Southwest Iowa Region MHDS
Mental Health & Disability Services

New Crisis Service – Planning and Prioritization

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Mission Matters
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Table of Contents

Our Strategic Planning Process 2

Perspectives 4

Programs and Services 5

Budget 10

Prioritization 11

Discussion points that need further exploration – program/service 14

Discussion points that need further exploration – miscellaneous 15

External Factors 16

Going Forward 19

Guiding Principles 27

Our Commitment 29

Recommendations 31

Appendix A – Participant List 33

Appendix B – Opening Activity – Day One 35

Appendix C – Pictures 37

Our Strategic Planning Process

Southwest Iowa Mental Health and Disability Services (SWIA MHDS) Region was seeking the input of stakeholders from the nine counties they serve (Cass, Fremont, Harrison, Mills, Monona, Montgomery, Page, Pottawattamie, and Shelby) to prioritize the updated proposed Chapter 24[1] rules by the Iowa State Legislature. Representatives from law enforcement, hospitals, mental health providers, substance abuse providers, people with lived experience and others were asked to give almost two full days of their time to plan for SWIA MHDS' future (see appendix A).

The objective of the two days was to gather a diverse group of stakeholders to get common understanding and consensus around a process and plan for prioritizing and implementing updated new core services surrounding complex needs.

Key areas of discussion included the following:

- Perspectives – hearing from each other about the different perspectives in the room
- Programs and Services – review of current services being offered in SWIA MHDS and possible new ones based on chapter 24
- Budget – SWIA MHDS' current budget, forecasted budget without the implications of House File (HF) 2456, and budget implications with HF 2456

Vision

It is the vision of SWIA MHDS to mindfully, creatively and responsibly serve the residents of our region.

With respect and dignity for all people being the center of our approach to providing and funding services, we will strive to offer choice based on individual need.

As funding is available, we will develop services for unmet needs working closely with stakeholders to enhance people's options within the region.

[1] Chapter 24 and House File 2456 are used interchangeably

- Prioritization – based on feasibility and need
- External Factors – identification of factors that must be planned for during expansion and building new programs
- Next Steps – for each of the programs that were prioritized, what are the critical next steps for success
- Guiding Principles – identification of the group's values and/or beliefs that may be used for program implementation and/or evaluation

Around 60 stakeholders participated during the two days. The structure of the time together included large group presentations, small group discussion, large group report out and large group facilitated discussion. Pre-read materials were sent out in advance (Planning process for 504, Annual Crisis data report and Core Services – HF2456 (condensed) – and an abbreviation sheet). As participants were arriving for day one, they were asked to share, "What are the three greatest concerns/needs for individuals with complex needs?" The comments are in appendix B, grouped by themes.

Mission Matters

This planning process was facilitated by Mission Matters. Mission Matters is a group of professionals who provide consulting services to non-profits, government entities, philanthropists, and socially responsible companies, with a special focus on leadership development, strategic planning, coaching, Board governance and capacity building.

Lead facilitator for this project was Beth Morrissette.

Appreciation

Thank you to the planning group from CHI Health that provided technical support in maximizing the Decision Accelerator facilitation space and their expertise in creating an agenda that helped to achieve a successful outcome.

Perspectives

The first small group activity was a structured conversation for participants to share where their professional work and/or personal life intersects with the mental health and disability system. As a team, they were asked to identify two to three ahas from their conversations. Keeping in mind, how do they connect with the crisis stabilization system as of today? Below are the different small groups ahas.

[2]Group B	Awareness/Education about services available is needed		Group F	Not understanding accessibility- a lot of clients in 'crisis' needing something else
	We anticipate greater utilization of services			Disconnect – lack of knowledge
	Success is often a result of collaboration			We are all connected by the complex needs clients we serve
Group C	Early Interventions		Group G	Better Networking – using those resources out there and connecting with them
	Funding			HIPPA – legal barriers (MOA to help share)
	Collaboration			Improve (Individual – quality of life, Community- Benefit to the community)
Group D	Create a roadmap of services (access first, identify services, navigation map, system knowledge/education, in-home public		Group H	Personal and Professional Stories of Challenges and Success
	How do we replicate successes			Better understanding of crisis system with protocols
	We have the passion and are connecting with others today?			Prevention, education, treatment improved access in both rural and urban communities
Group E	Utilization of mobile crisis, virtual (decrease commitments, decrease ED/IP visits, increase access, decrease incarceration)			
	Access provider transportation workforce			
	Communication and coordination of services			

[2] Note – there was no group A due to number of participants

Programs and Services

Building a shared foundation of understanding for the current programs and services being offered by the SWIA MHDS Region was important. The SWIA MHDS Region staff presented information about new services the SWIA MHDS Region began over the past few years to support crisis stabilization, current programs that are currently being operated for crisis stabilization services based on Chapter 24 rules and newly mandated programs listed in Chapter 24 (House File 2456).

NEW Services and Programs Since Regionalization

- Service Coordination in all counties
- Vocational Grant for supported employment
- Mental Health Court
- Jail Based Service Coordination
- Bridge Housing Program
- Data – ability to track outcomes and usage
- Better access for all counties

CURRENT

Crisis Stabilization System

- 24 Hour Crisis Line – HOPE4IOWA (Boys Town)
  - Includes referrals to appropriate services and emergency services when needed
  - Crisis Hotline for relief of distress in crisis situations and reducing risk of escalation

- Mobile Crisis Response – Mental Health Crisis Response Team (Heartland Family Service)
  - Fast response on-site for assessment and screening
  - Currently only activated by law enforcement
  - Team also serves as pre-commitment screener

- Assertive Community Treatment (ACT) – (Heartland Family Service)
  - A hospital without walls served by a multidisciplinary team under the supervision of a psychiatrist or ARNP.
  - Currently operating in Pottawattamie with ability to serve Harrison and Mills with possible expansion to rest of region.

- Residential Crisis Services (CSRS) – Turning Pointe (Waubonsie Mental Health Center)
  - 3-5 day stay to stabilize an individual back to pre-crisis state
  - Current program in Clarinda – 5 bed home

NEW MANDATED

Programs by House File 2456

- Access Service Network (Access Center)
  - For those who do not need hospitalization but need significant amounts of supports and services not available in other home community-based settings.
    - May include a combination of the following:
    - Intake assessment
    - Screening for multi-occurring conditions
    - Care Coordination
    - CSRS
    - Subacute
    - Substance Abuse Treatment
  - Each region designates at least one:
    - No reject, no eject – (Zero Exclusion)
    - 100 miles / 90 minutes
    - Designated residential based settings (CSRS/Sub Acute) - no more than 16 beds
    - Accredited for CSRS and licensed for Sub Acute
    - Licensed or have cooperative agreement for Substance Abuse Treatment Services or medical care that incorporates withdrawal management
    - Can serve individuals already under a court order
  - Provide the following based on comprehensive assessment (crisis evaluation):
    - Peer Support
    - Mental Health Treatment
    - Substance Use Treatment
    - Medically necessary physical health services
    - Care Coordination
    - Service Navigation
    - Warm Handoffs and linkages to services

NEW MANDATED

Programs by House File 2456 - continued

- Community Based Crisis Services (CBCS)
  - Like our CSRS but where the individual lives, works or recreates
  - Available 24-Hours a day
  - Includes telephone and walk-in crisis service and crisis care cooridnation

