

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
May 19, 2011, 9:30 am to 3:00 pm
Iowa State Capitol, Legislative Dining Room
Des Moines, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick	Cindy Kaestner
Lynn Crannell	Gary Lippe
Jan Heikes	Zvia McCormick
Richard Heitmann	Laurel Phipps
Chris Hoffman	Jack Willey
David Hudson	Craig Wood

MHDS COMMISSION MEMBERS ABSENT:

Senator Merlin Bartz	Representative Lisa Heddens
Richard Crouch	Linda Langston
Lynn Grobe	Susan Koch-Seehase
Senator Jack Hatch	Dale Todd
Representative Dave Heaton	Gano Whetstone

OTHER ATTENDEES:

Pam Alger	DHS, Targeted Case Management
Marilyn Althoff	Hills and Dales
Theresa Armstrong	DHS, MHDS, Community Services & Planning
Bob Bacon	U of Iowa, Center for Disabilities & Development
Teresa Bomhoff	Iowa Mental Health Planning Council; NAMI
Jim Ernst	Four Oaks
Connie Fanselow	DHS, MHDS, Community Services & Planning
Becky Flores	DHS, MHDS, Community Services & Planning
Karen Hyatt	DHS, MHDS, Community Services & Planning
Gretchen Kraemer	Iowa Attorney General's Office
Todd Lange	Office of Consumer Affairs
Laura Larkin	DHS, MHDS, Community Services & Planning
Geoff Lauer	Brain Injury Association of Iowa
Jerry Mayes	Olmstead Consumer Task Force
Beth Morrissette	Mental Health and Substance Abuse Network
Jeanne Nesbit	DHS, MHDS Division Administrator
Liz O'Hara	U of Iowa, Center for Disabilities & Development
Kelley Pennington	Magellan Health Services
Carolyn Pettit-Lange	Hillcrest Family Services
Ann Riley	U of Iowa, Center for Disabilities & Development
Rhonda Shouse	Iowa Mental Health Planning & Advisory Council

WELCOME AND CALL TO ORDER

Chair Jack Willey called the meeting to order at 9:15 am. Jack welcomed Commission members and guests and led introductions. No conflict of interest issues were identified for this meeting.

APPROVAL OF MINUTES

Laurel Phipps made a motion to approve the minutes of the April 21, 2011 meeting as presented. Craig Wood seconded the motion. The motion passed unanimously.

LETTER OF THANKS

Jack Willey proposed that the Commission send a letter to On With Life in Ankeny thanking Julie Fidler Dixon and her staff for the wonderful presentations and tour of the facility that they hosted for the April meeting. Jack said he was awed with what they are doing and accomplishing there and found it extremely impressive. Jan Heikes commented that she had visited there once before and was privileged to see someone taking their first steps; she said she sees it as a place where miracles happen every day. The Commission members agreed, by consensus, to send a letter of acknowledgement to On With Life.

ELECTION OF OFFICERS

Jan Heikes made a motion to re-elect Jack Willey as Commission Chair and Craig Wood as Commission Vice-Chair for another 12 month term. Laurel Phipps seconded the motion. The motion passed unanimously.

WORKGROUP PARTICIPATION

In lieu of forming internal committees and workgroups, the Commission members discussed how they could participate and contribute to the mental health redesign workgroups that will be forming soon. Jack Willey commented that he had served on the Court Mental Health workgroup last year they had good discussions, which he hopes will be used in moving forward. The Commission members indicated their areas of interest and recommended that two members whose terms recently ended also be included:

- Neil Broderick – children’s services
- Julie Fidler Dixon - brain injury
- Rick Hecht – regional administration
- Jan Heikes – regional administration or other
- Richard Heitmann – interested in working to incorporate Olmstead
- Chris Hoffman – children’s services or mental health
- David Hudson – brain injury
- Cindy Kaestner – mental health or regional administration

- Gary Lippe – mental health or children’s services
- Zvia McCormick– mental health or ID/DD
- Laurel Phipps – substance abuse, MH or BI, interested in veteran’s issues
- Craig Wood – regional administration

The preferences will be shared with DHS as they work to organize groups. Jack Willey said he hopes to have good Commission representation on each of the workgroups.

