County Rural Offices of Social Services MHDS Region

Regional Mental Health and Disabilities Services Community Services Plan

By

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FY18 Community Services Plan Overview

The 2017 Legislative session passed Senate File 504 which instructs MHDS Regions:

- To convene a Stakeholder Workgroup comprised of representatives from hospitals, the judicial system, law enforcement agencies, managed care organizations, mental health providers, crisis service providers, substance abuse providers, the national alliance on mental illness, and other entities, as appropriate, to meet on a regular basis effective 7/1/17. The desired outcome of this Workgroup is to create collaborative policies and processes relating to the delivery of, access to, and continuity of services and supports for individuals with mental health, disability, and substance use disorder needs;
- To review funding resources currently available (including but not limited to regional fund balances, Title XIX, and other funding sources) and to partner with other regions to provide needed services and supports to individuals with mental health, disability, and substance use disorder needs; and
- To identify the following Community Services Plan components
    - Planning and Implementation Timeframes and Assessment Tools for determining the effectiveness of the plan in achieving the Department's identified outcomes for success
    - Financial Strategies to support the plan

A. Stakeholder Workgroups

Mental health crises are costly in human, medical and financial terms. To be more effective, we need to work together. Mental health crises involve many players. A crisis may begin in a community home, involving direct support providers, managers and case workers; bring in law enforcement or crisis service specialists; and be routed to jail, an emergency room or a crisis observation center. Insurance, regional decision-makers, or community-based providers may influence that path. All these professionals play their part.

On June 28, 2017, Mental Health and Disability Service (MHDS) Regions and the Iowa Law Enforcement Academy (ILEA) hosted a Crisis Prevention & Mental Health Summit Roundtable. We brought together a broad variety of professionals who don't usually get to talk to each other to begin discussing and brainstorming ideas for improvement. We identified our goal as: Iowans with behavioral needs will be supported in their community from a public health not a public safety perspective. Collaboration was a common theme in our discussions:

- **Resource Collaborations - Training** (develop common language across stakeholder groups)
    - Mental Health First Aid (Family, Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
    - Crisis Intervention Training (Community Providers – information/support, Regions, MCOs, Law Enforcement)
    - C3 De-Escalation (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
    - Trauma Informed Care (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
    - Co-Occurring (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
    - SAMHSA Emails (Community Providers, Regions, MCOs, Law Enforcement, Hospitals)
    - Police & MH Toolkit (Community Providers, Regions, MCOs, Law Enforcement)

- **Resource Collaborations – Community Supports** (continuing to build community capacity)
  - Tele Psychiatry
  - Mobile Crisis Response Teams/MH Assessment
  - Jail Diversion/Re-Entry
  - Open Bed Tracking System
    - Crisis Stabilization
    - Crisis Observation
    - Transition Homes
    - Sub-Acute Supports
    - Substance Abuse Services

CROSS MHDS Region Backstory

The County Rural Offices of Social Services MHDS Region, CROSS, submitted a letter of intent to form a rural county region to Director Palmer on March 4,2013. January 27, 2014 The Region's 28E Agreement was approved and on June 30, 2014 the Regional Management Transition Plan was approved. CROSS began operating as a Mental Health Region July 1,2014. CROSS was initially comprised of six-member counties, on November 2015 CROSS was joined by Marion County to constitute the current seven-member county Region. Our seven-member counties came together because of our shared vision and goals for our rural county residents. We believe strongly that rural residents should be able to access services where they live, that delivery of care and supports is best provided in a person's home or as close to family as possible. As individual counties and now as a region we try to maximize funding through a blending of Medicaid dollars, county property tax dollars/regional dollars and collaborations with other regions and providers. Through the creation of services and financing local services we are supporting the local rural economy and creating much needed jobs.

The CROSS Regional Board set core guiding principles and values in serving individuals with disabilities for access to services and supports that are individually oriented, personal and family driven, recovery/resiliency oriented, trauma informed, culturally competent and multi-occurring capable. These core values are pinned by the underlying principles that all individuals with disabilities have a basic right to be productive citizens in the communities they call home with the same rights, privileges, opportunities, and responsibilities as other citizens. Services must be delivered with these core principles in mind, developed with the individual in a way that balances the needs, goals and desires of the individual within the budgetary constraints of the Region.

Since 2015 the Region has initiated and provided funding in full or part for the following services and evidenced based practices:

Crisis Services

- 24-hour Crisis Call Line through Foundation 2
- Tele-psychiatry, crisis evaluation and assessment and bed finding for each of the eight hospitals in our Region through Integrated Telehealth Partners.
- Crisis Residential Services through contractual collaboration with Heart of Iowa Region.

Evidenced Based Practices:

- Assertive Community Treatment (ACT) Program is the first rural ACT team in Iowa.
  - Assertive Community Treatment is an evidence-based practice. ACT provides an integrated set of other evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings.
- Permanent Supportive Housing is an evidence based practice that is being implemented through the ACT team to support the individuals associated with the ACT program. Supportive housing combines safe affordable housing with supportive services that help people who face the most complex challenges to live with stability.
- Integrated Treatment for Co-Occurring Disorders is another Evidenced Based Practice (EBP) that is being implemented in the Region through the Community Health Centers of Southern Iowa. This EBP provides for combined treatment for mental illness and substance abuse through the same therapist and team.

Jails/Law Enforcement

- Jail mental health services: The Region provides tele-psychiatry for four of the six jails in our region through ITP. The two jails not using ITP currently had and continue to have services through Advanced Correctional Health Care.
- Central Iowa Juvenile Detention transportation services for mental health committal and voluntary admissions to crisis residential services.
- CIT – Crisis Intervention Training: The Region has paid for a Sheriff, deputy and two local police officers to attend CIT training and keeps the offer open to all Sheriff departments.
- Mental Health First Aid: The Region provides free trainings to the public, providers, law enforcement on a continual basis.
- Stepping Up Initiative (a national initiative to reduce the number of people with mental illness in jails). All seven counties have passed resolutions to be a part of the initiative. Through this initiative CROSS Region disability coordinators are in the process of implementing a Re-entry program. Member Counties will be sending teams to participate in the Iowa Stepping Up summit being held October 2017. This is a county and region collaboration.

