March 27, 2013

To: Members of the Speaker’s Task Force on Mental Health

From: Matthew Stanford, WHA VP Policy & Regulatory Affairs, Associate General Counsel

Re: Comments and Recommendations for the Speaker’s Task Force on Mental Health

WISCONSIN HOSPITAL ASSOCIATION, INC.

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Wisconsin’s behavioral health care system is facing serious challenges and finding solutions is a top Wisconsin Hospital Association (WHA) priority. Since 2008, WHA’s Mental Health Task Force has worked with health care leaders throughout the state to identify regulatory, workforce and funding barriers that stand in the way of delivering accessible and well-coordinated care for individuals with mental health needs. To help facilitate the goals of the Speaker’s Task Force on Mental Health, WHA offers the attached document outlining identified problems and recommended actions for the Speaker’s Task Force.

The treatment, support, and understanding of mental illness has seen positive advances in recent years that have benefited many individuals with mental illness. Some advances are due to better diagnosis and treatment, some advances are due to cultural changes that have reduced but not eliminated stigma associated with mental illness, and some advances are due to policy changes such as laws enacting mental health parity.

However, while beneficial progress has been made in mental health care, many individuals affected by mental illness remain disadvantaged by public policy that has led to a fragmented mental health system that they cannot access or provides incomplete, uncoordinated care. Since its inception in 2008, WHA’s Behavioral Health Task Force has worked to identify tangible problems and find solutions to help remove barriers to a more modern, accessible, integrated, and consistent mental health system for Wisconsin.

One root cause of Wisconsin’s fragmented mental health policy is stigma. Stigma is a social problem, and WHA, consumer groups, health care providers, and businesses are working with organizations such as Mental Health America and Rogers InHealth to identify and implement evidenced based ways to address social stigma. However, society has also institutionalized stigma through policies at both the state and federal level that perpetuate outdated distinctions between mental health care and physical health care to the detriment of individuals with mental illness.

For example, by federal rule, hospitals with more than 16 beds that primarily serve adults with mental illness are excluded from Medicaid funding. Similarly, federal rules also place special bed limits and a differing payment methodology for small, rural critical access hospitals that provide inpatient psychiatric services.
Wisconsin also has examples of policy that perpetuates stigma by treating mental illness differently from other illness. For example, unlike health care services for physical illnesses, current Wisconsin law requires that county government pay for the state’s share of Medicaid funding for various mental health services.

Another frustrating example of stigma institutionalized in policy is Wisconsin’s mental health records law which stands in the way of modern holistic and coordinated care that integrates physical and mental health. That law, which predates federal HIPAA laws, not only perpetuates the stigma that mental health care is different from physical health care by requiring in practice that mental health information be separated from a patient’s physical health information in their medical record, but it also forces treating health care providers to make assumptions – a root cause of stigma - about an individual’s mental illness in the absence of accessible relevant information about the individual’s mental illness in the medical record.

In a time of important change in health care delivery and views on mental health, it is important that Wisconsin keep up with that change. Thus, WHA is pleased to see the bi-partisan interest in re-examining and modernizing mental health policy.

WHA looks forward to working with the Speaker’s Task Force as it completes its charge. Should you have any questions or would like further information, please feel free to contact Matthew Stanford, WHA Vice President Policy & Regulatory Affairs, Associate General Counsel, at 608-274-1820 or mstanford@wha.org.
WISCONSIN HOSPITAL ASSOCIATION, INC.

March 27, 2013

WHA RECOMMENDATIONS TO THE SPEAKER’S MENTAL HEALTH TASK FORCE

PRIMARY RECOMMENDATIONS

**Problem 1** – Statutory barriers stand in the way of modern holistic and coordinated care that integrates physical and mental health.

**Solution 1** – The Task Force should recommend the introduction and enactment of the Mental Health Care Coordination/HIPAA Harmonization Bill.

**Problem 2** – Wisconsin’s reliance on a county-based public mental health and substance abuse system has led to inefficiencies, differing levels of access to care, and an inefficient distribution of preventative and emergency mental health services throughout Wisconsin.

**Solution 2** – Accelerate efforts to develop a regional system for emergency mental health services.

**Solution 2.1** – The Task Force should direct the Legislative Council to research and report on Iowa’s recent transition from a county-based public mental health system to a regional-based public mental health system and identify benefits, costs, and barriers to Wisconsin if Wisconsin were to implement reforms similar to Iowa.

**Solution 2.2** – The Task Force should request the Wisconsin Department of Health Services (DHS) to report to the Legislature interim findings of the Regional Pilots for Mental Health and Substance Abuse Services, and by July 1, 2014, make recommendations to the Legislature for expanding the pilot statewide in the 2014-2016 biennial budget.

**Solution 2.3** – The Task Force should request DHS to review whether some or all state monies spent to maintain non-forensic services at the Mendota and Winnebago Mental Health Institutes could be better allocated to provide smaller, regional emergency detention facilities and involuntary inpatient psychiatric units or facilities. As part of such review, the Task Force should request that DHS explore whether such monies could be reallocated in such a way to capture federal funds.
**Problem 3** – County 51.42 Boards charged under the Wisconsin Mental Health Act with guiding local community mental health programs are not set up to best ensure intra-county collaboration on emergency mental health services.

**Solution 3** – The Task Force should support the enactment of WLC 0112/3, which was approved for introduction by the Joint Legislative Council Committee in January as a public policy strategy to systematically facilitate intra-county collaboration by ensuring hospitals and law enforcement are represented on 51.42 Boards.

**Problem 4** – Inconsistent psychiatric emergency detention practices and interpretations under Chapter 51 lead to inconsistent access to services and care across Wisconsin.

**Solution 4.1** – The Task Force should request DHS and DOJ to develop and implement a plan to collaborate to promulgate rules and/or best practices guidance on psychiatric emergency detention procedures under Chapter 51 to increase the likelihood of consistent application throughout Wisconsin’s 72 counties.

**Solution 4.2** – The Task Force should request an Attorney General’s opinion to clarify two areas of confusion regarding psychiatric emergency detentions in Wisconsin’s statutes.

- Health care providers often perceive that they could be viewed as responsible for decisions by law enforcement or county crisis agencies to not initiate and approve a psychiatric emergency detention for an individual that the health care provider believes is a danger to themselves or others. This source of concern could be mitigated if the Attorney General provided an opinion on the following question: If a health care provider believes an individual with mental illness, drug dependency, or developmental disability is a danger to themselves or others and requests law enforcement to initiate an emergency detention of the individual, has the health care provider fulfilled their duty to warn?

- Under Federal EMTALA law, hospital emergency departments have certain obligations regarding the evaluation, stabilization, and transfer of patients, though the obligations can depend on the wishes of the patient or an agent of the patient making decisions on behalf of the patient. When applying the EMTALA law, there has been some confusion, including among federal regulators, as to whether under Wisconsin’s emergency detention law is compatible with the Federal EMTALA law. This confusion could be mitigated if the Attorney General provided an opinion on the following questions: Is a law enforcement officer with custody of an individual under a Chapter 51 emergency detention an agent making decisions on behalf of the individual under Wisconsin law? What, if any, decisions about the individual’s evaluation, stabilization, or transfer in/from the emergency department must be made by the individual and not by the law enforcement officer with custody of the individual under Wisconsin law?

**Problem 5** – Perpetually low reimbursement for mental health services is a significant contributing factor for mental health services access difficulties in Wisconsin.
Solution 5 – The Task Force should support sustainable Medicaid reimbursement rates for mental health service providers.

OTHER AREAS NEEDING ATTENTION

Problem 6 – Some mental health regulations intended to improve care are not effective in improving care but are increasing the cost and complexity of providing mental health care and integrating mental health into primary care settings.

Solution 6 – The Task Force should recommend the addition of DHS 35, the outpatient mental health clinic certification rule, to the list of administrative code chapters to be reviewed under the Right the Rules project.

Problem 7 – Individuals with both mental illness and other chronic disease often incur significantly higher costs to the Medicaid program when such individuals do not have care management. The 2011-2013 state budget budgeted $1.5m GPR in savings due to the creation of a medical home model for individuals with a mental health diagnosis designed to provide care management for individuals with mental illness and other chronic disease. However, actual implementation of the medical home model has been difficult.

Solution 7 – For purposes of identifying strategies that the Study Committee could seek to employ to help DHS facilitate the creation of a medical home model for individuals with a mental health diagnosis, the Task Force should request DHS to provide the Task Force with additional information on the benefits of and barriers encountered in implementing a pilot for the Medical Home for Individuals with a Mental Health Diagnosis.

Problem 8 – The unnecessarily burdensome and duplicative Medicaid prior authorization process for mental health services increases the cost of providing mental health services.

Solution 8 – The Task Force should request that DHS seek input from providers and consumers on potential simplification and streamlining of the Medicaid prior authorization process for mental health services and develop and implement a new prior authorization process by a date certain.

Problem 9 – Health care providers are concerned that emergency detention decisions by county departments of community programs are sometimes not made in the best interest of patients or the public. Pursuant to the 2009-11 budget bill, county crisis services agencies hold exclusive control over approval of transports to emergency detention facilities. While a benefit of this policy decision is the reduction of some inappropriate emergency detentions, consolidating this power solely on a county agency often responsible for the cost of the emergency detention can also lead to inappropriate underutilization of emergency detention necessary for the stabilization of a vulnerable, acutely ill individual. Without appropriate oversight and checks and balances to...
ensure that necessary emergency stabilization is being provided, there is an increased likelihood that some individuals may not get the stabilization they need to protect themselves and others.

**Solution 9** – The Task Force should examine and consider modifying Wisconsin’s standards for making emergency detention decisions (as opposed to the emergency detention criteria themselves) including DHS 34 and Wisconsin’s minimum qualifications for county agency personnel making emergency detention approval or disapproval decisions.

**Problem 10** – Before passage, two important technical changes are needed to WLC 0073/5 which will be introduced as a result of the Legislative Council’s Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51. WLC 0073/5 makes multiple changes to Wisconsin’s emergency detention and involuntary commitment laws.

**Solution 10** – The Task Force should support the two technical changes to WLC073/5 recommended by WHA in its January 15, 2013 memo to the Legislative Council.

*Recommended Change #1* – Remove and replace potentially confusing “least restrictive” legal jargon in the bill with explicit language that would prohibit law enforcement from initiating an emergency detention on an individual willing to receive care.

*Recommended Change #2* – Replace the bill’s proposed earlier start of the emergency detention “72 hour clock,” to give health care providers time to psychiatrically stabilize an individual.

**Problem 11** – Some Wisconsin laws have created barriers to children receiving necessary psychiatric care.

**Solution 11** – The Task Force should work to pass the reasonable reforms in WLC 0014/1 designed to help better ensure minors in crisis receive the care that they need. WLC 0014/1 will be introduced as a result of the Legislative Council’s Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51.
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Overview: Mental Health Care Coordination/HIPAA Harmonization Bill

Brief Synopsis

- Federal HIPAA privacy and security law allows health care providers to communicate treatment information about a patient with other providers that are also treating the patient.
- Wisconsin law also allows such communication, unless the communication is from a treating mental health provider. Wisconsin places numerous restrictions on communications by treating mental health providers. These restrictions in turn create a barrier to the coordination of care for such patients that does not exist for other patients.
- The bill would permit, but not require, health care providers and others subject to the Federal HIPAA health information privacy and security law to communicate mental health information about a patient with other health care providers and entities subject to the Federal HIPAA law if the communication is made for treatment purposes, payment purposes, or health care operations purposes, and the communication is made in compliance with the HIPAA law. *Existing Wisconsin and HIPAA provisions limiting the disclosure of a “psychotherapy record” would continue to exist.* Except for the psychotherapy record, the federal HIPAA law does not treat mental illness differently than other illnesses.
- In order to better coordinate mental health care, both Hawaii in 2012 and Washington state in 2009 enacted a nearly identical bill; both bills passed both houses of each state without a single no vote.

Why is the Mental Health Care Coordination Bill important for Wisconsin?

The Mental Health Care Coordination Bill would remove barriers in Wisconsin law to the coordination of care for persons with a mental health diagnosis that do not exist for persons that do not have a mental health diagnosis and that do not exist in federal HIPAA law.

These statutory barriers have resulted in:

- Less coordinated and integrated care for this vulnerable population;
- Higher costs to Medicaid (and other payers and hospitals as well) due to uncoordinated care;
- Higher costs to implement technology that allows hospitals and clinics to electronically communicate and coordinate care for all patients; and
- A perpetuation of a stigma built on a false and fading belief that mental health illness isn’t a real medical illness and its treatment is shameful or embarrassing.

Wisconsin needs to amend its mental health law to end this disparate treatment of persons with mental health diagnoses, and remove statutory restrictions on psychiatrists and other mental health providers from coordinating a patient’s care with the patient’s other providers.

What are the benefits for Wisconsin?

- Optimized care for persons with mental health diagnoses through enhanced care coordination.
- Lower hospital readmission rates for individuals with mental health conditions
- Cost savings for Medicaid (and private payers) by enhancing care coordination.
- Lower health care information technology costs.
- Reduced regulatory burden by aligning parts of Wisconsin law with Federal law.
- Further equalization and integration of treatment for patients with mental illness.

How does the bill achieve these benefits?

A simple amendment would align a part of Wisconsin’s health privacy law dealing with treatment, payment, and health care operations with the Federal HIPAA privacy law.
Details: Mental Health Care Coordination/HIPAA Harmonization Bill

Benefits of the bill for Wisconsin

**Improves care for persons with mental health diagnoses through better care coordination.**
- Patient care can only be as good as the information available about the patient. Removing limitations on the communication of medically relevant information will allow health care professionals to better ensure that patients with mental health conditions are getting the best physical and mental health care possible.
- Studies are increasingly identifying correlations between physical and mental health related problems and finding that individuals with serious physical health problems often have co-morbid mental health problems. Health care providers and researchers are also finding that “coordinated care” is better care for the individual. To take advantage of these new understandings and provide better, more holistic and less stigmatizing care, health care providers are increasingly working to change existing siloed models of care that treat mental health and physical health separately to integrated models of care that treat mental health and physical health together, not separately. Removing statutory barriers that perpetuate the siloed model of care will better enable health care providers in Wisconsin to provide the best, most holistic treatment to individuals with mental health needs and further help reduce stigmas associated with mental illness.

**Enhances the intent of the Mental Health Parity Act by further equalizing treatment for patients with mental illness.**
- Wisconsin enacted mental health parity in 2010 to help equalize insurance coverage for mental illness with other medical conditions. However, Wisconsin’s special mental health privacy law continues to result in unequal coordination of care for persons with mental illness. To achieve true integration of mental health care, improve the care of patients with mental illness, and reduce health care costs, Wisconsin should follow the Federal lead and not differentiate mental illness and other illness for purposes of care coordination and communication.

