

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
April 21, 2011, 9:30 am to 3:00 pm
Red Cross Building, Conference Room
2116 Grand Avenue, Des Moines, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick	Pat Penning
Lynn Crannell	Laurel Phipps
Julie Fidler Dixon	Susan Koch-Seehase
Jan Heikes	Dale Todd
Richard Heitmann	Gano Whetstone
Chris Hoffman	Jack Willey
Cindy Kaestner	Craig Wood
Linda Langston (by phone)	

MHDS COMMISSION MEMBERS ABSENT:

Senator Merlin Bartz	Representative Dave Heaton
Richard Crouch	Rick Hecht
Senator Jack Hatch	Representative Lisa Heddens

OTHER ATTENDEES:

Theresa Armstrong	DHS, MHDS, Community Services & Planning
Bob Bacon	U of Iowa, Center for Disabilities & Development
Teresa Bomhoff	Iowa Mental Health Planning Council; NAMI
Dr. Bhasker Dave	Superintendent, Independence MHI
Diane Diamond	DHS, Targeted Case Management
Connie Fanselow	DHS, MHDS, Community Services & Planning
Becky Flores	DHS, MHDS, Community Services & Planning
Julie Jetter	DHS, MHDS, Community Services & Planning
Gretchen Kraemer	Iowa Attorney General's Office
Laura Larkin	DHS, MHDS, Community Services & Planning
Ron Mullen	Superintendent, Mt. Pleasant MHI
Jeanne Nesbit	DHS, MHDS Division Administrator
Mary Peterson	DHS, MHDS, Community Services & Planning
Deb Eckerman Slack	ISAC County Case Management Services
Jason Smith	Superintendent, Clarinda MHI
Karen Thompson	ASK Resource Center
Robyn Wilson	DHS, MHDS, Community Services & Planning

WELCOME AND CALL TO ORDER

Chair Jack Willey called the meeting to order at 9:35 am. Jack welcomed Commission members and guests and led introductions. No conflict of interest issues were identified for this meeting.

APPROVAL OF MINUTES

Pat Penning made a motion to approve the minutes of the March 17 meeting as presented. Laurel Phipps seconded the motion. The motion passed unanimously. Linda Langston was present by phone for the vote.

MHDS UPDATE

Mental Health Redesign - Jeanne Nesbit noted that there has been a great deal of discussion about mental health and disability redesign during this legislative session. DHS has received many requests for information and MHDS staff, including Robyn Wilson and Julie Jetter, has done extensive work on funding issues so that legislators can be well informed. Currently there are two distinct and very different versions of mental health redesign. The Senate bill (Senate File 525) was passed yesterday by the Senate, along party lines. It addresses adult mental health services first and directs the Department to provide a final report by December 31, with an interim report due in mid-fall. The expectation is that the General Assembly will use that report to finish the redesign effort next session. Further work on a system for developmental disabilities, co-occurring conditions, and brain injury would follow.

Under the Senate bill, the State would assume responsibility for the non-federal share of Medicaid services that are now paid for by counties. Medicaid costs are approaching about half of the total expenditures for counties, so that is a very significant change. County expenditures in 2010 were \$287 million and \$110 million of that went pay the Medicaid match. Since Medicaid is an entitlement program, that cost must be paid for all eligible recipients. Another major change is from the county structure to a regional service structure. The Senate bill would organize services around metropolitan areas and spread services to areas that need them. There would be eight regions organized around the eight identified cities (Ames, Cedar Rapids, Council Bluffs, Davenport, Des Moines, Iowa City, Sioux City, and Waterloo) and the counties would all become part of one of the regions.

