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OVERVIEW

TRANSFORMING IOWA'S BEHAVIORAL HEALTH CRISIS CONTINUUM OF CARE SYSTEM

Earlier this year, the Iowa Department of Health and Human Services (Iowa HHS) engaged Health Management Associates, Inc., (HMA) to assess Iowa's crisis continuum of care and make recommendations to strengthen the system's design, service delivery, funding and sustainability, and, most importantly, individual experiences and outcomes.

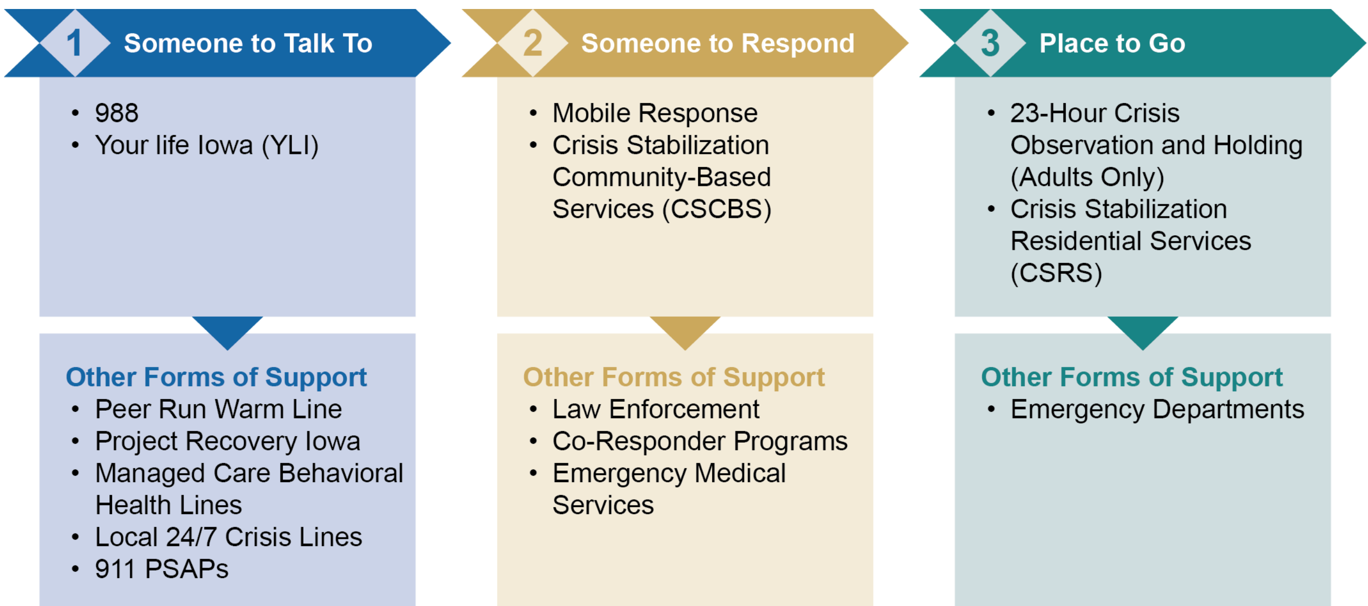
Rationale for the Assessment

Since the Substance Abuse and Mental Health Services Administration (SAMHSA) released its National Guidelines for Behavioral Health Crisis Care in 2020,[1] significant initiatives, such as the launch of 988, have propelled the state's efforts to ensure it has a comprehensive crisis system (inclusive of mental health and substance use) that is fully aligned with national best practices and equipped to meet the needs of Iowans.

Iowa HHS and the state as a whole have an opportunity to develop policy, standards, and practices that can transform Iowa's approach to people who are at risk of or who experience a behavioral health crisis.

SAMHSA's National Guidelines for Behavioral Health Crisis Care[2] describes three core pillars of a comprehensive and effective crisis continuum: someone to talk to, someone to respond, and someplace to go (see Figure 1).

Figure 1. Iowa's Current Behavioral Health Crisis Response Continuum



[1] National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020.

