



Mental Health and Disability Services Redesign 2011

Adult Mental Health Workgroup Minutes

Meeting #4

October 4, 2011, 10:00 am to 3:15 pm

Iowa State House, Room 115

Des Moines, IA

MINUTES

Attendance

Workgroup Members: Deb Albrecht, Jerry Bartruff, Teresa Bomhoff, Gilbert Cerveny, Becky Cleveland, Dr. Bhasker Dave, Lynn Ferrell, Dr. Michael Flaum, Chris Hoffman, Chuck Palmer, Patrick Schmitz, Kathy Stone

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Jack Hatch, State Senator, Senate District 33, (Polk County), Co-chairs of the Legislative Interim Committee on MHDS Redesign

Facilitator: Kevin Martone, Technical Assistance Collaborative (TAC)

DHS Staff: Theresa Armstrong, Nick Ford, Dennis Janssen, Jeanie Kerber, Laura Larkin

Other Attendees:

Jennifer Bauer	CANDEO
Jerry Burk	
Scott Caldwell	Lutheran Services of Iowa
Melissa Conley	Chatham Oaks, Iowa City
Vivian Davis	Chatham Oaks, Iowa City
Bob Emley	Grand View University
Kay Grotheo	AMOS MH/NAMI
Linda Hinton	ISAC
Sandi Hurtado-Peters	Iowa Department of Management
Todd Lange	Iowa Office of Consumer Affairs
Tony Leys	Des Moines Register
Michael Maher	Counseling Associates
Kelley Pennington	Magellan Health
Jessica Perry	Hillcrest Family Services/Peer Support Training Academy
Jenny Schulte	Advocacy Strategies

Deb Eckerman Slack	Iowa State Association of Counties/County Case Management
Kim Scorza	Seasons Center Karen Walters-Crammond, Polk County Health Services
Michelle Zuerlein	United States Psychiatric Rehabilitation Assn. (USPRA)

MEETING SUMMARY

Review of Regional Meetings regarding Mental Health and Disability System Redesign:

Director Palmer provided an update on the regional meetings being held around the state to provide additional opportunities for community input on the redesign process. A meeting was held in Sioux City on Sept. 30 that was attended by approximately 80 people. Two meetings were held in Ottumwa on Oct. 3. Rick Shults represented the Department at these meetings. A total of approximately 200 people attended the meetings. A meeting in Council Bluffs is scheduled for Oct. 7.

There has been a great deal of interest in the redesign and a lot of good input from the public. This input has paralleled what has been brought up in the work groups. Specific concerns that have been shared in the regional meetings include concerns from parents, families and consumers about legal settlement, anxiety about what the proposed changes will mean for individuals, identification of a need for jail diversion programs, strong support for peer support programs, concerns about funding of the new system, and questions about the value of regionalization. The Director shared that areas that are developing regional structures are seeing the potential benefits of collaboration as are their county supervisors.

Rep. Renee Schulte expressed her appreciation to the workgroup participants for their work and encouraged them to continue to work on development of specific recommendations for the Legislature to take action on.

Sen. Jack Hatch also thanked the workgroup for their efforts and stated that the Legislature plans on taking the workgroup recommendations and moving forward. All of the recommendations will be discussed and those that have a strong consensus will be moved forward in the legislative process. He is specifically interested in proposals that promote the integration of primary and behavioral health care, and improve coordination of services. Sen. Hatch stated that there have been some questions about consumer participation in the workgroup process. He expects consumers participating in the groups to speak up and also for the workgroup to keep the needs of the consumers in mind as they develop proposals.

Sen. Hatch shared the dates of the Legislative interim committee meetings. They are:

- Oct. 24 (topic: financing)
- Nov. 17 (topic: structure and core development of a statewide system that is regionally administered and locally delivered)
- Dec. 15 (topic: structure and core development of a statewide system that is regionally administered and locally delivered)

The Legislature will be looking at what the end product should be, health outcomes for adults and children, and better access to care. It is an aggressive timeline so now is the time to start making decisions.

Kevin Martone reviewed the briefing paper dated Oct. 4, 2011, Draft Summary of Recommendations. http://www.dhs.state.ia.us/docs/AdultMH_Briefing_Paper_10-03-2011.pdf

Kevin sat in on the regional workgroup meeting the previous week. The regional workgroup is working on developing a structure for a regional system. He feels that the workgroups are aligning. The regional group is asking about core services and how adult mental health services, adult intellectual and developmental disabilities, and children mental health and disability services work through the regions? Kevin states the children's disability workgroup is more focused on developing a system of care that is more individualized and family driven, while the adult mental health workgroup has been more focused on identification of a set of core services. It may be that a combination of both approaches would be optimal. Service needs would be developed through a person-centered planning process but there would be a set of core services available to meet individuals' needs.