The House bill (House File 626) is a product of the meetings the House has held nearly every Tuesday and Thursday morning during the session. During those meetings many providers and others attended and shared their ideas. The House bill has now passed through the subcommittee and is in Appropriations. It includes an interim legislative study committee that is to address the system for both children and adults with mental illness. It includes some provisions around PMICs (Psychiatric Medical Institutions for Children) and incorporates the community mental health center bill that was proposed by the Commission, with some adjustments for the other aspects of redesign. It also

makes some changes to the commitment law relating to substance abuse, and requires a group to look at data. It identifies adults and children with intellectual disabilities, other developmental disabilities and brain injury as target populations to be more fully addressed later. The House version assumes an end vision of the State being entirely responsible for the delivery of services, but does not specify the delivery structure. The bill came up in the House Appropriations Committee and was not acted upon. For now, discussion has been delayed and there is still work being done on how much money will be put forth.

There is a preliminary \$20 million dollar appropriation that was part of the conference committee bill (Senate File 209) that has already been passed and sent to the Governor. Jeanne said she understands the money is intended to reduce waiting lists or go to fund the risk pool, but the bill leaves some room for decision on exactly how that money will be used. It is a supplemental appropriation for this year and can be carried forward into 2012.

Jeanne said that the amount of work yet to be done to reach some agreement between the two separate versions seems daunting and that money is still a major factor to be worked out. Jeanne expects the work will continue and that by next month's meeting there may be something concrete. Jan Heikes asked if Jeanne was aware of a rationale or research behind the concept of building regions around eight specific metro areas. Jeanne responded that she was not. Jan commented that she has concerns about the proposal because she believes rural areas always lose out when they are tied to a metropolitan area.

Craig Wood commented that he believes most counties feel that SF 525 is preferable to HF 626. While a regional approach may not be preferred, the intent of the House bill seems to be that county involvement should be completely removed from the payment and management of services, and he thinks that local involvement is critical to the welfare of consumers. Teresa Bomhoff commented that she finds it preferable to have funds in the system from both county and state and feels the system leaves itself open for disaster when it relies on only one source of income.

County Funding Data – Julie Jetter and Robyn Wilson introduced a six-page handout of financial data shown by county. They explained that this information was gathered by the Department of Management from data the counties submit with their December reports and their March budgets. The first two pages show Fiscal Year 2010 beginning fund balances (on an accrual accounting basis), reported revenues, total available revenues, reported expenditures, reported fund balances, actual ARRA (American Recovery and Reinvestment Act) savings, and the SFY 2010 ending fund balance with ARRA dollars by county. The second page shows the SFY 2010 ending reported fund balances totaled \$67 million.

Pages three and four show the same totals for Fiscal Year 2011. The estimated ending fund balance total for 2011 is \$41.8 million. The spreadsheet shows that 15 counties are projected to have negative ending fund balances for 2011. The total of the negative

fund balances would be \$4.2 million. Julie noted that it is important to remember that county fund balances are specific to the individual county. If one county has a negative balance and another county has a high fund balance, the county with the high balance cannot be transferred to help make up the negative one. She also noted that several county totals are highlighted, which indicates they were based on estimated, not finalized data from the March budgets.

Pages five and six reflect the projected numbers for Fiscal Year 2012. With no ARRA dollars to be considered, there is an aggregate negative fund balance of \$2 million. By the end of SFY 2012, 43 counties are projected to have negative fund balances and the total of those negative fund balances is projected to be \$20.4 million. Robyn clarified that counties can only spend what they have available in revenues; they cannot spend more than that. These are accrual numbers, but when counties budget they can only budget for what they have on a cash accounting basis, which means there are already cuts that will have to be made to some of these figures.

A second two-page handout shows an overview of the actual dollars expended for mental health and developmental disability services from SFY 2008 through projections for SFY 2013. The maximum allowed county property tax dollars in SFY 2008 were \$125,781,915, meaning that was the maximum amount on aggregate that counties could levy. Once all other sources of funds were added in, the total of county, state, and Social Services Block Grant funding totaled \$329.9 million, the aggregate county ending fund balance was \$23.9 million, leaving just under \$306 million actual dollars expended. Robyn explained that because the MHDD fund is a closed fund, it can be determined how much was spent on services by looking at how much was available and how much is left. She noted that in SFY 2009 the Palo Energy Replacement Tax came into play and as a result the maximum allowed property tax dollars went down by \$627,414. That is because the Palo money was set up to be a dollar for dollar reduction in property taxes and does not increase the amount available to counties. For SFY, the actual dollars expended totals \$288.3 million.

