Iowa Mental Health and Disability Services Commission

Combined Annual and Biennial Report

DECEMBER 2024

IOWA | Health and Human Services

Contents

INTRODUCTION

This Combined Annual and Biennial Report of the Iowa Mental Health and Disability Services (MHDS) Commission is submitted pursuant to Iowa Code § 225C.6(1)(h)-(i). The report is organized in three parts: (1) an overview of the activities of the Commission during 2020, (2) recommendations formulated by the Commission for changes in Iowa law, and (3) an evaluation of the extent to which services to persons with disabilities are actually available to persons in each county in the state and the quality of those services, and the effectiveness of the services being provided by disability service providers in this state and by each of the State Mental Health Institutes established under Chapter 226 of the Iowa Code and by each of the State Resource Centers established under Chapter 222 of the Iowa Code.

Executive Summary

The Mental Health and Disability Services Commission (Commission) met a total of 12 times during 2024. All meetings were held virtually via Zoom. The Commission recommended the adoption of one MHDS Region's Policy and Procedure Manuals and submitted their annual Service Cost Increase letter. The Commission also heard the following presentations: Children's Behavioral Health System State Board, Iowa Autism Support Program Overview, Resources for Transitioning Youth, Suicide Risk for Veterans, Governor's Challenge and 988, Mental Health Awareness Month Recap and Managed Care Organizations value-added services.

The Commission offers the following recommendations to the General Assembly:

1. The MHDS Commission recommends that the legislature continue to support the implementation and expansion of a children's services system which utilizes and funds a full array of nationally recognized, evidence-based models of care for all children in the state who have behavioral and brain (mental) health needs, intellectual and developmental disabilities and brain injuries. We recommend the development of a collaborative model of services between mental health providers and the school systems that will integrate the systems to ensure that children receive a "whole child" person-centered planning with a "collaborative one team" approach to care. Collaborative care team development between the Department of Education (DE) and HHS has the potential to provide more wholistic consistent care to children.
2. The MHDS Commission recommends that the State require full implementation of mental health and behavioral health parity for all public and commercial insurance plans per the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). More information on MHPAEA can be found on the U.S. Centers for Medicare & Medicaid Services (CMS).
3. The MHDS Commission recommends, pursuant to HF 2673 (page 56), that state agencies prioritize screening and referral for brain injuries. These injuries, which are recognized as a disability and occur at a much higher prevalence in those individuals with behavioral health concerns, makes this intervention imperative.
4. The MHDS Commission recommends that the legislature continues to address the workforce shortage to ensure the availability of staff to provide the supports and services that individuals with behavioral and mental health needs, intellectual/developmental disabilities and brain injuries need to be able to live in the community when possible and institutions when necessary.
5. The MHDS Commission recommends ensuring the continuum of care adequately addresses the needs of individuals with increasing complexity of needs and services which currently are most effectively maintained in state facility care.
6. The MHDS Commission recommends continued funding for state facilities to maintain infrastructure, including security positions for Independence Mental Health Institute.
7. The MHDS Commission recommends the development of intensive multi-disciplinary support teams for all individuals being discharged from state facilities, and ongoing as determined by need rather than predetermined standards.

8. The MHDS Commission recommends expanding the availability, knowledge, skills, competitive compensation and benefits of professionals, paraprofessionals and direct support workers by implementing incentive programs to train, recruit and retain these professionals including but not limited to loan forgiveness programs and opportunities for fellowships.
9. The MHDS Commission recommends increasing the use of peer recovery specialists (mental health and/or substance use disorders) across the board in hospital settings, treatment facilities, mental health facilities, wellness centers and university settings.
10. The MHDS Commission recommends developing Administrative Service Organizations (ASO) service definitions and standards, performance outcomes and reporting requirements.
11. The MHDS Commission recommends implementing a district-wide plan to ensure adequate service provision in every county within the district, ensure service quality and performance outcomes, and report progress and outcomes to Health and Human Services (HHS).
12. The MHDS Commission recommends ensuring the ongoing statewide implementation of the Certified Community Behavioral Health Clinic (CCBHC) activities coordinates with the current implementation timeline of the CCBHC model.

Part 1: Overview of Commission Activities During 2024

Meetings

The Commission held 12 meetings in 2024. The meetings included two sessions held jointly with the Iowa Mental Health Planning and Advisory Council. Meeting agendas, minutes and supporting materials are distributed monthly to an email list of over 200 interested persons and organizations and are made available to the public on the Iowa Department of Health and Human Services (HHS) website. Commission meetings and minutes serve as an important source of public information on current mental health and disability services (MHDS) issues in Iowa; most meetings are attended by ten to 20 guests in addition to Commission members and HHS staff.

