

Iowa Mental Health Institute (MHI) Task Force

APPROVED MINUTES

Meeting 8: December 2, 2009, 10:00 am to 5:30 pm
Urbandale Public Library, Conference Room A
3520 86th Street, Urbandale, Iowa 50131

TASK FORCE MEMBERS PRESENT:

Neil Broderick
Preston Daniels
Ro Foege
Cindy Kaestner
Christine Krause

Christine Louscher
Vilas (Sid) Morris
Debra Schildroth
Annette Scieszinski
Maggie Tinsman

TASK FORCE MEMBERS ABSENT:

Thomas Hanafan

Dan Homan

OTHER ATTENDEES:

Pam Alger
Richard Anderson
Jess Benson
Linda Brundies
Mark Buschkamp
Lisel Eathington
Charlotte Eby
Connie Fanselow

DHS, MDHS Children and Youth Bureau Chief
State Representative, House District 97
Legislative Services Agency
Iowa Citizens' Aide Ombudsman
Cherokee Area Economic Development Corporation
Department of Economics, ISU
Lee News
DHS, Division of Mental Health and Disability
Services

Bill Gardam
Dave Heaton
Roger Munns
Kelley Pennington
Jule Reynolds
Patrick Schmitz
Renee Schulte
Jim Scott
David Swenson
Jeff Terrell
Marcia Tope

DHS, MHDS Interim Division Administrator
State Representative, House District 91
DHS Public Information Officer
DHS, MDHS Adult Bureau Chief
Office of Senator Tom Harkin
Plains Area Mental Health Center
State Representative, House District 37
TBM Senior Management Consultant
Department of Economics, ISU
DHS, Results Based Accountability
DHS, Results Based Accountability

WELCOME

Chair Ro Foege welcomed the Task Force members and other attendees and called the meeting to order at 10:10 a.m. He invited public comment as the first agenda item of the day.

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PUBLIC COMMENT

State Representative Dave Heaton commented: I will be presenting to group of state legislators from across the county in San Antonio tomorrow and the discussions of this Task Force about mental health in Iowa will be part of my presentation. One thing that has come out is the need for sub acute care. Another thing that deeply concerns me is where we going to find the people to deliver the mental health services our State so desperately needs. I have a report from Minnesota with information on what they are doing about recruitment and what Nebraska is proposing to do. Nebraska plans to fund stipends for two psychiatrist candidates a year and those candidates will spend time in rural settings for their practicums. I will have the reports sent to you and I hope you will consider them. The next Legislative session will be a difficult one and we will need all the support we can get.

Annette Scieszinski suggested that the members of the Task Force commend Representative Heaton for his interest and participation in the Task Force activities; the members made the acknowledgement.

Mark Buschkamp, Director of the Cherokee Area Economic Development Corporation commented: I talked to Senator Mike Flood from Nebraska about their restructuring efforts. Their process was not so much to contain costs but to comply with *Olmstead*. Their regional centers operate quite differently than our MHIs; in Nebraska lengths of stays were in months and years. They have downsized and specialized; reduced the total number of beds and consolidated services at specific locations. They have experienced problems in that they downsized before they started dealing with the sub-acute and other community issues. Their system is set up in regions, with each one funded by a legislative appropriation. Fortunately, some private providers have stepped up and the state is now paying for beds at private hospitals, but there is still a concern about sustainability.

REVIEW OF LAST MEETING

The minutes of the November 9 and November 16 meeting were approved. Ro Foege reviewed the work done at the last meeting on November 16:

- Jim Scott facilitated the process
- Bill Gardam presented an overview of the process of developing a State Plan and outlined the guiding principles
- The Task Force members shared their impressions of the MHI visits; “what we saw”
- The preliminary economic impact analysis was presented
- The members:
 - identified common themes
 - created combined priorities
 - reviewed their Legislative charge
 - performed a SWOT (strengths, weaknesses, opportunities, and threats) analysis

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- looked at trends
- started to develop priorities and recommendations

Ro said that today the Task Force needs to start integrating and putting all that information together into a report to the DHS, Governor, and Legislature.

