



**POLK COUNTY  
MENTAL HEALTH, INTELLECTUAL DISABILITIES, AND  
DEVELOPMENTAL DISABILITY SERVICES**

**FY13 ANNUAL REVIEW**

**TO BE SUBMITTED ON NOVEMBER 27, 2013**

## ACTUAL EXPENDITURES & SCOPE OF SERVICES

Polk County citizens are eligible for county-funded services if they meet financial eligibility criteria as well as one of the following population group categories: persons in need of mental health services (NCMI), persons with chronic mental illness (CMI), persons with intellectual disabilities (ID), or persons with developmental disabilities (DD). Funding for persons with developmental disabilities is subject to availability of funding, and waiting lists may be maintained for all other population groups if funding is not sufficient. For Polk County's fiscal year (FY13), July 1, 2012 through June 30, 2013 the reports are embedded within this annual report:

- Total Expenditures by Chart of Accounts Number and Disability Type (County Report #1)
- Persons Served by Age Group and by Primary Diagnostic Category (County Report #2)
- Unduplicated Count of Adults by Chart of Accounts Number and Disability Type (County Report #3)
- Unduplicated Count of Children by Chart of Accounts Number and Disability Type (County Report #3)
- Mental Health System Growth/Loss Report (County Report #4)
- Waiting List Report (County Report #5)

County Report 1								
Fiscal Year 2013 Total Expenditures by COA codes and Disability Type								
for Polk County								
Account Code	Description	Mental Illness	Chronic Mental Illness	Intellectual Disability	Developmental Disabilities	General Administration	County Provided Case Management	Service Total
4000	Case Consultation	\$37,500						\$37,500
5000	Public Education	\$37,923						\$37,923
11000	Direct Administration, Auditor, Manager/Other					\$3,407,483		\$3,407,483
12000	Purchased Administration					\$45,034		\$45,034
21374	Case Management - T19 Match		\$104,582	\$195,115	\$13,062			\$312,759
21375	Case Management -100 % County		\$63,844	\$16,078	\$743			\$80,665
21399	Case Management - for Medicaid reimbursement						\$9,736,455	\$9,736,455
22000	Service Management	\$234,631	\$741,776	\$52,752	\$120,200			\$1,149,358
31000	Transportation	\$491	\$140,850	\$240,853	\$53,408			\$435,601
32320	Homemaker	\$4,117	\$174,362	\$767	\$36,209			\$215,456
32322	Home Management Services			\$549	\$42			\$591
32325	Respite			\$47,242	\$392			\$47,634
32327	Protective Payee - Shopping Support	\$1,985	\$100,178	\$10,942	\$69			\$113,174
32328	Home/Vehicle Modification			\$1,562				\$1,562
32329	Supported Community Living	\$23,009	\$1,157,087	\$683,568	\$472,404			\$2,336,069
32399	Other Support	\$120,000	\$100	\$163,493	\$33,685			\$317,278
33345	Independent Rent Subsidy Contractors	\$158,184	\$471,065	\$53,686	\$3,376			\$686,311
33399	General Assistance	\$12,902	\$65,024	\$6,968	\$936			\$85,830
41305	Outpatient (Physiological Treatment)	\$47,017	\$4,526					\$51,543
41306	Prescription Medicine	\$330,748	\$77,887	\$697	\$1,212			\$410,544
41307	Nursing Services			\$5,246				\$5,246
42304	Emergency Treatment	\$426,921	\$2,670					\$429,591
42305	Outpatient (Psychotherapeutic Treatment)	\$1,928,501	\$239,771	\$3,141	\$7,738			\$2,179,150
42363	Day Treatment Services	\$40,000						\$40,000
42396	Community Support Services	\$95,871	\$3,915,528	\$740,759	\$765,635			\$5,517,793
42397	Psychiatric Rehabilitation	\$23,628	\$10,040					\$33,668
42399	Other (Psychotherapeutic Treatment)	\$50	\$50					\$100
43000	Evaluation	\$254,967	\$1,501	\$311	\$265			\$257,045
50360	Sheltered Work		\$2,118	\$22,916	\$10,315			\$35,348
50362	Work Activity		\$43,958	\$240,579	\$15,711			\$300,247
50367	Adult Day Activity	\$1,488	\$140,598	\$281,160	\$7,043			\$430,289
50368	Supported Employment	\$70	\$50,030	\$140,702	\$69,584			\$260,385
50369	Enclave		\$1,428	\$68,095	\$531			\$70,053
50399	Other Vocational and Day Services	\$1,035	\$41,127	\$41,496	\$21,502			\$105,160
63314	RCF (Community Based 1 - 5 Beds)		\$26,832					\$26,832
63315	RCF/MR (Community Based 1 - 5 Beds)			\$11,691				\$11,691
63318	ICF/MR (Community Based 1 - 5 Beds)			\$895,556	\$9,743			\$905,299
63329	Supported Community Living		\$455,660	\$3,041,592	\$197,355			\$3,694,607
64314	RCF (Community Based 6+ Beds)	\$6,239	\$493,259					\$499,498
64315	RCF/MR (Community Based 6+ Beds)			\$93,647	\$35,741			\$129,388
64316	RCF/PMI (Community Based 6+ Beds)		\$455,684	\$1,206				\$456,890
64317	Nursing Facility/ICF-PMI - Community Based		\$10,967					\$10,967
64318	ICF/MR (Community Based 6+ Beds)			\$1,001,315	\$11,506			\$1,012,821
64329	Supported Community Living (6+ Beds)		\$86,583	\$2,953				\$89,536
71319	Inpatient MHI	\$13,530	\$137,452					\$150,982
72319	State Resource Centers			\$404,942				\$404,942
73319	Inpatient Acute	\$880,839	\$224,994		\$487			\$1,106,319
74300	Related To Commitments	\$446	\$741	\$160				\$1,347
74353	Sheriff Transportation	\$3,307	\$2,020					\$5,327
74393	Legal Representation	\$31,753	\$15,778	\$503	\$340			\$48,374
75395	Mental Health Advocates	\$45,911	\$45,874					\$91,784
	Total County \$	\$4,763,061	\$9,505,943	\$8,472,241	\$1,889,233	\$3,452,517	\$9,736,455	\$37,819,449

Fiscal Year 2013  
for Polk County

<b>DISABILITY GROUP</b>	<b>Children</b>	<b>Adults</b>	<b>Unduplicated Total</b>
Mental Illness	521	5897	6418
Chronic Mental Illness	5	2203	2208
Intellectual Disabilities	466	1639	2105
Other Developmental Disabilities	1	276	277
Total	993	10,015	11,008

County Report 3							
Fiscal Year 2013 Unduplicated Count of Persons Served by COA and Disability Type							
for Polk County							
X Adults		Children					
Account Code	Description	Mental Illness	Chronic Mental Illness	Intellectual Disability	Developmental Disability	County Provided Case Management	Service Total
21374	Case Management - T19 Match		429	1093	82		1604
21375	Case Management -100 % County		62	12	1		75
21399	Case Management - for Medicaid reimbursement					2396	2396
22000	Service Management	186	545	64	99		894
31000	Transportation	3	125	505	29		662
32320	Homemaker	1	72	2	3		78
32322	Home Management Services			13	1		14
32325	Respite			138	1		139
32327	Protective Payee - Shopping Support	2	138	22	2		164
32328	Home/Vehicle Modification			1			1
32329	Supported Community Living	5	640	455	50		1150
32399	Other Support	1	1	115	4		121
33345	Independent Rent Subsidy Contractors	87	238	30	6		361
33399	General Assistance	81	90	10	1		182
41305	Outpatient (Physiological Treatment)	304	30				334
41306	Prescription Medicine	1721	179	4	5		1909
41307	Nursing Services			4			4
42304	Emergency Treatment	5	2				7
42305	Outpatient (Psychotherapeutic Treatment)	2859	257	5	9		3130
42363	Day Treatment Services	1					1
42396	Community Support Services	20	509	85	74		688
42397	Psychiatric Rehabilitation	9	8				17
42399	Other (Psychotherapeutic Treatment)	2	1				3
43000	Evaluation	52	4		1		57
50360	Sheltered Work		2	8	1		11
50362	Work Activity		58	111	2		171
50367	Adult Day Activity	1	172	295	4		472
50368	Supported Employment	1	77	198	35		311
50369	Enclave		8	38	1		47
50399	Other Vocational and Day Services	2	45	59	8		114
63314	RCF (Community Based 1 - 5 Beds)		4				4
63315	RCF/MR (Community Based 1 - 5 Beds)			3			3
63318	ICF/MR (Community Based 1 - 5 Beds)			85	1		86
63329	Supported Community Living		35	394	3		432
64314	RCF (Community Based 6+ Beds)	1	44				45
64315	RCF/MR (Community Based 6+ Beds)			24	1		25
64316	RCF/PMI (Community Based 6+ Beds)		66	1			67
64317	Nursing Facility/ICF-PMI - Community Based		4				4
64318	ICF/MR (Community Based 6+ Beds)			100	1		101
64329	Supported Community Living (6+ Beds)		22	1			23
71319	Inpatient MHI	5	2				7
72319	State Resource Centers			37			37
73319	Inpatient Acute	441	104		4		549
74300	Related To Commitments	4	5	1			10
74353	Sherrif Transportation	27	16				43
74393	Legal Representation	243	106	4	2		355
75395	Mental Health Advocates	12	19				31

