FINAL REPORT

MENTAL HEALTH STUDY COMMITTEE

Presented to the Legislative Council
and the Iowa General Assembly
January 1993

Prepared by the Legislative Service Bureau

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AUTHORIZATION AND APPOINTMENT

The Mental Health Study Committee was established by the Legislative Council for the 1992 Interim and charged "[to work with, and receive the final report of, the mental health task force charged with developing a plan for restructuring the service delivery system for persons with mental illness, mental retardation and other developmental disabilities, and brain injury. The interim committee will assist in the selection of a consultant to the task force, the cost for such services not to exceed $20,000.]" The members of the Study Committee were:

Senator Albert Sorensen, Co-chairperson
Representative Janet Adams, Co-chairperson
Senator Beverly Hannon
Senator Maggie Tinsman
Representative Merlin Bartz
Representative Rick Dickinson

BACKGROUND INFORMATION

The Study Committee was charged to work with the Mental Illness, Mental Retardation, Developmental Disabilities, and Brain Injury Service Delivery System Restructuring Task Force and to receive that Task Force's final report. That Task Force was created by the Seventy-fourth General Assembly, 1992 Session in Senate File 2355 which provides appropriations for human services (1992 Iowa Acts, chapter 1241, section 26). A copy of the legislation which created the Task Force is included in this report as Attachment 1.

The Task Force's membership included a legislative member from each chamber of the General Assembly appointed by the Legislative Council. The Legislative Council appointed two of the Study Committee members to the Task Force: Senator Maggie Tinsman and Representative Janet Adams. The Task Force organized in late September, holding meetings approximately every two weeks into December. The Study Committee was authorized one meeting day but did not physically meet. Decisions were made through staff contact with members.

By action of a telephone poll of its members, the Study Committee delegated its responsibility to work with the Task Force in retaining a consultant/facilitator by authorizing Senator Tinsman and Representative Adams to act on its behalf. Senator Tinsman and Representative Adams concurred with the Task Force in retaining the Technical Assistance Collaborative (TAC) of Boston, Massachusetts as the consultant/facilitator to the Task Force.

Mr. Stephen Day was the principal staff person for TAC. The Task Force held four meetings with Mr. Day in developing recommendations for submission to the Governor, Department of Human Services, and the Legislative Council.

RECOMMENDATION

The Legislative Council had delegated the responsibility of receiving the report to the Study Committee. At the direction of the Co-chairpersons, the report was sent to the Study Committee members for a vote on whether to submit the report to the Members of the General Assembly with either a recommendation for its consideration or without a recommendation for consideration. The vote tally from a telephone poll of the Study Committee members indicated support for submission of the report to the General Assembly with a recommendation for its consideration.

The report of the Mental Illness, Mental Retardation, Developmental Disabilities, and Brain Injury (MI/MR/DD/BI) Service Delivery System Restructuring Task Force is included in this report as Attachment 2. The Task Force report is comprised of the following five components:

1. A transmittal letter from the Task Force Co-chairpersons, Mr. Michael Brown and Mr. Paul Stanfield.
2. A listing of the Task Force membership.
3. Part I which provides recommendations for MI/MR/DD/BI service system changes.
4. Part II which delineates values and guiding principles for changing the MI/MR/DD/BI service system.
5. A memorandum from the Task Force consultant, Mr. Stephen Day of the Technical Assistance Collaborative, which provides observations and recommendations for service system development.

Sec. 26. TASK FORCE ESTABLISHED.

1. For the fiscal year beginning July 1, 1992, there is established a task force to develop a plan for restructuring the service delivery system for persons with mental illness, mental retardation and other developmental disabilities, and brain injury. The task force shall consist of individuals appointed by all of the following entities:

a. Iowa state association of counties.

b. Iowa association of rehabilitation and residential facilities.

c. Alliance for the mentally ill of Iowa.

d. Association for retarded citizens of Iowa.

e. Community mental health centers association of Iowa.

f. Iowa governor's planning council for persons with developmental disabilities.

g. Iowa farm bureau federation.

h. Iowa federation of labor.

i. Iowa association of business and industry.

j. Iowa citizen action network.

k. Iowa psychiatric society.

l. Iowa hospital association.

m. Department of human services.

n. Iowa coalition.

o. Iowa protection and advocacy service.

p. Coalition for persons with disabilities.

q. Prevention of disabilities policy council.

r. Iowa head-injury association.

s. Department of management.

t. Governor.

u. A member of the senate appointed by the legislative council.

v. A member of the house of representatives appointed by the legislative council.

2. The task force shall present a plan to the legislative council, the department of human services, and the governor, by December 1, 1992, which will implement a restructuring of the mental health, mental retardation, and developmental disabilities service system to be effective July 1, 1993. However, the funding portion of the plan referred to in paragraph "b" of this subsection is to be effective July 1, 1994. The plan shall address, but not be limited to, all of the following:

a. Multi-county structures for planning.

b. The funding responsibilities and the funding relationship between the state and counties, including but not limited to, the per diem reimbursement paid at the state mental health institutes.

c. The structure for service delivery.

d. Targeting services for state funding which are aimed at implementing the service quality standards in section 225C.28A and rights in section 225C.28B.

The task force shall be assisted by a consultant and facilitator in carrying out its responsibilities under this section.

3. It is the intent of the general assembly that the plan developed by the task force created in this section shall be considered for enactment during the 1994 Legislative Session.

Mental Illness, Mental Retardation, Developmental Disabilities and Brain Injury Service Delivery System Restructuring Task Force

January 5, 1993

The Hon. Terry Branstad, Governor
Mr. Charles Palmer, Director of Human Services
Senator Albert Sorensen and Representative Janet Adams, co-chairpersons, and members of the Mental Health Study Committee

Dear Governor Branstad, Director Palmer, and Study Committee Members:

The report of the Task Force created by 1992 Iowa Acts, Chapter 1241, Section 26 is submitted with this letter.