Officers

In April, Diane Brecht (Central City) was elected Chair of the Commission and Jack Seward (Washington) was elected Vice-Chair.

Membership Changes

Russell Wood (Ames), and Richard Whitaker (Davenport) completed their second terms in April 2024 and resigned from the Commission. Sarah Berndt (Wayland) and Don Kass (Remsen) completed their first terms in April of 2024 and are waiting for notice of re-assignment. In July, one new appointee joined the Commission: Kellee McCrory (West Branch) was appointed to represent as an advocate. Teresa Daubitz (Unity Point) resigned from the Commission in May 2024. The following vacancies remains on the MHDS Commission: one Consumer representative, two County Supervisors, two CPC Administrator and one CMHC Board Member.

Administrative Rules

The Commission did not consult with the Division of Behavioral Health and Disability Services on the development, review and approval of administrative rule packages during this period.

MHDS Region Policy and Procedure Manual Review

In June, the Commission recommended to Iowa HHS that a proposed change to the Heart of Iowa MHDS Region Policy and Procedure Manual be approved. The changes were primarily to make changes to their management plan’s policies and procedures.

Service Cost Increase Recommendation

In July, the Commission provided a recommendation for non-Medicaid expenditures growth funding to the Department and the Council on Health and Human Services. The Commission recommended increasing the previous year's budget by 3.4% to account for overall population growth, and the resulting increase in service utilization.

The Commission made the following additional recommendations:

1. We appreciate the state's recent increase in rates for mental health and substance use disorder treatment services. We recommend that the state reevaluate Medicaid fee schedules following implementation of the recent increase to ascertain if they support levels of compensation necessary for workforce expansion, especially in the current competitive work environment. We recommend the state continue to evaluate the sufficiency of all provider fee schedules, and again recommend that the state implement annual adjustments to the fee schedule based on inflation rates. Workforce shortages are noted in psychiatry, nursing, and licensed mental health professionals, along with many frontline support positions within behavioral health and disability service agencies.
2. Now that Iowa has become a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state, we recommend continued engagement with stakeholders in the development of a sustainable CCBHC model for the State of Iowa to reduce costs through improved outcomes.
3. We support a recovery-oriented system with a heightened focus on prevention and early intervention. To accomplish this, the Behavioral Health system must have sufficient rates to support a workforce to meet the needs of all Iowans.

Coordination with Other Statewide Organizations

The Commission held two joint meetings with the members of the Iowa Integrated Health Planning and Advisory Council (I-PAC), and the two groups regularly shared information throughout the year. The I-PAC Chair, Teresa Bomhoff, regularly attends Commission meetings, reports on I-PAC activities, and relays information between the Commission and the IMPHC. In May, Iowa Developmental Disabilities (DD) Council Executive Director, Brooke Lovelace, provided an overview of the DD Council and an update on their current work.

Coordination with the Iowa General Assembly

The Commission has three non-voting ex-officio members who represent each party of each house of the Iowa General Assembly. These legislative members attended meetings via Zoom or by phone as they were able during the year.

Reports and Informational Presentations

During 2024, the Commission received numerous reports and presentations on issues of significance in understanding the status of services in Iowa and recognizing promising practices for planning and systems changes, including: Children's Behavioral Health System State Board, Iowa Autism Support Program Overview, Resources for Transitioning Youth, Suicide Risk for Veterans, Governor's Challenge and 988, Mental Health Awareness Month Recap and Managed Care Organizations value-added services.

Children's Behavioral Health System State Board

Rich Whitaker provided updates of the Children's State Board in January and March. Sue Gehling provided an update in May. Division XIII of SF2385 repeals the Children's Behavioral Health State Board and assigns its duties to the Council on Health and Human Services. effective July 1, 2024.

Iowa Developmental Disabilities Council

In May, Iowa Developmental Disabilities (DD) Council Executive Director, Brooke Lovelace, provided an overview of the DD Council and an update on their current work.

Iowa Autism Support Program Overview

In January, Connie Fanselow, HHS, reviewed the Autism Support Program (ASP). This provides state funding for applied behavior analysis (ABA) services to children who are not eligible to receive ABA service funding through Medicaid or private health insurers and who meet certain diagnostic and financial eligibility criteria.

Resources for Transitioning Youth

In February, Doug Wolfe, Transition Program Manager, explained the transition planning process for youth in foster care. Transition planning starts with children in foster care who are 14 years of age or older. Consistent planning services are provided, with information about programs and services, youth-centered meetings and team support.

Suicide Risk for Veterans

In March, Dr. Wayne provided an overview from the Department of Veterans Affairs (VA) "2023 National Veteran Suicide Prevention Annual Report", which indicated a spike in suicides in veterans under age 45. There was a discussion on the report. Dr. Wayne shared that there is more information available through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which is part of the VA's ongoing efforts to reduce suicide risk among veterans.

