House File 689 - Introduced

HOUSE FILE 689
BY COMMITTEE ON APPROPRIATIONS

(SUCCESSOR TO HF 626)
(SUCCESSOR TO HSB 83)

A BILL FOR

An Act relating to mental health and disability services and substance-related disorders and mental illness commitment proceedings, making appropriations, and including effective date provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

SERVICES SYSTEM REDESIGN —— FUNDING

Section 1. MENTAL HEALTH SERVICES SYSTEM REDESIGN.

1. The general assembly intends to implement service system redesign for mental health services in which the department of human services assumes responsibility for administering publicly funded mental health services for children and adults beginning on July 1, 2012.

2. The legislative council is requested to authorize a legislative interim committee to meet during the 2011 legislative interim to develop a plan for implementing the redesigned mental health services system for children and adults. The plan shall be submitted to the general assembly for consideration and enactment in the 2012 legislative session. The plan shall include but is not limited to all of the following:

a. Identifying clear definitions and requirements for the following:

(1) Characteristics of the service populations.

(2) The array of core services to be delivered by providers in a manner that promotes cost-effectiveness, uniformity, accessibility, and best practices approaches.

(3) Outcome measures that focus on consumer needs.

(4) Quality assurance measures.

(5) Provider accreditation, certification, or licensure requirements.

b. A proposal for developing treatment services in this state to meet the needs of children who are placed out of state due to the lack of treatment services in this state.

c. A proposal for implementing the delivery of regionally coordinated and community-based information and referral, options counseling, care coordination, and targeted case management services.

Sec. 2. DEPARTMENTS OF HUMAN SERVICES AND PUBLIC HEALTH.

1. The departments of human services and public health

shall work with appropriate stakeholders designated by the departments to develop the proposals described in subsection 2. Progress on the proposals shall be shared with the legislative interim committee authorized pursuant to this division of this Act and a final report on the proposals shall be submitted to the governor and general assembly on or before December 15, 2011.

2. The departments shall develop the following proposals:

a. A proposal to emphasize service providers addressing co-occurring mental health and substance abuse disorders.

b. A proposal to address service provider shortages. In developing the proposal, the departments and appropriate stakeholders shall examine barriers to recruiting providers, including but not limited to variation in health insurance payment provisions for the services provided by different types of providers.

Sec. 3. INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITY AND BRAIN INJURY SERVICES SYSTEM REDESIGN.

1. In addition to mental health services, the general assembly intends to implement service system redesign in which the department of human services assumes responsibility for the administration of intellectual and other developmental disability and brain injury services for adults and children at a later time.

2. The legislative council is requested to extend the interim committee authorized pursuant to this division of this Act for the 2011 legislative interim or authorize a different legislative interim committee to meet during the 2012 legislative interim to develop a plan for implementing the redesigned disability services system for adults and children. The plan shall be submitted to the general assembly for consideration and enactment in the 2013 legislative session. The plan shall include but is not limited to all of the following:

a. Identifying clear definitions and requirements for the

following:

(1) Characteristics of the service populations.

(2) The array of core services to be delivered by providers in a manner that promotes cost-effectiveness, accessibility, and the best practices approaches.

(3) Outcome measures.

(4) Quality assurance measures.

(5) Provider accreditation, certification, or licensure requirements.

b. A proposal developed in conjunction with the department of public health to emphasize service providers addressing co-occurring mental health, intellectual disability, or substance abuse disorders.

c. A proposal for implementing the delivery of regionally coordinated and community-based information and referral, options counseling, care coordination, and targeted case management services.

Sec. 4. CONTINUATION OF WORKGROUP BY JUDICIAL BRANCH AND DEPARTMENT OF HUMAN SERVICES. The judicial branch and department of human services shall continue the workgroup implemented pursuant to 2010 Iowa Acts, chapter 1192, section 24, subsection 2, to improve the processes for involuntary commitment for chronic substance abuse under chapter 125 and serious mental illness under chapter 229. The recommendations issued by the workgroup shall address options to the current provision of transportation by the county sheriff; to the role, supervision, and funding of mental health patient advocates; and for civil commitment prescreening. Additional stakeholders shall be added as necessary to facilitate the workgroup efforts. the workgroup shall complete deliberations and submit a final report providing findings and recommendations on or before December 15, 2011.

Sec. 5. SERVICE SYSTEM DATA AND STATISTICAL INFORMATION INTEGRATION. The department of human services, department of public health, and the community services affiliate of the Iowa

state association of counties shall agree on implementation provisions for an integrated data and statistical information system for mental health, disability services, and substance abuse services. The departments and affiliate shall report on the integrated system to the governor, the joint appropriations subcommittee on health and human services, and the legislative services agency, providing findings and recommendations, on or before December 15, 2011.

Sec. 6. NEW SECTION. **225C.7A Disability services system redesign savings fund.**

1. A disability services system redesign savings fund is created in the state treasury under the authority of the department. Moneys credited to the fund are not subject to section 8.33. Moneys available in the fund for a fiscal year shall be used in accordance with appropriations made by the general assembly to implement disability services system improvements.

2. Notwithstanding section 8.33, appropriations made to the department for disabilities services that remain unencumbered or unobligated at the close of the fiscal year as a result of implementation of disabilities services system efficiencies shall not revert but shall be credited to the disability services system redesign savings fund.

DIVISION II

APPROPRIATIONS AND CONFORMING PROVISIONS

Sec. 7. CONFORMING PROVISIONS. The legislative services agency shall prepare a study bill for consideration by the committees on human resources of the senate and house of representatives for the 2012 legislative session, providing any necessary conforming Code changes for implementation of the system redesign provisions contained in this Act.

Sec. 8. PROPERTY TAX RELIEF FUND —— MENTAL HEALTH AND INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITIES SERVICES SYSTEM REFORM.

1. The moneys appropriated and credited to the property

tax relief fund pursuant to 2011 Iowa Acts, Senate File 209, section 21, if enacted, shall be credited to the risk pool within the property tax relief fund, to be distributed as provided in this section.

2. The amount credited to the risk pool pursuant to this section is appropriated from the risk pool to the department of human services for distribution as provided in this section.

3. a. For the purposes of this section, "services fund" means a county's mental health, mental retardation, and developmental disabilities services fund created in section 331.424A.

b. The risk pool board shall implement a process for distribution of the amount appropriated in this section to counties to be used to provide eligibility for services and other support payable from the counties' services funds for persons who are eligible under county management plans in effect as of December 31, 2010, but due to insufficient funding are on a waiting list for the services and other support. The period addressed by the funding appropriated in this section begins on or after the effective date of this section and ends June 30, 2012. The distribution allocations shall be completed on or before July 1, 2011.

c. The general assembly finds that as of the time of enactment of this section, the funding appropriated in this section is sufficient to eliminate the need for continuing, instituting, or reinstituting waiting lists during the period addressed by the appropriation. However, the process implemented by the risk pool board shall ensure there is adequate funding so that a person made eligible for services and other support from the waiting list would not be required to return to the waiting list if a later projection indicates the funding is insufficient to cover for the entire period all individuals removed from the waiting list pursuant to this section.

d. The funding provided in this section is intended to

provide necessary services for adults in need of publicly funded mental health and intellectual and other developmental disabilities services until the system reform provisions addressed by this Act are developed and enacted.

Sec. 9. IMPLEMENTATION. There is appropriated from the general fund of the state to the department of human services for the fiscal year beginning July 1, 2011, and ending June 30, 2012, the following amount, or so much thereof as is necessary, to be used for the purposes designated:

For costs associated with implementation of this Act:

..... $ 50,000

Sec. 10. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION III

PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

Sec. 11. Section 135H.3, subsection 1, Code 2011, is amended to read as follows:

1. A psychiatric medical institution for children shall utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident. <u>The membership of the team of professionals may include but is not limited to an advanced registered nurse practitioner.</u> Social and rehabilitative services shall be provided under the direction of a qualified mental health professional.

Sec. 12. Section 135H.6, subsection 8, Code 2011, is amended to read as follows:

8. The department of human services may give approval to conversion of beds approved under subsection 6, to beds which are specialized to provide substance abuse treatment. However, the total number of beds approved under subsection 6 and this subsection shall not exceed four hundred thirty. Conversion

of beds under this subsection shall not require a revision of the certificate of need issued for the psychiatric institution making the conversion. Beds for children who do not reside in this state and whose service costs are not paid by public funds in this state are not subject to the limitations on the number of beds and certificate of need requirements otherwise applicable under this section.

Sec. 13. Section 249A.31, subsection 2, Code 2011, is amended to read as follows:

2. Effective July 1, ~~2010~~ 2012, ~~the department shall apply a cost-based reimbursement methodology for reimbursement of~~ services provided by psychiatric medical institution for children providers shall be reimbursed as determined in accordance with the managed care contract awarded for authorizing payment for such services under the medical assistance program.

Sec. 14. PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN —— MANAGED CARE CONTRACT. The department of human services shall issue a request for proposals to procure a contractor to authorize, reimburse, and manage benefits for psychiatric medical institution for children services reimbursed under the medical assistance program beginning July 1, 2012. The department shall not procure this contract through a sole source contract process or other limited selection process.

Sec. 15. PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN —— LEVEL 2.

1. For the purposes of this section, unless the context otherwise requires:

a. "Psychiatric institution-level 1" means a psychiatric medical institution for children licensed under chapter 135H and receiving medical assistance program reimbursement.

b. "Psychiatric institution-level 2" means a psychiatric medical institution for children licensed under chapter 135H and receiving medical assistance program reimbursement and providing more intensive treatment as described in this

section.