[2] National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020.

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SOMEONE TO TALK TO

Best Practices & Iowa Gaps

Minimum Expectations to Operate a 24/7 Regional Crisis Call Service *(Someone to Talk To)*		Iowa Met Expectation
1.	Operate every moment of every day (24/7/365)	✓
2.	Staffed with clinicians overseeing clinical triage and other trained team members	✓
3.	Answer every call or coordinate overflow coverage	✓
4.	Assess risk of suicide within each call	✓
5.	Coordinate connections to mobile crisis team (MCT) services in the region	GAP
6.	Connect individuals to facility-based care via warm handoffs	✓
Best Practices to Operate a Regional Crisis Call Center To fully align with best practice guidelines, centers must meet minimum expectations and:		
1.	Incorporate Caller ID functioning	GAP
2.	Implement GPS-enabled technology to dispatch MCTs	GAP
3.	Utilize real-time regional bed registry technology	GAP
4.	Schedule outpatient follow-up appointments via a warm handoff	✓

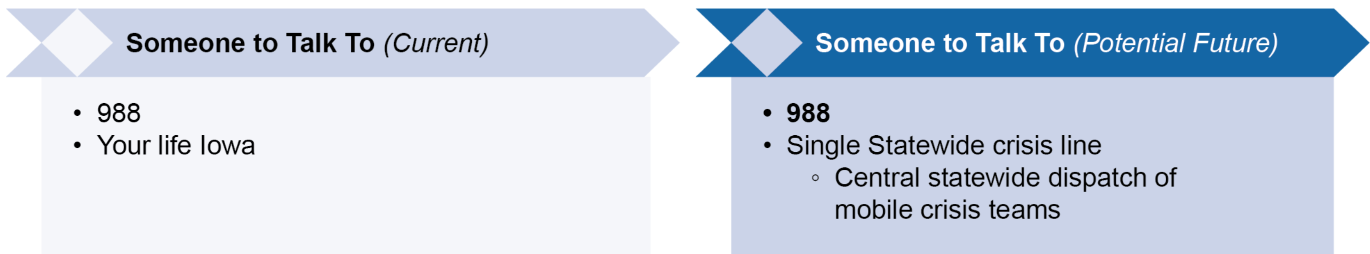
Key Findings

- Iowans prefer a single statewide crisis line.
- 911 PSAPs have significant interest in increased collaboration and partnership with crisis partners, including transfers to 988.
- Though the 988 to 911 pilots have yet to yield the desired results, the transfer of appropriate calls from 911 to 988 and additional support and resources may improve their partnerships, resulting in outcomes that may serve as test cases for scaling partnerships between 988 and 911 across the state.

Recommendations

- Transition to 988 as Iowa's single statewide crisis line; provide a funding model commensurate with resource needs and utilization patterns.
- Implement a statewide dispatch model for mobile crisis services through the 988 call center. Leverage Centers for Medicare & Medicaid Services (CMS) to enhance administrative claiming for mobile crisis support.
- Provide additional resources and support to reinforce the three 988–911 pilots to identify and mitigate any barriers and address issues identified in the 911 PSAP survey. Specific action steps include:
  - Grants to support pilot partnerships
  - Assist with refining the policies and templates related to call assessment and call transfer policies/protocols, memorandum of understanding to partnering 911–988
  - Guidance on liability and risk management
  - Telecommunicator training on behavioral health call risk assessment
  - Oversight support, including:
    - Cross-county learning collaborative and individual, tailored technical assistance
  - Centralized, standardized quality assessment and quality improvement including data collection and reporting

Figure 2. Iowa's Current "Someone To Talk To" Care Services vs. Iowa's Potential Future Services