County Report 3							
Fiscal Year 2013 Unduplicated Count of Persons Served by COA and Disability Type							
for Polk County							
Adults		X		Children			
Account Code	Description	Mental Illness	Chronic Mental Illness	Intellectual Disability	Developmental Disabilities	County Provided Case Management	Service Total
21375	Case Management -100 % County		3				3
21399	Case Management - for Medicaid reimbursement					470	470
22000	Service Management	2					2
42305	Outpatient (Psychotherapeutic Treatment)	410	1	1	1		413
43000	Evaluation	163		1			164

County Report 4					
Mental Health System Growth / Loss Report					
Fiscal Year 2013					
for Polk County					
DISABILITY GROUP	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Net
Mental Illness	2378	2163	2177	2238	-140
Chronic Mental Illness	1643	1252	1275	1264	-379
Intellectual Disabilities	1400	221	205	188	-1212
Other Developmental Disabilities	234	167	166	167	-67
<b>Total</b>	<b>5,655</b>	<b>3,803</b>	<b>3,823</b>	<b>3,857</b>	<b>-1,798</b>

County Report 5										
County Waiting List Report										
Fiscal Year 2013										
for Polk County										
Waiting List Reason	Mental Illness		Chronic Mental Illness		Intellectual Disabilities		Other Developmental Disabilities		Total	
	Currently Receiving a Service	Unservd	Currently Receiving a Service	Unservd	Currently Receiving a Service	Unservd	Currently Receiving a Service	Unservd	Currently Receiving a Service	Unservd
N/A	0	0	0	0	0	0	0	0	0	0
Funding Not Available	3	5	10	5	10	4	2	8	25	22
Service Not Available	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0
<b>Total:</b>	<b>3</b>	<b>5</b>	<b>10</b>	<b>5</b>	<b>10</b>	<b>4</b>	<b>2</b>	<b>8</b>	<b>25</b>	<b>22</b>

## PROVIDER NETWORK PROFILE

Polk County service contracts require that all providers meet all applicable licensure, accreditation or certification standards; however Polk County makes serious efforts to stimulate access to more natural supports in its service provider network. Successful attainment of positive outcomes, consumer and family satisfaction, and cost effectiveness measures are the most important factors in continued network participation. PCHS has identified access points within the provider network to assist individuals or their representatives to apply for services.

<b>PROGRAMS IN POLK COUNTY FUNDED BY PCHS</b>	<b>PROGRAMS IN POLK COUNTY FUNDED BY PCHS (programs denoted with an * are subject to funding availability)</b>
Behavioral Technologies 2601 E. University Avenue Des Moines, IA 50317 Tele: (515) 283-9109	Supported Community Living Enclave Day Activity Program
Broadlawn Medical Center – BMC 1801 Hickman Road Des Moines, IA 50314 Tele: (515) 282-2200	Adult Inpatient Psych Adult Outpatient Psych Adult Day Treatment Adolescent Day Treatment (FOCUS) Dual Diagnosis Services (mental illness and substance abuse) RCF/PMI
BMC–Community Access Program 2300 Euclid Ave., Suite B Des Moines, IA 50310 Tele: (515) 282-6770	Case Management Service Coordination Supported Community Living
BMC–PATH 2300 Euclid Ave., Suite B Des Moines, IA 50310 Tele: (515) 282-6750	Integrated Services Program
Candeo 9550 White Oak Lane Johnston, IA 50131 Tele: (515) 259-8110	Supported Community Living Supported Employment Employment Skills Training
Child Guidance Center, a division of Orchard Place 808 5 <sup>th</sup> Avenue Des Moines, IA 50309 Tele: (515) 244-2267	Outpatient Psychiatric Treatment Outreach
Children & Families of Iowa 1111 University Avenue Des Moines, IA 50314 Tele: (515) 288-1981	*Representative Payee
ChildServe Box 707 Johnston, IA 50131 Tele: (515) 727-8750	Case Management Respite Supported Community Living In-Home Home Health Care Services Day Habilitation Services

<p>Christian Opportunity Center  Box 345  Pella, IA 50219  Tele: (515) 628-1162</p>	<p>Supported Community Living</p>
<p>Community Support Advocates  6000 Aurora Avenue, Suite B  Des Moines, Iowa 50322  Tele: (515) 883-1776</p>	<p>Integrated Services Project  Case Management  Service Coordination</p>
<p>Crest  3015 Merle Hay Rd, Suite #6  Des Moines, IA 50310  Tele: (515) 331-1200</p>	<p>RCF/ID  Supported Community Living</p>
<p>Des Moines Area Regional Transit  1100 DART Way  Des Moines, IA 50309  Tele: (515) 283-8111</p>	<p>Transportation</p>
<p>Easter Seal Society  2920 30<sup>th</sup> Street  Des Moines, IA 50310  Tele: (515) 274-1529</p>	<p>Integrated Services Program  Case Management  Service Coordination  Supported Community Living  Respite  Adult Day Activity  Employment Skills Training</p>
<p>Eyerly-Ball Community Mental Health Services  1301 Center Street  Des Moines, IA 50309  Tele: (515) 243-5181</p>	<p>Outpatient Psychiatric and In-Office Clinical Treatment &amp; Evaluation  Elderly Outreach  Intensive Psychiatric Rehabilitation  *Mobile Crisis Team  *Mental Health Jail Diversion  Forensic Assertive Community Treatment  RCF/PMI  Supported Community Living</p>
<p>Golden Circle Behavioral Health  945 19<sup>th</sup> Street  Des Moines, IA 50314  Tele: (515) 241-0982</p>	<p>Integrated Services Program  Case Management  Service Coordination</p>
<p>Goodwill Industries of Central Iowa  4900 NE 22nd Street  Des Moines, IA 50313  Tele: (515) 265-5323</p>	<p>Supported Employment  Adult Day Activity  Work Activity  Employment Skills Training</p>
<p>Homestead  1625 Adventureland Drive, Suite B  Altoona, IA 50009  Tele: (515) 967-4369</p>	<p>Supported Community Living  Respite  Work Activity</p>
<p>H.O.P.E.  P.O. Box 13374  Des Moines, IA 50310  Tele: (515) 277-4673</p>	<p>Supported Community Living  Supported Employment  Respite  Consumer Directed Attendant Care</p>

<p>Link Associates  1452 29<sup>th</sup> Street  West Des Moines, IA 50266  Tele: (515) 262-8888</p>	<p>Case Management  Service Coordination  Supported Community Living  Respite  RCF/ID  Transportation  Supported Employment  Employment Skills Training  Work Activity  Adult Day Activity</p>
<p>Lutheran Services in Iowa  Des Moines Service Office  3125 Cottage Grove  Des Moines, IA 50311  Tele: (515) 274-4946</p>	<p>Respite  Supported Community Living</p>
<p>Mainstream Living, Inc.  333 SW 9<sup>th</sup> Street  Des Moines, IA 50309  Tele: (515) 243-8115</p>	<p>Supervised Living Apartments  Supported Community Living  RCF/PMI</p>
<p>Mosaic  11141 Aurora, Building 3  Urbandale, Iowa 50322  Tele: (515) 246-1840</p>	<p>Supported Community Living</p>
<p>Optimae LifeServices  602 East Grand Ave.  Des Moines, IA 50309  Tele: (515) 283-1230</p>	<p>Supported Community Living  Community Integration</p>
<p>Passageway  305 15<sup>th</sup> Street  Des Moines, IA 50309-3407  Tele: (515) 243-6929</p>	<p>Psycho-social Clubhouse  Supported Employment</p>
<p>Primary Health Care, Inc.  2353 SE 14th Street  Des Moines, IA 50320  Tele: (515) 248-1400</p>	<p>*Homeless Outreach</p>
<p>Progress Industries  5518 NW 88th Street  Johnston, IA 50131  Tele: (515) 557-1810</p>	<p>Supported Community Living</p>
<p>Strawhacker and Associates  4601 Westown Parkway  Suite 220  West Des Moines, IA 50266  Tele: (515) 223-7370</p>	<p>Rent Subsidy</p>
<p>Telligen  1776 West Lakes Parkway  West Des Moines, IA 50266  Tele: (515) 223-2900</p>	<p>Utilization Review</p>
<p>Trans Iowa, L.C.  1550 E Army Post Road  Des Moines, Iowa 50320  Tele: (515) 266-4500</p>	<p>Transportation</p>

WesleyLife Community Services  
P. O. Box 7192  
944 18th Street  
Des Moines, IA 50309-7192  
Tele: (515) 288-3334

