MH/DS OF THE EAST CENTRAL REGION (ECR)

MENTAL HEALTH AND DISABILITY SERVICES

COMMUNITY SERVICES PLAN

PREPARED BY:

EAST CENTRAL REGION STAFF

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DUE

OCTOBER 16, 2017

APPROVED BY THE REGIONAL GOVERNING BOARD

OCTOBER 13, 2017

WAYNE MANTERNACH, CHAIRMAN OF THE BOARD MH/DS EAST CENTRAL REGION

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FY18 SF 504: Community Services Plan

The 2017 Legislative session passed Senate File 504 which instructs MHDS Regions in three areas.

I. To convene a Stakeholder Workgroup comprised of representatives from hospitals, the judicial system, law enforcement agencies, managed care organizations, mental health providers, crisis service providers, substance abuse providers, the National Alliance on Mental Illness, and other entities, as appropriate, to meet on a regular basis effective 7/1/17. The desired outcome of this Workgroup is to create collaborative policies and processes relating to the delivery of, access to, and continuity of services and supports for individuals with mental health, disability, and substance use disorder needs

A. Stakeholder Meetings. (For workgroup attendees please see Appendix A)

MH/DS of the East Central Region is a 9 county region with three urban and six rural counties. We had 4 stakeholder meeting that focused on specific parts of the system. The idea was to give stakeholders a chance to consider areas that do not typically receive specific focus from the region or are not covered by Medicaid or other insurers.

1. Meeting #1: June 29, 2017 Mercy Hospital Cedar Rapids - Hallagan Room - 9:00-12:00

Focus: Law enforcement, jails, crisis services, jail diversion, hospitals, mental health centers
Pre-meeting: A survey was sent to law enforcement prior to the meeting. Following are responses:
Survey Results: Identified gaps in Behavioral Health system/substance abuse system per law enforcement
Process: There was large group discussion and then each county met with their own county teams. Finally the groups shared their ideas with the large group. The groups then met outside the 504 meeting for further discussion and planning. Their goal was to return to Meeting #2 with projects.

Responses from Law enforcement

- ACUTE CARE
  - Bed space is no where near what is required or facility won't accept due to past violence or trespass.
  - Usually just have to arrest because that's the only option
  - Hospitals not keeping patients and sending them home too soon.
  - ER won't admit person who was suicidal at site but at ER saying they are not suicidal when law enforcement observed some things
- OUTPATIENT
  - Not requiring outpatient follow up - Respondents not complying with outpatient treatment
  - No timely access to treatment and counseling
  - Some should be inpatient that they are trying to handle outpatient
  - More staff and quicker response times for suburbs.
  - 24/7 options - no therapists, mobile outreach, etc. policing is 24/7 and clients don't have crisis during normal business hours
- BIGGEST DRAIN ON TIME
  - Transport facility to facility and then wait
  - Sitting and waiting at hospitals. Sitting and waiting for placement to be found. Once was almost a week.
  - Civil standby and mental health issues.
  - The process of carrying out the committal from pick up the subject, to the hospital accepting the patient.
  - Committal issued by facility for re-eval and they track only to be advised by family client is back in treatment. Calls the facility, will not verify person is there so has to continue to make good faith search.
  - Average wait at hospitals 2 – 4 hrs – is excessive
- MOBILE CRISIS: 50 % know mobile crisis well and use 50% don't know well and rarely use
- CIT**:** Need to spread description of CIT training and dates offered across the region
- TRANSPORTATION: Departments want more information on alternative transportation

2. Meeting # 2: July 19, 2017 Mercy Hospital Cedar Rapids - Hallagan Room – 1:30- 4:30

- Report back from County tables: Description of any projects identified and an approximate cost if available. These will be previewed for the Regional Governing Board at the July meeting.
- Newly released DHS direction for serving people with complex needs discussed
- Plan going forward. Next meeting will focus on Residential Providers

3. Meeting with MCOs September 12, 2017 Pizza Ranch - Grinnell 11:00 – 2:30

The ECR management team and a representative from Public Health and United Way met with Amerihealth and United. We discussed the projects to date with input from the MCOs regarding the interest and viability of the projects.

4. Meeting # 3: September 18, 2017: Mercy Hospital Cedar Rapids - Hallagan Room – 9:00 -12:00

Focus: Residential Providers
Pre-meeting: A survey was sent to residential providers prior to the meeting. Following are responses:
Survey Results: How can complex cases be served and at what cost?

Note: The three clients below are currently being served in hourly programming living in their own apartments at a cost of about $90 per day. The cost estimates submitted by providers range from $400.00 per day to $300.00 per day and down. Notably we had a hospital who thought two of three needed 24 hour residential care. We may need to work with providers to make sure that there are immediate community openings so that people do not have to go to a higher level of care than necessary and that hospitals gain more understanding of appropriate levels of placement.

