

Recommendations and Comments from the Department of Human Services, Division of Mental Health and Disability Services on the *Report of Workgroups on Mental Health Systems Improvement*

Establishment of Workgroups:

As directed by the Iowa Legislature's 2007 HF909, and in order to build upon the partnership between the state and counties in providing mental health and disability services in the state, the Iowa Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS) established six workgroups for planning and recommendation purposes and engaged equal proportions representing the Department, counties, and service providers. Statewide associations representing counties and community providers appointed county and provider representatives to the workgroups. In addition, each workgroup included a representative of the MHMRDDBI Commission, the Mental Health Planning Council, consumers, and a statewide advocacy organization. Per HF909, workgroups were established for discussion and recommendations in each of the following areas:

- Alternative Distribution Formula,
- Community Mental Health Center Plan,
- Core Mental Health Services,
- Evidence-based Practices,
- Co-occurring Disorders, and
- Accreditation

Formulation of recommendations was to lead to comprehensive plan items. The workgroups met during the summer and fall of 2007. In order to draft a report of the workgroups, MHDS requested that each of the workgroups elect two members from each work group to participate in a steering committee to meet after the workgroups had met and in order to prepare a report for the Commission, the DHS Director, the Legislature and the Governor.

Explanation of the Documents:

Following over fifty meetings that involved over 100 stakeholders, the workgroup-elected steering committee members, MHDS and DHS staff, and technical advisor expert consultants prepared the *Report on the Workgroups on Mental Health Systems Improvements*. The *Report on The Workgroups* was distributed to the MHRMRDDBI Commission in the months of September through December 2007. In several Commission meetings, workgroup representatives and Steering Committee representatives verbally presented summary findings to the Commission. A written draft report was submitted to the Commission in December 2007. The comments and distribution of documents were reflected in the minutes of the Commission's meetings. Although not required in FH909, the Commission held a public hearing on the *Report of the Workgroups*. On December 13, 2007, the Commission's hearing was held, and verbal and written testimony was offered at a number of locations around the state.

This document, along with the *Report of the Workgroups and Steering Committee on Mental Health Systems Improvements*, and a number of additional documents prepared by MHDS are included with this submission to the Legislature and Governor's office. This document summarizes key recommendations from the *Report of the Workgroups*, prioritizes them, and additional information is provided by the MHDS to begin to design a comprehensive plan. The MHDS is offering this compendium based on a belief in the need for the integration of the key

recommendations of the workgroups since standing alone, no one set of recommendations from any individual workgroup would provide sufficient information to develop a comprehensive plan.

Each section in the following describes the purpose and scope of the Workgroup and the key recommendations from MHDS. Where indicated, explanations are also listed and APPENDICES containing supporting documents are referenced.

Alternative Distribution Formula

This Workgroup required that the Department submit a final report to the chairpersons and ranking members of the General Assembly's committees on Human Resources and the Joint Appropriations subcommittee on Health and Human Services, and to associated legislative staff, and the Governor's office on or before January 31, 2008.

The legislation requested that the Workgroup identify alternative formulas for distributing mental health, mental retardation, and developmental disabilities allowed growth factor adjustment funding to counties. The alternative formulas were to provide methodologies that, as compared to the current methodologies, more readily understood and better reflect the needs for services, respond to utilization patterns, acknowledge historical county spending, and address disparities in funding and service availability. The formulas should serve to strengthen the partnership between the Department and counties in the state's services system. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS does not support the majority of the recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee pertaining to Alternative Distribution Formula.

Explanation: During the course of workgroup meetings, several factors became evident:

1. The workgroups lacked adequate county information about the utilization of services to accurately model various funding mechanisms.
2. It was likely that the scope of the workgroup was too narrow and failed to account for major structural changes needed in the overall approach to funding all mental health and disability services and this could not be addressed within the scope of addressing only allowed growth factors.
3. Other issues, such as state and local taxation policy, global concepts of funding health care, and other large-scope issues often were discussed but outside of the scope of the Workgroup.
4. MHDS recommendations to contain the scope to the legislative mandate were resisted by some workgroup and steering committee members during the project process.
5. The development of case rate models (a core recommendation of the workgroup) could not be accurately prepared due to #1 above.
6. As a result of some of these factors, the MHDS has prepared a statement on Information Systems.
7. The global issue of funding the mental health and disability service system continues to be problematic and technical expertise on taxation models needs to study and make recommendations on this in the future.

