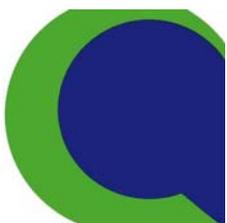


**Mental Health Comprehensive Medicaid Case Management:
A Review of Systems Coordination and Support for People
with Serious Mental Illness**

July 2008



New York State Commission on
Quality of Care and Advocacy
for Persons with Disabilities

Executive Summary

July 2008

Case management plays a central role in New York's mental health system, therefore, the Commission conducted a study of the experience of 50 adults receiving Mental Health Comprehensive Medicaid Case Management¹ services from 13 agencies in 4 counties in urban and rural New York State.

The study was designed to provide information regarding the quality of case management services by assessing sample individuals' access and linkage to other providers and services, and the assistance they received to improve their ability to live more independently and exercise choice. The Commission examined whether identified populations were being served by the sample agencies as specified by OMH. Finally, the Commission solicited the support and assistance of the New York Association of Psychiatric Rehabilitation Services and the Mental Health Empowerment Project to conduct a satisfaction survey of over 400 people around the state, to compare with the study group's satisfaction and opinions regarding the impact of case management services on their lives.

The Commission found that agencies were serving people OMH identified as eligible for case management services. Case managers met the educational and experience background required by regulations, and the average number of years that case managers were employed was approximately eight years; however, only 44 percent of the case managers interviewed reported that they received training in all areas identified as pertinent to their jobs. Only three sample agencies had written policies for both orientation and ongoing training for case managers, and of the 10 of 11² sample agencies who had written supervision policies, only 3 met or exceeded OMH guideline requirements on all the routine tasks for supervision.

Commission findings showed that while most people were able to make progress on their service plan goals, over one quarter of the people in the study did not make progress. Additionally, although 70 percent of the sample individuals' assessments and reassessments were comprehensive, 30 percent were not and were problematic in a number of areas. Case management plans were available for all 50 individuals; however 56 percent of the service plans did not address all assessed areas of need. Twenty-two percent of the service plans were not reviewed every six months. Over one quarter of the records were missing documentation on the individual's progress, and only 2 out of 10 people who were discharged from case management services during the study period left services because they accomplished their long-term goals.

The Commission found that most people in the study sample and those responding to the statewide satisfaction survey felt that their choice and independence were promoted by case management agencies. Ninety-two percent of both groups surveyed said their case manager respected their right to make decisions, and over 86 percent of both groups said they had enough information to make decisions about services, and that they determined what services they

¹ Mental Health Comprehensive Medicaid Case Management will hereafter be referred to as case management.

² The Commission visited 13 provider agencies that provided case management services, however two of the state case management programs operated under the administration of the not-for-profit case management service provider agency within the county for purposes of administrative policies and supervision.

wanted or needed with their case manager, although it is unclear how an individual's preference is included into the process of selecting a case management agency. The vast majority of both groups also said case managers helped them become more independent. Eighty-eight percent of the study group and 76 percent of the non-study group said their case manager assisted them in engaging in community activities. However, when asked about specific activities, both groups had significantly lower rates of satisfaction in meeting new people, finding interesting activities, getting involved with self-help and support groups, and joining community groups such as church or civic groups.

Finally, in some areas, coordination and linkage performed by case managers requires improvement. Case managers identified and communicated often with mental health, community (mostly landlords and probation officers) and social service providers; however, communication with health care providers and family happened less frequently. There also were no substance abuse providers identified in any of the records reviewed, although over 40 percent of the sample individuals had documented needs in this area. Findings also showed there were no education and only a single employer collateral identified, which proved inconsistent with the 11 people who had active education goals and the 21 people who had active employment goals. Findings also showed linkage and communication between case managers and hospitals was inconsistent over multiple hospitalizations experienced by people in the survey.

Recommendations

Commission 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.**

Commission 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 ensure 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.**

Commission 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 a minimum, allow the individual and their selected family/significant others (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 prevention 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.**

Commission 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.**

Commission 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 on their annual report to OMH.**

The Commission received a timely response from OMH on the recommendations in August 2008. OMH stated it is evaluating the Comprehensive Medicaid Case Management Program as it is currently structured as they move forward with their new outpatient redesign. Transition

into and out of CMCM services, employment of people with psychiatric disabilities, and the training and supervision of staff were emphasized in OMH's response. OMH has also agreed to address the recommendations by reviewing its guidelines and clarifying requirements in the new case management manual expected to be released in early 2009. Additionally, OMH will review requirements with individuals who monitor Comprehensive Medicaid Case Management programs to improve oversight.

Mental Health Comprehensive Medicaid Case Management: A Review of Systems Coordination & Support for People with Serious Mental Illness July 2008

Introduction

Case management is an integral component of the mental health service system in New York State. According to the New York State Office of Mental Health, case management should assist a person with serious mental illness to obtain needed medical, social, psychosocial, educational, financial, vocational and other services while helping the person make informed choices; access the most appropriate services to meet their needs; and achieve the maximum level of independence in the most appropriate and least restrictive setting.³ Case management is supposed to use strength-based and person-centered practices to achieve the individual's goals, and embraces the values of recovery and hope. In particular, Mental Health Comprehensive Medicaid Case Management is a voluntary "stand alone" service for people who need regular and ongoing case management services and is distinct from case management services offered in outpatient programs that meet an intermittent need for such services.

According to OMH, case management was first introduced to New York State as a Medicaid eligible program in 1985 under the Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272.) The Intensive Case Management program was established in 1989. As the years progressed, Medicaid case management was expanded in 1994 to include Supportive Case Management, and Blended and Flexible models of case management were added in 2001.⁴ All of these models, known collectively as Mental Health Comprehensive Medicaid Case Management (hereafter referred to as case management), vary in case load size, intensity of service and design.⁵

The central role of case management prompted the Commission to undertake this review of the quality and effectiveness of these services. Before beginning the study, the Commission met with stakeholder groups to better understand their perspectives on case management services, and later with OMH central office staff to clarify information and issues.

³ Mental Health Medicaid Case Management: Program Guidelines and Resource Materials, New York State Office of Mental Health, September 2001, Program Specifications section, p.1.

