STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
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Iowa Mental Health and Disability Services Commission

January 4, 2011

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COMBINED ANNUAL AND BIENNIAL REPORT OF THE IOWA MENTAL HEALTH AND DISABILITY SERVICES COMMISSION

This Combined Annual and Biennial Report of the Iowa Mental Health and Disability Services (MHDS) Commission is being submitted pursuant to Iowa Code § 225C.6(1)(h) & (i). The report is organized in three sections: (1) an overview of the activities of the Commission during 2010, (2) recommendations formulated by the Commission for changes in Iowa law, and (3) the Commission's evaluation of the extent to which services are available to persons with disabilities, and the quality and effectiveness of those services provided by disability service providers, the four State Mental Health Institutes, and the two State Resource Centers.

PART 1:

OVERVIEW OF COMMISSION ACTIVITIES DURING 2010

Meetings. The Commission held eleven meetings in 2010, including a two-day retreat and two joint meetings with the Iowa Mental Health Planning and Advisory Council. Each meeting draws, on average, about 22 participants in addition to Commission members.

Officers. In May, Jack Willey, a Jackson County Supervisor from Maquoketa, was elected Chair of the Commission, and Craig Wood, the Linn County CPC Administrator from Cedar Rapids, was elected Vice-Chair.

New Membership. Pursuant to a change in Iowa Code Section 225C.5(1) a new member who is a military veteran and is knowledgeable concerning the behavioral and mental health issues of veterans was added to the Commission. The first appointee to hold that position is Laurel Phipps of Marshalltown.

Statutory Changes in Duties. During 2009, the members of the Commission worked closely with the MHDS Division leadership to update, streamline, and focus its statutory responsibilities to better align with the current DHS structure, the current services system, and the resources available. A proposal was submitted to the General Assembly last year as part of the DHS legislative package, was approved, and went into effect July 1, 2010. The Commission's name was changed to the Mental Health and Disability Services Commission to simplify reference, reflect its close association the Division of Mental Health and Disability Services, and eliminate the use of the outmoded term "mental retardation." That terminology was also replaced by "intellectual disabilities" in official language referring to Commission duties to promote dignity and respect for all Iowans.

Also, as part of the statutory changes, the duty of determining whether to grant, deny, or revoke the accreditation of community mental health centers, mental health service providers, supported community living services, and case management providers was shifted from the Commission to the MHDS Administrator. The Commission retains responsibility for reconsideration and appeal of denials.

Service Accreditations. During the first six months of the year, the Commission reviewed and acted upon accreditation recommendations from the Iowa Department of Human Services, Division of Mental Health and Disability Services accreditation staff for 60 providers of services to Iowans with mental health, mental retardation, development disability, or brain injury related needs, including:

- 8 community mental health centers;
- 40 supported community living providers;
- 7 case management providers; and,
- 5 mental health services providers.

Committees and Workgroups. The Commission utilized committees and workgroups to review selected policy issues, including:

1. DHS Olmstead Plan and Children's Services. This Commission workgroup reviewed and offered input throughout the development of the DHS Olmstead Plan for Mental Health and Disability Services and discussed community provider issues, and the vision for the future of services to children and youth in Iowa, including the expansion of children's systems of care.

2. Legislative Priorities. This Commission workgroup focused on formulating recommendations for priorities relating to mental health and disability services in Iowa. The recommendations that were developed are included in Part 2 of this report.

3. Chapter 230A Core Services and Accreditation Reconsideration Process. This Commission workgroup focused on the role and expectations for community mental health centers in Iowa and developed specific recommendations for revisions to Iowa Code Chapter 230A, including identifying a set of core services and developing a safety net approach. They hope to spur the introduction of a bill containing those recommended changes during the 2011 legislative session.

4. Allowed Growth Factor. This Commission workgroup reviewed the history of mental health and developmental disabilities system funding since 1995 and developed the recommendation for allowed growth submitted to Governor Culver in November.

5. Data, Information, Outcomes, and Functional Assessment. This Commission workgroup was also involved in review and input on the development of the DHS Olmstead Plan for Mental Health and Disability Services and began preliminary planning and discussions on gathering currently available data and identifying additional sources of information to reflect service outcomes.

6. Annual and Biennial Reports. This Commission workgroup provided input on the development of this report and the recommendations contained herein.

Administrative Rules. The Commission reviewed, made recommendations on, and approved proposed administrative rules changes related to the State Payment Program to establish waiting list and disenrollment criteria and processes.

County Plan Review. The Commission reviewed and approved proposed changes to County Management Plans for Calhoun, Hamilton, Humboldt, Kossuth, Pocahontas, Webster, and Wright counties in north central Iowa, and Allamakee, Bremer, Buchanan, Delaware, Clayton, Fayette, Howard, and Winneshiek counties in northeast Iowa.

CMHC Waiver Approval. The Commission approved requests for waivers from the requirement to contract with a community mental health center for thirteen counties that sought waivers to contract with other mental health providers. The counties are: Bremer, Lucas, Sioux, Monona, Shelby, Sac, Van Buren, Jefferson, Muscatine, Louisa, Henry, Des Moines, and Lee.