Trainings

- Cline and Minkoff, co-occurring complex needs training for providers.
- 5 Star Quality training for providers
- Trauma informed Care for providers
- NAMI classes: The Region collaborated with South Central Behavioral Health and Southern Hills Regional Mental Health Regions to provide Family to Family and Basic Training to individuals from the regions. CROSS is actively developing a NAMI chapter in Marion County.
- C3 De-escalation for providers
- Mental Health First Aid for the public, churches, schools, law enforcement, hospital and homecare staff.

Collaborations
CROSS has entered into collaborations with numerous Regions to expand services and capacity while reducing costs.

- County Social Services Region utilizing their I-Start team to work with a complex needs individual. I-START is a treatment model serving people diagnosed with intellectual/developmental disabilities and co-occurring behavioral health conditions. This model of service supports and optimized independence, treatment, and community living for individuals with ID and behavioral health needs.
- Heart of Iowa Region – Crisis Residential Services
- Polk Region – C3 De-escalation training, Value Based Contracting
- NAMI Trainings with Southern Hills Region and Southern Behavioral Health Region

CROSS 504 WORK GROUPS

Cross Mental Health Region invited representatives from all providers of services and resources and Managed Care Organizations that work with and support individuals with mental health disabilities and substance abuse disorders to a convening on July 19, 2017. This action was in response to the legislative directive within Senate File 504. The purpose of the meeting was to engage in a facilitated discussion about clarifying what exists to support individuals with complex mental health disabilities and substance abuse disorders and then explore new processes and collaborative efforts to strengthen the overall system. The invitees were sent materials to review to aid the process. (2014 report “Community Integration Workgroup For Adults with Serious Mental Illness Final Report”, 2016 report “Health and Disability Services Redesign Progress Report”, 2017 report “Recommended Changes to Iowa’s Mental Health System for Individuals with Complex Needs”, “Community Integration Project Placement Handbook” Kansas, and I-START presentation to the smaller workgroup.) (See Appendix A for a list of invitees. See Appendix B for a list of attendees.)

The group members created a comprehensive list of what is available for this sub-set of individuals with complex mental health disabilities and substance abuse disorders throughout the region. The listing of available services and resources follows; however, it is important to clarify that the listed resources and services are not necessarily accessible to all individuals throughout the region and some have a waiting list.

What services exist?

- Counseling
- Psychiatry
- School-based mental health
- Behavioral health intervention
- Parent, child interaction, parenting
- Work place services – employee assistance programs
- Substance abuse counseling
- Hospitalization
- Crisis Residential Services - contractual
- Federally Qualified Community Health Centers
- Integrated Health Home Services
- Assertive Community Treatment (ACT)
- Jail diversion -Re-entry program
- OWI classes
- Anger management
- Residential services (ICF – waiver services)
- Community-based employment services
- Primary Care physicians who can prescribe
- Court Advocates
- Home and Community Based Services
- Care coordination (non-Medicaid or uninsured)
- 24-hour crisis line

The facilitators focused the next part of the discussion on the topic regarding existing funding and brainstorming avenues of the potential to tap unconventional funding. Participants reported that traditional sources to cover the cost of delivering services were private pay insurance, Medicaid, Medicare, employer-based services, and the counties' levy dollars. Noted was the one-time funding of $3.2 million region (county property tax / levy) dollars.

There is concern about service providers being able to sustain operations financially, especially given that the current reimbursements rates are not covering the costs of service delivery. The proposal for assigning stagnant 'tiers' with an associated reimbursable set of services is also detrimental to the financial sustainability of service providers. Mental health disabilities symptoms are often dynamic and can fluctuate dramatically. The services needed on any given day may quickly change on the next day with no time for reassessment for permission to move that individual to a tier that allows reimbursement for those additional services. A stressed system of non-profit service providers has already felt direct impacts in their ability to function and the group was in a consensus agreement that the region will experience an increase in closures of service providers.

The group members had discussion on possible grants from public and private sources that included Department of Justice, Veterans Affairs, Department of Human Service's De-categorization and gambling money within community foundations. Group members agreed that grants do not generally fund operational overhead and are not a reliable source for ongoing sustainability.

Group members named the barriers and obstacles they experience. The created list follows.

What are your barriers and obstacles?

- Gaps in funding
- Transportation
- Beds
- Facility closures
- Lack of substance abuse support
- Rates don't support costs
- Individuals have inconsistent advocacy team
- Staff shortages
- No residential beds available for people with co-occurring disabilities
- Providers reluctant (or won't) take individuals co-existing conditions & violent behaviors
- State hospitals won't accept individuals with co-existing conditions & violent behaviors
- Three-day hospital stays not enough
- Poor substance abuse system
- No triage system – de-escalation training needed
- Trauma-sensitive training/approach
- Placement issues
- IA code outdated and not current with evidence-based outcomes now required
- Lack of qualified professionals (esp. in rural areas)
- Legislative funding decreases

The group concluded the meeting with a discussion about other partners or regions with which they might work to sustain and increase services to individuals with complex mental health disabilities and substance abuse disorders. The list follows.

