★ Background

Although Iowa has made attempts to improve its behavioral health care delivery system, the system remains fragmented and is in need of more – more financial resources, more health care providers, more access points for patients needing services and more community resources to keep behavioral health patients healthy.

Hospitals see this need every day when patients in need of behavioral health services arrive in emergency rooms (ERs) as a last resort, and only hope for treatment. However, most hospital ERs are already overloaded and are not equipped to provide sufficient care for these patients in this setting. Likewise, if a patient is ultimately admitted to an inpatient psychiatric unit, Iowa does not have proper “post-acute” behavioral health services forcing hospitals to serve as “holding units” for individuals in need of longer-term behavioral health services and supports.

The lack of a coordinated care continuum for behavioral health services has led to capacity issues at hospitals of all sizes. Many rural hospitals do not have the physical infrastructure to provide care to patients in need of behavioral health care which means the patients need to travel to the nearest provider to receive care. The nearest provider is likely in an urban area, but with the volume of patients being funneled into these “hubs” of behavioral health care providers, wait times increase and oftentimes the patient’s condition can deteriorate further.

Iowa’s behavioral health system is missing at least two vital settings of care referred to as “sub-acute” and “post-acute” behavioral health services. With the bulk of behavioral health being delivered through an inpatient psychiatric unit or on an outpatient basis through a community mental health center or psychiatric clinic, there is no short-term care available that could help to prevent a costly hospital admission, nor are there adequate services to assist individuals transitioning back to their homes as a means to improve quality and further reduce hospital readmissions and ER use. IHA estimates that at any given time, approximately 25 percent of hospital inpatient psychiatric patients would be better served in an alternative care setting.

Adding to this problem, Iowa has an insufficient supply of behavioral health care providers, like psychiatrists, psychologists and other mid-level providers skilled in behavioral health care. Many hospitals report extended recruitment efforts that are to no avail.

★ Action Needed

While there are no easy solutions to these problems, IHA supports the following initiatives seeking to improve the effectiveness of Iowa’s behavioral health system as a means to improve the quality of life of Iowans in need of these services:

- **Increase behavioral health care access across the continuum.** Increased capacity across the continuum of care will help reduce the current bottleneck in the system that leaves patients unnecessarily languishing for days in hospital beds. By building a care continuum that includes sub-acute services, crisis intervention, crisis homes, nursing facility care and community-based services, more hospital inpatient beds will become available for acutely ill behavioral health patients.

  - **Increase crisis stabilization services in local communities.** Crisis stabilization is a less...
expensive form of care because it deescalates a situation before it devolves into a hospital admission, or worse jail time or even death. Increased funding for crisis services would be beneficial and keep people out of hospitals or other institutional care settings.

- **Increase utilization of “transitional level of care units”**. The state’s regional-based behavioral health system currently invests in “transitional level of care units” designed to assist patients in transitioning from an institutional setting to a home or community-based setting. The state of Iowa should commit to investing in programs like these to allow individuals to receive the care they need in the least costly, but highest quality setting. This could include a longer-term rehabilitation program that would assist patients who are difficult to place in an appropriate care setting. The state of Pennsylvania has successfully developed a plan that could be evaluated.

- **Increase sub-acute services**. Hospitals remain hesitant to embark on this new level of service due to the challenges presented under the current system. However, investing in this level of care would reduce hospital admissions and unnecessary ER use while also relieving the “bottleneck” of patients who are currently awaiting placement or discharge from a hospital, thus occupying an inpatient psychiatric bed that could be used for someone else in true need of acute care.

- **Days Waiting Placement**. Mandate MCOs pay hospitals a per diem payment for any patient who remains in a bed beyond the medically necessary timeframe. Currently, hospitals are not reimbursed for services that are provided outside of the MCOs predetermined window. However, in the vast majority of cases the hospital is attempting to locate a suitable setting for the patient, which can take considerable time. Hospitals should not be penalized for diligently working to find a suitable setting for the patient prior to discharge.

- **Expand telehealth opportunities for behavioral health services**. In 2015, Iowa passed a law requiring Medicaid to pay for services provided via telehealth in the same way it pays for services provided in-person. This same requirement did not extend to other payers, however. Therefore, the Iowa General Assembly should pass legislation that requires all health insurers to reimburse providers for the same services at the same payment rate, regardless of how the care was delivered. Expanding access to telehealth services along with fair provider reimbursement for these services will provide some relief to the state regarding the lack of psychiatrists and other behavioral health practitioners. Telehealth can enable a quicker diagnosis, increase access to specialty care, increase placement options for patients and decrease travel time required to reach care.

- **Revise Chapter 229**. Iowa Code Chapter 229 deals with voluntary, involuntary and emergency commitments for patients with mental illness. The state’s committal process has been administratively challenging for decades and it’s time for the Legislature to work with stakeholders to make a number of needed changes, including allowing hospitals to use the current “emergency hold” process at any time. The 48 hour hold is designed for a provider to employ when the court is closed on an evening, weekend or holiday. However, there are times when hospital requests are delayed (due to other, unrelated court business) that delays a patient’s admission or discharge. Allowing providers to hold a patient for 72-hours without a court order, allows the provider time to properly diagnose the patient, and would only involve the court should the patient’s condition remain unchanged within the 72 hour period.

- **Broaden scope of practice**. Because of the lack of inpatient psychiatric hospital bed space and behavioral health practitioners, IHA supports changes to the Iowa Code to allow certain health care providers to operate within their full scope of practice.
IHA supports changes to the mental health and substance abuse committal process in Iowa Code Chapters 229 and 125, respectively, to increase efficiencies and reduce the administrative burden placed on physicians, while still protecting the rights of citizens. Chapters 125 and 229 currently only allow a physician to conduct screening exams for commitments. These code provisions do not recognize the increased role of psychiatric advance registered nurse practitioners or other qualified non-physician practitioners trained in behavioral health care who practice independently in the state. Advanced registered nurses practice independently and their scope of practice allows them to perform several other federally-governed screening exams. With Iowa’s extreme shortage of psychiatrists, the state should remove as many barriers as possible for these practitioners to assist with mental health treatment. Therefore, the General Assembly should adopt legislation that allows advance registered nurse practitioners to perform the necessary committal screening exams required under Iowa Code Chapters 125 and 229.

IHA supports changes to the definition of case management as defined in 441 Iowa Administrative Code Chapter 24. The current definition requires a bachelor’s degree. For case management services, peer support specialists have often been used to serve in this capacity. **Therefore, the General Assembly should adopt legislation that allows peer support specialists to serve as case managers for behavioral health patients.**

- **Mental Health Institutes.** IHA continues to oppose any reductions to services or staff at the state’s remaining mental health institutes (MHIs). A vast majority of MHI patients cannot be cared for in any other setting making this level of care vital to Iowa’s behavioral health infrastructure. Following the state’s closure of two of the MHIs in Clarinda and Mount Pleasant, patients were dispersed across Iowa or transferred out-of-state and demand for behavioral health services through hospital emergency departments and inpatient psychiatric units increased.

IHA opposes any plan to further reduce the state’s mental health institutes. Furthermore, every effort should be explored to utilize the Clarinda and Mount Pleasant campuses for alternative care, such as sub-acute services, so that Iowa can get back on the path of investing in behavioral health care rather than cutting services and infrastructure which is leading to negative outcomes for patients and hospitals.