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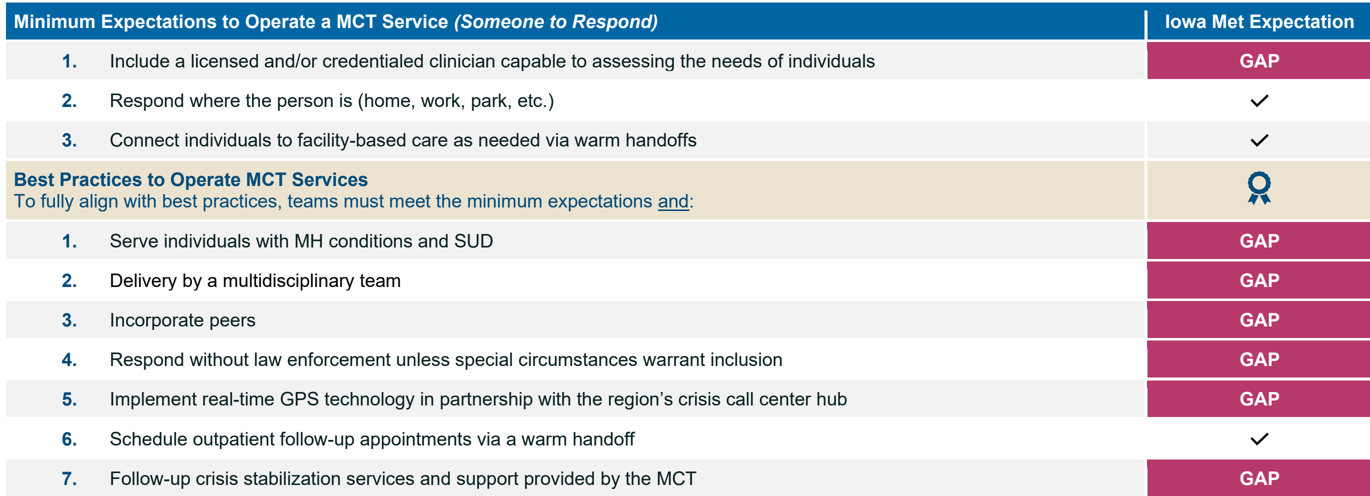
SOMEONE TO RESPOND

Best Practices & Iowa Gaps



	Minimum Expectations to Operate a MCT Service *(Someone to Respond)*	Iowa Met Expectation
1.	Include a licensed and/or credentialed clinician capable to assessing the needs of individuals	GAP
2.	Respond where the person is (home, work, park, etc.)	✓
3.	Connect individuals to facility-based care as needed via warm handoffs	✓
	Best Practices to Operate MCT Services To fully align with best practices, teams must meet the minimum expectations and:	
1.	Serve individuals with MH conditions and SUD	GAP
2.	Delivery by a multidisciplinary team	GAP
3.	Incorporate peers	GAP
4.	Respond without law enforcement unless special circumstances warrant inclusion	GAP
5.	Implement real-time GPS technology in partnership with the region's crisis call center hub	GAP
6.	Schedule outpatient follow-up appointments via a warm handoff	✓
7.	Follow-up crisis stabilization services and support provided by the MCT	GAP

Key Findings

- The pathway to statewide 9813-compliant mobile crisis services requires amending the codes that regulate mobile crisis services to align with 9813 requirements.
- Including Law Enforcement as crisis response staff is misaligned with best practices and 9813-compliant mobile crisis services.
- Expanding eligible qualified staff permitted to conduct a crisis assessment would positively impact workforce issues.
- Leverage telehealth to support a two-person MCT and enhance workforce efficiencies.
- Follow-up services by MCTs are not required per 441 IAC 24, which misaligns with best practices and 9813.

Crisis Stabilization Community-Based Services (CSCBS)

- CSCBS is underutilized. In its design, it duplicates 9813-aligned MCTs that provide robust follow-up services for the same time. Follow-up services provided by the MCT are both a best practice and a recommendation for mobile crisis response, reducing overreliance on EDs.

Law Enforcement

- Law enforcement's role in behavioral health crisis response varies across the state.
- Some jurisdictions have a more mature continuum of responses, ranging from mobile crisis only to law enforcement only, with an option for a co-responder program.
- The lack of mobile crisis response in some areas has led to an expanded role for law enforcement.

