Mental Health and Disability Services Redesign - Workgroup Recommendations

For Study Committee Discussion on Monday, December 19, 2011, 2:30-4 pm

Committee Members - These are workgroup recommendations submitted in October and reviewed by study Committee in November. DHS has accepted all of them except where indicated. The Study Committee Co-Chairpersons plan to also accept them unless committee discussion on December 19, indicates otherwise. Please indicate any item that you Oppose or Want More Discussion (no need to check the Accept box). Send to or call in to John Pollak, LSA, john.pollak@legis.state.ia.us or to your caucus staff person by Thursday afternoon, December 15, 2011.

Note: If you see DHS listed after a number, the Department expanded upon or modified the recommendation of the workgroup.

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
-Regional Workgroup-			
Regionalization Workgroup - Criteria for Formations of Regions			
1. The target population for regions should be in the range of 200,000 to 700,000 total people.			
2. Per SF 525: a. There must be the presence of or assured access to inpatient psychiatric bed capacity for the citizens of each region. b. There must be a state-certified Community Mental Health Center (CMHC) or a Federally Qualified Health Center (FQHC) that provides behavioral health services within each region. c. Regions must be comprised of contiguous counties.			
3. There must be no fewer than three counties per region.			
4. There is no upper limit on the number of counties that can be included in a region.			
5. There will be no specific criteria for minimum travel times or distances to administrative offices within a region.			
Regionalization Workgroup - Timeframe for Regional Formation & Implantation WORKGROUP REC			
6. January 2012 through June 30, 2013 – Regions voluntarily form.			
7. January 2012 through 2013 – The Department works with counties and nascent Regions to assist with Regional formation.			
8. July 1, 2013 – All Regions meet “formation” criteria and the “implementation” criteria by July 1, 2014.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
Regionalization - Timeframe for Regional Formation & Implantation DHS REC			
9. January 2012 Regions begin to voluntarily form and at this time technical assistance will be available for those requesting it.			
10. November 2012 DHS ensures all counties are part of a Region.			
11. January 2013 All Regions are formed and begin to organize.			
12. June 2013 Regions meet formation criteria.			
13. June 2014 Regions meet implementation criteria.			
Regionalization - Regional Governance			
14. Governing boards of counties would be comprised of one Supervisor (or their designees) from each of the counties included in a region.			
15. "One county-one vote" principle for the regional governing boards is to be adopted.			
16. DHS - The Department recommends that decisions related to use of tax dollars be made solely by elected officials, but flexibility be provided to the Regions to allow consumer/family and provider involvement in other decisions such as service development.			
17. Governing body for each region should have at least three consumer/family members on the board. The method of selection/appointment could be spelled out in each region's 28E agreement.			
18. DHS nor or other representatives of the state shall have a seat on the governing boards.			
19. Providers should have an active role in advising Regions in service system planning, implementation and quality improvement, but providers should not be included in the governing boards.			
20. The 28E agreements governing Regions could either support creation of a new organizational entity or could cement a regional consortium of participating counties.			
21. Adopt the definition of residency used by the MHDD Commission.			
22. DHS The Department supports the Regional Workgroup's definition of residency for persons who are not covered by Medicaid and would add the following clarifications: a. The Region where the person resides is financially responsible for the cost of non-Medicaid funded core services b. Where a person resides is where the person has an ongoing presence with the declared, good faith intention of remaining for an indefinite period. For persons who are homeless, residency means where they usually sleep.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
Regionalization Workgroup - Regional Financial Management			
23. WORKGROUP Regions should utilize a "single" checking account into which county levy funds would be deposited and from which they would be spent.			
24. DHS The Regional Workgroup discussed the concerns related to counties pooling their funds. The Department believes that there are adequate strategies to address this concern so that boards of supervisors may be confident that county levied funds are expended for individual county residents (i.e., "virtual" pooling whereby county funds are not actually intermingled).			
25. DHS - Regional Administrative Costs - DHS recommends that there be a definition of what is included in the legislatively proposed 5 percent administrative cap. Depending on the definition as well as what the 5 percent is based on, 5 percent may not be enough to perform all of the necessary administrative functions.			