REDESIGN FOLLOW-UP DISCUSSION

David Hudson asked why the charge to the brain injury group was different than the mental health and ID/DD groups. Geoff Lauer responded that the reason is because there is no existing set of core services or plan for funding brain injury services as opposed to the existing systems for MH and ID/DD. The BI workgroup will be charged with making recommendations on what a statewide brain injury services system should look like.

Jan Heikes noted that she was interested to hear the vision expressed by the legislators during yesterday’s panel, which seemed different to her than what she read in the bill. Their comments indicated they want regional administration and local delivery, which is more palatable than what some others have expressed, but with so many details to be worked out, it is still unclear what the actual result will be.

Cindy Kaestner noted that when the Commission workgroup wrote the CMHC bill language it was intended to stand alone for the CMHCs anticipated continuation of the county system. Now that the language has been put into a regional structure, there are significant aspects of it that don’t seem to fit.

Richard Heitmann commented that he sees a breakdown between consumers and those who purport to advocate for them. He said he has heard nothing about how this proposal will affect people at the consumer level. Jack Willey noted that he was surprised to hear Senator Hatch say yesterday that he had just had the first conversation with consumer about this because he would have expected that to happen much sooner. He said he also found it frustrating to get legislators to hear concerns from the consumer perspective.

Bob Bacon said he is concerned about an issue he raised yesterday relating to the potential state responsibility to fund an infrastructure for a statewide I &R system. He said that is an example of something that it makes sense to handle from a single source, but he doesn’t think the legislators heard that. He would like to have clarification on which of the workgroups will be looking at making sure the state is responsible for certain aspects of the infrastructure to support the system. Craig Wood commented that is also makes sense to have a statewide billing and payment system, and the state is not far away from having that now.

Chris Hoffman noted that substance abuse services have been functioning under a catchment area system since the 1980s. He said that system works well with small regions and he hopes there will be some discussion of making the proposed mental health regions smaller.

Craig Wood said that in Linn County they are looking at acquiring a new data base system which will mean a million dollar investment, so they are waiting to find out how this new system and the regions will operate to determine if they should move forward with that or not. He said he heard Senator Hatch say there is not political will to put more money into the system, yet he is concerned that if we shift to regions that have a standardized set of services, then counties with a higher level of services will have to lower their array to send money to other counties that need it to bring their level of services up to meet the to meet the core standard. He said if there are no more dollars going into the system and the existing dollars get spread more evenly across a region of counties, then a county like his may get less state dollars and may have to funding some of the services they now offer to consumers, such as the peer recovery center, medication services, and rent subsidies.

MENTAL HEALTH SERVICES REPORT FOR CHILDREN AND YOUTH

Laura Larkin presented an overview of the Implementation Status Report regarding the Mental Health Services System for Children, Youth, and their Families that was submitted to the Governor, the General Assembly, and the Commission in January. In 2008, the Iowa General Assembly passed a bill that identified the need for a children's mental health system and DHS was allocated \$500,000 to issue RFPs (Requests for Proposals) to start to developing a community based mental health system for children and youth. In January of each year the Department reports on the progress.

In 2008 an RFP was released and one project was funded for a local system of care in Polk and Warren Counties. The RFP was focused on developing local systems of care so families would have an access point similar to the 10-county Community Circle of Care project in northeast Iowa and based on the same principles:

- Empowering parents to access all the services that are available
- Making sure that children are receiving those services in their community and in their homes whenever possible
- Supporting children to remain in school and avoid involvement with juvenile justice or involuntary commitment

All systems of care projects look at how those outcomes are being affected. The current system for adults is much more consistent than it is for children. If a family lives in one of the 10 Community Circle of Care counties or in Polk, Warren, or Linn counties, there is someplace they can readily be referred for services – often if they live in other counties there is not a clearly identified access point beyond a community mental health center and their capacity to serve children varies.

