrative records updated, written copies of its orientation program, evidence of current licensure and certification of professional staff, and documentation of orientation and ongoing training received by program staff and volunteers.

III. Services.

(1) PLAN FOR COORDINATION OF SERVICES.

(a) Each emergency mental health services program shall prepare a written plan for providing coordinated emergency mental health services within their service area. The coordinated emergency mental health services plan shall include all of the following:

1. A description of the nature and extent of the emergency mental health service needs in its service area or region.
2. A description of the program's overall system of care for people with mental health problems.

3. An analysis of how the services to be offered by the program have been adapted to address the specific strengths and needs of the residents it serves.

4. A description of the services the program offers, the criteria and priorities it applies in making decisions during the assessment and response stages, and how individuals, families and other providers and agencies can obtain program services.

5. A description of the specific responsibilities, if any, which other mental health providers in the service area will have in providing emergency mental health services, and a process to be used which addresses confidentiality and exchange of information to ensure rapid communication between the program and the other providers and agencies.

6. Any formal or informal agreements to receive or provide backup coverage which have been made with other providers and agencies, and any role the program may play in situations in which an emergency protective placement is being sought for a person under state law.

7. Criteria for selecting and identifying clients who present a high risk for having a mental health crisis, and a process for developing, maintaining and implementing crisis plan on their behalf.

8. A description of the agreements, including any written memoranda of understanding which the program has made with law enforcement agencies, hospital emergency rooms within their service area, mental health institutes, which do the following:

a. Outline the role program staff will have in responding to calls in which a person may be in need of hospitalization, including providing on-site and over the phone assistance.

b. Describe the role staff will have in screening persons in crisis situations to determine the need for hospitalization.

c. Provide a process for including the emergency mental health services program in planning to support persons who are being discharged from an inpatient stay, or who will be living in the community under a civil commitment.

(b) If a program provides emergency services in conjunction with substance abuse services, child protective services or any other emergency services, the coordinated emergency mental health services plan shall describe how the services are coordinated and delivered.

(c) Prior to application for recertification a program shall review its coordinated emergency mental health services plan and adjust it based on information received through surveys, consultation with other participants in the plan's development and comments and suggestions received from other resources, including staff, clients, family members, other service providers and interested members of the public.

(2) GENERAL OBJECTIVES FOR EMERGENCY MENTAL HEALTH SERVICES. A program providing emergency mental health services shall have the following general objectives:

(a) To identify and assess an individual's immediate need for mental health services to the extent possible and appropriate given the circumstances in which the contact with or referral to the program was made.

(b) To respond to that need by providing a service or group of services appropriate to the client's specific strengths and needs to the extent they can be determined in a crisis situation.

(c) When necessary and appropriate, to link an individual who is receiving emergency mental health services with other community mental health service providers for ongoing treatment and support.

(d) To make follow-up contacts, as appropriate, in order to determine if needed services or linkages have been provided or if additional referrals are required.

(3) REQUIRED EMERGENCY MENTAL HEALTH SERVICES. An emergency mental health services program shall provide or contract for the delivery of all of the following services:

(a) *Telephone service.* A telephone service providing callers with information, support, counseling, intervention, emergency service coordination and referral for additional, alternative or ongoing services. The telephone service shall do all of the following:

1. Be directed at achieving one or more of the following outcomes:
 - a. Immediate relief of distress in pre-crisis and crisis situations.
 - b. Reduction of the risk of escalation of a crisis.
 - c. Arrangements for emergency onsite responses when necessary to protect individuals in a mental health crisis.
 - d. Referral of callers to appropriate services when other or additional intervention is required.
2. Be available 24 hours a day and 7 days a week and have a direct link to a mobile crisis service, a law enforcement agency or some other program which can provide an immediate, onsite response to an emergency situation on a 24 hour a day, 7 day a week basis.
3. Be provided either by staff qualified or by fully trained volunteers. If the telephone service is provided by volunteers or staff a mental health professional shall be on site or constantly available by telephone to provide supervision and consultation.
4. If staff at a location other than the program, such as a law enforcement agency or a 911 center, are the first to answer calls to the telephone service, ensure that those staff are trained by program staff in the correct way to respond to persons in need, are capable of immediately transferring the call to an appropriate mental health professional and identify themselves as being part of the emergency mental health services system rather than the law enforcement agency or other organization where the calls are being picked up.

(b) *Mobile crisis service.* A mobile crisis service that can provide onsite, in-person intervention for individuals experiencing a mental health crisis. The mobile crisis service shall do all of the following:

1. Be directed at achieving one or more of the following outcomes:
 - a. Immediate relief of distress in crisis situations.
 - b. Reduction in the level of risk present in the situation.

c. Assistance provided to law enforcement officers who may be involved in the situation by offering services such as evaluation criteria for emergency detention under state law.

d. Coordination of the involvement of other mental health resources which may respond to the situation.

e. Referral to or arrangement for any additional mental health services which may be needed.

f. Providing assurance through follow up contacts that intervention plans developed during the crisis are being carried out.

2. Be available for at least 8 hours a day, 7 days a week during those periods of time identified in the emergency mental health services plan when mobile services would be most needed.

3. Have the capacity for making home visits and for seeing clients at other locations in the community. Staff providing mobile services shall be qualified except that staff qualified may be included as part of a mobile crisis team if another team member is qualified. A mental health professional shall either provide in-person supervision or be available to provide consultation by phone.

(c) *Walk-in services.* A walk-in service that provides face-to-face support and intervention at an identified location or locations on an unscheduled basis. A walk-in service shall do all of the following:

1. Be directed at achieving one or more of the following outcomes:

a. Immediate relief of distress and reducing the risk of escalation in pre-crisis and crisis situations.

b. Referral to or arrangement for any additional mental health services which may be needed.

c. Self-directed access to mental health services.

2. Be available for at least 8 hours a day, 5 days a week, excluding holidays. The specific location or locations where walk-in services are to be offered and the times when the services are to be offered shall be based on a determination of greatest community need as indicated in the coordinated emergency mental health services plan developed under [sub. \(1\)](#).

3. Be provided by the program or through a contract with another mental health provider, such as an outpatient mental health clinic. If the walk-in services are delivered by another provider, the contract shall make specific arrangements to ensure that during the site's hours of operation clients experiencing mental health crises are able to obtain unscheduled, face to face services within a short period of time after coming to the walk-in site.

4. Be provided by persons qualified under the above. However, persons qualified shall work under the supervision of a mental health professional.

(d) *Short-term voluntary or involuntary hospital care.* Short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis. Short-term voluntary or involuntary hospital care shall do all of the following:

1. Be directed at achieving one or more of the following objectives:

- a. Reduction or elimination of the symptoms of mental illness contributing to the mental health crisis.
 - b. Coordination of linkages and referrals to community mental health resources which may be needed after the completion of the inpatient stay.
 - c. Prevention of long-term institutionalization.
 - d. Assistance provided in making the transition to a less restrictive living arrangement when the emergency has passed.
2. Be available 24 hours a day and 7 days a week.
 3. Be available for both voluntary admissions and for persons under emergency detention or commitment law.

(e) *Linkage and coordination services.* Linkage and coordination services to support cooperation in the delivery of emergency mental health care in the counties in which the program operates. Linkage and coordination services shall do all of the following:

1. Be provided for the purpose of achieving one or more of the following outcomes the Emergency Mental Health Provider organization will meet regularly with county Central Point of Contact staff regarding general emergency mental health issues as well as client-specific cases related to:
 - a. Connection of a client with other programs to obtain ongoing mental health treatment, support and services, and coordination to assist the client and his or her family during the period of transition from emergency to ongoing mental health services.
 - b. Coordination with other mental health providers in the community for whom the program is designated as crisis care backup, to ensure that adequate information about the other providers' clients is available if a crisis occurs.
 - c. Coordination with law enforcement, hospital emergency room personnel and other local service providers to offer assistance and intervention when other agencies are the initial point of contact for a person in a mental health crisis.
2. Be available 24 hours a day, 7 days a week as a component of the services offered under [pars. \(a\) to \(d\)](#).
3. Be provided by persons.

(f) *Services for children and adolescents and their families.* Each program shall have the capacity to provide the services identified in [pars. \(a\) to \(e\)](#) in ways that meet the unique needs of young children and adolescents experiencing mental health crises and their families. Services for young children and adolescents and their families shall do all of the following:

1. Be provided for the purpose of achieving one or more of the following outcomes:
 - a. Resolution or management of family conflicts when a child has a mental health crisis and prevention of out-of-home placement of the child.

b. Improvement in the young child's or adolescent's coping skills and reduction in the risk of harm to self or others.

c. Assistance given the child and family in using or obtaining ongoing mental health and other supportive services in the community.

2. Include any combination of telephone, mobile, walk-in, hospitalization and stabilization services determined to be appropriate in the coordinated emergency mental health services plan developed which may be provided independently or in combination with services for adults.

3. Be provided by staff who either have had one year of experience providing mental health services to young children or adolescents or receive a minimum of 20 hours of training in providing the services within 3 months after being hired, in addition to meeting the requirements for providing the general type of mental health services identified in [pars. \(a\) to \(e\)](#).

4. Be provided by staff who are supervised by a staff person qualified who has had at least 2 years of experience in providing mental health services to children. A qualified staff person may provide supervision either in person or be available by phone.

(4) OPTIONAL STABILIZATION SERVICES.

(a) In addition to services required under [sub. \(3\)](#), a program may provide stabilization services for an individual for a temporary transition period, with weekly reviews to determine the need for continued stabilization services, in a setting such as an outpatient clinic, school, detention center, jail, crisis hostel, adult family home, community based residential facility or a foster home or group home or child caring institution for children, or the individual's own home. A program offering stabilization services shall do all of the following:

1. Provide those services for the purpose of achieving one or more of the following outcomes:

a. Reducing or eliminating an individual's symptoms of mental illness so that the person does not need inpatient hospitalization.

b. Assisting in the transition to a less restrictive placement or living arrangement when the crisis has passed.

2. Identify the specific place or places where stabilization services are to be provided and the staff who will provide the services.

3. Have staff providing stabilization services that are qualified to provide services and with those staff qualified to supervise a person qualified under the above sections.

(b) If a program elects to provide stabilization services, the department shall provide or contract for on-site consultation and support as requested to assist the program in implementing those services.

(c) The department may designate a stabilization site as a receiving facility for emergency detention provided that the site meets the applicable standards under this chapter.

(5) OTHER SERVICES.

Programs may offer additional services, such as information and referral or peer to peer telephone support designed to address needs identified in the coordinated emergency mental health services plan but the additional services may not be provided in lieu of the services under [sub. \(3\)](#).

(6) SERVICES PROVIDED UNDER CONTRACT BY OTHER PROVIDERS.

If any service under [subs. \(3\)](#) to [\(5\)](#) is provided under contract by another provider, the program shall maintain written documentation of the specific person or organization who has agreed to provide the service and a copy of the formal agreement for assistance.

(7) SERVICES IN COMBINED EMERGENCY SERVICES PROGRAMS.

Programs which combine the delivery of emergency mental health services with other emergency services, such as those related to the abuse of alcohol or other drugs, those related to accidents, fires or natural disasters, or those for children believed to be at risk because of abuse or neglect, if the services identified in [sub. \(3\)](#) are available as required and are delivered by qualified staff.

IV. Assessment and Response.

(1) ELIGIBILITY FOR SERVICES. To receive emergency mental health services, a person shall be in a mental health crisis or be in a situation which is likely to develop into a crisis if supports are not provided.

(2) WRITTEN POLICIES. A program shall have written policies which describe all of the following:

(a) The procedures to be followed when assessing the needs of a person who requests or is referred to the program for emergency mental health services and for planning and implementing an appropriate response based on the assessment.

(b) Adjustments to the general procedures which will be followed when a person referred for services has a sensory, cognitive, physical or communicative impairment which requires an adaptation or accommodation in conducting the assessment or delivering services or when a person's language or form of communication is one in which staff of the program are not fluent.

(c) The type of information to be obtained from or about a person seeking services.

(d) Criteria for deciding when emergency mental health services are needed and for determining the type of service to be provided.

(e) Procedures to be followed for referral to other programs when a decision is made that a person's condition does not constitute an actual or imminent mental health crisis.

(f) Procedures for obtaining immediate backup or a more thorough evaluation when the staff person or persons making the initial contact require additional assistance.

(g) Procedures for coordinating referrals, for providing and receiving backup and for exchanging information with other mental health service providers in the service area, including the development of crisis plans for individuals who are at high risk for crisis.

(h) Criteria for deciding when the situation requires a face-to-face response, the use of mobile crisis services, stabilization services, if available, or hospitalization.

(i) Criteria and procedures for notifying other persons, such as family members and people with whom the person is living, that he or she may be at risk of harming himself or herself or others.

(j) If the program dispenses psychotropic medication, procedures governing the prescription and administration of medications to clients and for monitoring the response of clients to their medications.

(k) Procedures for reporting deaths of clients which appear to be the result of suicide, reaction to psychotropic medications or the use of physical restraints or seclusion, as required by state law and for:

1. Supporting and debriefing family members, staff and other concerned persons who have been affected by the death of a client.

2. Conducting a clinical review of the death which includes getting the views of a mental health professional not directly involved in the individual's treatment that has the training and experience necessary to adequately examine the specific circumstances surrounding the death.

(3) INITIAL CONTACT.

During an initial contact with an individual who may be experiencing a mental health crisis, staff of the program shall in a welcoming and supportive manner, gather sufficient information, as appropriate and possible given the nature of the contact, to assess the individual's need for emergency mental health services and to prepare and implement a response plan, including but not limited to any available information regarding:

(a) The individual's location, if the contact is by telephone.

(b) The circumstances resulting in the contact with the program, any events that may have led up to the contact, the apparent severity of the immediate problem and the potential for harm to self or others.

(c) The primary concerns of the individual or a person making the initial contact on behalf of the individual.

(d) The individual's current mental status and physical condition, any over-the-counter, prescription or illicit drugs the individual may have taken, prior incidents of drug reaction or suicidal behavior and any history of the individual's co-occurring disorders or abuse of alcohol or other drugs.

(e) If the individual is threatening to harm self or others, the specificity and apparent lethality of the threat and the availability of the means to carry out the threat, including the individual's access to any weapon or other object which may be used for doing harm.

(f) If the individual appears to have been using alcohol or over-the-counter, prescription or illicit drugs, the nature and amount of the substance ingested.

(g) The names of any people who are or who might be available to support the individual, such as friends, family members or current or past mental health service providers.

(4) DETERMINATION OF NEED.

(a) Based on an assessment of the information available after an initial contact, staff of the program

shall determine whether the individual is in need of emergency mental health services and shall prepare and implement any necessary response.

(b) If the person is not in need of emergency mental health services, but could benefit from other types of assistance, staff shall, if possible, refer the person to other appropriate service providers in the community.

(5) RESPONSE PLAN.

(a) If the person is in need of emergency mental health services, staff of the program shall prepare and initiate a response plan consisting of services and referrals necessary to reduce or eliminate the person's immediate distress, de-escalate the present crisis, and help the person return to a safe and more stable level of functioning.

(b) The response plan shall be approved as medically necessary by a qualified mental health professional either before services are delivered or within 5 days after delivery of services, not including Saturdays, Sundays or legal holidays.

(6) LINKAGE AND FOLLOW UP.

(a) After a response plan has been implemented and the person has returned to a more stable level of functioning, staff of the program shall determine whether any follow-up contacts by program staff or linkages with other providers in the community are necessary to help the person maintain stable functioning.

(b) If ongoing support is needed, the program shall provide follow-up contacts until the person has begun to receive assistance from an ongoing service provider, unless the person does not consent to further services.

(c) Follow-up and linkage services may include but are not limited to all of the following:

1. Contacting the person's ongoing mental health providers or case manager, if any, to coordinate information and services related to the person's care and support.

2. If a person has been receiving services primarily related to the abuse of alcohol or other drugs or to address needs resulting from the person's developmental disability, or if the person appears to have needs in either or both of these areas, contacting a service provider in the area of related need in order to coordinate information and service delivery for the person.

3. Conferring with family members or other persons providing support for the person to determine if the response and follow-up are meeting the client's needs.

4. Developing a new crisis plan under [sub. \(7\)](#) or revising an existing plan to better meet the person's needs based on what has been learned during the mental health crisis.

(7) CRISIS PLAN.

(a) The program shall prepare a crisis plan for a person who is found to be at high risk for a recurrent mental health crisis under the criteria established in the coordinated community services plan.

(b) The crisis plan shall include whenever possible all of the following:

1. The name, address and phone number of the case manager, if any, coordinating services for the person.
 2. The address and phone number where the person currently lives, and the names of other individuals with whom the person is living.
 3. The usual work, school or activity schedule followed by the person.
 4. A description of the person's strengths and needs, and important people or things in the person's life which may help staff to develop a rapport with the person in a crisis and to fashion an appropriate response.
 5. The names and addresses of the person's medical and mental health service providers.
 6. Regularly updated information about previous emergency mental health services provided to the person.
 7. The diagnostic label which is being used to guide treatment for the person, any medications the person is receiving and the physician prescribing them.
 8. Specific concerns that the person or the people providing support and care for the person may have about situations in which it is possible or likely that the person would experience a crisis.
 9. A description of the strategies which should be considered by program staff in helping to relieve the person's distress, de-escalate inappropriate behaviors or respond to situations in which the person or others are placed at risk.
 10. A list of individuals who may be able to assist the person in the event of a mental health crisis.
- (c) A person's crisis plan shall be developed in cooperation with the client, his or her parents or guardian where their consent is required for treatment, the case manager, if any, and the people and agencies providing treatment and support for the person, and shall identify to the extent possible the services most likely to be effective in helping the person resolve or manage a crisis, given the client's unique strengths and needs and the supports available to him or her.
- (d) The crisis plan shall be approved as medically necessary by a qualified mental health professional.
- (e) Program staff shall use a method for storing active crisis plans which allows ready access in the event that a crisis arises, but which also protects the confidentiality of the person for whom a plan has been developed.
- (f) A crisis plan shall be reviewed and modified as necessary, given the needs of the client, but at least once every 6 months.

(8) SERVICE NOTES.

As soon as possible following a client contact, program staff shall prepare service notes which identify the person seeking a referral for emergency mental health services, describe the crisis and identify or describe all of the following:

- (a) The time, place and nature of the contact and the person initiating the contact.
- (b) The staff person or persons involved and any non-staff persons present or involved.
- (c) The assessment of the person's need for emergency mental health services and the response plan developed based on the assessment.
- (d) The emergency mental health services provided to the person and the outcomes achieved.
- (e) Any provider, agency or individual to whom a referral was made on behalf of the person experiencing the crisis.
- (f) Follow-up and linkage services provided on behalf of the person.
- (g) If there was a crisis plan under [sub. \(7\)](#) on file for the person, any proposed amendments to the plan in light of the results of the response to the request for services.
- (h) If it was determined that the person was not in need of emergency mental health services, any suggestions or referrals provided on behalf of the person.

V. Client Service Records.

(1) MAINTENANCE AND SECURITY.

- (a) A program shall maintain accurate records of services provided to clients, including service notes prepared and crisis plans developed.
- (b) The program administrator is responsible for the maintenance and security of client service records.

(2) LOCATION AND FORMAT. Client service records shall be kept in a central place that is not accessible to persons receiving care from the program, shall be held safe and secure, shall be managed in accordance with standard professional practices for the maintenance of client mental health records, and shall be arranged in a format which provides for consistent recordkeeping within the program and which facilitates accurate and efficient record retrieval.

(3) DISPOSITION UPON PROGRAM CLOSING. An organization providing emergency mental health services under contract with the department shall establish a written plan for maintenance and disposition of client service records in the event that the program loses its certification or otherwise terminates operations. The plan shall include a written agreement with the department to have the department act as the repository and custodian of the client records for the required retention period or until the records have been transferred to a new program.

(4) CONFIDENTIALITY. Maintenance, release, retention and disposition of client service records shall be kept confidential as required under state laws.

VI. Client rights.

(1) POLICIES AND PROCEDURES. All programs shall comply with state laws on the rights of clients.

(2) CONFLICT RESOLUTION.

(a) A program shall inform clients and their parents or guardian, where the consent of the parent or guardian is required for services, that they have the option of using either formal or informal procedures for resolving complaints and disagreements.

(b) A program shall establish a process for informal resolution of concerns raised by clients, family members and other agencies involved in meeting the needs of clients.

(c) A program shall establish a grievance resolution system which meets the requirements under state law for a grievance resolution system.

VII. Client satisfaction.

(1) Each program shall have a process for collecting and recording indications of client satisfaction with the services provided by the program. This process may include any of the following:

(a) Short in-person interviews with persons who have received emergency services.

(b) Evaluation forms to be completed and returned by clients after receiving services.

(c) Follow-up phone conversations.

(2) Information about client satisfaction shall be collected in a format which allows the collation and comparison of responses and which protects the confidentiality of those providing information.

(3) The process for obtaining client satisfaction information shall make allowance for persons who choose not to respond or are unable to respond.

(4) Prior to a recertification survey, the program administrator shall prepare and maintain on file a report summarizing the information received through the client satisfaction survey process and indicating:

(a) Any changes in program policies and operations or to the coordinated community services plan made in response to client views.

(b) Any suggestions for changes in the requirements under this chapter which would permit programs to improve services for clients.

APPENDIX E: RFP for EMHCS

Request for Proposal (RFP) Iowa Department of Human Services Division of Mental Health and Disability Services

Emergency Mental Health Crisis Services

Purpose:

The Iowa Department of Human Services (IDHS), Division of Mental Health and Disability Services (MHDS) are seeking an organization to implement and manage comprehensive and integrated mental health crisis services. The goal of these crisis services will be to support the recovery and wellness of the individual through the use of clinical best practices of care, and with the use of natural and community supports wherever possible and appropriate, while facilitating access to appropriate emergency mental health treatment when needed. Services will include: a warm line, telephone crisis service, walk-in crisis service, mobile crisis service, and crisis residential service. The successful program will work collaboratively with MHDS and other community providers and inpatient psychiatric units within the region served by the program. The services will be available 24 hours a day, 365 days a year.

Respondents of this Request for Proposal must be a community mental health center accredited by IDHS/MHDS and may not be a provider of acute inpatient hospitalization services.

Pre-proposal Conference:

There will be a pre-proposal conference

Please note:

- Candidates are asked to limit attendance to two (2) people from your organization.
- Candidates need to RSVP to the RFP project officer, Charles Leist with the names of those planning to attend by close of business on
- Mr. Leist can be contacted at
- Questions for consideration at the pre-proposal conference must be submitted to Mr. Leist by close of business on

Questions should be submitted in writing by email to:

Any questions that arise after the pre-proposal conference should also be directed to the RFP project officer in the manner indicated above. The MHDS will accept questions up *until* _____ **5:00 p.m. All answers to questions will be distributed by** _____

Letter of Intent:

All candidates interested in submitting a proposal to provide EMHCS are required to submit a letter of intent by _____ The letter of intent should include, at minimum, the following:

- Name of the organization and partnering organization if applicable.
- Affirmation that the organization intends to submit a proposal to provide crisis services, and specifics about which services each agency within a partnership is intending to provide, if partnership arrangements are part of your proposal.
- Name, address, telephone number, and email address of the contact person for the proposal

Note: Respondents must apply with at least one other CMHC that is contiguous to their current county service area.

Only proposals from candidates that have submitted letters of intent will be considered.

Conflict of Interest:

If you are proposing that any portion of the EMHCS is arranged through a partnership with another organization, you will need to describe any potential conflict of interest and how you will address and resolve this and include with the letter of intent.

Communication Protocol: Contact with MHDS staff, concerning this RFP, unless occurring at the pre-proposal conference or through the RFP project officer, are grounds for disqualification. Funneling all questions through the RFP project officer, who will disseminate all questions and answers to candidates that submit letters of intent, ensures that all interested parties will receive the same information.

Important Dates:

_____	Pre-proposal conference
_____	Letters of intent to respond to the RFP due
_____	Proposals due
_____	Proposal review by the Review Panel
Week of _____	Short-listed candidate interviews

GENERAL REQUIREMENTS.

Background:

In preparation for this RFP, MHDS organized a stakeholders committee on EMHCS. This meeting was held on: _____.

The stakeholders included consumers, family members, providers and payers. The stakeholders committee reviewed a number of different information resources

1. Mental Health Systems Improvement Recommendations
2. Surgeon General's Report on Mental Health
3. Other EMHCS documents

Essential Elements of MHDS Vision for an EMHCS System:

1. Vision:

To build a fully integrated EMHCS system that utilizes a problem-solving approach that markedly increases access to a comprehensive range of person-centered, recovery-oriented crisis management and avoidance services. These services will provide opportunities to meet individuals' emergent needs, while serving them in the least restrictive setting and promoting and preserving community integration.

2. Mission:

For persons experiencing psychiatric crisis, a competent EMHCS system should be able to:

- a. Assist individuals in crisis to resolve crisis situations in a welcoming person-centered, empathic, recovery-oriented manner that helps people maintain themselves in natural settings whenever possible, while prioritizing a response to those who present a danger to themselves or others.
- b. Provide timely and accessible aid in a caring and recovery-oriented manner;
- c. Provide access to a wide range of recovery-oriented crisis stabilization options;
- d. Assist in stabilization as quickly as possible and assist consumers in returning to their pre-crisis level of functioning.
- e. Increase and maintain consumers community tenure;
- f. Aid in increasing consumers ability to recognize and deal with situations that may otherwise result in crises;
- g. Increase or improve consumer's network of community and natural supports, as well as their use of these supports for crisis avoidance and prevention; and
- h. Be cognizant of the stewardship of public funds

3. Services required:

- a. Consumer Driven Warm Line Services

- b. Telephone Crisis Services staffed by skilled recovery-oriented professionals to assess, make appropriate referrals, and dispatch mobile teams when appropriate;
- c. Walk-In Crisis Services
- d. Mobile Crisis Units who can respond to a crisis at the location where the crisis is occurring, within 45-60 minutes, with the primary goal of stabilization and diversion.
- e. Emergency Core Provider intake
- f. A range of Crisis Residential services to include:
 - A licensed Crisis Residential (8 beds), and
 - Crisis Diversion/Stabilization/holding beds (2)
- g. Access to Emergency psychiatric evaluation for adults and children.

4. Operations:

The EMHCS response system must:

- Provide clinically skilled and empathic assistance to individuals and families in crisis in order to help them avoid a crisis state when possible
- Conduct assessments of the person in crisis to determine an appropriate management plan
- Provide individuals who are in crisis the skilled help they need to keep both themselves and others safe during the crisis and to manage the situation as calmly and safely as possible
- Provide a range of crisis services that divert people from inpatient psychiatric hospitalization and emergency rooms whenever possible, to more recovery-oriented and less restrictive service alternatives;
- Operate 24 hours a day, 365 days a year
- Ensure that the physical setting is safe, secure, and conducive to best practice crisis management
- Provide assistance with completion of petitions and facilitation of access to involuntary evaluation and treatment pursuant to Iowa Code:
- Provide appropriate linkages and arrangements that eliminate or decrease the use of law enforcement as the primary responder to individuals in crisis, thus minimizing the criminalization of persons with behavioral crises
- Provide recovery oriented services that are adequate for individuals with multiple service needs, including but not limited to individuals with co-occurring disorders (e.g. substance abuse, mental retardation, traumatic brain injury, dementia,) and /or accompanying medical conditions as well as being sensitive to the special needs of older adults, children and adolescents
- Recruit and retain appropriately skilled and trained, linguistically, culturally competent and recovery-oriented staff
- Coordinate with the consumer's primary behavioral health provider
- Actively coordinate with staff from other service systems (Elder Services, Juvenile Justice, AEAs, etc.) to ensure appropriate outcomes
- Assist with transitioning the consumer from one level of service to another
Assure follow-up and post-crisis care with individual and significant others

- Incorporate evaluation and quality improvement protocols to measure the effectiveness of the crisis services
- Participate in MHDS contracted outcomes measurement systems
- Participate in MHDS Information Systems utilization and data reporting
- Market the service so general public as well as primary care physicians are aware of the service
- Develop a disaster contingency plan for interrupted phone service and other emergencies.
- Obtain appropriate licensing from MHDS for each service
- Develop service agreements with all appropriate inpatient behavioral health units and managed behavioral healthcare insurance companies

5. Staff Competencies:

Individuals staff must be dually trained (mental health and substance abuse) and competent for serving children, adolescents, adults and older adults, or the program must have staff from all competency areas at all times.

Staff competencies must include:

- Cultural competence
- Co-Occurring Disorders (MH/SA, MH/MR)
- Criminal Justice
- Adults
- Older adults
- Children and Adolescents

6. Supervision:

The program will have a supervisory structure sufficient to assure program standards as well as providing support for continuous quality improvement.

7. Record Keeping:

Must comply with MHDS and Medicaid documentation regulations.

8. Information Technology System:

The successful applicant will demonstrate:

A data management system that allows for

- Immediate access to client and resource data needed to provide clinically informed, efficient, safe, and coordinated crisis interventions and triage
- Measurement of performance against expected standards, outcome measurement, and monitoring and evaluation of program and service quality, especially in relation to effectiveness in reaching underserved populations.
- Call center technology to document all calls providing sufficient call detail and transfer capabilities
- Internet access, resource database, an electronic documentation and reporting system
- Capability to interface with the data collection system utilized to report to

- MHDS and Medicaid and invoice accordingly.

9. Quality Improvement:

Policies and procedures to support continuous quality improvement are essential. The successful applicant will demonstrate the capability to implement standard QI measures including recovery-oriented measures. Examples are:

- Track telephone responsiveness (# of rings until answer, hang-ups, etc) and utilization monthly
- Record and monitor phone calls for supervision, training and quality assurance
- Track incoming phone calls
- Tracking mobile crisis visits
- Track participation with inpatient treatment teams
- Track involvement in linkage with outpatient services post inpatient care
- Track utilization of assessments and outcomes measures.

In addition, the agency will have plans to develop a strong quality improvement plan focusing on improving both process and functional outcomes.

10. Collaborative Efforts:

The program will actively build collaborative operations with: Law Enforcement, Emergency Rooms, Inpatient Psychiatric facilities, school districts, prison/Youth Center, and community mental health providers.

The program must have protocols to support warm transfers and post-crisis follow up to other services or levels of care.

11. Community Advisory Board:

The Program must have community oversight from a community advisory committee with input from the payers, and made up of stakeholders (Core Providers, other providers of mental health services, Police, Transportation, Education, Elder Affairs, Corrections, AEA's, ARC, NAMI, consumers representing as many different interest groups as possible,) including representatives from underserved communities.

Duties will include the evaluation of the EMCHS system, consulting on cultural competency of providers and assisting with public relations.

Detailed Specifications

A. Consumer Driven Warm Line Capacity (Estimate 5 calls/day)

Warm lines are designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peer-run warm lines are a relatively new pre/post-crisis service. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers. Although a number of different service delivery models are practiced, this RFP requires that the EMHCS service be staffed a balanced manner including consumers, families, and mental health professionals, and that it be office-based.

Service Operations

- Help callers build peer support networks and establish relationships,
- Active listening and respect for consumer boundaries,
- Assure callers are safe for the night
- Facilitate a warm transfer to appropriate crisis services in an emergency

Operates 7 days/week, 4 hours weekday evenings, 6 hours weekend days

Staffing Supervision:

Masters level mental health professional.

Crisis Response Staff:

Appropriately experienced individuals who have passed the required training to operate a warm-line telephone support service. Appropriate experience and training includes any of the following:

- At least two years of working as a mental health or other related human service professional
- Qualification as a Certified Peer Specialist.
- Community residents who pass the required training and who can demonstrate the required competencies.

B. Telephone Crisis Service. (estimate: 450 calls/monthly)

The telephone crisis service is a 24-hour 7-day a week “hot-line” service that provides appropriate counseling, consultation and referral to individuals who are exhibiting acute symptoms of disturbed thought, behavior, mood, or social relationships, and to the families, friends or colleagues of those individuals on their behalf.

The goal is to support the person in such a way as to assure their safety and the safety of those around them, and to facilitate those actions that will best support their wellness and recovery.

Service Operations

- Operate 24 hours/365 days a year
- Provide counseling, consultation and information and referral services both to individuals (adults, older adults, and children) in distress and to people calling on behalf of those individuals.
- Provide recovery-oriented, person-centered services
- Coordinate crisis services across behavioral health service continuum including:
 - outpatient mental health and drug and alcohol providers,
 - inpatient providers,
 - case management services,
 - children and youth services,
 - aging services,
 - care managers from payers of service including Medicaid/Magellan
- Work effectively with 911 and other emergency services, including the police and Courts
- Provide phone follow up on mobile crisis services
- Directly transport and/or arrange for the safe and considerate emergency transport of individuals in crisis for treatment

Telephone crisis services are billable to Medicaid/Magellan and should also be billed, as indicated, to the individual’s commercial insurance carrier through network agreements where possible.

Staffing Supervision:

Supervisory staff must be at least licensed Masters level clinicians (LSW, LCSW, ACSW, or nurse with psychiatric experience)

EMHCS Staff:

- Crisis response staff should be Master’s level clinicians, (as above) if possible.
- Bachelor’s level clinicians are also acceptable with appropriate supervision and crisis training.
- Access to a psychiatrist for consultation and/or emergency evaluations when needed 24/7

C. Walk-In Crisis Services (estimate up to 50/month)

Walk-in crisis service is provided at a designated site where staff has face-to-face contact with individuals in crisis or with individuals seeking help for persons in crisis. The facility and program must be licensed according to MHDS accreditation regulations.

Service Operations

- Operate 24 hours/365 days a year
- Provide recovery-oriented, person-centered services in a welcoming, friendly and secure environment
- Service includes assessment and evaluation of the crisis, crisis de-escalation and direct management, recovery and strengths based crisis counseling, and accessing community resources as needed, and psychiatric and medical consultation.
- Use of an approved crisis evaluation tool(s) (should include evaluation of substance abuse issues and issues specific to older adults)
- Provide assistance with completion of petitions and facilitation of access to involuntary evaluation and treatment pursuant
- Act, where this is unavoidable to assure the safety of the individual or the community.
- Coordinate with _____ around petitions and warrants.
- Ensure that people are greeted immediately and served within 30 minutes of arrival
- Up to a total of three crisis counseling sessions to transition the individual in crisis into appropriate community services, and to support re-integration into the community after a hospitalization.
- Directly transport and/or arrange for the emergency transport of individuals in crisis for treatment

Staffing Supervision:

□ Supervisory staff must be at least licensed Masters level clinicians (LSW, LCSW, ACSW, or nurse with psychiatric experience)

Staff:

- Crisis response staff should be Master's level clinicians, (as above) if possible.
- Bachelor's level clinicians are also acceptable with appropriate supervision and crisis training.
- Access to a psychiatrist for consultation and/or emergency evaluations when needed 24/7
- Access to psychiatrist for bridge medication prescriptions 24/7
- Peer support (Certified Peer Specialist or similar)

D. Mobile Crisis Services (estimate approximately 50 per month and expect to increase with diversion focus)

Flexible mobile crisis teams are at the core of the vision for the MHDS EMHCS system. Mobile teams have the capacity to intervene quickly, day or night, wherever the crisis is occurring (e.g. homes, emergency rooms, police stations, outpatient mental health settings, schools, etc.) These teams can serve persons unknown to the system and should work closely with the police, crisis hotlines, hospitals, and ambulance, emergency services personnel. Mobile teams can operate out of a wide variety of locations, either centralized or distributed throughout the community. Although some mobile crisis teams may specialize in servicing adults or children exclusively, it is important to note that these teams often become involved in treating the entire family or other support system. In designing mobile crisis teams, it is critical to remember that what these teams do is far more important than the specific logistics of their operation. Mobile teams will be dispatched for most potential to intervene directly in an attempt to de-escalate the crisis and develop alternatives to involuntary hospitalization whenever possible.

While one of the goals of a mobile team is to provide recovery-oriented services that will link consumers to community support services, teams vary in their capacity to accomplish this task. Clear channels of access that are established between the team and community programs prior to team operations greatly enhance this effort.

Service Operations

- Provide recovery-oriented, person-centered services
- Operate 24 hours /365 days a year
- Emergency dispatch of mobile crisis teams to any location in the provider's service area.
- Ensure program responsiveness (*Response time is defined from the point at which it is identified that a mobile visit is appropriate to the arrival at the place where the individual is*)
 - 45 minutes is the goal for 75% of dispatches
 - Not to exceed 60 minutes

Service includes

- Assessment and evaluation of the crisis
- Crisis de-escalation and direct management
- Recovery and strengths based crisis counseling,
- Accessing community resources as needed,
- Psychiatric and medical consultation.
- Use of an approved crisis evaluation tool(s) (should include evaluation of substance abuse issues and issues specific to older adults)
- Ensure a warm transfer to appropriate follow-up community based counseling services
- Provide assistance with completion of petitions and facilitation of access to involuntary

- evaluation and treatment pursuant to state commitment procedures where this is unavoidable to assure the safety of the individual or the community.
- Coordinate with _____ around petitions and warrants
- Directly transport and/or arrange for the emergency transport of individuals in crisis for treatment.
- Provide transition support from inpatient care to community based services as follow up for those individuals they hospitalized through the crisis service.

Staffing Supervision:

Supervisory staff must be at least licensed Masters level clinicians (LSW, LCSW, ACSW, or nurse with psychiatric experience)

Staff:

Mobile crisis should be organized as teams. Teams will include:

- experienced Master level clinicians (LSW, LCSW, ACSW, or nurse with psychiatric experience)
- access to a psychiatrist for consult and/or emergency evaluations 24/7 when needed access to psychiatrist for bridge medication prescriptions 24/7 and can include:
 - peer support (Certified Peer Specialist or similar)
 - Bachelor's level clinicians
- Core mobile crisis team staff on duty should be dedicated to the mobile team only, at that time.
- Supplementary team members may be on call with appropriate on-call arrangements
- Staff must understand and operationalize their role as part of a service intended to meet the immediate need of the person and prevent the need for inpatient hospitalization.

E. Stabilization Services/Recovery Beds (estimated at 2 beds) and Crisis Residential Services (estimated up to 6 beds up to 10 days)

Focus of this service is to be a diversionary service to inpatient hospitalization. Crisis stabilization beds and crisis residential services are for adults aged 18 and over. Services are provided in a small residential facility that provides accommodation and continuous supervision for individuals in crisis who will agree to stay, and who will be safe, at this level of care in the community.

The service provides a temporary place to stay for individuals who need to be removed from a stressful environment or who need a short time to re-stabilize. Ideally the facility should be located in the same building as the crisis services or immediately adjacent. Access must be through approved referral sources. The facility must be licensed through MHDS Accreditation.

Approved Referral Sources:

- Walk-ins (with authorization by _____)

- Invited in from phone call initiated from Crisis Residential Program
- Crisis Intervention Services
- Mental Health service provider
- Inpatient hospital as a step-down to community outpatient services
- Criminal justice system: probation officer, prison social worker or medical social worker

Service Operations:

- Physical facility, housekeeping and maintenance and food service shall comply with all appropriate regulations and provide a welcoming and nurturing ambience that supports people's recovery.
- Service includes assessment and evaluation of the crisis, crisis de-escalation and direct management, recovery and strengths-based crisis counseling, and accessing community resources as needed, and psychiatric and medical consultation.
- Use of an approved crisis evaluation tool(s) (should include evaluation of substance abuse issues and issues specific to older adults)
- Medical Clearance: (def: - *an evaluation by a licensed physician who affirms that no medical conditions are present which preclude involvement in the placement.*)
- Either: Provider must have procedures in place to ensure that all individuals have medical clearance before admission, Or: Medical and nursing examination and diagnosis is available on site for all admissions who are housed over 24 hours.
- Prescription and administration of medication
- Moderate to high medical need/intensive medication monitoring
- Referral to D&A Detoxification and/or Residential Rehabilitation when medically necessary
- Case Management, including assistance with benefits applications and referrals for housing and community treatment.
- Development of an aftercare plan with community mental health resources/natural supports
- AA/NA or Dual Recovery meetings on site (or support and outreach to attend meetings in the community)

Staffing Supervision:

Supervision of the unit and individual supervision shall be provided by a physician, a registered nurse qualified as a Crisis Worker II, or a Licensed Master's Level Mental Health Professional.

Staff:

- Service is provided by treatment teams composed of at least one medical professional qualified to prescribe and administer medication and another person who is a mental health professional or Crisis Worker II.
- Two awake staff shall be on duty at all times, one of whom meets the qualifications of a Crisis Worker II.

- RN on site every day during daytime hours and
- Psychiatrist (Board Certified) available 24/7, including scheduled appointments and on-call as needed for:
 - emergency consultation
 - face to face evaluations when necessary
 - scheduled appointments for prescription of medication including bridge medication
 - authorization for administration of medication
- Peer support (Certified Peer Specialist or similar)

F. Community Education and Training

EMHCS staff plays a key role in educating the broader community about recognizing and responding appropriately to mental health crises, as well as the technicalities of initiating and facilitating involuntary commitments.

Proposal Requirements

Each area is assigned a point value that will be used to determine a score that demonstrates the quality, accuracy, and comprehensiveness, while embracing the mission and vision of the service system. Maximum limit of fifty (50) pages per proposal, excluding Budget information.

A. Describe your agency's relevant organizational experience and background information. Please address each point separately. (20 points)

1. Describe how the addition of this service to the continuum of services offered by your organization is consistent with your organization's mission and vision.
2. Describe your organization's history and relevant experience in:
 - Providing crisis services for consumers of behavioral health services; and
 - Working collaboratively with the behavioral health and other related service systems
3. Describe the strengths and advantages that your organization will bring to being an EMHCS provider. Address how your organization will plan for potential consequences and stakeholder concerns.
4. Describe your organization's current level of experience with employment of peers in the service system. Further describe the role you envision for the use of peers in an integrated crisis service system. What supports your agency will provide for peer staff members.
5. Describe your organization's governance structure. Include a list of your organization's current Board of Directors, the number of consumers and family members of behavioral health services on your Board and indicate whether or not there are any requirements for consumers on your organization's Board.
6. Describe any consumer advisory committees your organization currently convenes.
7. Describe your understanding of recovery principles and how your organization incorporates these principles into its governance and day-to-day operations. Describe something creative your organization has done within the last year that illustrates this.

8. Describe your organization's current system for program and system oversight and quality improvement.
9. Describe any experience your organization has in developing outcome measures and assessing service quality and effectiveness. Describe any experience your organization has in collecting and analyzing data to produce outcome measures
10. Describe your organization's current system for assuring cultural competence.

B. Describe your agency's plans to implement the proposed EMHCS. Please address all relevant points for each type of Crisis service separately and in order.

– ***Consumer Driven Warm Line (15 points)***

– ***Phone Crisis Services (15 points)***

– ***Walk-in Crisis Services (15 points)***

– ***Mobile Crisis Services (25 points)***

– ***Crisis Residential and Stabilization Services/Recovery Beds (25 points)***

1. Describe the proposed program organization. Describe whom you will partner with and what memoranda of understand you have or will obtain.
2. Describe how you will link seamlessly to the next service and provide follow-up.
3. Describe how the service will be accessible to the public, approachable, and user friendly.
4. Describe how crisis situations will be assessed and level of care decisions made, assuring that hospitalization is the last resort in a crisis response and that as far as possible, services are provided in the person's home and community using natural and/or familiar supports.
5. Describe your triage decision process. Describe your coordination and collaboration with the continuum of Crisis services as well as dispatch time frames for each level of crisis.
6. Describe how you will meet the particular needs of children/adolescents, older adults, individuals with co-occurring disorders (MH/MR, MISA, TBI etc), and families.
7. Describe how your staff will engage family members and other natural supports.
8. Describe how safety of crisis staff will be maintained.
9. Describe how you will assure safe transportation for individuals in crisis, appropriate to their need at the time. This may include:
 - Arranging for emergency or urgent transportation to hospital
 - Driving individuals to an appointment
 - Driving individuals to Crisis Residential Program location
10. Describe how the team will determine that a crisis is resolved.
11. Demonstrate how you will provide or assure aftercare services to support transition back to the community after an inpatient stay that resulted from a crisis event.

12. Describe how you will link and coordinate with other community services, including specialized behavioral health services such as family based services and case management as well as regular outpatient services, drug and alcohol services, police, adult protective services, elder services, and housing and shelter services and also with natural community resources such as places of worship, YMCA's, and other support groups.
13. Describe how staff will provide Information/Referral/Advocacy services, and describe what system you will use to maintain up-to-date information on current community resources.
14. Describe the proposed staffing and staff supervision plan. Include staff credentials, staff competencies, staffing patterns, job descriptions, supervision requirements, and method(s) of supervision.
15. Describe how you will utilize peer specialists or peer support staff.
16. Describe detailed plans for initial and ongoing staff training to ensure that staff are appropriately trained in:
 - Crisis evaluation and management, including use of specialized evaluation tools
 - De-escalation techniques
 - Appropriate interventions for special populations: (e.g. older adults, children, individuals with co-occurring disorders, individuals with delusional thoughts,)
 - Diversion or alternatives to crisis; using recovery based options such as WRAP (Wellness Recovery Action Plans) and APD's (Advanced Psychiatric Directives).
 - Accessing community resources
 - Requirements of the criminal justice system (police, prison, juvenile detention center, District justices, Courts,) in coordination with crisis
 - Working with families
17. Describe plans for program startup. Include a description of proposed site location and co-location.
18. Mobile Crisis Service Specifics:
 - Describe how Mobile Staff will provide a warm handoff to hospital clinical staff when the team is recommending inpatient care and follow-up with hospital staff to confirm a disposition.
 - Describe how response time requirements will be met, including to outer edges of the county. Explain the strategy for dispatching mobile teams during rush hour, special events with heavy traffic, and weather emergencies.
 - Describe techniques for handling high volumes of requests and competing priorities.

General (20 points)

1. Describe the process of how warm line, hotline, mobile, walk-in and crisis residential services will flow from the first call to the array of crisis services discussed in your proposal using a decision flow chart.

2. Describe procedures to assure immediate access to other services or levels of service in an emergency.
3. Specify how you will assure warm transfers throughout the continuum of all Crisis Services, and to external services (e.g. inpatient) where appropriate.
4. Describe your proposed record-keeping system.
5. Describe the information technology system to be utilized by the proposed program.
6. Describe how your organization will assess the quality of the services. Specify who will be responsible for this assessment and what it will entail. Describe how you will use data across the continuum of crisis services to improve the quality of services, identify service system gaps and make recommendations to bridge those gaps.
7. Describe your plans for including crisis services in your organization's overall outcomes measurement plan. Identify the priority outcomes for each of the crisis services identified in your proposal and how they are related to the overall goals of the integrated crisis service.
8. Describe your proposed procedures for assuring that the human and civil rights of individuals in crisis are protected.
9. Describe your organization's process for addressing consumer complaints and grievances.
10. Describe how you will build an EMHCS Advisory Board of stakeholders, that includes representatives from underserved and minority communities.
11. Describe your organization's plan for marketing this service to consumers, providers, and other system stakeholders.
12. Describe plans to educate community members including general education on crisis recognition and response, and also technical education on initiating and facilitating involuntary commitments, and alternative service options.