⁴ Ibid. Overview p.1

⁵ Traditional Intensive Case Management (ICM) uses an individual ICM with a case ratio of 1:12 a with minimum of four face-to-face contacts per month, and Traditional Supportive Case Management (SCM) uses a team approach with a case ratio of 1:20 or 1:30 with a minimum of two face-to-face contacts per month. The other three models use a blended approach: Flexible ICM uses an individual with a 1:12 case ratio with a minimum of two monthly but on average, four face-to-face contacts per month over the entire caseload; Blended and Flexible ICM uses a team approach with a 1:12 case ratio with a minimum of two face-to-face monthly contacts but maintain aggregate face-to-face; and Blended and Flexible ICM/SCM uses a team approach with the blended options of a) 1 ICM & 1 SCM, b) 1 ICM & 2 SCM, c) 2 ICM and 1 SCM, d) or any multiple of one of the above.

Sample Selection & Methodology

Medicaid billing codes for case management services were used to select a targeted sample of 50 individuals for whom case management services were billed for the time period of June 1, 2005 through May 31, 2006. For this time period, a total of 26,666 individuals received case management services statewide at a cost to Medicaid of \$98,306,083.

To review the quality of case management services in both urban and rural areas in New York State, the number of people served per county was used to select the two counties with the largest number of people served for the study time period; New York County, serving 9,398 people and Suffolk County, serving 2,447 people. Two rural counties, Jefferson, serving 173 people for the study time period, and Columbia County, serving 106 people for the same period, were selected for geographic diversity and because these counties had either the highest amount of Medicaid billings per person for the study period for a rural county (Columbia County at \$4,490 per person), or one of the highest for a rural county (Jefferson County at \$3,373 per person). To ensure that each county sampled would capture both ICM and SCM case management services, we also selected counties that had a state provider and at least one voluntary provider. In total, the Commission visited 13 sample agencies from four counties.⁶

A sample of 50 people who received case management services for the study period were then selected by computer generated names and comprised the Commission sample: 15 people in the 2 urban counties, and 10 people in the 2 rural counties.

The study had four major data collection components: (1) on-site interviews with administrators/case management supervisors, assigned case managers and people in the sample, including those terminated from case management services within the study period; (2) on-site reviews of individuals' mental health case management records; (3) interviews with Single Point of Entry (SPOE) representatives from Columbia, Greene, Jefferson, Suffolk and New York Counties; and (4) a survey of people outside the study who were currently receiving or had received case management services within the past two years, which was conducted in cooperation with the New York Association of Psychiatric Rehabilitation Services (NYAPRS) and the Mental Health Empowerment Project (MHEP).

The first site visit was conducted November-December 2006, and the remaining visits occurred from January – May 2007. Commission staff attended stakeholder regional meetings to explain the survey and solicit input between April-August 2007, and the collection of surveys continued through the end of October 2007.

⁶ One agency's main office was located in Columbia County but reviewers only learned once on site, that its case management service office was located in Greene County. Reviewers kept the sample and included Greene County in the SPOE interviews.

Study Objectives and Major Questions Answered By Study

The objectives of the study were four-fold:

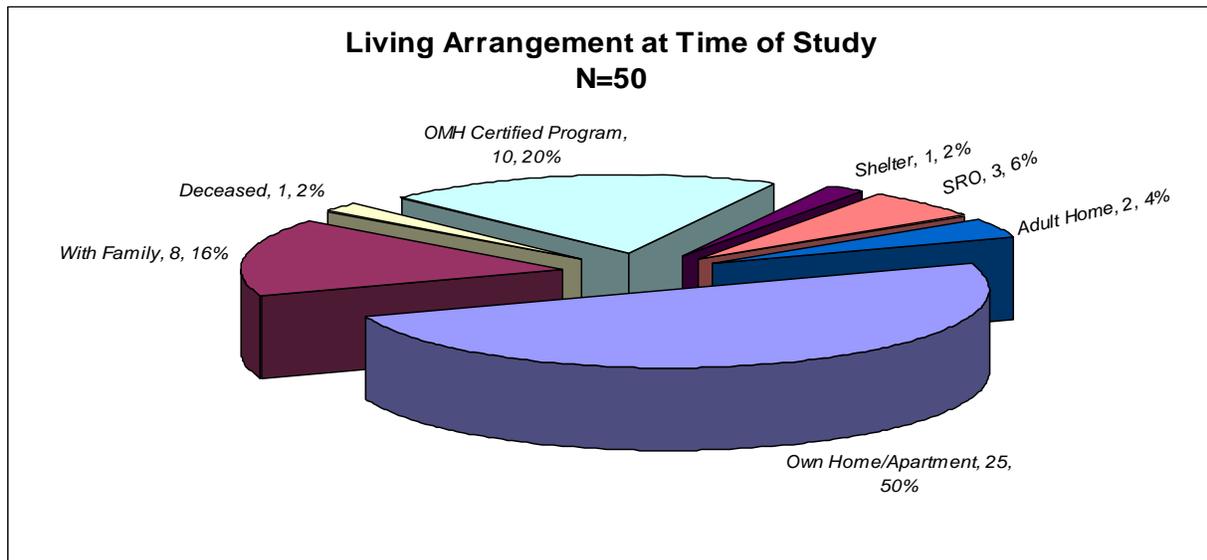
- I. Understand the quality of case management services rendered to a sample of people by assessing outcomes in their lives specific to:
 - ✓ assistance with and improved functioning to live more independently;
 - ✓ access and linkage to other providers and services;
 - ✓ involvement of collateral individuals in case management planning according to the wishes of the individual;
 - ✓ effective crisis intervention and discharge planning from hospitals; and
 - ✓ individuals' satisfaction and their opinions regarding the impact of services.
- II. Examine individual case management plans to determine if they were recovery-focused and person-centered by empowering the person to engage in decisions, to choose among available options, and to help the person develop and use support networks.
- III. Examine sample agencies written policies and procedures on case management functions, training and supervision.
- IV. Learn from case management administrators, case managers, stakeholders, and SPOE gatekeepers the challenges they are facing and their thoughts on how to improve the services for people referred to them.

These objectives lead the Commission to report its findings by answering the following four major questions.

1. Who are the men and women served by case management agencies?
2. Who is providing case management?
3. Is case management accomplishing its mission and goals?
4. Are people receiving case management services satisfied with these services?