- **Client 1 Description:**
  - MHI , Schizophrenia, Smokes marijuana
  - Client would like to meet with staff 2 x weekly. She would call if she needed more service. Current staff report that she will likely not be able to tolerate much more than a 15 minute visit. Verbally abusive to staff in person and by phone. Can be verbally aggressive in the community on occasion. Would need assistance getting to appointments.
  - Constant delusions. Thinks staff is breaking in or filming porn movies. Can be med non-compliant. Can tolerate one or two staff working with her. Has to be consistent staff or pronounced verbal aggression
  - She can do her ADLs and can grocery shop. Can keep the house picked up. Was banned from businesses in the past for panhandling in their parking lots. Police know her well but no serious charges. Police have called provider and return her to her home.
- **Brief explanation how agency would likely serve this client and cost per day estimate.**
  - If this was an hourly person that lived in her own home, two 15 minute visits would not be worth the time. She probably would not be able to tolerate any goal work. We are not able to bill for phone conversations, so that support would be completely out of pocket. Perhaps a peer support person or an advocate would be more appropriate. One person that could gain her trust might be able to open the door to more services.
  - Needs a half way home that Iowa does not have. He is not appropriate for a hab home but doesn't belong in the hospital. He needs a place where he can work on anti-social behavior with nurses and doctors monitoring him. Something like a Waiver home where staff are trained on working with people that have mental health needs. Also, K2 can be a deadly drug. He may need to detox from it and pot, then get appropriate medications to assist with his diagnosis.
  - He can be served in a Waiver home but would need more specifics before we could say what the budget would need to be. Typically people with high needs that may require holds to keep everyone safe are around $400 a day. I'm not for sure that would be appropriate here, though.
  - So we could probably handle this type of an individual but would set a fee of $100 per hour with a $100 min for anything less than an hour.
  - This would fit into the lowest tier of Hab services. We provide that level of care at the Tiered rate. We would not expect the region to pay above and beyond unless she required a lot of daily interaction through the phone. If this was the case we would request that we be reimbursed for the amount of time staff spent on the phone assisting her.

- He would fit into our 24 hour waiver home program. The cost would be around $300 a day. We would begin by providing 24/7 care. This would hopefully decrease the calls to the main office. He would be under staff supervision at all times. The staff would be available to take him to his doctor appointments due to being scheduled 24/7. Would try to work him into a day program in the area as he settled into the home. All of our 24 hour sites only have 2 clients. J would also request funding to assist in securing a home. We do not currently own any property and I don't intend to purchase but if I could form some type of a relationship with a landlord in Hazelton it would be a benefit to those individuals who require that location due to registry requirements.
- We are willing to complete assessments on any customer to assess for the customers need and assess if we are able to meet that person's needs. Our decision to provide care is individualized for each customer/situation and where we are currently at with openings and staff. I would question how the customer can only tolerate 15 min. visits and how we would be able to complete goal work and assist with getting to appointments. WE cannot provide transportation for the sake of transportation to medical or mental health appointments. This person would have to be a U4 to provide consistent less than 1 hour visits. I also question what goals this customer would want to work on with staff – sounds like she needs to set up MCO transportation to her appointments. Consistent staff is very hard to accommodate under normal circumstances, if the customer is continually verbally abusive towards staff, staff do not want to work under those circumstances and continually taking verbal abuse from anyone is not healthy. Not sure why you are asking for cost per day, if a customer has Medicaid and qualifies for Habilitation the funding is based off the tier they need and will complete.
- Approximately $125/day total cost for housing and Services. This applicant is a good candidate for a Permanent Supportive Housing Program. Our plan is that Housing Cost would be covered by the region and service costs billed to Medicaid.
- Hospital: Consider court order IM Rx and possible RCF placement.

- **Client 2 Description: PMICS, MHI Shelter, group homes, hospitals,**
  - Schizophrenia, Mild Autism, IQ of 89.
  - Was in a 24 hour hab home but they think he needs more service.
  - High risk of returning to jail. Scary thoughts in his head. Thoughts of wanting to hurt one staff. Reported it and different staff was assigned. He has been aggressive both in and out of jail. Thinks he could kill someone
  - Anti-social, intolerant of people but does have a couple of friends that are not the most upstanding individuals He is currently on probation.
  - He has some unhealthy sexual desires. Has ordered prostitutes off of a website. He robbed one prostitute. Worries about STDs. Yelling, inappropriate sexual comments.
  - Very structured. Seems to be willing to be med compliant. Hospitalized with a plan to jump in front of car. Denies voices.
  - Pot and K2 if others are doing it he joins in.
  - Little insight. When asked why he had multiple placements he said that he has autism and tells inappropriate jokes. Living on streets, not always med compliant. Some paranoia.
  - Self reports he was beaten and sexually molested by sister so has PTSD.
  - Would like to have a weighted blanket and a soft rubbing blanket. Questions seemingly out of the air. interview: How is ice cream made?
  - Doesn't have adequate independent living skills, doesn't know how to function in a home. Institutionalized since age 8
- **Brief explanation how each agency would serve this client and cost per day estimate.**
  - We would be willing to complete assessment to indicate if we can meet this person's needs, if a 24 hour hab.home feels he needs more care, he probably does. Hab. homes are set up to provide a safe, skill building living environment where customers can learn and grow to make positive changes in their lives. If you have one person living in that environment that is not capable of this all customers suffer. I would suggest him living in a house with all males and all male staff (hard to find), possibly even no roommates. The problem with serving high need customers is in our new environment providers will not get paid for it. They may pay for a U9 for 30 days but then the MCO want to tier them down to U5 as fast as possible but still expect providers to provided serviced needed, meanwhile providers take all the risk. We would need a guarantee of a U9 as long as needed
  - Hospital: Court order IM Rx, PMI then RCF level of care.

- **Client #3 Brief Description:**
  - MHI, RCFs, Sex offender registry
  - Called staff 30 – 40 times daily at the main office. He is lower functioning intellectually. When he doesn't get his way he lashes out. Has tantrums. Most docs refuse to work with him because he threatens to kill them or sue them. Threatens to quit services at least 2x monthly.
  - Incontinent, upcoming bladder surgery. 3 to 4 doc appts per month that he cannot attend alone. Can do ADLs and does a fair job picking up after himself. Needs assistance with laundry and cooking. Has not been aggressive against direct service staff. Does not use substances. Likes activities but must be supervised.
- **Brief description of service level and cost per day estimate.**
  - This applicant is a good candidate for a Permanent Supportive Housing Program. Our plan is that
  - Housing Cost would be covered by the region and service costs billed to Medicaid.
  - We would be willing to complete assessment to identify his needs and assess if we can meet these needs. Possibly start at a U9 Tier and maybe Tier down to U7 with time.
  - Hospital HAB group home with behavior modification.