2. The department of human services shall work with the department of inspections and appeals to develop a second level of care for psychiatric medical institutions for children licensed under chapter 135H, to be known as "psychiatric institution-level 2" to address the needs of children in need of more intensive treatment. The number of beds authorized for psychiatric institution-level 2 shall not exceed 60 beds. The number of beds in a level 2 program shall be limited to 12 beds.

3. The department of human services shall select providers to be authorized to provide psychiatric institution-level 2 beds using a request-for-proposal process. The providers shall be selected and contracts finalized on or before January 1, 2012. At least three but not more than five providers shall be selected based upon the following criteria:

a. Geographic accessibility.

b. Ability to provide needed expertise, including but not limited to psychiatry, nursing, specialized medical care, or specialized programming.

c. Ability to meet and report on standardized outcome measures.

d. Ability to provide treatment to children whose treatment needs have resulted in an out-of-state placement.

e. Ability to transition children from psychiatric institution-level 2 care to psychiatric institution-level 1 care.

4. a. Notwithstanding any provision of law to the contrary, for the fiscal year beginning July 1, 2011, the reimbursement rate for psychiatric institution-level 1 providers shall be the actual cost of care, not to exceed 103 percent of the statewide average of the costs of psychiatric institution-level 1 providers for the fiscal year. The costs shall not incorporate the uniform 5 percent reduction applied to such provider rates in fiscal year 2010-2011. It is the intent of the general assembly that such reimbursement rates in subsequent years be

recalculated annually at the beginning of the fiscal year. The average of the costs limitation shall not apply to the psychiatric medical institution for children located at the state mental health institute at Independence.

b. Notwithstanding any provision of law to the contrary, for the fiscal year beginning July 1, 2011, the initial reimbursement rate for psychiatric institution-level 2 providers shall be based on a prospective cost of care basis, not to exceed the actual cost of care for the psychiatric medical institution for children located at the state mental health institute at Independence. In subsequent years, it is the intent of the general assembly that the reimbursement rate for psychiatric institution-level 2 providers be the actual cost of care, not to exceed 103 percent of the statewide average of the costs of psychiatric institution-level 2 providers for the fiscal year.

5. The department of human services shall create an oversight committee comprised of psychiatric institution-level 2 providers and representatives of other mental health organizations with expertise in children's mental health treatment to address the following issues concerning psychiatric institution-level 2 providers and report to the department, governor, and general assembly as needed:

a. Identifying the target population to be served by providers.

b. Identifying admission and continued state criteria for the providers.

c. Reviewing potential changes in licensing standards for psychiatric institution-level 1 providers in order to accommodate the higher acuity level and increased treatment needs of children to be served by psychiatric institution-level 2 providers.

d. Reviewing the children in out-of-state placements with providers similar to psychiatric medical institutions for children to determine which children could be better served in

this state by a psychiatric institution-level 2 provider.

6. The department of human services shall annually report not later than December 15 to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services through 2016 regarding implementation of this section. The report shall include but is not limited to information on children served by both level 1 and level 2 providers, the types of locations to which children are discharged after level 1 and level 2 treatment and the community-based services available to such children, and the incidence of readmission for level 1 and level 2 treatment within 12 months of discharge.

DIVISION IV

MEDICATION THERAPY MANAGEMENT

Sec. 16. NEW SECTION. **249A.20B Medication therapy management.**

1. Beginning July 1, 2011, the department shall utilize a request for proposals process to select an entity to contract beginning July 1, 2012, for the provision of medication therapy management for any medical assistance program recipient who meets any of the following criteria:

a. Is an individual who takes prescription drugs to treat or prevent chronic mental illness, or is an individual who takes four or more prescription drugs to treat or prevent two or more chronic medical conditions.

b. Is an individual with a prescription drug therapy problem who is identified by the prescribing physician or other appropriate prescriber, and referred to a pharmacist for medication therapy management services.

c. Is an individual who meets other criteria established by the department.

2. For the initial contract period beginning July 1, 2012, the primary focus shall be provision of medication therapy management services to individuals with chronic mental illness.

3. *a.* The contract shall require the selected entity

to provide annual reports to the general assembly detailing the costs, savings, estimated cost avoidance and return on investment, and patient outcomes related to the medication therapy management services provided.

b. The entity shall guarantee demonstrated annual savings, including any savings associated with cost avoidance at least equal to the medication therapy management services program's costs with any shortfall amount refunded to the state.

c. As a proof of concept in the program for the initial year of the contract, the entity shall offer a dollar-for-dollar guarantee for drug product costs savings alone.

d. Prior to entering into a contract with an entity, the department and the entity shall agree on the terms, conditions, and applicable measurement standards associated with the demonstration of savings. The department shall verify that the demonstrated savings reported by the entity was performed in accordance with the agreed upon measurement standards.

e. The entity shall contract with Iowa licensed pharmacies, pharmacists, or physicians to provide the medication therapy management services.

4. The fees for pharmacist-delivered medication therapy management services shall be separate from the reimbursement for prescription drug product or dispensing services; shall be determined under the terms of the contract; and must be reasonable based on the resources and time required to provide the services.

5. A fee shall be established for physician reimbursement for services delivered for medication therapy management as determined under the terms of the contract, and must be reasonable based on the resources and time required to provide the services.

6. If any part of the medication therapy management plan developed by a pharmacist incorporates services which are outside the pharmacist's independent scope of practice, including the initiation of therapy, modification of dosages,

therapeutic interchange, or changes in drug therapy, the express authorization of the individual's physician or other appropriate prescriber is required.

7. For the purposes of this section, "*medication therapy management*" means a systematic process performed by a licensed pharmacist, designed to optimize therapeutic outcomes through improved medication use and reduced risk of adverse drug events in order to reduce overall health care costs, including all of the following services:

a. A medication therapy review and in-person consultation relating to all medications, vitamins, and herbal supplements currently being taken by an eligible individual.

b. A medication action plan, subject to the limitations specified in this section, communicated to the individual and the individual's primary care physician or other appropriate prescriber to address safety issues, inconsistencies, duplicative therapy, omissions, and medication costs. The medication action plan may include recommendations to the prescriber for changes in drug therapy.

c. Documentation and followup to ensure consistent levels of pharmacy services and positive outcomes.

Sec. 17. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION V

COMMUNITY MENTAL HEALTH CENTERS

COMMUNITY MENTAL HEALTH CENTERS —— CATCHMENT AREAS

Sec. 18. NEW SECTION. **230A.101 Services system roles.**

1. The role of the department of human services, through the division of the department designated as the state mental health authority with responsibility for state policy concerning mental health and disability services, is to develop and maintain policies for the mental health and disability services system. The policies shall address the service needs of individuals of all ages with disabilities in this state,

regardless of the individuals' places of residence or economic circumstances, and shall be consistent with the requirements of chapter 225C and other applicable law.

2. The role of community mental health centers in the mental health and disability services system is to provide an organized set of services in order to adequately meet the mental health needs of this state's citizens based on organized catchment areas.

Sec. 19. NEW SECTION. **230A.102 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Administrator"*, *"commission"*, *"department"*, *"disability services"*, and *"division"* mean the same as defined in section 225C.2.

2. *"Catchment area"* means a community mental health center catchment area identified in accordance with this chapter.

3. *"Community mental health center"* or *"center"* means a community mental health center designated in accordance with this chapter.

Sec. 20. NEW SECTION. **230A.103 Designation of community mental health centers.**

1. The division, subject to agreement by any community mental health center that would provide services for the catchment area and approval by the commission, shall designate at least one community mental health center under this chapter to serve as lead agency for addressing the mental health needs of the county or counties comprising the catchment area. The designation process shall provide for the input of potential service providers regarding designation of the initial catchment area or a change in the designation.

2. The division shall utilize objective criteria for designating a community mental health center to serve a catchment area and for withdrawing such designation. The commission shall adopt rules outlining the criteria. The criteria shall include but are not limited to provisions for

meeting all of the following requirements:

a. An appropriate means shall be used for determining which prospective designee is best able to serve all ages of the targeted population within the catchment area with minimal or no service denials.

b. An effective means shall be used for determining the relative ability of a prospective designee to appropriately provide mental health services and other support to consumers residing within a catchment area as well as consumers residing outside the catchment area. The criteria shall address the duty for a prospective designee to arrange placements outside the catchment area when such placements best meet consumer needs and to provide services within the catchment area to consumers who reside outside the catchment area when the services are necessary and appropriate.

3. The board of directors for a designated community mental health center shall enter into an agreement with the division. The terms of the agreement shall include but are not limited to all of the following:

a. The period of time the agreement will be in force.

b. The services and other support the center will offer or provide for the residents of the catchment area.

c. The standards to be followed by the center in determining whether and to what extent the persons seeking services from the center shall be considered to be able to pay the costs of the services.

d. The policies regarding availability of the services offered by the center to the residents of the catchment area as well as consumers residing outside the catchment area.

e. The requirements for preparation and submission to the division of annual audits, cost reports, program reports, performance measures, and other financial and service accountability information.

4. This section does not limit the authority of the board or the boards of supervisors of any county or group of counties to

continue to expend money to support operation of a center.

Sec. 21. NEW SECTION. **230A.104 Catchment areas.**

1. The division shall collaborate with affected counties in identifying community mental health center catchment areas in accordance with this section.