**Reduces hospital readmissions and creates other cost savings (for Medicaid and private payers) by enabling better care coordination.**
- A study by Johns Hopkins released in January 2013 indicates that the Mental Health Care Coordination/HIPAA Harmonization Bill would reduce hospital readmissions for psychiatric patients in Wisconsin by removing restrictions on non-psychiatric physicians ability to access psychiatric records. The study found that psychiatric patients were between 30-40% less likely to be readmitted to a hospital when non-psychiatric physicians were not restricted from accessing medical records created by a psychiatric physician.
- Further, the Wisconsin Department of Health Services (DHS) has indicated that fee for service Medicaid enrollees with a mental health diagnosis have higher Medicaid costs compared to Medicaid enrollees without a mental health diagnosis. To reduce Medicaid costs associated with poorly coordinated care, DHS has identified improved coordination of care for fee for service Medicaid enrollees with mental health conditions as a priority project.
- Removing communication restrictions on mental health professionals that do not exist for other treating professionals is critical to facilitating improvements in care coordination for Medicaid enrollees and others with mental health diagnoses and realizing care coordination cost savings for this population.

**Eases regulatory burden by aligning parts of Wisconsin law with Federal law.**

**Lowers health care information technology costs.**
- Health care providers are currently in a period of rapid adoption of information technology, particularly electronic health records (EHRs) in order to improve the quality of care of the patients that they serve. However, the implementation and upkeep costs for EHRs are very significant investments for hospitals and clinics.
- EHR vendors design their systems to meet Federal law, including HIPAA. Modifications to EHR products to meet Wisconsin-specific requirements can significantly increase the cost of an EHR product for Wisconsin health care providers. In some cases, even with modifications, work-arounds must be developed that reduce the capabilities and patient care benefits of the EHR. Wisconsin’s mental health privacy law is one such Wisconsin-specific variation from the national standard that increases EHR, health information exchange and other information technology adoption costs for many health care providers.
These costs are particularly borne by hospitals and clinics that offer psychiatric services, creating further burdens on psychiatric providers that already face high regulatory burdens and low reimbursement. In fact, partially due to these added burdens, psychiatrists have some of the lowest rates of adoption of EHRs.

Bill Specifics

Alignment with Federal HIPAA Privacy and Security Law
The bill would allow health care providers and others subject to the Federal HIPAA health information privacy and security law to communicate mental health information about a patient with other health care providers and entities subject to the Federal HIPAA law if the communication is made for treatment purposes, payment purposes, or health care operations purposes, and the communication is made in compliance with the HIPAA law. Existing Wisconsin and HIPAA provisions limiting the disclosure of a “psychotherapy record” would continue to exist. Except for the psychotherapy record, the federal HIPAA law does not treat mental illness differently than other illnesses.

Alignment with Existing Wisconsin Law Applicable to Non-Mental Health Information
The bill also explicitly aligns Wisconsin’s general health information privacy law governing communications of health information for treatment, payment, and health care operations with the federal HIPAA law. Although Wisconsin’s non-mental health information privacy law and HIPAA law are functionally equivalent for such communications, this simple amendment would explicitly bring Wisconsin law in line with federal HIPAA law.

Draft Language

SECTION 1. 146.816 of the statutes is created to read:

146.816 Uses and disclosures of protected health information.
(1) In this section:
(a) “Business associate” has the meaning given in 45 CFR 160.103.
(b) “Covered entity” has the meaning given in 45 CFR 160.103.
(c) “Disclosure” has the meaning given in 45 CFR 160.103 and includes redisclosures and rereleases of information.
(d) “Health care operations” has the meaning given in 45 CFR 164.501.
(e) “Payment” has the meaning given in 45 CFR 164.501.
(f) “Protected health information” has the meaning given in 45 CFR 160.103.
(g) “Treatment” has the meaning given in 45 CFR 164.501.
(h) “Use” has the meaning given in 45 CFR 160.103.

(2) Sections 51.30 (4) (a) and (e) and 146.82 and rules promulgated under s. 51.30 (12) do not apply to a use, disclosure, or request for disclosure of protected health information by a covered entity or business associate that meets all the following criteria:
(a) The covered entity or business associate makes the use, disclosure, or request for disclosure in compliance with 45 CFR 164.500 to 164.534.
(b) The covered entity or business associate makes the use, disclosure, or request for disclosure in any of the following circumstances:
1. For purposes of treatment.
2. For purposes of payment.
3. For purposes of health care operations.
FAQs: Mental Health Care Coordination/HIPAA Harmonization Bill

**Existing Disclosure Provisions**

Q: Are there exceptions under current Wisconsin law to the disclosure of mental health information without the individual’s consent?

A: Yes. There are over 27 exceptions in Wisconsin’s mental health confidentiality law that permit the release of treatment records without informed written consent. Some of the notable exceptions include:

- **Disclosures by DHS** “to the extent necessary to coordinate treatment for mental illness, developmental disabilities, alcoholism or drug abuse of individuals who have been committed to or who are under the supervision of the department.” §51.30(4)(a)7.
- **Disclosures to DHS or county human services agencies** “as is necessary to determine progress and adequacy of treatment.” §51.30(4)(a)5.
- **Disclosures to DHS or county human services agencies** for purposes of billing and collections. §51.30(4)(a)2.
- **Disclosures for treatment of an individual in a medical emergency, if the patient cannot provide consent.** However, disclosures under this provision, must be limited to only that part of the records necessary to meet the medical emergency. §51.30(4)(a)8.
- **Disclosures to a health care provider**, if necessary for the current treatment of the individual, but only the following information listed in §51.30(4)(a)8g.:
  - Individual’s name, address, date of birth and other relevant demographic information necessary for the current treatment of the individual,
  - The individual’s behavioral health provider,
  - The date of behavioral health services provided,
  - The individual’s medications, allergies, diagnosis, diagnostic test results, and symptoms.

**Inadequacy of the Itemized Disclosures Provision**

Q: The permission to make the itemized disclosures under §51.30(4)(a)8g. was enacted in 2007. Isn’t that enough information for care coordination purposes?

A: The items listed in §51.30(4)(a)8g. provides important information, but not a full picture of information that would be relevant to a treating provider. For example, such information does not include important information on plans of care, medical history, discharge instructions, functional status, treatment goals, etc. Also missing from that list is important information in medical notes from a mental health care provider such as why certain medications were prescribed as opposed to others. The attached document “Examples of Sharable Information: Current WI Mental Health Law vs. Federal Law” provides examples of important information missing from Wisconsin’s law.

**Permissive disclosure, not a required disclosure**

Q: Does the bill require a mental health provider to disclose information to another provider without the patient’s consent?

A: No. The bill is merely permissive. A mental health provider is not required to disclose information to another provider. Also, pursuant to HIPAA, a patient has the right to request a restriction on the disclosure of the patient’s information.
While a provider is not required to agree to a patient’s request, under Federal HIPAA law, a patient and provider are allowed to agree to a restriction on communications of the patient’s health information. If such an agreement is made, with limited exceptions, the provider would have an obligation under HIPAA to follow such an agreement.

**HIPAA alignment**
Q: Does this bill eliminate all Wisconsin privacy laws and substitute them with HIPAA?
A: No. The bill only addresses disclosures made for purposes of treatment, payment, or health care operations. Disclosures made for all other purposes, such as disclosures to law enforcement, family members, courts, employers, etc., remain unchanged under state law.

**Psychotherapy notes**
Q: Under the bill, restrictions on the disclosure of a HIPAA-defined “psychotherapy note” would continue to exist under both HIPAA and state law. What is a “psychotherapy note”?
A: HIPAA defines a “psychotherapy note” as “notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”

**Employers**
Q: Would this bill allow my physician to send information to my employer without my permission?
A: No. The sharing of health information for employment-related purposes without patient authorization remains prohibited under HIPAA and state law.

**Self pay patients**
Q: If I pay in full for a clinic visit, can I prohibit my health care professional from sending mental health information created during that clinic visit to my insurance company?
A: Yes. The bill does not change federal HIPAA provisions that prohibit disclosures of information to an insurer upon request from a self-pay patient.

**Disclosures to family members**
Q: Does the bill modify the law regarding disclosures made to family members regarding my care?
A: No.

**Covered entities and health care providers**
Q: What is a covered entity? Are all health care providers a covered entity governed by HIPAA?
A: A covered entity is a health care provider that transmits information in an electronic form, a health plan, or a health care clearinghouse. All covered entities are regulated under the HIPAA law. Nearly all health care providers transmit information in an electronic form and are thus governed by HIPAA.

**Business associate**
Q: What is a business associate?
A: In general, a “business associate” is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Covered entities may
disclose protected health information to an entity in its role as a business associate only to help the covered entity carry out its health care functions – not for the business associate’s independent use or purposes, except as needed for the proper management and administration of the business associate. All business associates are subject to HIPAA and must sign an agreement with the covered entity governing the use and disclosure of patient information in compliance with HIPAA.

**Payment**

Q: Why should health care providers be permitted to communicate mental health information for purposes of payment?

A: If a provider could receive information to treat a patient but not provide information to the patient’s insurer in order to be reimbursed for the treatment provided to the patient, physicians could be discouraged from agreeing to see patients with mental health conditions. Further, for disclosures for payment purposes, HIPAA requires that a provider take reasonable steps to limit disclosures to insurers to the minimum necessary to accomplish the intended purpose.

**Health care operations**

Q: Why should health care providers be permitted to communicate mental health information for purposes of health care operations?

A: Hospitals and clinics use, only as necessary, patient information in order to improve the quality and cost-effectiveness of the health care they provide. Excluding patients with mental health conditions from such quality and cost-effectiveness efforts impedes mental health related quality and efficiency improvements, which is a disservice to patients with mental health conditions and the providers that treat them. Further, for disclosures for health care operations purposes, HIPAA requires that a provider take reasonable steps to limit disclosures to the minimum necessary to accomplish the intended purpose.

**Re-disclosures**

Q: Why are the re-disclosure provisions in §146.82(5) and § 51.30(4)(e) preempted by the bill?

A: Those provisions discuss “re-disclosures.” HIPAA does not distinguish between “original” disclosures and “re-disclosures.” Under the bill, HIPAA would apply to disclosures for treatment, payment, or operations purposes whether the disclosure is an “original” disclosure or a “re-disclosure” of information.
Examples of Sharable Information Between a Patient’s Providers:

Current WI Mental Health Law vs. Federal Law

- Wisconsin law limits the information that a mental health provider may share, without consent, with another treating provider that is not a mental health provider in a non-emergency situation.

- In comparison, except for psychotherapy notes (which are described in the FAQ), unless the patient and health care provider have agreed to limit the disclosure of information that could be disclosed for the patient’s treatment, Federal HIPAA privacy and security law does not limit what may be shared between a patient’s treating providers.

- The table below compares the list of information that may be shared between a treating mental health provider and other providers under Wisconsin law with examples of information that can be shared under Federal HIPAA law.

- In addition, the table below highlights specific sharable information mentioned in the Federal Regulations.

<table>
<thead>
<tr>
<th>Key: Citations for the items listed below</th>
</tr>
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<tbody>
<tr>
<td>Wisconsin Statute: s. 51.30(4)(b)8g.</td>
</tr>
<tr>
<td>HIPAA: 45 CFR 164.501. Items specifically excluded from HIPAA’s “psychotherapy note” treatment disclosure restrictions.</td>
</tr>
<tr>
<td>Current Federal Meaningful Use Regulation: Federal Register Vol. 77, No. 171. Items that at a minimum must be included in “transitions of care summaries” created by health care providers’ EHR by 2014.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Wisconsin Law</th>
<th>Federal HIPAA Law</th>
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<tbody>
<tr>
<td>Information disclosed in such a circumstance is limited to the following information:</td>
<td>The following is a list of examples of information that can be shared under Federal HIPAA law and that are discussed in the context of other state or federal laws. (Note that some are redundant):</td>
</tr>
<tr>
<td>The individual’s name, address, and date of birth;</td>
<td>The individual’s name, address, and date of birth;</td>
</tr>
<tr>
<td>The name of the individual's provider of services for mental illness, developmental disability, alcoholism, or drug dependence;</td>
<td>The name of the individual's provider of services for mental illness, developmental disability, alcoholism, or drug dependence;</td>
</tr>
<tr>
<td>The date of any of those services provided;</td>
<td>The date of any of those services provided;</td>
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<td>The individual's medications</td>
<td>The individual's medications</td>
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<td>The individual’s allergies,</td>
<td>The individual’s allergies,</td>
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<td>The individual’s diagnosis,</td>
<td>The individual’s diagnosis,</td>
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<tr>
<td>The individual’s diagnostic test of biological parameters, but not the results of psychological or neuropsychological testing.</td>
<td>The individual’s diagnostic of biological parameters, but not the results of psychological or neuropsychological testing.</td>
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<tr>
<td>The individual’s symptoms.</td>
<td>The individual’s symptoms.</td>
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<tr>
<td>Other relevant demographic information.</td>
<td>Other relevant demographic information.</td>
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<tr>
<td>Medication prescription and medication monitoring notes,</td>
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<tr>
<td>Counseling session start and stop times,</td>
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<tr>
<td>The modalities and frequencies of treatment furnished,</td>
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<tr>
<td>Results of clinical tests</td>
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<tr>
<td>Any summary of an individual’s diagnosis:</td>
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<tr>
<td>Any summary of an individual’s functional status,</td>
<td></td>
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<tr>
<td>Any summary of an individual’s treatment plan,</td>
<td></td>
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<tr>
<td>Any summary of an individual’s symptoms</td>
<td></td>
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<tr>
<td>Any summary of an individual’s prognosis</td>
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<tr>
<td>Any summary of an individual’s progress to date.</td>
<td></td>
</tr>
<tr>
<td>Patient name</td>
<td></td>
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<tr>
<td>Referring or transitioning provider’s name and office contact information</td>
<td></td>
</tr>
<tr>
<td>Procedures</td>
<td></td>
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<tr>
<td>Encounter diagnosis</td>
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<tr>
<td>Immunizations</td>
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<tr>
<td>Laboratory test results</td>
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<tr>
<td>Vital signs</td>
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<td>Smoking status</td>
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<tr>
<td>Functional status, including activities of daily living, cognitive and disability status</td>
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<tr>
<td>Demographic information</td>
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<tr>
<td>Preferred language</td>
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<tr>
<td>A care plan that defines care management actions for the patient’s conditions, problems or issues and that includes the problem, goal, and any instructions that the provider has given to the patient.</td>
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<tr>
<td>Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider</td>
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<tr>
<td>Discharge instructions</td>
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<tr>
<td>Reason for referral</td>
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<tr>
<td>Problem list, including historical problems and not just diagnoses</td>
<td></td>
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<tr>
<td>Medication list</td>
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<tr>
<td>Medication allergy list</td>
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</tr>
</tbody>
</table>
Understanding Mental Illness

It is time to challenge mental health policy that is slowing holistic treatment

by Jerry L. Halverson, MD, President - Elect Wisconsin Psychiatric Association
and Matthew Stanford, JD, Vice President, Wisconsin Hospital Association

The treatment, support, and understanding of mental illness has seen positive advances in recent years that have benefited many individuals with mental illness. Some advances are due to better diagnosis and treatment, some advances are due to cultural changes that have reduced but not eliminated stigma associated with mental illness, and some advances are due to policy changes such as laws enacting mental health parity.