Cost (20 points)

Provide a detailed start-up budget and an annualized ongoing service budget for each crisis service discussed in your proposal. They must include procedures that will support your ability to accept all levels of insurance. Use the supplied Excel spreadsheets (located on the website) and include a Budget Narrative.

Budget must be submitted in a separate packet, sealed in an envelope.

- Staffing Hours of Operation
 - Salary/Personnel Roster
 - Job descriptions of Medical Director, Manager, Supervisor and Staff. Specify previous experience required and number of training hours in crisis intervention
 - Start-up Budget (for each service)
 - Annualized Ongoing Service Budget (for each service)
-

All proposals must be received at the MHDS Office by **5:00 pm on**

Ten (10) copies of the proposal should be mailed or delivered to:

**Charles Leist
Department of Human Services
Mental Health and Disability Services
5th Floor, Hoover Office Building
Des Moines Iowa**

Late proposals will not be considered regardless of the reason.

APPENDIX F:

A Draft Community Mental Health Centers Bill

With respect to mental health and disability service be it enacted by the Legislature of the State of Iowa,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Iowa Community Mental Health Services Centers Act”.

SEC. 2. FINDINGS.

There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

The U.S. Congress reported that (1) almost 60,000,000 Americans, or one in four adults and one in five children, have a mental illness that can be diagnosed and treated in a given year; (2) mental illness costs our economy more than \$80,000,000,000 annually, accounting for 15 percent of the total economic burden of disease; (3) alcohol and drug abuse contributes to the death of more than 100,000 people and costs society upwards of half a trillion dollars a year; (4) individuals with serious mental illness die on average 25 years sooner than individuals in the general population; and (5) community mental and behavioral health organizations provide cost-efficient and evidence-based treatment and care for millions of Americans with mental illness and addiction disorders.

Demand for healthcare that is both clinically –effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services “Toolkits”). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

Any effort to address concerns about the quality or quantity of workers in the mental health and disabilities service system must have as its goal *sustainable, practical* approaches. The answers are not to be found solely among existing service providers, in

our institutions of higher education, or in state government. What will serve Iowa's citizens best is a structure that brings together the strengths of all of these communities with a heightened focus on real-world solutions to the on-going crisis of having a competent, committed workforce in place to support people with mental illnesses and intellectual and developmental disabilities.

The vision of this **Community Mental Health Centers** bill combined with the Department of Human Services effort to build a Mental Health and Disability Services Training Institute is to systematically (and using the evidence-base on the provision of training) build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, state employees and provider service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the mental health and disability services workforce.

SEC. 3. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS. GRANTS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

(a) DEFINITIONS. —In this section:

(1) ELIGIBLE ENTITY. —The term 'eligible entity' means a qualified community mental health program accredited by the Department of Human Services under Ch. 24 accreditation standards.

(2) SPECIAL POPULATIONS. —The term 'special populations' refers to the following three groups:

(A) Children and adolescents with mental and emotional disturbances who have co-occurring primary care conditions and chronic diseases or co-occurring mental health and substance abuse disorders.

(B) Adults with mental illnesses who have co-occurring primary care conditions and chronic diseases or co-occurring mental health and substance abuse disorders.

(C) Older adults with mental illnesses who have co-occurring primary care conditions and chronic diseases or co-occurring mental health and substance abuse disorders.

(b) PROGRAM AUTHORIZED. —The Director of Human Services through the Division of Mental Health and Disability Services, shall award state grants to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings and the provision of services for persons with co-occurring mental illness and substance abuse disorders.

(c) APPLICATION. —To be eligible to receive a grant under this section, an eligible entity shall submit an application to the Administrator of Mental Health and Disability Services at such time, in such manner, and accompanied by such information as the Administrator may require. Each such application shall include—

(1) an assessment of the primary care needs of the patients served by the eligible entity and a description of how the eligible entity will address such needs; and
(2) a description of partnerships, cooperative agreements, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

(3) a description on the manner in which the applicant will develop, provide or contract for services for persons with co-occurring mental illness and substance abuse disorders in the applicant's service area.

(d) USE OF FUNDS. —

(1) IN GENERAL. —For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

(A) the provision, by qualified primary care professionals on a reasonable cost basis, of—

- (i) primary care services on site at the eligible entity;
- (ii) diagnostic and laboratory services; or
- (iii) adult and pediatric eye, ear, and dental screenings.

(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals as well as to other coordinators of care or, if permitted by the terms of the grant, for the provision, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity, of—

- (i) endocrinology services;
- (ii) oncology services;
- (iii) pulmonary/respiratory services; or
- (iv) cardiovascular services.

(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

(D) facility improvements or modifications needed to bring primary and specialty care professionals on site at the eligible entity.

(2) LIMITATION. —Not to exceed 15 percent of grant funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

(e) GEOGRAPHIC DISTRIBUTION. —The Director of Human Services shall ensure that grants awarded under this section are equitably distributed among community mental health centers in the geographical regions of the State of Iowa and between urban and rural populations.

(f) EVALUATION. —Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Administrator the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under

the grant.

(g) REPORT. —Not later than 1 years after the date of enactment of this section, and annually thereafter, the Director of DHS shall prepare and submit to the submit to the Human Services Council and appropriate committees of Iowa Legislature a report that shall evaluate the activities funded under this section. The report shall include an evaluation of the impact of co-locating primary and specialty care in community mental and behavioral health settings on overall patient health status and recommendations on whether or not the demonstration program under this section should be made permanent. The Director of DHS shall also prepare a report for the appropriate committees of the Iowa Legislation on the implementation of co-occurring disorders services for persons with mental illness and substance that describes service utilization, scope of the population needs, development of service providers for this population, functional assessments employed and reports of any special workforce development projects for this population.

(h) AUTHORIZATION OF APPROPRIATIONS. —There are authorized to be appropriated to carry out this section \$1,000,000 for fiscal year 2009. The DHS is authorized to hire expert consultants to assist the department in the implementation of this project.

SEC. 4. INTEGRATING TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE CO-OCCURRING DISORDERS.

FUNDING. —The Secretary shall make available to carry out this section, \$250,000 for fiscal year 2009. The DHS is authorized to hire expert consultants to assist the department in the implementation of this project.

(b) COMMUNITY MENTAL HEALTH PROGRAM. —For purposes of eligibility under this section, the term ‘private nonprofit organization’ includes a qualified community mental health program as defined under Ch. 230a and Ch. 24 accreditation standards.

SEC. 5. IMPROVING THE MENTAL HEALTH WORKFORCE - GRANTS FOR RECRUITMENT AND RETENTION

ESTABLISHMENT. —The Director of DHS, acting through the Administrator of the Mental Health and Disability Services, shall award grants to community mental health centers for innovative programs to address the behavioral and mental health workforce needs of designated mental health professional shortage areas.

(b) USE OF FUNDS. —An eligible entity shall use state grant funds awarded under this section for—

(1) loan forgiveness and repayment programs (to be carried out in a manner similar to the loan repayment programs carried out under subpart III of part D) for behavioral and mental health professionals who—

- (A) agree to practice in designated mental health professional shortage areas;
- (B) are graduates of programs in psychiatry, behavioral or mental health, advanced practice nursing, physician assistants;
- (C) agree to serve in community-based non-profit entities, or as public mental health professionals for the State or local government; and
- (D) agree to—
 - (i) provide services to patients regardless of such patients’ ability to pay; and
 - (ii) use a sliding payment scale for patients who are unable to pay the total cost of services.
- (2) behavioral and mental health professional recruitment and retention efforts, with a particular emphasis on candidates from racial and ethnic minority and medically-underserved communities;
- (3) grants or low-interest or no-interest loans for behavioral and mental health professionals who participate in the Medicaid program under title XIX of the Social Security Act to establish or expand practices in designated mental health professional shortage areas, or to serve in qualified community mental health programs as defined by the Director of DHS
- (4) placement and support for behavioral and mental health students, residents, trainees, and fellows or interns; or
- (5) continuing behavioral and mental health education, including distance-based education.

(c) APPLICATION. —

(1) IN GENERAL. —Each eligible entity desiring a grant under this section shall submit an application to the Director of DHS at such time, in such manner, and containing such information as the Director may reasonably require.

(2) ASSURANCES. —The application shall include assurances that the applicant will meet the requirements of this subsection and that the applicant possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

(e) SUPPLEMENT NOT SUPPLANT. —A grant awarded under this section shall be expended to supplement, and not supplant, the expenditures of the eligible entity and the value of in-kind contributions for carrying out the activities for which the grant was awarded.

(f) GEOGRAPHIC DISTRIBUTION. —The Director of DHS shall ensure that grants awarded under this section are equitably distributed among the geographical regions of the State of Iowa, the community mental health centers in Iowa and between urban and rural populations.

(g) EVALUATION. —Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Director of DHS the results of an evaluation

to be conducted by the entity concerning the effectiveness of the activities carried out under the grant.

(h) REPORT. —Not later than 1 year after the date of enactment of this section, and annually thereafter, the Director of DHS shall prepare and submit to the Human Services Council an appropriate committees of the Legislature a report containing data relating to whether grants provided under this section have increased access to behavioral and mental health services in designated mental health professional shortage areas.

AUTHORIZATION OF APPROPRIATIONS. —There is authorized to be appropriated to carry out this section, \$500,000 for fiscal year 2009. The DHS is authorized to hire expert consultants to assist the department in the implementation of this project.

SEC. 6. GRANTS FOR BEHAVIORAL AND MENTAL HEALTH EDUCATION AND TRAINING PROGRAMS.

(a) DEFINITION. —For the purposes of this section, the term ‘related mental health personnel’ means an individual who—

- (1) facilitates access to a medical, social, educational, or other service; and
- (2) is not a mental health professional, but who is the first point of contact with persons who are seeking mental health services.

(b) ESTABLISHMENT. —The Director of DHS, acting through the Administrator of the Mental Health and Disability Services, shall within the Mental Health and Disability Services Training Institute, establish a program to increase the number of trained behavioral and mental health professionals and related mental health personnel by awarding grants on a competitive basis to mental and behavioral health nonprofit organizations or accredited institutions of higher education to enable such entities to establish or expand accredited mental and behavioral health education programs with a specific focus on community service at community mental health centers of DHS operated facilities.

(c) APPLICATION. —

(1) IN GENERAL. —Each eligible entity desiring a grant under this section shall submit an application to the Director of DSHS at such time, in such manner, and containing such information as the Director may reasonably require.

(2) ASSURANCES. —The application shall include assurances that the applicant will meet the requirements of this subsection and that the applicant possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

(d) PRIORITY. —In awarding grants under this section, the Director of DHS shall give priority to applicants that—

(1) demonstrate a familiarity with the use of evidenced-based practices in behavioral and mental health services and in the delivery of evidence-based training of behavioral health professionals and direct care staff;

(2) provide interdisciplinary training experiences; and“(3) demonstrate a commitment to training methods and practices that emphasize the integrated treatment of mental health and substance abuse disorders.

(e) USE OF FUNDS. —Funds awarded under this section shall be used to—

(1) establish or expand accredited behavioral and mental health education programs, including improving the coursework, related field placements, or faculty of such programs; or

(2) establish or expand accredited mental and behavioral health training programs for related mental health personnel.

(3) develop training programs for behavioral health workforce through the Mental Health and Disability Services Training Institute or other DHS approved training vendors.

(f) REQUIREMENTS. —The Director of DHS may award a grant to an eligible entity only if such entity agrees that—

(1) any behavioral or mental health program assisted under the grant will prioritize cultural competency and the recruitment of trainees from racial and ethnic minority and medically-underserved communities; and

(2) with respect to any violation of the agreement between the Director of DHS and the entity, the entity will pay such liquidated damages as prescribed by the Director of DHS.

(g) GEOGRAPHIC DISTRIBUTION. —The Director of DHS shall ensure that grants awarded under this section are equitably distributed among the geographical regions of Iowa and between urban and rural populations.

(h) EVALUATION. —Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Director of DHS the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant.

(i) REPORT. —Not later than 1 year after the date of enactment, and annually thereafter, of this section, the Director of DHS shall prepare and submit to the Human Services Council and appropriate committees of the Legislature a report containing data relating to whether grants provided under this section have increased access to behavioral and mental health services in designated mental health professional shortage areas.

(j) AUTHORIZATION OF APPROPRIATIONS. —There is authorized to be appropriated to carry out this section \$250,000 for fiscal year 2009. The DHS is authorized to hire expert consultants to assist the department in the implementation of this project.

SEC. 7. IMPROVING ACCESS TO MENTAL HEALTH SERVICES - GRANTS FOR TELE-MENTAL HEALTH IN MEDICALLY UNDERSERVED AREAS.

(a) PROGRAM AUTHORIZED. —The Director of DHS, acting through the Administrator of Mental Health and Disability Services, shall award grants to eligible entities to provide tele-mental health in Medically underserved areas.

(b) ELIGIBLE ENTITY. —To be eligible for assistance under the program under subsection (a), an entity shall be a qualified community mental health program (as defined in Ch. 230a).

(d) APPLICATION. —

(1) IN GENERAL. —Each eligible entity desiring a grant under this section shall submit an application to the Director of DHS at such time, in such manner, and containing such information as the Director may reasonably require.

(2) ASSURANCES. —The application shall include assurances that the applicant will meet the requirements of this subsection and that the applicant possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

(d) USE OF FUNDS. —An eligible entity shall use funds received under a grant under this section for—

- (1) the provision of tele-behavioral health services; or
- (2) infrastructure improvements for the provision of tele-behavioral health services.

(e) GEOGRAPHIC DISTRIBUTION. —The Director of DHS shall ensure that grants awarded under this section are equitably distributed among the geographical regions of the State of Iowa and between urban and rural populations.

(f) EVALUATION. —Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Director of DHS the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant.

(g) REPORT. —Not later than 1 year after the date of enactment of this section, and annually thereafter, the Director of DHS shall prepare and submit to the Human Services Council and appropriate committees of Congress a report that shall evaluate the activities funded under this section.

(h) AUTHORIZATION OF APPROPRIATIONS. —There are authorized to be appropriated to carry out this section \$250,000 for fiscal year 2009. The DHS is

authorized to hire expert consultants to assist the department in the implementation of this project.

SEC. 8. IMPROVING HEALTH INFORMATION TECHNOLOGY FOR MENTAL HEALTH AND DISABILITY SERVICES PROVIDERS.

(a) IN GENERAL. —The Director of DHS, in consultation with the Director of the Department of Public Health, shall collaborate with the Administrator of the Division of Mental Health and Disability Services to—

(1) Develop and implement a plan for ensuring that various components of the state information infrastructure, including data and privacy standards, electronic health records, and community and regional health networks, address the needs of mental health, disabilities, and substance abuse treatment providers and consumer they serve; and

(2) Finance related infrastructure improvements, technical support, personnel training, and ongoing quality improvements.

AUTHORIZATION OF APPROPRIATIONS. —There are authorized to be appropriated to carry out this section \$250,000 for fiscal year 2009. The DHS is authorized to hire expert consultants to assist the department in the implementation of this project.

SEC. 9. WAGE STUDY.

(a) IN GENERAL. —Not later than 12 months after the date of enactment of this Act, the Department of Human Services shall conduct a state- and nationwide analysis, and submit a report to the Human Services Council and appropriate committees of the Legislature, concerning the compensation structure of professional and paraprofessional personnel employed by DHS facilities (mental health institutes, regional centers for the mentally retarded, and juvenile justice centers) qualified community mental health programs as defined under Ch. 230a as compared with the compensation structure of comparable health safety net providers and relevant private sector health care employers.

SCOPE. —In preparing the report under subsection (a), the Department of Human Services shall examine compensation disparities, if such disparities are determined to exist, by type of personnel, type of provider or private sector employer, and geographic region. The DHS is authorized to hire expert consultants to assist the department in the implementation of this project.

(c) AUTHORIZATION OF APPROPRIATIONS. —There are authorized to be appropriated to carry out this section, \$150,000 for fiscal year 2009.

Summary of Appropriations Requests:

SEC. 3. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS. GRANTS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS. \$1,000,000

SEC. 4. INTEGRATING TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE CO-OCCURRING DISORDERS. \$500,000

SEC. 5. IMPROVING THE MENTAL HEALTH WORKFORCE - GRANTS FOR RECRUITMENT AND RETENTION. \$250,000

SEC. 6. GRANTS FOR BEHAVIORAL AND MENTAL HEALTH EDUCATION AND TRAINING PROGRAMS. \$250,000

SEC. 7. IMPROVING ACCESS TO MENTAL HEALTH SERVICES - GRANTS FOR TELE-MENTAL HEALTH IN MEDICALLY UNDERSERVED AREAS. \$250,000

SEC. 8. IMPROVING HEALTH INFORMATION TECHNOLOGY FOR MENTAL HEALTH AND DISABILITY SERVICES PROVIDERS. \$250,000

SEC. 9. WAGE STUDY. \$150,000

Total: \$2,650,000

APPENDIX G

STATE OF IOWA CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS IMPLEMENTATION PROJECT CHARTER DOCUMENT

(1/24/08 REV.)

OVERVIEW

Individuals with co-occurring psychiatric and substance disorders and disabilities (COD) in Iowa are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. These individuals are frequently inadequately served in both mental health and substance abuse treatment and other disability settings, resulting in over-utilization of resources in the service systems they routinely access. In addition to having poor outcomes and high costs, individuals with COD are prevalent in all behavioral health settings. The prevalence of COD should be considered an expectation, rather than an exception within service systems.

We are using the broad, and somewhat imperfect terminology “co-occurring psychiatric substance disorders and disabilities” to reflect our recognition that in our system of care there are many people and families with many areas of complex struggle – not just mental health, substance abuse and gambling problems, but medical disorders and disabilities, cognitive and developmental disorders and disabilities, criminal justice system involvement and incarceration, homelessness and housing instability, domestic violence and trauma, parenting and child protection issues, and so on. We are starting this process by bringing together the system to start with co-occurring mental health and substance abuse services, but we also are acknowledging the need to develop competency to address complexity generally in a recovery oriented system, and to continue to welcome and engage other potential partner systems (health, developmental disability) to join us in the process as we make progress over time.

In 2005, Iowa appointed a team to attend a national policy academy and provide recommendations for system transformation. Continuing to work in Iowa, the team developed a report that contained specific recommendations for implementing a range of state level systems change strategies to provide more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with COD.

The Policy Academy Team adopted a consensus vision for the state, which is part of this current Charter document:

Every Iowan (EVERY IOWAN) will have access to integrated mental illness and substance use disorder services that are welcoming and responsive to their individual hopes and needs and support the recovery of individuals and families who need integrated care.

The COD workgroup has recommended that a charter process be initiated, that it be adopted by the COD Policy Academy, and that the MHDS Systems Improvement Steering Committee align the COD charter with any other workgroup charter documents.

Comprehensive, Continuous, Integrated System of Care

In order to implement the recommendations of this report, Iowa has convened key stakeholders including consumers, family members, state and county agency representatives providers, advocacy groups, and other interested parties that have agreed to adopt a comprehensive, continuous, integrated system of care model for designing statewide systems change to improve access and outcomes for individuals with COD. These stakeholders are committed to transforming the system to address COD needs within the context of existing resources.

In this model **every program becomes a co-occurring disorder program meeting basic standards of co-occurring disorder capability, and every one who does clinical care becomes a co-occurring disorder clinician having core competency in addressing co-occurring disorders.** The specific criteria for co-occurring disorder capability for each type of program and the specific criteria that define co-occurring disorder competency for each type of clinician and each level of training is intended to be defined in the course of this process. What is important however is to recognize that each program can be organized to become co-occurring disorder capable within its own mission, within its current license, and in relation to the population it customarily serves. Similarly, co-occurring disorder competency for clinicians does not mean that each clinician needs to get dually licensed, but rather that each person (even with no license) has a set of competencies to provide appropriate interventions within their level of training to the people and families that are currently in their caseloads.

This model is based on the following eight clinical consensus best practice principles (Minkoff, 1998, 2000).

- COD is an expectation, not an exception. This expectation has to be included in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.
- The core of treatment success in any setting is the availability of empathic, hopeful treatment relationships and organizational structures and changes that provide integrated treatment and coordination of care during each episode of care, and, for the most complex patients, provide continuity of care across multiple treatment episodes.
- Assignment of responsibility for provision of such relationships can be determined using the **four quadrant national consensus model for system level planning**, based on high and low severity of the psychiatric and substance disorder.
- Within the context of any treatment relationship, case management and care, based on the person's impairment or disability, must be balanced with empathic detachment, contracting, and opportunity for contingent learning, based on the person's goals and strengths, and availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.
- When COD is present, each disorder should be considered primary, and integrated multiple primary treatment is optimal.
- Mental illness and substance dependence are examples of chronic disorders that can be understood using a culturally responsive recovery model. These disorders have parallel phases of recovery (acute stabilization, engagement and motivational enhancement,

prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change.

- Treatment of any problem involves a combination of recommendations and teaching the skills to follow those recommendations. In addition, treatment must be matched not only to the diagnosis, but also to the phase of recovery and the stage of change. Treatment interventions are also matched to developmental level and level of cognitive ability.
- Outcomes must be individualized, including harm reduction; movement through stages of change; changes in type, frequency, and amounts of substance use or psychiatric symptoms; improvement in specific disease management skills and treatment adherence.

Using these principles, we have agreed to implement a comprehensive, continuous, integrated system of care in Iowa, with the following four core characteristics:

- A comprehensive, continuous, integrated system of care model requires participation from all components of the behavioral health system, with the expectation of achieving COD capability standards and planning services to respond to the needs of persons with COD.

These components include but not limited to:

- The Governor's Office
- The Iowa Legislature
- Iowa Department of Human Services
 - Mental Health and Disability Services
 - Facilities (MHIs, RCs, Juvenile Facilities)
 - Contractors
 - Iowa Medicaid Enterprise
- Iowa Department of Public Health
- Iowa Division of Insurance
- Iowa State Association of Counties
- Licensing/Certification Boards
- Iowa Department of Corrections
- Community Corrections Facilities
- Jails, Prisons
- Area Educational Authorities
- Courts/Magistrates
- Law Enforcement Officials
- University of Iowa Center for Disabilities Development
- Community Mental Health Centers
- Licensed Substance Abuse Providers
- Community Hospital Behavioral Health Units and Emergency Departments
- Private Behavioral Health Providers
- Health Care Providers
- MHRDDBI Commission
- Mental Health Planning Council
- Human Services Council
- Advocacy Organizations
- Family Organizations
- Iowa Department of Education
- Legislature
- Iowa Department of Insurance

- This model will be implemented initially with existing operational funding, within the context of existing treatment resources, by maximizing the capacity to provide reimbursable integrated treatment proactively within each single funding stream, contract, and service code.
- This model will incorporate utilization of the full range of evidence-based best practices and clinical consensus best practices for individuals with COD and promotes integration of appropriately matched best practice(s) treatments for individuals with COD.
- This model will incorporate an integrated treatment philosophy and common language using the principles listed above, to develop specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the system of care.

Action Plan

A. STATE INTERAGENCY COLLABORATION

1. Participating organizations or entities will each adopt this consensus document as an official policy statement, and disseminate it in official material to their constituencies, and incorporate its elements into official planning documents and other publications.
2. All statewide provider, consumer, and family organizations, (e.g., MHRDDBI Commission, Olmstead Task Force, Mental Health Planning Council), including, but not limited to those represented on the COD Policy Academy, will be offered an opportunity to participate in implementation of the COD plan, and to provide official resolution in support of this process.
3. The State will build on the Policy Academy to create a representative Steering Committee to oversee the statewide CQI process. Representation will be from: Iowa Department of Human Services (DHS), Iowa Department of Public Health (DPH), Iowa Department of Corrections (DOC), provider associations (including Iowa State Association of Counties, Iowa Association of Community Providers, Iowa Coalition of Children and Families, Iowa Substance Abuse Program Directors Association, Iowa Hospital Association, etc.), consumer advocacy organizations (i.e., NAMI, etc.). See above for detailed list of representatives.
4. The COD Steering Committee (#3 above) will provide project management, leadership and a partnership between the State and stakeholders and will oversee the planning and development of an infrastructure to communicate progress.
5. In particular, DHS and DPH are making a commitment to engaging in welcoming partnerships with providers, and to developing a process by which provider monitoring emphasizes a CQI partnership for this and other improvement activities.
6. DHS and DPH, along with providers, commit to partnerships with consumers, families and other system customers in designing, monitoring and evaluating the quality improvement activities and workgroups that are part of implementation.
7. IDHS and IDPH along with IDOC and AEAs will meet together regularly at the executive leadership level to review recommendations by the steering committee and to align policy statements to create consistent language. Each agency will have the goal of developing a policy statement that states that each agency is a priority client of the other for consultation, support, education, technical assistance, and outreach regarding COD services.

8. State agencies will make a commitment to improve welcoming and access for individuals and families with COD, by developing a process to create a statewide emergency services system that is a safety net service and which is aligned with this vision, and in which all services are designed to be COD capable.
9. State agencies will make a commitment to improve welcoming and access for individuals and families with COD, by developing a process to ensure that the statewide children's mental health is aligned with this vision, and that all services are designed to be COD capable.
10. Each state entity will use its incentive dollars (e.g. Federal block grant dollars, Magellan community reinvestment) to support COD capability development, and to continue to emphasize using EBP and consensus best practices to build universal capacity rather than just special programs.
11. State agencies will develop an initial process for regulatory clarification of what is permissible in COD services and develop a process to review and revise rules and regulations. DHS-MHDS and DPH will work on creating developmental language for accreditation and licensure that is mutually aligned and aligned with this process
12. State agencies will utilize the COFIT as a system fidelity outcome tool for measuring progress in CCISC implementation to create a baseline score and continue to use the tool at 12 month intervals to measure progress in this initiative
13. State agencies will initially encourage provider agencies to participate in this project voluntarily and will gradually increase expectations for providers to perform universal screening, identification, and data collection for COD services. This will promote systems transformation and attainment of COD capability, as part of contract requirements in future years
14. DHS will collaborate with IME to issue interpretive guidelines of existing regulations to clarify how providers can most efficiently use their existing funding to receive reimbursement for integrated treatment and to promote the capability of providers to offer co-located COD services.
15. Each State agency will develop policies and establish culture regarding welcoming COD persons into services.
16. Each State agency will develop a policy regarding integrated screening
17. Each State agency will encourage and incentivize providers/entities in each region to organize system development activities on a local level.
18. DHS will work with other state agencies and outside entities to enable each information system to collect basic data on COD prevalence.
19. DHS and DPH will develop mechanisms to organize statewide training (including a statewide change agent team initiative), consultation, and technical assistance to providers participating in this initiative (whether voluntarily or through contract requirement) to help each provider achieve implementation of the action steps listed below.

20. Create an organized communication network that disseminates information to all stakeholders in an organized and complete manner.

B. COLLABORATION WITH CONSUMER, FAMILY, ADVOCACY and PROVIDER ORGANIZATIONS

1. Provide official communication of participation to the State indicating they will adopt this consensus document as an official policy statement of the agency or participating organization, with approval of their governing board or equivalent.
2. Circulate the approved document to all staff or organizational members, including consumers and families involved in organizational change. Organizations will provide basic introductory training to all staff and involved consumers/families regarding the principles, the model, and statewide COD activities.
3. Assign leadership, staff, consumers, and families to participate in developing an empowered leadership team at the agency/entity level for internal quality improvement in this project, as well as representatives to participate in state level integrated system planning and program development activities.
4. Adopt the goal of achieving COD capability as part of the agency's/entity's short and long range strategic planning and quality improvement processes.
5. Participate in a self-survey at twelve-month intervals to evaluate the current status of COD capability.
6. Develop an action plan outlining measurable changes at the agency/entity level, the program level, the clinical practice level, and the clinician competency level to move toward COD capability.
7. Monitor the progress of the action plan at six-month intervals.
8. Participate in system wide training and technical assistance with regard to implementation of the action plan.
9. Participate in system wide efforts to improve identification and reporting of individuals with COD by incorporating specific improvements in screening and data collection in the action planning process.
10. Participate in system wide efforts to improve welcoming access for individuals with COD by adopting specific welcoming policies, materials, and expected staff competencies.
11. Participate in system wide efforts to enhance efficiency of utilization of existing funding for integrated treatment, by adopting instructions for how staff can bill for integrated services within a single funding stream, once instructions are provided by the state.
12. Assign appropriate clinical leadership to participate in locally based interagency systems planning.
13. Agree to participate in ongoing technical assistance/training and support to ensure consistent development and implementation of systems transformation efforts.
14. Invite staff, consumers, and families to participate in system wide efforts to develop COD capability standards, and systemic policies and procedures to support welcoming access in both emergency and routine situations.

15. Each agency should agree to take concrete steps to support and facilitate the development of at least one COD support (i.e., Dual Recovery) meeting in its local community, in collaboration with local consumer networks when available.
16. Participate in system wide efforts to identify scopes of practice, as well as core competencies (attitudes, values, knowledge, and skills) for all clinical and direct service staff regarding COD, and adopt the goal of COD competency for all clinicians in the agency as part of the long range plan.
17. Participate in clinical direct service staff competency self survey at twelve-month intervals, and use the findings to develop an agency specific training and COD competency development plan.
18. Identify appropriate clinical and administrative staff, as well as consumers and families to participate as trainers/change agents in the systems and to participate in the implementation of the agency's/entity's COD action plan.

APPENDIX H:

Vision for the Behavioral Health Workforce

Overview

Although it is well documented that having health and behavioral health care coverage greatly increases an individual's ability and willingness to access health care services, having health care coverage alone does not ensure access to health care services. Access requires that a sufficient number of appropriate health and behavioral health care professionals is available.

Globally, nationally, and locally the health care delivery system is facing a health workforce shortage. Iowa's situation is made even more acute by demographic factors such as an increasingly aging portion of the population (a population that also places more demand on the health and long-term care system), a more rural population an increasing portion of which are elderly compounded by a trend of workers leaving rural counties, and an increasing number of health care professionals reaching retirement age at a time when the population base of younger workers is decreasing. The supply of workers is also affected by pay, benefits, working conditions, nearby employers who can pay more (rural versus urban), national and global competition, and the state's educational system capacity for producing health professionals. The vision for the health care workforce is to provide a structure to coordinate health workforce planning, recruitment and retention efforts, and data collection, tracking, and accessibility efforts to stabilize and increase workforce capacity and to provide a basis for data-driven decision-making. Recruitment, retention, and education efforts should be enhanced through expansion of loan repayment and loan forgiveness opportunities, availability of an increased number of residencies and internships, and provision of technical assistance and mentoring strategies.

Efforts should continue to provide reimbursement of health professionals at a level competitive with the global and national markets. Recognition of the contributions of nurses, physician assistants, direct care workers and other medical providers needs to be represented by being a full partner in the health care system. The Commission sees a future where all health care workers should be provided health care coverage, especially the direct care workers who find they providing essential health care services but 45% of them cannot afford coverage themselves.

And in conclusion, the health care workforce of the future should focus more on wellness and prevention, i.e., a "health care" not a "sick care" system, and should maximize best practices and efficiencies in the delivery of services. To achieve this, our medical education institutions will need to upgrade their curriculum and be more pro-active in teaching preventive medicine. And the public should be made aware of the health workforce shortage and its impact.

Health and Behavioral Health Provider Shortages in Iowa.

Given Iowa's large rural and aging population, Iowa is facing significant challenges in recruiting and retaining an adequate supply of health and behavioral health care professionals. A 2005 report undertaken by the Iowa Department of Public Health through the *Center for Health Workforce Planning*, reported the following findings related to the healthcare workforce:

- In descending order of prevalence the professions include psychologists (47%), health services providers (45%), marital and family therapists (38%), nursing

home administrators (38%), mental health physicians (35%), mental health counselors (34%), dentists (34%), social workers (28%), advanced nurse practitioners (24%), physicians and registered nurses (23%), and chiropractors, licensed practical nurses, optometrist, and pharmacists (22%).

- The professions serving the mental health needs of lowans have the highest combined percentage of licensees age 55 and older and are at greatest risk of having a shortage of workers.
- There are fewer individuals entering at least 10 licensed professions. There are fewer 30 to 40 year olds in the majority of the professions than there are 40 to 50 year olds and often there are fewer 40 to 50 year olds compared to 50 to 60 year olds in a profession.
- These declines will impact the future ability of these professions to provide adequate services, especially to an aging population.
- All but five of Iowa's health care occupations exceed the national average of workers who are age 55 and older, increasing the risk for shortages in all but the professional areas of respiratory care practitioners, emergency medical technicians, physician assistants, physical therapists, and occupational therapists.

Key findings of the 2007 report of the *Task Force on the Iowa Physician Workforce* indicate:

- Iowa's overall supply of physicians has increased by 54 percent since 1980, but Iowa faces geographic and financial challenges in recruiting and retaining physicians. The main reason physicians leave is to move to another state and Iowa ranks 80th among 89. Medicare payment localities in payment schedule.
- Only 32 of Iowa's 99 counties have at least one psychiatrist, limiting accessibility to mental health treatment statewide.

Iowa has a large number of Health Professional Shortage Areas (HPSAs). These are federally determined geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility) in nature. The areas are also designated by health care type:

- primary medical care,
- dental, or
- mental health providers.

Iowa has 215 Primary Care Health Professional Shortage Areas. Thirty-eight counties are full or partial Primary Care HPSAs based on having a population to physician ratio of greater than 3,000:1 or having at least 30 percent of the population below 200 percent of the federal poverty level. The remaining Primary Care HPSAs are facility designations (the facility has a shortage of providers to serve the population it exists to serve) that include rural health clinics, community health centers, correctional facilities and state hospitals.

Iowa also has 49 Dental HPSAs. There are 10 geographic Dental HPSAs (the population to dentist ratio exceeds 5,000:1). 39 counties are demographic (based on special populations of low income and Medicaid recipients) Dental HPSAs (with a population to dentist ratio of at least 4,000:1 and at least 30 percent of the population having income at or below 200 percent of the federal poverty level). If the qualifier of having 30 percent of the population at or below 200 percent of the federal poverty level, 89 of Iowa's 99 counties would be Dental HPSAs.

Finally, 84 of Iowa's 99 counties are Mental HPSAs (there is at least a 20,000:1 population to psychiatrist ratio within a designated catchment area. Iowa has 16 catchment areas, most including multiple counties.

Behavioral Health Workforce Crisis

There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically –effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services “Toolkits”). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

The President’s New Freedom Commission on Mental Health in 2003 described the need for “significant changes in practice models and in the organization of services to improve access, quality and outcomes in mental health.” The Commission recognized that substantial changes are needed in both who does the work in mental health and how that work is done.

Three major reports have underscored concerns in this area. In their landmark *Quality Chasm* Series, the National Academy of Sciences/Institute of Medicine (2001, 2002, and 2003) focused on errors in healthcare delivery. While individual practitioners make errors, the IOM assigned responsibility for quality of care issues to the systems of care in which individuals practice and the educational institutions responsible for preparing those individuals. Quite simply the slow pace of educational reform has left the curriculum in training institutions lagging behind the changes in general healthcare and in mental health and developmental disabilities regarding evidence-based practices, multidisciplinary practice, and managed care approaches.

With an increase in consumerism, demand for more information and meaningful participation in treatment, there has been a major shift away from “traditional” clinical roles. However, the newer, non-traditional competencies, such as shared-decision making with consumers of care, are rarely addressed in training programs. Numerous professional organizations and accreditation entities have studied this issue over the last ten years.

During the period 2001-2004, with support by the federal government, the **Annapolis Coalition on the Behavioral Health Workforce** convened a series of national meetings and expert panels to build consensus on the current problems and issues in workforce training and to identify potential strategies for strengthening effectiveness and relevance of education offered to all segments of the workforce. The proceedings of these meetings are available at: www.annapoliscoalition.org. A considered focus of these meetings was on the description of competencies related to the treatment of mental health problems, mental illnesses, substance use disorders, and co-occurring illnesses.

In 2003, the Coalition reported on “Best Practices in Behavioral Workforce Training and Education. The “Best Practices” were:

1. Education and training are competency-based.
2. Students are taught to engage in life-long learning.
3. Practice guidelines are used as teaching tools.
4. Students develop competency with manualized therapies.
5. Teaching methods are evidence-based.
6. Curricula are routinely updated to address the values, knowledge and skills that are essential for practice in contemporary health systems.

7. Skill development focuses on clinical, clinical management, and administrative capabilities.
8. Professional training instills in students an understanding of the competing paradigms of service delivery and the diverse scientific, professional, economic, and social forces that shape healthcare.
9. Students train in treatment programs that are competitive in the healthcare marketplace and are similar to the sites in which they are likely to practice after the completion of training.
10. Training sites are diverse, interdisciplinary, and enable students to follow consumers throughout the continuum of care and the course of recovery.
11. The “workforce” is broadly defined and all segments of the workforce receive training. Training is offered to culturally diverse groups of individuals.
12. Consumers and families are engaged as teachers of the workforce.
13. Teachers and supervisors are experienced in providing treatment and currently involved in the delivery of healthcare.
14. The faculty of training programs is interdisciplinary in composition and represents a diversity of approaches to the delivery of behavioral healthcare.
15. Training programs reward faculty for teaching excellence.

The Annapolis Coalition has argued persuasively that states must broaden their workforce development focus and place much greater emphasis on direct care, paraprofessionals, who comprise more than half of the workforce in most treatment settings. The Coalition wrote:

“Within the field of behavioral health, formal and substantive training is most often provided to professionals in graduate programs. Unfortunately, the training offered to direct care staff members, many of whom have high school diplomas or bachelors degrees, is generally quite limited. To the extent that training is offered to these latter groups of individuals, it tends to be driven by accreditation and regulatory requirements and focuses on basic topics such as infection control and fire safety. Efforts to offer even minimal training are hampered by the high turnover rates among these segments of the workforce.

Within mental health and substance abuse treatment systems, these direct care personnel should receive substantive and ongoing training designed to address the functions that they fulfill during the enormous number of hours that they spend in contact with consumers. Since roughly 80% of resources in behavioral healthcare are human resources, there is no justification for deploying direct care personnel, but leaving them untrained.

In a similar vein, The Annapolis Coalition has placed emphasis on the need to support and development the capacities of consumers and family members to care for themselves and each other:

Similarly, much of the care given to individuals with mental and addictive disorders is provided directly by families and by consumers. In some sense, these may constitute the largest, yet most unrecognized, segments of the “workforce”. In addition to their role in providing family and peer support, the recovery movement has emphasized the central and active role that consumers should play in setting personal priorities, establishing the goals of treatment, and selecting services. While there have been notable efforts to develop and offer training about mental illnesses and addictions to families and consumers (i.e., NAMI), the vast majority still receives no substantive education. Concerted efforts are required to provide education that is tailored to the needs of families and consumers, and they should play a central role in developing and refining those educational programs.” (Hoge, Huey & O’Connell, 2003).

Behavioral Health Workforce Development Strategic Goals
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From 2005-2007, with underwriting from the Substance Abuse and Mental Health Services Administration, the Annapolis Coalition developed a comprehensive, national strategic plan on workforce development, *An Action Plan for Behavioral Health Workforce Development*. The

report has become a template for action to strengthen workforce in a number of states. The plan identifies seven goals, which are consistent with the goals of Iowa's reform of mental health and developmental disabilities services:

GOAL 1:	Significantly expand the role of individuals in recovery, and their families when appropriate, to: participate in, ultimately direct or accept responsibility for their own care; provide care and supports to others; and educate the workforce.
GOAL 2:	Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.
GOAL 3:	Implement <i>systematic</i> recruitment and retention strategies at the federal, state and local level.
GOAL 4:	Increase the relevance, effectiveness, and accessibility of training and education.
GOAL 5:	Actively foster leadership development among all segments of the workforce.
GOAL 6:	Enhance the infrastructure available to support and coordinate workforce development efforts.
GOAL 7:	Implement a national research and evaluation agenda on behavioral health workforce development.

While the work of the Annapolis Coalition cited above has focused largely on mental and substance use conditions, parallels to the field of intellectual and development disabilities are numerous. Recent work in the state of North Carolina has laid out the commonalities across these disorder populations and the potential benefits of a joined effort. (*North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse. Direct Support Professional Work Group Report*, November 2007, Hewitt, Edelstein, Seavey, Morris, and Hoge.)

Iowa's Center for Disabilities and Development reviewed trends in Iowa, noting that issues arise from the confluence of historical trends and from interests, which compete and occasionally overlap. Reviewing the movement to rebalance long-term care, for example, yielded the following observations:

- Community provider capacity to provide HCBS is circumscribed by their ability to recruit and retain competent staff. Workforce issues are reportedly more acute in rural areas.
- Iowa community providers cite both State Medicaid regulations (such as the 20% administrative cap, which limits the resources available for training) and county reimbursement restrictions as barriers to having sufficient funds for paying competitive wages, offering benefits, and training/retaining staff.
- Community providers do not receive rate increases with the same frequency as institutional providers limiting the providers' ability to offer merit or cost of living increases to their employees. Even when they do receive those increases, their effect may be negated by the caps on reimbursement rates or on service units available to individuals.
- There is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. Many providers train staff in-house, and some collaborate in bringing in outside resources for such specialized topics as working with people with dementia or behavioral issues. Iowa Caregivers Association and others offer a few sessions on the needs of specific populations at their annual members' conferences.
- Anecdotes about inadequately trained HCBS provider staff, high turnover rates and inconsistency in the daily provider team have discouraged some families from pursuing community living options for loved ones.

- Some community providers point to need for funding to decrease the discrepancy in wages and benefits between State Resource Centers and community-based employment.

If Iowa is to build and sustain a workforce capable of offering the highest quality, evidence-based services to its citizens with behavioral health, developmental and other disabilities, the foundation must be its workforce. Continuing to educate and train the workforce in an outmoded fashion cannot continue, and an infrastructure to meet the emerging demands must be created.

The Current Mental Health and Developmental Disability Workforce in Iowa

Iowa's current workforce includes a mixture of categories, disciplines and levels of education. There are significant shortages in highly trained specialties (child psychiatry, individuals cross-trained in treating co-occurring mental illnesses and substance use disorders, individuals cross-trained in treating co-occurring mental illnesses and intellectual/developmental disabilities, etc.) and significant challenges are presented in the recruitment and retention of skilled workers in many of the state's rural communities. Although Iowa has made strides in involving persons with disabilities and their families in the workforce, much work remains to be done. We have much work to be done in assuring the linguistic and cultural competence of our workforce.

For all of these reasons, it is time for Iowa to make a significant investment in the preparation, continuing education, and support for its behavioral and other disabilities workforce.

The Proposal

Training designed for the mental health and disability services workforce in Iowa is sporadic, decentralized, and lacks uniformity. The Mental Health and Disability Services Division of the Iowa Department of Human Services, the Iowa Consortium for Mental Health and the Iowa Disabilities and Development Center propose the creation of a specialized center to take the lead in meeting the state's need for standardized, centralized and customized development of the mental health and disability services workforce to be housed in the Des Moines area. The ultimate organizational structure of this center will require additional exploration, but a white paper prepared for MHDS (see Appendix B) provides some examples from other states. The first steps are to create infrastructure and a workforce collaborative to lead the further development of this workforce center.

In addition, this proposal includes a series of strategies proposed to address Iowa's workforce needs in mental health and developmental disability services. In order to ensure buy-in and demonstrate the utility of the core center concepts, the implementation of a series of training initiatives for high priority workforce development areas will yield tangible results.

Vision and Goals of the MHDSTI

The vision of the proposed Mental Health and Disability Services Training Institute is *to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.*

Programs

The goals will be accomplished through:

1. Train for Competencies
 - Develop training programs designed around worker needs and mental health and disability practitioner competencies and priorities.
 - Develop a standard training program for consumers and families to prepare them to serve as trainers.
2. Offer Comprehensive Evidence-based Training Programs
 - Promote and/or provide high-quality learning opportunities in accessible settings and formats in an “evidence-based” way.
 - Provide systematic, competency-based training programs for key mental health and disability transformation topics.
 - Develop and provide targeted educational initiatives related to the implementation of specific evidence-based practices such as Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Supportive Housing, Illness Management and Recovery, Family Psychoeducation, etc.
3. Build Systems that Support Practitioner Development and Career Ladders
 - Promote credentials and competency-based training requirements for mental health practitioners.
 - Implement training and development of competency-based Supervisory skills.
 - Seek partnerships with colleges/universities and other education providers to meet mutual practice and training needs of both mental health practitioners and students.
4. Build Systems/ Organizations that Support the Use of Evidence-based Practices
 - Support and model the values of mental health transformation towards the achievement of a recovery-oriented service delivery system that is consumer and family driven.
 - Serve as a technical resource to state agencies, community-based organizations, consumers and recovery organizations.
 - Coordinate existing resources to focus on and leverage training for implementation efforts.
5. Disseminate Current Mental Health Practice Research.
 - Provide current and state-of-the art treatment practice information and resources through specialized publications, web-based information, and the use of Telebehavioralhealth and Teletraining.
 - Provide coordinated and targeted technical assistance to Iowa’s provider community to ensure that policy infrastructure modifications are made to ensure that improved practices can be financed and delivered statewide.

Strategies and Structures to Achieve the Goals

Creation of an Iowa Mental Health and Disability Services Institute will require a methodical, multi-phased approach. Each of the elements detailed below is a building block designed to ensure success and sustainability. While these activities are discretely identified and budgeted for accountability purposes, they can and should be activated concurrently as part of a comprehensive planning and implementation design. In addition to the brief narratives provided in each section, a break out of expenditures appears in attached spreadsheets.

The development design proposed has two distinct elements, best described as (a) infrastructure development, and (b) special initiatives. The first provides the underpinnings necessary to keep the ultimate goal of sustainability, while the latter are focused on bringing immediate assistance to high priority concerns of the Iowa system. Creating an Institute in a vacuum will not engage stakeholder participation and buy-in unless the emerging Institute can demonstrate immediate return on investment.