2. *a.* Unless the division has determined that exceptional circumstances exist, a catchment area shall be served by one community mental health center. The purpose of this general limitation is to clearly designate the center responsible and accountable for providing core mental health services to the target population in the catchment area and to protect the financial viability of the centers comprising the mental health services system in the state.

b. A formal review process shall be used in determining whether exceptional circumstances exist that justify designating more than one center to serve a catchment area. The criteria for the review process shall include but are not limited to a means of determining whether the catchment area can support more than one center.

c. Criteria shall be provided that would allow the designation of more than one center for all or a portion of a catchment area if designation or approval for more than one center was provided by the division as of October 1, 2010. The criteria shall require a determination that all such centers would be financially viable if designation is provided for all.

Sec. 22. NEW SECTION. **230A.105 Target population —— eligibility.**

1. The target population residing in a catchment area to be served by a community mental health center shall include but is not limited to all of the following:

a. Individuals of any age who are experiencing a mental health crisis.

b. Individuals of any age who have a mental health disorder.

c. Adults who have a serious mental illness or chronic mental illness.

d. Children and youth who are experiencing a serious emotional disturbance.

e. Individuals described in paragraph *"a"*, *"b"*, *"c"*, or *"d"* who have a co-occurring disorder, including but not limited to substance abuse, mental retardation, a developmental disability, brain injury, autism spectrum disorder, or another disability or special health care need.

2. Specific eligibility criteria for members of the target population shall be identified in administrative rules adopted by the commission. The eligibility criteria shall address both clinical and financial eligibility.

Sec. 23. NEW SECTION. **230A.106 Services offered.**

1. A community mental health center designated in accordance with this chapter shall offer core services and support addressing the basic mental health and safety needs of the target population and other residents of the catchment area served by the center and may offer other services and support. The core services shall be identified in administrative rules adopted by the commission for this purpose.

2. The initial core services identified shall include all of the following:

a. Outpatient services. Outpatient services shall consist of evaluation and treatment services provided on an ambulatory basis for the target population. Outpatient services include psychiatric evaluations, medication management, and individual, family, and group therapy. In addition, outpatient services shall include specialized outpatient services directed to the following segments of the target population: children, elderly, individuals who have serious and persistent mental illness, and residents of the service area who have been discharged from inpatient treatment at a mental health facility. Outpatient services shall provide elements of diagnosis, treatment, and appropriate follow-up. The provision of only screening and referral services does not constitute outpatient services.

b. Twenty-four-hour emergency services. Twenty-four-hour emergency services shall be provided through a system that provides access to a clinician and appropriate disposition with follow-up documentation of the emergency service provided. A patient shall have access to evaluation and stabilization services after normal business hours. The range of emergency services that shall be available to a patient may include but are not limited to direct contact with a clinician, medication evaluation, and hospitalization. The emergency services may be provided directly by the center or in collaboration or affiliation with other appropriately accredited providers.

c. Day treatment, partial hospitalization, or psychosocial rehabilitation services. Such services shall be provided as structured day programs in segments of less than twenty-four hours using a multidisciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services based on the needs of the patient. These services may be provided directly by the center or in collaboration or affiliation with other appropriately accredited providers.

d. Admission screening for voluntary patients. Admission screening services shall be available for patients considered for voluntary admission to a state mental health institute to determine the patient's appropriateness for admission.

e. Community support services. Community support services shall consist of support and treatment services focused on enhancing independent functioning and assisting persons in the target population who have a serious and persistent mental illness to live and work in their community setting, by reducing or managing mental illness symptoms and the associated functional disabilities that negatively impact such persons' community integration and stability.

f. Consultation services. Consultation services may include

provision of professional assistance and information about mental health and mental illness to individuals, service providers, or groups to increase such persons' effectiveness in carrying out their responsibilities for providing services. Consultations may be case-specific or program-specific.

g. Education services. Education services may include information and referral services regarding available resources and information and training concerning mental health, mental illness, availability of services and other support, the promotion of mental health, and the prevention of mental illness. Education services may be made available to individuals, groups, organizations, and the community in general.

3. A community mental health center shall be responsible for coordinating with associated services provided by other unaffiliated agencies to members of the target population in the catchment area and to integrate services in the community with services provided to the target population in residential or inpatient settings.

Sec. 24. NEW SECTION. **230A.107 Form of organization.**

1. Except as authorized in subsection 2, a community mental health center designated in accordance with this chapter shall be organized and administered as a nonprofit corporation.

2. A for-profit corporation, nonprofit corporation, or county hospital providing mental health services to county residents pursuant to a waiver approved under section 225C.7, subsection 3, Code 2011, as of October 1, 2010, may also be designated as a community mental health center.

Sec. 25. NEW SECTION. **230A.108 Administrative, diagnostic, and demographic information.**

Release of administrative and diagnostic information, as defined in section 228.1, and demographic information necessary for aggregated reporting to meet the data requirements established by the division, relating to an individual who receives services from a community mental health center, may be

made a condition of support of that center by the division.

Sec. 26. NEW SECTION. **230A.109 Funding —— legislative intent.**

1. It is the intent of the general assembly that public funding for community mental health centers designated in accordance with this chapter shall be provided as a combination of federal and state funding.

2. It is the intent of the general assembly that the state funding provided to centers be a sufficient amount for the core services and support addressing the basic mental health and safety needs of the residents of the catchment area served by each center to be provided regardless of individual ability to pay for the services and support.

3. While a community mental health center must comply with the core services requirements and other standards associated with designation, provision of services is subject to the availability of a payment source for the services.

Sec. 27. NEW SECTION. **230A.110 Standards.**

1. The division shall recommend and the commission shall adopt standards for designated community mental health centers and comprehensive community mental health programs, with the overall objective of ensuring that each center and each affiliate providing services under contract with a center furnishes high-quality mental health services within a framework of accountability to the community it serves. The standards adopted shall be in substantial conformity with the applicable behavioral health standards adopted by the joint commission, formerly known as the joint commission on accreditation of health care organizations, and other recognized national standards for evaluation of psychiatric facilities unless in the judgment of the division, with approval of the commission, there are sound reasons for departing from the standards.

2. When recommending standards under this section, the division shall designate an advisory committee representing

boards of directors and professional staff of designated community mental health centers to assist in the formulation or revision of standards. The membership of the advisory committee shall include representatives of professional and nonprofessional staff and other appropriate individuals.

3. The standards recommended under this section shall include requirements that each community mental health center designated under this chapter do all of the following:

a. Maintain and make available to the public a written statement of the services the center offers to residents of the catchment area being served. The center shall employ or contract for services with affiliates to employ staff who are appropriately credentialed or meet other qualifications in order to provide services.

b. If organized as a nonprofit corporation, be governed by a board of directors which adequately represents interested professions, consumers of the center's services, socioeconomic, cultural, and age groups, and various geographical areas in the catchment area served by the center. If organized as a for-profit corporation, the corporation's policy structure shall incorporate such representation.

c. Arrange for the financial condition and transactions of the community mental health center to be audited once each year by the auditor of state. However, in lieu of an audit by state accountants, the local governing body of a community mental health center organized under this chapter may contract with or employ certified public accountants to conduct the audit, pursuant to the applicable terms and conditions prescribed by sections 11.6 and 11.19 and audit format prescribed by the auditor of state. Copies of each audit shall be furnished by the accountant to the administrator of the division of mental health and disability services.

d. Comply with the accreditation standards applicable to the center.

Sec. 28. NEW SECTION. **230A.111 Review and evaluation.**

1. The review and evaluation of designated centers shall be performed through a formal accreditation review process as recommended by the division and approved by the commission. The accreditation process shall include all of the following:

a. Specific time intervals for full accreditation reviews based upon levels of accreditation.

b. Use of random or complaint-specific, on-site limited accreditation reviews in the interim between full accreditation reviews, as a quality review approach. The results of such reviews shall be presented to the commission.

c. Use of center accreditation self-assessment tools to gather data regarding quality of care and outcomes, whether used during full or limited reviews or at other times.

2. The accreditation process shall include but is not limited to addressing all of the following:

a. Measures to address centers that do not meet standards, including authority to revoke accreditation.

b. Measures to address noncompliant centers that do not develop a corrective action plan or fail to implement steps included in a corrective action plan accepted by the division.

c. Measures to appropriately recognize centers that successfully complete a corrective action plan.

d. Criteria to determine when a center's accreditation should be denied, revoked, suspended, or made provisional.

Sec. 29. REPEAL. Sections 230A.1 through 230A.18, Code 2011, are repealed.

Sec. 30. IMPLEMENTATION —— EFFECTIVE DATE.

1. Community mental health centers operating under the provisions of chapter 230A, Code 2011, and associated standards, rules, and other requirements as of June 30, 2012, may continue to operate under such requirements until the department of human services, division of mental health and disability services, and the mental health and disability services commission have completed the rules adoption process to implement the amendments to chapter 230A enacted by this

Act, identified catchment areas, and completed designations of centers.

2. The division and the commission shall complete the rules adoption process and other requirements addressed in subsection 1 on or before June 30, 2012.

3. Except for this section, which shall take effect July 1, 2011, this division of this Act takes effect July 1, 2012.

DIVISION VI

PERSONS WITH SUBSTANCE-RELATED DISORDERS AND PERSONS WITH MENTAL ILLNESS

Sec. 31. Section 125.1, subsection 1, Code 2011, is amended to read as follows:

1. That ~~substance abusers and persons suffering from chemical dependency~~ persons with substance-related disorders be afforded the opportunity to receive quality treatment and directed into rehabilitation services which will help them resume a socially acceptable and productive role in society.