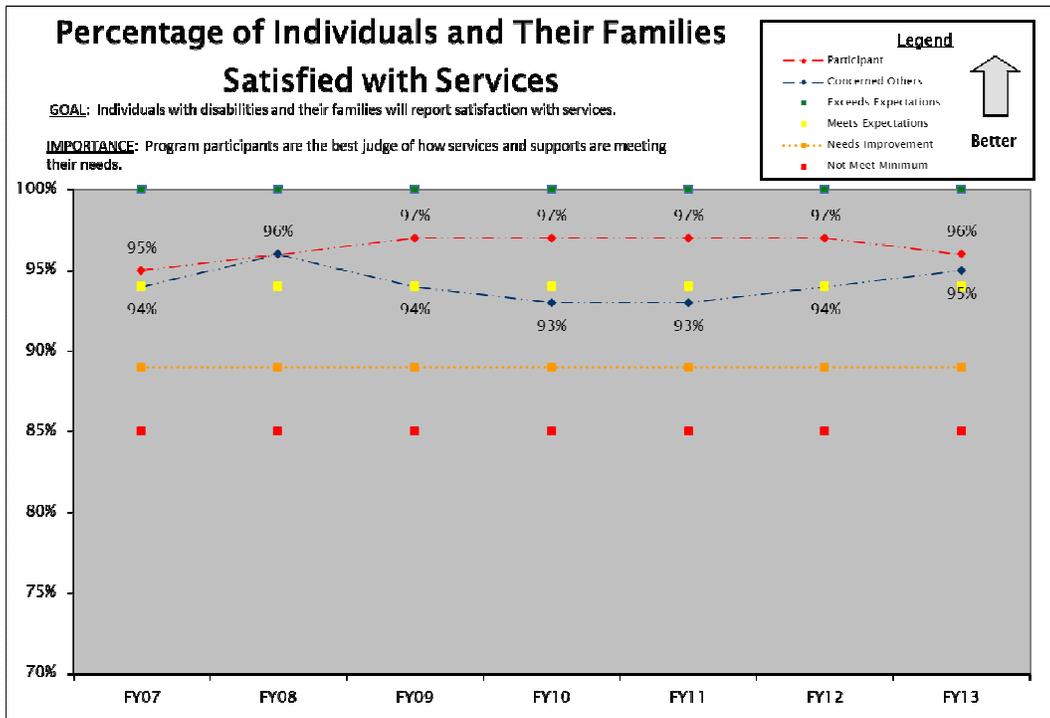
\*Homemaker Service  
\*Mobile Meals

## STAKEHOLDER INPUT & PARTICIPATION

Polk County includes participants, their families, and network providers in program planning, operations, and evaluation. The County's over-all approach to assuring the quality and effectiveness of all program components is through the provider network membership criteria, the County/PCHS contract, reports to PCHS, participant, collecting and summarizing information about appeals, grievances, and plans of correction; and obtaining a variety of participant and family satisfaction information. Stakeholder input was also incorporated into strategic planning focus areas.

FY13 stakeholder satisfaction was evaluated as a component of the overall Case Management, Service Coordination, and Integrated Services outcome evaluation process. Approximately 10% of all participants and family members were interviewed by phone or through a face to face interview by evaluators independent of Polk County Health Services. The survey process allowed participants to agree or disagree, with each survey question. The satisfaction with the system was very positive this year, with the overall satisfaction continuing to be high and stable ranging from 95% (family/concerned others) to 96% (participant satisfaction). Those receiving ongoing supports and their concerned others continue to view worker responsiveness, communication with family members, and staff turnover as key issues to consider when rating service satisfaction. Quality of life remains the lowest of rated areas.

### SYSTEM SATISFACTION RESULTS



## QUALITY ASSURANCE IMPLEMENTATION, FINDINGS, AND IMPACT ON PLAN

Plans are developed and revised based on stakeholder feedback, system outcome results, and review of trends in objectives. Following are the results of the 2012 – 2013 evaluation process.

### *SYSTEM OUTCOME RESULTS – INTEGRATED SERVICES PROJECT*

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The Integrated Service program consists of the four Integrated Service Agencies as well as Polk County Health Services, where all share risk and are vested in the program's success. The system was successful this year. Program system averages met or exceeded expectations in 12 of 16 outcome areas, maintaining an overall average of 77%. The system exceeded expectations in six outcome areas: Participant Satisfaction, Participant Empowerment, Somatic Care, Psychiatric Hospital Days, Emergency Room Visits, and Administrative Outcomes. The system met expectations in six outcome areas: Employment–Working Toward Self–Sufficiency, Employment–Engagement Toward Employment, Education, Community Inclusion, Negative Disenrollments, and Quality of Life. The system was particularly challenged in four areas: Community Housing, Homelessness, Jail Days, and Concerned Other Satisfaction.

One of the most important measures of any service program is satisfaction. If participants are not pleased with the service, they are less likely to participate in the program and the program will not be successful in meeting its objectives. The ISA system has consistently reported high participant satisfaction. Participants described staff as responsive to their needs, respectful, and dependable. Staff built close and caring relationships with participants, allowing them to provide sound advice, teach coping skills, and act as a reassuring safety net – all things that helped participants to better weather life's ups and downs and take on new challenges.

After several years struggling with the revised outcome, programs rose to the challenge this year for the participant empowerment outcome. Files documented that participants were active participants in goal development, individualized and measurable goals were in place and reviewed regularly, staff addressed employment or education participants, and services were well documented.

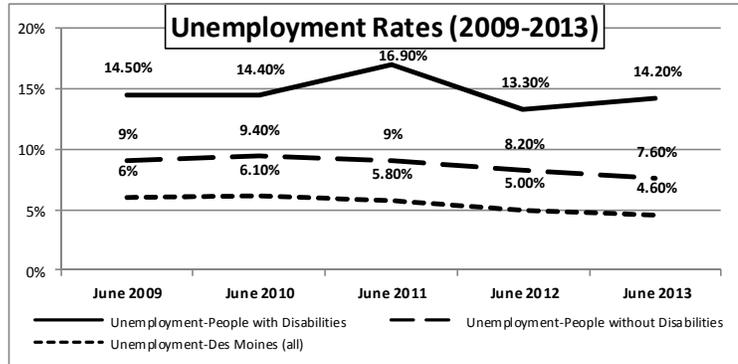
The ISA programs were successful again this year in making sure that almost all program participants received medical care during the year, either an annual physical or ongoing care for illnesses or conditions. The programs continued to maintain infrequent use of emergency rooms for psychiatric care. Although psychiatric hospital days increased, rates were still relatively low. ISA programs strive to build relationships with participants and providers so that they are able to connect individuals with appropriate treatment and help to monitor progress.

Not only were participants staying out of the hospital, they were also becoming more actively involved in their communities. Over the past eight years, the programs have reported a steady increase in participation in consumer directed, integrated community activities. This year, nine of every ten participants met the criteria for Community Inclusion, including participating in at least three activities or attending at least three events. File reviews indicate that participants were involved in a wide range of community activities, such as attending religious services or support groups, attending local cultural events, visiting local attractions, or volunteering. Community participation helps participants to feel that they are a part of their community and provide opportunities to establish natural supports and build relationships.

In addition to actively participating in their communities, program participants were more likely to be engaged in employment. Almost one in every three participants (30%) were working at least five hours per week. The majority of these (18%) were working 20 or more hours per week, earning at least minimum wage, an improvement from last year's reported 16%. Agencies work very diligently to encourage individuals to pursue employment, address their fears, and identify employment positions that would meet their needs. Once employed, agency staff continue to provide support for

individuals to maintain their employment. For some individuals, working a few hours is a first step in pursuing employment. They learn to adapt to a work schedule, build their resume, and experience how the added income does or does not affect the benefits they are receiving. With additional job skills and employment, these individuals will be better positioned to pursue more extensive employment or career opportunities.

Although employment outcomes may be challenging, economic indicators for Des Moines suggest that conditions may be improving. Unemployment rates have been decreasing nationally and in the Des Moines area. As of May 2012, the Bureau of Labor Statistics (BLS) estimated that the Des Moines Metropolitan area unemployment rate had dropped to 5.0% from 5.8% the year prior. Nationally, unemployment rates for individuals with disabilities increased from 13.3% in June 2012 to 14.2% by June 2013, while rates for individuals without disabilities declined (8.2% in 2012 to 7.6% in 2013). Employment of people with and without disabilities remained relatively stable (17.7% in June 2012 and 17.4% in June 2013 for people with disabilities, and 64.3% in June 2012 and 64.4% in June 2013 for people without disabilities).



Participating in community activities and being engaged in employment likely contributed to participants' reported quality of life. This year, participants were more satisfied with the quality of their lives. Average Quality of Life increased from 87% last year to 93% this year.

This year, the targets were increased for the Community Housing outcome. Although the reported results were similar to last year, the change in targets made the outcome more challenging for agencies to meet expectations. Revised in FY11, the Community Housing outcome requires that participants' housing meet safety, affordability, accessibility, and acceptability criteria. Supporting participants to live in the community has always been a priority of the ISA programs. This year, nearly eight of every ten program participants met all of the community housing criteria.

In contrast to many noted improvements, participants spent more days homeless this year. Average homelessness rates were the highest reported since the program began. Programs suggest that most of the homelessness was attributable to a few individuals who chose to remain homeless for longer periods of time and that improvements at Central Iowa Shelter have made individuals more comfortable staying there and less motivated to find and move into community housing.

Jail Days continue to be another challenging outcome area for the ISA system, although showing some improvement this year. This year's average is less than FY11 and FY12's historical highs. Programs continue to attribute the majority of their jail days to one or two participants. Sometimes, these participants remain in jail waiting for openings or arrangements to be finalized for community placements that could provide higher levels of care. Several program directors also mentioned that the judicial system has reduced expedited arraignments for most offenses. Therefore, participants who were arrested spent more time in jail waiting for an arraignment, bail decisions, and trial dates.