Allowed Growth. The Commission prepared and submitted its Allowed Growth Factor Adjustment Recommendation for fiscal year 2013 to Governor Culver pursuant to Iowa Code §331.439(3)(b), renewing our recommendation for State Fiscal Year 2012 of $69.9 million growth and requesting an additional 1% increase for State Fiscal Year 2013 to bring the allowed growth funding to $73.2 million. As we stated in making that recommendation, even then the increase is not sufficient to maintain existing levels of service and will result in service cuts and increasing numbers of counties with waiting lists, but we believe the amount of growth is reasonable in the current economic situation.

Coordination with Other State Agencies. The Commission developed a coordination plan for working with the Iowa Mental Health Planning and Advisory Council (MHPC), including holding two joint meetings of the groups a year, holding two joint meetings of the executive committees a year, sharing information by email and Sharepoint, and working together on the development of a shared legislative agenda. At the Commission's first joint meeting with the MHPC in January, each organization presented an overview of their background, purpose, membership,

and responsibilities. The executive director of the Iowa Developmental Disabilities Council also attended and presented a similar overview of her organization.

Letter Urging Extension of Enhanced FMAP. The Commission took action to urge the extension of an enhanced Federal Medical Assistance Percentage (FMAP) in June by drafting and sending letters to Senator Tom Harkin and Senator Charles Grassley asking them to support pending action in the U.S. Senate.

Human Services Council Budget Hearing. The Commission submitted written and in-person testimony to the DHS Human Services Council in July to share their position on allowed growth for county mental health and developmental disabilities budgets.

REPORTS AND INFORMATIONAL PRESENTATIONS

During 2010, the Commission also received reports and presentations on issues of significance in understanding the status of services in Iowa and recognizing promising practices for planning and systems change, including:

Mental Health Institute Task Force Report. In January, the Commission received and reviewed the final report of the Mental Health Institute Task Force, which visited each of the four MHIs in 2009 and reviewed their use, charged with making a recommendation for the closure of one of the facilities. Two Commission members, Cindy Kaestner and Neil Broderick, also served as MHI Task Force members. The Task Force recommendation was for no immediate facility closures. They further recommended that decisions about the future operations of the facilities be made in the context of the whole mental health service system, the people served, the interests of public safety, the total costs, and best known practices, and they also chose to adopt and support the recommendations made by the Acute Care Task Force for systems change.

State Payment Program (SPP). In March, the Commission received an overview of the State Payment Program and an update on the status of an SPP waiting list and potential disenrollment. Changes were proposed and made to the administrative rules in anticipation that it would become necessary to institute a waiting list for SPP funding and possibly disenroll recipients if program funds are not adequate to cover the costs. The State Payment Program serves between 3000 and 4000 people and reimburses counties for the costs incurred in delivering services to them according to a uniform chart of accounts. Waiting lists were utilized during SFY 2010, but disenrollment actions were avoided.

State Employment Leadership Network (SELN). In March, the Commission received an update on Iowa's participation on the State Employment Leadership Network. Iowa joined the network as a part of the Medicaid Infrastructure Grant (MIG) activities, which include increasing awareness about work incentives, working with people to develop self-employment opportunities, and provide training and information about asset accumulation and building self-sufficiency. State agencies are working with the SELN to develop a plan to address gaps in supported employment and improve employment outcomes for Iowans with disabilities or mental illness.

Mental Health First Aid and Psychological First Aid Training. In April, the Commission received a report on Mental Health First Aid and Psychological First Aid training coordinated by the DHS Division of Mental Health and Disability Services. Mental Health First Aid is intended to provide mental health literacy and education, give people confidence that they can deal with a

mental health crisis they encounter, and reduce stigma associated with mental health conditions. Psychological First Aid training is designed to give participants a set of skills to use at a time of trauma or during a crisis event to calm the situation, make sure people are safe, and establish steps to follow up. Both trainings are designed for anyone who is interested in acquiring the skills and have been presented to educators, law enforcement, community leaders, and members of the general public.

HCBS Waiver Statewide Waiting List. In April and again June, the Commission received reports from Iowa Medicaid Enterprise staff on Iowa's plan to move to a centralized statewide waiting list for HCBS Waiver services and developing prioritization criteria to guide movement of the waiting list.

County Funding. In May, the Commission participated in an interactive presentation to help members better understand the multi-step calculation for determining the allocation of county growth dollars to counties. They also heard from county Central Point of Coordination (CPC) Administrators about the cyclical effect of the formula on county fund balances and the resulting difficulty in long term planning.

DHS Olmstead Plan for Mental Health and Disability Services. Beginning in May, and continuing throughout the year, the Commission received regular reports and updates on the development of the Olmstead Plan for Mental Health and Disability Services, and reviewed and commented on the process, plan principles, draft goals, objectives, and action steps. Part 3 of this report will further discuss the Olmstead Plan and its importance to the long-term transformation of the services system.

Iowa Medicaid Program. In May, the Commission received a presentation from Iowa Medicaid Enterprise Director Jennifer Vermeer, including an overview of the Medicaid program in Iowa and emerging issues related to HCBS Waiver Services, statewide waiting lists, self-direction, preferred drug lists, and the passage of federal health care reform legislation.