Development of the Mental Health and Disability Services Training Institute

In the winter of 2006 and spring of 2007, the Iowa Department of Human Services (IDHS), Division of Mental Health and Disability Services (MHDS), in collaboration with the state legislature, embarked upon a Mental Health Systems Improvement (MHSI) initiative that included a number of workgroups focusing on systems change. One workgroup focused on evidence-based practices. In 2007, the Iowa legislature (HF909) directed the IDHS to:

“develop a comprehensive training program concerning such practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa Consortium for Mental Health.”

In the summer of 2007, the MHDS began a planning process that included the Iowa Consortium for Mental Health, the Center for Disabilities Development, the Iowa College of Public Health, the University of South Florida Mental Health Institute, ZiaPartners, Inc., and the Annapolis Coalition to form the Mental Health and Disability Services Training Institute (MHDSTI). That planning process sought to respond to the legislative mandate to develop a comprehensive training program as stated above.

Also during the summer of 2007 other workgroups were meeting with MHDS that included various stakeholders such as providers, county representative, family members, consumers and advocacy groups. Guided by expert technical advisors such as the Annapolis Coalition and the Iowa Consortium for Mental Health a plan evolved for the creation of the MHDSTI. The MHDSTI was envisioned as a center for evidence-based training on mental health and disability issues for professional and direct care staff providers, family, consumers, including DHS mental health institutes, resource centers, community mental health centers and other community substance abuse and mental health providers. Specific provider populations initially targeted by the MHDSTI were those offering co-occurring mental health and substance abuse disorder services, as well as those providing emergency mental health, children’s mental health, and school mental health services.

Iowa is in the process of transforming its publicly funded mental health system to a consumer and family-driven system that embraces prevention, resiliency, and recovery as guiding principles. Implementing that goal requires shedding old stereotypes of mental illness and replacing them with new attitudes and services that support people with mental illnesses. In the midst of this transition, the mental health system faces a crisis in providing appropriate mental health services to forensic clients. Without systematic and quality training as well as attention to effective strategies needed for implementation of new practices, the realization of Iowa’s transformation goals could be compromised.

This initiative will require dedicated in-state staff and resources to ensure that all relevant partners are included, and that the efforts to develop Iowa’s capacities are a constant focus of attention. For the initial year of this effort, we are proposing to hire a Project Director and an administrative assistant to manage all of the elements of the development process; the Project Director should be someone of demonstrated planning and organizing skills, with a good understanding of behavioral and other disabilities services, with additional expertise in the working with both academic and practice communities. In addition, funds are proposed for logistics support to convene meetings, publish reports, and to engage the services of needed consultants.

Total projected cost: \$200,000.00

Creating a Workforce Collaborative

Essential to the success of a statewide effort of this type is an infrastructure to identify and prioritize workforce problems, coordinate or implement interventions, and monitor outcomes. Perhaps most important, an infrastructure is necessary to link and leverage *existing* resources that are available within the state to strengthen its workforce.

The functions of such an infrastructure would include, but not be limited to the following:

Leveraging existing resources by:

- Identifying and disseminating information about existing workforce development resources (clearinghouse function).
- Coordinating workforce development efforts among various public and private agencies to achieve efficiencies and reduce duplication of effort.

Linking Iowa's mental health and higher education systems in a coordinated effort to develop a pipeline of culturally diverse and appropriately trained mental health providers. This includes:

- Educating educators about current trends in service delivery as a strategy for fostering relevant curricula in the educational system
- Working with the mental health, higher education, licensing systems, and payers to improve career ladders in mental health within Iowa.

Assessing routinely the mental health workforce development needs within Iowa, including:

- The magnitude, characteristics, and causes, of recruitment and retention problems, including the impact of compensation and benefits
- The accessibility, relevance, and effectiveness of training and education resources/program.

Planning in the form of a biannual strategic plan on mental health workforce development and report on the status of this workforce will be conducted by the Collaborative.

Implementing interventions to strengthen the workforce.

Promoting employment of consumers, youth, and family members in the mental health workforce.

Disseminating best practices in workforce development to employers of the mental health workforce.

Advising Iowa's executive, legislative, and judicial branches on workforce issues and policy.

Applying for other potential sources of funds to support workforce development.

The structure of the Collaborative would include a General Membership, Executive Committee, Standing Councils, and ad hoc workgroups.

Persons in recovery, youth, and the parents of children and youth with emotional and mental problems would play a major role in all structures.

Technology, in the form of web-enabled conference calls, will be used for selected meetings to maximize efficiency, minimize time and travel-related meeting costs, and foster access for consumers and family members.

The collaborative can serve as the **Advisory Council** to the Institute, ensuring that the voices of key stakeholders are heard, and that all elements of the system are engaged in the selection,

design, delivery and evaluation of the work of the Institute. The Collaborative sets the policy direction for the work of the Institute in strengthening Iowa's workforce.

The activities of the Collaborative would be the responsibility of the Project Director identified above in the Basic Infrastructure section; the Institute would staff the work of the Collaborative and provide its administrative home. Resources dedicated to this effort would include logistic support for meetings, development and dissemination of reports, and the services of content and process consultants to advise the process.

Total projected costs: \$150,000.00

Special Initiatives

The Institute should sponsor a series of inter-related initiatives as soon as basic infrastructure is in place. Based on the assessment of the Iowa Department of Mental Health and Disability Services, the following five initiatives should be funded during the first year of the Institute's development. The first initiative (focusing on supervision) is cross cutting and provides the foundation on which the successful dissemination of evidence-based practices can be built and sustained. The remaining five areas focus on areas of urgent need in Iowa's system of care, and addressing them in a manner consistent with the vision of the Institute (using evidence-based methods, incorporating the best science available, etc.) will provide credibility for further elaboration of the work of the Institute.

Supervision.

A critical element in successful system transformation is intervention at the level of service supervisors. Training clinicians and other direct-care workers in evidence-based practices requires an informed support system; the lynchpin in such a support system is the front-line supervisor. In its national work, The Annapolis Coalition has determined that there has been significant erosion in the role of supervision in service delivery; this has been the case in Iowa as well. The pressure for billable hours has shifted the role of clinical supervision away from the content of service delivery and toward more administrative and financial duties. A concentrated effort to provide training in **effective** supervision is a necessary core step in changing practice. Existing resources are inadequate to address the content of such training, much less to attend to the necessary policy and reimbursement strategies that will need to be developed to shift the system in the direction of evidence-based models.

The resources allocated here would provide for curriculum development and pilot implementation of supervisory training in the MHDS system of providers, as well as the development of relevant policy and protocol changes needed to ensure continuity in the dissemination of new models.

Projected total costs: \$100,000.00

Improved Services for Children, Adolescents and Their Families

This is already an identified high priority for Iowa MHDS, and this funding would ensure that there are resources available to the system to support dissemination of evidence-based strategies. Funds would provide for the engagement of experts in identified best practices and for implementation of training sessions and development of fidelity monitoring technologies to ensure that practices are implemented in a way that is consistent with the scientific findings that drive the practice.

Projected total costs: \$100,000.00

Improved Emergency Mental Health Crisis Services

Iowa's hospitals are struggling to meet the demands of persons with mental and developmental disorders in crisis, many of whom could be served both more effectively and in a more cost-effective manner by robust crisis and emergency mental health services, including such strategies as "Mental Health First Aid", peer supports, crisis prevention intervention, use of telephone "hotlines", and the like. Funding would provide for the engagement of key Iowa stakeholders, content experts in model design, and provision of basic training in new approaches to emergency mental health crisis services.

Projected total costs: \$100,000.00

Co-occurring Disorders

Iowa MHDS has identified co-occurring disorders (especially mental and substance-use disorders) as a high priority population that is currently un- or under-served. In addition, there are many individuals with co-occurring intellectual/development disorders and mental health/substance use disorders who are not receiving state of the art care. Funding would provide for statewide training on science-based interventions, and for the engagement of content experts for curriculum design and training delivery.

Direct Care Workforce.

Although there are efforts underway in Iowa to address the needs of the direct care workforce in the development disabilities area, more effort is needed there. According to the Center for Disabilities and Development, there is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. These efforts need to be expanded to begin to reach the direct care workforce in other areas of the MHDS service system, as well. Funding would provide for development of cross-disciplinary competencies, curriculum development, and training implementation for direct care workers in all MHDS service agencies.

Projected costs: \$100,000.00

Consumer and Family Training

Self-directed care is a cornerstone of contemporary practice, which has been recognized in the development disabilities field for some time, and is a hallmark of recovery- and resilience-oriented systems of care for people with mental and substance use conditions. While often given lip service, consumers and families will not be able to engage in effective management and leadership of their recovery plans without training, education and supports. Funding will provide for the use of existing training models (e.g., NAMI's "Family-to-Family" and "Provider Education" tools, the Certified Peer Specialist training models, etc.) or the development of curricula specific to the needs and desires of Iowa's consumer communities.

Projected costs: \$100,000.00

Professional recruitment strategies.

Iowa has experienced chronic shortages at the highest end of the workforce: psychiatrists, psychologists, and advanced practice nurses. Under this special initiative, Iowa will establish a pool of dollars to offer financial incentives (stipends, loan forgiveness, supplements) to individuals in the high-need categories who are willing to help meet the skills deficits, especially in our rural and frontier communities. We will select those strategies that have been demonstrated to provide

results, and match them to candidates who seem most likely to contribute to our system over time. Consumers seeking services in programs for those with chronic and persistent mental illness will benefit from the recruitment, placement and retention of up to eight psychiatrists, doctoral level psychologists or nurse practitioners with mental health specialization. Once placed in programs service the chronically and persistently mentally ill, these practitioners will provide professional mental health services to lowans that do not receive the services now.

Projected costs: \$200,000.00

Building on Existing Strengths

Iowa is fortunate to have in place existing structures that can support and enhance the development of the Institute. Chief among these are the Iowa Mental Health Consortium and the Iowa Center for Disabilities and Development. These two entities will play a significant role in the development and functioning of the new Institute, and their current work will be amplified and enhanced by the new structure. In addition to their work, there are several proposed federal efforts (specifically related to telemedicine and to enhanced recruitment and retention strategies for hard-to-find specialists) that would significantly broaden the impact of the proposed Institute.

SUMMARY

The case for transformation of services to people with mental and disability services has been made both nationally and in Iowa. Resources for these services have never been sufficient to meet demands, nor is that likely to change. These two imperatives demand that Iowa ensure that every dollar it spends on services in support of people with disabilities is spent wisely, and that public services for people with disabilities are designed and delivered in ways that ensure that they are effective. This cannot happen in the absence of a workforce that is adequately trained and supported to deliver the highest quality of care that can be delivered. The people who receive those services and supports, and the taxpayers, who pay for them, should expect nothing less. The creation of an Iowa Mental Health and Disabilities Training Institute is a defining step in ensuring that Iowa transforms its system to meet the highest standards possible.

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VIII. TASK FORCE SPECIALTY PRIORITIES

Members of the Task Force represent individual health care systems covering most of Iowa's geographic subregions. Each Task Force member was asked to submit a list of up to 10 medical and surgical specialties regarded as being of greatest need or in greatest demand in the member's region or system. Members were encouraged to consult colleagues in tailoring their specialty choices to their own region or health system. Further, they were asked to rank order the top five selections with one representing the greatest need/demand.

The results of this exercise are presented in Figure VIII.1. The first priority for each list submitted received a value of 5, the second a value of 4, and so forth. The last column in the table displays a specialty's mean rank plus the number of parties ranking the specialty. The top five workforce needs (or unmet demands) as perceived by Task Force members are above the red line and include psychiatry, neurosurgery, general internal medicine, orthopedic surgery and cardiology.

Task Force members were asked specifically to consider supply and demand for family physicians in their regions. The group, representing institutions that are sponsoring eight of Iowa's nine family medicine residencies, concluded that the present supply of family physicians is sufficient to meet current needs with the important caveat that efforts to meet the demand for rural family physicians need to be constant and focused.

An analysis of physician supply was conducted and discussed for each of these top five ranked specialties. The analysis considered data across four different supply perspectives: 10-year supply trend; geographic distribution by county; visiting consultant (outreach) activity; and population-to-physician ratios by county. Trend data were described as increasing, level, or declining based on rules concerning the net increase or decrease over the 10-year period reconciled with the pattern over the last two to three years.

FIGURE VIII.1
TASK FORCE ON IOWA PHYSICIAN WORKFORCE

Ranking* of Specialty Preferences											
Specialty	Mercy MC	Mercy DGR	Genesis	Mercy CH	WIS (Iowa) Wisco	WIS (Iowa) DEM	UI COOJK	Sum of Rank Values	Mean Rank	# Ranking Specialty	Total Score**
Psychiatry	5	5	3		5	4	3	27	3.86	6	9.80
Neurosurgery		3		3	4	5		17	3.43	4	6.43
Gen Internal Medicine		1	1	3	2		4	10	2.42	5	5.43
Orthopedic Surgery	3				3	1	3	10	2.42	4	5.43
Cardiology		4				2	2	8	2.14	3	4.14
Neurology	2	2					1	5	1.71	3	3.71
ObGyn					1	3		4	1.57	3	3.57
Phys Med/Rehab			3					3	1.71	2	3.71
General Surgery	4							4	1.57	3	3.57
Endocrinology				4				4	1.57	3	3.57
Vascular Surgery			4					4	1.57	3	3.57
Peds/Critical Care				3				3	1.43	3	3.43
Emergency Medicine	1		2					3	1.43	3	3.43

*Ranking: Each participant ranked his top 5 specialties based on the need/demand in his respective system. The first priority received a value of 5. The second priority received a value of 4, the third priority a value of 3, fourth priority a value of 2, and the fifth priority a value of 1.

**Total Score: The total score represents the specialty's mean rank plus the number of parties ranking the specialty.

Psychiatry

Figure VIII.2 shows that the 10-year supply of psychiatrists in Iowa had marginally contracted by the close of 2005. Particularly noteworthy is the recording of net losses for three of the last five years, especially in the context of a modest increase in the Iowa population during that time. Thus, by definition, the supply trend line in psychiatry is one of decline.

The geographic distribution of psychiatrists by county is displayed in Figure VIII.3. Just 32 of Iowa's 99 counties are home to at least one psychiatrist, although additional sites receive direct services from some of Iowa's psychiatrists who conduct outreach clinics as visiting consultants (Figure VIII.4).

Computations of county, state and U.S. population per psychiatrist are presented on the map in Figure VIII.5. Iowa has twice the population per psychiatrist compared to the nation (13,241 vs. 6,657). Therefore, Iowa has half the number of psychiatrists per 100,000 population (7.6) compared to the national figure (15.8). On the positive side, as noted on the map, 79% of Iowans reside within 20 miles of a psychiatrist, but given the unfavorable population to psychiatrist ratio, proximity does not equate well to access.

FIGURE VIII.2
IOWA PHYSICIAN SUPPLY
ANNUAL NET GAIN (LOSS) BY SPECIALTY
1996-2005

Psychiatry / All Subspecialties	Entered	Left	Net Gain (Loss)	Total
1995				224
1996	15	24	(9)	
1997	19	13	6	
1998	18	12	6	
1999	14	15	(1)	
2000	20	14	6	
2001	15	10	5	
2002	15	20	(5)	
2003	19	14	5	
2004	16	20	(4)	
2005	11	23	(12)	
Total	162	165	(3)	221
Annual Average	16	17	0	
1996 - 2005 Percent Change			-1.3%	
Current Trend			Declining	

Critical Demand Index (CDI)

The Task Force discussed the results of the above demand studies by individual specialty and then comparatively across specialties. An important outcome of the group's deliberations was the development of a method to quantify the intensity of demand across medical specialties. Two data sets must be available for this purpose: (1) the current demand in a given specialty expressed as a finite number of job opportunities and (2) the current supply in the same specialty.

The Task Force reasoned that when comparing two specialties which have a similar number of job openings but substantially different supplies, the one with the smaller supply base would likely experience a more *intense* demand. Using this logic, an index of demand intensity (the critical demand index) was computed by dividing the current demand by the current supply for each specialty in this analysis (Figure IX.13). The greater the fraction, the greater the intensity (or seriousness) of demand for the specialty. In the comparative analysis, two additional specialties — family medicine and general pediatrics

— were included because current demand data were readily available for them from another analysis.

The Task Force also reasoned that including the average number of physicians entering Iowa practices annually in each specialty would give the demand analysis a temporal dimension. Using the functionality of the Iowa Physician Information System, this annual average was computed for the selected specialties for the most recent 10-year period ending 2005 (Figure IX.13).

The conclusions from these computations include:

- The intensity of demand in neurology and psychiatry is twice that of the other non-primary care specialties and more than four-fold greater than family medicine and pediatrics, for which the current number of openings compared to the current supply is substantially more favorable.
- It takes, on average, two to three years longer to fill the typical neurology or psychiatry position than a position in any of the other specialties in the analysis.

FIGURE IX.13

CRITICAL DEMAND INDEX FOR SELECTED MEDICAL SPECIALTIES

	Current Year's Demand	Current Year's Supply	Annual Average CDI***	No. Entering	Average Years to Fill Position****
• Neurology	26	82	.32	5	5.2
• Psychiatry	64 (77*)	220	.29 (.35*)	16	4.0 (4.8*)
• Gen Internal Medicine	56 (79**)	407	.14 (.19**)	34	1.6 (2.3**)
• Ob/Gyn	28	215	.13	14	2.0
• General Surgery	24	198	.12	13	1.8
• Cardiology	20	168	.12	12	1.7
• Family Medicine	94	1271	.07	78	1.2
• General Pediatrics	10	229	.04	16	0.6

* If part-time positions are counted

** If hospitalists are counted

*** Critical Demand Indicator = current demand ÷ current supply

**** Average years to fill: Current demand ÷ the annual average number of these specialists entering Iowa during the prior 10 years yields an estimate of recruitment difficulty.

APPENDIX J:

MHDS Budget and Legislative Proposals

Attached are 2 proposals for legislative activities for the 2008 Legislative Session from the Department of Human Services, Division of Mental Health and Disability Services. They are:

1. Establishment of Code on Emergency Mental Health Crisis Services (LSB 5362)
2. Establishment of Code on Children's Mental Health Services (LSB 5355)

The attached describes the likely impact of these two initiatives on current and potential legislation, changes in rules, code or regulations.

Also attached are two page summaries describing the Department's rationale for development of the above two areas.

DHS Proposed Legislative Package

2008 Legislative Session

Policy area and code site (if available): Mental Health and Disability Services

MHDS 1: Emergency Mental Health Crisis Services (LSB 5362)

Briefly summarize the proposed change:

"Emergency mental health crisis services" means a coordinated system of mental health crisis services which provides an immediate response to assist a person experiencing a mental health crisis. An "Emergency Mental Health Services Provider" is defined as an organization, such as a community mental health center, that is accredited by the Department of Human Services to provide emergency mental health crisis services.

The proposed change calls for the creation of new code for the establishment, accreditation and operation of emergency mental health crisis services.

(1) The code would be promulgated to establish standards and procedures for certification of emergency mental health crisis service programs. The persons who need those services are persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. The Department of Human Services would contract directly with Community Mental Health Centers or Emergency Mental Health Services Providers for the operation of an emergency mental health program certified under this law.

(2) This code would apply to the department, to entities that request accreditation to provide emergency mental health crisis services and to state-contracted agencies that request accreditation to provide emergency mental health services.

(3) This code would relate only to the accreditation of programs providing emergency mental health crisis services. It is not intended to regulate other mental health service programs or other emergency service programs.

Reason for change:

There are no state-wide standards for the establishment, accreditation and operation of emergency mental health crisis services in the state. This is proposed as a result of recommendations from the legislatively-directed mental health systems improvement workgroups.

Budget and/or workload impact:

There is an impact in terms of workload for creating the revisions in Code which can be completed by MHDS and legislative staff; changes to the Code are related to the budget package submitted by DHS/MHDS to the executive and legislative branches this session.

\$6,000,000 is being requested to establish 24/7 emergency/crisis response services, provided by CMHC's regionally throughout Iowa.

Impact on the population we serve:

If enacted this would provide a safety net for all Iowans in need of emergency mental health crisis services throughout the state.

___Technical ___X_Policy

Explanation on LSB 5362: Emergency Mental Health Crisis Services

Section 1a.

Why is an Emergency Mental Health Crisis Services system important to Iowa?

Currently, all Iowans do not have access to Emergency Mental Health Crisis Services. In a recent survey, less than 20% of the counties in Iowa report having any type of emergency mental health crisis services.

The goals of emergency mental health crisis services include prevention of escalation of life events to crises, relief of the immediate distress of persons in crisis, prevention of individuals from doing harm to themselves or others, and promotion of independence for those who require ongoing mental health and /or substance abuse services. These goals, if available to all Iowans, are intended to stabilize individuals through community-based crisis services with the ultimate goal of reducing inappropriate hospitalizations or jail placements.

Emergency Mental Health Crisis Services *should provide welcoming and empathic*, co-occurring-disorder-capable crisis intervention, stabilization, support, counseling, pre-admission screening for persons requiring emergency psychiatric hospitalization, detoxification and follow-up services in all counties and for all people. This system currently does not exist for all Iowans.

All Iowans need access to Emergency Mental Health Crisis Services

- Every Iowan – not just the chronically mentally ill may need these services.
- Included are individuals with a diagnosed mental illness or co-occurring mental illness and substance abuse disorder.
- All individuals experience crises.
- All ages and all income levels (those who are insured, under-insured, or uninsured) may be affected.

Section 1b

How Does One Become an Emergency Mental Health Care Crisis Provider?

- Providers shall be accredited or approved by the Department to provide Emergency Mental Health Crisis Services.

Section 2a and b

Features of a crisis include:

- All individuals can experience a mental health crisis
- A person's perceptions determine the importance and significance of a crisis.
- Crises are usually time-limited episodes
- Crises are not necessarily pathological, as they may encourage growth and change,

Section 2c, d and e

Characteristics of Emergency Mental Health Crisis Services include:

- Welcoming, universal participation
- Focuses on individual strengths, not weaknesses
- A hopeful vision of recovery
- Co-occurring capability
- Empowered partnership of stakeholders
- Inclusion of the process of continuous quality improvement of services

Goals of Emergency Mental Health Crisis Services are:

- Symptom reduction,
- Stabilization of the individual
- Restoration of the individual to a previous or enhanced level of functioning.
- Connection to continuing care at the appropriate level of intensity, matched to individual family needs and requests

Section 3a and b

1) The Mental Health and Disability Services Division (MHDS) recommends that Community Mental Health Centers and other community providers apply for competitive state block grants (SBG). It is recommended that the funding of program capacity-developing operational grants is done with the General Fund through the Department of Human Services. These block grants may operate on a quarterly “settle-up” basis to offset uncompensated time to the limit of the grant award. The request is for the annual amount of \$6 million for up to ten (10) state block grants of \$600,000 each. MHDS has recently added staff to develop and monitor budgets, contracts, and grants as well as develop emergency mental health crisis technical assistance. The Division has experience in the development, issuance, monitoring and oversight of federal mental health block grants that are procured on an annual basis. The Division proposes to develop the Request for Proposal in early spring of 2008 for implementation in January of FY2009.

2) In order to appropriately consider the needs and interests of various stakeholders associated with Emergency Mental Health Crisis Services, to monitor the development of these services and to sustain long-term change, it is recommended that the MHDS Division develop and convene an interagency, coalition/network to monitor these services on a statewide basis. A wide range of stakeholders should be involved in a state-supported collaborative related to service implementation, utilization and future modifications of the acute mental health delivery system. This includes coordination with other mental health, substance abuse and co-occurring mental health and substance abuse services available through the state. The Division is already developing internal capacity to provide state leadership in this initiative through staffing provided through legislative support in FY2007 and FY2008.

Anticipated outcomes include the following:

- Increased utilization for mobile crisis and wraparound services
- Decreased inappropriate admissions to inpatient psychiatric units
- Decreased inappropriate admissions to correctional facilities
- Decreased readmissions to inpatient psychiatric units
- Decreased involvement by law enforcement in the management of community mental health incidents

Additional Future Actions Needed

(1) It is likely that Code needs to be promulgated to establish standards and procedures for accreditation of emergency mental health crisis service providers. There should also be modifications to Ch. 24 for the inclusion of standards related to emergency mental health crisis services. The individuals who need those services are persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. The Department of Human Services intends to contract directly with Community Mental Health Centers or emergency mental health services providers for the operation of an emergency mental health crisis services program.

(2) Code should apply to the Department’s responsibilities of statewide leadership and oversight of emergency mental health crisis services, to entities that request accreditation to provide emergency mental health crisis services and to state-contracted agencies that request accreditation to provide emergency mental health services.

(3) Code should relate only to the accreditation of programs providing emergency mental health crisis services. It is not intended to regulate other mental health service programs or other emergency medical service programs.

How are Emergency Mental Health Crisis Services different from Emergency Disaster Responses Services?

Disaster services are put into effect following a defined natural or man-made event such as a flood, tornado, hurricane, blizzard or act of terrorism adversely affecting individuals and communities. Disaster mental health counseling is provided immediately after the event, during mitigation and in long-term recovery. In addition, personnel who respond to the event may require Critical Incident Stress Management debriefing to reduce their risk of acquiring post-traumatic stress and depression. Emergency mental health crisis providers deal with daily acute emergencies. Emergency mental health crisis providers are trained in disaster response and may be part of the statewide effort when a Presidential Declaration has occurred. The Department is working to include the emergency mental health service providers in the plan for disaster mental health response.

DHS Proposed Legislative Package

2008 Legislative Session

Policy area and code site (if available): Mental Health and Disability Services

MHDS 2: Children's Mental Health Services (LSB 5355)

Briefly summarize the proposed change:

There is a lack of code or rule regarding the specific provision of children's mental health services and in certain areas of code children are specifically omitted as an eligible population. The Department of Human Services – Division of Mental Health and Disability Services propose the use and modification of model federal legislation currently being proposed in this area. (See attached).

Reason for change:

As a result of recommendations from the legislatively-directed mental health systems improvement workgroups there exists a need for development of state-supported children's mental health services throughout the state of Iowa.

The Spring 2006 Legislature directed the Department of Human Services (DHS) – Division of Mental Health and Disability Services (MH & DS) to make the changes necessary to "implement a comprehensive, continuous, and integrated state mental health services plan in accordance with the requirements of sections 225C.4 and 225C.6 and other provisions of this chapter, by increasing the department's responsibilities in the development, funding, oversight, and ongoing leadership of mental health services in this state..."

This legislation also states that "the general assembly intends that efforts focus on the goal of making available a comprehensive array of high-quality, evidence-based consumer and family-centered mental health services and other support in the least restrictive, community-based setting appropriate for a consumer..."

Per recommendation from the legislature, the MHDS worked with several stakeholder groups to identify various needs and gaps in the public mental health service system and make recommendations for changes. The mental health systems improvement workgroups and steering committee identified particular service gaps and disparities in mental health services for children and their families and has made recommendations for improvements. As current Iowa Code does not adequately identify mental health service responsibilities or eligibility requirements for children, it is necessary to create code that achieves this.

Budget and/or workload impact:

There is an impact in terms of workload for creating the revisions in Code which can be completed by MHDS and legislative staff; changes to the Code are related to the budget package submitted by DHS/MHDS to the executive and legislative branches this session.

Development of legislation in this area will increase the workload of the MHDS Accreditation staff as there will be a need to development, implement, and monitor standards.

\$3,000,000 is being requested to assist in the development of an infrastructure and local projects for children's mental health services.

Impact on the population we serve:

Youth who have mental health service needs will have access to core safety net mental health services in the least restrictive setting possible, preferably at home with their families and the need for more costly, high end care will be reduced.

___ Technical __X_Policy

Explanation of LSB 5355 DP – Children’s Mental Health Services

NEED: Although children’s mental health services exist in Iowa children’s mental health services are neither sufficient nor coordinated with other aspects of the children’s services network such as child welfare, juvenile justice, primary health care, substance abuse, or education services. Families are often left on their own to find services; service availability is limited, unavailable and varies statewide; and resources to support youth with mental health needs are limited. The juvenile justice and/or child welfare systems often become the systems of “default” which causes unnecessary burden and cost to those systems while also not adequately meeting youth and family needs.

There is a lack of code or rule regarding the specific provision of children’s mental health services and in certain areas of code children are specifically omitted as an eligible population. As current Iowa Code does not adequately identify mental health service responsibilities or eligibility requirements for children, it is necessary to create legislation and code that achieves this.

PURPOSE: Per legislation passed in 2006, the Department of Human Services (DHS) – Division of Mental Health and Disability Services (MHDS) was directed to make the changes necessary to “implement a comprehensive, continuous, and integrated state mental health services plan in accordance with the requirements of sections 225C.4 and 225C.6 and other provisions of this chapter, by increasing the department’s responsibilities in the development, funding, oversight, and ongoing leadership of mental health services in this state...”

This legislation also states that “the general assembly intends that efforts focus on the goal of making available a comprehensive array of high-quality, evidence-based consumer and family-centered mental health services and other support in the least restrictive, community-based setting appropriate for a consumer...”

The purpose of the proposed legislation is to ensure that youth with mental health disorders have access to mental health treatment, services, and supports in the least restrictive setting so they can live with their families and remain in their community.

INTENT: To meet the mental health needs of youth more appropriately in the community to prevent or reduce utilization of more costly, restrictive care such as institutional care, residential treatment, out of state placements, or other out of home placements; reduce unnecessary involvement of youth who have mental health needs with law enforcement, corrections, and juvenile justice; reduce unnecessary youth involvement with child welfare services; etc.

The Department of Human Services – Division of Mental Health and Disability Services proposes modifications to 225C to establish the state mental health authority’s responsibility to develop, implement, oversee, and manage the comprehensive community based children’s mental health system in Iowa.

Section 1-Purpose and definition

The purpose of this bill is to establish a comprehensive, community based children’s mental health system. Appropriate community level mental health services in Iowa currently do not exist on a consistent statewide basis. Some services and supports exist but are limited by funding, location, and insurance status of the family. As a result youth with serious mental health needs and their families often become unnecessarily involved with the juvenile justice and/or child welfare systems, or other out of home placements because they cannot access more appropriate community based mental health services.

The definition of a child or youth with serious emotional disturbance (SED) is a federal definition, and provides a framework for defining the population in need of comprehensive community based mental health services. As identifying youth with SED is a federal requirement of states, it is necessary that Iowa implement and use criteria to identify and assess youth who have a SED. Additionally, Iowa has received one federal grant and is working on a second federal grant with the Substance Abuse and Mental Health Services Administration to build systems of care for youth with SED which also require the use and implementation of standardized criteria to

identify and assess youth with a SED. The language in the bill which addresses the transition age 18-21 population is being included to fulfill requirements in Chapter 225C.6A, directing the department that the “redesign of the children’s system shall address issues associated with an individual’s transition between the two systems as ” they are at risk for many negative outcomes without adequate supports. The language in this bill promotes a more seamless transition from the child to adult mental health system.

Establishing the Mental Health and Disability Services Division as the lead responsible agency of the oversight and management of the children’s mental health system also fulfills requirements set forth in 225C and HF909, and is the consistent with federal requirements for states to establish a “state mental health authority”. This language simply reinforces existing responsibilities of MHDS to provide leadership, oversight, and funding in order to create a comprehensive, community based mental health service system that reduces inequalities of treatment, minimizes reliance on institutionally-based services, and diverts people with mental illness from unnecessary with the legal system to provide needed services, and promotes strengths-based, community and family driven services and supports.

Section 2-Initial Implementation

The services in the children’s mental health system will be provided by local providers using practices that are appropriate for the culture and needs of their community within the parameters of being evidenced based and consistent with system of care principals. The state will contract with these providers to develop services and supports that wrap services around a family, are responsive to individual and family needs, and provide services in the least restrictive setting possible. The competitive bidding process will allow providers to participate at the level that they are able to.

The Department of Human Services – Division of Mental Health and Disability Services proposes modifications to 225C to meet federal requirements and to carry out requirements set forth in HF 2780, HF 909, and 225C to meet the state mental health authority’s responsibilities to develop, implement, oversee, and manage a comprehensive community based children’s mental health system in Iowa.

APPENDIX K:

Evidence Based Practices

Introduction

Although the term “evidence based practice” has been used with increasing frequency over the past decade, it is still a relatively new term in health care and disabilities services. The work group put forth much effort to review various definitions of EBP to clarify the meaning of this term.

A summary of the various definitions and conceptions of the term “evidenced based practice” includes:

- **Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Sackett et al, 2000; Institute of Medicine, 2001).**
- Interventions for which there is consistent scientific evidence showing that they improve client outcomes (Drake, RE, et al, *Psychiatric Services*, 2001).
- An intervention with a body of evidence (i.e., rigorous research studies with specific target populations and client outcomes), specific implementation criteria (e.g., treatment manual), and a track record showing that the practice can be implemented in different setting (Bond G., et al, *Psychiatric Services*, 2001).
- Evidenced-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, *Policy Statement on EBP*, 2007).
- Evidenced-based medicine involves evaluating rigorously the effectiveness of healthcare interventions, disseminating the results evaluation and using those findings to influence clinical practice (Appleby J., Walshe K., and Ham C., 1995).
- Evidenced-based medicine is a set of strategies derived from developments in information technology and clinical epidemiology designed to assist the clinician in keeping up to date with the best available evidence (Geddes, 2000).
- It (EBP) recognizes that health care is individualized and ever changing and involves uncertainties and probabilities... Ultimately evidence-based practice is the formalization of the care process that the best clinicians have practiced for generations (McKibbon KA., 1998).

It is important to realize the varying definitions can be very different in terms of implementation and actual clinical practice. There are also differences between systems level evidenced- based practices and individualized client specific practices. Thus, the work group feels it is useful to think in terms of promoting the utilization of evidence-based models at **both** the systems level, as well as the specific intervention level. The definitions outlined in the third and fourth bullets above are the most commonly accepted definitions for EBP's within the mental health services field.

Parameters for assessment, choice and prioritization

In an effort to provide structure to the review of potential EBP's, each EBP was evaluated according to the following parameters:

- **Clarity of Construct:** To what extent is there clear agreement on what this means? Is there a manual to follow? Is it a circumscribed, teachable practice that can be replicated across sites?
- **Impact:** How much of an effect will an initiative in this area is likely to have? How many people will it be likely to affect?
- **Need:** How critical is the need for this service/intervention or initiative at this time?
- **Evidence-Base:** To what extent has the practice been demonstrated to yield good outcomes in rigorous studies across multiple sites?
- **Diversity:** Will this initiative impact diverse populations across the state, e.g., across culture, age groups, socio-economic groups?
- **Feasibility:** What is the likelihood that the initiative can actually succeed if undertaken?
- **Opportunity:** To what extent does this initiative make sense at this time- in terms of dovetailing with other initiatives?
- **Affordability:** What are realistic estimates of short-term (i.e., start up) and long-term costs?

Summary of Recommendations

In compliance with the legislative request – recommendations are provided below for the implementation of 2 evidence-based practices (EBPs) per year over the next 3 years for adults with serious mental illness and children and adolescents with serious emotional disturbances (i.e., a total of 6 practices over 3 years). However, there is universal concern among the workgroup that anything near full implementation of this many practices might overwhelm the capabilities of the system. Strategies to address this concern fall into two general areas, both of which may be applicable:

- 1) reduce the number of EBP's/year, e.g., to one/year for each population
- 2) clarify what is meant by "implementation", emphasizing that implementation doesn't have to be statewide. Rather, it may take the form of demonstration or pilot projects.

The recommended EBP's for adults and children are delineated here:

EBPs for Adults with Serious Mental Illness

Year 1:

A. Integrated Treatment for Co-occurring Disorders

The EBP workgroup is fully supportive of the overall "Comprehensive, Continuous, Integrated System of Care Model" as explicated by Minkoff. One specific implementation model is clearly laid out in the "[Integrated Dual Diagnosis Toolkit](#)" by SAMHSA. The workgroup supports expanded implementation of this model.

Critical components of the model include:

Integrated services: Clinicians provide services for both mental illness and substance use at the same time.

Knowledge about alcohol and drug use, as well as mental illnesses: Clinicians know the effects of alcohol and drugs and their interactions with mental illness.

Assessment: Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.

Stage-wise treatment: People go through a process over time to recover and different services are helpful at different stages of recovery.

Motivational treatment: Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse

Ongoing workforce development in core competencies in each of these areas must be pursued.

[Fidelity assessment](#) for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Peer Support

The EBP workgroup recommends the expansion of peer support services.

Although the evidence-basis for the effectiveness of peer support not been as strongly established in rigorous research studies as other recommended EBP's for adults, it is growing and there is increasing consensus and enthusiasm for the model, especially as pursued via the "[Georgia Model](#)" of peer support. This model revolves around "Certified Peer Specialists" (CPS). The workgroup recommends that the job [responsibilities and activities of the CPS](#) be built upon that which is in use in Georgia – and detailed in the appendix.

Peer support specialists should play an increased role in crisis intervention services, (e.g., in emergency room settings).

The MHDS should work with IME to ensure providers are appropriately reimbursed for peer support services.

The division must review and revise accreditation standards to describe the role, training, and quality assurance requirements of the CPS position.

Year 2:

A. Supported Employment

The EBP workgroup concluded that employment is a critical piece of recovery, and supported employment for adults with SMI is an evidence-based model that is being under-utilized in Iowa. With the introduction of the Medicaid Habilitation Option, and the CMS-funded Money Follows the Person Initiative/ Consumer Choice Option grant, it is felt that this is a good time to pursue this.

Supported employment revisions under the MR and BI Medicaid waivers need to be made consistent with or incorporated into the Habilitative services. The Habilitative services rules need to be reviewed and revised so as to be optimally consistently with the evidence-based practice model as described in the SAMSHA [Supportive Employment toolkit](#).

The Workgroup recommends that MHDS and IME ensure that providers are being appropriately reimbursed for supported employment services, and the MHDS must expand collaboration with Division of Vocational Rehabilitation.

Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA Supported Employment toolkit

Critical components and core principles of this supported employment model include:

- *Eligibility is based on consumer choice.* No one is excluded who wants to participate.
- *Supported employment is integrated with treatment:* Employment specialists coordinate plans with the treatment team: the case manager, therapist, psychiatrist, etc.
- *Competitive employment is the goal.* The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- *Job search starts soon after a consumer expresses interest in working.* There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like prevocational work units, transitional employment, or sheltered workshops).
- *Follow-along supports are continuous.* Individualized supports to maintain employment continue as long as consumers want the assistance.
- *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

[Fidelity assessment](#) for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Illness Management and Recovery (including Cognitive Behavioral Therapy)

"Illness management and Recovery" (IMR) refers to a set of evidence based principles and strategies that have been found to enhance recovery-oriented outcomes in adults with serious mental illness. The core components of IMR include:

- Psychoeducation, with the goal of improving consumer knowledge about serious mental illnesses
- Behavioral Tailoring, with the goal of helping people make informed choices regarding specific treatment recommendations including medications
- Relapse Prevention, with the goal of reducing symptoms, relapses and rehospitalization
- Coping Skills Training, with the goal of reducing the distress and functional impairment associated with persistent symptoms

Specifically, the IMR curriculum consists of nine modules, delivered in group or individual formats, typically taking six to nine months to complete. The modules include: recovery strategies, practical facts about mental illness, the stress-vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, getting your needs met in the mental health system.

Broadly, Cognitive Behavioral Therapy (CBT) is the underlying model, which unifies these components. Core competencies in CBT should therefore be an expectation across the mental health workforce.

Year 3:

A. Assertive Community Treatment (ACT)

Iowa currently has 5 ACT teams serving ~ 250 clients. It is estimated that the number that would qualify for and benefit from ACT in Iowa is ~ 2000 (based on an expected need of 2.2% of mental

health users, or 0.06% of adult population as per [Cuddeback et al.](#) It is estimated that ~ 15 ACT teams would be required for statewide access to ACT in Iowa. The workgroup recommended the implementation of one new team per year over the next 10 years.

The two major barriers to full statewide implementation involve funding and workforce issues. With an appropriate reimbursement strategy, ACT teams should pay for themselves within two years of start-up. Start-up costs are estimated at 500K for year 1 and 250K for year 2. Medicaid dollars are typically the primary source of payment for ACT. Payment for ACT services should be incorporated into Iowa's state Medicaid plan as a required rather than optional service.

As the availability of psychiatrists is a potentially rate limiting factor, accreditation standards that allow for nurse practitioners and/or physician's assistants to fill the psychiatric role should be pursued.

A key to the success of this "roll out" would be adequate training and support, e.g., in the form of an ACT TA center. Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA [Assertive Community Treatment](#) toolkit.

B. Family Psychoeducation

Family psychoeducation is an evidence-based program that can reduce relapse rates and facilitate recovery of persons who have mental illness. Psychoeducation is delivered by health care professionals, generally takes place over several months, and is linked to the treatment being received by the family member who has a mental illness. The main goals of working with families are to improve the quality of life for the person who has mental illness through collaborative treatment and management; and to reduce the stress and burden of family members while supporting them in their efforts to aid in the recovery of their loved one. Family psychoeducation has been shown to be useful in schizophrenia. The evidence base for other adult psychiatric disorders has been less well established.

The main barrier to family psychoeducation is typically concerns (real or perceived) about whether this activity meets typical standards for reimbursement. As is the case with parent training for conduct disorders, the evidence-based practice requires services not to the identified client – but rather to the supporters of that client. This can present a problem with respect to reimbursement. It is critical that barriers to funding for family psychoeducation be addressed, so that traditional third party reimbursement, e.g., from Medicaid, can be used to finance it.

It is recommended that training in core competencies for family psychoeducation in Iowa follow the model as laid out in the Family [Psychoeducation toolkit](#) from SAMHSA.

EBPs for Children and Adolescents

Year 1

A. School-based Mental Health Services

Research has yielded important advances in the development of effective treatment for children and adolescents who have mental health disorders. Early identification and treatment is critical as early identification of a mental health disorder and access to treatment prevents the loss of critical development years, can minimize the severity of a child's disability, has a greater effect in stabilizing a child's illness and contributes to long term positive outcomes of youth.

At the same time, the overwhelming majority of children with mental health disorders are often unidentified and youth do not receive needed treatment. The reason for this is largely because the symptoms of mental health disorders in youth are often not recognized as related to a mental

health disorder. Adults who are in regular ongoing contact with youth such as teachers, coaches, clergy, and others who work directly with youth do not receive training or other education regarding the prevalence, incidence, identification of risk factors, or other signs related to recognizing mental health needs in youth. Youth who are most in need are often difficult to engage in traditional treatment settings but often respond well to services when provided in more typical environments such as their home school.

As a result there is need to enhance the capacity of mental health professionals to identify and treat youth with mental health disorders in the school setting and for educational staff to receive education and training regarding meeting the mental health needs of youth in the school setting.

Although, there are several models for school based mental health services, the model that is the best fit to address current gaps between mental health services and schools in Iowa is to “house” mental health professionals within the educational setting for the purpose of:

- Early identification, screening, and assessment of mental health needs in youth.
- Linking youth and their families to appropriate mental health services supports and treatment, which includes services needed to help the child succeed in school and services needed beyond the educational setting.
- Facilitating timely access to services when more formal mental health services are needed.
- Providing education, consultation, and support to parents of targeted youth regarding youth’s mental health needs (both within and outside of school).
- Providing education, consultation, and training to educational staff regarding mental health needs of youth.
- Educating youth in the most appropriate, least restrictive educational setting.

The school based mental health service initiative will concentrate on:

- Improved collaboration and coordination at the state agency level between DHS-MHDD, the Department of Education, and the Area Educational Agencies (AEAs) with the goal of state level efforts extending to local school districts, AEA’s, special education services, Early Access, mental health service providers, and others involved in school based mental health services.
- Early identification, Screening and Assessment: A formal process for the early identification of mental health needs in youth, screening/assessment services, and coordination/referral to more formal mental health services when indicated.
- Coordination between home, school and active engagement of parents of youth.
- Mental Health education, training, consultation, and other support to educational staff about identifying mental health needs in youth and supporting youth with mental health needs in the classroom.
- School Based Mental Health Workforce Development needs: Training in core clinical competencies of specific evidence-based interventions for priority disorders needs to be available in a practical manner. This should focus on:
 - Parent Support, Education, and Training (e.g., Parent Child Interaction Therapy)
 - Cognitive Behavioral and Interpersonal Therapy approaches (e.g. Interpersonal Therapy – IPT for adolescents)
 - Early identification and intervention (e.g., ABCD II, Positive Behavioral Supports, etc.)
 - Co—occurring disorders

B. Intensive Case Management with Wraparound

Intensive Case Management is being recommended as a step towards the implementation of the System of Care Model. Intensive case management is a model of case management, which combines the typical coordination/brokerage of service functions with the provision of intensive direct services to the child/ youth and the child/youth's family. Intensive case management services for youth and families typically follow a Wraparound Model of service delivery. This model uses the approach of "one child at a time" individualized service planning to identify what the child and family's unique strengths and needs are.

Wraparound uses a team approach, includes other "key" people and/or agencies involved with the child and family in the service planning process and is typically coordinated by a case manager. The wraparound model is strengths based, family driven, community focused, outcomes driven, and is dedicated to keeping children and youth in the least restrictive environment appropriate to the youth's needs. The case manager convenes the Wraparound Team, facilitates the Wraparound process, coordinates across all services and service providers determined through the Wraparound process, and otherwise ensures that the most appropriate, least restrictive services are provided in the most efficient manner.

Year 2:

A. Parent Support, Education, and Training Services (e.g., Parent Child interaction therapy, Incredible Years, parent to parent support services, etc.)

Parent Support services are services provided by trained parent educators/advocates to work with parents who have children with serious emotional disturbance. Parent Support services include education and supportive services to parents, to otherwise help parents be active participants in their child's care. Parent support services typically follow a peer-to-peer model where parents of youth with serious emotional disturbance are trained to provide the support and educational services to other parents of youth with serious emotional disturbance. Parent Support and education services can be provided individually or in a group setting.

Parent Training Services are provided to parents who have youth with SED and are typically delivered in a more formal context, often in a group setting typically following a standardized curriculum.

Two examples of Parent Support, Education, and Training are:

1. Parent Child Interaction Therapy (PCIT): PCIT is an empirically supported treatment for youth with conduct disorders, which places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. With PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's pro-social behavior and decreasing negative behavior. This treatment focuses on two basic interactions: a). Child Directed Interaction (CDI) which is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; and b). Parent Directed Interaction (PDI) which resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.
2. The Incredible Years: This model is geared towards younger children with disruptive disorders (ages 4 – 8). It is focused on strengthening parenting competencies (monitoring, positive discipline, confidence) and fostering parental involvement in their

child's school experiences in order to promote a child's academic and social competencies and reduce conduct problems.

As there are several models of Parent Support, Education and Training, which focus on different targeted populations and age groups, it is recommended that flexibility be allowed for choice among the many options.