- Subacute
  - For people coming out of acute care hospitalization or at risk for acute care
  - Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.
  - Demonstrate a low level of stability through any two of the following conditions: 1. Presents moderate to high risk of danger to self or others. 2. Lacks adequate skills or social support to address mental health symptoms. 3. Is medically stable but requires observation and care for stabilization of a mental health condition or impairment.
  - Within 100 miles and within 24 hours of referral
  - Can be facility based or provided by an ACT provider in a community setting

- 23-Hour Crisis Observation and Holding
  - Secure and Protected, Structured and Monitored
  - Medically staffed
  - Psychiatrically supervised (ARNP or PA)
  - Access within 100 miles and 120 minutes
  - Include but not limited to: treatment, medication administration, meeting with family/others, referral to services
  - Doesn't meet inpatient but can't be managed in less restrictive setting
  - Period of observation to assist in stabilization and prevention of symptoms exacerbation
  - Actual or potential danger to self or others
  - Bed or comfortable chair

NEW MANDATED

Programs by House File 2456 - continued

- Intensive Residential Services (IRS)
  - o For individuals with most intensive SPMI o May have multi-occurring conditions
  - o 24-Hour supervision
  - o Behavioral and other support services
  - o Provided by HCBS Habilitation or ID Waiver SCL provider
  - o Region to designate at least one service provider

Budget

A key factor when expanding and/or adding programs and services is to understand the current resources available today and in the future. The SWIA MHDS believes it is critical to not only develop programs and services but to be a great steward of the tax dollar and build sustainable programs while keeping a stable Mental Health Levy. Regions across the state impose a levy based on a per capita rate for their annual revenue. The per capita's amount varies from Region to Region and in some cases, vary within the Region per county. Wide disparity exists within the Iowa Regions regarding the fund balance they have. Regarding the SWIA MHDS Region, they have a positive fund balance. With the recently passed HF 2456 they must reduce their fund balance to equal 20% of their annual budget. This creates unintended consequences. The table below outlines the funding basics of the SWIA MHDS Region.

- Mental Health Levy Caps on individual county taxable valuation
- Per Capita = a method to try to "equalize" county contribution based on population

  SWIA MHDS Region per capita history

  - FY15 – max levy + equalization ($47.28 (5) to $34.99)
  - FY16 - $33 per capita
  - FY17&18 - $23 per capita
  - FY19 - $21 per capita
- HF504 set new Per Capita maximums for each Region and 20% fund balance max by FY21 (still not equal across state but equal within region)
- (ex. Max $45.51 per person raises $4,258,917 in Pottawattamie County and $598,775 in Cass

Prioritization

Following the program and budget presentations, the participants were divided into seven small groups. Each small group was asked to identify the highest need and most feasible programs based on Chapter 24 rules in the SWIA MHDS Region. They used an x-axis (horizontal) to represent the feasibility and the y-axis (vertical) to represent need. Each small group was expected to reach consensus on where each new program or expansion of current program would fall in one of the four quadrants. Once each small group identified where each program fell on the xy-axis, they came back together as a large group. As a large group, we found consensus in the following prioritization.

High Feasibility, High Need

1. Expand Mobile Crisis Response
2. Access Center Network – Virtual
3. Expand Residential Crisis Services
4. Expand Assertive Community Treatment (ACT)

High Need, Low Feasibility

5. Intensive Residential Services
6. Access Service Network – Both Subacute and CSRS*
7. Access Service Network – Subacute*
8. Access Service Network – CSRS*
9. Community Based Crisis Services
10. Subacute (not part of Access Service Network)*

Note - *Conversation regarding Subacute and CSRS as part of the Access (no reject, no eject) was complicated. Discussion included whether these types of programs are under one roof or stand alone.

High Feasibility, Low Need

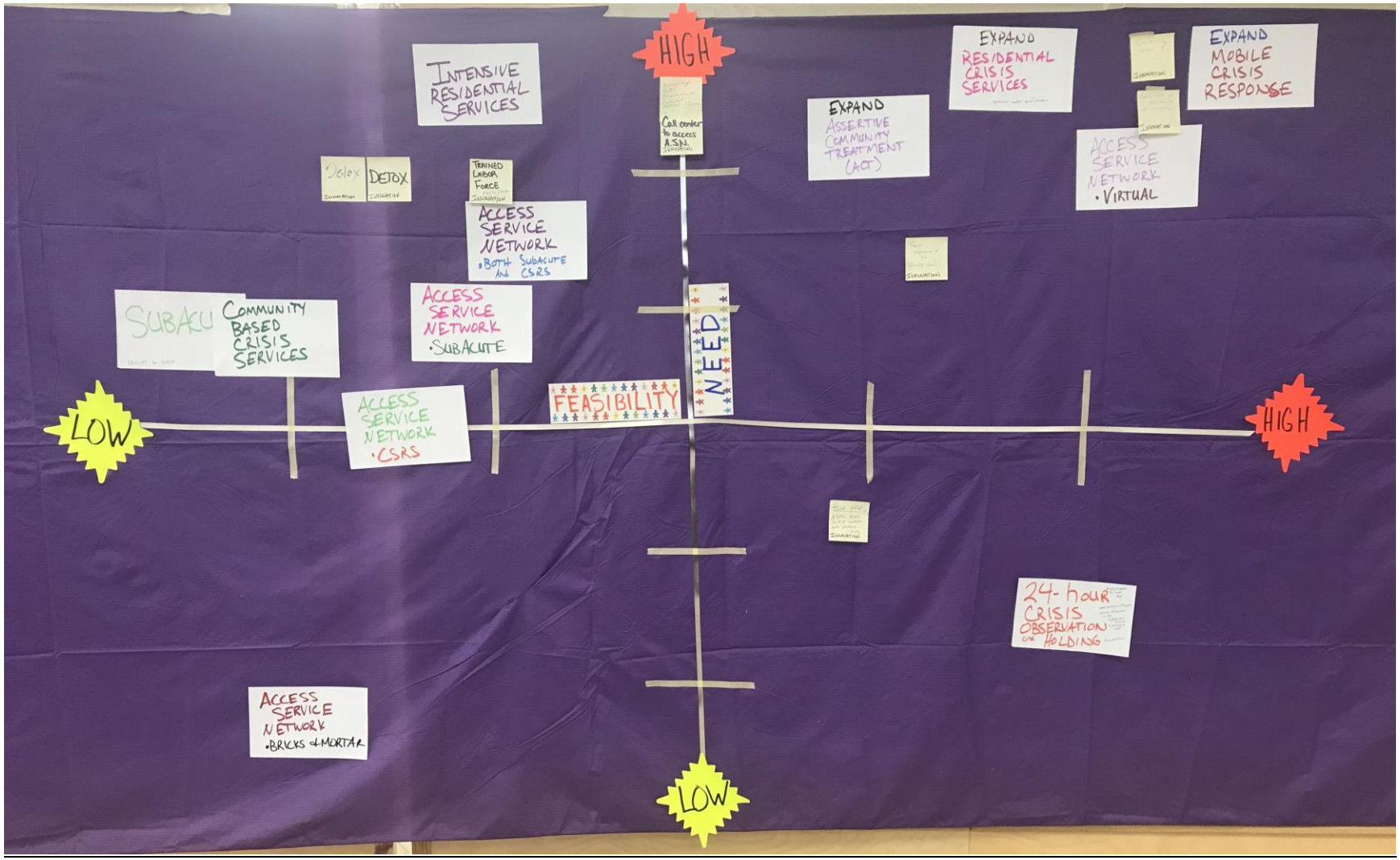
11. 23-hour Crisis Holding & Observation

