FINAL REPORT

# MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES, AND BRAIN INJURY SERVICE DELIVERY SYSTEM RESTRUCTURING TASK FORCE

Presented to the Legislative Council, Governor,
Director of the Department of Human Services,
and the Iowa General Assembly
January 1994

Prepared by the Legislative Service Bureau

# FINAL REPORT

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

January 1994

## BACKGROUND

The Mental Illness, Mental Retardation, Developmental Disabilities, and Brain Injury Service Delivery System Restructuring Task Force was created by the Seventy-fourth General Assembly, 1992 Session, in 1992 Iowa Acts, chapter 1241, section 26. During the 1992 interim period, the Task Force consisted of 23 members representing consumers, state and county officials, services providers, and business and industry. A Report was submitted for consideration during the 1993 legislative session. The members of the Task Force felt that there was inadequate time to complete a restructuring plan and many members continued to meet following submission of the report.

The Task Force's existence was formally continued by action of the Seventy-fifth General Assembly, 1993 Session, in 1993 Iowa Acts, chapter 172, section 46. For the 1993 interim, the membership was increased to 25 members to include additional legislators. The 1993 membership list is attached as Appendix 1 of this Report.

The Task Force has submitted the following three reports to the Governor and the General Assembly: an initial report in December 1992, a more detailed report in January 1993, and an interim report in the summer of 1993. This Report is intended to incorporate the elements of the previous reports in providing a comprehensive set of recommendations to restructure the service delivery system available to persons with disabilities.

## SUMMARY OF RECOMMENDATIONS

The Task Force has concluded that the current system of delivering and funding services is flawed beyond adjustment or modification and must be completely restructured. The Task Force recognizes that completely changing the system cannot be accomplished immediately. Change will require careful planning and revising of the responsibilities of all who are involved in the system. Consequently, this Report identifies a replacement system of services, recommends a process for implementing the set of replacement services, and provides initial steps for restructuring the current system until a significant amount of resources can be committed to a new system.

The recommendations can be categorized under the following general subject matter headings:

1. Revise services to be more focused upon the needs of consumers.
2. Move to equity of service availability around the state and to a core set of basic services.
3. Increase the leadership role of the state in service delivery and funding.
4. Maximize current financial resources in the near term through the use of federal funds and redirect funds away from institutional services to community-based services.
5. Restructure the system over the five-year period of FY 1994-1995 through FY 1998-1999 by expanding the use of the regional planning councils, implementing a revised role for the state, and capping county expenditures.

The recommendations contained in this Report focus upon the near term and the long term. The report is organized to set forth each recommendation in general terms followed by explanation and detailed action steps. Fiscal analysis of the recommendations is being prepared by the Legislative Fiscal Bureau for distribution during the 1994 Legislative Session.

## RECOMMENDATIONS I AND II: REVISE SERVICES - MOVE TO EQUITY OF SERVICE AVAILABILITY

The Task Force focused considerable attention on the components of a new service delivery system. The Task Force has consistently stressed that the services available to persons with mental illness, mental retardation, developmental disabilities, and brain injury should be tailored, consistent with the best professional judgment, to the needs of the persons who use the services. The initial reports identified basic principles for persons with disabilities and their families to be able to exercise choices and to be empowered to exercise basic rights and accept responsibilities, and for the development of a system that supports persons with disabilities' involvement with their communities.

In addition to basic values for a service system, the Task Force has outlined operational principles and specific core services that should be available to persons with disabilities in every area of the state. These items, which were identified in the initial reports, are attached to this Report as Appendix 2.

## RECOMMENDATION III: INCREASE STATE LEADERSHIP

Fragmentation is a major problem with the current system. The Task Force does not advocate a single centralized system. The Task Force advocates a locally focused system in which regional access, planning, and decision making is maximized. The Task Force

advocates that the state assume a greater leadership role by coordinating planning with the regional planning councils and providing the councils and other local governments with technical assistance, by developing data resources, by helping to maximize the use of federal resources, and by revising funding priorities from institutional care to community-based care. The state must establish and fully implement a public policy to serve all people with mental illness, mental retardation, developmental disability, and brain injury in order to successfully restructure the system of services and funding. This policy must include an increase in state funding of services in partnership with other governments.