- **Question 4: Hospital psychiatrists would like to place people directly into community** services but would need the provider to visit the hospital within 24 hours of contact, meet the client, make a decision and take the client the following day. Can your agency accommodate that request today? If not, how could you accommodate it in the future?
  - Two providers proposed a solution to rapid community placement from hospital inpatient units. The region can do an RFP.
  - Providers are indicating an interest in providing services either in a hourly or hab setting. We have one agency providing hourly services for people with complex needs.
  - The region is not aware that we have people stuck on psychiatric units. When we get someone that cannot be served in an existing 24 hour setting we will do a rapid, mini RFP and build services around the individual.
  - We have done a count of the known individuals who have experienced instability or have been turned down by all providers. We have so few we can serve them case by case.

- **Question #5. Do you think it's possible to get your staff turnover below 20%?**
  - Yes, if we paid them more and could provide decent benefits to all of the staff
  - Yes, it's possible but you have to be able to offer better wages and benefits. This is a very hard field to work in and burn out is a problem. The more variety and ways you can break things up for staff the better. Like we offer a lot of scheduling flexibility
  - Our turnover is at 33% and the average length of employment with our current staff is 5.5 years. If I could increase their wages I believe we would decrease the turnover. But due to the unknown with contracting with the MCO's I am hesitant to increase the starting wage.
  - Yes. currently have a staff turnover less than 20%. Competitive wages are a key to this as well as ongoing training and clinical support to team members.
  - We have been working on decreasing turnover for years, anything is possible and I would love to get our turnover down. I have never seen below 20% turnover. We are continually trying new things to decrease turn over- increase reimbursement rates so we can pay staff more.
  - The biggest challenge is to get them fully on board. It seems if they complete the probationary period they are more likely to stay long term. We have had a large number hired and quit before they start working.
  - The region is implementing a staff support and training center.

- **Question #6: There are complaints statewide and in a regional DSW survey that staff have** little training and are hired and put to work just to keep up with the demand. How is your agency training staff currently and what would you like to do in the future? How would you accomplish your goals?
  - We need to get more feedback from our staff on what works. We have a combination of classroom, on line and house specific training. In the future, I would like to see our middle managers be able to get out to sites to do more mentoring and modeling for staff. I would like to be able to hire more middle managers to make their case loads smaller so they would have that time, but unable to do that due to budget constraints

- Currently we do a lot of supervision when someone starts to make sure they are comfortable with the job and we offer 24/7 training assistance so our staff can always contact someone when they need help. In the future I would like to see our agency have some sort of computer training program that staff can engage in we are looking into a couple of them now.
- Currently our new hires must complete around 10-12 hours of training before they even work independently. They are required to shadow other staff until they feel comfortable and the client feels comfortable with them working alone. We provide a new employee training program which requires 2-4 hours of training at least once a month depending on how many new staff we have. They are required to attend a monthly team meeting as well as monthly meeting within their department. We also use College of Direct Support and they are assigned classes through that program regularly. We also just hired a new Director of Planning and Training. This allows that Director to seek out staff that are having difficulties and provide more training to them.
- Staff are provided with a significant amount of time for training and shadowing upon hire and prior to being assigned 1:1 to support a client. Staff receive ongoing clinical support from the Unit Director and Clinical Director for the programs. Clinical Directors hold monthly trainings to continue to develop clinical skills of staff at all levels in the program.
- We currently train staff by shadowing other staff, classroom training, direct supervisor coaching's, customer specific training. I would like to be able to make classroom training and hiring process more real life examples/role playing/etc. We currently working on creating video services, real life examples to train new staff
- The region is implementing a staff support and training center.

5. Meeting with Peers October 9, 2017 Mercy Cedar Rapids - Hallagan Room – 9:00 -12:00

We identified areas that the peers believe are of special interest to them including housing, transportation; Social Security Work incentives support, breaking the stigma of peer support with hospitals and recovery coach training. The group also endorsed some projects from the overall list of projects.

II. To review funding resources currently available (including but not limited to regional fund balances, supports to individuals with mental health, disability, and substance use disorder needs;

Funds identified were regional fund balances, Medicaid, Medicare, Public Health and United Way. In the short term there is adequate funding to address the needs. After the fund balance is spent down to 20% we believe that we likely be able to fund services we have developed if the modifiers are created so that Medicaid can begin to pay their share of the costs for Crisis Services, if providers are able to move to Medicaid billing for services and if the waiting list for people on the ID waiver ends. If Medicaid is unwilling to take their share of the costs, we will likely have to decrease services. The Fiscal Agent met with county auditors to share a spreadsheet to assist them to identify their county fund balance amounts on October 4th. **There is concern that at a 20% fund balance the urban counties can likely cash flow at the beginning of the fiscal year by borrowing, some rural counties in our region cannot.**

III. To identify the following Community Services Plan components

- Planning and Implementation Timeframes and Assessment Tools for determining the effectiveness of the plan in achieving the Department's identified outcomes for success
- Financial Strategies to support the plan

NOTE: None of the following projects have had funding approved by the regional governing board. The Regional Governing Board as a whole reviewed the projects and eliminated none of them. The Region is still in the process of choosing projects to be covered by the regional fund balance. The process used for identification of projects is as follows:

The Regional Governing Board referred the projects out to the individual county boards of supervisors to assist with planning. Each county board will meet and decide which projects will most benefit the individuals in their county. The individual counties will choose the projects of interest and then return the choices to the regional governing board. The regional board will make the final decisions about which projects are funded as set forth in the 28E Agreement 6.4e.

We anticipate that the process can be completed in January of 2018 and implemented immediately or as soon as available.

