



Technical Assistance Collaborative, Inc.

Quick Fixes or Structural Reform: An Evaluation of Iowa's Public Mental Health System

Final Report

Volume I: Narrative and Exhibits

Prepared for the

Iowa Mental Health Planning Council

December 1998

Exhibits

| | |
|---|------------|
| Overall Penetration Rates | Exhibit 1 |
| Readmission Rate | Exhibit 2 |
| Number of State Mental Health Agency (SMHA) Operated & Funded Beds Per 100,000 Persons | Exhibit 3 |
| Involuntary Admissions | Exhibit 4 |
| Administrative Cost Standards | Exhibit 5 |
| Mental Health Per Member Per Month Capitation Rates | Exhibit 6 |
| Telephone Speed of Answer | Exhibit 7 |
| Telephone Call Abandonment Rates | Exhibit 8 |
| Mental Health Institute's Rates of Involuntary Admissions | Exhibit 9 |
| Mental Health Institutes' Average Length of Stay | Exhibit 10 |
| Mental Health Institute Days per 1,000 Population by County | Exhibit 11 |
| Per Capita Gross County CMI/MI Expenditures | Exhibit 12 |
| Mental Health Access Plan (MHAP) Claims Paid per County | Exhibit 13 |
| MHAP Claims Paid and Gross County CMI/MI Expenditures Combined | Exhibit 14 |

Volume II - Appendices

| | |
|---|-------------|
| Key Informant Structured Interview Format | Appendix 1 |
| List of Key Stakeholder Interviewees | Appendix 2 |
| List of Focus Group Participants | Appendix 3 |
| Stakeholder Survey Form | Appendix 4 |
| Instruction on how to Complete the Stakeholder Survey | Appendix 5 |
| List of States and Individuals Contacted | Appendix 6 |
| Performance Data Request Form & Example of Request Letter | Appendix 7 |
| Summary of Initial Focus Groups | Appendix 8 |
| Detailed Results of Stakeholder Survey | Appendix 9 |
| Mental Health Institutes Utilization by County | Appendix 10 |
| Per Capita CMI/MI Expenditures by County | Appendix 11 |
| MHAP Claims Paid by County | Appendix 12 |
| Gross County CMI/MI/MHAP Expenditures Combined | Appendix 13 |

I. EXECUTIVE SUMMARY

Since the efforts of Dorethea Dix in the mid 1800's, government, be it state or county; has taken responsibility for the care and treatment of the most vulnerable in society – people with mental illness. Providing for this population has evolved through the years from largely institutional care in state facilities, to a system of support and rehabilitation in community settings. These later approaches coupled with new medications and treatment protocols have enabled many people with mental illness to lead satisfying lives in communities of their choice. Despite the gains made in recognizing and treating mental illness, planning, organizing, funding and delivering quality mental health care remains a difficult challenge for most governments to achieve.

In late 1997, The Iowa State Mental Health Planning Council sought to address this challenge by calling for the study and evaluation of Iowa's public mental health system. The Council, in cooperation with the Iowa Department of Human Services, developed a request for proposals to conduct an evaluation focusing on how the Iowa system of public mental health care compares to other state and county systems. This report details the results of that study.

Like most public systems, Iowa's system of public mental system is in transition. Over the last several years, new legislation, new funding, the advent of Medicaid managed behavioral healthcare have placed new demands and expectations on the Iowa system. While some of these initiatives have resulted in improvements in care, others have resulted in the closing of some community mental health centers, battles over legal settlement; and confusion over the roles and responsibilities of state and county government.

This evaluation has found that in many ways Iowa's mental health system compares favorably to those found in other states. Readmission rates at the state's mental health institutes are lower than some states, inpatient length of stays under the Mental Health Access Plan (MHAP) are low, and many of the state's county mental health systems have developed innovative services and programs. However, the evaluation has also found that Iowa's system of public mental health care is stymied by many organizational and financial considerations. These include multiple systems of care; multiple funding streams; a limited statutory requirement to provide community based care; limited state funding; heavy reliance on property taxes at the county level to fund care; and the lack of a shared vision among stakeholders and constituents. These issues have created a climate of animosity and mistrust among these stakeholders.

To address these issues, the evaluation recommends a series of new initiatives designed to streamline the organization and funding of mental health services in Iowa, and initiatives that will address service gaps which may exist in the current system of care for children and adolescents, and adults. Specifically, the evaluation recommends the following:

A. System Improvements

1. Increase the state's contribution to funding the mental health system to provide certain levels of property tax relief to Counties and to support development of a required minimum set of services across the state.
2. Retain the local administration of mental health services for the indigent.
3. Change the mental health statutory requirement to include a community based mental health service system with a minimum set of services that must be provided for adults with a serious mental illness and children and adolescents with serious emotional disturbance.
4. Simplify the eligibility system for people with serious mental illness by requiring counties to serve all eligible residents without reference to legal settlement.
5. Establish incentives for counties to collaborate in providing community based mental health services.
6. Encourage counties and county collaborations to develop the capacity to compete for future integration of Medicaid and other mental health funding sources.
7. End financing that encourages over-utilization of the state mental health institutes.
8. Clarify the role of the state in the mental health system to focus on allocating resources, setting standards, evaluating performance, and promoting quality improvement. Organize the structure of state staff to correspond to these functions.
9. Establish a minimum set of performance measures that all public mental health systems of care must collect and report.
10. Utilize benchmarking data to track system performance and to focus on particular areas of the Iowa system that needs improvement.
11. Encourage consumer and family participation in the governance and oversight of the state/county mental health system.
12. Provide technical assistance and support for meeting the needs of special populations, including the elderly and those with a dual diagnosis of mental illness and substance abuse.

B. Medicaid Improvements

1. Integrate Psychiatric Mental Institutions for Children with other Medicaid funds.

2. Expand utilization and enrollment in the Medicaid system for adults and children with mental illness to increase access to mental health services and maximize Federal Financial Participation (FFP).
3. Improve access to long-term and rehabilitative services by adding the Medicaid Rehabilitation Option to the state Medicaid Plan.
4. Improve protocols for client referral between the Iowa Plan and county administered services.

C. Technical Assistance Improvements

1. Better define the technical assistance needs of state and county systems of care to focus on treatment and service improvements; administrative and management improvements; and systems improvements.
2. Foster system-wide ownership of improvement initiatives by developing a collaborative model for delivering technical assistance.

Implementing these recommendations will not be easy. The difficulty lies in that these recommendations seek fundamental change in way the current system of care in Iowa is funded and administered. These types of change will require new appropriations, as will recommendations that seek to ensure that a minimum level of community care is available for children and adults across the state.

Government provision of mental health care has come a long way from the days of Dorethea Dix. By implementing these recommendations, Iowa can realize its long awaited goal of creating a cost effective, accessible and quality system of mental health care for its most vulnerable citizens.

The Technical Assistance Collaborative, Inc.

December 1998

II. INTRODUCTION

In December of 1997, the Iowa State Mental Health Advisory Planning Council through the Department of Human Services (DHS) engaged the Technical Assistance Collaborative, Inc. (TAC) to undertake an evaluation of Iowa's public mental health service system. The purpose of the evaluation was to assess the performance of Iowa's mental health system in relation to current standards, benchmarks and best practices found in public mental health systems in the United States. The evaluation had four key components:

- Task One Identification of Performance Indicators, Benchmarks and Best Practice Areas;
- Task Two Assessment of Iowa's Performance in Relationship to Performance Benchmarks and Best Practices;
- Task Three Identification of Technical Assistance Needs and Strategies to Improve Iowa's Performance in Relationship to Benchmarks; and
- Task Four Preparation of a Final Report and Recommendations.

TAC previously submitted reports summarizing Tasks One, Two, Three, and draft recommendations. This Final Report integrates the contents of all these documents, completing Task Four.

A. Purpose of This Report

The State Mental Health Planning Council charged TAC to evaluate Iowa's entire system of public mental health services as a whole. Thus, the scope of this project included: Iowa's Medicaid behavioral health managed care program; portions of the Medicaid mental health system that operate outside the managed care program (such as Psychiatric Medical Institutions for Children); community and institutional mental health services managed by Iowa's counties; and those children mental health services that are managed by the Department of Human Services in collaboration with decategorization boards. This required that the roles of the administrative bodies, including the Department of Human Services, the managed care organization contracted to managed Medicaid behavioral health services, ninety-nine counties, thirty-seven decategorization boards, seventeen human service administrations, and four state hospitals be considered. In addition, school systems and Area Educational Agencies that play important roles in children's mental health and related services were included as system stakeholders. The evaluation was to include:

- Quantitative data on the structure of Iowa's mental health system and evaluation of key indicators of its performance;

- Qualitative data collected through the perceptions and opinions of consumers and families and other key system stakeholders.

The Council charged TAC to develop criteria for the evaluation by seeking benchmarks for significant measures of performance of public mental health systems from other states and counties, and by identifying national and Iowa specific best practices in mental health service administration and provision. TAC then analyzed Iowa's performance with respect to these criteria and identified barriers that impede the delivery of mental health care in Iowa and opportunities for improvement. The team considered how to take advantage of those opportunities to most effectively address problems, and what technical assistance the state would need in order to do so.

B. Project Approach

Upon receipt of a contract from the Iowa Department of Human Services, TAC assembled a team of evaluators with considerable experience in the organization, financing and delivery of public mental health services. Led by Martin Cohen and Richard Dougherty, the evaluation team has made a number of trips to Iowa to interview key informants and conduct focus groups with stakeholders. In addition, the team reviewed documents and available data on Iowa's mental health system, and gathered information and relevant research to provide performance benchmarks and best practices to use as standards for this evaluation.

For Task Two, the team surveyed Central Points of Coordination (CPC's), Human Service Area Administrators (HSAA's), and Special Education Directors of Area Education Administrative (AEA) offices, asking them to rate different aspects of the current system. The team also compared Iowa's mental health system to mental health systems of other states and counties on certain performance indicators, to the extent that available data allowed. Completion of Tasks Three and Four drew upon this body of work to identify barriers and opportunities specific to Iowa's mental health system, and to identify Iowa's technical assistance needs. The Evaluation Team shared its findings and recommendations in regular meetings throughout the project with the Oversight Committee. In addition, the Team Leaders presented the conclusions of each report to the Committee. The reports were then refined and further developed to incorporate the Committee's input.

C. Organization of the Report

Section III of this report describes the methods used to collect the data needed for this project. Our stakeholder and key informant data collection included structured interviews with key stakeholders, focus groups, and the survey of administrators concerned with the local mental health system. We also describe how we sought and analyzed performance data for benchmarking Iowa to other mental health systems and for comparing Iowa county systems to each other. Finally, we conducted an extensive review of the literature regarding the practice of mental health treatment for information about best practices.

Section IV provides a description of Iowa’s current mental health system as it was organized during the period of this project, including the Medicaid system of care, the state/county system of care for adults with mental illness, and the children’s mental health services provided through the decategorization system.

Section V contains our findings from Tasks One, Two, and Three. First we describe what we learned from our Iowa informants through interviews, focus groups, and our survey. This is followed by our analysis of performance benchmarking data comparing Iowa’s overall system to other state and county systems, and analyzing variation between counties within Iowa. The next section describes best practices of relevance to Iowa. The final section summarizes the organizational, financial, legal, and political issues that serve as barriers to the improvement of Iowa’s mental health system.

Section VI provides an overview of strategic opportunities available to Iowa to improve its mental health service system. This is followed by our detailed recommendations for fundamentally restructuring Iowa’s state/county mental health system, and for addressing problems in its Medicaid mental health system. These recommendations also describe what kinds of technical assistance will be needed as part of these improvement initiatives and suggests a model for delivering technical assistance. Section VII is a brief conclusion.

III. METHODOLOGY

TAC sought input from a wide variety of system stakeholders from the beginning of the project both to identify issues of concern and to discover what they considered to be the strengths and weaknesses of the system in order to focus the evaluation. Simultaneously, TAC consultants interviewed key informants and identified key documents and data needed to understand how Iowa's complex mental health system operates. This information was collected from structured interviews and focus groups, using the methods described in Sections A and B. TAC also administered a survey to local system administrators that provided data on their perceptions and preferences that could be analyzed by type of community (rural or urban) and by type of respondent, as described in Section C.

This data on stakeholder perceptions was complemented by comparing Iowa to other states and counties, using a variety of performance measures. This effort raised a number of methodological issues described in Section D. Finally, TAC's approach to identifying relevant best practices in mental health service and administration are described in Section E.

A. Interviews

Key informant interviews were held during January and February of 1998. In all, 33 key informants were interviewed using a standard set of interview questions developed for this project. Each informant was sent a confirmation letter with the questions at least three days prior to the interview. The questions requested informants to recommend the primary goals for the evaluation, indicate how the evaluation could help them, and identify major problems or opportunities for improvement in Iowa's mental health delivery system. The full text of the questions is included in Appendix 1.

Interviewers attempted to adhere to these questions as much as possible, but by the very nature of these interviews, broader areas and topics were explored depending upon the knowledge or area of expertise of the interviewee. All those interviewed were told that their answers would be used to compile findings and observations, but that no specific answer would be attributed to a specific person. For that reason, no attributions are given to these observations.

The pool of key informants was developed by the Department of Human Services, Division of Mental Health and Developmental Disabilities, with suggestions from the project's Oversight Committee and the evaluators. A complete list of interviewees is included in Appendix 2. Interviewees included representatives from the following organizations or areas:

| | |
|---|---|
| Providers | <ul style="list-style-type: none"> • Community mental health centers • Rehabilitation agencies • Guidance centers • Children and family agencies • Homeless services • Supported employment |
| County Government | <ul style="list-style-type: none"> • CPC Coordinators • Iowa State Association of Counties |
| Mental Health and Developmental Disabilities Commission | <ul style="list-style-type: none"> • Members |
| Department of Human Services Leadership, Senior Management and Key Staff | <ul style="list-style-type: none"> • Mental Health and Developmental Disabilities • Adult, Children and Family • Medicaid/Mental Health Access Plan • Economic Assistance |
| Other State Agencies | <ul style="list-style-type: none"> • Elder Affairs • Education • Economic Development • Juvenile Justice |
| Advocacy Organizations | <ul style="list-style-type: none"> • Family • Consumer |
| Other Interested Organizations | <ul style="list-style-type: none"> • Child and Family Policy Center • MHAP Managed Care Vendor • University of Iowa, Iowa Consortium for Mental Health Services, Training and Research |

B. Focus Groups

Members of the evaluation team conducted five focus groups during the first two weeks of February. Group members were asked to identify current concerns in the mental health system, recommend issues that should be addressed in our evaluation, the most important benchmarks for that system, and ways that the evaluation could be of assistance. Finally, the groups were asked to consider their vision or wish list for improving the mental health system.

Some groups were able to discuss particular issues in more detail than others. Some of the groups did not focus on performance indicators in as much detail as others were able. This flexible approach allowed discussion and reporting of a breadth of issues for some groups, but more depth on certain, pressing issues for other groups, hence complementing each other in the end.

In order to ensure that TAC got a statewide perspective, additional focus groups were conducted in Council Bluffs, Des Moines, Iowa Falls, and Cedar Rapids in May.

Participants included consumers and families, Central Point of Coordination (CPC) administrators, and some providers. Given the high representation of CPCs during the second round of focus groups, discussions tended to focus on the county administrator's perspective in regards to the public mental health system in Iowa. In addition, consultants interviewed the Superintendents of all four Mental Health Institutes and some of their staff. Similar to the first round of focus groups, the themes covered during these focus groups varied depending on the perspectives of the attendees. A complete list of focus group participants is included in Appendix 3.

C. Stakeholder Survey

1. SURVEY CONTENT AND ADMINISTRATION

In an effort to assess the perceptions of key stakeholders regarding the performance of Iowa's public mental health system against national best practices, a key stakeholder survey was developed (provided in Appendix 4). TAC prepared a draft survey to the Oversight Committee for review and comment. After Oversight Committee suggestions were incorporated, the final survey was sent to all CPCs, HSAAs, and Directors of Special Education at AEAs to solicit structured feedback through the use of the standard survey instrument. At the request of Carl Smith of the Oversight Committee, the survey distributed to AEAs contained an additional section with questions tailored to the knowledge and experience of these stakeholders and their perceptions about the Iowa public mental health system.

Survey Administration

Respondents were provided instructions (Appendix 5) on how to complete the survey to ensure consistency. Each respondent was asked to complete only one survey, answering all questions if possible. Respondents were assured that no individual responses would be identified in order to encourage candor. Before distributing the survey, it was evident that certain terms or questions might be unfamiliar to some of the respondents, particularly Directors of Special Education at AEAs. To address these issues, Directors of Special Education were encouraged to pay particular attention to questions 36-42 and 56-62 as these related directly to mental health services provided to children and adolescents. In addition, all respondents were given the choice of selecting "N/A" as a response, indicating that they were unsure about an answer to a particular question, or did not have enough information to answer the question.

Survey Contents

The survey was organized to correspond to the best practice areas identified as important in Iowa's mental health system. The topics addressed by the survey are summarized below. Respondents were asked to rate agreement or disagreement with a particular statement about Iowa's public mental health system by circling a response from the following choices: strongly disagree, disagree, neutral, agree, strongly agree, or N/A (not able to answer the question or by responding to a 5-point scale specific to the question).

- State/County Relations: Appropriateness and clarity of the roles and responsibilities of DHS, CPCs, and the State County Management Committee (SCMC) in the administration and oversight of Iowa's public mental health system and opinions about the recently promulgated HF 2545 rules (the rules were in draft form at the time of survey).
- Community Empowerment Boards: Initial baseline of the reaction of stakeholders to the newly passed Community Empowerment Board legislation pertaining to the delivery of services to children from one to five years of age.
- Managed Care for Mental Health Service Provided to Medicaid Recipients: The impact of the MHAP program on accountability and quality of mental health care, cost shifting to county funded services, and coordination of care with county funded services.
- Multiple County Collaboration: Opportunities for multi-county collaboration; the practicality of such collaboration; and the likelihood of pursuing such collaborative efforts.
- Legal Settlement: Efficiency of legal settlement administrative processes, ease of understanding legal settlement rules, and its impact on the provision of mental health services.
- Eligibility: Respondents' reactions to the possibility of implementing statewide standards for consumer financial eligibility for services, and a minimum set of community based services available to all eligible consumers.
- Mental Health Services to Children and Adolescents: Coordination of care, decategorization, and quality/appropriateness of mental health services provided to children and adolescents; perception of the degree of availability/access and appropriateness of utilization of a range of mental health services for children and adolescents in the respondent county(ies).
- Mental Health Services to Adults: Perception of the degree of availability/access and appropriateness of utilization of a range of mental health services for adults in the respondent county (ies).
- Special Populations and Issues: Diversion from the criminal justice system; mental health service system coordination the criminal justice system; mental health services to the elderly; outreach to homeless persons; discharge planning after an inpatient stay; and family support for children with mental illness.
- Consumer and Family Involvement: Participation of consumer and family members in treatment planning and oversight, evaluation and planning matters for the local system of mental health care.

- Coordination with Special Education: Ease of access to the mental health service system by Directors of Special Education, overall quality, responsiveness, and adequacy of the service system in the multi-county respondent AEA.

2. *SURVEY ANALYSIS*

TAC staff tabulated results of the surveys and preliminary summary results were presented to the Oversight Committee in draft form at their August 5, 1998 meeting. Further analysis was performed by TAC staff to verify the results. TAC also stratified the results of the analysis for urban and for rural areas, and by type of respondent. If a single or multi-county CPC area population was greater than 30,000 persons according to most recent U.S. Census estimates, it was classified as urban, with all others classified as rural. Respondents were classified as CPCs, HSAs and AEs.

D. Performance Benchmarking

I. PERFORMANCE DATA

Collection of performance data on other mental health systems of care was unexpectedly challenging. Despite the prominence of important health data collection initiatives such as the Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee on Quality Assurance (NCQA), and the mental health focused Performance Measures for Managed Behavioral Healthcare Programs (PERMS), developed by the American Managed Behavioral Healthcare Association (AMBHA), and the measures included in the Mental Health Statistics Improvement Project (MHSIP), developed by the Substance Abuse and Mental Health Services Administration (SAMSHA), many state and county systems have not yet developed the capacity to produce the needed data.

TAC contacted state and county mental health administrators to request available data on the performance of their own systems of care. A full list of states and individuals contacted is provided in Appendix 6. We were surprised at the difficulty in getting data from states and counties. Many of those that did provide data expressed strong reservations about the validity of that data. The data that we were therefore able to obtain had significant limitations:

- First, some systems do not separate mental health services from other medical and health related services.
- Second, in some cases the organization of delivery systems varies widely from state to state, making it difficult in some cases to provide comparable data across funding streams or required services.
- Third, some administrators indicated that the data was supplied by contractors and the purchaser was not yet satisfied that the data collection methods were accurate. In other cases, unduplicated client counts were not available.

- Fourth, few systems have a full year of data available making it difficult present data for comparable periods.
- Fifth, much of the available data is specific to the Iowa system being measured and is either not collected by other systems, or is defined differently by other systems and is therefore not directly comparable.
- Finally, much of the available data pertains to aspects of mental health system performance that are no longer considered useful for system management. Few systems have fully implemented AMBHA or MHSIP measures.

We presented our initial data, including some data on commercial populations, to the Advisory Committee and jointly identified those measures for which data was available and which would provide the most meaningful comparisons to Iowa’s mental health system. The following 15 items were selected. The indicators in *italics* were not collected by most systems we surveyed due to difficulties in collecting it, and our analysis does therefore not include them. However, due to the availability of certain data elements such as capitation rates, additional indicators not included in the following list are included in our analysis.

| INDICATORS | |
|-------------------|--|
| 1. | Penetration Rate |
| 2. | Psychiatric Length of Stay |
| 3. | Inpatient Utilization |
| 4. | <i>Outpatient Utilization</i> |
| 5. | Readmission Rates |
| 6. | <i>Wait Times</i> |
| 7. | Telephone Access: Abandonment rate and speed of answer |
| 8. | Administrative Expenditures |
| 9. | Per Capita Direct Expenditures |
| 10. | <i>Community Tenure</i> |
| 11. | Involuntary Admissions |
| 12. | <i>Complaints and Grievances</i> |
| 13. | <i>Criminal Justice System Involvement</i> |
| 14. | <i>Service Denials</i> |
| 15. | <i>Geographic Availability</i> |

To collect this data, we developed a standard performance data request form and sent to twenty state and county mental health administrators across the country. Respondents were asked to define the parameters of their systems of care such as covered population, payor sources, and date range for reported data to provide a basis for determining applicability of the benchmarks. (See Appendix 7 for the performance data request form and example request letter.) In order to maximize the amount of data we were able to collect, we followed-up personally on the majority of requests by telephone calls or electronic mail messages. Despite these efforts, the response rate to our requests was lower than expected. We received responses from seven out of the twenty state and county mental health administrators contacted, a response rate of 35%. In addition, three of the seven

administrators who responded to our request stated that they were unable to provide any relevant data for our analysis. Additional data sources, such as the Internet and state public information offices, were contacted in order to augment the data received from our standard request. Our analysis does not include some of the data collected due to the fact that it represented systems and populations so different from Iowa that it would not have been useful for comparison purposes, or was considered too old to be of use for this study. As a result, this report includes graphical presentations and corresponding descriptions only for the subset of requested measures for which sufficient comparable data was collected.

We also collected and analyzed Iowa specific data from the Mental Health Access Plan (MHAP), the four MHIs, and from the County Management Information System (CoMIS). In addition, data was requested from national organizations such as the National Association of State Mental Health Program Directors (NASMHPD).

Despite our efforts to collect comparable data, the measures we have analyzed are from unique systems of mental health care and information systems, and may represent different periods of time, or different covered populations. In order to address the comparability of data, all sources are described in terms of the covered population, system of care, and date range of data. In addition, we attempted to minimize such differences by presenting data from the most recent time period data for public mental health systems only.

E. Best Practices

A review of national best practices in the field of mental health administration and service provision can help the stakeholders of the mental health system develop a more integrated vision for the future. TAC consultants identified areas of practice that would be of particular relevance in Iowa. The practices fell into four general areas: state-county relations, legal settlement, mental health services to children and adults (including special populations or services needs identified as significant in Iowa), and consumer involvement. For each area, TAC drew upon the consultants' knowledge as well as reviews of relevant literature to identify best practice standards, and to select programs or systems that provide examples of successful implementation of the practices. These best practice areas were provided for the review of the Oversight Committee, and based on Oversight Committee input were integrated into recommendations for system improvement. A list of references has been provided for additional information about best practices than was summarized in this report.