Low Need, Low Feasibility

12. Access Service Network – Bricks & Mortar

Each small group had the opportunity to add innovative or additional suggestions to be considered. They determined where they felt like they belong on the xy-axis. Consensus was NOT sought over the innovative suggestions. They were:

- Mobile team go to Hospitals to do assessment (High Need, High Feasibility)
- Preventative needed? (High Need, High Feasibility)
- Pscyh experience in ED – Educate staff (High Need, High Feasibility)
- Developing better information & referral Network / Service
- Detox (x2) (High Need, Low Feasibility)
- Trained labor force (pipeline and attract) (High Need, Low Feasibility)
- Call Center to Access ASN (High Need, Low Feasibility)
- Focus group (or study)– Atlantic model? Build on current space & providers (High Feasibility, Low Need)


HIGH
INTENSIVE RESIDENTIAL SERVICES
EXPAND RESIDENTIAL CRISIS SERVICES
EXPAND MOBILE CRISIS RESPONSE
Call center to access A.S.N.
EXPAND ASSERTIVE COMMUNITY TREATMENT (ACT)
ACCESS SERVICE NETWORK • VIRTUAL
Detox
DETOX
TRAINED LABOR FORCE
ACCESS SERVICE NETWORK • BOTH And SUBACUTE CSRS
SUBACU
COMMUNITY BASED CRISIS SERVICES
ACCESS SERVICE NETWORK • SUBACUTE
NEED
LOW
ACCESS SERVICE NETWORK • CSRS
FEASIBILITY
HIGH
24-hour CRISIS OBSERVATION and HOLDING
ACCESS SERVICE NETWORK • BRICKS & MORTAR
LOW

Discussion points that need further exploration – program/service

1. Expand Residential Crisis Services

- Would it be possible to contract with other regions to fill the gaps? Northern?
- How can the current program (Turning Point) maximize their location to serve more of the SWIA MHDS Region?

2. Access Service Network - Virtual

- Need to define what it would mean to be *virtual*. Would virtual be limited to assessment and coordination?

5. Intensive Residential Services (IRS)

- Limited number of individuals can receive this service across the state
    - This is 120 individuals, state-wide---but they are utilizing lots of the services
    - These are often individuals who are in hospitals for long periods because of gap in care options in the community
    - It's the 24-Hour piece that makes it not feasible because of secure staffing
- We have looked to habilitation funding for everything. They need custodial care because they are not stable enough to benefit from rehabilitation programming.
- What is the right support for the communities where IRS could be located?
- Could an ACT team go into one of these homes and be support for these programs. We need to have more conversation with the MCO's to see if this is an option. Then we can layer on services.

10. Subacute

- Subacute vs. Access Center/Network – Subacute can they work together?
- The participants are very concerned / hesitant about the inability to decline potential patients

11. 23-Hour Crisis Observation and Holding

- The participants felt this is somewhat already being done in Emergency Departments (ED)
  - but there is a need psychiatric support in the EDs?
  - Could increased telehealth in the EDs help overcome the need for 23-Hour Crisis Observation and Holding in the SWIA MHDS Region?
  - Increase in training staff in ED is a need
    - Develop ED practices that include telehealth for client stabilization
- Keep it (23-Hour Crisis Observation and Holding) decentralized

Discussion points that need further exploration – miscellaneous

Workforce

- High need for psychiatric staff and direct care workforce
- Security and safety risks are important
- Could residential services be grouped…Could sub-acute and observation be paired?
- Advocating for 24/7 psychiatric help (crisis observation center requires lots of staff)

Communication

- How do we support ED's to do referral of services?
- How do we communicate the understanding of how programs work together? What can be duel purposed…what cannot?

External Factors

Next, the team began identifying external factors that must be identified and planned for when expanding and/or building programs and services. Four major themes were identified amongst all small groups: Resources, Logistics, Program Support and Coordination.

External Factors
High Feasibility, High Need
1. Expand Mobile Crisis Response **2.** Access Center Network – Virtual
3. Expand Residential Crisis Services **4.** Expand Assertive Community Treatment (ACT)

RESOURCES	LOGISTICS	PROGRAM SUPPORT	COORDINATION
• Workforce – availability • Workforce – buy-in • Workforce – safety • Workforce – education • Workforce – knowledge on intellectual / developmental disability	• CSRS – needed in central or northern part of Region	• Expand who can initiate Crisis Response Team	• Coordination – legal issues • Coordination – technical issues • Hand-offs
• Cost – start up • Cost – Sustainability	• Location • Travel • Rural – time on the road	• Lack of telehealth providers • Psych medication	• Provider – resistance • No eject, no reject
• MCO • Save resources, time & money	• Transportation – to facility	• Free up acute beds • Prevent rehospitalization	• Capacity • Accessibility
		• Where do you start for prevention? Define priority	

External Factors
High Need, Low Feasibility

5. Intensive Residential Services **6**. Access Service Network – Both Subacute and CSRS
7. Access Service Network – Subacute **8.** Access Service Network – CSRS
9. Community Based Crisis Services **10.** Subacute (not part of Access Service Network)

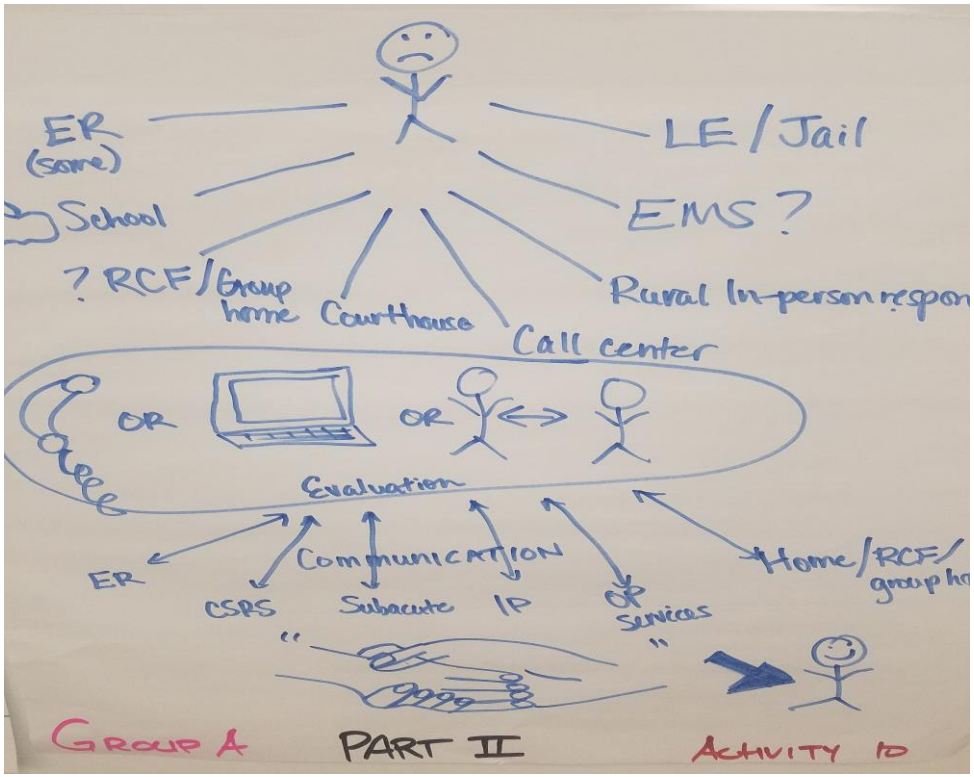
RESOURCES	LOGISTICS	PROGRAM SUPPORT	COORDINATION
• Workforce – qualified staff • Workforce – retention • Workforce – education, training	• Expanded services • Limited providers will to do CBCS • CBCS 24-Hours	• Safety & security – need appropriate client mix • Safety & security – law enforcement barriers to enforce residential norms • Safety & security – Limited security beds • Safety & security – discharged unexpectedly • Safety & security – too high needs for CSRS • Safety & security – limited funding for 1:2.5 staffing	• Technology • Need judicial system on board for ACN • Inappropriate referrals • Court orders to ASN without confirmation
• Costs – sustainability • Funding to support law enforcement to supervise / transport • Funding for detox	• Logistics in rural community	• Zero exclusion rule • Developed for complex needs – assist family-oriented services • Mandatory reporting concerns	• Accessibility – wrap around services • Accessibility – service
• MCO • MCO – reimbursement rate • U9 tier is insufficient		• Community – support of service (stigma, safety concerns, etc.)	• Developed for complex needs – CBCS can assist in CINA cases

