



# Mental Health and Disability Services Redesign 2011

## Intellectual & Developmental Disabilities Workgroup Minutes

Meeting #4

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

United Way Conference Center

1111 9<sup>th</sup> Street, Des Moines, IA

### MINUTES

#### Attendance

**Workgroup Members:** Jim Aberg, Ron Askland, Bob Bacon (Co-chair), Mary Dubert, Marsha Edington-Bott, Dawn Francis, Stephanie Gehlhaar, Jan Heidemann, Terry Johnson, Cindy Kaestner, Karalyn Kuhns (Chair), Roger Lusala, Mia Peterson, Susan Seehase, Dale Todd

**Legislative Representation:** Dave Heaton, State Representative, House District 91 (Henry County) and House Chair of the Health and Human Services Appropriations Subcommittee

**Facilitator:** Val Bradley, Human Services Research Institute (HRSI)

**DHS Staff:** Connie Fanselow, Jennifer Harbison, Deborah Johnson, Joanna Schroeder, Ken Tigges

#### Other Attendees:

David Adelman	IAFP/Cornerstone Government Affairs
Pam Alger	DHS, Targeted Case Management
Bob Bartles	Hope Haven
Ronda Bennett	Iowa Department of Inspections and Appeals
Jess Benson	Legislative Services Agency
Shelly Chandler	Iowa Association of Community Providers
Lonnie Cleland	Iowa Department of Public Health
Marcy Davis	Candeo
Steve Day	Technical Assistance Collaborative
Mardi Deluhery	Parent
Diane Diamond	DHS Targeted Case Management
Bob Emley	Grand View University
Kelly Espeland	IME Medical Services

Glenda Farrier	Cass Incorporated
Kyle Frette	Easter Seals Iowa
Zeke Furlong	Legislative Services Agency
Linda Hinton	Iowa State Association of Counties
Jeanie Kerber	DHS volunteer
Michelle Moore	Harmony House
Jim Nagel	Linn County
Sherri Nielsen	Easter Seals Iowa
Susie Osby	Polk County Health Services
Ann Riley	Center for Disabilities and Development
Hannah Roeder	Center for Disabilities and Development
Carol Saddoris	Discovery Living
Rik Shannon	Iowa DD Council
Heidi Smith	Lutheran Services in Iowa
Carol Warren	Progress Industries
Casey Westhoff	The Arc of Iowa
Dion Williams	Systems Unlimited

## Agenda

### Agenda Topics:

- Introductory Remarks and Overview of Agenda
- Review of results of Core Services discussion and responses to issues raised during last Workgroup meeting
- Review of summary of preliminary recommendations from first three ID Workgroup Meetings
- Best Practices and Trends in Workforce
- Group Discussion and Workforce key decision points
- Next Steps
- Meeting Summary
- Public Comment

### Meeting 4 Handouts:

- Meeting Agenda
- ID/DD Workgroup Core Services Recommendations
- Preliminary Recommendations of the Adult Intellectual Disabilities Redesign Workgroup
- Overview of Best Practices in Supporting and Maintaining a Competent and Committed Workforce
- Workforce Data in Iowa
- College of Direct Support Pilot Program in Iowa

### Additional Resources:

- Advocate and Consumer Recommendations
- County Core Services:  
[http://www.dhs.state.ia.us/docs/IDDD\\_CoreServicesPaper\\_10-07-2011.pdf](http://www.dhs.state.ia.us/docs/IDDD_CoreServicesPaper_10-07-2011.pdf)

## REVIEW OF PRIOR RECOMMENDATIONS:

Comments from Mary Dubert:

- After the last meeting I left with serious concerns about how case mgmt was being discussed for several reasons.
- Breaking assessment off and establishing a separate unit for that seems a clinically less effective way to establish need; seems less integrated.
- Relying too heavily on technology is also clinically questionable.
- The more interfaces you put in place and the more polarized they are the more opportunities you have for people to get lost in the system.
- It would be pragmatically difficult to completely dismantle the Iowa system case management system in the short run.
- Not sure what the vision is for case management is – regulations are the same but implementation varies.