IV. DESCRIPTION OF CURRENT SYSTEM

A. Administration and Overview

Historically, the state of Iowa has used a de-centralized, county-based system to administer, fund and provide mental health services to consumers. This is reflective of the population of the state in which an overwhelming majority of the counties are rural. Over the past several years, however, many legislative and other efforts have attempted to enhance the administration and delivery of mental health care throughout the State. These changes in the administration and organization of mental health services have somewhat altered the roles and responsibilities of the Iowa Department of Human Services, counties and private sector entities, in the administration, funding, and delivery of services throughout the State. In order to evaluate the system of care in Iowa, it is essential to not only understand the current system of care, but also the recent changes that have impacted this same system of care.

1. STATE ADMINISTRATION

The Iowa Department of Human Services (DHS) functions as the state mental health authority. In this capacity, it has responsibility for oversight of the statewide system of care, acting as the regulatory agency and accrediting entity for mental health centers and mental health providers. DHS promulgates and administers rules that govern mental health service delivery in the State. DHS also maintains responsibility for allocation of federal and state funds to counties in order that they can arrange for and provide care from persons in need.

In 1992, DHS was given a mandate by the legislature to develop managed care programs for the Medical Assistance Program (Medicaid) whenever feasible. After planning efforts, the Medicaid program, as administered by DHS, Division of Medical Assistance received waivers of Sections 1915 (b) and 1902 (a) of the Social Security Act to operate a single statewide contract for mental health services to Medicaid recipients. After initial delays due to procurement litigation, the Mental Health Access Plan (MHAP) was implemented in 1995. In 1998, the program was expanded and re-bid. The most recent Request for Proposal (RFP) integrated substance abuse services with the mental health services that have been contracted for under this plan in past years.

2. COUNTY ADMINISTRATION

While DHS maintains these roles, Iowa is primarily a county administered system of care which has undergone some recent modifications intended to enhance the overall county accountability in administrative capacities. Senate File 69 provided property tax relief to counties through state funding for the mental health, mental retardation, and developmental disabilities service system. The SF69 legislative changes resulted in an increase in state funding of mental health (MH), mental retardation (MR), and developmentally disabled (DD) services. The State of Iowa provided \$61 million for FY 1996, \$78 million for FY 1997 and \$95 million for FY 1998. At the same time, SF69 froze the county tax levy

monies that could be expended for MH/DD, thereby eliminating the option for county expansion of funding for these services. As a result these funds did not result in a lot of additional funds for services, since these funds were used for property tax relief.

This legislation also enhanced the county-based administration and management of these services. The law required counties to:

- **improve accountability, service coordination, and appropriateness of publicly funded mental health services;**
- **establish a Central Point of Coordination (CPC) process** (single point of entry process) either on a single county or multiple county basis; and
- **submit County Management Plans by counties (or multi-county CPC areas) to the State County Management Committee (SCMC).** These plans require that counties identify and describe the manner in which mental health services would be provided in the county, including requirements for planning, provider network identification and contracting, eligibility determination, service coordination, service tracking, evaluation and monitoring, and quality assurance.

Additional legislative changes and administrative rule changes have put in place financial incentives for demonstrable county administrative improvements. This legislation (HF 2545) requires collection and submission of performance measure data related to:

- equity of access to services,
- community-based supports,
- consumer participation, and
- administration.

The 99 Iowa counties are responsible for meeting the needs of elderly, poor, sick and disabled residents as set forth by the Code of Iowa. As part of these responsibilities, counties must the pay for hospitalization of persons in state operated mental health institutes (MHIs) and arrange for certain services to persons who are chronically mentally ill (CMI). At present, the 99 county systems individually submit County Management Plans, however there are 79 CPC administrators who manage the local systems of care for single and multi-county areas.

B. Funding

I. FEDERAL FUNDS

Supplemental Security Income (SSI).

Most disabled persons are eligible for the federal entitlement program serving aged, blind, or disabled persons Supplemental Security Income (SSI). SSI eligibility automatically

entitles the client to Medicaid (Title XIX), which covers medical expenses. SSI provides a monthly income level of \$494. In addition, SSI provides a monthly supplement to certain beneficiaries residing in congregate care facilities, such as Residential Care Facilities (RCFs).

Medicaid (Title XIX)

In addition to the primary health care and MHAP (Iowa Plan) benefits, the Medicaid program funds several special programs for the MH/MR/DD populations. These services include: Intermediate Care Facilities for Person with Mental Retardation (ICF/MR); Home and Community Based Waiver, which allows the state to redirect Medicaid funding from institutional setting to support a flexible array of community services on behalf of persons who MR/DD; and Enhanced Services.

Title XIX Enhanced Services

Enhanced services is used to identify three services that were added by DHS to the Medicaid Plan in 1989. These services require counties to pay half the match on the non-federal share when services are provided to persons with mental retardation, a developmental disability or chronic mental illness that are not in the Iowa Plan. In addition to these services, the state requires counties to pay 100 percent of the non-federal share for adult ICF/MR services and the home and community-based waiver for persons who would otherwise be in an ICF/MR. The Enhanced services are Case Management for persons with mental retardation, developmental disabilities and chronic mental illness, Partial Hospitalization and Day Treatment.

2. STATE FUNDS

MH/DD Services Funding

Community service funds are distributed to counties on a two-part formula: 50% based on the proportion of the poverty population and 50% based on the percentage of the total state general population. For FY'99, \$17.5 million was allocated to counties for community services. Recent legislative changes have modified the allocation of these funds to waive old regulations if these funds are used by counties in accordance with a state approved county management plan. In addition, HF 2545 has established a provision for an allowable growth fund. This growth fund includes \$18.1 million for FY'00, amounts to funds previously appropriated plus the 2.48 percent allowable growth factor recommended in the Governor's Budget. HF 2545 appropriates funds to each of four priority areas on a per capita basis, 75% based on poverty proportion and 25% based on percentage of the total state general population. The 75/25 formula replaces the 50/50 formula and is allocated as follows: Growth - \$12 million, Per Capita Expenditure Target Pool - \$2.1 million, Risk Pool - \$2 million, and the Incentive and Efficiency Pool - \$2 million. In order to receive money from the Incentive and Efficiency Pool, counties must submit data on time, collect and report selected performance measure data, receive an acceptable score on County Management Plan submissions in order to obtain these funds.

State Payment Program

The State Payment Program operates in conjunction with county funded services for people with mental illness, mental retardation or other developmental disabilities. The program

Technical Assistance Collaborative, Inc.

pays for services to a county resident without legal settlement in any county, when the resident county would otherwise be liable under the county management plan to provide the service if the resident had legal settlement in the county.

Services funded included adult day care, adult residential services, supervised apartment services, adult support, supported employment and other vocational services, and transportation. In FY1996 services to 495 people statewide were funded through this program. Those with mental retardation were 55% of all enrollees; those with a mental illness were 41% of all enrollees, and those with a developmental disability were 4% of all enrollees. Looking at only the new enrollees (from January 1996 through June 1996), 71% had a mental illness, 25% had mental retardation, and 4% had a developmental disability.

Property Tax Relief Payments

This payment began in FY 1995/96 to reduce the county levies for MH/MR/DD services. The funds were distributed to counties using a three part formula: the county’s share of the population; the county’s share of the state’s total taxable property valuation; and the county’s share of the base year MH/MR/DD expenditures (counties had the option of choosing either FY 1994 or FY 1996 as their base year). The county is required to reduce the MH/MR/DD levy by the amount received in state property tax relief payments.

Other Funds

Other state funds include the Family Support Subsidy, Special Needs Grants, Non-MH/MR/DD Local Purchase, and State Supplementary Assistance, which is primarily available to persons residing in residential care facilities.

Mental Health Institutes (MHIs)

The Mental Health Institutes are funded by a 100% up-front State appropriation. The appropriation is then reimbursed through billings to counties, the Mental Health Access Plan (MHAP), Medicare, private health insurance and revenues from goods and services sold to on-campus tenants. In FY 1997, because of per diem caps, counties pay less than the actual adult psychiatric per diem for each hospital. A table below summarizes the percentage for each respective MHI for FY 1997:

| State Mental Health Institute | Actual county percentage paid of adult psychiatric per diem |
|--------------------------------------|--|
| Cherokee | 32% |
| Mt. Pleasant | 34% |
| Independence | 36% |
| Clarinda | 50% |

The implications of this are that MHI costs are increasing the and as a result, counties are paying a lesser portion of the total cost.

3. COUNTY FUNDS

Property Tax

The county property tax is the second major funding source for services to adults with MH/MR/DD. Services to these persons along with other human service expenditures constitute anywhere from ¼ to ½ of county budgets. The county is also responsible for reimbursing the state for 80% of the capped per diem cost of care provided to adults in MHIs (Note: this may not represent the full cost of care provided by the MHIs.). The counties are also responsible for the entire non-federal share of the cost of care provided to adults in the Medicaid funded state hospital schools, community facilities licensed as ICF/MR, and the home and community based waiver program for persons with mental retardation. The state pays this share for children and adolescents. Beginning in FY 1996/97, the county established the county mental health, mental retardation, and developmental disabilities services fund in which all county revenues from taxes from the state and federal government, state payments, property tax relief funds and other sources designated for MH/MR/DD services are to be credited. All expenditures for MH/MR/DD services must be paid from this fund.

Beginning in FY 1996/97, the county levy for MH/MR/DD services is “fixed” at either the FY 1993/94 or FY 1995/96 level of expenditure, minus the amount of property tax relief dollars the county receives.

C. Service System

1. OVERVIEW

The organization of mental health services reflects a rural state with a philosophy of local control. Mental health services are organized around 93 of the State’s ninety-nine counties and 36 community mental health centers. There are 33 Community Support Programs affiliated with community mental health centers along with other accredited programs and entities within the State.

2. PROGRAMS AND PROVIDERS

Whether Medicaid funds, county funds, or other funding streams are used to pay for mental health services, those services are provided to Iowans by a system that incorporates a variety of elements. These resources include:

- **General Hospitals.** Twenty-five general hospitals with licensed psychiatric capacity of 995 beds.
- **State Mental Health Institutes (MHIs).** There are four specialty psychiatric hospitals known as Mental Health Institutes. All four are licensed as hospitals and provide inpatient psychiatric services to adults. Two serve children and adolescents.

- **Psychiatric Medical Institutions for Children (PMIC).** Iowa has 31 PMIC's with a capacity of 412 beds that provide long and short term care to children for mental health treatment.
- **Community Mental Health Centers and other Community Mental Health Providers.** Thirty-five Iowa agencies are accredited as Community Mental Health Centers (CMHC's). Services provided include partial hospitalization, day treatment, intensive outpatient, emergency, and evaluation.
- **Private Practitioners and Clinics.** Approximately 240 psychiatrists hold current Iowa licenses. Most practice in metropolitan or urban counties. Approximately 476 psychologists hold a current Iowa license. 1,388 social workers hold a current Iowa license as independent social workers. In addition, there are 255 individual mental health counselors with a master's degree in mental health counseling or a related field.
- **Community Supervised Apartment Living Arrangements, (CSALA's)** are accredited by the Division of MH/DD to provide supervised and/or supported living to persons with disabilities. Ninety of these programs currently provide services to person with mental illness.
- **Residential Care Facilities for Persons with a Mental Illness (RCF/PMI's)** provide 376 beds within seventeen licensed programs. These programs provide care in residential facilities to person with severe psychiatric disabilities who require specialized psychiatric care.
- **Immediate Care Facilities for Person with a mental Illness (ICF/PMI).** These programs provide care at the intermediate level to person who also need specialized psychiatric care.
- **Targeted Case Management.** Iowa Code requires that each county board of supervisors designate a targeted case management provider for eligible person with a chronic mental illness, mental retardation, or development disability.

D. Special Programs

1. IOWA'S MHAP

Iowa's Mental Health Access Plan (MHAP) is a managed behavioral health care plan through which most of Iowa's Medicaid recipients receive mental health services. MHAP has been in operation since March 1995 through a contract with Merit (formerly Medco) Behavioral Care of Iowa (MBCI) and operates under the direction of the Iowa Department of Human Services (DHS). In the first year of the MHAP, 253,360 person were enrolled. 31,636 (13%) person received authorizations for mental health services and 27,549 actually utilized MHAP services. 2,340 persons used services not previously funded under Medicaid prior to the implementation of MHAP. MHAP was recently re-bid to integrate substance abuse services with mental health services and is now termed the Iowa Plan

2. *DECATEGORIZATION OF ADULT DISABILITY SERVICES*

House File 702 passed during the 1997 session of the Iowa General Assembly provided for participation of up to three counties or groups of counties in a decategorization planning process. " Decategorization of the system involves changes in the status of categorical fiscal management, service eligibilities and policies, funding limitations, and payment methodologies. Linn County, Polk County, and Tama/Poweshiek Counties have been designated by the Department of Human Services to participate in the adult decategorization planning. These counties have met with DHS throughout the past year, and have recently developed a report to the Legislature of progress to date. A number of factors have delayed implementation of adult decategorization initiatives, including difficulty obtaining accurate funding data and numerous federal and state statutory and regulatory barriers to be overcome.

Any service currently covered/paid through any of the funding sources listed in the decategorization legislation should be included in the Adult Decategorization benefit package. These should include:

- MHI;
- General hospital inpatient psychiatric hospitalization;
- State Hospital School;
- The MHAP benefit package, including medically necessary transportation and any new services developed by the Iowa Access (MHAP) contractor;
- Any service specified in the Management Plans of the Adult Decategorization County(ies);
- Psychosocial rehabilitation, ACT, community support, skills training, and other services allowable under the Medicaid rehabilitation option;
- Housing assistance;
- Employment assistance;
- ICF/MR;
- HCBS;
- Vocational rehabilitation services; and
- Targeted Case Management.

3. *SERVICES FOR CHILDREN AND ADOLESCENTS*

Many of the same initiatives aforementioned in this report apply to the delivery of mental health services to children. The overall goal of the Iowa program is to ensure children and adolescents with severe emotional disorders and mental illness receive individualized care in their homes and community with maximum family involvement. Because no single agency has the financial and technical resources to meet the complex and changing needs of the child and the family, interagency collaboration in planning and coordination of services is required.

Children's Decategorization

Iowa started a two county demonstration children's Decategorization program, which consolidates traditional child welfare funding streams into a single child welfare fund. The aim of the decategorized fund is to develop family-oriented and community-based services not restricted by traditional definition and funding limitations. Recently the collaborative efforts of funding stream consolidation have been expanded to include 98 of the 99 counties.

Under decategorization, traditional funding streams for children and families are consolidated into a single child welfare fund and are not restricted by the individual funding levels of the historical service categories. This fund is composed of all or part of the amount that would be used for residents of these counties for family centered services, family preservation court ordered services fund, family foster care, group care, independent living, and adoption purchase of services. Through the consolidation of funding streams and elimination of service categories, funding flexibility can be achieved which would enhance the system's ability to develop service responses that are more beneficial to the needs of children and families.

Decategorization counties are expected to maintain budget neutrality. With savings realized through utilization of less restrictive and less costly services, funding can be redirected to develop alternative services that are more responsive to the needs of clients and their respective communities.

Iowa's MHAP (now the Iowa Plan) Program covers mental health services for most Medicaid children. Efforts have been made to improve access by promoting the development of alternative treatment, rehabilitation and support services and by promoting the development of services in rural areas. In addition, there is increased flexibility of services provided including supportive living, rehabilitation and crisis services for children and adolescents with a serious emotional disturbance.

CHIP Program

There are two phases to the Child Health Insurance Program (CHIP). Phase one has been completed and included expansion of Medicaid eligibility to all children under the age of 19 who are at or under 133% of the Federal Poverty Level (FPL). These children are entitled to all Medicaid benefits, including eligibility to receive mental health care under the MHAP Program (now the Iowa Plan).

Phase two, known as the Healthy and Well Kids in Iowa (HAWK-I) Program, will be implemented in January of 1999, to expand eligibility to all children under 19, who are at or under 185% of the FPL. For this phase, the State is in negotiation with a statewide third party contractor to administer the program. Any commercial plan may offer services to the eligible population as long as the proposed service package is equivalent to pre-established benchmark services packages—which maintain comparability to Iowa Plan services. There is a proposed co-payment on emergency services.

V. FINDINGS

This chapter presents our findings from the evaluation activities we conducted. Section A summarizes our interview findings. Summaries of the focus group perspectives appear in Section B and individual accounts of the initial focus groups appear in Appendix 8. The most significant conclusions from our survey of CPC's and other local administrators are discussed in Section C, and the detailed survey results are presented in Appendix 9. Section D presents our comparison of Iowa's performance to benchmarks from other systems of care and our comparison between Iowa counties. Section E presents our description of relevant best practices for Iowa's consideration, and Section F is our analysis of the legal, financial, political and regulatory characteristics of Iowa's mental health system that act as barriers to improvement of the system.

A. Interview Findings

Not surprisingly, people have different perspectives on Iowa's mental health system depending on where in the system they sit. Everyone acknowledged a concern over the system of care, noting that it has experienced tremendous organizational change in recent years. This includes the advent of Medicaid managed behavioral healthcare, and Senate File 69, which established a cap on county expenditures for mental health, and required development of County Management Plans. These plans have motivated counties to define their service system in new ways.

Many of those interviewed felt that given all of these profound changes, the system lacked a clear vision and direction for the future. On several occasions, reference was made to "fixing problems" within the system, but not establishing a common vision or direction for how adult and children's mental health services could or should be organized. This left people with a sense of continued frustration, and served to reinforce the status quo within the current system.

There were several key organizational or program issues that were consistently raised as problem areas. The first was the issue of legal settlement, the complex process by which counties take legal responsibility for the payment of services rendered on behalf of its citizens. Legal settlement is viewed by many as a major impediment in the delivery of care, in that they believe it is often used as a vehicle to deny responsibility for care, rather than responsibility for payment.

Legal settlement also appears to undermine inter-county relationships, and the state/county (ies) relationship. It appears from these interviews that considerable time and expense is spent on resolving issues of legal settlement between counties and the state. Several of those interviewed claimed that this process creates a climate of mistrust and provides opportunities to "game" the system to avoid responsibility for payment. As the state experiences more population shifts, issues of legal responsibility and payment may also increase. This will also likely add to the number of state cases, where the state assumes legal responsibility for care.

Related to the issue of legal settlement are relationships between counties and the state. There appears to be a constant tension between these parties over funding and policy direction. As the state puts more resources into the county-based system of care, and as the Iowa Plan continues to be a statewide program administered by the state, there will likely be continued struggles over control and direction of resources. The recently created State/County Management Committee (SCMC) is viewed as a vehicle to address these issues and tensions, but many feel the Committee lacks true authority. The County Management Plans are also viewed as a way to better understand the direction of each county, but many of those interviewed felt that these plans may not truly reflect actual practice within counties.

The statewide mandate for mental health services in Iowa is limited to county responsibility for MHI services. Because of this limited service mandate (which requires counties to reimburse the state for 80% of the capped per diem rate for an inpatient stay in the MHI), pressures to maintain MHI capacity and staffing, and recently enacted limits on county expenditures for all mental health services, there is no incentive to fund community services or reduce MHI utilization. These disincentives and resource constraints have made it difficult to promote or develop community services across the state. There is also concern about the growing role of the state's MHIs. Many of those interviewed are concerned that the MHIs, after a period of downsizing, are developing new specialty services, such as services to the dually diagnosed, that could be provided in community settings.

State/county relations may also be strained by the very nature of Iowa's system of care. Although the county-based system of care provides local control and local accountability, the resulting degree of local variation makes it difficult to promote a uniform system of care across Iowa. This was also noted by providers who contract with multiple counties and must adjust their treatment planning, financial and programmatic reporting according to each county's requirements. There are examples of successful cross-county collaborations, including the use of 28E agreements and other measures; however, the very nature of county "home rule" makes cross-county collaborative efforts difficult.

The multiple funding streams that make up Iowa's system of mental health care was also identified as a weakness that serves to fragment care. Currently, funding for mental health services may come from state and county appropriation, Medicaid--under the MHAP program, Medicaid--not under MHAP, and child welfare (deategorization). Each of these funding streams has a separate point of organizational accountability, and these funding streams rarely come together to promote a integrated system of services for consumers. There also appears to be no distinct funding stream for children's mental health services for those who are not Medicaid eligible.

Several of those interviewed also commented on the low rates available in Iowa for the payment of services. Although rates have been improved under the MHAP program, many felt that the move away from grant or program funding to fee-for-service reimbursements has hurt community providers, who are no longer able to subsidize MHAP rates with county grant-in-aid funds. These developments have exacerbated the problem of historically low rates. CMHCs have also been threatened by broader market changes, such as the increased

competition from for-profit providers of community mental health services, and large hospitals.

The limited availability of psychiatric rehabilitation services for adults was also noted. Iowa does not participate in the adult rehabilitation option for Medicaid, and as a result, funding for these services is limited to state/county funds. Since Iowa had not participated in the psychiatric rehabilitation option under Medicaid, many advocacy groups viewed the Medicaid waiver and implementation of Medicaid managed behavioral health care as a means to deploy more flexible services, especially psychiatric rehabilitation services. Over time, there has been some gradual recognition of the need for these services. Currently, MHAP is developing eight psychiatric rehabilitation pilots. Many also commented on the lack of a recovery focus in current programs. Those interviewed said they would hope the system could focus on the basic principles of community support and rehabilitation found in the U.S. Center for Mental Health Services' Community Support Program (CSP) for adults, and Children and Adolescent Service System Program (CASSP).

Other organizational changes desired by those interviewed included: a risk pool to resolve issues of legal settlement, the integration of funding streams into a single point of accountability and responsibility similar to the decategorization program for children, and better services for children, including better transition of children into the adult system of care.

B. Focus Group Summaries

Representatives from the following organizations participated in focus groups in February and May:

- Iowa State Association of Counties (ISAC)
- Community Mental Health Centers Association of Iowa, Inc. (CMHCs)
- Iowa Federation of Families for Children's Mental Health
- Iowa Alliance for the Mentally Ill (NAMI, Iowa)
- Consumer Resource and Outreach Project (CROP)
- Central Point of Coordination Administrators

A complete list of focus group participants is included in Appendix 3 and a full summary of the five initial focus groups is included in Appendix 8.

It is important to note that the perceptions of the focus groups are reported as near as possible to the way expressed by participants. There has been no attempt to change the statements or verify their accuracy, yet we have identified particular elements **as reported** in cases where the veracity of a particular statements was questioned in the comments we have received. It can be argued that regardless of the accuracy of all the statements, they

illustrate common perceptions or misperceptions throughout Iowa's system of publicly financed mental health care, and should therefore be part of an overall evaluation of the system. Reporting these in their original format will simply be one way of checking system progress in years to come. That is, if years from now, people still hold the same misconceptions about the Iowa system of care, then somewhere along the line, time, energy and resources were not devoted to addressing the underlying or related problem or correcting the misperception.

As expected, differing opinions of Iowa's mental health system were expressed during the focus groups; however, a number of common themes appeared. Participants from different focus groups raised the following as areas of concern: children's services, community-based services, variable standards from county to county, and legal settlement.

Children's services were identified by many as an area of the mental health system that needs improvement. Both providers and consumers pointed to the scarcity of children's services as well as the difficulty in accessing these services as a major concern. A frequently mentioned gap in the system is the transition of adolescents into the adult mental health system.

Many focus group participants stated that there is a reliance in the system on more intensive services rather than on community-based mental health services. The current system is viewed by many participants to be fragmented in the community support services provided, as well as lacking in support for community-based services. Families and consumers reported difficulty in accessing less intensive services such as community based mental health services and wrap-around services.

Many participants viewed variations in eligibility and funding from county to county as a major system weakness. As a result of these variations in eligibility and funding, services provided are also perceived to range from weak and confusing to comprehensive and supportive depending on the county. The variation from county to county was felt to be a major problem for consumer access.

Legal settlement, also raised during stakeholder interviews, was recognized by consumers and providers to be a key issue. During the focus groups, consistent problems in establishing a county of legal settlement were cited by consumers. Providers also indicated that dealing with the county of legal settlement outside their service area created additional administrative burdens for them.