Discussion of Section 1- Eligibility, Page 1 of the Draft Document:

Kevin reviewed the eligibility standards on page 1 and 2 of the document regarding age, residency, financial eligibility, and level of functioning.

Workgroup Comments:

- Concern about the financial eligibility guideline of 150% of poverty level as the income threshold. The workgroup had previously recommended that the income level be increased to 200% to be consistent with the substance abuse treatment system. Kevin recommended staying at 150% FPL as it is today due to uncertainty of the ability to fund services at the 200% level, especially if new services will be required to be implemented..
- There was continued concern about the inequity between the mental health and substance abuse systems.

- Rep. Schulte asked the group to keep in mind that a higher eligibility limit may limit amount of services available while a lower eligibility limit may allow for a wider range of services for a smaller group of eligible individuals.
- Question was asked, Do we know the financial implications of increasing to 200%? Kevin responded that this has not been developed.
- There is a concern that if we leave it at 150% now, it will never be increased.
- A concern was raised about if this would be “blanket” eligibility regardless of insurance status. Would a person with insurance not be responsible for their co-pays if financially eligible for assistance? The example was provided of an individual currently seeking service whose income is at 79% of poverty level, but is not eligible for county assistance due to having health insurance.
- A workgroup member was concerned about not receiving the briefing document until today. It seemed that there were pieces missing regarding issues previously discussed by the workgroup. There is a concern about the need for a sliding scale not being included, as well as people with insurance not being excluded from assistance. Kevin responded that the income eligibility level was changed but the other issues referenced were still present in the document.
- The concern was expressed that if the workgroup is intended to be a stamp of approval for what is presented, that is not the same as what was originally proposed. It was their understanding that the workgroup would be making proposals and recommendations. The eligibility issue was not on the agenda to be discussed today.
- Kevin responded that this document is being presented to the workgroup for review and refinement, and they would keep moving it to the next level each time.
- There was a concern about use of functional impairment scores to determine eligibility. The system should not exclude people who are doing well due to treatment but still need supports to help maintain progress. The group agreed this should be referenced in the report.
- Question regarding if the workgroup proposals have been compared to requirements of the Affordable Care? Will the proposed system be funding individuals at 134-200% of poverty level? Kevin stated that that has to be looked at over the course of the next two years in terms of what the benefit packages will consist of and the number of newly insured individuals.
- Sen. Hatch stated that we know what the Affordable Care Act says as it is law. We have to look at what we want to do as of July 1, 2013; then the second stage would be what happens when the ACA takes effect in 2014.
- A workgroup member stated that the perception of the workgroup’s charge was to describe the system they would like to see and not focus as much on the financing, that the workgroup could recommend and create common eligibility

standards and that it was the workgroup's prerogative to recommend the financial eligibility level, whether 150% or 200% of poverty level.

- Director Palmer responded that we are trying to glean what makes sense out of the recommendations, as they may be specific or may be parameters to develop further. There may need to be further small workgroups to more concretely identify such issues as outcomes. Eligibility issues are critical and fundamental, and the workgroup should weigh in and comment. DHS will try to get the data to look at the cost difference of funding services at the 150% vs. the 200% level, but the data is poor. There will be an ultimate financial limit that is available to the regions. There may be a tradeoff between who is eligible and the array of services available. The workgroup can recommend 200% as the eligibility guideline, but the region may run out of money at that level. There will be pressure on discretionary funding due to the economy in the next fiscal year. There may be pressure specifically on the state mental health budget. The workgroup may need to think through potential tradeoffs-such as would they prefer to have stronger jail diversion instead of other services.
- Question from the workgroup, What if the proposal went back to original language of equal to or less than 200%, and then review the cost data, and let the legislators decide what is fundable?
- Rep. Schulte responded that if you create a system that is not realistically able to be implemented then nothing will happen. There has to be a realistic plan that can be passed. The workgroup can also make alternate recommendations but if they pass too much on to the legislators the proposals may not get passed.
- Suggestion was made to recommend that financial eligibility stays at 150% in 2013 and then could increase to 200% in 2014 when ACA starts.
- Kevin stated that the system will not be created in one year, or by one piece of legislation. This process is setting the stage for ongoing change. We have to consider what services will be covered by Medicaid.
- Workgroup member comment: 150% of poverty level should be the minimum, but should be increased to 200% when possible, without a specified date.
- On the MHDS commission: the issue of counties lowering their eligibility to 150% when it has been higher has been considered. Counties say it is to be consistent with other counties in their areas. How should the workgroup figure this out, how do they get the right information to make an informed decision?
- Rep. Schulte stated that the Legislature has looked at how much costs are at different eligibility levels. LSA has some data but it hasn't been shared with the group. It can be shared at the next meeting.
- Director Palmer requested that Dr. Dave and Lynn Ferrell fashion a proposed recommendation regarding the financial eligibility guidelines, with eligibility set at 150% of FPL and if economically feasible, to eventually increase it to 200%. Director Palmer also stated that if the regional structure goes through, it should

