Iowa
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STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
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Mental Health, Mental Retardation, Developmental Disabilities and Brain Injury Commission

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COMBINED ANNUAL AND BIENNIAL REPORT OF THE MENTAL HEALTH, MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES, AND BRAIN INJURY COMMISSION

This Combined Annual and Biennial Report of the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury (MH/MR/DD/BI) Commission is being submitted pursuant to Iowa Code § 225C.6(1)(h) & (i). This report is organized in three sections, (1) an overview of the activities of the Commission during 2008, (2) recommendations formulated by the Commission for changes in Iowa law, and (3) the Commission's evaluation of the extent to which services are available to persons with disabilities, and the quality and effectiveness of those services provided by disability service providers, the State Mental Health Institutes established under Chapter 226, and the State Resource Centers established under Chapter 222.

PART 1: OVERVIEW OF COMMISSION ACTIVITIES DURING 2008

Meetings. The Commission held eight regular one-day meetings and one two-day retreat during 2008.

New officers. Dale Todd, parent of a child consumer from Cedar Rapids, was elected Chair of the Commission, and Jack Willey, a Jackson County Supervisor from Maquoketa, was elected Vice-Chair of the Commission.

Service Accreditations. The Commission reviewed and acted upon accreditation recommendations from the Iowa Department of Human Services, Division of Mental Health and Disability Services accreditation staff for 75 providers of services to Iowans with mental health, mental retardation, development disability, or brain injury related needs, including:

- 23 community mental health centers;
- 23 supported community living providers;
- 20 case management providers; and,
- 9 mental health services providers.

Workgroups. The Commission utilized committees and workgroups to review selected policy issues, including:

1. Institutions. The Commission reviewed the role of institutions within the array of services available in Iowa and the impact of current systems initiatives including the Money Follows the Person Grant, the Conner Grant, the *Olmstead* Supreme Court decision, and the U.S. Department of Justice involvement with Glenwood and Woodward Resource Centers.

2. Medicaid. The Commission reviewed and is in the process of developing recommendations regarding the State's Medicaid program, including uniform cost reporting, assessments, suspending rather than terminating eligibility for people in jail or prison, and HCBS Waiver eligibility requirements prior to hospitalizations that can interfere with access to adult services.

3. Duties. The Commission reviewed its own role in policy setting, advising, and discharging its statutory duties, in consultation with the Attorney General's office.

4. Law Changes. The Commission formulated recommendations to the Legislature for its priorities relating to mental health, mental retardation, developmental disabilities, and brain injury services. Those recommendations are included in Part 2 of this report.

5. Accreditation. The Commission reviewed the accreditation standards under Iowa Code Chapter 24, the Home and Community Based Services Waiver Program, and national accreditation bodies to identify opportunities for improvement in the accreditation process and accreditation standards, and the use of evidence based practices and outcome based standards and performance measures for accreditation.

6. Residency. The Commission drafted a definition of county residency for inclusion in administrative rules governing county management plans.

Administrative Rules. The Commission reviewed, made recommendations on, and approved proposed new administrative rules and proposed rule changes for public comment in the following areas:

- County Management Plans
- Risk Pool Board operations
- Mental Health Services for Children and Youth (subsequently withdrawn and held in abeyance)
- Emergency Mental Health Crisis Services System (subsequently withdrawn and held in abeyance)

The Commission also reviewed proposed changes to the Johnson County Management Plan.

Allowed Growth. The Commission prepared and submitted its Allowed Growth Factor Adjustment Recommendation for fiscal year 2011 to Governor Culver pursuant to Iowa Code §331.439(3)(b).

County Budgets. On March 21, 2008, as a follow-up to the their Allowed Growth Factor Adjustment Recommendation for fiscal year 2010, the Commission submitted information to Governor Culver and legislative leaders to illustrate the extent to which county budget shortfalls were directly impacting services available to consumers as a result of service cuts and the establishment of waiting lists for services.

Older Iowans. In March the Commission received a report from Dr. Brian Kaskie of the University of Iowa on the need for a coordinated system of mental health care services for older Iowans. The report noted that by the year 2030 one in every four Iowans will be over the age of 65. Iowa has one of the highest per capita numbers of persons over age 85 in the nation. Dr. Kaskie noted the need for appropriate, available, and effective mental health services for all populations in Iowa as a quality of life issue.