C. Survey Results

I. SURVEY RESPONSE

Surveys were mailed to a total of 133 stakeholders of the Iowa public mental health system, including 79 CPCs, 38 HSAAs, and 16 Directors of Special Education at AEAs. The results reported hereafter reflect the views of those that completed the survey and should not be viewed as representing other interests. The overall response rate is summarized in the table below:

| Respondent | Total Sent | Total Returned | Response Rate |
|---------------------------------|-------------------|-----------------------|----------------------|
| CPC | 79 | 44 | 55.6% |
| HSAAs | 38 | 17 | 44.7% |
| AEA Special Education Directors | 16 | 9 | 56.3% |
| Totals | 133 | 70 | 52.6% |

2. SURVEY ANALYSIS

The following pages include a section by section analysis of the results of the stakeholder survey. Since the detailed results for each question are included in Appendix 9, the analysis presented on the following pages presents highlights of each section in cases where the results of a particular question was notable or gave a strong indication about system performance or best practices. We have noted in our discussion when there was a notable difference between the results by respondent type or between the 11 responding urban CPC's and the 33 responding rural CPC's. The distinction by respondent type is useful in indicating perceptions of the system as a whole, whereas the distinction by urban/rural CPC area should be interpreted carefully due to the respective sample sizes, with attention given to the actual number of responses as opposed to the percentages of responses.

a. State/County Relations

There appears to be confusion over the roles of the state and counties in oversight and administration of the system of care.

- Over 70% of all CPCs responding disagreed or strongly disagreed that the current role of DHS in the oversight and management of the *statewide* public mental health system was appropriate, and roughly 70% disagreed or strongly disagreed that DHS oversight and management role of the *local* public mental health system was appropriate.
- However, a majority (52%) of the CPCs responding feel that their role in oversight and management of the *local* system is clearly defined, but results were mixed as to whether this role was appropriate.
- Many CPCs (40%) do not feel that they currently have an adequate and/or appropriate role in policy development and decision making regarding Iowa's public mental health system.
- County Management Plans are viewed as effective mechanisms for ensuring accountability by over 64% of the CPCs responding to the survey.
- Many (47%) of these same respondents agreed or strongly agreed that the local system accountability is enhanced if CPCs report performance data, and over 53% of CPC respondents agreed that statewide standards should be developed for tracking local system performance.

IMPLICATIONS

- There appears to be a need to more clearly define the roles and responsibilities of the state and those counties in the oversight and management of the both the local and statewide systems of care.
- The enactment of HF2545 and implementing rules requiring the collection and reporting of certain performance data appears to move in the right direction for ensuring accountability for local systems of care.
- It appears that CPCs are willing to submit plans and be measured, but feel a greater need to be involved in development of the performance standards by which they will be measured.

b. Community Empowerment Boards

Most of the respondent scores (roughly 35%) were in the neutral range on Community Empowerment Boards. As such, the results of this section do not give much information about respondents' perceptions of Community Empowerment Boards legislation. One Oversight Committee member observed that this might be due to concerns about the process by which information was disseminated regarding the Empowerment Boards. In addition, this response may be attributable to the fact that this legislation had just be enacted and there was little time for all communities to feel knowledgeable enough to respond to the questions.

c. Managed Care to Medicaid Recipients

In summary, it appears that many of the respondents have some negative reactions to the implementation of the MHAP program.

- Over 60% of the CPCs responding disagree or strongly disagree that MHAP has coordinated mental health services well with county managed services.
- Approximately 60% of all respondents feel that MHAP has resulted in substantial cost shifting to county systems of care. In urban areas, 9 out of 11 urban CPC areas responding as agreed or strongly agreed that MHAP has resulted in substantial cost shifting to county systems of care.
- Over 47% disagreed or strongly disagreed that MHAP has improved overall care for the persons it served, but a large number (37%) of respondents remained neutral on the matter.

IMPLICATIONS

Although the responses appear to illustrate overall negative reaction to the implementation of the MHAP program, it is difficult to identify a particular reason other than the perception that there is a great deal of cost-shifting to county managed systems of care. Of course, many other factors could be influencing this perception;

such as overall negative reaction to either managed care in general or perhaps objection to for-profit management of public mental health care.

d. Multiple County Collaboration

In the aggregate, the respondents show moderate interest in multiple county collaboration, with respondents feeling it is more practical for some administrative functions or services, and less practical for other functions/services. This section is best analyzed by assessing if there was consistency of response between respondent's perception of opportunities for collaboration, and likelihood to take action to initiate multiple county collaboration for a particular administrative function/service. Results show that on average 30% of respondents perceived that there was opportunity, and practicality in multiple county collaboration--and even likelihood for action to initiate multiple county collaboration for the following administrative functions or services:

- Information systems;
- Joint service planning and/or purchasing, particularly for crisis and other intensive or high cost services;
- Centralized intake and enrollment;
- Utilization management;
- Transportation services to facilitate access to services;
- Rehabilitation, vocational, and community integration services; and
- Regional solutions to long term housing needs.

IMPLICATIONS

Across CPCs, over 30% of the respondents chose the single response of “multiple county collaboration” for the above categories, compared to an existing structure which does not expressly provide incentives for this sort of activity. This could be interpreted as a potential interest in further exploring these opportunities, and the opportunity for the state to pursue further interest in this area. Notably, there was not much variation in the responses between urban and rural CPCs on these questions.

e. Legal Settlement

This section resulted in the most one-sided responses in the entire survey, illustrating strong feelings about the process of Legal Settlement.

- Over 83% of the respondents disagreed or strongly disagreed that the process of Legal Settlement was clear to consumers and family members.

- Over 52% of the respondents agreed or strongly agreed that Legal Settlement serves as a barrier to treatment.
- Over 61% of CPCs responding feel that the process of Legal Settlement is not an appropriate use of time, energy, and resources.
- Less than 30% of CPCs responding feel that the process of Legal Settlement is clear to providers.
- Over 67% of all respondents disagree or strongly disagree that Legal Settlement is an efficient process, with 45% all CPC respondents (both urban and rural areas) strongly disagreeing that Legal Settlement is an efficient process.

IMPLICATIONS

Simply stated, most respondents feel Legal Settlement is inefficient, difficult to understand, and serves as a barrier to treatment. Given these perceptions, it would be appropriate to look at alternatives means of administering the existing process of Legal Settlement or exploring more systemic changes that would obviate the need for the existing practice.

f. Eligibility

The results of the responses to questions of eligibility to show that respondents are in favor of establishing statewide standards for financial eligibility and minimum service requirements for community based services (other than MHI care).

- 56% of the respondents favored statewide financial eligibility standards, with rural CPC respondents comprising approximately 46% of those in favor of such standards.
- Over 58% of all respondents favored statewide minimum set of community based services other than services at MHIs.

IMPLICATIONS

The results to these two questions are considerable when viewed in the context of dissatisfaction with the process of Legal Settlement. Instituting statewide standards for eligibility and service responsibility may alleviate the need for county to county settlement if accompanied by a funding mechanism that allows both county contribution and equitable distribution of state funds. Since the financial implications of implementing such statewide standards would have a significant impact on the existing funding structure, these results must be examined carefully in light of a number of factors including the recent changes in the funding of county mental health services; implementation of incentive and risk pools; and the implementation of incentive fund.

g. Mental Health Service to Children and Adolescents

- Respondents generally feel that mental health services for children and adolescent are not well coordinated across services systems or funding streams.
- In spite of testimony to the contrary that was heard in interviews and focus groups in some parts of the state, over 54% of the respondents disagreed or strongly disagreed that the most efficient means of accessing mental health services for children and adolescents is through filing a CINA petition.
- Over 70% of the respondents felt that community based services are insufficiently available in the respondent county to meet the mental health needs of children and adolescents. This response was consistent among all respondent types and across urban and rural CPC areas.
- The perceptions of decategorization are mixed, with HSAAs feeling that it has improved the responsiveness of the local service system to children's and adolescents' mental health needs, while CPCs and AEAs were for the most part neutral on the subject.
- Overall, out of all survey respondents, the following services were identified by greater than 10% of respondents as both unavailable and very underutilized in the respondent area/county: Day Treatment; Crisis Residential; Volunteer Program; and Transportation.

IMPLICATIONS

The results of the questions pertaining to system issues show that there is a need for improvement in mental health services to children. This finding is consistent with focus group and interview results reported in the Task One report. In addition, the results argue for better service coordination for mental health services for children and adolescents across service systems and funding streams. The existing decategorization efforts are not perceived widely as being the most effective mechanism for achieving improved service coordination. This indicates a need to investigate either improvement in decategorization efforts or exploration of other system changes to improve the coordination of services.

Finally, regarding services to children and adolescents, the availability of a broader service array is desired among stakeholders. While the financial impact of expanding existing available services must be examined, there is clearly a perception that mental health services for children and adolescents must be improved in Iowa.

h. Mental Health Service to Adults

Greater than 10% of all respondents felt the following services were **both** unavailable and very underutilized in the respondent county/area:

- Assertive Community Treatment;

- Partial Hospitalization;
- Day Treatment;
- Wraparound;
- Diversion from the criminal justice system;
- Transportation;
- Dual diagnosis substance abuse/mental health;
- Vocational.

Greater than 50% of all respondents felt that there was the right amount of both availability and utilization the following services:

- Residential;
- Medication Management;
- Individual and Group Counseling;
- Case Management.

IMPLICATIONS

According to the respondents' perceptions, Iowa should consider enhancement of the service array available to adult consumers with mental health needs. In particular, respondents have identified a need for high intensity services that may serve as alternatives to inpatient care. The survey also confirms some of the feedback received through focus groups and interviews that access to services such as wraparound, and Assertive Community Treatment should be improved.

i. Special Populations/Issues

Out of the six questions asked in this section, the two most notable results were the following:

- 46% of all respondents feel that elderly persons with mental health needs do not have sufficient access to services;
- Over 53% of the respondents feel that mental health services are not well coordinated with the criminal justice system.

IMPLICATIONS

The results of this question are consistent with the response to a question on a related topic--access and utilization of diversionary services from the criminal justice system. In both cases, respondents are not satisfied with the existing system.

j. Consumer and Family Involvement

- Over 65% agree or strongly agree that consumers are involved in treatment planning, however only 38% of the respondents agree or strongly agree that families are appropriately involved in treatment planning;
- Respondents were mixed in their views about consumer and family involvement in planning, oversight and evaluation of the mental health system.

IMPLICATIONS

Responses indicate that consumer and family involvement in the public mental health system could be improved. In Iowa, as in many public mental health systems, consumer and family involvement varies from community to community. Based on turnout at focus groups and our assessment of levels of consumer and family involvement, TAC witnessed large and active consumer and family involvement in some parts of the state, with other parts of the state apparently not as active.

k. Special Education

- The state funded mental health services are seen as slightly more responsive than the than county funded services;
- Overall quality of mental health services is viewed as good by four out of the nine AEAs responding, however, most express difficulty in accessing mental health services, and feel that services are not well coordinated among service systems.

The results of this section indicate a need for improvements in coordination between school systems and the mental health services system.

D. Performance Benchmarking

The first part of this section presents our comparison of aspects of the performance of Iowa's mental health system to the most relevant benchmarks available from other state and county systems of care. As we have noted in discussing our methodology, there are significant limitations to these comparisons due to differences in the systems being measured. This work therefore can only be used as a starting point for further investigation and analysis rather than as a strong conclusion about Iowa's relative performance. The second part of this section describes our work with data produced by Iowa's MHAP and county financial reporting systems and DHS that has enabled us to compare Iowa counties and CPC's to each other.

1. BENCHMARKING IOWA AND OTHER SYSTEMS OF CARE

The benchmarking data collected for this report should provide state and county managers, policy makers, and other stakeholders in Iowa with a sense of how their public mental health system fits within the range of other programs. This benchmarking information should also assist stakeholders with their continuing efforts to improve quality, increase levels of access, and improve cost effectiveness. These efforts to utilize performance data and benchmarking to enhance Iowa's public mental health system will require additional data collection and further investigation in order to ensure improvement efforts are focused in the proper areas. In addition, any observations drawn from this data must take into account the system differences that exist in the data presented here. In order to address these differences, Table 1 on the following page describes the characteristics of those systems for which we have received data for our analysis.

This table includes key state and county characteristics that can influence the type of utilization and cost data presented here. Each state or county's type of plan is described in the data source section in order to distinguish between managed care, fee-for-service, and state supported programs. The majority of data presented in this report represents public sector managed care plans, such as Iowa's MHAP. Additionally, the covered population of each plan includes a description of the category of Medicaid eligibles and the characteristics of any non-Medicaid eligibles covered under the plan. All systems that provided data cover SSI eligibles, dual Medicaid/Medicare eligibles and/or some specified non-Medicaid eligibles. The majority of plans reported data on mental health services only; however, some systems did report data that includes substance abuse services. Each system's description also includes the date range of presented data as well as any additional important characteristics such as whether or not a plan includes state hospital utilization and costs in the data it reports. The section that follows includes both a graphical presentation of the benchmarking data as well as descriptions of the similarities and variations in mental health systems reflected by the data.

Table 1 – Mental Health System Characteristics

| State or County | Data Source | Eligible Population | Benefits Included | Date Range of Data | Additional Comments |
|--------------------------|---|--|--|-----------------------------------|--|
| Iowa | Mental Health Access Plan (MHAP) – managed care carve out | AFDC, SSI, SSI related under age 65, medically needy with no spend down | Data corresponds to time period when mental health services only were included | March 1997 – Feb. 1998 | Data includes care covered at state hospitals. Data does not include people enrolled in HMO plans. |
| | Mental Health Institutes – 4 state hospitals | State mandates state hospital coverage be provided for CMI population | Data corresponds to inpatient state hospital services | Fiscal Year 1997 | Psychiatric data was utilized wherever possible (not including substance abuse) |
| Arizona | Regional Behavioral Health Authority | Medicaid eligibles excluding the elderly and physically disabled who are in the AZ Long Term Care System | Mental health and substance abuse services | 1995-1998 contract | |
| Clark County, Washington | Regional Support Network – Prepaid Health Plan | All Medicaid recipients eligible plus expanded nonMedicaid eligibility | Mental health services only | July 1997 – June 1998 | Penetration rate for Medicaid population only |
| Colorado | Mental Health Capitation Pilot Program | All Medicaid eligibles | Mental health services only | Fiscal Years 1995 / 1996 | |
| King County, Washington | Regional Support Network – Prepaid Health Plan | All Medicaid recipients eligible plus expanded nonMedicaid eligibility | Mental health services only | Calendar year 1997 | Penetration rate for Medicaid population only |
| Massachusetts | MA Behavioral Health Partnership – managed care carve out | AFDC / Disabled Medicaid recipients plus Dept. of MH SMI population | Mental health and substance abuse services | Fiscal Year 1997 | Data does not include eligibles enrolled in HMOs |
| Montana | Mental Health Access Plan – managed care carve out | All Medicaid eligibles, nonMedicaid (SED or SMI and qualify based on income) and Dual Eligibles | Mental health services only | April 1, 1998 thru March 31, 1998 | |
| Ohio | Department of Mental Health – Fee-for-service | Medicaid / nonMedicaid eligible population | Mental health /dual diagnosis services | Fiscal Year 1997 | Readmission rate for all state hospital admissions |

| Table 1 – Mental Health System Characteristics | | | | | |
|---|---|--|--|---|--|
| State or County | Data Source | Eligible Population | Benefits Included | Date Range of Data | Additional Comments |
| Oregon | Medicaid Managed Mental Health Care Plan | All state residents below specified income level, Medicaid eligibles | Mental health and substance abuse services | 1995 contract for admin. rate, October 1, 1997 thru September 30, 1998 for capitation rates | Capitation rate does not include state hospitalization or long term care (inpt. > 21 days) |
| Vermont | Department of Developmental/Mental Health Services supported programs | All Medicaid recipients eligible to receive services at Dept. supported programs | Data for mental health programs only | Fiscal Year 1997 | Penetration rate for Adult Medicaid population only. Long term care services included. |

a. Penetration Rates

The percentage of covered persons receiving at least one type of mental health service during a specified time period is a global indicator of access. Penetration rates are one of the measures most frequently collected and reported.

Exhibit 1 demonstrates a range of state and county mental health system penetration rates, with the majority of systems reporting penetration rates for their Medicaid population. The penetration rates for reporting states and counties are higher than the penetration rate of 6.9% for Iowa’s Mental Health Access Plan from March 1997 through February 1998 with Massachusetts reporting the highest rate of 25% for its behavioral health carve out covering mental health and substance abuse services. Four of these public mental health systems reported penetration rates between 9.3% and 10.5% for time periods from 1995 through 1998 for systems that cover mental health services only. This range of rates appears to represent an achievable rate of penetration for systems covering Medicaid eligibles.

b. Readmission Rates

Readmission rates, the percentage of people discharged from inpatient care who are readmitted to inpatient care within a specified time period, can provide valuable information on the appropriateness of discharge and level of care decisions. In some cases, lower readmission rates also demonstrate the availability of community supports and less restrictive levels of care. Most inpatient psychiatric facilities and mental health care programs continually strive to reduce their readmission rates in

accordance with the rationale that lower readmission rates indicate appropriate level of care decisions and service availability.

Readmission rates are most commonly measured for a period of 30 days. We found 30-day readmission rates for community inpatient psychiatric facilities that ranged from 13% in Clark County to 16% in Massachusetts. As displayed in Exhibit 2, the 30 day readmission rate for Iowa's MHAP is 13.7%, well below the contractor's goal of less than 19%, and within the range of rates reported for other state and county systems. State hospital readmission rates were lower, at 6.6% for Iowa and 11.4% for Ohio. The overall readmission rate for Iowa's four MHIs is quite low compared to Ohio's state hospitals.

c. Number of State Mental Health Agency (SMHA) Operated & Funded Beds Per 100,000 Persons

The number of inpatient beds that are state mental health agency (SMHA) operated and funded per 100,000 state residents is shown in Exhibit 3. In the last decade, many states have struggled to reduce costly inpatient programs and increase community care. While some states have closed such facilities, other states continue to operate them. A per capita figure, using U.S. Census data, adjusts for the population differences that exist between states. The states displayed below were selected for geographic representation and/or their correspondence to other benchmarking data displayed in this report. NASMHPD data on the number of setup and staffed beds on the last day of Fiscal Year 1995 shows Iowa with 19 SMHA beds per 100,000 persons. Oregon had the lowest rate of 11 beds per 100,000 persons while Nebraska's rate of 35 beds per 100,000 was highest. Iowa's rate of SMHA beds falls in the low end of the range of other states with SMHA facilities.

d. Involuntary Admissions

Exhibit 4 displays data from Iowa and other systems on the percentage of total inpatient psychiatric admissions that are involuntary. Iowa's MHAP represents the lowest rate of 20.5% compared to the other Medicaid program, Clark County which is over twice as high, while the overall rate for Iowa's MHI admissions represents the highest rate of 73.4%. This rate of 73.4% is higher than any other data collected. The rate of involuntary admissions for MHIs is broken down into separate rates for each of the four MHIs in Part 2a following.

Comparison of the percentage of total inpatient psychiatric admissions that are involuntary ranges widely – particularly within Iowa, for reasons that are not clear. The range may be the result of the different types of systems measured and the population of eligibles they serve, or it may be due to differences in the practices of the treatment system. For example, Iowa's rate of involuntary admission in MHAP is less than half of that for another Medicaid program located in Clark County. However, Clark County's program also covers some non-Medicaid recipients whose eligibility is based partly on serious mental illness. This subset of recipients may be more likely to experience an involuntary hospitalization because of the seriousness of their illnesses. However, using this logic, we would expect to see high rates for

Ohio's state hospitals, but only 23% of state hospital clients are admitted involuntarily. This could be due to Ohio substituting community services for state hospital stays for many consumers needing involuntary admissions, or it could be due to a difference in other treatment practices. The most dramatic difference indicated in this exhibit is the extremely high rate of involuntary admissions to Iowa MHIs, compared to the other systems measured. This is consistent with our impressions that the MHAP program is limiting the increase in MHAP paid involuntary admissions in MHIS. Since the MHAP (and Iowa Plan) contract specifications entail financial penalties for large changes in the involuntary admissions, the state has protected against further abuses in this pattern of care. Many Iowa Counties may be overly reliant on state hospital services and on involuntary admissions. In addition, counties may be directing a higher volume of voluntary admissions to private hospitals due to MHAP reimbursement. Analysis of the utilization on a County by County basis can provide further information about this possibility. (See Section 2, c.)

e. Administrative Cost Standard

The amount of mental health expenditures a state or county has allocated for administrative costs provides data on the level of resources remaining for direct service expenditures. Most systems of care attempt to minimize the amount of administrative dollars expended in order to distribute as many resources as possible towards direct services for consumers. All the administrative cost percentages in Exhibit 5, with the exception of Ohio, represent standards, not actual expenditures. These administrative percentages range from a low of 5% in King County, Washington to a high of 16% in Utah. Iowa's standard that administrative costs should not exceed 15% of capitation payments is comparable to most of the administrative cost percentages we collected from state and county contract standards.

As the notes on the exhibit explain, the formulas used to calculate administrative percentages vary from system to system. In the case of Iowa, it is important to note that provisions of the most recent Iowa Plan RFP and resulting contract required prospective vendors to propose the percentage of the capitation payment required for administrative services including profit not to exceed 15% of the total capitation payment. This limit does allow a higher overall possible percentage of total payments to the vendor to be categorized as administrative and hence must be considered when comparing MHAP to other Medicaid managed behavioral health contracts. However, they provide a perspective that may help the state as it establishes incentives for administrative efficiency for county administered services.

f. Mental Health Per Member Per Month Capitation Rates

A number of factors, such as historical utilization, local health care costs, and population characteristics, influence rate setting for managed care programs. Given the trends toward increased managed care and more specifically managed mental health care, setting capitation rates for Medicaid and expansion populations while allowing for accessible care has become more and more important.

Exhibit 6 shows the per member per month (PMPM) capitation rates for Iowa's MHAP as well as other managed mental health care programs. The capitation rates are displayed according to category of assistance in order to allow for a more valuable comparison given the large differences in utilization and costs among different eligibility categories. The capitation rates for children and families range from a low of \$3.73 PMPM in Oregon and a high of \$42.33 PMPM in Montana. As expected, rates for the disabled are higher ranging from \$79.62 PMPM in Iowa to \$221.15 PMPM in Montana. Additionally, PMPM rates for dual eligibles range from \$13.65 PMPM in Iowa to \$111.77 PMPM in Oregon. With the exception of Oregon's exceptionally low rate for children and families, all of Iowa's capitation rates are lower than the rates from these selected states. The low rates for Iowa's MHAP may be attributed in part to the coverage of primarily acute care services.

These differences may reflect, as least in part, differences in plan benefits. For example, Montana's high capitation rate covers a comprehensive benefit including long-term care, medication management by primary care physicians, as well as acute inpatient/outpatient services and state hospital costs. As previously mentioned, Massachusetts' rate covers both mental health and substance abuse services, as do Oregon's and Arizona's. However, Iowa's rates appear to be much lower than such differences by themselves are likely to explain.

g. Telephone Speed of Answer

Telephone access to plan representatives, both clinical and customer support personnel, helps ensure enrollees and providers are receiving access to necessary information and/or services. This administrative measure of access is most commonly reported in two forms: speed of answer and abandonment rate. As seen in Exhibits 7 and 8, the rates Iowa's MHAP reported for these measures are well below the national standards set by the National Committee on Quality Assurance (NCQA) and comparable to the rates reported by other systems. Telephone speed of answer rates ranged from 10 seconds to 60 seconds while call abandonment rates ranged from 2% to 7.2%. Although Iowa MHAP's abandonment rate is within the NCQA standard, lower rates from other systems demonstrate that there is room for improvement. On the other hand, MHAP's average speed of answer of 10 seconds for the year March 1997 – February 1998 is better than other reported rates.

2. *BENCHMARKING WITHIN IOWA'S PUBLIC MENTAL HEALTH SYSTEM*

Comparing and analyzing Iowa's performance data within Iowa's system of care can highlight significant variations or similarities in the mental health care being provided across the state. This type of internal analysis will allow Iowa to address variation in provision of mental health care. We collected data from various sources within Iowa's public mental health system for this benchmarking analysis. Iowa's DHS provided specific figures for each of the four MHIs that included Fiscal Year 1997 data on involuntary and total admissions, average length of stay, and number of inpatient days. In addition, DHS reported gross county expenditures from Fiscal Year 1997 that aggregates the county, state, and federal contribution each county expends for people with a mental illness or chronic

mental illness. At our request, Merit Behavioral Care of Iowa supplied us with a MHAP claims data report. This report compiled the amount of claims paid by MHAP for each county based on dates of service between April 1, 1997 and March 31, 1998.