The challenge to this first-time assemblage of representatives of all groups with a stake in restructuring efforts was a major one. It was enthusiastically accepted in the realization that this was a one-time opportunity to bring about a more effective and efficient service delivery system for Iowans with mental illness, mental retardation, developmental disabilities or brain injuries.

The report is composed of two major task-force-authored sections and a set of observations and recommendations for service system development authored by Steven L. Day of the Technical Assistance Collaborative. Mr. Day was consultant to the Task Force.

"Part I: Recommendations" provides a five-year guideline for state action, beginning in the current fiscal year and extending through 1997. It builds on current Department of Human Services strengths and initiatives.

The recommendations rest firmly on a set of values from which operational principles evolve. The values and principles, together, provide a context for a core service system which is the minimum that should be available to clients and their families wherever they live in Iowa. These are outlined in "Part II: Values and Guiding Principles."

Summaries of task force meetings are available from the Legislative Service Bureau.

We call particular attention to the following recommendations of the Task Force:

1. **Iowa should give families and individuals to be served by the system a stronger voice in planning and policy development.**

2. **Iowa should clarify and refine the role of the Regional Planning Councils as an essential step toward achieving greater service effectiveness.**

The Regional Planning Councils, now established, are envisioned as the locus of community input, authority, needs assessment, planning and evaluation. The function of the councils must be supported. The cooperation of state, regional and local authorities must be enhanced.

3. **Iowa is not yet taking maximum advantage of all available federal funding resources and should step up efforts to do so. But the Task Force is emphatic that new dollars brought to the state should be used in ways that improve MI/MR/DD/BI services and not directed elsewhere in the state general fund.**

4. Iowa should plan to close or realign for other purposes two mental health institutes and one state hospital school within the next five years. As stated above, savings realized from such realignments should be used in ways that improve MI/MR/DD/BI services and not diverted elsewhere in the state general fund.

The Task Force, mindful of current state revenue limitations and local property tax restrictions, does not call for immediate additional state dollars, but it believes that it is imperative that the state initiate a five-year funding plan that would result minimally in an additional $5 million in state funds for community services in Fiscal Year 1995. In future years, increased state funds should be directed to community services to correct the current imbalance which places most of the burden on local property tax dollars and puts Iowa near the bottom among all states in state funding of mental health services.

The issue of funding services equitably and adequately remains the pivotal issue, but it is one which the Task Force feels it did not have adequate time to address fully. The related issues of legal settlement and mandatory services, while reviewed and discussed, were also deferred in the interest of time and remain unsettled.

These and other issues are well summarized by Mr. Day in his letter of Dec. 21, 1991, and the letter is a vital component of this report. His analysis of possible consequences of alternative approaches illustrates the need for more study and information-gathering than was possible during the short life of this Task Force. We therefore come to this recommendation:

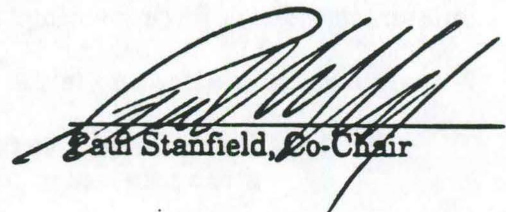
5. The Iowa MI/MR/DD/BI Service Delivery System Restructuring Task Force should be continued for six more months to permit it to make recommendations on remaining complex issues.

It is our observation as co-chairs that the motivation of this group is high. Task Force members – with combined experience amounting to decades of work with and on behalf of clients and families – have coalesced into a team with a level of trust and understanding that should not be lost.

We hope that these recommendations regarding some of the issues of great concern to you and other state policy makers will prove to be a useful guide to action in this vital area.

Sincerely,

Michael L. Brown, Co-Chair



Paul Stanfield, Co-Chair

MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES, AND BRAIN INJURY (MI/MR/DD/BI) SERVICE DELIVERY SYSTEM RESTRUCTURING TASK FORCE

(Updated 10/30/92)

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MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES, AND BRAIN INJURY (MI/MR/DD/BI) SERVICE DELIVERY SYSTEM RESTRUCTURING TASK FORCE

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IOWA MI/MR/DD/BI SERVICE DELIVERY SYSTEM RESTRUCTURING TASK FORCE

PART I: RECOMMENDATIONS FOR SERVICE SYSTEM CHANGES

I. FRAMEWORK

The Iowa MI/MR/DD/BI Service System Restructuring Task Force recommends to the General Assembly that the service system be based on the following principles:

1. The system should support and encourage consumer and family choice, empowerment, and community living.

2. Community services to support independent living and rehabilitation should be developed and made available based on individual consumer and family choice. One result of this service approach should be a reduction in the reliance on facility-based services.

3. Service system development should be fostered through increased state funding and financial incentives for community services as supports.

4. High quality and cost effective services should be supported by clear and simple regulatory approaches that (1) focus on outcomes for consumers and families. And (2) support flexible service development and management.

5. The service system should encourage the use of natural supports and generic services to the extent possible.

II. IMPLEMENTATION STEPS: IMMEDIATE ACTION

A. IMPLEMENT THE PLANNING COUNCIL PLANNING PROCESS

1. The Task Force recommends that the General Assembly establish requirements for Planning Councils that will ensure effective membership of a consumer or family member representing each area of disability, public and private providers, elected officials, and other interested parties. These requirements should assure an open planning process with maximum opportunities for input on the part of consumers, families, providers and other professionals, and the general public. They should also assure that Planning Councils make reasonable accommodations and provide reasonable support to facilitate this input from consumers and family members.

2. The Task Force recommends that the General Assembly require the Department of Human Services to facilitate local service planning by providing the following information and support to planning councils:

   - Drafts of state MI/MR/DD/BI plans that establish state-wide service goals, define service standards, or influence resource allocation; (However, the sequencing of planning should be that final state plans are developed only after local plans are completed).

