

# APPENDIX G

## STATE OF IOWA CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS IMPLEMENTATION PROJECT CHARTER DOCUMENT

(1/24/08 REV.)

### OVERVIEW

Individuals with co-occurring psychiatric and substance disorders and disabilities (COD) in Iowa are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. These individuals are frequently inadequately served in both mental health and substance abuse treatment and other disability settings, resulting in over-utilization of resources in the service systems they routinely access. In addition to having poor outcomes and high costs, individuals with COD are prevalent in all behavioral health settings. The prevalence of COD should be considered an expectation, rather than an exception within service systems.

We are using the broad, and somewhat imperfect terminology “co-occurring psychiatric substance disorders and disabilities” to reflect our recognition that in our system of care there are many people and families with many areas of complex struggle – not just mental health, substance abuse and gambling problems, but medical disorders and disabilities, cognitive and developmental disorders and disabilities, criminal justice system involvement and incarceration, homelessness and housing instability, domestic violence and trauma, parenting and child protection issues, and so on. We are starting this process by bringing together the system to start with co-occurring mental health and substance abuse services, but we also are acknowledging the need to develop competency to address complexity generally in a recovery oriented system, and to continue to welcome and engage other potential partner systems (health, developmental disability) to join us in the process as we make progress over time.

In 2005, Iowa appointed a team to attend a national policy academy and provide recommendations for system transformation. Continuing to work in Iowa, the team developed a report that contained specific recommendations for implementing a range of state level systems change strategies to provide more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with COD.

The Policy Academy Team adopted a consensus vision for the state, which is part of this current Charter document:

***Every Iowan (EVERY IOWAN) will have access to integrated mental illness and substance use disorder services that are welcoming and responsive to their individual hopes and needs and support the recovery of individuals and families who need integrated care.***

The COD workgroup has recommended that a charter process be initiated, that it be adopted by the COD Policy Academy, and that the MHDS Systems Improvement Steering Committee align the COD charter with any other workgroup charter documents.

### Comprehensive, Continuous, Integrated System of Care

In order to implement the recommendations of this report, Iowa has convened key stakeholders including consumers, family members, state and county agency representatives providers, advocacy groups, and other interested parties that have agreed to adopt a comprehensive, continuous, integrated system of care model for designing statewide systems change to improve access and outcomes for individuals with COD. These stakeholders are committed to transforming the system to address COD needs within the context of existing resources.

In this model **every program becomes a co-occurring disorder program meeting basic standards of co-occurring disorder capability, and every one who does clinical care becomes a co-occurring disorder clinician having core competency in addressing co-occurring disorders.** The specific criteria for co-occurring disorder capability for each type of program and the specific criteria that define co-occurring disorder competency for each type of clinician and each level of training is intended to be defined in the course of this process. What is important however is to recognize that each program can be organized to become co-occurring disorder capable within its own mission, within its current license, and in relation to the population it customarily serves. Similarly, co-occurring disorder competency for clinicians does not mean that each clinician needs to get dually licensed, but rather that each person (even with no license) has a set of competencies to provide appropriate interventions within their level of training to the people and families that are currently in their caseloads.

This model is based on the following eight clinical consensus best practice principles (Minkoff, 1998, 2000).

- COD is an expectation, not an exception. This expectation has to be included in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.
- The core of treatment success in any setting is the availability of empathic, hopeful treatment relationships and organizational structures and changes that provide integrated treatment and coordination of care during each episode of care, and, for the most complex patients, provide continuity of care across multiple treatment episodes.
- Assignment of responsibility for provision of such relationships can be determined using the **four quadrant national consensus model for system level planning**, based on high and low severity of the psychiatric and substance disorder.
- Within the context of any treatment relationship, case management and care, based on the person's impairment or disability, must be balanced with empathic detachment, contracting, and opportunity for contingent learning, based on the person's goals and strengths, and availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.
- When COD is present, each disorder should be considered primary, and integrated multiple primary treatment is optimal.
- Mental illness and substance dependence are examples of chronic disorders that can be understood using a culturally responsive recovery model. These disorders have parallel phases of recovery (acute stabilization, engagement and motivational enhancement,

prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change.