1. Who Are the Men and Women Served by the Case Management Agencies?

The Commission's study sought to understand who sample agencies were serving and if these were the people OMH intended case management agencies to serve. The Commission's sample of 50 adults, which was almost evenly divided between men and women (27 or 54 percent versus 23 or 46 percent), ranged in age from 19 to 78, with 54 percent between 40 and 65 years old. As shown below, at the time of our review 50 percent of the sample people lived in their own homes or apartments, and 24 percent lived in certified settings (community residence, apartment program or adult home).



The length of time people in the sample received case management services ranged from 1 to 12 years. Of the 50 individuals, 30 (60 percent) fell into the range of 3-6 years: four had one year; nine had two years; ten had three years; eleven had four years; six had five years; three had six years; four had seven years; one had eight years; and two had 12 years of case management services.

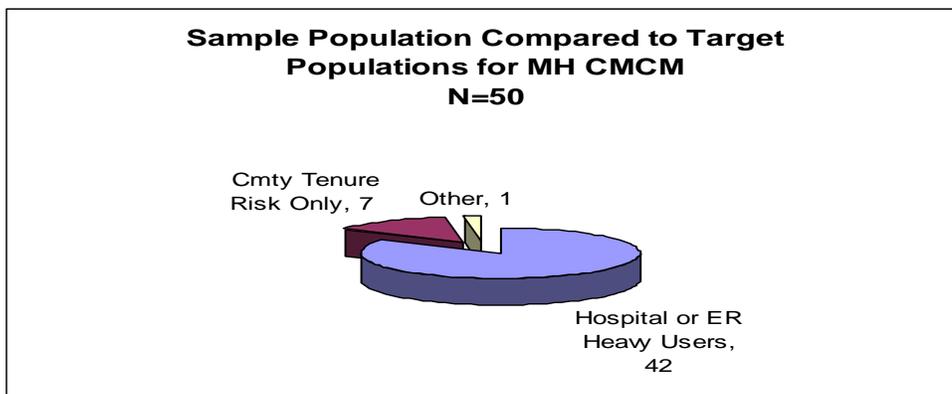
All 50 people in the sample were diagnosed with a serious mental illness; most were diagnosed with Schizophrenia or Schizoaffective Disorder (27 people or 54 percent), or with a Mood Disorder (Depression, Dysthemia, or Bipolar Disorder) (19 or 38 percent). Thirty-two people (64 percent) had active family, in-laws or friends. Fourteen people (28 percent) in our sample were parents of children less than 18 years of age but only 3 had their children living with them. Of these three individuals, one person additionally lived with their parent, and the other two lived independently in an apartment. Twenty-four people were assessed for employment needs but only 6 (12 percent) worked full or part-time.

The Commission looked to see if the 13 agencies were serving people identified by OMH to receive case management services by assessing the study sample using OMH guideline definitions of "representative subpopulations of the seriously mentally ill." Specifically, the

Commission first looked at Medicaid utilization data for a five-year period (September 1, 2001 through August 31, 2006) to see if the 50 sample people fell into the “*High Risk Heavy User*” category (i.e., those who cycle in and out of hospitals and emergency rooms). Next, the Commission used case management record information collected during our site visits to see if any of these 50 people also met the criteria for another applicable category of “*Mentally ill individuals at risk of losing community tenure.*”⁷ The Commission also included people who were determined to be at risk of losing their housing if they had a housing need or goal, and were currently living in or had a history of living in unstable housing situations.⁸

The result showed that people in the study were high risk/heavy users and/or at risk of losing community tenure. Forty-two sample people (84 percent) were hospitalized at least once with some having up to 14 hospitalizations and/or had multiple emergency room visits between September 1, 2001 and August 31, 2006.

More specifically, of the 42 people, 33 were hospitalized during the five-year period: 16 were hospitalized only one time, 13 people were hospitalized between 2 and 6 times, and 4 were hospitalized 10 or more times. This resulted in 98 total hospitalizations for these 33 people for the five-year period.

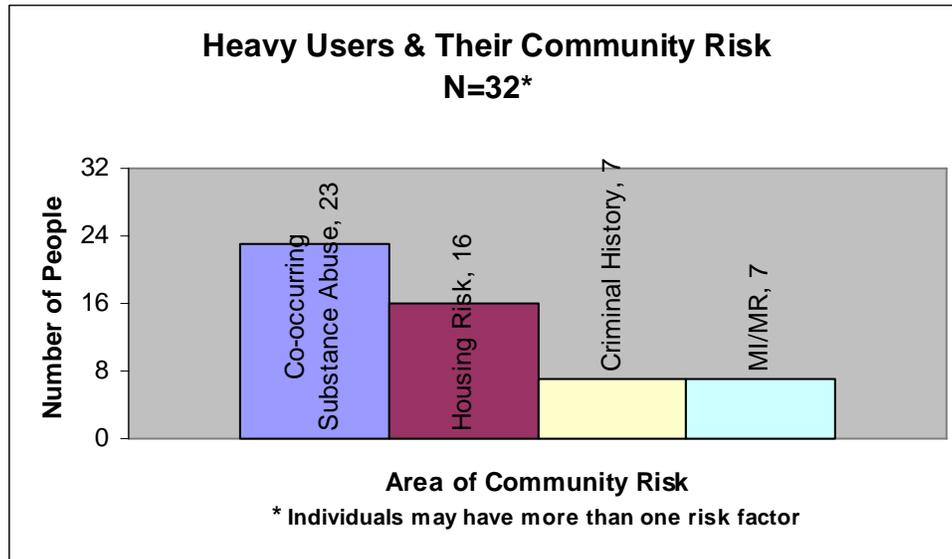


Equally important, 29 of the 42 people had multiple emergency room visits: 20 people went to the emergency room more than once but less than 10 times; 8 people went between 10-20 times; and one person went 35 times during the five-year period.

⁷ Risk of losing community tenure is defined as “mentally ill chemical abusers (MICA), involved with the criminal justice system, mentally ill/mentally retarded (MI/MR),” or people living with their aging parents. OMH guidelines also state that persons at risk of losing community tenure includes persons adjudicated under Mental Hygiene Law for assisted outpatient treatment (AOT); however the Commission’s study objectives purposely did not include AOT assigned individuals.

