State of New York
David A. Paterson
Governor

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Jane G. Lynch
Chief Operating Officer
NYS Commission on Quality of Care and Advocacy
for Persons with Disabilities
401 State Street
Schenectady, NY 12305

Dear Ms. ~~Lynch~~ Rine

Thank you for sharing the Commission's report regarding Mental Health Comprehensive Medicaid Case Management and for presenting the key findings to me and my staff. As described in your report, the Targeted Case Management (TCM) program has been the subject of much discussion following the Centers for Medicare and Medicaid Services (CMS) issuance of interim final regulations. Although those regulations are currently subject to a moratorium until April 1, 2009, their final promulgation would have significant impact on our current case management programs. OMH is evaluating the program as it is currently structured as we move forward in our outpatient redesign initiative and the Commission's report will assist us in that process.

Before addressing the individual recommendations in your report I would like to offer some general comments related to three important aspects of the OMH's case management program that are embedded in the report. These issues are described below.

The first issue is "flow". Flow is the movement of people within the mental health system that assures they are provided a level of support when they need it and for the duration that they require. Currently the system has a tendency to "clog" especially when resources are limited such as with case management. SPOA, although intended to monitor access to the case management system, does not optimize flow through the system. As part of the outpatient redesign analysis, OMH intends to create a system that does a better job in addressing flow.

The second issue is "training and supervision". It is important that the workforce be supported to provide best practices. Case managers must be able to practice a recovery-based model of service that promotes client-centeredness and the inclusion of natural supports. The training and re-training of the mental health workforce is central to many of OMH discussions in its outpatient redesign efforts.

The third issue is "employment". Persons with disabilities have a significantly higher incidence of unemployment than the general population. Persons with mental illness have the highest levels of unemployment out of all persons with disabilities, despite the

fact that greater than 75 percent of the individuals we serve state that one of their most desirable goals is to work. Case managers should be helping individuals to link to resources and services that can assist them in obtaining jobs.

It is commendable that, whenever possible, the report avoided assigning value to outcomes. While some outcomes, by their nature, could be viewed generally as negative (e.g., admission to inpatient care), there may not always be a negative impact on an individual level. For example, a specific admission to inpatient care may meet the individual's wellness plan and prevent an extended period of inpatient admission during which a permanent independent housing situation, job, or custody of a child may be lost.

Finally, I must point out that the report looked at a snapshot of the delivery system as it is currently designed. That design has case management services provided in a freestanding way, not associated with other funded or licensed programs. In the OMH outpatient redesign analysis, we are instead invested in creating a comprehensive, coordinated and accountable system of care that is recovery-based, can resolve crises, can provide mobile capacity and includes stronger links between case management and treatment services. Some of the recommendations included in the Commission's report might better be addressed through a redesign of the system, rather than providing additional guidance and monitoring to a system that may no longer represent the most appropriate approach.

Recommendations and OMH responses:

Recommendation #1 – That OMH Enhance the Quality of the Case Management Workforce by:

A. Improving orientation and ongoing training provided to case managers by requiring written policies and expanded training content; and
B. Improving case management supervision by requiring agencies to have clear supervision policies that are consistent with OMH guidelines.

OMH Response:

A. Training for case managers is a complex subject since case managers are not a homogeneous group. Supportive case managers (SCMs) have different minimum qualifications than intensive case managers (ICMs), profiles of cases for ICMs vs. SCMs, and the individual skill sets required are not the same. For example, not all case managers serve a population that includes persons who are involved with the criminal justice system. OMH facilitates training for staff by offering training directly, having included funds for training in the Medicaid rate that goes directly to the provider to pay for staff training, and via the New York State Case Management Coalition Annual Conference.
B. OMH is currently reviewing its guidelines and will clarify requirements for case management supervision in a new manual that is expected to be released in early 2009.

Recommendation #2 – That OMH Improve the Provision of Case Management Services By:

A. Developing a standardized assessment format to ensure assessments and reassessments are comprehensive;
B. Improving oversight to insure individual case management plans have goals that address all assessed areas of need, the individual's opinion on planned goals, and that plans and progress are reviewed and documented in a timely manner; and
C. Providing clear guidelines, similar to the New York City Single Point of Entry (SPOE), to all case management agencies about how to determine and document when a person should be transitioned from Intensive Case Management to Supportive Case Management, or discharged from case management services.