SFY 2010 was the high-point in ARRA funding and the total actual dollars expended were \$284.4 million. For SFY 2011, the projected total spending is \$313.8 million. This is the point where the projected fund balances from the first set of spreadsheets become important in trying to determine the projected expenditures. The projected amount for SFY 2012 is \$330.8 million and for SFY 2013 it is \$292.8 million. Also note that in SFY 2010 there were reductions in property tax relief, allowed growth, and community services totaling \$24.5 million as a result of temporary ARRA federal funds that allowed the state to reduce funding without harming the counties during that time period.

The second page of the spreadsheet gets into Medicaid expenditures. In SFY 2008, the counties were billed \$153.5 million for the non-federal share of Medicaid services for which they were responsible. Those services include ICF/MR (Intermediate Care Facility for Persons with Mental Retardation), HCBS (Home and Community Based) Waiver Services, ARO (Adult Rehabilitation Option), and half the cost of TCM (Targeted

Case Management) for persons with (MR) intellectual disabilities who have legal settlement in Iowa. In addition, counties were billed \$19 million for State Resource Center expenditures for people with legal settlement. The total county share of Medicaid costs billed was \$172.7 million. For SFY 2009 the total county share of Medicaid costs was \$155.8 million. In SFY 2010, with ARRA savings, the total was \$141.6 million.

Using SFY 2010 as a base, in SFY 2011 the phase out of ARRA funding will cost about \$11.3 million and the growth in Medicaid will cost about \$4.1 million, making the total projected Medicaid expenditures for 2011 \$157.5 million.

For SFY 2012, the FMAP (Federal Medical Assistance Percentage) decrease is projected to cost \$6.5 million, the ARRA phase out is projected to cost \$50.5 million, and the growth in Medicaid is projected to cost \$14.4 million, resulting in total Medicaid expenditures by counties of \$214.1 million.

For SFY 2013, the FMAP decrease is projected to cost \$12.2 million, the ARRA phase is projected to cost \$52.5 million, and the growth in Medicaid is projected to cost \$20 million, resulting in total Medicaid expenditures by counties of \$226.7 million.

Following the spreadsheet, note that taking the actual dollars expended less the Medicaid service costs, leaves the money available for non-Medicaid expenditures. That includes commitments, which are mandatory, out-patient services, services to people who are not eligible for Medicaid, and services to Medicaid-eligible people that Medicaid does not cover. Some of the non-Medicaid services are mandated by State law and some are not.

For SFY 2008, the non-Medicaid expenditures were \$133.3 million, for SFY 2009 they were \$132.5 million, and for SFY 2010 they were \$142.7 million. For SFY 2011 they are projected to be \$156.5 million and starting in SFY 2012 the amount of money available for non-Medicaid services shrinks dramatically to \$116.6 million, with a projected amount of only \$66.1 million for SFY 2013. By that time there may not be enough to cover the mandated non-Medicaid services.

Craig Wood commented that the Senate version retains people at the local level, within the regions, to help people access and coordinate services and he sees that as an important part of the system. He noted, however, that the presentation Robyn and Julie just completed indicates that it really doesn't matter who is managing the system if there is simply not enough money in it to support the need. He also noted that looking at the numbers, the county fund balances are all related to the enhanced FMAP, which everyone knew was going to come and go and it is important to note that fund balances do not reflect money that is being put away by counties, but money that will be needed and spent in a short amount of time.