ACUTE CARE TASK FORCE RECOMMENDATIONS

Kelley Pennington gave a brief overview of the work of the Acute Care Task Force and their findings and recommendations:

- The Acute Care Task Force was developed through the MHDS Division.
- In 2007 the Mental Health Systems Improvement Act required the Division of MHDS to form workgroups to look at redesigning the system.
- One aspect of the redesign was to provide a statewide acute care system.
- In the fall of 2008 about 60 stakeholders began to meet on a regular basis to talk about how Iowa provides services to people with mental health needs.
- About 50 to 60 people attended most meetings, including Legislators, consumers, advocates, and representatives of hospitals, community mental health centers, courts, State agencies, county central point of coordination administrators, the State Ombudsman's Office; many different perspectives.

They adopted guiding principles:

- Recovery-oriented and welcoming
- Community-based
- Least restrictive
- Client-centered
- Strengths-based
- Co-occurring capable
- Enhanced through Training and Education
- Evidenced Based Practices
- Peer and Family Support Systems, Prevention, Programming and Family education

The Acute Care Task Force found that our system is by default, not by design; it has been patched together, with change driven by resources, economy, and other factors. They developed an "access map" of how people move through the system. By default people go to the ER for mental health needs; emergency rooms are not the best equipped place to meet mental health needs, but they are often the first stop for people in crisis. People also end up in jails and inpatient psychiatric units; most of the options are for inpatient care, but that is often not the best care that could be offered to them.

Kelley shared information on what the review of data told the Task Force, including:

- Applications for adult mental health and substance abuse commitments in Iowa have increased 10% in the last five years.

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- Applications for children's mental health and substance abuse commitments in Iowa have increased 138% in the last five years.
- Iowa has more than 800 psychiatric inpatient beds, but many are occupied by people who could be discharged to a less intensive level of service.
- There is no standard procedure for locating available beds for court-committed individuals.
- Over the past 5 years, Magellan has paid more than \$32 million for the cost of people who remain on psychiatric units after they no longer meet the medical necessity standard for the inpatient unit.
- Over 40% of people in Iowa prisons have a mental illness or co-occurring diagnoses of mental illness and substance abuse.
- On any given day about 150 Iowa children are in out-of-state placements—most with Serious Emotional Disorders.
- According to 2006 figures, Iowa ranks 2nd highest in the nation in out-of-home placement of children.
- Suicide is the 3rd leading cause of death for adolescents nationally; it is the second leading cause in Iowa.
- The array of crisis services available in Iowa is minimal and not equitably dispersed across the State.
- Sheriff's departments do not have standardized tools for assessing the mental health and substance abuse needs of detainees.
- Less than 50% of emergency rooms surveyed have access to a behavioral health nurse or social worker to assist with evaluations and level of care decisions.
- When local community mental health center assessment services are offered for persons when mental health commitment applications are filed at Clerk of Court's offices, over 95 percent are diverted from psychiatric admission.

Acute Care Task Force Recommendations:

- Crisis stabilization centers for adults, and child and adolescent crisis stabilization services to serve people who need support but don't need to be in acute care beds.
- School-based mental health services to provide information to students and adults about mental health at the ground level where kids spend most of their time.
- Jail diversion programs, including education to sheriff's and police departments because we know that crisis intervention needs to happen at the level and providing treatment options is more productive than having people sit in jails.
- Sub-acute services that are 24-hour, comprehensive, and time-limited. Crisis stabilization and short-term residential services for people who are stable but not ready to go back home and back to work. These services will allow for intensive discharge planning and the time necessary to pull together resources that will work on a long-term basis.