Families in crisis who do not know where else to turn go to the courts to seek an involuntary commitment or they go to child welfare and ask DHS to take custody of the child.

The Children's Oversight Committee Report that was done in 2006 identified gaps in the system and they really haven't changed much since then. A lot of things have been done in parts of the state, but no overall change in the system has been accomplished. In response to a question, Laura said that the Community Circle of Care was included for funding in the Governor's budget, but the Central Iowa project was not. Funding for it was added back in through a Senate amendment in the amount of \$257,173, but it is uncertain what budget items will ultimately be funded.

The report identified issues that had been cited for redesigning the adult mental health and disability services system as also significant for children in need of mental health services and supports:

- The lack of a set of core services uniformly available throughout the state and lack of uniformity of service expenditures.
- The need to improve the array of community-based services and services to avoid the use or continued use of crisis services.

There is a clear need to improve community-based mental health services to avoid mental health commitments. Children are accessing involuntary commitment proceedings at a much higher rate than ever before. The number of juvenile mental health filings in 2004 was 667 and in 2009 it was 1574. Often times families are referred to the commitment process by mental health professionals because they don't know of other options. For example, a child may be receiving therapy once a week, but that is not enough and the family may go directly to a mental health commitment filing because they don't know what else to do. The child really doesn't need to be committed or meet the criteria for commitment, but has serious behavioral issues and does need a more intensive level of community-based services to remain at home.

Neil Broderick commented that he is familiar with the Orchard Place (Central Iowa) program that has focused on preventing children from being admitted to PMICs (Psychiatric Medical Institutions for Children). He said last year 50 kids were served under their community based program for \$400,000 and if they had been admitted to PMICs it would likely have cost about \$2,650,000, which makes it a very good return on investment as well as being better for children and families.

Laura said that a child's risk of returning to an institution is higher once they have gone there, and transitions back to the community are often challenging, so it is better for the child to stay at home and in school and receive the services they need there. If admission is necessary, it is also important to keep the length of stay as short as possible and get that child back home. Also, when a child is admitted to a PMIC involuntarily, the family does not have a case manager so it is difficult for families to

manage the transition of getting the child back home and getting the supports they need when the child returns to the community.

Some of the children the systems of care are working with right now are at PMICs and they are helping the family plan the transition back to the community and lay the necessary ground work so it will be successful. Systems of care can also do community work with families because they have funding other than Medicaid and help prevent lapses in services. The systems of care can be thought of as the “waiver before the Waiver” because systems of care serve families while a child is on a waiting list for HCBS Waiver services or for admission to a PMIC. Often after the child has received services, the family finds they don’t need admission to the PMIC. It is all about keeping kids in the community and home setting and is a perfect fit with the goals of the Olmstead Plan.

Pages 6 & 7 of the report show the outcomes and the number of children and youth served. The Central Iowa System of Care served 52 children in SFY 2010 and is projected to serve 80 children in each of SFYs 2011 and 2012. The Community Circle of Care served 509 children in SFY 2010, and is projected to serve about 500 children in each of SFYs 2011 and 2012.

Laura said they have found that often what families need are relatively low cost and cost effective services. They can fund things like respite, assistance with medications, and parent support. Often being able to talk to other parents or someone who they can call in a crisis situation is enough to give them the confidence to deal with a child who has difficult behaviors and keep them at home.

The Central Iowa project was projected to serve about 80 children during this fiscal year and they have already met that. They are currently at capacity. They have 3 care coordinators and one project manager. Each care coordinator serves about 25 to 30 children at any given time and the project manager serves a few children. In addition to the DHS funding, they also have \$60,000 of funding through the Juvenile Justice Advisory Council, which comes through the Department of Human Rights, Criminal Juvenile Justice Planning. That funding pays for services to children who are involved in or at risk of being involved in juvenile court.