Governor's Challenge and 988

In March, Julie Maas, Iowa HHS Suicide Prevention Director, provided an update on the 988 Suicide and Crisis Lifeline, which provides free and confidential emotional support to people in suicidal crisis or emotional distress through a national network of over 200 crisis centers. 988 provides specialty services for targeted populations, including military veterans, service members and their families. Additionally, Julie shared that Iowa has a team led by Iowa HHS and the Iowa Department of Veteran's Affairs with a purpose of bringing state, military, and community-based providers together to develop and implement a strategic plan to prevent and reduce suicide.

Mental Health Awareness Month Recap

In June, June Klein-Bacon shared an informational pamphlet developed by the Brain Injury Alliance of Iowa. Jack Seward shared activities of the Washington County Mental Health Coalition, including public library and local business events. Diane Brecht shared events such as the NAMI walk in Iowa City and Linn County fundraisers.

Coordination with Behavioral Health Division

Behavioral Health Division Director Marissa Eyanson, and Bureau Chief Theresa Armstrong, along with other staff from HHS have actively participated in Commission meetings throughout the year, communicated regularly, provided timely and useful information, and been responsive to questions and requests from Commission members. A significant portion of each Commission meeting has been devoted to updates and discussion on a variety of relevant issues and initiatives, notably including:

- Active Legislation regarding MHDS
- Legislative Session updates
- HHS Alignment
- Certified Community Behavioral Health Clinics (CCBHC)
- Crisis System Evaluation
- System Alignment/Service Delivery Alignment
- Behavioral Health Service System
- The Children's System State Board
- Future of MHDS Commission
- Disaster Behavioral Health and Project Recovery Iowa

Managed Care Organizations (MCOs) Value-Added Services

Representatives of each of Iowa's three Managed Care Organizations (MCOs) presented overviews of their respective value-added services for members. The value-added services were similar in structure across the companies with variations in the rewards offered. All three utilize incentives programs for members to engage in healthy behaviors and provide services, such as transportation, to reduce barriers to care.

Part 2: Recommendations for Changes in Iowa Law in 2024

On May 15, 2024, **House File 2673** was signed into law. Under this legislation, Iowa Health and Human Services (HHS) will combine the work and funding for mental health and addictive disorders into a Behavioral Health Service System, guided by a statewide plan, and focused on ensuring equitable access to prevention, treatment, recovery and crisis services. HHS will transfer the management of disability services from the local Mental Health and Disability (MHDS) Regions to the Division of Aging & Disability Services. Management activities will include identifying additional organizations to participate in the Aging and Disability Resource Center (ADRC) network and the creation of a disability services system. HHS will work with local Behavioral Health Administrative Service Organizations (BH-ASOs) to collaboratively coordinate and oversee services in each behavioral health district. The new Behavioral Health Service System will start July 1, 2025.The Commission offers the following prioritized recommendations to the General Assembly to ensure appropriate access to supports and services for Iowans with mental health needs, substance use disorders, intellectual and other developmental disabilities, aging, and brain injuries and to ensure the rights of all Iowans to receive supports and services in the community when possible and institutions when necessary, and to ensure that there is a focus on maintaining and increasing the quality of life of Iowans served. Specific care components warranting ongoing general assembly attention include:

1. Inadequate access to care is a barrier for Iowans.
2. Inconsistent treatment.
3. Provider networks lead to fragmentation and silos.
4. Deficiency in inpatient beds.
5. Workplace shortages.

Vision: The MHDS Commission envisions a Mental Health and Disabilities service system that offers supports, services, and funding that meet the needs of all Iowans, regardless of their age, disability, or address.

To achieve this vision, the MHDS Commission has established the following policy statements:

1. With the sunsetting of many boards and commissions that encouraged sharing of information, the Commission wants to ensure that the voices of Iowa's most vulnerable individuals accessing services, family members and advocates have a forum where information and expertise can be shared.