Workforce Issues. Also in March, the Commission received a report from John Morris, Executive Director the Annapolis Coalition, developers of A National Action Plan on Behavioral Health Workforce Development. The presentation included specific recommendations and strategies for Iowa to implement efforts to address workforce shortages of qualified and experienced mental health professionals in Iowa, most notably psychiatrists and psychologists.

Barriers to Community Integration. In May, the Commission received the Glenwood and Woodward Resource Centers Annual Report of Barriers to Integration identifying nine major barriers that are currently preventing individuals residing at the Resource Centers from being able to successfully be placed and live in the community:

- Level of staff supervision, assistance, or training required;
- Behavioral issues that pose a risk to the safety of self or others;
- Opposition by a family member or guardian;
- Level of physical environment or environmental supports needed;

- Level of health care supports needed
- Availability of appropriate educational, vocational, or retirement programs;
- Availability of an adequate level of supervision for leisure, social, and community activities;
- Availability of specific supports for children or seniors; and,
- On a waiting list for services or awaiting approval of funding.

Glenwood Resource Center. The Commission held its September meeting at the Glenwood Resource Center, toured the facility, and met with administrators and staff to discuss the U.S. Department of Justice report, ongoing corrective actions, and recent resident deaths. On several occasions during the year, the Commission discussed unexpected deaths that have occurred at Glenwood Resource Center, asking for and receiving open communications from DHS staff regarding the safety and supervision issues that surrounded some of the incidents. A majority of Commission members felt a more thorough review of the situation at Glenwood Resource Center was appropriate, while other members felt such a review was outside the Commission's purview. While other bodies have the responsibility and authority to investigate the deaths and review procedures and practices at the State Resource Centers, the Commission remains concerned and attuned to the ongoing oversight of the situation.

Accreditation Bureau Report. In October, the Commission received an assessment of the Accreditation process conducted by Lesa Yawn, Ph.D., J.D., at the request of DHS. The assessment reviewed the structure and processes of the DSH Accreditation Bureau, outlined the strengths of the current accreditation process, and included recommendations for short and long term improvement opportunities.

Project Recovery Iowa. In August, September and October, the Commission received update reports regarding disaster crisis counseling services being provided by the MHDS Project Recovery Iowa project. The report summarized the services being delivered through the Crisis Counseling Program. The report included data showing that in-person contacts had been made with nearly 18,000 Iowans, and over 5,000 Iowans had accessed some level of individual counseling through the project.

Mental Health Jail Diversion. In November, the Commission held its monthly meeting at the Story County Justice Center in Nevada, toured the facility, and received a report on the Story County Mental Health Jail Diversion Program, a cooperative project coordinated by the Story County Community Life Program to identify individuals with mental health disorders who have had interaction with law enforcement and, when appropriate, provide mental health, substance abuse treatment, and other supports in conjunction with or as an alternative to incarceration.

Ongoing Activities: The Commission has been charged with numerous mandated duties as well as duties that are contingent upon the extent to which funding is available. Multiple factors including lack of resources, staff changes within the Department of Human Services, shifts in public policy philosophies, and competing interests have resulted in action on some items to be delayed. The Department has expressed a renewed commitment to work cooperatively with the Commission to better facilitate its work. Similarly, the members of the Commission wish to express their commitment to work cooperatively with the current leadership of the Department and the Division of MHDS to identify duties and issues that are in need of attention and address them in a

coordinated and timely manner. The Commission also proposes working with the Department to develop and recommend to the Legislature a more focused approach to their scope of duties.

PART 2: RECOMMENDATIONS FOR CHANGES IN IOWA LAW

The Commission's recommendations for changes in Iowa law are consistent with recommendations the Commission has presented in prior years.

Priority 1: Fund MH/MR/DD/BI Services at a level adequate to meet basic needs:

- No Cuts in Services to Iowans with Mental Health and Disability-Related Needs
- Eliminate Waiting Lists for Persons in Need of Services

Proposed strategies:

(1) Remove dollar cap on county property tax levies and allow growth: The Commission believes that current funding for Mental Health, Mental Retardation, Developmental Disability, and Brain Injury services is inadequate. In 1996 the Iowa Legislature froze the county property tax contribution for Mental Health and Developmental Disability services. Twelve years later those dollars remain frozen at the same level. The State was expected to fund the increases that occurred in the cost of services, including the cost for new consumers. The State has not fulfilled that obligation and Iowans with mental health and disability-related needs are paying the price. Counties need the ability to generate additional revenue to meet the needs of their citizens.

