X. Integration and Transition Planning

The previous chapters of this report have provided considerable detail about consensus recommendations related to the specific objectives and topics covered by each Workgroup as defined by SF 525. Each chapter, standing alone, provides a road map for redesigning and reforming services for specific populations, and for addressing the structure, management and operations of desired systems of care for each priority population. Each chapter also points to issues and opportunities for cross-over and coordination among the recommendations. For example, each Workgroup has addressed people with dual or multiple conditions that will necessitate collaboration across services, providers and funding streams. However, by themselves the recommendations do not communicate a picture of a fully integrated and logically consistent system.

In Chapter VII, ***Regionalization***, a core concept of the recommendations is to establish a platform which can effectively manage coordination and collaboration among various systems of care and between these systems of care and other essential services such as housing and employment. This platform is specifically designed to provide a unified home base and single point of accountability for the integration of services around people's needs and choices. Uniform system management and accountability across systems is integral to attainment of the primary benefits of regional structures as outlined in Chapter VIII. [1]

An important feature of the integrated and unified systems contained in the consensus recommendations is that the system is driven by people in need of services. The system is not compartmentalized by age, by disability, by eligibility or by funding stream. Rather, it is organized to assure people a "no wrong door" experience regardless of where they present in the system. Facilitated access, consistency of service delivery and equity of service resource deployment are hallmarks of the recommended new system.

Uniform system management and integration of services does not mean that all consumers receive the same types of services, or that there's a one-size-fits-all model for service access, planning, delivery, and monitoring. Rather, the recommendations of the workgroups make it clear that there are needs for specialization and disability-specific expertise across all elements of the system. The importance of the unified single point of accountability is to facilitate movement between disability and funding stream silos for people with multiple needs. It is not intended to blur or mitigate the specific clinical expertise needed for each priority population.

1 The features and functions of the uniform and integrated platform for service management would be necessary to develop even if there were no local funds and no local governing boards. To our knowledge, no states operate systems of care without the benefit of regional/local intermediaries.

Integration across multiple systems

Adults and children in need of mental health, BI, or ID-DD systems interventions rarely just need one single service. Frequently, their conditions are multiple and complex, and their needs and choices change over time. In addition, consumers and their families age, their eligibility for various benefits changes and their living situations can evolve. For all these reasons, the redesigned system must have a clear and operational obligation to its consumers and constituents to assist them to manage transitions and cross system service planning. This is why all the recommendations include a focus on systems of care as well as on specific core services.

In addition to coordination and collaboration within the ID-DD, BI, mental health and children's systems of care, there are three other types of integration and coordination necessary. These are:

- ***Access to, joint service planning with, and service coordination among all the other delivery systems affecting a person's ability to have a life in the community***. These include education, employment, housing, transportation, law enforcement, adult and juvenile corrections, and substance use services. Each of these systems has its own eligibility rules, service modalities and resource limitations. Barriers to access to these various systems is known to be one of the major reasons people get into crises, need hospitalization, lose their program or home setting, or become institutionalized.
- ***Access to and coordination with physical health care***. People with ID-DD or MH disabilities are known to have poor access to primary healthcare, dental services, and specialty and long term healthcare services. All people with disabilities have a high potential to have chronic health conditions in addition their primary disability. In most states, children with multi-system involvement (Youth Services, Mental Health, Juvenile Justice), have no primary care physician and/or infrequent contact with physical health care. For all these reasons, a critical component of the recommended systems of care in this report is facilitated access to and coordination with physical and specialty health services. In several places the report includes recommendations to implement Health Homes. This is an allowable activity for Medicaid under the ACA, and could provide viable and flexible models for attaining good coordination between the disability services systems and the physical health systems. However, there are other current and promising models for achieving integration, and different approaches can work for different people.
- ***Integration between Medicaid and Non-Medicaid consumers and services***. There are many ways in which the Medicaid and non-Medicaid services systems need to collaborate and interact in Iowa. In some cases, people move back and forth between Medicaid eligibility and non-eligibility. In other cases people need both Medicaid funded and non-Medicaid funded services. Currently, the state behavioral health managed care contractor (Magellan) collaborates with the County-based CPCs to coordinate care for people who receive both Medicaid reimbursable services and non-Medicaid services. There are many other examples of coordination, including cross system activities related to Targeted Case Management and Home and Community Based Services Waivers. The existing degree of communication and collaboration between Medicaid and non-Medicaid people and services needs to be strengthened and expanded in the reformed system. In addition, as more individuals and families become

eligible for Medicaid after 2014, there will be a need to manage and facilitate the movement of people (service participants), services, and providers into the Medicaid funding stream.

Transition plan and phasing from current services to new recommended core services

As noted throughout the recommendations in this report, there will be a need to transition from the current system to the desired new system. This transition process must first and foremost be respectful of consumers and families, some of whom have been living or participating in their programs for long periods of time, and who are comfortable with their existing provider(s) of services. The transition must also be respectful of providers, many of whom have been doing what the system has asked of them for years, and who may have substantial capital investments in their program facilities. Finally, the transition must be cognizant of the available resources, both resources already in the system, and in any new resources that may become available. Clear choices will have to be made on the amount of transition progress that can be made in the context of available resources.

Transition planning and the implementation of system reforms are not linear processes. Rather, they are iterative, taking small steps and a prelude to being able to implement bigger changes later on. Early steps in the transition process are designed to: (a) provide learning and motivation to people in the system by producing quick and positive results; and (b) generate additional resources to support implementation of the next steps in the reform process. This is particularly true in an environment with constrained resources in which some system reforms must be put into place before larger scale reinvestments of existing resources can be accomplished.

Several of the recommendations emanating from the ID-DD, Mental Health, BI, and Children's Workgroups point to incremental resource development as a strategy for implementation of desired core services and other system reforms. They are also based on the realization that changes in one part of the system cannot be effectively be implemented unless other parts of the system are already in place. For example, the system will not be able to substantially reduce emergency department presentations and hospitalizations until crisis response services are in place. At the same time, currently there are insufficient resources available to invest in brand new crisis response systems throughout the state. Thus, the Workgroups recognized that sequential steps would have to be taken to begin implementation of crisis system components, so that resources can begin to be freed up to invest in later stages of implementation.

Across the Workgroups, there was an emerging sense of priorities with regard to early investments in system transformation and enhancements to core services. For example, expansion and enhancement of crisis services were mentioned by all Workgroups as being critical to the first stages of implementation. Jail Diversion programs were also identified as a priority, particularly in the Judicial Workgroup. Several Workgroups identified Positive Behavioral Supports or Neurobehavioral supports as critical both to sustain integrated community living and to prevent or reduce crises. For adults in the

ID-DD system and the mental health system, Supported Employment[2] was identified as a key component of reformed systems of services. For Children, the most important priority, which fits integrally with crisis services, is to expand comprehensive systems of care.

Throughout this transition, the system should strive to ensure a continuum of accessible, cost effective, high quality service modalities that help people achieve their fullest potential and live in the most integrated settings possible. This sense of priorities for transition could form the basis for new funding strategies for both the Medicaid and non-Medicaid programs that can further advance the redesign objectives. If there are to be any service expansion efforts in the next few years, in addition to current efforts to reinvest savings in the system, the funding could be directed towards these implementation priorities.

2 A SAMHSA-recognized evidence based practice.