2. The MHDS Commission recommends that the legislature continues to address the workforce shortage to ensure the availability of staff to provide the supports and services that individuals with behavioral and mental health needs, intellectual and developmental disabilities and brain injuries need to be able to live in the community when possible and institutions when necessary.
3. The MHDS Commission recommends that the legislature continue to focus on a stable and predictable long-term funding structure for child and adult behavioral, mental health, intellectual/developmental disability and brain injury services that is appropriate to support sustainability, growth and innovation over time. This includes workforce at all levels.
4. The MHDS Commission recommends that the legislature continues to support the implementation and expansion of a children's services system which utilizes and funds a full array of nationally recognized, evidence-based models of care for all children in the state who have behavioral and brain (mental) health needs, intellectual and developmental disabilities and brain injuries. We recommend the development of a collaborative model of services between mental health providers and the school systems that will integrate the systems to ensure that children receive a "whole child" person centered planning with a "collaborative one team" approach to care. Collaborative care team development between the educational experts and the mental health experts has the potential to provide more wholistic consistent care to children.
5. The MHDS Commission recommends that the legislature continues to support an environment that encourages and adequately funds the provision of needed services, as well as the development of additional services. This would include services that help maintain community tenure (such as an appropriate level of transportation), the expansion of services to additional populations (such as developmental disability and brain injury services) in all areas of the state, and access to an array of services including the state resource center and mental health institutes.
6. The MHDS Commission recommends that the legislature direct HHS to address consistency and delivery of needed services within and across ASOs and ADRCs, including but not limited to, standardizing definitions of services.
7. The MHDS Commission recommends that services included as part of performance-based contracts have stable identified resources available such as funding and workforce.
8. The MHDS Commission recommends that regulatory oversight and required training be commensurate with the intensity of services provided and potential risk to clients.
9. The MHDS Commission recommends stable and secure funding of the State Resource Center and Mental Health Institutes for ongoing programs and services, staff wages and training, and maintenance of facilities. These are vital in the continuum of services and supports available in Iowa.
10. The MHDS Commission recommends, pursuant to HF 2673 (page 56), that state agencies prioritize screening and referral for brain injuries. These injuries, which are recognized as a disability and occur at a much higher prevalence in those individuals with behavioral health concerns, makes this intervention imperative.

To create a system that realizes this vision and incorporates these policy statements, the MHDS Commission recommends the following specific actions:

1. Expand the availability, knowledge, skills and compensation/benefits of professionals, paraprofessionals and direct support workers as an essential element in building community capacity and enhance statewide access to a comprehensive system of quality mental health and disability services. In alignment with the Certified Community Behavioral Health Clinic model implement incentive programs to train, recruit, and retain professionals and paraprofessionals qualified to deliver high quality mental health, substance use disorder, disability and brain injury services.

   The workforce shortage in Iowa continues and has worsened over the past year. **Every level of care providers across the lifespan have been impacted** to include psychiatrists and other prescribers, therapists, nurses and front-line workers such as direct support professionals, respite providers and others. This shortage has significantly impacted Iowans ability to receive the care they need at every level. It has negatively impacted community providers ability to support individuals and families to access the services they need to remain at home or in the community. For example, families who need to access in home services for children, adults who are ready to transition into community-based settings from inpatient settings, long-term care settings such as nursing facilities, residential care facilities, the state mental health hospitals or correctional facilities.

   Special incentives encourage and support psychiatrists, psychologists, psychiatric physician assistants, advanced registered nurse practitioners, and other mental health and substance use disorder treatment professionals who are trained to stay and practice in Iowa and could attract professionals trained elsewhere to practice in Iowa and encourage their retention.

   Special incentives should also be extended to individuals who desire to work in community-based settings with individuals across the lifespan, especially nurses and front-line workers such as direct support professionals and respite providers. The development of such incentives would support the professional work that these additional professionals engage in.

   Direct Support Professionals (DSPs) are people who work directly with people of all ages who have a mental illness, physical disability, brain injury, and/or intellectual and other developmental disability with the aim of assisting the individual to become integrated into his or her community or the least restrictive environment. DSPs provide supports including work with HCBS Waiver and Habilitation Services. DSPs play a vital role in America’s workforce and economy including providing supports for employment services.

Professionals indicate that effective incentives include loan forgiveness programs and opportunities for fellowships. Such programs could be targeted to specific professionals and specialties that are most needed. Current loan forgiveness programs are restricted to areas that are designated as “Health Professional Shortage Areas” and should be expanded at all areas throughout the state to encourage professionals to provide services in Iowa as the impact of the workforce shortage, in general and in specific circumstances, is felt in both urban and rural areas across the State of Iowa. We also recommend that loan forgiveness programs, grants/scholarships for certification programs or training be expanded to include nurses and front-line workers such as DSPs who work in community settings.

Wages, benefits, and training for direct care workers must be competitive. To achieve this, all provider reimbursement rates, including rates for outpatient mental health services, from all payers, including Medicaid, and private insurance, need to be set at a level that is adequate to preserve service stability for clients, build community capacity, and enable safety net providers (including but not limited to CMHCs, HCBS agencies, and agencies providing substance use disorder treatment) to offer and expand access to services that meet the complex needs of individuals served by the MHDS system. Telephonic therapy should be a reimbursable service in limited circumstances where the internet access or the client’s technological skill level are inadequate. Access to the internet must continue to be enhanced throughout the state to permit greater utilization of telehealth.