Our analysis attempts to minimize the limitations to this Iowa specific data wherever possible. For example, in order to adjust for population differences across the state, per capita rates and rates per 1,000 people were calculated wherever applicable. Even given these efforts, limitations do exist in the data we present here. In particular, the gross county expenditure data available does not show the county, state, and federal contribution to county expenditures separately. As a result, any variations from county to county in per capita expenditures can not be attributed to a particular funding source. Furthermore, all the data collected does not correspond to the same time period. The analysis of variation *within* a particular indicator results in a stronger comparison than the comparison of *different* indicators due to the fact that date ranges may not be comparable. The following analysis addresses the utilization patterns across Iowa with respect to inpatient care provided at the four state Mental Health Institutes, Medicaid expenditures, and MI and CMI service expenditures from all contribution sources.

a. *Mental Health Institutes' Rates of Involuntary Admissions*

Rates for involuntary admissions for Iowa MHAP and MHIs compared to two other entities were quite varied. The percentage of total admissions to Iowa's four MHIs that were involuntary admissions is displayed in Exhibit 9. Though their rates vary from facility to facility somewhat, they cluster around 70% and are all substantially higher than other rates we were able to collect. Cherokee MHI has the lowest rate of involuntary admissions at 66.2% and Mt. Pleasant MHI has the highest rate at 78.6%. We recognize that a number of factors, such as the existence of specialized forensic units, and/or geographical location (e.g., rural location) may influence rates of involuntary admissions, depending on historical service patterns and availability of alternatives to inpatient care. However, these rates still seem to demonstrate a consistently high use of involuntary admissions in Iowa.

b. *Mental Health Institutes' Average Length of Stay*

The average length of stay in the Adult Psychiatric Units at the four MHIs appears in Exhibit 10. The average number of days ranges from a low of 26.0 days at Cherokee MHI to a high of 54.0 days at Independence MHI. Independence MHI's average length of stay of 54.0 days requires further investigation given that it is significantly higher than the average lengths of stay of all three other MHIs, which have a much lower range of 26.0 days to 32.0 days. The longer lengths of stay appear to explain the relatively low readmission rate; it appears that once hospitalized, individuals are staying for long periods of time. While this variation may be explained by specialized longer-term treatment programs, it could also reflect a difference practice style or the relative capacity of their counties to provide needed aftercare services for state hospital clients.

c. *Mental Health Institute Days per 1,000 Population by County*

Utilization data was collected on the number of MHI inpatient days for each county for Fiscal Year 1997. Taking into account the differences in county populations, a rate of MHI inpatient days per 1,000 people was calculated based on estimated census data from 1996.¹ As Exhibit 11 shows, great variation in utilization of MHI inpatient services exists across the state of Iowa. A sample of counties was selected in order to illustrate the range of MHI days per 1,000 that occurs from county to county. The selected counties represent a range of county populations and include the lowest and highest rate for this indicator as well as the indicators in the following two sections. (Refer to Appendix 9 for MHI utilization for each county.) The rates by county range from a low in Humboldt County of 1.2 days per 1,000 to a high in Wayne County of 82.4 days per 1,000. Additionally, we have calculated MHI utilization rates based on CPC areas. This analysis resulted in a similar range of utilization rates with Hancock County with the lowest rate of 2.49 days per 1,000 and Wayne County with the highest rate of 82.37 days per 1,000. (Refer to Appendix 10 for a complete list of MHI utilization by CPC area.) These data are particularly sensitive to individuals whose mental health need are unusually intense. However, the degree of variation indicates that significant regional differences in MHI utilization do exist.

d. *Per Capita Gross County CMI/MI Expenditures*

Data collected from the Iowa Department of Human Services (DHS) reports the gross amount, including the federal, state, and county contributions, each county spends on chronic mental illness (CMI) and mental illness (MI). A per capita rate for each county was calculated based on this county expenditure data from Fiscal Year 1997 and the estimated population of each county in 1996. Selected per capita rates are displayed in Exhibit 12 in order to show the range of rates that exists. (Refer to Appendix 11 for the complete list of calculated per capita expenditure rates.) The results of the analysis demonstrate a range of expenditure levels from a low of \$5.59 per capita in Decatur County to a high of \$61.14 per capita in Jasper County. Based on these county expenditures, the statewide per capita rate is \$29.49.

e. *Mental Health Access Plan (MHAP) Claims Paid per County*

Data on the amount of claims paid by MHAP per county is another indicator of the variation that exists across counties in Iowa when examining mental health expenditures. MBC of Iowa compiled claims paid data based on the dates of service from April 1, 1997 through March 31, 1998. Per capita rates were then calculated for each county based on this claims data and Exhibit 13 shows a selection of county rates. (Refer to Appendix 12 for the complete list of per capita rates.) The results indicate that variation in service expenditures between counties also exists for MHAP, although this range is smaller than the gross county expenditure range. Cherokee County represents the highest per capita rate calculated at \$40.05 while Grundy County represents the lowest per capita rate of \$1.61. The statewide per capita rate is \$11.98.

f. MHAP Claims Paid and Gross County CMI/MI Expenditures Combined

This analysis combines the gross county expenditure data and MHAP claims paid information in order to provide a proxy for total per capita mental health expenditures per county. Although the date ranges are not the same for both indicators, county expenditures include state fiscal year 1997 amounts while MHAP claims paid are for the period April 1997 through March 1998, the analysis should still be representative of the range of per capita expenditures that exist throughout Iowa. As displayed in Exhibit 14 and Appendix 13, the per capita rates based on the sum of these expenditure sources show Lyon County with the lowest per capita amount of \$13.34 and Jasper County with the highest per capita amount of \$71.04. Jasper County also has the highest per capita rate when analyzing just gross county CMI/MI expenditures.

3. *PERFORMANCE DATA AND BENCHMARKING SUMMARY*

Because of the many limitations of the data we have analyzed, we are left with some questions about the provision of treatment services that are raised by this analysis, but cannot be answered without further investigation. In addition, we have some strong conclusions about the need to address such limitations by improving the data collected.

Improvements in Data Collection

The preceding analysis has raised more questions than it can answer. We believe that the most significant areas for Iowa to further investigate are:

- a) The penetration rate for MHAP. Iowa should compare many of the parameters of its program to other programs to further evaluate whether increasing penetration is an appropriate goal. Population characteristics, covered services, and other aspects of the program may explain the differences. Iowa could also measure other indicators of Medicaid recipients' access to mental health services to see if recipients or providers identify limited access as a problem.
- b) The use of involuntary admissions to MHIs. This warrants a very close look since it may indicate an overuse of involuntary treatment, which mental health practitioners try to avoid as much as possible. While forensic treatment services in MHIs that are by definition involuntary may explain some part of the high rate, there may be a bias toward use of institutional and involuntary care based on the structure and past practice of Iowa's county administered system. If so, these practices can be re-oriented toward strengthening community based services that can prevent or shorten hospital stays. Further analysis to understand variations in lengths of stay and in county utilization may also provide insight into the role of MHIs in Iowa's mental health system.
- c) Variations in financing of mental health services between counties. Since financing of county administered mental health services is a significant challenge in Iowa's current system, understanding the variations in system financing and its effects is critical. Such financing differences may explain some of the differences in utilization of services

between Counties. The degree of variation between county expenditures in MHAP should also be better understood.

Recent national collection efforts, such as the Center for Mental Health Services (CMHS) sponsored Five State Feasibility Study on State Mental Health Performance Measures, have revealed difficulties and challenges similar to those we have identified during our collection and analysis of performance data. Results from the CMHS feasibility study as well as the planning efforts for the upcoming pilot test concluded that many states are not collecting data on performance measures and that those states that are collecting data do not do so according to a uniform set of measures. CMHS also recognizes the difficulty in comparing states to one another due to the system differences that exist in areas such as the defined eligible population. Despite these challenges, CMHS concluded that the benefits of performance data collection outweigh the problems that have been encountered and as a result plan to continue funding the implementation of performance measures and the corresponding data collection efforts.

The data collected in Iowa through CoMIS, Project 14 and continued development of MHAP reporting, has provided a useful starting point for beginning to evaluate performance of county administered services. However, that system has some significant limitations. First, as the state assumes a greater share of system funding, it must be able to track and understand the impact of its practices. Therefore, more detailed financial data that accounts for the separate contributions of federal, state and county entities must be developed. Second, efficiency of service administration is another key issue in Iowa. Many Iowans realize that 99 administrative entities are not an optimum number for efficiently managing Iowa's mental health system. However, it is not yet clear what level of coordination and collaboration will be most efficient. In order to begin to evaluate administrative efficiency, Iowa needs a measure that separates the costs of administering Mental Health services from the other services counties are responsible for administering.

In collecting such data, administrative costs must be collected in a consistently defined manner. Finally, Iowa will need to measure utilization of services in each county to begin to understand how availability and utilization patterns of a service array may influence outcomes and costs. While administrative cost and service utilization measures are included in CoMIS, the state needs to continue to refine the measurement definitions and methodology to ensure that the data will allow for accurate comparisons and provide a strong basis for decision-making.

E. Best Practices

The review of national best practices can provide a way to develop a more comprehensive vision for the future of the mental health system in Iowa. There are many examples of current best practices in the Iowa service system. These include, but are not limited to, MHAP performance measurement and the principles behind the provision of decategorization funding for children's services. In other areas, however, we believe that a review of national best practices in the field can help the stakeholders of the mental health system develop a more integrated vision for the future. This section summarizes the best

practices in state/county relations (Section 1), legal settlement (Section 2), mental health services to children (Section 3), mental health services for adults (Section 4), services for homeless persons (Section 5), rural mental health access (Section 6), dual mental health/substance abuse (Section 7), mental health and the elderly (Section 8), mental health and jails (Section 9), and consumer involvement (Section 10). We have drawn upon these practices in developing our recommendations for improvement presented in the next chapter.

I. STATE/COUNTY RELATIONS

Over the past several years, in efforts to increase the quality of health care, improve delivery systems, and control rising health care costs, state and local public mental health systems nationwide have experimented with dramatic system change. Iowa has experienced very rapid change as well, through the implementation of recent initiatives such as: the Mental Health Access Plan (MHAP) and soon the Iowa Plan for Behavioral Health (Iowa Plan); decategorization; and the introduction of County Management Plans. Each of these efforts to reform the publicly financed mental health service system has introduced changes in service delivery organization, design, and financing. As a result, many stakeholders, including most notably DHS, counties, and providers, are responding to these efforts by redefining roles and responsibilities at all levels of the system of care. Many interviewees in the focus groups expressed a need for slowing the pace of change, thereby allowing people and organizations more time to assess the effect of the changes on the public mental health system.

a. Statement of the Problem

Both the state and counties appear to want to implement accountable system change, but are having difficulty adapting to new roles and new expectations. Frankly stated, the rapid system change involving redefining of roles and responsibilities has created a lack of trust among stakeholders of Iowa's public mental health system, particularly between the state and counties. Counties are feeling pressure to manage eligibility and access to mental health services because of minimum service requirements for the MR population and recently enacted expenditure caps. The result is more aggressive utilization management techniques and pursuit of payment from county of legal settlement in order to save money or cap local contributions to mental health service expenditures. The state efforts at privatization through the statewide Medicaid managed behavioral health care vendor have introduced clearer contract expectations and increased the role of the state as a purchaser of health care services. The state and counties have attempted to transfer this approach to county funded services through the requirements in County Management Plans. However, the outcome of these efforts varies widely from county to county because of a need for further refinement of the management plan requirements, as well as a lack of consistent consumer eligibility standards and a core set of required minimum services (with exception of MHI services). As a result, there is wide variability in access to services from county to county.

In addition to developing more flexible services and controlling costs, the MHAP contract attempts to attain higher accountability demonstrable through use of performance indicators and outcomes. This introduction of managed care at the state level has “raised the bar” for accountability and performance in county funded services. County Management Plans are the beginnings of a more contractual relationship for county funded services, but the states and counties must still answer fundamental questions such as: What are the eligibility standards for consumer access to county funded-care? Should there be a minimum service package for county funded services? Should counties more systematically develop managed care capacities, or should they purchase some or all such functions from a third party? Should counties collaborate or pursue these options individually? Other states and counties have faced similar issues and there are varying approaches to achieve the same desire of a more accountable public mental health system. Regardless of the answers, the mere exercise of asking the questions is a step towards re-defining the roles and responsibilities of the DHS and counties.

b. Description of the Best Practice Area

Perhaps the most important component of best practice in regard to state county relations is defining clarity in roles and responsibilities for various functions throughout the public mental health system. Implementation of managed care, resource scarcity and higher expectations for more accountable systems of care continue to drive system change. These changes will inevitably challenge the lines of authority between counties and states. Therefore, it is critical to maintain an ongoing dialogue between states and counties to re-define roles and responsibilities as issues are encountered. These system changes are relatively recent, and state and counties across the county have adapted approaches to best suit their needs. Since many state and local mental health authorities are currently struggling with this issue, it is important to understand that no single model has proven more successful than any other. There are different approaches to re-defining roles and responsibilities for publicly financed mental health care and each may provide insight to Iowa administrators in their efforts to manage the change process.

c. Examples:

- 1) California Realignment: In California, the state and counties have worked collaboratively over the past several years in a realignment process that has gradually shifted responsibilities to counties for managing Medicaid mental health care under an at risk financial arrangement. The process was implemented gradually. The first step was putting counties at risk for managing inpatient services under a global budget for the state match only. This change has dramatically reduced utilization of state hospital services and allowed counties to develop outpatient alternatives. Soon, counties will assume management and risk for outpatient services as well, under some kind of financial arrangement. “As the realignment process developed, state and county roles became more distinct. The state assumed the role of project monitor, focusing on broad policy issues and promoting best practices. Counties took primary responsibility for managing and providing services.”²

- 2) Iowa South Central Seven: Another excellent example of county collaboration is taking place in South Central Iowa. In the fall of 1997, a consortium of counties and provider agencies in South Central Iowa (Adair, Adams, Clarke, Madison, Ringgold, Taylor, and Union Counties--South Central Seven) received a grant from the Iowa Department of Economic Development. The grant was given to secure consulting services to assess the current mental health, mental retardation, and developmental disability service system and administrative infrastructure. The purpose of the consultation was to determine strategies for making the service system as efficient as possible, in recognition of the fact that financial resources are extremely limited, and many priority consumers have unmet needs for services.

The South Central Seven have recently begun exploration of formation of a consortium through a 28E agreement or other mechanism, which may result in formation of a planning council, non-profit corporation, or both. If the participants, particularly the counties, decide to pursue this option, the planning council could also become the intermediary for CPC functions and case management. It might also merge or otherwise organizationally link with the entity (ies) performing administrative service functions on behalf of counties and providers. This type of approach can achieve great economies of scale through shared development or purchase of administrative functions such as: management information systems, provider credentialing, monitoring, and profiling the performance of all contracted providers in the South Central Seven provider network; or coordination of transportation services across the area. If such economies of scale can be achieved, it is possible that the savings could be re-invested in direct treatment or other supportive services to improve access to services or quality of services.

- 3) Iowa State/County Management Committee and State/County Assistance Team: The most resonant and local example of a best practice in state county relations is the State/County Management Committee (SCMC) and the State County Assistance Teams (SCAT). Although the structure and function of these two groups has been questioned by some, there is clearly recognition that both state and county interests must be addressed collaboratively through the SCMC. Joint approaches to standard setting that supports county development of managed care capacities is an approach that may bridge the gap between more aggressive competition models that have been used in other states. The ability to reward counties for positive performance results through use of the newly created incentive and efficiency pool in House File (HF) 2545 will provide the SCMC a greater role in encouraging continued progress in accountability. SCMC will now have financial incentives to enhance the existing policy setting role and responsibility to review/approve County Management Plans. Financial incentives are likely to enhance the development and refinement of the County Management Plans. Through this mechanism, DHS and the counties are continuing make advances to a more accountable system of care for county funded services. Many states have similar committee structures to address state-

county issues. The State/ County Assistance Teams similarly provides a strong model for the provision of technical assistance from the state to counties. Each of the 5 staff members works with approximately 20 counties, primarily in the development and implementation of County Management Plans. In a decentralized system like Iowa's, this model provides provide an important means for fostering consistency where needed, setting and maintaining quality standards, and identifying opportunities for counties to learn from one another.

- 4) Ohio METNET: The ten largest major metropolitan county mental health and alcohol and other drug addictions services boards METNET in Ohio have formed an alliance to develop standardized protocols for levels of care and utilization management. Although this project is also still in the developmental stages, these protocols will serve as the foundation for a more coordinated approach to delivering and arranging for behavioral health care services to consumers in these Board areas.

2. *LEGAL SETTLEMENT*

a. *Statement of the Problem*

The concept of legal settlements seeks to ensure that the counties' financial resources are not drained by paying high service costs for people that are not citizens of their county. There is also a belief among many that individuals with serious mental illness will move to the counties that have more comprehensive or highest quality benefits. Iowa statutory provisions require that a person acquire legal settlement in a county through continuously residing in that county for a one year period without receiving services. Although there are exceptions, counties generally have a responsibility to **provide services to residents** regardless of county of legal settlement. However, if the person has acquired settlement in another county, counties are required to seek reimbursement from the county of legal settlement for these services, thereby assigning financial responsibility for services rendered. These competing pressures induce a great deal of tension between counties seeking payment for services rendered to persons whose county of legal settlement is elsewhere.

There are also other factors further exacerbate the problems created by legal settlement:

- Counties are under increased pressure to manage financial resources, since the enactment of Senate File 69 limits the contribution of local levy dollars to mental health services;
- Eligibility for services varies from county to county;
- There is variation in availability of services from county to county.

These factors, when taken together, create an environment in which counties use legal settlement as a means to manage expenditures by seeking reimbursement for

care provided to person whose legal settlement is in a different county. Currently there is no formal or standardized mechanism to resolve inter-county disputes on reimbursement for out of county care.

b. Description of the Best Practice Area

Most states require crisis and emergency psychiatric services be provided at the time of presentation for service. In some states, once stabilization is achieved, there is a formal process for determining what the most appropriate next level of care is for the individual. In these circumstances where individuals are generally stabilized, a contact is made with the county of residence to either accept financial responsibility for continuing service with the out of county provider (which may not hold contracts with multiple counties), or arrangements are made for transportation with a provider under contract with the home county. Residency in these states does not require a waiting period until health or human service benefits are available. Some states require formal authorization procedures before any service is provided; others are after the fact billing. In most cases, prior authorization is required only for more intensive services, such as inpatient, and particularly residential placements.

c. Examples

- California Inter-County Agreements: In California there are agreements for authorization of services between county of residence and the host county. All host counties must provide a list of credentialed providers to the county of beneficiary (residence). Unless otherwise agreed to beforehand, the county of beneficiary does not offer rates to out of county providers that are higher than those offered by the host county. In order to handle disputes, parties have agreed to participate in a binding arbitration process for determining financial responsibility.
- Iowa Risk Pool: HF 2545 has established a risk pool of \$2 million, which is accessible by all counties on a loan basis, after exhaustion of budgeted county funds. Risk pool funds in excess of a county's levy limit do not have to be repaid. This risk pool would be administered by a risk board comprised of county and state officials, hence incorporating a very real structure that demonstrates an example of the state and county understanding that a joint approach to managing the changing roles and responsibilities is essential. This structure is intended to provide a peer monitored contingency fund to assist in county expenditures for MH/DD services. It has the potential to protect counties from financial concerns about not seeking reimbursement from their county of legal settlement. Although the criteria for accessing these funds are not yet established and the rules around handling potential disputes with the recommendation of the Risk Board, it is a step in the right direction. It may ease some of the pressure to manage utilization so closely and aggressively seek reimbursement from county of legal settlement.

3. *MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS*

a. Statement of the Problem

Decategorization in Iowa provides an example of best practice in integrating funding streams to promote development of local child welfare systems of care. This and other child serving systems provide a wide menu of service types that are accessed by seriously emotionally disturbed children. However, even with decategorization, there is a wide range of service types with different eligibility criteria that do not always function smoothly as an integrated continuum of care. Though DHS provides flexible wrap around services, such services do not appear to be widely understood and utilized leaving the impression that the service system may be overly reliant on residential service programs. It is also not clear how consistently mental health services are available to children whose mental health needs are less serious.

A significant set of services described as children's mental health services are provided with Child Welfare funding administered by the Decategorization Boards and with funding from the Juvenile Justice system. Some families perceive that receiving services from either organization is stigmatizing because these systems carry out court ordered actions for discipline or protection of children. Parents may also fear that disclosing problems they experience the staff of DHS may result in the removal of children from their home. These perceptions and concerns may constitute a barrier to receiving services for some families.

b. Description of Best Practice Area

In this section, we review the principles and core values of the Child Adolescent Service System Program (CASSP), that were developed in 1984 to guide federal, state, county and community governments in developing service systems for children with serious emotional disturbances. We then summarize work that has been done to realize these principles in a variety of different service systems. The principles address key issues including minimum service capacity, integration with other services, and access.

CASSP is guided by the following principles:

- Providing needed services in the child's home community to the greatest extent possible and providing in the least restrictive, most normalized environment clinically appropriate for the child;
- Involving families as full participants in service planning and implementation;
- Developing needed services and supports within communities. Access to a comprehensive array of services that address children's physical, emotional, social, and educational needs;

- Creating a child- and family-centered approach to service delivery that is strength-based (individualized);
- Emphasizing culturally appropriate services;
- Creating inter-agency cooperation and collaboration;
- Involving early identification and intervention; and
- Including delineated outcomes built-in accountability systems.

The CASSP initiatives were followed by a Robert Wood Johnson initiative called the Mental Health Services Program for Youth (MHSPY). CASSP and MHSPY projects provide some important models of best practice.

Minimum Service Capacity

CASSP stresses individualization of care and flexibility of service provision. These depend upon a continuum of care that can provide a progression from brief community based interventions to inpatient hospitalization. Stroul and Friedman provide a model of such a continuum:

| Non-residential Services |
|---------------------------------------|
| Prevention |
| Early Identification and Intervention |
| Assessment |
| Outpatient Treatment |
| Home-based services |
| Day Treatment |
| Emergency Services |

It is worth further describing the term, emergency services, that probably most brings to mind hospital emergency rooms, or, in the case of adolescents with aggressive behaviors, the police. Neither of these environments are appropriate emergency components of a CASSP service system. A preferred model would be that of a mobile crisis team with child-trained crisis clinicians and the backup of a pediatric psychiatrist. The mobile nature of the teams allows them, in most cases to perform assessment and stabilization in a more appropriate environment for children, including in the home.

| Residential Services |
|-----------------------------|
|-----------------------------|

| |
|--------------------------------|
| Therapeutic Foster Care |
| Therapeutic Group Care |
| Therapeutic Camp Services |
| Independent Living Services |
| Residential Treatment Services |
| Crisis Residential Services |
| Inpatient Hospitalization |

Foster care and group care, which are often considered child welfare services, can also provide an alternative to institutional placement for children with serious emotional disturbances. The inclusion of therapeutic camp services recognizes the importance of ongoing treatment and provision of appropriate recreational opportunities. In addition, families often require a safe place for their child to be in the summer in order to maintain needed employment. Crisis residential services are generally provided in small settings with staff trained in management of difficult behaviors. They offer individual, family, and group counseling, and have provision for medication management. They can prevent an institutional placement for a child, frequently can offer strong linkages with other community services, and should provide a more comfortable environment for families with troubled children.

MHSPY also includes Operational Services that are often necessary in order for families to make full use of treatment services. These services include:

| |
|------------------------------|
| Operational Services |
| Case Management |
| Self-help and support groups |
| Advocacy |
| Transportation |
| Legal Services |
| Volunteer Programs |

In developing a system of care, Stroul and Friedman note that less restrictive, community-based forms of treatment should be provided plentifully since they can be preventive of need for more restrictive and more expensive residential treatment models. Most children’s needs should be possible to meet in the community, reserving residential placements for the small number of children with the most severe conditions.

Wraparound Services

In developing individualized, family centered care, programs have learned that the continuum of programs listed above may not include all the services that families

Technical Assistance Collaborative, Inc.

with seriously emotionally disturbed children need in order to treat their child's condition in the best way. The term wraparound was developed to describe such services.