Sec. 32. Section 125.2, subsection 2, Code 2011, is amended by striking the subsection.

Sec. 33. Section 125.2, subsection 5, Code 2011, is amended by striking the subsection and inserting in lieu thereof the following:

5. *"Substance-related disorder"* means a diagnosable substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the most current diagnostic and statistical manual of mental disorders published by the American psychiatric association that results in a functional impairment.

Sec. 34. Section 125.2, subsection 9, Code 2011, is amended to read as follows:

9. *"Facility"* means an institution, a detoxification center, or an installation providing care, maintenance and treatment for ~~substance abusers~~ persons with substance-related disorders licensed by the department under section 125.13, hospitals licensed under chapter 135B, or the state mental health

institutes designated by chapter 226.

Sec. 35. Section 125.2, subsections 13, 17, and 18, Code 2011, are amended by striking the subsections.

Sec. 36. Section 125.9, subsections 2 and 4, Code 2011, are amended to read as follows:

2. Make contracts necessary or incidental to the performance of the duties and the execution of the powers of the director, including contracts with public and private agencies, organizations and individuals to pay them for services rendered or furnished to ~~substance abusers, chronic substance abusers, or intoxicated persons~~ persons with substance-related disorders.

4. Coordinate the activities of the department and cooperate with substance abuse programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local or private agencies in this and other states for the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders and for the common advancement of substance abuse programs.

Sec. 37. Section 125.10, subsections 2, 3, 4, 5, 7, 8, 9, 11, 13, 15, and 17, Code 2011, are amended to read as follows:

2. Develop, encourage, and foster statewide, regional and local plans and programs for the prevention of substance ~~abuse~~ misuse and the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders in cooperation with public and private agencies, organizations and individuals, and provide technical assistance and consultation services for these purposes.

3. Coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in the prevention of substance abuse and the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders.

4. Cooperate with the department of human services and the Iowa department of public health in establishing and conducting programs to provide treatment for ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders.

5. Cooperate with the department of education, boards of education, schools, police departments, courts, and other public and private agencies, organizations, and individuals in establishing programs for the prevention of substance abuse and the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders, and in preparing relevant curriculum materials for use at all levels of school education.

7. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders, which program shall include the dissemination of information concerning the nature and effects of ~~chemical~~ substances.

8. Organize and implement, in cooperation with local treatment programs, training programs for all persons engaged in treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders.

9. Sponsor and implement research in cooperation with local treatment programs into the causes and nature of substance ~~abuse~~ misuse and treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders, and serve as a clearing house for information relating to substance abuse.

11. Develop and implement, with the counsel and approval of the board, the comprehensive plan for treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders in accordance with this chapter.

13. Utilize the support and assistance of interested persons in the community, particularly ~~recovered substance abusers and chronic substance abusers,~~ persons who are recovering from substance-related disorders to encourage ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders to voluntarily undergo treatment.

15. Encourage general hospitals and other appropriate health facilities to admit without discrimination ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders and to provide them with adequate and appropriate treatment. The director may negotiate and implement contracts with hospitals and other appropriate health facilities with adequate detoxification facilities.

17. Review all state health, welfare, education and treatment proposals to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to substance abuse, ~~substance abusers, chronic substance abusers, and intoxicated persons~~ and persons with substance-related disorders.

Sec. 38. Section 125.12, subsections 1 and 3, Code 2011, are amended to read as follows:

1. The board shall review the comprehensive substance abuse program implemented by the department for the treatment of ~~substance abusers, chronic substance abusers, intoxicated persons~~ persons with substance-related disorders~~,~~ and concerned family members. Subject to the review of the board, the director shall divide the state into appropriate regions for the conduct of the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to city and county lines, population concentrations, and existing substance abuse treatment services.

3. The director shall provide for adequate and appropriate treatment for ~~substance abusers, chronic substance abusers,~~

~~intoxicated persons~~ persons with substance-related disorders~~,~~ and concerned family members admitted under sections 125.33 and 125.34, or under section 125.75, 125.81, or 125.91. Treatment shall not be provided at a correctional institution except for inmates.

Sec. 39. Section 125.13, subsection 1, paragraph a, Code 2011, is amended to read as follows:

a. Except as provided in subsection 2, a person shall not maintain or conduct any chemical substitutes or antagonists program, residential program, or nonresidential outpatient program, the primary purpose of which is the treatment and rehabilitation of ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders without having first obtained a written license for the program from the department.

Sec. 40. Section 125.13, subsection 2, paragraphs a and c, Code 2011, are amended to read as follows:

a. A hospital providing care or treatment to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders licensed under chapter 135B which is accredited by the joint commission on the accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the American osteopathic association, or another recognized organization approved by the board. All survey reports from the accrediting or licensing body must be sent to the department.

c. Private institutions conducted by and for persons who adhere to the faith of any well recognized church or religious denomination for the purpose of providing care, treatment, counseling, or rehabilitation to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders and who rely solely on prayer or other spiritual means for healing in the practice of religion of such church or denomination.

Sec. 41. Section 125.15, Code 2011, is amended to read as follows:

125.15 Inspections.

The department may inspect the facilities and review the procedures utilized by any chemical substitutes or antagonists program, residential program, or nonresidential outpatient program that has as a primary purpose the treatment and rehabilitation of ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders, for the purpose of ensuring compliance with this chapter and the rules adopted pursuant to this chapter. The examination and review may include case record audits and interviews with staff and patients, consistent with the confidentiality safeguards of state and federal law.

Sec. 42. Section 125.32, unnumbered paragraph 1, Code 2011, is amended to read as follows:

The department shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, subject to chapter 17A, considering available treatment resources and facilities, for the purpose of early and effective treatment of ~~substance abusers, chronic substance abusers, intoxicated persons,~~ persons with substance-related disorders and concerned family members. In establishing the rules the department shall be guided by the following standards:

Sec. 43. Section 125.33, subsections 1, 3, and 4, Code 2011, are amended to read as follows:

1. A ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder may apply for voluntary treatment or rehabilitation services directly to a facility or to a licensed physician and surgeon or osteopathic physician and surgeon. If the proposed patient is a minor or an incompetent person, a parent, a legal guardian or other legal representative may make the application. The licensed physician and surgeon or osteopathic physician and surgeon or any employee or person acting under the direction or supervision of the physician and surgeon or osteopathic physician and surgeon, or the facility shall not report or

disclose the name of the person or the fact that treatment was requested or has been undertaken to any law enforcement officer or law enforcement agency; nor shall such information be admissible as evidence in any court, grand jury, or administrative proceeding unless authorized by the person seeking treatment. If the person seeking such treatment or rehabilitation is a minor who has personally made application for treatment, the fact that the minor sought treatment or rehabilitation or is receiving treatment or rehabilitation services shall not be reported or disclosed to the parents or legal guardian of such minor without the minor's consent, and the minor may give legal consent to receive such treatment and rehabilitation.

3. A ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder seeking treatment or rehabilitation and who is either addicted or dependent on a chemical substance may first be examined and evaluated by a licensed physician and surgeon or osteopathic physician and surgeon who may prescribe a proper course of treatment and medication, if needed. The licensed physician and surgeon or osteopathic physician and surgeon may further prescribe a course of treatment or rehabilitation and authorize another licensed physician and surgeon or osteopathic physician and surgeon or facility to provide the prescribed treatment or rehabilitation services. Treatment or rehabilitation services may be provided to a person individually or in a group. A facility providing or engaging in treatment or rehabilitation shall not report or disclose to a law enforcement officer or law enforcement agency the name of any person receiving or engaged in the treatment or rehabilitation; nor shall a person receiving or participating in treatment or rehabilitation report or disclose the name of any other person engaged in or receiving treatment or rehabilitation or that the program is in existence, to a law enforcement officer or law enforcement agency. Such information shall not be admitted in evidence in

any court, grand jury, or administrative proceeding. However, a person engaged in or receiving treatment or rehabilitation may authorize the disclosure of the person's name and individual participation.

4. If a patient receiving inpatient or residential care leaves a facility, the patient shall be encouraged to consent to appropriate outpatient or halfway house treatment. If it appears to the administrator in charge of the facility that the patient is a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder who requires help, the director may arrange for assistance in obtaining supportive services.

Sec. 44. Section 125.34, Code 2011, is amended to read as follows:

125.34 Treatment and services for ~~intoxicated persons and persons incapacitated by alcohol~~ persons with substance-related disorders due to intoxication and substance-induced incapacitation.

1. ~~An intoxicated~~ A person with a substance-related disorder due to intoxication or substance-induced incapacitation may come voluntarily to a facility for emergency treatment. A person who appears to be intoxicated or incapacitated by a ~~chemical~~ substance in a public place and in need of help may be taken to a facility by a peace officer under section 125.91. If the person refuses the proffered help, the person may be arrested and charged with intoxication under section 123.46, if applicable.

2. If no facility is readily available the person may be taken to an emergency medical service customarily used for incapacitated persons. The peace officer in detaining the person and in taking the person to a facility shall make every reasonable effort to protect the person's health and safety. In detaining the person the detaining officer may take reasonable steps for self-protection. Detaining a person under section 125.91 is not an arrest and no entry or other record

shall be made to indicate that the person who is detained has been arrested or charged with a crime.