However, while beneficial progress has been made in mental health care, many individuals affected by mental illness remain disadvantaged by a mental health system that they cannot access or provides incomplete, uncoordinated care. Partly because of stigma, mental health care has for decades been segregated and siloed from physical health care. As a result, many individuals were not treated holistically but instead their head and body were treated separately. The results of that segregated treatment mentality for individuals with mental illness has lead to uncoordinated care and has not been good for many. For example, Americans with the most serious mental illnesses have been found to die 25 years earlier than others.

The good news is that links between “head and body” are becoming better understood and the health benefits of treating the whole individual are increasingly being recognized. Studies are increasingly identifying correlations between physical and mental health related problems and finding that individuals with serious physical health problems often have co-morbid mental health problems. We are finding that “coordinated care” is better care and more cost effective care.

To take advantage of these new understandings and provide better, more holistic and less stigmatizing care, health care providers are increasingly studying ways to better coordinate an individual’s mental and physical health care. However, overcoming decades of infrastructure, policy, and patient and provider expectations built on the premise that mental health care should be separated and siloed from physical health care is a significant challenge in implementing new models of coordinated and integrated mental and physical health care.

Overcoming these challenges to achieve better coordinated and holistic mental and physical health care together in Wisconsin will require cultural and policy change. Just as Wisconsin’s mental health community was at the forefront of advocating for mental health parity, Wisconsin’s mental health community needs to more fully discuss, identify and advocate for cultural and policy changes that can tear down the 20th century siloed care model and enable new models of coordinated and holistic mental and physical health care.

One such existing policy that needs new consideration is the current Wisconsin law restrictions on communications between a patient’s treating psychiatrist and other physicians and providers that provide care to the patient. While this policy served an important purpose in a pre-HIPAA and segregated model of mental health care, many believe that this policy is now doing more harm than good by making it more difficult for different members of the medical team to communicate about their common patients by placing barriers in the way of that communication.

In a time of important change in health care delivery and views on mental health, it is important that Wisconsin keep up with that change. With leadership from the mental health community to challenge the status quo we can help ensure that Wisconsin’s mental health policy and mental health care can be a progressive model for the rest of the country.

NAMI Wisconsin - A Green choice!

Each month, we get more and more requests from our members who wish to receive NAMI Wisconsin materials via email. We hear you and are working on ways to distribute The Iris and other important materials via email!

Going Green:
• Makes our members happy!
And
• Cuts down on paper, printing, and mailing costs!

If you would prefer to receive The Iris via email please let us know:
bobfox@namiwisconsin.org

8 - The Iris
Testimony for HLT 1/24/2012 10:00:00 AM HB1957

Conference room: 329
Testifier position: Support
Testifier will be present: Yes
Submitted by: Robert Scott Wall
Organization: Consumer, Family, & Youth Alliance
E-mail: robertscottwall@yahoo.com
Submitted on: 1/24/2012

Comments:
We support the streamlining of access to health records and believe that the HIPPA protections that are currently in place provide adequate protection for Hawai‘i's consumers.
FACT SHEET

Consumer, Family and Youth (CFY) Alliance

Established: April 2009 – Best Practices Conference
The focus is mental health and wellness

The Consumer, Family and Youth (CFY) Alliance was created to:
- assure collaboration of various organizations, communities and programs;
- provide a place to share information and educational opportunities;
- improve communication and coordination of activities;
- provide a unified voice for the consumers, family member and youth of Hawai‘i.

The CFY Alliance includes the following organizations (N=23):
- National Alliance on Mental Illness (NAMI-Hawaii)
- Hawaii Families As Allies (HFAA)
- Hawaii Youth Helping Youth (HYHY)
- United Self Help (USH)
- Mental Health America-Hawai‘i (MHA)
- Hawaii Clubhouse Coalition
  - Friendship House (Kauai)
  - Hale o Honolulu (Oahu)
  - Hale o Lanakila (Maui)
  - Hana Kalima (Molokai)
  - Hale ‘Olu ‘Olu (Hawaii)
- Community Children’s Councils (CCC) - statewide
- HOPE Impact
- Office of Consumer Affairs
- Parents and Children Together (PACT)
- Na Hui (CFY Hui)
  - Ikaika Nui Onipaa (Hawaii)
  - Ahonui Hui (Kauai)
- Oahu CFY Hui (Oahu)
  - Maui CFY Hui (Maui, Molokai, Lanai)
- Mental Health Transformation State Incentive Grant (MHT SIG)
Testimony In Support of HB1957 HD1 Relating to Health Care Information

House Committee on Consumer Protection and Commerce
House Committee on Judiciary
Wednesday, February 22, 2012, 2 p.m.
Conference Room 325

Representative Robert Herkes, Chair
Representative Gilbert S.C. Keith-Agaram, Chair

Aloha Members of the House Committees on Consumer Protection and Commerce and Committee on Judiciary.

NAMI Hawaii is strongly in support of this bill. The National Alliance on Mental Illness Hawaii (NAMI Hawaii) a State Organization of the National Alliance on Mental Illness (“NAMI”) and is dedicated to improving the quality of life of all whose lives are affected by mental illnesses through support, education, advocacy, and research. NAMI Hawaii is strongly in support of this bill.

Currently, restrictive laws, that were developed in Hawaii prior to the Federal HIPA laws, keep the State divisions, doctors and other important parties from being able to share information that is important to the treatment of people with severe mental illnesses. It is vital that the various entities be able to share relevant information. As it currently stands each agency has to start from the ground up, a process that is time consuming and often daunting.

Please pass bill HB 1957 HD1 Relating to Health Care Information.

Thank you.

Kathleen Hasegawa
Executive Director NAMI Hawaii
770 Kapiolani Blvd. Ste 613
Honolulu, HI 96813
Separate may not be equal: A preliminary investigation of clinical correlates of electronic psychiatric record accessibility in academic medical centers

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\textbf{A R T I C L E   I N F O}

Article history:
Received 31 October 2011
Received in revised form
1 November 2012
Accepted 8 November 2012

Keywords:
Electronic Medical Records (EMR)
Medical records
Psychiatry
Electronic Health Records (EHR)
eHealth

\textbf{A B S T R A C T}

Objectives: Electronic Medical Records (EMR) have the potential to improve the coordination of healthcare in this country, yet the field of psychiatry has lagged behind other medical disciplines in its adoption of EMR.

Methods: Psychiatrists at 18 of the top US hospitals completed an electronic survey detailing whether their psychiatric records were stored electronically and accessible to non-psychiatric physicians. Electronic hospital records and accessibility statuses were correlated with patient care outcomes obtained from the University Health System Consortium Clinical Database available for 13 of the 18 top US hospitals.

Results: 44% of hospitals surveyed maintained most or all of their psychiatric records electronically and 28% made psychiatric records accessible to non-psychiatric physicians; only 22% did both. Compared with hospitals where psychiatric records were not stored electronically, the average 7-day readmission rate of psychiatric patients was significantly lower at hospitals with psychiatric EMR (5.1% vs. 7.0%, \(p = .040\)). Similarly, the 14 and 30-day readmission rates at hospitals where psychiatric records were accessible to non-psychiatric physicians were lower than those of their counterparts with non-accessible records (5.8% vs. 9.5%, \(p = .019\), 8.6% vs. 13.6%, \(p = .013\), respectively). The 7, 14, and 30-day readmission rates were significantly lower in hospitals where psychiatric records were both stored electronically and made accessible than at hospitals where records were either not electronic or not accessible (4% vs 6.6%, 5.8% vs 9.1%, 8.9% vs 13%, respectively, all with \(p = 0.045\)).

Conclusions: Having psychiatric EMR that were accessible to non-psychiatric physicians correlated with improved clinical care as measured by lower readmission rates specific for psychiatric patients.

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1. Introduction

The United States is currently considering reforming many aspects of healthcare, including the universal implementation of EMR. Demonstrating and quantifying the potential improvement in patient care from the adoption of an EMR system can be difficult but is important if implementation is to occur in the near future [1–5]. Amarasingham and colleagues recently reported that each 10-point increase in the “automation of notes and records” score from the Clinical Information Assessment Tool contributed to a 15 percent lower odds of dying while hospitalized [6].

Psychiatry has lagged behind other medical disciplines in its adoption of EMR [3,5,7–9]. One potential explanation for this is the restricted access to psychiatric records within hospitals. It is often assumed that psychiatrists and patients both desire greater restrictions on access to psychiatric records. However, patient and psychiatrist opinions on this matter have been studied on a limited basis. At the University of Michigan Health System Department of Psychiatry, researchers found that of patients who did not want their psychiatric records transferred to an electronic system, a significant number cited fear of breach of confidentiality as their primary concern [10]. However, only 5% of their total patient population refused the transfer of their records, suggesting that actual patient opposition to electronic psychiatric records is rather small. While the desire to protect intimate details of a patient’s psychiatric history emerges from the best of intentions, it may also be that the assumption that these records should be treated separately is related to the stigma surrounding psychiatric disorders.

A negative attitude towards a person with a psychiatric illness based on societal assumptions, prejudices, stigma and often a lack of knowledge of an illness, can initiate a vicious cycle of discrimination and often a worsening of mental illness [11–13]. Current literature points to the stigma of mental illness as a causal factor for lower quality care. It also suggests stigma is a barrier to receiving care; specifically, the fear of stigmatization by society often prevents patients from seeking care for a mental illness. Surprisingly, this fear is inadvertently perpetuated even in the healthcare profession, where professionals are expected to have an understanding of the importance of psychiatric care.

Medical students admitted hesitation to seek help for a mental illness for fear of discrimination by peers as well as instructors [14]. The study found that the major barrier to help-seeking behavior was the perceived stigma of mental illness and stress. In addition to the fear of stigma, it was noted that apprehension about the confidentiality of services would not be maintained was also a reason that medical students did not seek help from services offered by their institution.

Much of the apprehension about EMR and unrestricted access to psychiatric records originates – correctly – from concern for confidentiality of records [2]. In response, it has become common practice to exclude details from psychiatric evaluations from a patient’s medical charts [15,16]. This endeavor, however, counters any efforts to bridge the gap between medicine and psychiatry. Instead, the separation of psychiatric records from other medical records reinforces that medical professionals see a distinct difference between psychiatry and other healthcare specialties. Furthermore, it fails to address the importance of an interaction between the two fields. In one study, all psychiatric patients with repeat visits to the emergency department had prior mental health records that were unavailable to ED clinicians at the time of the patient crisis [17].

The need to balance patient confidentiality with the provision of optimal quality of care requires careful consideration of the competing concerns of a variety of stakeholders. Because of factors that include stigma regarding psychiatric illness, the application of Health Information Technology to psychiatric care has lagged significantly behind somatic medical care.

There remains – and should remain – debate about how psychiatric medical records should be stored, and whether or not they should be made accessible to non-psychiatric physicians. Much of the debate centers on the issue of confidentiality [2,18]. We know of no prior exploratory investigation that has studied this issue systematically and descriptively. We further know of no prior examination of the impact of these decisions on the quality of psychiatric patient care (e.g., readmission rates, length of stay, etc.). Lastly, we are not aware of any published studies on the prevalence and availability of EMR in psychiatry.

In 2007 there were 18 hospitals listed on US News and World Report’s ranking of Best Hospitals in the United States. We surveyed all of these hospitals to determine if these centers have psychiatric EMR and whether unrestricted access is given to non-psychiatric practitioners. We then analyzed whether access to electronic psychiatric records correlated with improved patient care outcomes.

2. Method

We identified the nation’s top hospitals as those ranked on US News and World Report’s Best Hospitals list (2007). After initially conducting phone surveys asking about the psychiatric record keeping practices at these hospitals, we developed a forced-choice questionnaire on surveymonkey.com to confirm and standardize the results.

The survey focused on whether inpatient psychiatric admission and discharge summaries, psychiatric Emergency Department evaluations, and psychiatric consultation notes were paper or electronic and whether psychiatric records were “able to be viewed by non-psychiatric physicians while working on a medicine floor” (and, if so, whether access was “unrestricted”). We obtained responses from 100% of the hospitals from which we requested information through a two-step process. We identified an initial group of psychiatrists, generally the director of psychiatry residency training or the head of consultation-liaison psychiatry, to whom we emailed our survey (Supplementary Document). We obtained initial responses from psychiatrists at 14/18 (77.8%) hospitals. Additional psychiatrists were identified at the remaining four sites, and a second query returned results from the remaining four hospitals, hence data was collected from all sites by the end of 2008 (100%).

Hospital-level patient outcomes data were acquired through the University Health System Consortium (UHC)
Clinical Database. The database was queried to find the percentage of psychiatric and non-psychiatric patients readmitted (defined as patients who were re-hospitalized for any related or unrelated reasons to any service) within 7, 14, and 30 days of discharge, as well as the average length of stay (LOS) for psychiatric patients. A psychiatric patient was defined as someone whose discharge note was signed by a psychiatrist or a psychologist. The observation period was calendar year 2007. Based on these criteria, data was available for 13 of the 18 hospitals; therefore outcomes analyses (Tables 2 and 3) were performed on data from the 13 hospitals available through the UHC Clinical Database. The study’s protocol was reviewed by the Johns Hopkins Medical IRB approved on July 17, 2008 (Protocol NA_00020219).

We classified the hospitals into three separate groups for comparison: (1) those with a full psychiatric EMR (i.e., electronic psychiatric inpatient admission, discharge, and consultation summaries, and psychiatric ED notes) vs. those with paper records in at least one category, (2) those with four types of psychiatric records to which non-psychiatric physicians had unrestricted access vs. those with restricted records in at least one category and (3) those with fully accessible, electronic records vs. those with paper records and/or limited accessibility. All four types of psychiatric records had to be stored electronically and available without restrictions to non-psychiatric physicians in order to be in the group considered “fully” electronic or accessible with a score of 4 (we use “unrestricted access” and “fully accessible” interchangeably in this analysis).