- Treatment of any problem involves a combination of recommendations and teaching the skills to follow those recommendations. In addition, treatment must be matched not only to the diagnosis, but also to the phase of recovery and the stage of change. Treatment interventions are also matched to developmental level and level of cognitive ability.
- Outcomes must be individualized, including harm reduction; movement through stages of change; changes in type, frequency, and amounts of substance use or psychiatric symptoms; improvement in specific disease management skills and treatment adherence.

Using these principles, we have agreed to implement a comprehensive, continuous, integrated system of care in Iowa, with the following four core characteristics:

- A comprehensive, continuous, integrated system of care model requires participation from all components of the behavioral health system, with the expectation of achieving COD capability standards and planning services to respond to the needs of persons with COD.

These components include but not limited to:

- The Governor's Office
- The Iowa Legislature
- Iowa Department of Human Services
  - Mental Health and Disability Services
  - Facilities (MHIs, RCs, Juvenile Facilities)
  - Contractors
  - Iowa Medicaid Enterprise
- Iowa Department of Public Health
- Iowa Division of Insurance
- Iowa State Association of Counties
- Licensing/Certification Boards
- Iowa Department of Corrections
- Community Corrections Facilities
- Jails, Prisons
- Area Educational Authorities
- Courts/Magistrates
- Law Enforcement Officials
- University of Iowa Center for Disabilities Development
- Community Mental Health Centers
- Licensed Substance Abuse Providers
- Community Hospital Behavioral Health Units and Emergency Departments
- Private Behavioral Health Providers
- Health Care Providers
- MHRDDBI Commission
- Mental Health Planning Council
- Human Services Council
- Advocacy Organizations
- Family Organizations
- Iowa Department of Education
- Legislature
- Iowa Department of Insurance

- This model will be implemented initially with existing operational funding, within the context of existing treatment resources, by maximizing the capacity to provide reimbursable integrated treatment proactively within each single funding stream, contract, and service code.
- This model will incorporate utilization of the full range of evidence-based best practices and clinical consensus best practices for individuals with COD and promotes integration of appropriately matched best practice(s) treatments for individuals with COD.
- This model will incorporate an integrated treatment philosophy and common language using the principles listed above, to develop specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the system of care.

## Action Plan

### A. STATE INTERAGENCY COLLABORATION

1. Participating organizations or entities will each adopt this consensus document as an official policy statement, and disseminate it in official material to their constituencies, and incorporate its elements into official planning documents and other publications.
2. All statewide provider, consumer, and family organizations, (e.g., MHRDDBI Commission, Olmstead Task Force, Mental Health Planning Council), including, but not limited to those represented on the COD Policy Academy, will be offered an opportunity to participate in implementation of the COD plan, and to provide official resolution in support of this process.
3. The State will build on the Policy Academy to create a representative Steering Committee to oversee the statewide CQI process. Representation will be from: Iowa Department of Human Services (DHS), Iowa Department of Public Health (DPH), Iowa Department of Corrections (DOC), provider associations (including Iowa State Association of Counties, Iowa Association of Community Providers, Iowa Coalition of Children and Families, Iowa Substance Abuse Program Directors Association, Iowa Hospital Association, etc.), consumer advocacy organizations (i.e., NAMI, etc.). See above for detailed list of representatives.
4. The COD Steering Committee (#3 above) will provide project management, leadership and a partnership between the State and stakeholders and will oversee the planning and development of an infrastructure to communicate progress.
5. In particular, DHS and DPH are making a commitment to engaging in welcoming partnerships with providers, and to developing a process by which provider monitoring emphasizes a CQI partnership for this and other improvement activities.
6. DHS and DPH, along with providers, commit to partnerships with consumers, families and other system customers in designing, monitoring and evaluating the quality improvement activities and workgroups that are part of implementation.
7. IDHS and IDPH along with IDOC and AEAs will meet together regularly at the executive leadership level to review recommendations by the steering committee and to align policy statements to create consistent language. Each agency will have the goal of developing a policy statement that states that each agency is a priority client of the other for consultation, support, education, technical assistance, and outreach regarding COD services.

