MINUTES

Mental Health and Disability Services Study Committee

November 17, 2011

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson
Senator Joe Bolkcom
Senator Joni Ernst
Senator David Johnson
Senator Amanda Ragan
Senator Pat Ward

Representative Renee Schulte, Co-chairperson
Representative Dave Heaton
Representative Lisa Heddens
Representative Linda Miller
Representative Mark Smith
Representative Mary Wolfe

MEETING IN BRIEF

Organizational staffing provided by: John Pollak, Committee Services Administrator, (515) 281-3818

Minutes prepared by: Amber Desmet, Legal Counsel, and Patty Funaro, Senior Legal Counsel (515) 281-3040

I. Procedural Business

Call to Order and Adjournment. Co-chairperson Hatch called the second meeting of the Mental Health and Disability Services Study Committee to order at 8:36 a.m. in the Ola Babcock Miller Building, Des Moines, Iowa. In addition to the study committee members, Representatives Joel Fry, Mark Lofgren, and Jason Schultz attended the meeting. The meeting was adjourned at 5:12 p.m.

Approval of Minutes. The October 24, 2011, meeting minutes were unanimously approved as distributed.

Presentation Broadcast. Mr. John Pollak, Legislative Services Agency (LSA), Legal Services Division, discussed the live streaming of the meeting on the Internet.

Background. The Iowa Department of Human Services (DHS) initiated seven workgroups to develop proposals and provide recommendations to the study committee for the redesign of the services systems. Most workgroups met every other week from mid-August until the end of October, and DHS held several public hearings around the state.

II. Redesign Report Overview

Charles Palmer, director, DHS, and Mr. Steve Day, a consultant with the Technical Assistance Collaborative (TAC), commented on the process and structure of the workgroups in meeting and forming the recommendations for the interim report submitted to DHS on October 31, 2011. Director Palmer stated the presentations would discuss the work reports submitted, focusing on the recommendations while also noting where the workgroups lacked consensus. Director Palmer noted that even though workgroup members had diverse and strong opinions, did not all agree with the original legislation, and found funding to be an obstacle, the workgroups decided to focus on what is workable going forward. Director Palmer thanked the parents, advocates, and consumers for their participation throughout the process, noting that DHS is doing a redesign survey and has had over 600 respondents as of November 16. The parents, advocates, and consumers responding are placing a high emphasis on core services. Although clinical treatment is important, there is a need for a more holistic approach.

Mr. Day stated the workgroup process was gratifying because of the good working relationships and the well-structured process for the workgroups despite the limited 11-week time frame. The workgroups had high participation, including from legislators, staff, and many citizens. The consultants facilitated these discussions by presenting facts, pros and cons, and information from other states. The DHS website provided the means for interested citizens to track the progress of the workgroups as all materials were posted for the public. The interim report is based on the minutes of the workgroups' meetings, and reflects the consensus and product of each workgroup, the priorities of each workgroup, best practices in the field, and ideas and values for Iowa. Mr. Day noted the process needs to reflect the principles of the United States Supreme Court's *Olmstead* decision.

The individual workgroup reports can stand on their own, but the interim report content consistently reflects these principles in addressing the issues presented by the Legislature. Some issues are

specific to the particular disability, but across the workgroups, the report reflects an attempt to provide a platform to integrate three areas: services and access to services; funding streams; and resources inside and outside the system which focus not only on disability-related services, but on services to help individuals live in the community, such as employment, education, and housing. The report also focused on providing a time frame for phasing in implementation of the recommendations. Mr. Day also noted that providers and consumers have become accustomed to delivering and receiving certain services over time, and the system therefore cannot change overnight.

III. Adult Mental Health Workgroup Presentation

Mr. Christopher Atchison, University of Iowa College of Public Health, and Director Palmer discussed the report of the adult mental health workgroup. Mr. Atchison stated that Director Palmer framed the workgroup's discussion as not letting funding drive the discussion but instead focusing on being visionary and bold in determining what the system should be. Several other workgroup members, including Dr. Michael Flaum, University of Iowa, Ms. Teresa Bomhoff, Mental Health Planning Council and other groups, and Mr. Patrick Schmitz, NW Iowa Community Mental Health Center, also responded to study committee questions.

Multi-Occurring Disabilities/Co-Occurring Disabilities. Mr. Atchison explained the workgroup adopted a definition of a person with multi-occurring disorders and advised that it is imperative that in providing services, consideration of multi-occurring disabilities should be the expectation, not the exception. Cooperation between affected agencies, especially DHS and the Department of Public Health (DPH), is necessary because of that premise.

Eligibility. Mr. Atchison discussed the possibility of expanding income eligibility to 200 percent of the federal poverty level (FPL) rather than equal to or less than 150 percent of the FPL in 2014, pursuant to implementation of the federal Affordable Care Act (ACA). He also recommended an option for waiver of cost-sharing requirements if the individual circumstances warrant the waiver. Mr. Atchison also addressed the workgroup's recommendation to adopt a standardized functional assessment tool, such as LOCUS (Level of Care Utilization of Services), that would be utilized by all contracted providers who receive public funds for individuals receiving services beyond outpatient treatment.

Core Services. Mr. Atchison discussed a comprehensive system that would integrate and develop a discrete inventory of services to provide individuals with the care they need when they need it. This system would also identify where core services are available.

Outcome and Performance Measures. Mr. Atchison discussed the establishing of an Outcome and Performance Measures Committee to identify the measures and implementation plan.

Provider Qualifications and Monitoring. Mr. Atchison discussed the need for better coordination among multiple agencies, specifically DHS, DPH, and the Department of Inspections and Appeals (DIA). DIA should establish a process that would streamline accreditation, certification, and licensing standards.

Workforce Development. Mr. Atchison discussed the creation of a standing Mental Health and Disability Workforce Development Group, and the development of a peer workforce as the use of peer-delivered services is a best practice approach.

Member Questions and Discussion.