All the families all receive care coordination, wraparound planning, access to formal supports, and help in getting informal supports in place. For the Central Iowa System of Care, 70 percent of the children are on Medicaid and still do not get everything they need and are still at risk of going to a higher level of care. Families can access medication, respite, remedial services, or other things they need to keep the child at home. Sometimes it’s not about getting services paid for, it may include bringing in family members, friends, or neighbors who can help provide some respite, but the family had never asked before.

In response to a question, Laura responded that all PMIC beds in Iowa are usually filled and there is a waiting list.

COMMUNITY CIRCLE OF CARE

Gary Lippe presented an update on the Community Circle of Care (CCC) project. He said he will focus on the service model and values and next month when the Commission visits CDD, Vickie Miene will talk more about outcomes. He said it is important to understand the underlying values and how they translate into what they created to meet the need of children and families around the state.

In 1991 Dubuque County received a federal grant that it used to reduce the number of children in out of state placements. They established a process called “case facilitation” that most people now know as “family team meetings.” The point is to empower families to identify what they need to support their child at home and in the community. The process involves getting a team together to help a family figure out what they need to get their child back into the home and community or keep them there when contemplating an out of home placement. Within a few years, they were able to get all of the children back in state, and most of them back at home. In subsequent years they have used the same wraparound planning methodology on family court and juvenile justice cases. At the peak in the 1990s, there were about 80 to 90 children in group care, and they were able to get that number down to 25 to 30.

Gary said he worked with the children’s oversight group in 2004 and they identified the same kinds of needs:

- Parents need to know where to start
- They need some kind of evaluation process
- They need care coordination or navigation
- They need flexible funds to help fill gaps in services that are not paid for in another way
- They need a crisis line available 24/7

They learned it was preferable to make a comprehensive medical assessment and diagnosis, rather than just a mental health assessment to get a full picture of the child’s needs in all life domain areas. Community mental health centers were chosen to use as a core for that assessment, but they did not have a family-friendly reputation in the community, so work was done to get everyone focused on the value of having parents drive the system.

Care coordination became one of the primary functions. Care coordinators:

- lead family team meetings
- develop an individualized care plan
- research resources and make referrals
- assist with applications and paperwork
- assist in coordinating meetings and appointments
- assist in finding funding

In the family team meeting, care coordinators:

- ask the family what they need

- let the family set the agenda
- help identify natural supports
- help identify barriers and service gaps that can be taken to local community advisory meetings for solution focused discussion among stakeholders

It is important to note that sometimes what the family says they need is not the same as what the doctors think they need. This is a family-driven process. It is about individualized services, not about what was done for the last child or family, but what this child and family need and want. Family team meetings are held wherever the family wants – in their home, at school, at a provider, or other location.

Social supports are provided to caregivers:

- caregiver and family education
- parent consultants provide parent to parent support
- parenting classes
- crisis de-escalation strategies
- support groups in the local area led by CCC staff and trained local parents

Social supports are providers for youth:

- expression, prevention, and awareness activities
- digital storytelling
- art expression groups
- Youth Advisory Board
- Elevate –a group for former foster youth

Statistics reported on Family Support Services:

- 100% met face to face with a parent consultant
- 94.6% received emotional support
- 87.5% received specific information or training
- 83.9% were connected to community resources
- 41.1% has assistance at a school-based meeting
- 39.3% were connected with a family activity or parent support group
- 14.3% met with a parent consultant in their home or community
- 08.9% has a parent consultant accompany them to another agency appointment

The System of Care Values are:

- family voice and choice
- youth voice and choice
- strength-based
- culturally competent
- team-based
- natural supports
- individualized
- collaboration
- community-based

- outcome-based and data-driven
- persistence

During the year from July 2009 to June 2010, the Community Circle of Care reached:

- 509 children and families with clinical assessment, intensive care coordination, and/or home and community based wraparound services
- 836 children and families with other support services
- 1412 individuals with awareness, prevention, and expression activities
- 623 information and referral contacts
- for a total of 3380 people receiving services

The project has reached a large number of children and youth and had a dramatic impact in the area. Schools and providers know about the Community Circle of Care and work collaboratively.