3. A person who arrives at a facility and voluntarily submits to examination shall be examined by a licensed physician as soon as possible after the person arrives at the facility. The person may then be admitted as a patient or referred to another health facility. The referring facility shall arrange for transportation.

4. If a person is voluntarily admitted to a facility, the person's family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, the request shall be respected.

5. A peace officer who acts in compliance with this section is acting in the course of the officer's official duty and is not criminally or civilly liable therefor, unless such acts constitute willful malice or abuse.

6. If the physician in charge of the facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

7. A licensed physician and surgeon or osteopathic physician and surgeon, facility administrator, or an employee or a person acting as or on behalf of the facility administrator, is not criminally or civilly liable for acts in conformity with this chapter, unless the acts constitute willful malice or abuse.

Sec. 45. Section 125.43, Code 2011, is amended to read as follows:

125.43 Funding at mental health institutes.

Chapter 230 governs the determination of the costs and payment for treatment provided to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders in a mental health institute under the department of human services, except that the charges are not a lien on real estate owned

by persons legally liable for support of the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder and the daily per diem shall be billed at twenty-five percent. The superintendent of a state hospital shall total only those expenditures which can be attributed to the cost of providing inpatient treatment to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders for purposes of determining the daily per diem. Section 125.44 governs the determination of who is legally liable for the cost of care, maintenance, and treatment of a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder and of the amount for which the person is liable.

Sec. 46. Section 125.43A, Code 2011, is amended to read as follows:

125.43A Prescreening —— exception.

Except in cases of medical emergency or court-ordered admissions, a person shall be admitted to a state mental health institute for substance abuse treatment only after a preliminary intake and assessment by a department-licensed treatment facility or a hospital providing care or treatment for ~~substance abusers~~ persons with substance-related disorders licensed under chapter 135B and accredited by the joint commission on the accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the American osteopathic association, or another recognized organization approved by the board, or by a designee of a department-licensed treatment facility or a hospital other than a state mental health institute, which confirms that the admission is appropriate to the person's substance abuse service needs. A county board of supervisors may seek an admission of a patient to a state mental health institute who has not been confirmed for appropriate admission and the county shall be responsible for one hundred percent of the cost of treatment and services of the patient.

Sec. 47. Section 125.44, Code 2011, is amended to read as

follows:

125.44 Agreements with facilities — liability for costs.

The director may, consistent with the comprehensive substance abuse program, enter into written agreements with a facility as defined in section 125.2 to pay for one hundred percent of the cost of the care, maintenance, and treatment of ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders, except when section 125.43A applies. All payments for state patients shall be made in accordance with the limitations of this section. Such contracts shall be for a period of no more than one year.

The contract may be in the form and contain provisions as agreed upon by the parties. The contract shall provide that the facility shall admit and treat ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders regardless of where they have residence. If one payment for care, maintenance, and treatment is not made by the patient or those legally liable for the patient, the payment shall be made by the department directly to the facility. Payments shall be made each month and shall be based upon the rate of payment for services negotiated between the department and the contracting facility. If a facility projects a temporary cash flow deficit, the department may make cash advances at the beginning of each fiscal year to the facility. The repayment schedule for advances shall be part of the contract between the department and the facility. This section does not pertain to patients treated at the mental health institutes.

If the appropriation to the department is insufficient to meet the requirements of this section, the department shall request a transfer of funds and section 8.39 shall apply.

The ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is legally liable to the facility for the total amount of the cost of providing care, maintenance, and treatment for the ~~substance abuser or chronic~~

~~substance abuser~~ person with a substance-related disorder while a voluntary or committed patient in a facility. This section does not prohibit any individual from paying any portion of the cost of treatment.

The department is liable for the cost of care, treatment, and maintenance of ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders admitted to the facility voluntarily or pursuant to section 125.75, 125.81, or 125.91 or section 321J.3 or 124.409 only to those facilities that have a contract with the department under this section, only for the amount computed according to and within the limits of liability prescribed by this section, and only when the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is unable to pay the costs and there is no other person, firm, corporation, or insurance company bound to pay the costs.

The department's maximum liability for the costs of care, treatment, and maintenance of ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders in a contracting facility is limited to the total amount agreed upon by the parties and specified in the contract under this section.

Sec. 48. Section 125.46, Code 2011, is amended to read as follows:

125.46 County of residence determined.

The facility shall, when a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is admitted, or as soon thereafter as it receives the proper information, determine and enter upon its records the Iowa county of residence of the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder, or that the person resides in some other state or country, or that the person is unclassified with respect to residence.

Sec. 49. Section 125.75, unnumbered paragraph 1, Code 2011, is amended to read as follows:

Proceedings for the involuntary commitment or treatment of a ~~chronic substance abuser~~ person with a substance-related disorder to a facility may be commenced by the county attorney or an interested person by filing a verified application with the clerk of the district court of the county where the respondent is presently located or which is the respondent's place of residence. The clerk or the clerk's designee shall assist the applicant in completing the application. The application shall:

Sec. 50. Section 125.75, subsection 1, Code 2011, is amended to read as follows:

1. State the applicant's belief that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder.

Sec. 51. Section 125.80, subsections 3 and 4, Code 2011, are amended to read as follows:

3. If the report of a court-designated physician is to the effect that the respondent is not a ~~chronic substance abuser~~ person with a substance-related disorder, the court, without taking further action, may terminate the proceeding and dismiss the application on its own motion and without notice.

4. If the report of a court-designated physician is to the effect that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder, the court shall schedule a commitment hearing as soon as possible. The hearing shall be held not more than forty-eight hours after the report is filed, excluding Saturdays, Sundays, and holidays, unless an extension for good cause is requested by the respondent, or as soon thereafter as possible if the court considers that sufficient grounds exist for delaying the hearing.

Sec. 52. Section 125.81, subsection 1, Code 2011, is amended to read as follows:

1. If a person filing an application requests that a respondent be taken into immediate custody, and the court upon reviewing the application and accompanying documentation, finds

probable cause to believe that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is likely to injure the person or other persons if allowed to remain at liberty, the court may enter a written order directing that the respondent be taken into immediate custody by the sheriff, and be detained until the commitment hearing, which shall be held no more than five days after the date of the order, except that if the fifth day after the date of the order is a Saturday, Sunday, or a holiday, the hearing may be held on the next business day. The court may order the respondent detained for the period of time until the hearing is held, and no longer except as provided in section 125.88, in accordance with subsection 2, paragraph *"a"*, if possible, and if not, then in accordance with subsection 2, paragraph *"b"*, or, only if neither of these alternatives is available in accordance with subsection 2, paragraph *"c"*.

Sec. 53. Section 125.82, subsection 4, Code 2011, is amended to read as follows:

4. The respondent's welfare is paramount, and the hearing shall be tried as a civil matter and conducted in as informal a manner as is consistent with orderly procedure. Discovery as permitted under the Iowa rules of civil procedure is available to the respondent. The court shall receive all relevant and material evidence, but the court is not bound by the rules of evidence. A presumption in favor of the respondent exists, and the burden of evidence and support of the contentions made in the application shall be upon the person who filed the application. If upon completion of the hearing the court finds that the contention that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder has not been sustained by clear and convincing evidence, the court shall deny the application and terminate the proceeding.

Sec. 54. Section 125.83, Code 2011, is amended to read as follows:

125.83 Placement for evaluation.

If upon completion of the commitment hearing, the court finds that the contention that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder has been sustained by clear and convincing evidence, the court shall order the respondent placed at a facility or under the care of a suitable facility on an outpatient basis as expeditiously as possible for a complete evaluation and appropriate treatment. The court shall furnish to the facility at the time of admission or outpatient placement, a written statement of facts setting forth the evidence on which the finding is based. The administrator of the facility shall report to the court no more than fifteen days after the individual is admitted to or placed under the care of the facility, which shall include the chief medical officer's recommendation concerning substance abuse treatment. An extension of time may be granted for a period not to exceed seven days upon a showing of good cause. A copy of the report shall be sent to the respondent's attorney who may contest the need for an extension of time if one is requested. If the request is contested, the court shall make an inquiry as it deems appropriate and may either order the respondent released from the facility or grant extension of time for further evaluation. If the administrator fails to report to the court within fifteen days after the individual is admitted to the facility, and no extension of time has been requested, the administrator is guilty of contempt and shall be punished under chapter 665. The court shall order a rehearing on the application to determine whether the respondent should continue to be held at the facility.

Sec. 55. Section 125.83A, subsection 1, Code 2011, is amended to read as follows:

1. If upon completion of the commitment hearing, the court finds that the contention that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder has been sustained by clear and convincing evidence, and the

court is furnished evidence that the respondent is eligible for care and treatment in a facility operated by the United States department of veterans affairs or another agency of the United States government and that the facility is willing to receive the respondent, the court may so order. The respondent, when so placed in a facility operated by the United States department of veterans affairs or another agency of the United States government within or outside of this state, shall be subject to the rules of the United States department of veterans affairs or other agency, but shall not lose any procedural rights afforded the respondent by this chapter. The chief officer of the facility shall have, with respect to the respondent so placed, the same powers and duties as the chief medical officer of a hospital in this state would have in regard to submission of reports to the court, retention of custody, transfer, convalescent leave, or discharge. Jurisdiction is retained in the court to maintain surveillance of the respondent's treatment and care, and at any time to inquire into the respondent's condition and the need for continued care and custody.

