The Iowa County

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Mental Health and Disability Services in Iowa

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FEATURE - MH/DS in Iowa

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Iowa State Association of Counties

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To promote effective and responsible county government for the people of Iowa.

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Feature - Vision for Iowa MH/DS

A Vision for Iowa's Mental Health and Disability System

I am so pleased to see that we are finally having a badly-needed serious discussion of Iowa's mental health and disability services (MH/DS) system. Iowan's with mental illness should experience recovery and live safe, healthy, successful lives in their homes and communities. Sadly, some people have promoted the stereotype that mental illness only includes people experiencing serious acute symptoms that may require hospital treatment or those suffering from mild depression that might require mild outpatient treatment – nothing in between. The truth is that mental illness encompasses a wide range of complex conditions requiring a full array of treatment modalities.

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Community-based options (including the provision of supports to allow people to stay in their own homes) are recognized as the more appropriate and more successful approach to serving individuals with serious mental illness, as opposed to the large-scale use of institutions. The closure of two state mental health institutions in Iowa was not the problem and reopening those institutions is not the solution. While Iowa is among the bottom of states for state-owned inpatient psychiatric beds per capita, a national report shows Iowa's per capita number of inpatient psychiatric hospital beds in community hospitals per capita is at about the national average. In fact, we have more inpatient psychiatric beds today than we did just two years ago, and more are in development. But focusing on inpatient beds misses the mark. Too many inpatient beds are filled because we need to increase the availability of crisis, subacute, intensive outpatient, and intensive residential services. We also need to address the acuity mix of the beds we already have. Furthermore, Iowa needs a more robust system for co-occurring needs (involving the combination of substance abuse and mental illness).

We have made significant progress in developing and modernizing Iowa's MH/DS system. Iowa is ranked seventh in the nation for its mental health services in the 2017 report by Mental Health in America (moving up six spots from the previous year). One hundred and fifty-thousand more Iowans have mental health coverage through the Iowa Health and Wellness Plan. Since 2013, state and local governments in Iowa have invested about $2 Billion in MH/DS. That investment includes the expansion of more community-based services such as jail diversion programs and 24-hour crisis services along with a $4 million state investment in three new psychiatric medical residency programs. Iowa has also expanded the number of Assertive Community Treatment Teams, which provide individuals with a serious and persistent mental illness access to a team of mental health professionals 24 hours a day, seven days a week, and 365 days a year.

In addition, we continue to innovate, and that means having a vision for providing the full array of services needed by individuals with complex service needs. A Complex Service Needs Workgroup, consisting of experts, advocates and families recently completed a detailed report with recommendations for Iowa's MH/DS system to address the full array of services needed for our citizens. Another workgroup is currently working to design a comprehensive children's MH/DS system. The Complex Service Needs Workgroup Report will serve as a roadmap and vision statement for the development of a robust MH/DS system for Iowa, and this roadmap forms the framework for a bill sponsored by Senator Jeff Edler currently pending before the Iowa Legislature. This article will explain the vision for Iowa's MH/DS System created by the Complex Service Needs Workgroup Report and incorporated into Senator Edler's bill. This vision will make our system truly 21st century and will set us apart from other states.

The overriding principle of this vision is that the combined portions of the array of services recommended are a package since each of the services included are necessary to the success of the entire system. Also, the vision requires Iowa providers to deliver intensive services on a no-eject, no-reject basis. The principles also require the MH/DS Regions, the Managed Care Organizations (MCOs), and the Department of Human Services (DHS) to work together to fully implement and fund the system. Under the new system, the MH/DS Regions will include the following services as "core services": access centers; assertive community treatment; comprehensive crisis and sub-acute services; and intensive residential service homes. DHS will be required to establish a single set of provider qualifications and access standards. The plan also allows and encourages MH/DS Regions to strategically locate and share these intensive, specialized services.

In order to implement this vision, the following services will be developed and implemented in strategic locations throughout Iowa: Six Access Centers; 11 additional Assertive Community Treatment Teams; a full array of mental health crisis response and sub-acute residential services; Intensive Residential Service Homes serving a minimum of 120 individuals; and Tertiary Care Psychiatric Hospitals. Together, these services will provide a full array of necessary options for Iowans who experience mental health challenges. Each of these will be discussed separately.

Access Centers are short-term crisis and subacute residential services for individuals that have a serious mental health and/or substance use disorder that are medically stable, do not need inpatient psychiatric hospital level of care, and do not have alternative, safe, effective services immediately available to them. These Access Centers will have substance use disorder treatment or immediate access to withdrawal management services, will include care coordination, navigation, warm handoffs and linkages to needed services (housing, employment, shelters, etc.), and will accept court orders for mental health or substance use disorder treatment. The statutory limit of 75 publicly funded sub-acute beds will be eliminated.

Assertive Community Treatment (ACT) services provide team-based intensive, individualized, flexible treatment and supports to individuals with mental illness in their home and community. The ACT team includes psychiatry, social work, nursing, substance use disorder treatment, and vocational rehabilitation. Iowa has 10 ACT programs currently operating and one under development. The workgroup has determined that Iowa should have 11 more teams strategically located throughout the state.

Under the vision, MH/DS Regions will be required to develop, implement, and maintain the full array of crisis services as core services in strategic areas throughout Iowa. A single statewide 24- hour crisis line will be included in the full array of crisis services.

Intensive Residential Service Homes provide intensive, coordinated, residential supported community living services for individuals with the most intensive serious and persistent mental illness. These homes will be required to: have adequate staffing and compensation for staff; have access to substance use disorder services; coordinate clinical and residential services; have access to ACT services when appropriate; accept court ordered commitments; have a high tolerance for serious behavioral issues; and not eject or reject individuals referred to them based on the severity of the individuals' mental health and/or co-occurring needs.

Tertiary Care Psychiatric Hospitals treat individuals other mental health providers find too difficult or too dangerous to treat. These hospitals ensure seamless and successful integration back into the community by having strong linkages with the rest of the array of MH/DS including access centers. Under the plan, the Cherokee Mental Health Institute and the Independence Mental Health Institute (both operated by DHS) will be two of the designated tertiary hospitals. DHS and community hospitals with inpatient psychiatric programs will work together to identify additional tertiary care psychiatric hospitals.

Iowa's MH/DS system is better than most states, but it is not near where we want it to be. Iowans expect us to reach higher and to be more than just "competitive" with other states. We expect our state to be the best we can be. All of us want to create the kind of mental health service system of which all Iowans can be proud. I am confident that the implementation of the vision created by the Complex Service Needs Workgroup and incorporated into the bill offered by Senator Edler will begin the process of transforming Iowa's MH/DS system into one that treats our most vulnerable citizens in a way that meets their needs and gives them the most productive and successful lives possible.