Prior to analysis, the data were inspected for erroneously missing data, out of range values, and coding errors. Data from one hospital was removed from the patient outcomes analysis due to incomplete survey data response despite multiple attempts at follow-up. Nonetheless, we still present the descriptive information we obtained from the initial survey. Descriptive statistics on hospital demographic variables, outcomes variables, and predictor variables were calculated for the entire sample and for subgroups of hospitals stratified by use of EMR, accessibility of psychiatric records, and accessibility of electronic psychiatric records. Two-by-two contingency tables provided frequency and percent distributions and were used to describe the distribution of EMR use by accessibility of psychiatric records. The significance of group differences was evaluated by non-parametric procedures. A two-sample Mann–Whitney test was used for continuous measures and the Fisher’s exact test of independence was utilized for dichotomous variables. Two-tailed p-values are also reported. Due to the small sample size, multivariate analyses and parametric procedures that depend on a normal distribution were not calculated. Analyses for this study were conducted with SPSS 15.0 statistical software (SPSS, Chicago, Illinois, 2006).

3. Results

Table 1 summarizes the characteristics of the 18 hospitals that were studied: it showed whether their records were electronic and accessible to non-psychiatric physicians, the hospital and psychiatric department ranking in 2007, and the number of medical and psychiatric beds. To preserve the confidentiality of the hospitals that participated in this study, we de-identified them by listing them as hospitals 1–18 and by giving ranges for their rankings and beds.

There was no correlation between any of the examined hospital characteristics, such as their size or the ranking of their psychiatry specialty services, shown in Table 1, and their psychiatric record keeping practices (i.e., electronic storage or accessibility). Within the groupings established for our analyses (EMR Score 4 vs. EMR Score <4; Access Score 4 vs. Access Score <4; Combined EMR/Access Score 4 vs. Combined EMR/Access Score <4), we compared the demographics outlined above. The number of total hospital beds (p = .908, p = .739, p = 1.00, respectively) as well as the number of psychiatric beds was comparable across the groups (p = .093, p = .317, p = .257, respectively). Moreover, there was no statistically significant difference in the average hospital ranking between the groups (p = .324, p = .841, p = .571, respectively), nor were there any differences in the number of hospitals with a psychiatry specialty ranking in the top 24 (p = .608, p = .580, p = .520, respectively).

We first evaluated the prevalence of EMR in psychiatry. Each of the 18 hospitals had electronic records in at least one of the four psychiatric record categories (psychiatric admission note, discharge note, ED note, and/or consultation note). Three of the eighteen sites (16.7%) had electronic records in one category, 3/18 (16.7%) in two, 4/18 (22.2%) in three, and 8/18 in all four (44.4%). Six of the eighteen (33.3%) had electronic admission summaries, 8/18 (44.4%) discharge summaries, 8/18 (44.4%) psychiatric ED notes, and 14/18 (77.8%) consult notes, respectively.

While all sites had electronic records in at least one category, not all hospitals gave non-psychiatric physicians unrestricted access to at least one type of psychiatric note. Four of the eighteen sites (22.2%) had no accessibility, 5/18 (27.8%) were accessible in one category, 1/18 (5.6%) in two, 3/18 in three (16.7%), and 5/18 (27.8%) in all four. For each of the five hospitals that had only one type of note that was accessible to non-psychiatric physicians, it was the consult note that was unrestricted.

Of the five hospitals which had accessible psychiatric records, four had full EMR access as well. It is apparent that EMR facilitates accessibility; logistically, a hospital that granted non-psychiatric physicians unrestricted access to all psychiatric patient records maintained those records electronically 80% of the time, whereas 50% of the hospitals that maintained all of their psychiatric records electronically granted non-psychiatric physicians unrestricted access to all such records.

Table 2 shows comparisons of aggregate patient outcomes for psychiatric patients by psychiatric EMR use, accessibility of records, and electronic access to notes among the 13 hospitals whose information was available through the UHC Clinical Outcomes Database. Within hospitals with full EMR systems, the 7-day, 14-day, and 30-day readmission rates for psychiatric patients were lower compared to hospitals without full EMR. The 7-day readmission rate reached statistical significance (5.1% vs. 7.0%, p = .040). When parsed by accessibility, again into the groups with full accessibility vs. those without; hospitals with fully accessible psychiatric records had lower 7-day, 14-day, and 30-day readmission rates for psychiatric...
Table 1 – Hospital demographics.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Combined EMR/Access Score</th>
<th>EMR Score</th>
<th>Access Score</th>
<th>US News Psychiatry Ranking</th>
<th>US News Ranking</th>
<th>Number of Beds</th>
<th>Number of Inpatient Psychiatric Beds</th>
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<tbody>
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<td>1 4 4 4</td>
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<td>1-6</td>
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<tr>
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<td>2 4 4 4</td>
<td>1-3</td>
<td>7-12</td>
<td>1001-1500</td>
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<tr>
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<td>3 4 4 4</td>
<td>13-15</td>
<td>Unranked</td>
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<tr>
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<td>1-500</td>
<td>10-20</td>
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<tr>
<td>Hospital 5</td>
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<td>21-30</td>
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<tr>
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<tr>
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<tr>
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<td>13-18</td>
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<td>7-12</td>
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<td>16-18</td>
<td>7-12</td>
<td>1001-1500</td>
<td>71-80</td>
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</tr>
</tbody>
</table>

Notes:
Hospitals were de-identified and numbered to preserve the confidentiality of the sites. Hospital rankings and bed counts were broken into ranges for the same reason.

Three separate classification schemes were used to analyze the hospitals:
1) Combined EMR use and accessibility
2) EMR use
3) Accessibility of psychiatric records amongst non-psychiatric physicians

Four record types were considered:
1) Psychiatric admission notes
2) Psychiatric discharge summaries
3) Psychiatric ED notes
4) Psychiatric consultation notes

Hospitals were assigned a 0 or 1 for each note type:
1=Accessible and electronic psychiatric records, 0=Not accessible and/or electronic
“Electronic” was indicated as such a responses to the question of paper vs. electronic, and “accessible” was defined as yes to the survey questions: 1) are psychiatric records able to be viewed by non-psychiatric physicians while working on a medicine floor? 2) Is access unrestricted? A "0" was assigned to hospitals without electronic records or those who answered “no” to one or both of the accessibility questions, and a "1" to those that answered “electronic” and “yes” to the accessibility questions.

1=Electronic psychiatric records, 0=Paper psychiatric records
1=Accessible, 0=Not Accessible
Hospitals were assigned a score between 0-4, the sum of the values from the individual note type categories.
Grey lines denote hospitals whose outcomes data in the following data tables were not available through the UHC database.
Table 2 - Aggregate psychiatric patient readmission rates and length of stay by hospital-level EMR use of all notes, accessibility of all notes, and electronic access to all notes.

<table>
<thead>
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<th>EMR Score &lt;4 (n=5)</th>
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<th>% change</th>
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<th>Access Score &lt;4 (n=8)</th>
<th>p-value</th>
<th>% change</th>
<th>Combined EMR/Access Score 4 (n=4)</th>
<th>Combined EMR/Access Score &lt;4 (n=9)</th>
<th>p-value</th>
<th>% change</th>
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<tbody>
<tr>
<td>Related or Unrelated Readmissions, mean percentage (SD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>7 day</td>
<td>5.1 (2.9)</td>
<td>7.0 (1.6)</td>
<td>0.040</td>
<td>27.1</td>
<td>4.3 (1.0)</td>
<td>6.7 (2.9)</td>
<td>0.057</td>
<td>35.8</td>
<td>4.0 (1.0)</td>
<td>6.6 (2.7)</td>
<td>0.045</td>
<td>39.4</td>
</tr>
<tr>
<td>14 day</td>
<td>7.2 (3.1)</td>
<td>9.5 (2.3)</td>
<td>0.107</td>
<td>25</td>
<td>5.8 (0.9)</td>
<td>9.5 (2.9)</td>
<td>0.019</td>
<td>38.9</td>
<td>5.8 (1.1)</td>
<td>9.1 (3.0)</td>
<td>0.045</td>
<td>36.3</td>
</tr>
<tr>
<td>30 day</td>
<td>11.0 (4.0)</td>
<td>12.3 (3.1)</td>
<td>0.242</td>
<td>10.6</td>
<td>8.6 (2.1)</td>
<td>13.6 (3.1)</td>
<td>0.013</td>
<td>36.8</td>
<td>8.9 (2.4)</td>
<td>13.0 (3.4)</td>
<td>0.045</td>
<td>31.5</td>
</tr>
<tr>
<td>Average length of stay for patients with primary psych dx (days), mean (SD)</td>
<td>8.7 (2.0)</td>
<td>10.5 (1.0)</td>
<td>0.079</td>
<td>14.10</td>
<td>9.9 (2.2)</td>
<td>9.1 (1.7)</td>
<td>0.558</td>
<td>-8.80</td>
<td>9.3 (2.2)</td>
<td>9.4 (1.8)</td>
<td>0.877</td>
<td>1.10</td>
</tr>
</tbody>
</table>

Notes: Two-tailed significance based on Mann-Whitney U test
Psychiatric patients (n=16,364) are defined as patients admitted for observation with a discharge note signed by a child/adolescent psychiatrist, a general psychiatrist, a geriatric psychiatrist, or a psychologist.

Readmission rates are for psychiatric patients who were re-hospitalized for any related or unrelated reasons to any service.

% Change as the percentage decrease in readmission rate or LOS that a hospital would be predicted to experience were it to switch from a <4 category to a 4 category, based on the difference in our two groups.

Patients. The 14 day (5.8% vs. 9.5%, p = .019) and 30 day (8.6% vs. 13.6%, p = .013) rates reached statistical significance. Finally, when looking at the combination, hospitals with both full EMR and unrestricted accessibility of psychiatric records had statistically significantly lower 7, 14, and 30-day readmission rates (p = .045 in all categories). Despite the fact that not all comparisons reached statistical significance as described above, the readmission rates all trended in the direction of being lower in the groups with full psychiatric EMR and/or unrestricted access at all follow-up time points examined.

Use of a full EMR predicted a 10–27% difference in readmission rates. The accessibility of records predicted a larger decrease, ranging from 35 to 38%, and likewise, the combination of EMR and accessibility, between 31 and 39%.

The average LOS for psychiatric patients was comparable between the two groups when separated by EMR use, accessibility, and combined EMR use and accessibility (Table 2). Thus, it is likely that the psychiatric patients had comparable disease severity when the hospitals were grouped according to psychiatric EMR and accessibility.

In order to ascertain if the significantly lower rate of psychiatric patient readmissions was specific to psychiatric patients or merely an artifact, we assessed the readmission rates for all non-psychiatric patients using the same comparison groups (Table 3). There was no correlation between readmission rates for non-psychiatric patients and any of the three groupings used in the hospital comparisons shown in Table 2. This suggests that the findings for psychiatric patients are specific to the method by which this population’s records are stored and accessed.

4. Discussion

We determined that less than 50% of hospitals surveyed had all inpatient psychiatric records in an EMR system, less than 30% of hospitals gave non-psychiatric physicians access to all four types of psychiatric records, and less than 25% had both a full psychiatric EMR and fully accessible records. Our analysis also provides evidence that hospitals utilizing psychiatric EMR and making psychiatric records available to non-psychiatric doctors have lower readmission rates for psychiatric patients. LOS for psychiatric patients, a surrogate indicator of illness severity, was comparable regardless of how hospitals stored their psychiatric records and whether or not they gave access to non-psychiatric physicians. Thus the lower average rate of readmission in hospitals with accessible psychiatric EMR was unlikely to be due to differences in patient case severity. Non-psychiatric patients’ readmission rates did not differ between hospital groups, a finding that reinforced the specificity of the trend for lower readmission rates for psychiatric patients.

Whereas factors such as the socioeconomic status of the patient, level of social support, and the availability of local follow-up care can influence the likelihood of a patient’s readmission, we attempted to control for these variables using
Table 3 – Aggregate non-psychiatric patient readmission rates by hospital-level EMR use of all notes, accessibility of all notes, and electronic access to all notes.

<table>
<thead>
<tr>
<th></th>
<th>EMR Score 4 (n=8)</th>
<th>EMR Score &lt;4 (n=5)</th>
<th>p-value</th>
<th>% change</th>
<th>Access Score 4 (n=5)</th>
<th>Access Score &lt;4 (n=8)</th>
<th>p-value</th>
<th>% change</th>
<th>Combined EMR/Access Score 4 (n=4)</th>
<th>Combined EMR/Access Score &lt;4 (n=9)</th>
<th>p-value</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related or Unrelated Readmissions, mean percentage (SD)</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 day</td>
<td>5.4 (0.78)</td>
<td>5.1 (0.65)</td>
<td>0.661</td>
<td>-5.9</td>
<td>5.5 (1.0)</td>
<td>5.2 (0.49)</td>
<td>0.884</td>
<td>-5.8</td>
<td>5.6 (1.1)</td>
<td>5.1 (0.5)</td>
<td>0.44</td>
<td>-9.8</td>
</tr>
<tr>
<td>14 day</td>
<td>8.5 (0.78)</td>
<td>8.3 (1.2)</td>
<td>0.770</td>
<td>-2.4</td>
<td>8.4 (1.0)</td>
<td>8.4 (0.94)</td>
<td>0.884</td>
<td>0</td>
<td>8.6 (1.0)</td>
<td>8.3 (0.9)</td>
<td>0.643</td>
<td>-3.6</td>
</tr>
<tr>
<td>30 day</td>
<td>12.9 (0.87)</td>
<td>13.0 (1.8)</td>
<td>0.661</td>
<td>0.8</td>
<td>12.7 (0.91)</td>
<td>13.0 (1.4)</td>
<td>0.464</td>
<td>2.3</td>
<td>12.9 (0.9)</td>
<td>12.9 (1.4)</td>
<td>0.877</td>
<td>0</td>
</tr>
</tbody>
</table>

Notes:
- Two-tailed significance based on Mann-Whitney U test
- Non-psychiatric patients are defined as patients admitted for observation with a discharge note signed by a practitioner other than a child/adolescent psychiatrist, a general psychiatrist, a geriatric psychiatrist, or a psychologist.
- Readmission rates are for non-psychiatric patients who were re-hospitalized for any reason to any service.
- % Change as the percentage decrease in readmission rate that a hospital would be predicted to experience were it to switch from a <4 category to a 4 category, based on the difference in our two groups.

surrogate markers (such as hospital ranking and bed number) and found that they did not correlate with readmission rates. Moreover, the association between access to psychiatric EMR and lower readmission rates was specific to psychiatric patients and not to medical patients, who had similar demographic characteristics, indicating that these factors likely did not confound the relationship.

Hospitals with electronically accessible psychiatric records had lower percent differences in patient readmission rates, sometimes as great as 40% lower as compared to their counterparts that did not utilize such record keeping methods. Our findings, which indicate that improved healthcare outcomes depend on the state of Information Technology, are consistent with those of Amarasingham and colleagues.