B. In-Home and Community Based Services and Supports

In home and community based services and supports are another critical component of a System of Care Model. These services are typically provided under the supervision and/or coordination of a child's therapist and are a critical part of the child's treatment team. Providers in home and community based services may be a bachelors or para professional level staff that have standardized training in the specific service they are providing. These services are individualized based on the unique needs of the child and family and can be provided in any community location where children and families spend their time: in the family home, at school, or in any other community location. In home and community based services may include respite care, peer support, parent support, attendant care services, behavioral health aides, community psychiatric support and treatment, in-home therapy, etc.

Year 3

A. Family Functional Therapy (FFT):

Functional Family Therapy is a family-based intervention program for youth ages 11 – 18 who have demonstrated dysfunctional and maladaptive behaviors such as delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, or depression. It provides 8 – 30 sessions of direct service time for the referred youth and their families. The program can be delivered in a variety of settings including home, school, clinical and juvenile facilities.

While there are some programs in Iowa that are implementing this EBP, it is recognized as an expensive, difficult to develop practice. However, there appears to be evidence that the approach is cost-effective (across service systems) for appropriately identified clients and families. The EBP group recommends that FFT be pursued further in terms of supporting the funding of FFT in pilot sites as well as developing statewide training for the service in select locations.

B. Integrated Dual Diagnosis Treatment of Co-occurring Mental Health and Substance Abuse Disorders in Children and Adolescents

The evidence base on the effectiveness of integrated MH/SA treatment has not been well established for children and adolescents in the research literature. However, the EBP workgroup believes that the basic principles recommended by co-occurring experts as they apply to adults would likely benefit adolescents as well, and some might very well be generalized to children. Certainly, youth with mental health disorders and/or their parents sometimes also have substance abuse disorders and can maximize benefits from services when service providers are cross trained and have competencies in co-occurring disorders. Therefore it is recommended that

- mental health and substance abuse service providers are cross trained in co-occurring disorders
- The adult model of IDDT is further examined as a service approach that can be implemented with adolescents.

Appendix L:

Strengthening Iowa's Mental Health and Developmental Disability Workforce: Building and Sustaining Competencies

A White Paper Developed by

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Iowa Department of Human Services
January 2008

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Strengthening Iowa's Mental Health and Developmental Disability Workforce: Building and Sustaining Competencies

Allen Parks, EdD, MPH – Director
Division of Mental Health and Disability Services
Iowa Department of Human Services
January 2008

Background on Mental Health and Developmental Disability Workforce Development

There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically –effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services “Toolkits”). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

The President's New Freedom Commission on Mental Health in 2003 described the need for “significant changes in practice models and in the organization of services to improve access, quality and outcomes in mental health.” The Commission recognized that substantial changes are needed in both who does the work in mental health and how that work is done.

Three major reports have underscored concerns in this area. In their landmark *Quality Chasm* Series, the National Academy of Sciences/Institute of Medicine (2001, 2002, and 2003) focused on errors in healthcare delivery. While individual practitioners make errors, the IOM assigned responsibility for quality of care issues to the systems of care in which individuals practice and the educational institutions responsible for preparing those individuals. Quite simply the slow pace of educational reform has left the curriculum in training institutions lagging behind the changes in general healthcare and in mental health and developmental disabilities regarding evidence-based practices, multidisciplinary practice, and managed care approaches.

With an increase in consumerism, demand for more information and meaningful participation in treatment, there has been a major shift away from “traditional” clinical roles. However, the newer, non-traditional competencies, such as shared-decision making with consumers of care, are rarely addressed in training programs. Numerous professional organizations and accreditation entities have studied this issue over the last ten years.

During the period 2001-2004, with support by the federal government, the **Annapolis Coalition on the Behavioral Health Workforce** convened a series of national meetings and expert panels

to build consensus on the current problems and issues in workforce training and to identify potential strategies for strengthening effectiveness and relevance of education offered to all segments of the workforce. The proceedings of these meetings are available at: www.annapoliscoalition.org. A considered focus of these meetings was on the description of competencies related to the treatment of mental health problems, mental illnesses, substance use disorders, and co-occurring illnesses.

In 2003, the Coalition reported on “Best Practices in Behavioral Workforce Training and Education. The “Best Practices” were:

1. Education and training is competency-based.
2. Students are taught to engage in life-long learning.
3. Practice guidelines are used as teaching tools.
4. Students develop competency with manualized therapies.
5. Teaching methods are evidence-based.
6. Curricula are routinely updated to address the values, knowledge and skills that are essential for practice in contemporary health systems.
7. Skill development focuses on clinical, clinical management, and administrative capabilities.
8. Professional training instills in students an understanding of the competing paradigms of service delivery and the diverse scientific, professional, economic, and social forces that shape healthcare.
9. Students train in treatment programs that are competitive in the healthcare marketplace and are similar to the sites in which they are likely to practice after the completion of training.
10. Training sites are diverse, interdisciplinary, and enable students to follow consumers throughout the continuum of care and the course of recovery.
11. The “workforce” is broadly defined and all segments of the workforce receive training. Training is offered to culturally diverse groups of individuals.
12. Consumers and families are engaged as teachers of the workforce.
13. Teachers and supervisors are experienced in providing treatment and currently involved in the delivery of healthcare.
14. The faculty of training programs is interdisciplinary in composition and represents a diversity of approaches to the delivery of behavioral healthcare.
15. Training programs reward faculty for teaching excellence.

The Annapolis Coalition has argued persuasively that states must broaden their workforce development focus and place much greater emphasis on direct care, paraprofessionals, who comprise more than half of the workforce in most treatment settings. The Coalition wrote:

“Within the field of behavioral health, formal and substantive training is most often provided to professionals in graduate programs. Unfortunately, the training offered to direct care staff members, many of whom have high school diplomas or bachelors degrees, is generally quite limited. To the extent that training is offered to these latter groups of individuals, it tends to be driven by accreditation and regulatory requirements and focuses on basic topics such as infection control and fire safety. Efforts to offer even minimal training are hampered by the high turnover rates among these segments of the workforce.

Within mental health and substance abuse treatment systems, these direct care personnel should receive substantive and ongoing training designed to address the functions that they fulfill during the enormous number of hours that they spend in contact with consumers. Since roughly 80% of resources in behavioral healthcare are human resources, there is no justification for deploying direct care personnel, but leaving them untrained.

In a similar vein, The Annapolis Coalition has placed emphasis on the need to support and development the capacities of consumers and family members to care for themselves and each other:

Similarly, much of the care given to individuals with mental and addictive disorders is provided directly by families and by consumers. In some sense, these may constitute the largest, yet most unrecognized, segments of the “workforce”. In addition to their role in providing family and peer support, the recovery movement has emphasized the central and active role that consumers should play in setting personal priorities, establishing the goals of treatment, and selecting services. While there have been notable efforts to develop and offer training about mental illnesses and addictions to families and consumers (i.e., NAMI), the vast majority still receives no substantive education. Concerted efforts are required to provide education that is tailored to the needs of families and consumers, and they should play a central role in developing and refining those educational programs.” (Hoge, Huey & O’Connell, 2003).

A Focus on Competencies

Training has historically focused on students or employees participating in a curriculum, without thorough assessment of their skills at the completion of training. There is a major trend underway to change to a new workforce development paradigm that emphasizes building specific competencies, comprises of knowledge, skills and attitudes, with assessment of these competencies at the completion of training.

A national panel of experts convened by the Annapolis Coalition in 2004 issued a set of **general recommendations** on this topic:

1. Behavioral health competencies should be identified and assessed for a broadly defined “workforce” that encompasses: (a) the various providers who deliver care within the formal behavioral health system, (b) members of the general and specialty healthcare system and human service system who routinely encounter individuals with mental health problems or illnesses and substance use disorders, and (c) persons with these disorders and their families.
2. Initiatives to identify and assess competencies in behavioral health must strive to achieve reliability and validity through the use of established methods in the field of competency development.
3. All members of the behavioral health workforce should develop competencies in the identification, assessment, treatment and prevention of mental health problems or illnesses and substance use disorders, including care of individuals with co-occurring mental and addictive disorders.
4. The content of competency-based training and education must be broadened beyond the traditional clinical paradigm, to include prevention, early intervention, rehabilitation, and recovery- and resilience-oriented approaches to care.
5. The traditional focus on the competency of *individuals* in the workforce must be complemented by concerted attention to defining and assessing the competencies of treatment *teams*, *organizations*, and *systems* in which these individuals function.
6. Persons with mental health problems or illnesses, substance use disorders, and the families of these individuals should play a central role in building a competent workforce by having *formal* input into both the identification of essential competencies and into competency assessments of individual providers, treatment teams, service organizations, and systems of care.
7. All segments of the workforce must develop competencies in delivering culturally, linguistically and developmentally appropriate services.

8. Given the prevalence of stigma, disparities in access to care, and inequities in coverage for care for those individuals with mental illness and substance use disorders, a core competency that should be developed by all members of the behavioral health workforce is the ability to advocate effectively for individuals and for groups on individuals who are diagnosed with these disorders.
9. A “competency collaborative” should be established to link the multiple groups and organizations that are developing behavioral health competencies. This collaborative should identify the optimal common or core competencies to be demonstrated by most providers.
10. Federal, state, foundation, and professional association funding priorities should support a health services research agenda that evaluates the link between competent performance and healthcare outcomes.

The following are specific recommendations from Annapolis group on **competencies**:

1. Dedicate a greater proportion of the investment in human resources to developing those resources. Since some 75% of expenditures of MH/BH organizations are for human resources there should be payoff in investing in the individual human resources that comprise any organization.
2. Adopt and integrate the sophisticated methods for competency development and application that are readily available from business and industry.
3. Observe “exemplary” employees in order to identify and describe essential competencies.
4. Provide detailed information about required competencies to direct care staff, supervisors and trainers.
5. Increase the emphasis on developing skills and abilities in training.
6. Performance in “real world” settings should constitute the ultimate criterion of competency.
7. Link competencies to outcomes.
8. Teach students and practitioners to be self-directed learners and problem solvers.
9. Distinguish between Difficult to- and Easier-to-Develop Competencies (what kinds of competencies need a “program” vs. shorter “training”).
10. Shape treatment program to promote competent behavior.

The Annapolis Coalition stated:

“In this era of increased accountability for the use of scarce resources, we can no longer reward students for simply “doing time” in our educational systems. We can no longer afford to teach outdated modes of practice or fail to provide the workforce with the skills that are essential in modern healthcare systems. We no longer have the luxury to assume that students will get their “real” education as on-the-job training after the completion of their “formal” education. No longer should we tolerate the deployment of direct care personnel who have been given no substantive training in the treatment of individuals with mental illnesses and addictions. No longer should we ignore and fail to educate the vast reservoir of human resources that is comprised of consumers, families, and those working in the general medical, school and human service systems, where individuals so often seek help for their psychological and substance abuse needs.

There is growing concern about the quality of healthcare in American, accompanied by calls for reform. Improvements in the quality of care will be driven, in large part, by efforts to enhance the education of the workforce. If the field is to make progress in implementing best practices in treatment, it will be essential to implement best practices in workforce education... Human resources are the principal resource in behavioral health. We must nurture these resources and use them wisely.” (Hoge, Huey & O’Connell, 2003).

Workforce Development Strategic Goals

From 2005-2007, with underwriting from the Substance Abuse and Mental Health Services Administration, the Annapolis Coalition developed a comprehensive, national strategic plan on workforce development, *An Action Plan for Behavioral Health Workforce Development*. The report has become a template for action to strengthen workforce in a number of states. The plan identifies seven goals, which are consistent with the goals of Iowa's reform of mental health and developmental disabilities services:

- GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to: participate in, ultimately direct or accept responsibility for their own care; provide care and supports to others; and educate the workforce.
- GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.
- GOAL 3: Implement *systematic* recruitment and retention strategies at the federal, state and local level.
- GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.
- GOAL 5: Actively foster leadership development among all segments of the workforce.
- GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.
- GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.

While the work of the Annapolis Coalition cited above has focused largely on mental and substance use conditions, parallels to the field of intellectual and development disabilities are numerous. Recent work in the state of North Carolina has laid out the commonalities across these disorder populations and the potential benefits of a joined effort. (*North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse. Direct Support Professional Work Group Report*, November 2007, Hewitt, Edelstein, Seavey, Morris, and Hoge.)

Iowa's Center for Disabilities and Development reviewed trends in Iowa, noting that issues arise from the confluence of historical trends and from interests, which compete and occasionally overlap. Reviewing the movement to rebalance long-term care, for example, yielded the following observations:

- Community provider capacity to provide HCBS is circumscribed by their ability to recruit and retain competent staff. Workforce issues are reportedly more acute in rural areas.
- Iowa community providers cite both State Medicaid regulations (such as the 20% administrative cap, which limits the resources available for training) and county reimbursement restrictions as barriers to having sufficient funds for paying competitive wages, offering benefits, and training/retaining staff.
- Community providers do not receive rate increases with the same frequency as institutional providers limiting the providers' ability to offer merit or cost of living increases to their employees. Even when they do receive those increases, their effect may be negated by the caps on reimbursement rates or on service units available to individuals.
- There is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. Many providers train staff in-house, and some collaborate in bringing in outside resources for such specialized topics as working with people with dementia or behavioral issues. Iowa

Caregivers Association and others offer a few sessions on the needs of specific populations at their annual members' conferences.

- Anecdotes about inadequately trained HCBS provider staff, high turnover rates and inconsistency in the daily provider team have discouraged some families from pursuing community living options for loved ones.
- Some community providers point to need for funding to decrease the discrepancy in wages and benefits between State Resource Centers and community-based employment.

If Iowa is to build and sustain a workforce capable of offering the highest quality, evidence-based services to its citizens with behavioral health, developmental and other disabilities, the foundation must be its workforce. Continuing to educate and train the workforce in an outmoded fashion cannot continue, and an infrastructure to meet the emerging demands must be created.

The Current Mental Health and Developmental Disability Workforce in Iowa

Iowa's current workforce includes a mixture of categories, disciplines and levels of education. There are significant shortages in highly trained specialties (child psychiatry, individuals cross-trained in treating co-occurring mental illnesses and substance use disorders, individuals cross-trained in treating co-occurring mental illnesses and intellectual/developmental disabilities, etc.) and significant challenges are presented in the recruitment and retention of skilled workers in many of the state's rural communities. Although Iowa has made strides in involving persons with disabilities and their families in the workforce, much work remains to be done. We have much work to be done in assuring the linguistic and cultural competence of our workforce.

For all of these reasons, it is time for Iowa to make a significant investment in the preparation, continuing education, and support for its behavioral and other disabilities workforce.

The Proposal

Training designed for the mental health and disability services workforce in Iowa is sporadic, decentralized, and lacks uniformity. The Mental Health and Disability Services Division of the Iowa Department of Human Services, the Iowa Consortium for Mental Health and the Iowa Disabilities and Development Center propose the creation of a specialized center to take the lead in meeting the state's need for standardized, centralized and customized development of the mental health and disability services workforce to be housed in the Des Moines area. The ultimate organizational structure of this center will require additional exploration, but a white paper prepared for MHDS (see Appendix B) provides some examples from other states. The first steps are to create infrastructure and a workforce collaborative to lead the further development of this workforce center.

In addition, this proposal includes a series of strategies proposed to address Iowa's workforce needs in mental health and developmental disability services. In order to ensure buy-in and demonstrate the utility of the core center concepts, the implementation of a series of training initiatives for high priority workforce development areas will yield tangible results.

Vision and Goals of the MHDSTI

The vision of the proposed Mental Health and Disability Services Training Institute is

to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

Programs

The goals will be accomplished through:

1. Train for Competencies
 - Develop training programs designed around worker needs and mental health and disability practitioner competencies and priorities.
 - Develop a standard training program for consumers and families to prepare them to serve as trainers.
2. Offer Comprehensive Evidence-based Training Programs
 - Promote and/or provide high-quality learning opportunities in accessible settings and formats in an “evidence-based” way.
 - Provide systematic, competency-based training programs for key mental health and disability transformation topics.
 - Develop and provide targeted educational initiatives related to the implementation of specific evidence-based practices such as Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Supportive Housing, Illness Management and Recovery, Family Psychoeducation, etc.
3. Build Systems that Support Practitioner Development and Career Ladders
 - Promote credentials and competency-based training requirements for mental health practitioners.
 - Implement training and development of competency-based Supervisory skills.
 - Seek partnerships with colleges/universities and other education providers to meet mutual practice and training needs of both mental health practitioners and students.
4. Build Systems/ Organizations that Support the Use of Evidence-based Practices
 - Support and model the values of mental health transformation towards the achievement of a recovery-oriented service delivery system that is consumer and family driven.
 - Serve as a technical resource to state agencies, community-based organizations, consumers and recovery organizations.
 - Coordinate existing resources to focus on and leverage training for implementation efforts.
5. Disseminate Current Mental Health Practice Research.
 - Provide current and state-of-the art treatment practice information and resources through specialized publications, web-based information, and the use of Telebehavioralhealth and Teletraining.
 - Provide coordinated and targeted technical assistance to Iowa’s provider community to ensure that policy infrastructure modifications are made to ensure that improved practices can be financed and delivered statewide.

Strategies and Structures to Achieve the Goals

Creation of an Iowa Mental Health and Disability Services Institute will require a methodical, multi-phased approach. Each of the elements detailed below is a building block designed to ensure success and sustainability. While these activities are discretely identified and budgeted for accountability purposes, they can and should be activated concurrently as part of a comprehensive planning and implementation design. In addition to the brief narratives provided in each section, a break out of expenditures appears in attached spreadsheets.

The development design proposed has two distinct elements, best described as (a) infrastructure development, and (b) special initiatives. The first provides the underpinnings necessary to keep the ultimate goal of sustainability, while the latter are focused on bringing immediate assistance to high priority concerns of the Iowa system. Creating an Institute in a vacuum will not engage stakeholder participation and buy-in unless the emerging Institute can demonstrate immediate return on investment.

Development of the Mental Health and Disability Services Training Institute

In the winter of 2006 and spring of 2007, the Iowa Department of Human Services (IDHS), Division of Mental Health and Disability Services (MHDS), in collaboration with the state legislature, embarked upon a Mental Health Systems Improvement (MHSI) initiative that included a number of workgroups focusing on systems change. One workgroup focused on evidence-based practices. In 2007, the Iowa legislature (HF909) directed the IDHS to:

“develop a comprehensive training program concerning such practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa Consortium for Mental Health.”

In the summer of 2007, the MHDS began a planning process that included the Iowa Consortium for Mental Health, the Center for Disabilities Development, the Iowa College of Public Health, the University of South Florida Mental Health Institute, ZiaPartners, Inc., and the Annapolis Coalition to form the Mental Health and Disability Services Training Institute (MHDSTI). That planning process sought to respond to the legislative mandate to develop a comprehensive training program as stated above.

Also during the summer of 2007 other workgroups were meeting with MHDS that included various stakeholders such as providers, county representative, family members, consumers and advocacy groups. Guided by expert technical advisors such as the Annapolis Coalition and the Iowa Consortium for Mental Health a plan evolved for the creation of the MHDSTI. The MHDSTI was envisioned as a center for evidence-based training on mental health and disability issues for professional and direct care staff providers, family, consumers, including DHS mental health institutes, resource centers, community mental health centers and other community substance abuse and mental health providers. Specific provider populations initially targeted by the MHDSTI were those offering co-occurring mental health and substance abuse disorder services, as well as those providing emergency mental health, children’s mental health, and school mental health services.

Iowa is in the process of transforming its publicly funded mental health system to a consumer and family-driven system that embraces prevention, resiliency, and recovery as guiding principles. Implementing that goal requires shedding old stereotypes of mental illness and replacing them with new attitudes and services that support people with mental illnesses. In the midst of this transition, the mental health system faces a crisis in providing appropriate mental

health services to forensic clients. Without systematic and quality training as well as attention to effective strategies needed for implementation of new practices, the realization of Iowa's transformation goals could be compromised.

This initiative will require dedicated in-state staff and resources to ensure that all relevant partners are included, and that the efforts to develop Iowa's capacities are a constant focus of attention. For the initial year of this effort, we are proposing to hire a Project Director and an administrative assistant to manage all of the elements of the development process; the Project Director should be someone of demonstrated planning and organizing skills, with a good understanding of behavioral and other disabilities services, with additional expertise in the working with both academic and practice communities. In addition, funds are proposed for logistics support to convene meetings, publish reports, and to engage the services of needed consultants.

Total projected cost: \$200,000.00

Creating a Workforce Collaborative

Essential to the success of a statewide effort of this type is an infrastructure to identify and prioritize workforce problems, coordinate or implement interventions, and monitor outcomes. Perhaps most important, an infrastructure is necessary to link and leverage *existing* resources that are available within the state to strengthen its workforce.

The functions of such an infrastructure would include, but not be limited to the following:

Leveraging existing resources by:

- Identifying and disseminating information about existing workforce development resources (clearinghouse function).
- Coordinating workforce development efforts among various public and private agencies to achieve efficiencies and reduce duplication of effort.

Linking Iowa's mental health and higher education systems in a coordinated effort to develop a pipeline of culturally diverse and appropriately trained mental health providers. This includes:

- Educating educators about current trends in service delivery as a strategy for fostering relevant curricula in the educational system
- Working with the mental health, higher education, licensing systems, and payers to improve career ladders in mental health within Iowa.

Assessing routinely the mental health workforce development needs within Iowa, including:

- The magnitude, characteristics, and causes, of recruitment and retention problems, including the impact of compensation and benefits
- The accessibility, relevance, and effectiveness of training and education resources/program.

Planning in the form of a biannual strategic plan on mental health workforce development and report on the status of this workforce will be conducted by the Collaborative.

Implementing interventions to strengthen the workforce.

Promoting employment of consumers, youth, and family members in the mental health workforce.

Disseminating best practices in workforce development to employers of the mental health workforce.

Advising Iowa's executive, legislative, and judicial branches on workforce issues and policy.

Applying for other potential sources of funds to support workforce development.

The structure of the Collaborative would include a General Membership, Executive Committee, Standing Councils, and ad hoc workgroups.

Persons in recovery, youth, and the parents of children and youth with emotional and mental problems would play a major role in all structures.

Technology, in the form of web-enabled conference calls, will be used for selected meetings to maximize efficiency, minimize time and travel-related meeting costs, and foster access for consumers and family members.

The collaborative can serve as the **Advisory Council** to the Institute, ensuring that the voices of key stakeholders are heard, and that all elements of the system are engaged in the selection, design, delivery and evaluation of the work of the Institute. The Collaborative sets the policy direction for the work of the Institute in strengthening Iowa's workforce.

The activities of the Collaborative would be the responsibility of the Project Director identified above in the Basic Infrastructure section; the Institute would staff the work of the Collaborative and provide its administrative home. Resources dedicated to this effort would include logistic support for meetings, development and dissemination of reports, and the services of content and process consultants to advise the process.

Total projected costs: \$150,000.00

Special Initiatives

The Institute should sponsor a series of inter-related initiatives as soon as basic infrastructure is in place. Based on the assessment of the Iowa Department of Mental Health and Disability Services, the following five initiatives should be funded during the first year of the Institute's development. The first initiative (focusing on supervision) is cross cutting and provides the foundation on which the successful dissemination of evidence-based practices can be built and sustained. The remaining five areas focus on areas of urgent need in Iowa's system of care, and addressing them in a manner consistent with the vision of the Institute (using evidence-based methods, incorporating the best science available, etc.) will provide credibility for further elaboration of the work of the Institute.

Supervision.

A critical element in successful system transformation is intervention at the level of service supervisors. Training clinicians and other direct-care workers in evidence-based practices requires an informed support system; the lynchpin in such a support system is the front-line supervisor. In its national work, The Annapolis Coalition has determined that there has been significant erosion in the role of supervision in service delivery; this has been the case in Iowa as well. The pressure for billable hours has shifted the role of clinical supervision away from the content of service delivery and toward more administrative and financial duties. A concentrated effort to provide training in **effective** supervision is a necessary core step in changing practice. Existing resources are inadequate to address the content of such training, much less to attend to the necessary policy and reimbursement strategies that will need to be developed to shift the system in the direction of evidence-based models.

The resources allocated here would provide for curriculum development and pilot implementation of supervisory training in the MHDS system of providers, as well as the development of relevant policy and protocol changes needed to ensure continuity in the dissemination of new models.

Projected total costs: \$150,000.00

Improved Services for Children, Adolescents and Their Families

This is already an identified high priority for Iowa MHDS, and this funding would ensure that there are resources available to the system to support dissemination of evidence-based strategies. Funds would provide for the engagement of experts in identified best practices and for implementation of training sessions and development of fidelity monitoring technologies to ensure that practices are implemented in a way that is consistent with the scientific findings that drive the practice.

Projected total costs: \$100,000.00

Improved Emergency Mental Health Crisis Services

Iowa's hospitals are struggling to meet the demands of persons with mental and developmental disorders in crisis, many of whom could be served both more effectively and in a more cost-effective manner by robust crisis and emergency mental health services, including such strategies as "Mental Health First Aid", peer supports, crisis prevention intervention, use of telephone "hotlines", and the like. Funding would provide for the engagement of key Iowa stakeholders, content experts in model design, and provision of basic training in new approaches to emergency mental health crisis services.

Projected total costs: \$100,000.00

Co-occurring Disorders

Iowa MHDS has identified co-occurring disorders (especially mental and substance-use disorders) as a high priority population that is currently un- or under-served. In addition, there are many individuals with co-occurring intellectual/development disorders and mental health/substance use disorders who are not receiving state of the art care. Funding would provide for statewide training on science-based interventions, and for the engagement of content experts for curriculum design and training delivery.

Direct Care Workforce.

Although there are efforts underway in Iowa to address the needs of the direct care workforce in the development disabilities area, more effort is needed there. According to the Center for Disabilities and Development, there is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. These efforts need to be expanded to begin to reach the direct care workforce in other areas of the MHDS service system, as well. Funding would provide for development of cross-disciplinary competencies, curriculum development, and training implementation for direct care workers in all MHDS service agencies.

Projected costs: \$100,000.00

Consumer and Family Training

Self-directed care is a cornerstone of contemporary practice, which has been recognized in the development disabilities field for some time, and is a hallmark of recovery- and resilience-oriented

systems of care for people with mental and substance use conditions. While often given lip service, consumers and families will not be able to engage in effective management and leadership of their recovery plans without training, education and supports. Funding will provide for the use of existing training models (e.g., NAMI's "Family-to-Family" and "Provider Education" tools, the Certified Peer Specialist training models, etc.) or the development of curricula specific to the needs and desires of Iowa's consumer communities.

Projected costs: \$100,000.00

Professional recruitment strategies.

Iowa has experienced chronic shortages at the highest end of the workforce: psychiatrists, psychologists, Master's level licensed social workers, and advanced practice nurses. Under this special initiative, Iowa will establish a pool of dollars to offer financial incentives (stipends, loan forgiveness, supplements) to individuals in the high-need categories who are willing to help meet the skills deficits, especially in our rural and frontier communities. We will select those strategies that have been demonstrated to provide results, and match them to candidates who seem most likely to contribute to our system over time. Consumers seeking services in programs for those with chronic and persistent mental illness will benefit from the recruitment, placement and retention of up to eight psychiatrists, doctoral level psychologists or nurse practitioners with mental health specialization. Once placed in programs service the chronically and persistently mentally ill, these practitioners will provide professional mental health services to Iowans that do not receive the services now.

Projected costs: \$200,000.00

Building on Existing Strengths

Iowa is fortunate to have in place existing structures that can support and enhance the development of the Institute. Chief among these are the Iowa Mental Health Consortium and the Iowa Center for Disabilities and Development. These two entities will play a significant role in the development and functioning of the new Institute, and their current work will be amplified and enhanced by the new structure. In addition to their work, there are several proposed federal efforts (specifically related to telemedicine and to enhanced recruitment and retention strategies for hard-to-find specialists) that would significantly broaden the impact of the proposed Institute.

SUMMARY

The case for transformation of services to people with mental and disability services has been made both nationally and in Iowa. Resources for these services have never been sufficient to meet demands, nor is that likely to change. These two imperatives demand that Iowa ensure that every dollar it spends on services in support of people with disabilities is spent wisely, and that public services for people with disabilities are designed and delivered in ways that ensure that they are effective. This cannot happen in the absence of a workforce that is adequately trained and supported to deliver the highest quality of care that can be delivered. The people who receive those services and supports, and the taxpayers, who pay for them, should expect nothing less. The creation of an Iowa Mental Health and Disabilities Training Institute is a defining step in ensuring that Iowa transforms its system to meet the highest standards possible.

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APPENDIX A

PROVISIONAL BUDGET IOWA MENTAL HEALTH AND DISABILITIES TRAINING INSTITUTE

ELEMENT 1: Basic Infrastructure

Director	\$ 90,000.00
Administrative Asst	\$ 35,000.00
Office support	\$ 10,000.00
Logistics (travel, meals, printing, etc.)	\$ 40,000.00
Contractual Services (consultants, research, etc.)	\$ 25,000.00
Total Element 1	\$ 200,000.00

ELEMENT 2: Collaborative

Meetings (Hotel, meals, travel)	\$ 25,000.00
Other logistics (Printing, website)	\$ 25,000.00
Contractual Services Consultants, surveys, commissioned reports, faculty stipends, etc.)	\$ 100,000.00

Total Element 2	\$ 150,000.00
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Element 3: Supervision Initiative

Curriculum design/Technical Assistance	\$ 100,000.00
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Training sessions/materials	\$ 50,000.00
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Total Element 3	\$ 150,000.00
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Element 4: C&A Initiative

Curriculum design/Technical Assistance	\$ 75,000.00
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Training sessions/materials	\$ 25,000.00
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Total Element 4	\$ 100,000.00
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Element 5: Crisis Services

Curriculum design/Technical Assistance	\$ 75,000.00
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Training sessions/materials	\$ 25,000.00
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Total Element 5	\$ 100,000.00
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Element 6: Co-Occurring

Curriculum design/Technical Assistance	\$ 75,000.00
Training sessions/materials	\$ 25,000.00
Total Element 6	\$ 100,000.00

Element 7: Direct Care Staff

Curriculum design/Technical Assistance	\$ 75,000.00
Training sessions/materials	\$ 25,000.00
Total Element 7	\$ 100,000.00

Element 8: Consumer and Family Education

Curriculum design/Technical Assistance	\$ 75,000.00
Training sessions/materials/stipends	\$ 25,000.00
Total Element 8	\$ 100,000.00

Element 9: Recruitment and Retention Strategies

Design and oversight	\$ 30,000.00
Stipends, loan repayments, supplements	\$ 170,000.00

Total Element 9 \$ 200,000.00

TOTAL INSTITUTE DEVELOPMENT BUDGET \$ 1,150,000.00

APPENDIX B

Selected State Training and Research Institutes

October 11, 2007

*A brief review for the
Iowa Department of Human Services*

Prepared by

John A. Morris, MSW & Michael A. Hoge, PhD

The Annapolis Coalition on the Behavioral Health Workforce

The state of Iowa is wise to look toward sustainability of workforce development, and that suggests creating structures that are designed to span agencies, academia and constituent groups to ensure the structure's survival across changing leadership at the level of the Governor, agencies, or Legislature.

The developmental work to create such a structure must be driven by a clear set of principles, and these must be consistently reflected in any activities that are associated with the reform initiatives in Iowa. Drawn from prior work and recent discussions, we suggest that at least some of those core principles include:

- a. Consumer and family involvement in all aspects of the work must be at the forefront in matters of policy, research, training and education.
- b. Cross-agency, cross institution partnerships have to be visible
- c. Creating value for all participants¹ has to be a hallmark; benefits have to accrue to all stakeholders in order for sustainability over time
- d. Cultural and linguistic competency must be operationalized for Iowa in concrete, practical, and effective ways.
- e. Technology has to be used to help overcome barriers created by geography in a state as rural as Iowa.

The Annapolis Coalition team provides these brief thumbnail descriptions as background information for further discussion and investigation. They reflect a range of organizational structures, missions, and levels of financial support.

Louis de la Parte Florida Mental Health Institute (FMHI)

Parent Institution: University of South Florida

Location: Tampa, FL

Organizational structure: Status as a College within USF, headed by a Dean.

¹ E.g., the state must get answers to questions that matter; academics must have research topics and teaching opportunities that are relevant to their missions; consumers and families must feel that the actions make a difference in their lives; providers have to feel that their staff are more effective; etc.

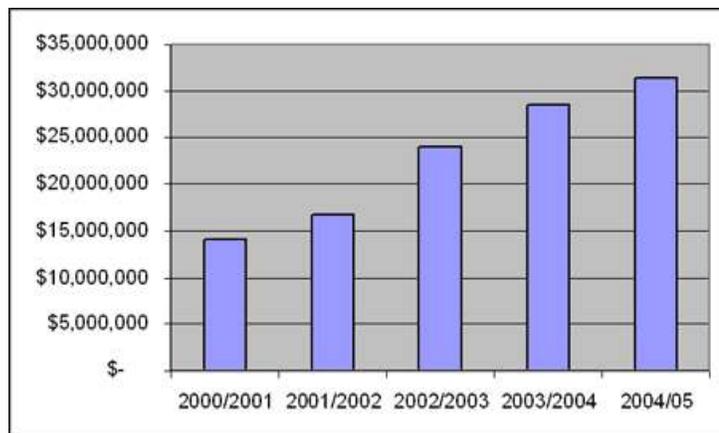
Overview: FMHI is one of the models that emerged from an inpatient service, and it is housed in the former hospital buildings on the campus of USF. They have some modest base funding, but have a very successful track record of pursuing research dollars; they also have a number of contracts with the State of Florida for training (much of it distance-education), staff development, research, evaluation and policy work. They have nationally recognized expertise in both adult and children's mental health, and mental health and law.

Director/CEO: Junius J. Gonzales MD, MBA

Website: www.fmhi.usf.edu

Budget: Approximately \$31,000,000.00. See chart below

Since 1986, FMHI's contract and grant activity has grown from \$2 million to over \$31 million. Funding has been awarded for research and development projects from federal and state agencies, private foundations, and corporate sponsors. The history of sponsored research for the past five years is shown in this chart. (Source: FMHI website, 11/14/06.)



Missouri Institute of Mental Health (MIMH)

Parent Institution: University of Missouri (Columbia)

Location: St. Louis, MO

Organizational Structure: Semi-independent unit within the University's Provost Office. Also has linkage to the School of Medicine.

Overview: MIMH also grew out of a large teaching hospital affiliated with the St. Louis State Hospital, and it is housed in one of the historic buildings on that campus. MIMH has been a center of research on consumer-operated mental health services, and is the host for the Internet-based Policy Information Exchange (PIE-on-Line). They pursue federal research and implementation dollars, and have significant contracts with the state for training (much of it distance education), research, evaluation and policy.

Director/CEO: Danny Wedding, PhD

Website: www.mimh.edu

Funding: Approximately \$5,700,000.00

California Institute for Mental Health (CiMH)

Parent Institution: CiMH is an independent, 501 (c) 3 not-for-profit organization.

Location: Sacramento, CA

Organizational Structure: CiMH was founded by the county behavioral health directors of California to be their research, training and policy support.

Governance is provided by a board of directors, a majority of who are members of the California Mental Health Directors' Association.

Overview: Because California's behavioral health system is largely county-driven; CiMH has historically focused on community-based interventions. They also have many contracts with the state office of mental health, and conduct much training and staff development activity for the state system. One of CiMH's strongest areas has been research and program development focused on the needs of multi-cultural populations. CiMH is currently playing a major role in the implementation of the California Mental Health Act (Proposition 63), which includes significant set-asides for training and workforce development activities.

Director/CEO: Sandra Naylor-Goodwin, PhD

Website: www.cimh.org

Funding: Approximately \$4,500,000.00

Nathan S. Kline Institute for Psychiatric Research

Parent Institution: New York Office of Mental Health

Location: Rockland Psychiatric Center, Orangeburg, New York

Organizational Structure: The Nathan Kline Institute is part of the New York Office of Mental Health.

Overview: The Nathan Kline Institute is one of the last remaining public mental health focused institutes that remains both part of the public mental health system and providing inpatient services. Their website references three priority focus areas: patient-oriented research programs emphasizing the causes,

diagnosis, treatment, prevention, and care of severe and long-term mental disorders; clinically-relevant, basic research on physiological and biochemical aspects of mental disease; and research on the cost, quality, and effectiveness of services for patients in mental health programs certified, operated, and/or funded by New York State.

Director/CEO: Harold S. Koplewicz, MD, Director

Website: www.rfmh.org/nki

Funding: Budget information not readily available. Core funding comes from the NY Office of Mental Health and the Research Foundation for Mental Hygiene, Inc., an affiliated not-for-profit. The Institute also competes for federal and foundation grant support.

Dartmouth Psychiatric Research Center (PRC)

Parent Institution: Dartmouth School of Medicine

Location: Concord, New Hampshire

Organizational Structure: The Dartmouth Psychiatric Research Center

Overview: The PRC conducts interdisciplinary research on services for individuals who have serious mental illness, primarily schizophrenia spectrum and bipolar disorders. The PRC specializes in developing effective interventions under research conditions, then translating these interventions into actual mental health service practices and evaluating their effectiveness in routine practice settings. PRC research incorporates multiple scientific perspectives, such as clinical, economic, and ethnographic. The PRC works with efficacy and services researchers to address the needs of multiple stakeholders through effectiveness research in routine practice settings. They have been instrumental in developing the SAMHSA funded toolkits for six evidence-based adult interventions, and consult to state and local behavioral health authorities on a range of best practices.

Director/CEO: Robert M. Drake, MD, PhD

Website: www.dms.dartmouth.edu/prc

Funding: Dollar amount not readily available. Mix of some base funding from NH Mental Health Department and Dartmouth; much support from competitive grants and contracts for training, staff development, etc.

Ohio Coordinating Centers of Excellence

Parent Institution: Ohio Department of Mental Health.

Location: 7 Coordinating Centers of Excellence located at various sites throughout Ohio:

Illness Self-Management and Recovery CCOE
(Medical University of Ohio)

Clusters CCOE
(Synthesis, Inc., Columbus)

Substance Abuse/Mental Illness CCOE
(Case Western Reserve University, Cleveland)

Mental Health/Criminal Justice CCOE
(Summit County ADAMHS Board, Akron)

Ohio Medication Algorithm Project (OMAP)
(Center for Quality Innovations & Research, Cincinnati)

Center for Innovative Practices – Multi-Systemic Therapy (CIP-MS)
(Stark County Mental Health Board, Canton)

Center for Learning Excellence (CLE)
(Ohio State University, Columbus)

Organizational Structure: Each is slightly different, as some are university affiliated and others are based in local not-for-profit organizations

Overview: Beginning in 1992, the Agency for Health Care Policy and Research and the National Institute for Mental Health funded the Schizophrenia Patient Outcomes Research Team (PORT) to develop and disseminate suggestions for the treatment of those living with schizophrenia, based on existing scientific evidence. These recommendations, published in their final form in 1998, were based on in-depth and comprehensive reviews of the "treatment literature" as well as a focus on the treatments that established a substantial evidence of efficacy, or effectiveness. Subsequently, the Ohio Department of Mental Health established seven (7) Coordinating Centers of Excellence to systematically disseminate and implement evidenced-based practices (EBPs) through Ohio's community mental health system. (Source: Ohio DMH website.) Additional description of the model can be accessed in Munetz, MR; Morrison, A; Krake, J; Young, B and Woody, M. (2006) State Mental Health Policy: Statewide Implementation of the Crisis Intervention Team Program: The Ohio Model, *Psychiatric Services*, Vol. 57, 1569-1571, November, 2006.

Director/CEO: Lon Herman, MA, ODMH Director of Residency, Training and Learning

Website: www.mh.state.oh.us/medicaldirdiv/clinicalbp/clinicalbp.ccoes.html

Funding: Blended funding, with significant state dollars supplemented by federal grants, training contracts, etc.

SUMMARY

None of the above models is recommended for Iowa, which should develop its own model to meet its unique needs, but they provide examples of structures and designs that have proven successful in assisting states to improve the quality of services.

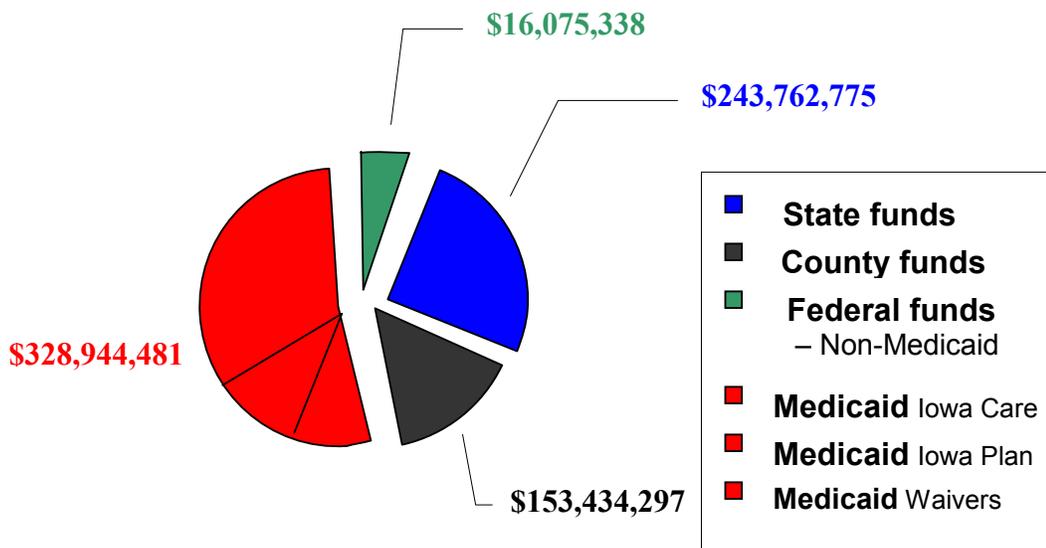
APPENDIX M:

The Mental Health and Disability System in Iowa – A View from the Data

Overview

In 2006 there were over \$1 billion in expenditures for mental health and disability services in the State of Iowa*. According to information provided by the DMDS, Chart 1 (below) depicts the breakdown by sources of funds of \$742,216 of funding for the 2006 for the combined Mental Health and Disability Services in the State of Iowa. These figures do not include Medicare, SSI or SSA expenditures. As can be seen from the chart, the major funding source is the federal government and this is primarily from in Medicaid reimbursements. The Iowa Medicaid Enterprise (IME), a division of the Department of Human Services (DHS) manages Medicaid funds through Medicaid “waiver” programs and *Iowa Care*. County funds represent the smallest portion of total expenditures with the counties contributing (21%) and the State contributing (33%). County and state contributions are general in the form of “match” to enable the state to obtain Medicaid reimbursement. Table 1 present the number of persons served with a diagnosis of MI or CMI as reported by counties for FY2006.

Chart 1: Mental Health & Disability Services Expenditures in Iowa*



Total: \$742,216,891

*These figures do not include Medicare, SSI or SSA expenditures in Iowa. Also not included is any expenditure from competitive grants. If those amounts were added the total would be over \$1 Billion spent on services per year. Source: DMDS

Table 1: Profiles of Persons with MI and CMI Served, All Programs by Age, Gender and Race/Ethnicity Unduplicated Count for 2006 as Reported by All Counties (Source: URS Data Files)

	Total				
	Female	Male	Gender Not Available	Race Not Available	Total
0-12 Years	7393	11560	10	3	18963
13-17 years	5652	6210	17	12	11879
18-20 years	2189	1516	10	9	3715
21-64 years	24044	15404	259	240	39707
65-74 years	460	326	10	7	796
75+ years	299	206	16	13	521
Not Available	91	77	42	39	210
Total	40128	35299	364	323	75791

I. Data Collection – 2007 Surveys

In the Summer of 2007, and as part of the MHDS Mental Health Systems Improvement initiative, initial surveys were sent to the state’s 33 Community Mental Health Centers (CMHC) and to the county’s Central Point Coordinators (CPC). Survey information was sought since there was no system or available data that could connect service utilization with expenditures.

A. Reliability and Validity Issues

We first examined the survey data from CMHCs and CPCs. The first question that was examined from the surveys was the extent to which CPCs and CMHCs reported similar services and expenditures for the same time period. The intent also was to get a robust picture of what services were being provided throughout the states by the CMHCs. Second, the level of funding provided to the CMHCs by the counties was also examined in order to assess if and where service gaps or irregularities might exist. It was noted that CPCs might report services other than those provided by CMHCs when asked to delineate the service array in their counties.

Initial response was poor from both entities. Follow-up surveys subsequently led to more complete data but continued to be incomplete making generalizations from analyses inconclusive due to missing data; to date 32 CMHCs and all but three CPCs responded. While missing data presents obvious challenges in terms of generalizability of the data at hand, it was felt that there was sufficient participation from survey respondents to assist in a better understanding of the general trends in service provision as shown in this section of the report.

1. Services Provided and Potential Service Delivery Gaps

Initially we sought to examine the extent to which CPCs and CMHCs reported similar services and expenditures for the same time period.

Table I shows the extent to which there was agreement from CPCs and CMHCs reports of the types of services actually provided. It was hoped that there would be a high degree of concordance of the services the counties reported to the state that they fund and the services the CMHCs believed they provide. Table I shows the number of CMHCs that report they actually provide a service and what the CPCs reported they believed they purchased. Table 2 does not show actual service utilization, rather only service provision *as reported by CPCs and CMHCs* for FY2006.

The information obtained from the surveys documents that services were not all provided by CMHCs. Overall, CPCs were more likely to report that more services were offered as compared to what was offered by CMHCs (means = 59.19 (sd=20.01) vs. 49.74 (sd=26.71) Pearson Correlation Coefficient = .692, p=.0001). The lowest rate of concordance in responses to the survey (a 30% or more difference) was found where CPCs stated that they provided

the following services more often than those stated by CMHCs: Crisis Stabilization, Targeted Case Management, Co-Occurring Mental Health and Mental Retardation Services, Supported Housing, and Supported Employment.

The data suggest at least three issues to consider. First, that service reporting by one or both entities regarding the provision of a set of services may be unreliable. Second, that the higher levels of services reported by CPCs may mean services are being provided in the county but not by CMHCs. Third, that over-reporting by CMHCs across some services categories may mean that consumers are not entering the system through the CPCs; rather they are entering directly at the CMHC. All three hypotheses are of concern for at least two reasons; that we do not have adequate IT capacity identify where consumers are entering into and served in the system, and that if the system continues to have more than one point of entry this could contribute to confusion on access, fragmentation of service, and possibly cost-inefficiency through duplication of efforts. It is also of interest that some of the services listed above are not being provided by CMHCs who are typically thought of as the “safety net” provider.