have a state group with regional representatives that look at funding, eligibility, access to services, waiting lists, and other issues with the goal of refining and re-tooling the system continuously.

Kevin Discussed Page 2, Regarding Functional Assessment:

The subcommittee met two weeks ago. Initially the group thought that there should be a standardized functional assessment but then decided that for initial evaluation and diagnosis, the professional's clinical judgment should be sufficient. The group still saw a need for a standardized functional assessment for the following purposes:

1. A standardized tool could be used as authorization for certain services in order to ensure consistency of services between recommendations from the functional assessment and the services actually received. However, clinical judgment should still trump assessment results.
2. This could provide standardized data and outcomes information across the system.
3. It would allow analysis by region and also identified needs by region. Are regions buying the services that their assessments say that they need?
4. Aggregate data could be used to inform policy makers, and payers about the system.

Workgroup Comments:

- The system needs a standardized tool; LOCUS is a great tool that has been tested in many settings. It would reassure funders that the clinician's judgment is valid. Also supports the need to protect individuals from losing eligibility when they improve-use functional impairment for initial approval vs. ongoing eligibility for services.
- Recommendation to take functional assessment out of the eligibility process but use it to cross-check that appropriate services are provided and help determine what those are. The presence of a functional impairment is implied in the diagnosis, it does not need to be assessed for every individual. The system should use standardized functional assessments mainly when individuals are accessing a higher level of services.
- Concern expressed about a rush to identify a diagnosis to ensure eligibility. Could presence of a functional impairment also be an indicator for eligibility?
- The system attempts to be conservative in diagnosis. We don't want to label people as diagnosis doesn't tell the whole story. For a person to receive an accurate diagnosis, functional impairment does have to be present, so this could be OK.
- Question regarding how this compares to Medicaid. Can a person get services the same way? Does Medicaid require a diagnosis immediately?

- It's not that different from Medicaid. Through authorization process, the clinician reports the functional impairment information gathered from assessment.
- For clinical eligibility, the basis should be the presence of a functional impairment based on their disability. We don't want to prematurely diagnosis people, but there should be a significant impairment based on their disability to be eligible for services.

Lynn Ferrell and Dr. Dave presented their proposal for a recommendation on increasing the financial eligibility limit. As of 2014, savings from expansion of coverage under the Affordable Care Act shall be considered to expand the poverty level for financial eligibility for the mental health and disability service system.

Further Workgroup Comments on Financial Eligibility, Cost-Sharing/Co-Pays and Funding, Page 2:

- What about requiring cost-sharing or co-payments? Is it a "may" or a "shall"? The workgroup had agreed on shall but states "may" in the draft document. The MHDS commission currently has the power to approve these cost-sharing arrangements.
- The workgroup could propose leaving it at "may," but concerned about giving regions the option to have co-payments or other differences may promote disparities.
- The MHDS commission should have a workgroup that considers insurance, logistical and financial issues, such as how do CMHCs collect co-pays from clients who have no ability or willingness to pay?
- Recommendation from Kevin that the group could recommend a "shall" with a recommendation to the commission to operationalize it, with an understanding that people have to pay something toward their care.
- An individual contributing toward the cost of his/her care encourages buy-in to the services, but how do we cover the uncompensated care? One provider reports collection rates of 40-50% for substance abuse services.
- Director Palmer summarized that the consensus is "shall" with some exceptions.
- Kevin asked for any further comment on standardized tools. There is also a tool sanctioned by the National Council that Patrick Schmitz is familiar with. Patrick stated that he doesn't think group needs to recommend a specific tool but there should be some examination as to why the LOCUS has not been widely utilized in Iowa.
- North Carolina uses functional assessments to explain why people are in congregate settings and defend Olmstead decisions. LOCUS can be used to foster discussions among stakeholders. It can be a neutral assessment when there are conflicting expectations.