A policy for increased state leadership and funding must provide direction for short-term action as well as long-term implementation. This report contains detailed recommendations for immediate legislative action during the 1994 Legislative Session and for implementation in FY 1994-1995 through FY 1998-1999.

## RECOMMENDATION IV: MAXIMIZE CURRENT FINANCIAL RESOURCES IN THE NEAR TERM THROUGH THE USE OF FEDERAL FUNDS AND REDIRECT FUNDS AWAY FROM INSTITUTIONAL SERVICES TO COMMUNITY-BASED SERVICES. (FY 1993-1994 AND FY 1994-1995)

Current financial resources can be maximized by the following means:

1. Carry over from one fiscal year to the next any unspent funding for persons with disabilities.
2. Capture all the federal funding available for services to persons with disabilities, beginning with vocational rehabilitation and housing funding.
3. Dedicate Medicaid savings from services to persons with disabilities to other Medicaid services for persons with disabilities.
4. Expand the use of Medicaid to pay for services for persons with disabilities.
5. Require the Department of Human Services to complete a five-year plan to close or to shift to other purposes two Mental Health Institutes and one State Hospital-School.
6. Implement statutory and regulatory changes to improve the system and service equity.
7. Provide for greater flexibility in the use of funds appropriated for disability services.

*1) Carry over from one fiscal year to the next any unspent funding for persons with disabilities.*

In FY 1992-1993, $3,285,634 reverted to the General Fund from MH/MR/DD appropriations to the Department of Human Services (DHS). Beginning with FY 1993-1994, unexpended funds should be targeted for the development and expansion of contemporary, community services to assist counties in their efforts. There should be an ongoing policy not

to revert these funds at the end of a fiscal year but instead carry the funds over into the succeeding fiscal year as additional funding for developing and expanding contemporary, community services.

*2) Capture all the federal funding available for services to persons with disabilities, beginning with vocational rehabilitation and housing.*

Additional federal funding can be drawn down for services to persons with disabilities. Iowa can capture at least $ 1.9 million in additional federal funds for vocational rehabilitation services and these funds can be used to provide vocational rehabilitation, including supported employment at the local level. During state FY 1992-1993 these available funds were not drawn down by the Department of Education. In addition, Iowa can utilize federal housing assistance by making special efforts to utilize this assistance for persons with disabilities.

For state FY 1993-1994, the match for federal vocational rehabilitation funding can be provided by local governments. 1993 Iowa Acts, chapter 179, section 1, subsection 3, paragraph "a", provides that funds other than state funds can be used as the match. This language allows county and private funds to be used for meeting the match. As counties already pay for vocational services, use of this funding for the match could result in an overall savings for counties or allow them to spend their savings or redirect the funding to expanded services or to services for more people. The Division of Vocational Rehabilitation of the Department of Education is the agency held responsible for the appropriate use of these funds and will need additional staff resources to ensure the funding is used appropriately.

The match provision only applies to state FY 1993-1994 so additional language must be included in the Department of Education's appropriation bill for state FY 1994-1995. The provision should not be used by the state to avoid a long-term funding responsibility. In fact, the state should provide an additional match for these federal funds. This provides a way for the state to increase its partnership in an area where the total cost liability is easily identified and controlled, thus helping to lower property taxes.

Other federal funding is available for housing assistance which could be targeted to provide housing outside institutional residential settings for persons with disabilities. The Task Force has identified these possibilities for tapping this federal funding:

a. Develop a state funding program for the purpose of providing matching funding to local governments for drawing down federal housing assistance.

b. The state should assist local governments, including planning councils, in implementing the advance planning needed to obtain federal housing assistance.

