

DRAFT
Internal Distribution Only

Rev: March 5, 2007

Transforming the Mental Health System in Iowa

Iowa Department of Human Services
Division of Mental Health and Disability Services

Overview

Our system of delivering mental health services¹ remains fragmented and uneven, in part based on the amount of property wealth that counties can tax. We have 99 counties making 99 different decisions. Some provide little or no mental health assistance beyond what is required by Medicaid, meaning there are few services short of institutionalization. Some provide a significant and inclusive array of services. The result is grossly unfair, with service based on geography rather than need. Some of the components of a delivery “system” are missing and some are “broken”.

Public spending in the State of Iowa on mental health and disabilities has risen dramatically. Last year we dedicated a Billion dollars to this effort in Iowa, a growth of 25 percent in just five years. Leading the growth has been federal funds, especially Medicaid, which contributes nearly half of all funding. While some shares of this funding have grown dramatically overall, county contributions have remained relatively stable. The county share is about 11 percent and is governed by both financial capacity of the county and by state law limitations imposed on counties since 1998.

At the present time there is tremendous interest in the method of allocating funding to counties, as there exists the potential for some dire consequences if the allocation system is not corrected. There is great concern that the current levy “cap” on counties associated with MHDS services will adversely affect individual consumers, families, providers, counties, agencies, and others. Yet, the current allocation system is just simply too complicated. Simplification would be an important step forward.

Across the US, many “county states” struggle with creating a fair and equitable system for counties and Iowa has tried to do so over the last decade. However, we are currently at a crossroads, so to speak, with the current method of allocating funding for MHDS services, as the current approach is not fair and equitable.

¹ In this paper the focus is on mental health services and not all disability services (i.e., those for mentally retarded, developmentally disabled, or brain injured).

Of interest to all of us should be, from a public policy perspective with regards to the state MHDS “system”, is that in the rush to solve the allocation problem that we don’t end up “throwing the baby out with the bathwater” or doing no more than creating a temporary “band aid” solution. Careful thought has to be given to what we do now as we do now to look for structural or policy choices which can reduce or eliminate future funding tensions that exist between counties, the state, providers, mental health centers and other parts of the system.

It is important to note that there are a number of components of the MHDS system that are going in the right direction.

1. The transformation of behavioral health in Iowa has been a “rebalancing” process where more funding is being allocated to community-based services.
2. While there has been growth in county expenditures, by far, the largest growth area has been in the use of federal dollars to transform and rebalance the system.
3. Compared to other states, Iowa’s MHDS system is doing very well in some areas and not so well in others...this is part of the continuing process of transformation.
4. The issue of equity in allocation should not be separated from the issue of how funding is to be spent, how “management controls” should be used, and how we should use what we know about MHDS services to provide services that are effective and lead to positive change.

Iowa has experienced an impressive growth in "waiver" spending, which waives Medicaid rules and permits services to prevent institutionalization. There are now 7,700 people with mental retardation getting this service, double the rate just six years ago. Still, we remain a national outlier in number of people in institutional settings. That's why we are so excited to use our recent \$50 million, five-year grant to help transition hundreds of these people to more homelike settings over the five years.

Advocacy by the Department of Human Services and the MH/MR/DD/BI Commission and leadership by our elected officials, have resulted in notable gains in just the last year or two. The Mental Health Parity Act Bill was enacted. We have a nation-leading program to provide mental health assistance to youth who "age out" of the foster care system. We no longer require parents to relinquish custody of their children in order to receive public-paid extended mental health. We have virtually eliminated the use of restraints and seclusion at our state institutions. We have a new state division that advocates for mental health, ending our status as one of the few states without such an entity. Iowa law now requires that anyone with a household income of at or below 150 percent of poverty is eligible for county-based behavioral health services, lessening frustrating disparities.

Table 1, below, lists a summary of current issues related to the state’s mental health system.