Desired Outcome for Success: The number of individuals who are in the emergency department over 24 hours because mental health, disability, or substance use disorder services are not available.			
Regional Strategy #1 **Provide services which enable people to divert from the ER or if admitted, remain in the region for hospitalization.**	**Anticipated Completion Date**	**Funding Source**	**Projected Cost**
De-escalation bed Benton County Bed to divert from ER at Psych units. Either Telehealth or Mobile Crisis to do evaluation for committal or transport to Psych ER if necessary.	June 2018	Braided Region and Medicaid	$38,700
Behavioral Access Center Johnson County: ER diversion, treatment and placement for MH and SA. Partners co-located at the Center: mobile crisis, therapists, substance abuse counselors, housing providers, homeless shelter providers, RNs, IHH and ACT,	Jan 2020	Region pays start up then covers non-Medicaid	$2,000,000
Access Center Linn: Long term plan Partners co-located at the Center: mobile crisis, therapists, substance abuse counselors, housing providers, homeless shelter providers, RNs, IHH and ACT	June 2018	Braided Region and Medicaid	$3,000,000
Low barrier winter emergency shelter This is a shelter that accepts homeless overflow from the main shelter when it is too cold to be outside. It is open during the winter months only in Johnson County,	Dec 2017	Region and City	$31,340 per year
Community Based Detox Cedar Rapids: This is a place where people are detoxed rather than having individuals who are intoxicated take mental health beds at the hospital. This would be start up costs. The region does not pay for detox or for straight SA treatment however helping this get established could free up 4 to 6 beds per night on the psych units. This could be absorbed into a behavioral access center in the future.	June 2018	Region pays start up then services covered by IDPH/Medicaid/Hospitals	$100,000
Pilot Peer Recovery Support Peer support for crisis, non-Medicaid (ie Linn County hospital ER) Not sure why this is here. We already would fund this.	April 2018	Region	$50,000
Rapid placement from ER or Psych unit. Write an RFP to see what community providers can do to take people within 24 hour period.	Jan 2018	Braided/ region would fund housing	$60,000
Pilot Mobile counseling 30 day follow up (using juvenile model) 1. Increase quantity and quality of follow up 2. Increase # of touches post crisis (define and quantify) 3. Define role of this follow up and Find answers to barriers to follow up	March 2018	Region	$99,240

Desired Outcome for Success: The number of individuals who are psychiatrically hospitalized 24 hours beyond the hospital determining them ready for discharge because community based mental health, disability, or substance use disorder services are not available.			
Regional Strategy #2 **Wrap services/supports around people who have complex barriers to success.**	**Anticipated Completion Date**	**Funding Source**	**Projected Cost**
Build services and supports around people with complex needs who are stuck at a hospital, MHI or other higher level of care. We will meet with the MCOs and others to build enough service in to get the person placed. Examples might be the MCO would pay for the services and the region would pay for an applied behavioral analysis consultation and training for immediate staff. Or if the person cannot maintain with neighbors at an apartment we could fund a house or mobile home rent and utilities.	January 2018	Braided Region/Medicaid	$750,000 per year
Permanent Supported Housing—Fairweather Lodge Johnson	January 2018	Region	$40,00 per year
Rent Subsidy-Enable clients to afford a place to live in the community.	Dec 2017	Region	$400,000

Desired Outcome for Success: The number of individuals with a mental illness, intellectual disability, or substance use disorder who the local or county police department report could have been diverted or released from jail if appropriate community based services were available.			
Regional Strategy #3 **Create new options for people who are jailed or returning from prison to assist them to integrate successfully into the community.**	**Anticipated Completion Date**	**Funding Source**	**Projected Cost**
Telehealth in jail - one year pilot.	Feb 2018	Region	$10,000 one year
Rural ACT team (Assertive Community Treatment) This is a team that is paid by Medicaid to provide community services to people with Schizophrenia primarily. The psychiatrist, social worker, nurse, substance abuse etc. are represented on the team. They assume full responsibility for all needs of the client. NOTE: ACT already exists in Linn and Johnson. Also wanted by Benton, Jones, Bremer, Iowa This may be better considered as part of the RCF planning because it would serve some of the same people.	June 2019	Region pays ramp up cost.	$310,000 start up
Fund 4 more crisis beds up to 8, for broader use as well as transitional care $441 Per day x 4 as well as transitional care.	Feb 2018	Region	$643,000

Desired Outcome for Success: The number of individuals involuntarily discharged from their community based mental health, disability, or substance use disorder provider without a new community based provider in place. This includes, individuals discharged to jail, homelessness, or hospital that are not returning to services with their current provider.			
Regional Strategy #4: **Create services, housing and transportation options for people who are unable to live or work with the typical provider or available housing.**	**Anticipated Completion Date**	**Funding Source**	**Projected Cost**
Starting Pointe Peer delivered Designated mobile unit, strategically placed in rural communities within the county for 1 week intervals. Provides peer support services, respite for those in small communities, access to MH resources and services with which smaller communities may be less familiar or may not have the ability to access.	90 days	Region pays start up costs	$300,000 per year
Housing Every county in the region has housing needs. Johnson and Linn have the most need but we would also like to specifically look at development in Hazelton in Buchanan for sex offender housing. Lack of housing leaves people at the most expensive levels of care.	5 years	Region/grants	$2,500,000 total
Transportation: transportation to meet needs outside of medical appts.	Feb 2018	Region	$550,000
TAV Health: Use to facilitate rapid referrals and the ability to ascertain people have successfully accessed the service.	Jan 2018	Region	$40,000
Law enforcement stationed at Unity Point and Mercy in Cedar Rapids. Law enforcement officer stationed at ER to take custody so other officers can leave. This will assist law enforcement to do timely pick-ups for committals.	Feb 2018	Region	$100,000