- **Workforce.** In response to a question from Co-chairperson Schulte regarding the workforce development group, Dr. Flaum stated that as is the case nationally, the mental health workforce is in crisis in Iowa and the need will only continue to increase. A realignment and redistribution of the existing workforce is needed. Reports developed in 2006 and 2008 and cited in the interim report specified what Iowa should do, including integration with primary care and creation of a workforce development task force. Nebraska closed several state institutions and shifted funding into this type of workforce development group. The cited reports highlight the need to develop recruitment and retention strategies, to shape curricula, to develop training opportunities in rural areas, and to work with primary care providers. The workgroup spent a great deal of time considering professional scope of practice. The workforce issue underlies system reform. There is a need for ongoing support of the workforce, including infrastructure development and development of core competencies for specific disability groups. Ms. Bomhoff commented that a workforce development group needs to include consumers and family members as well as state agencies.
- **Scope of Practice.** In response to a question from Co-chairperson Hatch regarding the studies or research available to guide changes in scope of practice, specifically for primary care providers, Mr. Atchison stated that no road map exists, but there is empirical data on how to better align care providers. Any change in scope of practice would be analogous to the development of rural health clinics in the 1970s. Initially, rural health clinics using nurse practitioners were viewed as a lower level of care. But now, 90 percent or more of care in rural areas is provided by these clinics and is beneficial to patients. Mr. Day commented that the idea of peer support is a new concept that would not affect other practitioners. He stated that the recommendation would not be to change the scope of practice, but to change what services practitioners provide within their existing scope of practice.
- **Provider Qualifications.** In response to Representative Heaton's question regarding licensure and skills required of personnel when individuals move from a higher level of care to the community, Kathy Stone, DPH, stated that DHS focuses on mental health and DPH focuses on substance abuse, but there has been a higher level of cooperation. The issue of coordination of licensing still remains, however. Representative Heaton also asked about the delivery of services and the need to encourage a partnership between primary care providers and mental health and substance abuse providers. Ms. Stone responded that DPH has added performance contract requirements for providers to provide both substance abuse and mental health services. The provider can subcontract for either type of service, but to the consumer, the service provision is seamless.

- **Data.** In response to Representative Smith's question concerning data collection (interim report pages 52-53), Ms. Stone stated that DHS, the Iowa State Association of Counties (ISAC), and DPH gather data about health, mental health, and substance abuse services. They are reviewing data collection efforts to determine what data is important to collect to guide decision making, and to eliminate extraneous questions.
- **Service Priorities.** In response to Senator Bolkcom's question regarding the priorities of the workgroup, Mr. Atchison said making sub-acute care services available would be a starting point. The workgroup tried to derive discrete service components that are individual and family-centered. Dr. Flaum stated the workgroup looked at the existing array of services and determined where the system is falling short and where the gaps are. One gap is the availability of sub-acute services that are a step down from acute care that could provide more appropriate services at a lower cost.
- **Service Levels.** Co-chairperson Hatch, referencing the interim report at pages 65-66, mentioned the need to further define the various levels of services as individuals transition from acute care to inform legislative implementation.
- **Funding Adequacy.** Senator Bolkcom noted the historic problem of inadequate funding. Ms. Bomhoff stated that each region should identify gaps. The region could create a business plan to fill those gaps within five years so that the regions are making the decisions rather than relying on legislation for the details. Director Palmer stated that in the next year or two the regions would have to address where the best investment is. The key first step is buying out county responsibility for Title XIX (Medicaid) services because increases in the non-federal share for Medicaid services will curtail the ability of counties to fund non-Medicaid mental health services. The General Assembly appropriated $35 million in new funding for FY 2011-2012. The General Assembly could buy out the county share of Medicaid costs by providing $47 million over a one- or two-year period and that would free up existing county funding for non-Medicaid services. The funding that would then be available to counties could be used for services that provide the best return on investment and could be tracked to provide accountability. There is a significant cost in the system remaining with the status quo. Director Palmer also stated that the implementation of ACA would be helpful in addressing funding and coverage issues. Director Palmer framed the discussion as involving a five-year plan.
- **Progress on Regions.** In response to a question from Representative Heddens regarding retaining county funding in 2013 and implementing the plan correctly, Director Palmer said the counties are talking and working together and should be allowed to voluntarily put their regions together. They would have a six-month period to work through the issues and the regional structures would be in place a year from the July 2013 implementation. In the following year, the region would put money into core services that were not in place depending on the funding available, especially if the state assumes responsibility for the non-federal share for Medicaid services to free up county funding.

IV. Brain Injury Workgroup Presentation

Mr. Jack Hackett, senior therapist, Iowa Health, and Mr. Geoff Lauer, executive director, Brain Injury Association of Iowa, discussed the report from the brain injury workgroup. The brain injury workgroup has a two-year charter. Mr. Hackett stated the focus to address brain injury is to educate others so there is understanding of the issues. They were joined by workgroup members Mr. Tom Brown, Community NeuroRehab, Mr. Ben Woodworth, Iowa Association of Community Providers, and Ms. Julie Fidler Dixon, On With Life, Inc.

Mr. Lauer noted that consensus among the group was high and was aligned with the *Olmstead* principles. About 95,000 people in Iowa are living with long-term disability from brain injury. People are now able to survive what would have been life-ending brain injuries so the number of people with brain injuries is rising. Mr. Lauer stated the cost of not responding to the needs of individuals with brain injury is high, so affordable and acceptable services must be made available.

The workgroup specified recommendations based on the degree of impact in improving the system and degree of deployment difficulty. The recommendations presented an array of core services, optimized core services, expanded core services, and new core services. Not all of the recommendations would require much additional funding.

Core Services. Mr. Lauer reviewed the core services recommendations. Mr. Lauer noted the Medicaid brain injury waiver currently has 580 individuals on the waiting list and there is typically a one-year wait. This is a problem because the brain is attempting to heal during that initial year and the trajectory of the outcome for that person changes if services are not provided. The post-acute inpatient skilled nursing level of care and outpatient neurorehabilitation are essential services. Currently, the Medicaid neurobehavioral services are unavailable in Iowa for children or adults. The brain injury registry outreach unit under DPH sends a letter to consumers which connects them with brain injury services.

Member Questions and Discussion.