While the full benefit of the transformation may take several years, I believe that Iowans will begin to see the impact of this change almost immediately. There is a synergy going on right now in Iowa concerning our mental health services system. Professionals, advocates, families and others can feel the wave of change that is occurring. Recognition of the need to address mental health issues was just the first step. After years of advocating for reform, many of us are confident that we are finally on the verge of creating the necessary transformation of our system because we have created the vision or roadmap for success. Now, the real work begins as Iowans "roll up their sleeves" to create a system offering a comprehensive array of services required to successfully serve Iowans who struggle with mental health issues.

Feature - Residential Access Centers

Residential Access Centers
"Are you crazy?" "You must be smoking something."

These are the speech balloons I saw above the heads of a group of mental health/substance abuse professionals the first time I suggested that there should be a place to take individuals that are having a mental health or substance abuse crisis meeting the following criteria:

1. Is open 24 hours a day and cannot reject the patient;
2. Is within 90 minutes of any Sheriff's Office;
3. Is only an emergency facility and should not hold someone for more than 72 hours; and
4. Has the appropriate staff on-site to handle any situation that may arise, such as a psychiatrist or psychologist, substance abuse counselors, security, and the appropriate support staff.

When these ideas were discussed with some of my colleagues that are sheriffs or deputies, we were focusing on what would help both the patient and our staff, such as getting people in crisis to the right place to receive the help they need without the patient and our staff sitting in an ER for days just to be told we now needed to drive across the state for bed placement. This criteria made sense to us, but it wasn't common practice in our state, especially in rural environments. As I researched other states, I found this concept wasn't something brand new, and in fact, other states were moving in this direction already.

Jason Sandholdt
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Marion County has a population of around 33,000 people, and I believe that puts it in the top 25% of counties in Iowa for population. The manpower it takes to guard a subject in a mental health crisis, at a local ER for sometimes four or five days, is not only expensive, but exhausting. We then pay a deputy or transport officer to drive almost 500 miles (round trip) for a bed in Sioux City or Cherokee from Knoxville, Iowa. To compound the issue, some individuals are released almost immediately, and we are left to have contact with them once again as soon as they get back to Marion County. Where they will likely pick up charges, be incarcerated, and pose a threat to staff, other inmates, and themselves in the county jail. At that point lies the question, why take them back to the hospital because we already know the person was released due to the lack of proper care for them in our state?

This is our reality and an example of what we have to deal with sometimes daily. How do the small counties in Iowa, that only have a staff of four or five deputies or no hospital in their county, handle these types of situations?

Then came our big break! The 2017 Iowa Legislature mandated that the mental health and disability services (MH/DS) regions work in their respective regions with various stakeholder groups and that the Department of Human Services should also convene a stakeholder work group to make recommendations relating to the delivery of, access to, and coordination and continuity of mental health, disability, and substance use disorder services and supports for individuals with mental health, disability, and substance use disorder needs, particularly for individuals with complex mental health, disability, and substance use disorder needs. The work group should come up with its own ideas while incorporating those of the MH/DS regions. Sheriff Tony Thompson from Black Hawk County and I were asked to join the work group to represent law enforcement.

Going into the first meeting I wasn't sure what to expect. I had my ideas and own priorities but would those coincide with representatives from mental health centers, NAMI, hospitals, the judicial system, family members, MH/DS regions, IDPH, and DHS. What actually happened over this past year of meetings was

Continues on page 11.

Feature - Children's MH/DS

Children's MH/DS

Children's health, especially mental health, is an area of increasing concern, not only across the state of Iowa, but across this nation. Today's children and adolescents are exposed to new challenges that no other generations have faced. There is more pressure than ever to learn an ever-expanding knowledge base in order to be successful in today's world. Medicine has allowed children who previously would have died from premature births, childhood cancers, congenital heart disease, or other medical issues, to live and prosper, but sometimes with the added challenges of physical disabilities, mental health issues, intellectual challenges, and the need for lifetime medications/services. Technology has provided great advances in accessing knowledge, but the significant amount of time devoted to social media and video games has resulted in increasing numbers of young individuals with depression. Questions about the safety of the schools because of mass shootings have contributed to increased anxiety among children as young as preschoolers. The increasing number of families with a family member who struggles with substance use, including opioids, has created environments in which children are increasingly exposed to adverse childhood events. These adverse childhood experiences, commonly referred to as ACEs[1], contribute to significantly higher rates of physical and mental health problems in later life.

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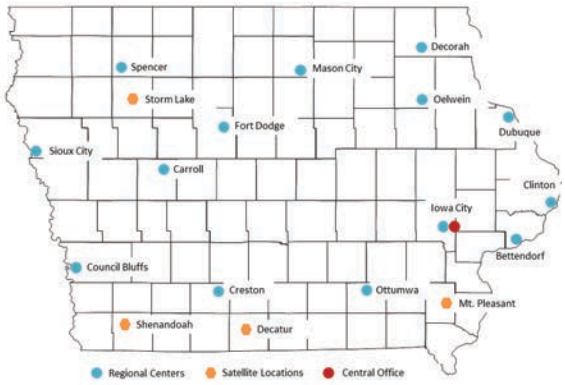
Children and adolescents with disabilities or special needs, including chronic medical conditions, physical disabilities, and mental health issues, make up an increasing percentage of the population. According to Iowa data from 2015 that was published in July 2017 in Iowans with Disability: 2017[2], there are 31,589 children under the age of 18 who have disabilities. This represents 4.3% of all Iowa children and adolescents.

Parent-reported information from the 2011-12 National Survey of Children's Health[3] showed that in the two to eight year-old population, one in seven children had a diagnosed mental, behavioral, or developmental disorder. At any time, 20% of all adolescents have a psychiatric diagnosis, and roughly 50% of these adolescents will suffer from mental illness at some time during their lifetimes. Most disturbing is the loss of the joys of childhood and the loss of life that can result from untreated physical and mental health problems. While rates of suicide in youth are decreasing in urban populations, recent data shows that rural youth are attempting and successfully completing suicide at a higher rate than other populations.

Working with these individuals is a rewarding and challenging career choice. The physicians, nurse practitioners, teachers, social workers, therapists, family support professionals, and care coordinators who encounter this population recognize how diverse their needs are. The state and the University of Iowa, as well as many other organizations, are constantly looking for ways to treat problems at an early age and prevent later, more complex issues from developing.

Child Health Specialty Clinics, a division of University of Iowa Hospitals and Clinics (UIHC) Pediatric Division of Child and Community Health, represents 14 regional clinics and four satellite clinics across the state of Iowa dedicated to serving children and youth 0-21 years old who have been identified as having special needs (see map). Last year, Child Health Specialty Clinics worked with 7,397 patients, either through clinical services, family engagement, or care coordination.