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- Expanded role of designated community mental health centers. The Task Force recognized that CMHCs across the State are providing some excellent services and with revisions to Iowa Code Chapter 230A, they could serve as access centers or hubs and become the “ER” for mental health in their communities and regions. Core safety net services suggested include:
 - 24/7 crisis emergency response
 - 24/7 mobile response
 - Screening services
 - Liaison with inpatient/residential when consumer is admitted
 - Crisis care coordination
- Psychiatric ER screening. Most hospitals don’t have access to mental health professionals to provide appropriate mental health screening to individuals who come to the emergency room and need access to telehealth and other resources for screening.
- Commitment diversion/Chapter 229 revisions. The Task Force found that courts across the State interpret Code provisions differently and made recommendations for a systematic procedure for commitments that should result in more appropriate care for people that is often less costly.

Kelley also shared some additional information about different costs of services in Iowa. She said the numbers reflect what Magellan is paying and noted that these services cannot be compared “apples-to-apples,” but can provide an average of services with various levels of intensity to provide some basis for comparison:

- Acute inpatient (hospital psychiatric unit) services cost about \$750 per day
- Sub-acute (less intensive 24-hour treatment) services cost about \$346 per day
- Partial Hospital Program (a 5-day outpatient program) costs about \$243 per day
- Crisis Stabilization Center services cost about \$123 per day
- Intensive Outpatient Program service (a 3-day program of intensive treatment) costs about \$81 per day

Kelley noted that Assertive Community Treatment (ACT) is really a form of community-based wrap-around services used by people in the community who could be receiving ACT services over a long period of time, sometimes seen every day. The cost “per day” isn’t directly applicable, but it could be estimated at about \$36.

Christine Krause expressed concern about having sub-acute patients on acute care units, noting that to be less costly than acute care, sub-acute care needs to be in a physically separate environment; the square foot cost in a hospital is high, and sub-acute care should also be less restrictive. Deb Schildroth noted that some residential care facilities have respite beds that are available for crisis stabilization. Kelley Pennington said that greater community capacity is needed because the quality of people’s lives depends on their ability to live and thrive in their communities.

Preston Daniels asked if there was any discussion about the tremendous increase in commitment applications for children. Pam Alger responded that Iowa has had high numbers in that area, but mental health commitments for children are still rare. She

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said that there have been changes in terms of access to services. Children used to be placed in DHS custody (CINA – Child in Need of Assistance) to get access to services. The Children’s Mental Health Waiver changed that, yet more children needed services than could be served by the Waiver so people go to the source of least resistance to access services and that became commitment.

Preston asked if there was any consideration of independent assessment services prior to commitment. Kelley Pennington responded that there was. She said that a lot of people who have been committed have only been kept on a psychiatric unit for one day, which tells us that the commitment probably was not needed; it was just used to get them to a safe place when another more appropriate option should have been available.

Patrick Schmitz commented that community mental health centers conduct pre-screening for voluntary commitments, but if a family goes to a court and asks for an involuntary commitment, a mental health professional may never be involved. Annette Scieszinski said that the involvement of the court is intended to inject independent decision-making, but often the information that the court has to rely on is anything but independent.

ECONOMIC IMPACT ANALYSIS

The Iowa Mental Health Facility Economic, Fiscal, and Community Impact Analysis Report prepared by David Swenson and Liesl Eathington, Iowa State University Department of Economics was presented by Dave Swenson.

The report is organized in five sections reflecting:

1. The baseline value of the mental health facilities in Iowa
2. The projected losses and gains for three different closure scenarios
3. The projected impact on state and local government
4. The projected travel and time consequences for patients and families
5. The demographic and economic profiles of the counties where MHIs are located

Dave identified three components of value:

- county supplied inputs
- labor income
- jobs

He said the facilities make a lot of instate purchases, including purchases from their local counties, but also from other counties that are removed from the facilities. Dave explained that the report shows a summary for each of the economic value of each of the MHIs for direct, indirect, and induced values and an inputs multiplier and total multiplier. Tables also reflect the total industrial output; value added, labor income, and jobs. The total multiplier means that for each \$1 worth of change in output, there is a corresponding amount of change in the other aspects of the economy. Dave said he found that facilities were not buying a lot in their local economies. He said the labor

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income is what people spend. A higher impact means more money is spent locally; a lower impact means less money is spent locally.