2. Continue to ensure a uniform, stable and adequate system, with flexibility to develop new and innovative services, which funds the ASOs and ADRCs to provide services for the needs of individuals with behavioral health, mental health, intellectual/developmental disabilities and brain injuries regardless of geography or age.

3. Develop a robust system of services which are readily available for children with mental health and developmental disabilities including intellectual disabilities and brain injuries to be coupled with the Children’s Behavioral Health System established in 2019.

   An integrated service system for children with mental health issues including serious emotional disturbances, intellectual/developmental disabilities and brain injuries is critical to their health and well-being. It must make effective and efficient use of our scarce resources and potentially reduce costs to the adult mental health and disability system. Early intervention and prevention are essential to reduce the incidence, prevalence, personal toll, and fiscal cost of mental illness, brain injuries, intellectual disabilities and developmental disabilities.

The service delivery system for children must align with “Family First” legislation and be evidence-based and include intensive, home-based treatment interventions that work with children and their families to improve long-term outcomes and prevent costly, traumatic, and largely unproductive out-of-home placements. The State should consider funding a pilot program of the Collaborative Care Model in the pediatric space to facilitate mental healthcare access in that underserved and vulnerable population. Services need to be developed in Iowa that negate or reduce the need for out of state placements for children with complex needs. To justify this recommendation and emphasize its importance to the general assembly the follow information is shared: “31 randomized control trials with more than 13,000 pediatric participants have documented improved mental health outcomes in both urban and rural settings. Funding streams exist at both Federal and State levels as do Collaborative Care CPT codes for both initial and subsequent collaborative care visits. As of August 2020, 16 State Medicaid programs were reimbursing the Collaborative Care Model.”

The actions by the Governor and the legislature in creating a system of care for children with behavioral health needs was a first step in providing for the needs of children with disabilities in Iowa. Expansion to include the development and management of a system of care for children in other diagnostic groups by the ASOs and ADRCs is paramount. In addition, the legislature must ensure that the state continues adequate funding for this system.

4. Create and maintain a data infrastructure that, among other things, facilitates evaluation, on an ongoing basis, of the implementation of evidence-based, evidence supported and promising practices.

   The state must develop and maintain a data infrastructure necessary to evaluate the impact of the supports and services provided using systemically consistent outcome measures. Partnering across departments and levels of government can reduce the costs of maintaining multiple systems that may be duplicating each other and would allow for better data analytics by creating a uniform structure for data reporting and analysis. The development of any new data systems should include input from end users and should be able to migrate data from legacy systems to reduce administrative burden.

5. Funding and incentives should be developed and maintained to encourage supports and services for individuals in Iowa with behavioral health needs and disabilities, which are evidence-based, evidence-supported and promising practices. Training for professional and direct care staff is necessary to achieve effectiveness. Reimbursements to providers must be adequate to provide this training and maintain an adequate and qualified workforce. Training should be required for entities who provide funding and evaluation of these programs.

6. The MHDS Commission recommends that the State require full implementation of mental health and behavioral health parity for all public and commercial insurance plans per the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). More information on MHPAEA can be found on the U.S. Centers for Medicare & Medicaid Services (CMS) **here**.

Part 3: Evaluation of the State Mental Health and Disability Services System

The extent to which services to persons with disabilities are available to persons in each county in the state and the quality of those services, and the effectiveness of the services being provided by disability service providers in this state and by each of the state mental health institutes established under Chapter 226 and by each of the state resource centers established under Chapter 222. (Iowa Code 225C.6(i)).

Report of the County and Regional Services

When the Iowa Legislature passed Senate File 2315 during the 2012 session, counties were required to regionalize; plan, develop and fund a set of core services; share state and local funding; and plan for expanded services and services to additional population groups as funds became available. Fifteen new mental health and disability service regions were created through 28E agreements, governed by members of county boards of supervisors in consultation with representatives of provider agencies and clients and families. The implementation of the new system commenced on July 1, 2014.

The Southern Hills region and the County Rural Offices of Social Services (CROSS) region both merged with the existing Heart of Iowa region as of July 1, 2024. There are currently 11 mental health regions.