*3) Dedicate Medicaid savings from services to persons with disabilities to other Medicaid services for persons with disabilities.*

The state has implemented various strategies intended to reduce the growth of Medicaid spending such as managed care and prior authorization of certain drugs. In FY 1992-1993,

$14,035,829 of the $276,161,251 appropriation for Medicaid was not expended and reverted to the General Fund of the State. In FY 1993-1994 and beyond, that portion of Medicaid reversions which relates to mental health, mental retardation, developmental disabilities, and brain injury should be redirected in the succeeding fiscal year to fund services for persons in these categories. For the best investment, the state should use these funds to implement additional Medicaid programs to provide community services, such as the personal care option, the Medicaid Rehabilitation option for persons with mental illness, and home- and community-based services waivers for persons with developmental disabilities and brain injuries.

*4) Expand the usage of Medicaid funding to pay for services to persons with disabilities.*

For services covered under Medicaid, the federal government will provide matching funds on approximately a 2-to-1 ratio. The Task Force consultants stressed that it is more important than ever to maximize the use of Medicaid because of pending or potential federal spending cuts and health care reform. The rationale is that the recent budget compromise calls for unspecified Medicaid cuts and health care reform may limit future increases in federal spending for Medicaid, so it may be more difficult in the future for a state to implement an option that has not been previously used.

The Task Force stresses the importance of making progress toward the general goal of increasing state participation in funding disabilities services. To further this goal, the state and counties should share the nonfederal portion of the costs of new Medicaid services for persons with disabilities.

As existing state and county funding is redirected, the funding should be used to implement the following Medicaid provisions:

a. Develop and implement the Medicaid rehabilitation option for persons with mental illness by redirecting state and county funds which are now used to purchase similar services.

b. Make personal assistance services available by implementing the personal care option in the Medicaid program and paying for the services by reducing state and county expenditures for institutional residential settings.

c. Develop and submit waivers under the Medicaid Home- and Community-based Services Waiver Program targeted to persons with developmental disabilities (other than mental retardation) and brain injuries by redirecting county and state funds which are now used to purchase similar services.

d. Modify the existing Medicaid Home- and Community-based Services Waiver Program directed to persons with mental retardation to facilitate downsizing the state hospital-schools.

*5) Require the Department of Human Services to complete a five-year plan for closing or realigning to other purposes two Mental Health Institutes and one State Hospital-School.*

The Department of Human Services should be directed to complete a five-year plan for closing or realigning to other purposes two Mental Health Institutes and one State

Hospital-School. The plan should ensure that community services are in place prior to the elimination of the institutional service and that the quality of the institutional services continues to be a priority while the quantity of services is being reduced. Any state or county savings should be directed to community services.

*6) Implement statutory changes to improve the system and service equity.*

a. Improve the legal settlement process used by the counties and the state. Until statewide service equity is achieved, the current process could be improved by implementing a binding arbitration or mediation process in determining the party legally responsible for the costs of services provided to a person with disabilities.

b. A fiscal year should be identified and adopted as the base year for overall county and state financial maintenance of effort for funding of services and support for persons with disabilities. Any financial maintenance of effort requirement should be crafted with the goal of first providing funding for a set of core services that would be available in each county.

c. Revise statutory provisions under the program which waives local building code requirements for certain community residences used by persons with disabilities to also include housing for persons with brain injury.

d. Revise regulatory provisions to reflect a consumer-centered system. It is possible that some regulations increase cost without improving quality for the consumer. A state/county ICF/MR cost-containment committee is reviewing ICF/MR requirements and the committee's findings should be widely disseminated for review and comment and be carefully considered by the Department of Human Services and Department of Inspections and Appeals.

e. Revise the membership of the Mental Health and Mental Retardation Commission to reflect all affected populations by filling unused local coordinating board slots with representatives of persons with developmental disabilities and persons with brain injury. In addition, expand the role of the Commission to include responsibility of planning for services to persons with brain injury and with developmental disabilities other than mental retardation.