   - Planning data, including state and national indicators of incidence and prevalence, census and related demographic and socio-economic data, analyses of service equity funding, and data from needs assessments or related studies;

   - Brief outlines and formats for the annual and five-year planning process;

   - Technical assistance in the planning process, and support in establishing consumer/family/provider advisory groups.

3. The Task Force recommends that the General Assembly require that each plan assign a single point of accountability and authority for MI/MR/DD/BI services, specify all access points for services and case management, and address equity of service access.

4. The Task Force recommends that the General Assembly appropriate funds to the Department of Human Services to fulfill the responsibilities of the Department.

5. The Task Force recommends that the General Assembly revise the Mental Health and Mental Retardation Commission membership to reflect all affected populations and that the role of the Commission be expanded to add the responsibility of planning for the unserved populations and to make recommendations on planning and services.

B. IMPLEMENT REVENUE INITIATIVES

The Task Force recommends that the General Assembly require the Department of Human Services to continue existing Medicaid initiatives and to immediately implement new initiatives for the purpose of rationalizing[1] service financing and generating new revenues for community service development. The department should:

1. Implement the Rehabilitation Option for all consumers/services;

2. Continue implementation of EPSDT for child/adolescent services;

3. Continue implementation of the existing Home and Community-Based Waiver for MR services;

4. Request a new Home and Community-Based Care Waiver specifically targeted for current ICF-MR (including State Hospital School) residents, for persons with other developmental disabilities or brain injury, and for persons affected by the Nursing Home Reform Act;

5. Expand utilization of community general hospitals for acute psychiatric hospitalization, with state subsidies for potential un-reimbursed care;

6. Retain all revenues generated through these initiatives for expanded community services developed through the local planning process, with priority for currently un-served or under-served individuals or groups, and for the creation or expansion of prevention and early intervention services;

7. Take steps to use existing state and county funding of vocational and related services to ensure that the maximum entitlement to federal Vocational Rehabilitation funding is received by the state;

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[1] Rationalizing funding means to ensure that state and county funds are used only after all other possible sources of revenue have been tapped, or to use state and county funds in a manner to attract the maximum amount of federal or non-public funding.

8. Take steps to obtain federal and related housing financing and housing subsidy funding to expand the supply of affordable supported housing; and

9. Ensure that all state savings realized from down-sizing or closing state hospital schools or mental health institutes are returned to the community for the purpose of enhancing community-based services.

C. CONTINUE THE WORK OF THE MI/MR/DD/BI TASK FORCE

The Task Force recommends that the General Assembly extend the MI/MR/DD/BI Restructuring Task Force, with its current membership, for a period of six months, and provide resources for staff support for the Task Force. The Task Force recommends that the General Assembly charge the Task Force to:

1. Outline a five-year budget strategy for adequately funding and developing core community services, consolidating all service funding at the local point of accountability and authority, enhancing consumer-based service funding, and exploring a managed care approach for MI/MR/DD/BI services;

2. Make recommendations with regard to the funding formula between counties and the state for MI/MR/DD/BI services. In this context, maintenance of effort of MI/MR/DD/BI funding on the part of counties should be defined, and provisions should be recommended to ensure maintenance of effort in an equitable fashion;

3. Work with DHS and other state regulatory agencies to remove or revise regulatory requirements that may unintentionally hinder creative and cost-effective local service development. In the process of revising regulations, the Task Force should focus on quality, performance, and outcomes for clients. An impact statement should be prepared for each proposed regulation, stating the benefits to consumers of the regulation, and estimating the cost of implementation;

4. Define outcome, performance, and quality measures to be applied to the local service system;

5. Refine the definition of the core service system, and define standards and methods of delivery for each service within the core service system; and

6. Make recommendations to change current County of Legal Settlement requirements to ensure that such requirements are not an impediment to the delivery of services.

D. The Task Force recommends that the General Assembly ensure that no additional service mandates are placed on the counties that require the expenditure of additional property tax levies. However, the General Assembly should assure that state funds appropriated for community services are used to achieve equity of service access, with first priority for individuals and groups currently not protected by existing mandates. The Task Force recommends that existing mandates be maintained, and that mandated services not be excluded from the possibility of new funding as funds become available.

III. IMPLEMENTATION STEPS: FISCAL YEAR 1994

A. The Task Force recommends that the General Assembly initiate new financing approaches for MI/MR/DD/BI services. The financing approaches should have at least the following elements:

1. County property tax funds should be held harmless from any further increased service costs.

2. Revenues generated at the state level through Medicaid or related initiatives should be allocated to counties for service expansion, based on the goal of achieving equity of access to core community services.

3. State funds should be used to assure continuity of care for individuals residing in counties other than their counties of legal settlement.

4. State funds should not be used to supplant overall current county expenditures. This should not be construed to alter the supports currently funded.

B. The Task Force recommends that the General Assembly require the Department of Human Services to complete a five-year plan for closing or re-aligning (to other purposes) two Mental Health Institutes and one State Hospital School. The plan should address:

1. Continuity of care and appropriate service access for all individuals who may have utilized facility resources.

2. Re-training, re-assignment, or related employment opportunities for all facility employees, and economic stability and re-investment for communities affected by facility closing or re-alignment.

3. Specification of the amounts and types of resources to be made available to the community system as a result of facility changes, specification of how these funds are to be used on an annual basis to achieve system goals, and assurance that all state savings from closings or realignment are designated for community service development.

C. The Task Force recommends that the General Assembly require the Department of Human Services to implement a state/county provider quality assurance/performance assessment system. At a minimum, the system should:

1. Assure maximum participation of consumers and families in quality assurance and performance reviews.

2. Eliminate duplication of federal or state accreditation/licensing requirements. This duplication places unreasonable cost burdens on providers.