Regionalization – Regions will be responsible for the following functions:			
26. Regional management and strategic planning			
27. Designation of access points			
28. Designation of targeted case management			
29. Designation of service management for non-Medicaid people/services			
30. Plan for core services			
31. Plan for systems of care			
32. Assure effective crisis prevention, response and resolution			
33. Provider network formation and management			
34. Provider reimbursement approaches for non fee-forservice modalities and for nontraditional systems of care providers			
35. Provider certification			
36. Grievances			
37. Appeals			
38. DHS - The Department recommends that consumers may appeal regional entities' decisions regarding eligibility for services, level of service or type of service provided. Appeals will be resolved through the Department's existing appeal process using the Department of Inspections and Appeals administrative law judges. The final decision will be made by the director of the Iowa Department of Human Services. Each Region must also be required to have a grievance process through which other disputes will be resolved.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
39. Quality management/quality improvement			
40. Assurance of payment of providers			
41. Funds accounting			
42. Financial forecasting			
43. Data collection and reporting			
44. Interagency and multi-systems collaboration and care coordination			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
-Adult Intellectual & Developmental Disabilities (ID-DD) Workgroup-			
Multi-Occurring Disabilities / Co-Occurring Disabilities			
1. Ensure that all components of the redesign (core services, outcomes, performance measures, provider standards and workforce development) are premised on the consideration of needs of people with multi-occurring conditions.			
Eligibility			
2. Standardize the eligibility process so tools and processes are streamlined.			
3. Expand the Intellectual Disabilities waiver to include individuals with developmental disabilities			
4. Consolidate waivers with overlapping target groups.			
5. Utilize a standardized assessment tool to evaluate support needs.			
6. Develop criteria that includes clinical/diagnostic variables as well as functional status for determination of DD eligibility.			
ID-DD - Core Services			
7. Consistent with Olmstead principles, services that expand and support community integration should be enhanced (e.g. supported community living, self-direction, transition services, supported employment). Recognizing that such expansion will take time, the current array of residential, day and vocational services should be continued.			
8. The ID-DD services system should transition to conflict-free case management.			
9. Best practice health and primary care services should be available in local communities.			
10. Best practice family support services should be provided to help families keep a member with a disability at home.			
11. With the expansion of the ID waiver to DD, explore whether services from other waivers may be appropriate to include (e.g. assistive technology).			
12. The following services should be added: o Crisis prevention and intervention o Behavioral intervention and positive behavior support services o Mental health outreach o Speech, occupational and physical therapies needed for habilitation			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
o Housing supports o Tele-health resources o Peer to peer support for self-advocates o Guardianship services with due process protections for individuals			
ID-DD - Outcome and Performance Measures			
13. Tie measurement to individual and family outcomes.			
14. Provider performance data should be aggregated, reported and public.			
15. Allocated staff to DHS to review and analyze all data.			
16. Create a Quality Improvement Committee.			
ID-DD - Provider Qualifications and Monitoring			
17. Consider the costs to providers in the development of quality monitoring efforts.			
18. Develop uniform, streamlined and statewide cost reporting standards/tools.			
19. Make quality monitoring information, including services, quality and location, easily available and understandable to all citizens.			
20. Establish regulations that are clearly understood and are accompanied by interpretive guidelines to support understanding by those responsible for applying the regulation.			
21. Develop a partnership with providers in order to improve the quality of services and develop mechanisms for the provision of technical assistance.			
22. Develop consistent data collection efforts based on statewide standards and make information available to all providers.			
23. Evaluate current provider qualification and monitoring efforts to identify duplication and gaps, and align with valued outcomes.			
24. Streamline and enhance current standards.			
25. Consider how accreditation fits in the certification of provider qualifications.			
ID-DD - Workforce Development			
26. Make College of Direct Support available at no charge to all ID-DD providers.			
27. Require every direct support professional demonstrate a level of competency in core curricula.			
28. Provide financial incentives for those providers that support staff to secure a voluntary certification from the National Alliance of Direct Support.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
29. Change current rate reimbursement formula to allow providers to bill such costs as a direct expense rather than an indirect cost.			
30. Have regional staff available to provide positive behavior supports training and to mount crisis intervention and prevention response modeled on IPART.			