MHSPY defines wraparound services as: flexible, nontraditional services that can be assembled along with traditional care such as day treatment or psychotherapy to create a service package that constitutes intensive care in home and community based settings. In-home support services, peer tutors, transportation, and live-in companions are examples of wraparound services.³

Other examples include in-home behavior management for parents, a trained mentor for a child, and back-up crisis support with team members available on a 24-hour basis. Several MHSPY programs have been successful in bringing children from residential placements to live successfully at home at lower cost and with favorable outcomes using well designed community services and flexible wraparound services.

Integration with Other Services

The CASSP recognizes that there are multiple agencies that may be involved with children with serious emotional disturbances and their families, including Mental Health, Child Welfare, Juvenile Justice, Schools, and the Medical System. The conflicting jurisdictions, mandates, eligibility criteria and funding mechanisms of these systems often create a fragmented system that cannot always provide the type of services most needed by the child and family. CASSP calls for integrating and coordinating services so that care can be family centered rather than agency centered.

Integration ideally needs to occur on many levels of the system of care including the funding and organizational structure of services systems, the provision of services, and in public information about service availability and eligibility. Many CASSP and MHSPY projects have pursued methods for integrating services by pooling funding, similar to Iowa's decategorization process. However, most CASSP projects have been focused primarily on children with serious emotional disturbances. While they frequently rely on local or regional community based planning for service development, they tend to be guided by strong models of a comprehensive service system. Comprehensive pooled funding models have been difficult to develop, and frequently they pool some, but not all children's services.

Another integrated model that shows great promise is the provision of school based health and mental health services. Schools are highly accessible to children and families, and provide a normalized and familiar environment for children. Furthermore, they facilitate consultation with teachers, with appropriate consent, and allow for the development of a comprehensive treatment plan with consistent elements between home, school, and therapy. This model can be of particular importance in rural areas where mental health services may be less accessible than in cities.

Access

Integration is also needed in such system functions as screening, information and referral in order to promote families' access to services for their children as early as possible. One consistent theme of the literature, and one consistent feature of most children's case descriptions is the difficulty parents face in trying to access appropriate services from the complicated children's service system. School personnel, medical personnel, and children's and family service agencies need to clearly understand service availability to provide parents with appropriate referrals. Ideally, a central source can provide parents with accurate information to access appropriate services.

Seeking Services for Children

The second level of access comes when a parent or other concerned adult seeks services for a child. The availability, location, attitude, and usefulness of the service will affect the degree to which access is encouraged or discouraged. Some measures of process can help in assessing the access provided to children's mental health services. For example, all of the following are measurable performance indicators: wait lists; waiting time for first appointments; distance or driving time from the family's home to service location; services available after school and in the evenings; provision of child care for other children in the family; and client satisfaction with access to services. However, these measures only reflect people who actually make use of services. If a service system is not well developed and is not widely known by other child serving agencies, a number of children who are in need of services may not even be attempting to access the system.

To get a sense of the overall adequacy of services, planners can compare the estimated incidence of mental health needs with the number of people served by the current system. In general, the incidence of both children and adults with mental health problems is greater than number of children and adults using mental health treatment services. SAMSHA estimates that only two-thirds of young people nationwide that need mental health services are getting them.⁴ SAMSHA also estimates that, at any one time, up to 20% of children and adolescents may have a mental health problem, while up to 10% may have emotional, behavioral, or mental health disorders that severely disrupt some aspect of daily functioning.

In developing children's service systems, a broad-based planning process with involvement of family members, community child serving agencies, and mental health providers can use such estimates as a starting place, adapting them based on their understanding of their own community's strengths and risk factors compared to the national average. A sense of the relative adequacy of the local service system combined with information about waiting lists, location of services, and waiting time for appointments can provide important starting points for determining priorities for improving access to children's mental health services in a particular community.

Eligibility for Children's Services

A third level of access concerns eligibility for services. Many different types of organizations serving children provide some version of mental health services. However, their eligibility definitions are not likely to be coordinated and thus, when they need to refer a child to a related service, the child will not necessarily meet eligibility criteria. In addition, if funding is severely limited, services will generally be restricted to the most seriously ill children, losing opportunities to prevent children with less serious illnesses from worsening.

c. Examples

- Vermont Mental Health Services Program for Youth (MHSPY): Best practice would call for providing easy access and broad eligibility to normalized, entry and preventive mental health services, such as school or organization based counseling (YWCA, for example). These providers would be well trained in screening so that they would be prepared to make referrals to outpatient mental health services when more intensive service was warranted. A broad and flexible array of family treatment, support, and education services would be available to families with children with more serious problems putting them at risk for residential placement. Standards for access to such services need to be interpreted broadly enough so that children do not have to “prove” a high level of risk by escalating their problem behaviors and families can get help before they burnout.

Vermont’s MHSPY project is called New Directions. It has been successful in planning community based services to enable children placed in out-of-state programs to be served in their own communities, providing both cost savings and reducing family separations. This program involves the use of a 1915(b) Medicaid waiver for targeted case management. The program was planned using CASSP funding that established an interagency governing structure at the state and local level with an advisory group that includes parent representation.

To implement the program the state had to plan and develop a statewide community based service system. The most important new components of the service system were a therapeutic case management program with two levels of intensity. Case managers have small caseloads and provide many services directly, such as respite, support and primary therapy, as well as coordination and facilitation. The responsibilities of these case managers were broadened to include both the child’s treatment plan and financial plan. Other services added to the service system include crisis stabilization; special education; intensive residential treatment; intensive family-based services; respite care; and therapeutic foster care.

- San Diego Heart Beat Initiative: In San Diego County, the Heartbeat Initiative, funded by the Annie E. Casey Foundation, is planning to pool funding from the major children’s agencies to serve children with serious emotional disturbance. They are also planning a system for single point of entry where parents can access a central children’s services information resource that can provide

referrals to comprehensive services for children. While the program has not yet begun operations, the county has begun to reorganize its administrative and clinical operations into a single organization and cost center. Due to the size of the county, regional comprehensive networks will be established with more flexible, risk-based financing provisions.

- North Carolina Community MH Services for Children and Families: North Carolina implemented its program under a SAMHSA grant for Comprehensive Community Mental Health Services for Children and Their Families in a portion of the state that historically has had relatively few services available for children with mental health problems and their families, and in which there was very little coordination among the child-serving agencies. In the first two years of its operation, those historical difficulties were well on their way to being overcome.

The program has focused particularly on opening communication between child serving agencies and the courts, and providing community-based alternatives for children who come into contact with the juvenile justice system. This effort showed notable results in the first full year; the number of children committed to juvenile justice facilities dropped by 28% from the prior year, even though the number of commitments from a neighboring county in the same court district increased during the same period. The money saved by decreasing the rate of commitment and serving these youth in the community in less costly ways resulted in sufficient savings to develop a group home with crisis beds.⁵

4. MENTAL HEALTH SERVICES TO ADULTS

a. Statement of the Problem

Iowa's county based system for adult mental health services is widely varied in terms of financial eligibility for services, philosophy of service provision, method of administration, and amount and types of services provided. In addition, it appears to be overly reliant on inpatient and institutional care, in part because of the emphasis in state law on county payment responsibility for MHI admissions. Our interviews were replete with concerns about the lack of rehabilitation services and an over-reliance on institutional levels of care.

In this section we present the principles developed over the last 20 years for the Community Support Program (CSP) that have been the guiding principles for many of the best practice programs in the counties. These principles address minimum service capacity, continuity of care, housing, and the needs of special populations. These principles are well developed and widely understood in Iowa and elsewhere. However, because of the variation between counties, Iowa does not fully realize these principles of service provision statewide at the current time. These principles can, however, provide a framework for identifying gaps in service, processes that are not consumer-centered or sufficiently flexible, or special needs that are not sufficiently met. They can guide counties with less developed mental health services to achieve the more comprehensive systems some counties have developed.

b. Description of the Best Practice Area

Community Support Program principles were developed to guide the development of a community based service system to support people with mental illness who had primarily been treated through institutionalization. As deinstitutionalization has proceeded, the community-based system gained experience and consumers began to develop their own voice. As a result, the goals of community support broadened from simple functioning outside the hospital, to supporting people with mental illness in developing full and satisfying lives with work, friends, and family and full participation as community members. CSP guidelines emphasize client self-determination, individualized and flexible services, normalized services and service settings, and service coordination. The CSP model emphasizes the following characteristics of client services:

- Services should be consumer centered, based on and responsive to the needs of clients, not the mental health system or providers;
- Services should empower clients by incorporating consumer self-help approaches in service planning and treatment goals as well as in policy making, planning and delivering services;
- Services should be racially and culturally appropriate;
- Services should be flexible. They should be available whenever needed, and for as long as they are needed;
- Services should be strength based, building on clients' assets and strengths in order to help them maintain a sense of identity, dignity, and self-esteem;
- Services should incorporate natural supports. They should be offered in the least restrictive, most natural settings possible;
- Services should meet the special needs of subgroups of individuals with mental illness, such as those with co-occurring substance abuse disorders, who are homeless, elderly, or are incarcerated;
- Service systems should be accountable to the users of services. The state should monitor service provision, involving consumers and family members in that process; and
- Services should be coordinated at the client, local and state level to ensure continuity of care and efficient and effective service provision.

1) Minimum Service Capacity

CSP emphasizes that client centered care should be provided flexibly in the least restrictive environments. This goal requires that a mental health system provide a minimum set of community based services that provide a continuum to best meet

different intensities and types of need. At minimum, the menu of community based mental health services needs to include:

- Outreach/location of clients – includes assuring transportation needed to allow access;
- Assistance in meeting basic human needs – food, clothing shelter, personal safety, medical and dental services;
- Mental health treatment care – inpatient, partial hospitalization, residential evaluation, prescription, medication management, and community based individual and group counseling;
- 24-Hour Crisis Assistance – includes telephone service, mobile crisis, crisis stabilization and temporary housing to provide quick response in resolving crises maintaining community status to the maximum extent possible;
- Psychosocial and vocational services – comprehensive services with a continuum of expectations for functioning in normal social roles, including client operated services, assistance in job skills and job coaching;
- Rehabilitative/supported housing – a range of transitional and permanent housing options as appropriate for people who need some extra support in their living arrangement in order to achieve greater independence;
- Assistance/consultation and education – for members of the general community to help them understand the nature of mental illness;
- Recognition of natural support systems – self-help groups, clubhouses, consumer and family groups, family involvement and support (with client consent);
- Grievance procedures/protection of client rights – mechanisms to protect client rights, both inside and outside mental health or residential facilities; and
- Case Management and Community Support – including Assertive Community Treatment Teams which facilitate effective use of formal and informal helping systems to help client make informed choice of services⁶.

As a back up to this system of care, residential, inpatient, and specialty programs are also needed as appropriate to the needs of the consumer population.

It is important to note the attention given to the basic necessities of food, clothing and shelter. Programs have found that these are often the most salient concerns for people with mental illness trying to live in the community. The Assertive Community Treatment program has embraced this need by including direct assistance with such issues as part of its flexible and individualized service delivery model. The ability of mental health services to assist consumers to successfully address major survival issues can provide the security necessary for clients to address their mental health and quality of life issues.

2) Continuity of Care

Consumers consistently express through surveys and other feedback that relationships are one of the most important aspects of their satisfaction with mental health services. Because of the value that consumers place on these service relationships, mental health systems need to maximize continuity of care. Such continuity can increase the efficiency of the system, since information about the client does not need to be transferred from one provider to another. In addition, for consumers for whom communication is difficult, a familiar provider may prevent misinterpretations that lead to less effective treatment.

One of the most significant challenges to continuity is the gap between hospital and community based services. Several methods have been developed to maximize continuity of care. Best practice in this area calls for outpatient follow-up for therapy and medication management within three to five days of discharge. Since hospitals may admit clients from outside their service area, this requires that they be knowledgeable and effectively linked with community based resources in a wide range of communities. In addition, some of the most seriously ill clients may need social services and supports, including referrals to appropriate housing. Effective continuity also requires community-based services to have the staffing and flexibility to respond to hospital aftercare needs as a priority.

Managed care organizations can promote continuity of care at the hospital level for people who need multiple hospitalizations through service authorization policies. First, a one-network inpatient facility needs to be designated as primary – with consumer involvement and choice – for each consumer who has experienced an inpatient admission. To maximize the consumer’s likelihood of being admitted to their primary facility if they need inpatient care, the managed care organization can identify that facility on their client information system and notify crisis teams or hospital emergency rooms to seek a bed at that facility first. There are logistical challenges in implementing this policy, but to the extent that it limits clients being assessed for diagnosis and treatment planning by multiple facilities it prevents duplicative information gathering and testing. To the extent that it promotes a consistent relationship between the staff of the client’s preferred hospital and the client, and a consistent treatment plan over time, it improves treatment.

Client directed care through advance directives is another method that tends to promote continuity and consistency, and allow clients to ensure that they receive the

type of treatment they prefer even when they are not able to clearly express those preferences. Outpatient providers or case managers assist clients, who may be at risk of decompensation or crisis, develop a plan to handle those situations. These may involve steps that the client finds effective in preventing or minimizing such situations, and also address the client's preferences if he or she needs crisis assistance. The advance directive is then filed with the crisis team that will be responsible for working with people in mental health crises in that geographic area. This provides crisis team workers with the information they need to fulfill the client's preferences, to contact people who are willing to support the client, and to use the techniques that have worked for the client in the past.

Assertive Community Treatment (ACT) programs have a number of service components that promote long term continuity with community based providers. First, such teams tend to define themselves as a long-term support for most of the clients they serve. Second, they minimize the need to interact with multiple service systems, by providing as many services as possible directly. In order to do so, they develop teams with multiple skills that are capable of delivering a wide variety of services. For example, a team might include a psychiatric nurse, a social worker, an occupational therapist, and a mental health worker. Within the team, the client will establish relationships with all or most team members. If a team member leaves, the client has other relationships with the team that continue, and a new team member is introduced.

Clients who are not willing to engage in traditional mental health treatment or who are unwilling to follow a prescribed medication regimen are often described as "non-compliant". They, in effect, decline continuity of care. Another strength of the ACT program is an ability to establish effective relationships with some individuals who reject conventional treatment approaches. ACT serves clients in normal settings such as their homes and other community settings. In addition, they provide both daily living supports and therapeutic treatment as directed by the consumer. By extending themselves into the client's chosen world and responding to the client's priorities, they can find a service mix that the client finds supportive and acceptable.

c. Examples

- New Hampshire New Beginnings Club House: The Monadnock Family Services Vocational Program in New Hampshire was recognized in 1993 by NASMHPD. This program developed from a day treatment program that was converted into the New Beginnings Clubhouse. New Beginnings is run on the Fountain House model, providing consumers with an opportunity to work in a transitional employment program. Two options are available when the club member is ready to move toward a more permanent vocational situation. Career Options is a vocational rehabilitation program funded from multiple sources. The program includes vocational assessment, individualized job readiness training, and choice of an occupational goal. The program has found more success by focusing primarily on vocational choices rather than on a consumer's mental illness.

- Wyman Way Co-op: The other option is Wyman Way Co-op, a consumer-run, self-supporting cooperative that performs a variety of services such as landscaping, janitorial services, construction, and furniture manufacture. It is owned and operated solely by a membership composed wholly of individuals with severe psychiatric disabilities. Originally funded and supported by a community health center, it has become self-supporting. Two-thirds of the co-op members leave to pursue independent employment.
- Practice Guidelines: On the medical end of the mental health treatment continuum, best practice initiatives tend to focus on development and implementation of practice guidelines and treatment pathways. The intention of these efforts is to combine what has been learned about the most effective treatment approaches for specific types of mental disorders, and to summarize them to guide psychiatrists and other providers, thereby reducing practice variation. Some providers resist adopting the guidelines, fearing that it will result in insufficient attention to individual cases. They point out that the guideline assumes that the diagnosis is known, while in real practice, it may take some time to reach a conclusive diagnosis. Acceptance of such guidelines can be promoted by involving providers in researching and developing the guidelines.

Some of the current practice guidelines address treatment of bi-polar disorder, mood disorders, substance abuse disorders, partial hospitalization, post-traumatic stress disorders, panic disorders, and depression. Groups such as the American Psychiatric Association, The Association for Ambulatory Healthcare, the Behavioral Network of Vermont, and the Harvard Mental Health Letter have been involved in developing such guidelines.

5. *HOMELESSNESS AND HOUSING*

a. Statement of the Problem

People with serious mental illnesses have difficulty locating and maintaining safe, affordable housing for a number of reasons. In addition to the sometimes debilitating symptoms of the illness itself, they often lack adequate income and social supports, and many have co-occurring disorders, including alcohol or other drug problems and acute or chronic physical health problems. They also face the stigma associated with their illnesses and the fears of potential landlords or neighbors. When there is stiff competition for low-income housing, individuals with mental illnesses may not be able to compete against others who do not have a disability or the stigma of mental illness. Therefore, they may be at greater risk of homelessness.

Without adequate community based support and access to supported housing, Iowa mental health consumers have experienced similar problems in accessing necessary housing services. Homeless shelters in Des Moines are routinely filled beyond capacity, with assertions that many of the individuals have recently been discharged

from inpatient settings. Residential treatment options include: Residential Care Facilities for Persons with a Mental Illness (RCF/PMI); Intermediate Care Facilities for Persons with a Mental Illness (ICF/PMI) and Community Supervised Apartment Living Arrangements (CSALA). These are expensive service options and routinely filled to capacity. In addition, the increased pressure on MHAP and counties to reduce costs through shortening inpatient stays or other utilization management measures may, in fact, be contributing to an increase in re-admissions to inpatient settings. These re-admission patterns can sometimes result from a lack of supported housing services may reduce overall inpatient admissions, breaking cycles of recurring acute psychiatric episodes.

b. Description of Best Practice Area

There is widespread agreement that when housing is permanent and flexible, and individualized support services are available as needed, people with serious mental illnesses can achieve and maintain residential stability in the community. For persons with mental illness, supported housing offers a safe, viable, more affordable alternative that reaffirms independence and community living. Supported housing is based on the commitment to: 1) assert the rights and choices of consumers of mental health services to access affordable, decent, and permanent housing, and 2) to develop a flexible and responsive system of community supports that may be accessed by consumers to assist them to maintain independence and quality of life in the community.

A number of factors have contributed to the movement toward supported housing for persons with mental illness:

- Deinstitutionalization and the shift toward community-based residential alternatives;
- Shortcomings of residential or other quasi-institutional settings in moving people with psychiatric disabilities toward independence;
- Increase pressures to manage inpatient utilization and cost;
- The increase in homelessness among individuals with mental illness; and
- The growing strength and recognition of the consumer empowerment movement, family advocacy organizations (AMI), and homeless advocates.

These contributing factors provide the rationale for a movement towards supported housing, but there often still exists a gap in the service array for persons with mental illness. In order to fill these gaps in the service array, progressive systems of care should attempt to provide independent living alternatives. This requires a set of core service capacities that sharply contrast traditional mental health services and service delivery. Thus, a movement to development of supportive housing often involves a significant reorganization of existing services. Some key components of the service array should include:

Technical Assistance Collaborative, Inc.

- Home-based services;
- Natural community supports;
- Housing-related activities, such as outreach to landlords/owners to encourage their acceptance of Section 8 vouchers (this creates a pool of housing opportunities for persons eligible for Section 8 housing);
- Assistance with housing search by case manager or other care provider;
- Developing a flexible and readily available safety net, such as respite and mobile crisis services; and
- Assistance with access to financial subsidies for housing costs, daily living expenses and health care.

All of these approaches require leadership at the local and state level to encourage and support this change; to re-prioritize programs and services and to build consensus around these new priorities. These changes may come at a cost to current services and programs either through re-deployment of staff and program dollars, or in some cases, complete program elimination. However, if structured properly, there is the likelihood that these independent living alternatives can result in a net savings in treatment costs and better client outcomes.

c. Examples

- Vera French Housing Development Corporation: In Davenport, the Vera French Community Mental Health Center (VFCMHC) recognized a need for supported housing for persons with mental illness. Persons served in their system needed housing, but not a placement in a treatment setting or the county care home operated by the VFCMHC. With broad participation of stakeholders, including DHS, Scott County, HUD, community leaders, the Chamber of Commerce, the Real Estate Board, NAMI Iowa, and local banking and finance representatives, they formed the Vera French Housing Development Corporation (VFHDC) in the Fall of 1994. This non-profit developed a housing plan and financing strategy aimed at leveraging federal, state, and local funding and technical assistance.

The VFHDC now is responsible for over 120 units, including single family homes, duplexes, and a couple large apartment buildings for persons with mental illness and development disabilities. Because VFHDC was an outgrowth of the VFCMHC, there are natural linkages with the services of the VFCMHC, including case management and other supportive services. Over the past couple years, the program has involved other local ecumenical organizations, and organizations concerned with homelessness and poverty to secure grant funding for continued development projects in the community.

- Baltimore Community Housing Associates: In 1992, Community Housing Associates (CHA), Inc., completed the purchase and rehabilitation of 15 residential properties in Baltimore, Maryland, to provide affordable housing for adults with mental illnesses. CHA blended private and public funding to develop the project, and made innovative use of case management services to provide supports to its residents. The CHA project is a useful model for mental health or community development agencies interested in developing housing for people with mental illnesses.⁷
- Michigan Supported Housing Development: In Michigan, several demonstration programs are underway to develop and support housing for low-income and special needs populations. The program strives to develop permanent independent living residences in non-institutional settings that offer with access to other community services. The Michigan Department of Community Health has joined with the Michigan State Housing Development Agency (MSHDA) and the New York City-based Corporation for Supportive Housing (CSH) to initiate demonstration programs in four Michigan sites. These are meant to develop affordable supportive housing for individuals who are homeless or at risk of becoming homeless, including those with psychiatric disabilities. The program will explore ways that state health (including mental health) and housing agencies can work together, in cooperation with other public and private organizations, to provide housing and supportive services to individuals who have very low incomes and special needs.

Local nonprofit sponsors selected by community-level partnerships will develop about 300 units of housing. Funding for the initiative will come from state allocations of federal housing and development program moneys including H.O.M.E., Community Development Block Grants (CDBG), low-income tax credits, and donations from private sources such as foundations. CSH will assist nonprofit housing developers to build organizational capacity and will provide bridge financing. To date the program has generated \$650,000, with the goal of reaching \$1.4 million for capacity building and bridge financing.⁸

6. *RURAL MENTAL HEALTH ACCESS*

a. *Statement of Problem*

“The delivery of mental health services to rural residents is often impeded by a shortage of mental health providers and by the reluctance of rural residents to seek specialty care because of stigma associated with mental illness and concerns about confidentiality⁹.” Many consumers and families expressed concern over lack of mental health providers in rural areas of the state, noting that commuting time or physical distance prevented them from accessing care. Some expressed interest in developing transportation resources to get to the nearest provider. While consumers and advocates have sought to increase access to care in rural areas (especially for children) through MHAP, there still remains a difficulty in assuming a sufficient number of providers in many rural counties.

In 1993, a focus group convened by the National Association of State Mental Health Program Directors (NASMHPD) noted the following about rural mental health in the U.S.:

- The public mental health system is often the only provider in rural areas;
- Rural areas experience much greater shortages of mental health professionals and health and allied professionals;
- Rural areas have much lower availability and accessibility to specialized mental health services;
- Rural areas have a disproportionate number of populations who are at risk for mental disorder; and
- Managed competition models that are based on competition among independent provider groups are not likely to be effective in rural areas.¹⁰

b. Description of the Best Practice Area

In order to provide access to mental health care in rural areas, a system of care should be designed to ensure access to services and providers within a reasonable time and/or physical distance. Since a full array of mental health services is uncommon in rural areas, it may be necessary to seek alternative service delivery options. These can be services such as use of more natural community supports, or another approach is to train persons in the community to assist in providing supportive roles and perhaps referrals upon identification of persons with more intense service needs. In some cases, the problem of access to mental health care in rural areas can be solved through development of coordinated transportation programs, providing access to and from provider sites. The challenge is finding the right blend of these approaches using resources in and near the community in meeting the need for rural mental health care.

States have addressed the issue of rural mental health care through outreach programs, training and recruitment of mental health providers in rural areas, training and deployment of community health workers, and use of tele-medicine. Many experts argue since such a significant amount of mental health care is provided by primary care providers in rural areas, that integration of mental health care with primary care is the most reasonable approach to providing access to mental health care in rural areas.

Recently, many states have turned to privately managed behavioral health contracts to correct the problem of access to mental health services in rural areas. Even though contract specifications have delineated clear expectations for increased utilization of mental health services in rural areas, at this point it appears that there is no uniform set of standards that has been used to determine adequacy of a behavioral care provider network under a Medicaid managed care contract.

