

Challenges and Opportunities for Mental Health and Substance Use Service Delivery in Central Iowa

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Executive Summary

The healthcare landscape, including mental health and substance use disorder services (hereafter referred to as 'behavioral health'), is undergoing unprecedented changes. Nationally, the implementation of the Affordable Care Act is providing health insurance coverage to more Americans and improving access to behavioral health coverage and services for many who did not previously have it. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits applicable health insurers from implementing more stringent limitations on behavioral health benefits than medical/surgical benefits. Healthcare organizations are beginning to recognize the impacts of social and emotional wellbeing on overall health and the need for collaborative models of care. Within Iowa, the state has applied for and been awarded State Innovation Model Planning and Testing grants to develop a multi-payer healthcare payment and service delivery model intended to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and the Children's Health Insurance Program (CHIP) beneficiaries. In addition, the statewide Mental Health Redesign is shifting the way that services are delivered and accessed.

In order to address the challenges and take advantage of the opportunities, the United Way of Central Iowa (UWCI) determined that an assessment of behavioral health services and funding would be beneficial for central Iowa to assist the organization in identifying priority needs and populations, gaps in services, and opportunities to make the greatest impact in the community. With significant investments in 14 mental health and substance use disorder (hereafter referred to as behavioral health) programs, behavioral health services support is a high priority for UWCI.

On behalf of the greater community, UWCI, in partnership with the Mid-Iowa Health Foundation and the Community Foundation of Greater Des Moines, solicited the services of the Technical Assistance Collaborative, Inc. (TAC), to study behavioral health services in central Iowa. Staff interviewed numerous stakeholders and key informants, including healthcare providers, behavioral health providers, human service agencies, law enforcement personnel, school districts, family members, associations, advocacy groups, and state and county personnel.

Key informants recognized that more Iowans have healthcare coverage today than ever before. They also identified a number of positive attributes of the behavioral health service system in central Iowa, including:

- Strong collaboration among agencies and organizations;
- A willingness to pursue innovation, such as Integrated Health Homes;
- A commitment to address the needs of low-income individuals and families with significant life challenges, including mental health disorders, substance use disorders, exposure to violence and homelessness; and
- A commitment to support individuals impacted by trauma, including refugees.

However, informants also identified gaps in services, insufficient supports and barriers to accessing care. Stakeholders suggested the need for:

- A children’s system of care, with Core services that provide for a full array of services and supports regardless of a child’s healthcare coverage;
- Better access to Psychiatry;
- Access to safe and affordable housing;
- Better access to treatment for Substance Use, and Co-Occurring Mental Health and Substance Use, Disorders; and
- Improved access to transportation.

The most striking barrier identified to accessing behavioral health care was the cost associated with health insurance. While more lowans now have healthcare coverage, many cannot afford the cost of premiums, deductibles or co-pays for behavioral health services. Additional areas of the system which were identified as needing improvement were: reducing the complexity of the healthcare system for both service recipients and providers; ensuring that existing services models are designed for the most effective and efficient care; enhancing the capacity of community-based behavioral health programs to meet the increasing demands for services as state institutions continue to downsize; and addressing gaps in support for relocated refugees.

TAC conducted extensive research on evidenced-based, best and promising practices, as well as leveraged the agency’s experience and expertise to formulate potential strategies and program models to address these findings. In addition, TAC identified a number of policies at the federal, state and local levels that must be addressed in order to resolve service gaps and barriers.

Recommendations

- I. **Establish a Children’s System of Care, Including Core Services for Children** to improve outcomes for children and their families and to increase efficiencies for the agencies that serve them.
- II. **Strengthen Community-based Behavioral Health Services for Adults** to insure that existing services are effective and efficient and that service gaps are addressed.
- III. **Enhance Psychiatric Capacity** through the support of telepsychiatry, consultation with primary care providers and leveraging psychiatric residencies.
- IV. **Promote and Establish a Permanent Supportive Housing Strategy** to create and sustain more affordable housing for individuals with behavioral health disorders.
- V. **Advocate for the Elimination of Disparities in Substance Use Services** to support a service array more in line with mental health treatment and supports.
- VI. **Address the Lack of Parity and Costs Associated with Healthcare Coverage** addressing high premiums, co-pays and deductibles that pose barriers for low-income central lowans to access behavioral health care.

- VII. **Increase Public Awareness of the Resources Available in Central Iowa and How to Access them** to inform central Iowans about the services that are available to assist them, where to find the services and important information individuals should know about how to access the services.
- VIII. **Improve Transportation Options and Coverage for Individuals with Behavioral Health Needs** in order for individuals and their families to be able to access available services and supports.
- IX. **Sponsor Provider Learning Opportunities** to help providers position themselves as thriving participants in healthcare reform.
- X. **Facilitate Community Forums** to support and focus stakeholders through the evolving healthcare environment in Iowa.
- XI. **Optimize Greater Des Moines' Commitment to Supporting Relocated Refugees** through community collaboration and approaches that have proven successful for other communities in addressing challenges with refugee relocation.

Introduction

The United Way of Central Iowa has identified that the changing behavioral healthcare landscape at the national, state and local levels presents both challenges and opportunities for central Iowa. Nationally, the implementation of the Affordable Care Act is providing health insurance coverage to more Americans and improving access to behavioral health coverage and services for many who did not previously have it. Within Iowa, the statewide mental health redesign and local reductions in services are shifting the way that services are delivered and accessed. Demand for mental health services in central Iowa has historically exceeded the supply of qualified professionals, presenting challenges for workforce recruitment necessary to insure access to care. Finally, healthcare organizations are beginning to recognize the impacts of social and emotional wellbeing on overall health and the need for collaborative models of care.

In order to address the challenges and take advantage of the opportunities, UWCI determined that an assessment of behavioral health services and funding would be beneficial to assist the organization in identifying priority needs and populations, gaps in services, and opportunities to make the greatest impact in the community.

United Way of Central Iowa, in partnership with the Mid-Iowa Health Foundation and the Community Foundation of Greater Des Moines, solicited the services of TAC to study behavioral health services in central Iowa with the goals of:

- Understanding the implications of national, state and local changes to coverage, service delivery and funding;
- Assessing community needs and identifying gaps in behavioral health services for children and adults in central Iowa;
- Determining what changes to the current behavioral health delivery system and services would be most beneficial to the community; and
- Identifying opportunities to improve service delivery, coordination and funding.

TAC is a national nonprofit organization that advances proven solutions to the housing and community support services needs of low-income people with disabilities and people who are homeless. For over 20 years, TAC has provided policy leadership, technical assistance and consultation for numerous federal, state and local government agencies, as well as for national policy and advocacy, philanthropic, and nonprofit organizations.

Sherry Snyder, Senior Consultant, served as the lead for the project, conducting research, key informant interviews and provider assessments and synthesizing the results. Kevin Martone, Executive Director, provided oversight of the project, as well as consultation based upon his extensive work on systems' redesign in Iowa. Together, Sherry and Kevin have more than 50 years of experience in providing consultation and administering mental health and substance use services at the state, county and provider levels.

Recognizing that high quality behavioral health services are a critical component of maintaining and improving the health and wellbeing of its community, UWCI, the Mid-Iowa Health Foundation and the Community Foundation of Greater Des Moines engaged TAC to assess the community's needs and provide recommendations for strategic planning efforts.

The Implications of National, State and Local Healthcare Reforms

Federal Healthcare Reform Initiatives

Olmstead

The *Olmstead* decision affirmed the right of individuals with disabilities to live in the least restrictive, most integrated settings suitable to meet their needs, and articulated the obligation for both state and local government to ensure that this occurs. The degree to which states have taken action to address this obligation has varied. States that have not developed and moved forward on implementing *Olmstead* plans have been the subject of intensive review and in some cases litigation brought forward by the Department of Justice, the federal agency tasked with enforcing the Americans with Disabilities Act and *Olmstead*.

Historically, state and local mental health systems have relied heavily on 'institutional' care, treatment in state hospitals and nursing homes that remove individuals with disabilities from their homes, families and friends. *Olmstead* requires that individuals have the opportunity and choice to live, receive treatment and participate in work and social activities in integrated settings.

In furtherance of community integration, Medicaid policy has recently adopted provisions and requirements for supporting individuals with disabilities in community integrated settings. Most recently, the federal Centers for Medicare and Medicaid Services published a final rule on Home and Community Based Services (HCBS), describing the types of services and settings in which Medicaid funding can be used. The rule applies to residential, day program and vocational settings and is forcing states to redesign how and where mental health services are delivered.

The Affordable Care Act

The Patient Protection and Affordable Care Act (ACA, also known as 'Healthcare Reform') was signed into law March 23, 2010.¹ The ACA included a number of reforms and requirements intended to expand healthcare coverage for low-income children and adults. A key mandate of the ACA was Medicaid expansion for single adults with income up to 138% of the federal poverty level (FPL). However, the Supreme Court determined the mandate for states was unconstitutional, resulting in states having the *option* to expand Medicaid coverage.

Governor Branstad opted to negotiate with the federal government to customize Medicaid expansion for Iowa and still receive enhanced federal funding. Under Iowa's plan, Medicaid pays the premiums for health insurance for single adults who obtain coverage through the Health Benefits Exchange (see further explanation of the Exchange below.) Benefits are more limited than under traditional Medicaid, such as excluding non-emergency medical transportation and residential substance use disorder treatment, and services are delivered by providers in the Plans' network, which may be different than providers traditionally enrolled in Medicaid. Please see page 9 for more information about Iowa's various Medicaid programs.