- Schools – colleges and universities
- Entities for loan repayments to incentivize mental health professionals to practice
- Iowa Area Development Group – develop an incentive program for new mental health professionals
- Department of Human Services and Iowa Medicaid Enterprise
- Iowa Department of Public Health Partners/Collaborators continued
- Vocational ReHab

A smaller working group of volunteers from the large group formed the Cross Mental Health Region 504 work group to develop strategies for an overall plan for the region that will increase the capacity for everyone who engages with individuals who have complex mental health, intellectual disability and/or substance abuse. Please see Appendix C for a list of the participants. The large group will reconvene once the plan is prepared so that everyone is aware of the strategies implemented and resources available.

The small 504 Work Group met in afternoon session on August 18 and 25th, and September 5 and 20th, 2017. While everyone utilizing mental health services and interacting with them will benefit from the strategic plan, the 504 Work Group focused on the most challenging sub-set of consumers who are those with complex mental health disabilities, intellectual disabilities and substance abuse disorders.

It first analyzed how the system currently handles a consumer presenting in crisis at an Emergency Department (ED) to inpatient care, to discharge and follow-up. The group discussed what changes were possible for transitioning care in the areas of communication and additional services. It determined what it had influence and control of and set aside what it identified as issues 'bigger than the region'.

1) The lack of safe and affordable housing requires state, city, local municipalities, and federal funds to address this larger issue.

   The Region provides short term rent subsidy and a capped permanent supportive housing program in conjunction with the Assertive Community Treatment Team; this barely scratches the surface of housing needs for individuals with disabilities. Apartment complexes and low-income family homes are needed especially in rural Iowa coupled with permanent supportive housing programs.

2) The lack of inpatient beds for complex needs individuals.
   Anecdotal information provided by the work group participants regarding inpatient availability for individuals who exhibit, or have historically exhibited, violent behaviors have almost no options for placement. State hospitals and some private providers have refused admitting a patient with violent behaviors citing liability issues, a lack of staff trained to manage this sub-set of consumers, the individual has an intellectual disability in addition to a mental illness but they do not work with the intellectually disabled, and the ward environment is not appropriate for the client are a few of the common reasons given.

According to the Treatment Advocacy Center, Iowa has 64 state hospital beds, down from 149 in 2010. If one of the 64 public beds happen to be open for an allowable admission of a consumer, it may or may not be an appropriate placement based on considerations such as gender or age, for example.

A minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. Like every state, Iowa fails to meet this minimum standard.

Beds in 2016	Beds in 2010	Beds lost or gained	Beds per 100,000 people	Census of forensic patients	% of all beds occupied forensic	State ranking in beds per capita
64	149	-85	2.0	38	59.4	51

(SOURCE: GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELMINATING STATE PSYCHIATRIC BEDS, Treatment Advocacy Center, 2016)

3) Medicaid funding tiers for complex needs individuals (Do not cover the fluctuating needs and costs of independent living requirements /24-hour staffing).
   Providers of home and community based services and Integrated Health Homes voiced much concern about the viability of provider services. Providers voiced concern over accepting an individual with high/complex needs, recertify funding every 30 days (requiring copious paperwork), and funding is frequently reduced to a lower tier after a few months but 24-hour services are still required. Providers are doing feasibility studies to determine if they will stop providing 24-hour home and community based services, limiting their service to hourly only. If this occurs a real gap in services will be created, individuals needing 24 hours services will no longer be able to access them in a community setting.

4) A lack of qualified mental health professionals within the workforce complicates the housing placement issue as well as the overall delivery of bundled services necessary for this sub-set. Possible reasons thought for the shortage may be due to low wage rates, job stress and workloads. Workforce development is bigger than the region, but putting mechanisms in place to incentivize mental health career professionals throughout the state may be a solution.

5) Mental health professionals must work within a medical model and its definition of 'recovery', but it does not necessarily directly translate. In a medical model, one is ill, is treated and cycles out of fluctuating medical services. There is an eventual prognosis for whether the patient returns to baseline or what the new baseline of health and ongoing medical services will require. Recovery for someone with mental illness looks very different, especially in this sub-set. We cannot categorize by illness and injury to standardize and define recovery as a medical model does. The functionality within a level of stabilization is unique to that individual and the need for services around that individual regarding psychological and behavioral therapy and medication will fluctuate. A broader discussion is necessary about what a 'mental health model' for services and reimbursements is that can better meet the actual needs of individuals with mental health disabilities and substance abuse disorders.

Small workgroup's strategic plan focused on filling the gaps in the continuum of care for people with complex mental health, intellectual disabilities and substance abuse disorders by building capacity for service providers. The strategies include crisis prevention, crisis stabilization and de-escalation options, access to experienced support professionals, improving communication channels and training opportunities.

B. Statewide Strategic Direction

Statewide Strategic Direction
The Department of Human Services released a report on February 22, 2017 which identifies two problem areas with Iowa's Mental Health System for Individuals with complex needs. The passage of Senate File 504 legislatively mandates the Mental Health and Disability Service Regions to identify strategies to address these issues as follows: **Problem #1:** The absence of a community plan and a fragmented approach in serving individuals, particularly those with complex needs. Appropriate services for individuals with complex needs need to be readily available statewide. To achieve this, the Regions will work with stakeholders and various funders to build the service continuum and ensure people receive continuity of care through a collaborative, community-based approach. **Goal:** Engage the community and develop implementation plans and processes to handle complex cases. **Problem #2:** There is a gap in care for patients with complex needs due to an incomplete service continuum and lack of continuity of care (case management and integrated health homes). Individuals are stuck at a higher level of care due to lack of services and a lack of provider willing to accept patients with complex needs. Through the Mental Health and Disability Service Redesign, Regions have been tasked with building a service system that closes the service gaps through the development of Evidenced Based Practices, Core Services and Additional Core Services as funding is available. Building the service continuum is imperative for individuals with complex needs to be discharged from higher levels of care than is necessary and works towards individuals receiving appropriate services. **Goal:** Build the service continuum and increase the continuity of care by having MHDS regions utilize current resources and braiding funds to build a comprehensive, full array of services.