External Factors *High Feasibility, Low Need* **11.** 23-hour Crisis Holding & Observation			
RESOURCES	**LOGISTICS**	**PROGRAM SUPPORT**	**COORDINATION**
• Workforce – availability • Workforce – education, training	• Multiple locations	• Safety & security	• Coordination – Not knowing where they go
• Cost – funding concerns		• Need pscyh experts	• Lack of follow-up
• MCO		• Additional services if individual doesn't need it or qualify	• Discharge disposition

Going Forward

Now that the group has recommended priorities based on feasibility and need and identified external factors, participants self-selected one of eight small groups to discuss specific programs to identify keys to success to operationalize the programs successfully. Below are the questions each group discussed and documented. After the key steps were identified, groups were asked to create an illustration to actualize their vision. One group had no volunteers to discuss going forward. Community Based Crisis Services was not discussed in this small group activity. This may be a validation of the low prioritization (9th – high need, low feasibility).

1. What is critical to consider as far as **safety** for this program/service?
2. What are key components to consider when we do a **warm hand-off** to enter this program? To exit this program? Communication? Coordination?
3. **Transportation** – what do we need to plan for?
4. Who/how could **assessments** be completed?
5. If we have a **Virtual Access Service Network** how would this program interconnect for success?
6. How will or could you or someone in a same profession be a **barrier** to success for this program? Be **helpful**?



Additional comments from the small group report out included:

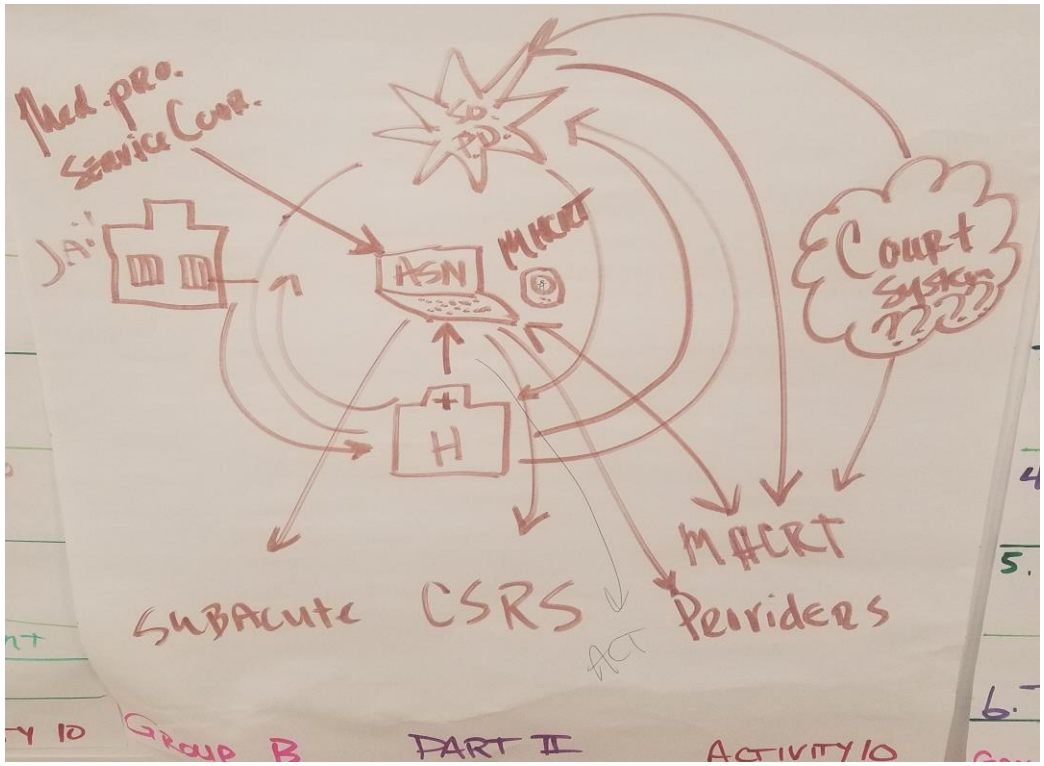
- WE WANT TO ADD:
  - mobile crisis to the ER
  - access for our schools
  - RCF (Residential Care Facilities) in the group homes so that if they have clients they can assess and give appropriate care.
  - Clerk of courts connection so they can direct them where to go to get an assessment/evaluation.

Group A – Expand Mobile Crisis Response

1. **Safety** – Collaboration - local medical facility, increase access points, collaboration and law enforcement
2. **Warm hand-offs** – Documentation system & access for various providers
3. **Transportation** – non-law enforcement (ex: Red Oak ED)
4. **Assessment** – Telehealth / take to patient
5. **Virtual Access Service Network** –

6a. **Barriers** – Not identified

6b. **Helpful** – maybe a licensed therapist doesn't have to be a responder, maybe it is a trained person who can take the first step and provide recommendations?



Additional comments from the small group report out included:

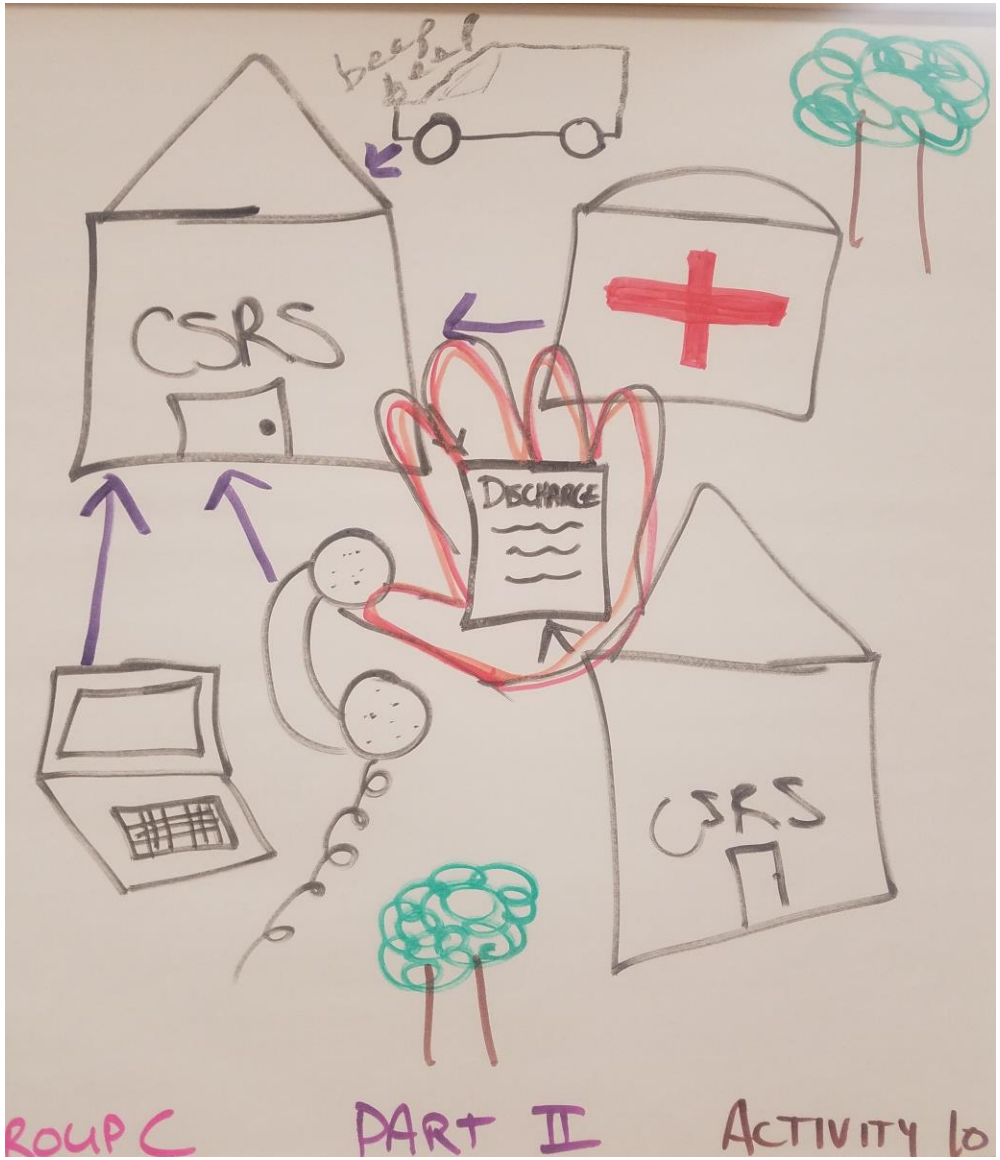
- Another region is utilizing transportation providers
- WE LOVE the virtual idea and it has to be an option.
- We also need a bricks and mortar to take people… this is an important conversation.
- There is a state law saying we (LE) "HAVE" to transport to ER—Policy discussion, we need legal discussions on this.

Group B – Access Service Network - Virtual

1. **Safety** – Goal: Ease of access (multiple options) – Law enforcement needs a place to go (no eject / no reject) ED?
2. **Warm hand-offs** – must have "warm hand-off" between all services
3. **Transportation** – needs to be improved. Who drives them where…then who drives them next?
4. **Assessment** – Who provides screening vs. assessment?
5. **Virtual Access Service Network** – Call center procedure needs to be defined

6a. **Barriers** – Legal discussions /liability

6b. **Helpful –** not identified



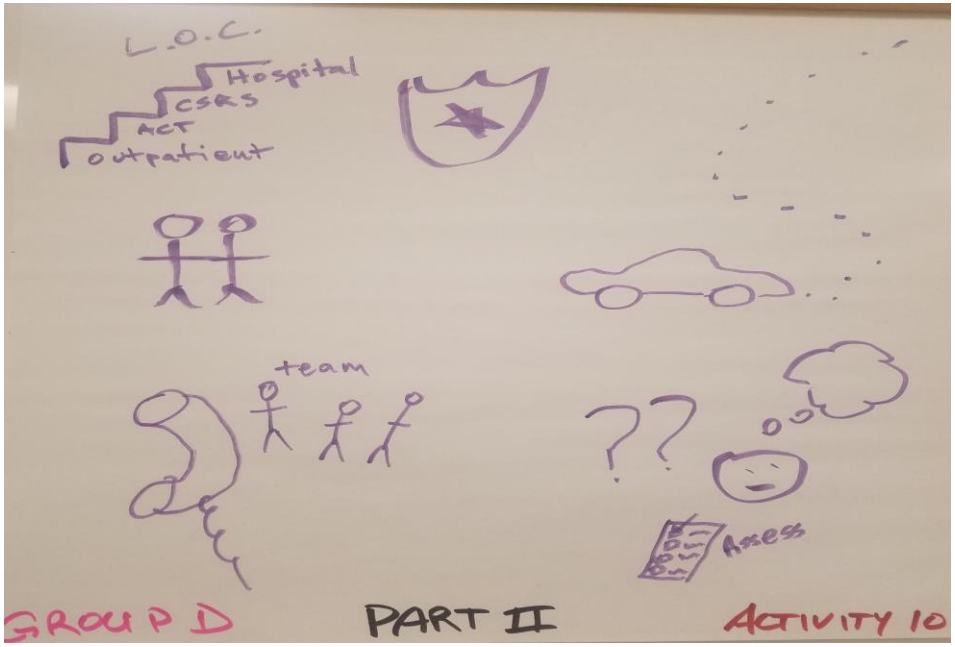
No additional comments noted

Group C – Expand Residential Crisis Services

1. **Safety** – Medical clearance / crisis screening
2. **Warm hand-offs** – After care plan – everything set-up prior to discharge
3. **Transportation** – Additional locations – availability of transportation (funding)
4. **Assessment** – Increase telehealth for assessments – utilize mobile crisis for assessments (dual license?)
5. **Virtual Access Service Network** – Direct contact from the network for placement / support

6a. **Barriers** – no referrals, criteria, staff

6b. **Helpful** – free up hospital / ED (dual license?)



Additional comments from the small group report out included:

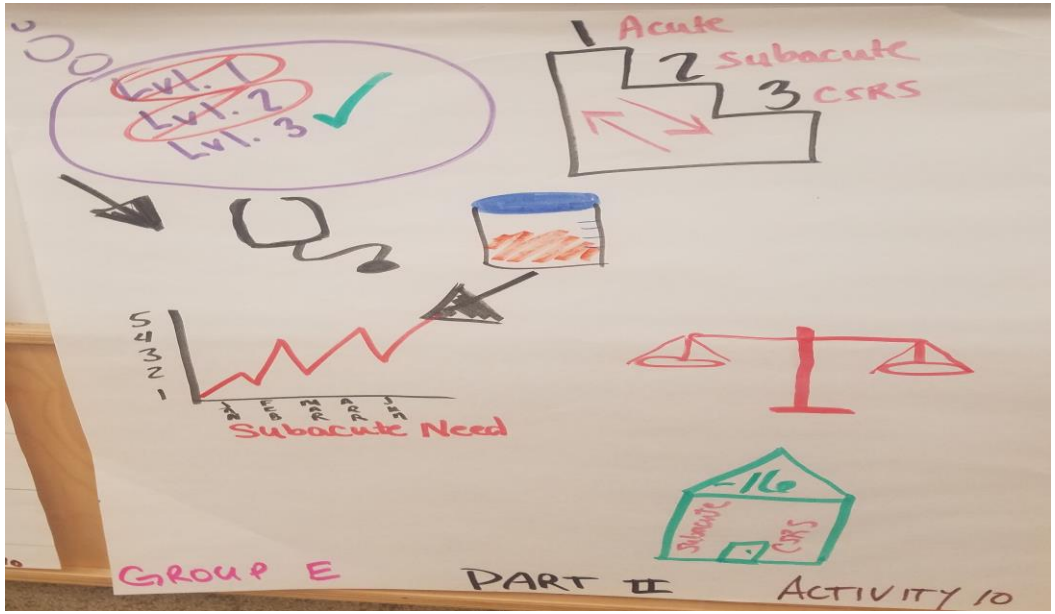
- If people are missing lots of appointments a referral to ACT
- Come do ride along visits with us
- We hope that we can be efficient with hospitalization to get folks back into the community as quick as possible
- People would have to transition from different providers, but ACT team would be a huge help to them.