Table 2. CMHC and CPC Survey Results of Service Provision FY2006				
CMHC and CPC Survey Results of Service Provision		CMHCs Survey	CPC Survey	% Difference
		% offer	% offer	
Column Label	Actual Survey Question	N=37	N=88	
Telephone Crisis Services 24/7	Telephone Crisis Services 24/7	87	92	5
Crisis Stabilization	Crisis stabilization and response including 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions Inpatient or other protective environment for treatment	33	68	35
Mobile crisis services	Mobile crisis services	8	17	9
Community-based crisis interventions for children and youth	Community-based crisis interventions for children and youth	31	39	8
Crisis intervention teams	Mental health crisis intervention services provided by teams of mental health workers (psychiatrists, RN's, MSW's, psychologists, psychiatric technicians)	28	36	8
Mobile crisis teams	Mobile crisis teams visit people in their homes or community sites, and others meet clients in clinics or hospital emergency rooms	17	20	3
Functional assessment and diagnosis	Functional assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.	92	92	0
Outcomes measurement tools	Outcomes measurement tools in order to monitor consumer outcomes in programs	56	57	1

Navigation, planning, linking, coordinating, follow-up, and monitoring	Navigation, planning, linking, coordinating, follow-up, and monitoring	64	76	12
Case Management	Case Management	44	59	15
Targeted Case Management	Targeted Case Management	19	66	47
Co-Occurring MH and SA	Co-Occurring Mental Health and Substance Disorders Services	56	68	12
Co-Occurring MH and MR	Co-Occurring Mental Health and Mental Retardation Services	42	76	34
Recovery-oriented services	Recovery-oriented services	81	59	22
Cognitive behavioral therapy	Cognitive behavioral therapy	94	66	28
Family psycho-education	Family psycho-education	47	61	14
Supported housing	Supported housing	14	52	38
Motivational enhancement	Motivational enhancement	44	30	14
Multi-systemic family therapy	Multi-systemic family therapy	25	44	19
Illness and medication management	Illness and medication management	83	89	6
Behavioral health and rehabilitative services	Behavioral health and rehabilitative services	61	72	11
Supported employment	Supported employment	14	60	46
Mental health advocacy	Mental health advocacy	64	72	8
Prevention and early intervention	Prevention and early intervention	44	60	16
School Mental Health Services	School Mental Health Services	75	52	23
Outpatient mental health services for children	Outpatient mental health services for children	89	77	12
Autism spectrum disorders services	Autism spectrum disorders services	31	38	7
Note: Black: =<10% difference; Blue: 11-19% difference; Green: 20-29% difference; Red: 30+% difference				

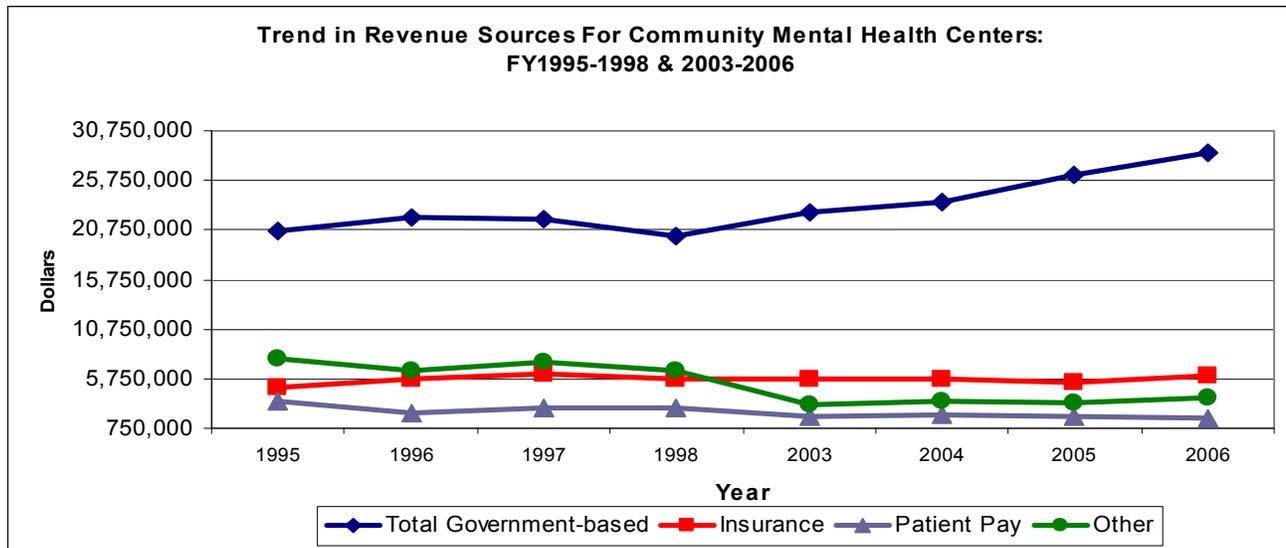
2. Level of CMHC Revenues base and Gaps in Service Provision

Other challenges in understanding service delivery needs are shown in examining the revenue base for CMHCs over time. Table 1.1 shows the overall distribution of revenue sources for CMHCs. Table 1.2 shows the distribution of government-based revenue sources only. Overall the data suggest an increase in government-based revenues over time. Within government-based revenue, the data suggest an initial decrease in revenues provided by counties (which is again on the rise) and a subsequent increase in revenues to the CMHCs through the Iowa Plan. Regardless of revenue distribution, the data show that expenditures run close to or exceed revenues. This data shows that the percent change increase of unduplicated caseloads routinely exceeds the percent change increase in per capita expenditures. As a result many counties (approximately 50% of all counties) ran a deficit in FY2006 (on the other hand 50% of all counties ran a surplus). Unfortunately data from FY1999 through FY2002 is unavailable leaving an incomplete and perhaps unreliable picture of revenue distribution over time. Care should be exercised in using this data for interpretation or significant policy initiatives as the data for 2006 shows net revenues increasing by more than 2000% yet expenditures exceeded revenues that year.

The data would suggest that a better formula for county and governmental dollars spent on persons with mental illness requires further contemplation to insure that counties have enough revenue to cover the basic needs of persons with

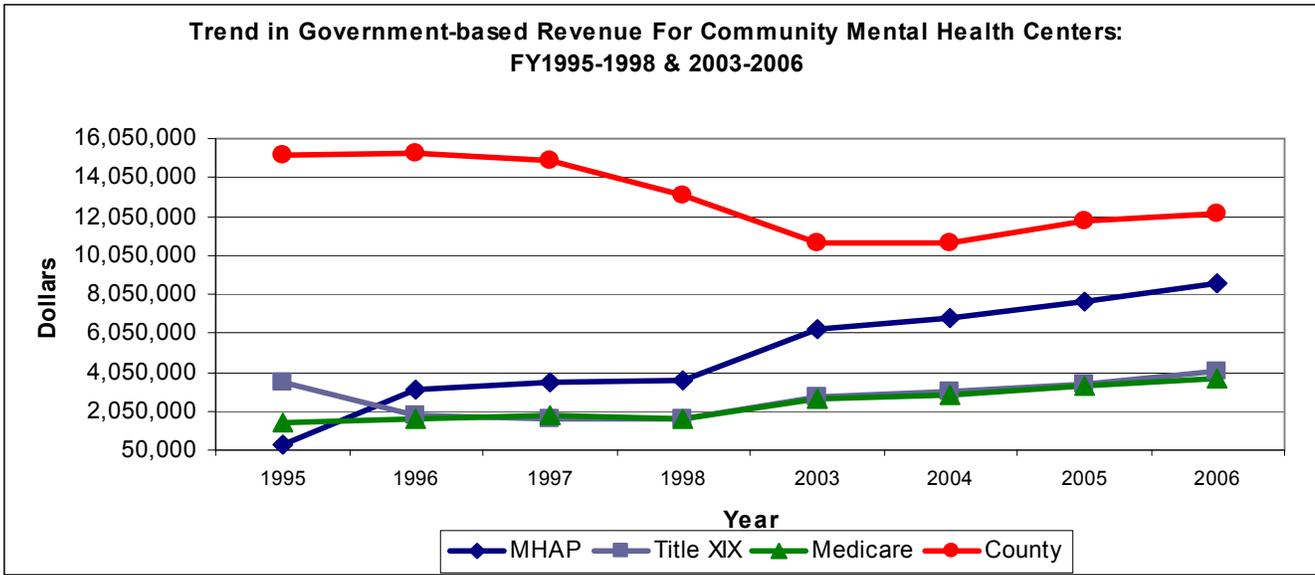
mental illness. One recommendation is to support the development and implementation of an alternative formula for the distribution of government-based dollars to insure access and parity across counties. Further data show significant variation in the reported provision of mental health care. These gaps in reported service provision should be addressed to build a system of care that maintains, to the best of its ability, a single point of access to a core set of services across Iowa.

Table 1.1 Distribution of Revenue Sources for Community Mental Health Centers



Actual	1995	1996	1997	1998	2003	2004	2005	2006
Total Government-based Revenue	20,622,418	21,966,009	21,910,514	20,161,985	22,436,543	23,470,826	26,238,099	28,526,385
Insurance	4,909,248	5,773,894	6,162,823	5,783,485	5,740,248	5,659,375	5,461,661	6,119,487
Patient Pay	3,437,322	2,238,881	2,777,444	2,868,275	1,915,645	2,127,224	1,977,572	1,816,087
Other	7,803,687	6,633,618	7,453,811	6,557,096	3,093,917	3,506,302	3,358,883	3,873,038

Table 1.2 Distribution of Government-Based Revenue Sources for Community Mental Health Centers



Actual	1995	1996	1997	1998	2003	2004	2005	2006
Iowa Plan (Mental Health Access) Plan	370,890	3,182,664	3,513,992	3,649,675	6,289,385	6,852,069	7,673,632	8,595,756
Title XIX	3,528,578	1,878,052	1,671,357	1,648,544	2,790,333	3,081,275	3,404,553	4,053,230
Medicare	1,480,032	1,628,056	1,839,125	1,691,890	2,651,702	2,827,898	3,379,994	3,710,984
County	15,242,918	15,277,237	14,886,040	13,171,876	10,705,123	10,709,584	11,779,920	12,166,415
Total Government-based Revenue	20,622,418	21,966,009	21,910,514	20,161,985	22,436,543	23,470,826	26,238,099	28,526,385

Another example showing the relationship between expenditures and subsequent service gaps can be seen in Figure 1. Figure 1 shows data from the Iowa Plan and indicates that dollars spent for persons in need of emergency mental health services is inconsistent with growing research in this area and developing systems of care in other states. This graph shows a significant trend to support the transportation of persons in crisis to emergency departments (EDs) rather than developing, implementing, and maintaining in-home or other alternative community-based mobile crisis services. In the most recent year Magellan reported that only \$35,000 was spent statewide on mobile crisis services. Lack of specific data on county expenditures for similar services makes a fiscal analysis nearly impossible.

Studies from other states including New York suggest that the broad design and implementation of community-based emergency services are positively associated with increased access, appropriate levels of treatment, and higher levels of clinical and socio-environmental outcomes for patients as compared to patients in crisis taken directly to EDs. Local reports from Iowa counties that do provide mobile services show significant financial return on investment when mobile crisis services are offered by CMHCs in collaboration with local law enforcement.

However, return on investment analyses must be reviewed with caution. Iowa currently has no service delivery outcomes data available to assess whether Iowans who use ED emergency crisis services show significantly positive outcomes as compared to the utilization of community-based alternatives. Such outcomes data would not only increase the capacity for quality assurance within our state, but to begin to examine cross-state comparisons when appropriate to better inform systems of care.

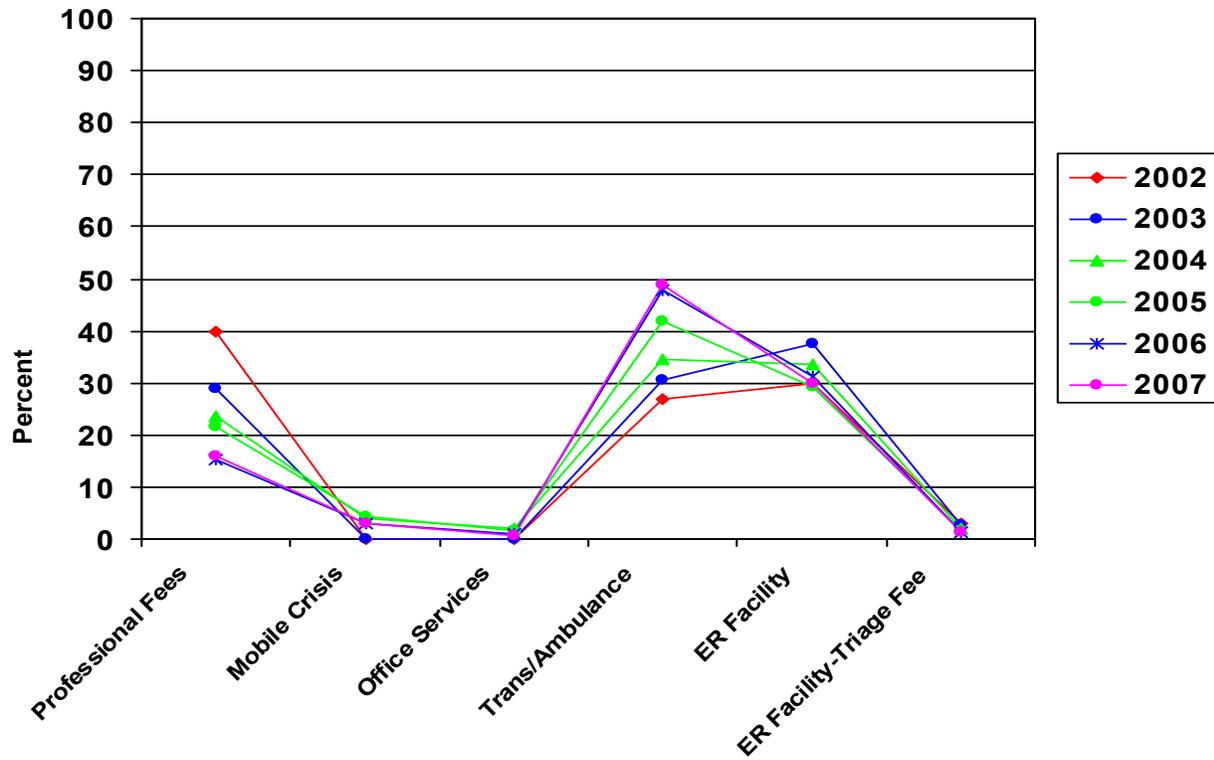


Figure I. Emergency Mental Health Services: Percent of Total Expenditures by Service and Year

Source: Magellan Behavioral Health

Other data examples that suggest poor reliability and validity of data exists in the reporting of expenditures by the CPCs to the Iowa Department of Management (DOM) as compared to the DHS County Management Information System (CoMis) reports sent to DHS. In this area we compared information provided to DOM by CPCs as well as the information provided by the CPCs to the DHS.

While the CPCs were the main sources for each of these reports there are discrepancies in overall reported expenditures across service categories. For example, the DOM reports generally document slightly higher expenditures for 'Treatments' and slightly lower expenditures for 'Living Arrangements' as compared to the CoMis reports across most populations (i.e., MI, CMI, MR, DD). See Figure 2-5.

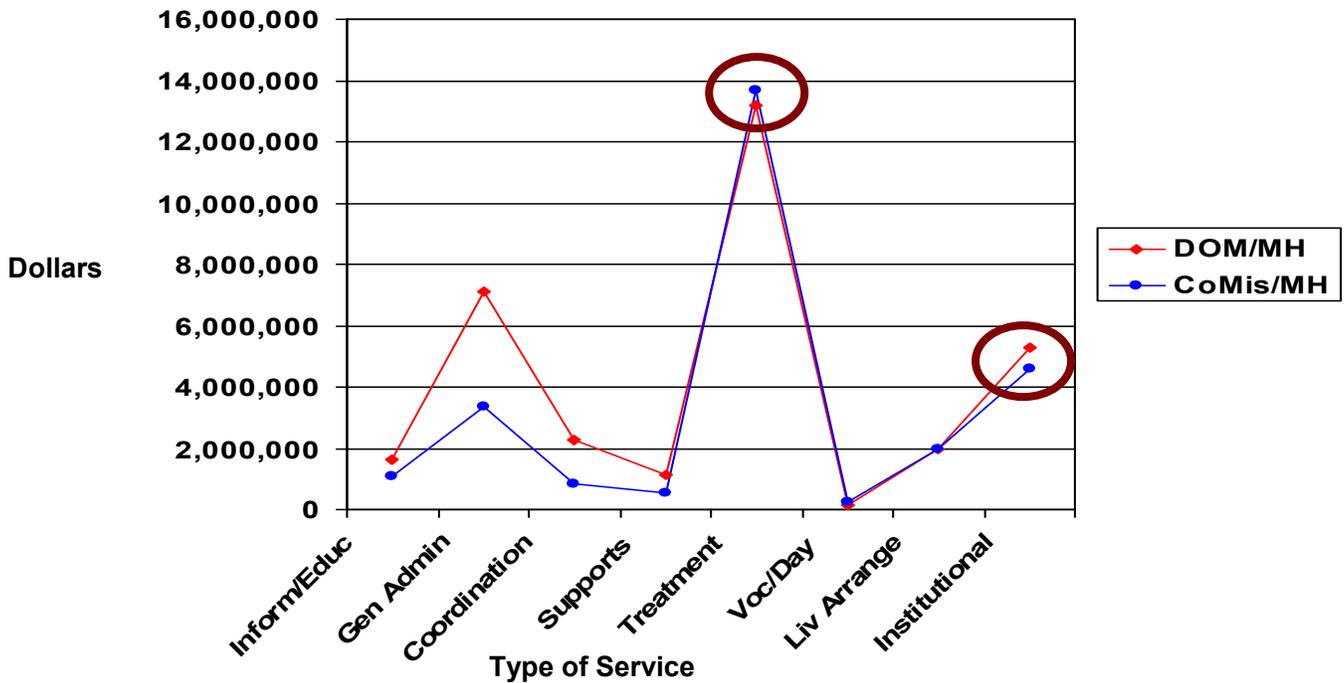


Figure 1. Expenditures for Mental Illness Across Service Categories FY2006: Comparison of Data from DOM and CoMis Reports

Sources: Department of Management (DOM) reports and CoMis data.

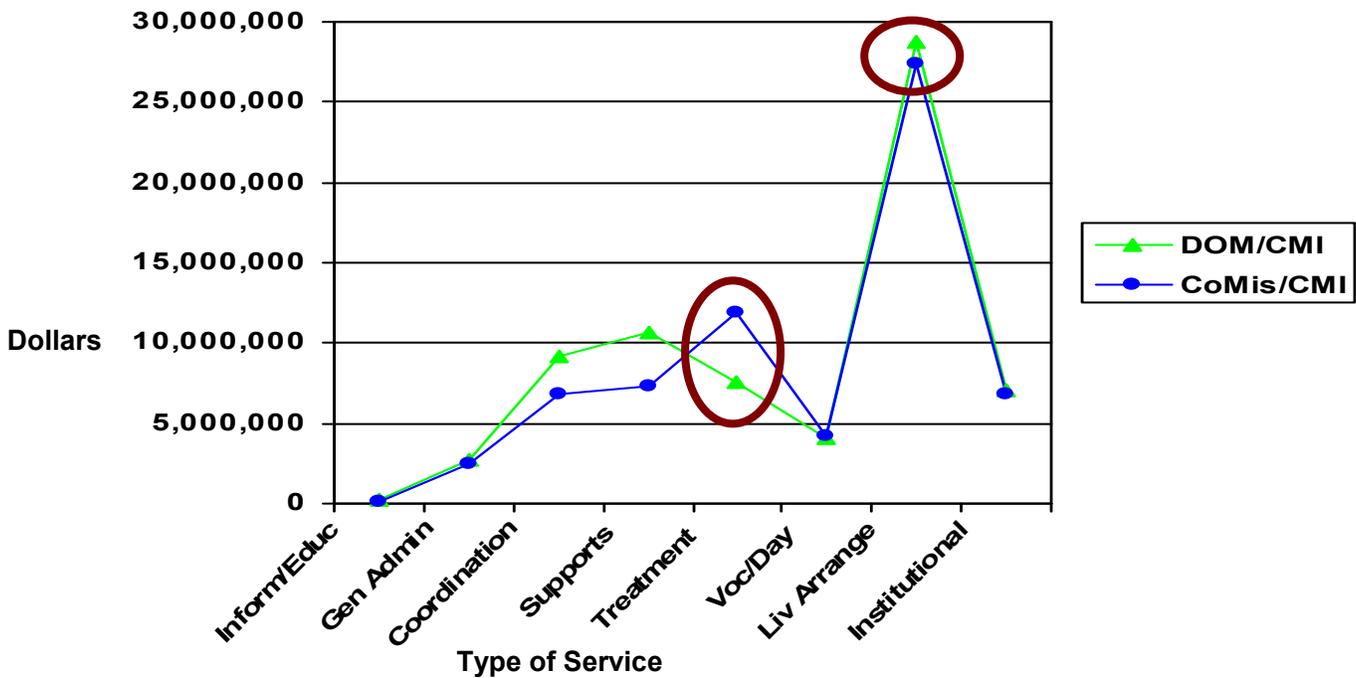


Figure 2. Expenditures for Chronic Mental Illness Across Service Categories FY2006: Comparison of Data from DOM and CoMis Reports

Sources: Department of Management (DOM) reports and CoMis data.

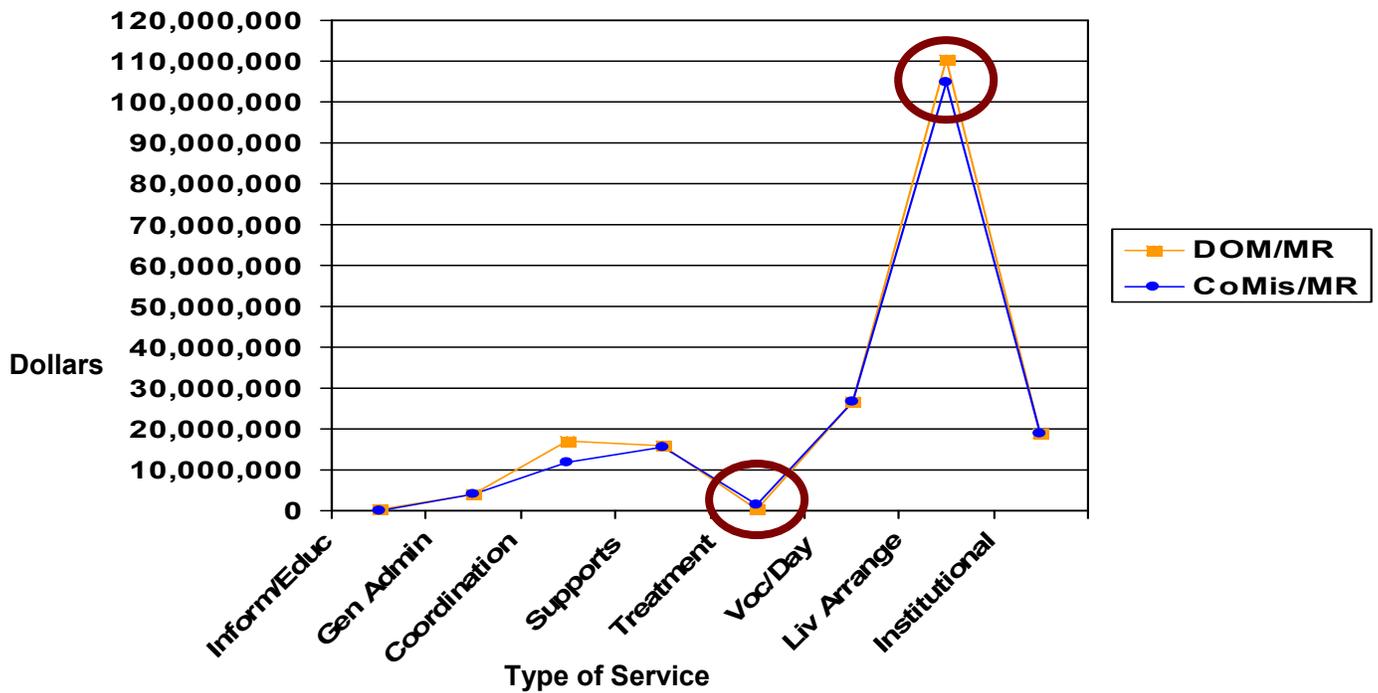


Figure 3. Expenditures for Mental Retardation Across Service Categories FY2006: Comparison of Data from DOM and CoMis Reports

Sources: Department of Management (DOM) reports and CoMis data.

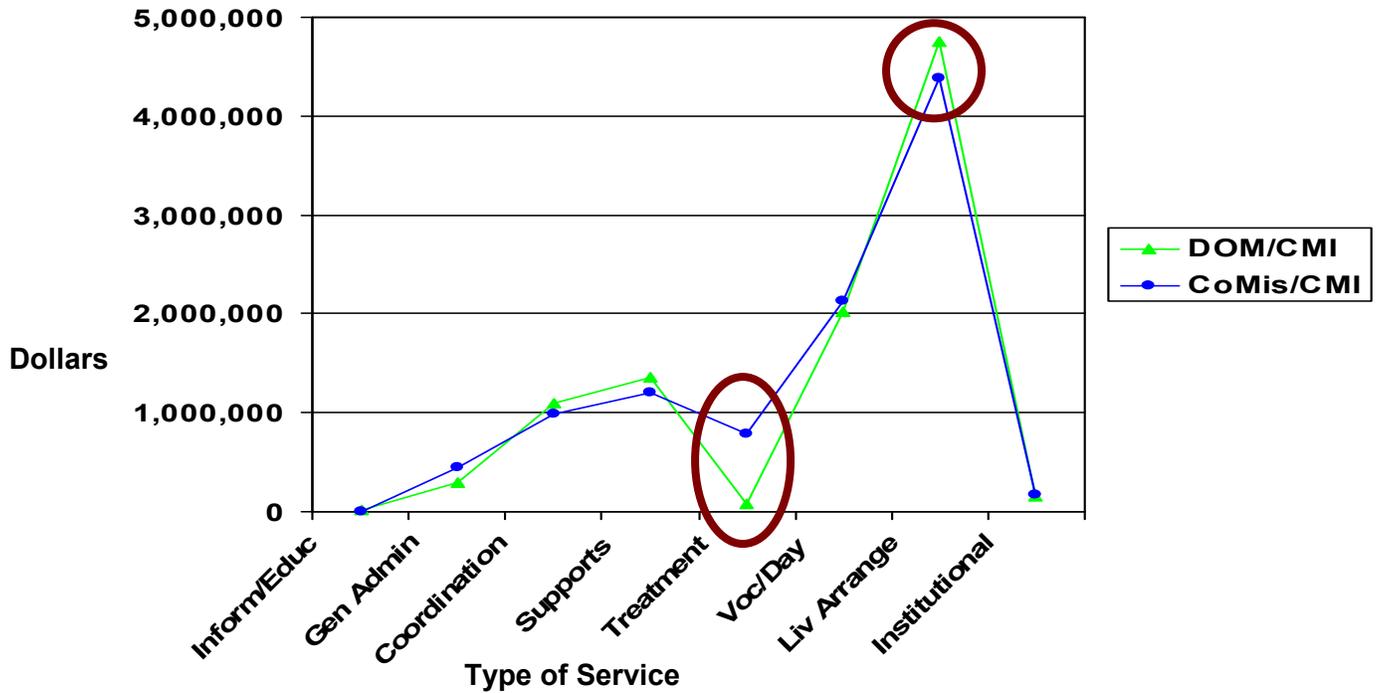


Figure 4. Expenditures for Development Disabilities by Service Categories FY2006: Comparison of DOM and CoMis Reports

Sources: Department of Management (DOM) reports and CoMis data.

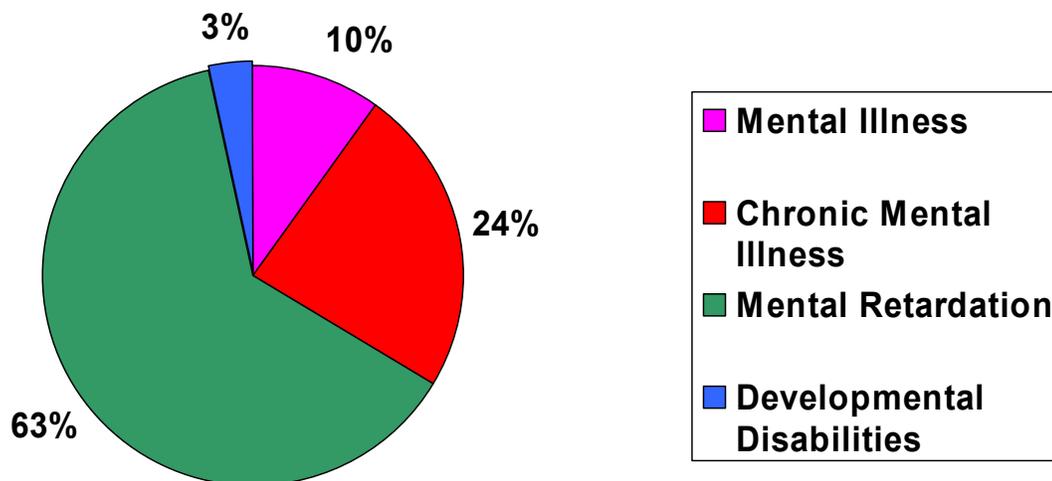
Figures 2-5 highlight at least two potential areas of concern for outcomes monitoring. First is that the information reported by the CPCs in separate formats for the DOM and the CoMis reports may be unreliable. Second, the challenges in reliability of the CPC data may not be due to reporting differences, rather, may be the reorganization of the information in an inconsistent manner. Again, inaccuracies point to problems associated with the lack of centralized IT capacity where data would be reviewed or “scrubbed” for consistency and reliability.

B. Overview of Expenditures by Target Populations and Comparative National Disease Rates

We examined the relationship between rates of prevalence and incidence of mental disorders reported to the state and the prevalence and incidence estimates promulgated by expert sources. Secondly, we sought to see what relationships existed between the services provided, expenditures for services, and prevalence and incidence estimates. Several assumptions are held: that local use of services is a proxy for prevalence and/or incidence; that allocation of funds to target populations was a proxy of local prevalence and incidence of mental disorders. These assumptions may be may not be valid.

The prevalence and incidence rate of MR and BI is unavailable in Iowa. The appropriate IT capacity to gather and track persons with MR and BI is unavailable. Using county data for example, Graph 1 shows the dollars spent by all counties for different populations. Compared to estimates of prevalence and incidence of various populations throughout the United States, the graph documents that a disproportionate share of county dollars are spent on persons with Mental Retardation and Chronic Mental Illness.

Over the last decade, several federal reports and other documents including the *Surgeon General’s Report on Mental Health* (1999), the *President’s New Freedom Report* (2003), and the *DSM-IV-TR* (American Psychiatric Association) suggest that among any age group, persons with mental illness represent approximately 20-25% of the population with a lifetime prevalence of 50%. County-reported expenditures in this category totaled 10%. Adults with Chronic Mental Illness represent approximately 5-7% of the population and youth with Serious Emotional Disturbances represent approximately 8-13% of all youth. County-related expenditures in this category totaled 24%. The prevalence of Mental Retardation occurs in 1% of the population. However there are different degrees of MR including mild (about 85% of all persons with MR), moderate (10%), severe (3-4%), and profound (1-2%). County-related expenditures in this category totaled 63%. The overall prevalence of Developmental Disabilities is quite small however there is a dearth of prevalence data that exists for distinct disabilities. County-related expenditures in this category totaled 3%.



Graph 1. Average Expenditures by Population Served FY1999-2006

Source: Department of Management (DOM) reports

1. Service Provision by Types of Services from 1999-2006, by Age Groups, and by Target Populations

Due to some discrepancies in the CoMis data with regard to service utilization (discussed elsewhere) the DOM reports were used to examine overall expenditures and service provision across age groups and populations served (i.e., MI, CMI, MR and DD) for fiscal years 1999-2006.

a. Target Population: Persons with Mental Illness

Figure 6 shows expenditures for all persons served with Mental Illness. These data show an overall increase in expenditures for General Administration, Treatment, and Inpatient care over the 8-year time period. An initial examination of the data show discrepancies across service areas as related to the what would be expected from the literature for persons with MI. One would expect that if expenditures increase for treatment, subsequently fewer dollars would be spent on inpatient care; thereby supporting an “early intervention, mental illness prevention and mental health promotion” approach to service delivery. However, the data suggest an alternative hypothesis. Increasing treatment, with minimal focus on coordination of care and support systems likely will not provide persons with mental illness the tools needed to be self-resilient. A growing body of research documents the importance of various treatment services, coordinated care and building support systems for persons with mental illness as critical components leading to self-resiliency.

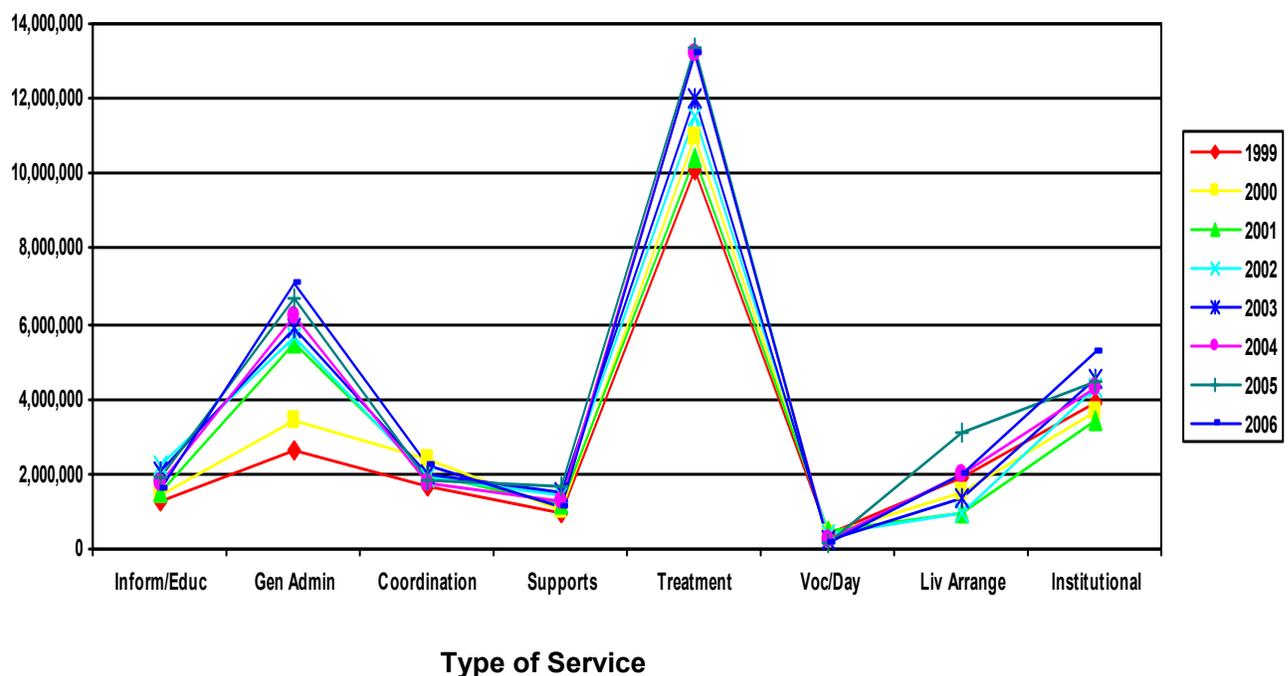


Figure 6. Expenditures for Persons with Mental Illness by Service Categories FY1999-2006

Note: There was an overall increase in Expenditures over time for General Administration, Treatment, and Inpatient Services.

Service data was further assessed by age groups. Figure 7 presents service provision by service categories and years for youth and adults with mental illness. The data shows that treatment services are decreasing for youth over time, while inpatient care is on the rise; and inpatient service utilization by children has reached similar levels as those for adults. This finding is of concern for two reasons. First it is inconsistent with the literature on desired goals of a systems of care which promotes higher levels of coordination, supports and treatment services in order to increase self-resilience over time and service utilization in the least restrictive setting. Second the data show a similar pattern of service delivery for adults however inpatient rates remain stable for adults at about 16%. It is very difficult to compare inpatient rates across states for many reasons. Rates have been shown to be associated with provider type and availability and the objectivity of treatment guidelines needed to aid in decisions regarding most appropriate treatment sites.

Also a state's poverty rate has shown to have a significant effect on a state's hospitalization rate for mental illness. An increase in a state's poverty rate is associated with a rather significant increase in a state's hospitalization rate for MHDS Report and Recommendations on Mental Health Systems Improvement APPENDIX M

mental illness. For example, research suggests that even one standard deviation increase in a state's poverty rate can increase the mental illness hospitalization rate by over 23%. The literature also indicates that unemployment is a significant determinant of institutionalization rates for mental illness. As unemployment increases, hospitalization rates for mental illness decrease. This could be explained by fiscal problems during economic downturns in financing hospitalization of mentally ill patients. Also, unemployment may be negatively related to the percent of the population with insurance to pay for hospitalization. These two factors may intertwine in times of unemployment so that people may be more stressed and likely to be diagnosed as mentally ill. Further as state per capita income increases, the rate of hospitalization for mental illness increases. This may be an indication that wealthy states can better afford to hospitalize mentally ill patients and insurance coverage likely rises with income. Finally patterns of hospitalization and re-hospitalization of persons with mental illness vary along rates of homelessness, medical morbidity, and psychiatric and substance use co-morbidity. Given the number of factors associated with the use of psychiatric utilization, comparison of inpatient rates is challenging and unavailable. Research findings would hopefully inform psychiatric epidemiological efforts to refine psychiatric and co-morbidity assessments for service delivery for this vulnerable population. More study of these patterns of service utilization in Iowa is indicated.

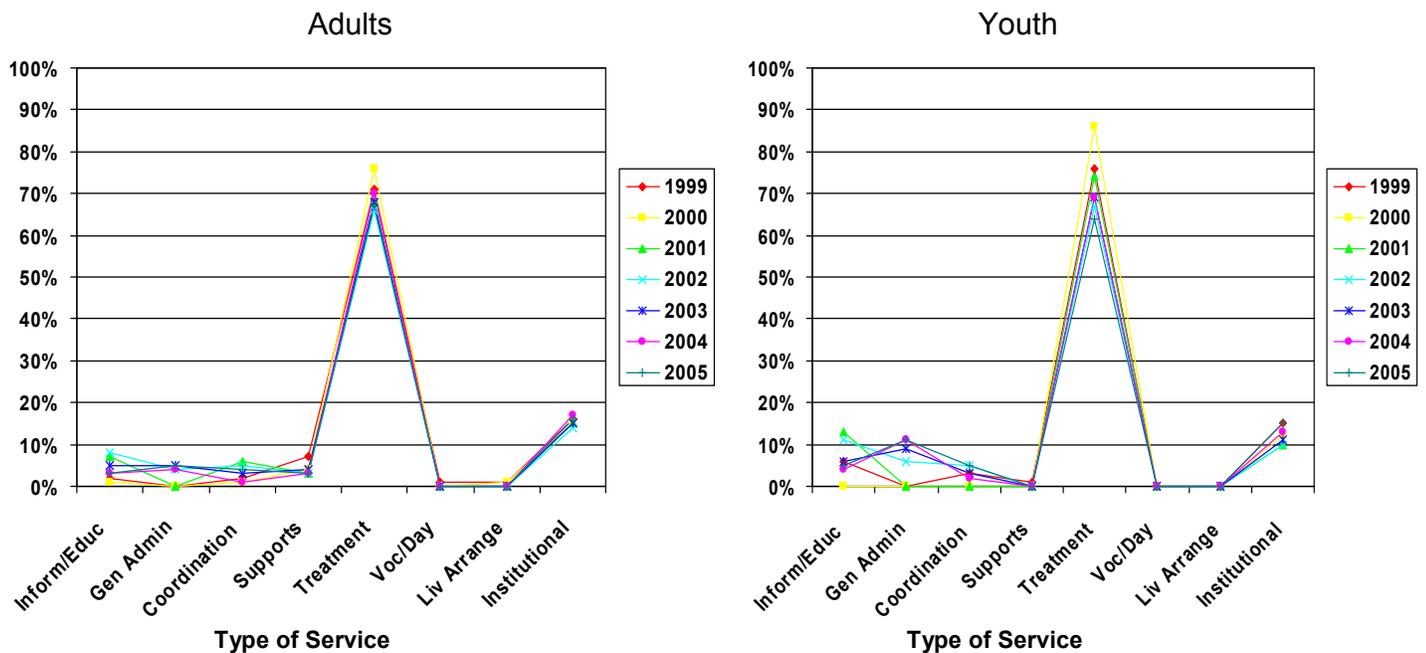


Figure 7. Percent of Adults and Youth with Mental Illness by Service Categories FY1999-2005

Note: Number of treatments decreased for youth, while Institutionalization is on the rise.

a. Target Population: Adults with Chronic Mental Illness and Youth with Serious Emotional Disturbance

Figures 8 and 9 show expenditure and service data for persons with Chronic Mental Illness. Figure 8 shows a general increase in expenditures for Coordination and Support services over time. Further, Treatments and Vocational/Day services have remained at relatively low levels, but steady over time. Finally, there is a decrease in expenditures for Living Arrangements while Institutional Care has remained relatively stable over time.

Trends in service delivery are dramatically different for adults with Chronic Mental Illness as compared to youth with Serious Emotional Disturbance. Figure 9 shows very different patterns of care for adults as compared to youth. In any year, as the numbers of Treatments for youth decrease there is a subsequent increase in Institutional care.

There are several factors that may contribute to findings for youth. Current research on Iowa youth suggests that many children and adolescents tend to enter the mental health system at more advanced stages of illness requiring inpatient care; even though the child may exhibit symptoms up to 2 years prior to seeking services. (Anderson et.al, 2003). Some of this is explained by type of illness and/or socio-environmental factors. For example, youth with

symptoms of depression (e.g., withdrawal) tend to be under-diagnosed and referred because their symptoms tend not to cause disruptive behavior. Also, youth with histories of abuse may present for care late in the system due to legal/social welfare implications. Growing numbers of youth in need pose a major challenge to the mental health of communities and individuals. The impact of mental disease is increasing as can be seen by the high levels of need within the juvenile justice, substance abuse and child welfare populations.

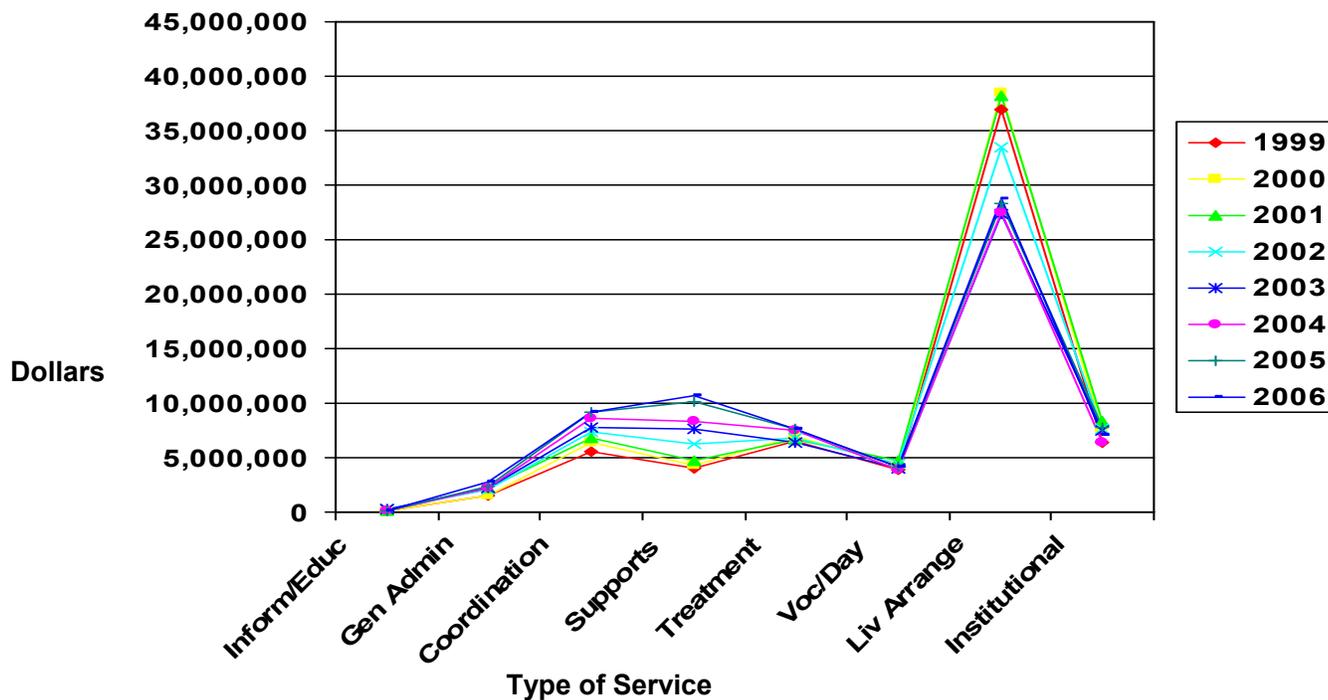


Figure 8. Expenditures for Persons with Chronic Mental Illness by Service Categories FY1999-2006

Note: There is an increase in expenditures for Coordination and Support services. Further, Treatments and Vocational/Day services have remained steady over time. There is a decrease in expenditures for Living Arrangements while Institutionalization has remained relatively stable over time.