Robyn Wilson explained that the ARRA savings came in retroactive to October of 2008, but counties did not know how much their savings would be until after they had certified

their SFY 2010 budgets and had been expending money in SFY 2009. They got an unexpected savings in SFY 2009 and SFY 2010, but no opportunity to budget or plan for it. The only time they were able to plan for the savings was for SFY 2011. Jan Heikes commented that from a management point of view, it does not make sense to increase services for a year and then be forced to reduce them or take services away from consumers; counties made an effort to use the money well to do what is right for consumers, but spending one-time money to do that is challenging.

Robyn Wilson noted that for small counties, costs can increase dramatically in a single year if they have more than one high-cost young adult entering the system and those counties really have no means of managing the increase. They can go to the Risk Pool for additional funds, but they will continue to have those people to fund every year and often have no ability to access additional funding through property taxes.

Children's Mental Health Awareness Week – Laura Larkin announced that the Governor will be signing a proclamation for Children's Mental Health Awareness Week next Thursday, April 28 at 1:30 pm at the Capitol. Laura shared a handout outlining a collaborative effort by the Iowa Department of Public Health, the Iowa Federation of Families for Children's Mental Health, DHS, and other providers to sponsor activities and events across the State that promote children's mental health awareness. Project Launch, a project of the Iowa Department of Public Health focused on the healthy mental and social development of children from birth through age eight is also sponsoring a series of webinars that are listed in the handout.

Olmstead – Theresa Armstrong handed out an April update on Olmstead Plan activities and explained that regular monthly or bi-monthly updates will be made available on the plan website at lowaMHDSplan.org.

MENTAL HEALTH INSTITUTE (MHI) SUPERINTENDENTS

Jeanne Nesbit asked the MHI superintendents to meet the Commission, talk about their facilities, and how they are involved with their communities and their colleagues at the community mental health centers. Ron Mullen is superintendent at Mt. Pleasant and also oversees corrections on that campus. Dr. Bhasker Dave is superintendent of the Independence MHI, and Jason Smith is superintendent of the Cherokee MHI. Mark Lund, superintendent of the Clarinda MHI, was unable to attend.

Dr. Bhasker Dave, Independence MHI – Dr. Dave spoke about Iowa's long history of providing care for people with serious mental illness. Treatment for people with serious mental illness began in the mid-19th century, when a Pennsylvania psychiatrist named Thomas Kirkbride developed a treatment approach and an architectural model for hospitals known as the Kirkbride model. All four of Iowa's MHIs were Kirkbride buildings. As Iowa's population grew and each one filled up, another was added. The first was built in Mt. Pleasant in 1861, the second in Independence in 1873, the third in Clarinda in 1888, and the fourth in Cherokee in 1902. Each main building was similarly built on a large campus. At the time the plans called for building the hospitals in rural

areas outside cities and over the years, population centers grew closer. The hospitals each featured a central core of four or five stories for housing administrative offices and staff, with wings going out on both sides to house the patients. As the central buildings were filled up, other buildings were built on the campuses. Initially the treatment was essentially humane care, including providing shelter, food, leisure activities, and work opportunities, but any real treatment for serious mental illness was very limited.

In the 1930s two Italian physicians found that patients who experienced seizures showed improvement in their symptoms of psychosis and developed a hypothesis of inducing seizures to treat mental illness that evolved into the treatment first introduced in 1939 and now known as ECT or Electroconvulsive Therapy. Then, in the early 1950s, the use of transcranial lobotomies became popular. The treatment did improve behaviors but also significantly dulled emotions, so proved not to be a very successful treatment method. The introduction of the first wave of antipsychotic drugs, which began in 1952 with Thorazine was the first significant step in improving the lives of people with serious mental illness. Up to that point, once people were admitted to a hospital, they usually stayed there for a long time. The average length of stay was seven years. With the introduction of effective medications, people improved enough to leave the hospital in a much shorter time and that started the move toward deinstitutionalization.