The current economic crisis and the devastation caused by natural disasters across Iowa in the last year have significantly increased the budgetary shortfalls counties were already experiencing. The same factors have placed a greater burden on local systems to address the crisis related needs of consumers as well as bringing new consumers into the system.

Medicaid costs continue to rise. Approximately half of all county budgets are consumed in paying the Medicaid match. When allowed growth is not sufficient to cover the increase in county dollars used for mandated Medicaid services, other discretionary county funded services including those that support persons not eligible for Medicaid must be cut or eliminated. Even in these difficult economic times, we must recognize that mental health and disability-related services are necessary to meet basic human needs and are essential to the health and well-being of our citizens, our communities, and our State. Our sense of urgency in this matter is underscored by the facts:

- One quarter (25%) of the population of our state live in a county that currently has a waiting list for mental health and disability services
- Even more counties are currently planning waiting lists for fiscal year 2010
- Half of our counties have a fund balance of less than ten percent (10%), which jeopardizes their ability to pay providers in a timely manner
- Twenty-four (24) counties have a negative fund balance
- Six ($6) million dollars in additional funding is required to bring those 24 counties to a fund balance of zero—that is $1 million more than the entire increase in allowed growth appropriated for fiscal year 2009
- Eighty-one (81) counties are levying the maximum allowed by state law

- The total unused levy capacity among the 18 counties not currently levying the maximum is only $4 million per year

When we fail to ensure that counties have the ability to muster the resources necessary to meet even the basic service needs of their citizens, we also fail to support their investment in building community capacity. In times like these when dollars are particularly scarce, it is even more critical that they are spent wisely and invested for our collective future. The longer we delay in addressing barriers to community integration that restrict choices available to individuals and families, the longer we perpetuate unnecessarily expensive and restrictive institutional care that serves to limit independence and productivity rather than nurturing abilities and supporting inclusion. The State must fully fund allowed growth in the MH/MR/DD/BI system and support legislation that would allow counties the option of using a levy rate cap instead of the current dollar cap. Changing to a levy rate cap would address the rising costs of services and enable counties to meet the needs of their consumers without painful service cuts. Iowa's counties are now levying 97% of the total statewide capacity. MH/DD budgets are in crisis. County Mental Health Management plans are being amended to reduce services because counties are not allowed to generate new dollars to meet their needs.

(2) Explore additional ways to generate revenue for services, including State Medicaid match: The Medicaid Program provides medically necessary services to Iowa's most vulnerable consumers. Medicaid serves as a safety net for consumers and an important source of federal funding that alleviates the cost to state and local governments. Even so, Iowa's 99 counties expend approximately $150 million a year in matching funds to access the federal Medicaid dollars. Phasing in greater State participation in funding the Medicaid match is an additional strategy for easing the burden on counties in economic crisis.

Priority 2: Implement a comprehensive statewide system for children's disability services: The Commission supports the MH/MR/DD/BI design recommendations to develop and implement a comprehensive and coordinated service system for all children with disabilities in Iowa. Key components of the design recommendation include supportive and preventative services that keep families together, better coordination, the availability of outpatient mental health services, and a mechanism for seamless transition into adult services. Children need to be in their homes and communities and have access to an array of services. It is simply what's right for children, families, and communities, and it will reduce the need for much more costly institutional services.

The responsibility for a system of care for children belongs with the State and includes the development of crisis intervention services, behavioral support services, and coordinating agencies in each community to assure that children and their families experience no wrong door when seeking information or needed services and supports. The Commission supports statewide expansion of the model exemplified by the SAMHSA Community Circle of Care grant project currently being piloted in ten northeastern Iowa counties. This model utilizes a team approach to seek creative solutions based on the family's strengths, needs, and culture, and design a community based wrap-around plan that is driven by the family, guided by the youth, and has the flexibility to change with the child over time. Continued funding to support an emergency mental health crisis services system is also needed, as effective crisis services are a vital component of a comprehensive statewide system.

An effectively working system of care for children will also incorporate mechanisms to coordinate efforts across state agencies including, at a minimum, the Department of Human Services, the Department of Education, the Department of Public Health, and Juvenile Justice.