Legislative Changes

In 2017, SF 504 created a statewide workgroup co-chaired by the Department of Human Services and Department of Public Health that included representatives from law enforcement, mental health and substance use disorder providers, hospitals, the judicial system, NAMI and the MHDS Regions. The statewide workgroup created “The Complex Needs Workgroup Report” which resulted in the passing of HF 2456. HF 2456 named the regions responsible for providing access to and funding intensive crisis services, access centers, assertive community treatment, and intensive residential service homes. The legislation requires a minimum of:

- Six Access Centers that include:
  - Assessment capabilities,
  - Residential subacute,
  - Residential crisis stabilization, and
  - Direct access to substance use disorder treatment

- Twenty-two Assertive Community Treatment Teams, and
- Intensive Residential Service Homes. There are currently nine providers with a total of 11 IRSH homes totaling 46 beds available.

These intensive services will require careful investment and multi-party collaborations to have successful outcomes.

In 2018, Governor Reynolds signed Executive Order 2 creating the Children's System State Board. The Board was directed to submit a strategic plan for building a children's mental health system with concrete solutions to the challenges that exist relating to children's mental health in the State of Iowa. The strategic plan resulted in the passing of HF690 which established the Children's Behavioral Health System and the Children's Behavioral Health System State Board. HF690 named the Regions responsible for providing access to the following core behavioral health services for children.

- Assessment and evaluation relating to eligibility for services
- Behavioral health outpatient therapy
- Education services
- Medication prescribing and management
- Prevention
- Behavioral health inpatient treatment.
- Crisis stabilization community-based services
- Crisis stabilization residential services
- Early identification
- Early intervention
- Mobile response

The Regions are also responsible for funding core services for children who meet the following requirements:

- Under the age of 18 and resident of the State of Iowa
- Diagnosed with a serious emotional disturbance
- Child's family has a family income equal to or less than five hundred percent of federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services

- A child's family whose household income is between one hundred and fifty percent but not more than five hundred percent of the federal poverty level shall be eligible for behavioral health services subject to copayment, a single statewide sliding fee scale, or other cost-sharing requirements approved by the department

In 2021, SF 619 changed the way MHDS Regions are funded, from a system based on county property taxes to a 100% state-funded system. The bill creates General Fund standing appropriation to the Department for distribution to the Regions through performance-based contracts. The bill also allowed for pay equity for telehealth delivered mental health care regardless of where the provider or patient are located. HF891 provided $1 million to reduce the waiting list for the Children's HCBS waiver, provided $3.9 million to increase the rates for Psychiatric Medical Institutions for Children (PMICs), and provided $11 million to increase rates for HCBS and habilitation services.

In 2022, HF2578, the House Appropriations Bill increased pay for front line staff, including $14.7 million for direct care staff providing home and community-based services, provided $7.4 million to take up to 200 Iowans with intellectual disabilities off the ID/HCBS waiver wait list, instructed the Department to implement a tiered rate reimbursement methodology for psychiatric intensive inpatient care, provided $1.2 million to increase rates for providers of behavioral health intervention services (BHIS) to children, and provided $385,000 to increase rates for providers of applied behavioral analysis services.

On May 15, 2024, Governor Reynolds signed HF2673 to implement a new Behavioral Health Service System for Iowa beginning on July 1, 2025. This transition plan provides information about the tasks the Iowa Department of Health and Human Services (Iowa HHS) will undertake to assure the successful establishment of the new behavioral health service system, the transition of mental health services from mental health and disability services regions to the Behavioral Health Service System, and the transfer of disability services from to the Division of Aging and Disability Services at HHS. This plan will be updated quarterly. The Behavioral Health Service System supports a statewide system of prevention, education, early intervention, treatment, recovery support and crisis services related to mental health and addictive disorders. The transfer of disability services to the Division of Aging and Disability Services is a key component of the development of the new Behavioral Health Service System.

Other Changes Impacting the MHDS System

Iowa Olmstead Plan

The Department continues to work with the Olmstead Consumer Task Force and other stakeholders to update the plan framework, include background information on programs and initiatives, and identify data to objectively measure outcomes for Iowans with disabilities and progress toward plan goals. The Olmstead Plan for 2021-2025 is currently under revision.

Service Access and Quality of Services Regions

MHDS Regions submit quarterly reports on regional activities to the Division of Behavioral Health within the Department. These reports reflect the availability of services for children and adults statewide. Compiled results are available in the Department's annual report to the legislature. Click **here** to see the most recent report. The following highlights reflect the status of services in the 13 regions in operation as of June 30, 2024:

- Ten regions had Crisis Stabilization Community Based Services for adults. The remaining three regions were developing the service.
- All 13 regions either had developed or contracted with another region for Crisis Stabilization Residential Services for adults.
- Twelve regions had Mobile Response with one region in development.
- All 13 regions had developed or contracted with another region for Subacute services.
- Eight regions had Assertive Community Treatment (ACT) available in all counties within the region, with four regions having the service available in a portion of their counties, and one region still developing the service.
- Seven regions had Intensive Residential Services sites within the region. All other regions have access to the service through contracts with other regions. Several other sites are being developed throughout the state.
- All 13 regions had services available through at least one of the seven Access Centers currently in operation within the state.
- Eleven regions had Crisis Stabilization Community Based Services for children available within the region, with the other two regions developing the service.
- Nine Crisis Stabilization Residential Services for children's sites were located within six regions. All other regions were also contracting for services through these programs.