Group D – Expand Assertive Community Treatment (ACT)

1. **Safety** – prolonged response time – rural. Proactive planning.
2. **Warm hand-offs** – Already being done.
3. **Transportation** – Farther to go – rural. Decrease ratio. there are standards for rural times to make this more manageable
4. **Assessment** – Has been within the team. Could be initiated by Access Center
5. **Virtual Access Service Network** – Has been within the team. Could be initiated by Access Center – virtual.

6a. **Barriers** – Changes in provider(s). Triangulation. Determine appropriate level of care

6b. **Helpful** – Economies of scale.



Additional comments from the small group report out included:

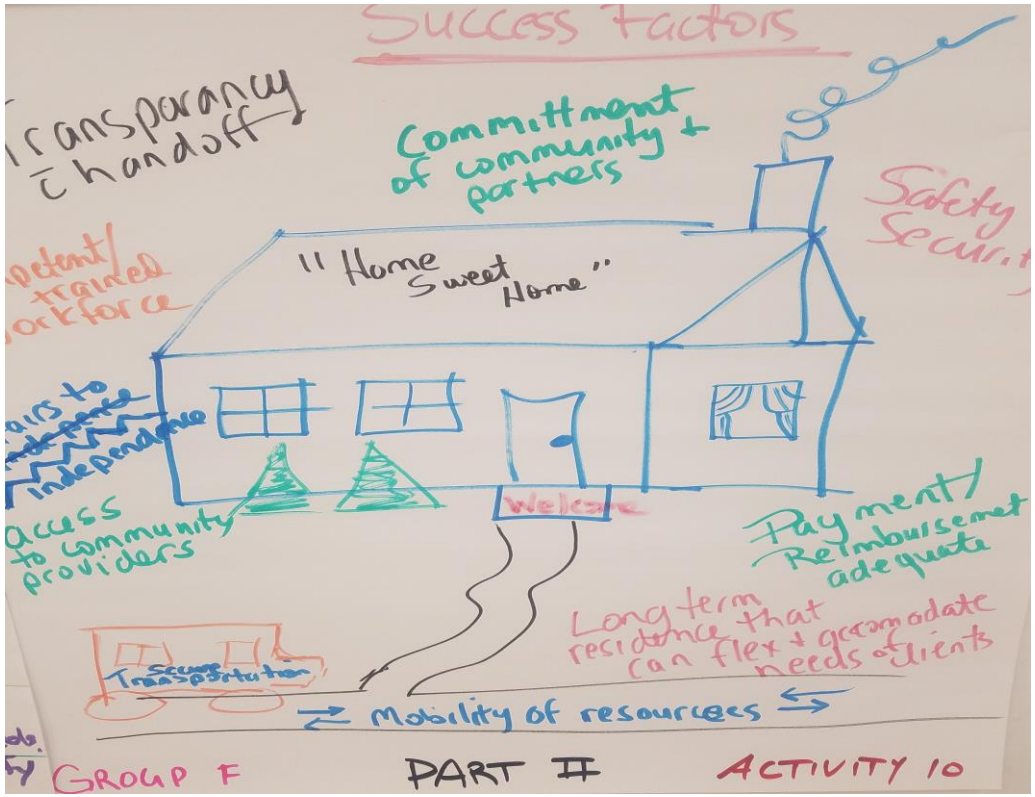
- WE need to define the level of care—referrals to subacute would need to come from Hospitals
- Rules for subacute – could we share resources in the same building?
- Commitment process – could a patient be court ordered?
- Do this all under one roof. Would this work?
- We need to define what the utilization would be? How would it be used?
- Critical access hospitals have beds, but resources may be scarce

Group E – Access Service Network – Both Subacute & CSRS

1. **Safety** – Clarify & define levels of care
2. **Warm hand-offs** – Medical clearance – Subacute only from hospital discharge or ED?
3. **Transportation** – Determine subacute utilization
4. **Assessment** – Commitment process review / changes
5. **Virtual Access Service Network** – ASN subacute & CSRS under 1 roof

6a. **Barriers** – Not identified

6b. **Helpful** – Not identified



Additional comments from the small group report out included:

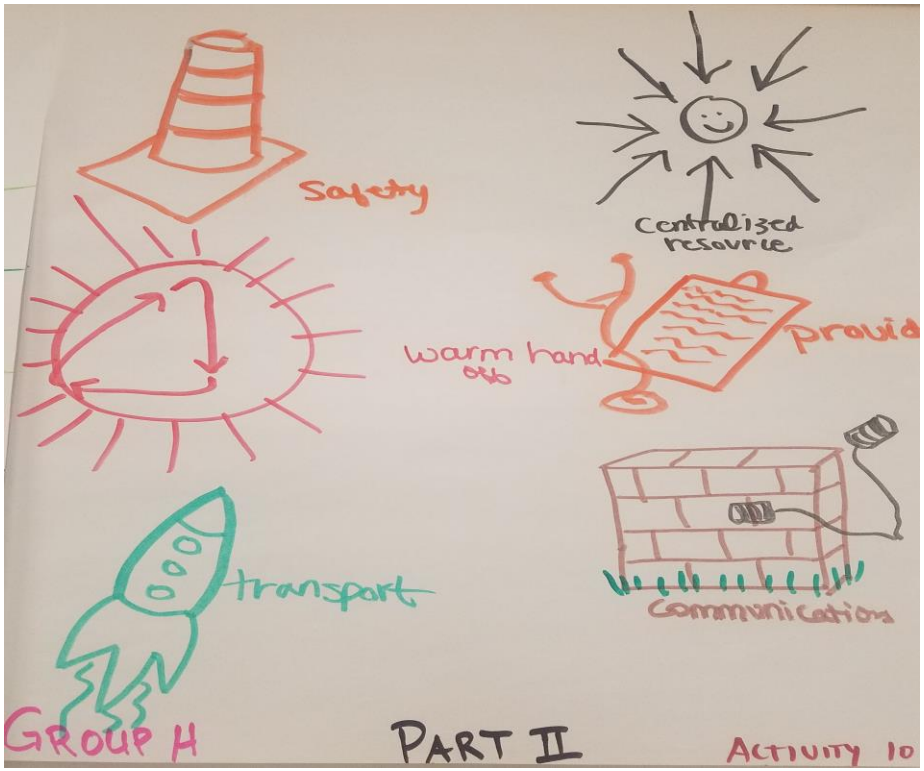
- This would be 4-5 people in a home
- Transparency is important for safety and to ensure we have all the players engaged
- Needs to be a community approach
- Mobility of resources…this is a major partnership piece…we need to have great working relationships to make this work

Group F – Intensive Residential Services

1. **Safety** – It's a home – longer term living & not a crisis stabilization situation. Intent is to provide some resemblance of safety / freedom in community living. Safety & security is crucial. Different way of thinking for community living.
2. **Warm hand-offs** – warm hand-off, collaboration, transparency. This is a community partnership!!!
3. **Transportation** – Secure Transportation is needed
4. **Assessment** – Not identified
5. **Virtual Access Service Network** – Not identified

6a. **Barriers** – Tier Rates inadequate to meet workforce needs. Should be paid same as GRC, other public entity

6b. **Helpful** – Not identified



Additional comments from the small group report out included:

- Staffing would need to be looked at
- Medication provider
- Psych support
- Grant funding for transport?

