Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

December 31, 2014

Michael Marshall
Secretary of Senate
State Capitol Building
LOCAL

Carmine Boal
Chief Clerk of the House
State Capitol Building
LOCAL

Dear Ms. Boal and Mr. Marshall:

Enclosed please find copies of the 2014 Iowa Mental Health and Disability Services Commission Combined Annual and Biennial Report to the General Assembly.

This report was prepared pursuant to the directive contained in Iowa Code § 225C.6(1)(h)-(i).

Please feel free to contact me if you need additional information.

Sincerely,

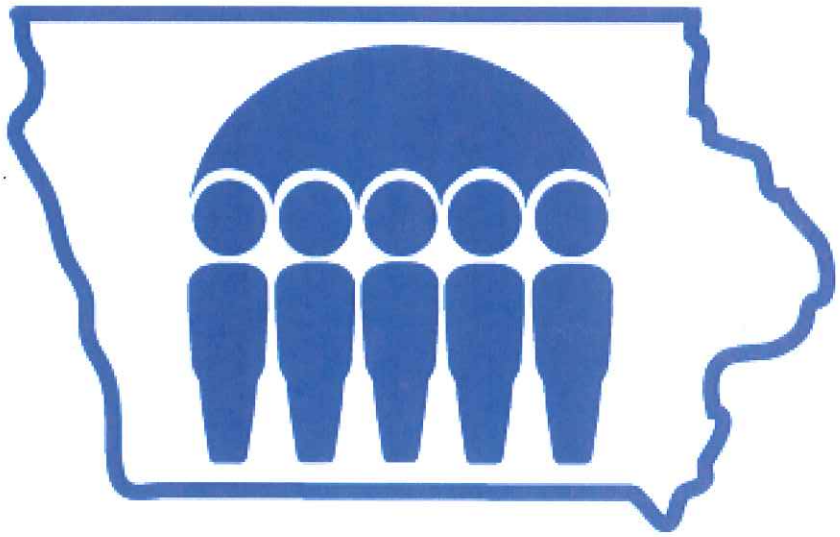
Jennifer Davis Harbison
Policy Advisor

JDH/av

Enclosure

cc: Terry E. Branstad, Governor
Senator Jack Hatch
Senator David Johnson
Representative David Heaton
Representative Lisa Heddens
Legislative Service Agency
Aaron Todd, Senate Democrat Caucus
Josh Bronsink, Senate Republican Caucus
Carrie Malone, House Republican Caucus
Zeke Furlong, House Democrat Caucus

Iowa Department of Human Services



Iowa Mental Health and Disability Services Commission Combined Annual and Biennial Report for 2014

December 2014

2014 COMBINED ANNUAL AND BIENNIAL REPORT

INTRODUCTON

This Combined Annual and Biennial Report of the Iowa Mental Health and Disability Services (MHDS) Commission is submitted pursuant to Iowa Code § 225C.6(1)(h)-(i). The report is organized in three parts: (1) an overview of the activities of the Commission during 2014, (2) recommendations formulated by the Commission for changes in Iowa law, and (3) an evaluation of the extent to which services to persons with disabilities are actually available to persons in each county in the state and the quality of those services, and the effectiveness of the services being provided by disability service providers in this state and by each of the State Mental Health Institutes established under Chapter 226 of the Iowa Code and by each of the State Resource Centers established under Chapter 222 of the Iowa Code.

Report Contents:

EXECUTIVE SUMMARY OF RECOMMENDATIONS

PRIORITY 1: Establish a stable and predictable long-term funding structure for mental health and disability services that is appropriate to fully implement the vision of redesign and to support growth and innovation over time.

1.1 Review the Medicaid offset and ensure that the savings to counties/regions from the Iowa Health and Wellness Plan are used to support regions in delivering core services and developing additional ("core plus") services in all areas of the state.

1.2 Ensure that provider reimbursement rates from all payers can be set at a level that is adequate to preserve service stability for consumers, build community capacity, and enable safety net providers (including community mental health centers and substance abuse treatment agencies) to grow and offer services that meet the complex needs of individuals served by the MHDS system.

1.3 Establish statewide standards and training requirements for judicial mental health advocates and place all employment responsibilities for the advocates with the MHDS regions.

1.4 Authorize a legislative study committee or workgroup to review policy, capacity, and funding issues related to the Medicaid Home and Community Based Services Waiver program, and to develop strategies for reducing waiting list numbers and waiting time.

1.5 Include transportation related to the delivery of mental health and disability services as a core service and reimbursable expense.

PRIORITY 2: Expand the availability, knowledge, and skills of professionals, paraprofessionals, and direct support workers as an essential element in building community capacity and enhancing statewide access to a comprehensive system of quality mental health and disability services.

2.1 Require state and regional cost settlement reimbursement methodologies to designate the cost of staff training and education as a direct service expense, allowable as a reimbursable expense for providers.

2.2 Support the training of mental health Peer Support Specialists and Family Support Peer Specialists utilizing nationally reviewed and accepted curricula based on proven service delivery models, and support the increased utilization of Peer Support and Family Support Peer Specialists by providing flexibility for part-time workers and opportunities for credentialing and advancement along a career path.

2.3 Implement incentive programs to train, recruit, and retain professionals and paraprofessionals qualified to deliver high quality mental health, substance abuse, and disability services.

PART 1:

OVERVIEW OF COMMISSION ACTIVITIES DURING 2014

Meetings. The Commission held twelve regular meetings and one telephone meeting in 2014. The meetings included two sessions held jointly with the Iowa Mental Health Planning and Advisory Council. Meeting agendas, minutes, and supporting materials are distributed monthly to an email list of over 250 interested persons and organizations and are made available to the public on the Iowa DHS website at http://dhs.iowa.gov/about/mhds-advisory-groups/commission. Commission meetings and minutes serve as an important source of public information on current mental health and disability services issues in Iowa; most meetings are attended by 15 to 25 guests in addition to Commission members and DHS staff.

Officers and Appointments. In May, Patrick Schmitz (Kingsley) was elected Chair of the Commission, and Suzanne Watson (Council Bluffs) was elected Vice-Chair. Patrick Schmitz was also appointed to represent the Commission on the Mental Health Risk Pool Board, and Marilyn Seemann was appointed to represent the Commission on the Autism Spectrum Disorder Expert Panel.