31. Make technical assistance available to providers for issues such as crisis intervention, workshop conversion, etc.			
32. Implement co-occurring disability cross training for mental health professionals as well as training for primary care practitioners on ID-DD behavioral issues.			
-Adult Mental Health (MH) Workgroup-			
Multi-Occurring Disabilities / Co-Occurring Disabilities			
1. All core services should be capable of working effectively with people who have co-occurring disabilities and those with more specialized needs such as older adults.			
Adult MH – Eligibility			
2. Persons receiving adult mental health services must be at least 18 years of age, be a resident of Iowa and have had at any time during the past year a diagnosable mental, behavioral or emotional disorder that meets the diagnostic criteria specified within the DSM-IV with the exception of the "V" codes, substance abuse disorders and developmental disabilities, unless they co-occur with another diagnosable mental illness.			
3. DHS - The Department recommends adopting the workgroup recommendation for eligibility for adult mental health services above and adding dementia and antisocial personality disorder to the exceptions unless these conditions co-occur with another diagnosable mental illness.			
4. An individual must have an income of equal to or less than 150% of Federal Poverty Level (FPL). In 2014, pursuant to the implementation of Patient Protection and Affordable Care Act, expand eligibility to 200% FPL.			
5. Co-payment and sliding fee scales are acceptable as long as there is the ability for the provider to waive the co-pay and adjust the sliding fee depending on individual circumstances.			
6. The Department recommends that providers of non-Medicaid services be allowed to waive co-payments if the provider is able to fully absorb the cost.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
7. Adopt a standardized functional assessment tool.			
Adult MH - Core Services			
8. Core service domains should include acute care & crisis intervention services, recovery supports, mental health treatment, mental health prevention, community living, employment, family supports, health and primary care services, and justice involved services.			
9. The system should move toward the availability of statewide evidence-based practices within each core service domain.			
10. Peer run self-help centers should be a service resource.			
11. Crisis services including a 24/7/365 crisis hotline, mobile response, 23-hour crisis observation, evaluation, holding and stabilization and crisis residential should be available in each region.			
12. A range of sub-acute residential services should be available in each region as both a step-down and inpatient diversionary service.			
13. Each county within a region should have access to a jail diversion program such as a Crisis Intervention Team (CIT).			
14. Each region should have at least one Assertive Community Treatment (ACT) team that can serve both Medicaid and non-Medicaid eligible individuals.			
15. The Department of Human Services should blend community support, supportive community living, and case management services into a single service that provides recovery-oriented support.			
16. Each region should have at least one health home system.			
17. Each region should establish supported employment and supported education programs.			
18. Regions should create mechanisms for family support services.			
Adult MH - Outcome and Performance Measures			
19. Outcomes should be measured across core service domains.			
20. Establish an Outcome and Performances Committee.			
21. The Department concurs that accountability for the use of significant amount of taxpayer funds must be demonstrated by rigorous and meaningful consumer-centered quality of life performance outcome measures. Because of this, the Department will begin publishing preliminary performance outcome measures using currently available data by the end of FY 2012.			
22. Tie data collection to outcomes.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
23. The Department recommends that all data be submitted directly to the Department, whereupon the data will be shared with the Regions, providers, Legislature, and public.			
24. Ensure sufficient DHS staffing to monitor outcomes and system effectiveness.			
25. Create singular repository at the state level for all data that is shared.			
26. Connect Electronic Health Records to the Iowa Health Information Network currently under development.			
Adult MH - Provider Qualifications and Monitoring			
27. Department of Human Services (DHS), Department of Public Health (IDPH) and Department of Inspections and Appeals (DIA) should establish a process to streamline accreditation, certification and licensing standards.			
28. DHS and IDPH should continue efforts to reduce licensure and inspection requirements.			
29. DHS and DIA should jointly review the standards and inspection process for Residential Care Facilities.			
30. Increase the number of staff dedicated to provider oversight.			
Adult MH - Workforce Development			
31. Create a standing Mental Health and Disability Workforce Development Group.			
32. Develop a peer workforce.			
33. DHS - The Department recommends the following improved workforce practices be undertaken statewide: • Expand the use of peer provided services. • Increase and improve peer service training including supporting the Peer Support Academy that provides leadership training for peers who provide consumer services. • Expand the use of the nationally recognized College of Direct Supports that provides online training for ID-DD and mental health Direct Support Professionals and supervisors in a proven, competency based and cost effective manner.			