3. Focus on outcomes for consumers and families, and on the relative cost-effectiveness of services.

IV. IMPLEMENTATION STEPS: FISCAL YEAR 1995 TO FISCAL YEAR 1997

1. The Task Force recommends that, beginning in Fiscal Year 1995, the General Assembly begin a five-year process of investing in new community services based on the budget plan to be developed by the Task Force. At a minimum, the General Assembly should appropriate $5 million in new funds for community services in FY 95.

2. The Task Force recommends that the General Assembly provide a statutory framework (public and/or non-profit) for the regional entities that have been designated as the single point of accountability and authority for MI/MR/DD/BI services.

3. The Task Force recommends that, once regional entities are legally established, the General Assembly assure that all MI/MR/DD/BI appropriations (including any remaining facility budgets) and revenues are allocated directly to the regional entities based on a formula that will enhance equity of service access.

IOWA MI/MR/DD/BI SERVICE DELIVERY SYSTEM
RESTRUCTURING TASK FORCE

PART II: VALUES AND GUIDING PRINCIPLES

January, 1993

I. VALUES

The service system in Iowa for persons with mental illness, mental retardation. developmental disabilities, or brain injury should be based on the following principles:

1. Choice: The ability of consumers and their families to exercise their own choices about the amounts and types of services received.

2. Empowerment: The reinforcement at all levels of the system of the fundamental rights, dignity, and ability of consumers to accept responsibility, exercise choices, and take risks.

3. Community: The principle that the system supports the right and ability of all consumers to live, learn, work, and recreate in natural communities of their choice.

Underlying these basic principles are a set of shared values. These values express what all participants in the service system believe and understand about the individuals they are dedicated to serve and support. They also express what consumers believe about themselves: their individual abilities, aspirations, and expectations for their lives. The following is a detailed list of these values:[1]

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[1] These values have been adapted from **HOUSING AS HOMES - SERVICES AS SUPPORTS**

1. **Persons with mental illness, mental retardation, developmental disabilities, or brain injury have the same fundamental rights as any other person. These rights include the right to vote; freedom of speech; freedom of religion; freedom of sexual expression; protection from the denial of life, liberty, property, and the pursuit of happiness without due process; and freedom from discrimination because of one's disability.**

2. **Unique individual and family strengths and needs, choices and preferences, are the basis for service planning and delivery.**

3. **Individuals and families have the right to participate in identifying service needs and planning to meet those needs. Service planning and delivery encourages and supports the natural support systems of individuals and their families. Consumers and families have the right to appeal if the service plan, service access, or service delivery does not meet their needs and choices.**

4. **Persons with mental illness, mental retardation, developmental disability, or brain injury have the opportunity to live, learn, work, and recreate in a manner as close as possible to the way other people live. Services are provided in a manner that encourage and support the development of each person's abilities and minimizes intrusion in or disruption of the person's life style.**

5. **Funding for service provision follows the individual and dynamic needs and choices of consumers and their families, rather than being committed to fixed service program types or settings to which consumers and families must adapt.**

6. **Consumers and family members are actively involved in service and support system planning, resource prioritization, program implementation, and evaluation of the quality and effectiveness of services.**

II. OPERATIONAL PRINCIPLES

Values define what the general public, the service system, and consumers and families believe about themselves and what they expect in terms of quality of life and well-being. Operational principles begin the process of defining how the system will ensure that all individuals who come in contact with the service system have an experience consistent with

the stated values. In combination, values and operational principles provide a context for assessing service system organizational options and operational approaches, as well as for evaluating service system quality and performance. The values and operating principles are the "Constitution" of the service system. That is, they set the fundamental standards and expectations for the system, and provide guidance for system evolution and response as both local and national conditions change. The following are the operating principles for the Iowa MI/MR/DD/BI service system:

1. **Single point of accountability and authority.**

    - It is recognized that there are multiple points of accountability within the service system. Wherever there is accountability, the locus and extent of accountability is clearly defined, and the necessary authority and resources are in place to assure accountability.

    - At the level of planning and program development, a single point of accountability and authority is in place to assure that consumers and their families receive appropriate access and service delivery in conformance with the service system values. This single point of accountability contains fiscal, administrative, and service management functions to assure coordination and equitable allocation of resources.

    - In recognition of consumer choice and empowerment, individuals are accountable for sharpening their own perception of their needs, and articulating these choices. Individuals have an obligation to be responsible and to accept the consequences of their choices and actions. To achieve this goal, the system must support individuals as they progress towards independence and self-advocacy, and consumers and their families are accountable for providing feed-back to the system about access, responsiveness, quality, and the effectiveness of services.

2. **Single point of entry**

- **The local entity responsible for planning and service development ensures that all consumers and their families have clearly identified and well publicized points of entry to the service system. The entry point(s) communicate the choices available, facilitate and coordinate access to services and advocate on behalf of consumers. The entry point(s) do not function as the gate keeper(s) to services, and consumers and their families may access individual services without passing through the single point(s) of entry.**

3. **Equity of service access**

- **Wherever an individual in need of MI/MR/DD/BI services resides in the state, she/he has reasonably equal access to the services of her/his choice.**

- **Individuals have reasonably equal access to services of their choice regardless of the type or category of disability they present.**

- **The Department of Human Services (DHS) provides appropriate funding allocation mechanisms, financial incentives, and monitoring of system performance to support the attainment of reasonable equity of service access.**

4. **Targeting service resources**

- **Each service planning and service development entity determines, on an annual basis and with significant input from consumers and their families, the prioritization of allocation of resources to varying consumers and service types.**

- **Financial resources shall be directed in a manner consistent with the guiding principles of the service system.**

5. Regional planning, funding, and service contracting

- Each Planning Council prepares a five year plan for MI/MR/DD/BI services. Each plan is updated annually.