Emergency Medical Services (EMS)

- EMS is a highly volunteer, unmandated service in Iowa.
- The lack mobile crisis response in some areas has led to an expanded role for EMS.
- EMS is interested in partnering with other first responders in developing models and solutions that best serve people in crisis.
- Planning should build on existing pilots and partnerships to inform future District-level, cross-sector crisis planning.

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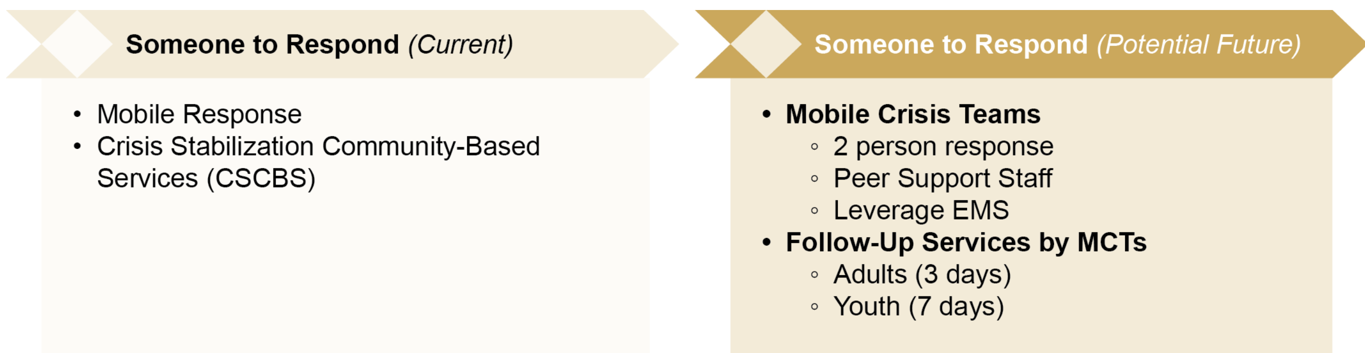
Recommendations

- Make the following amendments to 441 IAC 24 and 441 IAC 25 to align with best practices and Section 9813 of the American Rescue Plan Act (ARPA):
  - Require multidisciplinary team response that includes at least one behavioral healthcare professional to provide an assessment, along with other professionals/workers with expertise in behavioral/mental health crisis intervention
  - Include SUD in the definitions for crisis services to expand crisis services to serve people with SUD
  - Exclude law enforcement as qualified crisis response staff to align with 9813 requirements
  - Include telehealth as a permitted modality for MCT response
  - Require follow-up services conducted by the MCT with expectations and protocols for follow-up care after a crisis encounter
  - Explicitly require providers to offer services in people's preferred languages or provide access to trained interpreters
- Expand eligible qualified staff permitted to conduct a crisis assessment and make conforming changes to 441 IAC 24 and 441 IAC 25 to include master's level and bachelor's level providers.
- Iowa Medicaid should submit a State Plan Amendment to CMS by April 2, 2025, outlining the provider qualifications for the MCT. Include telehealth as a permitted modality for one of the two responders.
- Require MCTs to have a memorandum of understanding with schools to strengthen partnerships, maximize use of MCTs, and increase awareness among families about the availability of crisis service.
- Sunset CSCBS and require MCTs to provide follow-up services.
- Require ASOs to promote cross-partner crisis system planning and implementation oversight to ensure alignment and coordination across behavioral health (BH) crisis first responders (mobile crisis programs, law enforcement, and EMS) through the mandated District Partner Workgroup structure.
- Allow for EMS reimbursement when transporting to an approved alternative destination, such as an access center (see House Study Bill 617).
- Include emergency medical technicians (EMTs) as "qualified providers" in the SPA, amending Supplement 2, Attachment 3.1-A to align with 9813 requirements. Encourage and expand MCT and EMS collaboration to maximize EMT roles when responding to mobile crises, as appropriate.
- Strengthen EMS and mobile crisis partnerships, particularly in rural areas, to expand the limited workforce. The mobile integrated health pilots in Des Moines and elsewhere are examples.
- Include EMS in administrative service organizations (ASO) district cross-partner crisis system planning.
- Explore the use of technology to enhance mobile crisis response in collaboration with EMS (e.g., EMS connecting individuals to mobile response via telehealth).