5. Limitations and future studies

There are several potential limitations of this study. The small sample size (n = 18) along with the homogeneity of the type of hospitals limits the generalizability of the results. As we surveyed only one of the nation’s leading teaching hospitals, however, it is likely that the limitations noted in this cohort will only be magnified in a sample of smaller community hospitals. The study relied on the accuracy of the survey responses of local psychiatrists who were full time employees of the hospitals from which we sought information. Site visits were not undertaken to corroborate the reported methods of psychiatric record characteristics.

Further analyses are essential to confirm and extend the reported findings. Accessibility is a multi-faceted issue as there are many variations in each site’s EMR system, such as “break the glass” features, firewalls, etc. We addressed this ambiguity in the term “access” by clearly defining an “accessible” system as one which gives non-psychiatric physicians working on medicine floors direct and unrestricted access to the psychiatric records. In today’s inpatient healthcare system, time is at a premium for clinicians, and any additional impediments to gaining access to patients’ psychiatric records as compared to medical records could prove a deterrent. A follow-up study detailing the variation in EMR systems would be beneficial. A second point warranting follow-up would be stratifying readmissions to related psychiatric and unrelated non-psychiatric units to allow us to learn more about the interplay between psychiatric and medical care. Presumably, unrelated readmissions would necessitate more communication between the disciplines, as on an unrelated readmission to a non-psychiatric service where the availability of electronic psychiatric health records could be crucial to providing optimal continuity of care. Nonetheless, for a psychiatry-related readmission, use of an accessible EMR could also be critical. For instance, in an outpatient setting, a medical doctor could be alarmed about the mental status of his patient but not have access to the patient’s psychiatric records. Because the physician does not know the patient’s psychiatric discharge plan from his prior admission, the physician could be more likely to send the patient to the Emergency Department (ED), where the patient would be readmitted and re-evaluated. ED physicians who do not have access to psychiatric records could be more likely to readmit patients to psychiatric services because they lack information about their current treatment plan, appearance on discharge, follow-up plan, etc. A third important issue warranting follow-up in subsequent studies is whether non-psychiatric physicians take greater interest or attention in assessing psychiatric records when the are in EMR or non-EMR form. Finally, subsequent studies could address additional variables such as socioeconomic status of the patient and how they effect readmission rates independent of access to psychiatric EMR. These considerations must be explored in future analyses with a larger sample.

6. Conclusion

The data suggest a disparity in the health outcomes in psychiatric patients; it would be invaluable to further examine why such a disparity exists. This study suggests that to ensure a higher quality of care for psychiatric patients we must be willing to consider not only parity of coverage but also of record modernization and accessibility. Eventually, we can envision a time where psychiatric records will be treated with the same confidentiality as other health records; this may then help to dispel the stigma surrounding the often misunderstood nature of mental illness for clinicians as well as the general public.

Author contributions

Dana Kozubal contributed in literature search, study design, data collection, data analysis, data interpretation, article writing. Quincy Samus contributed in data analysis. Aishat Bakare contributed in article writing and editing. Carrilin Trecker contributed in data collection. Hei-Wah Wong contributed in Literature search and article writing. Huiying Guo contributed in literature search and article writing. Jeffrey Cheng contributed in article writing. Paul X. Allen contributed in data collection and data analysis. Kay R. Jamison contributed in project conceptualization, study design, data interpretation. Adam Kaplin contributed in literature search, study design, data interpretation, data analysis, and article writing.

Conflict of interest statement

Neither the authors nor those included in the acknowledgements have any conflicts of interest or financial interests in the material discussed in this manuscript. It should also be noted that the principal investigator, Adam Kaplin, had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Acknowledgements

We gratefully acknowledge the support of Nancy Davis and her Foundation for their leadership and support. We similarly acknowledge the help of Beth Ambinder, MBA, Johns Hopkins Department of Psychiatry Administration, Kim Coursen-Antinone, RN, MS, Johns Hopkins Department of Psychiatry Nursing, Margaret Garrett, BSN, JD, CPHRM, Johns Hopkins Legal Department, and Laura Fochtman, MD, SUNY at Stony Brook Department of Psychiatry in assisting the research that was done on hospital based electronic medical records.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.ijmedinf.2012.11.007.

Summary points

What was already known on the topic

- There had been no systematic assessment of how many psychiatric hospitals kept their mental health records in electronic or hand-written form, nor information about how often they provided non-psychiatric medical practitioners access to such records.
- It was clear that because of heightened stigma surrounding mental illness, psychiatric practitioners were reluctant to provide access to their patient’s mental health records. However there had been very little investigation of the potential consequences of restricting access to mental health records, for example the potential impact on their patient’s coordinated medical care.

What this study has added to our knowledge

- Our study illuminated the manner of storage (electronic vs. hand-written) of psychiatric records in the US by sampling the top rated psychiatric hospitals according to the US News and World Report. We also documented the rate that these records were shared with non-psychiatric physicians at the same hospitals.
- We were also able to provide evidence in support of the finding that the manner of storage (i.e. electronic) and access (i.e. unrestricted) of psychiatric records correlated with a significantly better healthcare outcome for psychiatric patients.

References


Overview of Mental Health & Disability Services
System Redesign Legislation
Source: Iowa Department of Human Resources (DHS), SF 525 and SF 2315
Revised: July 24, 2012

MENTAL RETARDATION TO INTELLECTUAL DISABILITY – SF 2247
- It is now the State of Iowa’s policy to refer to persons diagnosed with mental retardation as a person with an intellectual disability.
- Iowa Code has been changed.
- Administrative rules will be changed to match.
- Federal government programs will still refer to mental retardation.

JUDICIAL BILL – SF 2312
- Law enforcement officers must complete training on mental health once every four years.
- Nursing facilities and RCF administrators may decline a court ordered commitment.
- Clarifies the definition of mental health professional.
- Creates optional commitment pre-screening.
- Sets the agenda Judicial Workgroup next year (see below).

MHDS REDESIGN POLICY BILL – SF 2315
- Eligibility for non-Medicaid services – Effective July 1, 2013
  - Persons covered:
    - Persons with mental illness with some exceptions; and
    - Persons with an intellectual disability.
  - Income eligibility:
    - 150 percent of the federal poverty level (FPL) with no co-pay or fees;
    - May service those above 150 percent of FPL with approved co-pay and sliding fee schedules;
    - Must meet resource limitation rules;
    - Persons eligible for federally funded services or other support must apply for that support; and
    - DHS/Commission will establish rules for:
      - Co-pay and sliding fee schedule; and
• Resource limitations that will exclude retirement, burial, medical savings, or assistive technology accounts.

➢ Age – Adults 18 years of age or older:
  ▪ Exception for persons 17 years of age, receiving children’s services may be eligible for adult services three months prior to turning 18 years of age.

➢ Not have private insurance or be eligible for Medicaid funded services.

➢ Eligibility for individual services shall be determined through the use of standardized assessments:
  ▪ Functional Assessment processes are being developed. The assessments will begin sometime in FY2013.

➢ Future:
  ▪ Evaluate the fiscal impact of serving persons with a developmental disability who do not have an intellectual disability; and
  ▪ Evaluate the impact of providing non-Medicaid funded services to persons with a brain injury.

❖ Residency – Effective July 1, 2013
  ➢ The county in which the person is living and has established an ongoing presence with the declared good faith intention of living for an indefinite time, including those who are homeless.
    ▪ The person maintains residency in the county in which they last resided while the person is receiving services in a: hospital, correctional facility, halfway house for community based corrections or substance use disorder treatment, nursing facility, ICF/ID, RCF, college or university. This includes persons who come from out-of-state directly to these facilities.
  ➢ Separate dispute resolution process for residency is specified in the act.

❖ Services
  ➢ Regions shall ensure that services are available regardless of funding source.
  ➢ Providers must:
    ▪ Provide services only within the boundaries of their education, training, license, certification, consultation received, and supervised experience.
    ▪ Engage in appropriate study, training, consultation, and supervision before providing new techniques or interventions.
    ▪ Exercise careful judgment and take responsible steps to ensure competence in emerging areas of practice that do not have generally recognized standards.
  ➢ Regions must ensure access to providers that can:
    ▪ Provide services for persons with co-occurring conditions;
    ▪ Providing evidenced based services; and
    ▪ Provide trauma informed services.
Core services include – Effective July 1, 2013:

- **Treatment services** such as
  - Assessment and evaluation
  - Mental health outpatient therapy
  - Medication prescribing and management
  - Mental health inpatient
- **Basic Crisis Response** such as
  - 24 hour access to crisis response
  - Evaluation
  - Personal emergency response
- **Support for community living** such as
  - Home health aid
  - Home and vehicle modifications
  - Respite
  - Supportive community living
- **Support for employment** such as
  - Day habilitation
  - Job development
  - Supported employment
  - Prevocational services
- **Recovery oriented services** such as
  - Family Support
  - Peer support
- **Service coordination** such as
  - Case management
  - Health home
- **Sub-acute and crisis services**
  - Sub-acute Services
  - **Definition:**
    - Community-based or facility-based wrap-around services for a person having or at imminent risk of having acute or crisis mental health symptoms that threatens successfully remaining in the community, but does not require inpatient level of treatment;
    - Intensive recovery oriented treatment and monitoring with direct or remote access to psychiatry;
    - Outcome focused, interdisciplinary treatment; and
    - Time limited to 10 days or less unless otherwise approved.
  - **Facility-based sub-acute:**
    - General expectations are described in the bill;
 Publicly funded beds are limited to 50 beds spread geographically across the state from existing Certificate of Need beds; and
 DHS and DIA will collaborate to establish appropriate rules based on expectations described in the bill.

♦ Community-based sub-acute services.
  • Crisis pilot will allow DHS and DIA to establish appropriate regulations.
 DHS/Commission to provide further service definitions as needed.
 Expanded Core Services Regions will provide when funds are available:
  ▪ Comprehensive crisis response
    • 24 hour crisis hotline
    • Mobile response
    • Crisis residential services
  ▪ Sub-acute services
    • Facility based
    • Community based
  ▪ Justice involved services
    • Jail diversion
    • Crisis intervention training for law enforcement
    • Civil commitment prescreening
  ▪ Evidence based practices
    • Positive behavior support
    • Assertive community treatment
    • Peer self-help drop in centers
 Services can be provided beyond the Core and Expanded Core:
  ▪ May be provided once the Core and Expanded Core are in place;
  ▪ Person centered planning demonstrates the need for such services;
  ▪ Demonstrated efficacy of such practices; and
  ▪ An effective alternative to existing services.

❖ Regional Management:
❖ Regional Formation
  ▪ DHS shall encourage all counties to join into regions.
  ▪ Requirements:
    • Counties that form a region must be contiguous;
    • Consist of at least three counties;
    • Have the capacity to provide require core services;
    • Have a community mental health center or federally qualified health center with providers capable of providing mental health services or other similar services;
    • Have inpatient psychiatric services reasonably available; and
- A regional administrative structure with clear lines of accountability.

  Timelines
  - April 1, 2013 regions identify:
    - Which counties are forming into a region and have submitted a letter of intent; and
    - DHS agrees the region meets the requirements above.
    - Technical assistance is then available.
  - April 2 through July 1, 2013 DHS assists counties to join regions and assigns regions to counties if not exempted from joining a region.
  - December 31, 2013 counties meet initial requirements of regions and have joined a region unless exempted.
  - June 30, 2014 counties meet all requirements of regions.

  Counties may be exempted from joining a region:
  - DHS must approve all exemptions of counties joining into regions;
  - DHS/Commission will establish rules for a county being exempted from joining into a region;
  - Counties planning to apply for an exemption from joining a region must submit a letter of intent by May 1, 2013;
  - Counties wanting to be exempted from joining a region must submit application for an exemption by June 30, 2013;
  - Must meet the following regional requirements:
    - Provide all required core services;
    - Have a community mental health center or federally qualified health center with providers capable of providing mental health services or other similar services;
    - Have inpatient psychiatric services reasonably available; and
    - A regional administrative structure with clear lines of accountability;
  - Must have outcomes that are as good as regions; and
  - Must be as cost effective as regions.

- Regional Governance:
  - Counties must form under a 28E.
  - Must have a regional advisory committee.
  - At least one county supervisor per county as a voting member.
  - Consumer or actively involved relative designated by the advisory committee as an ex officio non-voting member.
  - Provider designated by the advisory committee as an ex officio non-voting member.
  - Regional administrator:
    - Under the control of the governing board; and
• Administrative staff shall include coordinators of disability services that meet minimum required qualifications.

➤ **28E Agreement shall include:**
  ▪ Purposes, goals, and objectives of the agreement.
  ▪ Identification of governance board membership, terms, methods of appointment, voting procedures, and other provisions including weighted voting if part of the agreement.
  ▪ Process for selecting executive staff.
  ▪ Counties participating in the agreement.
  ▪ Term of the agreement and methods for renewal or termination of the agreement.
  ▪ Methods for dispute resolution and mediation.
  ▪ Methods for termination of a county’s participation in the agreement.
  ▪ Provisions for formation and responsibilities of advisory committees.
  ▪ Administrative provisions shall include:
    • Methods for appointing and evaluating the CEO;
    • Functions and responsibilities of the CEO; and
    • Specifications of the functions of parties to the agreement including administrative subcontractors.
  ▪ Financial provisions of the agreement shall include:
    • Methods for pooling (or not pooling), managing and expenditures of funds;
    • Methods for allocating administrative funding and resources;
    • Contributions and uses of initial funding;
    • Process for use of savings for reinvestment; and
    • Performance of an independent annual audit.

➤ **Regional Finances:**
  ▪ Maintained in a combined account, separate county accounts or other arrangements.
  ▪ Meet the requirements of Office of Management and Budget (OMB) Circular A-87 that establishes principles and standards for determining costs for state, local government, and federally recognized Indian tribal governments.
  ▪ Must provide a separate account for:
    • Administration;
    • Purchase of services;
    • Services that are directly provided; and
    • DHS, in consultation with LSA, shall make recommendations regarding an acceptable administrative load.
  ▪ Funds provided through the MHDS Regional Services fund shall be provided through a performance based contract with DHS.