Group Discussion:

- Past systems tended to silo mental health and developmental disability services.
- This is a unique opportunity to do it differently.
- Really have to look at the potential additional federal money for conflict free case management under the Balancing Incentive Program (Affordable Health Care Act).
- There are probably now only seven or eight states that still allow case management to be provided by entities that also are service providers.
- What is conflict free case management? CMS has put out a bulletin that begins to lay out the principles.
- Is case management provided by the state (the funder) a conflict?
- Make it independent of people who provide the services.
- How are we going to fund case management within the regions?

Review of Preliminary Recommendations Draft:

Eligibility, assessment, and resource allocation:

- Standardized assessment tool that might be linked to resource allocation.
- Need to explore use of Supports Intensity Scale (SIS).
- Need for trained people doing assessments.
- Process should be standardized statewide.
- Should be done through the regions.
- Look at the overlap of SIS and current case management assessment which is quite lengthy itself.
- Streamline process.
- “Master” case managers who are trained to conduct the SIS.
- Look at utilization vs. authorization ratio.
- Making allowances for needs outside the ordinary established range.
- Resources should not be allocated randomly.

- Resources should be allocated equitably and rationally.
- Eligibility determination process should be standardized to the extent possible.
- Move to a DD definition.
- Consider consolidation of waivers (ID, Ill & Handicapped, potentially BI?) with level of care criteria.
- Opening up current waiver program to people with DD who do not have ID.
- We approach services to people with BI differently depending on whether the injury occurs before (DD) or after age 22.
- Could structure the entry to the BI waiver to be age neutral.
- Current BI Waiver has one cap, which takes into account all the individuals served and weighs the costs of the ICF (Intermediate Care Facility) and NF (Nursing Facility) levels of care to maintain cost neutrality.
- In other waivers there is a dollar amount attached to each different level of care.
- Functional test and clinical identification for DD.
- Transitions – understand what is working and what isn't.
- Concentrate on developing capacity and infrastructure.

#### Outcome Measurement:

- Aligning services with desired outcomes.
- Build and maintain capability for expansion of performance data collection.
- Develop regional quality assurance functions.
- Make quality review information available to the public.
- DHS quality improvement committee to look at data across processes.
- Develop standardized and consistent family and individual satisfaction surveys.
- Start with Iowa participation survey.
- Begin to aggregate information and identify trends.
- Staff and Information Technology (IT) resources.

#### Core services:

- All services currently offered as ID waiver services
- Recommend adding:
  - Crisis prevention and intervention
  - Behavioral Intervention and Positive Behavior Support Services
  - Mental Health Outreach
  - Services for treatment of co-occurring disabilities or conditions
  - Speech, Occupational and Physical Therapies needed for habilitation
  - Supports for finding and funding housing
  - Tele-health capabilities
  - Peer to peer support
- Olmstead-focused, “community first” goals and outcomes
- Services that expand and support community integration
- Thoughtful phase-down of institutionally based services
- Case management should be conflict-free and include:
  - Waiver eligibility determination and annual level of care redetermination process
  - Independent assessment of individual needs

- Ongoing monitoring of service delivery
- Identification of risk and planning to mitigate risk
- Consumer directed service planning
- Ability to access and navigate state and local resources
- Employment services including job development and supported employment
- Pre-vocational should be time limited and focused on an employment related goal
- Sheltered work services should remain in place for now with plans for gradual transition to more integrated employment services

#### Group Discussion:

#### Pre-vocational

- Concern for retaining pre-vocational services to provide people with more severe disabilities the opportunity to prepare for employment.
- It may take more than a year or even two or three for some people to be ready for more integration.
- Should be time limited, but limits should be flexible and responsive to the needs of the individual. \*Note: Time limiting pre-vocational services might not align with the new CMS interpretations.
  - States need to be careful about time limiting services.
  - Using person-centered practices, the team should be looking at what is an appropriate length of time, not having it arbitrarily limited by the state.
  - “Time limited” will be clarified to reflect the concern that pre-vocational services cannot be viewed as the goal or final step, but a part of the employment process.
- Don’t want to leave people with the most severe disabilities behind.
- Make sure that appropriate reviews are done and that the service continues to be appropriate on a case by case basis.