Group H – 23-Hour Crisis Observation & Holding

1. **Safety** – Buy-in
2. **Warm hand-offs** – Communication
3. **Transportation** – Funding
4. **Assessment** – Education
5. **Virtual Access Service Network** – Centralized resource

6a. **Barriers** – Not identified

6b. **Helpful** – Not identified

Guiding Principles

The final small group activity had participants lead a structured conversation within their small groups about possible values that they have observed during our time together over the past couple of days. These values represent the possible philosophy about SWIA MHDS Region programs that may be implemented and expanded. These values may be also be used for program evaluation when these programs are implemented. Each group was asked to come to consensus to three to four guiding principles. Each group then brought their guiding principles to a large group discussion. We clustered the small groups' guiding principles and built consensus as a whole group. Our guiding principles are listed below. The following page lists the items that informed the groups consensus.

Continuum of Care	Access	Workforce	Partnership / Networking	Leadership
Continuum of care	Zero exclusions	Compassion	Alliances	Advocacy
Ball Diamond "build it and they will come"	Open minded to zero exclusions	Passionate competent workforce	Partnership / accountability	Flexible payor – outside of the box, pilot programs
Prevention	Eject / reject	Education / training	+ communication	Sustainability
Communication (verbal / documentation) – 2-way, HIPPA, warm hand-offs	Accessibility – 24/7 nontraditional hours, change of mindset, virtual	Resources – Quality workforce, education	Collaboration – warm handoffs & TAV / communication	Broken system – silos, short sighted, zero long-term
Mental health continuum without gaps	Ease of access (clients & providers)	Quality workforce	Passion engaged region commitment	High hopes / unknown
	Access	+ training	Community partnership / collaboration	
	Virtual	Trained workforce	Collaboration – address & treat issue (trust), promote teamwork	
	Access (expansion, ease diversify, right services right time)	Training / continuing education / workforce development	Shared commitment to responsibility	

Our Commitment

At the end of the two days, there was a lot of energy and hopefulness. Each participant had the opportunity to identify what they commit to doing to support this important work. Below is the list of actions the participants have made to each other.

Brian	Embrace idea of no reject		**Jessica**	Finding better access to CSRS in Region
Greg	More street level officers trained		**Jenny**	Being advocate for small EDs
Sonya	Support service via Hotline		**Kate**	Open mindedness & advocate
Melissa	Help link to services to help with efficiency with LE & ED		**Mary**	Make sure substance abuse is not left out & expand into rural areas
Anna	Helping with legislative action (bring voices)		**Scott**	Build provider knowledge about the complexity
Lori	Improvement to access		**Marilyn**	Provide resources from CHI for support
Chuck	Ask Board to explore grant program		**Tami**	Commitment to the community
Mary Beth	Being a support – streamline & support of progress		**Bernie**	Leadership locally, advocacy, being at the table for planning with this group
Rhonda	Take the info back & share it with providers and law enforcement		**Sheri**	Train & support staff working with individuals with complex needs
Joe	Come back for ongoing conversation		**Mindy**	Community based crisis, layer partnership
Tyna	Take back to company and be a part of collaborative work		**Mark**	Learn more about core services and how we can be a part of the solution
Jenny	Stay educated to advocate to additional areas so they can utilize resources		**Bill**	Positive voice, encouragement to other LE for telehealth to reduce ED visits
Kent	Improving communication with courts and reduce barriers with courts and programs		**Jamie**	Collaboration – connect our staff to serve more complex needs
Sarah	Take back knowledge to frontline nurses – hear their questions and get answers back to them		**Kathy**	Carving out access for LE – CIT (Crisis Intervention Team) training bring to Iowa and problem solve to get to training from rural areas
Brent	Be a part of the workforce leadership development		**Lora**	Jennie Edmundson be a part of the continuum and a resource to other critical access ED
Karen	Coming back together for more progress		**Kendra**	Community education and networking
Karen	Hosting education in our area		**Molly**	Support collective effort to measure impact
Rene	Continue to work on eliminating stigma of mental health with nonmental health providers – willing to brainstorm to help individuals		**Dr. Joe**	Continued advocacy for wonderful programs & barriers – how to communicate about our patients' needs and will do committee work

Anne	Continue to use outside resources & educate other programs & services available		**Suzanne**	Staying open to all ideas & group consensus – stay positive
Denise	To make sure that Mercy hospital is at the table for the next phase		**Danelle**	Take priorities & help Region move forward
Tina	Advocate for mobile response and ACT in our area		**Lonnie**	Community education & networking
Brandon	Law enforcement training about mental health & provide information about resources available		**Kayla**	Document in a usable document
Rachel	Improving networking at All Care & accessibility to patients		**Beth**	Commit to looking at conversation over past 2 days and give gentle push
Rob	Implement & support any new ideas developed by group			

SWIA MHDS Region committed to the following:

- Bring the group back together in six months for one full day (per the team's request)
- Distributing this report and to have the report shared with legislators.
- Keeping the participants informed about the upcoming meetings and updates as the work moves forward and to leverage relationships as appropriate
- Continue the crisis service call and possibly use GoToMeetings for communication and next steps

Recommendations

- **External Factors** should be addressed by categories (i.e., resources, logistics, program support and coordination) and not specific external factors for each program (i.e., workforce for Mobile Crisis Response team). By addressing the external factors as categories allows for catalytic thinking. Thus creating larger system change to foster bigger impact over multiple areas versus taking one program at a time and addressing external factors one by one.
- **Going Forward** will be important to leverage participants passion and expertise. Ask for participants and additional stakeholders to volunteer and participate in on-going discussion and program development in the high priority areas. Maximize technology and system change thinking to maintain buy-in and support. Identify a specific SWIA MHDS Region staff to take point on each program. Include expectations for program providers for collaboration with other crisis stabilization programs within contracts.
- **Guiding Principles** need to be enhanced and defined more. This may be done in community meetings or an established task force by the Region. This task force may be a subset of the participants from this planning session or may be composed of Region Advisory Council members. Guiding Principles should be utilized in all program RFPs and program evaluations.
- **Our Commitment –** it is critical to schedule follow-up meeting as soon as possible for March 2019. Include original participant list and add new participants. Keep similar model for the agenda as it seemed to be very effective for the team, but have it program specific and external factors focused for the entire time. Have small groups report outs continue allowing for the opportunity to build on the teams' expertise and knowledge. It is recommended to do a conference call via technology like GoToMeeting in three months to participants and invitees that were unable to make the planning session. SWIA MHDS Region should give an update on the draft rules, progress since the planning session, a date for the one-day session in March and specific asks for the group to consider. When the SWIA MHDS Region meets with legislators about this report and the implications of HF2456, ask participants from the planning session to

join the meeting. This may be a way to convey in stories about the benefits and challenges with the programs and services available in the SWIA MHDS Region.

- **SWIA MHDS Region** should reflect on the original implementation of Core Services. This may include interviewing current stakeholders about what went well, what could have been better, and what were our lessons learned. Now that the SWIA MHDS Region has the stakeholder's priorities identified, creating a three to five-year strategic plan may be beneficial to identifying the time line for expansion and new development.
- **Leadership / Advocacy** appeared to be strong desire in the group of participants from the planning session. SWIA MHDS Region would benefit from thinking outside of the box to support the interests of leadership and advocacy development. Leveraging these committed individuals to continue to advocate for the individuals they provide programming to, the staff they support and the communities in which they live, and work would benefit from their leadership.