Summary of Current Issues

Increased consumer demand > more flexible, community-based services. (+)

County tax levy law limits County spending - creating a “pressure cooker” environment. (-)

The System continues to “rebalance”, change and grow. (+)

Overall expenditures increasing due to wider array of available services primarily through federal Medicaid funding. (+)

There are no “mandated” or “core services”. (-)

Also, there are no “regionalization/collaboration” or “core service agencies” that might offer management “efficiencies”. (-)

Key components of the system and their roles lack clarity in terms of populations, locations served (I.e., CMHCs, Emergency Service Providers). (-)

While they are part of the “solution” there is notable resistance to Evidence-based Practices and Outcomes approaches that demonstrate efficacy. (-)

There are inadequate infrastructures to set rates, train the system workforce in general and specifically in Quality Improvement, Evidence-based Practices, and Outcomes, and monitor system performance through IS. (-)

Workforce strategies ranging from paraprofessionals to advanced, clinically trained specialists. Geographic shortages of workforce in many areas of the state. (-)

These inequities have been pushed off the front pages, however, by the more immediate problem caused by a decade-old law that limits property tax levies for mental health care, meaning there is a sudden need for more state money to fill the breach.

Over the next two years, we must solve the funding crunch facing Iowa county-funded mental health services. To fail would jeopardize the services Iowa has worked so hard to achieve; especially those that bring dignity and independence, and that prevent institutionalization. But let's solve it in a way that will bring more uniformity and predictability of service and which will prevent the same funding problem from recurring.

As we work to solve the funding problem---and we must---let's also insist on more uniformity and transparency in service. Let's insist on evidence-based practices and outcomes, let's clarify and perhaps expand the role of community mental health centers, let's make the system easier to understand and, by all means, let's make sure that needy people receive assistance because they reside in Iowa, not just a particular county.

We believe the system will be considerably improved by having the State take on both more responsibility for funding as well as more authority to assure basic adequacy and access in all 99 counties.

The Framework for a Plan

While over the last decade there have been numerous attempts to develop a comprehensive mental health plan for the State of Iowa, these attempts have met with little success in real transformation to a “system of care”. In 2006, the legislature re-established a State Mental Health Authority through the creation of the Division of Mental Health and Disability Services (MHDS). The MHDS Division outcomes, if successful, will be consistent with mental health transformation efforts underway in other states through the US. In Iowa, the anticipated outcomes for the transformation efforts in mental health care are:

- Iowans understand that mental health is essential to overall health.
- A comprehensive, continuous, and integrated “*SYSTEM OF CARE*” approach is supported.
- Mental health and disabilities care is consumer and family driven.
- Disparities in mental health and disabilities services are eliminated.
- Early screening, assessment, and referral to services are common practice.
- Excellent care is delivered and research is accelerated.
- Technology is used to access care and information.

In September 2004, the National Association of State Mental Health Program Directors (NASMHPD) published their *Position Statement on a Framework for Comprehensive State Mental Health Systems*. They stated:

“On April 29, 2002, the President issued an Executive Order establishing the New Freedom Commission on Mental Health and directed it “to conduct a comprehensive study of the United States mental health service delivery system . . . and to advise the President on methods of improving the system.” In its final report released in July 2003, the Commission described a system in disarray, in which the services and supports that should be available to people with mental illness and their families are fragmented and frequently inaccessible. The report called for “transforming the existing, often intimidating maze of mental health services into a coordinated, consumer-centered, recovery-oriented mental health system.”

Though disappointed that the New Freedom Commission refrained from highlighting the enormous funding needs in the mental health system, the National Association of State Mental Health Program Directors (NASMHPD) concurs with the overall assessment of the Commission and supports the goals and recommendations it identified. Of particular importance to NASMHPD is the Commission’s Recommendation 2.4: that “each State, Territory, and the District of Columbia develop a Comprehensive State Mental Health Plan.” Within the framework described below, NASMHPD firmly embraces this objective.”