Each Child Health Specialty Clinic functions as an independent unit that also collaborates with the organization as a whole to reach overriding goals. For most clinics, there is a nurse practitioner, nurse, family navigator, and secretary as part of the staff. Several clinics also have social workers who are part of the Pediatric Integrated Home Health program. The nurse practitioners specialize in developmental pediatric issues and/or psychiatric health issues. Each of the family navigators has a child of his/her own with special needs and can help families traverse

Feature - Children's MH/DS

the medical, educational, social, and community organizations that are dedicated to serving children and youth with special needs, such as helping a family determine the need for a 504 Plan versus an IEP (Individualized Education Plan).

Inset below is a story from one patient whose family has been utilizing a variety of services over the past few years. Her progress is a joy not only for her family, but also for the different providers who have worked with her to ensure that her life is as complete as can be and to provide the family with necessary support through all the challenges.

Madison's Story

Original story first published in 2015 Year In Review

Our youngest daughter, Madison, was born with a partial trisomy 13 chromosome which has led to multiple health needs. Being able to utilize telehealth at our local CHSC regional center helps me to provide a more normal life for my other children and eliminate hours of travel to appointments from our home in Ottumwa. One of Maddie's main complications is feeding, and she is currently 100% G-tube fed. We get support both from the Ottumwa staff and from our Bettendorf-based dietitian through telehealth. Now when we have an appointment, I can take my other children to their grandparents' house and meet with multiple providers at the same time. Our family is thankful for the amazing support that has been provided by CHSC locally and via telehealth.

Update for 2017 Year In Review

Maddie is doing amazing! She has gone almost two years without her G-tube, her eyesight has improved, and she just became a big sister. Maddie's schedule is still very busy with doctor visits and therapy appointments, but she has been able to add a few new experiences to her daily activities. She goes to preschool in the mornings and has some of the highest marks in her class. She just performed in her first dance recital and also enjoys bowling, playing air hockey, and "playing restaurant" at home where she says, "Hi! What would you like?"

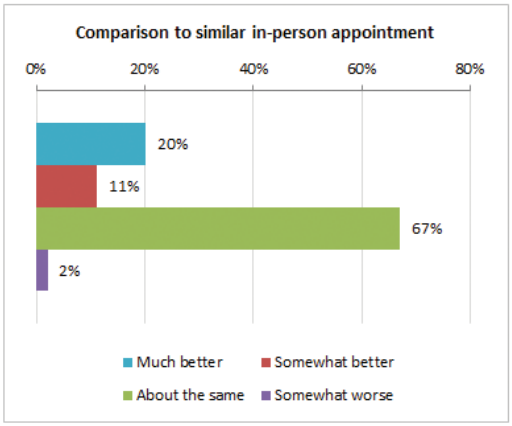
One thing that has remained consistent in Maddie's life has been the support of the CHSC. Not only did they help us switch Maddie to an enthusiastic oral eater, they continue to provide guidance for our family is so many other areas. Whenever I have a question, they are my first call, whether I'm looking for a medical supply company, have questions about behavioral issues, or need to get Maddie the extra support she needs in school. They are always there to not only point us in the right direction, but they join with our family and walk the road with us.

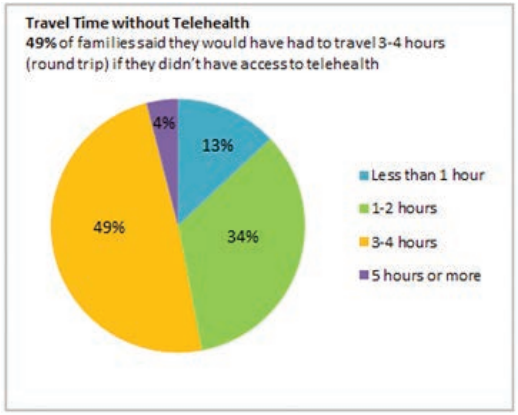
Funding for the Child Health Specialty Clinics has come through the Maternal and Child Health Services Block Grant, also known as Title V of the Social Security Act, which has operated as a Federal-State partnership since 1935. Additional funding is provided by the Iowa Legislature, UIHC, and various grants. As part of the Federal-State partnership, for every $4 of federal funding, states must provide at least $3 in state or local matching funds. In Iowa, the Title V program for Children and Youth with Special Health Care Needs is administered by the DCCH (Division of Child and Behavioral Health). Child Health Specialty Clinics collaborate with a variety of state organizations in making referrals, accepting referrals, and working with families directly.

These organizations include the Early ACCESS program through the Iowa Department of Education, which serves children from 0-3 years old who have been identified as at risk. The 1st Five Healthy Mental Development Initiative program through Iowa Department of Public Health, works with care coordinators across the state to help primary care providers identify services appropriate for families with special needs. The Regional Autism Assistance Program, previously funded through the Iowa Department of Public Health, has family navigators specifically designed to help families whose child/youth has a diagnosis of autism spectrum disorder.

Telemedicine has also provided Child Health Specialty Clinics with another way of addressing the need for specialized care. In a predominantly rural state, such as Iowa, there is a significant lack of pediatric specialists available in many counties. As a result, CHSC has been using telemedicine for the past seven to eight years to reach the families with need in their own communities. Currently, CHSC telemedicine services include child psychiatry, developmental pediatrics, genetics, neonatology, pediatric neurology, nutrition, and psychology. A new type of collaboration was recently started with the University of Iowa Department of Psychiatry in which the CHSC offices in Sioux City, along with some support staff, are working to provide adult psychiatric appointments to individuals with intellectual disabilities who are living in group homes, thus saving these adult patients 10 hours in transportation time and providing more consistent care. Future plans include general pediatrics, pediatric endocrinology, and LGBTQ clinics.

Results from a survey of 267 families who had utilized telemedicine services through CHSC over the past year demonstrated that 98% of families view the telemedicine appointments as about the same or better than in-person appointments. Probably the most rewarding statistic is that amount of time, money, and convenience provided to families. Travel for 49% of families saved three to four hours by using a local clinic providing telemedicine services for specialty care. Another 34% of families saved one to two hours. Working with legislators to ensure that this type of service is available for families is another way in which CHSC tries to provide gap-filling services throughout the state of Iowa.





Additional services provided through Child Health Specialty Clinics include an annual educational conference located in different quadrants of the state, monthly educational webinars, and consultation services in child psychiatry for primary care providers. The annual conference entitled Critical Conversations: Child Development and Mental Health Conference was started in 2016 in Iowa City. The conference is a collaborative effort between the CHSC CYC-I program and 1st Five. Last year, the conference was held in Carroll, and it will be held this year in Cedar Falls on May 11, 2018. The purpose of the conference is to provide primary care providers with educational lectures that cover a variety of issues that impact children and families throughout the birth to adulthood period. The Critical Conversations Conference for 2019 is scheduled to be in the southwestern part of the state. In conjunction with the annual conference, there are monthly educational webinars for primary care providers and care coordinators that are also co-sponsored by the CHSC CYC-I program and 1st Five. CYC-I (Children and Youth Consultation Service in Iowa), the program that provides the opportunity to speak with a child psychiatrist about patients in the medical home who are dealing with mental health issues, is available not only to primary care providers but also 1st Five care coordinators.