Home vs. Out of Home Placement:

- Most children served remain at home
- A few are placed out of home, but the care coordinator is still available to help them and their families with transitioning in and out
- Mental health commitments have been drastically reduced
- For the period from July 2009 to June 2010:
 - 92% remained at home or in a family foster home
 - 2% received involuntary psychiatric inpatient treatment
 - 3.5% received treatment in an Iowa PMIC
 - .01% received voluntary psychiatric inpatient treatment
 - 1.5% were placed in a residential treatment facility
 - 1% received inpatient substance abuse treatment

Families are interviewed every six months for a longitudinal study. Among families who received CCC services for at least 12 months:

41% of youth showed improvement in school performance

- 37% of youth showed improvement in school attendance
- There were more positive reports about the child's ability to complete homework and read at or above grade level
- There were fewer reports of parents missing days from work due to the child's behavioral or emotional problems
- There was a 21% increase in the number of caregivers who had a positive perception of their own functioning as parents

The most telling outcome is the overwhelming responses from parents that indicate the services help them deal effectively with daily problems. Gary said many families come to the project ready for their child to be placed because they are extremely frustrated and don't know what else to do and find that with CCC services they are able to not only keep their child at home, but have confidence to meet the challenges and function better as a family.

PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMICs)

Jim Ernst, President and CEO of Four Oaks in Cedar Rapids presented his perspective on the history of PMICs and the direction of service delivery that he said is moving in a more holistic direction to provide a broad-based approach to children and families.

PMICs offer an intensive inpatient program designed to serve the child welfare and juvenile justice system. About 85% of children in the child welfare system are identified as having a mental health issue. When the decision was made to allow children to be placed in PMICs without court involvement, the system changed. For families without court involvement, it creates some real issues because they don't have anyone to assist with care coordination. It is now recognized that PMICs are not the best primary service delivery system for most children.

It appears that funding for PMICs will go under Magellan's Iowa Plan in about year, which will place them in the holistic children's mental health system. Jim said it is important to make sure that Iowa builds a truly comprehensive approach for children and families, which may include some alternative services that are not in place today, including in the area of after-care.

Craig Wood asked about the section in Senate File 525 that addresses PMICs. Jim responded that there has been discussion about three things: (1) that PMICs will be going under Magellan's Iowa Plan in the next year or so; (2) whether Iowa needs to be a second, higher level of more intense PMIC care to prevent out of state placements, which will be looked at more closely over the next year; and (3) there is some reason to believe that all PMICs will be defined as IMDs (Institutions of Mental Disease) by federal legislation. If that happens, the PMICs will become responsible for payment of some expenses currently covered by Medicaid, including medical doctors, medications, and some other ancillary costs.

Neil Broderick commented that if that happens, it may also create a situation where the cost of those things to individual facilities would be much higher than they are through Medicaid and where the fiduciary responsibility to manage the facilities may come in conflict with what the children being served need. Jim said there would be many issues surrounding that kind of change that would have to be examined and worked out.

Jim said he believes a holistic system of care is needed that goes beyond mental or physical health care to position the child to become a successful adult. He noted that the mental health system, the child welfare system, the juvenile justice system, and the education system operate in silos and address different areas that all impact a child's life. About 85% of the children in the child welfare system have a mental health diagnosis; 50% to 60% of children in the juvenile justice system were in the child welfare system at some point during their lives; and almost 50% of the young people who left foster care become homeless within a year. Only about 60% of young people leaving the foster care system in Iowa graduate from high school by the time they are 19, yet nationally 87% of the young people coming out of foster care graduate – that

needs to be addressed. Jim said he believes that it is important to structurally cross through all systems for children and address their needs in all domains of their lives. It cannot just be a short term intervention. It is critical to follow up and stay engaged with kids through age 18 so there is someone there when they hit a crisis to help give them a boost through it. It also requires having some money that is not tied to a discrete funding "silo."