- The service plan defines the services to be provided; the method(s) of service access and delivery (i.e. contracted vs. direct delivery; consumer/family supported purchase, fee for service, or program component funding); prioritization of services by consumer need; and expected consumer outcomes and measures of service system performance. The plan designates entry point(s) and specifies how the functions of service authorization, individualized service planning, and consumer advocacy are to be performed.

- The five year plan outlines a process leading to coordinating and potentially consolidating the functions of resource allocation, contracting, and program development.

- A majority of the individuals participating in the regional planning process are consumers and family members. The regional planning entity shall include consumers and family members, county officials, providers, and professionals in the planning process.

- The function of service planning, resource allocation, and service coordination is separated from the function of direct service delivery.

- The Department of Human Services (DHS) develops a five year MI/MR/DD/BI plan, updated annually, reflecting and responding to the service needs and priorities outlined in the regional plans. This plan defines a core service system as a basis for continued service development at the regional level.

6. **Case management**

- **Case management includes assessment, individualized service planning, service linkage and brokerage, outreach, continuous care-giving, advocacy, and individual and family support.**

- **Case management is available, as frequently as necessary, to all individuals in need of service, without regard to financial or categorical eligibility. Individuals may elect not to receive case management, and access to other services is not affected by such a choice.**

- **Community support teams or similar service models may include the case manager, and/or may be accessed as a separate service.**

7. **Private/public service provision**

- **The regional planning/service development entity assures a high quality and cost-effective balance of publicly provided and privately contracted services.**

- **Increased diversity of services is encouraged to expand consumer and family choice.**

8. **Prevention**

- **Prevention strategies are emphasized for disabilities known to be preventable, balancing the need to direct limited resources at prevention and direct support. Early intervention, community-oriented services, and rehabilitation are emphasized for disabilities for which prevention is not currently a viable option.**

9. **Quality and performance monitoring**

- **The Department of Human Services establishes standards for service system quality and performance that are based on consumer outcomes, quality, and cost-effectiveness. DHS**

maintains a Performance/Outcome Task Force, with a majority of members being consumers and family members, to develop annual quality assurance and performance assessment plans, and to review the results of quality assurance and performance assessment activities.

- All public and private service providers have quality assurance and performance measurement plans and systems, including consumer and family monitoring and consumer satisfaction assessment. Information from these systems is routinely submitted to the funding source and the regional planning/service development entity.

10. **Training and technical Assistance**

- The DHS assures that training, re-training, and technical assistance is available to the regional planning/service development entities and the service providers to achieve system objectives and carry out service delivery in a manner consistent with the values and operating principles of the system.

III. VISION FOR THE SERVICE SYSTEM

The Iowa MI/MR/DD/BI service system is expected to undergo significant changes within five years. The purpose of describing a vision for the system is to answer the following question:

> "When consumers and/or their families request services, what should they expect in terms of the types of services available and the manner in which services are accessed and provided?"

Thus, the vision defines the constellation of services to be made available, the methods of providing such services, and the means by which consumers and their families access the services. The vision also defines how the primary service system will assist consumers and their families to access other services, such as income supports, education, housing, and medical care. The primary mission of the service system is to encourage the use of natural supports and generic services wherever possible.

In concert with the above-stated values and principles, the Iowa MI/MR/DD/BI service system includes but is not limited to the following set of core services:

1. **Supported affordable housing: In conformance with HOUSING AS HOMES - SERVICES AS SUPPORTS, supported housing provides access to low cost or subsidized housing. Individual consumers have rights of tenancy to the housing, and are not required to participate in any particular program(s) or service(s) to live in the housing. A flexible and dynamic array of services is made available to each tenant, based on her/his needs for supports to maintain independent living.**

2. **Supported employment: Consistent with vocational rehabilitation services, and in concert with transportation and assistive technology, supported employment assists consumers to move towards independent employment. Supported employment enhances workplace skills, advocates for employment in normal, private market settings, and assists employers to provide "reasonable accommodation" of work sites and work tasks.**

3. **Supported education: Supported education includes vocational rehabilitation and related services tailored to individual strengths and choices, and emphasize personal growth, empowerment, and independence.**

4. **In-home/community supports: Community support teams, family support providers, or similar providers assist consumers and families to manage activities of daily living, including personal care, housekeeping, shopping, and money management. Community support teams may also provide case management, access to assistive technology and transportation, assertive outreach, and early intervention services to assure that institutionalization or other more intensive service interventions are minimized.**

5. **Emergency services/crisis stabilization: Twenty-four hour, seven day per week mobile crisis intervention services assure maximum access to necessary services at a time of crisis, while at the same time minimizing the intensity and duration of the intervention. This service also provides psychiatric hospital pre-screening and diversion, to assure that only medically necessary admissions are carried out, and to assist courts in making correct decisions regarding involuntary commitments.**

6. **Case management**: Case managers provide outreach, individualized assessment and service planning, linkage to necessary services, advocacy, and family support. Case managers are the primary link between consumers and their families and the larger service system, and act on behalf of consumers and their families to ensure that an appropriate, flexible, and responsive array of services is accessible and provided. Case managers also assist consumers and families to access other benefits and entitlements, such as SSI, SSA, Medicaid, housing subsidies, and health care.

7. **Respite care**: Respite care assures that families and other primary caregivers are able to carry out typical activities of family and business life as well as caring for a disabled family member. Respite may also be used to provide a temporary living arrangement for individuals in crisis, with the goal of preventing institutional placement or more intensive long-term interventions.

8. **Foster care/family life care**: Foster care or family life care provides continuous in-home support in a natural family setting.

9. **Psychosocial services**: Consumer-driven supports and services that provide outreach, socialization, vocational, educational, and peer support.