Membership. In May, six new appointees joined the Commission: Thomas Bouska (Council Bluffs) was appointed as a representative of the Department of Human Services; Thomas Broeker (Burlington) was appointed as a county board of supervisors representative; Marsha Edgington (Osceola) was appointed as a representative of DHS state facilities; Kathryn Johnson (Cedar Rapids) was appointed to represent providers of services to individuals with intellectual and developmental disabilities; Geoffrey Lauer (Iowa City) was appointed to represent individuals with brain injury; and Michael Polich was appointed as a representative of providers of behavioral and substance abuse services. Lynn Grobe (Oakland) was reappointed to serve a second term. Four members, Chris Hoffman (Waterloo), David Hudson (Windsor Heights), Susan Koch-Seehase (Sumner), and Jack Willey (Maquoketa) completed their membership terms in April and were honored for their combined 26 years of service on the Commission. Jack Willey was recognized for his leadership as Commission Chair for four years.

Committee Workgroups. The Commission formed five ad hoc committees that each devoted significant time to Commission duties, including the development and review of administrative rules, the formulation of recommendations to DHS and the legislature, and creation of this report.

Crisis Response Services Rules Committee. Members Neil Broderick, Chris Hoffman, Betty King, Rebecca Peterson, Patrick Schmitz, Susan Koch-Seehase, Suzanne Watson, and Jack Willey met with MHDS staff and contributed input and feedback on the development of administrative rules for a new array of crisis response services in Iowa.

Legislative Recommendations Committee. Members Thomas Broeker, Jill Davisson, Lynn Grobe, Geoffrey Lauer, and Marilyn Seemann worked to formulate recommendations for the changes in Iowa law included in this report.

County and Regional Services Committee. Members Thomas Bouska, Richard Crouch, Lynn Grobe, Kathryn Johnson, Geoffrey Lauer, Sharon Lambert, Rebecca Peterson, Deb Schildroth, and Patrick Schmitz developed an evaluation of the extent to which services to persons with disabilities are actually available to persons in each county in the state and the quality of those services for this report.

MHI, SRC and Provider Services Committee. Members Neil Broderick, Marsha Edgington, Brett McLain, Marilyn Seemann, and Suzanne Watson developed an evaluation of the effectiveness of

services being provided by disability service providers, state mental health institutes, and state resource centers in Iowa for this report.

Cost Increase & Communications Committee. Members Thomas Broeker, Jill Davisson, Betty King, Michael Polich, Patrick Schmitz, and Marilyn Seemann formulated recommendations to DHS Director Chuck Palmer to include in his annual budget estimate an amount to be appropriated to the Mental Health and Disability Regional Services fund to address the increase in the costs of providing services for the succeeding fiscal year, and to advise the MHDS Division, the Council on Human Services, the Governor, and the General Assembly on budgets and appropriations concerning disability services.

Nominating Committee. Members Deb Schildroth, Rebecca Peterson, and Richard Crouch made recommendations for candidates for the offices of Chair and Vice-Chair for the 2014-2015 year.

Crisis Response Services Administrative Rules. The Commission and the Crisis Response Services Rules Committee devoted significant time to consulting with the Division of Mental Health and Disability Services on the development of administrative rules for a spectrum of new crisis response services during 2014. In January, DHS consultant Renee Schulte presented an introduction to the core and additional core crisis response services created by Senate File 2315, the mental health reform bill that became law in 2012. The Commission worked with DHS to draft rules establishing statewide standards for eight services: twenty-four hour crisis response, crisis evaluation, twenty-four hour crisis line, warm line, mobile response, twenty-three hour observation and holding, crisis stabilization community-based services, and crisis stabilization residential services. These rules will become a new division within IAC Chapter 24, which establishes standards for providers currently accredited by MHDS. The new division will establish the standards for the accreditation of crisis response service providers. The Crisis Response Services Rules Committee was established because of the complexity of creating standards for a coherent and coordinated system of new services, and was actively engaged in working with DHS staff as the rules were formulated over a six-month period. The crisis response services rules were an agenda item for seven of the 12 meeting during 2014 and during that time, the committee met for more than 22 hours and invested many additional hours of time reviewing drafts and providing feedback during the development process. In June, the Commission voted to approve the rules for filing the notice of intended action. Following public comment, additional committee time was devoted to reviewing comments and working with DHS to formulate responses and make changes. In September, the Commission took action to approve adoption of the rules, which took effect December 1, 2014.

Autism Support Program Rules. In January, Laura Larkin, DHS Children's Mental Health Specialist, presented an overview of the Autism Support Program Administrative Rules. These rules were presented to the Commission for the first time on October 17, 2013, when they were approved to move on to the Administrative Rules Review Committee and be published for public notice. The Autism Support Program provides funding for ABA (Applied Behavior Analysis) services to children under the age of nine who are not eligible for services through Medicaid or private health insurers and whose income is below 400% of FPL (Federal Poverty Level). The rules follow specific guidelines in the law that identify financial and diagnostic eligibility standards, the application and authorization processes, provider network qualifications, and the appeal process. The Commission voted to approve the adoption of the rules as presented in January, and the rules took effect April 1, 2014.

Medicaid Offset Data Submission Rules. In July, the Commission reviewed administrative rules for county data submission to calculate the Medicaid Offset that was established as part of the legislation creating the Iowa Health and Wellness Plan. The legislation directed the Department to go through a process to identify savings that counties would experience because costs for services

to individuals who had not had previously qualified for Medicaid or had other insurance coverage would shift to IHAWP. The 2014 legislative session established a new calculation of the savings, directed DHS to establish that amount, and report it to the counties by October 15, 2014. MHDS Division leadership met with regional administrators and reached an agreement on the data to be submitted. The rules needed to implement the process were limited, including a few definitions, establishing the data required to be submitted to DHS, the reporting timeline, and an alternate reporting methodology to be used if any county fails to meet the reporting timeline. In July, the Commission voted to approve filing of the notice of intended action. On September 25, the Commission held a special telephone meeting and acted to approve the adoption of the rules as emergency after notice. The rules took effect on September 25, 2014.

Service Cost Increase Recommendation. The Commission Cost Increase and Communications Committee formulated a cost increase recommendation letter, which was approved by the full Commission in August and forwarded to Director Palmer for consideration in making his DHS budget submission:

> *This letter is to communicate the recommendation of the MHDS Commission for addressing the increase in MHDS service costs in the DHS funding submission for State Fiscal Year 2016.*
>
> *As you know, The Mental Health and Disability Services (MHDS) Commission has a statutory duty to advise the Administrator, the Council on Human Services, the Governor, and the General Assembly on budgets and appropriations concerning disability services. (Iowa Code 225C.6) In addition, when Senate File 2315 became law in 2012, it created the mental health and disability regional services fund and afforded the MHDS Commission an opportunity to provide input into your annual budget submission to "determine and include in the estimate the amount which in order to address the increase in the costs of providing services should be appropriated to the fund for the succeeding fiscal year."*
>
> *The Commission values this opportunity for timely consultation regarding this aspect of the Department's budget estimate and has convened a committee to review available sources of information and formulate our three-part recommendation:*
>
> - *First, we recommend increasing the prior year's budget to address inflation, overall population growth based on the most recent census data, and growth in service utilization. Based on cost increase and inflation factors for mental health services published by the Substance Abuse and Mental Health Services Administration (SAMHSA), we propose applying an inflation and growth factor of at least two percent.*
> - *Second, we recommend that funds from the Medicaid offset be designated to stabilize the resources available to the MHDS regions for the full implementation of core services, and to provide opportunities for all regions to begin offering additional ("core plus") services throughout the state, with a focus on the development and expansion of crisis response, jail diversion, early intervention, and prevention services designed to reduce the need for longer term, more intensive, and more costly services.*
> - *Third, to ensure that individuals who are at risk of institutionalization have timely access to home and community-based options, we recommend that you include funding to make further significant reductions in the HCBS Waiver waiting lists in your budget request for Medicaid.*