In light of the above statement from NASMHPD, it is recommended that the State of Iowa develop and implement a Comprehensive, Continuous, and Integrated (CCI) State Mental Health Plan that increases the Department of Human Service’s involvement in the development, funding, oversight and ongoing management of the State’s Mental Health System. This document begins to describe the initial steps needed to develop such a plan over the coming months.

Values and Principles Essential To a Comprehensive, Continuous, Integrated State Mental Health System

Consistent with the planned outcomes listed above for the Iowa CCI for mental health, according to NASHMHPD, state mental health systems should be rooted in shared values. They should:

- “Provide convenient access to a comprehensive array of consumer- and family-centered services and supports in the least restrictive community-based settings appropriate for the consumer. Recognize and promote recovery and resiliency as expected outcomes for all consumers.
- Promote policies and practices that achieve for consumers the earliest possible detection of mental health problems and early intervention.
- Ensure that all health care programs address mental health with the same urgency as physical health and that the policies of all programs that serve adults and children with mental disorders – e.g., child welfare, Medicaid, education, housing, criminal and juvenile justice, substance abuse treatment, and employment services – consider their specialized mental health needs.
- Emphasize efficiency, effectiveness, and performance improvement; base resource allocation and planning on well-measured outcomes; minimize administrative costs; and promote evidence-based and promising practices. “

Further, and according to NASMHPD, building on this foundation, a successful comprehensive state system will share several common characteristics.

- First, developing an effective system must begin with the recognition that fundamental to planning the system will be establishing relationships and coordinating policy development and implementation activities among the applicable state agencies. In some cases, it may be necessary to redesign or reallocate resources from one agency to another in order to achieve goals that address consumer, and not governmental bureaucratic needs. For example, the is a wide body of evidence that shows the co-occurrence of mental health and substance abuse disorders that must be treated in a comprehensive, integrated system of care that does not perpetuate bureaucratic “silos” that create barriers to consumers and families from receiving needed services and treatment.
- Second, the state will need to ensure that other stakeholders play an active role in the process. This is most important with respect to the people the system is designed to serve. Consumers (including youth as well as adults) and family members and their advocacy organizations must be involved in all levels of the decision-making process, including the development, management, and oversight of the comprehensive system. In addition, since counties and local governments are responsible for the direct delivery and management of some aspects of mental health care delivery, their representatives will need to be actively engaged in the planning process. Other important sectors include, private providers and payors.

- Third, the state’s success in transforming its mental health system will be significantly affected by the role the Executive and Legislative branches play in the process. Leadership and ongoing support will be needed for years, not just legislative “sessions”.

According to NASMHPD,

“The State agency designated as the State Mental Health Authority (SMHA) must be perceived as a lead adviser to the Executive and Legislative branches regarding mental health policymaking. This role must be firmly established and preserved. While many agencies are critical to the development of comprehensive state mental health systems, only SMHAs have as their core mission the delivery of effective services to people with mental disorders. Further, SMHAs have the experience and expertise to develop comprehensive state plans, identify barriers and strategies to overcome them, measure and evaluate performance and outcomes, and implement comprehensive state mental health plans that respond to consumer and family needs and preferences. Moreover, given the fragmented nature of mental health care delivery and the fact that responsibility and accountability for the care of children and adults with mental illness is becoming increasingly diffuse, it is more important than ever that the role of the SMHA be secured and that focused leadership be maintained.”

Issues and Recommendations

1. Issue:

Increased consumer demand has led to more flexible, consumer-driven, community-based services. (+)

Recommendations:

- ▶ Stay the course, continue to support consumer and family-driven, community-based services consistent with federal initiatives.

- ▶ Align with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD) values and goals for creating a State Mental Health Authority (SMHA) that uses a “Systems of Care” approach.

Application examples: Northeast Iowa Children’s System of Care; Consumer Choices initiative.

2. Issue: County tax levy law limits County spending - creating a “pressure cooker” environment. (-)

Recommendation:

- ▶ Provide relief to counties who are fully utilizing their levy limits and who are presently maintaining adequate (<15%) fund balances.