- **Veterans Services.** In response to a question from Representative Heaton regarding the services that the federal Veterans Administration (VA) provides, Mr. Hackett stated the VA serves those with immediate or complicated needs at regional centers and also has clinic-level care. In order to qualify for VA care, the person has to know how to access the system, the treatment is different if the injury is determined to be service-related, and the veteran must access treatment within two years of the injury. If the veteran waits too long, the care is limited to that provided to all veterans and not specific to the brain injury. The regional center in Iowa City has only seen half of those estimated to qualify for care so the rest are either getting care elsewhere or foregoing the care. Mr. Hackett suggested focusing on how veterans access the system to improve provision of services. Mr. Brown commented that veterans are not usually diagnosed while they are on active duty. While they are in the more structured environment of active duty, they may not be aware of the effects of the injury. Once they return to the less structured environment of the community and attempt to reintegrate into the community, they may experience problems. This late recognition would likely place them outside of the VA system.

Ms. Fidler Dixon also commented that veterans' brain injuries are complex and locally based providers must be accessible. However, because many VA services are provided in regional centers, veterans often discontinue services to return home.

- **Veterans Numbers.** In response to Senator Johnson's question about the 16,000 Iowans that have been deployed to Iraq or Afghanistan and returned with a brain injury as the signature wound, Mr. Lauer stated that 20 to 30 percent of all returning veterans have a traumatic brain injury. Mr. Hackett stated the 16,000 number listed in the handout based on 2008 figures is fairly accurate, but the current actual figure is likely double.
- **Brain Injury Council Change.** In response to Co-chairperson Schulte's question on changing the name of the Governor's Advisory Council on Brain Injury to the Brain Injury Services Commission and expanding its scope to become the BI state policymaking body and establishing an Iowa interagency, intergovernmental brain injury coordinating committee, Mr. Woodworth stated the advisory council currently advises DPH, but the group wants to make direct recommendations to the General Assembly and the Governor. As to the intergovernmental brain injury coordinating committee, Minnesota has an intergovernmental coordinating body that is a public-private partnership to coordinate the needs of individuals with brain injury in the state. The coordinating body is able to apply for and receive federal funding and provides more coordination to give consumers the necessary tools. Mr. Woodworth noted that the VA should be included in the public-private partnership.
- **Brain Injury Service Administration.** In response to Co-chairperson Schulte's question regarding whether brain injury should be set apart from mental health as unique or should be viewed in a more holistic way with other mental health issues, Mr. Lauer said that brain injury is currently being addressed separately. Many times consumers present with multi-occurring issues, but brain injury is unique enough to require disability-specific services.
- **Neurobehavioral Issues.** In response to Representative Heddens' question on neurobehavioral services, Ms. Fidler Dixon stated that when recovering from brain injury, neurobehavioral issues arise. These issues do not require skilled care, but do require more than merely returning consumers to the home setting. She commented that neurobehavioral services should be administered at a residential level, and that Iowa lacks services at the acute level of care and afterwards. Neurobehavioral challenges need to be addressed on an ongoing basis throughout the individual's lifetime and different levels of service are needed at different times.
- **Funding.** In response to Senator Bolkcom's question on funding and priority items, Mr. Lauer stated the starting point is eliminating the Medicaid waiver waiting list and determining actual Medicaid eligibility before placing someone on the waiting list. The next step is to focus on neurobehavioral services, training, and resource facilitation, which would train families and others on best practices. Iowa City has a model that provides a link between training, service provision, and research and is a way to increase system capacity, which would attract more research funding.
- **Service Capacity.** In response to Representative Heaton's question about how much more service capacity for rehabilitation for brain injury is needed, Mr. Woodworth stated that the Association of Community Providers is working with DPH to develop the capacity with

providers. The difficulty is that out-of-state placements are reimbursed $800/day but in-state providers receive only $85/day. Providers are concerned that at such a low level of reimbursement, they will be unable to provide the appropriate services. In Omaha, rehabilitative services are provided that attract consumers from all over the state, but Iowa's Medicaid reimbursement rate cannot support such services. As a result, some individuals live in nursing facilities as an alternative.

V. Regionalization Workgroup Presentation

Ms. Mary Vavroch, retired Assistant Attorney General, and Director Palmer discussed the report of the regionalization workgroup. They were joined in this presentation by Ms. Lori Elam, Scott County Central Point of Coordination (CPC) administrator. The regionalization workgroup met for five days and listened to the pros and cons of forming regions. Ms. Vavroch stated the goal of the workgroup was to make recommendations to create a regional system to ensure equal and consistent access to services while ensuring accountability and proper stewardship.

Criteria for Formation of Regions. Ms. Vavroch stated the target general population for a region should be in the range of 200,000 to 700,000 people, but there should be flexibility and a mandatory population should not be required. The criteria for regions should be created by statute to result in roughly five to 15 regions. County formation should initially be voluntary but all counties should meet the formation criteria by July 1, 2013, or be assigned to a region by DHS.

Time Frame for Regional Formation and Implementation. Ms. Vavroch stated the regionalization process would take considerable time, with full implementation in July 2014. Ensuring that consumers were not put at a disadvantage was the most important issue for the workgroup. There was some controversy on the implementation date, but the time frame has two components: formation and implementation. Ms. Vavroch referred the committee to the interim report, pages 104 and 106, for details on the implementation phase.

Regional Governance. Ms. Vavroch stated the consensus of the workgroup was that each county in the region has a stake so each county would get only one vote. There was discussion on having providers on the board, but the recommendation was that providers should not be on the governing board. The workgroup concluded that Code chapter 28E would not need to be amended to accommodate regional agreements.

Regional Financial Management. Ms. Vavroch stated the regions should use a single account into which county levy and other funds would be deposited and from which funds would be expended to provide for accountability.

Regional Functions. The interim report provides a summary of regional functions. Some of the functions would require legislation to specify what is mandatory and what is discretionary. The regional management strategic plans should be set by statute with DHS discretion to approve plans. DHS would review the plans and the Mental Health and Disability Services (MH/DS) Commission would approve the plans as is currently done for county management plans. The workgroup concluded the county should have a financial stake in the system going forward and assumed county levy authority for MH/DS would continue. Legal settlement would be eliminated and replaced with a new definition of residency, but regional residency would not be used as a

basis for denial of services. Ms. Vavroch acknowledged that as long as the system is not totally based on a money-follows-the-person model, there would be disputes over legal responsibility to pay for services. However, any dispute should be able to be resolved under the existing statutory dispute resolution mechanism. Ms. Vavroch also stated that there should be a state fund for providing technical assistance to developing regions.