Another key provision of the ACA was a mandate for individuals to have insurance coverage. To assist individuals in complying with the mandate, the ACA established the creation of a Health

¹ <http://www.hhs.gov/healthcare/rights/>

Marketplace, also referred to as the Health Benefits Exchange (HBE).² The HBE allows consumers to compare plan benefits and price, provides consumer assistance, and facilitates plan enrollment. For individuals and families in Iowa, the HBE assists in determining eligibility for Medicaid and for those that do not qualify, the Exchange identifies health insurance plans and helps determine assistance/savings that individuals may qualify for, based on their income. Individuals who apply may qualify for premium tax credits that lower the costs of coverage. To qualify for assistance to purchase coverage, eligible individuals must:

- Be legally present in the United States; and
- Have a household income between 100% and 400% of the FPL.

The ACA anticipated that consumers would have choices among healthcare plans with varied costs and benefits. At first, Iowans did have a choice of two plans on the Exchange: CoOpportunity Health Plan was one of two providers on the state marketplace that attracted many customers with lower rates than other insurance companies. However, the company was reportedly in financial distress because it set its prices too low to support the healthcare needs of its customers. In December, the Insurance Commissioner took rehabilitation action due to financial concerns arising from insufficient capitalization, the lack of availability of additional capital from the Center for Medicare and Medicaid Services, and the delay of federal payments for risk mitigation programs until the second half of 2015.³

As a result, Iowans currently have access to only Coventry Health Plan on the Marketplace. In December, new Iowa Marketplace Choice Plan members were to be tentatively assigned to Coventry Health Plan, but were offered the option to move to the Iowa Wellness Plan, maintaining choice for beneficiaries.

Finally, the ACA defines certain categories of benefits as 'essential health benefits' (EHBs).⁴ Medicaid expansion and healthcare plans offered on the HBE must cover the EHBs. Essential health benefits include mental health and substance use disorder services, including behavioral health treatment, counseling and psychotherapy.

Optional Opportunities

In addition to the mandates cited above, the ACA includes a number of provisions that are optional for states to consider in reforming their healthcare systems. An important provision is for states to receive an enhanced federal Medicaid match for establishing Health Homes. Health homes provide comprehensive, coordinated care to members with chronic conditions. States may identify serious mental illness as a qualifying chronic condition. Please see page 8 for information on Iowa's Integrated Health Homes.

Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance

² <https://www.healthcare.gov/quick-guide/>

³ <http://www.coopportunityhealth.com/>

⁴ <https://www.healthcare.gov/glossary/essential-health-benefits/>

issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.⁵ MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Healthcare and Education Reconciliation Act of 2010 (collectively referred to as the 'Affordable Care Act') to also apply to individual health insurance coverage.

If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.

Iowans in need of mental health and substance use disorder treatment may not be realizing the benefits of the MHPAEA as envisioned. Please see discussion of this issue on page 13.

State Innovation Model Grants

The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer healthcare payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and CHIP beneficiaries—and for all residents of participating states.⁶ The Center for Medicare and Medicaid Services Innovation Center created the State Innovation Models Initiative for states/entities that are prepared for or committed to planning, designing, testing, and supporting evaluation of new payment and service delivery models in the context of larger health system transformation. The Innovation Center is interested in testing innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and CHIP, while maintaining or improving quality of care for program beneficiaries. The goal is to create multi-payer models with a broad mission to improve health, improve care, and decrease costs for beneficiaries of Medicare, Medicaid, and CHIP.

In 2013, Iowa received notice of approval for a Model Design Award. In December, 2014, the U.S. Department of Health and Human Services announced that Iowa was one of eleven recipients of the State Innovation Model Testing grant. The state's goals are:

- First, transform healthcare delivery by expanding the Accountable Care Organization (ACO) model and primary care provider assignments to cover the entire Medicaid population; align with other payers using standard measurement systems and quality ratings; and support the delivery system through technical assistance, community care teams, and more integrated use of health information technology and health information exchange.
- Second, to improve population health through community integration efforts focused on social determinants of health; tools to better engage and incentivize patients; and

⁵ http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

⁶ <http://innovation.cms.gov/initiatives/state-innovations/>

facilitating public/private partnerships for education and outreach. Iowa will demonstrate that a greater focus on the social determinant roots will accelerate transformation of healthcare and significantly improve outcomes, especially among Medicaid populations.

- Finally, Iowa will decrease per capita healthcare spending by monitoring both value and total cost of care; identifying specific populations that need additional interventions and care management; align public and private payers; track patient outcomes; and conduct rapid cycle evaluation and improvements. Combined, these efforts support a larger public value through greater transparency and access to data on costs and quality in the healthcare system, generate information that will drive competition, and create system-wide transformation delivering improvement and driving value throughout the healthcare marketplace.⁷

Multiple payers will be involved in the testing of grant activities throughout the course of the project, including Medicaid, Medicare, and private payers. Partner organizations include key state agencies, commercial health plans, ACOs, behavioral health, large healthcare systems, and academic institutions. Iowa will use the funds to continue stakeholder engagement through implementation and evaluation phases; fund practice transformation technical assistance and tools to evaluate and address the social determinants of health; fund community transformation grants for infrastructure and linkages to integrate public health and promote individual healthy lifestyles; provide additional support for Health Information Technology adoption and connectivity; fund data collection; and conduct both rapid cycle and comprehensive evaluations.

State and Local Healthcare Reforms

Mental Health and Disability Services Regions

Historically, administration of services for non-Medicaid eligible individuals with mental health disorders and intellectual and developmental disabilities was through the State's 99 county authorities. There was considerable variation in funding and consequently available services, which after many years led to the passage of legislation to develop a more comparable and efficient system statewide.

Senate File 525 provided guidance for both the structure and the process for reforming the Iowa Mental Health and Intellectual Disability-Developmental Disability (MH/ID-DD) system.⁸ SF 525 envisioned a uniform statewide system of core services accessed and managed through a set of regional entities that would assure service access and care coordination for non-Medicaid services. The overall goals of SF 525 were to:

- In the context of available resources, assure timely, consistent and equitable access by the citizens of Iowa to a uniform set of core services designed to produce positive outcomes for consumers and their families and for the communities in which they live;

⁷ <http://dhs.iowa.gov/ime/about/state-innovation-models>

⁸ https://dhs.iowa.gov/sites/default/files/2012Redesign_SF525_Enrolled_Jul20.pdf

- In the context of available resources, and being respectful of the strengths and traditional practices of the existing MH and ID-DD service systems, begin to transition toward integrated community services modalities: (a) that are consistent with Iowa's *Olmstead* plan; and (b) for which there is sufficient evidence that the services modalities will produce positive outcomes for consumers and their families;
- Assure the quality and cost effectiveness of the MH and ID-DD service systems through implementation of best practice services, strengthened overall state and regional monitoring and quality improvement, and consistent and timely data submission and analysis;
- Make best use and maintain effective stewardship of scarce public services resources through reduction of duplicative administrative functions and costs; and
- Implement a MH/ID-DD system that is simple, clear, transparent, easy to access, and understandable to all consumers, families, providers, and other stakeholders.

Senate File 525 served as the impetus for Senate File 2315, the Mental Health Redesign legislation⁹ that organized the 99 counties into fifteen regions that began operating as of July 1, 2014, to offer locally-delivered and regionally-administered services that meet statewide standards of care. Under SF2315 the regions are required to provide core services. These include:

- Treatment designed to ameliorate a person's condition, such as outpatient therapy or inpatient treatment, and medication management;
- Basic crisis response provisions, including 24-hour access to crisis services;
- Support for community living, such as home health aides and home and vehicle modifications, as well as respite services;;
- Support for employment, including prevocational services, job development and day habilitation;
- Recovery services, including peer and family support; and
- Service coordination, including coordinating physical health and primary care.

In addition to the core services, the regions SF 2315 requires the regions to provide 'core plus' services for individuals without Medicaid or other third-party coverage. Core plus services include:

- Comprehensive facility and community-based crisis services, such as 24-hour telephone hotline, mobile capacity, 23-hour observation/stabilization beds and crisis residential;
- Sub-acute services provided in facility and community-based settings;
- Justice system-involved services, such as jail diversion and Crisis Intervention Training for law enforcement officers; and

⁹ https://coolice.legis.iowa.gov/linc/84/external/SF2315_Enrolled.html

- Expanded use of evidence-based practices, such as Assertive community Treatment, Positive Behavioral Support and Peer self-help drop-in centers.

The goal of Mental Health Redesign is for adults in need of services to have access to a regional base of services that meet statewide standards to address their needs. Counties are able to pool their resources in order for their regions to offer the core services, as well as additional services grounded in evidence-based practices as funding allows.

SF 525 also mandated a two-year workgroup process for redesign of the children's disability service system. The workgroup recommended that a children's system of care be implemented through development of Integrated Health Homes that would provide care coordination and integrated services for children with serious emotional disturbance and other co-occurring conditions. The workgroup also recommended: creation of a Children's Cabinet comprised of stakeholders, family members, and state agency leaders to serve in an advisory and oversight capacity for the children's service system; identification of Core Services to be available for all children, regardless of their healthcare coverage; and development of a plan and strategy to bring children in out-of-state placements back home to Iowa.¹⁰

The Iowa General Assembly did not implement these recommendations and instead requested that the workgroup meet again in 2013 and submit further recommendations regarding the children's disability system.¹¹ The Department of Human Services (DHS) did, however, move forward with Integrated Health Homes (IHHs) as a platform for implementing a children's system of care. As of this writing, further recommendations for a children's system of care have not been implemented. The regions have not received additional resources and are not required to fund services for children. Regardless, some do fund outpatient mental health services and sometimes coordinate the involuntary commitment process for juveniles.