U.S. Supreme Court *Olmstead* Decision. In June and again in July, the Commission heard presentations by Assistant Attorney General Gretchen Kraemer on the 1999 U.S. Supreme Court Decision in the case of *Olmstead v. L.C. and E.W.* and its ramifications for state mental health and disability services systems. Ms. Kraemer noted that the U.S. Department of Justice is currently pursuing investigations or complaints for violations of the Americans with Disabilities Act in several states, and outlined statewide ADA complaints that the DOJ has filed against Arkansas and Georgia. The Commission also engaged in a discussion of the implementation of the *Olmstead* Decision, its focus on community integration, and the significance of the DHS Olmstead Plan for Mental Health and Disability Services.

Disaster Behavioral Health Response Teams. In July, the Commission received an update report on the Disaster Mental Health projects that have been active since the floods and disaster events of 2008. In addition to providing mental health counseling services and training, federal funds were used in Iowa to implement disaster behavioral health trainings and create the structure and format of the Disaster Behavioral Health Response Teams (DBHRT), which will continue to operate as a supplement to the resources available locally to meet disaster-related mental health needs.

Veteran's Mental Health and Polytrauma. In August, Michael J. Hall, neuropsychologist and co-director of the Polytrauma Support Clinical Team at the Veterans Administration Medical Center in Iowa City, and Jack Hackett, Vocational Rehabilitation and Employment Officer for the

U.S. Department of Veterans Affairs, presented information on a collaborative effort to support military veterans with traumatic brain injuries, post-traumatic stress disorder, and other mental health and trauma-related conditions. They highlighted the complex medical and behavioral health needs of military veterans and their families as a significant and growing area of need with potential for effective federal, state, and private collaboration.

State Resource Centers (SRC). In August, Woodward State Resource Center (WSRC) Superintendent Marsha Edgington-Bott and Glenwood State Resource Center (GSRC) Superintendent Zvia McCormick presented updates on SRC activities and programs, including the Iowa Program Assistance Response Team (I-PART), Dialectical Behavior Training (DBT), Money Follows the Person (MFP) transition activities, HCBS Waiver services, and other community outreach and community-based initiatives. Both superintendents indicated the SRCs are working on developing a more progressive focus on community outreach and skill acquisition to help support people in moving back to their community of choice.

Adult Services and Funding. In August, MHDS Division Administrator Jeanne Nesbit presented the first in a series of reports on the mental health and disability services system in Iowa, outlining the funding structures and service array currently available to adults with mental illness or disabilities in Iowa and the opportunities presented for systems improvement, including pursuing systems change initiatives identified in the DHS Olmstead Plan for Mental Health and Disability Services and opportunities made available through the implementation of health care reform.

Affordable Health Care. In October, the Commission received an updated overview on the planning and progress toward implementing Affordable Health Care in Iowa and the some of the initial challenges of defining essential benefits, establishing a health benefit exchange, and considering how behavioral health care and services related to intellectual and other disabilities can be integrated with primary health care.

Children's Services and Funding. In December, MHDS Division Administrator Jeanne Nesbit presented the second report on the mental health and disability services system in Iowa, outlining the funding structures and service array currently available to children and youth with serious emotional disorders or disabilities in Iowa and the opportunities presented for systems improvement, which include using a medical or health home model to improve the coordination of services, developing crisis respite services to help keep children and youth at home, and redesigning the remedial services program.

Olmstead Public Forums. In December, the Commission received a report on four "community conversations" on mental health and disability services in Iowa held during October and November in cooperation with State legislators to hear public comment on the draft DHS Olmstead Plan for Mental Health and Disability Services: State Representative Dave Heaton co-hosted an event in Mount Pleasant; State Senator Amanda Ragan and State Representative Linda Upmeyer co-hosted an event in Clear Lake; State Representative Lisa Heddens co-hosted an event in Ames; and State Senator Joe Bolkcom, State Senator Robert Dvorsky, and State Representative Mary Mascher co-hosted an event in Iowa City. State Senator Merlin Bartz also participated in the Clear Lake event. In addition, about 250 individuals, family members, providers, and community leaders participated, expressing support for the principles and goals of the plan and concern about the availability of resources to meet the needs identified.

Coordination with MHDS. DHS Director Charles Krogmeier, MHDS Division Administrator Jeanne Nesbit, and the staff of the Division of Mental Health and Disability Services have actively participated in Commission meetings throughout the year, communicated regularly, provided timely and useful information, and been responsive to questions and requests from Commission members. They have provided or coordinated reports and updates to the Commission on a variety of issues, notably including:

- Affordable Health Care
- Court Mental Health Study Group
- Disaster Behavioral Health Response Teams (DBHRT)
- DHS and State Budget Process
- DHS Olmstead Plan for Mental Health and Disability Services
- DHS Reorganization
- Emergency Mental Health Mobile Crisis Services System
- Iowa Program Assistance Response Teams (I-PART)
- Iowa Co-Occurring Recovery Network (ICORN)
- Legislative activities
- Mental Health Block Grant
- Mental Health First Aid
- Money Follows the Person (MFP)
- Office of Consumer Affairs (OCA)
- *Olmstead* Legal Issues
- Pre-Admission Screening and Resident Review (PASRR)
- Project Recovery Iowa
- State Employment Leadership Network (SELN)
- State Payment Program (SPP)
- System of Care Projects for children and youth
- Ticket to Hope program

PART 2:

RECOMMENDATIONS FOR CHANGES IN IOWA LAW

The Iowa Mental Health and Disability Services (MHDS) Commission recognizes that the members of this General Assembly face an unusually daunting task in allocating scarce resources and maintaining a balanced State budget. In making those difficult decisions, we remind you to carefully consider the health and safety needs of our most vulnerable citizens and recognize the human as well as the financial costs associated with policy and funding choices.