*7) Provide for greater flexibility in the use of funds appropriated for disability services.*

Even the best planning and budget projection systems cannot accurately predict the exact appropriation needed to provide the necessary quantity of services to individuals. The recent demonstration projects in certain counties in which the state funds for child welfare and juvenile justice are decategorized combine funding flexibility with planning. The decategorization projects allow tailoring of the purchase of services to an individual child's needs while remaining within an overall budget. Both the state and counties should initiate projects which utilize flexibility to shift moneys between appropriations in order to provide consumer-centered services.

**Recommendation V: Restructure the system over the five-year period of FY 1994-1995 through FY 1998-1999 by expanding the use of the regional planning councils, implementing a revised role for the state, and capping county expenditures.**

The restructuring would consist of the following major components:

1. Provide for an incremental shift from a county-centered system to a regional planning system based upon state-determined standards over the five-year period beginning with FY 1994-1995 and ending with FY 1998-1999.

2. Clarify the state role as one of standardizing services and service purchases, developing uniform eligibility guidelines, preparing comprehensive plans based upon regional input and equitable access to service opportunities regardless of geography and disability service grouping, and equalizing services between disability groups.

3. Revise funding for disabilities services by capping county expenditures and requiring the state and counties to maintain a specified level of spending.

*1) Provide for an incremental shift from a county-centered system to a regional planning system based upon state-determined standards over the five-year period beginning with FY 1994-1995 and ending with FY 1998-1999.*

Background

The regional planning councils were created in temporary law for FY 1992-1993 and FY 1994-1995. The counties were required to create the planning councils as a condition of receiving their share of state funding for services to persons with disabilities. The county or counties comprising a planning council are to include a population of at least 40,000 or utilize the borders of the Department of Human Services' county clusters. Under the provisions of the temporary law, there are 36 planning councils in the state. The membership of each planning council is to be determined by the counties comprising the council with certain specified representatives. The planning councils must annually submit plans for services within their area to the Department.

Recommendations

The Task Force recommends strengthening the planning council system by enacting the following provisions into permanent law:

a. Establish the councils as independent statutory entities.

b. Recommend the expenditure of all state and county funds and to the extent possible, federal funds, through the planning councils by the end of the four-year phase-in period of FY 1994-1995 through FY 1997-1998. Final financial authority should remain with the taxing jurisdiction.

c. By the end of the phase-in period, utilizing the core service package developed by the state, authorize the planning councils to recommend to the boards of supervisors associated with the planning area the services that would be available within a region. In addition, authorize the planning councils to recommend to the boards of supervisors which populations would be served in accordance with state-developed eligibility guidelines.

d. Allow the planning council system to evolve over time by establishing standards for adjusting a planning council area. Adjustments to a planning council area should allow for consideration of geographic distance, natural market areas, tax structure, population, and other factors concerning the counties which may comprise a planning area. Structure the planning council membership to be representative of consumers, family members of consumers, and members of the general public with no group constituting more than one-third of the council membership. Permit appointment of a citizen member by the local Department of Human Services administrative entity. Require a process for input by service providers and funders.

e. Require each planning council to develop five-year plans and to make recommendations to the state and to counties as to service and funding needs.

f. Prohibit councils from being service providers. Require qualified staffing services for the councils with the cost paid by the service funders. Staffing services could include needs assessments, plan development, working with providers and funders, and other needed services.

g. Establish a consumer appeal process.

h. The MH/MR Commission membership should be further revised to consist only of planning council representatives at the end of the five-year period.

*2) Clarify the state's role as one of standardizing services and service purchases, developing uniform eligibility guidelines, preparing comprehensive plans based upon regional input, equalizing access to service opportunities regardless of geography and disability service grouping, and ensuring equitable services between disability groups.*

Background

At the present time, state involvement in service delivery is limited because the primary funding sources and decision making are at the county level. The Task Force has indicated that the state role should be broadened in order to increase equity, consistency, and efficiency. At present, state responsibilities are exercised primarily by the Department of Human Services, Division of Mental Health, Mental Retardation, and Developmental Disabilities, with policy decisions made by the Mental Health and Mental Retardation Commission and by the regulatory functions administered by the Department of Inspections and Appeals. It is possible that health care reform will result in major changes to the health care delivery system and the state responsibilities for disabilities services could be privatized or otherwise changed. The recommendations in this section would apply to any central state authority.