Plan for Realigning Iowa's Mental Health Institutions

In effort to modernize the state's mental health delivery system, the DHS recently announced a proposal to realign its mental health institutes (MHIs) and to deliver care through the state's two nationally-accredited facilities at Independence and Cherokee. DHS intends to no longer fund the Mt. Pleasant and Clarinda facilities beyond June 30, 2015.¹²

DHS identified the agency's challenges with operating four MHIs across the state as a reason for the closures. In addition, DHS believes there are community-based programs and facilities available and more coming online, to serve the majority of Iowans' current and future mental health needs. DHS believes that reducing the number of MHIs will allow the state and mental health regions, who reportedly have more than \$100 million in surpluses at this time, to focus on expanding and offering quality inpatient psychiatric services for Iowans with the most critical mental health needs.¹³

10 http://www.dhs.state.ia.us/Partners/Partners_Providers/MentalHealthRedesign/Redesign-Reports.html

11 <http://dhs.iowa.gov/sites/default/files/Childrens-Disability-Services-Workgroup-Final-Report-Nov-15-2013.pdf>

12 <http://dhs.iowa.gov/>

13 Ibid

Reducing the number of state psychiatric beds and institutions is a national trend. Between 2009 and 2012, eight states closed nine state psychiatric hospitals. During that same time, 29 states closed a total of 3,222 state psychiatric inpatient beds.¹⁴ The *Olmstead* decision has prompted efforts by numerous states to end the unnecessary segregation of individuals with serious mental illness and other disabilities, and requires states to affirmatively plan and implement systems that prevent unnecessary institutionalization. In other states, hospital and bed closures have resulted from reduced state mental health budgets.¹⁵

Regardless of the reason for reduced state hospital capacity, funding must be redirected or new funding must be identified to support the increased demand placed on community-based services. Central Iowa stakeholders are concerned that the community behavioral health system is already strained to meet consumers' needs, and that the situation will only worsen with the closures absent additional resources.

Medicaid

Iowa continues to provide full Medicaid benefits to target groups of people, based on income levels. In addition to meeting certain income levels, individuals must belong one of the following eligibility groups in order to qualify for 'traditional' Medicaid:

- A child under the age of 21,
- A parent living with a child under the age of 18,
- A woman who is pregnant,
- A person who is elderly (age 65 or older),
- A person is disabled according to Social Security standards,
- A woman in need of treatment for breast or cervical cancer, or
- Others meeting special qualifications.

To be eligible for Medicaid programs you must live in Iowa, be a US citizen or a non-citizen who is in this country legally. Iowa does also provide Medicaid coverage for up to three days to pay for the cost of emergency services for non-citizens who do not meet citizenship, alien status, or social security number requirements. The emergency services must be provided in a facility, such as a hospital, clinic, or office that can provide the required care after the emergency medical condition has occurred.

In addition to traditional coverage Medicaid offers numerous programs in Iowa, including:

hawk-i: Health and Well Kids in Iowa (hawk-i, the State Children's Health Insurance Program) provides healthcare coverage for children of working families. No family pays more than \$40 per month and families with income up to 180% FPL pay no premiums.¹⁶

¹⁴http://www.nasmhpd.org/publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

¹⁵ *Ibid*

¹⁶ http://www.hawk-i.org/en_US/docs/MAGIIncomePremiumLevels012214.pdf

Health Homes provide whole person, patient-centered, coordinated care for Medicaid members with specific chronic conditions who are at risk for a second condition, such as hypertension, overweight, heart disease, diabetes, asthma, a substance use or a mental health disorder.

Integrated Health Homes are discussed below.

Managed Healthcare (MHC) insures that members have a primary care provider and that healthcare is delivered according to medical practice guidelines and state standards. There are two managed healthcare options; MediPASS and Meridian HMO, which provide coverage in select counties. Managed healthcare beneficiaries have access to all state plan benefits.

Iowa Wellness Plan covers adults ages 19 to 64 with household income at or below 100% of the Federal Poverty Level (\$11,490 for individuals or \$15,510 for a family of two). The Plan offers comprehensive health services, equivalent to the State Employee Health Benefit Package. Members can choose a provider from the statewide Medicaid provider network and are able to get care from local providers.

Iowa Marketplace Choice Plan covers adults age 19 to 64 with income from 101% through 138% of the Federal Poverty Level (between \$11,491 and \$15,282 for individuals or \$15,511-\$20,628 for a family of two). The Marketplace Choice Plan allows members to get healthcare coverage through select insurers with plans on the Health Insurance Exchange. Medicaid pays the premiums of the health plan for the member. Members get care from providers within the commercial insurance plan's network.

The Iowa Plan covers mental health and substance use inpatient and outpatient services which are carved out from Medicaid physical health plans. Magellan Behavioral Care of Iowa (Magellan), an affiliate of Magellan Health Services, works with the Iowa DHS and the Iowa Department of Public Health (DPH) to administer the Iowa Plan. Those with disabling mental and/or substance use disorders are considered medically exempt and thus are enrolled in the Medicaid State Plan.

Integrated Health Homes

During 2013 and 2014, IHHs were established for Medicaid enrollees with serious mental illness and serious emotional disturbance. IHHs are a team of professionals working together to provide whole-person, patient-centered, coordinated care for all situations in life and transitions of care to adults with serious mental illness (SMI) and children with social and emotional disturbance (SED). IHHs are administered by Magellan Behavioral Health of Iowa (MBH) who is responsible for:

- Identifying providers who meet the standards of participation of an IHH;
- Educating and supporting IHH providers in practice transformation and integrated care coordination;
- Continuously assessing the IHH provider's capacity to meet integrated care coordination standards;
- Providing infrastructure and tools to coordinate between behavioral health and physical health providers;

- Developing self-management tools for the individuals served;
- Managing and performing data analytics and outcome measures to evaluate service effectiveness and cost efficiency of care coordination and service delivery;
- Providing clinical guidelines and other decision support tools; and
- Providing technical support.

Eligible providers receive a capitated payment shared within the team of healthcare Professionals to cover Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services and Referral to Community and Social Support Services. A map of IHHs can be found at http://www.magellanof Iowa.com/media/964300/ihh_providermap_1-8-15final.pdf.

Medicaid Modernization

On February 16, 2015, the Iowa DHS released a Request for Proposals (RFP) for Governor Branstad's proposal for Medicaid Modernization. The initiative aims to improve the coordination and quality of care while providing predictability and sustainability for taxpayers in Medicaid spending. DHS proposes: 1) to enroll the majority of the Medicaid, *hawk-i* and Iowa Health and Wellness Plan enrollees in comprehensive managed care organizations (MCOs); and 2) to contract with two to four MCOs to provide comprehensive health care services, including physical health, behavioral health and long-term services and supports (LTSS). Individuals will either choose or be auto-assigned to a plan. In addition to all existing Medicaid services, the MCOs will have flexibility to create appropriate alternatives in order to avoid more costly treatment and/or placement. As proposed, the MCOs will be required to maintain current Medicaid providers and reimbursement rates for the first six months of implementation, after which they can identify their respective provider networks and negotiate different rates and payment structures. Service authorizations would be honored for three months from implementation and members would be able to maintain their existing case manager for six months.

Medicaid Modernization is proposed to go live on January 1, 2016. Based upon the timelines required for Medicaid managed care implementation in other states, this appears to be an aggressive timeframe, especially for counties and provider types with no past experience with managed care. Stakeholders have expressed concerns that the timeline does not afford adequate opportunity for their concerns to be addressed. In addition, stakeholders are concerned about the lack of clarity in how savings attributed to managed care implementation have been estimated.

Assessing Strengths, Gaps and Barriers to Care in Behavioral Health Services for Children and Adults in Central Iowa

Methodology

The Behavioral Health Services study was conducted between November, 2014, and March, 2015. TAC staff reviewed background materials and relevant documents to gain a clear understanding of the behavioral healthcare services and system in central Iowa. Staff interviewed numerous stakeholders and key informants, including healthcare providers, behavioral health providers, human service agencies, law enforcement personnel, school districts, family members, associations, advocacy groups, and state and county personnel. In total, 20 interviews and focus groups were held with more than 60 representatives. Please see Appendix A for a total list of individuals/agencies interviewed, and Appendix B for a list of questions used to initiate and guide the discussion.

Interviews with key informants took place telephonically and face-to-face at the UWCI building. Small group interviews were conducted with representatives from agencies with similar services delivery and mission. The themes that emerged from these meetings, interviews and reviews of written materials are included throughout this report.

Strengths of the Behavioral Health System in Central Iowa

Key informants identified numerous strengths of the agencies and systems that directly and indirectly support children and adults with behavioral health disorders in central Iowa.

Most, if not all interviewees cited examples of *collaboration* among community stakeholders. Agencies identified numerous relationships with other agencies, referral reciprocity, and attendance at multi-agency meetings and events. Some agencies have entered into more formalized partnerships, such as the tri-agency Integrated Health Home comprised of Youth Emergency Services and Shelter, Lifeworks and Orchard Place.

Increased access to health coverage was a positive accomplishment for Iowans, even if it's not the expansion of Medicaid as envisioned with passage of the ACA. More people have healthcare coverage in Iowa today than ever before.