In contrast to participant and quality of life satisfaction, the system reported a decline in concerned other satisfaction. The system level decline is largely the result of diminished satisfaction at a single agency, rather than an overall system trend. In interviews,

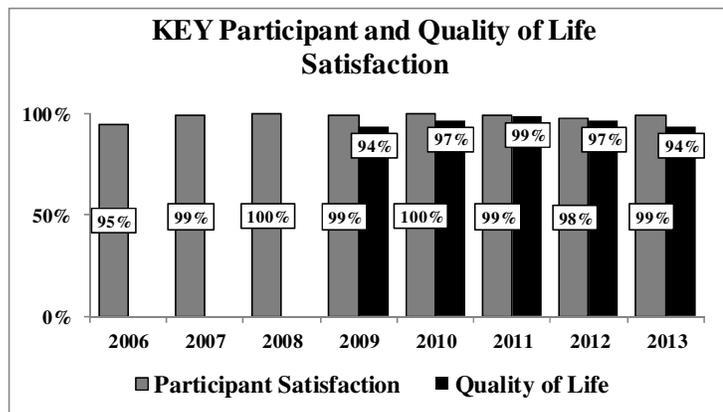
families and concerned others appreciated that programs stuck with participants and were there to assist them when families could not. By respecting participants, staff increased participants' self-esteem, a likely first step to becoming more self-directed and self-sufficient. Some families wanted more contact and information from the agencies or were concerned about the adequacy of funding and resources for the programs.

The Integrated Services system continued to meet expectations this year. Program staff have worked diligently to support participants to improve the quality of their lives by attending to their physical and mental health, participating in their communities, and engaging in employment.

*SYSTEM OUTCOME RESULTS – KNOWLEDGE EMPOWERS YOUTH*

The KEY program is a subsidiary Integrated Services Program for young adults transitioning from the foster care system. The program offers the same flexibility of services as the Integrated Services Program. Overall, the program met expectations this year. The program excelled in seven outcome areas and met expectations in five others. The program excelled in Education, Participant Satisfaction, Participant Empowerment, Somatic Care, Community Inclusion, Psychiatric Hospitalizations, and Administrative Outcomes. The program met expectations for Community Housing, Employment–Working Toward Self–Sufficiency, Employment–Engagement Toward Employment, Negative Disenrollments, and Quality of Life. The program was challenged in three outcome areas: Homelessness, Jail Days, and Emergency Room Visits for Psychiatric Care.

Consistent with previous evaluations, KEY participants report that they are very satisfied with the services that they receive and the staff who work with them. In interviews, participants praised KEY staff for being persistent and nonjudgmental, helping participants to become more independent and responsible adults. This year, participants reported being satisfied with the quality of their lives, although not as much as in the past few years. If they were dissatisfied, it was most likely with a lack of improvement in employment or school.



In part, participant satisfaction is a reflection of the dedication, resourcefulness and flexibility of the KEY staff. File reviews and interviews indicate that KEY staff see or are in contact with participants frequently. Program staff use cell phones, texting, email and face-to-face visits to provide support. They meet with participants in their homes, their friends' homes, the community and the KEY office. The program also has a Facebook page to communicate information about employment leads and deadlines for academic programs. Of note, the program had some staff turnover with two staff members leaving.

In part, participants' satisfaction with the program may reflect how much the staff support and contribute to their access and integration into the community. As with previous evaluations, the vast majority of participants (97%) met criteria for the Community Inclusion outcome. These young adults visited local attractions, participated in community events, and were active in their religious communities. The program reports that the youth are very willing to try new things, especially when it involves peers that they can relate to and socialize with.

More than one of every two participants was engaged in educational activities this year. Some new enrollees were finishing high school; others had to complete trainings or classes as part of their current employment. Several were balancing both work and school. In interviews, participants understood the value of education for career advancement. The program reports that participants often switch between work and school, working for a time then returning to school for a while. Several KEY participants have graduated from DMACC.

In contrast to the past three years, average psychiatric hospital days for the program declined. The program was also successful in ensuring that all participants received somatic care for the seventh year in succession. Thus, all participants received either an annual physical or ongoing care for medical needs.

Although the program was able to reduce psychiatric hospital days, it did report an increase in usage of the emergency room for psychiatric care. This year, ER visits for psychiatric care increased to 10 per year, compared to 4 last year.

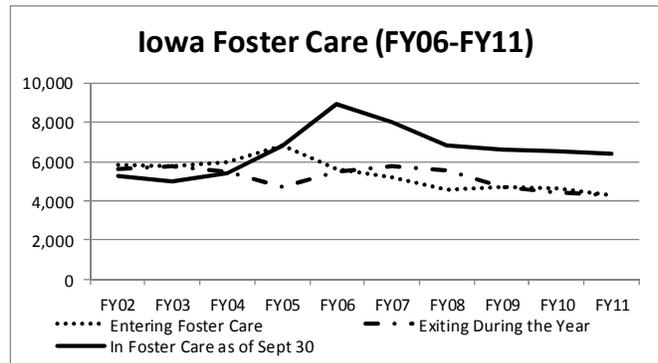
This year, the program maintained the percent of participants in Community Housing. Almost three of every four program participants' housing met safety, affordability, accessibility, and acceptability criteria. Participants tend to move frequently, and the program works diligently to evaluate and document the outcome criteria for each new housing situation in a timely fashion. The program reports that the new "Unstable Housing" event was useful for a few participants who moved frequently.

The program was also successful in supporting individuals to pursue and maintain employment. More than one of every three participants was engaged in employment, working at least 5 hours per week during the reporting weeks. More than one of four participants (29%) were working at least 20 hours per week and earning minimum wage or more. This year, one of every ten participants (9%) was working between 5 and 19 hours per week and earning at least minimum wage. The program's expectation has always been that all participants will be working or pursuing education.

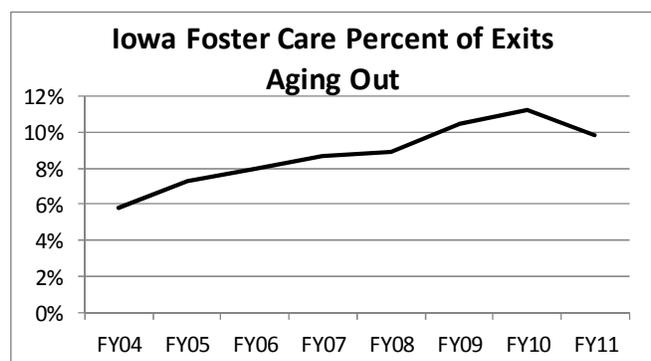
Although still a challenging area, the program did report less homelessness by participants this year than last year. While community housing is measured on a monthly basis, homelessness is assessed on a daily basis. Thus, KEY participants may be homeless for several days between housing changes, but ultimately establish a new housing situation by the end of the month that meets the safety, affordability, accessibility, and acceptability criteria.

The program also continues to be challenged to reduce jail days. This year, the program reported the highest jail usage since the program began.

As has been mentioned in previous evaluations, the KEY program serves an important community function, providing transitional support for youth in the foster care system to become responsible and productive adults. The most recent available statistics for Iowa suggest that the number of children in the foster care system has plateaued, down from the historic highs of FY06 and FY07. In FY11, the percent entering the system had decreased slightly, resulting in a decrease in the number in the system. Although fewer foster children were aging out of the system in FY11, the percent remains relatively high compared to a decade ago (U.S. DHHS, 2012). Thus, the need for the KEY program remains.



Pending legal challenges, 2014 provisions of the Patient Protection and Affordability Care Act of 2010 (Pub L No. 111-148) will require states to provide Medicaid to all youth aging out of the foster care system until age 26, regardless of income. These provisions were included in the act to provide insurance for former foster children, noting the higher rate of mental health and medical challenges that they face as adolescents compared to their peers (American Academy of Pediatrics, 2012). Several recent studies have indicated that continued support of former foster children is cost effective in terms of improved academic achievement and, therefore, income potential, as well as decreased likelihood of arrests and use of public benefits (Burley & Lee, 2010).



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### *SYSTEM OUTCOME RESULTS – FORENSIC ASSERTIVE COMMUNITY TREATMENT*

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The FACT program is a subsidiary Integrated Services Program, offering the same flexibility as the Integrated Services Programs but specifically serving adults who are at high risk or have a history of criminal justice involvement. Utilizing a self-contained team composed of professionals from psychiatry, nursing, addiction counseling, vocational rehabilitation, and the criminal justice system, this forensic focused best practice service model provides treatment, rehabilitation, and support services. Services are available seven days per week, twenty-four hours each day to assist individuals with building independent living and coping skills in real life settings.

The FACT program began serving individuals in November 2011. The program started the current fiscal year with 23 participants and ended the current year with 27. During the year, the program enrolled 12 new participants and disenrolled a total of 8 participants. Although developed as a five-person team approach, the program reports that it has run understaffed for most of the year. Individual staff cover multiple roles to make the model work. While the last evaluation provided baseline data, this is the first year for the FACT evaluation to have performance expectations for the outcome measures.

This year, the program was successful in minimizing negative disenrollments and use of the emergency room for psychiatric care. As staff have been able to work with and build supports for participants, the program was also successful in reducing jail days and psychiatric hospital days. Thus, participants spent less time in institutional care and more time in the community. Almost all program participants received somatic care during the year, either a physical, ongoing care, or a workup as part of a hospital or jail admission.