Recommendations

The following responsibilities should be assumed by the state, with a five-year phase-in period. The responsibilities dealing with consistency and efficiency should be dealt with first:

a. Beginning with FY 1998-1999, plan for the distribution of state and, to the extent possible, federal service system funding to the planning councils. As a first step, the

state should estimate state and federal funds that would be available to the planning councils beginning with FY 1994-1995.

b. Seek to maximize federal funding by drawing down federal grants and providing matching funding.

c. Define core and optional services for the state based upon a consumer-centered system.

d. Establish uniform eligibility guidelines.

e. Establish uniform purchase of service guidelines.

f. Establish uniform service payment rate methodologies.

g. Provide for quality assurance without additional regulation by setting standards for and accrediting service providers based upon outcome measures developed by national accrediting bodies. This approach should be initially tested through the use of pilot projects. The pilot projects should be a joint effort involving federal, state, and local programs and should include flexibility in funding and service delivery aspects.

h. Oversee equity of funding between disability population groups.

i. Prepare estimates of future state and federal funding which will be available to the planning councils.

j. Administer state services.

k. Prepare five-year plans with annual updates based upon the planning councils' plans.

l. Prepare annual budget recommendations based upon the recommendations of the councils.

m. Provide technical assistance to the planning councils.

*3) Consistent with the intent of recommendation V, the following strategy is recommended: revise funding for disabilities services by capping county expenditures and requiring the state and counties to maintain a defined level of spending.*

Background

Analysis of state, federal, and county expenditures in FY 1991-1992 indicates that nearly $400 million was expended for services to persons with mental illness or mental retardation (the cost analysis did not include expenditures for services to persons with brain injury or developmental disabilities other than mental retardation). The expenditures were paid by the following sources: counties, 53 percent; federal, 32 percent; and the state, 15 percent.

Recommendations

The following recommendations are intended to incrementally develop a defined level of county, federal, and state funds which will be available for planning purposes to the regional planning councils in accordance with the state-developed plan:

a. Beginning with FY 1995-1996, estimated state and federal funds are identified by the state to the regional planning councils for planning purposes. The planning councils make recommendations for the expenditure of these funds and county funds.

b. Beginning in the last quarter of FY 1994-1995, the state implements the rehabilitation option of the Medicaid program to provide services to an estimated 625 persons with mental illness. (Implementing this option is estimated to require an investment of approximately $400,000 with net savings of nearly $200,000 due to cost offsets.) Fifty percent of the nonfederal cost for the option would be paid from the MI/MR/DD/BI Community Services fund under which state funds are allocated to counties and the remaining 50 percent would be paid by the county of legal settlement.

c. The state annually expands those covered under the rehabilitation option by an estimated 625 persons in each of the following fiscal years: FY 1995-1996, FY 1996-1997, and FY 1997-1998. In each of these fiscal years, the nonfederal share of the cost would be paid as it was in the initial year.

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

(Updated 12-29-93)

Representative Patricia Harper
3336 Santa Maria Drive
Waterloo, IA 50702
H - 319/233-2106
(Iowa House of Representatives)

Representative Hubert Houser
R R 1, Box 143
Carson, IA 51525
H - 712/486-2597
(Iowa House of Representatives)

Senator Albert Sorensen
1004 Hancock Drive
Boone, IA 50036
H - 515/432-4089
(Iowa State Senate)

Senator Maggie Tinsman
3541 E. Kimberly Rd.
Davenport, IA 52807
O - 319/359-3624
H - 319/332-5522
(Iowa State Senate)

Ms. Darline M. Brown
4519 Grand Avenue
Des Moines, IA 50312
H - 515/255-4174

Mr. Michael L. Brown
Iowa Realty Commercial Brokers
6000 Westown Parkway, Suite 330W
West Des Moines, IA 50266-7711
O - 515/221-6631
FAX - 515/221-6652
(Iowa Association of Business & Industry)

