



Mental Health and Disability Services Redesign

Children's Disability Services Workgroup

Meeting #3
September 27, 2012, 10:00 am – 3:00 pm
Polk County River Place
2309 Euclid Avenue
Des Moines, IA 50310

MINUTES

ATTENDANCE

Workgroup Members: Jennifer Vermeer, Mark Peltan, Marilyn Althoff, Nicole Beaman, Paula Connolly, Deb Dixon, Jim Ernst, Jerry Foxhoven, Jason Haglund, Nick Juliano, Sheila Kobliska, Samuel Kuperman, Janice Lane, Kathy Nesteby, Jason Smith, David Stout, Debra Waldron

Legislative Representation: Senator Nancy Boettger, Representative Dave Heaton

Facilitator: Elizabeth 'Liz' Waetzig, Change Matrix

DHS/IME Staff: Director Charles Palmer, Joanna Schroeder, Laura Larkin, Pam Alger, Don Gookin, Jen Harbison, Sally Nadolsky, Carmen Davenport, Theresa Armstrong

Other Attendees:

Kelley Pennington	Magellan
Melissa Fitzgerald	Sequel Youth Services
Amanda Lynam	Sequel Youth Services
Judith Collins	INA/SOC
Rich Landis	Scott County SOC
Susan Osby	PCHS
Jane Schadle	IDPH
Rhonda (Boltz) Rairden	IDPH
John Pollock	LSA
Andy McGuire	Meridian Health Plan
Gaye Johnson	Child Serve
Kristie Oliver	Coalition for Family & Children Services
Amber DeSmet	LSA
Vickie Miene	CHSC/CCC
Cynthia Bishop	Eyerly Ball CMHC
Marilyn Austin	CPC

Jenny Schulte	LS2 Group
Sara Eide	Mercy Health Network
Kris Bell	SDC
Susan Fenton	LS2 Group
Sheila Hanson	CFDC
Danielle Oswald Thuls	CFPC
Jim Donoghue	IADE
Aaron Todd	LSA

WORKGROUP OVERVIEW

Jennifer Vermeer and Mark Peltan welcomed the workgroup, and asked for review and approval of the August 22, 2012, Meeting Minutes. The Meeting Minutes were approved with no changes.

Alyson Beytein, Laura Keehner, and Dr. Scott Lindgren presented on the Mercy Autism Center (MAC) Pilot Project in Dubuque. The Mercy Autism Center provides diagnostic, therapeutic and behavioral services to people with Autism Spectrum Disorders across the lifespan. Treatment, training and resources are available to individuals, families, caregivers, and health care professionals to promote the growth, independence and success of people with Autism Spectrum Disorders.

http://www.dhs.state.ia.us/uploads/AutismPilotProposal9-13_091812.pdf.

http://www.dhs.state.ia.us/uploads/AutismPilotProposalBudget9-13_091812.pdf

Mercy Autism Center uses a collaborative model with community agencies, such as school and therapists (OT, Speech, Behavioral), to gain the best outcomes for children/youth. The Mercy Autism Center has a variety of educational trainings to help families and caregivers of children/youth with autism. Training has three (3) components:

- Awareness Training - This increases awareness within the medical community and identifies the behaviors that lead to a diagnosis of autism. This training is aimed at decreasing negative behaviors.
- Family Navigator: In collaboration with the Child Health Specialty Clinics (CHSC), a family navigator helps families complete the paperwork and work through the process. This is time consuming, and often frustrating to families not familiar with public funded programs/services, such as HCBS waivers, respite, supported community living, etc.
- Applied Behavioral Analysis (ABA) Demonstration Site: This is an evidenced based methodology that focuses on behaviors/therapies that work. Children/youth learn developmental skills toward independence.

Mercy Autism Center has a collaborative relationship with the University of Iowa Hospitals and Clinics (UIHC). The UIHC reported the following:

- ABA does work, and has been integrated into preschool programs.
- Early intervention is the key to managing challenging behaviors.