This year, the program was more successful in encouraging and supporting participants to pursue educational opportunities. Three of the program participants were working on employment related training or taking college classes. In contrast, the program was challenged to meet employment outcome expectations. At most, two individuals were employed during any reporting week, one working toward self-sufficiency and the other engaged toward employment. The program reports that employers often are hesitant to hire individuals with criminal records. Thus, the program will face considerable challenges to both motivate participants and help them build employment skills, as well as to establish relationships with employers in the Des Moines area who are willing to employ program participants.

Unfortunately, program participants spent less time this year in housing that was safe, affordable, accessible and acceptable, and more time homeless. In part, these challenges were a result of changes in program policy. Initially, the program arranged for and paid for housing for almost all of the program participants. Toward the end of the first year, the program began developing housing agreements with participants which tie rent assistance to goals. The program takes into account both financial need and needs related to goals, such as the need for a safe environment to remain clean and sober or the availability of employment opportunities for participants seeking jobs.

Although demonstrating some improvement, the program continues to be challenged to meet documentation expectations. Reported results for Community Housing were adjusted due to lack of or inconsistent documentation. Participant empowerment was another challenging area. The program has become more proficient at ensuring that individuals develop individualized and measurable goals and that those goals are reviewed regularly. However, documentation that employment or education was addressed with participants was lacking for a couple of reviewed files. The “gentle hassling” approach of talking about and encouraging participants to pursue education and employment has been successful for other PCHS programs. Incorporating this approach may help the program to improve their performance, particularly for employment.

Recent research applying the FACT model suggests that participants may be well served by this approach. A recent review of community-based alternatives to incarceration for individuals with severe mental illness (Heilbrun, et al., 2012) finds that specialized Assertive Community Treatment (ACT) programs compared to the standard treatment result in fewer criminal justice events (e.g., bookings, convictions, jail time), improvement in substance abuse problems, as well as better functioning and economic self-sufficiency, particularly for programs with better fidelity to the ACT model. In within subjects studies, FACT participants have also been reported to have fewer psychiatric hospital days and jail days compared to the year prior to their participation in these FACT programs (McCoy, Roberts, Hanrahan, Clay & Luchins, 2004; Thresholds State, County Collaborative Jail Linkage Project Chicago, 2001; Weisman, Lamberti, & Price 2004).

Particularly compelling, a recent study which randomly assigned participants to FACT or a standard approach (n=134) in California (Cusack, Morrissey, Cuddeback, Prins, & Williams, 2010) found that participants in their FACT program had fewer jail incarcerations, more outpatient contacts, and fewer psychiatric hospital days than similar participants who received the standard, county-operated public behavioral health system services. Participation in their FACT program did result in somewhat higher outpatient costs, due to higher service usage, but this was partially offset by lower hospitalizations and jail days. Of note, the study randomly assigned participants to conditions, measured outcomes at one and two years post-randomization, and reported a high ACT model fidelity score for the FACT program in the study.

In the coming year, the FACT program will likely struggle with ongoing staffing issues. As of July 2013, the program has a new director, but has lost its program specialist. In addition to addressing staffing issues and orienting new staff to both the program model and the evaluation expectations, PCHS’s FACT program might do well by conducting ongoing fidelity assessments to determine and possibly improve their adherence to the ACT model, as well as reaching out to other similar programs in the country to learn from their successes.

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#### *SYSTEM OUTCOME RESULTS – CASE MANAGEMENT*

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The Case Management Program met expectations this year with a 79% overall performance. The program consists of six Case Management agencies. This year, five of the six Case Management agencies met or exceeded expectations in their overall performance. The Case Management Program exceeded expectations in the areas of Homelessness, Education Transition, Participant Satisfaction, Family and Concerned Other Satisfaction, Psychiatric Hospitalizations, Emergency Room Visits for Psychiatric Care, and Administrative Areas. The program met expectations for Community Housing, Involvement in the Criminal Justice System, Employment–Engagement Toward Employment, Adult Education, Participant Empowerment, Somatic Care, Negative Disenrollment, and Quality of Life outcomes. The system was challenged by three outcome area: Employment–Working Toward Self–Sufficiency, Case Management Involvement in Child Education, and Community Inclusion.

As has been the case for the past seven years, the Case Management system continues to maintain high participant and concerned other satisfaction and satisfactory levels of quality of life. In interviews, participants and concerned others mentioned how much they appreciate the knowledge and resourcefulness of Case Managers. They describe these staff members as truly dedicated professionals who are there to advocate for individuals who may not have others to advocate for them. Staff members treat both participants and concerned others with respect and assist them to find the best fitting services to meet their needs; they also provide support and assistance when issues arise with service providers.

Participants and family members have reason to be satisfied with the system. The system excelled in supporting participants so that few were homeless, spent time in psychiatric hospitals, or visited emergency rooms for psychiatric care. Participants spent fewer days in jail than in the past two years. More adults were pursuing education and employment opportunities. Teenagers were involved in transition activities, better preparing them for independent living as adults. Negative disenrollments, the majority of which are participants who have been sentenced to prison, have remained relatively low at about 1%. Agencies continue to be diligent in completing administrative outcomes.

Although the system was challenged by Community Inclusion, in part as a result of increased targets, more than eight of every ten participants were active in their communities. In file reviews, evaluators saw an unprecedented variety of community activities. Each year this list grows, providing additional suggestions for staff at all programs to share with their participants. In interviews, both participants and family members credited Case Managers with increasing participants' access to, and comfort in, the community. Some family members described how participants would be shut-ins without services. Across agencies, participants reported being more able to deal with others due to decreased anger and increased self-esteem, a necessary cornerstone for pursuing community activities, school, volunteerism, and work. In turn, both participants and families reported that involvement in such pursuits increased participants' sense of purpose and well-being, improving their mental, and sometimes physical, health. These first steps were predicated on individuals' relationships with their Case Managers, who took the time to get to know participants, recognized their potential, and sometimes gently encouraged them to realize it.

Over the past four years, the Case Management system has been able to reduce and maintain reductions in psychiatric hospital days, averaging less than two days per participant per year. Participants were unlikely to visit the emergency room for psychiatric care, averaging 3 ER visits per year for every 100 Case Management participants. Participants also spent less time in jail this year, averaging about 1.5 days per participant. It is of note that individuals who are arrested often lose their eligibility and are transferred to other county service programs, and, therefore, their jail days are not accrued by the Case Management program. This issue also affects negative disenrollments, as individuals who are in jail are often ineligible for Case Management. Thus, PCHS may want to consider whether number of arrests might be a more comparable statistic for the program.

As participants' community involvement and education has gradually improved over the past several years, file reviews suggest that participants are choosing what they want to do and services are supporting them in their individual pursuits. Almost one of every four adult participants was involved in education opportunities, working on a GED, finishing high school, pursuing college courses or involved in continuing education options. These educational opportunities are likely to enhance employability for these participants.

This year, adult participants were also more likely to be engaged toward employment. One of about every four participants was working at least five hours per reporting week, up from one of every five last year. All of the programs that serve adult participants reported increases for employment. In addition to improvements in economic conditions, gradual growth in community involvement, education, and continued gentle constant encouragement all likely contributed to improvements in employment. Supported employment programs have expanded to meet increased demand and PCHS continues to reimburse employment providers meeting employment milestones.

In terms of child education outcomes, the Case Management system was challenged by the Case Management Involvement in Child Education outcome. This result is often an issue of annual individual education plan (IEP) meetings being scheduled for all students over a few days. Thus, Case Managers who serve primarily child participants are unable to attend meetings for all their child participants when the meeting schedules overlap. Despite being challenged by the outcome, file reviews indicate that Case Managers are involved with child participant education issues, visiting students at school, meeting with teachers, and discussing education issues with parents. In interviews, several parents expressed how helpful it was for them when Case Managers were able to attend school and individualized education plan meetings. Having Case Managers informed and involved in the school plans helps to promote efficiency of services, consistency in communication, and ability for service providers to support the goals that students are working on at home and at school.

This year's evaluation indicates that more than 8 of every 10 participants are living in safe, affordable, accessible and acceptable housing. Unfortunately, four of the six agencies continue to struggle with documentation for this outcome area. For most, it is a matter of assessing new housing situations promptly after a move and updating information in the electronic system in a timely fashion. In the related area of homelessness, agencies have been able to keep the number of days to about one per three participants. Case Managers work diligently to arrange services so that individuals can maintain their housing or to find alternative housing when issues arise.

Although the evaluation indicates that the Case Management system met expectations this year, the system faces transitions in the coming year. As of June 30, Golden Circle discontinued their Case Management program, transferring participants to Eyerly Ball's Integrated Health Home (IHH). As of July 31, Broadlawns CAP program will transfer their eligible participants to Broadlawns' own IHH. The participants with the remaining providers for mental illness, CSA and Easter Seals, will need to be transferred to an IHH by December 31, 2013. While the programs have worked to minimize disruptions for participants, for example transferring Broadlawns' CAP staff to their IHH program, there are likely new processes and procedures, as well as staff changes, to which participants, program directors, and oversight agencies will need to adjust. Although PCHS will remain as the regional Central Point of Coordination for participants and, therefore, hopes to continue to measure outcomes so as to monitor and report to participants' system progress, evaluations of the IHH programs will be the purview of Magellan, under contract from the Department of Human Services. Without the chronic mental illness population, which this year made up over a third 38% of Case Management cases, the strengths and challenges of the Case Management program may change. However, Polk County's Case Management system has demonstrated its dedication to enhancing the lives of people with mental health issues, intellectual disabilities, and developmental disabilities for more than a decade, and the program's focus on the individuals served should continue to ensure that they are supported and included in their communities.