Sec. 56. Section 125.84, subsections 2, 3, and 4, Code 2011, are amended to read as follows:

2. That the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is in need of full-time custody, care, and treatment in a facility, and is considered likely to benefit from treatment. If the report so states, the court shall enter an order which may require the respondent's continued placement and commitment to a facility for appropriate treatment.

3. That the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is in need of treatment, but does not require full-time placement in a facility. If the report so states, the report shall include the chief medical officer's recommendation for treatment of the respondent on an outpatient or other appropriate basis, and the court shall

enter an order which may direct the respondent to submit to the recommended treatment. The order shall provide that if the respondent fails or refuses to submit to treatment, as directed by the court's order, the court may order that the respondent be taken into immediate custody as provided by section 125.81 and, following notice and hearing held in accordance with the procedures of sections 125.77 and 125.82, may order the respondent treated as a patient requiring full-time custody, care, and treatment as provided in subsection 2, and may order the respondent involuntarily committed to a facility.

4. That the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is in need of treatment, but in the opinion of the chief medical officer is not responding to the treatment provided. If the report so states, the report shall include the facility administrator's recommendation for alternative placement, and the court shall enter an order which may direct the respondent's transfer to the recommended placement or to another placement after consultation with respondent's attorney and the facility administrator who made the report under this subsection.

Sec. 57. Section 125.91, subsections 1, 2, and 3, Code 2011, are amended to read as follows:

1. The procedure prescribed by this section shall only be used for ~~an intoxicated~~ a person with a substance-related disorder due to intoxication or substance-induced incapacitation who has threatened, attempted, or inflicted physical self-harm or harm on another, and is likely to inflict physical self-harm or harm on another unless immediately detained, or who is incapacitated by a ~~chemical~~ substance, if that person cannot be taken into immediate custody under sections 125.75 and 125.81 because immediate access to the court is not possible.

2. *a.* A peace officer who has reasonable grounds to believe that the circumstances described in subsection 1 are applicable may, without a warrant, take or cause that person to be taken

to the nearest available facility referred to in section 125.81, subsection 2, paragraph *"b"* or *"c"*. Such ~~an intoxicated or incapacitated~~ a person with a substance-related disorder due to intoxication or substance-induced incapacitation who also demonstrates a significant degree of distress or dysfunction may also be delivered to a facility by someone other than a peace officer upon a showing of reasonable grounds. Upon delivery of the person to a facility under this section, the examining physician may order treatment of the person, but only to the extent necessary to preserve the person's life or to appropriately control the person's behavior if the behavior is likely to result in physical injury to the person or others if allowed to continue. The peace officer or other person who delivered the person to the facility shall describe the circumstances of the matter to the examining physician. If the person is a peace officer, the peace officer may do so either in person or by written report. If the examining physician has reasonable grounds to believe that the circumstances in subsection 1 are applicable, the examining physician shall at once communicate with the nearest available magistrate as defined in section 801.4, subsection 10. The magistrate shall, based upon the circumstances described by the examining physician, give the examining physician oral instructions either directing that the person be released forthwith, or authorizing the person's detention in an appropriate facility. The magistrate may also give oral instructions and order that the detained person be transported to an appropriate facility.

b. If the magistrate orders that the person be detained, the magistrate shall, by the close of business on the next working day, file a written order with the clerk in the county where it is anticipated that an application may be filed under section 125.75. The order may be filed by facsimile if necessary. The order shall state the circumstances under which the person was taken into custody or otherwise brought to a facility and the grounds supporting the finding of probable

cause to believe that the person is a ~~chronic substance abuser~~ person with a substance-related disorder likely to result in physical injury to the person or others if not detained. The order shall confirm the oral order authorizing the person's detention including any order given to transport the person to an appropriate facility. The clerk shall provide a copy of that order to the ~~chief medical officer of the facility~~ attending physician, to which the person was originally taken, any subsequent facility to which the person was transported, and to any law enforcement department or ambulance service that transported the person pursuant to the magistrate's order.

3. The ~~chief medical officer of the facility~~ attending physician shall examine and may detain the person pursuant to the magistrate's order for a period not to exceed forty-eight hours from the time the order is dated, excluding Saturdays, Sundays, and holidays, unless the order is dismissed by a magistrate. The facility may provide treatment which is necessary to preserve the person's life or to appropriately control the person's behavior if the behavior is likely to result in physical injury to the person or others if allowed to continue or is otherwise deemed medically necessary by the ~~chief medical officer~~ attending physician, but shall not otherwise provide treatment to the person without the person's consent. The person shall be discharged from the facility and released from detention no later than the expiration of the forty-eight-hour period, unless an application for involuntary commitment is filed with the clerk pursuant to section 125.75. The detention of a person by the procedure in this section, and not in excess of the period of time prescribed by this section, shall not render the peace officer, attending physician, or facility detaining the person liable in a criminal or civil action for false arrest or false imprisonment if the peace officer, physician, or facility had reasonable grounds to believe that the circumstances described in subsection 1 were applicable.

Sec. 58. NEW SECTION. **125.95 Advocates — duties — compensation — state and county liability.**

1. *a.* In each county with a population of three hundred thousand or more inhabitants, the board of supervisors shall appoint an individual who has demonstrated by prior activities an informed concern for the welfare and rehabilitation of persons with substance-related disorders, and who is not an officer or employee of the department of public health nor of any agency or facility providing care or treatment to persons with substance-related disorders, to act as an advocate representing the interests of persons involuntarily committed by the court, in any matter relating to the persons' commitment for treatment under section 125.84 or 125.86. In each county with a population of under three hundred thousand inhabitants, the chief judge of the judicial district encompassing the county shall appoint the advocate.

b. The court or, if the advocate is appointed by the county board of supervisors, the board shall assign the advocate appointed from the person's county of legal settlement to represent the interests of the person. If a person has no county of legal settlement, the court or, if the advocate is appointed by the county board of supervisors, the board shall assign the advocate appointed from the county where the treatment facility is located to represent the interests of the person.

c. The advocate's responsibility with respect to any person shall begin at whatever time the attorney employed or appointed to represent that person as respondent in commitment proceedings, conducted under sections 125.75 to 125.83, reports to the court that the attorney's services are no longer required and requests the court's approval to withdraw as counsel for that person. However, if the person is found to be a person with a substance-related disorder at the commitment hearing, the attorney representing the person shall automatically be relieved of responsibility in the case and an

advocate shall be assigned to the person at the conclusion of the hearing unless the attorney indicates an intent to continue the attorney's services and the court so directs. If the court directs the attorney to remain on the case, the attorney shall assume all the duties of an advocate. The clerk shall furnish the advocate with a copy of the court's order approving the withdrawal and shall inform the person of the name of the person's advocate.

d. With regard to each person whose interests the advocate is required to represent pursuant to this section, the advocate's duties shall include all of the following:

(1) To review each report submitted pursuant to sections 125.84 and 125.86.

(2) If the advocate is not an attorney, to advise the court at any time it appears that the services of an attorney are required to properly safeguard the person's interests.

(3) To be readily accessible to communications from the person and to originate communications with the patient within five days of the person's commitment.

(4) To visit the person within fifteen days of the person's commitment and periodically thereafter.

(5) To communicate with medical personnel treating the person and to review the person's medical records pursuant to section 125.93.

(6) To file with the court quarterly reports, and additional reports as the advocate feels necessary or as required by the court, in a form prescribed by the court. The reports shall state what actions the advocate has taken with respect to each person and the amount of time spent.

2. The treatment facility to which a person is committed shall grant all reasonable requests of the advocate to visit the person, to communicate with medical personnel treating the person, and to review the person's medical records pursuant to section 125.93. An advocate shall not disseminate information from a person's medical records to any other person unless done

for official purposes in connection with the advocate's duties pursuant to this chapter or when required by law.

3. The court or, if the advocate is appointed by the county board of supervisors, the board shall prescribe reasonable compensation for the services of the advocate. The compensation shall be based upon the reports filed by the advocate with the court. The advocate's compensation shall be paid by the county in which the court is located, either on order of the court or, if the advocate is appointed by the county board of supervisors, on the direction of the board. If the advocate is appointed by the court, the advocate is an employee of the state for purposes of chapter 669. If the advocate is appointed by the county board of supervisors, the advocate is an employee of the county for purposes of chapter 670. If the person or another person who is legally liable for the person's support is not indigent, the board shall recover the costs of compensating the advocate from that other person. If that other person has an income level as determined pursuant to section 815.9 greater than one hundred percent but not more than one hundred fifty percent of the poverty guidelines, at least one hundred dollars of the advocate's compensation shall be recovered in the manner prescribed by the county board of supervisors. If that other person has an income level as determined pursuant to section 815.9 greater than one hundred fifty percent of the poverty guidelines, at least two hundred dollars of the advocate's compensation shall be recovered in substantially the same manner prescribed by the county board of supervisors as provided in section 815.9.

Sec. 59. Section 229.1, subsection 14, Code 2011, is amended by striking the subsection and inserting in lieu thereof the following:

14. *"Mental health professional"* means the same as defined in section 228.1.

Sec. 60. Section 229.1, subsection 16, Code 2011, is amended to read as follows:

16. *"Serious emotional injury"* is an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a licensed physician or other ~~qualified~~ mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.

