MINUTES

Inmate Geriatric and Psychiatric Patients Study Committee

November 30, 2011

MEMBERS PRESENT:

Senator Tom Hancock, Co-chairperson

Representative Chris Hagenow
Representative Lisa Heddens
Representative Todd E. Taylor

MEETING IN BRIEF

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I. Procedural Business

Call to Order. Co-chairperson Hancock called the second meeting of the Inmate Geriatric and Psychiatric Patients Study Committee to order at 10:15 a.m. on November 30, 2011, in the Supreme Court Chamber (Room 103), at the State Capitol. The committee lacked a quorum on the part of the Senate.

Adjournment. The meeting adjourned at 2:00 p.m.

Next Meeting. The next meeting of the committee will be on Thursday, January 12, 2012, at 1:00 p.m. in Room 22, State Capitol.

II. Background

The Legislative Council established the Inmate Geriatric and Psychiatric Patients Study Committee to examine treatment and placement options for inmate geriatric and psychiatric patients who are under the care, custody, and control of the state, or for patients who are otherwise housed at the Iowa Medical and Classification Center at Oakdale or other correctional facilities for geriatric or psychiatric treatment. The committee is comprised of five Senators and five Representatives. The committee is authorized to meet for two meeting days.

III. Introductory Remarks

Co-chairperson Hancock gave brief introductory remarks. He noted that, in the absence of a committee quorum, the committee would not be approving the minutes from the September 28, 2011, committee meeting and that no formal committee action would be taken at this meeting. He extended his appreciation to the Department of Corrections (DOC) for hosting the committee's first meeting at the Iowa Medical and Classification Center (IMMC) in Coralville on September 28, 2011. He commented on a recent news report concerning the assault of a nursing home resident by a registered sex offender living in the nursing home (Pomeroy Care Center in Pomeroy, Iowa), noting that the issue of placing elderly registered sex offenders in nursing homes is a difficult issue, but that this committee's charge deals with the issue of the placement of nonviolent offenders under the care, custody, and control of the DOC in alternative facilities, not violent offenders.

IV. Department of Corrections

Mr. John Baldwin, Director of the DOC, spoke to the committee about an executive branch study conducted by the Department of Human Services (DHS), Department of Public Health (DPH), Department of Inspections and Appeals (DIA), Board of Parole, and the DOC required by 2011 Iowa Acts, chapter 134 (SF 510), relating to the development and establishment of behavioral treatment options for inmate geriatric and psychiatric patients under the care, custody, and control of the state. The agencies developed recommendations to maximize treatment and long-term living opportunities while achieving fiscal efficiencies, which Mr. Baldwin highlighted. The recommendations were based upon the state implementing a multilevel approach to provide geriatric and psychiatric patients currently under the care, custody, and control of the state with the best opportunity for long-term success, both in patient and financial terms, to include the private sector, public and private partnerships, and government services. This approach would include

contracting with private nursing homes to house a portion of the geriatric inmates and psychiatric patients in private secure wings, with an emphasis on an understanding of the level of risk for all parties involved prior to such an undertaking; the use of existing state Mental Health Institute (MHI) space for particular defined services without making these services part of the DHS mental health system; designing and financing apartments for groups of offenders and patients who are in need of assisted living; the expansion of subacute beds for long-term care; the utilization of case management, independent living arrangements, and home community services; and the use of existing DOC space, if available.

Mr. Baldwin also noted that the report recommended consideration of related recently submitted recommendations of the Mental Health Redesign Workgroups and Iowa's Aging Network Redesign. He emphasized the importance of considering the long-term impact that any systematic changes may have on geriatric and mental health issues facing the DOC, and in particular, the impact on the need for additional local behavioral health care providers working with geriatric and psychiatric populations within the DOC. Mr. Baldwin stated if changes are made to existing laws relating to geriatric inmates and psychiatric patients, anywhere from 50 to more than 400 inmates could be impacted depending on how the new law is structured. He further stated the average cost for housing an offender at the IMCC in FY 2011-2012 was $157 per day per offender while the average cost for housing an offender in a private nursing home, after Medicaid reimbursement, would be $58 per day per offender.

Committee members discussed information submitted by the DOC comparing costs of services provided to specific populations of geriatric inmates and psychiatric patients at the IMMC, private nursing homes, and the Clarinda MHI. Co-chairperson Hancock noted there are more regulations and rules when considering placements in federal/state facilities than private facilities. Representative Taylor raised a question about the cost comparisons of services provided to Medicaid-eligible persons and paroling appropriate offenders to nursing homes and stated it is necessary to get an accurate picture of the cost savings, especially for the appropriations process. Co-chairperson Hancock also asked Mr. Baldwin for a categorization of psychiatric and geriatric inmates and Representative Hagenow wants that information to also include any estimated costs.

V. Clarinda Treatment Complex (CTC)

Mr. Mark Lund, Superintendent of the CTC, presented an overview of the CTC, located in Clarinda, Iowa, and composed of the Clarinda MHI and the Clarinda Correctional Facility (CCF). Mr. Lund discussed whether the MHI portion of the complex would be a viable option to consider for the placement of geriatric inmates and psychiatric patients. The Geropsychiatric Nursing Facility at MHI is the number one-ranked nursing home in the state. A 20-bed living unit is currently available for immediate occupancy for geropsychiatric patients and another unit could be available after extensive renovations. Mr. Lund noted that the geropsychiatric patients at the MHI are a unique population because all have been previously removed from 10 to 15 nursing homes prior to being admitted to MHI. The patients suffer from serious cognitive losses or dementia and significant behavior problems, although none are convicted felons. He noted placement of some of the patients at the MHI may be court-ordered.

