Iowa Department of Human Services

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Jerry R. Foxhoven
Director

November 30, 2018

Charles Smithson
Secretary of Senate
State Capitol Building
LOCAL

Carmine Boal
Chief Clerk of the House
State Capitol Building
LOCAL

Dear Ms. Boal and Mr. Smithson:

Enclosed please find copies of reports to the General Assembly relative to the Tertiary Care Psychiatric Hospitals Report.

This report was prepared pursuant to the directive contained in Iowa Acts Chapter 1056.18.

Please feel free to contact me if you need additional information.

Sincerely,

Mikki Stier
Deputy Director

Enclosure

cc: Kim Reynolds, Governor
Senator Amanda Ragan
Senator Mark Costello
Representative David Heaton
Representative Lisa Heddens
Legislative Service Agency
Kris Bell, Senate Democrat Caucus
Josh Bronsink, Senate Republican Caucus
Natalie Ginty, House Republican Caucus
Kelsey Thien, House Democrat Caucus

Iowa Department of Human Services

Tertiary Care Psychiatric Hospital Workgroup Recommendations

November 30, 2018

Introduction

Iowa Acts Chapter 1056, section 18 directs the Department of Human Services (DHS) and the Department of Inspections and Appeals (DIA), to convene a stakeholder workgroup to review the role tertiary care psychiatric hospitals have in the array of mental health services, establish the roles and responsibilities of tertiary care psychiatric hospitals, determine the viability of the mental health institutes becoming a tertiary care psychiatric hospital, examine potential sustainable funding, and determine admission criteria. The workgroup is to provide its recommendations to the Legislature and Governor by November 30, 2018.

Problem to be Solved

Some inpatient psychiatric hospital units have difficulty safely and effectively serving a small number of individuals with the most severe and challenging symptoms of mental illness. Safely serving this small number of children and adults (individuals) requires higher levels of specially trained staff and specially designed units. It is common for individuals with the most severe and challenging symptoms of mental illness to remain in the emergency departments for long periods of time waiting to be accepted by an inpatient psychiatric hospital unit. Iowa needs to designate an adequate number of inpatient psychiatric hospital units to safely and effectively meet the needs of children and adults with the most severe and challenging symptoms of mental illness. The Workgroup recommends that this service be referred to as psychiatric intensive care (PIC).

Solution

Iowa needs to designate, create, and fund an adequate amount of PIC hospital units to safely and effectively meet the needs of a relatively small number of individuals (children and adults) with the most severe and challenging symptoms of mental illness. This is needed in addition to ensuring the requirement of increasing and improving intensive community based services for individuals with severe complex needs in Iowa Acts Chapter 1056.

Recommendations

After comprehensive discussion and consideration the Workgroup recommends the following.

Requested Legislation

The Workgroup recommends that the 2019 Legislature direct the Department of Human Services and Department of Inspections and Appeals to develop rules that establish PIC units using recommendations of this report and have rules noticed by January 1, 2020.

Role and Responsibilities of PIC Hospital Units:
Within the current array of mental health services, PIC hospital units serve the role of providing the most intensive inpatient psychiatric hospitalization treatment and care an individual can receive. PIC hospital units serve individuals with the most acute and serious mental illnesses who are struggling to improve at a psychiatric hospital or who psychiatric hospitals believe they cannot safely or effectively serve.

PIC Characteristics:
The Workgroup recommends that a PIC should have the following minimum characteristics:

- An institutional commitment to deliver PIC services from administrator to direct care staff.
- An area that is specifically designed for function and safety.
- Skilled and specialized staff that can effectively care for and treat individuals with serious mental illness who meet admission criteria.
- An adequate number of staff to safely care for and treat individuals.
- The ability and willingness to provide longer term treatment than is typically provided, if necessary.
- The ability to appropriately utilize seclusion and restraint.
- The capability of providing evidence based practices and state of the art treatment.

Admission Criteria Guidelines:
Individuals served by PIC hospital units must have a serious mental illness and have a current, severe, imminent risk of serious harm to self or others as exemplified, but not limited to:

- Have complex comorbidities.
- A request for patient transfer has been rejected by inpatient level of care due to severity of symptoms.
- Is nonresponsive to typical intervention or is treatment refractory.