Some states have approached implementation of managed care differently in rural areas. For instance, Ohio officials have chosen not to expand mandatory enrollment of rural county recipients in Medicaid HMOs. In Oklahoma, HCFA made special requirements for Managed Care Organizations (MCOs) in rural parts of the state, including requirements of use of tele-medicine and alternative services to increase access to care in rural areas.

c. Examples

- Mansfield, Pennsylvania Provider Training Program: In Mansfield, Pennsylvania, a program was designed specifically to train middle level psychologists for work in rural settings. All students undertake practicum work in a rural community hospital in the first year and later undertake an internship in a rural health program. The program has been reasonably successful in attracting and maintaining psychologists for practice in rural communities.
- Kansas Tele-Psychiatry Network: The Mental Health Consortium of Kansas has recently implemented a statewide tele-psychiatry network. According to a recent article in *Mental Health Weekly*, it will be the country's largest tele-video system for the delivery of community mental health services. The network, developed in part as a result of a recent closure of a state hospital, is intended to: a) increase access to services in rural areas, targeting care for elderly and adolescents; b) reduce hospitalization through expansion of crisis intervention; c) decrease travel time for psychiatrists; d) improve crisis management through immediate medication management and evaluation; and e) create more cost-effective transitions upon discharge from hospitals through follow up tele-psychiatry visits.

Funding for the \$1.1 million network originated from a combination of state and private sources, including \$550,000 from the United Methodist Health Ministry Fund. The Network will serve 83 sites, including 30 CMHCs, the Kansas MH/DD Department and, two state-operated psychiatric hospitals.

After a successful pilot program, implementation of the statewide network will enable sites pay a moderate monthly fee for using the network to exchange data, view video for tele-psychiatry consultation, and view software applications on a PC screen. The network is set up for point to point communication to ensure protection of patient confidentiality.¹¹

7. DUAL (MENTAL HEALTH/SUBSTANCE ABUSE) DIAGNOSIS

a. Statement of the Problem

In recent years, both mental health and substance abuse practitioners have become more aware of the high incidence of dual disorders among their clientele. Estimates of prevalence vary. Studies estimate incidence mental illness in one-third to one-half of substance abusers; while almost one-third of people diagnosed with a mental illness have a history of some drug abuse or dependence in their lifetime. Incidence

of co-existing disorders in either mental health or substance abuse treatment programs is considerably higher. In substance abuse treatment programs, the incidence of mental illness is 50 to 65%, while one Medicaid managed care organization found an incidence of dual disorders of up to 70% in its inpatient psychiatric population.¹² These levels of incidence are both higher than in the general population. This degree of prevalence clearly calls for the provision of mental health treatment that can also meet the special needs of people with a co-existing substance abuse disorder. Our work in Iowa suggests that regulatory barriers and separate funding streams have kept mental health and substance abuse services largely separate for each other. To the degree that this is the case, consumers with dual diagnosis may not receive the treatment that would best meet their needs.

b. Description of the Best Practice Area

One of the first challenges in treating dual diagnoses is in identifying both diagnoses. Either the mental health or the substance abuse treatment system may be the initial contact for a person with dual diagnoses, and therefore each system must be prepared to screen for and assess for the presence of the other type of disorder. However, the service systems and their practitioners are not consistently trained to recognize the other type of disorder, or in how to address it upon proper identification. In addition, the screening and assessment tools used in substance abuse treatment do not necessarily work as well for a psychiatric population that has been found to have differing reactions to some drugs of abuse than the general population. In recent years, however, screening and assessment tools have been developed and used in psychiatric settings to identify the need for substance abuse. Policies calling for universal screening using a valid screening tool can quickly increase the identification of people with dual diagnoses.

Treatment of dual diagnoses remains a challenge. The differences in training, level of credentialing, and treatment philosophy between mental health and substance abuse professionals means that the two treatments are not easily integrated. In practice, this has generally meant that those consumers both of whose diagnoses are being treated are being treated in sequential, or at best, parallel programs. Thus, a mental health provider may complete treatment and refer the client for substance abuse treatment, or a person with mental illness completes a detoxification program and is referred for mental health services. It is not common for a mental health and substance abuse practitioner to actively collaborate in a treatment plan.

However, even when these barriers are overcome, and practitioners attempt integrated treatment, many challenges remain. The variety of mental illnesses and substance use, the phases of illness or addiction, or the phase of recovery from either, and the history of both disorders can combine to provide a complex picture that varies considerably from person to person. Clinicians face the difficulty of determining whether one disorder is primary and the other secondary or whether both are primary. In addition, the differences in training and treatment philosophy

make may it difficult for clinicians to effectively collaborate in an integrated treatment approach.

One integrated treatment model developed in Massachusetts at the Caulfield Center, described further below, has a program using the similarities of the twelve-step addiction recovery model and the more recent mental health recovery/rehabilitation model as the shared framework. This allows mental health and substance abuse clinicians to communicate and collaborate to meet the needs of a dual diagnosis population. At the least, cross-training of mental health and substance abuse clinicians in each other's methods and theoretical perspectives is a starting point in providing the shared understanding and language that is necessary for effective collaboration and learning.

Finally, people with dual diagnosis are among the most high-risk for other types of problems, such as HIV/AIDS and homelessness. Thus, the service systems must effectively address a range of environmental and social support issues in addition to finding effective integrated treatments for the dual disorders.

c. Example

- Massachusetts Caulfield Center Dual Diagnosis Treatment: The Caulfield Center near Boston, Massachusetts has developed a notable integrated dual diagnosis inpatient treatment. The integrated treatment philosophy was developed from identifying the compatibility between the twelve-step model and the recovery model. Examples of this include: the definition of disorders as lifelong disorders; responsive to rehabilitation, but carrying the risk of relapse; the effect of stigma and the need to address it in treatment; the significance of denial in the early stages of rehabilitation, and the need for effective strategies to address it; the importance of ongoing support from peers; and the recognition of phases of recovery.

The facility provides both mental health and substance abuse treatment, and combines them on an individualized basis considering such factors as the individual's type of mental illness and substance use; the individual's phase of recovery from the two types of disorder; and whether one disorder is secondary to the other. There is no standard treatment track for a specific diagnostic combination.

- Community Support Demonstration for young adults with MI/SA: The Community Support Demonstrations of services for young adults with severe mental illness and substance use disorders conducted during 1987 to 1991 remain a rich source of information about community based dual diagnosis treatment. The implementation materials such as manuals, assessment tools, and training materials provide guidance for others developing such programs. The evaluation components also demonstrated important outcomes, including reduced hospitalization for program participants, and reduced use of substances.

One of the important lessons of this project is that this particularly treatment resistant group can be engaged in long-term community treatment approaches that provide high degrees of continuity and outreach into the normal environments of the participants. Second, programs learned that abstinence is generally not a viable first treatment goal; motivational approaches that introduce a move toward acceptance of abstinence are necessary for many individuals. This learning led to a better understanding of the long-term nature of substance abuse recovery for this group and the development of stage-wise treatment approaches. These stages involve engagement in services, developing motivation to pursue abstinence, attaining abstinence with skills and supports, and preventing and dealing with relapses.¹³

8. *MENTAL HEALTH AND THE ELDERLY*

a. Statement of the Problem

“Between 15 and 25 percent of older persons experience some form of mental illness. This ranges from depression, anxiety, bereavement adjustment problems and substance abuse to schizophrenia, personality disorders, paranoia, compulsive behaviors, and dementia.”¹⁴ This need for mental health services will likely increase as the population ages. In addition to these mental health needs, many elderly persons also are in need of medical, social and supportive services, further complicating the design of appropriate programs and services for the aging population.

The need for mental health services for the elderly in Iowa is further complicated by the rural geography of the state. Outreach programs and identification of mental illness among geographically disperse (and sometimes isolated) elderly populations require innovative approaches to identify persons needing treatment. Even if needs are identified, access to services can be limited, and there is often limited availability of providers with specialization in psycho-geriatrics.

The mental health needs of the elderly may go undetected by family or even physicians who are unable to distinguish characteristics of aging from the need for mental health services. Even if these mental health needs are identified, they are often complicated by other medical and social needs. In these cases, families often turn to nursing homes or other residential care settings. In circumstances less complicated by other medical needs, more interactive community programs may allow the individual to stay in the home.

b. Description of the Best Practice Area

An effective service delivery system for mental health services to the elderly should include mechanisms for identification of persons with treatment needs, an array of services that address not only the mental health needs of older persons, but also their medical and social needs in the least restrictive environment possible. In some circumstances, complicating medical conditions often make it difficult or impossible to provide family care for older persons in the home. Nursing homes and other

residential programs can provide medical care and social supports, but should also have the capacity to detect and arrange for mental health care when identified as a treatment need. Finally, case management and frequent attention to monitoring medication, are essential to keeping the person functioning independently. Effective mental health service systems for the elderly offer services that address both mental health care and coordination with other appropriate social and medical services.

c. Examples

- Linn County, Iowa Rural Geriatric Outreach Program: Programs such as the Rural Geriatric Outreach Project in Linn County provide an example of how to identify and assess treatment needs, provide and arrange for appropriate mental health, medical care and social services in a rural Iowa county. The program used a variety of referral sources, including treatment providers, case managers, outreach specialists, and non-traditional referral sources, e.g., mail carriers, or sheriff's office employees. The approach was to deploy a broad range of persons with regular interaction with elderly in rural areas to assist in identification and referral to appropriate treatment or other service providers.

This program resulted in treatment for over 360 individuals and training for families, peer counselors and care providers. It was independently evaluated as cost-effective and appeared successful in identifying treatment need and delivering services.

- Rhode Island Specialized MH Services in Nursing Facilities: The Rhode Island Department of Mental Health, Retardation and Hospitals, in collaboration with the State Medicaid Agency, added "Specialized Mental Health Consultation to Nursing Facilities" as a covered service. This service is designed to allow nursing facilities to access expert clinical consultation from Rhode Island's eight community mental health centers on psychiatric and/or behavioral concerns designed to impact both on an individual case and, by logical extension, on the operation of the facility as a whole. Although Medicaid mandates that nursing facilities must provide a baseline level of mental health services to residents within the facility's daily rate, this program was intended to address client behavior when it reaches a level of severity that requires a level of expertise beyond that which the facility would normally be expected to provide under Medicaid.

These two examples focus on outreach and identification of need. One strives to monitor for symptoms of mental illness in elderly persons, provide support and refer to treatment if necessary. The second seeks to identify persons who require a more intense level of service and arrange for appropriate care in the place of residence—in this case a nursing facility. Another example may include use of county nurses to provide case management, and medication monitoring for elderly persons who live in geographically disperse areas of the state. While there are many different approaches, all share common themes of outreach and/or identification of need, provision of service or arranging the service to

meet the social and behavioral needs of the individual—whether in a nursing home or in the community.

9. MENTAL HEALTH AND JAILS

a. Statement of the Problem

People with mental illnesses comprise 10-15 percent of the jail and prison population in this country. There is growing concern that this number is growing as state and local mental health authorities have made admission to state hospitals more difficult. In a survey conducted by the National Alliance for the Mentally Ill in 1993, 69 percent of jails report seeing more or far more inmates with serious mental illness compared to ten years ago. Many individuals are incarcerated simply because local courts and law enforcement officials are unable to respond to persons with mental illness because of a lack of adequate resources. Without adequate community resources, these individuals are often taken to jail.

Despite the increase in persons with mental illness who are incarcerated, there are many innovative and model programs that are designed to keep people with serious mental illnesses from entering jails and prisons, and effective treatment programs for those whose criminal activity requires incarceration.

b. Description of the Best Practice Area

The first hallmark of model programs is to keep people with serious mental illness from entering the jail system. This can be accomplished by ending the practice of jailing mental health consumers who have committed no crime. It is standard practice in many states to use jails as holding or detention facilities for mental health consumers when no treatment or crisis service is available or accessible. Most states have developed laws that prohibit this practice. In many states the alternative is accessible mobile crisis intervention and stabilization programs which can respond to situations that would ordinarily result in a jail lock-up.

In situations where a mental health consumer has committed a petty crime or misdemeanor, jail diversion programs have been successful in seeing that these consumers are diverted out of the criminal justice system and back into the mental health treatment system. These programs usually involve the use of mental health staff who daily screen the jail population at time of arraignment, and recommend to the judge mental health services in lieu of continued jail time.

For those who commit more serious crimes and must be held in a jail or prison, many state and local mental health authorities have developed joint programs with corrections to offer a wide array of mental health services within jail and prison facilities. These include a full array of medication management, counseling and community re-entry planning.

c. Examples

- Ohio's Lucas County Forensic Monitoring: Ohio's Lucas County has developed a three-step process for responding to the issue of mental health consumers in

jail. The first step is a 24-hour, seven days a week mobile outreach services that is available to law enforcement. This service will guarantee to relieve an officer of a crisis situation involving mental health within 20 minutes of the call. This highly specialized mental health team can direct admissions to a number of hospitals if needed, or can transport the individual to a 14-bed crisis stabilization service, which can provide up to three days of service. For those who may need to be incarcerated, the county also provides a community mental health team that is housed at the county jail. The team is responsible for in jail treatment and for the development of community linkages upon the release of the patient.

- Florida's Broward County Court Specializing in Mental Health Related Cases: In June, 1997, a court specializing in cases involving persons with mental illness was established in Broward County, Florida. The court seeks to minimize the amount of time persons with mental illness and co-occurring substance abuse disorders spend in jail. The court is convened daily, hearing cases ranging from minor misdemeanors such as trespassing, to more serious misdemeanors, such as battery. The court confers with a court monitor from the community mental health system, the public defender, the state's attorney and others to gather information about the case. Often, there is an immediate referral to a local community mental health provider. In other cases, inpatient evaluation is necessary. In all cases, all parties work together to determine the most appropriate course of action, including development of a services plan for the judge's consideration.¹⁵
- Memphis Crisis Intervention Team (C.I.T.): The Memphis Police Department deploys specially trained police officers who are on call during regular duties to respond to incidents involving persons with mental illness or co-occurring mental illness and substance abuse disorders. The 40-hour training is provided by the University of Tennessee Medical Center, as well as veteran CIT officers. When responding to the crises, the officers are often able to resolve matters on the spot without taking further action. In other cases, the consumers are transported to emergency facilities where the mental health staff will assume responsibility. The program structure allows incidents to be handled quickly and reduces the amount of time officers spend during the intake process.¹⁶

10. CONSUMER INVOLVEMENT

a. Statement of the Problem

Consumers of public mental health services do not often have a meaningful role in the planning, delivery and monitoring of public mental health systems. These systems often neglect the consumer as someone whose ideas, views, and opinions can help define and shape how these systems can best respond to the needs of consumers and their families. Those who have direct experience as consumers of public mental health services are often able to articulate how these systems can be improved.

For Iowa, the fragmentation in service delivery is often apparent to consumers before it is apparent to others in the system. For this reason, opportunities to involve consumers in the planning, delivery and monitoring of public mental health systems should help system planners, overseers and funders identify areas for program improvement and strategies for success.

b. Description of Best Practice Area

Lately, there has been new attention placed on the role of the patient in health care delivery. Much of the discussion about patient's "bill of rights" and managed care regulations is about how to involve the patient in their own health care decision making, and in the assessment of the care that is provided to them. In mental health care, the patient is often overlooked in treatment planning, program design, service delivery and assessments of quality. Many believe that the patient's mental illness may leave them unable to make informed or rational decisions in these areas. For some this may be partially or episodically true, but for the majority of mental health consumers served by the public mental health system, they are a resource with some insights into how the system and their own care may be improved.

Consumer involvement in the planning, delivery and quality assurance of public mental health systems has been a hallmark of progressive public mental health systems. Many states and counties have embraced the role of the consumer in these critical areas and have developed mechanisms to foster consumer involvement in these areas. These efforts can be categorized into four key areas of involvement: system planning/governance; treatment planning; employment; and quality assurance.

1) *System Planning/Governance*

The Federal Government has recognized the role that consumers have in system planning and governance. Consumer involvement is a requirement for state mental health planning and block grant decision making. Counties and providers have also embraced the role of consumers in mental health planning and decision making. Many state systems now require significant consumer involvement in state, regional or local mental health boards, commissions or governing boards.

Best practice in this area is reflected in two ways. First, is the role that consumers have on planning and governance boards. Typically, consumers are represented as advisors to the system. Current best practice has consumers moving from roles that are advisory in nature, to full voting powers as given to other members of such boards.

Second, is the number of opportunities consumers are given to participate. Typically, most systems that involve consumers in planning and governance commit only one slot or position to consumer representation. Current best practice has consumers filling more than token positions. More progressive systems even require that the majority of positions or slots be filled by consumers and family members.

Georgia and Texas are examples of states that impose such requirements on local and regional planning and governance boards.

2) *Treatment Planning*

Another area of consumer involvement is the opportunity for consumers to actively participate in their own treatment planning. Traditionally, consumers were given little to no choice in what services they would receive and from who or where they might go to obtain services. Progressive mental health delivery systems are now creating opportunities for consumers to participate in their treatment planning and in what choices they have available to them.

Some state mental health systems now include evidence of consumer involvement as a performance indicator for state and local systems of care and managed care plans. Best practice sites also include requirements for treatment options to be presented to consumers. For most services, two or more providers (or clinicians) are available to provide the services, and that the choice is left to the consumer as to which provider they are interested in receiving their care from.

Another development in treatment planning has been the use of advanced directives as a mechanism to have mental health consumers plan for relapses, or the need for emergency psychiatric services and inpatient care at time of acute episodes of illness. Advance directives allow consumers to plan for critical service intervention at times when they are stable, so that when the consumer is unstable, their wishes and desires for treatment and support can be accommodated. Although this is a relatively new development in the field, several states and managed care organizations are using advanced directives to improve consumer involvement in treatment planning at time of crisis.

3) *Employment*

Consumer involvement in the planning and delivery of mental health services is no where more apparent than in the employment of consumers within public mental health systems. Many mental health systems now actively create opportunities for consumers to be employed in the mental health system both in direct and non-direct care positions.

Self-help is one of the eleven major components of a Comprehensive Community Support System as identified by the National Institute of Mental Health in the 1980s. The National Association of State Mental Health Program Directors endorsed a position paper in 1989 recommending that “client self-help and mutual support services should be available in each locality.” Most mental health systems now actively encourage the development of consumer operated drop-in centers and other services that offer self-help and mutual support.

As a best practice area, consumer employment in mental health has moved beyond the operation of consumer-run drop-in centers to the hiring of significant numbers of

service recipients into jobs within or controlled by the state and local mental health authority. Proactive recruitment and hiring of mental health consumers has been a requirement for many state and local mental health agencies and providers. Most state behavioral managed health care contracts now require minimum consumer employment levels, as do some contracts for the purchase of services by state and local mental health agencies.

In many cases, the employment of consumers into the mental health work force has raised a number of questions regarding the acceptance and support for consumers among existing staff, what kinds of positions should be considered, and how should confidentially be protected. Many states and county authorities have struggled with these questions, but there is now a growing body of research and experience that can be used to address these issues. The California Institute for Mental Health recently published a monograph for county authorities in that state on how to achieve the successful employment of consumers in the public mental health workforce.

4) *Quality Assurance*

Another area for consumer involvement in public mental health systems is in the assessment and monitoring of care provided. Consumer involvement in this area is critical in both state and local mental health care delivery. Not only is consumer feedback a hallmark of most total quality improvement processes, but consumer feedback has become a standard for improving customer relations in most service industries.

Despite some progress, the mental health care industry lags behind other health care sectors in terms of measuring consumer satisfaction. While private industry has been developing, testing and fine-tuning methods to measure consumer satisfaction with everything from shampoo to fast food, the methods and procedures that measure satisfaction with mental health services remain fraught with ambiguity, unreliability, and questions of bias. However, this field of study is progressing and professional literature is beginning to reflect that progress. The literature clearly shows that individuals with psychiatric disability have opinions, attitudes, and preferences about the full range of life issues and that, given the opportunity, they provide essential input to a consumer satisfaction process.

There are many ways that consumer input can be solicited and several reasons why it makes sense to do so. Some organizations make the decision to turn the entire project over to a consumer organization. Alternatively, the organization may create an advisory committee or focus group for the project comprised of consumers as well as family members, staff, researchers, and other appropriate community members. The key to success will be in creating an environment where consumers have real opportunities to assist in the design, development, and implementation of the project.

“Consumer satisfaction” is a broad term. There are many reasons why an organization may choose to measure the satisfaction of its clients or consumers.

Philosophically, an organization may determine that it is a necessary component of consumer empowerment. Programmatically, it can be an effective way to identify gaps and weaknesses in the system, and to improve services. In addition, consumer satisfaction reports may be one component of a provider profile, a quality improvement process, or one type of input for a policy development process. Further, the results obtained through such a process may be useful in lobbying efforts, in a budget development process, or in the determination of resource allocations across a system of care.

c. Examples

- Planning/Governance—Georgia Blue Ribbon Commission on MH/MR/SA: In a reorganization of its community mental health system, the Georgia State Legislature created a Blue Ribbon Commission on Mental Health, Mental Retardation and Substance Abuse. The Commission developed recommendations for the creation of new regional mental health boards that would have the authority to allocate all resources within the region, including state hospital resources. In order to ensure that these boards represent the best interests of consumers and families, the Commission recommended (and the Legislature approved) language that required consumers to be a majority of the members appointed to serve as the governing board of the regional board. In addition, the legislation required that an equal number of family members who have used or are using the service system be appointed to serve on the regional board. This requirement is credited with bringing about significant change in how dollars are allocated and which services have been promoted, including a reduction in expenditures for state institutional care.
- Employment—Sacramento County Consumer Advocates: Sacramento County California has developed 101 paid consumer positions within its mental health system, including a consumer advocate who serves as member of the county’s executive management team. The county used existing job classifications to hire its initial consumers, and has developed an educational training program with the local community college to train consumers interested in employment. The program has graduated 23 consumers. This training program has helped consumers meet the county’s minimum educational and training requirements. In addition, provider contracts now require that agencies under contract to the county for the provision of mental health services employ consumers.
- Quality Assurance—Philadelphia Consumer Satisfaction Team: The Philadelphia Consumer Satisfaction Team (CST) was authorized by the Philadelphia County Office of Mental Health in 1990. It is an independent non-profit organization governed by a Board of Directors, which represents all constituencies in the Philadelphia mental health system. It was originally conceived in response to the closing of a state hospital with the purpose of providing follow-up support for former patients and individuals that might have become patients of that hospital. Their motto is “listening to people first.” Believing it to be more responsive to consumer needs, the project intentionally

chose to utilize conversation and a subjective reporting mechanism, rather than a formal survey or questionnaire method. They believe that their power comes through the continuous feedback they provide to city and state officials and to the providers of services.

The Team is focused upon problem resolution as a method of achieving consumer satisfaction, and among the outcomes that are listed in the Team's literature is the movement of group homes to safer locations, staff changes, and the installation of air conditioning at a program. In their literature, the CST explains their theory that the elements that are necessary to replicate their work are the "concept" and "philosophy" and not the duplication of the "agency."

Since its inception, the CST has experienced continual growth; during the last reported fiscal year the Team conducted more than 320 site visits and interviewed more than 2,600 consumers (duplicated count). It is also doing consulting and training on its methodology on a state, national and international basis.

The project is staffed by a combination of consumers and family members who receive ongoing training, and whose mission is to listen to consumers and families of consumers in order to determine the level of satisfaction they experience. They learn about what parts of the mental health system is working, what needs to be developed, and what needs to be changed. They do this by conducting personal interviews with consumers at program sites throughout the county, sponsoring consumer "speak-outs", conducting unannounced site visits to programs, and reporting on their findings to representatives of county and state government as well as service providers.

F. Barriers

Any analysis of a public mental health system must take into account the many legal, political, organizational, and financial barriers that impede real progress or change within such systems. Our analysis of the Iowa Mental Health System has identified several such barriers that must be considered when planning for or implementing recommendations for change.

I. LEGAL BARRIERS

a. Limited Statutory Requirement to Provide Mental Health Care

The most significant barrier to effective public mental health services in Iowa is limited statutory requirements for the provision of care. The current statute specifically provides a public (county) responsibility for the provision of mental health services within MHIs. This statute seems stuck in a time when care in state institutions was the only method of treatment available to people with mental illness. Today, this statute is woefully out-of-date, as the preferred method of mental health treatment and support is care in community. Some counties in Iowa have been

known to use this narrow requirement as a way to deny responsibility for providing community care. Others recognize that effective community care is not only more appropriate, but can be more cost effective. A change to the statute is needed to recognize public responsibility for community care, and encourage the development of services in local communities.