Desired Outcome for Success: Support staff and providers across the region to stabilize and grow workforce.			
Regional Strategy #5 Increase workforce stabilitiy. Agencies are reporting from a 30% to 60% yearly turnover of direct service staff which fundamentally impacts the ability of providers to offer quality services to the clients they have as creating a barrier to growth to accommodate new clients.	**Anticipated Completion Date**	**Funding Source**	**Projected Cost**
WRAP Training to increase peer staff availability	Mar 2018	Region	$50,000
Recovery Coach Training to increase peer staff availability	Mar 2018	Region	$20,000
Private secure car for MH commitment transports (pay overage) This would save the sheriff from transporting people all over the state.	Dec 2017	Region	$300,000 per year
Direct Service Worker Resource Center: assists DSWs to stretch their dollars to maintain financial stability and offer management classes to grow middle management staff. This is a pilot to stabilize the workforce.	Nov 2017	Region	$50.000
Social Security Work Incentive Consultant: Peer workers as well as clients are limited in the number of hours they work due to concerns about income and social security.	Mar 2018	Region	$60,000
Meet with hospital staff to fight peer employment bias: Hospitals may view peer staff with concerns that do not apply to non-disabled workers.	Mar 2018	Region	$5,000
Family to Family Facilitator Training	Mar 2018	Region	$7,500
Community of Practice around Suicide Prevention and Care Using consistent language for the care and prevention of suicide by all (law enforcement, community based providers, hospitals, funders), Zero Suicide Academy, plus interventions such as: CASE Approach (Chronological Assessment of Suicide Events) ASIST (Applied Suicide Intervention Skills Training): full and modified courses, AMSR	Mar 2018	Region	$15,000
Ongoing Support:Training Facilitators: CIT, ASIST, safeTALK, MHFA Zero Suicide Academy, plus interventions such as: CASE Approach (Chronological Assessment of Suicide Events) ASIST (Applied Suicide Intervention Skills Training): full and modified courses AMSR (Assessing and Managing Suicide Risk) and safeTALK	Mar 2018	Region	$15,000
Suicide assessment and intervention –same language risk/care needs, QPR (Question, Persuade, Refer) -online training or can be in person Foundation 2 assist with assessing which QPR should be taken by each individual, SuicideTALK (90 minutes in person by Foundation 2	Mar 2018	Region	$10,000

B. Plan for Regional Fund Balance Spend Down

Individual County Boards of Supervisors will consider the projects above and approve those they think will benefit their counties specifically and the region in general and then submit the plan to the ECR Board to approve. When the determinations are made by each county board and approved by the ECR Governing Board, the counties will then lower their levys to meet the 20% fund balance requested. However, several counties, especially rural counties do not believe 20% will allow them to meet expenses particularly in the first quarter.

C. Summary

The meetings alone, even if no money was spent, were beneficial. One supervisor stated that they had never sat down with so many people from different vocations to discuss mental health. We found out several things.

First, many people did not know everything that is available in the region. We found that some professionals did not know about mobile crisis, crisis beds, jail diversion, or subsidized housing for example.

Second, It was good for different groups, for example law enforcement, to see how others in their profession were utilizing services like mobile crisis. People appeared to be convinced to make changes just by listening to another county in the large group discussions.

Third, it was interesting to see how some parts of the system are biased towards peers and other parts openly embraced them and saw their value.

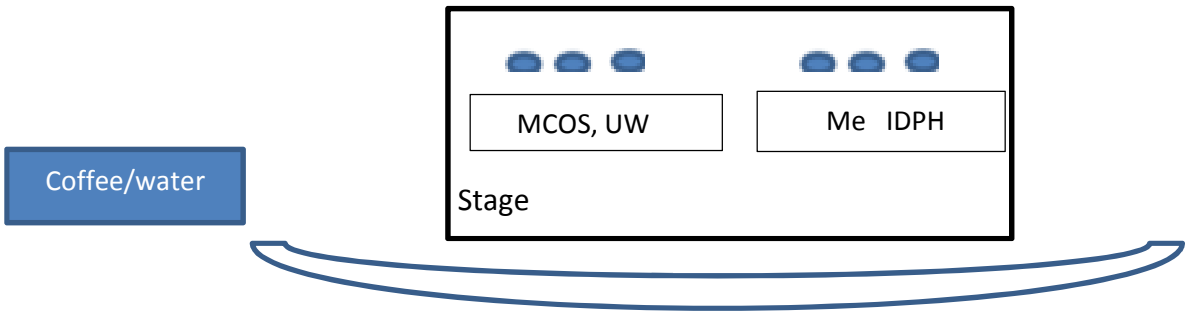
Law enforcement has fully accepted mental health training. Crisis services were quickly able to collaborate with different parts of the system to change their standard practice in specific cases and adjust to meet specific needs. There was a substance abuse provider that was now willing to make a change that had been advocated by the hospitals for several years prior to the new director. Jail diversion actively participated in the discussions and assisted in project planning groups outside of the regional meetings.

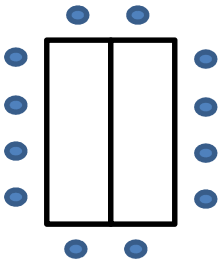
Residential providers had some good ideas to make openings for rapid discharge from the hospital. We had a provider willing to expand our ACT program to a rural county(s). It was somewhat surprising that the residential providers varied so greatly on their approach to serving people with complex needs. The range of costs per day was significant. It was also surprising to see the hospital assign a higher level of service to people discharging vs the community residential providers who believed they could serve the individual in a lower level of care. The peers championed needs that no one else did including housing and transportation.