The Workgroup recommends that the rules written, in consultation with mental health field experts, for PIC inclusionary and exclusionary admission criteria to be precisely crafted based on the outline above to include only a small number of individuals with the most severe symptoms of mental illness that psychiatric hospital units cannot safely and effectively serve.

PICs should not be expected to serve individuals that have no treatable serious mental illness, including individuals who only have sexual offenses, have dementia with serious behavior issues, or other serious, non-psychiatric conditions and may need services similar to nursing facilities. The Workgroup notes that the legislature directed another workgroup to develop recommendations for individuals similar to these.

Referral Method:
The referring entity will contact the PIC with information pertaining to the patient's needs. The PIC hospital unit will determine appropriateness of individual to be served by a PIC hospital unit. The PIC hospital unit should respond as soon as possible to the referring person with the PIC's admission decision based on admission criteria, capacity and capability.

If the PIC hospital unit denies admission to the referred inpatient individual, the referring entity may request a reconsideration. This will be a provider-to-provider conversation. The referring entity's provider should provide additional information that indicates how the patient meets the PIC admission criteria. The PIC hospital unit must respond to the referring entity as soon as possible once the decision to accept or deny the patient has been made.

The Department of Human Services and the Department of Inspections and Appeals should develop rules relating to the referral method that complies with state and federal requirements, such as the Emergency Medical Treatment and Labor Act.

Viability of Mental Health Institutes as PIC Hospital:
The mental health institutes (MHIs) currently function similar to PICs and are potentially capable of becoming PIC hospital units. The following challenges must be addressed for MHIs to be effective PICs:

- Finding qualified candidates for staff can be difficult at times being located in a more rural area. Addressing this may require an increased amount of funding for staff to incentivize people to come work in rural area with individuals who have some of the most severe symptoms of mental illness.
- Due to the unit layouts, there is space limitation. With individuals with the most severe symptoms of mental illness, more space per patient would be needed to keep patients safe. This would mean opening up additional units, decreasing the number of patients served, or designating a certain number of beds as PIC beds.
- Currently the MHIs do not have any security staff. With the potential of increased dangerousness of patients, security staff may be needed. If security staff is needed, additional funding is required.
- The MHIs would need additional funding to meet emerging standards in order to provide state-of-the-art treatment and physical environment to best treat individuals with the most severe mental health symptoms that keeps them and others safe.

The MHIs cannot serve all patients needing PIC services at their current capacity. Therefore the Workgroup recommends implementing its recommendations to determine how many other psychiatric hospital units would be interested in becoming a PIC hospital unit. Community providers would experience similar challenges to the MHIs in moving to a PIC hospital unit. If there is lack of interest by community providers in becoming a PIC hospital unit, an alternative might be funding additional capacity of the

MHIs. Currently the MHIs and other community inpatient psychiatric hospital units are serving as de facto PIC units.

Sustainable Funding and Capacity:
Hospitals willing and able to serve the small number of individuals with the most severe and challenging symptoms of mental illness should be appropriately compensated for this additional work and expense.

The Workgroup recommends that the Legislature directs the Department of Human Services and the Iowa Hospital Association to jointly develop a recommendation for adequate Medicaid and MHDS Region reimbursement for PIC services and what additional resources MHIs need to meet PIC service requirements by March 1, 2019.

The Workgroup further recommends that the Department of Human Services reports to the Legislature the number of PIC units/beds that are needed and where PIC units/beds should be strategically located throughout the state. The Workgroup also recommends the Legislature directs the Department of Human Services to annually report on the sufficiency of the full array of intensive mental health services to the Legislature and Governor including PIC beds as well as to explore collecting data from emergency departments.

The Workgroup observes that many inpatient psychiatric hospital admissions are funded by private health insurance or Medicare. Lack of funding from these sources will hinder progress on the Workgroup's recommendations and shift a greater responsibility of funding on to other public payment sources such as Medicaid.