**For further information, see:
APPENDIX A Information Systems**

Community Mental Health Centers

The plan shall be submitted to the Governor and General Assembly on or before January 31, 2008. The workgroup should prepare a phased plan for increasing state responsibility for and oversight of mental health services provided by community mental health centers and the providers approved to fill the role of a center. The plan shall provide for an initial implementation date of July 1, 2008. Proposed administrative rules and legislation to amend chapter 230A as necessary to implement the core services beginning July 1, 2008 should be reviewed. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Develop Emergency Mental Health Crisis Response Services in response to a major systems need.
2. Develop Children's Mental Health Services, as they are non-existent in many counties.
3. Develop School Mental Health Services with the CMHCs throughout the state to offer mental health expertise to families and students.
4. Begin to regionalize CMHCs through funding multi-CMHC projects to serve low-incidence populations (those that are typically high cost programs to individual counties) through collaborative operation of services.
5. Address significant behavioral health workforce issues in all regions of the state.
6. Review the current rate of payment for mental health services to determine if the current rate covers the actual cost of service provision. Included in this also should be a review of the rates for substance abuse and co-occurring mental illness and substance abuse disorders services.
7. Establish the State Mental Health Authority (SMHA) as the statewide policy-making entity for required core safety net services and establish that the CMHCs are primary providers of those services.
8. Establish the SMHA as the statewide oversight entity of other mental health services and service providers (i.e., accrediting body).
9. Determine the role, relationship, and responsibilities of the SMHA and the counties regarding financing and managing the public mental health system:
 - a. Endorse that the SMHA is responsible for funding services identified as required core "Safety Net" services (i.e., non-federal portion of Medicaid; Emergency Services, funding for uninsured/underinsured),
 - b. Endorse that the SMHA is responsible for the financing of the non-federal portion of all other community level mental health services funded through Medicaid.
 - c. Ensure that individual counties are responsible for funding other mental health services based on local need as identified in the *County Management Plan*. This should include responsibility for other local service needs for children.
 - d. Delineate in greater detail the contents and requirements for reporting to the SMHA by counties in their County Management Plans.
10. The non-federal portion of community level mental health services remain with one entity and become the responsibility of the SMHA.

Note: There was considerable discussion in the workgroup about delineation of financial responsibilities for payment for the non-federal portion of mental health services funded through Medicaid being split between the state and the counties. State responsibility for financing the non-federal portion of some Medicaid funded mental health services (i.e., required core Safety Net services) and County responsibility for financing other Medicaid funded mental health services can result in competing interests, influence service provision based on funding responsibilities rather than clinical need, and/or result in other unintended consequences that can negatively impact service access and provision for adults, youth, and their families.

11. Revise *Chapter 230A: Community Mental Health Centers* to enhance the state's role in oversight, funding, and support of CMHCs.

12. Revise *Chapter 24* to:
 - a. Establish minimum standards for accreditation of CMHCs as an agency with responsibility for required core safety net services.
 - b. Establish standards for accreditation of emergency mental health crisis response services.
 - c. Change accreditation of other mental health service providers. Focus on accreditation standards for services rather than providers (i.e., providers would then need to meet standards for a service to provide that service).
13. Revise, amend, or develop other related areas of Iowa Code and/or Administrative Code to be consistent with Mental Health Systems Improvement recommendations.
 - a. Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Reps, Commission, IME, etc.).
 - b. Include language clarifying the role of the SMHA.
 - c. Assess accreditation process of other MH service providers (i.e., accreditation by individual service or by provider entity). Incorporate necessary changes as it relates to changes, additions of Medicaid services.
 - d. Utilize the support and expertise of others such as consultants and legislative staff.
 - e. Ensure accreditation standards for mental health service providers and related mental health service standards (i.e., Habilitation Services, Remedial Services, and Psychosocial Rehabilitation, Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations.
 - f. In collaboration with the Judicial System, include an assessment and recommend revisions to code related to voluntary and involuntary psychiatric commitments (Ch. 229).
14. Convene a workgroup or task force of representative stakeholders to analyze larger funding issues such as the amount of funding needed for safety net services that address the financing for uninsured, underinsured, and uncompensated care.
 - a. Assess how current county/state funding is being utilized for uncompensated care (i.e., determine what is being matched to Medicaid, what is not, etc.).
 - b. Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what segments? Where are responsibilities shared?).
 - c. Determine if there is existing funding that can be leveraged for Medicaid services.
 - d. Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy-in program for people with disabilities.
 - e. Assess the pros, cons, and unintended consequences related to funding responsibilities and financing mechanisms.
 - f. Utilize a financing model that supports the service needs of consumers and youth, removes cons and other unintended negative consequences, promotes collaboration (and eliminates cost shifting) across responsible parties, and contributes to the successful implementation of Mental Health Systems Improvement.
 - g. Coordinate the findings of this group with MHDS and IME regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.
15. DHS establish a multi-agency workgroup with MHDS and IME to revise the Medicaid State Plan and the various Medicaid service options related to mental health so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:
 - a. Add/revise services that support the financing of core required Safety Net services (i.e., Emergency Mental Health Crisis Response Services, Intensive Case Management Services, Peer Support and Parent Support).