It appeared that the group less inclined to see a need for change were some of the hospitals. It was mentioned at a couple of meetings that people who are hospitalized often are the victims of repeated medication changes over a short period of time at they move from the hospital to a residential setting and then into the community because they see different doctors as each place. Some hospital staff seem to struggle with how the funding system interacts. It seemed a couple of times as if they did not have an alternative when their initial plan did not work. They do not seem to communicate with the region when they are having problems.

Overall the process was fascinating and was an excellent idea for a process from DHS to the regions.

Hallagan Room Layout





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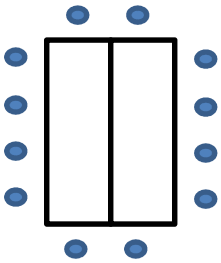

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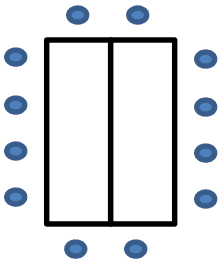
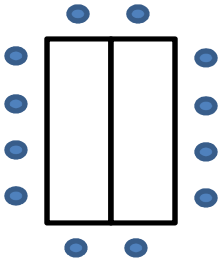
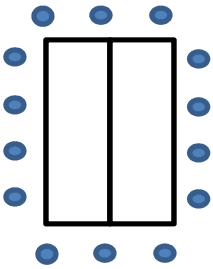


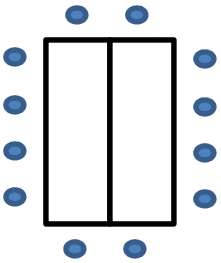
DELAWARE 12



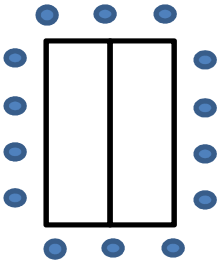
IOWA 12



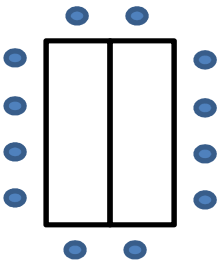
DUBUQUE 14



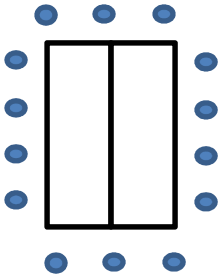
JONES 12



JOHNSON 14



BENTON 12



LINN 14

(30 additional chairs)

Coffee, water, snacks

APPENDIX A

Stakeholder Meeting #1: June 29, 2017 Mercy Hospital Cedar Rapids - Hallagan Room - 9:00-12:00

Focus: Law enforcement, jails, crisis services, jail diversion, hospitals, mental health centers

TABLES BY INVITATION

BENTON	
LAST NAME	AGENCY
Miskemen	AbbeHealth
Kelley	ASAC
Reekers	BC Sheriff Deputy
Tippett	Sheriff
Zander	ECR
Nelson-Miller	Foundation 2
Breja	6th Dist. Jail Diversion
Rothman	Magistrate
Slezak	Peer
Bierschenk	Region Gov. Bd
Martinez	Virginia Gay Hosp.
Smith	Virginia Gay Home Hlth
Erhardt	Virginia Gay Hosp.

BREMER	
LAST NAME	AGENCY
Dashner	Co. Atty. Ofc
Wadding	Co. Atty Ofc
Whitney	Sheriff Dept.
Lentzkow	Covenant Clinic Psych
Heidemann	ECR
Martel	Foundation 2
Hildebrandt	Region Gov. Bd
Meyer	Sumner Hospital
Gitch	Unity Point Peer Support
Kohls	Waverly Health Ctr
Rathe	Waverly Health Ctr
Atty	Waverly Health Ctr

BUCHANAN	
LAST NAME	AGENCY
Ferenzi	AbbeHealth
Clouse	County Atty Ofc
Fridal	Buch. Co. Health Ctr
Palmer	Buch. Co. Health Ctr
Davison	ECR
Bergman	Family member
Copely	Foundation 2
Gissel	Region Gov. Bd
Wolfgram	Sheriff
Grosser	DOC

DELAWARE	
LAST NAME	AGENCY
Koehn	AbbeHealth
LeClere	Sheriff
Petlon	ECR
Morrissey	Foundation 2
Rattenborg	Magistrate
Hauschild	Manchester PD
Taylor	Manchester Reg. MC
Helmrichs	Reg. Gov. Bd
Borgerding	Hillcrest

DUBUQUE	
LAST NAME	AGENCY
Kennedy	Sheriff
Jansen	ECR
Merrick	Hillcrest
Duccini	Jail Diversion
Hassler	Medical Assoc. Clinic
Whitty	MH America Dubuque
McDermott	Mercy Medical Ctr
Prier	SASC
Peters	Unity Pt., Finley Hosp.
Lange	Amerigroup/Life Conn.
Bucko	NAMI

IOWA	
LAST NAME	AGENCY
Trefz	AbbeHealth
Austin	ECR
Pinkham	Jo. Co. Crisis Ctr
Goedken	Successful Living

JOHNSON	
LAST NAME	AGENCY
Vranish	AbbeHealth
Reedus	Jo. Co. Crisis Ctr
Seymour-Guard	ECR
Shaw	ECR
Bailey	Iowa City PD
Diersen	Iowa City PD
Peckover	Jail Alternatives
Connolly	Johnson Co.
Pulkrabek	Sheriff
Deatsch	Sheriff Dept.
Issah	NAMI
Day	NAMI/RPlace
Patel	Peer
Clemson	UIHC

JONES	
LAST NAME	AGENCY
Karminiski	AbbeHealth
Husman	ASAC
Schultz	ECR
Herman	ECR
McKean	Family member
Peddycoart	Foundation 2
Borgerding	Hillcrest
Lyons	Magistrate
Lovaas	Jones Co. Public Health
Briesmister	Jones Reg. MC
Metzger	Probation/Parole