10. **Psychiatric day treatment**: Day treatment provides a short term (usually less than 45 days) alternative to psychiatric hospitalization. Day treatment also begins the process of community re-integration for individuals after a psychiatric hospitalization.

11. **Psychiatric inpatient care**: Hospitalization for acute exacerbations of major mental illness, short term whenever possible.

12. **Family support**: Peer and/or professional support for family members to provide accurate and up to date information about a disabled family-member's condition, about appropriate methods of home intervention and support, and about approaches to working with the formal service system, including advocacy and self case management training. Family support groups also assist family members with the process of providing care over extended periods of time.

13. **Medication management:** Psychiatrists or psychiatric nurses under psychiatric supervision assist mental health consumers to maintain appropriate medication regimens, and assure that necessary medical monitoring is carried out. This also includes medical and nursing support for other individuals with disabilities needing support to manage medications.

14. **Outpatient treatment:** Individual, group, and/or family counselling provided by licensed mental health clinicians.

15. **Substance abuse treatment:** Inpatient and outpatient substance abuse treatment and support tailored to the needs and choices of individual consumers.

MEMORANDUM

TO: IOWA MI/MR/DD/BI SERVICES SYSTEM RESTRUCTURING TASK FORCE

FROM: STEPHEN L. DAY, CONSULTANT TO THE TASK FORCE

DATE: DECEMBER 21, 1992

RE: OBSERVATIONS AND RECOMMENDATIONS FOR SERVICE SYSTEM DEVELOPMENT

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The Iowa MI/MR/DD/BI Restructuring Task Force met four times between mid-October and mid-December. In this very brief time period, the Task Force addressed a number of complicated issues, and made decisions which, if implemented, will have significant beneficial effects for consumers and their families. The following are a set of observations[1] that may be helpful to the Task Force during the continued planning and implementation process:

1. **Funding Formula:** Clearly, a major impetus for the creation of the Task Force was the funding formula for services, particularly the high proportion of county property tax funds which are supporting both institutional and community-based services. Most recommendations for correcting this situation would have the state take on a higher proportion of institutional costs, and/or would have the state assume a greater share of the local match for Medicaid. Implementation of these recommendations would alleviate the financial burden on the counties, and would make Iowa more consistent with the vast majority of other states in terms of the categories and levels of services supported with state funding.

   However, this approach may have some unintended long term consequences. First, counties would have a somewhat greater incentive to send individuals to institutional settings, since non-county funds would be paying a higher proportion of the costs. Second, it would have the effect of removing direct control of service dollars from the county-regional system, which is the level at which individual service planning, service access, and service development is intended to take place.

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[1] Many of these are synthesized from ideas presented by Task Force in meetings or in individual discussions.

The Task Force has recommended that all service funding ultimately be allocated to the regional single point of accountability and authority. This is intended to support the principle that dollars follow individual consumers as their needs and choices change, and would facilitate the development of a managed care approach that has positive incentives for flexible, non-facility-based services. Thus, in some ways the desire to shift funding burden to the state would have the opposite effect of the long term recommendations of the Task Force.

Perhaps the simplest solution, and one which has been recommended in the past, would be to replace current county service funding with a population/tax base-adjusted general levy. This would ensure equity of funding burden among counties, and would obviate the issue of county of legal settlement. State funds could be blended with general levy funds to provide a single funding mechanism for all services. The general levy approach would also support regionalization of service development and service management without complicated accounting or service access procedures at the county level. Under a general levy system, counties could still voluntarily appropriate additional local funds for MI/MR/DD/BI services.

If the general levy approach is not implemented, then another solution would be to allow counties to freeze county funding at current levels and use new state revenues and appropriations to develop new community services and achieve equity of service access among the counties. The current Task force recommendations to the General Assembly essentially follow this approach. Consistent with this approach, the state could provide financial incentives for achieving policy objectives, such as implementing effective regional planning, redeploying resources to develop new priority services, and reducing rates of utilization of state hospital school and mental health institute beds. To overcome the problems of equity and county of legal settlement, new sources of funds are required. This approach can not be expected to have a positive impact on local services if the level of state service funding remains constant.

The option of shifting institutional costs and Medicaid share to the state should remain under consideration. Although this solution is not consistent with the long term vision for the local service system, it could provide some positive short-term incentives for system change. For example, if the state were more responsible for a greater share of institutional costs, the state would have a greater incentive to shift services to a community-based model. The fixed costs now consumed by institutions represent a "drag" on the overall service system, making it difficult to allocate a significant portion of over-all service funding in a flexible manner responsive to individual consumer needs and choices. Thus, to the extent the state has an incentive to reduce institutional costs, funds could be re-deployed to community services. Under

the current funding formula, the state has virtually no incentive to undertake the difficult process of shifting institution-based services to community-based services.

Shifting Medicaid share to the state would also provide greater incentives to counties to implement Medicaid waiver and other creative Medicaid services. It is in the state's interest that counties implement these initiatives, both to increase federal participation in the costs of services, and to accelerate the process of shifting from higher cost, higher intensity services to lower cost, lower intensity services.

Finally, the Task Force has recognized that community service dollars should be planned for and spent at the level closest to the consumer. If the state were to assume a greater share of MHI costs and ICF/MR Medicaid share, then existing county funds could be re-directed to local community-based services. Although this is only partially consistent with the long term vision, it would at least reinforce the principle that county dollars are spent for local services for local consumers, rather than spending county dollars on distant institutions.

It should be noted that changes in the funding formula will not correct the fundamental under-funding of the Iowa MI/MR/DD/BI service system. Even if all revenue initiatives are successful, and if all local services are re-structured to be maximally efficient, there will remain large gaps in services, and many deserving consumers and their families will remain un-served. Thus, while all other positive changes are being implemented, it continues to be necessary to advocate for additional funding for the MI/MR/DD/BI service system.