- It is important that a functional assessment be done by someone who knows the consumer well, not just an intake worker.
- Kevin also mentioned that he has spoken to Drs. Minkov and Cline last week regarding co-occurring disorders/complex needs. They have sent information but it is not ready to be distributed yet. It is anticipated that their information can assist with outcomes measures and also workforce recommendations.

Discussion of Section 2-Outcomes and Performance Measures, Page 3 of Draft Document:

Kevin suggested that an ongoing smaller workgroup be formed to define outcomes and performance measures. Kevin reviewed outcomes recommendations listed:

1. Outcomes for each of the domains: the group should also think about how workforce development relates to this.
2. How does the data gathered relate to identified outcomes?
3. There is discussion regarding whether data should come in to a single repository at the state level, but available to all parts of the system –the regions, Medicaid, and DHS.

Discussion of Section 3, Core Services, Page 5 of Draft Document:

Kevin asked if the group approved of the core service domains for each region. It is adapted from the SAMHSA Good and Modern service array, but has Iowa specific features.

- The goal is to ensure a continuum of services but not box people into a specified list when there is a need for flexibility for non-treatment services provided in a wraparound/system of care modality.
- What parameters do we put around services for a person, when a range of services are identified? At what point does a system say no, we won't pay for that, whether for financial or clinical reasons?

Workgroup Comments:

- If a service is not available in one area, but it is in another, do we reduce it for everyone?
- How does it work within Consumer Choice Options?
- How do we define the difference between a want and a need? We do need a review process or will get things funded that shouldn't be paid for publicly?
- The ID system uses a standardized assessment to identify services, identify a budget and then build the services. But the taxpayer may still look at it and say why I am paying for this?

- Linn County is dealing with a \$5 million dollar deficit. The county has to look at what they are funding, and why. How can we fund optional services if we can't buy basic services?
- We need to focus on the healthcare aspects of the services. Is it the responsibility of this workgroup to determine payment for quality of life needs?
- Optional services may reduce use of more expensive basis/core services such as a fishing license for an individual so they can participate in a healthy activity. Would Medicare/Medicaid pay for this?
- We should focus on basic services, not the optional.
- Kevin commented that it is correct that Medicaid won't pay for some those things, but the redesign process is bigger than just those issues. A wellness center is an example. It is critical for some people's recovery but may not be funded by Medicaid. The regions will have to figure this out, but we wouldn't want one region to refuse to pay while others will. Kevin recommended that there be parameters for reimbursement of services through the regions. These are listed on page 6 of the draft document and below:
 1. A person-centered planning process should be used to justify the need for particular services.
 2. The services should be recognized as having an evidence base to support them.
 3. Conversely, regions should move away from reimbursing services that do not have an evidence base or are not consistent with Olmstead principles.
- Should keep in mind treating the whole person and the need for recovery supports. What works for one person may not for the next.
- The group should define the process, more than the parameter and be more general than specific.
- Regarding items 2 and 3, a focus on EBP's may limit access to services. Many treatments are valid but without the evidence base. Suggestion to add to #3- "need to avoid services that evidence demonstrates a negative effect from."
- The workgroup may not be able to define limits on non-traditional services. The Access to Recovery (ATR) program through IDPH funds these types of services but it is very individualized.
- Kevin stated that the regions will have to develop strategic plans to carry out the recommendations, manage their budgets, and develop some type of authorization/utilization management process.
- IDPH figured out through the process of implementing ATR what was reasonable and fit within the guidelines and budget. It is difficult to define initially how much each service will cost.
- Suggestion to keep core services at the domain level. New services will come up and may not fit within the "list"-but be worthwhile. There is a need for flexibility to serve individuals and focus on achieving outcomes but a concern about allowing

language “should be available” being too loose. It could create or allow regional inequity.

- Medicaid has flexibility in Magellan to develop new services and pilot programs.
- Should the goal be equity in outcomes instead of equity in provision of services?
- Polk County has an individualized budget for each client-based on assessment of their needs. We might lose good outcomes if the system is too prescriptive. If we leave too much flexibility in the recommendations, it will allow counties/regions to not do the service because they don’t have to. Flexibility can go both ways.

Core Services and Programs Document Discussion:

Kevin clarified the differences between core services in column 2 and core program/services in column 3. Column 2 is the actual services that might be used while column 3 is the program that might deliver those services. The purpose is to help us think about what services are here and what needs to be here.

Director Palmer clarified that the core service domains in column 1 are a “shall.” Whether the core services are “mays” or “shalls” has not been decided.

Workgroup Comments:

- Core services should mean available in a region regardless of a provider.
- Services that shall be reimbursed based on a person-centered plan.
- It is good to give regions some flexibility but should every region have an ACT team? Should that be mandated or identify the services provided by an ACT team and then let the regions decide how to deliver it?