OMH Response:

A. Standardization of assessments and plans is an issue that OMH has confronted on several occasions. Many agencies have electronic records that are built on a variety of platforms that link to billing and quality assurance systems, and a centrally produced form would not integrate with their current (and often expensive) systems. Standardized forms are also only as good as the information that is added to them. The issue may not be the need for standardized forms but may be more closely related to recommendation #1, i.e., the need for better training and closer supervision within the individual case management programs. Also, OMH will clearly state all of the areas that an assessment should cover when the revised case management manual is issued. Employment will be emphasized.
B. OMH promotes a recovery-based mental health system. Within that system, an individual identifies his or her own goals. If an assessment identifies that a case manager can assist an individual to achieve his or her chosen goals by providing case management services then those services should be provided, reviewed and documented in a timely manner. OMH will review these requirements with those individuals who monitor case management programs to improve oversight in these areas.
C. Every county in the State has a SPOA process. OMH will provide guidance to counties, reminding them that it is expected that their process should include guidelines for reviewing the progress of individuals receiving case management services that includes evaluation of the transition of individuals to appropriate levels of case management services.

Recommendation #3 – That OMH Enhance the Promotion of Choice and Independence By:

A. Issuing guidelines to increase opportunities that promote the individual's participation in selecting a case manager and agency upon the onset of services, and at minimum, allow the individual and their selected family/significant other (i.e., the person's natural supports) to attend the SPOE meeting when their case is discussed:

B. Requiring all case management agencies to have policies for developing case management service plans and emergency crisis intervention plans that include the individual and their selected natural supports, and document their participation or the reason for not participating. Copies of all plans should be given to the individual; and
C. Issuing guidelines to ensure the review of each agency's service dollar use by OMH regional offices. OMH should also determine why providers do not use "lodging/respite" and "crisis specialists" categories and encourage the use of service dollars to help people attain their education and employment goals.

OMH Response:

A. OMH is currently reviewing its guidelines and will clarify existing guidance regarding participation in the SPOA process and in choosing a case manager in the new manual that is under development.
B. OMH is currently reviewing its guidelines and will clarify existing guidance related to developing crisis/emergency/wellness plans that include the individual and natural supports in the new manual that is under development.
C. Current spending plan guidelines related to the use of service dollars no longer include the categories as described in recommendation 3C. Service dollar use is reviewed during monitoring visits. Current spending plan guidelines state, "The use of the service dollars in the case management programs should include participation of the consumer, who should play a significant role in the planning for, and the utilization of, service dollars." OMH will reinforce this statement during monitoring visits and encourage case mangers to use service dollars in support of the individual's employment and educational goals.

Recommendation #4 – That OMH Formalize and Improve Coordination and Linkage By:

A. Requiring case management agencies to improve communication with family/natural support collaterals, non-mental health collaterals including but not limited to substance abuse and education collaterals, as well as the individual's decisions regarding the case manager's communication with these providers and their family/natural supports and document this; and
B. Establishing guidelines to formalize and increase communication between case management agencies, local hospitals rendering psychiatric care and SPOEs to improve care by requiring the case manager be notified of the individual's hospitalization and be advised and involved in discharge planning.

OMH Response:

A. OMH is currently reviewing its guidelines and will clarify existing guidance to encourage the communication with collaterals as identified by the individual, within legal parameters governing confidentiality and the sharing of protected healthcare information, in the new manual that is under development.
B. OMH is currently reviewing its guidelines and will clarify existing guidance related to establishing communication between professional collaterals, within legal parameters governing confidentiality and the sharing of protected healthcare information, in the new manual that is under development.

Recommendation #5 – That OMH Expand the Satisfaction Survey and Use It to Help Guide Services By:

A. Expanding its current requirement of interviewing at least two individuals per agency during a monitoring visit by requiring case management agencies to also conduct surveys of all individuals receiving case management services and its impact on their overall quality of life, and include the results and changes in practice in their annual report to OMH.

OMH Response:

A. The experience that individuals have regarding their participation in and receipt of services from case management programs is significant and of great importance to the OMH, and we will consider the use of a recipient satisfaction survey in the future. There may be ways, however, to capture this information other than by conducting satisfaction surveys. OMH will provide guidance to case management providers regarding the collection and reporting of satisfaction data and how the results may impact practice in the annual report submitted to OMH.

In conclusion, I appreciate the effort involved in the implementation of this study and the development of the associated report. We will take action to implement many of the recommendations contained therein, and as we continue in our efforts to redesign the community mental health system, we hope to transition to a system of care that embraces many aspects included in your report. If you have any questions regarding this response please contact Robert Myers at (518) 486-4327.

Sincerely,

Michael F. Hogan, Ph.D.
Commissioner

cc: Robert Myers, Ph.D.