When essential and cost-effective supportive services to people with mental health and disability-related needs are not adequately funded, the result is more emergency room visits, more emergency psychiatric hospitalizations, more involvement with law enforcement, corrections, and the courts, more abuse and neglect, and potentially more preventable deaths. We urge you to preserve the necessary and basic supports of daily living for Iowans with special needs by fully funding the MHDS Commission's modest allowable growth recommendation to the Governor, and by supporting cost effective mental health and disability-related services that are needed more than ever in these difficult economic times.

At a time when so many Iowans are suffering because of lost income, jobs, health care benefits, and homes, are struggling to recover from natural disaster losses, and are facing the challenges

of returning from military deployments, our community mental health and disability services system is a critical safety net for a growing number of individuals and families. We have identified the following four priorities for mental health and disability services in Iowa:

PRIORITY 1: ENSURE THE BASIC MENTAL HEALTH AND DISABILITY NEEDS OF IOWANS

Fund cost-effective mental health, intellectual disability, developmental disability, and brain injury services at a level adequate to meet basic needs.

PRINCIPLE: Maintain needed services and allow growth necessary to eliminate waiting lists and prevent more expensive interventions and placements, give counties flexibility in determining when growth is needed, and take steps to integrate primary health care, mental health care, developmental disability, brain injury rehabilitation, and substance abuse services.

STRATEGIES:

(1) ***SUPPORT DHS OLMSTEAD PLAN*** - Adequately fund the services and activities identified and prioritized in the DHS Olmstead Plan for Mental Health and Disability Services to make the plan a reality.

(2) ***REPLACE PROPERTY TAX CAP*** - Replace the dollar cap on county property tax levies with a levy rate cap and allow counties flexibility in determining which base year to use as the capitation rate. The dollar cap has remained unchanged since 1997. It has been estimated that if the 1996 levy rates were applied today, there would be approximately $50 million more county dollars available to fund current service needs.

(3) ***PROTECT COUNTY FUND BALANCES*** - Hold counties harmless for increased fund balances resulting from the enhanced FMAP (Federal Medical Assistance Percentage) for FY 2010.

(4) ***PROMOTE MENTAL HEALTH PARITY*** - Build on the Affordable Health Care Act to achieve Mental Health Parity for all insurers. Parity in private insurance coverage would reduce reliance on public mental health services and would better support a comprehensive array of services statewide.

(5) ***RETAIN OPEN ACCESS*** - Retain open access to mental health medication. Preferred drug lists requiring prior approval for exceptions may be a generally effective cost containment measure, but create the potential for even greater costs when applied to mental health medications. The medications with the fewest side effects are often the newest and not the 'preferred medications.' Consumers who experience unpleasant side effects from older medications are less likely to stay on them and, as a result, are more likely to be hospitalized or require other more expensive forms of treatment.

(6) ***ALLOW MEDICAID SUSPENSION*** - Allow for the suspension rather than the termination of Medicaid benefits for persons entering a correctional facility for up to 12 months. If it is determined that person remains eligible for benefits at the time of release, benefits could then be immediately re-instated and the individual would have prompt access to mental health medications and necessary treatment that will help deter re-offending.

(7) ***SHIFT COMMITMENT COSTS*** - Transfer the costs of commitments and persons in state hospitals from counties to the State as another step toward the elimination of legal settlement. Increase the use of mental health jail diversion programs and special needs courts and promote other appropriate alternatives to commitment.

(8) ***INTEGRATE SERVICES*** - Develop an implementation plan for integration of primary health care, mental health care, developmental disability, brain injury rehabilitation, and substance abuse services as a part of federal healthcare reform, following a the basic characteristics of a comprehensive, continuous, and integrated System of Care model.

(9) ***PROMOTE SYSTEM EFFICIENCIES*** - Promote cost-saving efficiencies and less-restrictive service options including:

- ***COMMUNITY-BASED*** - Redirecting resources from expensive institutional care to more cost-effective community-based services Initiating or increasing client participation for some services
- ***CONSISTENT*** - Evaluating Medicaid program integrity, regulations, and policies for efficiency and consistency in meeting the needs of Iowans
- ***EFFECTIVE*** - Replicating programs that demonstrate cost-effectiveness and positive outcomes for people
- ***MODERN*** - Utilizing technology to improve system efficiency
- ***FOCUSED*** - Insuring that federal funds received for health care purposes are obligated to health care and not diverted for other use
- ***SIMPLIFIED*** - Minimizing processes and paperwork to reduce costs

PRIORITY 2: BUILD COMMUNITY CAPACITY

Take steps designed to build community capacity to serve Iowans with mental illness, intellectual and developmental disabilities, or brain injuries in non-institutional settings.

PRINCIPLE: Adults and children should have access to needed services and supports in their communities and should not have to resort to nursing home or institutional living.