➤ **Regional Services Management Plan including counties exempted from joining a region:**
Iowa Department of Human Services

- DHS/Commission shall determine plan requirements and plan format.
- Components:
  - Annual service and budget plan;
  - Policies and procedures manual; and
  - Annual report.
- Initial plan shall be submitted by April 1, 2014.
- Annual services and budget plan shall be approved by the governance board and the Director of DHS based on rules adopted by the Commission. It will include:
  - Budget and financing provisions to meet the service needs in the region;
  - Scope, cost and funding of services in addition to core services;
  - Location of local points of access;
  - A plan for assuring effective crisis prevention, response, and resolution;
  - Provider reimbursement;
  - Financial forecasting measures; and
  - Designation of targeted case managers.
- The annual report shall include the actual number of persons served, moneys expended and outcomes achieved. The annual report is due on December 1st each year.
- Policies and procedures shall be approved by the Regional governance board and the Director of DHS in consultation with the Commission and include:
  - Financing and service delivery including the annual service and budget plan administration;
  - Enrollment and eligibility;
  - Method for developing annual service and budgeting plan;
  - Managing utilization and access to services;
  - Quality assurance and improvement processes;
  - Risk management processes; and
  - Process for designating targeted case management providers.
  - Qualifications for TCM shall be established in rule and include:
    - Implementation of evidenced based models;
    - Qualifications of TCM providers;
    - Performance based outcomes related to health, safety, work performance, and community residency;
    - Standards for service delivery; and
    - Methods for complying rules including electronic record keeping and internet based training.
  - A Regional plan for systems of care.
  - Measures for providing services in a decentralized manner utilizing the strengths of administrators and service providers.
• Plan for provider network formation.
• Service provider payment provisions.
• A process for resolving grievances.
• Measures of interagency and multisystem collaboration and care coordination.
  ▪ The Regional Plan must include provisions for providing services to persons with co-occurring conditions.
  ▪ Counties exempted from joining a region must meet all requirements under this chapter for a regional service system, management plan, governance board, regional administrator, and any other applicable provisions.
  ▪ Regions may also:
    • Subcontract for management/administration.
    • Provide assistance to persons not covered by the bill if the county provided such services before joining a region, if funding permits.
    • Implement a services waiting list if sufficient funds are not available.

❖ Administrative Appeals
  ➢ Expedited Administrative Appeal of Regional Administrators’ Decisions once Regions are formed:
    ▪ A person can request an expedited appeal of a regional administrator’s service related decision that could cause an immediate danger to the person’s health or safety.
    ▪ DHS hears the expedited appeals immediately and renders a decision.

❖ Modifies the functions and duties of MHDS and the Commission as follows:
  ➢ Clarifies planning activities and the need to take into account what other entities are doing;
  ➢ Adds assisting regional governance boards;
  ➢ Requires emphasis be placed on evidence-based practices and community supports as preferable to inpatient services and institutional settings;
  ➢ Clarified a system of identifying, collecting, analyzing, and publishing outcome data to measure service effectiveness;
  ➢ Emphasized collaboration with DIA in rule making for disability services;
  ➢ Added a MHDS fund through which money is distributed in accordance with a performance based contract;
  ➢ Added posting the establishment of waiting lists on the internet;
  ➢ Clarified the role of the Commission in adopting rules; and
  ➢ Using a standardized functional assessment to determine eligibility for individualized services.

FY 2013 WORKGROUPS
Children’s Workgroup
- Recommend a service system for children with disabilities to develop services in Iowa needed to bring out-of-state children home.

Judicial
- Study and make recommendations regarding consolidation of involuntary commitment process for persons with substance-related disorders, intellectual disability, and mental illness.
- Study and make recommendation for the feasibility of establishing an independent statewide patient advocate program.

Data and Statistical
- Implement an integrated data and statistical information system.
- Include examination of the current ISAC system for use in gathering data.

Outcomes
- DHS shall identify, collect and analyze service outcome data to assess service effectiveness.
- Outcomes Workgroup shall recommend specific outcomes and incorporate those previously established by the Commission.
- Performance based contracts shall include, but not be limited to:
  - Access standards;
  - Penetration rate for the number of persons served;
  - Utilization rates for inpatient and residential treatment;
  - Readmission rates for inpatient and residential services;
  - Employment of persons receiving services;
  - Administrative costs;
  - Data reporting; and
  - Accurate and timely claims processing.

Workforce Workgroup
- Led by the Iowa Department of Public Health.
- Address issues to ensure an adequate and well-trained work force.
- Review training, level of competency, core curricula, and certification.

Transition Committee
- Consult with DHS on the transition from the current MHDS system to a regional service system.
- Use data to consider whether improvements are warranted.
- Consult with DHS regarding rules for transition funding.
Interim Study Committee
- Analyze viability of MHDS financing provisions during 2012 and 2013 legislative interims.
- Will consider recommendations from the Transition Committee.

Regulatory Requirements: DIA, DHS, and DPH shall streamline provider requirements.

FINANCING
MHDS Redesign
- Reinstates the county MHDS levy.
- Addresses disputed billings.
  - Forgives disputed billings for services through FY 2011.
    - DHS is developing an analysis of these disputes and will be communicating with counties regarding how to formally complete this process.
  - Establishes a separate appeals process for billings for FY 2012 and beyond.
- Establishes a Transition fund.
  - A transition fund is established for FY 2013 for one time assistance for services that are not funded by Medicaid.
  - DHS/Commission establishes rules for recommending eligibility to receive transition funding. Eligibility provisions include:
    - Application by the county board of supervisors.
    - A county must have a certified levy at the maximum amount allowable.
    - Independently verified financial information that includes:
      - Actual and projected cash;
      - Accrued fund balances;
      - Detailed accounts receivable and payable;
      - Budgeted revenue and expenditures;
      - Identified amount requested; and
      - Administrative costs.
    - County service information including:
      - Type, amount, and scope of services provided compared with other counties;
      - The extent to which the county subsidizes services it directly provides;
      - Extent to which services provided are in the county’s management plan; and
      - Extent to which the county provides services to persons other than persons with a mental illness or intellectual disability or to persons whose income is above 150 percent of the federal poverty level.
A sustainability plan including how funds will be used in the transition year to allow the county to remain within available funding in FY 2014.

- Counties must apply for transition funds by October 15, 2012.
- DHS will make a recommendation to the governor and general assembly for the appropriate amount of funding needed for transition by December 1, 2012. Note: no funds are yet appropriated for transition at this time.

- Establishes a method for equalizing the amounts of funding counties receive for non-Medicaid services.
  - The equalization method goes into effect July 1, 2013.
  - Will be included in the part of the interim study committee analysis.

DHS FY 2013 Appropriations

- The state payment program will continue in FY 2013 funded by SSBG/TANF.

Buy-out Medicaid.

- $40 M new funding.
  - The DHS appropriations bill contains sections that delete codes requiring that counties pay the non-federal share of Medicaid.
  - The following funds were transferred to a MHDS Redesign Fund to be used to pay the non-federal share of Medicaid:
    - Property tax relief including added $7.2 M;
    - PALO;
    - Allowed Growth;
    - Community Services;
    - State Payment Program; and
  - The following fund was transferred to the Medical Assistance program:
    - The balance of undistributed funds remaining in the Risk Pool.

Changes as a Result of the State Taking Responsibility for the non-Federal Share of Medicaid

- State Resource Centers (SRCs): SRCs will bill counties for April, May and June 2012 in July for Medicaid ICF/ID services. Counties will receive no further Medicaid bills for SRCs after July 2012.

- Medicaid Billing: Last FY 2012 Medicaid bills for Medicaid funded services for which counties provide the non-federal share will be sent early August 2012 for bills processed through the last week in July 2012. Counties will receive no further Medicaid bills for FY 2012 after August 2012.

- IME is in the process of changing ISIS work flows effective July 1, 2012. Specific information will be sent out once completed.
  - At this time continue to approve the service plan
    - Do not end service plans already approved.
- CPCs will continue to approve service plans through June 30, 2012.
  - IME will authorize new plans beginning July 1, 2012
  - IME is open to hearing more from CPCs about the processes they have used to approve service plans.
- CPCs continue to have a critical role as the local point of access to all services both Medicaid and county funded. CPCs are critical in assuring people receive needed, effective services in the least restrictive setting.

- Counties are responsible for non-Medicaid funded services consistent with the counties’ management plan.
  - Counties should continue to contract for individuals without Medicaid and for services not covered by Medicaid.
  - Cash flow issues: Counties will not receive their first county funding until October 1st.
    - Provision allows counties to transfer moneys from other funds to the MHDS fund for cash flow purposes provided the other funds are repaid by the end of the fiscal year.
  - Allow counties who received Risk Pool funding in FY 2012 to use it in FY 2013.
  - Balance incentive program.
Iowa Department of Human Services

Transition Committee Report

January 10, 2013
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Introduction

The purpose of this report is to provide information and recommendations to the Iowa Legislature related to the implementation of Senate File 2315: the Mental Health and Disability System Redesign Legislation enacted in 2012. This report summarizes the deliberations and recommendations of the Transition Committee.

In consultation with the Legislative leadership, the Department of Human Services (“Department”) formed the Transition Committee to focus on the transition from the existing mental health and disability system (MHDS) into the new regional system. This committee included several members from the Regionalization Workgroup that assisted to develop recommendations for the regional system design that was a basis for last year’s Legislative action (SF 525). New participants were added to increase representation of the Mental Health and Disability Services (MHDS) Commission and county officials, both of which are important participants in the implementation process. A complete list of the membership of the Transition Committee is included as Appendix A of this report.

The goal of the committee is to transition to a regional mental health system that provides local access to services and supports, is regionally managed and measured through statewide standards. The specific tasks of the Transition Committee include:

- Identify and recommend resolutions for issues arising from the mental health and disability system transition;
- Serve as a resource for the Department as it assists counties forming into regional entities;
- Make recommendations that would create a clear locus of accountability and responsibility in the MHDS system; and
- Consult with the Department and the MHDS Commission as they establish rules for county exemption from a region and rules and requirements for the Mental Health and Disability Services Redesign Transition Fund.

The Transition Committee met five times in person, and twice by conference call between July 31, 2012, and December 2012. The Committee anticipates continuing its work beyond the delivery of this report, to assist the Department and the Legislature as they consider and perhaps adopt the recommendations of this report, and to continue to advise and facilitate the implementation process through the up-coming year.

Status Report

The Transition Committee spent part of each meeting discussing two issues directly relevant to the success of the redesign implementation. These were: (a) financial issues at the county level that could influence the formation of regions and/or highlight issues related to the Redesign Transition Fund; and (b) status reports of the numbers and types of regions under consideration by counties.
Financial issues at the county level

Prior to counties submitting applications for transition funds, the Department was watching the counties’ financial conditions. As of the end of October 2012, it appeared that 70 counties are in good financial condition and are likely to end the fiscal year with positive fund balances, while 29 counties appeared to have insufficient funds to meet all obligations and may end the year with negative fund balances. Some of these counties may have difficulty meeting their obligation to reimburse the state for Medicaid match costs incurred prior to the state assuming full financial responsibility for all Medicaid costs. It appears there is not a correlation between financial challenges within counties and eligibility to receive an allocation from the Redesign Transition Fund. That fund is specifically designed to assure continuity of services for consumers while counties are transitioning into the regional system, not to assist counties to meet prior financial obligations. This will be discussed in more detail in the recommendations below.

The Department has conducted an analysis of the drivers of financial issues among the 29 counties that appeared to have fiscal challenges. It appears there are a number of factors that have influenced county financial issues and that these are often interactive. While not always the case counties experiencing several of the factors seem to have more challenging financial issues. The drivers of financial problems at the county level include but are not limited to:

- A lower maximum allowable MHDS county levy;
- A history of higher per capita spending for Medicaid services;
- A history of higher per capita spending for non-Medicaid services;
- A history of higher spending per person served for non-Medicaid services;
- A history of higher use of psychiatric inpatient services; and/or
- A history of serving a higher number of persons per 1,000 persons in the general population.

The Department plans to continue to watch these financial situations on a county-by-county basis. In many cases, the solutions will not necessitate reduction in services nor will they necessarily require regional partners to share in the solution, although that could be an option. One option would be for the Legislature to appropriate state general funds to meet local obligations.

Progress in Regional Formation

The Department has been monitoring local discussions and potential partnerships among counties as they form themselves into regions. As of October 30, 2012, the Department understood there were 96 counties in the process of forming approximately 15 regions. Information on these potential regions is summarized in the table below:
Summary Information on Counties forming Regions

<table>
<thead>
<tr>
<th>Number considering model</th>
<th>Number of counties considering this model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single County Region w/ waiver</td>
<td>2</td>
</tr>
<tr>
<td>Two County Region with Waiver</td>
<td>2</td>
</tr>
<tr>
<td>Region with 3 Counties</td>
<td>1</td>
</tr>
<tr>
<td>Region with 4 counties</td>
<td>2</td>
</tr>
<tr>
<td>Region with 5 counties</td>
<td>6</td>
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<tr>
<td>Region with 6 Counties</td>
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<tr>
<td>Region with 7 Counties</td>
<td>3</td>
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<tr>
<td>Region with 9 Counties</td>
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</tr>
<tr>
<td>Region with 18 Counties</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
</tr>
</tbody>
</table>

Results of the Transition Committee Work
The Transition Committee had several specific recurring agenda items intended to result in specific recommendations to the Department and the Iowa Legislature. These included specific recommendations related to rules for the Transition Fund and the granting of waivers for single county operations. It should be noted that in the case of the development of rules, the Transition Committee was an active and effective partner with the Department and the MHDS Commission. The recommendations of the Transition Committee also included some more generic topics regarding desired models and administrative practices for the operations of newly formed regions.

Recommendations related to these key topics are summarized below.

Recommendation: Rules for the Transition Fund
The statutory framework for the Transition Fund specifies that the funds are to be for FY 2013 for one time assistance to sustain services for populations currently receiving non-Medicaid funded services as approved by the county’s management plan. The statute required that county Boards of Supervisors be the applicants for the funds; that the county be levying the maximum allowable for that county; and that there be independent verification of the applicant county’s financial position. To be eligible for funding, counties had to demonstrate that the amount, duration and scope of current county services cannot be maintained in the absence of transition funding.

The Mental Health and Disability Services Redesign Transition Fund rules were adopted and became effective on September 11, 2012. The rules specified that applications for Transition Funds were to be submitted to DHS by November 1, 2012. Applicant counties were instructed to use a specific form for their submissions. The

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1 SF 2315 Section 23
2 Form 470-2125
form replicates all the consumer targeting criteria, core services\(^3\) and financial information specified in the rule, and were to be verified independently by the applicant county’s auditor.

The Department received 32 applications for Transition Funds. The applications were reviewed, and the Department made its recommendation to the Legislature in its December 4, 2012 report.

**Recommendation: Readiness Criteria for Operations as a Region**

Once recommendations related to the rules and application processes for the Transition Fund were completed, The Transition Committee began discussions of criteria that could be used by the Department to evaluate whether one or two counties\(^4\) could qualify for a waiver to function as a region. The Committee recognized that before criteria for a waiver could be discussed, it would be necessary to have a more general discussion of threshold criteria to be met by groups of counties seeking Department approval to operate as a region. One specific reason for this is that the statute specifies that counties seeking waivers must meet all standards and requirements applicable to multi-county regions.