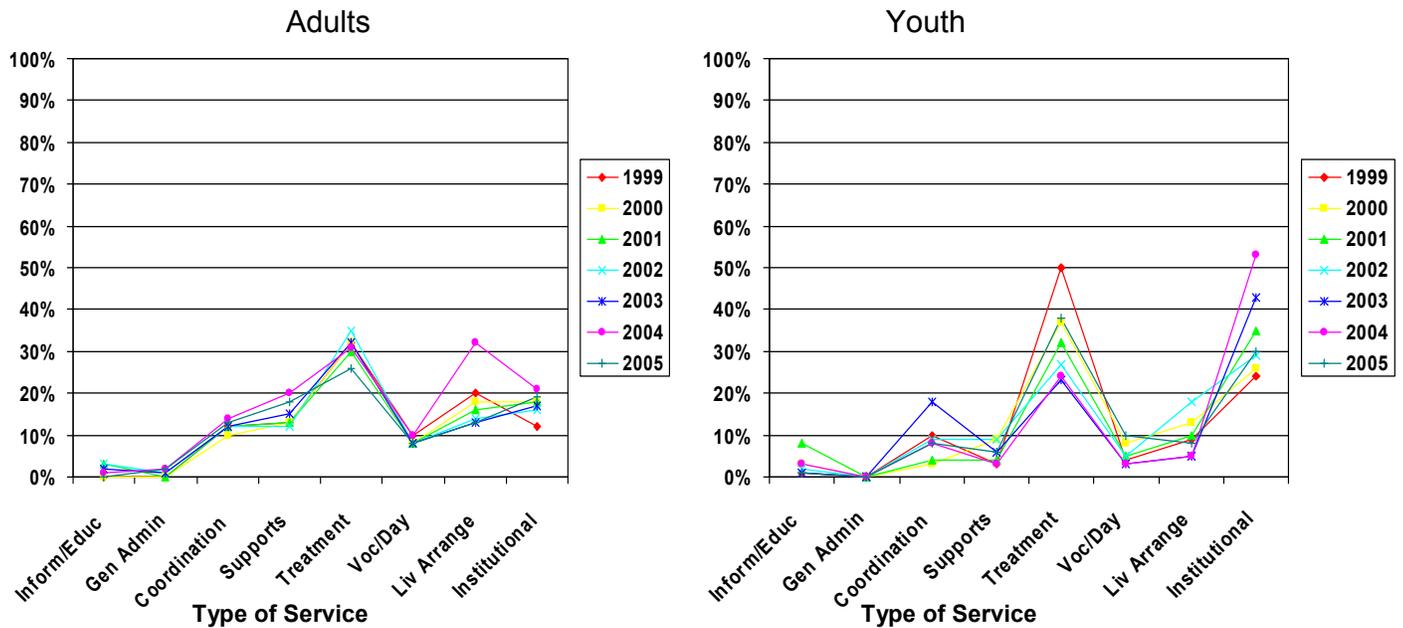


Figure 9. Percent of Adults with Chronic Mental Illness and Youth with Serious Emotional Disturbance by Service Categories 1999-2005

The data for adults presents a very different pattern of service utilization; there has been a decrease in treatments, low levels of vocational and day services, and a fairly dramatic decrease in community living arrangements over time. Institutionalization has remained rather steady for adults at around 16-17%.

Historically state beds for persons with chronic mental illnesses have decreased. However, community-based alternatives for persons with chronic mental illness lacked the kinds of supporting services many times required by persons with CMI. For example, a large number of publications have documented that CMHCs did not develop around the needs of persons with CMI; they have less competency to treat persons with CMI and no inpatient capacity. Persons with CMI looked more and more to the private sector for inpatient needs. However over the past five years due to negative operating margins, 63% of states have experienced declines in the number of general hospital specialty unit psychiatric beds and 38% have experience a decline in the number of private psychiatric hospital beds. The impact of bed closures has resulted in a shortage in psychiatric beds around the country including Iowa (National Association of State Mental Health Program Directors Research Institute, 2006). (See Table II, Graph 2, and Graph 2a for current bed capacity in Iowa by organization, county and bed type). There has been a similar result on number of available psychiatrists in Iowa. Decreased bed capacity has led to a decrease in the psychiatric workforce over time, particularly psychiatrists.

The impact of decreasing resources in the service delivery system has led to, by default, persons with CMI using emergency departments (ED) as a source of regular care due to a lack of appropriate points of entry and treatment alternatives. ED departments, which generally run negative operating margins, (but are the number one referral for inpatient beds) tend to ask for type of insurance for persons with MI/CMI presenting voluntarily. As existing hospital beds do need to be filled, research data suggest that not all persons admitted to the inpatient service present with clinical symptoms consistent with a need for this level of service intensity (Anderson et al). This implies that patients admitted can be treated within the reimbursed LOS lessening the likelihood of negative operating margins. Research data suggests that persons with CMI brought to the ED involuntarily are stabilized and transferred as quickly as possible to state hospital beds. Research also suggests that uninsured or underinsured persons with CMI are many times stabilized in the ER and sent home with a referral. In most cases, it is this latter group that makes up the bulk of ED readmissions, persons who are homeless, persons who make up a disproportionate number of offenders in jails and prisons and persons more likely to be recidivists (See Figures 9 and 10). Iowa data is very consistent with national data in this regard. There is also a paucity of data regarding the needs of mentally ill persons when presenting to Ers. In some cases they are directed to go to the ER by treatment teams but are unwelcome by ER staff. Extensive analysis of this situation and the outcomes of these processes is warranted.

Also, the average length of stay for inpatient psychiatric units across Iowa is approximately 4 days (Iowa Hospital Association/Magellan). There is no current measure of clinical functioning associated with these stays and no clear data to show which, if any, crisis symptoms have been stabilized in this short length of stay.

While one must be cautious about these trends; a closer look at the data makes a compelling case. Between the years 97-98 and 2000 there is a flattening of the line related to MHIs suggesting a leveling off in bed capacity. Subsequently during the same time period there was a slight decrease/leveling off of prison admissions, a decline in prison readmissions and in the number homeless. After continued decreases in bed capacity at the MHIs after 2000, the data shows a corresponding increase in prison admissions, re-admissions, and homelessness.

Table II. Community, State and Federal Hospitals in Iowa 2007: Psychiatric Bed Capacity

Name of Hospital	City	County	Beds	Hospital Designation
Alegent Health Mercy Hospital – CB	Council Bluffs	Pottawattamie	30	Community
Allen Health System	Waterloo	Black Hawk	21	Community
Broadlawns Medical Center	Des Moines	Polk	24	Community
Buena Vista Regional Medical Center	Storm Lake	Buena Vista	10	Community
Cass County Memorial Hospital	Atlantic	Cass	8	Community
Covenant Medical Center	Waterloo	Black Hawk	23	Community
Ellsworth Municipal Hospital	Iowa Falls	Hardin	10	Community
Genesis Medical Center – Davenport	Davenport	Scott	39	Community
Great River Medical Center	West Burlington	Des Moines	8	Community
Greater Regional Medical Center	Creston	Union	9	Community
Iowa Lutheran Hospital	Des Moines	Polk	65	Community
Jennie Edmundson Hospital	Council Bluffs	Pottawattamie	29	Community
Keokuk Area Hospital	Keokuk	Lee	14	Community
Mahaska Health Partnership	Oskaloosa	Mahaska	8	Community
Mary Greeley Medical Center	Ames	Story	23	Community
Mercy Iowa City	Iowa City	Johnson	19	Community
Mercy Medical Center – Cedar Rapids	Cedar Rapids	Linn	20	Community
Mercy Medical Center – Clinton	Clinton	Clinton	14	Community
Mercy Medical Center – Des Moines	Des Moines	Polk	32	Community
Mercy Medical Center – Dubuque	Dubuque	Dubuque	36	Community
Mercy Medical Center – North Iowa	Mason City	Cerro Gordo	28	Community
Mercy Medical Center – Sioux City	Sioux City	Woodbury	21	Community
Ottumwa Regional Health Center Inc.	Ottumwa	Wapello	23	Community
Sartori Memorial Hospital, Inc.	Cedar Falls	Black Hawk	15	Community
Shenandoah Medical Center	Shenandoah	Page	6	Community
Spencer Hospital	Spencer	Clay	16	Community
St. Anthony Regional Hospital	Carroll	Carroll	14	Community
St. Luke’s Health System, Inc.	Sioux City	Woodbury	8	Community
St. Luke’s Hospital	Cedar Rapids	Linn	74	Community
The Finley Hospital	Dubuque	Dubuque	9	Community
Trinity Regional Medical Center	Fort Dodge	Webster	20	Community
University of Iowa Hospitals and Clinics	Iowa City	Johnson	73	Community
Cherokee MHI	Cherokee	Cherokee	58	State
Clarinda MHI	Clarinda	Page	55	State
Independence MHI	Independence	Buchanan	95	State
Mt. Pleasant MHI	Mt. Pleasant	Henry	79	State
VA Central IA Health Care	Knoxville	Marion	327	Federal

VA Medical Center	Iowa City	Johnson	93	Federal
<i>Total Psychiatric Beds</i>				
			749	Community
			287	State
			420	Federal VA

Source: The IHA, the AHA, and Magellan 2007

**MHI and Prison Admissions and Prison Readmissions:
FY 1995-2006**

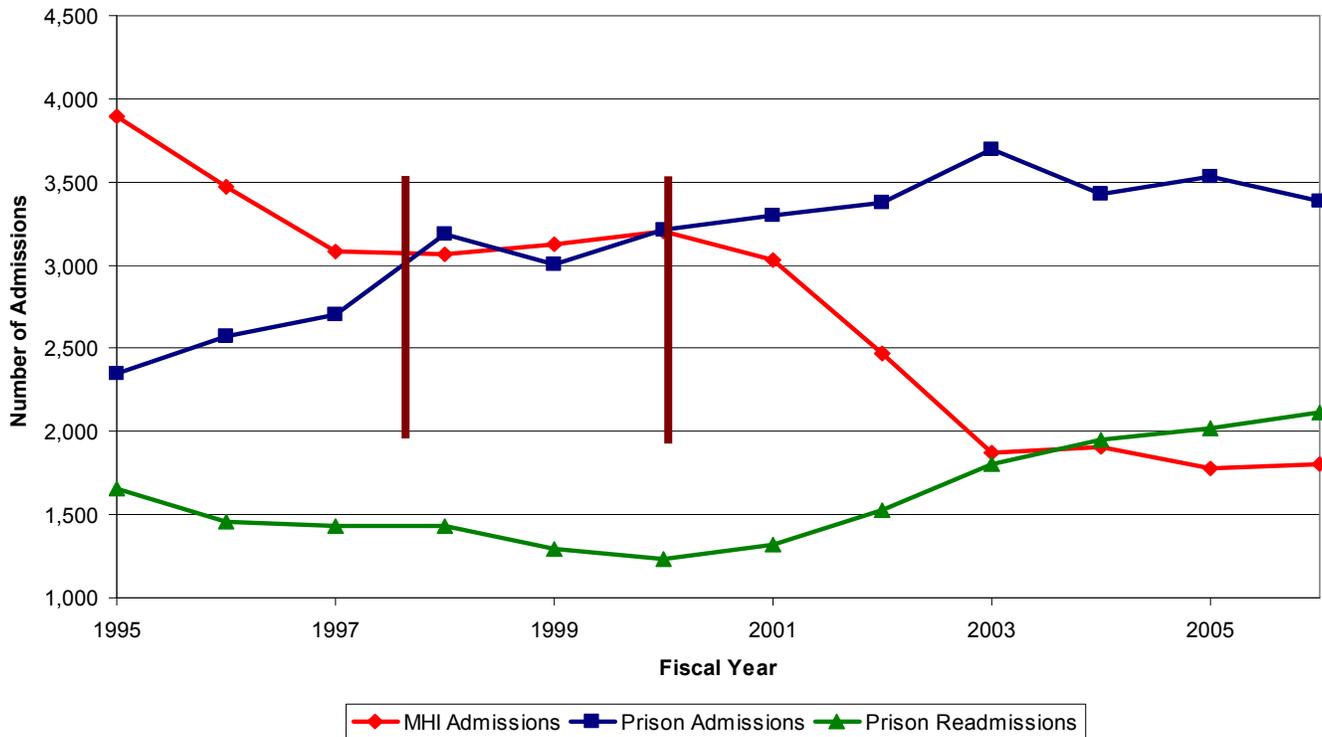


Figure 9. Trend in the Number of Admissions to Mental Health Institutions and Prisons and the Number of Prison Readmissions

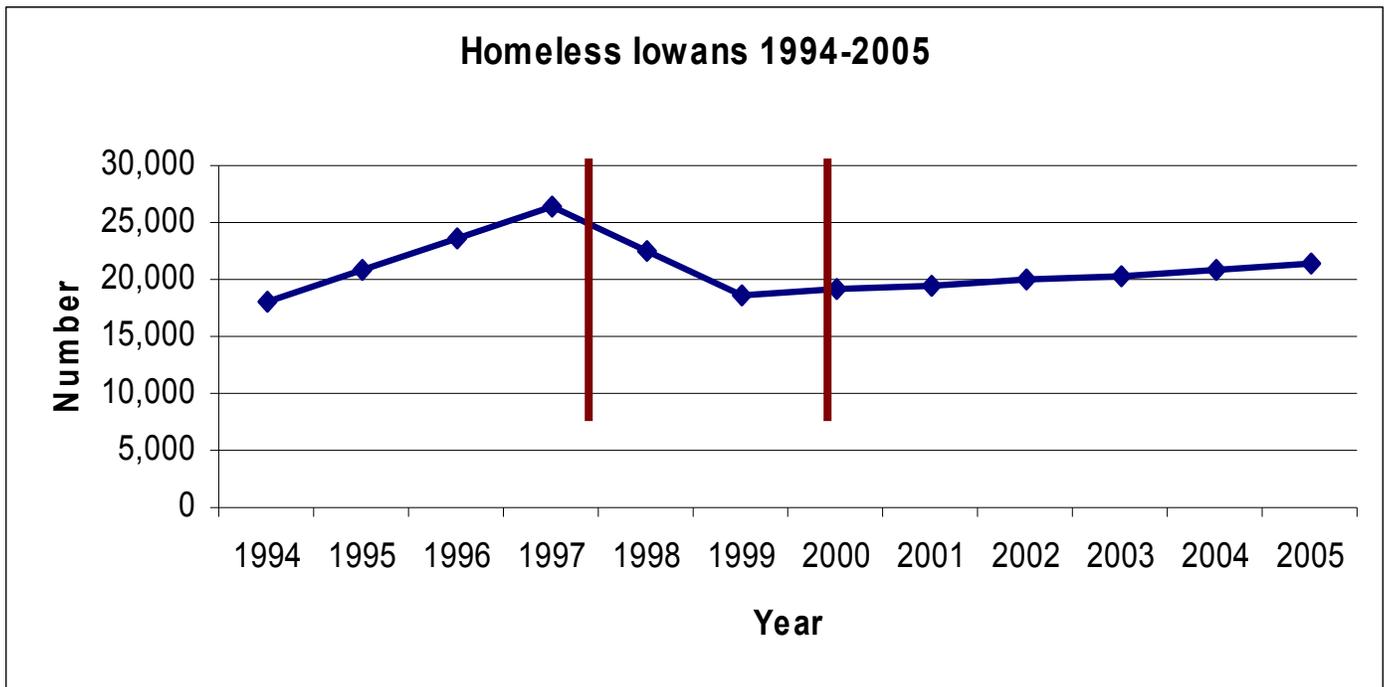


Figure 10. Trend in the Number of Homeless Iowans

b. Target Population: Persons with Mental Retardation

The data in Figure 11 suggests that persons with MR end up in long-term out-of-home living arrangements with little more than adaptive support services (e.g., Activities of Daily Living such as brushing teeth, getting dressed, etc.). In fact, Iowa is among the leaders in the nation in the number of Intermediate Care Facility beds for persons with MR; however Figure 11 does not tell the entire story.

The overall picture of service delivery to persons with MR can be misleading. When broken out by age groups, we come to an interpretation that is better supported by epidemiological research on prevalence and services research for MR populations.

As suggested above, the majority of persons with MR (about 85% of all persons with MR) have Mild MR. As a group, people with this level of MR typically develop social and communication skills during the preschool years, have minimal impairment in sensorimotor areas, and often are not distinguishable from children without MR until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, persons with Mild MR usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild MR can usually live successfully in the community. As suggested by Figure 12, youth generally receive more coordination of care and likely end up with fewer living in sheltered settings. As we move along the continuum of severity of MR, we see a shift in Figure 12 to adults with lower levels of coordination and higher levels of sheltered care. The degree to which may be determined by severity of MR.

Persons with Moderate MR generally profit from vocational training and with moderate supervision can attend to their personal care. Persons with Moderate MR also benefit from training in social and occupational skills. In their adult years, the majority is able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general workforce.

Most persons with Severe MR acquire little communication speech and can be trained in elementary self-care skills. In their adult years they may be able to perform simple tasks in closely supervised settings. Most adapt well to life in the community, in group homes or with their families, unless they have an associated handicap that requires specialized nursing or other care.

Persons with Profound MR have an identified neurological condition that accounts for their MR. They display considerable impairments. Optimal development may occur in a highly structured environment with constant aid and

supervision and an individualized relationship with a caregiver. Motor development and self-care and communication skills may improve if appropriate training is provided. Some persons can perform simple tasks in closely supervised and sheltered settings.

In Iowa we have no uniform, mandatory assessment and reporting of severity of illness and needs across the MR population to assess whether in fact people are being served in the most appropriate service setting according to their presenting needs. More evidence is needed documenting service needs and system outcomes for persons with MR including clinical and socio-environmental factors, service coordination and cost benefits. The literature suggests that clinician decisions on admission criteria and admission policies vary widely. Studies point to a range of factors associated with clinical decision-making including clinician variables, clinical concerns, and social systems. As delivery systems become increasingly organized and accountable, uniform assessment and guidelines will assume a critical role in level-of-care decision-making ensuring that admission decisions are consistent with current clinical criteria and standards for care. Given the high costs of care, understanding the complexities and management of persons with MR is clearly a concern and suggests that providers need to be better informed about treatment strategies that are of the greatest benefit for persons with MR.

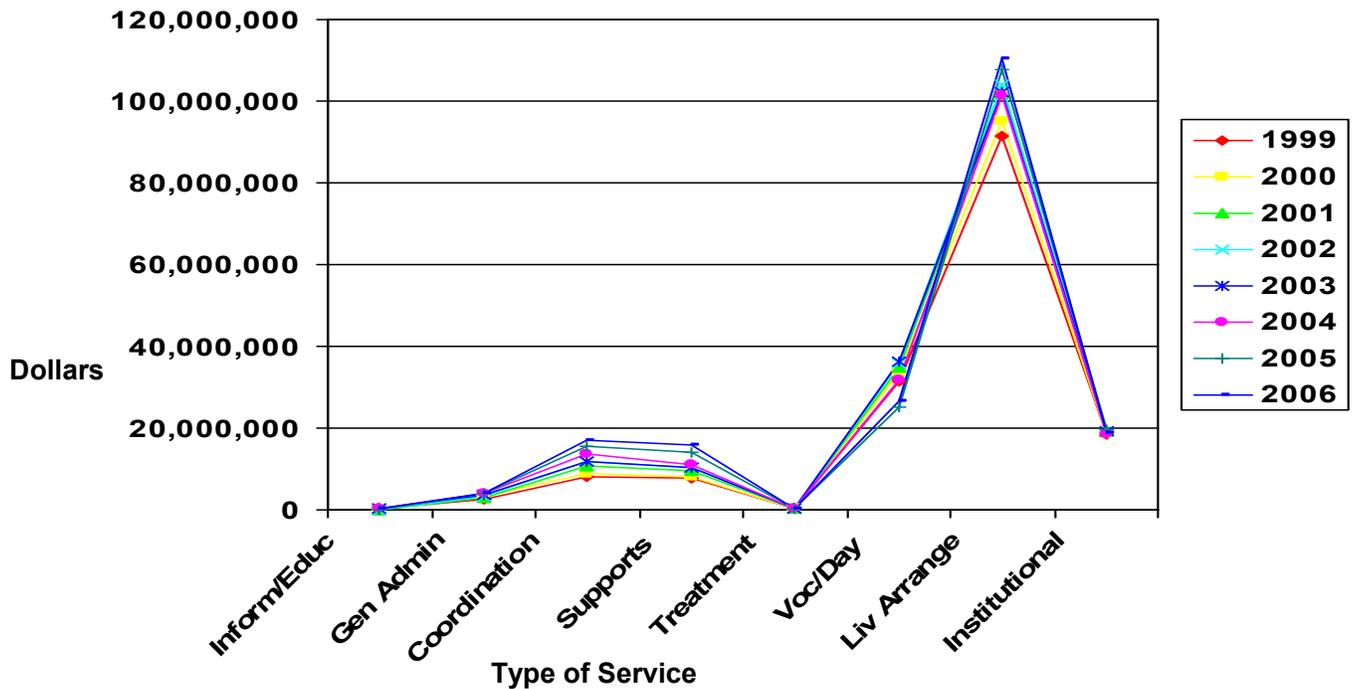


Figure 11. Expenditures for Persons with Mental Retardation by Service Categories FY1999-2006

Note: There is a general increase in expenditures for Coordination, Supports, and Living Arrangements over time. Persons with MR have significantly higher levels of expenditures for Institutionalization as compared to all other population groups.

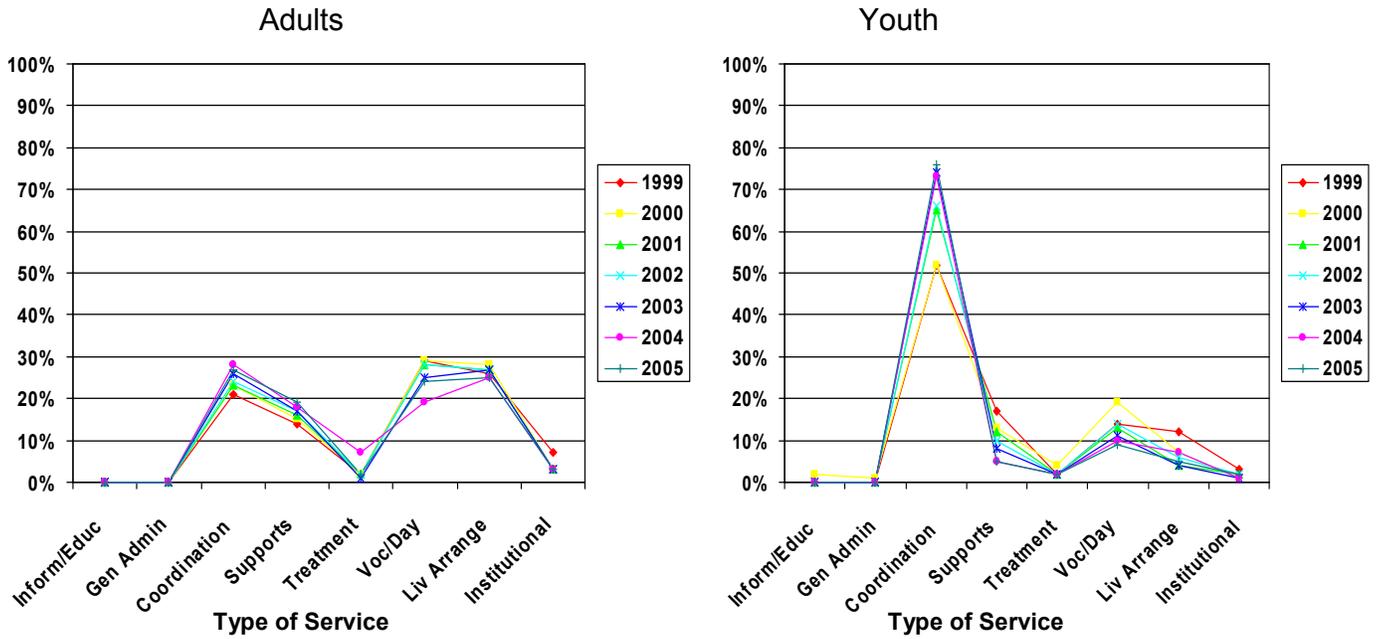


Figure 12. Percent of Adults and Youth with Mental Retardation by Service Categories FY1999-2005

2. Overview of Services by Target Populations

County data (year unknown) was used to assess the percent of mandatory and voluntary (i.e., based on consumer need and available funds) services provided across MI, CMI, MR, and BI populations.

Figure 13: Services to Persons in All MH Categories

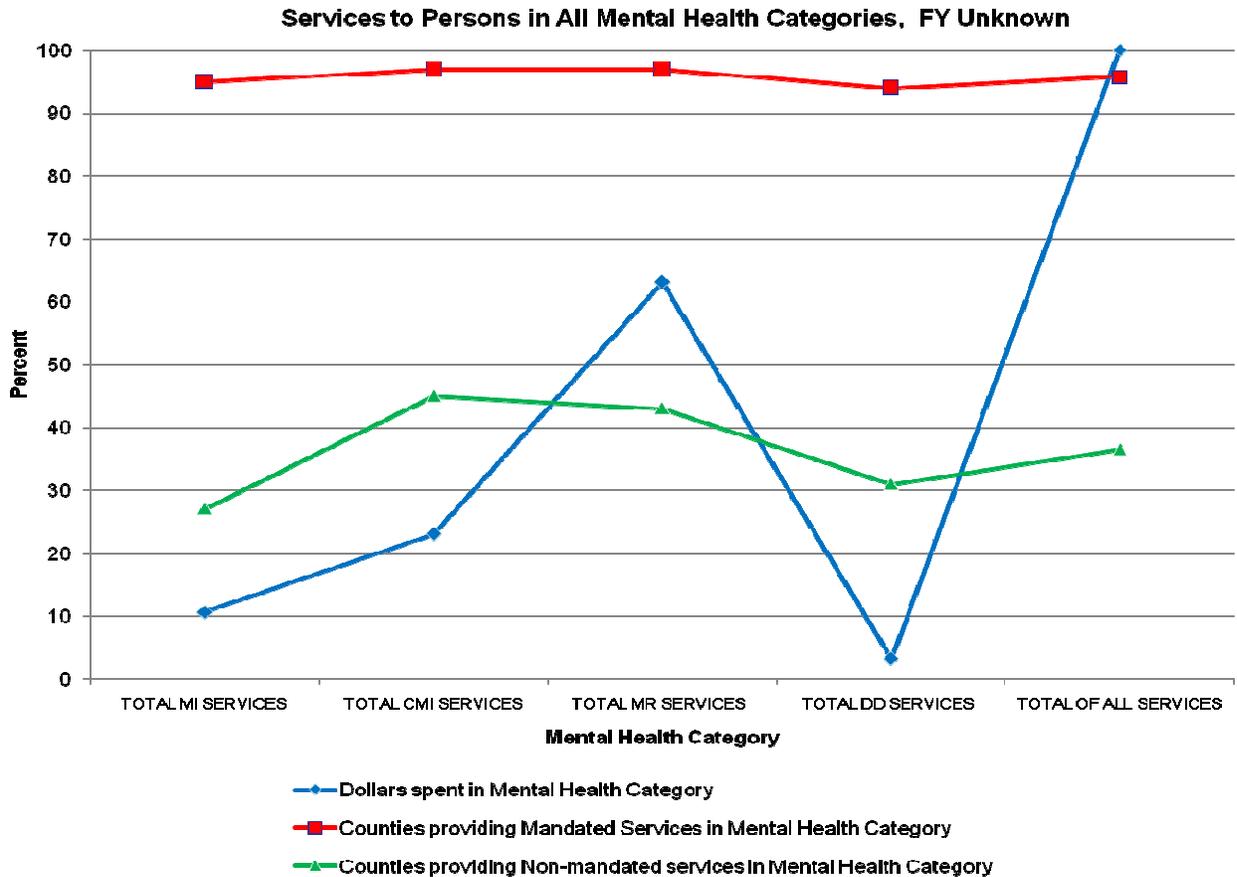


Figure 13 above provides data that suggests some data capability issues. First, counties typically provide mandated services when there is a consumer in need of that service. Second, on average, counties provide less than 50% of voluntary services to consumers. This may be due to low consumer demand or low priority by counties given current rates of revenues and requirements for mandatory services provided.

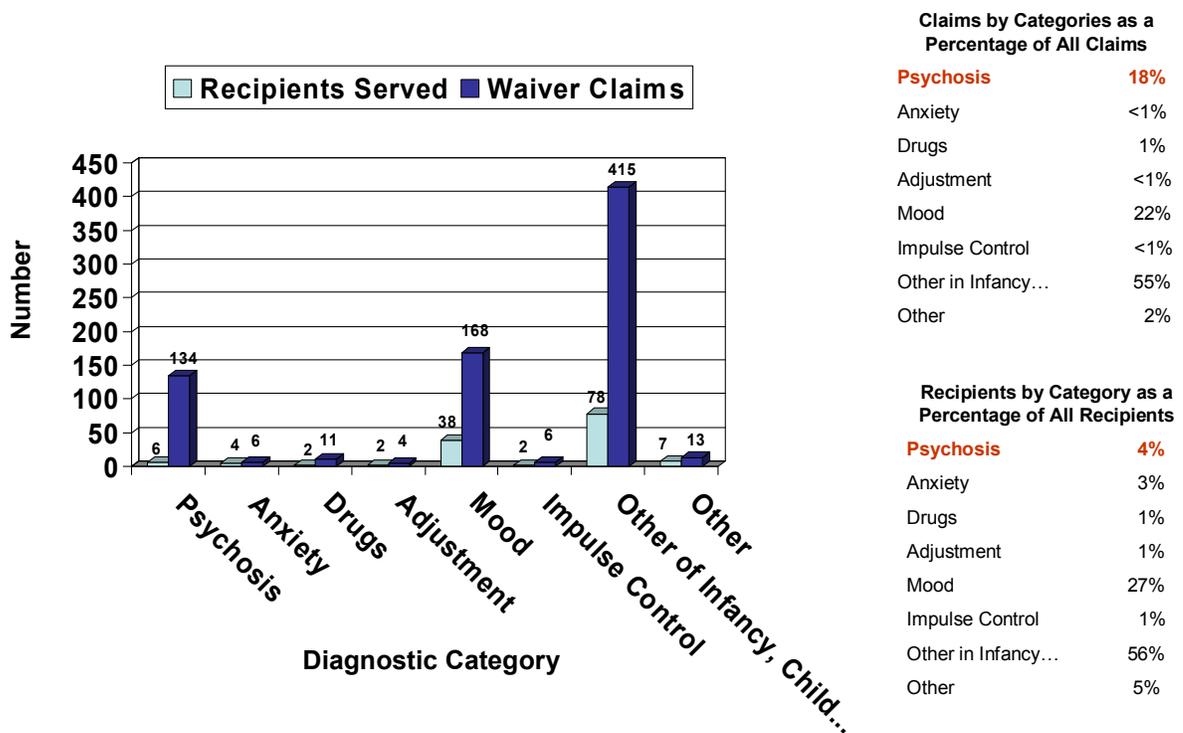
The data used to create the above data was from an unknown year. We compared this data to the County Management Plans for FY2007-09 (using a single county as an example). In comparing data several discrepancies are noted at the end of this table below.

X = Services planned for FY07-09 as documented by CPCs in the County Management Plan for Adair County considering consumer needs and resources available.
 O = Services provided as reported by CPCs for Adair County: FY Unknown. Circles in Black show services offered in the Unknown FY, however are not planned as documented in the County Management Plans for FY07-09 as completed by CPCs.
 M = Mandated Services

County: Adair						
SERVICE	MI	CMI	MR	DD	BI	
4x03 Information and Referral	●	●	●	●	●	\$0.00
4x04 Consultation.	X O	X O #	●	●	●	\$3,720 #
4x05 Public Education Services	X O	X O #	●	●		\$1,978 #
4x06 Academic Services.						\$0.00
4x11 Direct Administrative.	X O	X O	X O #	●		\$22,829 #
4x12 Purchased Administrative						\$0.00
4x21- 374 Case Management- Medicaid Match.		X O M #	X O M #	X O M		\$8,086 #
4x21- 375 Case Management -100% County Funded						\$0.00
4x21- 399 Other.						\$0.00
4x22 Services Management.		#				\$1,651 #
4x31 Transportation (Non-Sheriff).		X O #	X O M #			\$11,456 #
4x32- 320 Homemaker/Home Health Aides.			X O M			\$0.00
4x32- 321 Chore Services						\$0.00
4x32- 322 Home Management Services			X O M			\$0.00
4x32- 325 Respite.			X*O M			\$0.00
4x32- 326 Guardian/Conservator.						\$0.00
4x32- 327 Representative Payee						\$0.00
4x32- 328 Home/Vehicle Modification			X O M			\$0.00
4x32- 329 Supported Community Living		●	X O M			\$0.00
4x32- 399 Other.		X O M	● M #			\$6,778 #
4x33- 345 Ongoing Rent Subsidy.						\$0.00
4x33- 399 Other						\$0.00
4x41- 305 Outpatient						\$0.00
4x41- 306 Prescription Medication.		#	#			\$3,649 #
4x41- 307 In-Home Nursing			● M			\$0.00
4x41- 399 Other			#			\$60 #
4x42- 305 Outpatient	X O	X O #				\$31,135 #
4x42- 309 Partial Hospitalization.		X O M				\$0.00
4x42- 399 Other.		#				\$900 #
4x43- Evaluation.	X O	X O #				\$15,655 #
4x44- 363 Day Treatment Services		X O M #				\$6,600 #
4x44- 396 Community Support Programs	X O	X O				\$0.00
4x44- 397 Psychiatric Rehabilitation						\$0.00
4x44- 399 Other						\$0.00
4x50- 360 Sheltered Workshop Services.		X** O #	X O M			\$2,114 #
4x50- 362 Work Activity Services		X**O M #	X O M #		other #	\$17,813 #
4x50- 364 Job Placement Services.						\$0.00
4x50- 367 Adult Day Care.		X O M	X O M #			\$2,213 #
4x50- 368 Supported Employment Services		X**O #	X O M #			\$2,898 #
4x50- 369 Enclave		#	X O #			\$41,291 #
4x50- 399 Other.		#	● #			\$18,366 #
4x63- 310 Community Supervised Apartment Living Arrangement (CSALA) 1-5 Beds		X**O #	X O			\$1,505 #
4x63- 314 Residential Care Facility (RCF License) 1-5 Beds		X** O	X O			\$0.00
4x63- 315 Residential Care Facility For The Mentally Retarded (RCF/MR License) 1-5 Beds			X O			\$0.00
4x63- 316 Residential Care Facility For The Mentally Ill (RCF/PMI License) 1-5 Beds						\$0.00
4x63- 317 Nursing Facility (ICF, SNF or ICF/PMI License) 1-5 Beds						\$0.00

When we examined Medicaid Waiver programs, some unique discrepancies showed up between number of claims for a particular diagnosis and the disproportionate share of expenditures related to these claims. For example, below is the information for the Children's Mental Health Waiver. The data shows that while only 4% (n=6) of all recipients were given a diagnosis of Psychosis, psychosis as a major diagnostic category resulted in 18% (N=134) of all claims. Outside of the fact that psychosis is a difficult to treat disorder and requires a disproportionate number of claims (higher service utilization), we also need to exam the possibility of alternative hypotheses. First we must ask if there is a global assessment criterion for psychosis and if so are youth receiving treatment in line with adequate assessment criteria? Second we must ask the extent to which there are evidenced-based treatments for youth with psychosis and whether such treatments are globally utilized. Finally, we have no information with regard to outcomes for this vulnerable population. We do not have access to data at the treatment/services information level or quality assurance level. Developing such IT capabilities would likely lead to the best possible outcomes for youth and their families in a fiscally responsible approach to service provision.

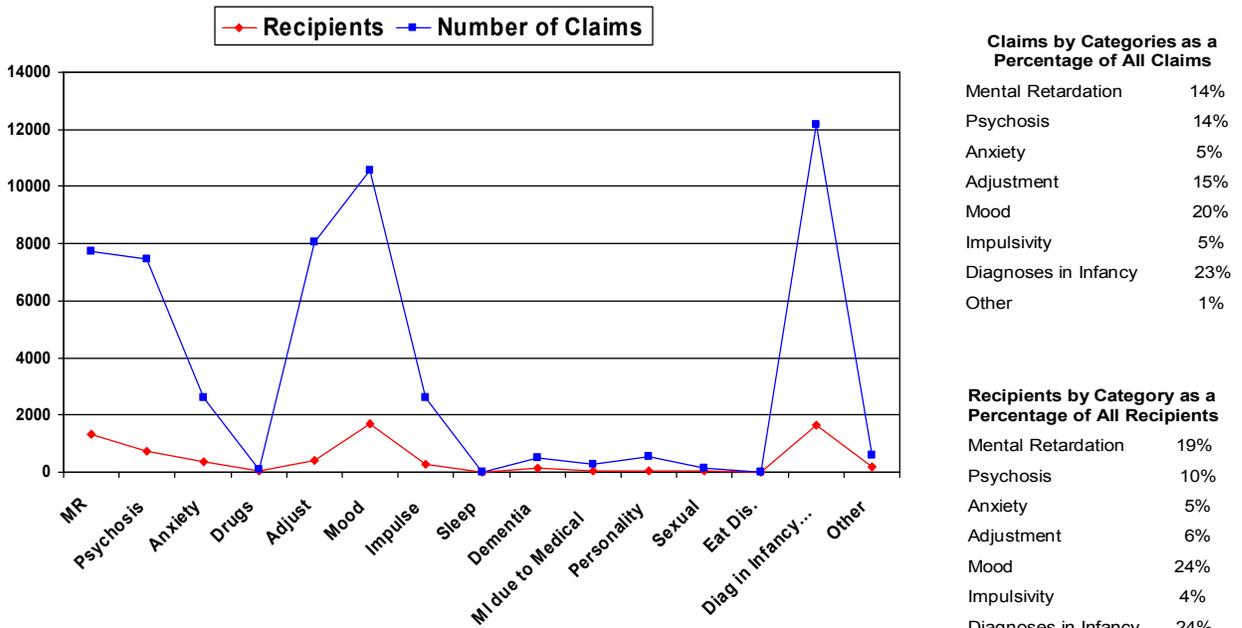
Children's Mental Health Waiver Claims by MI Primary Diagnosis First Date of Service in State Fiscal Year 2006



Note: There were an additional 268 Recipients who had no diagnosis associated with 2,995 Waiver Claims. It cannot be determined what portion of these claims were for serious emotional disturbances or for general medical problems and therefore were not included.

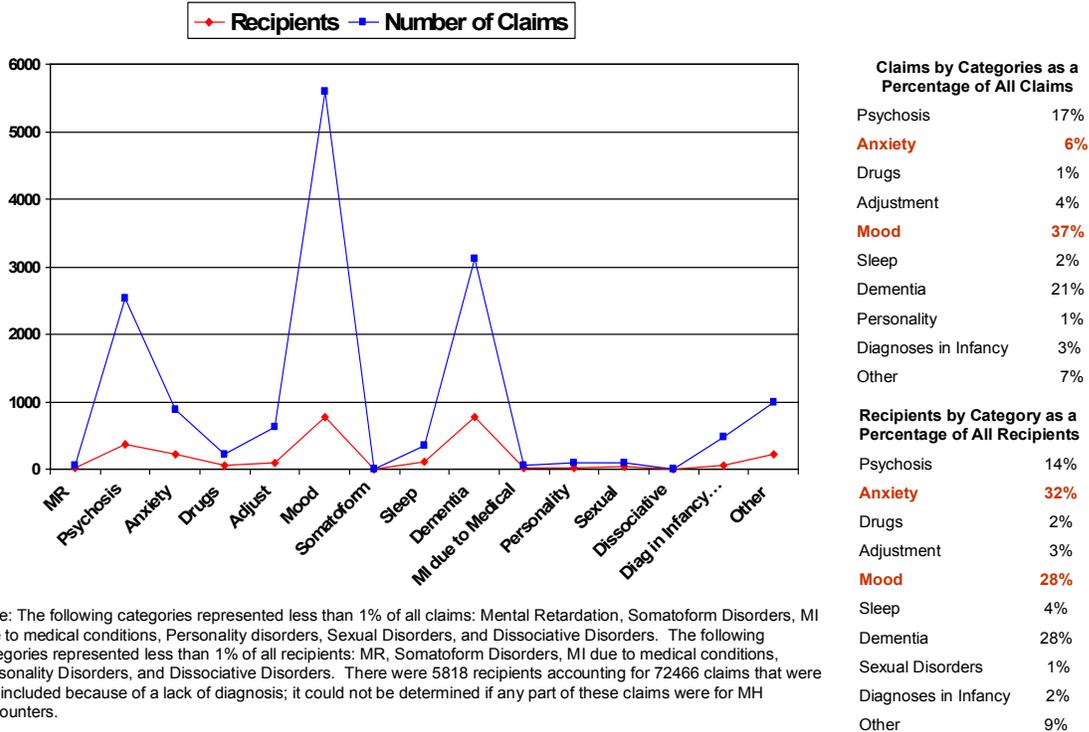
Following are Waiver Program data for other populations. While similar findings can be seen in most of these Waiver programs, one other point is worth noting. The following programs show high levels of co-occurring psychiatric problems. For example, it is noted in the literature that persons with MR suffer from co-occurring disorders between 40-70%. Such a finding again provides support for globalized assessment, adequate resources and training in appropriate treatment for persons with co-occurring disorders, and better IT capacity to reach down to the service level of care provided. One other finding should be noted. In the Elderly Waiver, while 32% of older adults experience anxiety; anxiety only accounts for 6% of all claims suggesting possible under-treatment of this major diagnostic categories in older adults.

Mental Retardation Waiver Recipients and Claim Counts by MI Primary Diagnosis: 2006



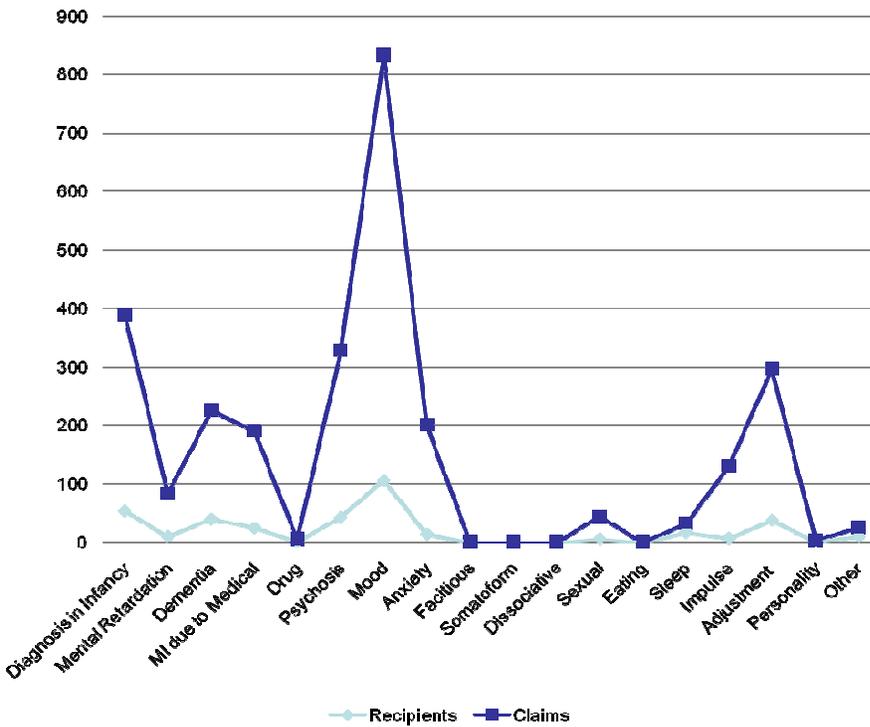
Note: The following categories represented less than 1% of all claims: drugs, sleep disorders, dementia, MI due to medical conditions, sexual disorders, and eating disorders. The following represent less than 1% of all recipients: drugs, sleep, Dementia, MI due to medical conditions, personality disorders, sexual disorders, and eating disorders.

Elderly Waiver Recipients and Claim Counts by MI Primary Diagnosis: 2006



Note: The following categories represented less than 1% of all claims: Mental Retardation, Somatoform Disorders, MI due to medical conditions, Personality disorders, Sexual Disorders, and Dissociative Disorders. The following categories represented less than 1% of all recipients: MR, Somatoform Disorders, MI due to medical conditions, Personality Disorders, and Dissociative Disorders. There were 5818 recipients accounting for 72466 claims that were not included because of a lack of diagnosis; it could not be determined if any part of these claims were for MH encounters.

Brain Injury Waiver Recipients and Claim Counts by Primary MI Diagnosis: 2006



Recipients by category as % of all Recipients

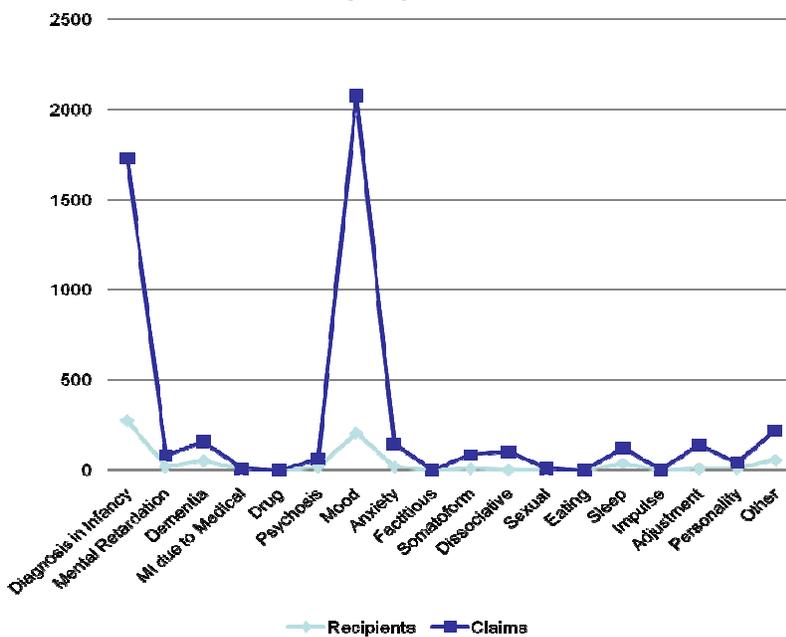
Diagnosis in Infancy	14
Mental Retardation	3
Dementia	11
MI due to Medical	7
Drug	1
Psychosis	11
Mood	28
Anxiety	4
Sexual	2
Sleep	5
Impulse	2
Adjustment	10
Personality	1
Other	3

Claims by category as % of all Claims

Diagnosis in Infancy	14
Mental Retardation	3
Dementia	8
MI due to Medical	7
Psychosis	12
Mood	30
Anxiety	7
Sexual	2
Sleep	1
Impulse	5
Adjustment	11
Other	1

The following categories represented less than 1% of all recipients: Factitious, Somatoform, Dissociative, and Eating Disorders. The following categories represented less than 1% of all claims: Drug, Factitious, Somatoform, Dissociative, Eating, and Personality Disorders.