Mr. Fritz Krueger
Special Education Director
Arrowhead Area Education Agency
1235 5th Ave. S., Box 1399
Fort Dodge, IA 50501
O - 515/576-7434
FAX - 515/576-4743
(AEA Directors Association)

Ms. Judy Dierenfeld, Executive Director
Community Mental Health Centers
Association of Iowa, Inc.
321 East Walnut St., Suite 320
Des Moines, IA 50309
O - 515/243-2126
(Community Mental Health Centers Assn. of Iowa, Inc.)

Ms. Paula Dierenfeld
Office of the Governor
State Capitol Building
Des Moines, IA 50319
O - 515/281-6331
(Governor Terry E. Branstad)

Mr. Jerry Downin
Iowa Farm Bureau Federation
5400 University Avenue
West Des Moines, IA 50265
O - 515/225-5530
(Iowa Farm Bureau)

Ms. Kay Graber, President
Grant Wood AEA
4401 6th St. SW
Cedar Rapids, IA 52404
O - 800/332-8488
(Iowa Head Injury Association)

Ms. Jane Halliburton
Story County Supervisor
Story County Courthouse
900 6th Street
Nevada, IA 50201
O - 515/382-6581
(Iowa State Association of Counties)

Ms. Claudine Harris
Alliance for the Mentally Ill of IA., Inc.
219 Ronalds Street
Iowa City, IA 52245
H - 319/338-1459
O - 319/356-0055
(Alliance for the Mentally Ill of IA., Inc.)

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

Jerry Lewis, M.D.
221 N. 4th Avenue E.
Newton, Iowa 50208
O - 515/792-7871
(Iowa Psychiatric Society)

Ms. Patricia A. Markham, Administrator
Cass County Memorial Hospital
1501 East Tenth Street
Atlantic, IA 50022
O - 712/243-3250
(Iowa Hospital Association)

Mr. J. Gary Mattson, Executive Director
Exceptional Persons, Inc.
760 Ansborough Avenue
P. O. Box 4090
Waterloo, IA 50704
O - 319/232-6671
(Iowa Coalition for Persons with Disabilities)

Ms. Kit Olson
The Arc of Iowa
715 East Locust
Des Moines, IA 50309
O - 515/283-2358
(ARC/Iowa Representative)

Mr. Charles M. Palmer, Director
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
O - 515/281-5452
(Department of Human Services)

Ms. Janet Phipps
Department of Management
State Capitol Building
Des Moines, IA 50319
O - 515/281-7811
(Department of Management)

Mr. Mervin L. Roth, Executive Director
Iowa Protection & Advocacy Services, Inc.
3015 Merle Hay Road, Suite 6
Des Moines, IA 50310
O - 515/278-2502
(Iowa Protection & Advocacy Services, Inc.)

Mr. Keith Ruff
601 South Gilbert, #611
Iowa City, IA 52240
O - 319/338-3870
H - 319/354-3912
(Governor's Planning Council for Developmental Disabilities)

Mr. Paul Stanfield
321 E. Walnut, Suite 370
Des Moines, IA 50309
O - 515/243-3944
(Iowa Citizen Action Network)

Mr. David Van Ningen
Hope Haven, Inc.
1800 19th Street
Rock Valley, IA 51247
O - 712/476-2737
(Iowa Association of Rehabilitation and Residential Facilities)

Ms. Verna Welte
Marian Health Center
801 Fifth Street
Sioux City, IA 51101
O - 712/279-2146
H - 712/239-3965
(Prevention of Disabilities Policy Council)

Mr. James J. Wengert
2000 Walker Street
Suite A
Des Moines, IA 50317
O - 515/262-9571
(Iowa Federation of Labor)

# IOWA MI/MR/DD/BI SERVICE DELIVERY SYSTEM
# RESTURUCTURING TASK FORCE

## PART II: VALUES, OPERATIONAL PRINCIPLES, AND CARE SERVICES

(Excerpted from the Task Force report previously submitted
in January 1993)

## I. VALUES

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

1. **Choice:** The ability of consumers and their families to exercise their own choices about the amounts and types of services received.
2. **Empowerment:** The reinforcement at all levels of the system of the fundamental rights, dignity, and ability of consumers to accept responsibility, exercise choices, and take risks.
3. **Community:** The principle that the system supports the right and ability of all consumers to live, learn, work, and recreate in natural communities of their choice.