LINN	
LAST NAME	AGENCY
Johnson	AbbeHealth
Gay	ASAC
Mullen	Cedar Rapids PD
Clark	ECR
Foege	Family member
Malloy	Heartland Strategies
Lamb	Jail Diversion
Theilen	Linn Co. MHDD
Alliger	Mercy MC
Tiernan	NAMI
Miller	Peer
Rogers	Reg. Gov. Bd
Lawrence	St. Luke's Hosp.
Meade	St. Luke's Hosp.
Peddycoart	Foundation 2
Loftsgard	Sheriff Ofc

Stakeholder Meeting # 2: July 19, 2017 Mercy Hospital Cedar Rapids - Hallagan Room – 1:30- 4:30

Continuation: Law enforcement, jails, crisis services, jail diversion, hospitals, mental health centers

TABLES BY INVITATION

BENTON	
LAST NAME	AGENCY
Miskimen	AbbeHealth
Kelley	ASAC
Schneider	ASAC
Zander	ECR
Nelson-Miller	Foundation 2
Kluth	6th Distr. Jail Div.
Breja	6th Distr. Jail Div.
Reekers	Sheriff Dept.
Tippett	Sheriff

BREMER	
LAST NAME	AGENCY
Wadding	Bremer Co. Atty Ofc
Lentzkow	Covenant Clinic Psych
Heidemann	ECR
Martel	Foundation 2
Hildebrandt	RGB
Meyer	Sumner Comm. Hosp.
Gitch	Unity Point Peer Sup

BUCHANAN	
LAST NAME	AGENCY
Ferenzi	AbbeHealth
Fridal	Buch. Co Hlth Ctr
Palmer	Buch. Co. Hlth Ctr
Davison	ECR
Bergmann	Family member
Copley	Foundation 2
Shonka	Reg. Gov. Bd
Wolfgram	Sheriff

DELAWARE	
LAST NAME	AGENCY
Koehn	AbbeHealth
LeClere	Sheriff
Petlon	ECR
Morrissey	Foundation 2
Rattenborg	Magistrate
Hauschild	Manchester PD
Taylor	Manchester Reg. MC
Helmrichs	Reg. Gov. Bd
Duccini	Jail Diversion
Lange	Amerigroup
Borgerding	Hillcrest

DUBUQUE	
LAST NAME	AGENCY
Jansen	ECR
Merrick	Hillcrest
Duccini	Jail Diversion
McDermott	Mercy MC
Peters	Unity Pt., Finley Hosp
Lange	Amerigroup
Prier	SASC

IOWA	
LAST NAME	AGENCY
Trefz	AbbeHealth
Frazier	Prelude
Pinkham	Jo. Co. Crisis Ctr
Austin	ECR

JOHNSON	
LAST NAME	AGENCY
Vranish	AbbeHealth
Reedus	Jo. Co. Crisis Ctr
Seymour-Guard	ECR
Shaw	ECR
Diersen	Iowa City PD
Deatsch	JC Sheriff Ofc
Peckover	Jail Alternatives
Connolly	Johnson Co.
Pulkrabek	Sheriff
Day	NAMI/RPlace
Issah	NAMI
Patel	Peer
Clemson	UIHC

JONES	
LAST NAME	AGENCY
Karminski	AbbeHealth
Husman	ASAC
Herman	ECR
Peddycoart	Foundation 2
Wheeler	Jones Co. Reg. Hosp.
Lyons	Magistrate
Lovaas	Jones Co. Public Hlth
Briesemeister	Jones Reg. Med. Ctr
Metzger	Jail Diversion
Swisher	Sheriff Ofc
Kluth	Jail Diversion

LINN	
LAST NAME	AGENCY
Johnson	AbbeHealth
Gay	ASAC
Mullen	Cedar Rapids PD
Clark	ECR
Foege	Family member
Lamb	Jail Diversion
Grady	Judicial
Thielen	Linn Co. MHDD
Loftsgard	Sheriff Ofc
Alliger	Mercy Medical
Tiernan	NAMI
Davis	NAMI
Miller	Peer
Rogers	Reg. Gov. Bd
Lawrence	St. Luke's Hosp.
Meade	St. Luke's Hosp.

Stakeholder Meeting # 3: September 18, 2017: Mercy Hospital Cedar Rapids - Hallagan Room – 9:00 -12:00

Focus: Residential Providers

TABLES BY INVITATION

BENTON	
LAST NAME	AGENCY
Miskimen	AbbeHealth
Kelley	ASAC
Smith	VGH Public Health
Zander	ECR
Wagner	ECR
Bierschenk	Reg. Gov. Bd
Breja	Jail Diversion
Erhardt	Virginia Gay Hosp
Lane	Virginia Gay Hosp
Schaller	Abbe IHH

BREMER	
LAST NAME	AGENCY
Gitch	BH Grundy Peer Support
Meyer	Sumner Comm. Hosp
Heidemann	ECR
Rathe	Waverly Health Center

BUCHANAN	
LAST NAME	AGENCY
Ferenzi	AbbeHealth
Schwarting	B & D Services
Davison	ECR
Esch	ECR
Brickman	Full Circle
Orent	Plugged In Iowa
Copley	Foundation 2
Karminski	Abbe Health

DELAWARE	
LAST NAME	AGENCY
Petlon	ECR
Lee	ECR
Mellon	G & G
Brecht	Penn/Chatham
Morrissey	Foundation 2
Orent	Plugged In
Johnson	AbbeHealth

DUBUQUE	
LAST NAME	AGENCY
Gehling	ECR
Jansen	ECR
Lang	Hillcrest
Borgerding	Hillcrest
Luedtke	Hillcrest
Duccini	Jail Diversion
Hassler	Medical Assoc. Clinic
Prier	SASC