Ill & Handicapped Waiver Recipients and Claim Counts by Primary Diagnosis: 2006



Recipients by category as % of all recipients

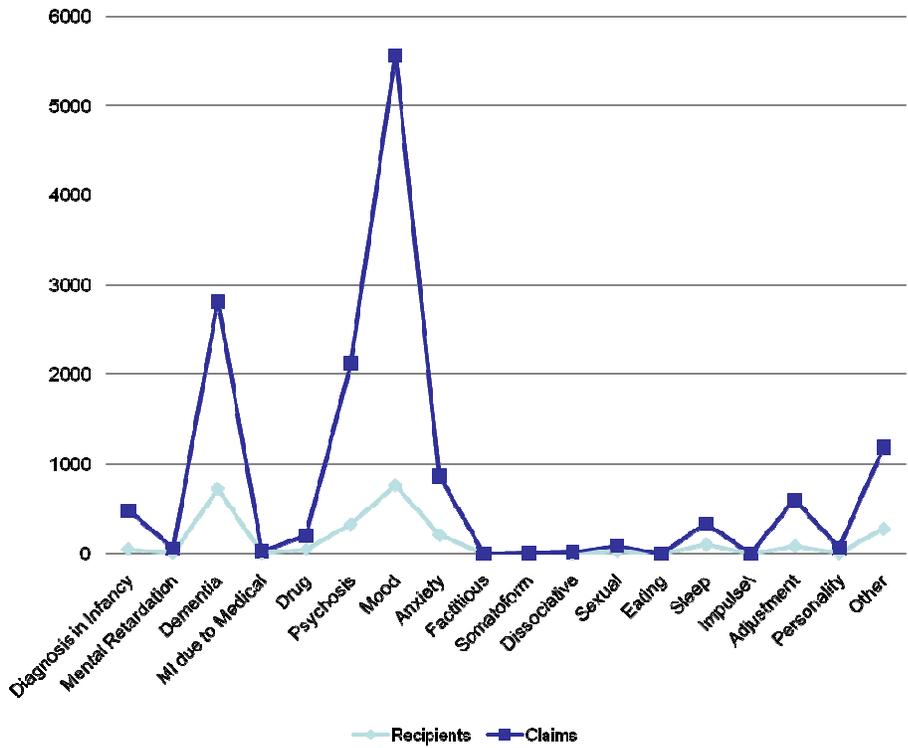
Diagnosis in Infancy	37
Mental Retardation	3
Dementia	7
MI due to Medical	1
Psychosis	2
Mood	28
Anxiety	3
Somatoform	1
Dissociative	1
Sexual	1
Sleep	5
Adjustment	1
Personality	1
Other	8

Claims by category as % of all claims

Diagnosis in Infancy	34
Mental Retardation	2
Dementia	3
Psychosis	1
Mood	41
Anxiety	3
Somatoform	2
Dissociative	2
Sleep	2
Adjustment	3
Personality	1
Other	4

The following categories represented less than 1% of all recipients: Drug, Factitious, Eating, and Impulse Disorders. The following categories represented less than 1% of all claims: MI due to Medical, Drug, Factitious, Sexual, Eating, and Impulse Disorders.

Physical Disabilities Waiver Recipients and Claims Counts by Primary Diagnosis: 2006



Recipients by category as % of all recipients

Diagnosis in Infancy	2
Dementia	27
Drug	2
Psychosis	12
Mood	28
Anxiety	8
Sexual	1
Sleep	4
Adjustment	3
Other	10

Claims by category as % of all claims

Diagnosis in Infancy	3
Dementia	19
Drug	1
Psychosis	15
Mood	38
Anxiety	6
Sexual	1
Sleep	2
Adjustment	4
Other	8

Note: The following categories represented less than 1% of recipients: Mental Retardation, MI due to Medical, Factitious, Somatoform, Dissociative, Eating, Impulse, and Personality Disorders. The following categories represented less than 1% of all claims: Mental Retardation, MI due to Medical, Factitious, Somatoform, Dissociative, Eating, Impulse, and Personality Disorders.

C. Conclusions

The data in this report represents a first stage of in-depth data analysis with regard to the mental health and disabilities services delivery systems. While this report represents a first stage of data mining, ongoing analyses will be continued. However, we have enough data now to show the inconsistencies between data bases with regard to fully understanding the revenues and expenditures in the system, how many people are actually served, and the treatment they receive. A good deal of these problems could be addressed by expanding the Department’s IT capabilities. First, some of the databases provide good data, however many provide conflicting data making analysis and interpretation a major challenge. The Department would benefit from integrating some of the databases that contain more reliable and valid information. Second, having better data for analysis would come from the extent to which different sources could/would use similar data sets. Third, a good amount of data is lost because much of the data reporting is not mandatory. Mandatory reporting must be implemented in order to more fully understand who is treated, for what and where. Finally, the Department must implement an outcomes measurement program to ascertain the effects on investments in key programs, services and initiatives. Currently this area is significantly under-funded.

APPENDIX N1:

CMHC Survey Responses

Mental Health Systems Improvement Project

Rank Order Distribution of Key Services by Percent Responding “YES”

Key Service Development Priority	Number of Respondents	YES Responses	Percent of responses	Rank
Mobile crisis services	36	5	13.9%	1
Supported housing	36	5	13.9%	1
Supported employment	36	5	13.9%	1
Mobile crisis teams	36	6	16.7%	2
Targeted case management	36	7	19.4%	3
Multi-systemic family therapy	36	9	25%	4
Autism spectrum disorders services	36	10	27.8%	5
Crisis intervention teams	36	10	27.8%	5
Community-bases crisis interventions for children and youth	36	11	30.6%	6
Crisis stabilization	36	12	33.3%	7
Co-occurring MH and MR	36	15	41.7%	8
Case Management	36	16	44.4%	9
Motivational enhancement	36	16	44.4%	9
Prevention and early intervention	36	16	44.4%	9
Family psycho-education	36	17	47.2%	10
Outcomes measurement tools	36	20	55.6%	11
Co-occurring MH and SA	36	20	55.6%	11
Behavioral health and rehabilitative services	36	21	58.3%	12
Navigation, planning, linking, coordinating follow-up and monitoring	36	23	63.9%	13
Mental health advocacy	36	23	63.9%	13
School mental health service	36	27	75%	14
Recovery-oriented services	36	29	80.6%	15
Illness and medication management	36	29	80.6%	15
Telephone crisis services 24/7	36	31	86%	16
Outpatient mental health services for children	36	32	88.9%	17
Functional assessment and diagnosis	36	33	91.7%	18
Cognitive behavioral therapy	36	34	94.4%	19

APPENDIX O:

Mental Health Systems Improvement

Executive Summary

This report reflects the recommendations provided by stakeholders to the Department of Human Services Division of Mental Health and Disabilities Services. In the spring of 2007, the Iowa Legislature passed the S909, which contained a division on *Mental Health Systems Improvement* that directed the Department of Human Services (DHS), Division of Mental Health and Disability Services (MHDS), to form and lead planning workgroups in order to make recommendations to the Legislature. The legislation was directed at the MHDS and included requests to have recommendations reviewed by the MHRDDBI Commission and the DHS Director. (Note: along with the Human Services Council, and the Mental Health Planning Council, the MHRDDBI Commission serves an advisory capacity to the DHS on mental health issues).

The legislation stated:

“In order to build upon the partnership between the state and counties in providing mental health and disability services in the state, the workgroups established for purposes of this subsection shall engage equal proportions representing the department, counties, and service providers. The county and provider representatives shall be appointed by the statewide associations representing counties and community providers. In addition, each workgroup shall include a representative of the commission, the mental health planning and advisory council, consumers, and a statewide advocacy organization.”

In June 2007 MHDS formed six (6) workgroups that met in the months of June through October and listed their recommendations to the Systems Improvement Steering Committee. Workgroups were comprised of county, provider agency, consumer, family, advocacy, state agency and expert advisors totally nearly 100 individuals consistent with legislative direction. This report contains the recommendations from those workgroups and the steering committee comprised of workgroup-elected “Steering Committee” members. Agendas, minutes, and meeting documents were made public on the DHS website. In addition to workgroup and steering committee meetings held in the summer and fall of 2007, numerous meetings were held with provider organizations, advocacy organizations, state agencies, the Human Services Council, Mental Health Planning Council and MHRDDBI Commission where major discussions on this initiative were held in the latter half of 2007.

This document contains the following major sections:

1. Overview of this Initiative
2. Workgroup Timelines
3. Background on Workgroups
 - a. Alternative Distribution Formula
 - b. Community Mental Health
 - c. Core Mental Health Services
 - d. Mental Health and CSA Standards & Accreditation
 - e. Co-Occurring Disorders
 - f. Evidence-based Practices
4. Specific Recommendations from Each Workgroup
 - a. Alternative Distribution Formulas
 - b. Community Mental Health Center Plan
 - c. Core Mental Health Services
 - d. MH and CSA Standards & Accreditation
 - e. Co-Occurring Disorders
 - f. Evidence-based Practices

This document does not contain specific funding requests for the legislature as such requests come from DHS as part of its budget development process.

1. Overview of this Initiative

In the winter of 2005, the Iowa Department of Health and Human Services contracted with a collaborative group of researchers at the University of Iowa to develop a white paper for the 2006 legislative session that addressed necessary first steps toward a mental health system transformation. Along with other materials, those report assisted the legislative process during the 2006 session to authorize House File 2780 which enabled the development and implementation of a Division of Mental Health and Disability Services (MHDS).

In 2007 the Legislature, in collaboration with the MHDS, developed a section of the DHS Appropriation bill (S909) entitled: "Mental Health Systems Improvement (MHSI). The MHSI legislation required the DHS/MHDS to form six major workgroups with directives to focus on major areas of interest in the mental health system to the Legislature. This report describes the workgroup development and review process, the timelines, workgroup membership and major recommendations from the workgroups and workgroup steering committee.

2. Workgroup Timelines

The following is the timeline for the development of a series of recommendations to the Iowa Legislature. There was no specific requirement for the MHDS or Commission to hold public hearings as group membership, representativeness and specific instructions to the groups was included in the enabling legislation.

Meeting dates, times and locations were published on the DHS website along with a wide range of workgroup documents, agendas, minutes and presentations. Hundreds of documents were reviewed.

There were a number of key milestones with some due late in the 2008 calendar year:

TIMELINES MHSI WORKGROUPS	Due to Commission	Due to DHS	Due to Legislature
PHASE I			
Alternative Distribution Formulas	11/1/07	12/1/07	1/31/08
Community Mental Health Center Plan	10/1/07	11/1/07	1/31/08
Core Mental Health Services	10/1/07		1/31/08
MH and CSA Standards & Accreditation	12/1/07		1/31/08
Co-Occurring Disorders	4/1/08	5/1/08	6/1/08
Evidence-based Practices		9/1/07	1/31/08
PHASE II			
Comprehensive Plan	11/15/08		12/15/08

Frequency of Workgroup Meetings

In order to attempt to meet the deadlines outlined above, each workgroup met at least six times during the summer and into the fall of 2007 to review a large number of documents about the mental health system, to participate in presentations from senior DHS staff and Technical Advisors, and to discuss documents and make recommendations to the Steering Committee. The Steering Committee had several meetings also during the summer and fall to review the minutes and products of the workgroups. The Steering Committee met weekly during September 2007 to review the recommendations made by the workgroups and developed lists of recommendations.

Agendas, Minutes, Documents Reviewed by Workgroups

Each workgroup published agendas, distributed documents, took attendance and kept written minutes of every meeting and posted all documents as well as calendar information on the IDHS/MHDS website. Meetings were held in various locations around the Des Moines area. Workgroups were asked to review documents of other workgroups as material was appropriate and a number of presentations provided by DHS staff and Technical Advisors were posted on the website for public view.

3. Background on the Workgroups

In order to meet the requirements set forth by the legislature, each workgroup had a specific focus in terms of possible improvement in the mental health system. The following are excerpts from the legislation as well as additional direction provided by staff and advisors for the workgroups to assist them in preparing recommendations.

Alternative Distribution Formulas

According to the legislation this workgroup was to:

“Identify alternative formulas for distributing mental health, mental retardation, and developmental disabilities allowed growth factor adjustment funding to counties. The alternative formulas shall provide methodologies that, as compared to the current methodologies, are more readily understood, better reflect the needs for services, respond to utilization patterns, acknowledge historical county spending, and address disparities in funding and service availability. The formulas shall serve to strengthen the partnership between the department and counties in the state’s services system.”

This workgroup reviewed the current funding distribution formulas and methods for MH and Disability Services to counties. They reviewed approaches taken by other states and identified resources needed, anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup.

Community Mental Health Center Plan

According to the legislation this workgroup was to:

“Prepare a phased plan for increasing state responsibility for and oversight of mental health services provided by community mental health centers and the providers approved to fill the role of a center. The plan shall provide for an initial implementation date of July 1, 2008. The plan shall be submitted to the commission on or before October 1, 2007. The department shall ensure that key stakeholders are engaged in the planning process, including but not limited to the commission, mental health services providers, individuals with expertise in the delivery of mental health services, youth and adult consumers, family members of consumers, advocacy organizations, and counties.

This workgroup reviewed current Ch. 230a Code standards and CMS core service standards for community mental health centers. There was a special focus in this workgroup on co-occurring disorders, children’s mental health, school mental health and emergency mental health services. Specific recommendations for emergency mental health, children’s mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

Core Mental Health Services

According to the legislation this workgroup was to:

“Identify core mental health services to be offered in each area of the state by community mental health centers and core services agency providers. The workgroup for this task shall be established no later than August 1, 2007. The core services shall be designed to address the needs of target populations identified by the workgroup and the services may include but are not limited to emergency services, school-based mental health services, short-term counseling, prescreening for those subject to involuntary treatment orders, and evidence-based practices. The division shall submit to the commission on or before October 1, 2007,

proposed administrative rules and legislation to amend chapter 230A as necessary to implement the core services beginning July 1, 2008. “

The workgroup reviewed the current matrix of services included in the Medicaid contract with Magellan Behavioral Health regarding services to be provided as well as other potential “core services” that could be available for children, youth and adults. Specific core services will minimally include: emergency mental health services, etc. Each CMHC or CSA will be expected to contract or have a letter of agreement with a local inpatient psychiatric unit to serve consumers in need of inpatient hospitalization. The workgroup will identify resources needed, anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup. Specific recommendations for emergency mental health, children’s mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

Mental Health & Core Service Agency Standards & Accreditation

According to the legislation this workgroup was to:

“Identify standards for accreditation of core services agencies that are not a community mental health center but may serve as a provider approved to fill the role of a center. Such core services agencies could be approved to provide core mental health services for children and adults on a regional basis.”

This workgroup reviewed the current CMHC standards (Ch230a) and recommended revisions according to the delineation of core services to allow CMHCs to operate under the direction of the DHS MHDS. The workgroup recommended accreditation standards for core service agencies as well as emergency mental health and children’s services. A review of standards from other states occurred. Consideration by this workgroup was given on supporting continuous quality improvement activities, the inclusion of co-occurring and systems of care principles in the standards. The workgroup identified resources needed, discussed anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup. Specific Ch230a changes were developed. Specific recommendations for emergency mental health, children’s mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

Co-Occurring Mental Health and Substance Abuse Disorders

According to the legislation:

“The division and the department of public health shall give priority to the efforts underway to develop an implementation plan for addressing co-occurring mental health and substance abuse disorders in order to establish a comprehensive, continuous, and integrated system of care for such disorders. The division and the department of public health shall participate in a policy academy on co-occurring mental health and substance abuse disorders as part of developing an implementation plan for commission review by April 1, 2008.”

In the summer of 2007, per the above direction, IDHS and IDPH resumed meetings of the COD Policy Academy. DHS/MHDS engaged the services of Dr. Kenneth Minkov and Dr. Chris Cline to provide support and technical assistance on reviving the Policy Academy as well as facilitate the design and implementation of a model for co-occurring disorders. Through collaboration between the Policy Academy and the Workgroup a Charter Document (see Appendix) was prepared to begin implementation of systems change across agencies and throughout the mental health and substance abuse system. The workgroup recommended ongoing development of the COD model through implementation of the Charter document with a wide range of organizations and agencies.

Evidence-based Practices

According to the legislation this workgroup was to:

“(1) Begin phased implementation of evidence-based practices for mental health services over a period of several years. (Not later than October 1, 2007, in order to provide a reasonable timeline for the implementation of evidence-based practices with mental health and disability services providers, the division shall provide for implementation of two adult and two children evidence-based practices per year over a three-year period.”

(2) The division shall develop a comprehensive training program concerning such practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa consortium for mental health and mental health service providers. The division shall consult with experts on behavioral health workforce development regarding implementation of the mental health and disability services training and the curriculum and training opportunities offered.

(3) The department shall apply measures to ensure appropriate reimbursement is available to all providers for the implementation of mandated evidence-based practices and request appropriate funding for evidence-based practices from the governor and general assembly as part of the implementation plan. The implementation plan shall be submitted to the governor and general assembly on or before January 31, 2008.

(4) The department shall provide the commission with a plan for review to implement the provisions of this paragraph "f".

This workgroup developed a three-year sequence to implement a range of children, youth and adult EBPs that also carefully considered the needs for staff orientation, training and supervision in EBP areas. The focus on workforce development training was recommended for all levels of mental health and disability services including CMHCs, MHIs, and State Resource Centers; DHS operated Juvenile facilities, PMICs and Core Service Agencies. The development and implementation of a Mental Health and Disability Training Institute was recommended where training programs must demonstrate that they employ evidence-based practices for teaching/training. The workgroup began the identification of resources needed, anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup. An interagency collaborative workforce development group was recommended with ongoing mentorship from the Annapolis Coalition on Workforce Development. Specific recommendations for emergency mental health, children’s mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

4. Discussions and Review with the MHRDDBI Commission

A number of meetings were held with the MHRDDBI Commission over the time period when the Workgroups and Steering Committee met. Updates as well as draft reports were provided to the Commission on the following dates: August XX, September XX, and October XX, 2007. Individual workgroup and steering committee members presented summary reports to the Commission at its annual retreat. Minutes of the Commission meetings reflect that draft documents were distributed to Commission members, workgroup and steering committee members as well as project technical advisors on a number of occasions before the distribution of this current draft.

5. Recommendations from the Workgroups

The legislation related to this project did not specify the manner in which recommendations were to be obtained, nor in what manner they might be weighted or prioritized. Therefore, recommendations are not listed in order of priority or importance. While there was often considerable discussion about some recommendations, there was often consensus on many of them.

Following an election by the workgroups of steering committee “representatives” the steering committee met for several weeks to summarize the recommendations. There was often consensus on many of the recommendations but there was also considerable disagreement on a number of recommendations. The steering committee was often reminded to attempt to remain within the scope of the charge for the workgroups from the legislature. However, some members of the steering committee persisted in requiring discussion and recommendations on a wide range of issues outside of the scope of the specific, individual workgroup.

The following sections of this document list the workgroup recommendations as prepared by the Steering Committee. Considerable editing was required to eliminate redundant recommendations and capture the intent as well as, when indicated, specific language from the workgroups. During later drafts of this document there were dozens of email edits and recommendations circulated regarding the recommendations and follow up meetings held with DHS staff and workgroup/steering committee members. Consideration was given to preparing a section on “minority views” but this was not included. As can happen in committees, there was often major disagreement among workgroup and steering committee members on recommendations despite attempts to reach consensus. A particularly contentious series of discussions were held related to the Alternative Distribution Formula recommendations.

A. Alternative Distribution Formula Workgroup

Workgroup Members

Technical Advisor

Dr. William Hudock

DHS Representatives

Jim Overland

Harold Templeman (former DHS employee)

County Representatives

Linn Adams

Jill Eaton (Alternate)

Karen Walters-Crammond

Service Provider Representatives

Dave Becker

Earl Kelly

Commission Representatives

Jane Halliburton

Rick Hecht

MH Planning and Advisory Council Representatives

Teresa Bomhoff

Michael Winchell

Consumer Representatives

John Curtis

Todd Lange

Statewide Advocacy Organizations Representatives

Mardi Deluhery

Richard Shannon

Margaret Stout

The Alternative Distribution Formula (ADF) Workgroup would like to acknowledge the following steps, which the Legislature has taken in response to the recommendations of the MH/MR/DD/BI Commission:

- 150% of Poverty level was established as the standard eligibility guideline for disabilities services that are provided by counties.
- Service eligibility was changed on 7-1-07 so that eligibility is determined by the county management plan in the county of residence and paid for by the county of legal settlement.
- Community Mental Health Centers, psychiatrists and inpatient psychiatric units are being funded on a cost based system (For Medicaid clients only). Most Community Mental Health Centers had been operating at a financial loss.

NOTE: Cost based reimbursements also apply to other Chapter 24 accredited providers – it is not limited to just CMHC's – per HF909.

- A new Division of Mental Health & Disability Services was established within the Dept. of Human Services.

The present situation:

- The original formula to distribute mental health and disability funds was modified in the last 12 years with calculation changes in an effort to channel the funds to the counties where the county property taxes, allowed growth, MHDD community services, and property tax relief were not sufficient to address the service needs.
- The State Legislature determined that the calculation changes were necessary to encourage some counties to spend their fund balances and adequately levy county dollars for mental health.
- The calculation changes have increased the level of complexity and obscured a full understanding of the actual costs and expenditures.
- The present formula used is too complicated to be a transparent transaction.

The ADF workgroup was asked to explore methodologies that:

- Are more readily understood,
- Better reflect the needs for services,
- Respond to utilization patterns,
- Acknowledge historical county spending,
- Address disparities in funding and
- Promote service availability.

The ADF Workgroup used the following values to identify a possible replacement formula for distributing fund appropriations from the State's General Fund and the Health Care Trust Fund:

- Simplification
- Flexibility
- Adequate to cover core services funding so access to core services is available state-wide.
- Adequate to allow for additional services above core services.
- Replacement of legal settlement as a basis for determining allocations with the determination of where the individual receives services
- Better meet the needs of the service population
- Allow money to follow the person

The ADF Workgroup recommends a two-step process in creating a new distribution formula:

- Making adjustments to the present formula
- Creating an alternative distribution formula to reach a system of mental health funding that reflects the values outlined above.

The elimination of legal settlement will not occur until an alternative distribution formula is developed, which is the goal of the ADF Workgroup. Through an alternative formula, the allocation of money will follow the person in that it will be based on where an individual receives services rather than where they reside.

Description of the Present Distribution Formula

The current formula for the allocation of funds to the counties includes growth appropriation dollars and the MHDD Community Services appropriation dollars. Over the years a number of adjustments have been made to the formula to insure that money goes to the counties with the greatest need. Greatest need has been defined as a county with a fund balance below 10%.

This is how the formula worked for the allocation of the money in fiscal year 2007:

- The first step is to determine the allowed growth allocation. In 2007 this was \$12,000,000, which was based on the latest general population estimate for each county.
- The second step is to determine the per capita allocation, which is based on the latest general population estimate for eligible counties. A county is eligible if:
 - ⇒ The county levied 100% in the current year,
 - ⇒ The county had a fund balance below 25% in the previous two years, and
 - ⇒ The county had net expenditures below \$116.77 per capita in the previous year.
- The third step is to determine the community services allocation of which 50% is based on the latest general population estimate and 50% on the most recent poverty population data. In 2007 this amount was \$17,727,890.

These three funding pools add up to an initial state allocation of \$61,853,614.

- Counties with a fund balance of less than 10% are now allocated additional funds,
- Those counties with a fund balance less than 5% will be awarded an amount equal to 3% of their gross expenditures last year.
- Those counties with a fund balance between 5-10% are awarded 2% of their gross expenditures last year.

Instead of \$61,853,614, the state only appropriated \$54,189,038 to counties for Mental Health Allowed Growth so we need a mechanism to get from the initial allocation to the final appropriation – that mechanism is called the withhold factor. The withhold factor is an equitable way of reducing each county's allocation by a proportionate amount of the shortage in the appropriation.

For 2007 the withhold factor is \$7,664,576, the difference between the initial allocation and final appropriation.

The withhold factor only affects counties with fund balances between 10% and 25% and is calculated by dividing the amount of the state appropriation that is left over after the initial allocation of funds to counties and the additional award to those counties having a fund balance less than 10%. Each county's initial allocation is then multiplied by the withhold factor to get the final allocation.

But one more factor is taken into consideration and that is the ledge. The ledge says that a county can only lose an amount of money equal to the amount by which its fund balance exceeds 10%. After these calculations are completed and the ledge factor applied, the result is the final allocation for each county.

Adjustments to the current formula have been made because of a number of factors. Over time, the freezing of the dollar amount counties are allowed to raise through property taxes has resulted in large fluctuations in the levy rate in some counties, a steady decline in the levy rate for some counties, and a continued wide variance among the counties. There is no relationship between the amount of money available to a county through property taxes and property tax relief and the amount of money needed to provide services to its citizens. So the base level of funding is uneven.

Adjustments have also been made to ensure that state funds are not used to replace county dollars. Thus, the level of fund balance and the extent to which counties levy the maximum amount allowed have become large factors in the formula.

The current formula ignores many of the factors that contribute to the level of need in a county. These include such things as the number of individuals actually receiving services, the levels of service they need, and the array of services offered by the county. It also does not allow for a reasonable transition from using legal settlement as the primary factor in determining which

county will pay for services for a particular individual. It has long been a goal in the state to move to payment based on residency rather than legal settlement. Currently, counties continue to pay for individuals, even if they move out of the county. If the state funding formula would allow for funds to follow the individuals as they move, legal settlement could be eliminated as a basis for payment responsibility.

Proposed Budget Numbers Formula

The ADF Workgroup proposes the following budget numbers formula, using FY09/10 as an illustration:

- A. Determine the current Fund 10 Budgeted Expenses (i.e. FY09/10)
- B. From the Fund 10 amount, subtract the following amounts:**
 - Unallowable Expenses
 - FY09/10 Budgeted Revenues other than Allowed Growth
 - FY07/08 Accrual Fund Balance (or for an earlier calculation, use FY06/07 Accrual Fund Balance)
 - The FY09/10 County Property Taxes budgeted for Fund 10
 - Any amount of County Property Taxes that the county could have levied, but did not levy
- C. Use the subtotal from the above calculation and add a % of the current (i.e. FY09/10) Fund 10 Budgeted Expense that represents a reasonable fund balance target. 10-15% has been suggested as reasonable.**
- D. The resulting figure is the Gross Allowed Growth Needed

If the Legislature appropriates less than the Total Gross Allowed Growth Needed, each county's share would be proportionately reduced.

Under the proposed budget numbers formula, several issues would have to be addressed for the formula to work.

- Counties would have to prepare budgets that reasonably addressed the level of services needed in the county. It appears unlikely this has occurred since the number of MH dollars each county was allowed to spend has been frozen since 1996. The dollars available drive the services that can be offered.
- Administrative rules would have to be established to define unallowable expenses.
- It appears to be a labor-intensive process to review each of the 99 county budgets each year.

The ADF workgroup concluded –

- Instead of recommending an “interim” formula such as the proposed budget numbers formula and then a “final” alternative formula –
- The workgroup would recommend some “adjustments” to the present formula and then a “final” alternative formula.

Most efforts should be expended to implement the final (or alternative) formula as soon as possible. There was consensus that the longer-term recommendation (alternative formula) is where the committee wishes to go.

Points Regarding a Formula Change or Alteration

The ADF workgroup made these points regarding the alteration of a distribution formula or switching to an alternative formula:

- There must be winners and losers if the total dollars remains the same.

- Altering any variable of the formula will lead to a different set of winners and losers and to different degrees of gain and loss.
- Formulas can reflect principles (e.g. equal weighting based on population, distribution based on cost of services provided, etc.) but use of such formulas will lead to winners and losers compared to the status quo.
- The current formula reflects both principles and years of political adjustments that resulted in some counties getting more and some getting less. Any change or simplification of the formulas will result in unraveling of some of these political adjustments. As such, it will create both winners and losers in ways that may be unanticipated.
- Different stakeholders will reach different conclusions regarding whether any changes to the existing formula are fair. The open question is how one supports one's conclusions regarding the comparative fairness of different formulas. The committee early on reached the conclusion that some of the adjustments in the existing formula were both difficult to understand and potentially less fair than the formulas that recently have been discussed.
- The committee gets to make recommendations, but ultimately the legislature gets to decide whether the recommended changes (or some variation of them) are preferable to the existing formula. Their decisions likely will be based both on the logical strength of the recommended formula and on the political realities that confront the various counties.

Other Alternative Formulas explored but discarded

1. Use MH/DD population rather than general population in the present formula – The ADF Workgroup couldn't run these numbers with any accuracy since we could not determine an unduplicated count of consumers in each county.

2. Use SSI population per county rather than general population and poverty in the present formula – The ADF Workgroup was unable to test this alternative for lack of accurate numbers of consumers.

3. Use a budget numbers formula instead of the present formula - Instead of using population as the base, the base is the level of expenses each county anticipates it will need to spend to reasonably address the needs of its consumers.

Adjustments to the Present Formula

The ADF Workgroup recommends submitting the following changes to the 2008 Legislature, to be effective starting with the FY 09 Allowed Growth Calculation. The legislative recommendations should include two items, which are required for a county to be eligible for funds through the MHDD Community Services and Allowed Growth formula:

- The county would be required to levy at 100% of maximum dollars except where the cost per thousand levy rate will exceed a reasonable maximum rate per \$1000 valuation. The ADF Workgroup initially is recommending that the maximum rate be \$3.00, but others involved in property tax policy are recommending \$2.50. Only a few counties' maximum levies exceed \$2.50.
- The county's fund balance would have to be less than 15%.

The fund balance used in the calculation would be one year earlier than the current formula.

For example – for FY 09/10, in the present formula, the FY 08/09 Fund 10 balance is used (1 year prior). The proposed adjustment to the current formula would use the FY 07/08 Fund 10 balance- 2 years prior).

With the fund balance adjustment described in the previous paragraph, the law can also require that the distribution of funds through the MHDD Community Services and Allowed Growth formula be calculated by January 1 for the subsequent fiscal year, and by July 1, 2008 for FY 09.

The ADF Workgroup identified 32 counties that are currently or will likely soon be experiencing a funding crisis, based on fund balance, percent of maximum levy, and counties' reports of service reductions and/or waiting lists.

If the recommended changes in percent of maximum levy and percent of fund balance would be used for the FY08 formula using FY06 fund balances, all of the counties with funding crises would receive the same amount or more funding than with the current formula.

The Alternative Formula

The Alternative Formula proposed is: county allocation = client/consumer #'s X case rate.

The Alternative Formula we are recommending is a conceptual formula that will reflect true costs - one that will be sensitive to:

- Changes in the number of consumers
- The intensity of need
- The level of services provided as well as other factors that may be important such as ability to pay, poverty rates, etc.
- Other resources available to those individuals (natural supports, Medicaid, etc.)

Two important tasks must be completed to move from the present formula to the proposed Alternative Formula:

1. Establishing an accurate, unduplicated count of consumers

Not having an accurate unduplicated count of consumers compromises the accuracy of any formula or fairness of any policy where the money follows the person (where the allocation for a case goes to the county managing the case).

The first year of services will be completed June 30, 2008, in which services were managed by the county of residence but paid for by the county of legal settlement. It was not the exclusive arrangement for payment of services for a consumer, however.

There were still instances when some of the services provided were paid by the county of residence, not the county of legal settlement. Another factor affecting unduplicated count of consumers was in situations where some counties allocated their funds to service providers as a block grant, therefore, no count of consumers was done.

These factors (and possibly others) cause wide fluctuations in numbers of consumers served being reported. The situation has created difficulty determining an unduplicated count of persons being assisted.

Specific rules and definitions should be developed for reporting # of MH/DD persons being served so an unduplicated count of persons being served can be achieved. The present definition and method of reporting is not working. Counties are counting consumers served in different ways.

2. Establishing a Case Rate

This new methodology will be well aligned to the cost of service. By this we mean that there is a difference in cost based on severity of need or based on intensity of service provided. These two

different approaches are often reflected through level of functioning (severity of need) measurements and through level of care (intensity of services) measurements respectively. We could use one or both of these types of measures.

The benchmarks will be:

- The data is understandable in simple terms and
- There is wide agreement that the data is accurate and complete

A functional assessment team has been meeting since May 2004. A case rate methodology is not yet established but pieces of the process are underway to establish a case rate methodology. To achieve the alternative distribution formula, the following steps should be completed:

- Define the factors which group people together
 - ⇒ Receiving Medicaid or not receiving Medicaid
 - ⇒ High, medium, low functioning*
 - ⇒ Severity of illness based on -
 - Developmental disability
 - Mental retardation
 - Chronic mental illness
 - Mental illness
- Design service packages and estimated costs based on -
 - ⇒ Core services
 - ⇒ Additional services
 - ⇒ A determination of costs that will be included in the case rate
- Need data systems in place to track costs & information**
- Address how the case rate might work if it is adjusted by the county's levy and fund balance.
- Establish a stop loss pool to provide additional funding for individuals whose service costs fall significantly outside the parameters of the rate cell that is the basis for their payment.

* **Standardized Functional Assessment Group - LOCUS software (for MH/MR/DD/BI cases) purchased for 6 demonstration counties and was offered to counties on a voluntary basis by January 2007, although counties do not yet have access to the scores through the software. ICAP software (for MR and DD cases) purchased for 4 demonstration counties in January 2007.**

The State Legislature authorized an appropriation of \$260,000 in HF 2780 for FY 2007 to move these tasks forward. The same appropriation was provided in HF 909 for FY 2008. These funds could be used to make significant progress toward the development of the case rate methodology.

** ISAC has obtained funding through IOWAccess Fund to begin establishing a statewide database. This statewide database will be able to record all necessary information, including functional assessment data and the cost of services. The basic system should be available in 2008.

How Case Rates Could Work

A case rate is a statistically determined cost of providing services for a cluster of individuals with the same disability or disabilities and similar levels of functioning.

Step 1. Establish case rates.

Assume we have released an RFP, hired a consultant, they have analyzed the data, and we now have 25 rate cells. The rate cells represent quarterly dollar amounts needed to serve the average client in that rate cell.

Rate Cell A = \$1,000 Rate Cell B = \$4,000 Rate Cell C = \$2,500

Step 2. County X sends a current case count for each rate cell.

Rate Cell A = 15 Rate Cell B = 24 Rate Cell C = 17

Step 3. Calculate total dollars needed.

Rate Cell A: 15 X \$1,000 = \$ 15,000

Rate Cell B: 24 X \$4,000 = \$ 96,000

Rate Cell C: 17 X \$2,500 = \$ 42,500
\$153,500

Step 4. Calculate quarterly allocation to County X.

(Total dollars needed) – (One fourth of the minimum county levy for Fund 10)
= County X Allocation
\$153,500 – (\$285,420 X ¼) = \$82,145

The final determination of a county's allocation should include some consideration of each county's fund balance.

- An operational definition should be established for a maximum fund balance (maybe the 10% that is used in the withholding calculation now) before it is used in the calculation of a county allocation.
- This definition should consider whether a county levies more than the minimum (maybe a proportional calculation)
- or maybe there was some plan (strategic) about levying extra funds to accomplish a specific task (such as mandated core services).

Any of these ideas could be incorporated in the case rate calculation and the fund balance component.

The Appendix shows a comparison of the present formula, the proposed interim formula, and the proposed alternative formula.

As the Alternative Distribution Formula Workgroup was meeting other issues surfaced about which we wanted to make recommendations but they were outside the scope of our charge. As a result, we are making a separate report discussing those issues and sharing our recommendations.

B. Community Mental Health Center Plan

Community Mental Health Workgroup Members

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Carol Porch

Recommendations from the Workgroup:

1. THE CMHC Workgroup supported the Core Services Workgroup recommendations and added the following:

“Prevent any unfunded mandates. Address resource needs related to the uninsured, underinsured, uncompensated care, etc. Ensure that adequate resources are dedicated to successfully implement required changes related to the Mental Health Systems Improvement Process.

a. The CMHC Workgroup recommends the following:

- Review the current rate of payment for mental health services to determine if the current rate covers the actual cost of service provision. Include a review of the rates for substance abuse services.
- *“Create eligibility criteria for core services which:*
 - *Determines service access by individualized clinical eligibility/medical necessity as determined by a standardized functional assessment.*
 - *Addresses barriers for people who are uninsured or under-insured that hinder service access.*

Ensures access to mental health services for people of all ages, regardless of ability to pay (i.e., includes children and older adults, is not limited to adults.”

- *Focuses on the priority populations of:*
 - *Anyone as determined by individualized clinical need is eligible for Outpatient Services.*

- *Anyone experiencing a self-defined psychiatric emergency is eligible for Emergency Services.*
- *Individuals experiencing SMI/SED eligible for an additional array of Specialized Community Based Service.*

b. The CMHC Workgroup recommends clarification that *"anyone regardless of ability to pay"* does not mean services would be provided free of charge but does mean following standardized financial eligibility criteria.

c. The CMHC Workgroup also recommends the implementation of a standardized sliding fee schedule for persons above the financial eligibility criteria.

2. Establish the State Mental Health Authority as the statewide oversight entity for required core safety net services and of the CMHC's as providers of those services. Also, establish the State Mental Health Authority as the statewide oversight entity of other mental health services and service providers (i.e., accrediting body).
3. Establish a statewide public safety net and utilize the community mental health centers as the public safety net with the responsibility to ensure the statewide availability of required core safety net services that includes 24/7 access to emergency services.
4. Maintain the role of other Core Service Providers as a valuable part of the total system of care.
5. Establish a process for the State Mental Health Authority to determine service areas or regions to be served by the CMHCs for the required core safety-net services.
6. Ensure people with mental health needs have access to core services regardless of their ability to pay (i.e., to fund uninsured, underinsured) following clinical eligibility criteria, financial eligibility criteria, and implementing a standardized sliding fee schedule for persons whose income exceeds financial eligibility criteria.
7. Prioritize public funding and service provision of Required Core Safety Net Services to persons of any age who meet priority/targeted population criteria (as outlined in the Core Services Workgroup Report).
8. Determine the role, relationship, and responsibilities of the State Mental Health Authority and the counties regarding financing and managing the public Mental Health System. The CMHC Workgroup is recommending:
 - a. State Mental Health Authority responsibility for funding services identified as Required Core Safety Net services (i.e., non-federal portion of Medicaid; funding for uninsured/underinsured),
 - b. State Mental Health Authority responsibility for the financing of the non-federal portion of all other community level mental health services funded through Medicaid **for all ages**.
 - c. Individual county responsibility for funding other mental health services based on local need as identified in the County Management Plan. This **includes** responsibility for other local service needs for children.
9. The CMHC Workgroup is recommending that responsibility for the non-federal portion of community level mental health services remain with one entity and become the responsibility of the State Mental Health Authority and of Medicaid. **Note:** There was considerable discussion in the workgroup about delineation of financial responsibilities for payment for the non-federal portion of mental health services funded through Medicaid being split between the state and the counties. State responsibility for financing the non-federal portion of some Medicaid funded mental health services (i.e., required Core Safety Net services) and County responsibility for financing other Medicaid funded mental health services can result in competing interests, influence service provision based on funding responsibilities rather than clinical need and/or

result in other unintended consequences that can negatively impact service access and provision for adults, youth, and their families.

10. Phase the implementation of Mental Health Systems Improvement recommendations over a 3-to-5 year time period.

11. Revise *Chapter 230A: Community Mental Health Centers* to incorporate the recommendations of the Mental Health Systems Improvement process.

12. Revise *Chapter 24* to:

- a. Establish minimum standards for accreditation of CMHC's as an agency with responsibility for required core safety net services.
- b. Change accreditation of other Mental Health Service Providers. Focus on accreditation standards for services rather than providers (i.e., Providers would then need to meet standards for a service to provide that service).

13. Revise, amend or develop other related areas of Iowa Code and/or Administrative Code to be consistent with Mental Health Systems Improvement recommendations.

- Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Rep.'s, Commission, IME, etc.).
- Revise CMHC Code to incorporate recommendations about CMHC's as safety providers responsible for Core Required Safety Net Services.
- Include language about the role of the State Mental Health Authority
- Assess accreditation process of other MH service providers (i.e., Accreditation by individual service or by provider entity?). Incorporate necessary changes as it relates to changes, additions of Medicaid services.
- Utilize the support and expertise of others such as consultants and legislative staff
- Ensure accreditation standards for mental health service providers and related mental health service standards (i.e., Habilitation Services, Remedial Services, and Psych.Rehab. Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations.
- Include an assessment and revisions to code related to voluntary and involuntary commitments.

14. Convene a workgroup of representative stakeholders to analyze the amount of funding needed for safety net services that address the financing for uninsured, underinsured, uncompensated care.

- Assess how current county/state funding is being utilized (i.e., Determine what is being matched to Medicaid, what is not, etc.).
- Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what segments? Where are responsibilities shared?).
- Determine if there is existing funding that can be leveraged for Medicaid services.
- Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy in program for people with disabilities.
- Assess the pros, cons, and unintended consequences related to funding responsibilities and financing mechanisms.
- Utilize a financing model that supports the service needs of consumers and youth, removes cons and other unintended negative consequences, promotes collaboration (and eliminates cost shifting) across responsible parties, and contributes to the successful implementation of Mental Health Systems Improvement.

- Coordinate the findings of this group with MHDD, IME, and Magellan regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.

15. MHDS, IME, and Magellan work together to revise the Medicaid State Plan and the various Medicaid service options related to MH so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:

- Add/revise services that support the financing of core required safety net services (i.e., Crisis Intervention Services, Intensive Case Management Services, Peer and Parent Support.).
- Utilize Medicaid administrative funding to support the financing of core required safety net services such as Screening and functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
- Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other “typical” CMHC services can be provided in any community location.
- Revise Hawk-I (S-CHIP) to include core required safety net services and to offer a similar MH benefit package as Medicaid.
- Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, and Psych. Rehab. Services, Children’s Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.

16. MHDS, IME, and IDPH work together to:

- Conduct an analysis of and work together to resolve administrative, policy, and funding related to the provision of services to persons with co-occurring disorders.
- Resolve inconsistencies/remove barriers between funding streams for mental health and substance abuse services.
- Work towards integrated funded for persons with co-occurring disorders.
- Institute joint outcomes regarding service provisions for persons with co-occurring disorders.
- Develop a data tracking system that can track and identify services provided to persons with co-occurring disorders across services systems (i.e., Mental Health Services, Substance Abuse Services, Inpatient Treatment, etc.). Implement this data tracking system within 3 years.
- Complete a review of the rates paid for mental health versus substance abuse services to ensure that the rates are comparable to one another based on level of service, qualifications of staff, etc.

C. Core Mental Health Services

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Patricia Schafer

Recommendations from the Workgroup:

1. Ensure that lowans of all ages have access to a comprehensive array of core mental health services and that services can be accessed statewide.
2. Ensure emergency services can be accessed anytime of the day or night (i.e., 24/7) throughout the state for anyone, any age experiencing a psychiatric crisis.
3. Ensure timely access to all core services (including psychiatry and emergency services).
4. Standardize the target population definitions used for adults (i.e., Chronic Mental Illness is sometimes used, Serious Mental Illness is sometimes used), so that everyone is using the same one. Use the term Serious Mental Illness and create a definition that is in keeping with the Federal definition for Serious Mental Illness.
5. Create and implement a definition/targeted population of serious emotional disturbance (SED) for youth that is in keeping with the Federal definition for Serious Emotional Disturbance.
6. Create eligibility criteria for core services which:
 - Focuses on priority populations and determines service access by clinical eligibility/medical necessity and financial eligibility criteria (i.e., Outpatient and Emergency Services for anyone in need regardless of ability to pay; “Specialized CSS/CBS Services” for individuals experiencing SED/SMI).
 - Addresses barriers for people that hinder service access related to insurance limitations or having no insurance.

- Ensures access to mental health services for people of all ages (i.e., includes children and older adults, is not limited to adults).
- Addresses service delivery barriers for providers that results in achieving what is expected with service provision.

7. Ensure that youth experiencing serious emotional disturbance and adults experiencing serious mental illness have access to Specialized Services (IE: the services that can be provided anywhere in the community) locally, in their own homes and their own communities.

8. Implement intensive case management services as a core services (and an EBP) for both adults experiencing serious mental illness and youth experiencing serious emotional disturbance by July 1, 2008.

9. Utilize the community mental health centers as the public safety net with the responsibility to ensure the statewide availability of core services and 24/7 access to emergency services. Ensure that the new standard of care focuses on local availability, personal contact, and local coordination of services.

10. Maintain the role of other Core Service Providers as a valuable part of the total system of care.

11. Address Behavioral Health Workforce Shortages in the following areas:

- Psychiatry,
- Other mental health professionals (i.e., doctoral-level Psychologists; other licensed practitioners; BA and para-professional level staff).
- Develop an organized statewide program to recruit and retain mental health specialists.
- Look at other models to address the gap in psychiatry such as:
 - Telemedicine
 - Implement specialized training in mental health for primary care physicians
 - Utilize other medical professionals (IE: primary care physicians, ARNP's, physician assistants, etc.) as "extenders" of psychiatrists.
 - Define an organized statewide program to recruit psychiatrists and other behavioral health workforce professionals where there are shortage areas.

12. Ensure the new standard of care for mental health supports an integrated health model (e.g. co-location of related service providers; integration of mental health with primary care physicians; etc.).

13. Assemble an Acute Mental Health Care Task Force including relevant agencies (i.e., Providers, County Attorneys, Judges, Law Enforcement, Child Welfare, Schools, Hospitals, CPC's, etc) consumers and family members to review models and approaches in acute mental health services to determine how such services should be carried out in Iowa.

- Include representation from the Core Services Workgroup on the Emergency Services task Force.
- Include representation from Core Services on the Acute Care Task Force.
- Ensure that the work of Core Services Workgroup, The Emergency Services Task Force and the Acute Care Task Force are well coordinated.

14. Develop education/training processes of all service providers in Co-Occurring Disorders. Have MHDS and IDPH work together to address barriers in policies, procedures and reimbursement mechanisms related to providing services to persons with co-occurring disorders. Ensure data tracking methods include the ability to adequately track persons with co-occurring disorders (i.e., service and outcomes data).

15. Create a state level/statewide funding pool specifically for the purchase of medications for people who are uninsured/underinsured. Allow this funding stream to be utilized for lab testing, other services, etc. directly related to medication management. A statewide Medication Assistance Program with oversight and management by MHDS is recommended in order to secure additional resources such as:

- Resources related to administrative costs of managing Medication Assistance Programs.
- Prescription assistance programs with pharmaceutical companies (i.e., in kind contributions, reductions in purchasing, etc.).
- Federal funding or other resources to support the purchasing of medications.

16. Prevent any unfunded mandates. Ensure that adequate resources are dedicated to successfully implement required changes related to the redesign of the Iowa mental health system.

- Address resource needs related to the uninsured, underinsured, etc.
- Identify approaches to deal with increasing levels of uncompensated care.
- Ensure that any requirements for CMHC's and Inpatient facilities to have a letters of agreement with one another is not misinterpreted to mean CMHC's have financial responsibilities for the cost of inpatient care (and vice versa).