- UIHC provides training to Mercy Autism Center and the UIHC Autism Center is available for consultation.
- A UIHC psychologist does clinical work and research in the area of functional behavioral analysis and this work is research based and effective.
- Assist in data collection.
- Secured grants to use telehealth for ABA training with parents.
- The main goal is to show how this service can make a difference for children/youth and their families. It can be replicated in other geographic areas of Iowa, and can be used in collaboration with the System of Care (SOC) model.

The following reflects the question/answer segment following the presentation.

- Who is the glue that keeps the collaboration going? MAC staff reported that there has to be community commitment. At the present time, there are no letters of agreement with the communities; rather, the community has agreed to be part of the team.
- Are other communities doing this? No. Insurance does not pay for treatment of autism. Treatment has to be ABA, and there are some agencies doing ABA components. The UIHC is working with the Iowa City Schools on ABA.
- MAC makes a difference in moving the child to as near normal as they can be. When behavior changes, there is an opportunity to get involved early to prevent crises as the child/youth ages. What is the return on the Medicaid investment? There is data from the last 20 years, including costs. The estimated cost over a lifetime is \$3-4 million. We can change the outcome for these children/youth.
- Where do you find ABA certified professionals? The current Iowa insurance law mandates that individuals be credentialed as a Board Certified Behavioral Analyst (BCBA). This credential requires higher levels of education and experience. There are efforts to get more training programs established. The Iowa Department of Education (DOE) trains teams to handle challenging behaviors, but children/youth still need professional help outside the school setting.
- What do you think is the most single strategy to keep other agencies involved? What is your vision for moving this forward in Iowa? The data and research will keep agencies involved. You cannot argue with the data. It will be important to get this type of program in small town Iowa.
- In looking at your proposal for funding, some collaborators seem to be missing as we look at overall systems of health. It is important that Early Access and others be involved. How many children/youth are served by this project and what is your return on the investment? ABA demonstration site is set up for 10 children/youth. Four (4) children/youth completed the program this summer.
- One has to be very careful to only focus on diagnosis. Children/youth need to be as independent as they possibly can.

Liz Waetzig began the discussion on System Components and parlayed it with the information from Mercy Autism Center staff. Workgroup members emphasized the following:

- There is a need for communities and agencies to partner. There is a sense of urgency to come together to meet the needs of children/youth.

- Project Launch has a local and statewide component. Iowa is doing well with Project Launch.
[http://www.dhs.state.ia.us/uploads/Project%20LaunchChildrensMentalHealthDocument\(2\)_091812.pdf](http://www.dhs.state.ia.us/uploads/Project%20LaunchChildrensMentalHealthDocument(2)_091812.pdf)
- Maryland has been working diligently in identifying services for children/youth. Workgroup member will get the article to the workgroup.

Specific System Components are as follows:

- Awareness
- Family Navigators
- Early Intervention
- Evidence Based Treatment Model
- Skill/Strategies in all Environments
- Crisis Prevention
- Crisis Intervention
- Evaluation of Models and other Systems
- Innovative Strategies to Increase Access
- Tenacity to Drive Collaboration and Maintain Involvement

Liz Waetzig summarized the vision for this workgroup and the SWOT analysis which focuses on what is in place and what is needed. During the previous workgroup meeting, Jennifer Vermeer drafted a graphic highlighting the Iowa System for Children, complete with a Governing Structure and local entities to support the children/youth and their family, such as services, agencies, school, etc.

http://www.dhs.state.ia.us/uploads/IowaSystemForChildrenChart_Ver2Sept24_100112.pdf

A critical question to address is what is the rationale for this system? Discussion followed with the following components being identified as necessary for the Iowa System for Children:

- Financial efficiency and responsibility.
- Work toward creating independent adults who are maximizing their independence with minimal support.
- Accessibility of services, which lead to more durable outcomes.
- Increase provider capacity for meaningful involvement.
- Holistic care across silos.
- Stability of program development and sustainability.
- Widespread adoption across Iowa.
- Common language.
- Increase early identification and intervention.
- Knowing and doing what works, and using resources effectively.
- Family driven and flexibility to use what is needed; avoid being prescriptive.
- Increasing diversity in Iowa.
- Way to measure fidelity.