Figure 3. Iowa's Current "Someone To Respond" Care Services vs. Iowa's Potential Future Services



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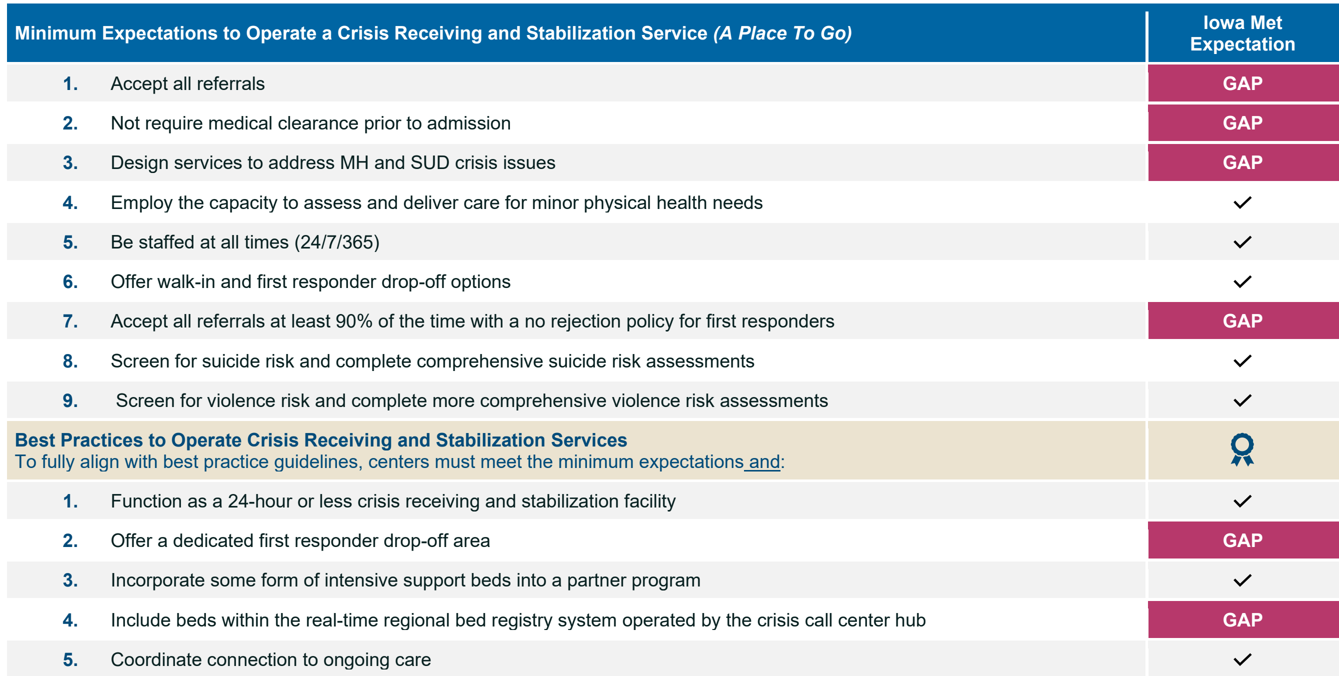
A PLACE TO GO