#### Guardianship

- Suggestion to add guardianship services to core list.
- Either establish an office of public guardianship or provide funding for assisting people in obtaining guardianship.
- Explore other models?

#### Systems issues

- Need to look at the difference between Medicaid and non-Medicaid services.
- Need to make it one system so there is no shifting of responsibility between state, county, or region.
- Have to look at the issue of serving the people who are more difficult to serve.
- How do we develop the necessary resources?
- Crisis intervention services cannot be adequate without appropriate resources to support the person in stabilizing and returning to their home setting.

## **OVERVIEW OF BEST PRACTICES IN SUPPORTING AND MAINTAINING A COMPETENT AND COMMITTED WORKFORCE**

#### Workforce Challenges:

- There are not enough direct support professionals to meet the growing demand.

- There has been a demographic shift to more individuals 65 and older and the number is climbing.
- Number of females ages 25 to 44, who comprise the primary population of caregivers, is staying level.
- Those factors create a “care gap” in the U.S.

#### Changes in Expectations for Direct Support Professionals (DSP):

- Roles are changing.
- More people are living in smaller community settings and receiving individualized supports.
- DSPs are increasingly isolated from a chain of command.
- Need to rely more on their own knowledge and skills to solve problems and manage situations.
- Increased expectations of DSPs to provide skilled support such as crisis management.
- Have more contact with families, which also requires skills in dealing with cultural competence issues.

#### What We Know About Turnover:

- The U.S. average turnover rate is about 50%.
- Factors include wages, benefits, supervision, and conflict with co-workers.
- There is a significant turnover range across and within organizations.
- Turnover is substantially higher in residential and in home services than in day services.
- We do not have good data:
  - Inconsistent methodologies have been used
  - Difficult to determine who and how to count

#### Turnover is Expensive:

- Cost of a new hire is about \$2,800 to \$3,500.
- There are about 850,000 DSPs in the U.S.
- For U.S. residential DD services alone, the total cost based on these and other factors is about \$1.2 million.

#### Hidden Costs of Turnover:

- When turnover is at 50%, supervisors spend about 18% of their time with new or exiting employees.
  - 12% of time training new staff
  - 4% of time recruiting and hiring staff
  - 2% of time on separations and terminations

#### Wages and Benefits:

- Low wages; around \$8.50/hour.
- A family of four earning that lives below the poverty line.
- Most positions don't have benefits.

- When benefits are offered, the cost to the employee often prevents them from utilizing the benefits.
- A person earning \$10/hour makes \$400/week and the average out of pocket insurance premium for family coverage is \$300.

#### Wages Matter:

- Wyoming 2002 Wage Initiative showed:
  - As starting wage, average wage, and total compensation increased, the turnover rate dropped from 52% to 37%.

#### What We Know:

- Staff are more likely to stay if:
  - They hear about the job from someone within the organization.
  - They have a realistic preview of the job and the people they will be supporting.
  - They feel valued and treated fairly by supervisors.
  - They are involved in care plan meetings.
  
- Staff are more likely to leave if:
  - They have problems with co-workers.
  - They have problems with supervisors.
  - They receive inadequate pay or benefits.

### **TRENDS IN BEST PRACTICE**

#### Voluntary credentials:

- Illinois, Kansas and Ohio have developed voluntary credentialing programs for DSPs.
- The National Association of Direct Support Professionals has instituted a voluntary credential.

#### Kansas Statewide Workforce Development Plan:

- “Kansans Mobilizing for Change” had an impact in reducing turnover.
- Strategies:
  - Developed Workforce Plan
  - Trained supervisors
  - Interventions video shown to DSPs
  - DSP organization started
  - College of Direct Support utilized for DSPs
  - Piloted apprenticeship model
  - Targeting marketing
- Results:
  - DSP turnover rate reduced from 58% to 49%.
  - Supervisor turnover rate reduced from 23% to 16%.
  - Early turnover reduced from 48% to 41%.