In the late 1940s and early 1950s, there were 1800 patients on the campus at Independence. By the mid-1960s, that number dropped to 350 and slower reductions followed. At that time, Iowa had a system of county homes where many of the people could go and live in a structured residential setting if they did not return to their own homes or family homes. That system helped Iowa avoid having large numbers of homeless people with serious mental illness, which became an issue in some other states. Until the 1990-91 economic recession, which led to statewide budget cuts, censuses on all four campuses remained about the same. As a result, the specialized substance abuse programs at Cherokee, Independence, and Clarinda were closed and consolidated at Mt. Pleasant. The specialized psycho-geriatric programs at Mt. Pleasant, Independence, and Cherokee were closed and consolidated at Clarinda. Independence went from 240 beds to 170 and that number was maintained until the recession of 2000-2001. At that time, statewide budget cuts resulted in the loss of 40% of the MHI beds. Independence dropped from 170 beds to 95.

Budget cuts associated with the current recession that began in 2008 have led to staff reductions at Independence from 288 staff to 235 and that also means a reduction in capacity. Until the 2000-2001 reductions, patients could readily be admitted with a commitment order or CPC approval. Since those reductions there has been a waiting list for admission. People often wait for admission at a community based hospital or a care facility of some sort. The patients who come to the MHI are generally the ones who have not improved in a 5 to 7 day hospital stay and who are difficult to manage.

Person-centered discharge planning starts with first client contact at the MHI. For the last fiscal year, there were 254 discharges and only 16 had stayed longer than six

months. The median length of stay is about 48 days. The MHIs are a provider of last resort and serve as a safety net for patients who cannot be safely served in the community with the capacity currently available. They work with community providers to transition even those people with the most challenging behaviors back to community settings.

The Independence MHI serves adults in 28 counties in north east Iowa and children in 43 counties in eastern Iowa, with the Cherokee MHI serving children in the western counties. If, however, there is a patient in another part of the state who needs a bed and the closer MHIs are filled, any MHI may accept that patient, so there is overlap in the areas served.

Ron Mullen, Mt. Pleasant MHI - The Mt. Pleasant campus, as well as the Clarinda campus, is shared with the Department of Corrections (DOC). Ron is the superintendent of the MHI as well as overseeing the operation of the correctional facility; his position is shared, which means he is employed by both DHS and DOC. The correctional facility now occupies the buildings that were originally the MHI and the MHI occupies a corner of the campus – about 76,000 square feet.

Mt. Pleasant MHI is preparing for its 150th anniversary; the first patient was admitted in February of 1861. The original Kirkbride building was damaged by more than one fire over the years and developed structural problems, so the main building was rebuilt about 1960. There are about 1000 men in the medium custody correctional facility and there are about 100 women in a special needs prison unit that adjoins the MHI. The MHI currently has 9 adult psychiatric beds, down this year from 14, and a dual diagnosis program, which simultaneously treats mental health issues and substance abuse. The dual diagnosis program has recently increased from 15 to 19 beds because it is in high demand and has a waiting list.

Mt. Pleasant also has a substance abuse program, the Iowa Residential Treatment Center (IRTC), currently with 45 beds, down from 50 at the beginning of the year. Total admissions for SFY 2010 were 807. There were 805 total admissions in SFY 2009. The MHI has 83 staff and 14 staff that are shared with DOC. The shared positions include administration, dietary, and grounds maintenance. Ron said they are working hard to maintain the beds they have been embarking on a lot of training programs since they have many new staff hired after the early retirement program last year.