- The 988 Suicide and Crisis Lifeline, formerly the National Suicide Prevention Lifeline, went live on July 16, 2022, for call, text, and chat. HHS is contracted with Foundation 2 Crisis Services and CommUnity Crisis Services and Foodbank to provide 988 Crisis Services in Iowa. These services include 24/7 call, chat, and text, follow up services, warm handoffs to mobile response, and connection to local community-based crisis services.

Additional core services developed by the regions include jail diversion and transition programs, as well as pre-screenings for individuals under civil commitment. Some regions are providing wellness recovery centers in rural areas and are also offering Crisis Intervention Training (CIT) for law enforcement. The regions collectively offered a total of 83 CIT trainings during FY24.

Areas of Achievement

The MHDS Regions continue to surpass expectations in the development of core and additional core services. Initially, there was an intentional investment into Community-Based Services by the regions to meet access standards. HF 2456 highlighted the focus over the last two years and moved Crisis Services into the core service domain, and are now a requirement of the regional service array such as Mobile Response, 23-hour observation, Crisis Stabilization and Subacute Services

HF690 established the Children's Behavioral Health System and directed MHDS Regions to develop the core and additional core services displayed above. This has enhanced broader collaboration between the regions to help families access services for their children. The MHDS Regions continue to develop and expand these services as some regions already provided services to children before the system implementation.

HF2546 established tiered reimbursement rates for inpatient psychiatric care. By January 1, 2023, HHS will implement a tiered reimbursement rate for inpatient psychiatric care with rates determined based on level of care.

Concerns and Identified Gaps

- Continued workforce shortage including direct care staff, prescribers, therapists and other mental health and behavioral health providers.
- Challenge for providers when Managed Care Organizations (MCOs) do not provide correct and timely payments. Payment rates are often inadequate to cover the actual cost of providing services.
- Pre-authorization requirements are not consistent or timely across the MCOs. MCOs lack knowledge on evidence-based practices such as ASAM or the nature of the services provided.

- While some rates have been increased, the lack of comprehensive rate increases for mental health and substance use disorder treatment services have had a negative impact on hiring, development and retention of fully equipped workforce.
- Lack of timely access to and availability of a comprehensive array of services that can effectively serve individuals with severe multiple complex needs. Siloed services related to brain injury (BI), intellectual disabilities/developmental disabilities (ID/DD) and addictions contributes heavily to this issue as most MHDS Regions do not fund BI services, and BI is not recognized as a multi-occurring condition with serious mental illness (SMI) or addiction.
- The lack of intensive psychiatric hospital beds that shifts responsibility for acute care settings to the community hospital network which currently lacks the ability to appropriately treat individuals with severe multiple complex needs. The legislature has sought to address this issue with HF2546, which established tiered reimbursement rates for inpatient psychiatric care, but it continues to be a concern at this time.
- Lack of specification and standardized training requirements for administration of the Mayo Portland Adaptability Inventory-IV (MPAI-IV) for assessors.
- Judges and magistrates should be provided with standardized training, court order forms, and protocols within and across all the judicial districts in the State to eliminate inconsistencies in mental health committals and provide timely access to appropriate placements for patients.

Report of the MHI, SRC, and Disability Services Committee

Mental Health Institutes (MHIs)

The primary issues of concern for both Cherokee and Independence Mental Health Institutes (MHIs) continue to be recruitment and retention of staff and a high volume of inquiries vs. a low volume of availability for psychiatric care. Current bed capacity at Cherokee MHI is 36 adult beds with 12 available beds prioritized for forensic patients. At Independence MHI, capacity remains at 20 adult beds and 36 child / adolescent beds. The MHI average length of stay continues to rise furthering the availability problem.

MHIs continue to experience a high volume of inquiries despite significant bed availability in the private sector. In addition, patients who need inpatient psychiatric care alongside additional support often spend a significant amount of time waiting in emergency rooms due to private sector hospitals denying admission.

Additional support needs of this cohort of higher complexity patients are varied and include those who need heightened supervision, such as those at risk of falls or elopement, individuals who need additional support with activities of daily living such as eating, mobility or hygiene and those who present heightened assaultive or aggressive behaviors that may be disruptive or dangerous to others.