For any additional information or questions, please contact Susan Pike, MD, at UIHC Child Health Specialty Clinics, susan-pike@uiowa.edu.

Bibliography included on page 18.

Feature - MH/DS Regions

Mental Health and Disabilities Regions

The regional system of care for mental health and disability services (MH/DS) is funded by Iowa counties. The employees who work in the system are Iowa county public servants. The services they fund help Iowa county residents. These services are structured with the idea of dignity and respect for the people who need the service.

MH/DS regions were developed at the direction of the Iowa Legislature as per SF 2315 and went into effect on July 1, 2013. All regions were formed under Iowa Code Chapter 28E in compliance with Iowa Code §331.390 and went live by July 1, 2014.

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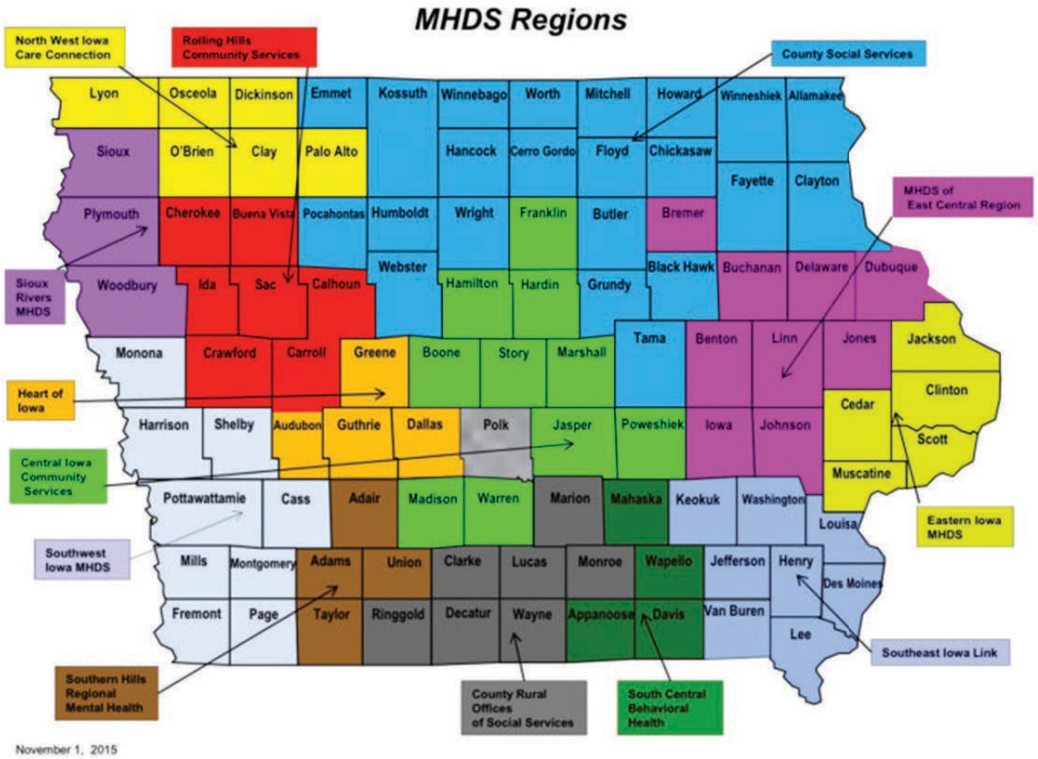
The Governing structure of regions include, at a minimum, representation from each member county an assigned board of supervisor (voting member) and ex-officio members to include a provider representative and an individual that utilizes services or relative of such an individual. Additionally, each region has an advisory board consisting of individuals that utilize service and/or relatives of such an individual, service providers, and governing board member(s). The advisory board performs the function of informing the Governing Board of issues pertaining to the MH/DS system and the individuals we serve.

All funds of an MH/DS region are designated funds and are under the control of the region governing board. Funds can be maintained at the local member county level (Fund 10) and/or the region fiscal agent level (Fund 4150). Revenues are derived primarily from local property tax levies of the county and spending authority is under the control of the region governing board. Fund balances are also under the spending authority of the region governing board but were derived from the previous county based mental health system formulary which consisted of property tax dollar levies, state funds, federal pass thru funds, and/or revenues derived thru consumer purchase/reimbursement of service or resource.

In 2017, SF 504 made changes to the financing of regions. Previously, the cap for county members/regions was their 1995 rates with backfill from the state to increase finances to the $47.28 cap (if needed) or the levy capacity was reduced to the $47.28. Backfill was authorized for one year but then was swept away to facilitate financial resources to the state/Medicaid system. Presently, SF 504 maintained the same cap of $47.28 for all regions but equalized levy capacity within a region but not to exceed the $47.28 cap.



The new region equalized caps were predicated on the July 1, 2017 regional per capita expenditure target amount which is the sum of the base expenditure amount for all counties in the region divided by the population of the region.

The regional per capita expenditure target amount will remain as stated above beginning July 1, 2018 and each subsequent year. Another caveat of SF 504 is the directive to reduce fund balance to either 20% (regions with 100,000 or over population) or 25% (regions with less than 100,000 population) cash flow across fiscal years.

Feature - MH/DS Regions

The penalty to not meet that target threshold is reduction in levy capacity effective July 1, 2021. For full detail please see Iowa Code § 331.391 and/or SF 504.

Counties have had caps put on their ability to levy. These caps were set in 1995 and, sometimes forgotten, were adjusted down for any county that was levying above the statewide average of $47.28 per capita. According to the Legislative Services Agency, the maximum total levy authority in 1996 was over $125 million. Overall, counties can only levy about $114 million to support services for persons with disabilities including mental health concerns. This means that the funding for the regional system of care has been reduced by $11 million below 1995 levels.

In the past, the county system paid for many services including the non-federal share of Medicaid. Due to legislative changes, the state of Iowa now pays for this through Managed Care. The change to privatization of Medicaid has changed what regions pay. At this point, the primary and secondary purpose of regional dollars is system development (creating services) and funding non-Medicaid services, such as some residential and vocational services. Due to this, some decision makers believe that regions have been removed from funding Medicaid services. However, this is not the case.