2. *POLITICAL BARRIERS*

a. Lack of Understanding about Mental Illness

In many ways Iowa is burdened by a general lack of understanding and sympathy for the needs of people with mental illness. In the course of the evaluation we heard many stories about the confusion between mental illness and mental retardation, and the perception that the root of the mental health problem may be in personal failings by those afflicted, and not the recognition that this is a biological illness requiring treatment. The strong work ethic among citizens of Iowa may perpetuate the myth that hard work and personal responsibility will “cure” the problem. This results in reluctance to spend tax dollars on mental health service, and in continued stigmatization of individuals who use mental health services. This lack of understanding and sympathy for mental illness as a public responsibility and public trust may be directly related to the underfunding of mental health services by the state and counties.

b. Lack of a Shared Vision

There appears to be no clearly articulated vision within Iowa as to how the public mental health system should operate. Each “camp” has its own ideas about the how the system should be organized, financed, and administered, and frequently pursues correction of its most significant concerns through legislative involvement. And, while there may overlapping ideas and solutions to many of the problems in Iowa’s system of care, there is a lack of shared vision among these “camps”. This lack of shared vision creates disharmony when seeking new funding or structural change in the public mental health system. Legislative involvement in “fixes” sponsored by one or another stakeholder group results in a piecemeal approach to reform and initiatives that are not well supported throughout the system.

c. A Spirit of Animosity

Throughout this evaluation we have been struck by the high level of animosity and mistrust that pervades the public mental health system. There appears to be a desire to fix blame, rather than to fix problems. There is a great deal of distrust between counties and the state; advocacy organizations and the state; providers and counties; the MCO and counties; the MCO and providers; and so on. Many times in the course of this evaluation, the term “mean spirited” was used by stakeholders to characterize the relations between/among mental health constituencies in the Iowa system. It is our experience that when tensions rise to this level, elected officials and legislators in particular are reticent to become involved in a process of meaningful change for fear of alienating existing supporters. If there is to be systemic change in Iowa’s public mental health system, there must be a spirit of

cooperation and collaboration among these constituencies that leads to real problem solving.

d. Heavy Historical Reliance on Property Tax

The heavy reliance that Iowa places on property taxes to fund the mental health system serves as a barrier to adequate funding of the system of care. Senate File 69 has helped reduce the amount of local property taxes that go to public mental health services by increasing the amount of state funding for these services. However, almost half of the public mental health system remains funded by property taxes. In an agricultural economy such as Iowa's, property taxes represent a significant tax burden to farmers. Their concern over rising property taxes may further weaken public support for funding of mental health services that, in many counties, together with mental retardation services represent the largest single public expenditure of these revenues.

In addition, the use of property taxes to fund services often results in inequities in funding among communities. Richer communities often have more complete systems of care, while poorer communities offer less service. In its original distribution of state funds for property tax relief, funds were allocated half on the basis of historical spending levels and half on the basis of population, tending to perpetuate the existing inequities between counties. Currently, the allocation formula has been revised to put greater weight on population than on past expenditures, and about 10% of allowable growth funds have been put into a pool whose purpose is to bring the counties with the lowest per capita expenditures to the level of the 75th percentile. While these changes begin to address the inequities created by property tax based funding, the funds allocated toward reaching the target are not yet sufficient to ensure that the counties that meet this target will be able to provide a desirable minimum service set for people with mental illness.

e. Quick Fixes Rather than Structural Reform

Iowa has a long history of trying to fix organizational and financial problems in its public mental health system. Recent changes found in Senate File 69, and more recently in HF 2545 have provided for: shifts in funding from county to state; development of new state/county management approaches; and creating incentive funds for the distribution of state resources. While these changes are significant, they are often viewed as "quick fixes" to correct problems or issues, rather than as a series of initiatives designed to bring long-term and fundamental reform to the Iowa system. As a result, constituency groups concerned with mental health care in Iowa have become used to looking for the quick fix. These fixes may be worthwhile, but at some point they may create other problems or create unrealistic expectations as to the level of change anticipated from the quick fix. Senate File 69 may be a good example. Here, the expectation was on changing how services were financed. The quick fix was property tax relief, and while very important, did little to change the level of funding available for mental health care.

3. ***ORGANIZATIONAL BARRIERS***

a. Multiple Systems of Care

Iowa's multiple systems of care result in a fragmented system of services, concerns over system boundary management, and the lack of a single point of accountability in Iowa for public mental health services. There are five distinct components of the state's public mental health system. They include the following components: portions of the Medicaid-funded mental health system managed by the MCO; portions of the Medicaid mental health system which operate outside the MCO contract (such as PMIC beds); state operated MHIs; community and institutional mental health services managed by Iowa's counties; and children's mental health services that are managed by the Department of Human Services collaborating with decategorization boards. Each of these systems also has multiple area management entities, such as ninety-nine counties, thirty-nine decategorization boards, thirty-eight human service administrations, and four state hospitals. School systems and Area Educational Agencies play important roles in decategorization boards and have significant interfaces with children's mental health and related services. The state and some Counties play dual roles in the system by virtue of directly delivering as well as administering purchased services. For example, the state operates the Mental Health Institutes paid for by Counties, and provides targeted case management services for some Counties while some counties operate their own residential and other programs.

b. Ninety-nine Counties

The basic organizing entity for public mental health services in Iowa is county government. Iowa's ninety-nine counties are the designated Central Point of Coordination (some counties use a multi-county CPC), and provide funding for almost half of the service system. Although decentralized and local service delivery is considered an important hallmark for health care delivery, there is an administrative cost to having so many organizing entities. Iowa's strong identification with county governance and county boundaries makes cross county collaborations or multi-county approaches to service delivery, purchasing, and administration difficult, and therefore infrequent. Although some counties have combined their efforts for the CPC, most counties have chosen to keep their systems county specific. This results in a public mental health system that has tremendous variability across the state. This variability is evident in differences among counties in eligibility, service array, and funding levels.

c. Limits on the Scope and Power of the State Mental Health Authority

The Iowa Division of Mental Health and Mental Retardation is a relatively small division exercising somewhat limited leadership in the design, development and oversight of the state's public mental health system. The Division has taken on many issues with success (housing, homelessness, and disaster services), but does not have the resources to provide extensive leadership to the state's public mental health system. Not only is staffing limited, but the fragmentation in services and

funding streams identified above, limits the Division's real authority over much of the public mental health system.

4. FINANCIAL BARRIERS

a. Multiple Funding Streams

The fragmented system of service delivery described above is a result of and complicated by multiple funding streams being used to fund the public mental health system. These include Federal Mental Health Block Grant funds, state appropriations for institutional and community services for adults and children, Medicaid, and county property tax funds. While multiple funding streams are common in public mental health systems, Iowa's system is more complicated than most due to the myriad of systems of care that have been created over time. Very rarely do these funds come together in one administrative entity (either state, county or managed care organization) or in a way that provides a comprehensive approach to service planning and delivery. There is also limited flexibility within these funding streams, which constrains the way that these administrative entities may use these funds for particular aspects of client care. The presence of multiple funding streams also presents the potential for cost and care shifting. Although we were not asked to gather specific evidence of cost shifting in our review of the Iowa system, numerous stakeholders reported this to be a problem in the current system design and were concerned about the potential for future cost shifting.

b. Limited Medicaid Program

The limited nature of the Iowa Medicaid system also serves as a barrier to care. The current system uses a 1915(b) Waiver from the Health Care Financing Administration to implement managed care principles and technologies for mental health services. Now in its second iteration, this waiver has resulted in some broadening of the benefit available to those with mental illness through achieved savings and better benefit management. On the downside however, there had been no use of optional, psychosocial rehabilitation services prior to the waiver. As a result, many psychosocial rehabilitation and community support services that other public systems use to treat and support people with serious mental illness are not included in the base funding for the Iowa Medicaid system. This has resulted in Medicaid being primarily used to fund traditional inpatient and outpatient services for this population, while the field has moved beyond these services to a broader array of psychosocial and community support services. Although some county systems in Iowa are developing these latter services, they must depend on non-Medicaid funds and miss the opportunity to leverage federal financial participation for these services.

A major impediment in the Iowa mental health system is the lack of a discrete appropriation dedicated to funding a defined set of children's mental health services. The majority of children's mental health services in Iowa are provided by the Department of Human Services as a part of the overall child welfare system. The child welfare service continuum is expansive, but appears to be directed more

toward institutional and residential care rather than in outpatient and community support services. Mental health services are components of the interventions that are included in the child welfare system, and Decategorization Boards can flexibly allocate resources to address mental health needs. Yet there appears to be no defined set of child mental health services as found in other states under the federal Child and Adolescent Service System Program (CASSP).

Furthermore, many family members and others reported to us that mental health services for children were very difficult to receive without giving up custody of their child. This is likely related to the child welfare focus of the services. Without a distinctly defined children's mental health service system, consumers, administrators and citizens do not have a clear basis for holding DHS and the Decategorization Boards accountable for the delivery of those services. Parents have a hard time understanding what services are available and whether their children are eligible for them, and parents of children who are served by the existing system can be stigmatized in the community by a presumption that they have parenting problems. (We note that a separate appropriation and minimum set of services does not preclude administration by Decategorization boards with authority to provide alternative services if they offer a superior service.)

c. Limited Financial Support

Although it is difficult to arrive at a true per capita expenditure for public mental health care in Iowa, the last available data (1993) from the National Association of State Mental Health Program Directors shows that Iowa ranked 53rd among the 53 states and territories in per capita state mental health agency expenditures. While this figure does not include county funds or those appropriated since 1993 (SF 69); Iowa is listed at \$13 per capita, with the next closest state/territory being Puerto Rico at \$21. Even if we use the 1997 per capita county expenditures for mental health services and MHAP expenditures (see Appendix 13), Iowa's total per capita expenditure for mental health services in **1997** would be \$41.47. This is still more than \$12 below the **1993** national per capita rate of \$54. It is obvious that the Iowa system has limited funding, making the development of new or expanded community services, or the attainment of best practice models, difficult. Limited funding also contributes to the tensions within the system as clinicians and administrators struggle to make difficult decisions between competing needs. To minimize the difficulty, entities seek ways to limit the individuals for whom they are responsible and locate other entities that can be held responsible. This can cause the client involved to experience difficulties in accessing needed care.

VI. RECOMMENDATIONS

Iowa's current system for providing mental health services for uninsured SMI adults and SED children has significant barriers that restrict its ability to correct problems or to improve. Iowa stakeholders have been struggling to address the problems of the system and are not satisfied with their abilities to make a difference. All too often they find themselves working at cross-purposes with other system stakeholders and a sense of frustration and distrust has developed. TAC believes that attempting to improve the system as it is currently structured will not ultimately be successful. In order for the system to truly improve, Iowa must boldly address the root causes of some of its most significant problems by providing state funding for a minimum set of services to clients meeting statewide eligibility standards and clinical or functional necessity criteria. We recognize that this and related recommendations are ambitious and will require new funding, legislative changes, and extensive public discussion and advocacy. As a result, some of the recommendations may be controversial, and thus may need to be implemented over a longer time horizon.

Iowa's current system for providing Medicaid mental health services was strengthened when it was restructured into the Iowa Plan for Behavioral Health. Iowa's experience developing and improving this program provides a model of successfully addressing issues of system design, and offers opportunities for program expansion. However, the program needs strong ongoing monitoring, especially around its boundaries with the county administered service system, to fully realize its potential.

A. Strategic Opportunities for Addressing Barriers

This section provides an expanded overview of those aspects of Iowa's system of care that offer strategic opportunities for addressing fundamental structural problems in county administered services, and for improving and expanding its Medicaid managed care program. It is followed by detailed recommendations for implementing these strategies.

1. DEVELOP CONSENSUS BY ADDRESSING WELL-RECOGNIZED PROBLEMS IN THE STRUCTURE OF THE STATE/COUNTY MENTAL HEALTH SYSTEM.

The results of TAC's survey of CPCs, HSAA's Directors of Special Education, and its extensive stakeholder input through focus groups indicate some similar opinions regarding the identification of problems and values. We believe that the state can build upon these areas to develop consensus and begin to resolve some of the conflicts that reduce the ability of the mental health constituency to influence relevant public policy. For example, stakeholders gave consistently low ratings to the system of legal settlement. They also consistently recognized the significant limitations in the current financing system and the constraints they place on the further development of the system. Stakeholders also have interest in strengthening community support and rehabilitation services in the current system.

These sentiments provide a basis for eliminating legal settlement by moving toward a system where the state has primary responsibility for financing the mental health system, where eligibility standards are consistent statewide and a minimum set of services are available statewide. The current mechanism established by HF 2545 for distributing a portion of the state funding to reduce system disparities and encourage system improvement is moving in this direction.

Such standards and financing can be built into the current system that assigns counties the responsibility for service administration. Counties have a well-established role as purchasers and providers of community based mental health services with administrative resources and procedures for fulfilling these functions. Some have created excellent service systems that developed service strategies well suited to meeting Iowa's particular needs. Also, some Counties have collaborated to realize economies of scale. The state and county mental health leadership have implemented methods for the state to oversee county mental health service provision such as County Management Plans and CoMIS. Significant further improvements can be realized by disseminating and replicating successful service approaches.

Many counties have collaborated to realize administrative savings and allow for more specialized administration of mental health services. These multi-county collaborations are models that should be encouraged to serve as more efficient methods for administering mental health services than a county by county system. A smaller number of administrative bodies at a more optimal size would also make it easier to increase the degree of standardization in the mental health system. Consolidating administrative services will help counties prepare for the next stage of system integration that could combine Medicaid mental health service system and the state/county funded system for people with serious mental illness. Bringing Medicaid management to a regional level will provide services closer to each community and increase responsiveness to community needs. In order to meet standards set for Medicaid managed care programs, many county administrative systems will need technical assistance to strengthen their capacity for purchasing services, managing care, and managing provider networks.

2. *ENCOURAGE INCREASED CONSUMER PARTICIPATION IN THE STATE/COUNTY MENTAL HEALTH SYSTEM.*

The state has also been increasing the role of consumers and family members by its requirements for the Iowa Plan, in its own staffing and licensing procedures, and through requirements for consumer and family participation in developing County Management Plans. The new Incentive and Efficiency Pool includes incentives for measurement of consumer participation in planning and of consumer satisfaction. The state can use similar methods to encourage counties to increase the involvement of consumers and family members in oversight and governance of county administered mental health services.

3. *CONTINUE TO ADDRESS THE PROBLEMS OF THE IOWA PLAN.*

Iowa's success in designing the Medicaid Mental Health Access Plan, and strengthening the program's structure when developing the Iowa Plan for Behavioral Health provides a model

for state leadership in the design of a major mental health system initiative. The strong design of this statewide model can help build acceptance for increased standardization of the state/county mental health system. Iowa can also address the problems that the system has encountered in implementation. The most significant criticisms of MHAP's operations has been the concern that some recipients are being denied medically necessary care, and that costs of treatment are being shifted onto county services. Opportunities also exist to expand the Medicaid program both in persons served and in services provided. Finally, the state can build upon the advances it has made in planning dual diagnosis treatment for Medicaid recipients by setting similar standards for dual diagnosis treatment in its state/county mental health system.

4. *SUPPORT IMPROVEMENT INITIATIVES WITH A COMPREHENSIVE TECHNICAL ASSISTANCE PROGRAM.*

The capacity of Iowa's mental health system to realize its strategic opportunities can be fostered through a comprehensive technical assistance effort with system-wide ownership. Iowa has an opportunity to develop an Institute for System Improvement with participation of the state, counties, providers, and advocacy groups. Existing technical assistance funds and expertise can be combined and coordinated through this institute to carry out a commonly agreed upon comprehensive training agenda.

B. *Recommendations for System Improvement*

We have developed a set of specific recommendations Iowa to act upon its strategic opportunities to improve its mental health system. These are not "easy fixes"; the recommendations are challenging in their breadth and scope because major structural reform is necessary to change some of the financial and organizational dynamics of the mental health system. The recommendations are not only challenging, but they are fundamentally interrelated. Changing one part of the system without carrying out other related changes will jeopardize the effectiveness of the intervention. For example, broadening the statutory requirements for mental health services to include a minimum set of mental health services cannot be implemented without providing a more adequate funding base for the system. The inefficient system of legal settlement is also related to the adequacy of the funding base. It cannot be eliminated unless Counties have adequate funds for serving their residents.

Our recommendations call upon Iowa to continue the process of integrating its multiple funding sources and fragmented service systems, building upon its county administered service system and its Medicaid program. Section A contains a set of recommendations for fundamentally restructuring the state/county-administered system, including the strengthening of consumer and family participation. Section B describes recommended strategies for improvement of the Medicaid system. Section C contains our recommendations for a comprehensive and integrated technical assistance model that will foster these changes by building the capacity of the different participants in the mental health system to carry out their roles.

I. RECOMMENDATIONS FOR IMPROVING STATE/COUNTY FUNDED MENTAL HEALTH SERVICES

In order to address the variability and fragmentation in the state/county mental health service system effectively, TAC believes that the state must make fundamental changes in the definition of the program and in its method of funding. Making the recommended changes will require the Department to make a clear case, enroll key stakeholders, and advocate with the legislature and public at large.

a. Increase the state's contribution to funding the mental health system to provide certain levels of property tax relief to counties and to support development of the required minimum services.

The only way that the state can accomplish the recommendations that follow is to assume responsibility for funding this service system, relieving counties from the burden of funding the mental health system from their limited property tax bases. The state should increase its share of funding for mental health services from the current level of approximately 60%, gradually increasing these allocations to reach 100% funding of required minimum services. This increase should occur over several years, including the funds already planned for property tax relief. Since property tax relief funds provide only limited funding for system growth, the state will need to develop additional distribution mechanisms to support Counties. This would be to expand their mental health services to meet minimum service standards for adults and in developing a network of state/county funded mental health services for children. The state will need to identify the extent of the gaps in the service system in order to assess the financial cost of assuming primary funding responsibility. The state must also assess the feasibility of meeting the entire identified need. In addition the state will have to develop an allocation method that takes each county's property tax base and eligible service population into account, similar to the per capita target expenditure pool of HF 2545.

The state may wish - at least in the immediate future - to preserve restrictions that ensure that state property tax relief funds are not used for expansion of services. However, as the state assumes a greater share of system financing and the real estate tax base has experienced several years of relief, the state should consider relaxing or lifting the restriction on Counties raising taxes or increasing existing funding of mental health services. This will allow them to provide services beyond those mandated in order to meet particular local needs. Eventually, the state should create incentives for counties to provide additional services.

The state may need to develop a new revenue source, such as a designated share of sales tax revenues, to fund statewide development of a required minimum service set. In order to provide a public forum for making this decision, the state should establish a Select Committee to consider and recommend an appropriate revenue source and funding mechanism. We understand that this recommendation may be controversial, yet believe that without this level of support for the mental health system, standardization and consistency of services will never be achieved.

b. Retain local administration of mental health services for the uninsured.

State funding, statewide service standards and state eligibility standards for the mental health system do not preclude control close to the community. Local administration, strongly preferred in Iowa, can be retained by clarifying the role of Counties in administering the system and strengthening the Department's processes for holding counties accountable. The Counties offer important resources for the improvement of the mental health system, having developed models for professionalization of the CPC function, shared administration, comprehensive service systems, and innovative services responsive to rural areas and other special needs. Their contributions as participants in the State/County Management Committee, and the technical assistance and leadership they exercise through the Iowa State Association of Counties also support continued improvement of local mental health administration. The state should further develop its infrastructure for effective management of a regionally administered system, including the CPC system, County Management Plans, the State/County Technical Assistance Team, and CoMIS.

c. Change the mental health statutory requirement to include a community based mental health service system with a minimum set of services that must be provided for adults with a serious mental illness and children with serious emotional disturbance in Iowa.

A statutory code defining a minimum set of community based services for Iowa citizens meeting standard clinical and financial eligibility criteria is necessary in order to create an acceptable minimal standard that will be met across the state. This will create a mandate for meeting the needs of children with serious mental illness for the first time.

We recommend that Iowa base these statewide eligibility standards on the new Center for Mental Health Services definitions of Adults with Serious Mental Illness and Children with Serious Emotional Disturbance as its clinical eligibility criteria. The advantage of these definitions is that they are simple and clearly written, they are based both on diagnosis and on functional impairment, and they are consistent with the definitions for the federal Mental Health Block Grant. Iowa's current definition is somewhat lengthy and does not include diagnostic criteria. In addition, after assessment of the financial impact, TAC believes that Iowa needs to set standard statewide financial eligibility criteria, determining whether to include both income and asset standards, and requirements for documentation. The state may also wish to consider establishing a sliding fee scale for certain services in order to serve a larger eligibility group.

The state of Iowa should statutorily define a minimum set of institutional and community based services for adults with serious mental illness based on CSP principles, and for children with serious emotional disturbance based on CASSP principles. We recommend that the minimum system of care include the following services. Virtually the same set of services should be available to both children and adults. However, programs should be designed for and clinical staff should have

appropriate training and experience in serving the target age group. We stress that this is not the set of services the set TAC would recommend as optimal. Rather, they define a minimum acceptable (or basic) treatment safety net for children and adults with mental illness.

- Crisis Intervention and Crisis Stabilization Beds: Crisis and emergency services are critical elements of a service system, ensuring timely care to stabilize acute episodes of mental illness at the least restrictive level appropriate to the need. These should include residential stabilization services for adults and for children that provide a non-institutional setting that can appropriately stabilize known clients who don't need the medical services provided by a hospital. Making these services available statewide will help prevent undesirable responses to episodes of mental illness, such as incarceration or - for children, placement in a hospital setting; help people with chronic conditions maintain their stability in the community during acute episodes, thereby reducing homelessness; and divert some hospital admissions.
- Outpatient Care: Outpatient services, including medication management, can provide the least restrictive treatments, assisting people to manage their illnesses and any medications with greatest independence.
- Case Management: Case management services assist consumers and families whose conditions require additional support to access and coordinate mental health and supportive services.
- Certain Transportation Services: Due to the rural nature of the state, Iowa may need to provide certain transportation services in circumstances where eligible individuals cannot otherwise access needed treatment.
- Rehabilitation Services: Consumers whose illnesses have been stabilized may need rehabilitation assistance to improve their functioning in vocational and other community settings. Once higher functioning and community participation is attained, the support and structure they offer can support the consumer's psychiatric stability.
- Residential Services: Some consumers may be at risk of homelessness without financial and/or hands-on support in community living.
- Partial hospitalization: Partial hospitalization offers hospital level of care for people who have stable home environments. It can be used to stabilize people experiencing acute episodes or as a step-down after inpatient treatment.
- Residential Treatment for Children and Adolescents: Residential treatment settings for children provide 24-hour intensive psychiatric care in smaller and less institutional settings than hospitals. These child-centered programs provide a desirable alternative to hospitalization when medical care is not needed.

- Acute Hospital Care: Acute hospital services are needed when individuals experience short-term psychiatric episodes.
- Long-term Hospital/Residential Care: Finally, long-term hospital and residential treatment services are needed when individuals need highly structured, long-term treatment and rehabilitation.

The statute should be carefully structured to focus on creating a strong set of minimum services to be provided when medically necessary in order to avoid creating absolute entitlements. In addition, it should provide for waivers that allow rural counties to provide equivalent services that will be feasible and effective in rural areas through non-traditional means. The state will have to analyze its current service system to identify the service gaps that must be filled to create this minimum service system, and then compare the systems current funding to the cost of developing the needed services in order to plan a funding strategy. The state's methods for developing the minimum service set should not limit development of the service system beyond minimum standards, and should eventually foster county support of a second tier of desirable services beyond the minimum set. Such services could include community support, expanded supported housing services, and expanded rehabilitation services. If needed, eligibility for these non-required services could be set at higher levels. Over time, if state funds allow, the state can allocate funds for development of the second tier of services.

The Department and other mental health system stakeholders will need to address negative attitudes about mental illness and its treatment in order to make a strong case for creating these new services.

d. Simplify the eligibility system for people with serious mental illness by requiring Counties to serve all eligible residents without reference to legal settlement.