8. State agencies will make a commitment to improve welcoming and access for individuals and families with COD, by developing a process to create a statewide emergency services system that is a safety net service and which is aligned with this vision, and in which all services are designed to be COD capable.
9. State agencies will make a commitment to improve welcoming and access for individuals and families with COD, by developing a process to ensure that the statewide children's mental health is aligned with this vision, and that all services are designed to be COD capable.
10. Each state entity will use its incentive dollars (e.g. Federal block grant dollars, Magellan community reinvestment) to support COD capability development, and to continue to emphasize using EBP and consensus best practices to build universal capacity rather than just special programs.
11. State agencies will develop an initial process for regulatory clarification of what is permissible in COD services and develop a process to review and revise rules and regulations. DHS-MHDS and DPH will work on creating developmental language for accreditation and licensure that is mutually aligned and aligned with this process
12. State agencies will utilize the COFIT as a system fidelity outcome tool for measuring progress in CCISC implementation to create a baseline score and continue to use the tool at 12 month intervals to measure progress in this initiative
13. State agencies will initially encourage provider agencies to participate in this project voluntarily and will gradually increase expectations for providers to perform universal screening, identification, and data collection for COD services. This will promote systems transformation and attainment of COD capability, as part of contract requirements in future years
14. DHS will collaborate with IME to issue interpretive guidelines of existing regulations to clarify how providers can most efficiently use their existing funding to receive reimbursement for integrated treatment and to promote the capability of providers to offer co-located COD services.
15. Each State agency will develop policies and establish culture regarding welcoming COD persons into services.
16. Each State agency will develop a policy regarding integrated screening
17. Each State agency will encourage and incentivize providers/entities in each region to organize system development activities on a local level.
18. DHS will work with other state agencies and outside entities to enable each information system to collect basic data on COD prevalence.
19. DHS and DPH will develop mechanisms to organize statewide training (including a statewide change agent team initiative), consultation, and technical assistance to providers participating in this initiative (whether voluntarily or through contract requirement) to help each provider achieve implementation of the action steps listed below.

20. Create an organized communication network that disseminates information to all stakeholders in an organized and complete manner.

## **B. COLLABORATION WITH CONSUMER, FAMILY, ADVOCACY and PROVIDER ORGANIZATIONS**

1. Provide official communication of participation to the State indicating they will adopt this consensus document as an official policy statement of the agency or participating organization, with approval of their governing board or equivalent.
2. Circulate the approved document to all staff or organizational members, including consumers and families involved in organizational change. Organizations will provide basic introductory training to all staff and involved consumers/families regarding the principles, the model, and statewide COD activities.
3. Assign leadership, staff, consumers, and families to participate in developing an empowered leadership team at the agency/entity level for internal quality improvement in this project, as well as representatives to participate in state level integrated system planning and program development activities.
4. Adopt the goal of achieving COD capability as part of the agency's/entity's short and long range strategic planning and quality improvement processes.
5. Participate in a self-survey at twelve-month intervals to evaluate the current status of COD capability.
6. Develop an action plan outlining measurable changes at the agency/entity level, the program level, the clinical practice level, and the clinician competency level to move toward COD capability.
7. Monitor the progress of the action plan at six-month intervals.
8. Participate in system wide training and technical assistance with regard to implementation of the action plan.
9. Participate in system wide efforts to improve identification and reporting of individuals with COD by incorporating specific improvements in screening and data collection in the action planning process.
10. Participate in system wide efforts to improve welcoming access for individuals with COD by adopting specific welcoming policies, materials, and expected staff competencies.
11. Participate in system wide efforts to enhance efficiency of utilization of existing funding for integrated treatment, by adopting instructions for how staff can bill for integrated services within a single funding stream, once instructions are provided by the state.
12. Assign appropriate clinical leadership to participate in locally based interagency systems planning.
13. Agree to participate in ongoing technical assistance/training and support to ensure consistent development and implementation of systems transformation efforts.
14. Invite staff, consumers, and families to participate in system wide efforts to develop COD capability standards, and systemic policies and procedures to support welcoming access in both emergency and routine situations.

15. Each agency should agree to take concrete steps to support and facilitate the development of at least one COD support (i.e., Dual Recovery) meeting in its local community, in collaboration with local consumer networks when available.
16. Participate in system wide efforts to identify scopes of practice, as well as core competencies (attitudes, values, knowledge, and skills) for all clinical and direct service staff regarding COD, and adopt the goal of COD competency for all clinicians in the agency as part of the long range plan.
17. Participate in clinical direct service staff competency self survey at twelve-month intervals, and use the findings to develop an agency specific training and COD competency development plan.
18. Identify appropriate clinical and administrative staff, as well as consumers and families to participate as trainers/change agents in the systems and to participate in the implementation of the agency's/entity's COD action plan.