C. Regional Strategies to show improvements in the Outcomes for Success as identified by the Department of Human Services

The four measurements for success identified by DHS are:

1. The number of individuals who are in the emergency department over 24 hours because mental health, disability, or substance use disorder services are not available.
2. The number of individuals who are psychiatrically hospitalized 24 hours beyond the hospital determining them ready for discharge because community based mental health, disability, or substance use disorder services are not available.
3. The number of individuals with a mental illness, intellectual disability, or substance use disorder who could have been diverted or released from jail if appropriate community based services had been available.
4. The number of individuals involuntarily discharged from their community based mental health, disability or substance use disorder provider without a new community based provider in place. This includes, individuals discharged to jail, homelessness, or hospital that are not returning to services with their current provider.

CROSS Region Strategic Plan Components: Description and Rationale:

The CROSS strategy to address individuals with complex needs and desired outcomes is a two-prong approach.

First Prong, development of crisis services within our Region: Mobile Crisis Teams and a Crisis Stabilization Center.

Crisis Stabilization Center (CSC)

The CSC will be a soothing calm atmosphere where well trained professional behavioral health staff will evaluate, assess, medically clear and find placement for individuals who need inpatient care. Those individuals who do not require acute inpatient care but will benefit from a lower level of care will be able to utilize the Center's other services which will include: 7 sub-acute beds, residential crisis beds, 23-hour observation, sobering center and peer support counseling.

The Center will be linked with our crisis hot line, mobile crisis teams, I-START and ACT. This will allow law enforcement to drop off anyone with a mental health crisis to the Center and then return to their communities. Central Iowa Juvenile Detention Center will be a transportation option to the inpatient facility if that level of care is needed.

CICS (Central Iowa Community Services Region) is willing to partner with CROSS by providing 2 sub-acute slots, additional startup dollars and referrals from Madison, Warren, Jasper, Poweshiek. MHDS of East Central Region is partnering to provide 3 sub-acute slots and will have access to the center for overflow needs. South Central Behavioral Health is willing to subcontract for services to meet overflow needs. Pine Rest will be the developer and provide ongoing management. Pine Rest is applying for a Federal Grant to help with development and equipment costs. CROSS is providing 3.1 million dollars and 2 sub-acute slots.

Sustainability will reside in braided funding. Fee for service payments from (MCOs) Medicaid, Private 3rd Party, and Regions funding eligible individual clients. In addition to funding sustainability requires referrals, by partnering with other regions the number of referrals will remain a consistent and at a level to meet costs. Having a robust mobile crisis team appropriately triaging and referring individuals to the crisis stabilization center instead of a hospital emergency room will improve the Center's utilization and appropriate care for those utilizing crisis services.

The center's sub-acute and crisis residential beds will provide HCBS service providers who may be dealing with an individual with ongoing behavioral challenges a respite. The individual can be moved to the Center for a short-term stay giving the Center, provider staff and I-START team an opportunity to develop a person centered behavioral plan and develop de-escalating strategies. This strategy is aimed at extending a provider's ability to continue services and encourage others to accept individuals with complex needs. The I-START coordinator will follow the client back into the provider setting to observe and train direct care staff on site to properly implement the individual's behavioral plan, make plan changes as appropriate with input from the I-START team. The I-START coordinator and team will follow the client for 12-18 months and provide 24-hour accessibility.

The Crisis Stabilization Center will impact all four indicators.

Indicator 1 – Reduce or eliminate emergency room utilization for mental health assessments and in-patient placements. Reduce the number of inpatient admissions by offering other and more appropriate levels of care.

Indicator 2- Sub-Acute beds and crisis residential beds offer step down placement for individuals from inpatient care. Those with challenging behaviors will be assessed for I-START or ACT for long term services.

Indicator 3- The Center's Crisis Residential Beds will offer additional placement opportunities as the ACT, I-START, and the Region's Re-entry Program coordinators develop person centered plans and sustained placement.

Indicator 4- Providers will be able to access sub-acute for clients, receive specialty support through I-START or refer to ACT.   The specialty supports will increase staff competency working with the individual, behavioral plans will reduce the frequency of behaviors greatly reducing or eliminating the need for involuntary discharge.

Mobile Crisis:

Mobile Crisis provides integrated, short-term crisis response, stabilization and intervention for adults and children experiencing a mental health or chemical dependency crisis. The Team goes to where the individual is located. If the crisis cannot be resolved in the field the individual will be sent to the Crisis Stabilization Center for further evaluation and treatment. CHCSI (Community Health Center of Southern Iowa) will take the lead at mobile crisis development. Planning will begin this fiscal year and implement in 2019. Sustainability will be achieved with funding support through Medicaid (MCO) funding. This service is one of the crisis services awaiting finalization on billing code modifiers and rates which should be in place by the end of 2018.

Mobile Crisis will impact all four indicators.

Indicator 1- Mobile Crisis will reduce the number of individuals presenting for mental health evaluation and treatment at the emergency department. Individuals being managed by the team will be referred to the appropriate community services and followed up by the team next day to assure the individual follows through with referrals or if further intervention is needed. Individuals needing more care than the mobile crisis team can provide will be taken to the Crisis Stabilization Center.

Indicator -2 & 4 Mobile Crisis responding to situations at a habilitation or waiver home will evaluate the individual, try to de-escalate the situation and where appropriate refer to the I-START, ACT, or Crisis Stabilization Center. Having this form of intervention early in the escalation process will assist the provider with increasing staff competency working with the individual, reduce reoccurrences and supporting the provider in accepting the client back into services in addition to decreasing inpatient referrals.

Indicator 3- Mobile Crisis is a part of the intercept one model for jail diversion. Mobile crisis works closely with local law enforcement, identifying behavioral health disorders in the field, de-escalating behaviors and diverting individuals to treatment instead of incarceration if illegal activity has not occurred.