Member Questions and Discussion.

- **"Assured Access."** In response to Senator Johnson's question regarding the meaning of "assured access" as mentioned in the criteria listed in the interim report, Ms. Vavroch stated the language came from legislation and means the consumer can access services outside the region.
- **Board Composition.** In response to Senator Johnson's question on why the workgroup decided that providers should not be voting on the regional governing board, Ms. Vavroch stated the best practice rule is that the provider should not be on the board because of potential conflicts of interest.
- **Access to Board.** In response to Senator Bolkcom's question on consumers' access to regional board members, Mr. Day stated that other states have implemented various approaches for consumers to access the board, such as holding meetings in each county once a month, often using telecommunications.
- **Region Size.** In response to Representative Heddens' question regarding the lack of a limitation on the number of counties in a region, Ms. Vavroch stated the workgroup determined that they did not want to set an upper limit on the number of counties because it could be difficult for some smaller counties to reach a population number that allows for efficiencies in the system.
- **Regional Administration.** In response to Representative Heddens' question on the role of administrative offices, Ms. Vavroch stated there would be an administrative office for every region, but that office may not be an access point and there may be multiple administrative offices.
- **Transition.** In response to a question from Representative Heddens on the transition issue, Ms. Vavroch stated that the workgroup determined there would be two phases in establishing regions: formation and implementation. The interim report includes criteria for each phase.
- **Appeal Rights.** In response to Representative Smith's question on the appeal rights for consumers, Ms. Vavroch stated this concern was reflected in the regional management plans and will have to go through the rulemaking process. The appeals process would be a mandated requirement and it may be similar to what is currently in place. Mr. Day commented that the appeal process needs to be consistent throughout the state, whereas the grievance process could be more informal and does not need to be consistent statewide.
- **Code Chapter 28E.** When responding to Representative Smith on what changes need to be made in the law to reflect the workgroup's recommendations, Ms. Vavroch stated the workgroup only reviewed Code chapter 28E and determined no changes were required.
- **Funding.** In response to Senator Bolkcom's question on how regions would handle pooling of funds, regional legal settlement, governance, and the repeal of the county levy, Ms.

Vavroch stated that the workgroup assumed county levy authority would continue and that until such time as there is a statewide money-follows-the-person structure, the regions will use residency rather than legal settlement to determine the responsibility to pay for services provided to individuals who reside outside the region. However, statutory provisions should be put in place to prohibit denial of services, pending a determination of responsibility to pay. Director Palmer stated the counties would pool money and provide accountability so the public can determine whether contributions are used appropriately. Director Palmer stated the simplest way to do this is to reinstate the levy. He also stated there is still an opportunity for functions to be administered at the county level.

- **Additional Services.** In response to Senator Ward's question on counties providing services above and beyond what is paid for by the pooled money, Director Palmer stated that counties can continue providing additional services, but individuals who reside outside the county may access the services under the regional system. The money would be pooled and the regional board would determine the availability and needs.

  In response to Senator Ward's questions about the disparate resources between some larger counties versus the smaller counties and the concept of "core plus" services, Ms. Elam stated that the workgroup discussed that some counties can currently be seen as providing core plus services, and if that approach continues, there is going to be a problem of disparate resources. Director Palmer stated that bringing counties with fewer resources up to the base level of the rest of the region would cost more money initially and then more in the future. However, through the redesign, the system should become more efficient and affordable by providing the right services at the right time. As to the source of additional funding, Director Palmer stated that the workgroup did not discuss any other funding from counties besides the reinstatement of the levy.

- **CPC Role.** In response to Representative Heaton's question regarding the CPC's role in the organizational structure, Ms. Vavroch stated the administrator for the region could have similar functions to a CPC administrator and that role could be dispersed throughout the region. The CPC may not have the same title or functions, but could still be involved in the system utilizing its expertise. The CPC might be an employee of a new entity and might be a county employee, but that would depend on the Code chapter 28E agreement.
- **Regional Decisionmaking.** Representative Heaton commented that an issue could still exist regarding the struggle between the state's obligations and the county's obligations. In response to Representative Heaton's question on a situation where the governing board would opt to reduce services or to prioritize use of services reimbursed by the state, Director Palmer stated that the Code chapter 28E agreement would determine provision of services. He also noted that the larger counties in the workgroups originally supported the "one county-one vote" decision because they felt that moving away from this approach would engender lack of trust.

  Co-chairperson Hatch commented that Polk County and Linn County acknowledged the simplest and fairest approach was the "one county-one vote" system, but the members of the workgroup spoke as individuals. In subsequent discussions with other supervisors of large counties, there was opposition to the "one county-one vote" approach. Ms. Elam also

stated that Scott County supervisors and ISAC have raised concerns about the approach. Ms. Elam also mentioned that the pooling of money is a concern.

VI. Judicial-DHS Workgroup Presentation

Mr. David Boyd, state court administrator, Iowa Judicial Branch, and Ms. Donna Richard-Langer, workgroup facilitator under contract with DHS, discussed the report of the Judicial-DHS workgroup. Mr. Boyd stated the charge for the workgroup was structured differently than the other workgroups since it began working in the summer of 2010, and will likely continue. The workgroup focused on improving the involuntary commitment process under Code chapter 229 and nine areas of focus specified in SF 525.

Transportation. Mr. Boyd stated the workgroup focused on safety, efficiency, and the needs of the consumer. The workgroup determined that transportation should be provided for the committal process, that regions should designate a transportation coordinator, and that reimbursement should cover all costs.

Pre-commitment Screening. Mr. Boyd noted the workgroup's recommendation for pre-commitment screening as a core service. This approach was implemented in Warren County in 2007, but was discontinued due to lack of statutory authority. The pre-commitment screening would allow the consumer to connect with a mental health professional prior to the commitment hearing. The data showed that 60 percent of the cases that come before the court for an involuntary commitment are not appropriate and should more appropriately be referred to a substance abuse provider, primary care provider, or a mental health treatment.