⁸ OMH guidelines also define “representative subpopulations” as persons who are homeless (living on the streets or in shelters) but the Commission also included people who were deemed as having a “housing risk” as those who may have been homeless during some part of the review period of the study but may have cycled in and out of certified housing programs, or those who moved back to a more restrictive setting, or those living with family but having a goal for finding alternate housing.

Of these 42 people who were hospitalized and/or in and out of the emergency room, 32 people⁹ were also at risk of losing community tenure during the study period either because of a co-occurring substance abuse problem (23 people), and/or because they had involvement with the criminal justice system (7 people), had a diagnosable cognitive disability in addition to a mental health diagnosis (7 people) and/or were at risk of losing community housing (16 people).



Of the remaining 8 people in the sample, 7 people were at risk of losing community tenure only. The eighth individual did not have any hospitalizations, or emergency room visits, or risk factors for losing community tenure - - a 78-year old person living in an adult home, taking part in a recent OMH initiative to provide independent mental health case management services in adult homes serving individuals with a diagnosable mental illness. Applying the criteria discussed above, it appeared that sample agencies were serving people who OMH intended case management agencies to serve.

⁹ Fifteen of the 32 people had 2-4 risk factors for losing community tenure.

2. Who is Providing Case Management Services?

“They had person-centered planning training and it’s kind of nice to have a say now.”

Case Management Survey response

The Commission reviewed the qualifications, training, and supervision of the case managers in each of the sample agencies in order to answer the second question of the study.

Case Manager Educational Background and Tenure

All 34¹⁰ case managers met the educational and experience background required in regulations. The ICMs reported that they held a Bachelor or Master’s degree in health-related or teaching fields, with work experience in the mental health field. The SCMs reported they had either a Bachelor’s or Master’s degree with a practicum in the mental health field or that they met the work experience required for a New York State case manager.¹¹

Most of the case managers in the study reported that they had been in their job for over two years.¹² The average number of years that case managers were employed was 7.8 years; the shortest tenure was less than three months, and the longest was 28 years for an SCM and 20 years for an ICM.

Training Received by Case Managers

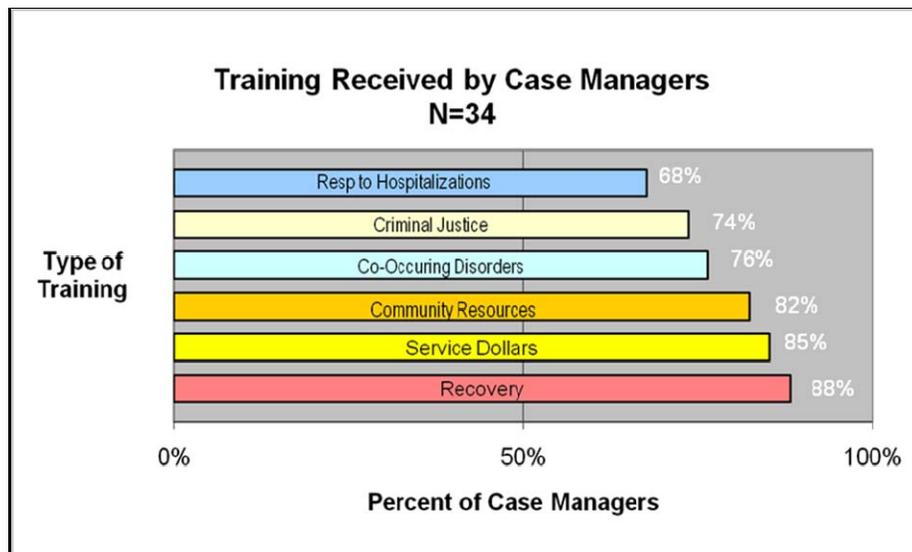
Training develops and refines needed skills and provides knowledge that relates directly to job requirements. There were no written guidelines for training of case managers except for a New York State Department of Labor requirement for safety training. Stakeholders stated their concern to the Commission regarding the quality of training and supervision of case managers and mentioned several training topics relevant to the work of case managers that were in question. Therefore, Commission reviewers asked case managers and administrators if case managers had received any training in the six areas listed in the chart on the next page.

The findings showed that over 80 percent of the case managers interviewed reported that they had received training on recovery-focused/person-centered service plans; use of wrap around service dollars; and accessing community resources. Additionally, over 70 percent of the case managers reported that they had received training on co-occurring treatment disorders; and involvement with the criminal justice services. Sixty-eight percent reported that they received training in responding to hospitalizations. Only one case manager, employed for only three months, reported receiving no training at all.

¹⁰ Two case managers left employment by the time of the Commission’s study and could not be interviewed. Additionally, eight case managers were providing services to more than one individual in the sample.

¹¹ See Title 18 NYCRR Section 505.16(e) *Qualifications of providers of case management services*.

¹² Seventeen out of 19 ICMs were employed over two years, and 11 out of 15 SCMs were employed over two years.



Although most case managers reported receiving training in some of the areas identified by the Commission, 44 percent¹³, of the 34 case managers interviewed reported that they received training in all six areas pertinent to their jobs.

All of the 11¹⁴ agency program administrators reported that they make ongoing training available to case management staff and encourage them to attend trainings. However, only three programs had written policies for both orientation and ongoing training.

All but two of the 11 agencies provided the Commission with lists of training offered during the previous year. Many programs provided trainings on psychiatric disorders, ethics, cultural competency, sexual abuse and reporting, domestic violence, pharmacology, health issues including first aid, hepatitis, TB, HIV, and HIPPA privacy and security, Medicaid billing and other administrative issues like Medicare Part D, person satisfaction surveys, incident reporting and safety training.¹⁵

Three programs in New York City use a twelve-week course provided by Hunter College in conjunction with OMH to provide training to new case managers. The topics covered in this course appear to address the six areas identified by the Commission.

In addition to the three agencies that reported using the twelve-week Hunter College Course for new staff, five other agency administrators reported developing a formal orientation of their own, and one program reported using materials from a case management training manual

¹³ 15 case managers (10 ICMs and 5 SCMs)

¹⁴ The Commission visited 13 provider agencies that provided case management services, however two of the state case management programs operated under the administration of the not-for-profit case management service provider agency within the county for purposes of administrative policies and supervision.