Second Prong, is aimed at the provider level with I-START and C3 De-escalation training.

I-START

I-START is a nationally recognized program model since 1988. I-START (Iowa, Systemic, Therapeutic, Assessment, Resources & Treatment) was started in 1988 by Dr. Joan Beasley and her team to provide community-based crisis intervention and prevention service for individuals with intellectual and developmental disabilities (IDD) and mental health needs. I-START is a comprehensive model of service supports that optimizes independence, treatment, and community living for individuals with IDD and behavioral health needs.

I-START provides prevention and intervention services to individuals with intellectual/developmental disabilities and complex behavioral needs through crisis response, training and consultation. The goal is to create a support network that can respond to crisis needs at the community level. Providing community based, person centered supports that enable an individual to remain in their home or community placement is the priority. Working closely with providers, families and the community I-START provides individualized training to staff, family and community supports working with an individual with complex needs. The one on one training and observation is focused around an individualized behavioral and crisis plan. This approach has proven to reduce behaviors, institutional placement, and provider involuntary discharges.

I-START is not currently reimbursable through Medicaid or other funders. This service will receive ongoing funding by the region until other funding mechanisms develop. I-START will directly or indirectly impact all four indicators by increasing staff effectiveness, reducing behaviors that require inpatient treatment or law enforcement involvement.

C3 De-escalation

C3 De-escalation is a practice aimed at providers, community, law enforcement, schools, families and anyone who touches the life of an individual with complex needs or in mental health crisis. C3 can be used to 1) de-escalate clients. 2) de-escalate themselves (staff, law enforcement, etc.) 3) teach clients to de-escalate themselves, within their abilities. The training provides innovative, practical techniques that works with brain

function to calm aggressive or distraught individuals. It is appropriate for use with people with severe and persistent mental health disorders, substance use disorders, co-occurring disorders, or intellectual disabilities.

Our plan will be to participate with seven other regions in a pilot of training trainers in the techniques so they in turn can train others in the technique, provide support and feedback. This approach will impact indicators 1 thru 4 by decreasing critical incidents (injuries, hospitalization and incarceration).

CROSS Published Resource Directory

Additional support to medical personnel and law enforcement will also come in the form of a directory detailing mental health providers and services in the region.

Service Identification Card and Business Associate Agreements

To expedite and ensure appropriate placement and treatment the development of a social history and medication card will be created for use by the individual and service providers to submit to mental health professionals, medical professionals and emergency response teams. This will greatly improve the ability of all involved personnel to prescribe the right form of treatment and referral for the individual. Second, an expanded use of Business Associate Agreements (BAA) would substantially improve the ability of the CROSS region to speed up the referral process, make it easier to collect and retrieve data, provide more appropriate placement services (e.g. use of history/medication card) and to increase interpersonal interaction with the individual (e.g. de-escalation).

Coordination Meetings

CROSS MHDS service coordinators, Integrated Health Home coordinators and representatives of the Managed Care Organizations will meet monthly to discuss shared clients' needs to be more pro-active in problem solving and responding to each client's needs. The group will monitor progress, problem solve and look for possible improvement for MHDS products and services.

Desired Outcome for Success: The number of individuals who are in the emergency department over 24 hours because mental health, disability, or substance use disorder services are not available.			
Regional Strategy #1 Reduce visits to ED by complex mental health needs individuals **Regional Strategy #2 Improve the capacity of providers to work with complex mental health needs individuals for sustainable placement options.**	**Anticipated Completion Date**	**Projected Cost**	**Funders**
C3 de-escalation training (Strategy # 2)	6/30/2018	$8,714	CROSS MHDS Region
I-START (Strategy #2)	6/30/2018	$139,000	CROSS MHDS Region through contractual relationship with County Social Services Region
Monthly coordination between MCO's, IHH, and Regional CEO to pro-actively brainstorm and coordinate the ongoing needs of clients identified in the system with complex mental health disabilities to reduce crisis events. (Strategy #2)	3/31/2018	$0 (High staff time)	CROSS MHDS Region, MCOs/Medicaid, IHHs-(Community Health Centers of Southern Iowa, Crossroads, Capstone) HCBS providers
Mobile Crisis Unit (Strategy #1)	6/30/2019	$250,000	CROSS MHDS Region, Medicaid fee for service through MCOs/Medicaid for sustainability.
Crisis Stabilization Center (Sub-acute, Crisis Residential, 23-hour observation, Peer Counseling) (Strategy #1)	6/30/2020	$2,800,000 $ 600,000	CROSS MHDS, Central Iowa Community Services, Pine Rest ($600,000 grant) Contract with South Central Behavioral Health Region for overflow coverage, MHDS of East Central Region for overflow needs, Medicaid fee for service through MCOs and 3rd party payors for sustainability.

Desired Outcome for Success: The number of individuals who are psychiatrically hospitalized 24 hours beyond the hospital determining them ready for discharge because community based mental health, disability, or substance use disorder services are not available.			
Regional Strategy #3 Reduce admissions to inpatient facilities to more appropriate level of care. **Regional Strategy #2 Improve the capacity of providers to work with complex needs individuals for sustainable placement options.**	**Anticipated Completion Date**	**Projected Cost**	**Funders**
C3 de-escalation training (Strategy #2)	See above	See above	See above
I-START (Strategy #2)	See above	See above	See above
Monthly coordination between MCO's, IHH, and Regional CEO to pro-actively brainstorm and coordinate the ongoing needs of clients identified in the system with complex mental health disabilities to reduce crisis events. (Strategy #2)	See above	See above	See above
Crisis Stabilization Center (Sub-acute, Crisis Residential, 23-hour observation, Peer Counseling) (Strategy #3)	See above	See above	See above