23-hour Hold. Mr. Boyd commented that Code chapter 229 will soon reach its 40th anniversary of enactment without any major changes to its structure or study on its effects. The workgroup addressed court authorization to order a 23-hour involuntary hold. The current involuntary hold of a patient for not more than 48 hours as provided by Code section 229.10 is similar to a pre-commitment screening. Some but not all counties have beds available for this purpose. The workgroup recommended resolving the difference in Code chapter 229 between the emergency commitment process and the business hours process by providing for a 48-hour hold to be available at all hours rather than ending at the end of the business day. He also stated that doing so would affect the functions of magistrates and that lay-trained magistrates (of which there are only 14 of 152 total magistrates) would need to be given additional statutory authority.

Qualified Mental Health Professional. Mr. Boyd explained that the definition of a mental health professional pursuant to Code chapter 228 is not currently synonymous with the definition of a qualified mental health professional in Code chapter 229. The workgroup recommended eliminating the definition and all references to the term in Code chapter 229. The workgroup supported the SF 525 amendment that would allow a psychiatric advanced registered nurse practitioner to provide the annual report to the court for an outpatient committal without an evaluation of the patient by a psychiatrist.

Advocate. Mr. Boyd stated the workgroup recommended broadening the mental health advocate system into a state system with a uniform job description, rather than having the district court administrator or chief judge administer the advocates system. He recommended an autonomous

system controlled neither by the judicial branch nor DHS. Funding should be provided by the state rather than the counties, and payment for services should be based on a consistent reimbursement standard. This type of system would be similar to the Court Appointed Special Advocate (CASA) or the public defender structure within the state.

Jail Diversion Program and Mental Health Courts. The workgroup recommended creating a comprehensive jail diversion program as a core service and implementing a mental health court to include both diversion and condition of sentencing models. Black Hawk County had such a program, and in its first three years, 74 percent of defendants successfully reentered the community. Mr. Boyd cautioned that a jail diversion program is very labor-intensive and would require additional resources.

Law Enforcement. Mr. Boyd explained that currently, no uniform curriculum exists for law enforcement mental health training. The workgroup recommended comprehensive training of law enforcement every three years and that consumers should be involved in the training. He also stated that more front-end and ongoing training is needed.

Residential Care Facility (RCF). Mr. Boyd commented that placement in an RCF should only occur after the facility is notified and accepts the person.

Member Questions and Discussion.

- **Civil Commitment.** Representative Smith commented that there are three different statutory bases for civil commitment (Code chapters 125, 222, and 229). He stated that the 23-hour hold is necessary because a person who is agitated could be committed when it is unnecessary, and supported the workgroup recommendation for authorizing a 48-hour hold at any time rather than implementing a new 23-hour hold procedure.
- **Jail Diversion.** In response to Representative Wolfe's question on how jail diversion programs could be established in the regional system, Mr. Boyd stated that regions could implement the jail diversion programs, although the regions would not necessarily match judicial districts, so there would be some complications.

  In response to Senator Ragan's question regarding jail diversion programs, Mr. Boyd stated each region would have a jail diversion program.

- **Pre-commitment Screening.** In response to Senator Johnson's question regarding pre-commitment screening, Ms. Richard-Langer stated that ideally the family would be present to compile a history, which would allow the mental health professional to provide options other than commitment. Representative Smith commented that currently, the person has no contact with a mental health professional if brought to the court for an involuntary commitment during business hours, but during emergency hours the mental health professional probably does evaluate the person before a magistrate is called. Mr. Boyd added that often a family may proceed to involuntary commitment as a first option when it is not necessary.
- **Judge's Authority.** In response to Representative Wolfe's question regarding a judge's authority, Mr. Boyd stated that statutorily a judge cannot arrange for an evaluation during a hearing, but the judge has more flexibility when the person is cooperative.

- **Magistrate Training.** In response to Representative Wolfe's question regarding training for magistrates, Mr. Boyd stated there is a need for continuous, multi-disciplinary training with magistrates, medical professionals, and providers. He also stated that there is a need for understanding among this group regarding the differences in the meaning of certain legal and medical terms.
- **Facility Placement.** In response to Representative Heaton's query regarding the court's placement of committed persons and the information needed for a judge to correctly place a person, Representative Smith stated that the problem in placement could be alleviated by pre-commitment screening and training for magistrates. Mr. Boyd also noted that in order for the judge and magistrate to appropriately place an individual, beds would have to be available that match the individual's needs. Currently, there is a shortage of available beds in some geographic areas across different care levels. Judges and magistrates often have no choice but to place individuals where beds are available regardless of the level of care needed.

  In response to Representative Heaton's question on RCFs and state versus county or regional funding, Ms. Diane Brecht, executive director of Penn Center, Inc., RCF, stated there are multiple problems in moving people from one level of care to another. She also stated that in order to accept a client and safely serve that individual, the RCF must have a funding stream before accepting the client. She acknowledged the acceptance of an individual would be faster and access would be greater if the need to validate the funding stream was eliminated. Representative Heaton commented that this puts the sub-acute level of care at risk because the RCF will not take the individual without funds, and the county or region can refuse to provide those funds. Director Palmer stated that the global budget administered by counties is capped but the issue is whether the county plan allows for certain placements and if the county has sufficient funding.
- **Mental Health Courts.** In response to Senator Bolkcom's question regarding mental health courts, Mr. Boyd said a drug court judge could preside over a mental health court if there was time and the crimes involved in a mental health court would likely be serious or aggravated misdemeanors. Mr. Boyd stated he did not know what the cost would be for mental health courts statewide.

VII. Adult Intellectual and Development Disabilities (ID/DD) Workgroup Presentation

Mr. Robert Bacon, director, University of Iowa Center for Excellence on Disabilities, and Mr. Rick Shults, DHS Mental Health and Disability Services Division administrator, discussed the report of the Adult Intellectual and Developmental Disabilities Workgroup. Mr. Bacon stated that all elements of the redesign are premised on the idea that persons often have multi-occurring or co-occurring issues.