Co-chairperson Hancock asked about the medical capacity of MHI including the staffing. Mr. Lund explained the MHI is not an acute inpatient hospital program, it is not a referral place for persons with disabilities, and it is not a facility that can take care of persons with brain injuries. The Clarinda MHI is a geropsychiatric nursing home and a skilled nursing facility. Doctors make rounds every day. The MHI shares some limited services and staff with the DOC.

Representative Taylor asked about the security around MHI. Mr. Lund stated the geropsychiatric nursing unit is locked (doors that go to the living unit) but there is no fence around the facility and there is no security staff. Representative Heddens asked about the costs per patient per day for the geropsychiatric nursing unit. Mr. Lund responded the per diem cost is $590 per day per patient, and at the current Medicaid rate for reimbursement, the state share would be approximately $327 per day per patient.

VI. Board of Parole (BOP)

Ms. Elizabeth Robinson, Chairperson of the BOP, spoke to the committee about geriatric and medical parole. She informed the committee the BOP utilizes a risk assessment tool in granting or denying work release or parole. This risk assessment tool has been validated four times since its creation and is currently undergoing validation again by the Division of Criminal and Juvenile Justice Planning (CJJP) of the Department of Human Rights. Risk assessment scores which range from two to nine are based on the facts of the case, the history of convictions, the type of crime, and the time frame between multiple crimes, where applicable. Currently, 2.7 percent of active parolees are revoked each month. Inmates are assigned a risk score with a score of two posing the least risk and a score of nine posing the most risk. The inmates with the highest risk require a unanimous vote of the members of the BOP in order for such a person to be released on parole. She noted the BOP does consider the geriatric and medical needs of an inmate being reviewed for parole but public safety is an overriding factor when considering an inmate for parole. Prior to enacting a form of geriatric or medical parole, she suggested the General Assembly conduct public hearings to develop support from the general public.

Co-chairperson Hancock questioned what happens to inmates who become seriously ill in prison and would these inmates be more likely for parole. Ms. Robinson responded that in reviewing these cases, the BOP would review medical and psychiatric reports but any final determination would be based upon public safety.

Co-chairperson Hancock emphasized the need for the BOP to be involved in the committee's recommendations. He requested additional information from the Association of Paroling Authorities International (APAI) in regard to how other states are treating this issue.

VII. Department of Human Services

Ms. Jennifer Vermeer, Director of the Iowa Medicaid Enterprise, and Mr. Rick Shults, Division Administrator for DHS, Division of Mental Health and Disability Services, spoke about inmate Medicaid eligibility with the committee. Ms. Vermeer stated that Medicaid is not available to inmates of public, nonmedical institutions and a DOC inmate is only eligible for Medicaid if the person is admitted to a medical institution (such as a hospital) as an inpatient and the medical institution is not owned, operated, or on the grounds of a penal institution. In order for an inmate to

qualify for Medicaid, the inmate is first required to be paroled and classified as disabled or to be 65 years of age or older. If a state-run facility is created to house disabled or geriatric inmates who have been paroled, such a facility is required to be fewer than 16 beds in order to meet Medicaid reimbursement requirements.

Co-chairperson Hancock asked why facilities are limited to fewer than 16 beds. Mr. Shults responded that this requirement is a long-standing federal rule to prevent long-term housing of large numbers of disabled and geriatric populations in one institution. Ms. Vermeer responded that states often apply for waivers to be excluded from this federal requirement. She also stated that policymakers need to identify the inmates to be served, ages, types of health issues, types of treatment needed, and whether a facility is available that will meet the Medicaid reimbursement requirements. Mr. Shults warned policymakers about developing a treatment option for a certain population without knowing the ultimate demand for the treatment.

Dr. Jason Smith, Superintendent of the Cherokee MHI operated by DHS, was recognized by the committee to answer questions about the Civil Commitment Unit for Sexual Offenders (CCUSO) at the Cherokee MHI. The CCUSO provides a secure, long-term, and highly structured setting to treat sexually violent predators who have served their prison terms, but who, in a separate civil trial, have been found likely to commit further violent sexual offenses. There are currently 90 patients civilly committed as sexually violent predators. The CCUSO can house up to 150 offenders.

In response to a question by Representative Hagenow about the eligibility requirements for admission to CCUSO and why not all of the beds are filled, Dr. Smith responded that it is often difficult for an offender to meet the eligibility requirements of this program because the data indicates that as they age, the risk for reoffending drops.

VIII. Committee Discussion

Representative Hagenow commented this is a complex area and it would be helpful to have integrated and specific proposals from the various departments as well as all stakeholders involved with these issues. Representative Heddens noted the importance of looking at the preventative side of the issue prior to incarceration. Co-chairperson Hancock agreed it will take time to solve the issues raised by this committee, and he would like all stakeholders to collaborate on possible solutions.

IX. Materials Filed With the Legislative Services Agency

The following 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's Internet website at:
https://www.legis.iowa.gov/Schedules/committee.aspx?GA=84&CID=542

1. Tentative Agenda
2. Proposed Rules
3. Comparison of Costs by DOC/DHS
4. Medicaid Eligibility for Inmates
5. Treatment Options for Geriatric and Psychiatric Patients

6. Board of Parole Handout
7. Board of Parole Risk Spreadsheet
8. Clarinda Treatment Complex

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