The Transition Committee recognized that moving from single county to regional operations would be a developmental process, and that not all regions would be able to meet all criteria at the beginning of the process. However, the Committee also recognized that regions will have to meet certain basic criteria (a) to meet the requirements set out in SF 2315; and (b) to enter into a performance contract with the Department for the first year of operations. There was general consensus among Committee members that the following list represents objective threshold criteria for regional operations. It should be noted that single or two-county regions are required to meet the same threshold criteria for regional operations as larger regions.

1. Planning
   a. The region has a complete management plan/business plan and is developing an operations manual that meets all new statutory requirements that includes provision of core services as defined by SF 2315, eventual provision of core plus services.
   b. The management plan demonstrates effective linkages with other public and private service planning, authorizing or delivery entities to assure continuity of care and coordination of services with regard to physical health, housing, employment, education, courts, criminal justice and other applicable community services and supports.
   c. The plan documents the input of consumers, families, providers, and other stakeholders in the plan development process.

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\(^3\) Current services as per the county management plan

\(^4\) Because the statute specifies a minimum of three counties per region, a two-county region would still have to receive a waiver for DHS to operate as a region.
2. Access
   a. There are a sufficient number and adequate geographic distribution of designated access points to assure convenient access throughout the region.
   b. Protocols for timely responses to routine, urgent and emergent requests for services are in place.
   c. There is a plan to communicate access points and related information to all actual and potential consumers, families, referral sources and other key community stakeholders.
   d. There is a 24/7/365 telephone contact system in place.
   e. The management plan addresses access issues: in rural areas, for cultural/linguistic minorities, for people with physical and other disabilities, etc.

3. Provider network sufficiency
   a. The region has contracts or memoranda of understanding (MOU) with providers for each of the core service domains as defined by SF 2315 and any other services included in the management plan.
   b. Providers in the network that are also Medicaid certified providers agree (via contract or MOU language) to collaborate with the region to assure care coordination and continuity of care across Medicaid and non-Medicaid services.
   c. The provider network includes at least one community mental health center that can serve the entire region and/or one FQHC with outpatient mental health service capacity to serve the entire region.
   d. The provider network includes at least one inpatient mental health facility with documented capability and willingness to provide inpatient acute care as applicable to residents of the region.
   e. The provider network includes sufficient providers to offer reasonable choice and convenience of access to services throughout the region’s service area.
   f. All providers in the network have the applicable licensure/certification/accreditation to qualify as providers in Iowa.
   g. Regional or contracted provider capacity is identified to address pre-admission screening and hospital and jail diversion functions and capacities.

4. Targeted Case Management (TCM)
   a. The region assures that consumers have choice of conflict free targeted case management providers with the capacity to meet the case management needs of enrolled consumers.
   b. The Region assures that designated TCM providers are certified by Medicaid.
5. Utilization management/utilization review
   a. The region has (or contracts with) sufficient skilled clinical capacity to conduct or review clinical assessments; review individual service plans; apply standard clinical protocols as defined in the management plan; and issue service authorizations/re-authorizations in a timely and clinical appropriate manner.
   b. The region has in place a process and capacity to address and make timely decisions on first level appeals of service denials.

6. Quality management
   a. The region has identified a staff person with lead responsibility for quality management and quality improvement (QMGI), and will develop a quality management plan with specific objectives, action steps and indicators of quality improvement within the first year of operations.
   b. The quality management plan will incorporate performance measures required by the Department.
   c. The region has a plan and designated staff to review outcome and performance data on a regular basis and to document the ways in which outcome and performance data are used for quality improvement.

7. Business management
   a. The region has a business and financial risk management plan to assure precise financial analysis and early warning of financial risks, and that identifies the percentage of budget to be set aside for an internal risk pool.
   b. The region has sufficient IT capacity to receive, adjudicate and pay provider claims and to meet all state data reporting requirements.
   c. The region has a staffing plan that identifies sufficient staff expertise and functional capacity to meet all requirements for operating as a region.
   d. The total administrative costs of the region do not exceed the administrative costs limitations established by the Department.

The Transition Committee recommends that the Department provide guidance to regions on the above types of operational criteria to facilitate their planning and development process. The Department will provide direct technical assistance to regions if appropriate to facilitate development of systems and capacities to assure effective implementation of the new regions.

**Recommendation: Recommendations for Waivers for Single (or Dual) County Operations**
The above general criteria for regional operations were then used by the Transition Committee to develop recommendations related to (a) qualifications to apply for a waiver; and (b) criteria for review of such applications if received. The statute is very clear that a single (or dual) county applicant for a waiver would have to meet virtually all the statutory requirements that apply to multi-county regions. The MHDS Commission also held several discussions of this issue and provided feedback and guidance to the
Transition Committee with regard to formulation of the rules and criteria for waiver applications and review.
The Transition Committee reached consensus that the following principles reflect the intent of the statute with regard to single (or dual) county waivers:

1. A single (or dual) county region must meet all the statutory, regulatory and performance requirements as a multi-county region.
2. A single (or dual) county region will have to submit a new county management plan/business plan (including manual) and have it approved in the same way as a multi-county region.
3. A single (or dual) county region will have to have a plan to meet performance criteria and standards in the same manner as a multi-county region.
4. It is recognized that steps to meet management plan and performance requirements for multi-county regions are developmental, and the same would be true for single county regions.

The Department has developed an outline of draft rules for single (or dual) county operations under a waiver granted by the Director of the Department. These were presented to the Transition Committee at the meeting on October 30, 2012. After discussion, and with additional input from the Committee members that are also members of the MHDS Commission, the Transition Committee reached consensus that the following outline is appropriate:

OUTLINE:
RULES FOR EXEMPTING COUNTIES FROM FORMING INTO REGIONS
October 30, 2012

Counties wishing to be exempted from forming into regions of counties of three or more must submit applications that meet the following requirements. A county/county must demonstrate that the requirements are currently being met or provide a viable plan for meeting each requirement. The Director may deny a county/county waiver application if:

- The county/county cannot demonstrate it/they currently meet the requirements, and
- The county/county do not have a viable plan for meeting the requirements, or
- At any point the county/county do not meet any regional requirement consistent with 331.438B 5.

- Community engagement – Demonstrate that in the county or counties has/have:
  - Active operational understandings (e.g., memorandum of understandings) with other public and private service entities such as:
    - Physical health;
    - Housing;
    - Employment;
    - Education;
    - Courts; and
    - Criminal Justice.
- Obtained input from consumers, families, providers and other stakeholders regarding adequate community engagement.

- Access to core services – Demonstrate that in the county or counties there is/are:
  - A sufficient number and adequate service access points.
  - Access points that have been communicated to potential consumers, families and referral sources.
  - Effective response for emergencies including a 24/7/365 telephone contact system.
  - Access to service providers that have demonstrated the capability of providing:
    - Treatment that objectively meets the fidelity of evidenced based practices including:
      - Strengths based case management and/or assertive community treatment;
      - Illness management and recovery;
      - Family psycho-education;
      - Supportive housing;
      - Integrated treatment for co-occurring disorders; and
      - Supported employment;
    - Services to persons with co-occurring conditions including two or more of the following – mental illness, intellectual disability, developmental disability, brain injury, or substance use disorder; and
    - Trauma informed care.
  - Sufficient amounts of services that demonstrate that the per capita number of individuals:
    - Each disability category served by the county or counties is at least equal to or exceeds the statewide average;
    - Use of in-patient psychiatric hospital services is less than or equal to the statewide average; and
    - Using intermediate care facilities for individuals with intellectual disabilities is less than or equal to the statewide average.

- Provider network sufficiency – Demonstrate that the county or counties has/have:
  - Contracts to provide each service in the required core service domains in sufficient amounts to ensure a network of properly licensed and accredited providers can provide needed services without an undue wait times due to insufficient provider capacity;
  - A contract with a community mental health center or federally qualified health clinic that provides psychiatric services that provides services in the county or counties; and
  - An inpatient psychiatric hospital program within 100 miles of the county or counties.

- Targeted case management – Demonstrate that in the county or counties there is/are:
- Sufficient trained case managers or care coordinators to serve individuals needing the service at the required case load levels;
- Targeted case management that is strengths based and conflict free; and
- A choice of case management providers.

- Utilization management and review process – Demonstrate that the county or counties has/have:
  - Sufficient skilled clinical capacity to issue clinically appropriate service authorizations.

- Quality Management/Improvement Process – Demonstrate that the county or counties has/have:
  - A quality management/improvement plan that is managed by qualified staff;
  - Incorporates performance measures required by the department; and
  - A plan to review outcomes and performance measures regularly and to use the review to improve services.

- Staffing – Demonstrate that the county or counties staffing meets the requirements of 331.438B 3:
  - The regional administrator is under the control of the governing board; and
  - The regional administrator(s) shall have a bachelor's degree in a human service related field or public or business administration or relevant management experience.

- Business Management – Demonstrate that the county or counties has/have:
  - A risk management plan that:
    - Accurately forecasts expenditures and revenue;
    - Provides an early warning of financial risks; and
    - A provision for effectively managing risk;
  - The capability to fund current and on-going service obligations;
  - An average cost of service per individual equal to or less than the statewide average;
  - Administrative costs, as a percentage of non-Medicaid service expenditures, that are less than or equal to the statewide average;
  - Maintain funding in designated accounts;
  - An accounting system that conforms with OMB – A 87; and
  - A process for performing an annual independent audit.

- Forming into a region is unworkable – Demonstrate that the county or counties has/have:
  - Contacted all contiguous counties and determined that forming into a region with those counties is unworkable; and
  - Identified the reasons why forming into regions with contiguous counties is unworkable.

- Maintain an approved management plan that meets all requirements.
It will be noted that the above outline includes some specific objective and measurable indicators related to performance. These are included because SF 2315 specifically requires single (or dual) counties to meet the same performance and outcome levels as the average of the regions. The new outcome and performance standards and indicators for regions are still in development. Further, it will take at least 1 year to generate performance data for the regions once the new indicators are implemented. Thus it is necessary to use existing data from current county MHDS operations for the purposes of the initial review of applications for single (or dual) county operations. Renewal of such waivers in subsequent years can be tied to the new outcome and performance requirements as data become available.

The Department is preparing draft rules for consideration by the MHDS Commission, and is also in the process of developing a format for counties to use if applying for a waiver. By statute, counties wishing to apply for a waiver must submit a letter of intent by May 1, 2013. At this time it is not clear whether any counties will be requesting a waiver and submitting a letter of intent. Currently, there are only two counties that have indicated some interest in requesting a waiver.

**Recommendation: Guidance to the Department and the Director on Regional Formation and Implementation Issues**

In the process of discussing the process and criteria for waivers for single (or dual) county operations, the Transition Committee developed a number of guiding principles related to the decision-making process. These principles are informed by considerable input from the MHDS Commission, which has been discussing the same topics and is responsible for promulgating the rules related to both the Transition Fund and single county waivers. The following is a summary of these guiding principles:

1. **Legislative Intent:** The Committee emphasized that it was the intent of the Legislature that counties join regions. The provision for granting waivers is not intended to encourage counties to remain as single county operations. Rather the intent of the waiver process is to provide a small amount of discretion on the part of the Department to address situations in which joining a region is not feasible, and single (or dual) county operations is deemed by the Director of the Department to be in the best interests of consumers.

2. **Urban core:** The Department should encourage regions in the formation process to include at least one populous urban core with numerous service providers and a variety of necessary other non-mental health and intellectual disability resources (education, employment, socialization, faith community, etc.). A non-populous county without an urban core and sufficient range and choice of providers should be encouraged to join a region, and should be discouraged from applying for a waiver for single county operations.

3. **Minimum population size:** The Department should encourage counties to join in regions that have sufficient population and active caseload sizes to facilitate risk management, and to minimize per capita administrative cost ratios. Single
counties with relative low populations and case load sizes should be discouraged from applying for a waiver to function as a single county region.

4. **Effect on surrounding counties**: When reviewing applications for waivers to be single county regions, the Department should take into account the effects on surrounding counties of granting such a waiver. This is particularly the case if the surrounding counties would be deprived of an urban core and sufficient population and case load sizes if the waiver is granted.

5. **Flexibility**: The discretion and flexibility of the Department and the Director with regard to approving waivers and/or approving multi-county regions should be emphasized, particularly during the first 2 to 3 years while regions are still in the development stages. The Director also needs to have authority and discretion to assign “orphan” counties to a region if necessary.

6. **Administrative Review**: A process for appealing Department decisions on granting waivers or approving regions is not currently included in the statute. It might be appropriate in the upcoming Legislative session to amend SF 2315 to include such an appeals process.

**Recommendation: Additional Recommendations for Regional Operations**

The Transition Committee recognizes that the Department will be responsible for oversight and management of the new regions and thus will need authority to specify administrative functions and criteria as well as outcome and performance standards for the regions. The Department and the regions together will need some flexibility and discretion to (a) make best use of administrative capacities, systems and personnel from the counties as they form into regions; and (b) determine allowable administrative functions, staffing and costs for the regions. At the same time, the Department must assure consistent and efficient management of public resources for non-Medicaid services at the regional level.

The Committee members agree that guidance to the counties as they form regions should be as concrete as possible. The Committee therefore discussed and reached consensus on some model administrative practices, or examples, which could be used by the Department and the regions to facilitate implementation. These could also be used by counties forming regions to evaluate whether their initial plans for administrating a given region are efficient and feasible. The following is a brief outline of these recommendations.

**Example of Job Description for Regional Director**

**General Principles**

1. Appointed by Board established by 28E agreement.
2. Serves at pleasure of the Board.
3. Has performance evaluated (annually) by the Board.
4. Functions as the Board’s designated single point of accountability for all regional operations and finances.
Job Functions
1. Functions as staff to the Board, oversees agendas and minutes, etc.
2. Develops and oversees communications with and input from relevant consumer, family and other stakeholder advisory groups.
3. Assures consumer and family input into needs assessments and strategic plan development.
4. Oversees development of the regional management plan (strategic and business plan) and operations manual.
5. Oversees development of the annual regional budget.
6. Oversees agency operations, including personnel, benefits, space, training, etc.
7. Implements a budget tracking and risk management plan to assure that annual expenditures remain within the annual budget.
8. Accountable for the region’s compliance with all state requirements, including performance targets.
9. Develops regional administrative staffing plan and job descriptions.
10. Hires, supervises and evaluates the performance of regional administrative staff.
11. Designates regional access points.
12. Designates targeted case management providers, including conflict free case management where applicable.
13. Oversees the process for assessments, person centered planning, service plan development, service authorization, re-authorization and continuing review (utilization management and utilization review – UM/UR).
14. Oversees development and contracting for the provider network to assure all core services are available and accessible to the defined target populations.
16. Assures timely and accurate payment of provider claims.
17. Oversees development and maintenance of effective working relationships and memoranda of agreement with all regional partners (housing, employment, education, social services, courts, police, hospitals, physical health providers [FQHCs], etc.).
18. Develops and oversees effective and transparent processes for coordinating service access and care planning for people receiving Medicaid services.
19. Assures that all financial, program, service, client and performance data are collected and reported in a timely and accurate basis.
20. Oversees development and implementation of the regional quality assurance plan.
22. Develops monthly, quarterly and annual reports as specified by the Board and the Department.