Desired Outcome for Success: The number of individuals with a mental illness, intellectual disability, or substance use disorder who the local or county police department report could have been diverted or released from jail if appropriate community based services were available.			
Regional Strategy #4 Reduce the number of incarcerations of individuals with complex needs.	**Anticipated Completion Date**	**Projected Cost**	**Funders**
Mobile Crisis Unit	See above	See above	See above
I-START	See above	See above	See above
C3 De-escalation Training	See above	See above	See above
Crisis Stabilization Center (Sub-acute, Crisis Residential, 23-hour observation, Peer Counseling)	See above	See above	See above

Desired Outcome for Success: The number of individuals involuntarily discharged from their community based mental health, disability, or substance use disorder provider without a new community based provider in place. This includes, individuals discharged to jail, homelessness, or hospital that are not returning to services with their current provider.			
Regional Strategy #5 Stabilization of individual prior to behavioral escalation leading to involuntary discharge. **Regional Strategy #2 Improve the capacity of providers to work with complex needs individuals for sustainable placement options.**	**Anticipated Completion Date**	**Projected Cost**	**Funders**
C3 de-escalation training (Strategy #2)	See above	See above	See above
I-START (Strategy #2 and #5)	See above	See above	See above
Monthly coordination between MCO's, IHH, and CROSS Region CEO to pro-actively brainstorm and coordinate the ongoing needs of clients identified in the system with complex mental health disabilities to prevent crisis events. (Strategy #2)	See above	See above	See above
Crisis Stabilization Center (Sub-acute, Crisis Residential, 23-hour observation, Peer Counseling) (Strategy #5) In addition, the Region is exploring joining with County Social Services (CSS) Region to develop a START Resource Center. The center will provide short-term emergency and planned respite for individuals receiving services from the I-START team.	See above	See above	See above

Data Collection

The Regions have developed data collection tools to be used uniformly throughout all the regions. The CROSS region will have data collected from all hospitals within the region through ITP, data collection from the jails and providers will be gathered by the disability service coordinator in each member county monthly.

D. Plan for Regional Fund Balance Spend Down

The Region has identified $3.2 million for fund balance spend down.

List new service investments with time frames for implementation.	Projected Costs	Collaborations	Contribution to Project
Create Mobile Crisis	$ 250,000	CROSS MHDS, Community Health Centers of Southern Iowa	CROSS - $250,000 Program Development and management
Crisis Stabilization Center (Sub-acute, Crisis Residential, 23-hour observation, Peer Counseling)	$ 2,800,000	CROSS MHDS, Pine Rest, CICS Region	CROSS - $3,100,000 Pine Rest – $600,000 – Program Development and management CICS-$
Medical Card for use by providers and patients, Regional Directory	$ 500	CROSS MHDS	CROSS MHDS
C3 De-escalation train the trainer training	$ 8,714	CROSS MHDS	CROSS MHDS
I-START	$ 139,000	CROSS MHDS	CROSS MHDS – contractual relationship with CSS Region.
Total Expenditure	$ 3,199,714		

Projected Fund Balance Information:

504 Fiscal Projections with no additional growth or cost of living allocations

	Fy17	FY18	FY19	FY20	FY21	FY22	FY23
Region Tax Revenues	$3,243,087	$2,873,816	$2,873,816	$2,873,816	$2,873,816	$2,873,816	$2,873,816
Region Expenditures	$2,816,843	$3,133,632	$5,333,632	$4,849,527	$2,873,816	$2,873,816	$2,873,816
Beginning Fund Balance	$4,945,471	$5,410,797	$5,150,981	$2,691,165	$715,454	$715,454	$715,454
Region Ending Fund Balance	$5,410,797	$5,150,981	$2,691,165	$715,454	$715,454	$715,454	$715,454
Fund Balance less encumbrance		$1,950,981	$1,691,165	$715,454	$715,454	$715,454	$715,454
ENCUMBRANCE		$3,200,000	$1,000,000	$0	$0	$0	$0

All member counties except for Marion County are levying at 100% of their new 504 max levy amount. Marion County chose not to increase their levy to the new 504 regional rate of $39.13 per capita. All projections are calculated on Marion County remaining at $32.74 per capita, $6.39 per capita, below the regional rate. Since CROSS is nearly at its maximum levying amount there are no dollars for growth or service expansion after FY2020. Should service demand exceed the tax levy dollars the region will reduce or eliminate non-core services and if necessary initiate a waiting list.

Property Tax Savings

The following chart illustrates the realized property tax savings from CROSS member counties since FY2013 when regions began to transition and the new property tax rates for FY2018. Mental Health funding has been reduced and property owners have realized a total property tax reduction of $397,764.

CROSS Region

Property Tax Levy Reduction from old Max Levy FY 2013 to new Fy18 Actual Levy

County	FY13 Old Max Levy	FY18 Actual Levy	Difference
Clarke	$430,599	$362,325	-$68,274
Decatur	$321,858	$321,667	-$191
Lucas	$441,861	$339,746	-$102,115
Marion	$1,140,803	$1,089,896	-$50,907
Monroe	$340,278	$312,001	-$28,277
Ringgold	$342,082	$198,322	-$143,760
Wayne	$254,099	$249,859	-$4,240
Total reduction in property tax since Regionalization			-$397,764