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

1. Persons with mental illness, mental retardation, developmental disabilities, or brain injury have the same fundamental rights as any other person. These rights include the right to vote; freedom of speech; freedom of religion; freedom of sexual expression; protection from the denial of life, liberty, property, and the pursuit of happiness with due process; and freedom from discrimination because of one's disability.

---

[1] These values have been adopted from HOUSING AS HOMES - SERVICES AS SUPPORTS, a report compiled by the Department of Human Services, Division of Mental Health, Mental Retardation, and Developmental Disabilities, submitted to the Iowa General Assembly, December 1990; on file with the Legislative Service Bureau.

2. Unique individual and family strengths and needs, choices, and preferences are the basis for service planning and delivery.
3. Individuals and families have the right to participate in identifying service needs and planning to meet those needs. Service planning and delivery encourages and supports the natural support systems of individuals and their families. Consumers and families have the right to appeal if the service plan, service access, or service delivery does not meet their needs and choices.
4. Persons with mental illness, mental retardation, developmental disability, or brain injury have the opportunity to live, learn, work, and recreate in a manner as close as possible to the way other people live. Services are provided in a manner that encourage and support the development of each person's live style.
5. Funding for service provision follows the individual and dynamic needs and choices of consumers and their families, rather than being committed to fixed service program types or settings to which consumers and families must adapt.
6. Consumers and family members are actively involved in service and support system planning, resource prioritization, program implementation, and evaluation of the quality and effectiveness of services.

## II. OPERATIONAL PRINCIPLES

Values define what the general public, the service system, and consumers and families believe about themselves and what they expect in terms of quality of life and well-being. Operational principles begin the process of defining how the system will ensure that all individuals who come in contact with the service system have an experience consistent with the stated values. In combination, values and operational principles provide a context for assessing service system organizational options and operational approaches, as well as for evaluating service system qualify and performance. The values and operating principles are the "Constitution" of the service system. That is, they set the fundamental standards and expectations for the system, and provide guidance for system evolution and response as both local and national conditions change. The following are the operating principles for the Iowa MI/MR/DD/BI service system:

### 1. Single point of accountability and authority

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

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

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

**2. Single point of entry**

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

**3. Equity of service access**

- Wherever an individual in need of MI/MR/DD/BI services resides in the state, she/he has reasonable equal access to the services of her/his choice. Individuals have reasonably equal access to services of their choice regardless of the type or category of disability they present.

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

**4. Targeting service resources**

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

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

### 5. Regional planning, funding, and service contracting

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

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

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

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

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

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

### 6. Case management

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

- Case management is available, as frequently as necessary, to all individuals in need of service, without regard to financial or categorical eligibility. Individuals may

elect not to receive case management, and access to other services is not affected by such a choice.

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

**7. Private/public service provision**

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

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

**8. Prevention**

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

**9. Quality and performance monitoring**

- The Department of Human Services establishes standards for service system quality and performance that are based on consumer outcomes, quality, and cost-effectiveness. DHS maintains a Performance/Outcome Task Force, with a majority of members being consumers and family members, to develop annual quality assurance and performance assessment plans, and to review the results of quality assurance and performance assessment activities.

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

**10. Training and technical Assistance**

- The DHS assures that training, retraining, and technical assistance are available to the regional planning/service development entities and the service providers to

achieve system objectives and carry out service delivery in a manner consistent with the values and operating principles of the system.