ICF/PMI Facility Variance Request. In April, Dawn Fisk, Administrator of the Division of Health Facilities, Department of Inspections and Appeals (DIA) and Mindla White, Medicare/Medicaid Bureau Chief II, with responsibility for long-term care facilities in southeastern Iowa, presented a variance request from DIA administrative rules for the Commission's consideration. Iowa Administrative Code Chapter 65 rules for Intermediate Care Facilities for Persons with Mental Illness (ICF/PMI) require facilities to have the services of a Qualified Mental Health Professional (QMHP), and also provide for the DIA Director to grant variances from that requirement with the approval of the MHDS Commission. Such variances are rarely requested. A certified nursing facility licensed as an ICF/PMI located in Keokuk made the request on March 26, when, despite the provider's considerable efforts, they found the facility temporarily without the services of a Qualified Mental Health Professional (QMHP). The facility had other contracted staff that they continued to rely on pending the hire of a new QMHP. They had identified a person for potential hire who was scheduled to meet all of the qualifications in June 2014 and requested a short-term variance until the candidate could complete the work for a Master's Degree. The Commission acted to approve the variance for a period of time not to exceed four months.

Coordination with the Iowa Mental Health Planning and Advisory Council. The Commission held two joint meetings with the members of the Iowa Mental Health Planning and Advisory Council (IMHPAC) in May and October. The two groups routinely shared information throughout the year. Mental Health Planning and Advisory Council Chair, Teresa Bomhoff, regularly attends Commission meetings, reports on MHPAC activities and relays information between the Commission and the Council. The Council reported on their July visit to the Iowa Veteran's Home in Marshalltown, and shared several areas of focus:

- Recommendations for future use of Community Mental Health Services Block Grant funds
- Expansion of training and employment opportunities for Peer Support Specialists
- Appropriate sentencing treatment for offenders and prisoners with mental illness
- Availability of and access to crisis, acute care, and subacute care services
- Open access to mental health medications
- Mental health workforce shortages

Coordination with the Iowa Developmental Disabilities Council. In May, Executive Director Becky Harker presented an update on the activities and goals of the Iowa Developmental Disabilities (DD) Council to both the Commission and the IMHPAC at their joint meeting. The DD Council works to support Iowans with developmental disabilities to make choices, take control of their lives, and understand and participate in the public policy process. The DD Council sponsors initiatives including:

- Publishing a guide to mental health and disability services redesign
- Conducting voter trainings in communities around the state
- Managing *IDaction*, a project with more than 8000 registrants designed to engage people in decision-making processes that affect them
- Keeping people informed about public policy through *InfoNet, Perspectives in Policymaking,* and *The InfoNet Guide to the Iowa Legislature,* and other means
- Organizing a Self-Advocacy Conference held in Coralville in October
- Through *The Iowa Coalition for Integrated Employment (ICIE),* working in partnership with DHS, the Iowa Department of Education, and Iowa Vocational Rehabilitation Services, to create a cross-agency coalition to improve systems so that Iowa youth with a developmental disability have fully integrated, and competitive work opportunities, and policies, practices, and funding are aligned to support employment expectations

PROFESSIONAL DEVELOPMENT ACTIVITIES

The Commission holds an annual two-day meeting each May, with the second day focused on new member orientation, training, and professional development, which included:

Commission Duties. The Commission reviewed its statutory duties, with particular attention to rule making and other specific responsibilities related to MHDS redesign, regionalization, and reporting on the scope and quality of services available in our state.

Ethical Considerations. Assistant Attorney General Gretchen Kraemer presented a review of Iowa's open meetings and open records requirements, and discussed conflict of interest, lobbying, communications, and other ethical considerations for Commission membership.

The Administrative Rulemaking Process. Harry Rossander, DHS Bureau Chief for Policy Coordination, presented an overview of the Department of Human Services administrative rulemaking process with particular attention to the Commission's role in reviewing and approving Department rules related to mental health and disability services.

REPORTS AND INFORMATIONAL PRESENTATIONS

During 2014, the Commission received numerous reports and presentations on issues of significance in understanding the status of services in Iowa and recognizing promising practices for planning and systems change, including:

Federal HCBS Services Rules. In January, Theresa Armstrong, MHDS Bureau Chief for Community Services and Planning, informed the Commission about newly released Center for Medicare and Medicaid Services (CMS) rules on home and community-based (HCBS) services. The rules include a "settings provision" requiring that all home and community-based settings are integrated and meet certain qualifications within five years, including:

- The setting is integrated in and supports full access to the greater community.
- The setting is selected by the individual from among options.
- The setting ensures individual rights of privacy, dignity, and respect, and freedom from coercion and restraint.
- The setting optimizes autonomy and independence in making life choices.
- The setting facilitates choice regarding services and who provides them.

In May, the Commission heard a second presentation on the HCBS rules and the process the Iowa Medicaid Enterprise had established for gathering public input. The intent of the rules, which apply to Iowa's seven HCBS Waivers and the Medicaid habilitation program, is to:

- Define HCBS settings by the nature and quality of the individual person's experiences
- Ensure that people who are receiving services and supports have full access to community living to same extent as people who are not receiving Medicaid HCBS services
- Expand opportunities for people to receive supports in the most integrated settings
- Provide for individual choice in living arrangements, service providers, and life choices
- Ensure that individual rights are not restricted
- Avoid regimentation in daily activities, schedules, and personal interactions

Care Coordination. In February, MHDS Administrator Rick Shults presented an overview of care coordination plans, some of the more significant changes that were anticipated for adults with Serious Mental Illness (SMI) and children with a Serious Emotional Disturbance (SED) with the

introduction of Integrated Health Homes, and associated changes in the use of Targeted Case Management services.