Kevin identified this as the difference between System of Care and Core Services approaches.

Director Palmer stated that there is a need to identify the core services: how to fund them across the regions, the availability of resources to fund mandated services, how long will it take to get to full implementation and what is the cost. We want regions to make decisions based on return on investment

Further Workgroup Comments on the Crisis Prevention and Intervention Domain on Page 1:

- We should think about core services as mandated services, an agreement with the identification of outpatient services as a core/mandated services.
- Agreement with list of services in column 3 but how should the group mandate what each region provides?

- Kevin's comment: programs in column 3 are "shalls." We want them in a system and then regions would have to demonstrate how they are going to provide it or facilitate access from another region.
- Should group be making a recommendation on columns 1 and 3 as the mandated/core services?
- There was a question about placement of longer term inpatient treatment in the crisis prevention and intervention domain. It also designates MHI's as the provider, when no other service has a provider identified. How does this affect those receiving RCF/ICF on a longer term basis, and does it belong in this domain?
- Kevin's response: core domains are mandated and the services in column 3 should also be mandated.
- What does mandated mean? Is it an entitlement? Does it mean a mandate for each activity under each service?
- Kevin's response: it means the service has to be available in the system and if the group thinks it should be a mandate, it needs to be defined and stated as such.
- What does Psychiatric Emergency Screening (PES) mean?
- Kevin: each region should have a PES program, this includes all the items underneath it on page 1, column 3 (24-hour hotline, mobile response, 23-hour crisis stabilization).
- There was a question about the term "respite" related to crisis services and question of where MHI's fit in the crisis array.
- Currently MHI's do provide acute care for commitments.
- Regarding respite: it is more of a planned service, not an emergency service. There was a suggestion that respite and crisis residential could be the same thing. Provide in the same place but possibly for different reasons.
- Director Palmer suggested that the group define the term and its use. In the ID system, the caretaker is the one receiving respite, not the consumer. Caretaker may also need respite in the mental health system.
- There was a question of moving MHI to longer term services domain. There was a suggestion to remove references to the MHI or any specific provider in the document. Also, local hospitals do provide long term care and treatment by default when there is no other place for a person to go.
- There was a suggestion to have acute inpatient only in this domain and any long term hospitalization elsewhere.
- Regarding ordering the services by level of intensity, the 24-hour "warm" line should be first in the array.
- Question from Kevin regarding approval of the warm line concept. It has an evidence base and can help divert individuals from higher intensity services. The group was in agreement with including it.

Discussion of Domain 2: Mental Health Treatment Services:

Workgroup Comments:

- Comments regarding identification of telepsychiatry as a service, Workgroup felt that it's a delivery system, not an actual service, and that it should not be mandated as not every region would need it. Suggestion to state that telepsychiatry will be commonplace across the region. Suggestion from Director Palmer to leave the "how" to the region, and the workgroup should define the "what".
- Should diagnosis and assessment be added as a service? Is day treatment an EBP? Does the group want clubhouse as a core service?
Kevin's response: he views Diagnosis and Assessment as a column 2 service- outpatient treatment is how you receive it.

Further Workgroup Comments:

- Partial hospitalization/day treatment doesn't work in rural areas. ACT teams work much better to reach the clients where they are at.
- There is a concern that we are creating boxes that will end up in legislation that we will be stuck with for years.
- Director Palmer's comment: we will need a continuous improvement process to keep adjusting and improving the system. We will need to keep readjusting the system. We may have pilots that are then replicated across the system.
- Kevin's comment: regarding the services identified in the briefing paper, there is a set of services that should be included in the system: peer delivered systems, crisis services, ACT, supported housing, and health homes. They should be included even if the group doesn't mandate specific services in Column 3.
- As soon as we put a list in code, we are stuck with it. The group can define the service domain, with definitions of the service, and then let the region provide the services that is appropriate. For example, respite has a different definition depending on which program is using it.
- The group wants to provide some flexibility but also specify certain modalities that must be present.
- Kevin's comment: the group should specify the EBPs and best practices, so we don't lose them.
- We need to make sure the basics are identified in code. Also, when new services are added, are they removing any services from the array? Are the providers willing to take on new services while still being expected to provide the existing services as well? If the funding is there for services, providers will hire staff and provide the services.
- Policy and funding may not go together.

- How does the transition happen between old system and services and new ones? As the regions are operationalized, they will have to do this in a coordinated fashion. It is important to support providers to continue providing services. We don't want them to lose existing providers.
- The workgroup returned to consideration of the briefing document recommendations. Peer delivered services, page 7: the workgroup had no objections to a requirement to have one self-help center in each region or other aspects of the section.