#### National DSP Credential Program:

- National credentialing program for DSPs was launched July 1, 2006 by the NADSP.
  - Industry driven and voluntary.
  - Establishes national patterns for work-based learning and instruction.
  - Based on nationally valued competencies (Community Support Skill Standards), the NADSP Code of Ethics and DSP Professionalism.
  - Affordable, flexible, portable, and nationally recognized.
  - Includes verification process to confirm certification status.

#### College of Direct Support:

- Online training for direct support workers and supervisors.
- Includes: civil rights and advocacy, community inclusion, cultural competence, DSP ethics, employment supports, functional assessment, medication support, person-centered planning, safety, healthy lives, etc.
- CDS usage grew from about 36,000 learners in Sept. 06 to 46,000 in March 07.

#### Important Initiatives at the State Level:

- Supporting pre-service training
- Developing of regulations and rules based on competencies versus prescriptive statute and policies
- Allowing flexibility in training delivery
- Establishing credentialing and apprenticeship programs
- Post-secondary education and career paths
- Curriculum options

#### What has worked at the state level:

- Collaboration
  - Secondary and post-secondary education
- Labor
- Health
- Stakeholder groups
  - Direct Support Professionals
  - Individuals and families
  - Advocates
  - Providers
  - Policy makers

#### Supporting People in their Own Homes and Natural Settings:

- Less people living in structured settings.
- Individually tailored training responsive to the needs of the individual, family and the Individualized Service Plan.
- Families and individuals need help learning how to recruit, hire, manage, and fire DSPs.
- Role of fiscal intermediary in training and supporting families.

#### Workforce Challenges and Trends in Iowa:

Iowa's current workforce challenges:

- Insufficient capacity for crisis prevention and management, which can hamper the ability of the system to successfully transition individuals to the community.
- Variation in approaches to case management and variation in case loads, especially outside Targeted Case Management.
- Difficulty in funding necessary training; no consistent state funding to support training.
- No generally accepted agreement on the competencies that should be expected from support staff.

Need for Training Related to Evidence Based Practices:

- Person-centered planning
- Positive behavior supports
- Self-direction
- Family support
  - Understanding family dynamics and cultural aspects
- Supported employment
- Support brokerage

Standardization of Case Management Roles and Competencies:

- CM is knowledgeable about the service system, state and local resources and benefits.
- CM advocates for the person.
- CM facilitates the service planning meeting and monitors delivery of services.
- CM ensures the individual's health and well-being is maintained.
- CM is available and helpful.
- The individual has the choice of case manager and case management agency.
- CM has a reasonable caseload.

Self-Direction in Iowa:

- Individuals can hire employees of their choice to provide personal assistance and other independent living supports.
- Service options include:
  - Self-directed personal care
  - Self-directed community and employment supports
  - Individual directed goods and services

Recent Training Initiatives in Iowa:

- Training through the College of Direct Support (CDS).
- Made available by funding from Money Follows the Person (MFP), the Real Choice Systems Change grant and legislative support.
- Role of University Center on Excellence in Developmental Disabilities (UCEDD) as the statewide administrator.
  - Helps providers learn to use the system, select training modules, and work with providers.