2. **County of Legal Settlement: Clearly, county of legal settlement will remain an issue as long as counties provide a high proportion of service funding. However, the current county of legal settlement law and practice inhibits freedom of choice and freedom of movement among consumers, and creates substantial barriers to equitable service access. Assuming that the funding formula issues discussed above are resolved, then the county of legal settlement law should be replaced by a "county of legal residence" law. The principle of legal residence is consistent with federal law and federal public welfare and public housing regulations. It also will continue to protect counties from service costs associated with individuals "shopping" for better services, or individuals with no legal place of residence.**

   As recommended by the Task Force, state funds should be used to assure continuity of services for all individuals adversely affected by the county of

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legal settlement issues until the funding formula is rectified. This is particularly true for individuals needing community services during the one year waiting period necessary to establish legal settlement.

The state currently uses state funds to pay MHI (and possibly SHS) costs for individuals with no county of legal settlement. The state should be encouraged to use some of these current expenditures to develop innovative community services designed to reduce utilization of institutional beds. In this way the state could stimulate the process of community service development while at the same time overcoming some of the structural barriers inherent in the county of legal settlement requirements.

3. **Equity of service access: The fundamental principle supported by the Task Force is that all consumers, regardless of where they choose to live within Iowa, have reasonably equitable access to core community services. Given the current funding formula, and the vast disparities in per capita service funding among the counties, it will be difficult to operationalize this principle.**

   As noted several times in discussions of the Task Force, high per capita service funding does not necessarily represent a well developed and responsive community service system. Nor does relatively low per capita funding necessarily indicate a lack of creative solutions at the community level. It is also true that in some counties the population is so small that having one or two additional individuals in a state hospital school or MHI could radically alter the calculation of per capita funding without actually reflecting on the amount of community services available within the county. Thus, the real issue in assessing relative equity of access to services is performance: the actual quality, effectiveness, and costs of each local service system in meeting the needs of local consumers.

   There are a number of dimensions to assessing performance. These could include:

   - **Attaining positive outcomes over time within reasonable cost parameters for consumers in the areas of symptom moderation, personal and social functioning, successful learning and work experiences, and perceived physical and mental well-being;**

   - **Attaining a high degree of satisfaction among consumers and families with the quality, responsiveness, and effectiveness of services offered;**

- **Reducing bed day utilization in hospital, state hospital school, ICF/MR, or other high cost, high intensity, or large scale congregate settings;**

- **Reaching out to and meeting the needs of a high proportion of consumers within the region, as estimated by epidemiological methods as well as identified through local needs assessments.**

It should be the responsibility of the state, in concert with consumers and families, to develop operational definitions of performance measures and to implement a data system that collects the necessary data to assess performance and equity on an annual basis. Collecting the type of data outlined above will also have long term positive benefits for the service system, as all sectors of the system will have incentives to be accountable for achieving common performance standards.

In addition to performance factors, the state should take into account:

- **The fixed costs of maintaining certain core services, such as emergency services and case management, regardless of the size of the service area;**

- **Natural variations in local service costs related to geography, the relative supply of service personnel, transportation convenience, and other factors affecting the cost of doing business at the local level.**

- **Local choices about service system development that may achieve similar outcomes but with different levels or types of services costs.**

4. **Targeting/Gatekeeping: The Task Force was reluctant to establish targeting criteria, primarily because there was consensus that the system should not be conceived on the assumption that resources would always be limited. There was also recognition that defining priority categories of consumers is very difficult, and often creates the appearance of pitting one consumer group against another.**

   However, in reality there is no state or local service system that has ample resources to address all the needs and choices of consumers. Service system managers, and therefore case managers, are faced on a day-to-day basis with making hard decisions about who will and who won't get served with limited

resources. Thus, explicit targeting priorities and gatekeeping functions become necessary components of the local service system as it develops.

Iowa, as with many other states, wishes to keep the service system, and "eligibility" for services broadly defined. This means that individuals with less severe and/or intermittent needs would not have service access reduced on the basis that resources were targeted to more disabled. long-term consumers. In implementing this policy choice, the state and counties will need to focus on two issues:

- First, individuals needing low intensity or short term services should get just that. It is not uncommon in many state and county service systems that this type of consumer may access a broader range of services than necessary, or may remain in service longer than necessary. The function of gatekeeping in these cases, recognizing the importance of consumer and family choice, is to "triage" individuals into a service plan that maximizes the individual's strengths and resources, and minimizes dependency on the service system. Using this approach, a relatively large number of individuals can be served at relatively low cost to the service system.

- Individuals needing multiple, complex services over a predicted long period of time should remain the core focus and responsibility of the public MI/MR/DD/BI service system. These are the individuals for whom private insurance, Medicaid, and Medicare often do not provide the necessary range and types of coverage. They are also individuals who are often most difficult and exhausting to serve, such as profoundly retarded children with multiple medical complications, or homeless mentally ill substance abusers. Even with adequate financing, many parts of the private sector are not yet prepared to serve these types of consumers.

Thus, while keeping the service system relatively open and unrestricted for individuals with less intense needs, it is also necessary to ensure that the system concentrates on meeting the needs of those individuals who are both most difficult to serve and least likely to be able to access services in the private sector. In addition to defining priorities and implementing gatekeeping through case management and possibly other entry points, the state and counties should develop performance criteria and financial incentives to ensure that the local service system, and providers within the system, reach out to and adequately address the needs of these individuals.

5. **Changing role of providers:** There was much discussion in the Task Force about the effects of the proposed service system restructuring on providers and the programs they currently manage. The primary issues are:

- Changing from relatively large scale, facility-based congregate programs to small scale, home-based, and non-congregate programs (i.e., sheltered workshops vs. supported employment);

- Changing from program-based funding to fee-for-service or voucher-type funding in which dollars follow individual consumers.