Crisis Services, Page 7:

Workgroup Comments:

- Should the civil commitment process be addressed here? Response was that the Judicial –DHS workgroup is working on this.
- Is that workgroup looking at changing the role of ARNP in the commitment process?
- They are considering who can sign commitment papers. Currently it is the doctor only, but then follow up can be by an ARNP.
- There is a concern regarding crisis residential services. Regions may be limited by current licensure requirements. This needs to be addressed if it is a mandate.
- Regarding statement on page 7 regarding facilitating civil commitments. Suggestion is that it should be “diverting individuals from civil commitment.” Judicial-DHS workgroup is looking at pre-commitment screening processes also.

Discussion of Sub-Acute Services, Page 8

- Discussion of Jail Diversion, page 8. Kevin clarified that a jail diversion program could be CIT or a formal jail diversion program.
- Suggestion was made that corrections and law enforcement should be part of this discussion.
- It shouldn't be the regions solely responsible for implementing this as law enforcement may not participate in a local area.
- Is it the program or is it the outcome that is required? Jail diversion programs or CIT as a method to achieve diversion?
- Law enforcement gets 4 hours of mental health training out of their 15 week training, although a significant part of their workload is mental health driven. The law enforcement academy is strengthening efforts to train officers, but CIT teams should be locally planned and driven.
- It is hard to do this on a city by city basis.
- The goal is to prescribe meaningful interaction between mental health and law enforcement. Does it need to be a specific program?
- The group should look at models already in Iowa.

- The group needs a definition of jail diversion.
- Suggestion to reference the sequential intercept model as a guide.
- There are local efforts on mental health/law enforcement programs but not coordinated statewide.
- Kevin asked the group if this should be a mandate for the region.
- Recommendation for partnerships between law enforcement and mental health either through the regions or statewide. There should be a partnership between each region as judicial districts have disparities also. It is important to use local champions in law enforcement as well as mental health to promote this.

Discussion of Supported Housing, Page 8:

Kevin identified this as a hybrid of supported housing and community support services (CSS). Asked the group to identify what guidelines or mandates they wanted for this service.

Workgroup Comments:

- There are challenges with CSS. Some counties don't pay for it if Medicare doesn't cover it. Right now it is primarily funded by the Iowa Plan. It needs to be mandated.
- There was a suggestion to fold case management and CSS together, and move away from the broker model.
- There could be a blend of case management, CSS, and supported community living (SCL). It would be more of a team model than a broker model. More could be served and more needs addressed.

For the next meeting, Kevin asked the group to think through the implications of blending the models.

Discussion of Health Homes, Page 9:

Kevin asked the group for input on what should be said about this in the recommendations. How do we define the care coordination function in the system in order to address high utilization of services by a small group of consumers?

Workgroup Comments:

- We will need to integrate primary care but not sure how. \Should the regions be responsible for assuring that clients served have a health home, either through the mental health or primary care system?
- The new pilots through Magellan for Integrated Health Homes should provide data/outcomes on how to provide this service. Whole health care is the direction

that we need to go in. A small percentage of users of Medicaid are high utilizers of service and funds. We need better coordinated, patient centered care in order to save money and improve care.

- We need primary care representatives, judicial, law enforcement, corrections as well as county supervisors on regional boards.
- Kevin commented that the field is moving toward coordinated care. Some individuals need more intensive levels of care coordination. It's important to ensure representation of all types of care, not just hospital driven.

Discussion of Supported Employment and Supported Education, Page 9:

Workgroup Comments:

- Can we shift away from pre-vocational services and sheltered workshop models while we move toward supported employment?
- Director Palmer noted this is a major topic of discussion in the ID workgroup. Some individuals want to maintain them.
- For individuals with mental illness, it is also being recommended for phase out. The mental health system is not as invested in it as the ID system.
- There might need to be a statement that says sheltered workshop is not a supported program.
- Rep. Schulte stated that we need statements that define what should go away, what stays and why.
- ACT is good but do we need to include other types of services that are similar. Some ACT teams don't comply with fidelity to the model. There should be guidelines on what does it mean to be an ACT team.
- Community support teams are a service similar to ACT but not as intensive.

Kevin asked the workgroup to identify any other services that the workgroup wants to recommend moving away from.