- b. Utilize Medicaid administrative funding to support the financing of core Safety Net services such as assessment, screening and already identified functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
 - c. Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other “typical” CMHC services can be provided in any community location.
 - d. Revise HAWK-I (S-CHIP) to include core required mental health safety net services and to offer a similar mental health benefit package as Medicaid.
 - e. Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, and Psych. Rehab. Services, Children’s Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.
16. In relation to Co-Occurring Disorders and in the context of the Co-Occurring Disorders Policy Academy, MHDS, CMHCs, IME, and IDPH should develop a concrete plan to work together to:
- a. Conduct an analysis of and work together to resolve administrative, policy, and funding related to the provision of services to persons with co-occurring disorders.
 - b. Resolve inconsistencies/remove barriers between funding streams for mental health and substance abuse services.
 - c. Work towards integrated funding for persons with co-occurring disorders.
 - d. Institute joint outcomes regarding service provisions for persons with co-occurring disorders.
 - e. Develop a data tracking system that can track and identify services provided to persons with co-occurring disorders across services systems (i.e., Mental Health Services, Substance Abuse Services, Inpatient Treatment, etc.). Implement this joint data tracking system within 3 years.
 - f. Complete a review of the rates paid for mental health versus substance abuse services to ensure that the rates are comparable to one another based on level of service, qualifications of staff, etc.

For further information, see:

- **APPENDIX B on State Mental Health Authority**
- **APPENDIX C on Ch. 230a Community Mental Health Center Revisions**
- **APPENDIX D Draft Emergency Mental Health Crisis Response Services Code**
- **APPENDIX E Draft Emergency Mental Health Crisis Response Services Request for Proposals**
- **APPENDIX F Draft Iowa CMHC Act**

Core Mental Health Services

The charge to this workgroup was to identify core mental health services to be offered in each area of the state by community mental health centers and core services agency providers. The core services are to be designed to address the needs of target populations identified by the workgroup, and the services may include but are not limited to emergency mental health crisis response services, school-based mental health services, short-term counseling, prescreening for those subject to involuntary treatment orders, and evidence-based practices.

The Report of The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following:

1. Ensure that lowans of all ages have access to a comprehensive array of core mental health services and that services can be accessed statewide.
2. Ensure emergency mental health crisis response services can be accessed anytime of the day or night (i.e., 24/7) throughout the state for anyone, any age experiencing a psychiatric crisis.
3. Ensure timely access to all core services (including psychiatry and emergency mental health crisis response services).
4. Standardize the target population definitions used for adults (i.e., Chronic Mental Illness is sometimes used, Serious Mental Illness is sometimes used) to specify who is eligible for what core services. Use the term Serious Mental Illness (SMI) and create a definition that is in keeping with the federal definition for SMI.
5. Create and implement a definition/targeted population of Serious Emotional Disturbance (SED) for youth that is in keeping with the federal definition for SED.
6. Create eligibility criteria for core services which:
 - a. Focuses on priority populations and determines service access by clinical eligibility/medical necessity and financial eligibility criteria (i.e., Outpatient and Emergency Services for anyone in need regardless of ability to pay; “Specialized CSS/CBS Services” for individuals experiencing SED/SMI).
 - b. Addresses barriers for people that hinder service access related to insurance limitations or having no insurance.
 - c. Ensures access to mental health services for people of all ages (i.e., includes children and older adults, is not limited to adults).
 - d. Addresses service delivery barriers for providers that results in achieving what is expected with service provision.
7. Ensure that youth experiencing SED and adults experiencing SMI have access to specialized services (i.e., the services that can be provided anywhere in the community) locally, in their own homes and their own communities.
8. Implement Intensive Case Management (ICM) services as a core service for both adults experiencing SMI and youth experiencing SED.
9. Utilize CMHCs as the public safety net with the responsibility to ensure the statewide availability of core services and 24/7 access to emergency mental health crisis services. Ensure that the new standard of care focuses on local availability, personal contact, and local coordination of services.
10. Address Behavioral Health Workforce Shortages in the following areas:
 - a. Psychiatry, Advanced Practice Nurses, Physician’s Assistants.
 - b. Other mental health professionals (i.e., doctoral-level Psychologists, Licensed Independent Clinical Social Workers and other licensed practitioners; BA and para-professional level staff).