Regions are still required to fund services to anyone below 150% of the federal poverty level without any fees. In contrast, the state Medicaid expansion only covers people up to 133% of the federal poverty level. Also, many regions pay for services for individuals on the waiting lists for waiver services and have historically paid for the time it takes a person to be determined eligible for Habilitation funding. These waiting lists have been years long. Finally, regions have continued to pay for crisis services that would be payable by Medicaid. These services are just waiting for codes to be developed to allow for billing. This also, has been ongoing for years.

There is often a misunderstanding that, since Iowa has closed two of the four Mental Health Institutes, there are no services available. However, due to paying for many crisis services that are integrated into the community, regions have developed a robust system of care for persons in crisis. The services run from 24-hour hotlines to services like Mobile Crisis Response, Crisis Stabilization Centers, and tele-health in emergency departments and in jails. While there is a subset of individuals who have very complex needs, regions, in collaboration with managed care organizations and the Department of Human Services, have been exploring and developing services to meet the needs of those individuals.

Feature - Residential Access Centers

Continued on page 6.

that I became more educated about all aspects of MH/DS and substance abuse, not just the parts that touch me as a sheriff but also the parts that touch all of the workgroup members. I learned that without other systems in place on the back end of the system, such as Sub-Acute Facilities, my priority of Access Centers would not be able to thrive. That if we have ACT (Assertive Community Treatment) teams in place the hope is we will reduce the number of patients we even need to take to the ER. That sometimes there are patients that have to have Intensive Residential Service Homes in order for them to succeed, and there are times that some patients may need to be at a Tertiary Care Psychiatric Hospital or Institute. As work group members we put aside our own priorities and came together to try to develop the best plan for the State of Iowa.

That brings us to today. As I write this I am anxiously waiting for legislation to be introduced by Senator Edler that is supported by the Governor's Office that will start the process of implementing the suggestions of the work group. I realize there may need to be compromises in the legislation and that it won't be implemented overnight, but it will at least start moving our state in the right direction for **Proper Health Care** for individuals with mental health and substance abuse conditions.

I hope that within the next couple years, mental health and substance abuse patients are not stuck sitting in some ER somewhere waiting for a bed to open up but will be given the **Proper Health Care** right when they walk in the door of a facility. I hope my deputies will no longer have to drive hundreds of miles for that bed. I hope we have ACT teams that wrap their arms around patients in their own communities, and I hope we have enough facilities, both acute and sub-acute, that patients are not stuck in the system somewhere. The last thing I hope is that we someday treat a person that is going through a mental health or substance abuse crisis the same way and with the same level of importance and urgency as we do a heart attack or stroke patient that needs **Proper Health Care**.

Feature - Disaster Response Puerto Rico

Disaster Medical Assistance Response to Hurricane Maria

Jessica Peckover
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The adventure begins…

October 30 – Text Conversation with Steve Dolezal (Johnson County Sheriff's Office Chief Deputy and Deputy Commander for MW-01 Disaster Medical Assistance Team).

> **Steve**: You wanna deploy to Puerto Rico? Nov 5-Nov 21 (impregnated, avoidant pause by me)
> **Me:** Ummm if I'm honest I'm a little freaked out. No electricity, no running water, no cell phone reception, separated from my home by a WHOLE. BUNCH. OF. WATER. Oh, and I have a flight out of Cedar Rapids on November 22. I *must* be back for that.
> **Steve:** I don't think it's as bad as you think. I'll put you in contact with some folks who have been down there. Talk with me tomorrow.

October 31 – I "unintentionally" don't follow up with Steve.

November 1 – Phone call from Steve.

> **Steve**: What are you doing?
> **Me**: Walking into a meeting. Who is this?
> **Steve**: It's Steve…so about Puerto Rico. We still don't have a mental health specialist rostered.
> **Me**: Oh yeah ok, um, walking into a meeting. Super busy. Let me think about it. I'll take it from here. No need to connect me to anyone.

The next nine hours (decision must be made by 6:00 pm) involve me engaging in a raucous internal debate rivaled only by guests on Jerry Springer. The discernment process ends as all good, healthy decision making should: Magic 8 Ball. I fought hard. Went for best out of three. Then five. Ok FINE…but will I make it back for my flight on the 22nd?? Magic 8 ball: "It is certain." Sigh. Got it. Message received. I'm going to Puerto Rico. I emailed the administrative officer for MW-01 and committed to a two-week deployment to an unspecified mission in Puerto Rico. Flight leaves at 6:00 am on Sunday, November 5.

November 2 through November 4 are a blur of cancelling work commitments, getting a flu shot, purchasing and packing all the things needed for deployment to an austere environment…oh and getting my stuff together. If I was about to deploy as the mental health specialist for a team of first responders, I better find my center fast and get myself mentally prepared.

What is DMAT and MW-01?

Let's back up and clarify a few terms. DMAT = Disaster Medical Assistance Team. DMAT is a professional emergency medical response force under the federal Health and Human Services department. MW-01 = Midwest 01, a recently developed DMAT which consolidated teams from Iowa, Nebraska, and Missouri. The deployment Nov 5-Nov 21 to Puerto Rico was the first full team deployment as MW-01. DMATs include the following positions: command staff, logistics, safety and security, medical doctors, nurse practitioners, physician assistants, nurses, paramedics, pharmacists, respiratory therapists, chaplains, and mental health specialists. My role on the team is mental health specialist. The position is designed to support first responders on deployments. Assisting with patients experiencing crisis/trauma response and/or presenting with behavioral health needs (mental health/substance abuse/developmental disabilities) is a function of the position as well.

The deployment

Upon return from Puerto Rico many have asked me about the experience, how is Puerto Rico *really* doing, is it as bad as the media portrays, what are the top three take aways, etc.? My responses have been pretty vague and non-committal "Yeah, it was…good? The conditions varied around the island. The people there are incredible. I'm grateful to have had the opportunity to serve in that capacity.

Feature - Serving in Puerto Rico

It was…overwhelming? Is that the word? Apparently exhausting, I slept 14 hours when I got home." But the truth is, I hadn't really spent any time processing the experience. So let's spend some time unpacking what happened.

I will start by saying it was a multi-layered experience. I have been on DMAT for seven years, and this was my very first deployment. I go big. Forget those deployments to the Democratic/Republican National Conventions or any of those mainland disasters in New York, Louisiana, or Texas. I wait for those that have the potential of going to the bathroom in a bucket. In truth, I struggle with the unknown and those who know me *might* describe me as a bit of a prior planner (euphemism for control freak), so this experience was as much of a personal rubber band moment as it was an opportunity to serve the people of Puerto Rico and support my team.