Children's Mental Health Report. In February, Laura Larkin, Children's Mental Health Specialist for MHDS, presented an overview of the Mental Health Services System for Children, Youth & Families Implementation Status Report, a legislatively mandated report that DHS submits to the General Assembly and the MHDS Commission every January. The report was created to inform the legislature on progress toward establishing a statewide children's mental health system in Iowa. Since the report was initiated in 2008, systems of care (SOC) projects have been established in 14 counties and, as of July 1 of this year, integrated health homes (IHH) have been implemented statewide. The SOC and IHH programs improve access for children and youth with Serious Emotional Disturbance and other qualifying mental health disorders to mental health treatment and services in the least restrictive setting possible, and support them in their families and communities.

Same Day Mental Health Services. In March, Patrick Schmitz shared information about an initiative that a group of five of Iowa's community mental health centers have engaged in to readapt their business practices and build the capacity to offer mental health services to people the same day services are requested. The centers participating in the initiative through a collaborative grant are: Plains Area MH Center, Abbe Center for Community MH, Black Hawk-Grundy MH Center, MH Center of North Iowa, and CMHC of Mideastern Iowa. Their efforts have focused on adequacy of capacity, documentation, client engagement and outcomes, compliance with national standards, making the best use of clinician time, and making data-based decisions.

Transition to Regionally Administered MHDS Services. In March, Commission members exchanged information about regional development in their respective areas of the state, discussing a variety of transition issues, including:

- Administrative structure
- Liability for the administrative aspects of the regions
- Contracting for regional services
- Provider rates and cost reporting
- Coordination with community mental health centers
- Efforts to enroll eligible individuals in the Iowa Health and Wellness Plan
- Access to safety net services
- Planning for budgeting and service utilization
- Equalization and the Medicaid offset

Office of Consumer Affairs. In April, June Lackore, Director of the Office of Consumer Affairs (OCA), presented an update on the program. June introduced OCA's five regional coordinators who work part time in their communities with volunteer advisory committees to share information, gather feedback to the Department, collaborate with other groups, and provide outreach to people in their communities on mental health issues. OCA is funded by the federal Community Mental Health Services Block Grant and also uses newsletters, brochures, web and social networking sites to inform Iowans about the philosophy of recovery and available resources.

Legislative Panel Discussion. In May, two of the Commission's legislative members, Representative Lisa Heddens, District 46 (Story County) and Representative David Heaton, District 84 (Henry County), shared their perspective on the 2014 legislative session, legislation affecting mental health and disability services, and issues that are expected to carry over to the 2015 session, including:

- Equalization funding
- Capacity for regions to provide core and additional core services

- Management of HCBS Waiver waiting lists
- Reinstatement of the Office of Substitute Decision Maker
- Collaborative Safety Network Workgroup
- Elder Abuse Workgroup
- Developing a Juvenile Court tracking and information system
- Addressing the uniform cost report
- Developing the framework for a children's mental health system
- Addressing the shortage of mental health professionals in the state

Office of Substitute Decision Maker. In July, Paige Thorson, Legal Services Developer from the Office of Substitute Decision Maker, presented an overview of the re-established office within the Iowa Department on Aging. The focus of the office is to create a statewide network of people who can provide substitute decision-making services for adults in Iowa who are not able to maintain their physical health or manage essential aspects of their financial resources where no family member or other person is available to do so. The office will recruit and train people who are appropriate and willing to serve as guardians, payees, and substitute decision makers, and will advocate to protect people, ensure their safety, and assist them in planning for incapacity. Substitute decision makers protect people from abuse and exploitation, medical or financial crisis, loss of their home or savings, and becoming trapped in costly and inappropriate levels of care.

Balancing Incentives Program. In August, the Commission heard an update on the Balancing Incentives Program (BIP), the federal award that supports states in moving more spending toward community-based programs than facility-based services. In 2012, Iowa started the program with about 42% of state spending going to community-based services; as of March of this year, the balance has shifted to 52% spending for community-based programs. The state receives 2% more in Federal Medical Assistance Percentage for home and community based services under the BIP program, which requires that states implement three practices:

1. *No wrong door access.* DHS is working collaboratively with Life Long Links and Area Agencies on Aging to establish access points statewide.
2. *Core standardized assessments.* Iowa is implementing use of the Supports Intensity Scale (SIS) for people with intellectual disabilities is the first step, with assessment tools for other disability groups to be rolled out over the next year.
3. *Conflict-free case management.* Policies are developed to prevent conflicts of interest and ensure that individuals have freedom of choice in selecting service providers and agencies.

State Resource Center Barriers Report. In August, Marsha Edgington, Superintendent of Woodward State Resource Center, presented an overview of the Glenwood and Woodward Resource Centers Annual Report of Barriers to Integration for the 2013 calendar year. The purpose of the report is to provide a comprehensive assessment of the major barriers to individuals moving to more integrated settings and indicate actions the State can take to overcome the barriers. The report came about as a part of a Department of Justice settlement with the Resource Centers in 2004. Five major barriers have been identified:

1. Interfering behavior that makes it difficult for community providers to ensure safety for the individual or others.
2. Underdeveloped social skills that interfere with social interactions in an integrated setting.
3. Health and safety, which includes multiple severe or sensitive health conditions that require a high level of care and monitoring.
4. Availability of day programming or vocational opportunities that provide the person with meaning, interest, and structure.
5. Individual, family, or guardian reluctance to support the person in leaving the SRC.

The SRCs continue to work to eliminate these barriers through the provision of training to community provider agencies, the engagement of a Board Certified Behavior Analyst, referral to the Money Follows the Person program, sharing information with guardians and family members, and working with MFP transition and vocational specialists. Both SRCs also continue to follow a plan to reduce their number of beds by at least twelve each year.

Money Follows the Person. Also in August, Brooke Lovelace, MFP Program Coordinator, presented an update on the Money Follows the Person program. The program offers enhanced services and supports for a transition year to assist people in moving from facility-based living to community-based living. Since 2008, Iowa has been working to move individuals with an intellectual disability (ID) or brain injury (BI) out of the State Resource Centers and other Intermediate Care Facilities for persons with Intellectual Disabilities. In January of 2014, Iowa received permission from the Centers for Medicare and Medicaid Services to also work with people living in nursing facilities who have ID or BI to transition to community living. MFP transition specialists assist individuals in planning, preparing for, and making the move, and continue to work with the person in the new community setting for the first year following the move. MFP funds can be used to help to set up the person's new house or apartment with furniture, supplies, utility deposits, grocery staples, and clothing. Funds can also be designated for enhanced environmental modifications to the home, assistive technology, durable medical equipment costs that exceed allowable Medicaid costs, mental health outreach, behavioral programming, and crisis services. Since 2008, 604 individuals have been referred to the program and 329 have been transitioned into community settings. As of July 31, 2014, 212 individuals had successfully completed 365 days of MRP services and transitioned to the Intellectual Disabilities Waiver, and 193 individuals were actively participating in the program.