- c. Develop an organized statewide program to recruit and retain mental health specialists.
- d. Look at other models to address the gap in psychiatry such as:
 - Telemedicine and consultation support to other prescribers
 - Specialized training in mental health for Primary Care Physicians (PCPs)
 - Utilization of other medical professionals (i.e., ARNPs, PAs, etc.) as “extenders” of psychiatrists.
 - Define an organized statewide program to recruit psychiatrists and other behavioral health workforce professionals where there are shortage areas.

11.Ensure the standard of care for mental health supports an integrated health model (e.g. co-location of related service providers; integration of mental health with primary care physicians).

12.Support the ongoing collaboration of an Acute Mental Health Care Task Force including relevant agencies (i.e., Providers, County Attorneys, Judges, Law Enforcement, Child Welfare, Schools, Hospitals, CPCs, consumers and family members) to review models and approaches in acute mental health services to determine how such services should be carried out in Iowa.

13.Develop training opportunities for all service providers of Co-Occurring Disorders.

14.Create a state level/statewide funding pool specifically for the purchase of medications for people who are uninsured/underinsured. Allow this funding stream to be utilized for lab testing, other services, etc. directly related to medication management. A statewide Medication Assistance Program with oversight and management by MHDS is recommended in order to secure additional resources such as:

- a. Resources related to administrative costs of managing Medication Assistance Programs.
- b. Prescription assistance programs with pharmaceutical companies (i.e., in kind contributions, reductions in purchasing, etc.).
- c. Federal funding or other resources to support the purchasing of medications.

15.Prevent any unfunded mandates. Ensure that adequate resources are dedicated to successfully implement required changes related to the redesign of the Iowa mental health system.

16.Address resource needs related to the uninsured, underinsured that lead to uncompensated care.

17.Identify approaches to deal with increasing levels of uncompensated care.

18.Ensure that any requirements for CMHCs and Inpatient facilities to have a letters of agreement with one another is not misinterpreted to mean CMHCs have financial responsibilities for the cost of inpatient care (and vice versa).

19.Ensure that the shift to community-based service provision is supported through all related processes across agencies.

Accreditation Standards

The Workgroup was to provide recommendations on accreditation changes associated with mental health systems improvement to the Governor and General Assembly on or before January 31, 2008. The charge was to identify standards for accreditation of core services agencies that are not a community mental health center but may serve as a provider approved to fill the role of a center. Such core services agencies could be approved to provide core mental health services for children and adults on a regional basis. The workgroup’s recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Name a CMHC accreditation task force to revise the Ch. 24 standards following the revision of Ch. 230a.

2. Develop new standards that support a fundamental Continuous Quality Improvement process similar to that seen by the Joint Commission on Accreditation of Healthcare Organizations to restore governance, administrative, and services sections and that more completely detail standards specific to CMHCs.
3. Restore community planning, consultation and education services to the definitions of mental health services.
4. Accreditation activities should ensure the following:
 - a. CMHCs establish and continuously monitor staff credentials and scope of practice provided to served consumers,
 - b. Staff improvement should continue to serve as an important standard establishing the staff development plan, organizational plans and resources, and
 - c. Supervision, consultation, and peer review be defined and incorporated within CMHCs continuous quality improvement system.
5. Provide MHDS Accreditation staff with standardized tools and processes, and accreditation standards should reflect and allow for service information to be recorded and accessed electronically.
6. Ensure that Accreditation standards provide for the development of outcome and process indicators on which continuous quality improvement occurs.

Co-Occurring Disorders

The Report of The Workgroups recommendations for this section can be found in APPENDIX O.