I was instructed to pack like I was being dropped off at the island where Tom Hanks found himself making friends with Wilson. If "Be Prepared" is the name of the game, "Be Patient" is the surname. The ongoing rhetoric was: HHS stands for Hurry Hurry Stop and what you're being told right now could possibly change in seven minutes. It was fantastic exposure therapy for this recovering control freak. Hi my name is Be Prepared Be Patient. I'm ready for my first DMAT deployment. Information trickles in one morsel at a time. Your flight leaves at 6:00 am on November 5. You'll fly to Atlanta. Once you're in Atlanta you'll find out when you will be chartered to San Juan, Puerto Rico. Fun, I love the uncertainty game. Let's play.

Upon arrival in Atlanta I am shepherded to a conference room at the Hilton to do "Fit Testing." In all my naiveté I'm thinking push-ups, sit ups, like Presidential fit test from PE class. Um, not so much. It's more like ER doc meets beekeeper. Their first question, "anyone claustrophobic?" Oooo me, me. Yeah I'm the QUEEN of claustrophobia. Did I tell you about the time I set off 42 alarms at the Latin American Tower in Mexico City because I couldn't go in the elevator? I set off an alarm every time I opened a door, on every single floor. 42 floors. The security guards were in quite a tizzy. Their response, "yeah, just get through it. It'll only take about 45 minutes." YES! I was hoping this deployment would be my path to healing all. the. things. Approximately 33 seconds into the experience I thought I might pass out and die and my rational brain thought, at least I'm in a room full of medical professionals. They'll know what to do. BUT *spoiler alert* I didn't die. Not even one time during the whole deployment. Fit testing = deployment victory number 1! Jess-1, Death-0. Not that it's a competition or anything.

In the spirit of consistency for all things Be Patient, we were convened at 9:30 pm the night before being sent to our mission to be informed where our mission would be. We were going to Fajardo. Woo hoo…wait, what does that mean? Turns out, it means a fantastic deployment with amazing people (on the team and in the community). We were a mere one hour bus ride away from our two week home…a mini tent city in a parking lot down the hill from a hospital. The team's primary function would be to staff an outpatient clinic that served, on average, 120 patients per day. There were three sleeping tents where

Feature - Serving in Puerto Rico

we had the opportunity to nest with 13 of our closest teammates. My tent was fairly uneventful and conducive to sleep. The same could not be said for the command tent that housed a medical doctor with night terrors. Luckily she had good and faithful teammates who collectively agreed not to, under no circumstances, move her cot outside the tent in the midst of her nocturnal screaming and flailing.

I was surrounded by a dedicated team of doctors, nurses, paramedics, logistics, safety and security, command staff, and community volunteers working long hours to serve the people of Puerto Rico. For many of these team members, this was their second deployment in response to Hurricane Maria. They had sacrificed time with family, home, and employment to serve in this capacity. Many of them were veteran DMAT members having deployed to many disasters including Hurricane Katrina, Sandy, Harvey, Haiti earthquake, etc. I was humbled by the opportunity to serve and connect with the people of Puerto Rico and equally humbled and inspired by the team members I worked, slept, ate, and cried beside and connected with for two weeks.

The people of Puerto Rico are proud, determined, and incredibly grateful. Patients repeatedly expressed their gratitude for the quality patient care received. In a tent. Through a translator. They shared their stories of billboards on top of homes, schools still closed due to their function as a shelter, family members missing, lack of electricity, water, telecommunication, etc. Yet they remained grateful. And playful. And connected.

I had no idea what to expect in my role as mental health specialist, with the patients or with the team members. It was my first experience providing crisis intervention and mental health assessments to patients through an interpreter. As a clinician we are trained on the importance of building rapport with people we serve. Speaking through a translator certainly created an obstacle in that area. And then there is the experience of the translators. Quick example. In meeting with a patient experiencing depression, I asked if he was having thoughts of suicide. The translator stopped, looked at me, and said "I can't ask that!!" My response: then you better teach me some Spanish quick because this is going to happen. For the most part, effective interventions were made, but I must admit it was difficult for me. I wanted to provide a comprehensive treatment plan and address all the psychosocial contributing factors, a commendable goal perhaps, but completely unattainable given the circumstances. I imagine the medical staff experienced similar feelings. Although, the providers did pull out some impressive MacGyver-esque solutions using the resources available to them to meet the needs of patients.

Given that team members were staffing what was essentially an urgent care clinic versus earlier deployments to Puerto Rico in which team members were having to discern judicious use of medical supplies for those who had a chance for survival, I wasn't sure how staff would respond emotionally to this deployment. While the medical needs may have shifted since the September deployments, the people and their experience of disaster and heartbreak had not. Therefore, staff were not without opportunities to sit with their emotions in response to the experience of the people they were serving. Additionally, I would be remiss not to consider the impact of 12-hour shifts, language barriers, and two weeks of communal living with 35 adults. Oh, and turns out, I'm not the only one who struggles a little with uncertainty, the unknown, and lack of information. My role as mental health specialist to team members included tending to self-care needs, bringing coffee and water, reminding them to take breaks, holding space while they cried, providing a listening ear for venting, and of course periodic arts and crafts for friendly competition prizes.

Ohhhh, and the story has a subplot. I was deployed with two team members I'd never met but learned we were connected, through different paths, to a tragedy that occurred in 2013. In our own way, each of us had an opportunity to process, vent, emote, share shock and surprise, and gain greater insight into that incident. While I had no idea what I was signing up for on my first deployment, I certainly did NOT expect that to be included in the package.

In closing, I have to circle back and thank Major Steve Dolezal for encouraging me to go. It was an opportunity to say yes rather than saying no out of fear. I've been trying to formulate a succinct summary statement for the 16-day experience. Let's try this one: Healing for the patients, healing for Puerto Rico, and healing for me.

Maybe I now have my response when asked about the experience…

ISAC Board Meeting Summary – Friday, January 19
ISAC President Lonny Pulkrabek called the meeting to order and led the Board in the Pledge of Allegiance.

ISAC Past President and retired Johnson County Attorney J. Patrick White swore in President Pulkrabek, the ISAC Executive Committee, and members of the 2018 ISAC Board of Directors.

The meeting minutes of the November 15, 2017 ISAC Litigation Committee, the November 16-17, 2017 ISAC Board of Directors, and the December 15, 2017 ISAC Litigation Committee were approved.

President Pulkrabek recessed the ISAC board and reconvened following the Iowa Counties Technology Services (ICTS) Board meeting.

Brad Holtan reviewed balances for the ISAC checking, savings, and investment accounts as well as aging accounts receivables. He reviewed all funds and programs in detail and answered questions. The financial report was approved.

Erin Dickinson, Crueger Dickinson, updated the Board on the opioid litigation. Erin answered questions from the Board, and the Board amply discussed the litigation as well as other desired efforts to address the epidemic as an Association.

Bill Peterson presented a letter from Washington County addressed to the Board regarding the Board's action in encouraging counties to enjoin the opioid litigation. The Board discussed the contents of the letter, the process that was taken to involve counties in the opioid litigation, and the authorities of the Board in general and its abilities related to this effort. The Board approved President Pulkrabek responding via letter.