Sec. 61. Section 229.10, subsection 1, paragraphs b and c, Code 2011, are amended to read as follows:

b. Any licensed physician conducting an examination pursuant to this section may consult with or request the participation in the examination of any ~~qualified~~ mental health professional, and may include with or attach to the written report of the examination any findings or observations by any ~~qualified~~ mental health professional who has been so consulted or has so participated in the examination.

c. If the respondent is not taken into custody under section 229.11, but the court is subsequently informed that the respondent has declined to be examined by the licensed physician or physicians pursuant to the court order, the court may order ~~such limited detention of~~ that the respondent ~~as is necessary~~ be detained for a period of not more than twenty-three hours to facilitate the examination of the respondent by the licensed physician or physicians or other mental health professionals. The detention period begins upon the respondent's admission. Except as otherwise provided, the court may also order that payment be made to the appropriate provider for services associated with the detention period under this paragraph.

Sec. 62. Section 229.12, subsection 3, paragraph b, Code 2011, is amended to read as follows:

b. The licensed physician or ~~qualified~~ mental health professional who examined the respondent shall be present at the hearing unless the court for good cause finds that the licensed physician's or ~~qualified~~ mental health professional's presence or testimony is not necessary. The applicant,

respondent, and the respondent's attorney may waive the presence or the telephonic appearance of the licensed physician or ~~qualified~~ mental health professional who examined the respondent and agree to submit as evidence the written report of the licensed physician or ~~qualified~~ mental health professional. The respondent's attorney shall inform the court if the respondent's attorney reasonably believes that the respondent, due to diminished capacity, cannot make an adequately considered waiver decision. *"Good cause"* for finding that the testimony of the licensed physician or ~~qualified~~ mental health professional who examined the respondent is not necessary may include but is not limited to such a waiver. If the court determines that the testimony of the licensed physician or ~~qualified~~ mental health professional is necessary, the court may allow the licensed physician or the ~~qualified~~ mental health professional to testify by telephone.

Sec. 63. Section 229.15, subsection 3, paragraph a, Code 2011, is amended to read as follows:

a. A psychiatric advanced registered nurse practitioner treating a patient previously hospitalized under this chapter may complete periodic reports pursuant to this section on the patient if the patient has been recommended for treatment on an outpatient or other appropriate basis pursuant to section 229.14, subsection 1, paragraph *"c"*~~, and if a psychiatrist licensed pursuant to chapter 148 personally evaluates the patient on at least an annual basis~~.

Sec. 64. Section 229.21, subsection 2, Code 2011, is amended to read as follows:

2. When an application for involuntary hospitalization under this chapter or an application for involuntary commitment or treatment of ~~chronic substance abusers~~ persons with substance-related disorders under sections 125.75 to 125.94 is filed with the clerk of the district court in any county for which a judicial hospitalization referee has been appointed, and no district judge, district associate judge, or magistrate

who is admitted to the practice of law in this state is accessible, the clerk shall immediately notify the referee in the manner required by section 229.7 or section 125.77. The referee shall discharge all of the duties imposed upon the court by sections 229.7 to 229.22 or sections 125.75 to 125.94 in the proceeding so initiated. Subject to the provisions of subsection 4, orders issued by a referee, in discharge of duties imposed under this section, shall have the same force and effect as if ordered by a district judge. However, any commitment to a facility regulated and operated under chapter 135C, shall be in accordance with section 135C.23.

Sec. 65. Section 229.21, subsection 3, paragraphs a and b, Code 2011, are amended to read as follows:

a. Any respondent with respect to whom the magistrate or judicial hospitalization referee has found the contention that the respondent is seriously mentally impaired or a ~~chronic substance abuser~~ person with a substance-related disorder sustained by clear and convincing evidence presented at a hearing held under section 229.12 or section 125.82, may appeal from the magistrate's or referee's finding to a judge of the district court by giving the clerk notice in writing, within ten days after the magistrate's or referee's finding is made, that an appeal is taken. The appeal may be signed by the respondent or by the respondent's next friend, guardian, or attorney.

b. An order of a magistrate or judicial hospitalization referee with a finding that the respondent is seriously mentally impaired or a ~~chronic substance abuser~~ person with a substance-related disorder shall include the following notice, located conspicuously on the face of the order:

NOTE: The respondent may appeal from this order to a judge of the district court by giving written notice of the appeal to the clerk of the district court within ten days after the date of this order. The appeal may be signed by the respondent or by the respondent's next friend, guardian, or attorney. For a

more complete description of the respondent's appeal rights, consult section 229.21 of the Code of Iowa or an attorney.

Sec. 66. Section 229.21, subsection 4, Code 2011, is amended to read as follows:

4. If the appellant is in custody under the jurisdiction of the district court at the time of service of the notice of appeal, the appellant shall be discharged from custody unless an order that the appellant be taken into immediate custody has previously been issued under section 229.11 or section 125.81, in which case the appellant shall be detained as provided in that section until the hospitalization or commitment hearing before the district judge. If the appellant is in the custody of a hospital or facility at the time of service of the notice of appeal, the appellant shall be discharged from custody pending disposition of the appeal unless the chief medical officer, not later than the end of the next secular day on which the office of the clerk is open and which follows service of the notice of appeal, files with the clerk a certification that in the chief medical officer's opinion the appellant is seriously mentally ill or a ~~substance abuser~~ person with a substance-related disorder. In that case, the appellant shall remain in custody of the hospital or facility until the hospitalization or commitment hearing before the district court.

Sec. 67. Section 230.15, unnumbered paragraph 2, Code 2011, is amended to read as follows:

A ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is legally liable for the total amount of the cost of providing care, maintenance, and treatment for the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder while a voluntary or committed patient. When a portion of the cost is paid by a county, the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is legally liable to the county for the amount paid. The ~~substance abuser or chronic~~

~~substance abuser~~ person with a substance-related disorder shall assign any claim for reimbursement under any contract of indemnity, by insurance or otherwise, providing for the ~~abuser's~~ person's care, maintenance, and treatment in a state hospital to the state. Any payments received by the state from or on behalf of a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder shall be in part credited to the county in proportion to the share of the costs paid by the county. Nothing in this section shall be construed to prevent a relative or other person from voluntarily paying the full actual cost or any portion of the care and treatment of any person with mental illness~~, substance abuser, or chronic substance abuser~~ or a substance-related disorder as established by the department of human services.

Sec. 68. Section 232.116, subsection 1, paragraph l, subparagraph (2), Code 2011, is amended to read as follows:

(2) The parent has a severe~~, chronic substance abuse problem,~~ substance-related disorder and presents a danger to self or others as evidenced by prior acts.

Sec. 69. Section 600A.8, subsection 8, paragraph a, Code 2011, is amended to read as follows:

a. The parent has been determined to be a ~~chronic substance abuser~~ person with a substance-related disorder as defined in section 125.2 and the parent has committed a second or subsequent domestic abuse assault pursuant to section 708.2A.

Sec. 70. Section 602.4201, subsection 3, paragraph h, Code 2011, is amended to read as follows:

h. Involuntary commitment or treatment of ~~substance abusers~~ persons with a substance-related disorders.

Sec. 71. CONFORMING PROVISIONS. The legislative services agency shall prepare a study bill for consideration by the committee on human resources of the senate and the house of representatives for the 2012 legislative session, providing any addition necessary conforming Code changes for implementation of the provisions of this division of this Act.

Sec. 72. EFFECTIVE DATE. This division of this Act takes effect July 1, 2012.

EXPLANATION

This bill relates to mental health and disability services and substance-related disorders and mental illness commitment proceedings and makes appropriations. The bill is organized into divisions.

SERVICES SYSTEM REDESIGN —— FUNDING. This division states legislative intent to redesign the services system for mental health, intellectual and other developmental disabilities, and brain injury over the next several years.

2011 Iowa Acts, Senate File 209, provides for the repeal of the statutory authority for significant elements of the county administered adult mental health and intellectual and other developmental disability services effective July 1, 2013.

The division states legislative intent to implement the redesign by having the department of human services assume responsibility for administering publicly funded mental health services for adults and children beginning on July 1, 2012.

The legislative council is requested to authorize a legislative interim committee during the 2011 legislative interim to develop a plan for the mental health services redesign for consideration by the general assembly in the 2012 legislative session. The plan is required to identify clear definitions and requirements for core services, outcomes that focus on consumer needs, and various other elements of the system.

The departments of human services and public health are required to develop and submit proposals relating to services addressing co-occurring mental health and substance abuse disorders and to address service provider shortages, including barriers to recruiting providers. The departments are required to submit the proposals to the governor and general assembly on or before December 15, 2011.

The legislative council is also requested to either

continue the 2011 legislative interim committee or authorize a different legislative interim committee to meet during the 2012 legislative interim to develop a redesign plan for the department of human services to assume responsibility for administration of intellectual and other developmental disabilities and brain injury services. The plan is to include elements similar to the plan for mental health services and is to be submitted for consideration and enactment in the 2013 legislative session.

A directive is provided for continuation of the judicial branch and department of human services workgroup which met during the 2010 legislative interim to improve the processes for involuntary commitment for substance abuse under Code chapter 125 and serious mental illness under Code chapter 229. Additional recommendation requirements are added along with a requirement to report by December 15, 2011.

The departments of human services and public health, and the community services affiliate of the Iowa state association of counties are required to agree on implementation of an integrated data and statistical information system for mental health, disability, and substance abuse services and report to the governor and representatives of the legislative branch by December 15, 2011.

New Code section 225C.7A, creates a new disability services system redesign savings fund to which savings resulting from implementation of services system efficiencies are to be credited. Moneys in the fund are required to be appropriated to implement services system improvements.

APPROPRIATIONS AND CONFORMING PROVISIONS. This division addresses conforming statutory provisions and provides appropriations.