17. Ensure that the shift to community based service provision is supported through all related processes across agencies. Utilize the State Mental Health Authority as the lead agency responsible for the oversight, management, and implementation of Mental Health Systems Improvement efforts. Include consumer, family member, and other key stakeholders as relevant.

18. MHDS conduct a cross system review of all related administrative processes, policies and procedures, accreditation standards, Iowa Code, reimbursement mechanisms (i.e.; grants, fee for service, etc.), funding streams (i.e.; Medicaid, state/county funds, etc.), Medicaid Service Definitions, Medicaid Options (i.e.; current construct of the state plan, other options, etc.). Work with relevant agencies to make revisions and/or additions as necessary to carry out the implementation of Mental Health Systems Improvement efforts.

19. MHDS, IME, and Magellan work together to revise the Medicaid State Plan and the various Medicaid service options related to MH so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:

- Add/revise services that support the financing of core required safety net services (i.e., Crisis Intervention Services, Intensive Case Management, Peer and Parent Support, etc.).
- Utilize Medicaid administrative funding to support the financing of core required safety net services such as Screening and functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
- Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other "typical" CMHC services can be provided in any community location.
- Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, Psych. Rehab. Services, Children's Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.

20. MHDS, IME, and IDPH work together to revise mental health benefits under SCHIP:

- Revise Hawk-I (SCHIP) to include core required safety net services and to offer a similar MH benefit package as Medicaid.
- Conduct an analysis of and work together to address administrative, policy, and funding barriers related to the provision of services to persons with co-occurring disorders.

21. MHDS conduct an analysis of Iowa Code to determine any necessary revisions/additions needed to align Code and Administrative Code with Mental Health System Improvement efforts.

- Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Rep.'s, Commission, IME, etc.).
- Make necessary revisions, additions, and deletions.
- Utilize the support and expertise of others such as consultants, legislative staff.
- Ensure accreditation standards for mental health service providers and related mental health services standards (i.e., Habilitation Services, Remedial Services, Psych.Rehab. Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations
- Include an assessment and revisions to code related to voluntary and involuntary commitments.

22. Finance Plan: Utilize the Alternate Distribution Formula workgroup to address larger financial needs and comprehensive financial plan to fund the system (Core required safety net services). Have the workgroup:

- Assess how current county/state funding is being utilized (i.e., What is being matched to Medicaid, what is not, etc.).
- Determine if there is existing funding in the system that can be leveraged for Medicaid services.
- Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what pieces? Where are responsibilities shared?).
- Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy in program for people with disabilities, etc.
- Coordinate the findings of this group with MHDS, IME, and Magellan regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.
- Identify funding needed and address funding mechanisms for people who do not have insurance or are underinsured across all ages (i.e., includes children) within the identified priority populations.

The workgroup recommends the following as core required safety net services:

Core Services Chart	
Traditional Outpatient Clinical Services	
Service Type	Eligible Population
- Individual, Family, Group Therapy	Anyone, any age in need of mental health services

<ul style="list-style-type: none"> - Psychiatric/Medical Services - Medication Management - Psychological Services: - Testing, Evaluation, etc 	
Emergency Services	
Service Type	Eligible Population
<p>Examples:</p> <ul style="list-style-type: none"> - 24/7 Crisis/emergency Response - 24/7 Mobile Response - Screening Services - Crisis Case Management/ coordination of care - In-home crisis stabilization - Out of home crisis stabilization - Explore standardized models such as CIT <p>NOTE: The recommended Acute Mental Health Task Force will determine what the model/ definitions/core services for emergency services.</p>	<p>Individuals of all ages who are experiencing a mental health related crisis</p>
Specialized Community Based Services for Youth	
Service Type	Eligible Population
<p>General Community Based Services (CBS) following a System of Care model and a Wraparound approach. Examples include but are not limited to:</p> <ul style="list-style-type: none"> - Intensive case management - In-home supports - Behavioral health aides - School Based Services - Parent Support Services - Early identification and assessment - Transitional Services - Psychosocial Group Services (IE: day treatment; after school programs; etc.). <p>Note: CBS services for youth are similar to CSS Services for adults. CBS Services are provided anywhere youth and families need them: home, school, community, etc.</p> <p>Decisions need to be made about which CBS</p>	<p>Youth Experiencing Serious Emotional Disturbance (SED)</p>

services are required as core service, which services are optional.	
Specialized Community Based Services for Adults	
Service Type	Eligible Population
<p>General Community Support Services which includes:</p> <ul style="list-style-type: none"> - Intensive Case Management Services - Supported Community Living Services – standardize the model (IE: Medicaid, Definitions in code, etc. utilize the same language and same model). - Peer Support Services - Psychosocial Rehab. Group/day Treatment services <p>Note: These are services that can be provided anywhere adults need them: home, work, community, etc.</p> <p>Decisions need to be made about what is a required core service, what is optional.</p>	Adults experiencing serious Mental Illness (SMI)
Other Service Areas	
Service Type	Eligible Population
Education/Training in Co-Occurring Disorders (i.e.: Mental Health/Substance Abuse).	All behavioral health services (i.e.: mental health, substance abuse, etc.). All providers (i.e.: mental health, substance abuse, corrections, etc.)
Education/Training in other Co-Occurring Disorders (i.e.: Mental Health/ MR&DD).	
Outreach and Public Education	General Public

D. Standards & Accreditation

Workgroup Members

- Technical Advisor**
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- DHS Representative**
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- County Representatives**

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Recommendations

1. Begin major revision of Ch. 24 accreditation standards to address the wide array of issues listed in the preceding section. It was thought unlikely that the workgroup could or should propose a draft of specific accreditation standards. The workgroup did believe it within its charge to develop both general as well as more specific and targeted recommendations that would be incorporated into standards and used to shape their direction and application.
2. Develop current standards specific to CMHCs.
3. Include new standards that support a fundamental continuous quality improvement process similar to that seen by the Joint Commission on Accreditation of Healthcare Organizations to restore governance, administrative and services sections that more completely detail standards specific to CMHCs.
4. Delineate standards be comprehensive to the operations of a CMHC addressing issues that have been identified earlier and the process of accreditation should reflect the importance of having strong, consistent standards for CMHCs across Iowa
5. CMHC standards should incorporate expectations for community ownership and responsiveness.
6. Community planning, consultation and education services are restored to the definitions of mental health services.
7. CMHCs have a defined linkage to the states mental health authority and the counties in their service areas.
8. CMHCs should develop and obtain affiliation agreements with other providers of core mental health services as they carry a responsibility of providing or partnering with others to provide core mental health services.
9. Community mental health centers establish written statements of understanding that define the relationship and the role of service coordination where a close continuing interaction occurs.
10. Accreditation activities should ensure that CMHCs establish and continuously monitor staff credentials and scope of practice provided to served consumers
11. Staff improvement should continue to serve as an important standard establishing the staff development plan, organizational plans and resources.
12. Supervision, consultation and peer review be defined and incorporated within CMHCs continuous quality improvement system.
13. MHDS Accreditation staff should be adequately resourced to carry out more comprehensive quality assurance reviews and accreditation site visits.
14. MHDS Accreditation staff should be provided with standardized tools and processes

15. Accreditation standards should reflect and allow for service information to be recorded and accessed electronically
16. Accreditation standards provide for the development of outcome and process indicators on which continuous quality improvement occurs.
17. An Accreditation implementation work group is formed to develop a working draft of new standards for distribution, review, discussion, further revision and submission for adoption
18. The Department of Health is actively involved in the process to ensure that there is increasing compatibility in the processes to be used and standards that are developed between DHS and DPH.
19. Funding be provided to adequately fund a community mental health center accreditation and continuous quality improvement team.

E. Co-Occurring Disorders

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The workgroup identified four major areas for improvement:

- a. Incorporation of a vision statement for a comprehensive, continuous and integrated system of care for individuals with co-occurring disorders.
- b. The development a charter document for Co-occurring disorders systems development and expansion.
- c. Ongoing participation in a Co-Occurring Disorders Policy Academy
- d. Ongoing consultation on systems development work

F. Evidence-based Practices

Workgroup Members

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Kenda Jochimsen

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Background of Evidence-Based Practices

Although the term “evidence based practice” has been used with increasing frequency over the past decade, it is still a relatively new term in health care and disabilities services. The work group put forth much effort to review various definitions of EBP to clarify the meaning of this term.

A summary of the various definitions and conceptions of the term “evidenced based practice” includes:

- Interventions for which there is consistent scientific evidence showing that they improve client outcomes (Drake, RE, et al, *Psychiatric Services*, 2001).
- An intervention with a body of evidence (i.e., rigorous research studies with specific target populations and client outcomes), specific implementation criteria (e.g., treatment manual), and a track record showing that the practice can be implemented in different setting (Bond G., et al, *Psychiatric Services*, 2001).
- Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Sackett et al, 2000; *Institute of Medicine*, 2001).
- Evidenced-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, *Policy Statement on EBP*, 2007).
- Evidenced-based medicine involves evaluating rigorously the effectiveness of healthcare interventions, disseminating the results evaluation and using those findings to influence clinical practice (Appleby J., Walshe K., and Ham C., 1995).
- Evidenced-based medicine is a set of strategies derived from developments in information technology and clinical epidemiology designed to assist the clinician in keeping up to date with the best available evidence (Geddes, 2000).
- It (EBP) recognizes that health care is individualized and ever changing and involves uncertainties and probabilities... Ultimately evidence-based practice is the formalization of the care process that the best clinicians have practiced for generations (McKibbon KA., 1998).

It is important to realize the varying definitions can be very different in terms of implementation and actual clinical practice. There are also differences between systems level evidenced- based practices and individualized client specific practices. The definitions outlined in the third and fourth bullets above are the most commonly accepted definitions for EBP's within the mental health services field.

Work group Parameters for assessment, choice, and prioritization of EBP's - In an effort to provide structure to the review of potential EBP's, each EBP was evaluated according to the following parameters:

- Clarity of Construct: To what extent is there clear agreement on what this means? Is there a manual to follow? Is it a circumscribed, teachable practice that can be replicated across sites?
- Impact: How much of an effect will an initiative in this area likely to have? How many people will it likely affect?
- Need: How critical is the need for this service/intervention or initiative at this time?
- Evidence- Base: To what extent has the practice been demonstrated to yield good outcomes in rigorous studies across multiple sites?
- Diversity: Will this initiative impact diverse populations across the state (e.g. across cultural groups, age groups, socio-economic groups, etc.)?
- Feasibility: What is the likelihood that the initiative can actually succeed if undertaken?
- Opportunity: To what extent does this initiative make sense at this time in terms of dovetailing with other initiatives?
- Affordability: What are the realistic estimates of short-term (i.e., start up) and long-term costs?

Conclusions - In keeping with the legislative direction outlined in HF 909 – recommendations are provided below for the implementation of two evidence-based practices (EBPs) per year over the next three years for adults with serious mental illness and children and adolescents with serious emotional disturbances (i.e., a total of six practices over 3 years). However, there is universal concern among the workgroup that anything near full implementation of this many practices might overwhelm the capabilities of the system. Strategies to address this concern fall into two general areas, both of which may be applicable:

- 1) reduce the number of EBP's/year, e.g., to one/year for each population
- 2) clarify what is meant by "implementation", emphasizing that implementation doesn't have to be statewide. Rather, it may take the form of demonstration or pilot projects.

Evidence Based Practice Recommendations

The recommended EBP's for adults and children are summarized below:

EBPs for Adults

Service Delivery Model:

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

Year 1:

1. Integrated treatment for Co-occurring Mental Illness and Substance Use Disorders
2. Peer Support

Year 2:

1. Supported Employment
2. Illness Management and Recovery (including CBT)

Year 3:

1. Assertive Community Treatment
2. Family Psychoeducation

EBPs for Children and Adolescents

Service Delivery Model:

SYSTEM OF CARE MODEL

Year 1:

1. School-based Mental Health Services
2. Intensive Case Management with Wraparound

Year 2:

1. Parent Support, Education, and Training
2. In-Home and Community Based Services and Supports

Year 3:

2. Functional Family Therapy

I. EBPs for Adults with Serious Mental Illness (Detailed Description):

Year 1:

A. Integrated Treatment for Co-occurring Disorders

The EBP workgroup is fully supportive of the overall “Comprehensive, Continuous, Integrated System of Care Model” as explicated by Minkof. One specific implementation model is clearly laid out in the “Integrated Dual Diagnosis Toolkit” by SAMHSA. The workgroup supports expanded implementation of this model.

Critical components of the model include:

- *Integrated services:* Clinicians provide services for both mental illness and substance use at the same time.
- *Knowledge about alcohol and drug use, as well as mental illnesses:* Clinicians know the effects of alcohol and drugs and their interactions with mental illness.
- *Assessment:* Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.
- *Stage-wise treatment:* People go through a process over time to recover and different services are helpful at different stages of recovery.
- *Motivational treatment:* Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse

Ongoing workforce development in core competencies in each of these areas must be pursued.

Fidelity assessment for this model should be conducted across all CMHC’s on a regular (e.g., at time of accreditation) basis.

B. Peer Support

The EBP workgroup recommends the expansion of peer support services.

Although the evidence-basis for the effectiveness of peer support not been as strongly established in rigorous research studies as other recommended EBP's for adults, it is growing and there is increasing consensus and enthusiasm for the model, especially as pursued via the "Georgia Model" of peer support. This model revolves around "Certified Peer Specialists" (CPS). The workgroup recommends that the job responsibilities and activities of the CPS be built upon that which is in use in Georgia – and detailed in the appendix.

Peer support specialists should play an increased role in crisis intervention services, (e.g., in emergency room settings).

The MHDS should work with IME to ensure providers are appropriately reimbursed for peer support services.

The division must review and revise accreditation standards to describe the role, training, and quality assurance requirements of the CPS position.

Adults, Year 2:

A. Supported Employment

The EBP workgroup concluded that employment is a critical piece of recovery, and supported employment for adults with SMI is an evidence-based model that is being under-utilized in Iowa. With the introduction of the Medicaid Habilitation Option, and the CMS-funded Money Follows the Person Initiative/ Consumer Choice Option grant, it is felt that this is a good time to pursue this.

Supported employment revisions under the MR and BI Medicaid waivers need to be made consistent with or incorporated into the Habilitative services. The Habilitative services rules need to be reviewed and revised so as to be optimally consistently with the evidence-based practice model as described in the SAMSHA Supportive Employment toolkit.

The Workgroup recommends that MHDS and IME ensure that providers are being appropriately reimbursed for supported employment services, and the MHDS must expand collaboration with Division of Vocational Rehabilitation.

Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA Supported Employment toolkit

Critical components and core principles of this supported employment model include:

- *Eligibility is based on consumer choice.* No one is excluded who wants to participate.
- *Supported employment is integrated with treatment:* Employment specialists coordinate plans with the treatment team: the case manager, therapist, psychiatrist, etc.
- *Competitive employment is the goal.* The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- *Job search starts soon after a consumer expresses interest in working.* There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like prevocational work units, transitional employment, or sheltered workshops).
- *Follow-along supports are continuous.* Individualized supports to maintain employment continue as long as consumers want the assistance.
- *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

Fidelity assessment for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Illness Management and Recovery

"Illness management and Recovery" refers to a set of illness management techniques directed at adults with serious mental illness ... (fill in)

Adults Year 3:

A. Assertive Community Treatment (ACT)

Iowa currently has 5 ACT teams serving ~ 250 clients. It is estimated that the number that would qualify for and benefit from ACT in Iowa is ~ 2000 (based on an expected need of 2.2% of mental health users, or 0.06% of adult population as per Cuddeback et al). It is estimated that ~ 15 ACT teams would be required for statewide access to ACT in Iowa. The workgroup recommended the implementation of one new team per year over the next 10 years.

The two major barriers to full statewide implementation involve funding and workforce issues. With an appropriate reimbursement strategy, ACT teams should pay for themselves within two years of start-up. Start-up costs are estimated at 500K for year 1 and 250K for year 2. Medicaid dollars are typically the primary source of payment for ACT. Payment for ACT services should be incorporated into Iowa's state Medicaid plan as a required rather than optional service.

As the availability of psychiatrists is a potentially rate limiting factor, accreditation standards that allow for nurse practitioners and/or physician's assistants to fill the psychiatric role should be pursued.

A key to the success of this "roll out" would be adequate training and support, e.g., in the form of an ACT TA center. Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA Assertive Community Treatment toolkit.

B. Family Psychoeducation

Family psychoeducation is an evidence-based program that can reduce relapse rates and facilitate recovery of persons who have mental illness. Psychoeducation is delivered by health care professionals, generally takes place over several months, and is linked to the treatment being received by the family member who has a mental illness. The main goals of working with families are to improve the quality of life for the person who has mental illness through collaborative treatment and management; and to reduce the stress and burden of family members while supporting them in their efforts to aid in the recovery of their loved one. Family psychoeducation has been shown to be useful in schizophrenia. The evidence base for other adult psychiatric disorders has been less well established.

The main barrier to family psychoeducation is typically concerns (real or perceived) about whether this activity meets typical standards for reimbursement. As is the case with parent training for conduct disorders, the evidence-based practice requires services not to the identified client – but rather to the supporters of that client. This can present a problem with respect to reimbursement. It is critical that barriers to funding for family psychoeducation be addressed, so that traditional third party reimbursement, e.g., from Medicaid, can be used to finance it.

It is recommended that training in core competencies for family psychoeducation in Iowa follow the model as laid out in the Family Psychoeducation toolkit from SAMHSA.

I. EBPs for Children and Adolescents (Detailed Description):

Year 1:

A. School-based Mental Health Services

The capacity to identify and appropriately treat youth with mental health needs should be enhanced in schools, because that's where the children are. Those most in need are often those most difficult to engage in traditional treatment settings. Research also indicates that school based mental health services are an effective means for early identification, intervention, and treatment of mental health needs of youth.

The school based service initiative will concentrate on:

- Improved collaboration and coordination at that state agency level between DHS-MHDD, the Department of Education, and the Area Educational Agencies (AEAs) with the goal of state level efforts extending to local school districts, AEA's, special education services, Early Access, mental health service providers, and others involved in school based mental health services..
- Early identification, Screening and Assessment: A formal process for the early identification of mental health needs in youth, screening/assessment services, and coordination/referral to more formal mental health services when indicated.
- Coordination between home, school and active engagement of parents of youth.
- Mental Health education, training, consultation, and other support to educational staff about identifying mental health needs in youth and supporting youth with mental health needs in the classroom.
- Training in core clinical competencies of specific evidence-based interventions for priority disorders must be available in a practical manner. This should focus on:
 - parent education and support (e.g., Parent Child Interaction Therapy)
 - cognitive behavioral and interpersonal approaches
 - early identification and intervention (e.g., ABCD II)
 - co—occurring disorders

B. Intensive Case Management/ Wraparound:

Intensive Case Management is being recommended as a step towards the implementation of the System of Care Model. Intensive case management is a model of case management, which combines the typical coordination/brokerage of service functions with the provision of intensive direct services to the child/ youth and the child/youth's family. Intensive case management services for youth and families typically follow a Wraparound Model of service delivery. This model uses the approach of "one child at a time" individualized service planning to identify what the child and family's unique strengths and needs are. Wraparound uses a team approach, includes other "key" people and/or agencies involved with the child and family in the service planning process and is typically coordinated by a case manager. The wraparound model is strengths based, family and community focused, and dedicated to keeping children and youth in the least restrictive environment appropriate to the youth's needs. The case manager coordinates all services, ensuring that the most appropriate, least restrictive services are provided in the most efficient manner.

Year 2:

A. Parent Support, Education, and Training Services (e.g., Parent Child interaction therapy, Incredible Years, parent to parent support services, etc.)

Parent Support services are services provided by trained parent educators/advocates to work with parents who have children with serious emotional disturbance. Parent Support services include education and supportive services to parents, to otherwise help parents be active participants in their child's care. Parent support services typically follow a peer-to-peer model where parents of youth with serious emotional disturbance are trained to provide the support and educational services to other parents of youth with serious emotional disturbance. Parent Support and education services can be provided individually or in a group setting.

Parent Training Services are provided to parents who have youth with SED and are typically delivered in a more formal context, often in a group setting typically following a standardized curriculum.

B. In-home and Community Based Services and Supports

In home and community based services and supports are another critical component of a System of Care Model. These services are typically provided under the supervision and/or coordination of a child's therapist and are a critical part of the child's treatment team. Providers of in home and community based services may be a bachelors or para professional level staff that have standardized training in the specific service they are providing. These services are individualized based on the unique needs of the child and family and can be provided in any community location where children and families spend their time: in the family home, at school, or in any other community location. In home and community based services may include respite care, peer support, parent support, attendant care services, behavioral health aides, community psychiatric support and treatment, in-home therapy, etc.

Year 3

A. Family Functional Therapy (FFT):

Functional Family Therapy (FFT) is a family based intervention that follows a systemic model to intervene with youth and families at risk of delinquency **and** out of home placement. FFT sessions are "phasic" with each phase building on another to increase engagement with the family and improve treatment outcomes.

While there are some programs in Iowa that are implementing this EBP, it is recognized as an expensive, difficult to develop practice. At the same time there appears to be evidence that the

approach is cost-effective across service systems for ***appropriately identified*** clients and families. The EBP group recommends that FFT be pursued further in terms of supporting the funding of FFT in pilot sites as well as developing statewide training for the service in select locations.

6. Other Major Recommendations

The recommendations listed above will be the subject of further study and perhaps a future report by MHDS. The other major recommendations represent a synthesis of comments and individual recommendations and not necessarily directly recommended by all of the workgroups or steering committee members.

In addition to the specific recommendations previously listed in the workgroup sections, a number of major recommendations were presented during the course of the workgroup and steering committee meetings. They were related to the:

- a. role of the State Mental Health Authority
- b. creation of “standing” interagency collaborative task force groups
- c. need for emergency mental health crisis and disaster plan services
- d. development of behavioral health workforce priorities
- e. children’s mental health
- f. uniform information/data systems

The recommendations listed above will be the subject of further study and perhaps a future report by MHDS. The other major recommendations represent a synthesis of comments and individual recommendations and not necessarily directly recommended by all of the workgroups or steering committee members.

APPENDICES

APPENDIX A: FY08 County Mental Health Budgets

<u>County Name</u>	<u>2006 population</u>	<u>MH Service Fund Levy \$'s</u>	<u>Maximum MH Levy \$'s</u>	<u>Variance</u>	<u>MH Services Levy Rate</u>	<u>%</u>
Statewide	2,982,085	119,434,297	125,781,915	6,347,618	-	95.0%
ADAIR	7,714	309,066	309,066	0	0.85053	100.0%
ADAMS	4,192	172,315	191,282	18,967	0.81335	90.1%
ALLAMAKEE	14,796	786,773	786,775	2	1.37965	100.0%
APPANOOSE	13,422	552,197	607,651	55,454	1.65000	90.9%
AUDUBON	6,278	595,900	595,900	0	2.42718	100.0%
BENTON	26,962	681,482	908,642	227,160	0.72709	75.0%
BLACK HAWK	126,106	5,779,823	5,779,837	14	1.55159	100.0%
BOONE	26,584	878,976	878,976	0	0.93210	100.0%
BREMER	23,837	720,183	1,294,995	574,812	0.86151	55.6%
BUCHANAN	21,045	1,292,163	1,292,163	0	1.74973	100.0%
BUENA VISTA	20,091	535,610	669,512	133,902	0.74202	80.0%
BUTLER	15,073	389,899	389,899	0	0.70511	100.0%
CALHOUN	10,437	431,560	431,560	0	0.91409	100.0%
CARROLL	20,963	1,621,769	1,800,630	178,861	2.10000	90.1%
CASS	14,124	789,047	789,047	0	1.58483	100.0%
CEDAR	18,326	968,646	968,646	0	1.20585	100.0%
CERRO GORDO	44,384	2,284,794	2,284,794	0	1.26084	100.0%
CHEROKEE	12,094	468,897	477,158	8,261	0.86623	98.3%
CHICKASAW	12,412	400,575	572,250	171,675	0.73756	70.0%
CLARKE	9,156	430,559	430,559	0	1.45124	100.0%
CLAY	16,801	402,866	402,866	0	0.51892	100.0%
CLAYTON	18,251	868,795	868,795	0	1.23879	100.0%
CLINTON	49,782	2,883,428	2,883,428	0	1.71082	100.0%
CRAWFORD	16,948	1,012,457	1,012,457	0	1.87795	100.0%
DALLAS	54,525	1,524,538	1,524,538	0	0.61967	100.0%
DAVIS	8,602	426,870	426,870	0	1.85977	100.0%
DECATUR	8,656	321,858	321,858	0	1.55855	100.0%
DELAWARE	17,848	926,948	926,948	0	1.17386	100.0%
DES MOINES	40,885	1,751,030	1,751,030	0	1.55888	100.0%
DICKINSON	16,924	412,509	412,509	0	0.29492	100.0%
DUBUQUE	92,384	4,360,995	5,165,648	804,653	1.43779	84.4%
EMMET	10,479	820,900	820,900	0	2.19525	100.0%
FAYETTE	20,996	773,024	773,024	0	1.02594	100.0%
FLOYD	16,441	610,064	610,064	0	1.06608	100.0%
FRANKLIN	10,708	358,934	358,934	0	0.65053	100.0%
FREMONT	7,737	323,535	462,193	138,658	0.92442	70.0%
GREENE	9,809	445,282	627,158	181,876	1.05997	71.0%
GRUNDY	12,320	376,434	530,188	153,754	0.66090	71.0%
GUTHRIE	11,344	614,141	614,141	0	1.28372	100.0%
HAMILTON	16,087	860,241	860,241	0	1.29708	100.0%
HANCOCK	11,680	629,221	629,221	0	1.02116	100.0%
HARDIN	17,791	850,000	898,104	48,104	1.29475	94.6%
HARRISON	15,745	920,559	920,559	0	1.65031	100.0%
HENRY	20,405	846,381	846,381	0	1.45769	100.0%

HOWARD	9,677	364,201	364,201	0	0.90862	100.0%
HUMBOLDT	9,975	473,531	473,531	0	1.06603	100.0%
IDA	7,180	300,889	300,889	0	0.90251	100.0%
IOWA	16,140	684,236	729,235	44,999	0.98000	93.8%
JACKSON	20,290	787,145	787,145	0	1.19125	100.0%
JASPER	37,409	3,120,466	3,120,466	0	2.79587	100.0%
JEFFERSON	15,945	434,068	607,300	173,232	0.85326	71.5%
JOHNSON	118,038	3,138,395	3,138,395	0	0.68713	100.0%
JONES	20,505	883,021	883,021	0	1.22306	100.0%
KEOKUK	11,081	227,995	490,075	262,080	0.50000	46.5%
KOSSUTH	16,011	736,575	1,140,780	404,205	0.83870	64.6%
LEE	36,338	2,164,720	2,164,720	0	2.25492	100.0%
LINN	201,853	8,195,141	8,195,141	0	1.10117	100.0%
LOUISA	11,858	103,362	601,189	497,827	0.20000	17.2%
LUCAS	9,543	378,000	441,861	63,861	1.55384	85.5%
LYON	11,636	248,113	248,113	0	0.48887	100.0%
MADISON	15,547	534,189	534,189	0	0.96149	100.0%
MAHASKA	22,298	1,227,887	1,227,887	0	1.67013	100.0%
MARION	32,987	923,682	1,089,896	166,214	1.00000	84.7%
MARSHALL	39,555	2,115,400	2,115,400	0	1.72296	100.0%
MILLS	15,595	609,781	609,781	0	1.00549	100.0%
MITCHELL	10,856	610,215	610,215	0	1.35988	100.0%
MONONA	9,343	375,993	375,993	0	0.89146	100.0%
MONROE	7,725	340,278	340,278	0	1.00570	100.0%
MONTGOMERY	11,365	258,818	369,740	110,922	0.65952	70.0%
MUSCATINE	42,883	2,055,392	2,055,392	0	1.43848	100.0%
O'BRIEN	14,409	570,532	570,532	0	1.08215	100.0%
OSCEOLA	6,629	195,225	195,225	0	0.65240	100.0%
PAGE	16,263	652,027	652,027	0	1.47282	100.0%
PALO ALTO	9,549	688,176	688,176	0	1.56591	100.0%
PLYMOUTH	24,906	363,771	363,771	0	0.36835	100.0%
POCAHONTAS	7,794	440,242	440,242	0	1.07569	100.0%
POLK	408,888	14,439,175	14,439,175	0	0.92743	100.0%
POTTAWATTAMIE	90,218	3,515,633	4,745,180	1,229,547	1.09603	74.1%
POWESHIEK	19,007	444,227	444,227	0	0.58060	100.0%
RINGGOLD	5,289	342,082	342,082	0	1.52769	100.0%
SAC	10,682	579,215	579,215	0	1.26625	100.0%
SCOTT	162,621	3,308,032	3,308,032	0	0.54958	100.0%
SHELBY	12,489	885,694	885,694	0	1.86539	100.0%
SIoux	32,525	1,027,388	1,027,388	0	1.00456	100.0%
STORY	80,145	3,066,575	3,066,575	0	1.05510	100.0%
TAMA	17,890	568,799	568,799	0	0.80350	100.0%
TAYLOR	6,540	140,346	140,346	0	0.58543	100.0%
UNION	12,093	751,659	751,659	0	2.16044	100.0%
VAN BUREN	7,836	240,000	314,328	74,328	1.16885	76.4%
WAPELLO	36,010	2,276,391	2,447,733	171,342	2.72908	93.0%
WARREN	43,926	1,084,011	1,084,011	0	0.82602	100.0%
WASHINGTON	21,529	578,045	781,141	203,096	0.76099	74.0%
WAYNE	6,542	254,099	254,099	0	1.15117	100.0%
WEBSTER	38,960	2,146,797	2,146,797	0	1.73627	100.0%
WINNEBAGO	11,216	433,910	433,910	0	1.12609	100.0%
WINNESHIEK	21,263	1,178,944	1,428,756	249,812	1.51462	82.5%

WOODBURY	102,972	3,564,086	3,564,086	0	1.20460	100.0%
WORTH	7,698	441,512	441,512	0	1.19561	100.0%
WRIGHT	13,419	554,967	554,967	0	0.98983	100.0%
Total	2,982,085	119,434,297	125,781,915	6,347,618		

April 3, 2007

APPENDIX B: Levy Rates - county levies only

	FY97	FY01		FY06		FY08	
	Levy Rate	Levy Rate	% of max levy	Levy Rate	% of max levy	Levy Rate	% of max levy
Adair	\$ 1.1183	\$ 0.5192	56.30%	\$ 0.8907	100.00%	\$ 0.8505	100.00%
Adams	\$ 1.1371	\$ 0.9769	100.00%	\$ 0.9487	100.00%	\$ 0.8134	90.10%
Allamakee	\$ 1.8790	\$ 1.5306	100.00%	\$ 1.1357	82.52%	\$ 1.3797	100.00%
Appanoose	\$ 2.4361	\$ 2.0651	100.00%	\$ 1.8000	96.09%	\$ 1.6500	90.90%
Audubon	\$ 2.5339	\$ 0.4333	20.14%	\$ 1.8379	73.05%	\$ 2.4272	100.00%
Benton	\$ 1.6232	\$ 0.5894	55.03%	\$ 0.5000	50.00%	\$ 0.7271	75.00%
Black Hawk	\$ 2.6285	\$ 1.9277	100.00%	\$ 1.6524	100.00%	\$ 1.5516	100.00%
Boone	\$ 1.4902	\$ 1.0225	100.00%	\$ 1.0558	100.00%	\$ 0.9321	100.00%
Bremer	\$ 2.4409	\$ 0.4563	25.25%	\$ 0.5996	35.23%	\$ 0.8615	55.60%
Buchanan	\$ 2.1933	\$ 1.6694	82.41%	\$ 1.5637	82.36%	\$ 1.7497	100.00%
Buena Vista	\$ 1.2271	\$ 0.2670	27.61%	\$ 0.7614	80.00%	\$ 0.7420	80.00%
Butler	\$ 1.0460	\$ 0.7403	100.00%	\$ 0.7554	100.00%	\$ 0.7051	100.00%
Calhoun	\$ 1.0812	\$ 0.7978	100.00%	\$ 0.9929	100.00%	\$ 0.9141	100.00%
Carroll	\$ 2.8548	\$ 0.8201	36.49%	\$ 1.6500	67.78%	\$ 2.1000	90.10%
Cass	\$ 1.9612	\$ 1.6608	100.00%	\$ 1.7626	100.00%	\$ 1.5848	100.00%
Cedar	\$ 1.7799	\$ 1.0049	72.88%	\$ 1.2814	100.00%	\$ 1.2059	100.00%
Cerro Gordo	\$ 1.9866	\$ 1.5237	100.00%	\$ 1.3602	100.00%	\$ 1.2608	100.00%
Cherokee	\$ 1.1556	\$ 0.3516	38.78%	\$ 0.7000	75.75%	\$ 0.8662	98.30%
Chickasaw	\$ 1.2264	\$ 0.4293	34.95%	\$ 0.9595	87.37%	\$ 0.7376	70.00%
Clarke	\$ 2.2047	\$ 1.7197	100.00%	\$ 1.4521	100.00%	\$ 1.4512	100.00%
Clay	\$ 0.8184	\$ 0.6025	100.00%	\$ 0.5700	100.00%	\$ 0.5189	100.00%
Clayton	\$ 1.8365	\$ 1.4051	100.00%	\$ 1.2730	100.00%	\$ 1.2388	100.00%
Clinton	\$ 2.2929	\$ 1.3885	72.30%	\$ 1.9087	100.00%	\$ 1.7108	100.00%
Crawford	\$ 2.1400	\$ 1.6401	87.52%	\$ 1.8400	94.18%	\$ 1.8780	100.00%
Dallas	\$ 1.5338	\$ 0.1470	13.09%	\$ 0.6191	77.02%	\$ 0.6197	100.00%
Davis	\$ 1.9412	\$ 1.9640	100.00%	\$ 1.7966	100.00%	\$ 1.8598	100.00%
Decatur	\$ 2.1237	\$ 1.7018	100.00%	\$ 1.5808	100.00%	\$ 1.5586	100.00%
Delaware	\$ 1.5312	\$ 1.3403	97.99%	\$ 1.2411	100.00%	\$ 1.1739	100.00%
Des Moines	\$ 2.0981	\$ 1.1695	74.85%	\$ 1.5713	100.00%	\$ 1.5589	100.00%
Dickinson	\$ 0.5734	\$ 0.4512	100.00%	\$ 0.3513	100.00%	\$ 0.2949	100.00%
Dubuque	\$ 2.6842	\$ 2.1456	98.80%	\$ 1.2536	70.00%	\$ 1.4378	84.40%
Emmet	\$ 2.3388	\$ 1.6779	75.64%	\$ 2.0787	87.82%	\$ 2.1953	100.00%
Fayette	\$ 0.7220	\$ 0.9075	78.68%	\$ 1.0341	100.00%	\$ 1.0259	100.00%
Floyd	\$ 1.4997	\$ 1.1583	100.00%	\$ 1.1257	100.00%	\$ 1.0661	100.00%
Franklin	\$ 0.9308	\$ 0.4009	57.53%	\$ 0.7228	100.00%	\$ 0.6505	100.00%
Fremont	\$ 1.4146	\$ 1.2238	100.00%	\$ 1.0121	78.36%	\$ 0.9244	70.00%
Greene	\$ 1.5764	\$ 1.2814	100.00%	\$ 1.5542	100.00%	\$ 1.0600	71.00%

Grundy	\$ 1.3127	\$ 0.4191	42.03%	\$ 0.9716	100.00%	\$ 0.6609	71.00%
Guthrie	\$ 1.7079	\$ 0.9000	65.59%	\$ 1.3990	100.00%	\$ 1.2837	100.00%
Hamilton	\$ 1.6750	\$ 1.2642	100.00%	\$ 1.3828	100.00%	\$ 1.2971	100.00%
Hancock	\$ 1.3449	\$ 0.3626	32.17%	\$ 1.1883	100.00%	\$ 1.0212	100.00%
Hardin	\$ 1.7474	\$ 0.6864	50.11%	\$ 1.2401	82.95%	\$ 1.2948	94.60%
Harrison	\$ 2.1780	\$ 0.8020	51.12%	\$ 1.2235	70.61%	\$ 1.6503	100.00%
Henry	\$ 2.0370	\$ 1.1501	76.43%	\$ 1.4768	100.00%	\$ 1.4577	100.00%
Howard	\$ 1.3558	\$ 1.0509	100.00%	\$ 0.9821	100.00%	\$ 0.9086	100.00%
Humboldt	\$ 1.3054	\$ 0.6768	68.48%	\$ 1.0680	100.00%	\$ 1.0660	100.00%
Ida	\$ 1.0798	\$ 0.8639	100.00%	\$ 0.6500	70.44%	\$ 0.9025	100.00%
Iowa	\$ 1.4338	\$ 1.1020	100.00%	\$ 0.9841	90.77%	\$ 0.9800	93.80%
Jackson	\$ 1.7729	\$ 1.3375	100.00%	\$ 1.2356	100.00%	\$ 1.1913	100.00%
Jasper	\$ 3.5482	\$ 2.7231	100.00%	\$ 2.2579	80.12%	\$ 2.7959	100.00%
Jefferson	\$ 1.5401	\$ 0.7000	59.57%	\$ 0.9994	77.99%	\$ 0.8533	71.50%
Johnson	\$ 1.2987	\$ 0.9355	100.00%	\$ 0.7745	100.00%	\$ 0.6871	100.00%
Jones	\$ 1.9346	\$ 1.4021	100.00%	\$ 1.2923	100.00%	\$ 1.2231	100.00%
Keokuk	\$ 1.4314	\$ 1.0276	95.65%	\$ 0.5998	53.58%	\$ 0.5000	46.50%
Kossuth	\$ 1.1896	\$ 0.9181	70.13%	\$ 1.0245	74.86%	\$ 0.8387	64.60%
Lee	\$ 2.8082	\$ 1.1924	55.69%	\$ 2.3578	100.00%	\$ 2.2549	100.00%
Linn	\$ 1.7453	\$ 1.3256	100.00%	\$ 1.1432	100.00%	\$ 1.1012	100.00%
Louisa	\$ 1.5389	\$ 0.3973	31.80%	\$ 1.0627	83.37%	\$ 0.2000	17.20%
Lucas	\$ 2.3925	\$ 1.9819	100.00%	\$ 1.4015	76.11%	\$ 1.5538	85.50%
Lyon	\$ 0.7975	\$ 0.5043	100.00%	\$ 0.5454	100.00%	\$ 0.4889	100.00%
Madison	\$ 1.6505	\$ 0.6513	53.96%	\$ 0.7581	72.00%	\$ 0.9615	100.00%
Mahaska	\$ 2.3306	\$ 1.2065	66.59%	\$ 1.7200	100.00%	\$ 1.6701	100.00%
Marion	\$ 1.3628	\$ 1.1629	89.13%	\$ 1.2218	100.00%	\$ 1.0000	84.70%
Marshall	\$ 2.3237	\$ 0.7197	37.23%	\$ 1.2396	66.65%	\$ 1.7230	100.00%
Mills	\$ 1.6372	\$ 0.6690	59.11%	\$ 1.1490	100.00%	\$ 1.0055	100.00%
Mitchell	\$ 1.8759	\$ 1.0124	66.94%	\$ 1.3958	100.00%	\$ 1.3599	100.00%
Monona	\$ 1.1515	\$ 0.3000	34.64%	\$ 0.8000	83.87%	\$ 0.8915	100.00%
Monroe	\$ 1.2311	\$ 0.9040	100.00%	\$ 0.8000	76.20%	\$ 1.0057	100.00%
Montgomery	\$ 1.2313	\$ 0.2570	25.96%	\$ 0.7504	75.57%	\$ 0.6595	70.00%
Muscatine	\$ 2.0403	\$ 1.6290	100.00%	\$ 1.2437	80.28%	\$ 1.4385	100.00%
O'Brien	\$ 1.2993	\$ 1.0348	100.00%	\$ 1.1040	100.00%	\$ 1.0822	100.00%
Osceola	\$ 0.7273	\$ 0.5427	82.11%	\$ 0.6783	100.00%	\$ 0.6524	100.00%
Page	\$ 1.8003	\$ 0.3306	25.01%	\$ 0.9000	63.77%	\$ 1.4728	100.00%
Palo Alto	\$ 1.9447	\$ 1.2831	79.39%	\$ 1.6712	100.00%	\$ 1.5659	100.00%
Plymouth	\$ 0.4599	\$ 0.3026	81.46%	\$ 0.3912	100.00%	\$ 0.3684	100.00%
Pocahontas	\$ 1.2156	\$ 0.9246	98.70%	\$ 1.1442	100.00%	\$ 1.0757	100.00%
Polk	\$ 1.7230	\$ 1.2639	100.00%	\$ 1.0320	100.00%	\$ 0.9274	100.00%
Pottawattamie	\$ 2.6337	\$ 0.6357	34.59%	\$ 1.0603	63.22%	\$ 1.0960	74.10%
Poweshiek	\$ 0.9691	\$ 0.6474	100.00%	\$ 0.5977	100.00%	\$ 0.5806	100.00%
Ringgold	\$ 2.1612	\$ 1.8477	98.93%	\$ 1.6701	100.00%	\$ 1.5277	100.00%
Sac	\$ 1.3535	\$ 0.7981	69.13%	\$ 1.0992	80.50%	\$ 1.2663	100.00%
Scott	\$ 0.9941	\$ 0.6837	100.00%	\$ 0.5798	100.00%	\$ 0.5496	100.00%
Shelby	\$ 2.2007	\$ 0.6091	33.87%	\$ 2.0656	100.00%	\$ 1.8654	100.00%
Sioux	\$ 1.0164	\$ 1.0452	100.00%	\$ 1.0608	100.00%	\$ 1.0046	100.00%
Story	\$ 1.9756	\$ 0.5426	40.93%	\$ 1.1163	100.00%	\$ 1.0551	100.00%
Tama	\$ 1.2180	\$ -	0.00%	\$ 0.8343	100.00%	\$ 0.8035	100.00%
Taylor	\$ 1.0011	\$ 0.7349	100.00%	\$ 0.6332	100.00%	\$ 0.5854	100.00%
Union	\$ 2.8856	\$ 1.6470	71.78%	\$ 2.2112	100.00%	\$ 2.1604	100.00%

Van Buren	\$ 2.0501	\$ -	0.00%	\$ 1.1510	76.35%	\$ 1.1689	76.40%
Wapello	\$ 3.6999	\$ 2.4157	74.84%	\$ 2.6887	87.74%	\$ 2.7291	93.00%
Warren	\$ 1.5490	\$ 0.9012	79.24%	\$ 0.8010	91.67%	\$ 0.8260	100.00%
Washington	\$ 1.1942	\$ 0.8641	77.00%	\$ 0.8068	74.00%	\$ 0.7610	74.00%
Wayne	\$ 0.8331	\$ 1.2201	100.00%	\$ 1.1705	100.00%	\$ 1.1512	100.00%
Webster	\$ 2.2628	\$ 1.3795	81.37%	\$ 1.4476	80.35%	\$ 1.7363	100.00%
Winnebago	\$ 0.8921	\$ 0.7387	67.81%	\$ 1.1083	100.00%	\$ 1.1261	100.00%
Winneshiek	\$ 2.7645	\$ 1.5548	70.51%	\$ 1.5146	80.35%	\$ 1.5146	82.50%
Woodbury	\$ 1.8126	\$ 0.7976	58.91%	\$ 1.2711	100.00%	\$ 1.2046	100.00%
Worth	\$ 1.7322	\$ 0.7852	54.70%	\$ 1.1774	87.54%	\$ 1.1956	100.00%
Wright	\$ 1.1763	\$ 0.9222	100.00%	\$ 1.0268	100.00%	\$ 0.9898	100.00%
Average of Rates/Statewide %	\$ 1.6931	\$ 1.0081	78.96%	\$ 1.1873	90.48%	\$ 1.1844	94.95%
Highest	\$ 3.70	\$ 2.72	100.0%	\$ 2.69	100.0%	\$ 2.80	100.0%
Lowest	\$ 0.46	\$ -	0.0%	\$ 0.35	35.2%	\$ 0.20	17.2%
Median	\$ 1.64	\$ 0.92	81.4%	\$ 1.14	100.0%	\$ 1.08	100.0%
# at maximum levy			39		59		73

APPENDIX C: FORMULAS

Factors of Present Formula	Adjustments to the Present Formula	Factors of Alternative Formula Proposed
Eligibility criteria – to be eligible for funding, each county must prepare an application, provide statistical information and meet the reporting deadline -98 of 99 counties met the reporting deadline FY 07	Eligibility criteria – same as present formula	Eligibility criteria – same as present formula
Eligibility criteria - Code requires levy rate to be at least 70% of maximum to receive funds. 92 of 99 counties were above 70% for FY 07. 67 counties levied at 100%	Eligibility criteria – Each county would be required to levy at 100% of maximum except where the levy rate will exceed \$3.00 per \$1000 valuation (or other maximum rate to be determined)	Eligibility criteria – Each county would be required to levy at 100% of maximum except where the levy rate will exceed \$3.00 per \$1000 valuation (or other maximum rate to be determined)
Eligibility criteria – The MH fund balance has to be less than 25%. 67 counties had fund balances below 25% for FY 07.	Eligibility criteria – The MH fund balance has to be less than 15%.	Eligibility criteria – The MH fund balance has to be less than 15%.
1) population estimate - based on each county's percentage of total state population using most recent census estimate	1) population estimate - based on each county's percentage of total state population using most recent census estimate	Use MH/DD client #'s X case rate <i>There will also be a need for an allocation for services outside the case rate – for example: prevention and administration costs.</i> <i>Eliminates legal settlement.</i> <i>Meets the needs of the people served.</i> <i>Money follows the person.</i> <i>Simplification, flexibility</i> <i>Can be adjusted quarterly</i>
2) poverty population data – based on each county's percentage of total state poverty population.	2) poverty population data – based on each county's percentage of total state poverty population. Use the 2-year-old fund balance instead of the 1-year-old fund balance in the formula. The allowed growth will be calculated by Jan. 1 for the subsequent fiscal year. We recommend the changes be passed in FY 08 legislation so it will be effective for the FY09 allowed growth calculation.	<i>Counties should be able to calculate the dollars they may receive at the beginning of the year rather than having to wait until the middle of the year to know how much money they have to work with.</i> <i>Requires having data systems and definitions in place. It will be imperative to have – an unduplicated count of clients per county and a case rate methodology established.</i>
3) per capita net county expenditures not used in 08	Not applicable	Not applicable