STRATEGIES:

(1) ***ADDRESSING WORKFORCE SHORTAGES*** - Addressing the critical shortage of mental health and other professionals by:

- *SUPPORTING TRAINING & CREDENTIALING* - Supporting efforts to develop a competency-based curriculum and credentialing system for direct support professionals that values and promotes community-based services mental health and disability-related services through the use of established learning systems such as the College of Direct

Support. Building competent direct support professional workforce also requires that training become a direct cost.

- *EXPANDING MENTAL HEALTH RESIDENCIES* - Developing and implementing a plan to expand opportunities for community psychiatry residency positions and training for psychiatric physician assistants, psychiatric nurse practitioners, and psychiatric social workers at multiple locations in Iowa.

- *UTILIZING PEER SUPPORT* - Expanding the use of trained and credentialed peer support specialists and family support services.

- *EXPANDING ASSERTIVE COMMUNITY TREATMENT (ACT)* – Building on the five existing Assertive Community Treatment (ACT) teams to establish statewide coverage.

(2) ***DEVELOPING CRISIS STABILIZATION*** - Developing crisis stabilization beds and sub acute care beds statewide utilizing a recovery model as recommended by the Acute Care Task Force and further supporting recovery with wellness centers, drop in centers, and peer support services.

(3) ***EXPANDING CHILDREN'S SYSTEMS OF CARE*** - Building on Iowa's two current children's system of care projects in northeast and central Iowa to create a comprehensive statewide system for children's disability services.

(4) ***INCREASING WAIVER FLEXIBILITY*** - Raising the monthly individual cap on waiver services for children to provide flexibility and support the ability of families to keep their children at home, in school, and out of expensive residential placement. If families cannot access critical services such as respite care when they need it, children are vulnerable to abuse and neglect or out-of-home placement.

(5) ***EXPANDING BRAIN INJURY SERVICES*** - Eliminating the need for a waiting list for brain injury services by fully funding the HCBS Brain Injury Waiver at the projected level of growth approved by the Centers for Medicare and Medicaid Services (CMS) and by removing the dollar funding cap that prohibits the provision of services at a level necessary to prevent institutionalization or out of state placement.

(6) ***EXPANDING ID WAIVER*** - Amending the HCBS Intellectual Disabilities Waiver to include individuals with autism spectrum disorders and determine eligibility through an individual clinical assessment based on functional impairment.

PRIORITY 3: ADOPT A PROPOSAL FOR REVISING IOWA CODE CHAPTER 230A

Adopt recommendations for revisions to Iowa Code Chapter 230A, governing the organization and operation of Community Mental Health Centers in Iowa.

PRINCIPLE: Community mental health centers should play a critical role in the statewide system that serves Iowans who have mental health disorders and/or experience mental health related crises. The recommendations are proposed with a long-term vision of (1) Establishing a statewide organized public safety net of services for Iowans of all ages who have mental health

disorders; (2) making an array of core safety net services available to Iowans regardless of their place of residence or economic circumstance; and (3) assuring to provision of quality services.

STRATEGY: ***UPDATE CHAPTER 230A*** - Revisit the original proposal presented in 2010 for updating the statutory provisions governing the role and operation of community mental health centers to reflect current needs and expectation as one step in implementing improvements to Iowa's system of public mental health and disability services. Consider the role of CMHCs in the implementation of federal health care reform and the establishment of a comprehensive, continuous, and integrated System of Care model, including the use of technological enhancements such as telemedicine.

PRIORITY 4: LAY THE FOUNDATION FOR REVISING IOWA CODE CHAPTER 229

Further develop recommendations for revisions to Iowa Code Chapter 229, governing mental health commitments in Iowa.

PRINCIPLE: The number of mental health commitments in Iowa is growing and too often individuals go through commitment proceedings because it is the path of least resistance to a "bed," not because the person truly needs to be committed. Alternatives need to be developed that are less expensive and more effective in addressing the needs of individuals in need of mental health services.

STRATEGY: ***REVISE CHAPTER 229*** – A workgroup including representatives of the judicial system and the mental health system is currently meeting to develop recommendations for changes in the commitment process. We support coordinated and continued efforts to review and update Chapter 229 to better meet the needs of Iowans with mental illness, to alleviate the burden of unnecessary commitment proceedings on the services system, and minimize the disruption in the lives of individuals experiencing mental health crises. Our recommendations to develop crisis stabilization services, expand Assertive Community Treatment statewide, and increase the use of mental health jail diversion programs and special needs courts are examples of systemic changes that can also contribute to the reduction of unnecessary commitments.

PART 3:

EVALUATION OF THE STATE DISABILITY SERVICES SYSTEM

Availability of services in each county of the State. In Iowa, county government has planning, service funding, and service delivery responsibilities to persons with mental illness and intellectual disabilities based on legal settlement, utilizing a combination of federal, state, and county dollars. State government controls the minimum levels of service provided by mandating which services counties are required by law to finance and by setting the level of funding the State provides to counties through Allowable Growth and Property Tax Relief. State government also must approve each county plan for MHDD services and rejects plans that do not meet minimum requirements. Service availability varies among counties and is a reflection of many factors, including the tax base in effect at the time the county property tax levies were frozen and geographic proximity to population or business centers. Many counties are still able to exceed the minimum State requirements, although that number is dwindling as State funds are reduced. DHS data show that 51,286 individual adults and children were

served by the county system in State Fiscal Year 2009. That number represents an increase of almost 8% from SFY 2008.[1]