Jason Smith, Cherokee MHI – Jason has been in the role of superintendent for about four months. The Cherokee MHI opened in August of 1902, taking patients from the Independence and Clarinda facilities. Cherokee is a good example of the Kirkbride architecture that has been well maintained. At the beginning of the 1960s, Cherokee had over 1000 beds and by the end of the decade was down to a little over 300 beds. In the mid-1950s, Cherokee established a psychiatric residency program. From the 1960s through the 1980s, 191 psychiatrists completed the residency program. They currently employ a part-time psychiatrist who graduated from that program about 20 years ago. During the late 1990s, a PA (Physician Assistant) fellowship program was

developed. About 15 people have completed that program and there are currently two participants. Program graduates help to expand the pool of professionals working in Iowa.

The number of child and adolescent beds has recently been reduced to six, serving the western half of the State. Jason noted that it is not unusual for the MHIs to have one or more individuals who require one-on-one care and observation around the clock to maintain their safety. That need is very staff intensive and it is difficult to find out-placements that can support that level of need. They focus on utilizing their existing talent at the MHIs and the State Resource Centers for planning and achieving placements outside the facility.

Laurel Phipps asked why the facilities run at less than capacity when there is a high demand for services. Jeanne Nesbit responded that beds are empty because they are not funded. There are plenty of buildings and facilities available, but the budget often does not allow for the staff and other support that is needed for them to be used. In response to a follow-up question, Jeanne noted that all of the facilities are licensed as hospitals.

Dr. Dave explained that in 1955 there were 560,000 state hospital beds in the United States at a time when the U.S. population was 165 million. Today there are fewer than 50,000 beds nationwide for a population of 300 million. That means the number of per capita beds have dropped from 340 per 100,000 to a national average of 17 per 100,000. The most recent data from 2005 showed that Iowa ranks 47th in the number of public sector beds available in the State. At that time Iowa had 8.1 beds per 100,000. Today if all beds were fully funded, Iowa would be at 5.8 beds per 100,000 and that number is going to be further reduced.

There is a greater demand than the beds available and that is why there are waiting lists. Also the number of patients who can be served at any given time depends on the number of staff available to serve them. That is necessary for the safety of the patients and the staff and according to regulatory standards. For example, Dr. Dave said, Independence has had two wards for children - a children's ward for ages up to 14 and an adolescent ward for ages 14 to 18, and each must have an RN (Registered Nurse) available for each shift. With the staff reductions over the last two years, there are not always enough nurses available to cover both wards for all shifts, so the wards have to be merged. Ron Mullin explained that the needs of individual patients may also impact bed capacity. When there are patients who need one-on-one staffing around the clock, other beds may have to remain unfilled to allow staff resources to be committed to those patients with the high intensity need for supervision.

Craig Wood asked what can be done to attract psychiatrists to practice in Iowa. Dr. Dave responded that there is a national shortage of psychiatrists, but Iowa also ranks 47th in the number of psychiatrists, with only 5.6 per 100,000 people. He explained there may be several reasons in addition to the national shortage. The payment system for medicine depends on something called Relative Value Units or RVU, which are

calculated nationally can be detrimental to certain medical specialties, such as psychiatry, family practice, and internal medicine. Compared to other specialties, their RVU is small, and their reimbursement from Medicare and Medicaid is much less. That makes it difficult to recruit medical students to those specialty areas and each year available residency slots may go unfilled. At one time there were programs in Independence, Cherokee, and Iowa City. Now the only psychiatric residency program in Iowa is in Iowa City with about eight graduates each year, and at least half of those leave the State after graduation; few of the others stay in Iowa longer than two years. Also, in Iowa the psychiatrists are centered in a few urban areas. There are about 70 psychiatrists in Iowa City, 40 in Des Moines, and about 20 in Cedar Rapids. Sixty-two Iowa counties have no psychiatrists. When a psychiatrist retires or leaves a community mental health center in many areas of the state it is very difficult to find a replacement. Psychiatric services in Iowa are reimbursed at an even lower rate than some surrounding states.

Telepsychiatry can be useful, but there are problems because one psychiatrist can still only serve a limited number of people and there also needs to be trained staff people on site, with the patient, who are prepared to manage a crisis or assist with the patient's immediate needs. Reimbursement for telepsychiatry is less as well.