Current Array of Mental Health Services:
The current array of mental health services should be better utilized or enhanced. The Workgroup recommends:

- All services required by Iowa Acts Chapter 1056 needs to be fully implemented. The Workgroup observes that:
    - Mental Health and Disability Services Regions, in cooperation with the Medicaid managed care organizations, must develop, implement, and adequately fund all Iowa Acts Chapter 1056 services.
    - The Legislative study committee should review funding to ensure there are sufficient resources to develop, implement, and maintain the Iowa Acts Chapter 1056 services.
    - Successful implementation of newly required services in Iowa Acts Chapter 1056 is imperative to ensuring that individuals receive the appropriate level of care as well as reduce psychiatric hospitalization admissions and assist in timely psychiatric hospitalization discharges.
- Support implementation of the Children's System State Board's strategic plan.
- That the Iowa Psychiatric Society holds an initial symposium in 2019 that will help to further educate primary care and emergency room staff on the

management of psychiatric emergencies, treatment, and stabilization. This effort should be done in such a way that it can be sustained and repeated over time.

- Workforce issues in behavioral health must be addressed including, but not limited to, securing loan forgiveness and tuition grants for those dedicated in working in the mental health field such as those obtaining masters of social work, physician assistants, advanced registered nurse practitioners, physicians, and psychiatrists.
- Providers receive National Alliance on Mental Illness (NAMI) Provider Education to help increase quality of care and enhance empathy for individuals with mental illness and their families.
- That the inpatient psychiatric hospital bed tracking system is fully utilized by:
    - Providing on-going training for hospitals and emergency departments in using the system.
    - Add a category in the bed tracking system that identifies PIC hospital unit beds.

Overcoming Forensic Barriers:

The Workgroup identified forensic patients as those who have been charged with a crime and are:

- Being evaluated to determine competency to stand trial;
- Found incompetent to stand trial and have been ordered to receive competency restoration treatment; or
- Found not guilty by reason of insanity and have been ordered to receive mental health treatment.

Typically these forensic patients are served by the Department of Corrections at Oakdale or the MHIs at Independence and Cherokee. Except for competency evaluations, treatment for forensic patients tends to be for a considerably longer length of time than for non-forensic patients.

The Workgroup recommends the following to address serving forensic patients who have been charged with a crime and are in need of a competency evaluation, competency restoration, or been found not guilty by reason of insanity:

- Encourage intense, structured community services to serve individuals with mental illness that have committed violent crimes when the individual can be safely served in the community.
- Recognize a small number of individuals may be served long term at the MHIs or Department of Corrections due to level of dangerousness.
    - Serving these individuals in MHIs long term effectively reduces the available space for other individuals with severe mental illnesses.
    - Serving forensic patients at the Department of Corrections long term reduces the bed availability for new 812 cases (evaluation and restoration to competency). Some of these individuals may be found not guilty by

reason of insanity, have violent histories and will need longer term treatment.

- If timeliness of competency evaluations becomes an issue, increased resources to provide adequate reimbursement should be provided for community providers to complete competency evaluations where the individual is at (e.g., jail or community). Encourage exploring alternatives for competency restoration evaluations and treatment.

It should be noted that the Workgroup identified the need for enhanced communication among the individual being charged, attorneys, courts, jails, providers, and others to prevent confusion and misunderstandings that occur frequently when serving forensic patients.

Appendix A: Tertiary Care Psychiatric Hospital Workgroup [alpha order]

Name	Agency
Patrice Fagen: Co-chair	Department of Inspections and Appeals
Rick Shults: Co-chair	Department of Human Services
Jackie Bailey	Mental Health Advocates
Kevin Carroll	Iowa Hospital Association- UnityPoint
Kermit Dahlen	Iowa Behavioral Health Association- Jackson Recovery
Bhasker Dave	Mental Health Institute- Independence
Jerome Greenfield	Department of Corrections
Peggy Huppert	National Alliance on Mental Illness-Iowa
Steve Johnson	Iowa Hospital Association - Broadlawns
Kevin Kincaid	Iowa Hospital Association- Knoxville
Kelley Pennington	Amerigroup
Jodi Tate	University of Iowa
Mary Thompson	Mercy
Kim Wilson	MHDS Region
Don Woodhouse	United Healthcare