On July 1 of this year a 300-child, 3-year pilot project will be launched in Cedar Rapids. It will be a public-private partnership. The children who participate will be followed through age 18. They will range from kids who are in crisis (juvenile justice or child welfare involvement) or at high risk (poverty, school problems, or mental health diagnosis). It will be funded almost entirely with private dollars and will require a \$2 million commitment over 3 years. There will be control group of 300 and an outside evaluator.

The project will include:

- A comprehensive assessment
- Progress management for 18 months
- Follow-up to age 18

Jim said they have been working on projecting the cost of the follow-up and found it will be less costly than they would have thought. The highest cost will be for the 18 months of progress management. They will use family driven practices and the goal is to get enough data to show that, as a State, we need to find ways to transcend the "silos" with both public and private money for long term success.

Jan Heikes asked why they chose age 18 for the follow-up rather than continuing to age 21. Jim responded that there are still challenges in figuring out how to get to age 18 in terms of both the follow-up services and funding. He said they realize that most young people would probably need support longer than that, and the hope is that there may be a way to do that, but it's not a commitment they are ready to make now.

MAGELLAN IOWA PLAN SERVICES FOR CHILDREN AND ADOLESCENTS

Kelly Pennington from Magellan Health Services presented an overview of services for children and adolescents available through the Iowa Plan. The Iowa Plan is a managed care plan for mental health and substance abuse services that covers most of Iowa's Medicaid recipients and substance abuse services funded by the Iowa Department of Public Health. The Department of Human Services originally awarded the contract to Magellan in 1995 and it has continued since then. Sixty-six percent of all enrolled participants are children 18 years of age or younger. The penetration rate for enrollees accessing services was 15.11% for SFY 2010, with more than 41,000 children and adolescent receiving a mental health or substance abuse service. There was a jump in total enrollment during SFY 2010, most likely due to more families becoming financially eligible for Medicaid and a push by DHS to get all eligible children enrolled.

The total amount expended for inpatient and community-based services for SFY 2010 was about \$33.4 million. Twenty-three percent funded inpatient services and seventy-seven percent funded community-based services. The Iowa Plan greatly expanded the array of services available to children and adolescents, although not all children receive all services. Kelley shared a handout outlining the service array and showing program information and statistics. Because children thrive in their homes and communities, at the end of the year any funds that are left from the capitation rate go back to the State or to the Community Reinvestment Fund, so there is no profit resulting from longer inpatient stays. The average length of stay is approximately five days and the 30-day readmission rate is 11.3%. In SFY 2010, Magellan facilitated over 500 joint treatment-planning sessions, the majority of them being held on behalf of 308 children and youth served by Intensive Case Management to determine what the child really needs to stay or return home, stay in school, and be successful in the community.

Each month 2.5% of the capitation payment goes into the Community Reinvestment Fund along with any remaining service funds that are not returned to the State. About \$3 million a year goes into the fund and it provides an opportunity to think outside the box and invest in doing promising things. Some of the projects it has funded related to kids include crisis stabilization services, family support services, peer education and support programs, I-PART, school-based prevention and early intervention services, training to extend psychiatric capacity, and telehealth. The idea with all Community Reinvestment projects is that if they prove to be successful, they will become fee for service options.

Outcomes measurement can be very challenging in the world of social services and mental health. Magellan is using an assessment tool called CHI-C (Consumer Health Inventory-Child). It is used every six months to gauge the child's progress or stability. Through a contract with MHDS, Magellan is enrolling all community mental health centers to use the CHI (the adult version) and the CHI-C. Ninety-nine percent of Iowa CMHC clinicians are now using the tools. For the period from August 2007 through April 2011, 17,424 CHI-C assessments have been completed. Sixty-two percent of members showed improvement in physical health and 20% showed clinically significant improvement in physical health. Sixty-two percent of members showed improvement in psychosocial health and over thirty-seven percent showed clinically significant improvement in psychosocial health.