Eligibility. Mr. Bacon noted that eligibility for services used to be determined by an intelligence test. The process now assesses the functioning, ability, needs, and support of the person. The assessment considers what it takes to make the person successful in the community. Mr. Bacon stated there is a current pilot project in Iowa for standardizing this assessment. This assessment

tool would also be used for resource allocation. The workgroup recommended standardizing the eligibility process and expanding the intellectual disabilities waiver to accept those with other developmental disabilities. Sixty percent of county funds are used for services to persons with intellectual disabilities. The workgroup also recommended consolidating the waivers with overlapping target groups such as ill and handicapped, brain injury, physical disabilities, and intellectual disabilities.

Core Services. Mr. Bacon stated the workgroup focused on the *Olmstead* principles and supports moving to a system of person-centered, integrated community services based on best practices. The workgroup agreed that the current array of services should be considered "core" in order to avoid disruption in the lives of the clients if these services were to be discontinued. Expansion of core services would be premised on the "community-first" approach with priority placed on the outcomes and goals of *Olmstead*. The consensus of the group was that change would have to be slow, as no one benefits from a precipitous change.

Other core services supported by the workgroup include conflict-free case management, health and primary care, and family support. With regard to additional core services, Mr. Bacon stated that crisis prevention and intervention, behavioral intervention and positive behavior support services, and mental health outreach are absolutely essential and need to be added, and speech therapy needs to be provided for rehabilitation, not just habilitation. He further added that a housing program is necessary and a rent program should be created with the Iowa Finance Authority. The workgroup also supported adding the use of tele-health resources and peer-to-peer support.

Outcome and Performance Measures. Mr. Bacon stated that measurements should be tied to achievement of positive outcomes for individuals and families. The workgroup recommended that performance data be aggregated and publicly reported, that data be analyzed by DHS across systems to develop quality improvement strategies, and that standardized family satisfaction surveys be developed.

Provider Qualifications and Monitoring. Mr. Bacon stated that providers are concerned about simply adding qualifications without considering what is currently in place and streamlining the current system. He stated that technical assistance should be provided in a quality way.

Workforce Development. Mr. Bacon recommended that the College of Direct Support, an online curriculum and system for direct support professionals administered through the University of Iowa, should be available at no charge to all ID/DD providers. He also stated that every direct support professional should be required to demonstrate a level of competency in core curricula.

Member Questions and Discussion.

- **Assessments.** In response to Co-chairperson Schulte's question regarding assessments, Mr. Bacon stated that individual assessment is needed for ID and DD services. He further stated case managers do not have time to administer the assessment and full-time assessors are needed.
- **Medicaid Waivers.** In response to Representative Heaton's question regarding Medicaid waivers, Director Palmer stated that if someone moves from the state and plans on

returning, that person can remain on the waiver by having a return plan, notifying the state of this, and returning in a reasonable period of time.

- **Rent Subsidy.** In response to Senator Bolkcom's question regarding the rent subsidy, Mr. Bacon stated that 60 percent of the funding allocated for this year is obligated, and funding did run out last year.
- **College of Direct Support.** In response to Representative Heddens' question regarding the College of Direct Support, Mr. Bacon stated that grants and contracts are helping, but there are ways of financing change. He stated there is a lack of competency training. He stated that 45 providers are using the College of Direct Support and more than 1,500 are being trained.
- **Workforce.** Representative Heddens also commented that a workforce task force should be tied in with the Iowa Partnership for Economic Progress, since this is an economic development issue. She also suggested that an individual with a disability or a family member should be on that task force.

VIII. Children's Disability Workgroup Presentation

Dr. Mark Peltan, clinical psychologist, Mercy Behavioral Services, and Ms. Jennifer Vermeer, Medicaid director, DHS, discussed the recommendations of the Children's Disability Workgroup. This workgroup has a two-year charter to create a system of programs and services, including bringing children home from out-of-state placements and keeping children in the state to receive necessary services. In the first year, the workgroup is concentrating on identifying gaps, reviewing promising practices, developing initial recommendations for core services, and proposing a process to bring children home.

Dr. Peltan stated that the health home model can be used to provide essential care for children. Another promising practice is the systems of care model currently being piloted in various areas in Iowa to provide a coordinated network of community-based services and supports for children who are at risk for out-of-home placement and their families. The workgroup recommended the state adopt a broad systems of care model that is inclusive of more children, youth, and families, and provided a recommended definition of systems of care.

Core Services. The workgroup recommended the rollout of specific new core services. One new core service is intensive care coordination services rather than case management. The intensive care coordination services would fall under specialized health homes and would focus on coordinating the delivery of multi-system, multi-component services.

The workgroup also recommended funding the new service of family peer support under the auspices of the specialized health home to provide support to families. A third new service recommendation is provision of crises services, including crisis intervention and crisis stabilization services.

With regard to existing services, the workgroup recommended enhancing intensive community-services based treatment and more flexible use of psychiatric medical institutions for children (PMICs).

Health Home Model. The workgroup recommended the development of a children's health home model for service delivery. Ms. Vermeer stated the health home model is an option under ACA and will have enhanced federal financing. The model would fill a gap in the children's mental health system. The new model would have dedicated care service providers with low caseloads, which are not available in the present system. Under the model, the care coordinator would deal with the complex children's system. This approach would also be a good model for the adult system.

The workgroup recommended a short-term goal of bringing children back to Iowa from out-of-state placements. There are currently 150 children in out-of-state placements with an additional 450 at risk of such placements. The workgroup recommended a strategy to be delivered through a managed care plan using a request for proposals (RFP). The RFP would seek providers to serve children based on a community-first focus. The RFP would use the health home model, consider innovative reimbursement models, and consider the use of resources such as therapeutic foster care. The RFP would also address the rural and urban distinctions in the state. Implementation would begin in the Spring of 2013.

Member Questions and Discussion.