Best Practices & Iowa Gaps



	Minimum Expectations to Operate a Crisis Receiving and Stabilization Service *(A Place To Go)*	Iowa Met Expectation
1.	Accept all referrals	GAP
2.	Not require medical clearance prior to admission	GAP
3.	Design services to address MH and SUD crisis issues	GAP
4.	Employ the capacity to assess and deliver care for minor physical health needs	✓
5.	Be staffed at all times (24/7/365)	✓
6.	Offer walk-in and first responder drop-off options	✓
7.	Accept all referrals at least 90% of the time with a no rejection policy for first responders	GAP
8.	Screen for suicide risk and complete comprehensive suicide risk assessments	✓
9.	Screen for violence risk and complete more comprehensive violence risk assessments	✓
	Best Practices to Operate Crisis Receiving and Stabilization Services To fully align with best practice guidelines, centers must meet the minimum expectations and:	
1.	Function as a 24-hour or less crisis receiving and stabilization facility	✓
2.	Offer a dedicated first responder drop-off area	GAP
3.	Incorporate some form of intensive support beds into a partner program	✓
4.	Include beds within the real-time regional bed registry system operated by the crisis call center hub	GAP
5.	Coordinate connection to ongoing care	✓

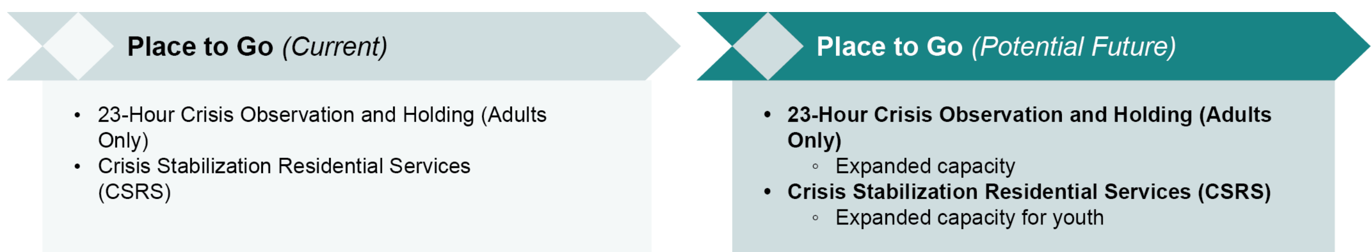
Key Findings

- 23-hour crisis observation services and crisis stabilization residential services do not serve individuals with SUD, which is not in alignment with best practices and 9813 compliant mobile crisis services.
- Given the limited data available at the time of this report, it is unclear whether 23-hour crisis observation service is underutilized. Data is not collected by all hospital-based providers and is necessary to fully understand the utilization patterns.
- The CMS time and distance analysis suggests inequity in access to 23-hour and observation for metro, micro metro, and rural counties.
- The CMS time and distance analysis suggests inequity in access to youth crisis residential services for metro, micro metro, and rural counties.

Recommendations

- Ensure reporting compliance by all 23-hour crisis observation providers.
- Conduct a county-level assessment of time and distance standards for 23-hour observation to determine optimum location need for additional beds.
- Increase the bed capacity for 23-hour observation and holding services.
- Conduct a county-level assessment of time and distance standards for crisis stabilization residential services (CSRS) to determine optimum location need for additional beds.
- Increase the bed capacity for youth CSRS.

Figure 4. Iowa's Current "Somewhere To Go" Care Services vs. Iowa's Potential Future Services