The Department of Human Services should be commended for obtaining approval of the state plan amendment for *Integrated Health Homes for Children*. The addition of Care Coordination and Support Services for children and their families is a step in the right direction. Behavioral health providers are participating in the alternative approach for delivery of care and payment for services.

The Community has made a substantial commitment to addressing the issue of housing and homelessness. Housing Tomorrow, an initiative to develop the region's first housing plan, was made possible in 2013 through collaborations between the Housing Trust Fund and the Community Foundation of Greater Des Moines, United Way of Central Iowa and Polk County. The plan seeks to address the concentration of traditional affordable housing options, encourage development near nodes and along transit corridors, and promote a diverse housing

stock that will fit the needs of Greater Des Moines' diversifying population and allow residents to age in place.

In addition, shelters such as Youth Emergency Shelter and Services (YESS) and Iowa Homeless Youth Center for homeless youth and Central Iowa Shelter and Services (CISS) for homeless adults receive significant community support. Polk County Health Services has a Service Coordinator located at CISS to further assist anyone with mental health concerns. These resources reflect the community's awareness that helping people obtain housing and supports is a more effective solution for addressing homelessness, by stabilizing individuals' health and wellbeing, as well as enhancing the safety and economic viability of the community.

Polk County Health Services has formed a Systems Integration Team for the Polk County Region. With the umbrella of the Guiding Coalition – there are four workgroups that have been established to address significant challenges faced by behavioral health providers in the Region:

- Systems integration;
- Supportive workforce development;
- Clinical workforce development; and
- Community Awareness and Acceptance.

These workgroups can serve as the foundation for identifying solutions to these pressing issues and others as articulated by the community.

Finally, a strength of the Greater Des Moines area is its *willingness to welcome and embrace refugees*. Individuals fleeing from extreme poverty, religious persecution and war in their native countries find assistance and support in central Iowa. Much of the assistance is from the federal government and religious organizations. But not all needed services and supports are covered by these resources. Private central Iowa funders help to fill in the gaps.

Gaps in Services

While there were some differences identified during the Key Informant interviews, respondents overwhelmingly identified a similar set of services and supports that are not readily available for children and adults in central Iowa.

System of Care for Children

According to Nick Gerhart, Commissioner for the Iowa Insurance Department, Iowa ranks second in the nation for providing healthcare to children of low-income families. In addition, Medicaid and CHIP provide a robust array of covered services for children who qualify. Iowa has an approved Medicaid waiver for children with Serious Emotional Disturbance (known as the Children's Mental Health Waiver). Yet a consistent message from key informants was that Iowa needs a System of Care for children with behavioral health disorders.

While Iowa provides coverage for low-income children, not all services are eligible for Medicaid, and not all children will have continuous coverage despite the availability of Medicaid, the CHIP

and expansion under the ACA. Some children only qualify for Medicaid when admitted to a psychiatric medical institution for children (PMIC) and then lose eligibility when discharged. Admission to a PMIC is a costly way to qualify for Medicaid, and loss of eligibility upon discharge disrupts a child's access to aftercare in order to sustain the benefits from their residential treatment. The waiting list for the Children's Mental Health Waiver is very long with reports of families waiting for more than two years for services. The Regional Authorities are not funded to provide critical services that Medicaid cannot cover.

The Children's Mental Health Redesign Workgroup recommended the establishment of a minimum set of Core Services available to all children regardless of their healthcare coverage. Services would fall under four domains of care:

1. Prevention, Early Identification, and Early Intervention;
2. Behavioral Health Treatment;
3. Recovery Supports; and
4. Community-Based Flexible Supports.

The Iowa Legislature did not move forward with establishing Core Services for children and youth with behavioral health needs in Iowa. Medicaid attempted to fill the service gap by obtaining approval for IHHs for children with SED. IHHs provide a good foundation for a system of care, opportunities to engage more children and the ability to monitor outcomes. While not legislatively mandated, many of the recommended Core services are currently provided by child serving behavioral health providers in central Iowa and may be covered by Medicaid as part of its state plan or through a waiver, through federal grants, state general funds, or some combination. However, *not all of the identified services are currently available to children and youth with behavioral health disorders in Iowa*. Medicaid-funded services would have a greater impact if delivered within a system with shared values, policy and guidance directing the provision of all children's behavioral health services.

Absent an organized approach and point of accountability, Iowa lacks a holistic 'system of care' for children. System of Care is an approach that transforms the way that categorical systems at the state and county levels serve youth and families who have complex needs and are involved in mental health plus child welfare, and/or juvenile justice. Youth guided and family driven, the approach embraces the use of evidence-based practices, including Hi Fidelity Wraparound. In 2009, the Iowa Legislature approved state funding for System of Care pilot projects, ultimately serving children and youth in 14 counties. Orchard Place was awarded funding to serve children and youth in Polk and Warren Counties. The types of services offered under System of Care include:

- Coordination of services across mental health and medical providers, schools, juvenile court, child welfare, other social supports; and
- Financial support to access clinical services and other non-clinical supports. Clinical supports include community-based respite, therapy, skill building, and as needed, medication or other co-pays. Non-clinical supports, such as housing, food, transportation, and environmental modifications.

The System of Care initiative implemented by Orchard Place has had great success. Outcomes associated with the children who have participated in the program include:

- 100% of children enrolled in System of Care were transitioned to lower, less expensive levels of care and/or maintained with the family home;
- 100% of youth enrolled in System of Care had no new Juvenile Court Services involvement one year post discharge;
- 98% of youth remained safe with no additional child abuse or neglect; and
- 97% of youth had no child welfare Children in Need of Assistance petitions file at 12 months.

When the state of Iowa initiated the Integrated Health Home program, System of Care funding was then directed to support those children who are not Medicaid-eligible. In spite of the positive outcomes, the 100% state-funded grants were not included in the Governor's proposed budget for 2016–17.

Availability of Psychiatry

Respondents within and external to the behavioral health system identified the lack of psychiatry as a significant concern. While the issue is more extreme in the rural areas of Iowa, central Iowa residents also experience delayed access to psychiatric care—some respondents identified a wait of up to six months for an appointment, particularly for a child psychiatrist. Factors identified as contributing to the shortage included:

- Low reimbursement rates make it difficult for public sector providers (providers that rely heavily on government funding, such as Medicaid) to attract and retain psychiatrists.
- Hospitals, prisons and the Veterans Administration offer better compensation, benefits and less demanding work.
- While the cost of living is relatively low in Iowa, the state is competing for specialists with urban centers which offer higher payment for their services and a larger pool of service recipients, including private pay.
- Psychiatry is one of the lowest paid specialties in medicine.

Attracting and retaining staff was identified for all positions within the public sector behavioral health system. Low reimbursement rates were identified as the top reason that providers are not able to retain staff, especially for substance use disorder service providers whose Medicaid rates are much lower than mental health provider rates.¹⁷ In addition, the demanding nature of entry level work, where the least paid staff spend the most time with individuals with challenging and complex needs, adds to the likelihood that staff will leave for other fields or better paying jobs once they've gained experience.

Housing

The lack of safe and affordable housing was identified as a gap in the system by key informants across the board. Nationally, the lack of affordable housing in which individuals hold their own

¹⁷Per Iowa department of Public Health

lease for an apartment of their choice that is integrated into the community, is cited as a primary barrier to individuals with disabilities being able to live successfully in their communities.¹⁸

Affordable housing has been a historical problem for individuals with disabilities on limited incomes in central Iowa but has grown more so recently with the reduction in Single Room Occupancy (SRO) sites to create market-rate housing within the city. The Randolph Hotel is the most recent example. According to a study conducted by the Polk County Housing Trust Fund, the Randolph, like SRO buildings across the country, was a de facto form of 'housing of last resort' for many people facing substantial barriers to housing.¹⁹ Many of its residents were mentally or physically disabled, had poor rental histories, and/or had limited income, all of which precluded them from accessing rental housing. These residents were often unable to pay a security deposit, or to pass typical background checks. The SRO did not have these requirements and individuals could pay by the night.²⁰

SROs are far from the 'gold standard' for housing for people with disabilities. Access to subsidized housing is also very limited. As of 2014, Section 8 housing choice vouchers in Des Moines were being offered to individuals and families from the 2008 waiting list.²¹ The Iowa Finance Authority operates a small voucher program, and Polk County Health Services operates a small voucher program targeted for individuals receiving waiver services but the need for supported housing far exceeds the programs' resources.

While the rates of homeless and chronically homeless in the state of Iowa declined between 2010 and 2012, the percent of unsheltered homeless increased by 22.3%.²² The largest concentration of homeless in Iowa is in Polk County, which had about 30 percent of the statewide total in 2012.²³ CISS supports approximately 2,000 homeless women and men each year. At its peak this past winter the director reported housing 100 adults *in addition to* the shelter's 209 bed capacity. The need far outweighs the demand and shelters do not address the root cause of homelessness. The homeless are often viewed as a deterrent to businesses and tourism. In August, 2014, the city's Office of Economic Development evicted 50 men and women living in tent camps under bridges. As of April 1, 2015, another series of evictions is set to take place, causing stress on shelter and other support services.

In addition to regularly exceeding its capacity, CISS is also challenged with how to more effectively and efficiently serve the growing number of individuals with behavioral health disorders. Individuals often present at the shelter with mental health symptoms, medical needs and concerning behaviors. The Des Moines Police Department must be dispatched to the shelter in order to access the Mobile Crisis Team, a requirement which can delay de-escalation and stabilization of the crisis. The community also accrues costs for emergency medical transportation that could be avoided if expanded primary care services were available on-site at the shelter.