Priority 3: Address the psychiatric and direct support workforce shortage: The Commission supports a statewide effort to recruit psychiatrists, psychiatrically trained and certified physicians' assistants and nurse practitioners, social workers, and direct support workers. The shortage of qualified professionals is a critical and growing problem in both rural and urban areas across the State. Qualified community-based service providers and direct support workers deserve wages and benefits comparable to workers at state run facilities. Psychiatric telemedicine has proven to be successful in certain areas and should be enhanced to create statewide availability, with reimbursement available from Medicaid and all other payers. Incentive grant programs, active international recruitment, and other viable strategies should be developed and implemented.

Priority 4: Implement statewide uniform provider cost reporting: In 2007 the Iowa General Assembly enacted House File 309, requiring the development of a uniform cost report for certain services reimbursed through the Department of Human Services and counties. While work has been done toward that goal, no such report has yet been implemented. The Commission considers implementation of uniform cost reporting a public policy priority and believes that counties, the Department of Human Services, and other stakeholders can work together to develop and put into statewide use one uniform provider cost report. Features of such a cost report should include: County Rate Information System (CRIS) principles, uniform cost centers, standardized definitions of costs, all provider revenues and costs, and each specific service regardless of funding stream. The use of a uniform system of reporting would greatly enhance the capacity of providers, counties, and the State in defining and analyzing the costs of services.

PART 3: EVALUATION OF THE STATE DISABILITY SERVICES SYSTEM

Availability of services in each county of the State. Iowa continues to experience geographic disparity in available services. Our traditional county based system, while accommodating local control and planning, also contributes to inequity in service availability and funding between rural and urban areas, and among different regions of the State. Over ten years ago, Senate File 69 froze county mental health and disability services budgets. Since then no new State dollars have been appropriated to close service gaps, which has perpetuated service disparities that were in existence at the time. Service providers are limited or unavailable in significant rural areas of Iowa.

The shortage of psychiatrists, psychologists, and other trained mental health professionals is particularly noteworthy. Most urban areas offer greater availability of providers, but waiting lists and county budget shortfalls often impact access to those service providers in urban areas as well as rural, as referenced in our legislative recommendation for changes to increase the level of funding available statewide. Even in urban areas where psychiatrists and other mental health professionals appear to be available in adequate numbers, however, they are often not accessible to many who need their services because they do not accept Medicaid or other publicly funded patients.

Currently nine counties, representing 25% of the State's population, have notified the Department of Human Services that they have established waiting lists for State Fiscal Year 2009. The nine counties are: Boone, Cerro Gordo, Clinton, Howard, Kossuth, O'Brien, Osceola, Polk, and Scott. Many other counties have announced their intention to institute waiting lists for fiscal year 2010.
As a state we have created a collective vision that people with disabilities will have the opportunity to live, work, learn, and participate fully in the communities of their choice. We must invest in building the community capacity necessary to support that vision.

Quality of services in each county of the State. The quality of services throughout the State is often reflective of the same funding factors that impact the availability of services. While system-wide efforts to maintain high quality services through licensing, accreditation, professional development, and introduction of results based accountability standards contribute to quality improvement, shortages of professional providers, turnover and shortages in direct care and support staff, and funding issues negatively impact the overall quality of services.

Efforts are underway to address some of the inequity in service provision through statewide initiatives including the development of an emergency mental health safety net, a coordinated system of children's mental health services, specialized services for individuals with co-occurring disorders, and workforce development. The system needs to continue to be encouraged to value the delivery of services in the community and as close to where the consumer lives as possible, and to continue the reduction of congregate service delivery to the greatest extent safe and reliable options are available. The use of continuous quality improvement activities, functional assessments, and consumer outcomes measures also need to be supported and encouraged statewide. In 2006 the Commission approved a way to compare five critical measures by county from data already reported to the Department of Human Services. To date the Commission has not received reports on that effort.

The Department of Human Services Division of Mental Health and Disability Services is emphasizing the achievement of results and the use of evidence-based and promising practices with the federal mental health services block grant funding to community mental health centers. These practices are being systematically introduced across the State while implementing a contract to collect outcome information from each agency. Outcome information gathered will be used to improve the quality of services for persons with mental health and disability needs. MHDS has contracted with Telesage for a consumer outcomes measurement system to be implemented statewide over the next several years. The system is now being piloted. Initial reports are expected to be available in the spring of 2009, and at that time the reliability of the data gathered will be evaluated.