Integrated Health Homes. In August, Kelley Pennington, Director of the IHH program at Magellan Health Services, and David Klinkenborg, an Associate Director of the IHH program, presented an update on the Integrated Health Home Initiative. Magellan is working in partnership with the Iowa Medicaid Enterprise to implement the program, which involves moving to a "whole person" model of addressing mental health needs. The federal government pays 90% of the Medicaid costs for the first two years for each of three phase-in groups in Iowa. IHHs focus on making sure that individuals have access to primary care, care coordination, and any specialty care they need. Quality of life factors such as housing, transportation, and other issues that can impact a person's overall health also receive attention. Early outcomes for people after participating in an IHH for six months include:

- 16% reduction of mental health emergency department visits
- 18% reduction in mental health inpatient admissions
- 16% reduction in medical inpatient days
- 12% reduction in medical emergency department visits

Subacute Mental Health Care Facilities Administrative Rules. In September, Jim Friberg, Special Services Bureau Chief, Iowa Department of Inspections and Appeals, gave an update on the status of subacute mental health care facilities administrative rules. The rules, which will become a new chapter in the Iowa Administrative Code, provide for the establishment of basic standards for the operation of subacute care facilities to ensure the safe and adequate diagnosis, evaluation, and treatment of persons with serious and persistent mental illness so that they are able to experience recovery and live successfully in the community. DIA collaborated with DHS on the development of the rules, and DHS is responsible for issuing a Request for Proposals for establishing 50 subacute care beds across the state, as authorized by the legislature.

Multi-Occurring Training Initiative. Also in September, Mary Mohrhauser, MDHS Mental Health Specialist, shared an update on the DHS multi-occurring training initiative. Dr. Ken Minkoff and Dr. Christine Cline of Zia Partners have been under contract with DHS to provide quarterly training and

technical assistance to mental health and disability service providers throughout the state. The training initiative began to increase provider capacity to address the co-occurring needs of people with both mental health and substance use issues. In 2011, it was broadened to include intellectual and developmental disabilities, brain injury, and all multi-occurring service needs.

Youth Mental Health First Aid. In October, Karen Hyatt, MHDS Emergency Mental Health Specialist, presented an overview of Youth Mental Health First Aid (MHFA) Training activities. The MHDS Division has obtained funding to host training for trainers of the Youth MHFA curriculum, which is designed for adults who work with youth. The Youth MHFA training was offered to sixty current MHFA instructors across the state and eighteen of them completed the training. Iowa now has 22 Youth Mental Health First Aid qualified trainers.

Thinking Outside the Employment Box. Also in October, Lin Nibbelink, MHDS Employment Specialist, shared a new publication called "Thinking Outside the Employment Box: Entrepreneurs with Disabilities Share Their Self-Employment Success Stories." The publication is a product of an Employment Development Initiative (EDI) Grant from the National Association of State Mental Health Program Directors (NASMHPD), focused on increasing self-employment opportunities for people with disabilities, including serious mental illness. The EDI funds were used to sponsor a series of two-day workshops for individuals with disabilities and their family members on how to start a business. Workshop participants worked with self-employment consultants and benefits planners who advised them on how to utilize and manage the disability benefits available to them to create a business plan and create their own employment opportunities. A small amount of the grant was used to interview Iowans with disabilities that have started or are working on starting their own businesses and compile eighteen success stories into a publication to promote self-employment as a viable option for Iowans with disabilities.

Iowa Health and Wellness Plan. The Commission received regular updates on the Iowa Health and Wellness Plan and enrollment since its inception on January 1, 2014. At last report, over 110,000 individuals have enrolled and have access to health care. Since the dental program began May 1, at least 17,000 members have received dental care. The Commission is particularly interested in the medical exemption process that is intended to identify people in the IHAWP groups who have chronic physical or mental illnesses, or disability-related needs, and move them into the Medicaid State Plan, which provides greater access to the specific kinds of enhanced services they need. The eligibility criteria include a variety of chronic health conditions, including serious mental illness. The process of identifying individuals who qualify has lagged behind IHAWP enrollment since an individual must enroll in a health care plan before they can complete an application form and receive a determination of their eligibility for medical exemption. The Iowa Medicaid Enterprise is now able to use claims data to identify and notify more potentially eligible individuals. It has been estimated that 15,000 or more Iowans could benefit from the medically exempt program. The most current enrollment numbers for each plan by county and other materials related to the IHAWP are made available on the IME website at: http://www.ime.state.ia.us/iowa-health-and-wellness-plan.html

Regional Development and County Technical Assistance Activities. The Commission also received regular updates throughout the year from the MHDS Division leadership on county technical assistance activities related to financial and regionalization issues and transition activities. This information helped inform the Commission's input on the development of administrative rules and on formulating recommendations for changes in Iowa law.

COORDINATION WITH MHDS

DHS Director Chuck Palmer participated in the May and September meetings to share his perspectives and listen to feedback from Commission members. MHDS Division Administrator Rick Shults, Community Services and Planning Bureau Chief Theresa Armstrong, and other staff members

from the Division of Mental Health and Disability Services have actively participated in Commission meetings throughout the year, communicated regularly, provided timely and useful information, and been responsive to questions and requests from Commission members. A significant portion of each Commission meeting has been devoted to updates and discussion on variety of relevant issues and initiatives, notably including:

- Accountable Care Organizations
- Autism Support Program
- Children's mental health services
- Closure of the Iowa Juvenile Home
- Community Integration Workgroup
- Core standardized assessments
- Cost settlement
- County and regional funding issues
- Crisis stabilization pilot project
- DHS budget, staffing, and services
- DHS facilities operations
- Employment initiatives
- Equalization funding
- HCBS Waiver waiting lists
- Hospital bed tracking report
- IDPH-MHDS Workforce Workgroup
- Iowa Medicaid State Plan, program, and policy changes
- IVRS mental health workgroup
- Medicaid Offset
- Mental Health Community Services Block Grant
- MHDS Requests for Proposals
- Non-emergency medical transportation
- Out of State Placements
- Peer support & family peer support services
- Pending and newly enacted legislation
- Regional formation and management
- Regional annual service and budget plans
- State Innovation Model
- Targeted Case Management

PART 2:

RECOMMENDATIONS FOR CHANGES IN IOWA LAW IN 2015

On July 1, MHDS regions officially assumed responsibility for the administration of the redesigned MHDS system after several years of planning and preparation. The transition to a redesigned system is progressing well, but is far from complete. More work remains to be done to fulfill the promise of comprehensive statewide access to a basic set of cost-effective community-based mental health and disability services that offer Iowans better access to health care, employment, and supportive services, and more opportunities for choice and community participation. Improved access to preventative and early intervention services has the potential to significantly reduce the demand for the most intensive, highest cost services by minimizing emergency room visits, emergency psychiatric hospitalizations, and involvement with law enforcement, corrections, and the courts. The MHDS Commission recommends actions to ensure that the system is supported by a stable and predictable long-term funding formula, an adequate workforce, and sufficient provider capacity.