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AREAS OF STANDARDIZATION IN THE PROVISION OF CRISIS SERVICES

Area	Key Findings	Recommendations
Quality Management	• Opportunities exist for additional data elements that align with best practices and would allow for a holistic approach to crisis care and for measuring and monitoring health disparities including: ○ Race and ethnicity ○ Social determinants of health (SDOH) ○ Sexual orientation/gender identity ○ Use of telehealth ○ Team composition (to monitor use of paraprofessional and/or peers) ○ Law enforcement involvement ○ Percentage of follow-up provided by MCTs to adults and youth ○ Duration of follow-up provided by mobile team to adults and youth	• Expand data collection for MCTs to include: ○ Race and ethnicity ○ SDOH ○ Sexual orientation/gender identity ○ Use of telehealth ○ Team composition to monitor use of paraprofessional and/or peers ○ Law enforcement involvement ○ Percentage of follow-up provided by mobile team to adults and youth ○ Duration of MCT follow-up provided to adults and youth • Expand quality metrics for MCTs to include: ○ Disposition ○ Number and percentage of people who receive follow-up contact from the MCT within a defined period ○ The number and percentage of encounters that include a peer support specialist on the MCT ○ The number and percentage of crisis calls when the MCT engages/requests law enforcement response ○ Measure of individuals' and families' satisfaction with services
Crisis Assessments	• Use of a universal assessment across all MCTs has the benefit of ensuring that consistent information is collected for all individuals served, allowing them to contribute to a standardized data collection approach.	• Implement a universal crisis assessment inclusive of a health-related social needs screening and the level of care utilization system (LOCUS®).
Trainings	• Current required trainings for MCTs are not aligned with best practices and 9813. • Integrating people with SUD into populations that mobile crisis providers serve necessitates that all crisis staff to receive SUD-related training.	• Institute a requirement for standardized MCT trainings aligned with best practices and 9813 for mobile crisis teams and make conforming changes to 441 IAC 24 and 441 IAC 25.
Use of Peers	• Iowans overwhelmingly support including peer support staff in mobile crisis services. • A recovery coach is the one Iowa-established peer role that is not included in permitted crisis response staff per 441 IAC 24. • MCTs do not consistently use peer staff. • The requirement of a minimum of one year of experience in behavioral or MH services is a significant barrier to recruiting eligible peer support staff.	• Include Recovery Coaches as eligible crisis response staff and make conforming changes to 441 IAC 24 and 441 IAC 25. • Allow the provision of supervised peer support "on the job experience" for one year in lieu of "one year of experience in behavioral mental health services," in addition to completion of the training requirements established by the Iowa Peer Workforce Collaborative. Make conforming changes to 441 IAC 24 and 441 IAC 25.
Technology	• Opportunities exist to leverage technology to improve access to crisis stabilization services.	• Add 23-hour crisis observation and holding services beds and CSRS to CareMatch and permit public access to this bed registry.
Behavioral Health Administrative Service Organization (BH-ASO) and Sustainable Funding	• Iowa's regulatory framework for behavioral health crisis services is fragmented. The Iowa regulatory framework must be streamlined to effectively implement the integration of mental health and addictive disorder services, including crisis services. • With the new BH ASO structure, Iowa has an opportunity to align contracting processes to better coordinate BH crisis services and ease administrative burden.	• Consolidate Iowa Administrative Code licensure and accreditation requirements into one BH administrative code. The new consolidated administrative code should include specific approvals/certifications for safety net providers to secure a robust crisis continuum of care. To incent providers to participate in the crisis continuum of care, Iowa should implement payment incentives for approved safety net providers. • Implement consistent contracting practices for ASOs across BH districts. These practices should include consistent contracting standards for the provider network and alignment with Medicaid requirements to reduce administrative burden and ensure a consistent continuum of care regardless of funding source. Iowa HHS should replicate the Colorado's universal contracting provisions and/or Washington State's model contract. • Inventory of all funding sources, including amounts and limitations for use, as well as the costs associated with one-time ramp-up and ongoing delivery of the crisis continuum components. This exercise should include a review and assurances that available funding streams are being maximized, such as Medicaid, as opposed to use of more flexible funds intended to be used as a payer of last resort (MHSB/state funds). • Informed by the forecasting and inventory exercise (recommendation above), maximize available funding strategies across the crisis continuum, including revisiting previous attempts through legislation to secure non-treatment dollars for sustainment of 988 as well as legislation that supports commercial plan participation in coverage of crisis services to avoid passing this expense on to the public system as "payer of last resort." (See National Association of State Mental Health Program Directors 988 model bill.) • Leverage design phase for new districts and ASO structure to create cross-payer (ASO, Medicaid managed care organization, commercial plan) standardization of service definitions and rates for crisis services, as well as requiring cross-payer participation by crisis providers within their networks to mitigate the variability and inconsistent experience of crisis system users that can occur with absent, competing, and/or misaligned approaches.

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