18 <https://psychiatryonline.org/doi/abs/10.1176/appi.ps.201300230>

19 <http://www.pchtf.org/about-us/recent-news/new-report-examines-the-need-for-single-room-occupancy-housing/>
20 Ibid.

21 <http://affordablehousingonline.com/housing-search/Iowa/Des-Moines/>

22 http://b.3cdn.net/naeh/bb34a7e4cd84ee985c_3vm6r7cjh.pdf

23 <http://archive.desmoinesregister.com/article/20130209/NEWS/130209002/Numbers-homeless-receiving-services-Iowa-nation-fairly-stable>

Acute Psychiatric Inpatient Care

Several stakeholders expressed concern over the lack of acute care beds for children, as well as adults experiencing mental health distress. Iowa ranks 47th in the nation for publicly funded hospital beds, based on the state's population.²⁴ If the Governor's proposal to close Mt. Pleasant and Clarinda is approved, Iowa will have a total of 64 state operated psychiatric beds for adults and 32 beds for children and adolescents.

In addition, there are private psychiatric facility beds and inpatient beds in local hospitals. There are three local psychiatric inpatient units in Des Moines: Mercy Medical Center provides 18 inpatient acute care beds for adults; Broadlawns Medical Center provides 30 inpatient beds for adults; and Unity Point provides 16 inpatient beds for children and adolescents, and 40 beds for adults. Stakeholders report problems in accessing beds for individuals presenting with difficult to manage behaviors, and for people with certain types of healthcare coverage. Individuals have reported waiting for days in the emergency room for a bed to become available. DHS's intent to further reduce state operated psychiatric services has the potential to create even more demand on this already stressed resource.

Substance Use Disorder Services/Co-Occurring Disorders Treatment

The final theme expressed by many key informants was the inequity between mental health and substance use disorder (SUD) services in Iowa, as well as the lack of sufficient capacity to treat co-occurring mental health and substance use disorders (COD). Most agencies identified SA as a major factor contributing to the poverty, instability and trauma that children as well as adults are exposed to. Yet the presence of a substance use disorder alone doesn't satisfy eligibility for an IHH—individuals must also have a serious mental health illness or social and emotional disorder to qualify. 'Medicaid expansion' does not include SUD residential treatment as a covered benefit. Medicaid only covers Peer Support for individuals with serious mental illness, not addictive disease.

In addition to inequities in services, there are inequities in reimbursement. In 2014 the Iowa General Assembly passed House File 2463 which directed the Iowa Department of Public Health (IDPH) to work with stakeholders to review reimbursement provisions for substance-related disorder providers.²⁵ The purpose of the study was to determine:

- If rates for publicly funded SUD services were adequate;
- If SUD service rates should be re-based;
- If SUD reimbursement is equitable to reimbursement for similar behavioral health services; and
- If the increase in healthcare coverage will impact SUD service providers.

²⁴http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf
²⁵ http://coolice.legis.iowa.gov/linc/85/external/HF2463_Enrolled.html

The workgroup issued a report of findings in December, outlining discrepancies in reimbursement methodologies and rates for SUD services, and providing recommendations for addressing the disparities.²⁶

Informants also identified the lack of adequate treatment options for COD. This finding was further reinforced in the Community Integration Workgroup for Adults with Serious Mental Illness Final Report.²⁷ In an effort to meet the demand and expand business opportunities, provider organizations are adapting and working to form partnerships and services that are COD capable.

Transportation

Stakeholders consistently identified the lack of reliable and affordable transportation as a barrier to employment, to shopping and to accessing healthcare. While non-emergency medical transportation is a covered benefit under traditional Medicaid programs, it is not a covered benefit under the Iowa Wellness or Marketplace Choice Plans. The Department of Health and Human Services (HHS) initially approved a one-year waiver from providing non-emergency transportation to newly eligible adults, and recently approved an extension of this waiver through July 31, 2015. However, HHS stated that the current data raises concerns about access to care and any subsequent extensions will be based on Iowa's ability to submit data to HHS that demonstrates the waiver does not impact access to care, especially for individuals below 100 percent FPL.²⁸

Public transportation is limited to bus service and taxi cab service in Greater Des Moines. Polk County Health Services, Central Iowa Community Services and the Heart of Iowa provide transportation assistance to cover the cost for trips to medical and behavioral health appointments, employment, grocery shopping and other select activities for people with a diagnosis of mental illness and/or limited income. However, there are areas in central Iowa where transportation just isn't available regardless of the assistance provided. The Des Moines Area Regional Transit Authority does offer 'how to ride' training free of charge to facilitate access and efficiency for riders. In addition, there are reduced fares for persons with disabilities and refugees. Otherwise, a monthly bus pass for local routes costs \$48. Para-transit service *begins* at \$3.50 per trip, with added cost based on the distance of the transport. Taxi service is also limited and typically cost-prohibitive for low-income families.

Refugee Relocation Assistance

Central Iowa is not the only region facing challenges in trying to adequately support relocated refugees. In response to concerns raised across the country, the Government Accounting Office (GAO) was asked by Congress to examine (1) the factors resettlement agencies consider when determining where refugees are initially placed; (2) the effects refugees have on their

26 House File 2463 Report – December 2104, Substance Related Disorder Reimbursement Provisions.

27 https://dhs.iowa.gov/sites/default/files/Community_Integration_Workgroup_for_Adults_with_SMI_Final_Report_12.15.2014.pdf

28 <http://www.communitycatalyst.org/resources/publications/document/guide-to-policy-waiver-compromises.pdf>

communities; (3) how federal agencies ensure program effectiveness and integrity; and (4) what is known about the integration of refugees.²⁹ The GAO found that:

1. While federal agencies provide parameters for local relocation agencies to determine community readiness for relocation initiatives, the parameters lack specificity and rely on local organizations to adopt the parameters to reflect local strengths and needs;
2. Federal reimbursement for refugee assistance has been reduced significantly in recent years, from three years of support per refugee to six to eight months of support, better aligned with the goal for rapid employment and self-sufficiency; and
3. Local Relocation agencies receive funding based on past practice—current year funding is based on the number of placements in the past year, incenting placement activity at the same or even higher level in order to avoid funding cuts.

Nationally, most public entities, such as public schools and health departments generally said that voluntary relocation agencies notified them of the number of refugees expected to arrive in the coming year, but did not consult them regarding the number of refugees they could serve. Although they share in the responsibility for providing services to refugees, some of the health care providers and schools that had not been consulted on, or even notified of, the number of refugees that were to be resettled sometimes felt unprepared to do so.

Determining if the mental health provider community is adequately prepared to support refugees can be challenging. According to Carly Ross, Director of the U.S. Committee for Refugees and Immigrants (USCRI) Field Office in Des Moines, it is difficult to accurately measure mental health issues in refugee adults and children as they tend to be under-reported at arrival or may not become apparent until after refugees have lost contact with their initial physician. Studies have shown rates of Post-Traumatic Stress Disorder (PTSD) and major depression in resettled refugees to range from 10-40% and 5-15%, respectively. Children and adolescents often have higher levels with various investigations revealing rates of PTSD from 50-90% and major depression from 6-40%. Risk factors for the development of mental health concerns include trauma, delays in the asylum application process, detention, and the loss of culture and support systems. It's important to note that the effects of trauma persist when untreated; studies on Cambodia refugees showed that 62% of the refugees still suffered from PTSD and 51% suffered from depression even two decades after the trauma.³⁰ While this behavioral health services study did not include a review of the Refugee Relocation processes in central Iowa, many stakeholders interviewed shared examples of support that local communities provide to supplement gaps in federal assistance. One example is the cost of interpreter services necessary for the Des Moines Public School District's Pre-School social workers to serve young children and their families. Several stakeholders involved with the school district reported that more than 100 languages and dialects are spoken by children and their families they serve. While interpreter services are eligible for federal funding for children grades kindergarten

29 Refugee Resettlement, "Greater Consultation with Community Stakeholders Could Strengthen Programs," Government Accounting Office, 2012.

30 www.uniteforsight.org/refugee-health/module2

through 12th grade, the funding does not cover the costs for pre-school children. Local funders cover the cost.

Barriers Impeding Access to Behavioral Health Services

In addition to the need for additional services, there are systemic issues which are creating challenges for individuals and families in need of behavioral health services, as well as providers of those services.

High Costs Associated with Healthcare Coverage

Having insurance and being able to access care are not the same, as evidenced by numerous stakeholder examples. As described earlier in this report, individuals enrolled in the Iowa Marketplace Choice plan are now offered only Coventry through the Exchange. The behavioral healthcare coverage under Coventry was described as 'pretty poor' without exception. The Insurance Commissioner has taken a positive step by allowing new enrollees up to 138% of FPL to also choose traditional Iowa Medicaid coverage. However, individuals and families above 138% do not have that option.

In addition, according to Commissioner Gerhart, only one-third of persons insured in Iowa are covered by plans that fall under the Commission's jurisdiction to enforce ACA mandates including Parity. A large percentage of insured Iowans has healthcare coverage through employee self-insured plans. While often managed by recognized health plans, these policies may not be bound by the same rules, and often have higher co-pays, deductibles and more restrictive benefits and coverage. Insured individuals in need of mental health and substance use disorders treatment may not have the money needed to pay the co-pays or deductibles—they are only able to access treatment if the Regional Authorities cover the co-pays or services are supported through other funding sources.