Creativity is thinking up new things. Innovation is doing new things. A powerful new idea can kick around unused for years, not because its merits are not recognized, but because nobody has assumed responsibility for converting it from words to actions. Ideas are useless unless used. The proof of their value is only in their implementation.

Theodore Levitt

Appendix A – Participant List

REPRESENTATION	NAME	ORGANIZATION	REPRESENTATION	NAME	ORGANIZATION
Crisis Service Provider	Sonya Fittje	Boys Town	**Sheriff**	Bill Ayers	Cass
Crisis Service Provider	Jessica Coburn	Waubonsie	**Sheriff**	Brandon Doiel	Harrison
Crisis Service Provider	Joe Bauer	Heartland Family Service	**Sheriff**	Rob Ambrose	Pottawattamie
Hospital	Joseph Hoagbin	CHI Mercy Medical Director	**Police**	Greg Schultz	Council Bluffs Police
Psychiatric Acute Inpatient	Kathy Capobiano		**SWIA MHDS Governing Board**	Richard Crouch	Mills
Psychiatric Acute Inpatient	Denise McNitt	CHI Mercy Hospital	**SWIA MHDS Governing Board**	Steve Kenkel	Shelby
Psychiatric Acute Inpatient	Marilyn Rhoten	CHI Mercy Hospital	**SWIA MHDS Governing Board**	Randy Hickey	Fremont
Psychiatric Acute Inpatient	Anne Smith	Jennie Edmundson	**SWIA MHDS Governing Board**	Chuck Morris	Page
Psychiatric Acute Inpatient	Kendra Wilson	Jennie Edmundson	**SWIA MHDS Governing Board**	Jennifer Herrington	Waubonsie MHC
Psychiatric Acute Inpatient	Lora Cobbs	Jennie Edmundson	**SWIA MHDS Governing Board**	Nicole Rocha	Client/Family Rep.
Emergency Dept	Jennifer Lefeber	Myrtue Medical Center	**Outpatient CMHC**	Teena Seguin	Missouri Valley CHI
Emergency Dept	Sarah Townsend	CHI Mercy	**Outpatient CMHC**	Kate Smith	Myrtue Medical Center
Emergency Dept	Tamara Bardon	Jennie Edmundson	**Outpatient CMHC**	Brian Shotwell	Waubonsie
Emergency Dept	Jenny Gilleland	Montgomery County	**Outpatient CMHC**	Fran Tramp	Burgess
Emergency Dept	Renee Nauman	Clarinda Regional Health	**Outpatient CMHC**	Scott Halverson	CHI Psychiatric Associates
Emergency Dept	Rhonda Curtis	Shenandoah Medical Center	**Outpatient CMHC**	Mary O'Neill	Heartland Family Service
Emergency Dept	Melissa Hobbie	Shenandoah Medical Center	**Outpatient/Medical**	Rachel Stolz	All Care Health Center
Emergency Dept	Renee Nauman	Clarinda Regional Health	**Courts**	Kent Wirth	Pottawattamie Fourth District
Community Based Service Providers	Karen Williams	Anchor Homes	**Substance Use providers**	Laurie Cooley	Zion
Community Based Service Providers	Jill Anstey	REM	**Region Advisory Council**	Sherrie McDonald	Connections AAA
Community Based Service Providers	Mindy Blair	ACT - HFS	**Region Advisory Council**	Anna Killpack	parent
Community Based Service Providers	Becky Smith	Pursuit of Independence	**Region Advisory Council**	Jamie Barnum-Gross	CWI

Community Based Service Providers	Sherri Clark	Nishna Productions		**SWIA MHDS Region Staff**	Lonnie Maguire	SWIA MHDS Region Staff
Community Based Service Providers	Brent Dillinger	Crossroads of Western Iowa		**SWIA MHDS Region Staff**	Danelle Bruce	SWIA MHDS Region Staff
Community Based Service Providers	Mark Stromer	Vodec		**SWIA MHDS Region Staff**	Mary-Beth Roskens	SWIA MHDS Region Staff
Community Based Service Providers	Karen Hadley	Mosaic		**SWIA MHDS Region Staff**	Molly Brown	SWIA MHDS Region Staff
Community Based Service Providers	Kathy McQueen	Country Care		**SWIA MHDS Region Staff**	Suzanne Watson	SWIA MHDS Region Staff
NAMI	Bernie Wagoner	NAMI				

Appendix B – Opening Activity – Day One

Southwest Iowa Region Strategy Session | 8.29.18 Opening Activity What are the three greatest concerns/needs for individuals with complex needs?								
Programs & Services	**Payment**	**Financial Concerns (client perspective)**	**Acute Services**	**Access**	**Supports**	**Process**	**Communication**	**Training / Professional Development**
Residential Services Support (separate from habilitation) (x2)	MCO regional payment so provider can continue to provide	Basic Needs (food, shelter, healthcare) (x2)	Change in involuntary process	Access to appropriate care/services / providers (x2)	Ability to get supports that will help	Change in the process	Do all medical providers know my health issues?	Doctors/Therapists equipped
Agencies equipped to handle their needs	Payer Source	Can I afford the care? And all my living expenses?	Crisis stabilization	Accepting facility placement	Availability of Needed and necessary resources and programs	Great variation of law enforcement protocol	Inter-agency collaboration and communication	Knowledgeable case management
Detox	MCO dropping tiers	Employment /Income	Emergency services @ crisis point	Access to need OP services	Community Resources	Freedom & self-autonomy	Where to go for additional resources?	Recruit/Retention of providers
Detox outside of jails and hospitals	Inability w/ MCO caps to have 1:1 funding for staffing	Financial (x6)	Intensive care when I need it	Access to psychiatry	Companionship / Support	Provider accountability in transfer of client	Where to go when in crisis?	Proper meds used by Psychiatrists
Higher than RCF but not acute		Housing safe and affordable & Long- term housing options (x6)	In-patient long-term (chronic care) vs. acute care (x2)	Appropriate Therapeutic Placement	Knowing what resources, they need and where to find them	Uniform assessment at all levels		Mental health management training of staff at ALL levels of care

Southwest Iowa Region Strategy Session | 8.29.18 Opening Activity (continued)

What are the three greatest concerns/needs for individuals with complex needs?

Programs & Services	Payment	Financial Concerns (client perspective)	Acute Services	Access	Supports	Process	Communication	Training / Professional Development
Access to full continuum of care for those with substance use disorder or co-occurring SUD/MI			Increase bed availability for in-patient needs	Cannot get folks into hospitals	Live in community of choice	When do we know when a person has met goals and is ready to transition?		Staff/Community clinician attitudes and approaches to the work
Patients in hospitals longer than necessary due to placement issues			Not enough acute beds	Enough resource providers for all who need it	Psychiatrist/ med management availability			Staffing/training to acquire staff
Not enough integrated care			Immediate/crisis assistance to patients presenting to the ED not needing hospitalization	Getting seen in a timely manner	Who is going to help me?			Training for community providers
Non-discrimination of services delivery				Lack of access to immediate services	Resources			Training for staff in community-based programs
Providers who offer recovery services				Lack of higher-level placements	Providers (x3)			Well-Trained Staff (x2)
Short-term housing solutions to help stabilize				Lack of placement options	Overuse of ED's for behavior issues			
Placement (of IP Services, high acuity chronic needs, high acuity acute needs) (x6)				Lack of mental health support for community providers	Recovery Community			
Substance use services				Needing long-term care	Transportation (x4)			
Tx for co-occurring disorder (someone with high MH needs and substance use)				Timely access to services				

Appendix C – Pictures