- ▶ In the near future, determine alternative formulas for allocation that are “transparent” in terms of easily understood than the current complex formulas being used. Test for different allocation formulas to better reflect needs for services, utilization patterns, historical county spending, and so on.

Application: Propose '08 allowed growth.

3. Issue: Current state infrastructures create barriers to access and service delivery of Co-Occurring Disorders services.

Recommendations:

- ▶ Continue the work previously started by IDPH and DSH to develop an implementation plan for Co-Occurring Mental Health and Substance Abuse Disorders in order to provide a Comprehensive, Continuous, and Integrated System of Care.

- ▶ Reinforce collaboration between agencies and develop interagency plans to address this need.

Application: \$50,000 to engage DHHS, SAMHSA and through collaborative policy development.

4. Issue: The System continues to “rebalance”, change and grow. (+)

Recommendations:

- ▶ There is an ongoing need to continue the rebalancing efforts through the development of an 18-month, phased-in implementation plan to locate responsibility for additional major elements of mental health and co-occurring disorders services to the Department of Human Services – Division of Mental Health and Disability Services with service and planning components with IDPH.
- ▶ Identify a small workgroup to develop the key components of the plan within 90 days. Initial focus of the plan will be identification of activities associated with state oversight of Community Mental Health Centers (CMHCs).
- ▶ Review and recommended amendments to Ch 230a, CMHC Standards, and the development of standards and requirements for Emergency Services Providers.

5. Issue: There are no “mandated” or “core services”. (-)

Recommendations:

- ▶ Establish workgroup to identify core “safety net” services to be offered by CMHCs. Included in this would be: Emergency Services, School Mental Health, as well as other Evidence-based Practices for uninsured, seriously mentally ill/emotionally disturbed adults/children.
- ▶ Draft legislation and rules to establish requirements for core services to be provided by CMHCs amending Ch. 240a.

6. Issue: There are no “regionalization/collaboration” or “core service agencies” that might offer management “efficiencies”. (-)

Recommendation:

- ▶ Within twelve months establish accreditation requirements for core service agencies that could provide core services for children, youth and adults on a regional basis throughout the state.

7. Issue: Key components of the system and their roles lack clarity in terms of eligibility, population(s) served, service locations (i.e., CMHCs, Emergency Mental Health Services). (-)

Recommendations:

Within 90 days, develop a plan for the DHS to assume leadership and assign significant financial responsibility to include:

- ▶ Revisions as necessary to Ch 240a
- ▶ New accreditation standards for Community Mental Health Centers
- ▶ Development and implementation of mandated, core safety net services
- ▶ Development of statewide standards for Emergency Mental Health Services such as:
 - ▶ mobile outreach, crisis intervention, prescreening for involuntary admissions to psychiatric facilities, and short-term counseling.
- ▶ Recommendations on methods of payment for Emergency Mental Health Services
- ▶ Assign significant financial responsibility to Department of Human Services

8. Issue: While they are part of the “solution” there is some growing resistance to change to Evidence-based Practices and Outcomes approaches that demonstrate efficacy. (-)

Recommendations:

- ▶ Phase-in EBP implementation over several years with a rollout program of two adult and two child EBPs per year.
- ▶ Develop comprehensive training program for CMHCs, state facilities, and other community providers.
- ▶ Ensure appropriate reimbursement is available to all providers for the implementation of mandated EBPs.

9. Issue: There is insufficient infrastructure to train the system workforce, implement Evidence-based Practices, and Outcomes, or monitor system performance through IS. (-)

Recommendations:

- ▶ Redesign Co-Occurring Mental Health and Substance Abuse Disorders in order to implement a comprehensive, integrated System of Care.
- ▶ Develop and Implement a Collaborative Behavioral Health Workforce Competency Training Plan consistent with the findings and recommendations of the SAMHSA-sponsored Annapolis Coalition.
- ▶ Coordinate IS development efforts with Mental Health Institutes and Iowa Medicaid Enterprise.