Finally, HHS has approved a waiver to charge Iowa Medicaid managed care enrollees premiums of \$5 per month (50% – 100% FPL), and premium assistance enrollees \$10 per month (100% – 138% FPL) *beginning in 2015*. Rigorous research has shown that individuals with low incomes are more likely to be negatively impacted by cost-sharing than higher-income people are, because they have less disposable income and must use much of their limited incomes to meet other basic needs, such as food and shelter. The RAND Health Insurance Experiment, considered the definitive study on this issue, found that cost-sharing led to a much larger reduction in the use of medical care by low-income adults and children than by those with higher incomes.³¹

DHS has assured HHS that failure to pay premiums will not result in lost coverage for anyone, and enrollees can apply for a hardship waiver to be exempt from the required premiums.³² In addition, enrollees can mitigate premiums by participating in the 'Healthy Behaviors program,' by having a wellness exam and a health risk assessment. According to

31 J. Newhouse, *Free for All? Lessons Learned from the RAND Health Insurance Experiment*, Cambridge: Harvard University Press, 1993.

32 <http://www.communitycatalyst.org/resources/publications/document/guide-to-policy-waiver-compromises.pdf>

early data released by the state, approximately 15 percent of eligible enrollees completed the wellness exam and the health risk assessment requirements that would absolve them from paying premiums in 2015.³³ It is too early to tell what the overall impact of premiums will have on enrollees that do not participate in the Healthy Behaviors program or that do not apply for a hardship.

Navigating a Complex and Evolving Healthcare System

As described in the previous section on understanding changes at the national, state and local levels there is a tremendous level of complexity to the evolving healthcare system and lack of knowledge for how to navigate the multiple initiatives. Individuals and families who want and need behavioral health services often seek treatment when a crisis emerges; they need timely response. In spite of efforts to change the practice, individuals who do not have a relationship with a primary care or behavioral health provider or what services and resources may be available to them still rely heavily, and often inappropriately, on emergency departments for care. The 23-hour Crisis Observation Center was established as an alternative to emergency room visits.

Iowa, and more specifically, Greater Des Moines, has a number of informational tools available to assist individuals in accessing needed behavioral health services and supports. 2-1-1 offers both online as well as telephone access to information. DHS is contracting with Iowa's Aging and Disability Resource Center to enhance the capabilities of LifeLong Links³⁴ to serve as the statewide resource for accessing services and supports for individuals with multiple disabilities across the Lifespan. While these resources exist, it appears that individuals in need, as well as stakeholders involved in the behavioral health system, are not fully aware of their functionality.

Even the most forward-thinking agencies were described as 'trying to find their way' through the evolving healthcare environment. **Given the multitude and complexity of changes it's not surprising that providers experience confusion and uncertainty.** Adding to their angst is the lack of technical assistance in 'figuring it out.' While the recently awarded SIM grant includes the provision of technical assistance in its description, behavioral health providers have yet to receive it. A 'wait and see' approach is not likely to help providers plan and prepare for business practices that will be necessary to compete and thrive in the future. Larger agencies and those associated with healthcare systems may be further ahead in areas such as information technology, electronic health records, billing systems, etc. But smaller, less resource-rich behavioral health providers may not have, or be aware of, resources for investments they will need.

It's clear that all healthcare payers, government and private, are moving toward performance targets and outcomes, with an emphasis on 'value-based purchasing.' Providers would benefit from gaining a better understanding of data: what data to collect, how to analyze the data and how to use data to improve service quality and agency performance.

³³<https://www.legis.iowa.gov/docs/publications/SD/632296.pdf%20%20>

³⁴ www.lifelonglinks.org

Equally important, providers may not know where and how to position themselves as future 'players.' For example if a provider has invested in, or is considering, becoming certified as an IHH, how will that role align with a Medicaid Accountable Care Organization approach? Behavioral health providers do not have the resources to meet short-term and constantly-changing service models. Providers would welcome and benefit from a voice for their concerns, carried by an organization with significant influence within the system, but with no 'skin in the game.'

Recommendations for Improving Behavioral Health Services in Central Iowa

Iowa is devoting considerable effort and resources to transform its healthcare delivery system, including the provision of mental health and substance use disorder services. Stakeholders have identified gaps in care and challenges in accessing care. Identifying solutions in the midst of systems transformation may seem overwhelming on one hand, or be viewed as the ideal opportunity for change on the other. The following **recommendations for addressing service gaps and barriers to care** are presented for consideration by the members of the central Iowa community.

- I. **Establish a Children's System of Care, Including Core Services for Children** to improve outcomes for children and their families and to increase efficiencies for the agencies that serve them.
- II. **Strengthen Community-based Behavioral Health Services for Adults** to insure that existing services are effective and efficient and that service gaps are addressed.
- III. **Enhance Psychiatric Capacity** through the support of telepsychiatry, consultation with primary care providers and leveraging psychiatric residencies.
- IV. **Promote and Establish a Permanent Supportive Housing Strategy** to create and sustain more affordable housing for individuals with behavioral health disorders.
- V. **Advocate for the Elimination of Disparities in Substance Use Disorder Services** to support a service array and payment rates more in line with mental health treatment and supports.
- VI. **Address the Lack of Parity and Costs Associated with Healthcare Coverage** resolving high premiums, co-pays and deductibles that pose barriers for low-income central Iowans to access behavioral health care.
- VII. **Increase Public Awareness of the Resources Available in Central Iowa and How to Access them** to inform central Iowans of the services available to assist them and their families.
- VIII. **Improve Transportation Options and Coverage for Individuals with Behavioral Health Needs** in order for individuals and their families to be able to access available services and supports.
- IX. **Sponsor Provider Learning Opportunities** to help providers position themselves as thriving participants in healthcare reform.
- X. **Facilitate Community Forums** to support and focus stakeholders through the evolving healthcare environment in Iowa.

- XI. **Optimize Greater Des Moines’ Commitment to Supporting Relocated Refugees** through community collaboration and approaches that have proven successful for other communities in addressing challenges with refugee relocation.

Each recommendation is described in detail below.

I. Establish a Children’s System of Care, Including Core Services for Children

Continue advocating for adoption of the 2013 Children’s Disability Services Workgroup’s recommendations for a System of Care (SOC) that provides an organized approach and point of accountability for addressing the behavioral health needs of children, regardless of their funding source, and includes the identification of Core Services.

The goal of a behavioral health system benefit design is to provide high quality services to meet the range of clinical, family, age, gender, and cultural needs of the youth. The services that are available in a system should reflect the scientific knowledge that is available. Additionally, services should align with the important role that families, schools and communities have in supporting children’s behavioral health. A number of services and supports have been found effective to support children with behavioral health conditions. As described in the Centers for Medicare and Medicaid May 2013 Informational Bulletin regarding Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions,³⁵ the implementation of home and community-based services for this population has made significant improvement in the quality of life for these children, youth, and families.

Findings include:

- Reduced costs of care;
- Improved school attendance and performance;
- Improvement in behavioral health and emotional strengths;
- Improved clinical and functional outcomes;
- Increased stability in living situations;
- Reduced suicide attempts; and
- Decreased contacts with law enforcement.

These outcomes were achieved through the delivery of a core set of services:

Health Promotion, Screening & Early Identification	Standardized Assessment	Trauma Informed Systems Approaches	Mobile Crisis & Stabilization	Intensive In-Home Family Based Therapies
Intensive Care Coordination: Wraparound	Youth Specific Substance Use Disorder Services	Parent/Youth Peer Support	EBPs in Outpatient	EBPs in 24-hour Care

³⁵ <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>

Transition to Adulthood: Employment, Housing	Respite	Goods & Services (Flexible Funds)	Tele-Behavioral Health	Therapeutic Mentoring
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1. Initiate a public campaign to garner support for implementing SOC. In addition to outcome data from Orchard Place, 'Helping Children and Youth with Serious Mental Health Needs: Systems of Care'³⁶ provides outcome data on the impact of Systems of Care.
2. Elevate advocacy for the establishment of minimum Core behavioral health services for children across all funding sources in order to achieve positive outcomes for youth.
3. Solicit existing stakeholder groups engaged in children's mental health discussions, including the National Alliance of Mental Illness – Central Iowa's newly established Children's Mental Health Group, the ACEs 360 Committee, and A Mid-Iowa Organizational Strategy's Mental Health Community Conversation group to pull together key stakeholders to advocate for a shared agenda for children's behavioral health services with state agencies, legislators, and other policymakers.

II. Strengthen Community-based Behavioral Health Services for Adults

Given the existing concern over the lack of psychiatric inpatient acute care beds in central Iowa, and the DHS plan to downsize state psychiatric institutional beds it is critical to direct the communities collective resources toward maximizing the effectiveness and efficiency of community-based services in central Iowa, focusing on evidence-based practices.

1. Advocate that DHS allocate a portion of the 'state and regional' surplus identified toward shoring up community-based services and supports in the Greater Des Moines regions could be a positive solution.
2. Work with Polk County Health Services, Central Iowa Community Services and Heart of Iowa to identify and request resolution of policy or operational concerns with existing services. For example, requiring that the Mobile Crisis Team be dispatched via police dispatch centers and accompanied by the Des Moines Police can result in the protracted delivery of crisis stabilization services, which can cause a person's condition to worsen during the wait time.
3. Work with the Services Integration Team and Central Iowa Community Services officers to identify and expand services to fill gaps in care, such as expanding Supported Employment Services, and infusing Certified Peer Specialists and Recovery Coaches in

³⁶ <http://store.samhsa.gov/product/Helping-Children-and-Youth-With-Serious-Mental-Health-Needs-Systems-of-Care/SMA06-4125>

all levels of behavioral health care in the regions.