### College of Direct Support:

- UCEDD program worked with Iowa Medicaid Enterprise.
- Online training.
- Free access to the CDP for providers enrolled in the MFP initiatives.
- 44 providers have utilized training.
- 1,400 employees have gotten training on a variety of topics.
- Training for supervisors, direct services staff, used as orientation.
- Works for any size provider.
- Providers only have to be interested and willing to enroll a person in the MFP program.
- Under this demonstration, providers do not have to pay the administrative fee of about \$2,800/year.
- Includes a return on investment tool that allows them to track the value of the training and decide if they should continue to move forward with implementation of CDS.
- Can take a variety of particular training courses; individually work through lessons and take periodic tests.
- CDS will also help modify the curriculum to meet specific needs.
- Each unit has on the job training tools so that a supervisor can look at how the individuals trained are applying what they have learned.
- Supervisor tools serve to identify workers who meet competencies.
- Workers need reinforcement for the training in their work environment.
- There are discussion board opportunities.
- The provider still covers the cost of the employee's time to take the courses, but it is available online at any time.
- Uses English or other language.
- Training can serve to help tie pay rates to demonstrated competencies.
- One small provider's incident reporting dropped significantly because they were better prepared to anticipate and prevent incidents.

### Iowa Providers have used CDS:

- In orientation training
- For managers
- Training all employees on positive behavior supports
- Started at the supervisor level
- To improve workforce:
  - Pay by merit; applied CDS competencies to job descriptions.
  - Supervisors are required to meet 90% competencies on testing.
  - DSPs are required to meet 80% competencies on testing.
  - Looking at career path options; deciding which courses should be a part of those options.

### Iowa Providers report:

- Starting to see decrease in turnover after using CDS.
- Initial concern about time spent in taking courses.

- Found it is better training and is geared toward adult learning styles.
- Has really decreased the cost of orientation.
- Online training can be challenging for people who are less technologically experienced; staff is generally positive about it.
- One provider has trained 100% of staff and at least 80% have had competencies measured.

#### Discussion of CDS:

- MFP has been a demonstration of many things, including what happens when the state makes this kind of training available for free.
- Some states use Medicaid administrative dollars to cover the cost.
- Could recommend that it should be the responsibility of the state to make this kind of infrastructure available.

### **KEY WORKFORCE QUESTIONS TO CONSIDER**

- What competencies are needed to support the recommended service and support array discussed at the last workgroup session?
- How do we ensure that providers have access to comprehensive and robust training resources?
- What role should the state/regions can play in providing training?
- What techniques that have been successful in the state in recruiting, training, and retaining staff?
- What are the priority areas in terms of staff development that ought to be tackled first?
- Given the central nature of case management, what types of training should be available to enhance person centered planning, self direction, etc.?
- What should be the role of the state in determining training and competency requirements?
- What are the priorities for training statewide?
- What funding should be available to ensure that direct support staff is trained?
- Is there merit in developing a voluntary certification?
- What types of collaborate efforts can be mounted to enhance the status, training and competence of staff?
- How can Iowa take advantage of existing resources?

### **GROUP DISCUSSION**

Counties respond to draft of proposed core services:

#### Polk County:

- Many are Medicaid services and would be available in any county.
- In Polk, the same services are provided to those who do not qualify for the waiver, but they are 100% county funded and may be subject to a waiting list.
- Polk has developed a PBS network and all providers are a part of it.
- The goal is to provide services within the county and so individuals do not have to leave.

- Have developed services for people with dual diagnosis.
- It would help to have that as part of core services.

#### Bremer County:

- Most are the mandated services until you get to community living.
- Independent support broker services are available in Bremer County, and some housing or rental assistance is also available, but not necessarily to the extent it is in other places.
- County does not specifically offer PBS, but does offer outpatient mental health counseling.
- Have utilized IPART services for behavioral issues.
- In Bremer and some counties, non-Medicaid eligible people receive the same services, in some counties they do not.
- That information is available from county reports to the state.

#### Group Discussion on Cost Issues:

- Will need to look at cost estimates and what the costs of different service packages would look like.
- Is the statewide waiting list going to potentially create a non-Medicaid eligible group?
- By adding the DD population, would we add a potentially much larger non-Medicaid population for service eligibility?
- If we expand the waiver to cover DD, many of the current non-Medicaid eligible people being served would become Medicaid eligible.
- Do we want to create a sliding fee schedule?
- Do we want to services available at some cost to lower to middle income people who don't qualify for Medicaid?
- Will there still be some county dollars going into the services funding pot?
- The regional group will be looking at that question.
- In accord with the ACA Medicaid expansion, should we have a sliding fee scale from 133% to 400%?
- More people will be eligible to receive State Plan services under the expansion.