Although there are scattered mental health services currently available to children, including services under the Medicaid SED waiver, this is an area in need of major development. One of the key gaps is the absence of a system of care designed to provide access to necessary services to enable children to live with their families and remain in their own community.

In State Fiscal Year 2007 Iowa received its first Federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to fund a system of care project in a ten county area of northeast Iowa. The Community Circle of Care created pursuant to this grant is a collaborative project of the Iowa Department of Human Services, Iowa Child Health Specialty Clinics, the University of Iowa Center for Disabilities and Development and others. It serves children and

youth with serious emotional and behavioral challenges. The project model utilizes a team approach to seek creative solutions based on the family's strengths, needs, and culture, and design a community based wrap-around plan that is driven by the family, guided by the youth, and has the flexibility to change with the child over time. The Commission supports the provision of state funding to support statewide expansion of this model as a comprehensive system of care for children and youth.

We also reiterate our belief that an effectively working system of care for children must feature truly coordinated efforts across state agencies including, at a minimum, the Department of Human Services, the Department of Education, the Department of Public Health, and Juvenile Justice. Several other initiatives discussed elsewhere in this report also are designed to enhance the efficacy of the services system, including the use of evidence based practices, better coordination of service for persons with co-occurring disorders, the Money Follows the Person Grant, Project Recovery Iowa, and the movement toward results based measurement throughout the system. Projects such as these that focus on enabling Iowans with disabilities to remain in their communities and support them in living as independently as possible all contribute to greater efficacy of the system.

The DHS Division of Mental Health and Disabilities Services continues to facilitate movement toward widespread use of results-based and outcome-based measurements, including the use of client/consumer satisfaction and quality measures. An array of approaches are being used, including:

- Continued accreditation and survey activities for targeted case management, supported community living, intensive psychiatric rehabilitation, community mental health centers and other mental health providers
- Support and technical assistance to designated providers regarding the implementation of evidence based practices
- Technical assistance and consultation to counties, providers, consumers, families, and other stakeholders related to policies, data, resources, reporting systems, and other information and assistance to improve the mental health and disability services system
- Coordinated and monitored activities across Iowa state agencies that affect Iowans with disabilities
- Training events to enhance capacity in targeted areas identified through system planning efforts
- Establishing an Acute Mental Health Care System Workgroup in cooperation with other departments and agencies
- Coordinating with the Annapolis Coalition in the completion of the Behavioral Health Workforce System review
- Submitting an earmark-funding request for the Behavioral Workforce Recruitment and Retention.
- Offering Functional Assessment Training to providers
- Developing a Co-Occurring Disorders Pilot Project
- Developing and submitting a 2nd Children's System of Care Mental Health grant application
- Providing training to providers on acute care systems development, functional assessments and mental health first aid through a $100,000 Technical Transformation Initiative awarded by NASMHPD to MHDS
- Securing a Data Infrastructure Grant from SAMHSA to improve utilization reporting

- Awarding an Outcomes Measurement System contract to Telesage to measure SAMHSA-mandated consumer satisfaction
- Drafting a multi-year Mental Health and Disability Services strategic plan

Effectiveness of services provided by disability service providers in this State. The overall effectiveness of services provided in venues other than the State Mental Health Institutes and State Resource Centers should be measured by how well they enable persons to remain in their community and live as independently as possible with a disability. Their effectiveness is also dependent on the overall framework for support that is available on a statewide basis.

Iowa's 99 counties provide disability services to over 53,000 individuals living in Iowa's communities through the combined use of federal, state, and county resources. Most adult mental health and disability services are managed directly by counties. Iowa's publicly funded disability services for children are primarily managed by the Department of Human Services and the Juvenile Court system. Counties do not manage mental health and disability services for children, who receive services that may be disjointed because they are accessed through multiple systems, including the Medicaid program, local providers, and the educational system. One of the key gaps is the absence of a system of care designed to provide access to necessary services to enable children to live with their families and remain in their own community. Earlier in this report we outlined the efforts to implement a statewide "systems of care" project built on the current regional Community Circle of Care project. This model offers real promise in filling this serious gap by increasing the coordination of services to children and increasing the efficacy of services in supporting families so that children can remain at home.