4. Work with the Services Integration Team to identify opportunities for providing primary health care, such as Community Health Centers that serve individuals with behavioral health disorders.
5. Work with the Services Integration Team to support more cost-effective services at the CISS by supporting daily on-site primary care and public safety resources during peak demand times. CARE LINK – Community Medical Centers, Inc., provides primary health care services at local shelters in San Joaquin County, California;³⁷ Unity Health Care provides services throughout the community, including sites located in emergency shelters and homeless service facilities across Washington, D.C.³⁸ An alternative option is the use of mobile health units, which can deliver medical and behavioral healthcare at homeless and emergency shelters, as well as to homeless individuals on the street.³⁹
6. Work with stakeholders in central Iowa to identify barriers to the provision of treatment for individuals with co-occurring mental health and substance use disorders. The Departments of Human Services and Public Health Services worked together to promote COD treatment, and identified multiple resources for COD services. In addition, Magellan has provided training and facilitated ongoing opportunities for providers to discuss cases and share best practices,⁴⁰ yet, reportedly, barriers still exist.

III. Enhance Psychiatric Capacity

There are a number of approaches states are using to address the shortage of psychiatric capacity in the public behavioral health system which could be opportunities for the community to support in central Iowa.

1. **Support of technology required for telepsychiatry.** Telepsychiatry is especially important for the diagnosis and treatment of children and adults with more complex presentations and needs. The approach is being used in Iowa and is a Medicaid reimbursable approach to service delivery. Telepsychiatry does require initial investment in equipment and technology that some behavioral health and primary care providers are not able to afford. **There is considerable opportunity to initiate and support policy efforts to increase access to telepsychiatry and to promote identification of state and other funding sources for small grants.**
2. **Enhance the capabilities of Primary Care Providers.** In many communities and especially in rural areas, primary care providers will continue to diagnose and treat individuals with behavioral health disorders. Enhancing their expertise and comfort level is an effective strategy for better service delivery. “Grand rounds” or case reviews led by psychiatrists with groups of primary care providers have proven effective. An example is

37 <http://www.communitymedicalcenters.org/services/care-link.htm>

38 <http://www.unityhealthcare.org/HealthHomeless.html>

39 <http://www.nhchc.org/wp-content/uploads/2012/02/mobilehealth.pdf>

40 <http://www.magellanoflowa.com/media/135685/integrated%20co-occurring.pdf>

Project ECHO out of New Mexico.⁴¹ Although originally developed to address shortages of medical specialists, the approach has been successfully adapted to shoring up primary care practitioners' expertise in providing behavioral health care as well.

3. **Solicit interested parties in the central Iowa area along with corporate sponsors to help sponsor psychiatric residents to increase the psychiatric capacity in central Iowa.** The Iowa legislature appropriated \$2 million to the Iowa Department of Public Health for medical residencies, with preference for psychiatrists and family practitioners. The funds are being dispersed via an RFP. Funds cover only a percentage of start-up costs and the applicant has to provide matching funds. In addition, the initial grant is for three years, with no assurance of funding to support the costs of a resident (\$180,000 per year) on an ongoing basis. Broadlawns has proposed to fund four residents and would like to have a mid-level fellowship for two alternative practitioners – either an Advanced Registered Nurse Practitioner or a Physician Assistant. The Broadlawns psychiatric residency program and mid-level fellowship program would help to spread training locations to central Iowa and help to increase the numbers of critically needed practitioners.

IV. Promote and Establish a Permanent Supportive Housing Strategy

Central Iowa needs a **strategy for creating and sustaining more permanent supported housing (PSH) for individuals with disabilities.** Evictions of homeless individuals from under bridges and camp areas are sometimes seen as the only solution when other stable housing options are not available. The evictions use many resources and can overwhelm the jail and criminal justice systems. As an alternative, there is considerable evidence⁴² that PSH:

- Reduces homelessness;
- Increases housing stability and retention;
- Increases participation in mental health and substance use disorder treatment;
- Decreases use of emergency departments;
- Improves health outcomes;
- Is cost-effective; and
- Improves quality of life.

This recommendation is consistent with the findings and recommendations as outlined in the Community Integration Workgroup Report.⁴³

1. The community should continue to support efforts by the Homeless Coordinating Council and the Continuum of Care Board to create a plan for PSH for individuals who are homeless or at risk of homelessness.

⁴¹<http://echo.unm.edu/about-echo/>

⁴² <http://store.samhsa.gov/shin/content//SMA10-4510/SMA10-4510-07-TheEvidence-PSH.pdf>

⁴³ https://dhs.iowa.gov/sites/default/files/Community_Integration_Workgroup_for_Adults_with_SMI_Final_Report_12.15.2014.pdf

2. Insure that affordable housing efforts align with Housing Tomorrow’s efforts to develop an extensive plan to address affordable housing in central Iowa.
3. Adopt the Polk County Housing Trust Fund report’s recommended policy that for every SRO unit eliminated a PSH unit must be created.⁴⁴
4. Support and enhance the coordinated centralized intake system by:
 - a. Ensuring that mental health continues to be identified and tracked as a barrier to accessing stable housing.
 - b. Fostering collaboration and participation by shelters throughout the community; full participation and engagement will ensure consistency.
 - c. Assisting with identification of resources for sustainability.

V. Advocate for the Elimination of Disparities in Substance Use Services

Given the impact of substance abuse on Des Moines and the surrounding communities, the lack of adequate support for substance use disorder services must be addressed.

1. Advocate for substance use service reimbursement rates to more closely mirror rates for similar mental health services.
2. Advocate for Medicaid to include Peer Support for adults with Addictive Disease.
3. Advocate for Medicaid expansion to cover drug and alcohol residential treatment.

VI. Address the Lack of Parity/Costs Associated with Healthcare

While many health plans in Iowa may not fall under the Insurance Department’s ability to enforce the ACA and MHAEPA, the inequities in coverage for behavioral health services places a heavy burden on individuals in need of services and the communities in which they live. Other sources of funding, such as the Regional Behavioral Health Authorities and private funding sources, are called upon to fill in the coverage that health plans don’t provide.

1. Advocate for the enforcement of Parity with applicable healthcare plans.
2. Engage the Kennedy Forum, whose mission is “to unite the health care system, and rally the mental health community around a common set of principles: Fully implement the 2008 parity law, bring business leaders and government agencies together to eliminate issues of stigma, work with providers to guarantee equal access to care, ensure that policymakers have the tools they need to craft better policy, and give consumers a way to understand their rights.”
3. Work with providers to track and quantify the impact of the lack of parity. For example, providers should capture the amount of service that is uncompensated or subsidized

⁴⁴ <http://www.pchtf.org/about-us/recent-news/new-report-examines-the-need-for-single-room-occupancy-housing/>

using private sources and foundations as a result of health insurers' service denials, service limitations and co-pays.

4. Educate providers and service recipients about the options to participate in the Healthy Behaviors program, or to apply for a hardship, thereby eliminating the required premiums for Medicaid and premium assistance enrollees.
5. Work with providers to track the impact of premiums on services to Medicaid managed care and premium assistance enrollees.

VII. Increase Public Awareness of the Resources Available in Central Iowa and How to Access Them

1. Create a collaborative effort between 2-1-1, LifeLong Links, Iowa COMPASS, and the regional mental health entities to create common messaging and identify ways to streamline services.
2. Organize a public awareness campaign for the key organizations that provide information and referral to help individuals better understand who to call for various needs. Promotional strategies used in other states include public service announcements, advertising in local newspapers and circulars, disseminating informational flyers at cultural and ethnic events, and including information with DHS mailings/notices.

VIII. Improve Transportation Options and Coverage for Individuals with Behavioral Health Needs

Resolving the lack of adequate and affordable transportation is essential for the recovery of individuals with behavioral health challenges.

1. Advocate for including non-emergency medical transportation as a covered benefit under the Iowa Wellness and Iowa Marketplace Choice plans would help to improve access to behavioral health care for their members.
2. Insure that **Mobilizing Tomorrow**, the Metropolitan Planning Organization's long-range transportation plan that outlines how the MPO's member communities region will invest approximately \$600 million in transportation funding over the next 35 years, considers the needs of individuals with behavioral health disorders.
3. Access the Substance Abuse and Mental Health Services Administration's toolkit "Getting There: Helping People with Mental Illness Access Transportation."⁴⁵ This toolkit provides a wealth of information, including emerging best practices, such as the innovative use of public transportation, as well as creation of specialized opportunities

45 <https://store.samhsa.gov/shin/content/SMA04-3948/SMA04-3948.pdf>

such as consumer-run services, potential sources of funding to develop transportation initiatives, and recommendations for developing transportation initiatives.

IX. Sponsor Provider Learning Opportunities

Work with the Polk County Health Services Systems Integration Team to assist providers in navigating evolving healthcare models.