IOWA	
LAST NAME	AGENCY
Trefz	AbbeHealth
Austin	ECR
Armentrout	Systems Unltd
Nachazel	ECR
Hurst	Jail Alternatives

JOHNSON	
LAST NAME	AGENCY
Teague	Caring Hands & More
Shaw	ECR
Weston	ECR
Winslow	Goodwill
Hurst	Jail Alternatives
Benedict	Optimae
Berg	Prelude
Goedken	Successful Living
Appell	UIHC
Ikerd	Optimae
Vranish	AbbeHealth

JOHNSON	
Rickey	AbbeHealth

JONES	
LAST NAME	AGENCY
Nelson	AbbeHealth
Schneider	ASAC
Herman	ECR
Fahey	ECR
Voss	Jones Reg. MC
Wensel	To the Rescue
Karminski	AbbeHealth
Schatzle	AbbeHealth
Sorensen	Systems Unlimited

JONES	

LINN	
LAST NAME	AGENCY
Johnson	AbbeHealth
Gay	ASAC
Hebl	Discovery Living
Ravn	Discovery Living
Welty	ECR
Clark	ECR
Morrissey	Foundation 2
Jamison	Goodwill
Metzger	Jail Diversion
Roll	Mercy BH
Alliger	Mercy MC
Alliger	Mercy MC

LINN	
Drish	REM Iowa
Rogers	Reg. Gov. Bd
LaGrange	RHD
Meade	St. Luke's Hosp.

Stakeholder Meeting #4: October 9, 2017 Mercy Hospital Cedar Rapids - Hallagan Room - 9:00-1

Focus: Peers and others receiving services

We met as a large group instead of at separate county tables.

LAST NAME	
Black	McElmeel
Buswell	A. Miller
Cortimiglia	S. Miller
Day	Morrissey
Gitch	Nemmers
Harris	Orent
Hart	Packingham
Howe	Patel
King	Pena
Koons	Rathe
Krause	
Lange	
Lentzkow	

LAST NAME	
Todd	
Wright	
Zehms	
McElmeel	
A. Miller	
S. Miller	
Morrissey	
Nemmers	
Orent	
Packingham	
Patel	
Pena	
Rathe	

Regan	
Schatzle	
Sell	
Austin	
Clark	
Dhondt	
Esch	
Heidemann	
Herman	
Jansen	
Shaw	
Zander	

Meeting with MCOS: September 12, 2017: Pizza Ranch in Grinnell – 11:00 – 2:30

EAST CENTRAL REGION	
LAST NAME	AGENCY
Dhondt	ECR
Clark	ECR
Davison	ECR
Petlon	ECR
Austin	ECR
Shaw	ECR

INVITED GUESTS	
LAST NAME	AGENCY
Clymer	United Way
Hashman-Evans	United Healthcare
Sear	AmeriHealth Caritas
Emrich	Linn Co. Public Health

INVITED FUNDERS AND OTHER GUESTS WHO ATTENDED

MEETING #1	
LAST NAME	AGENCY
Dhondt	ECR /Facilitator
Hashman	United MCO
Davis	NAMI Iowa
Triplett	IDPH
Wright	United Way ECI
Blomme	Foundation 2

MEETING #2	
LAST NAME	AGENCY
Dhondt	ECR / Facilitator
James	Unity Point
Malloy	Heartland Strategies

MEETING #3	
LAST NAME	AGENCY
Dhondt	ECR/Facilitator
Wright	United Way
Malloy	Heartland Strategies
Blomme	Foundation 2

AUDIENCE ATTENDEES

MEETING #1	
LAST NAME	AGENCY
Mineart	AbbeHealth
Lange	Amerigroup Iowa
Bridgewater	ARC ECI
Schramp	ARC ECI
Schwarting	B & D Services
Moser	CVCSS
Brecht	Penn/Chatham
Smith-Duggan	Penn/Chatham
Winslow	Goodwill
Jamison	Goodwill
Billmeyer	Hills & Dales
Althoff	Hills & Dales
Murphy	Iowa Hosp. Assn
Reekers	JAMI, Tama Co. MHA
Noack	Life Connections Recovery
Kendall	Lifelong Links
Goedken	Successful Living
Vallum	Waverly Health Center

MEETING #1	

MEETING #2	
LAST NAME	AGENCY
Mineart	AbbeHealth
Hanken	Advancement Svcs
Lange	Amerigroup Iowa
Bridgewater	ARC ECI
Schramp	ARC ECI
Schwarting	B & D Services
Moser	CVCSS
Brecht	Penn/Chatham
Smith-Duggan	Penn/Chatham
Healzer	Families, Inc.
Winslow	Goodwill
Jamison	Goodwill
Althoff	Hills & Dales
Billmeyer	Hills & Dales
Murphy	Iowa Hosp. Assoc.
Reekers	JAMI, Tama Co MHA
Koerperich	JETS
Lange	Jones Co. Atty
Noack	Life Connections Recovery
Kendall	LifeLong Links
Emrich	Linn Co. Public Hlth
Paulsen	Life Connections
Benedict	Optimae LifeServices

MEETING #2	
Drish	REM Iowa
LaGrange	RHD
Goedken	Successful Living

MEETING NUMBER 3	
LAST NAME	AGENCY
McCannon	Caring Hands & More
Berkson	Caring Hands & More
Thomas-Dusing	Caring Hands & More
McFarland	Four Oaks
Brickman	Full Circle
Menders	Full Circle
Helm	Hillcrest
Fisk	Horizons
Reasner	Linn Co. Public Health
Streng	REM Iowa
McFarland	Family member
Pakebier	REM Iowa
Fridley	AmeriHealth
Koehn	AbbeHealth
Smith-Duggan	Penn/Chatham
Cahalan	AbbeHealth
Henry	AbbeHealth
Wyant	AbbeHealth

MEETING NUMBER 3	