The MHDS supports the recommendations from the Co-Occurring Disorders Workgroup:

- a. Incorporate a vision statement for a comprehensive, continuous and integrated system of care for individuals with co-occurring disorders.
- b. Develop and use a charter document for Co-occurring disorders systems development and expansion.
- c. Continue collaboration with IDPH and active participation in a Co-Occurring Disorders Policy Academy.
- d. Ensure ongoing future consultation on co-occurring systems development work.
- e. Begin development of pilot, co-occurring projects around the states in collaboration with providers and CMHCs.
- f. Utilize various management tools developed through the Co-Occurring Policy Academy to facility the implementation of a Comprehensive, Continuous, and Integrated System of Care of Co-Occurring Disorders.

For further information, see:

- **APPENDIX G Co-Occurring Disorders Policy Academy Charter**

Evidence-based Practices

Legislation directed the MHDS to begin phased implementation of evidence-based practices for mental health services over a period of several years in order to provide a reasonable timeline for the implementation of evidence-based practices with mental health and disability services providers. The legislation directed the division to provide for implementation of two adult and two children evidence-based practices per year over a three-year period. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The Department supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Implement the three-year plan for rolling out EBPs for children and adults (see below for additional details).
2. The Department supports the definition of EBPs put forth by the Institute of Medicine in 2001 (i.e., EBP is the integration of best research evidence with clinical expertise and patient values (Sacket, et al, 2000; Institute of Medicine, 2001).
3. The Department recommends that training in the delineated EBPs be conducted through a newly created Mental Health and Disability Services Training Institute (MHDSTI) in collaboration with the Iowa Mental Health Consortium, the Center for Disabilities Development, and with expert technical assistance from the Annapolis Coalition.

The recommended EBPs are summarized below:

Children and Adolescents

Key Service Delivery Model:

SYSTEM OF CARE MODEL

- | | |
|---------|---|
| Year 1: | <ol style="list-style-type: none"> 1. School-based Mental Health Services 2. Intensive Case Management with Wraparound |
| Year 2: | <ol style="list-style-type: none"> 1. Parent Support, Education, and Training 2. In-Home and Community Based Services and Supports |
| Year 3: | <ol style="list-style-type: none"> 1. Functional Family Therapy 2. Integrated Dual Diagnosis Treatment of Co-Occurring Mental Illness and Substance Abuse Disorders |

Adults

Key Service Delivery Model:

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

- | | |
|---------|--|
| Year 1: | <ol style="list-style-type: none"> 1. Integrated treatment for Co-occurring Mental Illness and Substance Use Disorders 2. Peer Support |
| Year 2: | <ol style="list-style-type: none"> 1. Supported Employment 2. Illness Management and Recovery (including CBT) |
| Year 3: | <ol style="list-style-type: none"> 1. Assertive Community Treatment 2. Family Psychoeducation |

Comprehensive Training Program and MHDS Training Institute

The Legislature directed the MHDS to develop a comprehensive training program concerning practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa Consortium for Mental Health and mental health service providers. The Legislature directed the Division to consult with experts on behavioral health workforce development regarding implementation of the mental health and disability services training and the curriculum and training opportunities offered.

Beginning in the summer of 2007 the MHDS engaged the services of the *Annapolis Coalition*, leading national experts on training and behavioral health workforce development. The MHDS held a series of meetings with the Annapolis Coalition, the Iowa Consortium for Mental Health

and the Iowa Center for Disabilities Development in order to plan the development of a comprehensive training program per legislative direction. MHDS and the Annapolis Coalition held meetings with IDPH, and offered presentations with at MHMRDDBI Commission meetings, the Mental Health Planning Council, and a joint meeting of the Iowa Senate and House Human Resources Committees to discuss behavioral health workforce issues. The MHDS also recently worked with the Annapolis Coalition, the Consortium and Center for Disabilities Development and the Western Interstate Consortium of Higher Education (WICHE) to identify specific behavioral workforce needs with academia, in rural locations, and with primary healthcare providers. Most recently a proposal to develop a Mental Health and Disability Services Training Institute has been developed to address multiple issues of behavioral health workforce needs in Iowa.

THE CHALLENGE. There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically-effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services Administration's "Toolkits"). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

A SOLUTION FOR IOWA. Any effort to address concerns about the quality or quantity of workers in the mental health and disabilities service system must have as its goal *sustainable, practical* approaches. The answers are not to be found solely among existing service providers, in our institutions of higher education, or in state government. What will serve Iowa's citizens best is a structure that brings together the strengths of all of these communities with a heightened focus on real-world solutions to the on-going crisis of having a competent, committed workforce in place to support people with mental illnesses and intellectual and developmental disabilities.