- The broker case management model should be considered as well as large congregate care facilities.
- Director Palmer stated that we will need to revisit the large RCF model of services. There are concerns about the levels of acuity and severity handled in these facilities, as well as the mix of populations in the facilities including age, mental illness, intellectual disability, and correctional placements co-mingled. The workgroup may not solve it but it will be put on the table.
- Kevin stated that overall, we want to try to serve people in their homes, in least restrictive settings, and use much smaller facilities. The workgroup has to define what will be paid for in the redesigned system, but may have to pay for both types of services (large facilities as well as community based) while moving from one to another. It is a huge challenge.

- Rep. Schulte stated that we pay for services in RCF and that drives people toward it, contrary to Olmstead. We need to reimburse for what we are trying to accomplish. The workgroup needs to consider the function of MHI's. Should that look different than it does now? It is not possible, politically to close them but with more resources in place could their function be changed?
- Director Palmer stated that we will add it to the agenda.
- Regarding locked versus unlocked facilities and difficult, unresponsive patients, where do they go? Should the RCF's and MHI's be geared to the most difficult patients?
- Director Palmer stated that closure of an MHI was considered and it didn't work. We need to fit the MHIs into the system being created. MHI is already a state resource, why not use it, and provide different levels of care? Look at what services are there and what is possible for the step down and sub-acute types of services.
- Kevin stated that the Olmstead workgroup is also working on this. It becomes a civil rights issue as well as a funding issue. The workgroup should be aware of federal court decisions regarding this.
- This idea deserves good thoughtful consideration. Some patients don't respond as quickly, and some patients end up at the MHI because nobody will take them in the community. There are people who are chronically acute in their illness. They don't need MHI services all the time, but no lower level is available.
- At Independence, children in the PMIC can move back and forth between acute and sub-acute levels of care as needed. Not all inpatient care is crisis driven. Workgroup member asked if this was going to be on the agenda.
- Comment on Family Support Services, Page 9: This is needed to support successful outcomes of the person.

Discussion of Chart on Comparison of Crisis Residential and Sub-acute Services:

- Could the purpose of crisis residential also be step-down services?
- Kevin stated yes, but it would be important not to fill the beds with people who are not in crisis.
- Could sub-acute be separated as provided for substance abuse or mental health, or recognized as providing a co-occurring service if capable of treating both? Substance Abuse residential facilities are currently providing a great deal of mental health services.
- Once we introduce the co-occurring statement, we need to make sure it is included across the array of services.
- For crisis residential, who makes the decision to allow admission? There will need to be controls regarding this.
- Sub-acute may have more entities referring to it than crisis residential.

- Regarding the recommended length of stay in crisis residential, there was a suggestion for it to be 30 days instead of 0-7 days. An individual may need longer to resolve their crisis or get connected to services.
- Suggestion to use language “expected mean length of stay” but people could stay longer if necessary.
- There is a concern about people moving from facility to facility due to time limits. There is also a concern about lack of availability of beds due to people staying longer than necessary.
- Kevin noted that cost is also a consideration. If a person stays longer in a least restrictive setting than they would have in an acute care setting, it will erase the cost savings.
- There is a concern about the time needed to recover from a psychotic break and ensuring people have adequate supports to do so.
- Kevin cautioned the group to be careful about reliance on a linear approach. The system should not be focused on movement from one level to another and assuming that step-down is always indicated. Ideally, a person would move from crisis residential services back to their home with community supports. There will also need to be a continued stay review. The payment source may end payment and placement if it does not appear necessary.
- Sub-acute care can serve both sides of the spectrum, both as a diversion from inpatient, and after inpatient to help the individual progress in their recovery. A person may not recover within the identified time frames.
- Regarding locked/unlocked status: crisis stabilization is for people who are in hospitals inappropriately, not for people who should be in hospitals so it is appropriate to be an unlocked facility. Sub-acute may need to be locked or unlocked due to the type of individuals who may access this.
- Kevin asked the group to keep in mind that people can receive intensive supports in the home, receipt of crisis services or sub-acute services. It is not dependent on going to a facility.
- Concern about the proposed maximum size of sub-acute, is 6 too small?
- Kevin responded that smaller size is best practice. Increasing it to 16 does not support better outcomes, and tends to be more noticeable in a community. Over 16, there is no possibility of Medicaid match to offset state/regional expenses.
- What about the medically fragile? Will sub-acute serve them?
- Kevin stated that nationally there are smaller facilities that serve individuals who have mental health needs and are medically fragile. The system would have to decide what type of staffing would be needed. This type of facility might bring in Medicaid not currently captured in the larger facilities.
- The locked vs. unlocked question was revisited as some individuals may require more security. Kevin replied that if a person doesn’t meet civil commitment criteria then they shouldn’t be in a locked facility. That is an Olmstead issue.