Liz Waetzig identified this workgroup as the GPS for system change, and the workgroup was working on a couple of routes to the Iowa System for Children. The various systems need to work together. There is a learning process, and everyone comes to the table with varying perspectives. A variety of questions were raised in the discussion:

- What are the next steps? What do we have now? What is needed? What is the most important element to identify an entity as a System of Care? How do we spur development in the community? What is the Baseline? Do we identify Plan A and Plan B for the Legislature?
- There has to be a way to make referrals back to local providers. There has to be a mechanism that is a baseline.
- We know what we want. Do we focus on the Out of State children/youth and craft a system for them? Then have another focus to expand the system for Iowa children/youth? We do need to find a way to rollout the system across Iowa vs. in certain geographic areas.
- We need to think from an Economic Model standpoint. How can we be more efficient with the money we have? This will help to reduce costs with a population and then reinvest the money in the community for the children/youth. Saving will be realized in the long-term.
- How do Health Homes fit into the System of Care (SOC)?
 - SOC does a great deal of alliance building with various professionals involved with the child/youth and family.
 - SOC also supports the family to receive what they want and maintain a balance with what the system can provide.
 - SOC has different levels of care coordination based on the level of need for the child/youth and family.
 - SOC works with current agencies that are involved with the child/youth.
 - SOC is a medical model that is blended with the social service model.
- What kind of state governance or management would you recommend as an economic model?
- What does the reinvestment aspect look like?
- Plan for the most needs but have a thoughtful way to work its way down to include all children/youth.

Jennifer Vermeer shared that the Legislature has endorsed the Health Home concept and appropriated money for the state match. This is being written into the State Plan. This creates some building blocks for the Redesign, and a big opportunity to provide investment in the core infrastructure of the Redesign. Ms. Vermeer further reported that Medicaid does not pay for care coordination right now, but under Health Homes, Iowa Medicaid will pay 90 percent from federal funds and 10 percent from state funds for care coordination. CMS will only pay for one (1) case manager/coordinator to avoid a duplication of service.

Workgroup members continued to explore work around Health Homes, care coordinators, and how care coordination in a Health Home fits within the System of Care model. Discussion focused on care coordination through an Accountable Care

Organization (ACO) where accountability is tied to outcomes and provider reimbursements.

Care coordinators would be responsible for:

- Managing total care of the child/youth.
- Manage data/financial costs.
- Develop the framework of costs based on engaging with the family to set goals, identifying resources, and determining the lowest level of cost.
- Collaborates with other agencies (child welfare case manager and juvenile court officer would have legal case management of the child/youth).
- Cannot duplicate roles and need to make it consistent when children/youth enter and leave systems.
- Provides continuity to follow a child/youth as they go through different levels of care.
- Responsible for aftercare plan that is created with the child/youth and family.
- Engages in building alliances with other agencies.
- The levels of coordination are based on the level of need.

A Specialized Health Home would be responsible for:

- Defining an array of services for the child/youth and family.
- Having the flexibility to use telemedicine.
- Starting at an organizational level, and be sophisticated enough to have gained/achieved national accreditation.
- Having parameters around partnerships in the area.
- Having financial stability.
- Promoting geographic accessibility.
- Having a generalist with relationships and fidelity/standards to the model.
- Providing a continuum of care and follow-up.
- Contributing to the statewide understanding of need.

Jennifer Vermeer reported that children/youth with a Serious Emotional Disorder (SED) and certain functional deficits would be served in a Specialized Health Home. Other children/youth would be served in a Primary Health Home. The reimbursement for a Specialized Health Home would be higher than a Primary Health Home. Children/youth in a Specialized Health Home would transition to a Primary Health Home once the child/youth and family were stable. At this time there are approximately 8,000 Iowa children/youth with a SED based on data from Magellan.