Three closing and patient allocation scenarios were examined:

1. Moving all adults to the nearest MHI
2. Moving all adults in proportion to the capacities of the non-closing facilities
3. Moving all adults in equal thirds to each of the non-closing facilities

In all scenarios the children were moved to either Cherokee or Independence.

For each scenario:

- staffing and salary follows patient movement
- other variable costs (food, etc.) follows patient movement
- each has a loss of jobs and labor income and gain to other remaining MHIs that it is possible to net out

He noted that in each of the scenarios, the gains change very little.

Fiscal Impacts include:

- reductions in local government revenue
- families move
- reductions in population
- reductions in school enrollment and funding
- decreases in residential property value
- decline in retail sales

In terms of patient and family consequences, the analysis looked at a set of indicators:

- The distance in miles
- Travel time in hours
- Travel costs in dollars

He noted that the numbers for Cherokee and Independence are high because of the assumption that all children will go to one or the other. The numbers for Mount Pleasant are negative because people who are now traveling there would be served closer to home under other scenarios.

The regional socio-economic summaries by counties of facilities looked at:

- the population growth rate from 2000 to 2008
- The employment growth rate from 2000 to 2007
- The percent working in the county in 2006
- The unemployment rate in 2008
- The most current unemployment rate as of October 2009
- The retail sales “pull factor” for 2008 (other sales “leaking out” of the county)
- The personal income index for 2007
- The wage and salary index for 2007
- The non-farm proprietors in 2007

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Conclusions:

- The report provides projections about the potential consequences of government decisions.
- It does not tell you what choice is more desirable and does not measure benefits and costs to society and people, only economic impact.
- It is a planning tool to help understand the consequences of a closure decision.
- The report shows potential losses to communities and also potential gains.

Annette Scieszinski commented that the analysis could “reward” inefficiencies if they have resulted in more spending. Dave Swenson said that in his analysis if he increases government spending, he then increases taxes and decreases household spending because they would have to be used to offset the spending increase.

Dave said that nothing in the analysis deals with the transition costs of closing down and moving people and programs to other facilities and the effect on people and families for transferring patient care to other facilities can't be quantified.

A lunch break was taken at 12:35 p.m.

The meeting resumed at 1:20 p.m.

Ro Foege explained that at the request of the Task Force, Bill Gardam and MHDS staff had compiled the information from the last meeting and started to formulate a draft report. He indicated that the afternoon session would be spent walking through the draft, and making it reflect what the Task Force agreed on for inclusion in the final report.

Bill Gardam said the working document reflected what he “heard the Task Force say” and that he welcomed any correction or embellishment they wanted to make. He outlined recommendations in five areas:

1. Facility closure
2. Forensic evaluation and treatment
3. Acute care service and capacity
4. Community based system
5. General recommendations

Jim Scott asked the members of the Task Force to work through the document page by page, review, change, edit and come to agreement about the content. Bill Gardam made and highlighted the edits as they were discussed and agreed upon.

FINALIZING THE REPORT

Bill Gardam will make the changes identified by the Task Force and sent it out by email for their final review.

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Sid Morris said he would like to receive feedback on what happens with the recommendations. Jess Benson noted that he staffs the Health and Human Services Committee and he could facilitate having the Task Force make a presentation to them. Ro Foege said he would be available to Director Krogmeier, the DHS Human Services Council, or the Governor's Office as well.

By unanimous vote, the Task Force members approved the final report in concept as reflected by the draft revisions, contingent on approval of the final document.

Ro thanked the members of the Task Force for their efforts, for keeping focused on providing services to people who need them, and commented that he really enjoyed working with them.

The meeting was adjourned at 5:00 p.m.

Minutes respectfully submitted by Connie B. Fanselow.