1. Educate providers about the various healthcare initiatives in process in Iowa, the roles and requirements of providers for each initiative, and the opportunities for behavioral health partnerships and provider participation. Well-informed providers will make better decisions in charting their course in the evolving healthcare transformation.
2. Medicaid Modernization, as proposed, has significant implications for providers of primary care, behavioral health and long-term services and supports. Community leaders need to continue efforts to build and strengthen providers' capacities to thrive in an integrated managed care network. Providers would benefit from sharing and learning from each other, as well as providers in other states that have implemented comprehensive Medicaid managed care programs. Resources such as 'How Have Long-Term Services and Supports Providers Fared in the Transition to Medicaid Managed Care? A Study of Three States,'⁴⁶ conducted by Truven Healthcare Analytics, can offer insights into lessons learned. Kansas and Texas are states where Medicaid benefits for physical health, behavioral health, I/DD and long-term services and supports have been contracted out to managed care companies. Sharing early lessons learned from their provider communities could be very helpful for providers in central Iowa.
3. Identify opportunities for training and technical assistance on delivering value-based service delivery—the tools and resources providers need to be effective in negotiating to participate in health plans' provider networks.

X. Facilitate Community Forums

Continue to provide opportunities for providers, advocates, consumers, etc., to convene and share policy recommendations, best practices, etc., facilitated by an entity with sufficient clout to garner participation, but with no vested interest in a particular outcome. Convening such a forum on a regular basis would offer providers and other stakeholders a sense that their issues and concerns will be heard and help to focus participants on solutions during this ever-changing environment.

XI. Optimize Greater Des Moines' Commitment to Supporting Relocated Refugees

Numerous agencies, organizations and individuals within the community touch the lives of individuals re-locating to central Iowa from trauma-filled lives in other countries. Many of these agencies independently wrap services and supports around individuals and their families, unaware of gaps that others may also be trying to address.

⁴⁶ <http://aspe.hhs.gov/daltcp/reports/2013/3LTSStraneses.shtml>

1. Support the work of the Refugee Planning Coalition and ongoing opportunities to enhance support of refugee health and mental health. Examples that have proven effective for other communities include:⁴⁷
 - a. Fargo, North Dakota. In the 1990s local service providers and the local voluntary refugee relocation agency formed a Refugee Advisory Committee to provide a formal, community-based structure for finding solutions to challenges in resettling refugees. The committee included representatives from the local voluntary agency, state and county social services departments, various city departments, school districts, as well as local health care providers.
 - b. Boise, Idaho. City officials formed a roundtable group to develop a Refugee Resource Strategic Community Plan in 2009 to work with the local voluntary agencies, the state refugee coordinator's office, and community organizations to identify strategies for successful resettlement of Boise's refugees.
 - c. Village of Skokie, Illinois. This Chicago suburb created a strategic plan to help facilitate the integration of immigrants, including refugees, by (1) establishing a coordinating council of key service providers, (2) developing a system to improve providers' access to interpreters, and (3) recruiting and training immigrant and refugee community leaders for government commissions and school boards, among other strategies.
 - d. Lancaster, Pennsylvania. Franklin & Marshall College took a variety of steps to help facilitate the integration of refugees, including using student volunteers to teach refugees English, tutor refugee students, and help refugee families enroll their children in school and access public health services. In addition, the college partnered with a local voluntary agency affiliate to plan a community conference on refugee integration with the goals of (1) better understanding and addressing the needs of refugees, (2) identifying strategies for fostering rapid integration, and (3) developing a broad coalition of organizations serving refugees that could continue to work together on these issues in the future.
2. Identify policies and procedures at the federal, state and local level which need to be addressed in order to improve outcomes and efficiencies. Federal policies to be addressed include:⁴⁸
 - a. Ensuring that administrative cost reimbursements are forward looking and based on planned refugee admissions rather than backward looking and based on actual arrivals, allowing the agencies to plan for new refugees and to maintain

47 Refugee Resettlement, "Greater Consultation with Community Stakeholders Could Strengthen Programs," Government Accounting Office, 2012.

48 http://www.resettlement.eu/sites/icmc.ttp.eu/files/Resettlement_at_Risk.pdf

the local staff and expertise necessary to resettle refugees effectively.

- b. Working with stakeholders to identify indicators of integration that include factors beyond short-term employment, among them long-term employment, civic participation, health and wellbeing, and English proficiency. Benchmarks should be established for these indicators, progress toward success should be measured, and data should be collected.
3. Contact 'Welcoming America' to identify best practices to guide a robust and productive consultation process and provide training to ensure that all resettlement agencies benefit from the effective practices and experiences of other communities. An example for central Iowa communities could be how to create efficient, effective ways to screen and treat the complex mental health issues experienced by this population by establishing partnerships between refugee organizations and primary care and behavioral health organizations.

Appendix A: Mental Health/Substance Use Services Environmental Scan Key Informants

Organization Name	Individual Contact	Contact Title	Interview Date
GROUP 1			
Broadlawns Medical Center	Earl Kilgore Dr. Janice Landy	Director of Integrated Health Homes Head of Psychiatry	5-Nov-14
Primary Health Care	Kelly Huntsman	Executive Director	4-Nov-14
La Clinica de la Esperanza	Karen Reinecke	Clinic Administrator	4-Nov-14
Polk County Health Department	Rick Kozin	Director	4-Nov-14
Dallas County Health Department	Shelley Horak	Director	4-Nov-14
Warren County Health Department	Jodene DeVault	Director	4-Nov-14
GROUP 2			
Mercy Medical Center	Teri Fredregill	Director of Mercy Behavioral Health Help Center	4-Nov-14
Unity Point Health	Kevin Carroll	Executive Director of Behavioral Health	4-Nov-14
VA Hospital	Mardi Barnes	Suicide Prevention Coordinator	4-Nov-14
GROUP 3			
Eyerly Ball	Early Kelly Torry Simmons	Executive Director Mobile Crisis Team Director	4-Nov-14
Central Iowa Shelter and Services	Tony Timm	Executive Director	4-Nov-14
Law Enforcement	Kelly Drane	Officer trained to respond to MH calls	4-Nov-14
GROUP 4			
Central Iowa Community Services	Jody Eaton	Jasper County Regional representative	4-Nov-14
Heart of Iowa	Darci Alt	CEO	4-Nov-14

Organization Name	Individual Contact	Contact Title	Interview Date
Polk County Health Services	Karen Walters-Crammond	CEO	4-Nov-14
GROUP 5			
Indianola High School	Kyle Bandstra	Guidance Counselor	4-Nov-14
Heartland AEA	Dave Wood for Paula Vincent	Regional Director	4-Nov-14
GROUP 6			
Bridges of Iowa	Tom Jackowski	CEO	5-Nov-14
Optimae	Bill Dodds	CEO	5-Nov-14
Goodwill Industries of Central Iowa	Marlyn McKeen	Executive Director	5-Nov-14
Mainstream Living	Bill Vaughn	Executive Director	5-Nov-14
Easter Seals	Sherri Nielsen	CEO	5-Nov-14
Community Support Advocates	Christina Smith	Director	5-Nov-14
Candeo	Marcy Davis	Director	5-Nov-14
UWCI Funded Partners			
PolK County Crisis and Advocacy	Betty Devine	Director	5-Nov-14
Mecca	Wendy Danicourt	Vice-President	5-Nov-14
Children and Families of Iowa	Janice Lane	Chief Operating Officer	5-Nov-14
Visiting Nurses	Cari Spear	Nurse Consultant	6-Nov-14
Youth Emergency Services and Shelter	Steve Quirk	Chief Executive Officer	6-Nov-14
Des Moines Public Schools Social Workers	Susie Guest Jamie Gilley	Early Childhood Prog. Administrator Director, SUCCESS	6-Nov-14
Employee and Family Resources	Tammy Hoyman	Chief Executive Officer	6-Nov-14
Catholic Charities	Nancy Galeezi	Executive Director	6-Nov-14
Orchard Place	Anne Starr	Chief Executive Officer	6-Nov-14
Telephone Interviews			6-Nov-14
DHS/Medicaid/IDPH	Theresa Armstrong and Laura Larkin;	Bureau Chief and Executive Officer of Bureau of MH and DD Services; area DHS service manager; IDPH Behavioral Health Division Director	5-Nov-14
DHS/Medicaid/IDPH	Tracy White and Michael McInroy	Social Work Administrators	5-Nov-14

Organization Name	Individual Contact	Contact Title	Interview Date
NAMI – Central Iowa	Teresa Bomhoff and Barb Glass	Advocates	4-Nov-14
Iowa Department of Public Health	Kathy Stone	Director of Division of Behavioral Health	14-Jan-15
Iowa Insurance Division	Nick Gerhart	Insurance Commissioner	14-Jan-15
AMOS (A Mid-Iowa Organizing Strategy)	Paul Turner	Lead Organizer	12-Jan-15
Iowa Department of Aging	Joseph Sample	Aging and Disabilities Resource Center, LifeLinks	20-Feb-15
Polk County Health Services	Susan Osby	Oversees Community Living Services, including Homelessness	12-Mar-15

Appendix B: Mental Health/Substance Use Services Study – Key Informant Interview Questions

How does your agency interface with the mental health and/or substance use disorder service systems in central Iowa?

1. Based on this experience, what works well in the current mental health and substance use disorder service systems?
2. What are the areas of the systems that need improvement?
 - a. Are you aware of gaps in mental health services for children and adults in central Iowa?
3. What changes to the current mental health delivery system and services would be most beneficial to the community?
4. Based on your understanding of national, state and local changes to coverage, service delivery and funding what do you see as the greatest challenges for mental health and Substance Use providers in central Iowa?
 - a. What are the greatest opportunities for mental health and substance use disorder service providers to improve outcomes for service recipients in central Iowa?
5. Is there anything I haven't asked about that you think would be important to consider as part of this study?