Kristi Harshbarger updated the Board on a lawsuit that could influence counties and other local governments. The Board authorized expending up to $1,000 on a friend of the court brief as discussed.

Brad supplied the Board with and reviewed the completed ISAC 990 and ISAC Education Foundation 990. The 990s were approved.

2018 ISAC Board of Directors

Front Row (L to R):
3rd Vice President: Wayne Reisetter, Dallas County Attorney
1st Vice President: Eric Stierman, Dubuque County Treasurer
President: Lonny Pulkrabek, Johnson County Sheriff
2nd Vice President: Burlin Matthews, Clay County Supervisor

Middle Row (L to R):
Public Health: Kathy Babcock, Chickasaw County
Past President: Peggy Rice, Humboldt County Auditor
Assessor: Jean Keller, Bremer County
Supervisor: Carl Mattes, Humboldt County
Community Services: Russell Wood, Franklin County
Auditor: Carla Becker, Delaware County
Environmental Health: Joe Neary, Palo Alto County

Back Row (L to R):
Supervisor: Denny Wright, Sioux County
Emergency Management: AJ Mumm, Polk County
Past President: Joan McCalmant, Linn County Recorder
Planning and Zoning: Shane Walter, Sioux County
Past President and NACo Representative: Melvyn Houser, Pottawattamie County Auditor
NACo Board Member: Grant Veeder, Black Hawk County Auditor
Recorder: Kim Painter, Johnson County
Information Technology: Joel Rohne, Worth County
Conservation: Matt Cosgrove, Webster County

Not pictured:
Engineer: Brad Skinner, Montgomery County
Veterans Affairs: Elizabeth Ledvina, Tama County

Bill Peterson gave an overview of the budget process for the ISAC FY 2019 budget. The ISAC Executive Committee will meet to review the budget and make recommendations on January 31, the ISAC Board will be asked to recommend the budget to the membership during its February 9 meeting, and the FY 2019 budget will be brought to the full membership for approval during the Spring Conference General Session on March 15.

Brad asked board members to read the conflict of interest statement and to return signed copies to him.

Kristi gave a summary of the history of ISAC's involvement with State Election Administrators Training (SEAT). SEAT is now a subcommittee of the Iowa State Association of County Auditors (ISACA) after the expiration of the 28E agreement, and ISACA would like for ISAC to be more involved and provide a variety of services to SEAT. The Board reviewed and approved the agreement for services.

ISAC Brief

Bill recommended approval of professional activities and fees associated with the ISAC Group Health Program for which ISAC will engage Kingston Life and Health. The consulting agreement will include three major functions: 1) Consulting services to ISAC management of the ISAC Group Health Program related to the future design of the Program; 2) Direct services to members at a much-reduced rate; and 3) Creation of an ancillary benefits trust for the delivery of benefit services to members. Financing of the agreement will include $5.50 per contract per month and $6.25 per contract per month for members of the ISAC Group Health Program. ISAC will receive 25% of the revenue of any ancillary benefits trust. Kingston Life and Health will be included as an ISAC Endorsed Preferred Vendor and an ISAC Elite Preferred Vendor. The consulting agreement was approved as recommended.

Bill recommended that ISAC refund 50% of the Case Management and Mental Health and Disability Services (CM&MHDS) reserves back to the counties that remained members through its termination. The 28E stated that all funds would go to ISAC. The refund amounts by county were reviewed. The Board amply discussed the refunds and the logistics for the distribution of the funds. The Board approved the refunds as presented.

Rachel Bennett gave a demo of the new ISAC mobile app that will be a resource and tool for members to use throughout the year. It will also include conference apps for the ISAC Spring and Annual Conferences

Bill reported that it's been requested that ISAC support the Governor's 2018 Future Ready Iowa Summit. A contribution of $1,000 was approved.

Rachel reported that ISAC has created two videos related to property taxes – one advocating for full funding of the backfill and one educating on the role of the county in the property tax process. She showed the videos and discussed plans for their roll out. Rachel also gave an update on legislative communications including the use of a new mass email service provider and a redesign of both the ISAC Update and the Supervisors Capitol News.

Jamie Cashman and Lucas Beenken gave an update on the actions taken during the first week of the legislative session and meetings between ISAC staff, President Pulkrabek, and legislative leadership.

Kelsey Sebern reported that ISAC University was a success with around 190 attendees. Speakers and the new location received high marks.

Rachel explained changes to County Day at the Capitol that include no affiliate tables/displays around the Rotunda and no pre-event update from staff at a different location. The event will take place from 11:00 am – 3:00 pm at the Capitol with lunch being served at 11:30 am. Meeting Room 116 will act as a meeting place for ISAC members and staff.

Rachel reported that changes made to the opening of registration for the 2018 ISAC Spring Conference were successful. Separating registration from hotel reservations by one week enabled everything to run smoothly. One-day registrations were also offered, but most members opted for the full conference registration. Kelsey discussed that registrations are consistent with past conferences, but hotel reservations are way down. She explained that ISAC will be in danger of receiving high attrition fees if more rooms are not filled within our conference hotel blocks. Kelsey reviewed the conference agenda and board events during the conference.

Rachel gave an overview of the ISAC webinar schedule for 2018 and registration numbers for past webinars. Overall, the average participation has declined.

President Pulkrabek and Bill reported on the NCCAE State Association Presidents and Executive Directors meeting that they attended in early January in Washington, D.C. It was very busy, but it was a great educational and networking experience.

Rachel reviewed a tentative schedule for Iowa attendees of the NACo Legislative Conference being held in March in Washington, D.C.

Board members shared issues, concerns, ideas, achievements, etc. with other board members.President Pulkrabek adjourned the ISAC Board meeting.