Recruitment and retention, specifically with regards to nursing staff, are a focus as the MHIs attempt to address staffing shortages and try to stay competitive with the overall job market. Child / adolescent bed capacity remains a focus as HHS has seen this as a space with the most significant, ongoing need for additional capacity both in inpatient psychiatry and in residential care and treatment settings. The MHIs are also reviewing the forensic, or justice-related service needs to determine how and where this population can best be served.

State Resource Centers (SRCs)

On April 7, 2022, the Department announced the closure of the Glenwood Resource Center (GRC). The decision was based on a variety of factors including the inability of GRC to meet many of the U.S. Department of Justice (DOJ) requirements related to a looming consent decree. In addition, GRC continued to experience significant recruitment and retention problems for front line and clinical staff. GRC had a census of 152 at the time of the closure announcement. As of June 18, 2024, all GRC clients were transitioned into the community. The Woodward Resource Center (WRC) has a census of 126. The Department will continue to monitor GRC residents for at least one year after their moves to ensure a successful transition.

Areas of concern

Currently, there is little communication between the state facilities and community-based settings with most of it being during an individual's transition to or from the community. Cross-system data sharing would enhance and improve the linkages within the MHDS System. This could allow facilities to monitor and lend expertise to the course of treatment for individuals who've returned to community-based services and would help HHS system planners better determine the efficacy of services provided.

There is a need for additional resources to ensure positive outcomes for individuals. Residential community provider capacity, especially with expertise in individualized supports for patients with complex needs, should be increased. The lack of continuing supports for individuals with complex needs causes a recurrence of hospitalizations and repetitive cycle of treatment needs which prevents successful re-entry into the community. Intensive case management services are essential for long term management of symptoms and should be prioritized.

The nature of the work at the MHIs is changing due to serving individuals with progressively more acute or severe symptoms and behaviors, as well as the increase in admissions of persons who are also involved with the criminal justice system.

This shift presents challenges for retaining nursing staff because of the difficulty in serving these individuals and increased safety concerns. An increase of security staff has proven to be beneficial at Cherokee MHI and should be a model considered at Independence. Additionally, increased staff training is needed to ensure the team members are prepared to meet the changing needs and populations of individuals served by the MHIs safely and effectively.

Lastly, in addition to serving adults with serious complex needs, there is a need for increased specialization within the MHI and SRC institutions to meet the needs of highly complex, traumatized youth. This is primarily due to an increasing demand to serve both child welfare and justice involved youth at the MHIs and the SRCs. This increased need may also point to a need for improved upstream interventions including primary and secondary prevention and early intervention services such as stigma reduction, parenting classes, crisis and suicide prevention, long term recovery support and peer support groups. In addition, additional investment in community-based justice involved services and the development of alternative, community-based residential care options would help to ensure that youth are able to gain access to care prior to needing the high intensity intervention of an MHI or SRC.

Conclusion

As Iowa once again, initiates a dramatically different system of care in our state, the vision must always remain focused on the needs of Iowans. As we implement this new model, the Commission wants to ensure that all stakeholders' voices are heard, especially those impacted by mental health and disabilities. We must ensure access to care, adequate funding for service providers, address the workforce shortage, and ensure predictable resources so that services may continue, and new and innovative services may be supported.

The MHDS Commission members have been deeply invested in the work they were charged with ensuring services were consistent, encouraging stable funding, and focusing on the best interest of all Iowans. Our desire is for the HHS Council to continue working towards the best interests of all stakeholders. By doing so, Iowa will be able to continue to have high quality and innovative services and long-term stability for Iowans.

This report is respectfully submitted on behalf of the members of the Mental Health and Disability Services Commission.

Diane Brecht, Chair

Appendix A: MHDS Commission Membership List 2024

Member	Represents	City
Betsy Akin	Parent or Guardian of an Individual Residing at a State Resource Center	Corning
Diane Brecht, Chair	ID/DD Providers – Iowa Association of Community Providers	Central City
Linda Dettman	HHS Director's Nominee	Grimes
Mike Fidgeon	Substance Abuse Service Provider; Behavioral Health Association	Dubuque
Sue Gehling	Provider of Children's MHDD Services	Breda
June Klein-Bacon	Advocate – Brain Injury	Waterloo
Kellee McCrory	Service Advocate	West Branch
Kathy Norris	HHS Director's Nominee	Moville
Jack Seward, Co-Chari	County Supervisor	Washington
Terri Steinke	Parent of a Child Consumer	Urbandale
Dr. Kenneth Wayne	Veterans	Clive
Senator Jeff Edler	Senate Majority Leader (ex-officio)	State Center
Representative Megan Srinivas	House Minority Leader (ex-officio)	Des Moines
Senator Sarah Trone Garriott	Senate Minority Leader (ex-officio)	Windsor Heights