#### Group Discussion on Workforce Issues:

##### What is the role of the state in developing the infrastructure for workforce?

- IDPH has been working on a credentialing system for direct care workers under a HRSA grant.
- It includes a core curriculum for all workers followed by training modules for five different career paths, including home health support.
- There are a lot of people out in communities providing services who are not CNAs, but do have training and competence.
- There is not one specific title (such as CNA) for people doing home and community based services and those individuals are harder to track and count.
- Interagency coordination is needed.

- There should be a set of recognized competencies for people serving the DD population.
- The state could identify a core training and threshold of competencies and providers could set their own training expectations at or above that.
- Don't create multiple systems for training and demonstrating competencies.
- For people who are earning the pay of DSP, providers need to pay for and offer training as a incentive to getting people into the jobs.
- Where should funding for training come from?
- Providers have tried to get the HCBS cost report format changed to have training fall into direct service costs rather than administrative costs which are capped.
- Changes that increase the cost of the waiver cannot be made without legislative action.
- Perhaps a staff training coordinator could be allowed to be claimed under direct service training cost.
- Providers could pay for staff training time and the state could pay for the cost of the training through supporting the CDS.
- Management and supervisor training is key to promoting quality service.
- Putting all the tools together would help get the state where it wants to go.

What kind of crisis prevention and response capacity should there be in every region?

- The IPART program is working well but the statewide need is far above what the Woodward team can provide.
- They use assessment tools to determine which requests receive priority.
- A regional presence would be beneficial.
- Priority is given to situations where the individual is at high risk of being displaced.
- Addressing chronic behavioral extremes that are ongoing can be a proactive way to prevent crisis situations.
- The IPART Team does observation and develops a behavior support plan with the provider that can be carried out in the setting the person is in.
- The teams support and train providers and staff.
- Sub-acute settings need to be created within a region.
- No mechanism is yet in place to support the cost of maintaining such a setting when it is not in use.
- Work centers don't have to be shelter environments and can involve bringing people from the community into the center to work.
- It may still be a struggle in rural Iowa in getting enough numbers of people to make supported employment services work.
- We should have a means for providers who have found ways to make supported employment pay and work in a rural community to share what they have learned with other providers.
- Training for crisis prevention and response teams in each region.
- Peer to peer technical assistance resource for providers.
- MFP has moved 157 people but it is the same challenges again and again related to community capacity; the redesign needs to address those challenges.

### Credentialing:

- Pursue a system of voluntary certification?
- Provide financial incentive for providers?
- Consider enhanced Medicaid reimbursement?
- Identify partners at state level for training?
  - Department of Public Health
  - Community Colleges
  - Department of Labor
  - Workforce Development
  - Others?
- Need to make sure that any training offered by the state is what providers need.
- Don't want to set skill/training levels for direct care workers that keep good people out of the field.
- IDPH credentialing model exempts people who serve only one individual or one or two family members.

### Co-occurring/Behavioral Issues:

- What do we do to make sure there is no wrong door?
- The conventional mental health system does not deal well with people with ID.
- The systems of support are not designed for people with ID.
- It takes some cross training.
- Broaden the audience to include family practice physicians and pediatricians.
- When we don't have resources that are geared to handle difficult situations, people call the police or access the emergency room.
- They need more appropriate options.
- Need a well developed system that deals with more challenging behaviors and with co-occurring needs.
- Currently we don't do well with the relatively small amount of people who have very challenging behavior.

### MEETING SUMMARY:

#### Core Services:

- Add guardianship services
- Reconsider role of pre-vocational and workshop employment services

### POTENTIAL RECOMMENDATIONS FOR WORKFORCE

- Initiate state supported infrastructure for provider training through the College of Direct Support.
- Provide incentives for a voluntary credentialing system.
- Make technical assistance available – including peer to peer consultation –to providers for such issues as positive behavior supports, crisis intervention, workshop conversion, etc.
- Develop financial incentives for supervisor and direct support professional training.