Discussion followed with the following points:

- This model does not get to the early intervention/detection that is needed.
- Workgroup member wondered if this process could be more seamless with cost savings with an agency that has done a system redesign before. The larger the entity to manage it, the more they have the ability to manage the risk and contain costs. This cannot be underfunded.

- The children/youth will need a Primary Health Home based on developmental needs. It was suggested that the model be built and then have the available monies to fit the model.
- Workgroup member expressed that this concept will actually create another silo from a coordination point, and this is not as difficult as the workgroup might think it is.
- An ACO looks at the total cost of care. Iowa is trying to create a system that is parallel to an ACO.
- Who is accountable for the cost of care? The ACO or the Specialized Health Home?

Liz Waetzig referred to a graphic with several circles on it that overlap. The overlap represents the overlap of responsibilities by the entities. It was emphasized that Specialized Health Home is a temporary service.

The discussion then focused on how many Specialized Health Homes would be needed. Aspects to consider are:

- How are they spread out across Iowa? Can they be regionalized?
- Would it be based upon concentration of eligible population?
- The minimum number of cases for a Specialized Health Home to be viable depends on the structure.
- The more money upfront increases the number of children/youth and family that can be served.
- The System of Care (SOC) in northeast Iowa functions like a Specialized Health Home. The children/youth are stabilized and then transitioned back to their Primary Health Home.
- Specialized Health Homes seem to be split by diagnosis and specialties within specialties. It might be better to look at contractual agreements with specialty practices.

Liz Waetzig referred the workgroup to the SWOT list that was developed at an earlier workgroup meeting, and identified three (3) models to consider.

http://www.dhs.state.ia.us/uploads/ChildrenDisWkgrpDiscussionDRAFT9_27_2012_100112.pdf

- Formal - It would look like a Children's Cabinet, and would be sustained by Legislative order. It would also be of longer duration and would establish policy and fund services. This would take a top tier of major state systems, and share accountability across state departments.
- Semi-Formal - It would look like the Early Access Board that would have mandated and voluntary members. This board would recommend policy.
- Informal - This model is one where organizations choose to participate based on commitment rather than mandates.

Workgroup member discussion followed with the following comments/ideas:

- The best success and accountability would come from the formal level.
- The Iowa Collaboration for Youth Development (ICYD) is a possible place to begin in the development of a children's system. The work of the ICYD has a

narrower focus than the vision/charge of the workgroup but the basic tenets are in place. There is legislation that supports the efforts of this group.

- The ICYD does great work, but this workgroup's charge is larger in scope. The children's system needs to cover children/youth, 0-21.

A draft of the Iowa System for Children was shared with the workgroup. This graphic identifies the state departments as part of the governing structure and service supports under the Accountable Care Organization or Care Management Entity. This represents a more formal approach to system change and development.

http://www.dhs.state.ia.us/uploads/IowaSystemForChildrenChart_Ver2Sept24_100112.pdf

Next Steps:

- Workgroup members were asked to read/review the State Expansion document that was sent to them.
http://www.dhs.state.ia.us/uploads/SOC_ExpansionStudyReportFinal_091812.pdf
- Workgroup will review the minimum standards for a Specialized Health Home and Primary Health Home at the next meeting.

PUBLIC COMMENT

Comment:

It is important to look at behavioral health accreditation standards with the Redesign. It is equally important to look at incentivizing the system to move forward; this could be part of the development of outcome measures.

Comment:

Iowa's Project LAUNCH targets children ages birth through eight years old within a designated area in inner city Des Moines. Programs provided through Project LAUNCH focus on families in poverty and those from minority populations who are traditionally underserved. Funds are used to provide direct services to families and to build system infrastructure, thereby increasing the state's capacity to address children's physical, social, emotional, behavioral, and cognitive needs. This project uses evidenced based practices and is integrating behavioral health into primary care. Think about this project as recommendations are made regarding the Redesign.

**Next meeting: October 22, 2012 from 10:00 am to 3:00 pm at Polk County River Place, 2309 Euclid Avenue, Des Moines, IA 50310.

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 Redesign workgroups will be posted there