Qualifications
1. Master’s degree in management or human services/public policy (or bachelor’s degree with 5 years management responsibility).
2. Minimum three years management responsibility (five years preferred) that includes accountability for organizational operations and budget (i.e., not just management of clinical or direct service staff).
3. Experience managing and overseeing business systems, including finance, accounting and information technology.
4. Knowledge of mental illness and intellectual disabilities.
5. Knowledge of human services systems, including Medicaid and non-Medicaid mental health and Intellectual disabilities financing and service delivery systems.
6. Experience developing and managing strategic and business plans.
7. Experience with using financial tracking and outcome and performance data for organizational management and quality improvement.

Example Functional Table of Organization for Regions (note: this is not a staffing plan and the boxes on the chart do not represent FTEs)
Business Plan Components
The Transition Committee understands that each region will be developing a regional strategic plan and operations manual as part of their initial and ongoing operations. As part of the Regional Plan, the Transition Committee recommends that additional attention be paid to business planning. In this context, business planning includes accurate budgeting and tracking of expenditures, and also risk management to ensure that public funds are spent in the most efficient and effective manner. The challenge for regions will not just be to live within a fixed budget; it will also be to assure that the maximum amount of funds possible actually get spent on services for priority consumers. Under spending is frequently as much of an issue as overspending in a fixed budget, risk management environment.

Thus, the Transition Committee recommends that the business plan component of the regional strategic/business plan receive special attention. The following are some recommended elements for inclusion in the business plan:

1. Projected annual budget
   a. Administrative budget within the cost cap
   b. Provider payments

2. Analyses of revenue sources
   a. Projected annual revenues by source
   b. Projected monthly revenues by source

3. Monthly expenditure projections
   a. Provider payments
   b. Regional administration - payroll
   c. Historic analysis of average monthly client inflows and outflows and service authorization patterns

4. Monthly cash flow analysis (variance between projected monthly revenues and projected monthly expenditures)
   a. Historic analysis of receivables and effect on monthly cash flow
   b. Historic analysis of claims payment - adjustment factors by service/provider type

5. Method for accruing claims costs

6. Method for cleaning out un-paid claims

7. Method for tracking incurred but not received (IBNR) and received but unpaid claims (RBUC)

8. Assessment of financial risk factors – both to cash flow and to annual budget
   a. Revenue reduction/interruption
b. Unplanned expenditures
   i. Provider payments
   ii. Other (liability, etc.)

c. Provision for operating reserve

d. Provision for accessing fund balance
   i. Provision for accessing county fund balances for cash flow management and budget risk management if the fund balances are not pooled under the region

9. If applicable, identification of the fiscal intermediary for the region
   a. Specification of the functions and accountabilities of the fiscal intermediary

10. Specification of staff functions and accountabilities for financial tracking and risk analysis
    a. Description of the administrative firewall between budget/finance functions and service authorization and management functions

11. Specifications data and analytic approaches for linking intake, enrollment, service authorization, service utilization and client flow information with the budget tracking and risk management functions.

**Administrative Cost Cap**

SF 2315 requires the Department to collaborate with the Legislative Services Agency (LSA) to develop a standard administrative cost calculation and cap, or limit, for regions. The Department has been engaged in these meetings and is in the process of developing a recommended model. There is recognition that because counties (regions) will no longer have funds to pay the match for Medicaid, the denominator of total budget managed is smaller, thus the percentage of funds spent on administration will be greater. This is not necessarily an increase in administrative costs, but is related to the total amount of funds managed by the regions. The Department is currently defining which functions are truly administrative, and which functions are consumer services. This is a complex task, since some functions, such as care coordination and service management, have both administrative and service delivery components. Once the Department and LSA have developed a model for calculating administrative costs, it will be field tested in several counties (regions). The results of the field test will inform development of the final administrative cost definitions and limitations.

**Transition Committee Recommendations for Legislative Action**

On December 20, 2012, the Transition Committee identified several areas that they believe need further action by the Mental Health and Disability Services Redesign Fiscal Viability Study Committee. While some of the recommendations are broader in scope than the specific objectives of the Transition Committee, the Committee members believe making such recommendations would be consistent with the charge to: “Identify and recommend resolutions for issues arising from the mental health and disability system transition.”
The following recommendations are made by the Transition Committee and are not those of the Department.

**Transition Funding**
Although not within the mandate of the Transition Committee, the Committee did develop recommendations related to the Transition Fund. The Transition Committee believes that an alternative should be developed different from the one provided by the Department.

In general, it was the sense of the Committee members that there is greater need for funding to assure continuity of services than was reflected in the Department’s recommendations. There was also concern about the emphasis on equity as a principle for funding. Committee members felt that Transition Funds were intended to assure no consumers lost services as a result of the transition, and therefore needed to reflect the current status quo of funding levels and priorities. It was noted that some counties that did not apply for Transition Funds had already reduced services to work within restricted budgets. Therefore, Committee members felt that the policy issue should be “fairness,” not just “equity”.

Committee members also made the point that counties/regions will need to have fund balances to be able to pay provider bills and sustain operations. If regions are expected to start operations without available fund balances, they will be financially insecure. The Committee does not believe this to be the intent of SF 2315 or the Transition Fund.

The Transition Committee recommends that a Transition Fund allocation method be developed and approved that uses the entire available CHIP contingency fund for the transition and unintended consequences related to redesign of Iowa’s mental health delivery system passed by the 2012 Legislature.

Committee members observed that the MHDS Commission recommended adopting at least Scenario One described in the Department’s Transition Fund Report.

**Recommendation:** No consumer, child or adult loses services as a result of the transition.
Several members of the Committee expressed their belief that the Legislature intended to preserve services for adults and children during the transition to a regional MHDS system. This position is similar to the discussion regarding the intent of the Transition Fund summarized above. Some Committee members have heard of counties cutting or restricting services because of limited funding, and/or to make sure they were not in a deficit situation, which could make them less attractive as partners in regions.

**Recommendation:** Establish $47.28 as the guidance for counties in determining their budget.
Committee members support enacting equalization funding at the $47.28 per capita level as proposed during the FY12 Legislative session. Some members indicated that certain counties had not applied for Transition Funds based on the belief that the $47.28
per capita funding would be sufficient to continue to provide services within the region. Committee members stated that it is important for counties/regions to begin budget planning for SFY14 as soon as possible and need to know if $47.28 will be the operative funding target. In the future, the per capita funding level should continue to be adjusted based on the documented service needs of priority consumers for core and core plus services in the future.

**Recommendation:** Allocation of equalization funds should be given to a region to be shared equitably among the counties in the region.
Committee members recommend that equalization funds up to the $47.28 level be awarded to regions as opposed to individual counties. Committee members believe this will reinforce the principle of pooling funds, and will allow regions to attain equalization of service access within their regions.

**Recommendation:** The Mental Health and Disability Services Redesign Fiscal Viability Study Committee establish an appeals process for counties requesting an exemption from joining a region if the Chapter 17A appeals process is deemed not effective.
The Transition Committee has noted that the Director of the Department has considerable discretion in (a) approving the make-up of regions; (b) assigning “orphan” counties to regions; and (c) granting or denying waivers for single or dual county operating as regions. Currently there is no specific language in SF 2315 that establishes an appeal mechanism related to these decisions. It is recognized that there is a generic appeals mechanism already in statute (Chapter 17A), but this might not be applicable to the above situations. Thus, the Transition Committee felt that the Mental Health and Disability Services Redesign Fiscal Viability Study Committee should review the appeal process issue and propose new statutory language if necessary.

**Recommendation:** Set aside the requirement for submitting a strategic plan for SFY14 as counties move to regionalization. The management plan will stay in place.
Several Committee members have noted that counties are operating under management plans that, although already extended for one year, will expire before all counties are effectively in regions with newly approved management plans. Committee members believe that the strategic action plan component could reflect the transition into regional structures. However, the current county management plan that details target populations, services, providers, access points, etc. should remain in effect until a county is officially joined into a region and a new regional management plan is approved.

**Recommendation:** The Mental Health and Disability Services Redesign Fiscal Viability Study Committee begin to look at systemic barriers to implementing co-occurring and multi-occurring service development and coordination strategies.
Committee members noted that some counties have coordinated local substance use disorders service funding (e.g., for detoxification services) with MHDS funding under the auspices of the central point of coordination administrator and county management
plan. This informal approach has assisted certain counties to facilitate integrated treatment for individuals with dual diagnoses of mental illness and substance use disorders, and has assisted counties to reduce administrative costs. SF 2315 requires the adoption of evidence based practices, and specifically endorses dual competencies for mental illness and substance use disorders among providers. However, there is currently no provision in SF 2315 that specifically allows counties to delegate certain substance use disorders funds management and service coordination functions to regions. The Transition Committee believes this issue requires further study and analysis in the next year.

Recommendation: Set June 30, 2013 as the end date for county obligations for Medicaid bills. After that date, the state would receive any credits and pay any obligations resulting from retroactive cost adjustments, etc. This would allow counties to move forward with budgeting.

Committee members and many constituent counties have experienced situations where Medicaid bills (and associated state bills to counties for match) can take long periods of time to be adjudicated, and frequently there are retroactive adjustments. Given the transfer of Medicaid responsibility and state funding from the counties to the state, counties need a clear break point beyond which they would no longer be liable for retroactive Medicaid match liabilities. Remaining property tax is insufficient to cover designated core services and pay old Medicaid bills. Enactment of this measure would facilitate budgeting and funds management within the new regional structures.

Recommendation: Money that is used for the current state payment program for services for individuals who are 100 percent county funded continue to be given to counties for SFY14.

State payment funds were available to counties to pay non-Medicaid services for individuals with no legal settlement. As counties transition to regions, the Committee requests these funds continue to be appropriated to the Department to allocate to counties (regions) to fund non-Medicaid services.

Recommendation: Individuals in the community corrections system have access to MHDS services and appropriate funding is allocated to pay for these services.

Committee members have noted that individuals under the control of the Department of Corrections (DOC) are residing in community settings as opposed to correctional facilities. While residing in the community, these individuals have a need for, and could benefit from, mental health and substance use disorder treatment services. Committee members agree that the regional MHDS system is most appropriate to access and assure provision of mental health services for people in these community living settings; however, there is no funding mechanism to support service provision for these individuals. The Committee recommends that the Legislature designate the MHDS service system as the appropriate mechanism to deliver services and determine an appropriate service funding mechanism with adequate funds to pay for the services.

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5 Substance use disorder services are managed by Magellan, not the regional MHDS system.
Additional Requests by the Committee

There were two issues for which the Committee sought additional assistance for regions as they develop.

- Transition Committee members question how regions will obtain and pay for general liability insurance, particularly with regard to targeted case management. The Committee requests that the Department provide technical assistance to regions with regard to liability insurance as they develop their 28E agreements and begin organizational development and operations.

- The Transition Committee recognizes that the Department and LSA are working on a model for calculating regional administrative costs. A pilot for gathering administrative costs will be developed and field tested soon. The Committee would like assurance that regions will not be penalized in the administrative cost calculations because of the removal of the non-federal share of Medicaid from their budgets. The Committee recognizes that the denominator for administrative costs has changed, but it is not yet clear what the result will be in the new administrative cost model.

Conclusion

The Transition Committee believes that counties in Iowa are making strong and good faith efforts to form themselves into regions as specified by SF 2315. Over the course of the Transition Committee meetings, and in concert with the MHDS Commission, much progress has been made in setting specific and concrete rules for access to Redesign Transition Funds and applications for waivers to operate as a single or dual county region. Much clarity has also been achieved relative to effective administrative operations and practices for the newly forming regions. The committee is satisfied that SF 2315 is on track to effective implementation, and that only minimal adjustments might be needed either administratively or legislatively to facilitate on-going implementation.

The Transition Committee understands that the Legislature will receive and review this report, and will make a determination about any future actions to be taken either through appropriations or statute. At the same time, consideration will be given to whether a continued role for the Transition Committee would be appropriate over the upcoming year. One important function of the committee has been to discuss and provide guidance to the Department on implementation issues as they arise. The Transition Committee could also assist the Department if any unintended consequences related to regional formation and operations arise next year. The membership of the Transition Committee is broadly representative of many parties engaged in the implementation process, and thus is well poised to assist the Department with problem identification and solution formulation. The Department will communicate with the Legislature about possible continued operations of the Transition Committee after this report has been reviewed by the Legislature.
Appendix A
Transition Committee Members
## Transition Committee Members

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<thead>
<tr>
<th>Name</th>
<th>Agency</th>
<th>Job Title</th>
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<tbody>
<tr>
<td><strong>Chair,</strong></td>
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<tr>
<td>Palmer, Charles M</td>
<td>Department of Human Services</td>
<td>Director</td>
</tr>
<tr>
<td><strong>Co-Chair,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincoln, Bob</td>
<td>County Social Services Region</td>
<td>Central Point of Coordination</td>
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<tr>
<td>Bomhoff, Teresa</td>
<td>Polk County</td>
<td>Parent of Mental Health consumer</td>
</tr>
<tr>
<td>Brownell, Robert</td>
<td>Polk County Board of Supervisors</td>
<td>County Supervisor</td>
</tr>
<tr>
<td>Fokkena, Holly</td>
<td>Butler County</td>
<td>County Auditor</td>
</tr>
<tr>
<td>Guenthner, Jack</td>
<td>Plymouth County</td>
<td>County Supervisor</td>
</tr>
<tr>
<td>Heikes, Jan</td>
<td>Allamakee/Winnesheik Counties</td>
<td>Central Point of Coordination</td>
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<tr>
<td>Schmitz, Patrick</td>
<td>Plains Area Mental Health Center</td>
<td>Executive Director</td>
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<tr>
<td>Severtson, John</td>
<td>Opportunity Village</td>
<td>Chief Executive Officer</td>
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<tr>
<td>Tretina, Nancy</td>
<td></td>
<td>Parent of Intellectual Disability Consumer</td>
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<tr>
<td>Willey, Jack</td>
<td>Jackson County</td>
<td>County Supervisor</td>
</tr>
<tr>
<td>Rep. Lisa Heddens</td>
<td>Iowa House of Representatives</td>
<td>State Representative</td>
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<tr>
<td>Rep. Dave Heaton</td>
<td>Iowa House of Representatives</td>
<td>State Representative</td>
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<td>Sen. Jack Hatch</td>
<td>Iowa Senate</td>
<td>State Senator</td>
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