- In order to support the costs involved in training staff, the current rate reimbursement formula should be changed to allow providers to bill such costs as a direct expense rather than an indirect cost.
- There needs to be cross training for mental health professionals regarding the needs of people with co-occurring disabilities. There should also be training for primary care practitioners regarding the appropriate response to behavioral issues among people with ID/DD.
- Identify and work with other state agencies as partners in training and workforce development.
- Make IPART services available statewide to enhance capacity for serving people with challenging behaviors and addressing crisis situations.
- Consider further how to address wage and benefit issues.

## **NEXT MEETING**

The next ID/DD Workgroup is scheduled to meet on Tuesday, October 18, 2011 from 10:00 am to 3:15 pm at the United Way Conference Center, 1111 9<sup>th</sup> Street, Des Moines, IA.

Meeting 5 Agenda Topics:

- Best Practice & Trends in Provider Qualifications and Monitoring
- Provider Qualification & Monitoring Key Decision Points
- Provider Qualification & Monitoring Workgroup Recommendations

## **PUBLIC COMMENT**

Comment:

On a variety of issues discussed:

- Suggest using a separate private organization for Targeted Case Management.
- The Waiver system was set up because of the variety of funding sources.
- Need for coordination of programs, providers, and resources to address co-occurring focus.
- Fully supportive the need for significant rewriting of rules, regulations, and funding for community providers to support “community first” philosophy.
- Agencies ended pre-vocational services after a year because IME would no longer fund them.
- There is a need to try to support people who are unemployed.
- Support for voluntary credentialing and the use of the College of Direct Support.
- Community providers are fighting an uphill battle with Iowa Caregivers who prefer a medically prescriptive credentialing model.
- Currently there is not a sufficient career path for direct support workers.

Comment: Service dollars need to be attached to the person. There is a set of core services throughout the state. Those counties that have the system of care services provide what the person needs to be functional in the community. The redesigned system needs to be able to provide what an individual needs most to be functional without necessarily providing it for everyone. For example, if a person needs a bus pass to live and work in the community, the system should be able to fund that, but that does not mean we should pay for everyone to have a bus pass.

At the last meeting this group had a long discussion about sheltered work. I don't feel that what I heard in the room was reflected in the minutes. Sheltered work is not a "low priority" to be phased out; it is a valued service for many people.

When we talk about cost reporting, we refer to 20% for indirect costs, which is true but not accurate. In fact it is only 20% of direct costs, which is actually 16.67%. Providing incentives for training may be problematic. The provider has to pay for the training up front but may only get paid more for having trained staff in a year or two and that is a cash flow issue.

Comment: It is not so much a matter of where case management sits, but that it is person centered and that case managers have a reasonable case load and regular meetings with clients. Case managers currently arrange for clients to receive services from other providers because they can do it better and have more expertise. Some people with great people skills don't have computer skills for electronic documentation. Polk County has some great outcomes defined and developed over about 10 years that the workgroup can look at more closely.

Comment: Some individuals will not be able to maintain competitive employment and sheltered work may be the way they can be productive working adults. It may also be the least restrictive environment for some people. We don't want to squeeze down the work options available to people.

Comment: I really like the idea of the training and incentives, but am concerned about how it will be paid for to get staff to the desired level of competencies. The better an organization is at doing business, the more the rates go down. Please take a look at that and allow providers incentives for doing a good job and running a lean, efficient organization.

Comment: Iowa uses retrospectively prospective rates. Cost reports are due September 30 for the prior fiscal year. Delays occur and it is about 18 months from start of the fiscal year until the rate becomes

effective. Even if everything flows perfectly it could be 15 months and there are lots of possibilities for mistakes and errors. Unfortunately providers “pay” for those delays. If they have had increases in business, they don’t get to increase their rate until the next year.

Comment: Perhaps we should write new prospective rates each year.

**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.