¹⁵ The case management safety guidelines state that the New York State Department of Labor has recommended that case managers should have annual training in dealing with potentially assaultive individuals, and that programs should provide documentation that each case manager received the training. Six of the 11 agencies showed evidence of providing safety training.

for adult mental health services developed by the University of Kansas. The remaining two programs reported using informal orientation programs, such as new case managers “shadowing” more experienced case managers, and new case managers talking to “key” staff.

Supervision

The Commission examined agency policies on supervision and oversight of case management services. There are no regulations concerning supervision but OMH guidelines do describe minimum qualifications for the position of coordinator/supervisor of case management services and list “routine review tasks” of SCM team members and the supervisor. The tasks are: case review team meetings, individual case manager supervision and record review by supervisor.¹⁶ The OMH guidelines do not specify what routine review tasks ICMs perform.

The Commission’s finding showed that 10 of the 11 sample agencies had written supervision policies but only three agencies met or exceeded OMH guideline requirements on all three routine tasks for supervision. One agency did not have a written supervision policy, and the remaining six agencies fell somewhere in between.¹⁷

Commission 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.

¹⁶ Mental Health Medicaid Case Management: Program Guidelines and Resource Materials, New York Office of Mental Health, September 2001, p.9.

¹⁷ See Appendix I for a summary of supervision policies for each agency.

3. Is Case Management Accomplishing Its Mission and Goals?

“My services here keep me alive, keep me out of jail. My services help me be a better man.”

Case Management Survey response

The mission and goals of case management are to assist people in gaining access to the most appropriate services according to their needs through coordination and linkage; to help them achieve their maximum level of independence; and to help people make informed choices. Social services regulation also defines case management as “a process which assists persons eligible for medical assistance to access necessary services in accordance with goals contained in a written case management plan.”¹⁸

In order to assess whether or not case management services are accomplishing these mission and goals, Commission staff spoke to people receiving and providing services, and reviewed case records and agency policies and procedures to determine if:

- People were making progress on service plan goals;
- Case managers were providing the assistance required in regulations;
- Choice and independence were promoted; and
- Linkages were made to needed services.

3.A. How Well People Progressed

The Commission examined case records and then asked case managers about the person’s progress on their goals where warranted, and also about circumstances in the person’s life affecting progress overall. Both the documented evidence in the case management record and the information from case managers were used to determine if case management services were helping people make progress on their goals.

Overall, most people were able to make progress on their service plan goals with the assistance of their case manager. Nevertheless, over one quarter of the people in the study did not make any progress. The following graphic shows exactly how the people in the sample fared with their prescribed case management services.



¹⁸ Title 18 NYCRR Part 505.16 (a) (1)

Specifically, over half (60 percent) or 30 out of 50 sample individuals made progress on the majority of their current case management goals.¹⁹ The example below illustrates this finding.

Mr. P, age 46, had a long history of serious mental illness, becoming acutely agitated and explosive, was depressed and suicidal, resulting in many inpatient hospitalizations in the past. After two years and eight months of ICM services, Mr. P had progressed on his goals. Most recently, there was a notable decrease in his depression, improved self-management of his symptoms, and he was becoming more sociable and trusting in others. His growth and increased self-confidence had allowed him to take part in social outings with others receiving services and his ICM, although his ability did not extend outside this network. At the time of the review, he also showed signs of awareness on how to better manage his money by requesting more frequent checks in smaller amounts to pay his bills, and could separate impulse buys from practical purchases at the grocery store to follow his meal plan. Mr. P lived in an independent apartment and attended a day program with success.

In the second category, 7 additional individuals (14 percent) were struggling with achieving progress on case management goals, demonstrating fluctuations in functioning, but clearly benefitting from case management services.

Ms. J, age 61, was referred for ICM services because of her history of multiple hospitalizations since 1972. After receiving ICM services for three years, Ms. J still struggled with her goals to stay out of the hospital and to improve her patience with others. She experienced a steady decline between September and October 2006, with mood swings beginning again and talking to herself. She had altercations with neighbors, missed medications, and finally, by October 2006, faced eviction from her independent apartment because her physical aggression toward the building maintenance men increased. The apartment manager agreed to not pursue a formal eviction until the ICM could make other living arrangements, but this never occurred as Ms. J was hospitalized twice in 2007.

After her last hospitalization, the ICM reported that Ms. J was doing the best she had ever done, due to Lithium treatment. Nevertheless, the situation remained tenuous at the time of the Commission's follow up visit. Ms. J was taking her medications, going to appointments, had apologized to her neighbors but was struggling to set limits with her drug dependent granddaughter. The landlord had not pursued eviction due to the ICM's intervention. When reviewers met with Ms. J in her apartment, she was pleasant, welcoming and said that her ICM "is excellent." Nevertheless, the ICM reported that Ms. J will continue to need ICM services to assure continued success.

Another 8 individuals (16 percent) did not have overall favorable outcomes in their lives as they showed no progress on the majority of their goals. Within this category, there were those people who could not make progress despite the aggressive support of their case manager working in conjunction with related service providers. The following example illustrates this point.

¹⁹ Two of these 30 people were successfully discharged from case management services.

Mr. S, age 46, received ICM services for approximately one year. Mr. S resided in a transitional housing residence and was on parole. His residence director, his parole officer and his ICM partnered to closely monitor his drug use and assaultive behaviors. He required verbal cues to complete his activities of daily living, missed his psychiatric appointments and prescribed medications if not monitored, and continued to use his personal needs allowance money and sold his clothes to buy street drugs.

Although Mr. S's ICM, residence director, psychiatrist and parole officer had weekly and sometimes daily contact, Mr. S tested positive for street drugs for approximately three months. His parole officer placed him in a 28-day drug rehabilitation program in June 2005, but he decompensated psychiatrically, was subsequently hospitalized in a general hospital psychiatric unit in October 2005 and then required re-hospitalization in a downstate psychiatric center in January 2006.

A second example below illustrates that there were also people in this category who did not make progress with their case management goals because, although they too, had a difficult time engaging with service providers, the case manager also failed to address assessed areas of need or did not pursue needed follow up.

Mr. H, age 34, had a history of homelessness, lacked a high school diploma, was unemployed, and relapsed to alcohol and drug use resulting in multiple psychiatric hospitalizations dating back to 2002 and going AWOL from the a residence in February 2005. He was referred to ICM services by the mental health center for support with finding housing and maintaining stable mental health.