Counties pay the non-federal share of Medicaid funded services (Federal Medical Assistance Percentage or FMAP) for adults receiving Home and Community Based Intellectual Disability Waiver services, Intermediate Care Facility for Mental Retardation (ICF/MR) services, Targeted Case Management, and Habilitative Services. The fifteen-year-old cap on property taxes continues to hold county MHDD dollars at the amount budgeted for State Fiscal Year 1996, with a maximum allowable levy amount of $125,781,915.[2] In SFY 2009, eighty-one of our ninety-nine counties levied 100% of the maximum allowed.[3] A temporary increase in the FMAP rate due to the provisions of the American Recovery and Reinvestment Act (ARRA) has resulted in short-term funding relief to counties of approximately $23 million for SFY 2009, $40 million for SFY 2010, and $33 million for SFY 2011. When the ARRA funding ends on June 30, 2011 counties will face a significant increase in expenditures just to continue services on a status quo basis. Some counties were able to add to their fund balances in State Fiscal Year 2009 due to the retroactive nature of the Federal Medical Assistance Percentage (FMAP) increase for State Fiscal Year 2009. Those fund balance increases will be essential in State Fiscal Year 2012, and could help alleviate some cuts in services if growth is allowed. If growth is not allowed, many counties are likely to exhaust their fund balances, institute waiting lists, and reduce services.

Services to Iowans with mental health and disabilities are an investment in our communities. As a state we have created and codified a collective vision that people with disabilities will have the opportunity to live, work, learn, and participate fully in the communities of their choice. Community participation also lends itself to increased productivity, including competitive employment and entrepreneurial opportunities as well as the development of natural supports that can serve to reduce reliance on public resources. As a state, we must find ways to invest in building the community capacity necessary to fulfill that vision.

Quality of services in each county of the State. Our services system relies on licensing, accreditation, professional development, and program standards to ensure the delivery of quality services by providers and practitioners throughout the State. We are also developing greater reliance on outcome and results-based performance measures and should continue to gather more data to accurately evaluate how well our services system is addressing the needs of adults, children, and families and how well the system is producing the outcomes we value. Quality and effectiveness of services are closely linked. Our evaluation of the areas of greatest need and our recommendations for improving both the quality and effectiveness of services in Iowa follow.

Effectiveness of services provided by disability service providers in this State. The overall effectiveness of disability service providers in Iowa should be measured by how well they enable persons to remain in their community and live as independently as possible with a disability or mental health condition. Their effectiveness is also dependent on the overall framework for support that is available on a statewide basis. Availability, quality, and effectiveness of services are all inter-related and need to be evaluated and addressed in the context of the whole services system. The Commission has reviewed the report of the Acute Care Task Force, which revealed serious shortages in acute care beds. Recommendations to address those shortages included preventing admissions through crisis stabilization and related services and improving community-based post-discharge or “step down” services, as well as increasing the number of qualified mental health professionals available to serve hospitals and community-based programs. During the 2010, the Commission has also reviewed, given input,

and followed the development of the DHS Olmstead State Plan for Mental Health and Disability Services, a plan to enhance community capacity in accordance with the 1999 U.S. Supreme Court *Olmstead v. L.C. and E.W.* Decision.

Service system improvement is comprehensively addressed in the DHS Olmstead Plan for Mental Health and Disability Services, which has been developed over many months with the participation and input of hundreds of stakeholders. The five-year Plan includes on-going and new initiatives to guide Iowa through a focused system transformation. Our recommendations for improving the quality, availability, and effectiveness of services throughout Iowa highlight or align with many of the Acute Care Task Force recommendations and with the DHS Olmstead Plan objectives and action steps:

- **Recruit and Retain Mental Health Professionals**. A critical area of need is the statewide shortage of psychiatrists, psychologists, and other mental health professionals. The federal expansion of Medicaid benefits serves to emphasize the need to address the shortage of medical professionals and mental health professionals in particular. The Iowa Department of Human Services has proposed a plan to provide opportunities for ongoing education and fellowship for medical professionals, in addition to a stipend for Physician Assistants (PA), Advanced Registered Nurse Practitioners (ARNP), and psychologists. Iowa DHS-operated facilities already provide internships and fellowships for registered nurses, social workers and others. Providing incentives for advanced medical professionals to work at State-operated facilities could serve the dual function of ensuring sufficient numbers of qualified medical personnel to provide supervision and oversight at those facilities and increasing the number of advanced medical professionals recruited to work in Iowa and receive specialized training in clinical areas including psychiatry.

- **Develop a System of Care to provide community based services for children and youth with serious mental health disorders and their families**. Iowa has two current children's system of care projects: the Central Iowa System of Care (CISOC) and the Community Circle of Care (CCC) in north eastern Iowa. The overall goal of both programs is to help children remain in their homes, schools, and communities and avoid intensive and restrictive levels of treatment. The projects have achieved results in reducing CINA petitions due to the need for mental health services, diverting youth from involuntary commitment for mental health, and reducing school suspensions and expulsions. Continuation is of the current projects and the development of systems of care projects for children and youth in other areas of the state is an important component of building community capacity in Iowa.