## III. VISION FOR THE SERVICE SYSTEM

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

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

Thus, the vision defines the constellation of services to be made available, the methods of providing such services, and the means by which consumers and their families access the services. The vision also defines how the primary service system will assist consumers and their families to access other services, such as income supports, education, housing, and medical care. The primary mission of the service system is to encourage the use of natural supports and generic services wherever possible. In concert with the above-stated values and principles, the Iowa MI/MR/DD/BI service system includes but is not limited to the following set of core services:

1. **Supported affordable housing:** In conformance with HOUSING AS HOMES -- SERVICES AS SUPPORTS, supported housing provides access to low-cost or subsidized housing. Individual consumers have rights of tenancy to the housing, and are not required to participate in any particular program(s) or service(s) to live in the housing. A flexible and dynamic array of services is made available to each tenant, based on her/his needs for supports to maintain independent living.
2. **Supported employment:** Consistent with vocational rehabilitation services, and in concert with transportation and assistive technology, supported employment assists consumers to move towards independent employment. Supported employment enhances workplace skills, advocates for employment in normal, private market settings, and assists employers to provide "reasonable accommodation" of work sites and work tasks.
3. **Supported education:** Supported education includes vocational rehabilitation and related services tailored to individual strengths and choices, and emphasize personal growth, empowerment, and independence.
4. **In-home/community supports:** Community support teams, family support providers, or similar providers assist consumers and families to manage activities of daily living, including personal care, housekeeping, shopping, and money management. Community support teams may also provide care management, access to assistive technology and transportation, assertive

outreach, and early intervention services to assure that institutionalization or other more intensive service interventions are minimized.

5. **Emergency services/crisis stabilization:** Twenty-four hour, seven-days-per-week mobile crisis intervention services assure maximum access to necessary services at a time of crisis, while at the same time minimizing the intensity and duration of the intervention. This service also provides psychiatric hospital prescreening and diversion, to assure that only medically necessary admissions are carried out, and to assist courts in making correct decisions regarding involuntary commitments.
6. **Case management:** Case managers provide outreach, individualized assessment and service planning, linkage to necessary services, advocacy, and family support. Case managers are the primary link between consumers and their families and the larger service system, and act on behalf of consumers and their families to ensure that an appropriate, flexible, and responsive array of services is accessible and provided. Case managers also assist consumers and families to access other benefits and entitlements, such as SSI, SSA, Medicaid, housing subsidies, and health care.
7. **Respite care:** Respite care assures that families and other primary caregivers are able to carry out typical activities of family and business life as well as caring for a disabled family member. Respite may also be used to provide a temporary living arrangement for individuals in crisis, with the goal of preventing institutional placement or more intensive long-term interventions.
8. **Foster care/family life care:** Foster care or family life care provides continuous in-home support in a natural family setting.
9. **Psychosocial services:** Consumer-driven supports and services that provide outreach, socialization, vocational, educational, and peer support.
10. **Psychiatric day treatment:** Day treatment provides a short-term (usually less than 45 days) alternative to psychiatric hospitalization. Day treatment also begins the process of community reintegration for individuals after a psychiatric hospitalization.
11. **Psychiatric inpatient care:** Hospitalization for acute exacerbations of major mental illness, short-term whenever possible.
12. **Family support:** Peer and/or professional support for family members to provide accurate and up-to-date information about a disabled family member's condition, about appropriate methods of home intervention and support, and about approaches to working with the formal service system, including advocacy and self-case management training. Family support groups also assist family members with the process of providing care over extended periods of time.
13. **Medication management:** Psychiatrists or psychiatric nurses under psychiatric supervision assist mental health consumers to maintain appropriate medication regimens, and assure that necessary medical monitoring is carried out. This also includes medical and nursing support

for other individuals with disabilities needing support to manage medications.

14. **Outpatient treatment:** Individual, group, and/or family counseling provided by licensed mental health clinicians.
15. **Substance abuse treatment:** Inpatient and outpatient substance abuse treatment and support tailored to the needs and choices of individual consumers.