It was not always apparent that the ICM made attempts to coordinate with other treatment providers to help Mr. H obtain his goals. For example, the ICM did not document contacts with the mental health center despite the apparent impact of Mr. H's substance abuse on his tendency to decompensate. The ICM also did not document regular communication with the shelter case manager. The ICM repeatedly restated Mr. H's goals in the case management progress notes and said that Mr. H was compliant but did not offer much other information on his progress. The only indication in the case management record was the Acuity Scale ratings got worse indicating "occasional minor impairments" to "frequent minor impairments."

Finally, in June 2006, the ICM met with the case manager for the shelter where Mr. H was living, and learned that Mr. H was repeatedly agitated, requesting his PNA money and saying he wanted to leave the shelter. Despite this agitation, the ICM did not contact the mental health center for possible intervention when after one year and 11 months of ICM services, Mr. H left the shelter without obtaining permanent housing, or engaging in mental health or substance abuse services. The ICM also did not contact the mental health center when Mr. H's ICM services were terminated in August 2006.

Finally, the remaining five sample individuals (10 percent) demonstrated no change, experiencing neither substantial gains nor failures on their prescribed goals. Some individuals in this category also had little or no changes in their case management plans throughout the review period or the case management plans remained silent on assessed areas of need.

Mr. G, age 30 had been receiving ICM services for one year and 11 months at the time of the Commission’s review. His case management plan indicated “no change” in his goals for this same time period, despite Mr. G occasionally complying with prescribed medications but not always keeping his psychiatric appointments, occasionally complying with paying his bills but sometimes falling behind in his rent and utility bills. His progress on other planned goals was not documented in the case management record. His progress on his goal to refrain from drug use and his goal to get a GED were not discussed. His assessed areas of need, in particular, eating and sleep problems, and argumentative and verbally aggressive behavior, did not have corresponding goals or an explanation. The ICM was only able to verbally explain that Mr. G lived in an independent apartment, received services from a psychiatrist and independent therapist, and spent most of his day babysitting one of his three children, none of whom lived with him, and that the babysitting was limiting what Mr. G was able to do.

Mr. G’s life was not moving significantly in one direction or the other, and the lack in change in goals prevented new approaches to better assist him with budgeting or perhaps looking for part-time work in the evenings or on weekends when he was not babysitting. He had other major areas of dysfunction that were totally left unaddressed, which could have overshadowed movement on his goals. Mr. G’s life continued as it always had, with little intervention by his ICM.

3.B. The Provision of Case Management Services

“My attributes and potential are encouraged, so that treatment is moving toward wellness.”

Case Management Survey response

The assistance provided under case management includes the following required functions:

- assessment and reassessment;
- case management planning;
- monitoring and follow up; and.
- exit planning.

In order to assess how well case managers performed these functions, the Commission reviewed each of the individual’s records and reviewed agency policies and procedures. A discussion of our findings in each area follows.

Assessment and Reassessment

Comprehensive assessments and reassessments are central to all other case management functions. OMH guidelines and governing regulations require the individual and case manager to begin the case management process with a written assessment of the person's strengths and needs in specified areas, barriers to care and existing gaps in services. A comprehensive assessment determines the need for medical, social, psychological, educational, financial, vocational or other services. Reassessments are required every six months or when there is a change in a person's situation.

Commission findings showed that:

- Eighty percent of the assessments and reassessments in the sample records cited the individual's strengths and needs; and
- Seventy percent of the assessments and reassessments were comprehensive and addressed all of the required areas and/or clearly described how the person functioned.

While the majority of records reviewed contained comprehensive assessments, 30 percent of those records were not comprehensive and were problematic in a number of areas. In one example, there was no initial assessment found in the record, and the reassessment did not list the person's strengths and needs, and therefore, lacked any meaningful discussion of areas of need. Most disturbing, the date on the reassessment was two months after the last documented contact with the person receiving case management services.

Further, a review of assessments across all sample agencies showed that there was not a standard format used for completing assessments. Rather, these agencies devised their own systems and forms for documenting assessments and reassessments or sometimes substituted Assisted Outpatient Treatment (AOT) forms. OMH guidelines and state regulation do not require a standard form for completing assessments unless the person receives AOT.²⁰ The lack of a standard form for assessment may have contributed to the lack of comprehensive assessments and reassessments in almost a third of the records reviewed and subsequently prevented these case managers from using assessments as a meaningful planning document.

Case Management Planning

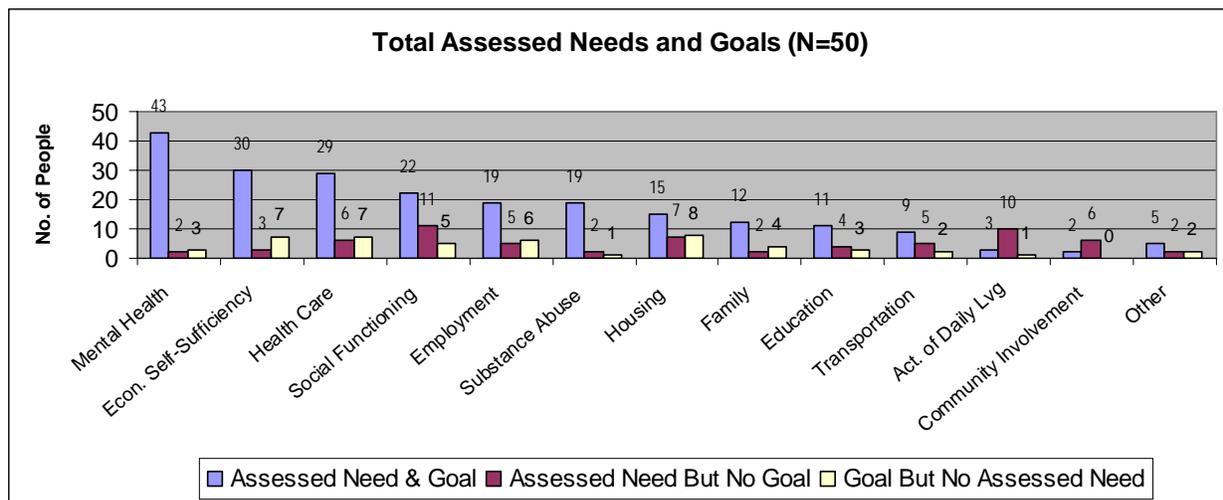
Information collected through the assessment is used to develop a specific plan of service that lists goals and actions to address the needs identified in the assessment. Although there was a written case management plan for all 50 individuals, 28 (56 percent) of the service plans did not address all assessed areas of need. Specifically, 17 plans did not address two to five identified areas of need, and the remaining 11 plans missed one area of need. The following example illustrates the problem.