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#### *SYSTEM OUTCOME RESULTS – SERVICE COORDINATION*

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The evaluation suggests that the Service Coordination program met expectations this year. The system met or exceeded expectations in 12 of the 17 outcome areas. The system exceeded expectations for Participant Satisfaction, Concerned Others Satisfaction, Appropriate Disenrollments, Psychiatric Bed Days, Emergency Room Visits for Psychiatric Care, and Administrative Areas. The system met expectations in the areas of Community Housing, Engagement Toward Employment, Empowerment, Somatic Care, Negative Disenrollments, and Quality of Life. The system was challenged in five areas: Homelessness, Involvement in Criminal Justice, Employment Working Toward Self-Sufficiency, Adult Education, and Community Inclusion.

The Service Coordination system had provided three functions – a triage to help determine what services individuals needed and which program would best serve their needs, a program for individuals that needed only minimal services and supports, and a place for new referrals to receive minimal services while they waited for openings in the other programs. During FY12, the need for the waiting list function was reduced, and the program served only the triage and minimal services functions. In addition, individuals served in ICFs were no longer served under the program. Although the program served both triage and minimal services functions, the evaluation includes only those receiving minimal services. Therefore, this is the first year for which programs are evaluated based solely on participants receiving minimal services and not including those from the triage track or ICFs.

An important measure of any service system is the satisfaction of system participants and their concerned others. This year, the service coordination system excelled for both Participant and Concerned Other Satisfaction, demonstrating improvements in both areas. Both participants and their concerned others were very satisfied with the services and supports that they received from the Service Coordination system. In interviews, participants praised their staff for being knowledgeable, resourceful, and supportive and were grateful for the assistance that the staff and system can provide. Participants also reported being satisfied with the quality of their lives and the improvements and progress that they have made since entering Service Coordination.

In addition to satisfaction measures, the system performed well in several areas. Almost eight of every ten program participants were living in housing that was safe, affordable, accessible and acceptable. Few participants were negatively disenrolled. Even without the triage participants, many programs were effective in transferring participants to other programs when they needed a higher level of care or appropriately disenrolling them to independence when they no longer needed services. Program participants had few if any visits to the emergency room for psychiatric care and spent little time in a psychiatric hospital. Almost all participants received somatic care during the year. Based on the annual file review, agencies improved their documentation for both Community Housing and Participant Empowerment. Thus, the program has been successful in meeting many of the needs of its participants.

In contrast to the last several years, the system reported improved performance for both employment outcomes. More than one of every four participants (27%) was engaged toward employment, working at least five hours per reporting week and earning at least minimum wage. However, only 15% of participants were working at least 20 hours per week. While this is an improvement over the 11% reported last year, this falls short of PCHS's expectation of at least 18% of individuals working toward self-sufficiency. In time, individuals working at least a few hours may build the confidence and skills and be able to gain additional hours at their current employment or pursue better employment opportunities.

This year, the system reported several challenging areas. Overall, fewer participants engaged in adult education activities and community inclusion events. As with many of PCHS's other systems, agencies reported that Service Coordination participants spent more days homeless and in jail than in the past five years.

Changes in the results from previous years are difficult to interpret because of the system-level changes this year. Changes may be the result of several factors including the reduced size of many programs, the reduction in the diversity of populations served (e.g., no ICF participants, no triage participants), and the elimination of the waiting list. The Service Coordination system should be commended for being able to sustain its overall performance in the face of extensive system alterations. Thus, the program has once again demonstrated its resilience and adaptability to meet the needs of many different individuals.

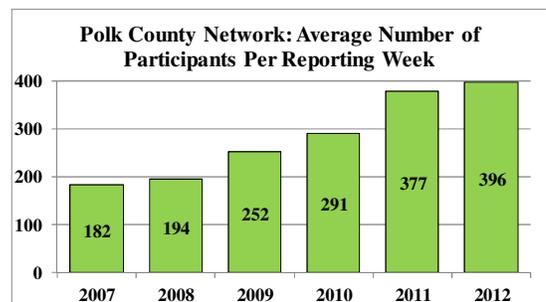
*SYSTEM OUTCOME RESULTS – SUPPORTED EMPLOYMENT*

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In this sixth year, the Supported Employment Scorecard Evaluation suggests that the supported employment network continues to be successful in supporting individuals to obtain and maintain employment. The network is composed of five service providers (Candeo, Goodwill Industries, H.O.P.E., Link Associates, and Optima Life Services). Over the past six years, the supported employment network has continued to increase the number of individuals served. Participants report being satisfied with the services they receive and the staff who work with them. Programs report that employed participants received higher wages and worked more hours than in 2011. The network reported a small increase in the percentage of participants working toward self-sufficiency (i.e. the percentage of participants working 20 or more hours a week and earning at least minimum wage) from 33% in 2011 and 36% in 2012. The evaluation found that documentation of employment barriers and wages and hours worked improved in 2012.

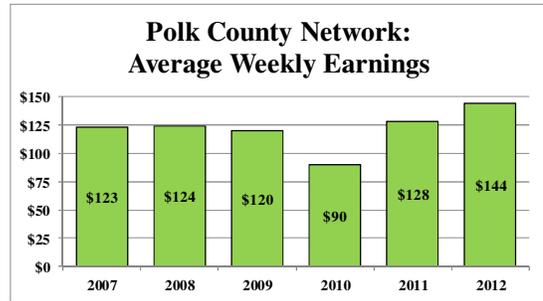
The annual System Employment Scorecard Evaluation serves as the foundation for the Pathways to Self-Sufficiency Employment Scorecard, a tool to support informed choice. Choosing an employment agency is an important decision. The scorecard documents the efforts of Candeo, Goodwill Industries, H.O.P.E., Link Associates, and Optima Life Services supported employment programs to increase the quality of life of individuals served as well as their commitment to providing responsive, efficient, and effective employment services.

The Polk County Network continues to expand, more than doubling its capacity in 5 years. Agencies continue to report that there is a demand for their services and most continue to expand to meet that demand. The system served almost 400 participants per reporting week in 2012, an increase of 5% compared to 2011. The typical participant had an intellectual disability (77%), qualified for Level 3 supports (44%), presented with four barriers to

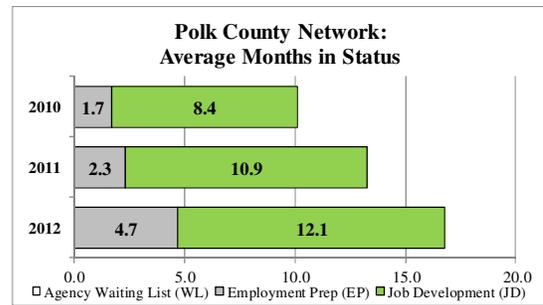


employment, and spent almost 5 months in employment preparation and a year in job development.

Supported employment participants continue to report increased average weekly earnings. In 2012, participants averaged over \$8 per hour and worked about 17 hours per week. Although the average hourly rate remained stable compared to last year, the increase of an hour per week resulted in an average increase of about \$16 per week compared to 2011. Participants are most likely to be working in housekeeping or janitorial services.



Along with increases in the number of participants served and the wages that employed participants are earning, the amount of time that participants spend waiting to be employed are also increasing. Agencies reported individuals did not have to wait to get into a supported employment program, but spent more time gaining additional employment skills and finding a job. Regardless of whether participants acquired employment in 2012, supported employment participants doubled the amount of time that they spent in employment preparation and invested an additional month in job development on average this year.



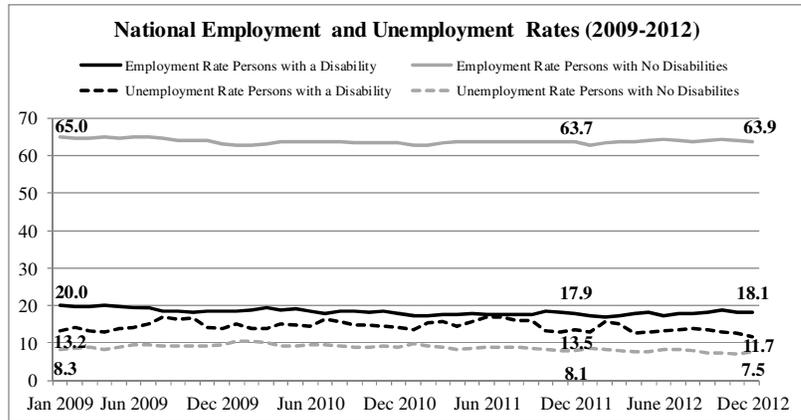
Based on quarterly data, participants spent more than 16 months preparing for and seeking employment. Of those who sought employment, less than half (43%) obtained employment during the year. Nationally, the Bureau of Labor Statistics (BLS 2012) estimated that individuals seeking employment, regardless of disability status, averaged 8.5 months (mean 37.0 weeks, median 18.1 weeks) unemployed in 2012, compared to more than 9 months (mean 39.7, median 21.0 weeks) in 2011. Of note, only one provider, Optima Life Services, provided employment preparation services. Their reported increases in the amount of time that individuals spent in this status is likely attributable to their new Project Search program where individuals spend 6 months building skills and interning for an employer.