Appendix A

CROSS Regional Workgroup Invited Participants
Large Group

Agency	First Name	Last Name
Clarke County Hospital	Erin	Dykes
Decatur County Hospital	Greg	Boattenhamer
Decatur County Hospital	Andi	Masters
Monroe County Hospital	Gail	Herra
Pella Regional Hospital	Joyce	Berkenes
Wayne County Hospital	Darin	Relph
Knoxville Hospital and Clinics	K.	Jones
Ringgold County Hospital	K.	Schuster
Lucas County Health Center	JoBeth	Lawless
Pella Hospital	Y	O'Brien
Iowa Hospital Association	K.	Murphy
Circle of Life	Kristie	Barns
Decatur County Sheriff	Ben	Boswell
Clarke County Sheriff	Rob	Kovacevich
Lucas County Sheriff	Brett	Tharp
Marion County Sheriff	Jason	Sandholt
Marion County Sheriff	Chad	Des Planque
Monroe County Sheriff	Dan	Johnson
Ringgold County Sheriff	Mike	Sobotka
Wayne County Sheriff	Keith	Davis
Lamoni Police Department	Bob	Bell
Leon Police Department	Jason	Holt
Chariton Police Department	Tyler	Ruble
Knoxville Police Department	Dan	Losada
Albia Police Department	Jay	Andrews
Corydon Police Department	Alan	Fry
Clarke County-Magistrate	Diana	Rolands
Decatur County-Magistrate	Angela	Hill
Lucas County-Magistrate	Brandon	Shelton
Marian County-Associate Judge	Steven	Guiter
District 5B-Judge	Patrick	Greenwood
Monroe County-Magistrate	Kevin	Maughan
Ringgold County-Magistrate	Jim	Pedersen
Ringgold Court Advocate	Kathy	Beam
Decatur, Wayne, Monroe, Marion- Court Advocate	Kelly	Yeggy
Clarke and Lucas- Court Advocate	Betty	Bolsby
Corydon-Attorney	Jenna	Lain

RHD	Gina	Hiler
RHD	Amy	Bunger
Amerigroup	Kari	Cam
Amerigroup	Jill	Cook
AmeriHealth Caritas	Matt	Faidley
United Health Care	Mark	Dearden
CHCSI	Danielle	O'Brien
CHCSI	Samantha	Cannon
CHCSI	Devin	Stark
Christian Opportunity Center	Mickey	Edwards
Tenco - provider	Stephanie	Gehlhaar
Southern Iowa Resources for Families (provider)	Elizabeth	Schmidt
Crossroads	Pete	Brantner
Crossroads	Clint	Brown
Crossroads	Kris	Richey
Iowa Hospital Association	Natalie	Ginty
RHD	Jenna	Lane
ITP	Jay	Ricke
Abhomes	Dave	Russell
Integrated Treatment Services	Karen	Sallis
Capstone Behavioral Healthcare	Julie	Smith
Mosaic	Rhonda	Wilcox
Pella Pine Rest Christian Services	Jean	Holthaus
National Alliance on Mental Illness	Judy	Davis
Governor’s Office of Drug Control Policy	Dale	Woolery
State Representative District 27	Joel	Frye
State Senator District 14	Amy	Sinclair

Appendix B

504 Working Large Group Participants List – 7-19-2017

Agency	First Name	Last Name
Clarke County Hospital	Erin	Dykes
Circle of Life	Kristie	Barns
Decatur County Sheriff	Ben	Boswell
RHD	Gina	Hiler
RHD	Amy	Bunger
Amerigroup	Kari	Cam
AmeriHealth Caritas	Matt	Faidley
United Health Care	Mark	Dearden
CHCSI	Danielle	O'Brien
Crossroads	Kris	Richey
Christian Opportunity Center	Mickey	Edwards
Sheriff - Marion Co.	Jason	Sandholdt
Tenco - provider	Stephanie	Gehlhaar
Sothern Iowa Resources for Families (provider)	Elizabeth	Schmidt
Ringgold Court Advocate	Kathy	Beam
Pella Regional Hospital	Joyce	Berkenes
Decatur County Hospital	Greg	Boattenhamer
Crossroads	Clint	Brown
Marion County Sheriff	Chad	Des Planque
Iowa Hospital Association	Natalie	Ginty
RHD	Jenna	Lane
ITP	Jay	Ricke
Abhomes	Dave	Russell
Integrated Treatment Services	Karen	Sallis
CHCSI	Devin	Stark
Mosaic	Rhonda	Wilcox
CROSS	Becky	Fletchall
Crossroads	Mary	DeLong
CROSS	Katie	Fisher
Wayne County Hospital	Mike	Thomas
Hope Wellness Center	Melinda	Austin
Lucas County Sheriff	Brett	Tharp
Lucas County Health Center	Jayma	Hoch
Amerigroup	Kari	Cam
Marion PHI Cross	Kim	Dorn
ITS	Kim	Zanting
Integrated Counseling	Cheryl	Garland

Appendix C

504 Small Working Group Participants List

Meeting Dates: August 18 and 25th, and September 5 and 20th, 2017

Agency	First Name	Last Name
Clarke County Hospital	Erin	Dykes
CROSS	Kathy	Lerma
CROSS	Angela	Nelson
RHD	Gina	Hiler
RHD	Amy	Bunger
Amerigroup	Kari	Cam
AmeriHealth Caritas	Matt	Faidley
CHCSI	Danielle	O'Brien
Crossroads	Kris	Richey
Christian Opportunity Center	Mickey	Edwards
Sheriff - Marion Co.	Jason	Sandholdt
Tenco - provider	Stephanie	Gehlhaar
Marion County Sheriff	Chad	Desplanes
RHD	Libby	Welbes
AmeriHealth Caritas	Steven	Sehr
Crossroads	Mary	DeLong
CROSS	Tiffany	Hopkins

Appendix D

Definitions: Terminology, Acronyms, Phrases

Acute-Exhibit violent behavior, have addiction problems (either drugs or alcohol) and maybe sexual offenders with suicidal thoughts-must be placed in a state/hospital treatment facility.

ARNP- Advanced Registered Nurse Practitioner, An ARNP may provide healthcare services to Iowans of all ages in primary and/or ambulatory, acute, and long-term settings. The ARNP practices within their scope of practice based upon their educational background and the standards and guidelines established by their national certifying body (i.e. American Nurses Credentialing Center, American Academy of Nurse Practitioners).