- A commitment could be transferred to another facility other than a locked one. People are committed to RCF's which are not locked.
- Kevin asked if the workgroup if it is necessary to add a non-inpatient locked facility to the system, and would this be consistent with Olmstead. . There should be sub-acute services that are more intense in acuity and staffing levels, but that residents may go off-site during the day for programming or services.. Kevin stated that some state hospitals have self-help centers on campus that individuals can come and go freely. Because a person is in a sub-acute level of care, doesn't mean they have to be in a locked facility.

Reimbursement:

Workgroup Comments:

- What does case rate mean for sub-acute reimbursement and will brief respite be available in sub-acute?
- Due to time constraints, service and service options were tabled until next session.

Final Workgroup Comments:

- Regarding core services, we need to make sure we repeal current mandates when adding these new ones.
- Regarding regions, if services are Medicaid funded and then Medicaid cuts back, is the region responsible for making up the difference?
- Is the region the payer or just the management entity?
- Regions should be required to keep waiting lists to show need for services.
- Rep. Schulte commented that Linn County now has a waiting list but now that providers are aware of it, they are not referring so the waiting list doesn't reflect the true situation.

Kevin asked that for homework before the next meeting the workgroup review the workforce development document. He reminded them that the next meeting is the last meeting and to think about a schedule for phasing in of the new system and what gets prioritized for initial implementation.

Director Palmer asked that the workgroup think about the process of giving input on the final reports as they are prepared. He also stated that this process is not going to be over when meetings end. We will need to consider what will continue regarding the workgroup process. The MHDS commission will have and increased role, the regions will be working together but in the short term, how do we continue involvement of the workgroups through the process?

PUBLIC COMMENT

Comment: Magellan staff Kelley Pennington provided clarification on questions raised during the meeting regarding Magellan services. Providers can evaluate without diagnosis. There are codes that allow them to bill for this. Magellan also uses up to 18% of funds for integrated services that are not traditionally Medicaid funded services, and 2 % for community reinvestment projects that promote emerging services. Kelley also reminded the group that the acute care task force examined sub-acute and crisis residential several years ago and there are several reports available on this. She stated that it would be confusing to have multiple hot lines and warm lines. Will there be a provider of last resort in each region for the difficult people who get stuck on the acute care units or don't have a place to return to.

Comment: The hard work of the group is appreciated. The concern is funding and how much goes toward mental health. DHS response: it is a small amount actually of the total system costs.

Comment: Concerned about amount of work to do and funding for services that don't exist right now like crisis residential. How will it be funded? Existing RCFs could play a role in provision of sub-acute services. The chart of proposed core services says RCF is not a core service because it's not consistent with supported employment. The individual doesn't agree with this. There are some people who are chronically mentally ill who do better in RCF's than in independent living. They have people who cycle through apartments, RCF and hospital because they cannot live independently. The workgroup is requested to consider RCF's and Department of Inspections and Appeals staff when developing rules and models.

Comment: Training and workforce issues are critical. All RCF's are not the same in terms of skill levels and training. The individual is in favor of smaller residential settings but these not any better than larger ones, if training is not improved. The core

services chart is confusing. Clubhouse and IPR are both treatment models and philosophies and things are getting confused in the model. The workgroup was requested to be careful of one-track models that focus on just one type of services.

Comment: Regarding supported employment eligibility criteria, if an individual is successful with supported employment, a person may surpass the income guidelines. It is important to allow regions to support people when successful. Are some services available regardless of income like peer centers? The importance of having continuous treatment teams and having multiple models available was stressed. Community support teams and community support services in Iowa are not the same as in other states and need to be defined.

Comment: Regarding person centered planning, the Money Follows the Person model is positive. There is a misconception that if we let the person in recovery handle their money, they will squander it. Peer support specialists help individuals develop personal responsibility. Regarding the comments about using funds to buy fishing poles or other recreational items, a fishing pole can be a recovery tool. It gets people out of their isolation. It promotes exercise and engagement in a productive activity. Encouraged the group not to be too limiting in what can be funded.

Comment: Evidence Based Practices are good but we shouldn't box ourselves in. Peer support services are new so evidence may not be there; however, peer support and the peer support training academy promote recovery.

Comment: There is a definition of jail diversion on the SAMHSA/GAINS website. Teresa Bomhoff handed out two one-page summaries on workforce development studies and Polk County consumer and administrative outcomes.

The next meeting will be held on Oct.18 at the Capitol building.

For more information:

Handouts and meeting information for each workgroup will be made available at:
<http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.