During calendar year 2010, Magellan spent about \$25.5 million on mental health services for children and adolescents and about \$5.4 million on substance abuse services for children and adolescents. Combined with \$106.4 million expended by the Iowa Medicaid Enterprise (IME) for subacute/PMIC services, remedial services, and the Children's Mental Health Waiver, the total cost of MH and SA services to children and adolescents was \$137.3 million.

BEHAVIORIAL HEALTH INTERVENTION SERVICES

Kelley explained that remedial services are moving to the Iowa Plan on July 1, 2011 and the name will be changed to Behavioral Health Intervention Services (BHIS). In the next year, PMIC services will also be transitioning to the Iowa Plan. Remedial services are supportive, directive, and teaching interventions provide in a community-based or residential group care environment. They are skill building services, designed to improve a child's functioning in his or her everyday life. They are very specifically for kids with a mental health diagnosis to assist them in learning age-appropriate skills to manage their behavior and regain or retain self-control. To qualify, a child or adolescent must have a comprehensive assessment and a major Axis I [clinical disorders, including major medical disorders] diagnosis. The intention is that these services would address part of a child's needs and they would also receive services addressing other needs.

Also, on July 1, quality assurance changes go into effect, including:

- Utilization management guidelines to assure that services are based on established criteria, people receive the appropriate services, and benefit from them
- Provider credentialing standards for service provider qualification, organizational infrastructure and oversight, and clinical support and supervision
- A comprehensive, quality management plan to assure education and training to providers, measure member outcomes, provider and program performance, and improve program integrity
- A service authorization process to assure that the appropriate type and amount of services are being delivered to met the individual's mental health needs
- A Payment strategy set on a fee-for-service basis that aligns with the cost of service delivery

There utilization management guidelines lay out what BHIS can be and what it cannot be. The provider standards address the characteristics of organizations that can provide services – they must have policies and procedures, they must have a board of directors or other oversight, and they must do background checks, among other requirements. Community BHIS workers will now be required to have a bachelors degree. Training and technical assistance will be offered as a part of continuous quality oversight.

FAREWELL TO JEANNE NESBIT

Jack Willey presented Jeanne Nesbit with flowers and a card on behalf of the Commission in recognition of her last day of employment with DHS. He expressed his appreciation for her efforts and everything she has done to assist the Commission and thanked her for her service. He said the Commission would miss her, but will look forward to participating in the selection of a new administrator.

A lunch break was taken at 12:25 p.m.

The meeting reconvened 1:10 p.m.

MEMBER ETHICS AND RESPONSIBILITIES

Gretchen Kraemer presented a short video on ethics and responsibilities for Commission members.

HILLCREST NORTHEAST IOWA CRISIS STABILIZATION PROJECT

Carolyn Pettit-Lange presented an update on the Hillcrest Northwest Iowa Crisis Stabilization project. She said the concept for crisis stabilization services has been brewing in Iowa for years. This project is beginning with a seven county area. Magellan Health Services released an RFP under the Community Reinvestment program and the northeast Iowa application was selected but felt they needed more than one year of funding to get the project up and running. MHDS then offered to provide additional funding that would support a second year of operation.

Carolyn outlined the strengths that the northeast Iowa area brought to the project, including strong connections and collaborative relationships, an available workforce, and an existing wellness center. They share a recovery-based philosophy that embraces the belief that a positive future is possible. They utilize practical application of recovery principles, using WRAP (Wellness Recovery Action Plan) and borrowing some points from primary care. Rather than trying to mobilize intensive crisis services (“putting the surgeon in the ambulance”) they developed an approach to have trained people to get folks to the services they need when they are in crisis. They recognize the value of lived experience as a new approach to the workforce shortage. They strive to be passionate, welcoming, and maintain a mission-driven staff.

There are two separate crisis stabilization programs that are starting up under this project.