PROVIDE APPROPRIATE, PREDICTABLE, AND STABLE FUNDING

PRIORITY 1: Establish a stable and predictable long-term funding structure for mental health and disability services that is appropriate to fully implement the vision of redesign and to support growth and innovation over time.

1.1 Review the Medicaid offset and ensure that the savings to counties/regions from the Iowa Health and Wellness Plan are used to support regions in delivering core services and developing additional ("core plus") services in all areas of the state.

The MHDS Commission recommends this action because:

- The MHDS regions need stable and predictable revenues so that new services can be developed with the confidence they will be sustainable.
- Growth in capacity will be necessary to enable the system to meet the needs of persons with developmental disabilities, brain injuries, or physical disabilities.
- The full impact of the change from legal settlement to residency, the adequacy of the $47.28 per capita levy formula, the effect of the introduction of Integrated Health Homes, and the long term savings from the Iowa Health and Wellness Plan has not yet been established and funding needs should continue to be reviewed and evaluated.
- Counties/regions will need resources to build and maintain a robust and sustainable array of crisis response services, which promise to reduce disruption people's lives and divert many from emergency rooms, in-patient psychiatric treatment, and incarceration.
- Some source of risk pool funding needs to be available as a safety net for the system.
- Regions need flexibility; equalization funding could be discontinued if a statewide minimum levy rate for mental health and disability services was set and counties had the ability to set a higher levy rate with local support.

1.2 Ensure that provider reimbursement rates from all payers can be set at a level that is adequate to preserve service stability for consumers, build community capacity, and enable safety net providers (including community mental health centers and agencies providing substance abuse treatment) to offer and expand access to services that meet the complex needs of individuals served by the MHDS system.

The MHDS Commission recommends this action because:

- The successful implementation of MHDS redesign relies on the use of rate-setting methodologies that compensate providers for increasing their capacity to address the complex service needs of individuals and serving individuals with challenging behavior or support needs.
- As responsibility for payment shifts from counties to insurance companies through the Iowa Marketplace Choice Plan, the availability of an adequate provider network and financial viability of safety net providers will depend on reasonable reimbursement rates from third part insurers.

1.3 Establish statewide standards and training requirements for judicial mental health advocates and place all employment responsibilities for the advocates with the MHDS regions.

The MHDS Commission recommends this action because:

- Uniform statewide standards and training would improve consistency and uniformity in the interpretation of policies and the delivery of services.
- Placing employment responsibilities for the judicial mental health advocates with the MHDS regions would provide accountability, a structure for supervision, and would save taxpayer-supported resources by allowing regions to manage staffing levels and travel costs.

1.4 Authorize a legislative study committee or workgroup to review policy, capacity, and funding issues related to the Medicaid Home and Community Based Waiver program, and to develop strategies for reducing waiting list numbers and waiting time.

The MHDS Commission recommends this action because:

- Four of Iowa's seven HCBS Waivers, the Brain Injury, Children's Mental Health, Health and Disability, and Physical Disability Waivers routinely have waiting lists with wait times of up to two years; in September and October of 2014, the Iowa Medicaid Enterprise reported more than 9,000 names on the lists.
- Individuals who remain on the waiting list for an extended period of time are at a higher risk of institutional placement, which is disruptive for families, expensive, and contrary to Iowa's goal of promoting individual choice and supporting inclusive community living.
- Multiple strategies for improving access to services, including policy changes and additional funding, should be considered.
- Individuals seeking services are not currently screened for eligibility and may apply for more than one waiver, so the actual number of eligible applicants waiting for services cannot be accurately determined; a pre-screening process at the time of application could identify those who are not eligible, refer them to other appropriate services, and eliminate them from the list.
- Individuals who are found to be potentially eligible in a pre-screening process could be triaged for services based on their level of need and risk of institutionalization.

1.5 Include transportation related to the delivery of mental health and disability services as a core service and reimbursable expense.

The MHDS Commission recommends this action because:

- Transportation is a vital component of access to all services. Many of the individuals served by the public mental health and disability services have few resources to arrange or pay for their own transportation.
- In many rural areas of Iowa, public transportation options are limited and the distances people must travel to service providers can be an insurmountable barrier to access if the cost of transportation is not covered.
- The availability of reimbursement would encourage the development of more transportation providers in areas where they are not currently available.

BUILD WORKFORCE CAPACITY

PRIORITY 2: Expand the availability, knowledge, and skills of professionals, para-professionals, and direct support workers as an essential element in building community capacity and enhancing statewide access to a comprehensive system of quality mental health and disability services.

2.1 Require state and regional cost settlement reimbursement methodologies to designate staff training and education as a direct service cost, allowable as a reimbursable expense for providers.

The MHDS Commission recommends this action because:

- Limitations in provider capacity are a barrier to increasing community inclusion, and access to training is a key factor in building capacity.
- Including training costs as a direct expense supports access to statewide training and technical assistance that will assist providers in attaining the skills to capably serve individuals with complex, challenging, or specialized support needs.
- On-going training is critical to the maintenance of high quality standards and effective utilization of research-based and evidence-based practices.
- Providers must be able to adequately support staff training as they adapt to the use of new practices, such as trauma informed care, and to serve new populations, such as individuals with brain injury or developmental disabilities.

2.2 Support the training of mental health peer support specialists and family support peer specialists utilizing nationally reviewed and accepted curricula based on proven service delivery models, and support the increased utilization of peer support and family support peer specialists by providing flexibility for part-time workers and opportunities for credentialing and advancement along a career path.

The MHDS Commission recommends this action because:

- The implementation of core services statewide has created a new demand for peer support as a service.
- The statewide introduction of Integrated Health Homes has created a new demand for peer support and family support peer specialists as members of care coordination teams.
- The MHDS system will rely on building and maintaining an adequate peer workforce that is trained to uniform professional standards and is supported in career advancement.

- The utilization of peer support and family support specialists is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice.
- Expanding the use of trained peer professionals is an effective method of addressing workforce shortages.

2.3 Implement incentive programs to train, recruit, and retain professionals and paraprofessionals qualified to deliver high quality mental health, substance abuse, and disability services.

The MHDS Commission recommends this action because:

- Redesign has not relieved the shortage of psychiatrists or the barriers to accessing acute psychiatric care in our state; adequate funding and resource allocation is needed to ensure access to appropriate care throughout the state.
- Special incentives are needed to encourage and support Psychiatrists, Psychiatric Physician Assistants, Advanced Registered Nurse Practitioners, and other mental health and substance abuse treatment professionals who are trained in Iowa to stay and practice here.
- Special incentives could attract professionals trained elsewhere to practice in Iowa and encourage their retention.
- Professionals indicate that effective incentives include loan forgiveness programs and opportunities for fellowships; programs could be targeted to specific professionals and specialties that are most needed.