Craig Wood asked Ron Mullen what he thought about developing a forensic mental health facility. Ron responded that it would be a good idea. He said telepsychiatry is used in the corrections system, where many of the prisoners are manageable with medication and have supervisory staff present. The most difficult to manage individuals are housed in a hospital-type setting at Oakdale.

Richard Heitmann commented that over the years he has had various positive experiences with the facilities at Mt. Pleasant, Independence, and Clarinda and he recognizes that the MHIs and correctional facilities are serving an important need.

PLANNING CALENDAR

Next month will be the May retreat. The Commission will meet jointly with the Mental Health Planning Council on Wednesday, May 18 and will also meet on Thursday, May 19. The agenda is still being developed and a Commission dinner will be planned for Wednesday evening. The four newly-appointed members will be joining the Commission in May.

NOMINATIONS COMMITTEE REPORT

Jan Heikes and Lynn Crannell served as an ad hoc nominations committee. Jan Heikes reported that they are nominating Jack Willey to serve another term as Commission Chair and Craig Wood to serve another term as Vice-Chair. The annual election of officers will be held at the May meeting.

COMMISSION MEMBER RECOGNITION

Jack Willey presented Certificates of Appreciation to Julie Fidler Dixon, Rick Hecht, and Pat Penning, whose terms of service end April 31. Jack and the other Commission members recognized the contributions they have made to the Commission during their terms and expressed their thanks.

PUBLIC COMMENT

Jan Heikes shared greetings from Jerry Mayes, who asked her to report that he is in the process of moving to Des Moines and hopes to see everyone at subsequent meetings. She also announced that the Community Circle of Care project won its Facebook contest by two votes and they will be awarded \$5000 to continue their Mental Health First Aid Training efforts in northeast Iowa.

JUNE MEETING

Jack Willey shared that a suggestion was made to hold the June meeting at the Center for Disabilities and Development in Iowa City. Bob Bacon said that CDD would be happy to host the meeting and talk about the history and role of CDD, as well as the projects they work on in partnership with MHDS, the Iowa Department of Public Health, the Department on Aging, and others. He said he would welcome suggestions from the Commission members on how to make it a valuable and productive experience for them. It was also suggested that it might be a good time to focus on developmental disability issues, including Money Follows the Person, employment, disability and health, and the College of Direct Support. Clinical professionals could be invited to share information on best practices. Craig Wood said he would like to hear about people with intellectual disabilities who may be served at MHIs and how people with challenging behaviors are being served. The Commission agreed by consensus to meet at CDD in June.

Dale Todd commented that he was experiencing some difficulty in changing HCBS Waivers for his son. Jan Heikes noted that she believes DHS workers are doing their best, but that the recent staff cut backs have made getting those types of things that require paperwork to be processed more difficult for everyone and that legislators should know that the DHS staff cuts have had a real impact on people in the community.

Jack Willey commented that he is frustrated that recommendations by the Commission and others seem to be ignored by legislators. They say they have the money to take over funding the entire system, yet they say they do not have the money to fund allowable growth. Craig Wood commented that they have talked about replacing the money counties are now providing, but that doesn't do anything to meet the needs that are currently unmet or to allow growth. Dale Todd commented that the Commission needs to make sure they get their message to the legislators.

Bob Bacon commented that Representative Dave Heaton is a real champion for the workforce shortage issue. He secured funding for the physician extender program at Iowa City and has some creative ideas like tuition forgiveness programs for physicians who would choose to stay and practice in Iowa.

The meeting was adjourned at 12:10 p.m.

ON WITH LIFE TOUR AND PRESENTATION

The Commission toured the On With Life facility in Ankeny from 1:00 pm to 3:00 pm and heard a presentation on traumatic brain injury and brain injury rehabilitation.

Minutes respectfully submitted by Connie B. Fanselow.