²⁰ AOT forms included "AOT Baseline Assessment," "Quarterly Report," and the "OMH Follow Up Assessment Form 254."

Ms. C’s current case management plan, dated 9/21/06, did not address three out of five assessed areas: mental health, where a “severe need” was unexplained; health care, where a “moderate need” was not explained; and economic self-sufficiency where a “mild need” was left unexplained. Further, there was a blank 9/21/06 assessment referring the reader to “see the psychosocial for impairments” that could not be found in the record, nor could agency management produce this document upon the Commission’s request.

Compounding this problem, 11 (22 percent) of the service plans were not reviewed every six months as required by OMH or the review merely stated “no change from previous plan” without further explanation or rationale.

The chart below shows that there were some categories, most notably activities of daily living and community involvement, where an individual had an assessed need but no service plan goal to address the assessed need. This finding suggests that the case management plan was not updated, or that case managers were not addressing needs in these areas.



Additionally, over half of the individuals in the Commission’s study had assessed needs and service plan goals related to mental health, economic self-sufficiency, health care, and social functioning. Less than half had assessed needs and goals pertaining to employment, substance abuse, housing or education.

The OMH regional offices²¹ that monitor case management programs, cited some of the sample agencies for deficiencies in assessment and/or service plan documentation²². The most frequently cited area of deficiency was service plan documentation. Seven programs were found to have some deficiency in service plans. These deficiencies included failure to: address the

²¹ In Suffolk County, a community based organization that operates the SPOE also conducts site visits to case management programs.

²² Monitoring reports reviewed were conducted between June 2005 and June 2006, a period that encompasses all but one month of the Commission’s study period.

needs identified in assessments, prioritize goals and make them measureable and attainable, and complete reviews on schedule. Two of these seven agencies also had deficiencies cited for assessments not being comprehensive.

Monitoring and Follow Up

Monitoring and follow-up are necessary to ensure that the service plan is adequately addressing the person's needs. OMH guidelines and regulations²³ state monitoring and follow up of case management services includes "collecting data and documenting in the case record the progress of the recipient." Major findings showed that 37 (74 percent) case management records documented the individual's progress on all goals. Conversely, 13 (26 percent) case management records were missing documentation of progress on at least one goal for the individual.

Of the 13 records missing documentation, seven had between two to four goals without documentation on the individual's progress. Based on this extensive lack of documentation, it was difficult to get an accurate picture of how well these people did overall by reviewing their record. However, in nine of the cases where the record was silent on goal progress, the case manager was able to provide information to the Commission about the individual's progress during the case management interview. Thus, it appeared that case managers were monitoring progress but case records did not reflect their follow up on over one-quarter of the sample individuals.

Exit Planning

OMH guidelines and governing regulations dictate when discharge from case management services should occur. Reasons for discharge include reaching long-term goals, moving out of the social services district or moving to a higher level of care such as state psychiatric centers or a community residence. People enrolled in case management can also choose to terminate services on their own. There are no guidelines or regulations concerning if or how discharge criteria can be applied to people who are difficult to treat, dissatisfied, or refuse to cooperate with case management services.

Ten (20 percent) of the people in the study were discharged from case management services during the Commission's study period. Although our study findings showed that the majority of sample people made progress on their service plan goals, only two out of ten people left case management because they met their long-term goals. The following table shows the reasons for discharge.

²³ Title 18 NYCRR Section 506(c)(6)(iv)

Table 1: Number of People Discharged and Reason

Number of Persons	Reason for Discharge from CM
2	Achieved long term goal
2	Moved out of area
1	Transferred to another CM agency
2	Requested discharge
2	Moved to higher level of care and no longer eligible for CM services
1	Stopped participating, contact lost
10	Total

Additionally, during the Commission’s review period, only four individuals (8 percent) transferred from ICM level to an SCM level of service.

Policies

OMH guidelines state that case management programs shall have written policies and procedures that address how the determination is made to change, transfer or terminate services and ensure continuity of services if applicable. OMH guidelines also require that the person receiving services be involved in the decision to end services and their involvement must be documented.²⁴

Only one of the 11 agencies had written policies addressing all of the OMH requirements stated above; six agencies had written policies that covered at least one of the areas outlined in OMH guidelines; and the last four agencies had no written policies, with three relying solely on a form developed by their county SPOE that conformed to the OMH Guidelines.

There are no guidelines addressing discharge if someone cannot be found, refuses to cooperate, or has challenging behaviors. However, two of the 11 agencies had their own written policies about what to do if someone cannot be found or refused to cooperate, and two agencies had a policy permitting discharge due to behavior.

The form used by New York City agencies provides clear guidance about when to transfer a person from an ICM to SCM level of service and when to discharge a person because they have achieved all of their goals. In addition, the New York City case management discharge criteria developed by the SPOE and used by all case management agencies in the City requires case managers to try to engage people who are resisting services for at least one month if the person is not de-compensating. Case managers in New York City must also try to find people who are missing. If the person cannot be located, the case manager is required to file a missing person’s report.

²⁴ Mental Health Medicaid Case Management: Program Guidelines and Resource Materials, New York Office of Mental Health, September 2001, p. 8.

Commission 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 ensure 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 New York City SPOE, to all case management agencies about how to determine and document when a person should be transitioned from ICM to SCM, or discharged from case management services.**

3.C. Promoting Independence and Choice

“Another great thing about my ICM and the program in general is the genuine respect.”

Case Management Survey response

Case management services are voluntary and designed to assist individuals in making informed choices, access the most appropriate services according to their needs, and achieve maximum independence in the least restrictive environment. The Commission recognizes that the preference of the individual is paramount to the success of case management, and it is through that lens that the Commission examined how well sample agencies promoted the choice and independence of individuals.