Both of these changes will have long term benefits for consumers and their families. They should also benefit funding sources (federal, state, county, private) in that there will be greater incentives for lower-cost services, and there will be a clear accountability link established between service dollars spent and outcomes for individual consumers. However, these changes put providers at some risk, both because of their capital investments in current large scale residential and day program facilities, and because of the uncertainties of a more "market driven" purchase of service system.

Therefore, implementation plans at the state and planning council levels should take into account the need to phase in system changes in a manner that accommodates the financial realities of the current provider system. Strategies could include:

- Providing a reasonable time frame for converting existing real estate to other purposes to permit providers to convert existing capital to new program models;

- Providing a mix of program funding in concert with fee-for-service funding for a transitional time period;

- Establishing a state-wide "pre-qualification" process whereby providers could qualify to do business in multiple jurisdictions, and thus could market directly to counties, planning councils, families, and consumers.

While being sensitive to the needs of the current provider system for time and support to change to new models of service delivery, the state and counties should remain firm in their commitment to the changes. Next to closing state hospitals or state hospital schools, accomplishing this type of change in the provider system will be the most difficult to accomplish. Thus, system managers should remain clearly focused on the long-term system goals for

consumers and their families while negotiating with providers for necessary changes.

Another key to the successful implementation of changes will be to pay providers a rate that adequately covers all their costs of delivering services in new ways. Financial incentives are usually the most effective force for positive system change. Conversely, continued restrictions on rates of reimbursement for small-scale community services, if not corrected, will continue to provide dis-incentives for current providers to go through the painful process of converting real estate to other purposes, re-training staff, and putting themselves at risk for reimbursements in a market-driven system.

6. **Medicaid initiatives: Given the pressure to contain current Medicaid expenditures, implementing new Medicaid revenue initiatives may encounter some resistance, or at least receive a low priority on the part of the state. However, these initiatives have the best promise of providing new revenues at a time when neither county or state appropriations can be increased. At a policy level, Medicaid expenditures and revenues should be viewed as broadly as possible. That is, all current state and county service expenditures should be viewed as a whole, and then Medicaid should be factored into net state/county costs. For example, if private general hospitals are used for acute psychiatric admissions, state Medicaid share may be increased. However, in the context of over-all state/county Mental Health Institute costs, there are likely to be net savings from this strategy.**

As the Task Force discussed Medicaid revenue issues, many issues were raised relative to the difficulty and uncertainty of certain initiatives. However, most states and local jurisdictions have already overcome these types of issues, and have successfully implemented programs that take full advantage of available federal Medicaid reimbursement. Using the above example, most states have found that less than five per cent of general hospital psychiatric care cannot be reimbursed through a combination of Medicaid, Medicare, and private insurance. In some jurisdictions 100% of psychiatric inpatient care is reimbursed through Medicaid or private insurance. Also, most states have successfully implemented the rehabilitation option to access Medicaid reimbursement for services previously funded with 100% state/county dollars.

The State could pursue Section 1915(a) and 1915(b) waivers to control access to new services, such as rehabilitation option and personal care services. This could alleviate some of the fear on the part of the state that revenues attained by implementing these initiatives would be offset by increases in the number of individuals accessing services. Under these waivers, access can be defined for select priority consumer groups and can be controlled through the case

management system. The selection of providers offering such services may also be limited.

7. **Housing: The independent supported housing model espoused by the Task Force depends on affordability as well as the availability of flexible supports. Thus, a key element in implementation of the core service system will be accessing federal and non-public housing resources to ensure that there is an adequate supply of safe, decent, and affordable housing for consumers. At both the state and county levels, an aggressive effort is necessary to attract financing and rental subsidies, support housing development and management entities, and link supports and services with housing.**

   The designation by the General Assembly of the Department of Human Services as a public housing authority could provide an excellent mechanism for accomplishing at least part of this task. HUD acceptance of the designation is pending, and may require some creative negotiation. Assuming that the designation is approved, the state will still have to mount a concerted effort, with a clear and defendable strategy, to receive rental assistance and related supported housing resources from HUD. The state will also need a strategy to leverage federal resources with other public and private housing financing mechanisms to expand the supply of affordable supported housing.

   Municipal and county public housing authorities, community development corporations, and other non-profit housing sponsors also need to be poised to apply for federal housing funds, such as McKinney and Section 811, as these become available. This combination of state DHS and local efforts is necessary to bring new federal housing resources into Iowa, which in turn supports the development of the desired core service system without the necessity of adding new state or county funds.

8. Moratorium on the development of new congregate settings: This issue was discussed by the Task Force, but was not included in the recommendations. The purpose of the recommendation is to ensure that, even if the system cannot develop rapidly towards small scale settings, no new large scale congregate settings are developed that are inconsistent with long-term system goals. This idea has merit, and should receive additional consideration. Operationalization of the principle could include:

   - A moratorium on the development of any new ICF/MRs and on the conversion of existing county care facilities or residential care facilities (RCFs) to ICF/MRs;

   - A moratorium on the development of any congregate living facilities serving more than four individuals, unless each

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individual would have at least a separate room with lavatory facilities;

- **A moratorium on the development of congregate day services, including congregate vocational services, unless the program met the definition of psychosocial services in the core services plan.**

On a more personal note, I would like to thank the members of the Task Force, the Chairs, and the staff of the Legislative Service Bureau for the high degree of communication, cooperation, and effort to reach consensus on difficult issues during this process. I enjoyed working with all of you, and I feel you all made your best efforts to make the Task Force process productive and successful. The course of service system restructuring determined by the Task Force will be long, difficult, and sometimes frustrating. The key to success will be the development of committed leadership at the state and local levels to ensure that implementation proceeds in the face of the inertia and obstacles that are always present when fundamental system change is undertaken. For both the General Assembly and for the members of the Task Force, it will be important to focus on putting in place leadership with appropriate authority and resources to follow through on the multi-year implementation process.