The legislative services agency is required to prepare a study bill for the committees on human resources of the senate and house of representatives for the 2012 legislative session providing any conforming Code changes for implementation of the

sytem redesign provisions contained in the bill.

In 2011 Iowa Acts, Senate File 209, an appropriation was made from the general fund of the state for fiscal year 2010-2011 to the property tax relief to be distributed in accordance with a later enactment. The bill provides for the Senate File 209 appropriation to be credited to the risk pool within the property tax relief fund. The risk pool board is required to implement a distribution process that will ensure there is sufficient funding to eliminate the need for continuing, instituting, or reinstituting waiting lists for services covered under county service management plans through June 30, 2012.

An appropriation is provided to the department of human services for costs associated with implementation of the division.

The division takes effect upon enactment.

PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN. This division relates to psychiatric medical institutions for children (PMICs).

Code section 135H.3, relating to the nature of care provided, is amended to provide that the membership of the team of professionals utilized by a PMIC may include an advanced registered nurse practitioner.

Code section 135H.6, relating to conditions for issuance of a PMIC license, is amended to provide that the requirement for a certificate of need and the limitation on the number of beds statewide for PMICs does not apply to beds for children who do not reside in this state and whose service costs are not paid by public funds in this state.

Code section 249A.31, relating to cost-based reimbursement under the medical assistance (Medicaid) program, is amended to provide that effective July 1, 2012, Medicaid reimbursement for PMIC providers will be provided in accordance with the managed care contract for authorizing PMIC services.

The department of human services is required to issue a

request for proposals to procure a contractor to authorize, reimburse, and mange PMIC benefits under the Medicaid program. The department is prohibited from procuring the contract through a sole source or other limited selection process.

The department of human services is required to work with the department of inspections and appeals to develop a second level of PMIC care for children in need of more intensive treatment. Limitations on numbers of level 2 beds and providers are applicable.

MEDICATION THERAPY MANAGEMENT. This division relates to implementation of medication therapy management provisions under the Medicaid program in new Code section 249A.20B. The department of human services is required to implement the provisions through a request for proposals process to select a contractor beginning July 1, 2012.

Criteria for participation by individuals who take a number of prescription drugs, fees and reimbursement provisions, and definitions are included.

The division takes effect upon enactment.

COMMUNITY MENTAL HEALTH CENTERS. This division relates to the requirements of community mental health centers under Code chapter 230A and repeals and replaces Code chapter 230A which was originally enacted by 1974 Iowa Acts, chapter 1160.

The division maintains the requirements under current law for accreditation of community mental health centers to be performed by the department of human services (DHS), division of mental health and disability services, in accordance with standards adopted by the mental health and disability services commission. 2008 Iowa Acts, chapter 1187, required the division to utilize an advisory group to develop a proposal for revising Code chapter 230A and for revising the accreditation process for centers. Until the proposal has been considered and acted upon by the general assembly, the division administrator is authorized to defer consideration of requests for accreditation of a new community mental health center or

for approval of a provider to fill the role of a center. The proposal was submitted to the governor and general assembly April 17, 2009. The division provides for implementation of the proposal.

The current Code chapter provides for community mental health centers to either be directly established by a county or counties and administered by a board of trustees or by establishment of a nonprofit corporation operating on the basis of an agreement with a county or counties. Code section 225C.7 allows the department of human services to authorize the center services to be provided by an alternative provider.

The division of the bill replaces this approach by requiring the mental health and disability services division and commission to identify catchment areas of counties to be served by a center. The general requirement is for one center to be designated to serve a catchment area but more than one can be designated if exceptional circumstances outlined in the division are determined to exist.

New Code section 230A.101 describes the regulatory and policy role to be filled by the department and the service provider role of the community mental health centers.

New Code section 230A.102 provides definitions. These terms, defined in Code chapter 225C, are adopted by reference: "administrator" (administrator of MH and disability services division), "commission" (mental health and disability services commission), "department" (DHS), "disability services" (services and other support available to a person with mental illness, MR or other developmental disability or brain injury), and "division" (MH and disability services division). In addition, the terms "community mental health center" and "catchment area" are defined to reflect the contents of the division.

New Code section 230A.103 provides criteria to be implemented by the division for designation of at least one community mental health center to serve a catchment area

consisting of a county or counties. Various operating and services requirements are to be addressed in the terms of an agreement between the designated center, the division, and the counties comprising the catchment area.

New Code section 230A.104 provides for the division to implement objective criteria for identifying catchment areas for centers. A general limitation of one center per catchment area is stated, however, the criteria are to include a formal review process for use in determining whether exceptional circumstances exist for designating more than one center for a catchment area. The other stated criteria involve determinations of financial viability for a center to operate.

New Code section 230A.105 lists the characteristics of the target population required to be served by a center. The list includes individuals of any age experiencing a mental health crisis or disorder, adults who have a serious or chronic mental illness, children and youth experiencing a serious emotional disturbance, and listed individuals who also have a co-occurring disorder. The specific clinical and financial eligibility criteria are required to be identified in rules adopted by the commission.

New Code section 230A.106 requires each designated center to offer core services and support addressing the basic mental health and safety needs of the target population and other residents of the catchment area. The core services are to be identified in rules adopted by the commission.

An initial list of core services is specified to include the following: outpatient services; 24-hour emergency services; day treatment, partial hospitalization, or psychological rehabilitation services; admission screening for voluntary patients; community support services; consultation services; and education services.

In addition, a center is responsible for coordinating associated services provided by other unaffiliated agencies to members of the target population and for integrating services

provided to the target population in residential or inpatient settings.

New Code section 230A.107 requires a designated center to be organized as a nonprofit corporation. However, a for-profit corporation, nonprofit corporation, or county hospital providing services under a waiver approved as of October 1, 2010, may also be designated.

New Code section 230A.108 requires release of administrative, diagnostic, and demographic information as a condition of support by any of the counties in the catchment area served by a center. Language with a similar requirement is part of current law in Code section 230A.13, relating to annual budgets of centers.

New Code section 230A.109 states legislative intent regarding provision of federal and state funding supporting centers and for the amount of funding to be sufficient for core services to be provided regardless of an individual's ability to pay for the services. This section also states that provision of services is subject to the availability of payment sources for the services.

New Code section 230A.110 provides for accreditation standards for centers to be recommended by the division and adopted by the commission. The standards are to be in substantial conformity with certain national standards. The division is directed to use an advisory committee to assist in standards development. In addition, the standards recommended are required to include various organizational requirements.

New Code section 230A.111 addresses how the review and evaluation components of the accreditation process are to be performed.

An implementation section authorizes centers operating under current law as of June 30, 2012, to continue operating until the rules are adopted, catchment areas are identified, and centers are designated, as required by the division of the bill. The division and commission are required to complete

those requirements on or before June 30, 2012.

Except for the requirement for the division and commission to develop administrative rules, which takes effect July 1, 2011, the division takes effect July 1, 2012.

PERSONS WITH SUBSTANCE-RELATED DISORDERS AND PERSONS WITH MENTAL ILLNESS. This division makes various changes to Code chapters 125 (chemical substance abuse) and 229 (hospitalization of persons with mental illness).

Code chapter 125: The division replaces the terms "chemical dependency", "chronic substance abuser", and "substance abuser" in Code chapter 125 with the terms "substance-related disorder" or "person with a substance-related disorder", and makes conforming Code changes. A "substance-related disorder" is defined as a diagnosable substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the most current diagnostic and statistical manual of mental disorders published by the American psychiatric association that results in a functional impairment. The division also replaces the term "intoxicated person" with the term "a person with a substance-related disorder due to intoxication or substance-induced intoxication" and makes conforming Code changes.

The division provides that a peace officer who has reasonable grounds to believe that a person with a substance-related disorder due to intoxication or substance-induced incapacitation who has threatened or inflicted physical self-harm or harm on another person in an emergency situation who also demonstrates a significant degree or distress or dysfunction may be delivered to a facility by someone other than a peace officer upon a showing of reasonable grounds.

New Code section 125.95 provides for the appointment of an advocate to represent the interests of persons with substance-related disorders in any matter relating to the person's commitment for treatment, either by the county board

of supervisors or the chief judge of the appropriate judicial district. The advocate's duties include reviewing reports, visiting the person who has been committed, communicating with medical personnel treating the person, and filing reports with the court. The advocate shall receive reasonable compensation for the advocate's services.

Code chapter 229: The division replaces the term "qualified mental health professional" with the term "mental health professional", defined as an individual who holds at least a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, nursing, and social work, or the individual is a physician and surgeon or an osteopathic physician and surgeon, holds a current Iowa license if practicing in a field covered by an Iowa licensure law, and has at least two years of post-degree clinical experience, supervised by another mental health professional, in assessing mental health needs and problems and in providing appropriate mental health services. This definition is the same definition for a mental health professional contained in Code section 228.1 (disclosure of mental health and psychological information).

The division provides in Code section 229.10, relating to physician's examination and report, that a person who is the subject of an application for involuntary hospitalization who has declined to be examined pursuant to court order may be ordered by the court to be detained for not more than a 23-hour period to facilitate the examination. The court may also order that payment be made to the appropriate provider for services associated with the detention.

Code section 229.15, relating to periodic reports required by care providers, is amended to eliminate a requirement for patients receiving outpatient treatment from an advanced registered nurse practitioner to have an annual personal evaluation from a psychiatrist.

The division takes effect July 1, 2012.