THE NEW VISION. The vision of the proposed Mental Health and Disability Services Training Institute (MHDSTI) is to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others, and educate the workforce.

THE BUILDING BLOCKS. The implementation of the new vision for Iowa will build upon simple, practical approaches:

The creation of basic infrastructure to manage the process and the creation of a **Workforce Collaborative** to bring together the many skills, voices, and talents needed to implement sustainable change.

A series of tangible work products that address immediate and urgent needs in Iowa's current mental health and disability service system:

- Strengthening the competences of line supervisors—the lynch pin in supporting change and improving quality is the quality of supervision.
- Strengthening the competencies of staff that work with children, adolescents and their families.
- Addressing the needs of our crisis and emergency services statewide.

- Building capacity to serve people with co-occurring conditions, such as mental illnesses and addictive disorders, or mental illnesses and developmental disorders.
- Improving the competencies of front line staff, which spend the most time with people receiving services, yet often receive the least training.
- Supporting consumers of services and their families to become more effective partners and care givers, and to engage them in training the rest of the workforce.
- Providing incentives to recruit and retain highly skilled professionals.

ACHIEVING SUCCESS. Many partners will be required to achieve success, but failure cannot be an option for Iowa. We have recognized the need, and it is within our capacity to move ahead quickly and effectively to make the new vision for our workforce a reality.

For further information, see:

- [APPENDIX H Workforce Vision](#)
- [APPENDIX I Workforce Data](#)

Comprehensive Plan

The Legislature directed MHDS to complete a written plan describing the key components of the state's mental health services system, including the services addressed in this subsection and those that are community-based, state institution-based, or regional or state-based.

This document contains a wide range of recommendations that should be considered integral to the phased rollout of an improvement plan. The Legislature directed that the plan should incorporate the community mental health center plan provisions. In addition, the MHDS was directed to complete a written plan for **“the Department to assume leadership and to assign and reassign significant financial responsibility for the components of the mental health services system in this state, including but not limited to the actions needed to implement the provisions of this subsection involving community mental health centers, core mental health services, core services agencies, co-occurring disorders, and evidence-based practices”**. We are pleased to present this document in support of that plan.

In its legislative proposals, submitted to the Governor in the Fall of 2007, the MHDS included recommendations for funding levels, payment methodologies for new emergency mental health crisis response, children's mental health and school mental health services. Per legislative direction, a more complete plan shall be submitted to the Governor and General Assembly on or before January 15, 2009. The Workgroups recommendations for this section can be found in APPENDIX O.

Presently, the MHDS recommends the following PHASED changes to be updated on or before January 15, 2009 in the following outline:

Phase I:

Develop and Implement

- Data infrastructure and capacity to monitor system utilization.
- CMHCs as lead agencies on the implementation of Emergency Mental Health Crisis Response Services through an RFP process via state “block grants”
- Children's Mental Health Services are designed and developed.
- School Mental Health Services are designed and developed
- Co-Occurring Disorders Programs and Services are piloted through the auspices of the Co-Occurring Disorders Policy Academy and MHDS technical advisors.

- MHDS develops and implements the Mental Health and Disability Services Training Institute through “state psychiatric papers” funds
- Functional Assessment and Outcomes Systems are developed and implement by MHDS in collaboration with CMHCs, MHIs, RCs and Juvenile facilities.
- Create necessary legislative, code, rules, and standards associated with phase changes.

Phase II:

Development and Implement:

- Acute Mental Health Task Force and in collaboration with counties, judicial system, law enforcement, health care systems and other major stakeholders update mental illness commitment procedures
- CMHC and Inpatient Program Information Network with Electronic Linkage with MHIs, RCs, and JJ facilities
- Establish MHDS as provider of Intensive Clinical Management Program
- Contract with a Pilot Regional Mental Health Authority
- Programs and Services for Individuals with Dual MH/MR disorders
- Create necessary legislative, code, rules, and standards associated with phase changes.

Phase III:

Develop and Implement:

- Early Intervention Programs
- Programs and Services for Persons with Autism Spectrum Disorders
- Programs and Services for Older Adults
- Create necessary legislative, code, rules, and standards associated with phase changes.

For further information, see:

- **APPENDIX J Legislative Proposals**
- **APPENDIX K Evidence-based Practices**
- **APPENDIX L Workforce Development Proposal**
- **APPENDIX M A Data View**
- **APPENDIX N CMHC and CPC Survey Responses**
- **APPENDIX O Recommendations from the Workgroups and Steering Committee**