10. Issue: Rate escalation continues to increase for MR/DD services at a high rate.

Recommendations:

▶ Continue to monitor and provide oversight capacity. Develop, if needed, external contract to review rate-setting processes and results.

Phases of Mental Health System Transformation

Key elements of the mental health system transformation are projected to occur over an 12-to-24 month period in several overlapping phases.

Phase I: Community Mental Health Centers (6 – 12 months)

It is recommended that Phase I of system transformation in Iowa begin with the redesign of the state's Community Mental Health Centers. In Phase I, the DHS will assume leadership for the 33 existing Community Mental Health Centers. Presently, this is not budgeted.

During this phase, considerable definition and realignment of safety net services will occur. It is anticipated that the CMHCs will be the focal point for the development of a regional emergency service network that provides crisis intervention, mobile emergency outreach, crisis counseling and other wrap-around services to predefined service areas. Presently, this is not funded.

In concert with internal expansion of MHDS capacity, a key component of the CMHC system will be the development and expansion of services for Children and Youth with mental health and co-occurring disorders. The development of CMHC-based school mental health services is envisioned as part of this effort. There are currently some proposals to pilot school based mental health under consideration. Presently this is not funded.

Legislative amendments to Ch. 240a will be required as part of this process as well as a delineation of services to be provided, reimbursement levels for services; standards associated with accreditation and survey evaluation procedures. Legislative changes will require approximately one year of development time. Staffing will be needed at the DHS/MHDS Divisional level for oversight of CMHCs. Final changes may occur in the next session.

Authority for this Phase I effort already exists. In 2006, the Iowa Legislature enacted HF 2780 which included the authority for the Department of Human Services, Division of Mental Health and Disability Services Administrator to recommend and the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Commission to adopt standards for community mental health centers and comprehensive community mental health programs, with the overall objective of ensuring that each center and each

affiliate providing services under contract with a center furnishes high quality mental health services within a framework of accountability to the community it serves. Also, as part of HF 2780, Annual Audits of CMHCs were authorized.

Phase II: Development of a Comprehensive, Continuous Integrated System for Co-Occurring Disorders (12 – 18 months)

The major work in Phase II will focus on the development of a collaborative plan to establish a comprehensive, continuous, integrated system for co-occurring disorders (COD). Through collaboration with a recognized national expert in COD system, community mental health and substance abuse providers and other state agencies, the DHS/MHDS will participate in the development of this system with the state's Community Mental Health Centers and DHS facilities. According to Minkoff (2004):

“The implementation of a complex multi layered system model requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process that involves interaction between all layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the size or complexity of the system. Implementation can occur in systems of any size (entire state, regions, counties, complex agencies, individual programs), and in any population or funding stream (adults, elders, children; Medicaid, private payers, state block grant funds; urban/rural; culturally diverse populations). In order to organize the complexity of this process the authors have developed the “Twelve Step Program of Implementation” (first implemented in Michigan in 2002), and have created a CCISC Toolkit to provide a framework for evaluating and monitoring progress at the system level, the program level, and the clinician level.”

Phase III: Assessment of Regionalization of Resources (18 – 24 months)

Phase III will involve the development of low-incidence population services at the existing state facilities (mental health institutes and resource centers) to provide services that are currently unavailable to counties due to the low frequency of specific populations to be served. Phase III will also review the effectiveness of Phase I activities on reducing admissions and readmissions to state-operated or other community based inpatient facilities – thus ensuring community-based services to seriously mentally ill consumers. In this Phase planning and initial development work will occur with regards to the implementation of programs and services for older adults. Specific focus on nursing home consultation, Alzheimer's and dementia services, and alternative housing models will be identified.

Many of the elements described in the preceding are consistent with the transformation efforts previously recommended by the MH/MR/DD/BI Commission. If implemented these recommendations will lead the state on the road to a comprehensive, continuous, and integrated “*SYSTEM OF CARE*” approach is supported where disparities in mental health and disabilities services are eliminated, early screening, assessment, and referral to services are common practice, excellent care is delivered and research is accelerated, and technology is used to access care and information.