As noted in previous evaluation reports, supported employment agencies often are challenged by frequent staff turnover for both job developers and job coaches. To begin to address this issue, this year's evaluation includes results from an online survey of direct support staff at four of the five supported employment agencies. One agency chose not to have their staff members participate. More than two-thirds (68%) of the direct support staff members responded to the survey. The results indicate that staff members enjoy their jobs, especially working with program participants and collaborating with co-workers. Survey respondents also provided a wealth of suggestions for improving the system, including ways to use technology to enhance efficiency, providing incentives or additional reimbursement for staff members who work evening and weekend shifts, and providing work schedules more in advance to employees.

One of the areas that employees suggested for improvement was the use of technology for documentation. The evaluation indicates that while documentation improved in some areas it continued to be challenging in others. System results suggest that agencies improved their accuracy documenting barriers to employment and reporting week information, including wages earned and hours worked. However, three of the five agencies reported decreased accuracy and continue to be challenged by documenting services. For most, this was an issue of the infrequency of contacts or the lack of documenting those services. Some individuals being served were seen rarely over the course of the calendar year, or, if they were seen, the services were not documented. In response to the employee satisfaction survey, several employees suggested the desire for additional training on documentation and suggested ways to use technology to make the documentation process easier and more efficient for them.

As the system plans for the coming year, national and local employment statistics suggest small improvements in rates of employment. Nationally, employment and unemployment rates improved slightly both for individuals with and those without disabilities from December 2011 to December 2012. In Polk County, unemployment rates decreased from 6.3 in June 2011 to 5.4 in June 2012 (Gordon, 2012), although still nowhere near their pre-recession rate of 3.4 in 2006.

Although these employment statistics are encouraging, both the Iowa Policy Project (Gordon, 2012) and the Economic Policy Institute (Mishel & Shierholz, 2011) caution that the long period of high unemployment rates has contributed to stagnant wage rates, lower family incomes, and decreasing average wealth for employed individuals. The Iowa Policy Project's recent report, "The State of Working Iowa" (Gordon, 2012), notes that the state is losing jobs in higher-wage sectors while gaining jobs in lower-wage



sectors, employers are less likely to provide health care coverage and, when they do, employees are having to contribute more of their pay for annual family premiums. These issues are exacerbated by the increase in the percent of individuals with higher educational attainments who are employed in low-wage jobs. Schmitt and Jones (2012) report that from 2009–2011 close to half (44.4%) of Iowans in low-wage jobs have completed at least some college, compared to one in four (25.6%) from 1979–1981. Thus, network providers will continue to be challenged as their participants compete with more highly educated applicants even in low-wage positions. Programs such as Medicaid for Employed People with Disabilities (MEPD) may continue to be needed to help participants access health-care coverage. The system may want to investigate ways to encourage financial literacy to help working participants stretch their resources.

Despite challenging economic conditions, the Polk County Network continues to provide supported employment services to an increasing number of individuals. This report reflects those individuals' appreciation of the providers' continuing efforts to support them in their pursuit of meaningful, sustaining employment. The programs should be commended and recognized for their continued efforts to find and implement innovations, from convening support groups to incorporating more evidence-based practices. Thus, the Polk County Network continues to rise to the challenge of providing individualized and quality supported employment services to the residents of Polk County.

## WAIT LIST INFORMATION

Polk County makes every attempt to maintain eligibility guidelines and service availability as outlined in the Polk County Management Plan. However, the ability to do so is contingent solely on the Iowa Legislature's appropriating sufficient funds to maintain current eligibility and services and to meet projected increases in the number of new participants. When necessary, individuals placed on the wait list are first served by the date placed on the wait list, in compliance with federal requirements (see also County Report #5).

## PROGRESS TOWARD GOALS AND OBJECTIVES

### STRATEGIC PLAN ~ FISCAL YEAR 2013 YEAR END STATUS

Polk County Health Services, Inc. exists to support improved access to health care and to promote full citizenship for people with mental illness, intellectual disabilities, or developmental disabilities. FY13 is the fourth year of the three year plan. During the 2012 legislative session, counties were granted extensions on their FY10 – FY12 strategic plans due to the Mental Health Disability Services re–design effort. Polk County’s strategic planning focus areas are presented.

#### STRATEGIC COMMITMENT #1: SYSTEM RESOURCES & INFRASTRUCTURE

**PINNACLE ISSUE #1:** We can not control funding availability because of state and federal priorities and uncertainties. We must continue to adapt and resolve funding changes to ensure that the greatest number of people are able to receive quality supports.

**PINNACLE ISSUE #2:** All providers are challenged with recruiting and retaining qualified staff. Providers are being held to higher level of accountability with heightened audits and an increase in the amount of detail needed to meet minimum Medicaid documentation standards. Federal and State policy over–interpretation has resulted in a re–direction of resources from direct services to paperwork and technology. Providers are additionally challenged by state caps on allowable mileage reimbursement despite rising fuel costs.

**GOAL:** To establish a system of resource and infrastructure management to accommodate demands on the capacity of the system.

OBJECTIVE #:	OBJECTIVE DESCRIPTION:
1	Increase revenues by working with legislators, other counties, providers, consumers, and their families.
2	Deliver services on a timely basis in appropriate settings and in an effective and efficient manner.
3	Work with provider agencies to identify creative tools for recruiting and retaining qualified staff.

#### **FY13 STATUS:**

- Objective 1 (Increase revenues by working with legislators, other counties, providers, consumers, and their families.):
  - An application for FY13 Transition Funds was denied. PCHS staff advocated throughout FY13 for the Legislature to appropriate funds at the \$47.28 per capita level. In order to be eligible to receive FY14 funding, about \$9 million in Medicaid bills for services prior to 7/1/12 were paid on June 26<sup>th</sup>. Additionally, \$1.7 million of the \$7.7 million in Risk Pool funding received in FY12 was not expended by June 30<sup>th</sup> and will need to be paid back to the State during FY14.
  - PCHS staff participated in re–design meetings. Changes were made to Polk MIS to record County of Residence. Additionally, residency information was sent to the Iowa State

Association of Counties (ISAC) to incorporate into County Community Services Network (CSN) reports.

- There was no progress in creating a Consumer Council.
- Polk County received an exemption to be a one County region. MHDS re-design implementation was complicated by the roll-out of Integrated Health Homes (IHHs) in Polk County. Toward the end of the fiscal year, administrative rules were proposed for core services and regions. The Department of Human Services did not implement level of support assessments for individuals with intellectual disabilities by June 30<sup>th</sup> as directed by the 2012 session of the Legislature, so Polk County continued to use its own tools. PCHS staff continue to monitor impact of system changes on individuals served.
- PCHS staff monitored potential effects of the Affordable Care Act on Polk County responsibilities and resources. Eyerly Ball and Broadlawns began converting care coordination for persons with mental illness from Targeted Case Management to Integrated Health Homes (IHHs). PCHS staff worked with Eyerly Ball & Broadlawns to make the transition to IHHs as seamless as possible to consumers and to preserve quality services in spite of significantly higher caseloads in the IHHs.
- Objective 2 (Deliver services on a timely basis in appropriate settings and in an effective and efficient manner.):
  - PCHS staff continue to monitor the length of time it takes service coordinators to determine eligibility and connect individuals with on-going services. FY13 was the first year the Service Coordination program triaged individuals based on the urgency of their situation. Individuals served during FY13 averaged about 50 days to be connected with ongoing Service Coordination, Targeted Case Management, and Integrated Services. Individuals with emergent needs were seen within 19 days while individuals without emergent needs were seen within 28 days (an average of 25 days).
  - Targeted Case Managers continue to spend about 15% of their time in face to face, phone, and collateral contacts.
  - To implement the change in state law to base payment on residency instead of legal settlement, Case Managers coordinated transitions for individuals living outside of Polk County in community based settings to other case management service providers.
- Objective 3 (Work with provider agencies to identify creative tools for recruiting and retaining qualified staff.):
  - The Positive Behavior Support (PBS) Network sponsored several nationally recognized speakers including Dr. Ken Minkoff to provide an overview of multi-occurring disorders and Tonier Cain to share her inspirational story and to provide an overview of trauma informed care. The PBS Network additionally collaborated with Iowa-based resources to provide ongoing training and technical assistance with Motivational Interviewing, person-first language, trauma-informed care, employment, and to facilitate a roundtable discussion.

**FY13 KEY INDICATOR:**

Metric	FY13 Goal	Jul12 to Sept12	Oct12 to Dec12	Jan13 to Mar13	Apr13 to Jun13
Average length of time to first face to face contact in Service Coordination Triage	Baseline	14 days	13 days	25 days	25 days

## STRATEGIC COMMITMENT #2: EMPLOYMENT

**PINNACLE ISSUE:** Employment services must continue to be re-designed to fit our values. While PCHS and Polk County network providers have reached consensus about the value of employment, there remains a lack of clarity about the purpose of employment among other stakeholders. Public perception does not view individuals with disabilities as capable of working. Current services and funding streams do not promote increased self-sufficiency.