Hillcrest Crisis Recovery Team

- Opened on December 23, 2010
- Building to get up to speed
- Provide urgent care walk-in support at the wellness center
- Getting 5 to 7 referrals per week

Referrals come from community partners – mainly hospitals, law enforcement, and schools. When people go to the emergency room and don’t meet the criteria for a psychiatric admission, they are sent directly to the wellness center and meet immediate with a crisis counselor.

They have limited mobile capacity, can do screening for significant behavioral health issues and trauma, provide service and support coordination, and emergency shelter when necessary. The crisis recovery hotline is coming soon and they are working to have it ready to serve the entire area by July 1.

Carolyn said they use a very common sense approach. The person who comes in defines the crisis and the crisis counselors and peer support specialists work to help them address the issues they identify. It takes a takes a lot of creativity. They prove tools, supports, and concrete steps for the individual to take. They make referrals and develop action plans. They are not first responders, so if the person is not safe in any way, then first responders are called.

The 23-hour Bed – The idea for a 23-hour bed is that a person comes to a small community-based hospital where there is an agreement in place. The person is experiencing a mental health crisis but does not need to be admitted. There is then a 23-hour period to pull together a team with the ER attending physicians, a Peer Support Specialist, and an on-call crisis counselor who deploys the Peer Support Specialists and immediately starts to set up outpatient supports. Telehealth can be used to connect to a psychiatrist. There may also be enough time to stabilize the person and build intensive community supports to avoid admission.

The provider for this part of the 2-year project is Northeast Iowa Behavioral Health (NEIBH) in Decorah. They will serve Allamakee, Clayton, Fayette, Howard, and Winneshiek counties. The goal is to have it become a billable service. Part of the expectation is that they will be serving some folks who do not have funding. They will do their best to access funding from private insurance, public sources, and get people whatever benefits they are entitled to receive, but people in need will not be turned away so they know there will be some services provided that will never be paid. That's very much what community mental health centers do.

Carolyn said they also hope to be able to have a peer support and parent support staffed warm-line service, which will help give people support before they reach the crisis stage. They are doing some outreach to Jackson and Washington counties and hoping to start spreading the crisis stabilization model throughout Iowa.

Jan Heikes commented Howard County Hospital has chosen not to be a part of this and it is much closer for people in our counties to go to Minnesota or Wisconsin hospitals than to go to Dubuque or Waterloo, and a lot of it has to do with the relationships that are built between the community partners. Carolyn noted that Hillcrest already serves a significant number of people who live in Illinois and Wisconsin. She said that she thinks the spirit of collaboration in the area has a lot to do with the fact that they are used to crossing those kinds of traditional boundaries in a way people in other areas are not.

The sustainability of the model beyond the two years of grant funding depends on transitioning it to a fee for service. Peer Support services are going to a 15 minute unit for billing. Staff credentialing will play an important role also.

They are also working on community education, promotion, and awareness and Critical Incident Training (CIT) for law enforcement. Carolyn said she wants to work to get crisis stabilization on the list of core services for Iowa under the new redesign effort and will have more data to share by fall.

PUBLIC COMMENT

Teresa Bomhoff urged that the redesign workgroups be mindful of ensuring cultural competence, and said she hopes the judicial workgroup will be expanded to include mental health courts and jail diversion programs.

REDESIGN WORKGROUPS

Jan Heikes commented that over the last few years DHS personnel has changed frequently and often that means the “game plan” changes as well. She said she hopes that the need for continuity and adequate staffing in MHDS will be recognized because what happens there is incredibly important for the rest of the system and she hopes people will advocate for the Olmstead Plan and the continuation of the current game plan it has set out.

Connie Fanselow will send out information on redesign workgroups as it become available and will share workgroup preferences expressed by Commission members with the MHDS leadership charged with assembling the groups.

Jack Willey noted that he hopes Commission members will make every effort to participate in meetings to assure that a quorum is present and they are kept well informed about issues of concern.

The meeting was adjourned at 2:00 p.m.

Minutes respectfully submitted by Connie B. Fanselow.