Effectiveness of services provided by the State Mental Health Institutes established under Iowa Code Chapter 226. Iowa's four Mental Health Institutes located at Cherokee, Clarinda, Independence, and Mount Pleasant provided approximately 2100 persons with access to quality inpatient mental health and/or substance abuse treatment services during State Fiscal Year 2008. The MHIs provide critical access to quality mental health care for low-income children and adults, and serve persons committed through the judicial system. All four MHIs also offer consultation services to community-based mental health providers to facilitate less restrictive community-based placement of patients. The presence of an MHI in each quadrant of the State, assures critical accessibility services.

In addition to basic access, the four State MHIs provide specialized mental health services including substance abuse treatment, dual diagnosis treatment for persons with mental illness and substance addiction, psychiatric treatment for children, and long-term psychiatric care for geriatric adults. The MHIs also have a role in addressing the shortage of quality medical and mental health providers in rural areas through post-graduate training for Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) at the Cherokee MHI.

For State Fiscal Year 2008, the Mental Health Institutes report:

- 97.7% of clients show improvement in ability to function as evidenced by an increase in the Global Assessment of Functioning (GAF) score
- 92.8% of adult clients remain in the community for at least 30 days following MHI discharge

- 85.5% of substance abuse clients successfully complete or receive maximum benefit from the program

Effectiveness of services provided by State Resource Centers established under Iowa Code Chapter 222. Iowa's two State Resource Centers, located at Woodward and Glenwood, provided approximately 620 adults and children who have mental retardation and related conditions with Intermediate Care Facility Treatment services during State Fiscal Year 2008. The two State Resource Centers also provide a variety of treatment and outreach services to individuals with mental retardation or other development disabilities who live in community settings, and assist SRC residents in reaching individual goals and successfully returning to community living.

Since 1994 the State Resource Centers have been operating under the terms of the Conner Consent Decree which requires that individuals are admitted only after the Department of Human Services determines that no appropriate community based services are available. The Conner Decree, the 1999 *Olmstead* Supreme Court Decision, the U.S. Department of Justice Consent Decree, and changing perspectives about community inclusion have all contributed to a gradual down-sizing of the State Resource Center population over the last 15 or so years. SRC staff work actively with residents, their families, and community service providers for the successful transition of resident into community services. The current population of the two facilities is about 547. A decrease of 24 residents (about 4.4%) is projected during the next fiscal year. That projection would place the overall reduction in number of residents since SFY 2003 at 23.3%.

For State Fiscal Year 2008, the State Resource Centers report:

- 69% of SRC residents earned wages through on or off campus employment
- 89% of discharged SRC residents remained in the community for at least 180 days

While we recognize the need for a full continuum of care options in our State, the Commission has two areas of concern with regard to the State Resource Centers:

First, the recent deaths at Glenwood State Resource Center along with on-going monitoring by the U.S. Department of Justice and other agencies have focused attention on issues related to the care, supervision, and safety of residents at the State Resource Centers. It is critical that all such concerns are openly addressed and resolved and that continuous quality assurance and improvement are a priority.

Our second concern is that even though efforts have been undertaken to identify the barriers to community integration for Resource Center residents, our system seem unresponsive. Significant numbers of individuals continue to enter, or are unable to leave the Resource Centers because appropriate community-based options have not been developed or adequately funded to support their intensive behavioral needs. As a state, we need to expand community capacity to be responsive to the needs of all who choose community living. It will take a coordinated effort on the part of community providers, educators, advocates, the Department of Human Services, and other state agencies to address existing barriers.

Summary. The State disabilities services system continues to work to provide access to quality care for all Iowans with disabilities by:

- improving the array of community services and supports so more people can stay in their community rather than entering institutions
- providing services that encourage appropriate family involvement and support people in staying and living at home
- strengthening and supporting families and care-givers
- ensuring safe and healthy living environment for persons with special needs and vulnerable populations
- increasing access to community-based services for persons with special needs and vulnerable populations
- ensuring consistent assessment of need and a more uniform identification of the specific services and/or supports each person needs to continue to live in the location of their choice
- offering evidence-based and competency-based training for clinicians and direct care staff

The focus and goal of systems improvement must be an improved quality of life for all Iowans with disabilities.

Respectfully submitted,

Dale Todd
Chair, MH/MR/DD/BI Commission

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