Assertive Community Treatment (ACT)- Assertive Community Treatment is an evidence-based practice. ACT provides an integrated set of other evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings.

Business Associate Agreements (BAA)- Any individual or entity that performs functions or activities on behalf of a covered entity that requires the business associate to access personal health history (PHI) is considered a business associate, according to Health and Human Services (HHS). It is hoped that these negotiated agreements between MH service providers and treatment facilities will help to monitor diagnosis, referral and follow-up treatment services.

C-3 De-escalation Training-is a skill-based program that assist ER/ED, LE and MH providers in an innovative, practical technique that works with brain function to calm aggressive or distraught individuals. It's a best practice for use with people with severe and persistent mental health disorders, substance use disorders, co-occurring disorders, or intellectual disabilities.

Care Match System- is a framework for designing mental health services and supports for children and youth who have a serious emotional disturbance, and their families, through a collaboration across and involving public and private agencies, families and youth.

Chapter 24-the section of Iowa Code that deals with accreditation of providers of services to persons with mental illness, mental retardation, and developmental disabilities.

Complex Needs- Those individuals with complex care needs, also known as "super-utilizers," tend to have a history of chronic illness, multiple comorbidities, special needs and other non-clinical complications that may be related to unstable housing, employment, food and transportation and interaction with the criminal justice system. They often use emergency departments and inpatient services when home and community-based interventions could be employed with good outcomes and at lower costs.

Developmental Disabilities (DD) - Developmental disability is a diverse group of chronic conditions that are due to mental or physical impairments. Developmental disabilities cause individuals living with them many difficulties in certain areas of life, especially in "language, mobility, learning, self-help, and independent living."

Emergency Department or Room (ED or ER)-the hospital area most likely defined by an individual's immediate or perceived need of medical or mental health services. Generally, one of two places persons with complex needs end up, the other being a jail or place of incarceration.

Home Based Habilitation (Hab-Homes) Habilitation Services is a program to provide Home and Community Based Services (HCBS) for Iowans with the functional impairments typically associated with chronic mental illnesses. Services are provided in the person's home and community. Typical examples would be assistance with medication management, budgeting, grocery shopping, personal hygiene skills, etc.

Intermediate Care Facilities (ICF)- An intermediate care facility provides medical care and related services in a residential setting to individuals having an intellectual, mental health, developmental, or physical disability that does not require hospitalization or continuous medical attention.

Iowa Hospital Association (IHA) - The Iowa Hospital Association is the organization that represents Iowa hospitals and supports them in achieving their missions and goals.

Emergency Medical Treatment and Active Labor Act (EMTALA) is an act of the United States Congress, passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It requires hospital Emergency Departments that accept payments from Medicare to provide an appropriate medical screening examination (MSE) to individuals seeking treatment for a medical condition, regardless of citizenship, legal status, or ability to pay.

Intellectual Disability (ID)- Individuals who may have one or more intellectual disabilities characterized by significant limitations both in *intellectual* functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills.

Integrated Health Home (IHH) - The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. Three IHHs serve CROSS Region, CHCSI (Community Health Centers of Southern Iowa, Crossroads, and Capstone.

I-START- (Systematic, Therapeutic, Assessment, Resources & Treatment) provides prevention and intervention services to individuals with intellectual and/or developmental disabilities (IDD) and mental health needs through crisis response, training, consultation, and outreach.

Iowa Tele-Psychiatry (ITP)-a service providing 24/7 access to a psychiatrist who will perform psychiatric evaluation and treatment recommendations to the ED physician. The service includes inpatient bed finding assistance. The service is provided by the CROSS Region to all hospitals within the Region.

Law Enforcement (LE)-includes all individuals primarily responsible for public safety (e.g. police, sheriff, etc.) and the legal aspects of the MH process to include the county attorney, magistrate and presiding judge.

Level of Care Designation-a referral for treatment level as determined by a trained and certified psychiatric or behavioral specialist.

LifeLongLink (LLL)- LifeLongLink is Iowa's call network of Aging and Disability Resource Centers, whose purpose is to expand and enhance the state's information and referral resources for older adults, people with disabilities, veterans and caregivers as they begin to think about and plan for long-term independent living.

Local-Occasional occurrences of complex needs, which are both random and infrequent, but when occurring, need immediate treatment, but at a local level-may be released to family or a residential care facility

Mental Health (MH) - Mental health includes a person's emotional, psychological, and social well-being. It affects how we think, feel, and act. A mental illness however is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines.

MSW- is a master's degree in the field of is a master's degree in the field of social work. It is a professional degree with specializations compared to Bachelor of Social Work (BSW). It is a professional degree with specializations compared to Bachelor of Social Work(BSW).

Medical Model- a method of treatment that includes diagnosis and treatment to solve the immediate medical situation presented at any point in time and is often short term. (i.e. ailment-treatment-cure). It is not a model that should be incorporated in the case of a person suffering from MH issues which can, and most often do entail, long-term treatment, or medication and counseling.

Mental Health Court-a legal model whereby the person suffering from a MH issue may be assisted by the legal system to find the appropriate level of care and treatment without incarceration.

Mobile Crisis Team-a trained team of psychiatric, behavioral and/or paraprofessionals who respond to a person suffering from a MH crisis in the community setting to perform an evaluation/assessment and based on the assessment proceed with the appropriate disposition or placement of the individual. If disposition is to the home the team follows up with the individual within 24-48-hour window.

Residential Care Facility (RCF) - are non–medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, and transportation.

Sub-Acute- "Subacute care facility for persons with serious and persistent mental illness" or "subacute care facility" means an institution, place, building, or agency with restricted means of egress providing subacute mental health services for a period exceeding twenty-four consecutive hours to persons in need of the services.

Unduplicated Census- Beneficiaries who experience multiple spells of illnesses (multiple visits and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.