

Community Integration Workgroup
October 15, 2014 10 AM to 3 PM
Grimes Office Building; Room B-100
400 E. 14th St, Des Moines, IA
MEETING MINUTES

COMMUNITY INTEGRATION WORKGROUP MEMBERS PRESENT:

Rick Shults	Jen Bauer
John Bigelow	Teresa Bomhoff
Diane Brecht	Jennifer Early
Steve Johnson	Earl Kilgore
June Klein	Steve Miller
Marcia Oltrogge	Jason Orent
Deb Schildroth	Suzanne Watson
Brent Wightman	Deb Dixon
Terri Rosonke	Theresa Armstrong
Laura Larkin	Renee Schulte
Kevin Martone	

COMMUNITY INTEGRATION WORKGROUP MEMBERS ABSENT:

Joel Wulf

OTHER ATTENDEES:

Michelle VanMaaren	Story County Community Life
Rachele Hjelmaas	Legislative Services Agency Legal
Jess Benson	Legislative Services Agency
Zeke Furlong	Iowa House Legislative Staff
Charles Palmer	Director, Iowa Department of Human Services
Debra Brodersen	Spencer Hospital
Braden Daniels	Life Connections
Erin Drinnin	United Way of Central Iowa
Tom Brown	Advisory Council on Brain Injuries
David Higdon	Polk County Health Services

WELCOME AND CALL TO ORDER

Kevin Martone called the meeting to order at 10:05 a.m. and led introductions. Kevin introduced the agenda and the group charter. Both had been emailed to the group in advance of the meeting along with several other handouts.

NATIONAL CONTEXT OF MENTAL HEALTH SERVICES

Kevin Martone presented information about the national outlook for mental health services. The context included the adult service array from SAMHSA and NAMI. It also included information on cost comparisons and policy directions.

The Community Integration Definition:

“Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual’s choosing; afford individuals choice in their daily life activities and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings.”

“By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated with exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals’ ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.” U.S. Dept. of Justice

The presentation continued with information about state psychiatric hospitals from the NASMHPD Medical Directors council; the vital role of State Psychiatric Hospitals. 2014

Information about community residential settings was provided along with an update of Department of Justice involvement in states across the nation. In DOJ settlement agreements, the following services are often recommended: supportive housing; assertive community treatment; case management; crisis services and supported employment.

Key issues to consider: Is there access to services? Are people getting the right services at the right time at the right level of intensity? Are systems working together to provide services?

Information given on key services and supports including housing and related services. Barriers to accessing services have not changed much since 2003. Main issues with cost or reimbursement issues; stigma; did not know where to seek treatment and others.

Concerns with community programs addressed including legacy programs versus evidence based programming; lack of supported employment and education programs; peer-delivered services not statewide; rural and urban issues; restrictive criteria for services and workforce shortages.

Groundwork laid for discussion of challenges and opportunities in Iowa after lunch.

GROUP DISCUSSION

The workgroup acknowledged that there are pockets of good services and programming in Iowa but not across the whole state. There are urban versus rural issues present.

Needs in Iowa outlined to include: workforce, reimbursement issues, and housing.

Iowa needs to come to consensus about what Olmstead means for the state.

DIRECTOR PALMER INTRODUCED TO THE GROUP

Director Palmer thanked the workgroup for their willingness to participate. Issues that we need to address in this stage of redesign include: sustainability and predictability; the children's system; upcoming legislative session with funding concerns. This is a journey.

RICK SHULTS – HISTORICAL PERSPECTIVE OF REDESIGN

High level of participation in the process with a shared vision:

“Iowans that have mental illness experience recovery and live safe, healthy, successful, self-determined lives in their community.”

Regions just began in July 2014. Now we are ready for the next level of the journey.

Additional pieces of history discussed by workgroup members to include Medicaid eligibility for prisoners re-entering the community; streamlined process for medically exempt persons; Integrated Health Homes successes and challenges

PUBLIC COMMENT

Former Gov. Vilsack signed executive order 27 to implement Olmstead changes. Maybe it is time to review where we are as a state. The treatment of persons with a brain injury needs to be addressed and reviewed. Medicaid reimbursement rates should be reviewed specifically related to peer support. Rental assistance is a barrier for many in Iowa. “Affordable” housing is not affordable.

Break for lunch was taken at 12:00 p.m.

The meeting resumed at 1:05 p.m.

GROUP DISCUSSION

Kevin noted that the Mental Health Committee in the Redesign process made several recommendations about services that ultimately resulted in the legislated core services. The recommendations made in 2011 for services needed in the system are consistent with

trends in the field and are an opportunity for this group to recommend ways for the Regions and providers to ensure they are serving people with serious mental illness well.

The group discussed the crisis services that are being developed. Each region is at a different point in development. Regions are determining which services are needed based on the population they serve. There is no requirement for standards for crisis services in regions. The rules were written for providers on how to provide the services.

There is an opportunity to expand the use of tele-health in crisis services especially in rural areas. Regional providers are learning how to work together to create a more seamless system. Providers need assurance that funding will be there. Community based services are needed beyond the crisis care.

A barrier theme in the discussion: there is not a systems approach to bring players together to set up crisis services, capacity challenges.

Concerns noted that providers are struggling to make the bottom line now before expanding into new services. Reimbursement issues are another barrier theme noted.

Where is Iowa in community integration? Is there cost benefit of community services?

People are staying in higher level settings longer waiting for the next placement, due to lack of community capacity. Estimated 10-20% of persons in hospitals are waiting for something else. Main group include those with co-occurring MH/SA issues; aggression and sexual offenders.

There seems to be a “transition” setting missing including delays in getting people on to Medicaid or into an IHH. If Medicaid transitions can be improved when people leave prison, can’t it be done for persons leaving institutional care? To summarize: transition and how it works or does not with IHH; capacity for those with dangerous reputations but are now stable; and Medicaid eligibility.

We are missing a real opportunity not including law enforcement education in this discussion. There needs to be an understanding of community living programming; crisis training.

Clarity of service levels and definitions are needed. Many services “sound the same”. Differences are more than funding streams. The use of acronyms does not help with misunderstanding.

The balancing incentive in Iowa talks of a single point of access as a requirement. No wrong door, single point of entry process has begun in Iowa with ADRCs and LifeLong Links. We discussed state versus local referral source. The group wanted to know more information about this plan before making a recommendation.

DISCUSSION THEMES

1. Want to make the system navigable and easily accessible.

2. Role of law enforcement
3. There should be services and housing for the most difficult to serve consumers.
4. Workforce issues
5. Reimbursement
6. Strategies to support sustained recovery
7. Housing including rental assistance

PUBLIC COMMENT

Hardest to serve population will need individualized care packages and flexible funding to make it work. Issues in hospitals remain due to workforce shortages. Goal should be to serve more in the community and less in corrections. Regions are having issues serving persons in their own areas with placements from all over the state.

NEXT MEETING

The next meeting of the Community Integration Workgroup is scheduled for Thursday, November 6, 2014. The meeting will be at United Way 1111 9th St Des Moines Room F.

The meeting was adjourned at 3:10 p.m.

Minutes by Renee Schulte.