- **Develop a System of Care to provide community-based emergency mental health crisis services** to serve any person who is experiencing a mental health crisis or is in a situation likely to turn into a mental health crisis if supportive services are not provided, regardless of age, income, insurance coverage, diagnosis, or severity of the crisis. In 2011 the Iowa Medicaid program and MHDS will fund a system of care project in eleven designated counties to establish a model and gather outcome data to guide future statewide development of emergency mental health crisis service delivery.

- **Act on the Recommendations of the Acute Care Task Force.** We support the recommendations of the Acute Care Task Force[4] that were developed by a group of sixty or more stakeholders who met over a two-year period to design a coordinated set

of recommendations to MHDS for cross-system planning and implementation of expanded acute care services, which include:

- CRISIS STABILIZATION. Statewide availability of crisis stabilization centers for adults to provide 24-hour access to shelter, food, social support, and comprehensive treatment services for persons experiencing a mental health crisis who are voluntarily seeking assistance and do not need inpatient hospitalization, and statewide availability of 24-hour access to a continuum of crisis services including mobile outreach services and community-based stabilization centers for youth and adolescents.

- SCHOOL BASED MENTAL HEALTH SERVICES. Statewide availability of school-based mental health services including primary prevention, early intervention, and intensive services to all students with emotional, substance abuse and mental health needs.

- JAIL DIVERSION. Statewide availability of programs that divert non-violent adult and juvenile offenders with serious mental illness and co-occurring mental health and substance use disorders away from jail and provide linkages to community-based treatment and support services.

- SUB-ACUTE SERVICES. Statewide availability of time-limited services that provide 24-hour comprehensive treatment to individuals who have received acute care in an inpatient setting, and have not yet been adequately stabilized such that they can be discharged to their own home or other residency setting.

- COMMUNITY MENTAL HEALTH CENTERS. Statewide availability of enhanced community mental health centers structured to serve as community Access Centers, and including an array of 24-hour a day acute services and a mandated core safety net of services available regardless of age, income, or diagnosis.

- PSYCHIATRIC EMERGENCY ROOM SCREENING. Statewide availability of appropriate psychiatric assessment and care services in emergency room settings.

- COMMITMENT DIVERSION. Reviewing and redefining mental health commitment procedures in Iowa and revising Iowa Code Chapter 229 to achieve statewide consistency among county courts, providers, mental health administrators, and policymakers, focusing on consideration of the individual, innovation, and efficiency.

Effectiveness of services provided by the State Mental Health Institutes established under Iowa Code Chapter 226.[5]

The four mental health institutes (MHIs) located in Cherokee, Clarinda, Independence, and Mount Pleasant provide access to acute psychiatric care for Iowans who need mental health treatment and specialized mental health related services. The MHIs serve both voluntarily and involuntarily admitted persons.

The MHIs provide a variety of behavioral care programs:

- Adult Acute Psychiatric Care – Each of MHIs offer acute psychiatric services to adults, with a total of 105 acute care beds available.

- Child and Adolescent Acute Psychiatric Care – Cherokee and Independence MHIs have 37 inpatient beds for providing acute psychiatric services to children and adolescents.
- Acute Services for Co-occurring Substance Abuse and Mental Illness – the Mount Pleasant MHI has 15 dual diagnosis treatment beds.
- Substance Abuse Treatment Services – the Mount Pleasant MHI has a 30-bed substance abuse treatment unit that represents about 7.2% of the total number of residential substance abuse treatment beds in Iowa.
- Geropsychiatric Services – the Clarinda MHI has a 30-bed long-term care unit that serves older adults with mental illness.
- Sub-acute Care for Children – the Independence MHI has a 30-bed Psychiatric Medical Institution for Children (PMIC).

A total of 2017 individuals were served at the MHIs in SFY 2010. The combined average daily census of the four facilities was 231 in SFY 2010 and they periodically have waiting lists for admission. The MHIs constitute approximately 23.3% of the 804 in-patient funded psychiatric beds in the State.[6] In SFY 2010, approximately 80% of adult psychiatric admissions are involuntary.

For State Fiscal Year 2010 the MHIs reported:

- 97.5% of clients showed improvement in ability to function[7]
- 96.4% of adult clients remained in the community for at least 30 days following MHI discharge
- 80.4% of substance abuse clients successfully completed or received maximum benefits from their program
- 0.759 hours of restraint per 1000 hours of inpatient care during SFY 2010

Considering the shortage of psychiatrists, psychologists, and other mental health professionals throughout the State, and particularly the limited access to services in many rural areas of Iowa, the Mental Health Institutes can be most effective in serving as a regional resource for specialized psychiatric services, including outreach and support for community mental health providers.

Effectiveness of services provided by State Resource Centers established under Iowa Code Chapter 222.[8]

The two State Resource Centers located in Glenwood and Woodward provide a variety of treatment and outreach services to individuals with intellectual or other related developmental disabilities. Discharge planning begins at admission and clients receive assistance in reaching individual goals and returning to their communities.

A total of 496 individuals were served in the State Resource Centers during SFY 2010, which represents about 22% of the 2248 individuals served in Iowa ICF/MR facilities. During SFY 2010, 17 individuals were admitted to the SRCs and 56 individuals were discharged. Thirty-two fewer individuals were served than in SFY 2009 as the SRCs continue to support the transition of residents to appropriate community-based settings. The number of individuals served has decreased by 27.3% since SFY 2003 and an additional 30-bed reduction is planned for SFY 2011.