- **Care Coordinator.** In response to Co-chairperson Schulte's question regarding intensive care coordination, Ms. Vermeer stated that the health home coordinates and integrates the individual's health-related needs, but also would participate in cross-system referrals and linkages including the education component. Dr. Peltan stated the workgroup spent a lot of time discussing frustration with the education system, especially with small school systems and suggested the health home coordination could help.
- **Work Plan.** In response to Co-chairperson Schulte's question regarding the two-year charge, Dr. Peltan stated that most of the energy was focused on the first-year goal of getting children back from out-of-state placements. Because the first year discussions focused on mental health, in the second year the workgroup will focus on other disability groups.
- **Reimbursement.** In response to Representative Heaton's question on applying the health home to local primary care providers, Ms. Vermeer stated the payment method under the health home is a per-member, per-month payment. Nurses and social workers would provide many services under the health home model.
- **Medicaid Waiver.** In response to Representative Heddens' question regarding the Medicaid Children's Mental Health (CMH) waiver, Dr. Peltan stated there is a need to establish more flexibility regarding the allocation of slots and the admission requirements in the PMIC system to allow children who are placed in a PMIC to retain a place on the waiver.
- **Education.** In response to Representative Heddens' comment regarding the need for education resources when children are placed in PMICs or otherwise are receiving services, Dr. Peltan stated the workgroup discussed and recognized this problem.
- **Regional Integration.** In response to Representative Wolfe's question regarding inclusion of the children's health home system in the regional structure, Ms. Vermeer said that this has yet to be determined but should readily work into the regional structure. Director Palmer stated that the children's system is being considered last because the initial focus

was on the services involving county funding. It would make sense to include the children's mental health system in regionalization to provide easier transition between the children's and adult systems. If not, it would create another "silo" or disconnect in the system which should instead serve the whole person and the person's family.

- **Commitments.** In response to Representative Wolfe's question on mental health commitments, Dr. Peltan stated commitments are often the result of lack of information. The focus on crisis intervention should therefore alleviate the problem with commitments.
- **Multiple Systems.** In response to Senator Bolkcom's question on the children's mental health system, Ms. Vermeer stated that children are involved in multiple systems—education, acute behavioral systems, physical health systems, juvenile justice systems, child welfare, and others, so it is more complicated than the adult system. Ms. Vermeer commented that $150 million was spent by Medicaid on children's mental health, not including child welfare, education, or juvenile justice services. She also relayed parents' frustration in navigating through the complicated children's mental health system.
- **Duplication.** In response to Co-chairperson Schulte's question regarding duplication of services, Dr. Peltan discussed the need for integration of primary health care into the system, noting that the children's health home could act as a means of integration.

IX. Residential Care Facility Overview

Ms. Kathy Butler, CEO and administrator of Partners for Progress, and Ms. Brecht made presentations on residential care facilities.

Ms. Brecht stated that the majority of RCFs were converted county homes for the elderly and individuals with intellectual disabilities. Currently, RCFs serve persons with chronic and serious mental illness. RCFs serve 1,419 people, of which 622 are court-ordered commitments. In a 2010 RCF survey, 1,126 of those served had mental health issues.

RCFs provide clients with shorter stays and focus on transitioning people back into the community. RCFs offer programs to help develop illness and medication management, discuss when the person should seek medical or psychiatric support, and offer other support and community integration services. Some facilities have psychiatrists that come to the facility, and others have access to psychiatric advanced registered nurse practitioners, counselors, occupational and physical therapists, and family practice services. Some RCFs also offer substance abuse assistance and address co-occurring disorders.

The majority of persons entering RCFs come after three to five days in acute care. RCFs are a step in the continuum of care and serve as a transition from and an alternative to acute care.

The handout distributed was put together for the Judicial/DHS Workgroup and only addresses the RCFs that evolved from county institutions. There are 37 of those facilities, and the facilities average 36 residents. The RCFs are located throughout the state. RCFs operate under 481 IAC 57, which was not originally designed for the current clients.

Administrators in RCFs are concerned about the proposed changes to the mental health system because the majority of their funding currently comes from the county.

Member Questions and Discussion.

- **Core Services.** Co-chairperson Schulte commented that an RCF is not a paid-for service, but rather is a residential placement. Therefore, RCFs are not on the core service list. Co-chairperson Schulte also commented that RCFs are very different depending on where they are located and special licensing might be an option. Director Palmer stated that RCFs serve an important function to certain consumers and it is a question of defining the core services RCFs would provide. He said that RCFs could be a sub-acute service and probably do serve that function now, but they also serve a wide variety of populations. He commented that licensure could be considered in defining the core services provided by an RCF and the population served. Director Palmer stated that RCFs will continue to succeed and have a future in the regionalization structure, although they may not have the same name.
- **RCF/PMI.** In response to Representative Heaton's question regarding the difference between a general RCF and an RCF for Persons with Mental Illness (RCF/PMI), Ms. Butler stated that general RCFs could be licensed for PMI, but to do so the RCF would have to change licensure without receiving any additional funding or benefit. Ms. Brecht commented that staffing is higher in a PMI.
- **Sub-acute.** In response to Representative Heaton's question on providing sub-acute care in an RCF, Ms. Brecht stated that current rules act as a barrier to accepting a client on a crisis basis.
- **Medicaid Requirements.** In response to Co-chairperson Schulte's question on RCFs with more than 16 beds being considered institutions for mental disease and therefore not eligible for reimbursement under the Medicaid program, Director Palmer stated that is a major barrier but thought that other mixes of funding could be considered.

X. Public Comment

Iowa Association of Community Providers. Ms. Shelly Chandler with the Iowa Association of Community Providers (IACP) stated that providers would be interested in being a part of the workforce group mentioned by the adult mental health workgroup. She also mentioned that Mr. Brown was able to start his neurorehab services for BI only by going through a lengthy process to receive exemptions or exceptions from existing rules. She also requested that providers be on the governing body of the regional boards and stated that conflicts between providers and consumers could be managed. She stated that a detailed structure should exist for appeals and grievances. She also asked for clarification on whether certification of providers would be regional or statewide. She stated that conflict-free case management is a very real problem that all levels of care face because they all engage in case management. Ms. Chandler also commented on the need for training of providers of ID/DD and brain injury services on multiple-occurring disorders. She also requested funding for the College of Direct Support.

***Olmstead* Task Force.** Dr. Jerry Mayes with the *Olmstead* Task Force voiced the task force's disagreement with the ID/DD recommendation stating that the current array of residential, day and vocational, and other ancillary services be considered core services, while more community-based

services are developed. The task force recommended that the six best practice areas listed on pages 26-30 of the interim report be considered core principles.