-Brain Injury (BI) Workgroup-			
BI Workgroup - Core Services - All services currently offered should continue:			
1. Neuro- Resource Facilitation (NRF). (IDPH)			
2. Iowa Brain Injury Resource Network (IBIRN). (IDPH)			
3. Community Based Neurobehavioral Rehabilitation services funded through state Medicaid dollars. (DHS)			
4. Medicaid Home and Community Based Services (HCBS) Brain Injury Waiver program and services. (DHS)			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
5. Post-Acute inpatient skilled nursing level of care and outpatient neurorehabilitation. (DHS)			
6. Medicaid-funded intensive neurobehavioral services at the hospital, nursing facilities (including SNF and ICFMR), and community based services, currently unavailable in Iowa to children and adults (PMIC). (DHS)			
7. Other Medicaid Plan Services applicable to Brain Injury, e.g., acute care, NF, etc. (DHS)			
8. Brain Injury Registry Outreach letter. (IDPH) Optimized Core Services			
BI Workgroup - Optimized Core Services			
9. Determine eligibility at the time of application for Medicaid Waiver funding based on fiscal, functional and diagnostic criteria and referral to Neuro-Resource Facilitation.			
10. Prescreen individuals for brain injury at all access points.			
11. Replace current assessment tools with standardized tool to assess cognitive, psychosocial and functional abilities and needs.			
12. Provide funding to eliminate waiting period for HCBS Brain Injury waiver.			
13. Increase availability of acute to home neurobehavioral services to reduce out of state placements (OSS) and bring people back to Iowa.			
14. Increase availability of post-acute neurorehabilitation services to reduce OSS placements and bring people back to home.			
BI Workgroup - Expanded Core Services			
15. Amend Iowa Code Chapter 135.22 Brain Injury Registry to align with the brain injury definition in IAC 441-83.81 and require the BI Registry notification in administrative rule.			
16. Improve time for receipt of outreach letters generated from the BI Registry			
17. Expand the scope of the Residential Care Facilities specialized in licensure to include BI			
18. Expand current NRF services and caseloads to align with national average and develop veteran specific services.			
19. Adopt conflict-free case management for BI services.			
20. Provide and increase funding for unfunded BI Service Program cost-share component at the IDPH.			
21. Rename Governor's Advisory Council on BI to Brain Injury Services Commission and expand scope to become BI state policy making body.			
BI Workgroup - New Core Services			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
22. Implement a standardized BI screening tool.			
23. Form and support an Iowa interagency, intergovernmental Brain Injury Coordinating 24. Committee.			
25. Review and revise funding mechanisms, rate structures, service definitions and reimbursement methodologies.			
26. Deploy BI competency training and education in existing and new crisis intervention programs and jail diversion programs.			
27. Deploy and expand tele-health services for BI and multi-occurring disorders.			
28. Develop a statewide, interdisciplinary BI consultation team to serve the regions.			
29. Deploy and expand services to engage survivors of BI and their families.			
30. Develop and deploy web-based, comprehensible BI resource information and services database/directory.			
31. Provide specialized BI training for direct service providers.			
32. Provide flexible and reliable transportation services.			
33. Deploy phone follow up service to individuals receiving BI Registry outreach letter.			
34. Develop acute inpatient hospital-based neurobehavioral treatment programs.			
35. Develop and deploy a follow-up outreach service for those served by the BI Injury Resource Network.			
-Judicial-DHS Workgroup-			
Judicial-DHS - Recommendations on the current provision of transportation by the county sheriff:			
1. Transportation should be provided for Court Committal process.			
2. Regions should designate a transportation coordinator.			
3. Revise reimbursement model to cover all costs.			
Judicial-DHS - Recommendations on civil commitment prescreens:			
4. Provide a provision in Chapter 229 that allows for a pre-commitment screening process prior to the initial filing.			
5. Pre-commitment screening services for involuntary commitments should be a core service.			
6. There should be a pre-commitment screening service, fulfilled by either the CMHC or designated facility contracted by the region, for involuntary commitments.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
Judicial-DHS - Recommendations on court authorization to order an involuntary hold of a patient under Chapter 229.10 for not more than 23 hours who was not initially taken into custody, but declined to be examined pursuant to a previous order			
7. Make a change in Chapter 229.22 to allow for the 48-hour hold to be available 24 hours a day. This would necessitate a change in section 602.6405, subsection 1, concerning limitations on non-lawyer magistrates.			