The state should establish statewide clinical and financial eligibility standards and require each county to serve eligible individuals residing in that county, eliminating the expense and possible delay of determining county of legal settlement. Counties should be required to provide crisis services at time of presentation without prior authorization, and to provide medically necessary acute inpatient care in emergencies. Eligibility for non-crisis services can be determined when the person's condition has been stabilized. The state should also determine requirements for pre-authorization of services that provide an appropriate level of control over utilization of intensive services and allow eligible individuals to have prompt access to less intensive services.

In addition, the state will need to define how residence is determined in uncommon situations such as temporary residence, homelessness, etc. State allocation methods should be based on the number of clients served in the previous reporting period in order to ensure that funds follow clients. Simplifying access to care will eliminate delays for consumers and reduce administrative expenses of providers and Counties.

e. Establish incentives for Counties to collaborate in providing community-based mental health services.

Legislation should specifically encourage Counties to collaborate in administering mental health services in order to realize economies of scale. The initiative pursued by the Iowa South Central Seven is an example of such collaboration. State funding for administration of the mental health system should be distributed in a way that creates incentives for realizing such economies. For example, to avoid rewarding inefficient administrative operations, state administrative funding should not be distributed to reimburse actual costs. Rather the distribution method should be proportionate to the service population, and ideally should be based on a standard percentage of direct costs. In setting that percentage, the state should look for appropriate benchmarks to serve as guides, both within Iowa and in other comparable county systems. Establishing a ceiling on allowable administrative costs can also encourage Counties to seek opportunities for administrative efficiency. In order to set these standards and ceilings at a realistic level, the state will need to develop more accurate and standardized methods for measuring county administrative costs.

The state should also continue the approach it has begun with HF 2545 that establishes an Incentive and Efficiency pool. Funds could be made available to support the development of joint administrative infrastructure such as shared MIS systems, provider credentialing, provider monitoring, transportation services, etc.

f. Encourage counties and county collaborations to develop the capacity to compete for the future integration of the Medicaid and other mental health services.

The state should encourage counties to develop structures and processes to manage Medicaid benefits in the future, and provide technical assistance to them in developing this capacity. It should define minimum acceptable administrative capacity, and should encourage improvement beyond that standard. For example, the state could sponsor a process to work with the State County Management Committee to develop protocols for levels of care and utilization management that can be applied statewide and that will guide Counties to improve their managed care capabilities. Counties that develop effective and efficient managed care capabilities will be well positioned to take on regional management of Medicaid directly or on a sub-capitated basis.

g. End financing incentives that encourage overutilization of Mental Health Institutions. Make funding available for community based services.

The state of Iowa should charge Counties for the full cost of Mental Health Institution services, reducing the subsidy to fund other mental health services. In addition, they should establish a system in which Counties contract each year for a specific number of bed days. The Counties should manage their admissions to the number of available bed days. The state can then size its operations to maintain only those beds for which Counties contract, eliminating excess capacity. The state funds freed by increasing unit of service charges to the counties should be used as targeted

incentives to counties for strengthening community services needed to prevent state hospital admissions or to stabilize state hospital patients returning to their community.

h. Clarify the role of the state in the mental health system to focus on allocating resources, setting standards, evaluating performance, and promoting improvement. Organize the structure of state staff to correspond to these functions.

The statutory requirement for a minimum service system together with the state's increased responsibility for financing the system should be accompanied by regulations that authorize the State Mental Health Authority to allocate resources, set eligibility and service standards, evaluate performance, and promote best practices within the mental health services system. The staff and budget of the agency should be structured to correspond to these functions. The state authority should work collaboratively with Counties, developing formal processes that consistently include review and input by the State County Management Committee in policy development, standard setting, and implementation planning. The role of Counties should be to purchase, provide and manage mental health services that meet or exceed consumer expectations and the standards set by the state, and to contribute to statewide planning and policy development.

Current state functions that will need to be delegated to others over time include provision of targeted case management and most contracted services except those used to test innovative program designs. State oversight functions should be strengthened with more capacity to analyze county performance, develop benchmarks, provide technical assistance, and promote improvement. These resources should be strongly integrated with the Institute for System Improvement recommended for strengthening Iowa's technical assistance capacity.

i. Establish a minimum set of standard measures that all public mental health systems of care in Iowa are required to collect and report.

Many data collection efforts currently underway are a positive start to statewide standardized data reporting in mental health services, (e.g. CoMIS, Iowa Plan, and new HF545 performance measure requirements). However, collection efforts need to become more standardized in order to utilize the data, and to improve the quality of mental health care across all systems in Iowa. System stakeholders recognize the need for and value of benchmarking. Over 53% of CPC respondents to our survey agree that statewide standards should be developed for tracking local system performance.

The state of Iowa should focus first on collecting and reporting on a core set of performance measures across all mental health systems of care. The initial standard set of measures should be derived from data that is relatively simple to collect and report. This core set should be expanded to include more measures, as stakeholders become more sophisticated in collecting and reporting measurement data and in comparing system performance. Based on our experience collecting data, the

following set of measures are recommended for an initial minimum set because they can feasibly be collected from the Medicaid and the county administered systems in Iowa.

- Overall penetration rate;
- Actual administrative expenditures as a percentage of total expenditures;
- Cost by service type (inpatient vs. outpatient resources);
- Grievances and appeals per covered population;
- Inpatient utilization (separated by state and non-state hospital days); and
- Outpatient utilization (visits per thousand).

We recommend incrementally expanding this small set of measures only after collection and reporting of the initial set has been successfully implemented. The main goals of this measurement effort should be to improve the quality of mental health care being provided to residents of the state of Iowa, reduce the variation that currently exists across the state, and to increase the accountability of the different systems of care. We recommend that the state develop the capacity to measure its mental health systems on the following indicators as a second stage of benchmarking.

- Readmission Rates (at least readmission within 30 days, if possible 90 and 365 too)
- Psychiatric average length of stay (separated by state and community hospital)
- Telephonic access –average speed of answer and abandonment rate
- Denial rates – service denial and application denial
- Consumer satisfaction rates – standardized survey
- Involuntary admission rates

Other measures that will eventually be of value in managing Iowa's mental health systems include:

- Wait times
- Level of Functioning
- Community tenure
- Geographic availability

Technical Assistance Collaborative, Inc.

- Family involvement in treatment for children
 - Incarceration rates for people with mental illness
 - Claims payment turnaround
- j. Utilize benchmarking data to track system performance and to focus on particular areas in Iowa’s public mental health system that need improvement.***

The benchmarking data we were able to collect shows considerable variation within the state of Iowa as well as departures in some areas from other states and counties. These data suggest that Iowa’s most dramatic opportunity to improve its mental health system is to move CPCs toward more consistent practices in the use of mental health institute, hospital and community services. Initially, standardizing eligibility, access, and utilization patterns should be priorities in order to reduce the variation in service delivery within the state and to improve Iowa’s performance compared to other systems of care. Moving forward, benchmarking between CPCs and/or Counties as well as to other systems of care will allow Iowa to identify opportunities for improvement and determine the relative priority of available opportunities.

- k. Encourage consumer and family participation in the governance and oversight of the state/county mental health system.***

The state should encourage counties to expand their involvement of consumers and family members in their mental health service system. Consumers and family members provide important input about the relative priority of different types of services, and consumer satisfaction should be a key aspect of provider performance. Currently, consumers and family members can participate with other stakeholders in county mental health service planning functions. In addition, the state has established incentives for consumer involvement by tying funding from the Incentive and Efficiency Pool to county measurement of consumer participation and consumer satisfaction. The state should also provide technical assistance and consider other forms of financial encouragement for Counties to involve consumers and family members in the oversight and governance of mental health services. For example, Massachusetts has established a venture capital fund to provide start-up funds for consumer operated services, and reimburses consumers for their time and transportation expenses.

- l. Provide technical assistance and support for meeting needs of special sub-populations.***

Defining responsibility for providing a minimum set of mental health services to children meeting eligibility criteria for serious mental illness, and allocating specific funds for those services will be a significant improvement in Iowa’s mental health system. The funds and responsibilities should continue to be managed through the existing administrative structure of decategorization boards because they are structured to provide maximum flexibility for coordinating care and individualizing family centered services. In addition, they are a mechanism to closely coordinate

children's mental health services with schools, the child welfare authority, and with the juvenile justice system.

However, the minimum service set should not be established in a way that compromises the flexibility of decategorization boards to substitute alternative services that better meet a child's specific need than a required service. The state should also encourage provision of school-based services to promote access and coordination. The statutory mandate should establish a pathway for obtaining intensive mental health services that does not require parents to give up custody, and make the state and counties accountable for meeting the needs of children with serious emotional disturbance.

The state in its role overseeing both mental health and substance abuse treatment, must carefully consider how to address the needs of clients of the state/county mental health system who have concurrent substance use problems. Effectively treating dual diagnoses is a necessary component for addressing the needs of clients at high risk for homelessness and AIDS/HIV. Counties should be responsible for identifying substance abuse problems in their mental health clientele, and referring them to state funded services that will soon be administered by the Iowa Plan. Similarly, Counties should have processes for accepting referrals for mental health treatment from the state funded substance abuse service system. Finally, the state should require that Counties develop mental health services competent to treat dual diagnoses with integrated programming. The capacity for providing such treatment by community based programs will be improving from the training that the Iowa Plan MCO is required to provide.

People with dual diagnoses of mental illness and mental retardation have unique needs that are difficult for each system of care to meet fully. In its requirements for county service systems, the state should specifically require that counties assess the service needs of such clients, and develop and implement plans to meet those services. At the state level, the State Mental Health Planning Council should actively collaborate with the Mental Retardation/Developmental Disabilities Council to coordinate program policies and identify and address technical assistance needs.

Stakeholders indicated that services to meet the needs of elderly Iowans with mental illness are not well developed. Iowa has a large proportion of elderly residents, and this is projected to increase. Improving services for this subpopulation requires a multi-pronged approach that improves identification and outreach to people in need, especially in rural areas, replicating efforts such as that developed by Linn County. The Department of Human Services must also work with the Department of Elder Affairs to determine how to best increase psycho-geriatric services where they are needed, considering recruitment, telemedicine, cross-training, or other strategies.

Finally, by requiring counties to develop a more consistent set of crisis services, the state can minimize the use of jails as holding or detention facilities for people with mental illness who have not committed a crime.

2. ***RECOMMENDATIONS FOR IMPROVING THE MEDICAID MENTAL HEALTH SYSTEM***

Iowa's restructuring of its MHAP program into the Iowa Plan for Behavioral Health has addressed the structural causes of the most significant criticism we heard about Iowa's MHAP program, the Medicaid diagnostic criteria that may have limited dual diagnosis treatment. In reprocurring managed care services, the state has integrated management of Medicaid mental health and substance abuse services, included state provided substance abuse services, and expanded diagnostic eligibility criteria to allow for provision of dual diagnosis treatment to Medicaid recipients. In addition, the contract establishes a requirement for the managed care organization (MCO) to develop dual diagnosis programming and provide training in dual diagnosis treatment.

Some of the structural barriers between PMICs and the managed Medicaid program have been eliminated. Those institutions providing substance abuse treatment for adolescents are included in the Iowa Plan, and, while those providing mental health treatment are not a covered service, children receiving services are enrolled in the Iowa Plan and eligible for care coordination and aftercare planning from the MCO.

Iowa's Medicaid mental health should be improved in some additional ways.

a. Integrate resources used to fund the Psychiatric Mental Institutions for Children (PMIC) system with other Medicaid funds.

Having made children receiving PMIC services eligible for the Iowa Plan, Iowa should next integrate Medicaid resources that fund psychiatric PMIC services with other Medicaid funds for children's mental health services under the management of the Iowa Plan MCO. This will provide better flexibility in the use of service dollars to follow the child, reduce inappropriate utilization of high intensity treatment settings, and reduce the fragmentation in the children's mental health system.

b. Continue to expand utilization and enrollment in the Medicaid system for adults and children with mental illness to increase access to mental health services and maximize federal financial contribution.

The provisions of the State Child Health Insurance Program (SCHIP) provide an opportunity for Iowa to improve mental health treatment for children by increasing Medicaid enrollment and/or offer alternative health insurance for uninsured children in low-income families. With the expansion of eligibility in Phase I and Phase II, there have been significant increases in eligibility. Continuing to improve children's access to Medicaid mental health services will improve access for children with mental health needs for whom services are currently limited.

Comparison of Medicaid penetration rates for MHAP to other states suggest that access to service in Iowa may be restrictive. In addition, some stakeholders questioned whether the MCO was inappropriately denying services to MHAP eligibles. The state should conduct further analysis of service authorization and denial practices of its MCO, and further study its mental health penetration to determine whether the Iowa Plan is treating all its Medicaid recipients with mental health needs, and if not, why. Based on this review, strategies for improving the

penetration rate should be developed and implemented. Since the MCO's capitation rates have been based on estimates of penetration and utilization in a fee for service equivalent system, the state will also need to determine how it may have to pay for the costs of higher penetration.

c. Improve access to long-term and rehabilitative care by adding the Medicaid rehabilitation option to the state plan, if possible.

Currently, Iowa does not participate in the Medicaid rehabilitation option, and is therefore able to fund long-term and rehabilitative services only from state funds. Iowa should enter into discussions with HCFA about the possibility of incorporating long-term care and the rehabilitation services into its state Medicaid plan, providing an expanded funding base for services that are important as part of a comprehensive service system. These flexible services are strongly oriented toward community stability, maximum functioning, and recovery.

d. Improve protocols for client referral between the Iowa Plan and the county administered service system.

Respondents to our survey of local administrators indicated a strong concern about MHAP eligibles being inappropriately denied Medicaid services and falling to the responsibility of the counties. Clarifying the responsibilities of the counties and standardizing eligibility for county administered services statewide will provide a better basis for strengthening cross-system transfer and coordination. However, the state should not wait until this system is in place to improve the difficult relationship between CPC's and the Iowa Plan.

The state should lead a collaborative quality improvement initiative on this issue. The initiative should include key staff from the Iowa Plan MCO, representatives from the State County Management Committee, and CPCs. The initiative should include the collection of data from MIS, stakeholder perceptions, and follow-up of individual cases. These data should be analyzed to define the scope and nature of the problem, identify root causes, and develop methods for addressing them. The initiative should result in a protocol for transfer and referral of consumers from one system to another, and a plan for monitoring compliance with the protocol and evaluating its effectiveness. This protocol and monitoring method should be subject to state approval, and the state should regularly review compliance. The state may wish to repeat the relevant questions from the TAC survey to determine whether CPC ratings of the Iowa Plan have improved. The protocol should be revised based on evaluation findings and as the county administered system develops.

3. RECOMMENDATIONS FOR TECHNICAL ASSISTANCE

Implementing change in Iowa's public mental health system will require a concentrated effort at encouraging change at the state, county and provider levels. This change can be fostered through a program of technical assistance and training which focuses on the needs of consumers and families, and increases the capacity of providers, county CPCs, state mental health institutes, and the state division of mental health and mental retardation to provide and manage a community based system of care. This capacity building will allow

Technical Assistance Collaborative, Inc.

county administrative systems to assume more functions in order to bring service planning, management, and oversight closer to the consumer and the community. This is already happening in various parts of the mental health system. But for the full benefit of such efforts to be realized, the state needs to expand the scope of its own efforts, partner with others who have important resources available to support technical assistance, and ensure that technical assistance is consistently available throughout the state.

a. Define Technical Assistance Needs.

The state should use its current state-county assistance teams, as well as groups such as the state planning commission, county and provider associations to develop a definitive list of technical assistance needs. Our analysis of Iowa's public mental health system suggests a three pronged approach to technical assistance that focuses on a) Treatment and Services Improvement; b) Administration/Management Improvements; and c) System Improvements.

Treatment and Services Improvement: This area of technical assistance would deal with those areas that directly affect client care. This includes the development and deployment of new services models, best practices, clinical advancements, new medication protocols, and community support models. Of particular importance is how Iowa gains new knowledge in these areas, disseminates this knowledge to the field, and encourages implementation. Technical assistance efforts should focus on the following specific treatment and service improvement areas immediately:

- The development and implementation of crisis diversion services;
- The development of non-institutional community support programs for difficult to serve children and adolescents;
- The implementation of assertive community treatment programs;
- The implementation of new treatment approaches for those with a dual diagnosis; and
- Implementing community support models in rural areas.

Technical assistance in each of these areas should be structured to include a program of written materials development and dissemination, training, funding for pilot initiatives or for program modifications, site-based consultation, multi-site collaborations, evaluation and measurement, and wide dissemination of progress and results.

Administrative/Management Improvements: This area of technical assistance would deal with those areas which directly affect the administration and management of components of the public mental health service system. This includes the organization, financing, and monitoring of state services, county CPC's, direct care providers, and the Iowa Plan. Of particular importance is how Iowa improves its existing capacity to effectively manage resources, including how the principles and

technologies of managed care can be applied to those parts of the system that are now not in managed care. We believe that technical assistance efforts should focus on the following specific administrative or management improvement areas immediately:

- The development of utilization management protocols and systems;
- Methods for provider contracting;
- Using risk-based provider payment methodologies;
- Developing and implementing common eligibility standards; and
- Methods for moving beyond legal settlement.

As with treatment and service improvements, this area will require structured programs of training, on-site consultation, model development and pilots, and knowledge dissemination.

Systems Improvements: This area of technical assistance would deal with those areas which directly affect how the entire system of care operates. This includes the development and deployment of performance measures, quality improvement strategies, levels of consumer and family involvement, and cross-system integration (education, child welfare, health, and corrections). Of particular importance is how Iowa uses information to set expectations about it should operate, and how it continually and systematically seeks to improve its system of care. We believe a technical assistance effort should focus on the following specific system improvement areas immediately:

- Setting realistic performance measures;
- Gathering data for performance measurement;
- Implementing and using consumer satisfaction measures;
- Methods for involving consumers and family members in system management and oversight; and
- Cross collaborative models for delivering mental health services in schools and child welfare settings.

Specific technical assistance approaches for this area should include the development of easy to use templates, software, training, and the implementation of pilot initiatives.

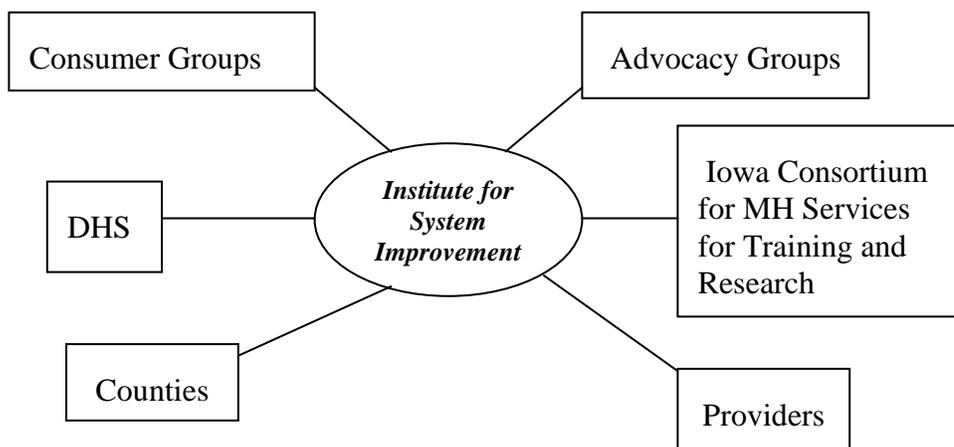
b. Foster system-wide ownership of improvement initiatives by developing a collaborative model for delivering technical assistance.

As important as it is to define the system’s technical assistance needs, it is equally important to develop methods to deliver technical assistance that have buy-in from the broad array of constituency groups who are ultimately responsible for making the system work. Technical assistance responses in Iowa should be thought of as system efforts, not just efforts directed at one type of program. Improvements targeted to one segment, such as mental health institutes or community mental health providers, should be shared with other aspects of the system of care. This collaborative nature of service improvement will result in a better understanding of how the entire system needs to operate.

To encourage a collaborative approach to technical assistance, we propose the development of an Iowa Institute for System Improvement. This consortium would be developed with ownership and funding by the state, counties, provider organizations, and advocacy organizations. The Institute could be an adjunct to the current consortium at the University of Iowa, but would have as its focus the development of direct technical assistance to all parts of the service system.

To jump start the development of such an institute, we recommend that current technical assistance efforts funded by the state or other sources would be allocated to a this new institute. This would include resources of the current state/county assistance teams, as well as any technical assistance resources that other entities. A portion of the state’s federal block grant, or new federal resources, such as those under the Mental Health Statistics Program, could also be directed to the institute.

This model is not unique, but for Iowa it creates a place where all components of the system can come together to effect change. While the initial focus is down the system, the ultimate goal is for the institute to serve as a catalyst for change up the system as well.



VII. CONCLUSION

Iowa has an opportunity to approach its county based program boldly, making a clear and compelling case for providing a minimum set of mental health services available statewide, without respect to legal settlement. If the state provides the funding base for this system, it will free the counties to focus their administrative efforts on effectively managing services, rather than administering a cumbersome legal settlement determination process or struggling with difficult decisions to ration limited treatment resources. This will make a dramatic difference to consumers, who will then be able to access a standard minimum set of services available on the basis of financial and clinical eligibility and functional necessity. This will not be determined by where they live, and they will have opportunities to participate in the planning and evaluation of those services. These changes will also eliminate a major administrative burden on providers and lessen their risk of providing services for which there is no payer. With a more adequately funded and more understandable mental health system, some significant sources of tension and conflict will be eliminated, providing the possibility of more productive partnerships among system stakeholders to address continuing opportunities for improvement in the system.

¹ At the time of our analysis, 1996 population estimates were the most recent available data.

² National Technical Assistance Center, Networks Newsletter, (Fall 1997) NASMHPD Research Institute, Inc., *California Exemplifies Effective State-County Mental Health Partnership*

³ Cole, Robert F. Ph.D. with Poe, Stephanie L., *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families*, Washington Business Group on Health, 1993, p. Washington Business Group on Health, 1993, p. 115.

⁴ Prevalence of serious emotional disturbance in children and adolescents. Mental Health, United States, 1996. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. U.S. Department of Health and Human Services, 1996.

⁵ Farmer, Betsy, Ph.D., Draft - Selected Experiences and Findings on Managing Care from the Comprehensive Community Mental Health Services for Children and Their Families Grantees, National Resource Network for Child and Family Mental Health Services at the Washington Business Group on Health, March 1996.

⁶ Adapted from Stroul, B.A., *Models of Community Support Services: Approaches to Helping Persons with Long Term Mental Illness*, published by NIMH August 1986.

⁷ Community Information Exchange, Draft Case Studies on Special Needs Housing, Washington, D. C. , April, 1995

⁸ National Technical Assistance Center, *Michigan Embarks on Innovative Housing Initiative*, Program Directors, 2 pages, Document. [Online] <http://www.nasmhpd.org/ntac/>

⁹ Bird, D.C., Lambert, D., Hartley, D., Beeson, PG., and Coburn, A.F., Working paper # 3, (March, 1998) Maine Rural Health Research Center, Muskie School of Public Policy, Abstract

¹⁰ Wagenfeld, Murray, Mohatt, and DeBruyn. Mental Health and Rural America: 1980-1993, An Overview and Annotated Bibliography, Office of Rural Health Policy, April , 1993.

¹¹ Mental Health Weekly, Kansas Consortium Develops Statewide Telepsychiatry Network, Vol. 8, No. 14, April 6, 1998, pp.1-3.

¹² Crowe, Ann H. MSSW, ACSW, and Reeves, Rhonda, MA, Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, Public Health Services, SAMHSA, Center for Substance Abuse Treatment, 1994.

¹³ Mercer-McFadden, Carolyn, Drake, Robert E., Brown, Neal B. and Fox, Rita S., *The Community Support Program Demonstrations of Services for Young Adults with Severe*

Mental Illness and Substance Use Disorders, 1987-1991, *Psychiatric Rehabilitation Journal*, Winter 1997, 20:3.

¹⁴ Schraft, Gretchen E., Ph.D., M.H.S., and Randolph, Frances L. Dr. P.H., M.P.H., *Innovative Community-Based Services for Older Persons with Mental Illness*, Center for Mental Health Services, November 1994, p 1.

¹⁵ National Technical Assistance Center, *Networks Newsletter, Building Bridges Between Mental Health and Criminal Justice, Strategies for Community Partnerships*, Spring, 1996), pp. 1-10.

¹⁶ National Technical Assistance Center, *Networks Newsletter, Building Bridges Between Mental Health and Criminal Justice, Strategies for Community Partnerships*, Spring, 1996), pp. 1-10.