PART 3:

THE EXTENT TO WHICH SERVICES TO PERSONS WITH DISABILITIES ARE ACTUALLY AVAILABLE TO PERSONS IN EACH COUNTY IN THE STATE AND THE QUALITY OF THOSE SERVICES, AND THE EFFECTIVENESS OF THE SERVICES BEING PROVIDED BY DISABILITY SERVICE PROVIDERS IN THIS STATE AND BY EACH OF THE STATE MENTAL HEALTH INSTITUTES ESTABLISHED UNDER CHAPTER 226 AND BY EACH OF THE STATE RESOURCE CENTERS ESTABLISHED UNDER CHAPTER 222. (Iowa Code 225C.6(i))

EVALUATION OF THE STATE DISABILITY SERVICES SYSTEM
Report of the County and Regional Services Committee

In the two years since the enactment of Senate File 2315 during the 2012 legislative session, counties have been working to form into service regions. As a reflection of this significant system-wide change, this year's report is intended to serve as a "baseline" reference as the new regions just beginning to become fully operational. Once operations are established, issues related to available services and the quality of those services can be more accurately addressed.

Iowa's counties have historically been the responsible entities for planning, funding, and service delivery to persons with mental illness and intellectual disabilities. In FY 2013, 44,405 adults and children were served by the county system. That number represents a decrease of almost 20.5% from FY 2012. The major contributing factor to this decrease was the state's assumption, in FY 2013, of responsibility for the entire cost of the non-federal share of Medicaid costs previously shared by counties. This shift in funding responsibility started the movement towards redesign of the disability services system. When the Iowa Legislature passed Senate File 2315 during the 2012 session, counties were required to regionalize; plan, develop, and fund a set of core services; share state and local funding; and plan for expanded services and services to additional population groups as funds become available. Fifteen new mental health and disability service regions, governed by members of county board of supervisors in consultation with representatives of provider agencies and clients and families, have now been created through 28E Agreements. The implementation of the new system commenced on July 1, 2014, and regions have submitted plans to DHS for transition, budgets and services, regional management, and access to services. DHS is responsible for review and approval of the regional plans.

Other Changes Impacting the MHDS System

Iowa Health and Wellness Plan: The Iowa Health and Wellness Plan was enacted to provide comprehensive health coverage for low income adults ages 19 through 64 and is Iowa's plan to provide expanded Medicaid coverage pursuant to the federal Affordable Care Act. The Iowa Health and Wellness Plan replaced the IowaCare program as of January 1, 2014 and offers coverage for medical, mental health, and substance abuse services to low income Iowans. The plan offers two options:

- The Iowa Wellness Plan for adults ages 19 through 64 with income up to and including 100% of the Federal Poverty Level through Iowa Medicaid
- The Marketplace Choice Plan for adults ages 19 through 64 with income 101% to 133% of the Federal Poverty Level through specific private insurance carriers, initially Coventry and Co-Opportunity.

As of November 26, 2014, there were 113,168 people enrolled in the Iowa Health and Wellness Plan and over 12,000 were approved for the Medically Exempt status, which provides full Medicaid coverage for people with serious mental illness, substance use disorders, and other chronic health related conditions. Access to full Medicaid coverage provides funding for important support services, including ACT (Assertive Community Treatment), Habilitation, Community Support, Intensive Psychiatric Rehabilitation, Peer Support, and Integrated Health Homes. The identification of individuals who qualify for the Medically Exempt status has been delayed by multiple application steps, locating individuals who may qualify, completing the application process, and the lack of claims data prior to January 1. Ongoing efforts are being pursued to simplify the process, to make health care providers and the community at large familiar with the process, and to utilize the claims data now available to identify and enroll eligible individuals. As more individuals qualify for Medicaid coverage through the Iowa Health and Wellness Plan, their ability to access needed services is improved. Concerns still remain, however, related to HCBS Waivers, that have lengthy and growing waiting lists, as some individuals have remained on the list for one to two years to access those services.

Integrated Health Homes: Iowa began working with health homes approximately three years ago, when Integrated Health Homes (IHHs) for children and adults were piloted in five areas of the state. The intent was to work with individuals using a holistic approach to manage medical and mental health conditions. In July 2012, medical homes were established in medical clinics across the state and focused primarily on individuals with two or more chronic health conditions. In July 2013, the Integrated Health Home (IHH) program managed by Magellan started a three phase statewide roll-out that is now complete. Members of the IHH program are served by a team of professionals including a nurse, care coordinator, peer support specialist (for adults) or family support specialist (for children). As of July 1, 2014, there were 26 agencies offering IHH services to adults across the state and 26 agencies offering IHH services to children. The total number of individuals served in IHHs as of the time of this report was approximately 18,000. Many of these adults and children had been served through Targeted Case Management programs and had been used to a certain level of contact with and support from their case managers. The IHHs operate differently from the traditional case management model and further clarification will be needed to determine if the transition to IHHs will also create a different set of expectations.

Balancing Incentives Program: Iowa's Balancing Incentives Program (BIP) has also played a significant role in MHDS redesign. Iowa applied for the BIP program (formerly the Balancing Incentives Payment Program or BIPP) in 2012. The federal award calls for moving more dollars toward community-based programs and less funding spent on institutional or facility-based services. The BIP program requires that states implement three practices: No wrong door access to services, standardized assessments, and conflict-free case management. Iowa started with about 42% of state spending going to community-based services. In return for efforts shifting the balance of state funding toward community-based services, the federal government has authorized 2% more in matching funds for specific types of Medicaid home and community-based services. As of the last quarter of FY 14, Iowa's balance was 52% community and 48% facility, which surpasses the goal of more than 50%. There may continue to be some fluctuation and the balance in favor of community-based services will need to be maintained. The balance is only about dollars spent, not about numbers of people served in facility or community settings; on an individual basis, the focus is on providing services in settings that are appropriate to meet each person's needs.

CMS HCBS Services Rules: The Center for Medicare and Medicaid Services (CMS) released new federal rules for Home and Community-Based Services (HCBS) in January 2014. These rules reflect standards established by the Americans with Disabilities Act (ADA) and the *Olmstead* Supreme Court Decision related to defining where HCBS services can be delivered. The rules apply to all services and include additional requirements for provider-owned or controlled HCBS residential settings. The

new rules also establish a person-centered planning process, and stress that individuals have the opportunity to guide their own service planning and choose their providers. CMS is allowing a transition period of up to five years for full compliance, and the Iowa Department of Human Services is working on an evaluation of HCBS providers and services to help guide the transition process.