Judicial-DHS - Recommendations on revising requirements for mental health professionals involved in court committal process:			
8. Remove from Chapter 229 the title and definition of Qualified Mental Health Professional and any reference to it.			
9. Support the provision that only a physician is to examine the patient and provide a report to the court during committal process.			
10. Support the provisions that a Psychiatric Advanced Registered Nurse Practitioner may provide the annual report to the court for an outpatient committal.			
Judicial-DHS - Recommendations on the role, supervision and funding of mental health and substance-related disorder advocates:			
11. Amend section 229.19 to change legal settlement to residency.			
12. Implement statewide mental health advocates job description adopted by the Judicial Council.			
13. Single point of accountability, that is independent and autonomous, should be applied for all mental health advocates.			
14. Implement single point of accountability, such as the Child Advocacy Board, public defenders office or the Court Appointed Special Advocate Structure, that oversees policy, training, supervision, and audits of the advocate.			
15. Advocates should be appointed to individual cases based on where the individual resides or at the discretion of the state authority overseeing mental health advocates.			
16. The funding should be moved from the county to the state with consistent reimbursement standards developed.			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
17. An advocate may be assigned in cases of dual commitment (chapter 125 and 229).			
Judicial-DHS - Recommendations on implementation of jail diversion programs:			
18. Create a comprehensive jail diversion program that is a core service.			
19. Mandate specialty training for those such as law enforcement and corrections personnel similar to the Crisis Intervention Training (CIT) or Mental Health First Aid.			
20. Iowa should implement a Mental Health Court that includes both Diversion and Condition of Sentencing models.			
Judicial-DHS - Recommendations on comprehensive training of law enforcement in dealing with persons in crisis:			
21. Officers should receive additional training in mental health each three year period similar to that provided in CIT and Mental Health First Aid.			
22. Consumers should be part of officer training.			
Judicial-DHS - Recommendation on educating judicial magistrates and advocates on ways to enhance the consistency of services for individuals who are court ordered to a residential care facility:			
23. Placement to a residential care facility should occur only after notification and acceptance by the facility.			
-Children's Disability Workgroup-			
Recommendations			
1. Rollout new and expanded core services necessary to bring children and youth home from out of state treatment centers and provide alternative services to keep children and youth from leaving Iowa.			
2. Develop a children/youth Health Home model for service delivery.			
3. Develop a short-term strategy to bring children and youth back to Iowa through a managed care plan that uses the Health Home model.			
4. Institute a Systems of Care Framework for Children's Services in Iowa. Here is a summary definition: *A child and family driven, cross-system spectrum of effective, community-based services, supports, policies, and processes for children and youth, from birth – young adulthood, with or at risk for physical, emotional, behavioral, developmental and social challenges and their families that is organized into a flexible*			

Workgroup/Recommendation	Accept	Oppose	Want More Discussion
coordinated network of resources, builds meaningful partnerships with families, children and young adults, and addresses their cultural and linguistic needs, in order for them to optimally live, learn, work, and recreate in their communities, and throughout life.			
Core Services			
5. Implement intensive care coordination services.			
6. Implement family peer support services.			
7. Implement comprehensive crisis services.			
8. Enhance current intensive community-based treatment services.			
9. More flexibility in use of Psychiatric Medical Institute for Children.			
Outcome and Performance Measures			
1. Outcome and performance measures should measure what is meaningful to a child, youth or family member.			
2. Create a standard uniform measurement of outcome and performance.			
3. There should be a central repository for data collection and analysis that is shared across child and youth-serving systems.			
Psychiatric Medical Institution for Children (PMIC) Workgroup			
Implement a statutory or administrative requirement that providers participating in the Medicaid Program be required to contract with PMICs and to accept the Medicaid fee-for-service rates for providing care to children in PMICs. (submitted 12/9/11)			