**GOAL:** Polk County will see movement toward self sufficiency.

OBJECTIVE #:	OBJECTIVE DESCRIPTION:
1	Continue to explore additional supports/services as people begin moving toward self sufficiency.
2	Continue to develop community integration supports/services within current restrictive budget constraints.

### FY13 STATUS:

- Objective 1 (Continue to explore additional supports/services as people begin moving toward self sufficiency.):
  - Members of the Employment Transition Committee met with the Case Management Positive Behavior Support (PBS) team to discuss the desire to develop a collaboration that will identify and break down barriers.
  - The Employment Guiding Coalition reviewed outcome data collected. Reasons for discharge were expanded and revised to be similar to service coordination discharge reasons to allow better analysis. Employment status was redefined to better address wait times.
  - Employment Transition Committee reviewed new services added/scheduled to begin. A Case Management Training presentation was also developed.
  - Direct Support Professional (DSP) training was added to the State Direct Care Training Initiative. The Des Moines Area Community College (DMACC) course was scheduled for the first class of DSP students.
  - Candeo began a pilot project with the state initiative to implement Customized Employment for six individuals with significant barriers.
  - Short term, curriculum based skills training in partnership with Casey's was developed by Link Associates.
- Objective 2 (Continue to develop community integration supports/services within current restrictive budget constraints.):
  - PCHS staff are working to revise monitoring methodology now that counties no longer have access to Medicaid waiver service information for individuals we serve.

### FY13 KEY INDICATOR/S:

Metric	FY13 Goal	Jul12 to Sept12	Oct12 to Dec12	Jan13 to Mar13	Apr13 to Jun13
Increase the percentage of adults in the labor force working 20 or more hours per week at minimum wage or higher	>18%	12%	11%	11%	12%

Increase the percentage of adults in the labor force working greater than 5 hours per week at minimum wage or higher	>18%	24%	25%	24%	23%
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## STRATEGIC COMMITMENT #3: COMMUNITY LIVING

**PINNACLE ISSUE:** While the state institutions still use restrictive techniques, community providers may not, but the positive alternatives haven't yet become part of the community provider culture. Residential providers are not comfortable serving a growing number of individuals with complicated and sometimes intense needs and, as a result, these individuals enter and over-utilize inappropriate levels of care (i.e. jail or hospital) or are forced to leave Polk County to access services.

**GOAL:** Provide opportunities for individuals to live healthy and productive lives within the community.

OBJECTIVE #:	OBJECTIVE DESCRIPTION:
1	Develop ability to provide residential/support services to all individuals within Polk County.
2	Explore ways to provide services to individuals with immediate needs.
3	Develop/implement Community Living Scorecard.
4	Explore alternative funding streams to fund residential/support services.

### FY13 STATUS:

- Objective 1 (Develop ability to provide residential/support services to all individuals within Polk County.):
  - Developed a plan to give individuals living outside of Polk County in large residential facilities the option to move back to Polk County or to smaller community living programs. As of June 30<sup>th</sup>, 32 individuals are receiving community living supports outside of Polk County in licensed facilities. The net number funded and living outside Polk County in licensed facilities reduced by 80 individuals. This reduction was due, largely, from the State assuming financial responsibility for ICF/ID services.
- Objective 2 (Explore ways to provide services to individuals with immediate needs.):
  - Residential Options continues to meet on a bi-weekly basis to help individuals live and work within the community. Targeted Case Managers, Service Coordinators, and Integrated Services Staff were supported in their coordination efforts for almost 70 individuals.
- Objective 3 (Develop/implement Community Living Scorecard.):
  - The Community Living Scorecard was originally designed to function as a management tool to support community living providers. Authorizations for Medicaid funded services, the foundation of connecting individuals to community living providers, were no longer entered into Polk MIS effective 7/1/12. Discussions to identify data collection options also re-visited the purpose and scope of the Scorecard. The Positive Behavior Support (PBS) outcomes related to workman's compensation claims, staff turnover due to job dissatisfaction, and consumers' major incident reports were discontinued during the fiscal year and thus will not be included into the Scorecard. The next Community Living Scorecard Evaluation is scheduled for the spring of 2014.
- Objective 4 (Explore alternative funding streams to fund residential/support services.):

- Continued to monitor service authorizations to make sure county funds are not used for individuals who are eligible for Medicaid-funded programs.

**FY13 KEY INDICATOR/S:**

Metric	FY13 Goal	Jul12 to Sept12	Oct12 to Dec12	Jan13 to Mar13	Apr13 to Jun13
Decrease net number of individuals moving out of Polk County to licensed facilities.	Baseline	36 Individuals (-76)	33 Individuals (-78)	34 Individuals (-79)	32 Individuals (-80)

## STRATEGIC COMMITMENT #4: TREATMENT

**PINNACLE ISSUE:** The goal of mental health treatment is often based on a medical model of symptom remediation or elimination before people can get on with their lives. Treatment models based on recovery and resiliency concepts and principles offer people a better chance to live a full and productive life.

**GOAL:** Treatment services will incorporate recovery concepts and principles and people will receive the treatment service that best fits the treatment goals.

OBJECTIVE #:	OBJECTIVE DESCRIPTION:
1	Offer training opportunities for practitioners on recovery concepts.
2	Incorporate recovery concepts and principles into services.
3	New services must explicitly state how recovery principles will be applied.
4	Increase collaboration between treatment, residential and employment providers based on a common recovery based plan.

**FY13 STATUS:**

- Objective 1 (Offer training opportunities for practitioners on recovery concepts.):**
  - PCHS staff continued to collaborate with the Positive Behavior Support (PBS) Network, Community Living, and Employment Guiding Coalitions to provide on-going training opportunities related to motivational interviewing, trauma informed care, multi-occurring disorders, and positive behavior support. Jeanie Kerber facilitated another session of Motivational Interviewing this year. She additionally provided individual technical assistance to PBS Network agencies. Gladys Alvarez, Orchard Place, presented to the PBS Network on Trauma Informed Care. Dr. Ken Minkoff provided an overview on multi-occurring disorders.
- Objective 2 (Incorporate recovery concepts and principles into services.):**
  - This year's work with treatment providers shifted from utilization review to continued implementation of the Medication Access Program and creating capacity for doing serum medication analysis at the Eyerly Ball Clinic. The Medication Access Program was successful in establishing a contract with Primary Health Care Inc., so Eyerly Ball service recipients could access the 340B pharmacy. One of the unintended benefits of this collaboration was developing co-location of primary care services at the Eyerly Ball Clinic.
  - Implementation of treatment providers' offering an outpatient model that is expected to cover 80% to 90% of new referrals for frequency and duration of outpatient services has been slow, however Eyerly Ball and Broadlawns developed open access appointment scheduling in an attempt to decrease wait times and achieve better access outcomes.

- PCHS staff continued to work with the Criminal Justice Coordinating Council (CJCC) to develop therapeutic alternatives to incarceration. PCHS staff prepared and presented a monthly report to the CJCC. The Jail Diversion Team and PCHS staff developed a fidelity tool from the values, objectives, and operational processes outlined in the Sheriff's Post Booking Jail Diversion Program Description. The Jail Diversion fidelity tool is a mean of evaluating the program.
- Objective 3 (New services must explicitly state how recovery principles will be applied.):
  - PCHS staff met monthly with the Forensic Assertive Community Treatment Team to discuss recovery based principles as the Team was developing. In May of 2013, Broadlawns developed a hospital transition program. The program is designed to support people during a transition from the hospital to their residence before hospitalization. The goal is to release people from the hospital who need some additional assistance but do not need the assistance on an acute care unit.
- Objective 4 (Increase collaboration between treatment, residential and employment providers based on a common recovery based plan.):
  - Iowa's implementation of the Affordable Care Act did not begin to take shape until June 2013 so it was difficult to begin discussing the policy, operations, and implications of Health Reform with treatment providers. PCHS staff and the treatment providers focused on the legislative change from legal settlement to residency. There was no progress on developing a common treatment plan. PCHS and Eyerly Ball planned to pilot a common treatment with Eyerly Ball's Electronic Medical record once Case Management began using the system.

**FY13 KEY INDICATOR/S:**

Metric	FY13 Goal	Jul12 to Sept12	Oct12 to Dec12	Jan13 to Mar13	Apr13 to Jun13
First offered appointment for outpatient treatment	<10 days	0	0	0	0
Minimize jailing individuals with mental health issues thru Mobile Crisis Team	<2%	2%	2%	2%	2%

## NUMBER, TYPE, AND RESOLUTION OF APPEALS

While County policy is outlined in the County Management Plan, the Service Appeal Board reviews circumstances in which Polk County funds are authorized, allocated or expended and one of the following is true: the specific service needed is not included in the County Management Plan; the chosen provider is not a member of the PCHS Provider Network; the service is to be provided outside Polk County, the participant does not meet financial eligibility; the participant does not meet the clinical or service access criteria; the participant has legal residence in Polk County, has legal settlement in another county, has a payment denied by county of legal settlement, but is otherwise eligible for and needs a service contained in the Polk County Management Plan; the participant is enrolled in the Program for Assertive Community Treatment (PACT) services at Golden Circle Behavioral Health and the PACT team is requesting short-term residential or vocational services to treat psychiatric symptoms; or the participant has legal settlement in Polk County and residency in another county. Another function the Service Appeal Board fulfills is to review and determine resolution of appeals. During this fiscal year, there were no appeals presented to the Service Appeal Board.