Effectiveness and Quality of Services in Each County of the State. The availability, quality, and effectiveness of services are all interrelated and should be evaluated and addressed in the context of the services system as a whole. As a part of the current system transformation, there is an expectation that outcomes and performance-based measurements will be identified that can be utilized to both evaluate and improve service delivery. For example, as the MHDS regions enter into contracts with service providers, those agreements must address and measure outcomes. Additionally, the IHH programs have established benchmarks, which are reported to Magellan. As an initial step in the transition to a regional system, each MHDS region was required to submit an Annual Service and Budget Plan to DHS. As reported by the regions in their Annual Service and Budget Plans, the expenditures for all the regions total $146 million, and the regions report $183 million in revenues available; the difference is accounted for by the fund balances regions need to carry forward for cash flow purposes.

The following is an overview of the plans submitted July 1, 2014:

- About 46% of funds are budgeted to core services
- About 6% of funds are budgeted to additional (core plus) services:
    - 11 regions have included community and facility based crisis response services and 13 of the regions are planning to develop or fund some crisis services
    - 7 regions have included justice involved services
    - 9 regions have included additional Evidence Based Practice (EBP) services, such as supported employment and supported housing
- About 8 % of funds are budgeted to administration
- The remaining funds are budgeted to other services, including educational, information and referral, housing and rental assistance, and transportation
- The plans also include some services to non-mandated populations:
    - 2 regions identify some services to children
    - 15 regions identify some services to persons with developmental disabilities other than intellectual disabilities
    - 7 regions identify some services to persons with brain injury

The Regional Annual Service and Budget Plans can be found on the DHS website at: http://dhs.iowa.gov/mhds-providers/providers-regions/regions/service-budget

Areas of Achievement.

New service areas have been developed and were implemented prior to redesign, including:

- Sub-acute services. New administrative rules for this level of care have recently been completed.
- Commitment diversion. At least four commitment pre-screening programs have been established in the state since 2011. These programs allow families to learn about other service options and use the commitment process as a last resort, when necessary.
- Crisis stabilization. At least three new crisis stabilization facilities or centers have been created. The administrative rules for an array of crisis response services have recently been

completed and many regions are planning for new and expanded services to support individuals in crisis.

Concerns and Identified Gaps.

Several service system improvement needs that were identified in the Commission's earlier reports still require attention:

- Improving recruitment and retention of mental health professionals, especially psychiatrists
- Taking further steps toward the development of a comprehensive system of care for children and youth with serious mental health disorders and their families by focusing on a wider range of services and supports so that they are not involved unnecessarily in the child welfare or juvenile justice system by default:
    - Filling the gap between intensive treatment and returning home by establishing step down services for youth moving out of PMICs (Psychiatric Medical Institutions for Children), Mental Health Institutes (MHIs), or psychiatric hospitalization
    - Supporting collaboration of all state agencies and systems involved in children's services including DHS, the Department of Education, the Department of Public Health, and juvenile justice.
    - Supporting the development of therapeutic schools for children and adolescents with mental health conditions who are otherwise at risk of being placed in PMICs or out of state.
- Developing a robust array of crisis response services in all areas of the state
- Addressing significant gaps in services available to individuals with brain injuries by adding brain injury as a population group that is required to have access to core services
- Identifying safe and affordable residential options for individuals who have resided in Residential Care Facilities (RCFs) that are closing; addressing the limited availability of community-based settings such as 24-hour supervised habilitation sites and post-acute treatment settings
- Preventing long stays in hospital emergency rooms due to lack of placement options
- Ensuring timely access to appropriate care for all Iowans

Report of the MHI, SRC, and Disability Services Committee

After reviewing the available data in an effort to evaluate the effectiveness of the services being provided by disability service providers in this state and by each of the state mental health institutes and each of the state resource centers, the Commission concluded that information measuring the effectiveness of services continues to be extremely limited. True evaluation of the services system requires qualitative data, as well as that quantitative information that is more readily available. Toward that goal, the Commission reviewed current measurements and offers recommendations for future statewide data collection.

The information currently gathered by the Mental Health Institutes and Resource Centers is primarily census data rather than qualitative measurements of satisfaction and outcomes. The number of discharges from State Resource Centers is available, but whether their community placement was successful, or if people are being moved from provider to provider due to problems with their service is needed to provide a complete picture of effectiveness and outcomes. Waiting lists only capture information on individuals who are accepted on the waiting list They do not capture any information on how many people did not apply for the list because they are in inappropriate places such as jails or hospitals because there are no other options available. Admissions and discharge data is available

for the Mental Health Institutes, but there is not a way to track where people are discharged to, and if they have a good outcome following their MHI treatment. Similarly, community providers currently gather their own programmatic data, but there is no statewide repository for such data and the provider data collection methodology and measurements vary. Counties have been required to gather statistical data for years. While this collection has been based on the same data requirements, analysis of the data in regard to potential outcomes has not been generated. Efforts are underway to begin collecting outcomes through the regions, but this new regional system, guided by DHS, is still in the early stages; it will take time to develop a data gathering system which has tools to measure actual quality outcomes and effectiveness of providers.

During the MHDS Redesign process, a workgroup was established to look specifically at practices and recommendations around data collection. The Outcome and Performance Measures Committee Report of December 14, 2012 outlines the group's recommendations. That report suggests the information should come from providers and regional statistical data, as well as from service recipients and their families, which will require the development and use of surveys. A determination should be made about what additional data needs to be collected, where the data will come from, and what collection will cost.

The Commission makes the following recommendations regarding data collection:

- Identify what data could be used to measure outcomes and effectiveness
- Standardize the collection of data that reflects outcomes and effectiveness of services regionally and statewide
- Develop a statewide reporting method that can measure individual satisfaction and quality of life. For example: Is the individual stable where they are living? Is the individual satisfied with their living environment? Is the individual satisfied with their employment or day activities?
- When looking at utilization rates for MHIs and SRCs, consider collecting data on prior residential services and readmission rates
- Identify methods to evaluate cost-effectiveness when comparing programs and outcomes
- Use available information management systems, such as the Community Services Network (CSN), to develop reports that will help to establish meaningful performance measures

SUMMARY

Over the last several years, Iowa has made great strides toward the development of a statewide network of accessible, effective, and sustainable services that will support Iowans with mental health and disability-related needs in being healthier, more productive, and more fully integrated citizens. We urge all stakeholders to recognize what has been accomplished and renew their commitment to work together to ensure that our new regionally administered MHDS system has adequate resources to meet the challenges of transition and growth to achieve high quality and long-term stability.

This report is respectfully submitted on behalf of the members of the Mental Health and Disability Services Commission.

Patrick Schmitz, Chair

Mental Health and Disability Services Commission Members 2014-2015		
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