Iowa Alliance of Community Mental Health Centers (CMHCs). Mr. Brice Oakley, speaking for the CMHCs, noted the need to balance eligibility, administrative costs, and provider issues. He reviewed his written comments enumerating six recommendations: the need to set regional mechanics; set regional and state functions; set provider role expectations, especially for CMHCs; set specific tasks for the workforce group; make participation decisions on the federal Affordable Care Act; and consider transition schedules and separate schedules for ID/DD issues.

Parent. Ms. Rhonda Shouse, a parent representative, noted the gaps in children's mental health in Iowa. She stated that Iowa has no entry point and there really is no children's mental health system. She noted the need to do things right the first time.

Consumer and Consumer Guardian. Ms. Sharon Lambert, a consumer and guardian of her 20-year-old grandson with multi-occurring disorders, including bipolar disorder, gave testimony on her experience with Code chapter 229, beginning when her grandson was age 13. She recommended that guardians be given more input into the proceedings.

Peer Action Disability Support (PADS). Mr. Bob Cihla of Linn County commented on the core services and stated that PADS is opposed to including ICF/MRS and structured workshops as core services because they are not effective or efficient. He also noted the need to stay consistent with *Olmstead* principles as noncompliance with *Olmstead* can lead to litigation.

Iowa Psychological Association. Ms. Amy Campbell with the Iowa Psychological Association stated that eliminating the definition of qualified mental health professional in Code chapter 229 would cause default to a similar but different definition in Code chapter 228. This would lead to a problem for psychologists because they likely do not meet the definition listed in Code chapter 228 since they only have one year post-degree supervision and one year of pre-degree supervision rather than two years of post-degree supervision.

Iowa Mental Health Planning Council. Ms. Bomhoff submitted several handouts to the committee. Ms. Bomhoff noted that not all gaps in the system have been addressed. The Mental Health Planning Council would support the reinstatement of the county levy. She also noted that establishment of a workforce task force and transformation to regionalization should take place quickly. Ms. Bomhoff noted the need for law enforcement and primary care providers on the governance board of regions. She also stated the unavailability of treatment beds needs to be addressed immediately. She commented that missing pieces in the interim report include: addressing medications under Medicaid; addressing waiting lists; addressing suicide prevention, as there are 330 suicides per year in Iowa on public record as compared to 50 homicides per year and 10,000 calls from veterans are made each month to suicide hotlines; and addressing the rewriting of the civil commitment laws.

Chatham Oaks RCF—Children's MH Services. Ms. Vivian Davis with Chatham Oaks, an Iowa City RCF, stated that more people are moving out of RCFs and then returning, so she cautioned about time-limited services. She also requested that RCF staff be included in conversations on sub-acute care. Ms. Davis also provided testimony that she has a child with mental illness that the family tried to keep close to home. She stated that even as a service provider, she had problems

navigating the children's mental health systems, as the service coordination is severely lacking. She also noted the lack of transition services as children with mental illness enter adulthood.

Easter Seals. Ms. Sherri Nielsen with Easter Seals commented on the importance of conflict-free case management, but stated there needs to be focus on a team approach. She stated that their case managers have 26 clients on average and those relationships need to be person-centered. She also noted the need and desire for providers and services to be creative and innovative.

XI. Member Discussion

Co-chairperson Hatch opened the discussion for comments on what the committee needs to address in the next meeting and what committee members need to do to be successful.

Representative Heaton asked how detailed the committee needs to be in its recommendations for legislation. Co-chairperson Hatch commented on the intention to focus on consensus points in developing the initial legislation. The committee needs a place to start, so the committee's bill will begin as including consensus points, and may change during the legislative process.

Co-chairperson Schulte noted the expertise at the table and stated there are ideas that could be implemented without funding, such as the reorganization of the court committal chapters.

Senator Bolkcom stated the need for consensus-building at the December 19 meeting. He also stated that the committee would need to discuss funding versus non-funding fixes, the five-year plan, the five-year funding picture, and the need for $47.5 million to buy out the county responsibility for Medicaid. He emphasized the need to discuss the availability of resources with leadership.

Representative Heddens stated that in order to have a discussion on funding, there needs to be clarity to the proposal and more details to sell the idea. She especially noted the need for defining local access points in the regional structure and the need for more details on the appeal process, as well as whether a reinstated property tax levy would afford core or core plus services. Representative Smith noted the options on property taxes and the need for partnership with the counties.

XII. Materials Filed With the Legislative Services Agency

The materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the "Committee Documents" link on the Committee Internet website at:

http://www.legis.iowa.gov/Schedules/committeeDocs.aspx?GA=84&CID=541.

1. Iowa Mental Health and Disability Services System Redesign-Preliminary Report, Department of Human Services.
2. Workgroup Membership List.
3. Workgroup Summary 1-Adult Mental Health.
4. Workgroup Summary 2-Brain Injury.
5. Workgroup Summary 3-Regionalization.

6. Workgroup Summary 4-Judicial/DHS.
7. Workgroup Summary 5-Adult Intellectual and Developmental Disabilities.
8. Workgroup Summary 5A-ID/DD Definitions.
9. Workgroup Summary 6-Children's Disability.
10. Workgroup Summary 6A-Children's Disability, Children's Mental Health Home Diagram.
11. Map of RCFs Converted from County Care Facilities.
12. Residential Care Facility (RCF) data and overview.
13. Residential Care Facilities in Iowa: Status Review report submitted 12/15/2010 by Governor's DD Council.
14. IA Lic. RCFs-Converted from Co. Care Fac. w/admission considerations for difficult-to-place people (K. Butler, Willow Hts. RCF-10/2011).
15. Public Comment-IA MH Planning Council-Recs & Comment on Preliminary Report.
16. Public Comment-Comparison of Core Services in Workgroup Preliminary Reports by Ms. Bomhoff.
17. Public Comment-Fed MH Block Grant Change Recs by IA MH Planning Council.
18. Public Comment-Redesign Concerns by Peer Action Disability Supports (PADS) Board.
19. Public Comment-IA Alliance of Community MH Centers.

G:Legal Services/Minutes/2011/3815IC.docx