Most of the individuals admitted to the SRCs have significant behavioral or medical issues and a mental health diagnosis in addition to an intellectual disability or related condition. Complicating conditions include seizure disorders, high risk of choking or aspiration due to eating or swallowing disorders, and high risk for sustaining injuries related to behavior.

The SRCs provide a variety of programs:

- Residential treatment (ICF/MR) services for individuals with intellectual disabilities or related conditions who have been unable to secure effective services in the community.
- Time-limited assessment to assist community-based providers in developing specialized skills to meet client needs were provided to 10 individuals during SFY 2010.
- Facilitation of transition for individuals from the SRCs to community based services, including active participation in the Money Follows the Person program.
- HCBS Waiver services are provided at 22 locations in communities surrounding the SRCs. During SFY 2010, the SRCs provided respite services to 29 individuals, supported community living services to 48 individuals, and supported employment services to 38 individuals.
- Iowa Program Assistance Response Team (I-PART) provides expert crisis assistance to families and community service organizations and programs to manage unsafe or unacceptable behavior of individuals with co-occurring intellectual disabilities and mental illness or autism. I-PART services are designed to assure that individuals are able to continue their community services and avoid:
    - Involuntary discharge from community placement
    - Formal referral for admission to the State Resource Centers
    - Hospitalization for psychiatric concerns
    - Arrest or incarceration
    - Placement out of State

  Since I-PART was created in January 2010, 141 referrals or inquires for behavioral consultation have been received, 62 consultations have occurred, and over 2000 providers, family members, and other community members have received training.

For State Fiscal Year 2010 the SRCs reported:

- 71% of individuals served earned wages through on or off-campus employment
- 85% of discharged individuals remained in the community for at least 180 days
- 32 individuals transitioned to the community using Money Follows the Person (up from 16 in SFY 2009)

In SFY 2011, each of the SRCs plan to pursue the creation of a crisis stabilization home in the community that will accommodate up to 3 individuals as a further step in avoiding frequent emergency hospitalizations, discharges from community services, institutionalization, or incarceration. The goal will be to stabilize the individual, develop a plan based on behavior analysis, and, in most cases, return the individual to the community within 21 days. These programs will create models that can be duplicated by others in other parts of the State.

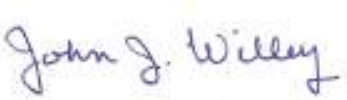
The State Resource Centers can be most effective in serving as a regional resource for specialized intellectual disability and behavioral psychiatric services, including continuing to develop and implement crisis assistance services, and provide training and outreach to support community providers, particularly with respect to meeting the need for services to address challenging behaviors.

SUMMARY. The Commission supports the DHS Olmstead Plan for Mental Health and Disability Services, its vision of "A Life in the Community for Everyone," and its foundational principles, goals, and objectives. We are, however, concerned about the availability of resources to fully implement the initiatives of the Plan and to truly build the community capacity envisioned. Our specific and immediate concerns include system funding and identified gaps and inequities in service access, including:

- Funding for allowed growth
- Addressing provider rate reductions
- Reducing or eliminating waiting lists for community services
- Ensuring reasonable provider reimbursement rates
- Supporting provider and staff training as a direct cost
- Addressing the shortage of mental health professionals
- Meeting transportation needs
- Ensuring appropriate and affordable housing options
- Providing supported employment and employment opportunities
- Supporting access to social activities

Services to Iowans with mental health and disabilities are an investment in our communities. When the basic needs of people with mental illness or disabilities are not met in their homes and communities, the only remaining options are higher cost and more restrictive. In addition, the Obama Administration has made compliance by states with the Americans with Disabilities Act (ADA) a priority. Failure to demonstrate adequate progress toward the community integration goals of the *Olmstead* Decision will place Iowa at risk for U.S. Department of Justice enforcement actions akin to those that are already ongoing in several states. The potential human and economic costs of that risk should be unacceptable to us all. We urge you to support a modern, effective, consistent, and accessible system of community-based mental health and disability services for all Iowans. It is a wise and necessary investment that will yield a sound return for our citizens and our state's economy.

Respectfully submitted on behalf of the members of the Mental Health and Disability Services Commission,



John (Jack) Willey
Chair, MHDS Commission

Cc: Michael E. Gronstal, Senate Majority Leader
Paul McKinley, Senate Minority Leader
Kraig Paulsen, Speaker of the House
Kevin McCarthy, House Minority Leader
Legislative Services Agency
Charles J. Krogmeier, DHS Director
Jennifer Harbison, DHS Legislative Liaison
Jeanne Nesbit, DHS Administrator of MHDS

[1] *Aggregate report submitted by counties on December 1, 2009.*
[2] *DHS SFY 2009 data*
[3] *DHS SFY 2009 data*
[4] *Recommendations for Creating a Statewide Mental Health Acute Care Service System, MHDS Acute Care Task Force 2009*
[5] *DHS data, see SFY 12 Offer #401-HHS-011: Mental Health Institutes*
[6] *Iowa Hospital Association, March 2010 staffed private psychiatric beds*
[7] *Evidenced by an increase in the Global Assessment of Functioning (GAF) score*
[8] *DHS data, see SFY 12 Offer #401-HHS-012: State Resource Centers*