2018 Calendar

March 2018
3-7 NACo Legislative Conference (Washington, D.C.)
14 County Day at the Capitol (Iowa State Capitol, Des Moines)
15-16 ISAC Spring Conference (Veterans Memorial Community Choice Credit Union Convention Center, Des Moines)

April 2018
10-11 Iowa Governor's Conference on Public Health (Holiday Inn Des Moines Airport)
15-18 ISSDA Civil School (Holiday Inn Des Moines Airport)
19 HIPAA Program Meeting (Polk County River Place, Des Moines)
26 ISAC Board of Directors Meeting (ISAC Office)

May 2018
16-18 Treasurers Conference (Burlington)
23-25 NACo WIR Conference (Sun Valley, Idaho)

June 2018
10-14 Iowa County Attorneys Spring Conference (Okoboji)
12-15 ITAG Conference (Sheraton, West Des Moines)
20-22 Recorders Summer School (Gateway Hotel and Conference Center, Ames)
27 ISAC Board of Directors Meeting (ISAC Office)

July 2018
11 ISAC Scholarship Golf Fundraiser (Toad Valley Golf Course, Pleasant Hill)
12-13 ICEA Midyear Conference (Ames)
13-16 NACo Annual Conference (Nashville, Tennessee)
25-27 Auditors Annual Conference (Iowa City)

August 2018
21 ISAC LPC Retreat (Veterans Memorial Community Choice Credit Union Convention Center, Des Moines)
22-24 ISAC Annual Conference (Veterans Memorial Community Choice Credit Union Convention Center, Des Moines)

September 2018
16-19 ISSDA Jail School (Holiday Inn Des Moines Airport)
20 ISAC LPC Meeting (ISAC Office)

October 2018
3-5 ISAC Board of Directors Retreat (Johnson County)
3-5 Iowa Environmental Health Association Fall Conference (West Des Moines Marriott)
21-24 Assessors Fall Conference (Holiday Inn Des Moines Airport)

November 2018
15-16 ISAC Board of Directors Meeting (ISAC Office)

December 2018
2-5 ISSDA Winter School (Holiday Inn Des Moines Airport)
12-14 Iowa County Engineers Conference (Veterans Memorial Community Choice Credit Union Convention Center, Des Moines)

If you have any questions about the meetings listed above or would like to add an affiliate meeting to the ISAC calendar, please contact Kelsey Sebern at ksebern@iowacounties.org.

2018 ISAC Preferred Vendors

Endorsed Elite Preferred Vendor
County Risk Management Services, Inc. representing ICAP and IMWCA

Elite Preferred Vendor
IP Pathways
Kingston Life and Health

Endorsed Platinum Preferred Vendors
Iowa Public Agency Investment Trust (IPAIT)

Platinum Preferred Vendors
Election Systems & Software
Henry M. Adkins and Son
ISG
Matt Parrott/ElectionSource
MidAmerican Energy
Northland Securities, Inc.
"Solutions," Inc.
The Schneider Corporation
Tyler Technologies
Endorsed: Wellmark Blue Cross Blue Shield of Iowa

Gold Preferred Vendor
Ahlers & Cooney, P.C.
Community State Bank
CoreLogic
Cost Advisory Services, Inc.
D.A. Davidson
Delta Dental
DEVNET, Inc.
Diamond Mowers
Dorsey & Whitney LLP
Eagleview
Forecast5
ImageTek-Inc.
ITC Midwest, LLC
Purple Wave Auction, Inc.
Speer Financial, Inc.
The Sidwell Company
Vanguard Appraisals, Inc.
Wells Fargo
Ziegler CAT

Silver Preferred Vendors
Cott Systems, Inc.
Midwest Peterbilt Group
Nyhart

Endorsed Preferred Vendors
National Association of Counties (NACo)
Nationwide Retirement Solutions
U.S. Communities

Children's MH/DS Bibliography from page 8:
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3. US Maternal and Child Health Bureau. Date Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health. http://child-healthdata.org/about/news/news-detail/2018/02/15/2016-nsch-dataset-is-ready-for-request

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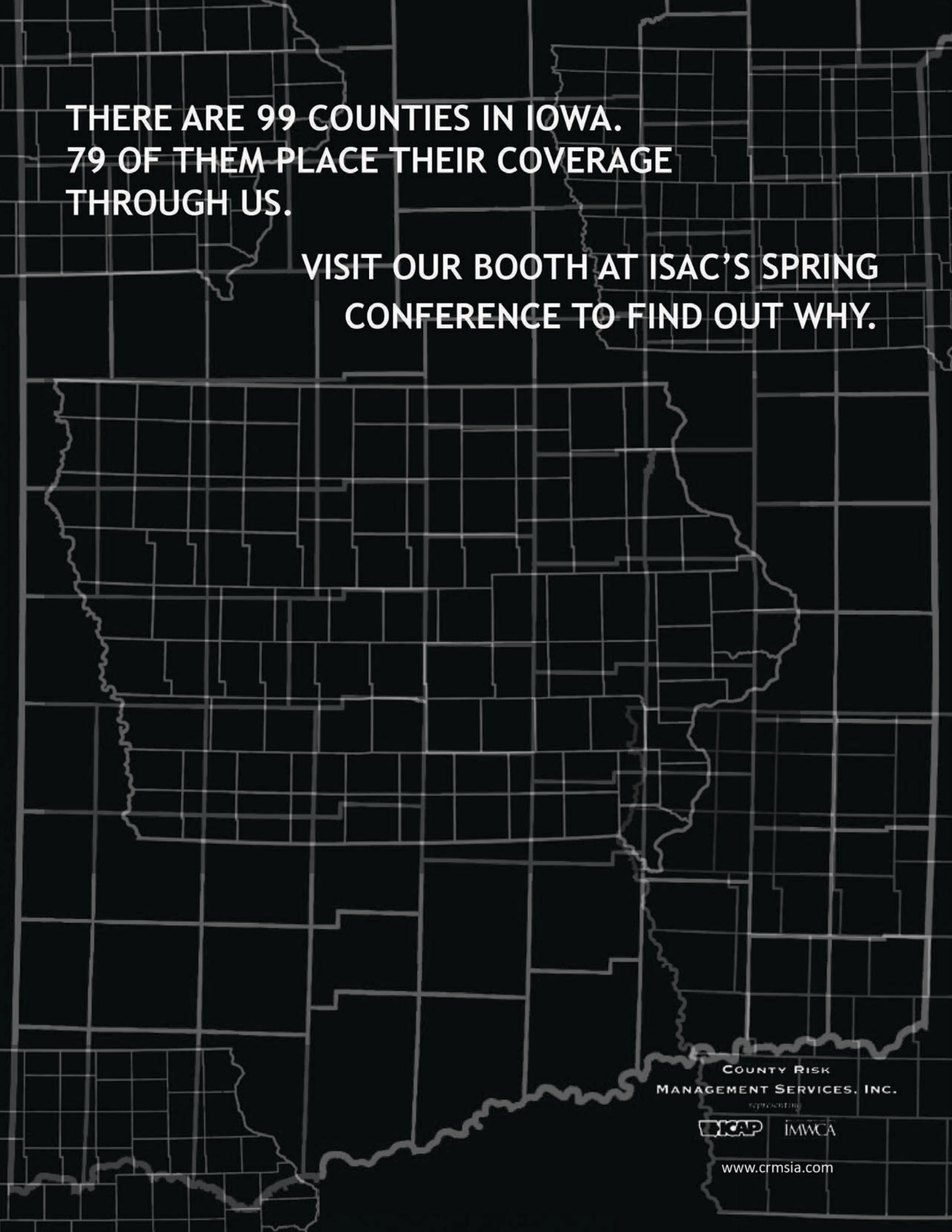
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