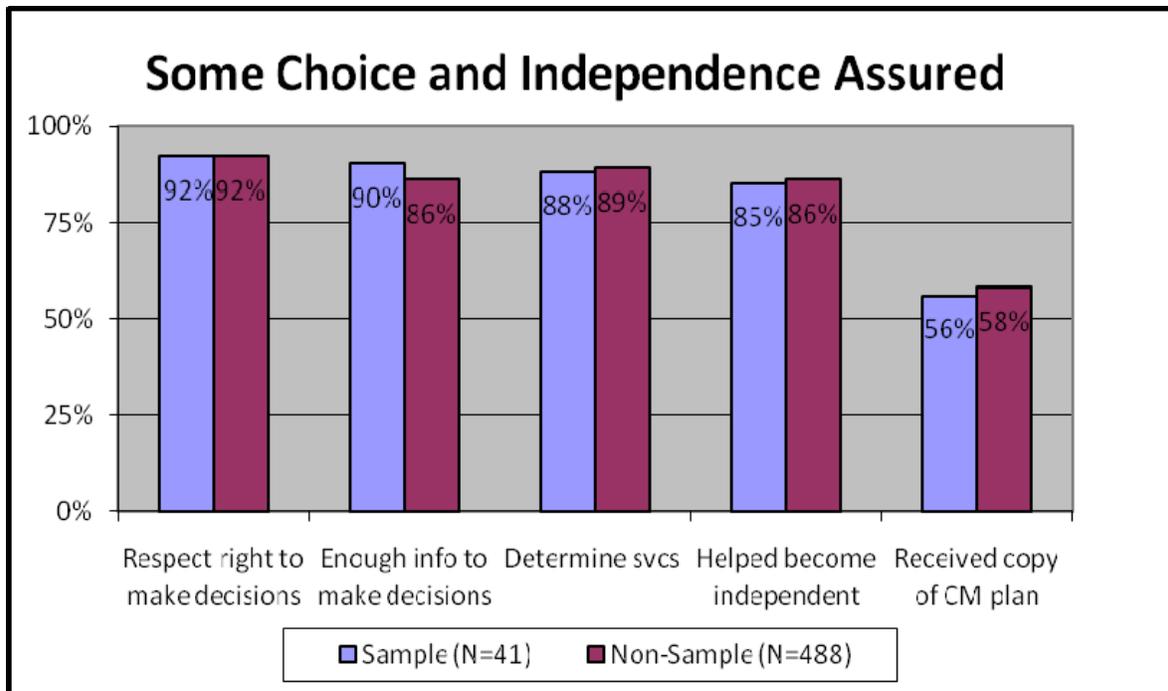
The Commission interviewed 41 of the 50²⁵ individuals in the sample, surveyed individuals outside the study who were receiving case management services at the time of the study or who had received case management services within the last two years. The Commission also reviewed case management records, use of service dollars, and each of the sample agencies’ written policies. Agency administrators, case managers and Single Point of Entry (SPOE) county coordinators were also interviewed to determine if they supported and promoted independence and choice.

Opinions of the Individuals Served

Overwhelmingly, people surveyed said that their case manager empowered them to engage in decisions, implying that they were an active participant in their services. In fact, survey results showed some of the highest positive response rates related to questions concerning

²⁵ Of the 50 individuals in the sample study only 41 agreed to be interviewed or complete survey questionnaires.

decision making and independence. A vast majority of both survey groups said the case manager respected their right to make decisions for themselves and helped them become more independent. The following bar graph shows the positive response rates to questions concerning independence and choice for both the study and non-study groups.²⁶



Record Documentation

Similar to what individuals reported in the survey, the documentation of the case management planning process showed that a majority of people in the study sample were empowered to engage in planning. For the majority, or 80 percent (40) of people in the study sample, there was documentation that they participated in case management service planning. Participation was documented in a variety of ways, such as in progress notes, a separate comment section by the individual, self-assessment and/or signatures by the individual on case management plans. For the remaining 20 percent (10), there was no documented evidence of participation in case management planning.

In addition, 56 percent of the study sample, and 58 percent of the non-study group said they received a copy of their case management plan. Although the Commission reviewers could not find any policy or regulatory requirement to give people a copy of their plan, the Commission reviewers believe that such a policy would be prudent to further individual involvement, self-determination and independence.

²⁶ The complete survey of people in the sample and the non-study group is discussed under the section entitled, “Are people receiving case management services satisfied?” found on page 28, and is presented in its entirety in Appendix II.

In regard to promoting independence, the case management record documentation confirmed that 80 percent (40) of the sample individuals were working with their case managers on issues of importance to them. For the 20 percent (10) of individuals remaining, documentation in the progress notes described the person's apparent avoidance of services. Avoidance of services was typically characterized as the individual not showing up for appointments etc. This documentation confirmed the Commission survey findings that over 85 percent of the study group and non-study group felt their case manager helped them become more independent. Equally important, 90 percent of the study group and 87 percent of the non-study group also said they have a better life because of their case manager.

When people in the sample were not working with their case manager, there was evidence in case management records that in nine out of the 10 cases, the case manager was actively attempting to reengage or keep the person engaged in their service.

Agency Policies

All 11 sample agencies reported that they provide information to the individual by explaining case management services upon intake, however, this was not documented in 82 percent (41) of the case management records as required.

All 11 agencies answered affirmatively that they have a dispute resolution process for allowing an individual to request a change in his/her case manager or some other case management provider if the individual has a complaint about either party. Nevertheless, no agency sampled described a process or had a written policy that promotes choice in selecting a case manager at the onset of case management services.

Single Point of Entry

Single Point of Entry (SPOE) systems are operated by local government or contract agencies to screen all referrals for case management and housing. SPOEs in the counties from which the study sample was drawn, did not operate in the same fashion. Four counties held at least monthly meetings with service providers to review individual applications for case management. One county used more of a triage-unit approach, establishing the individual's need for case management, and then directly referring the person to the case management agency chosen by the SPOE.

Sample SPOE counties in fact, operated fairly closely to OMH expectations that SPOEs will control access to case management services and ensure that individuals will be matched to an appropriate level of service based on need. OMH also states that SPOEs can use a triage process that prioritizes access to service. Nevertheless, OMH also sets the expectation that "...Provisions should also be made to incorporate and consider recipient preferences and choices as part of the operation of SPOE..."²⁷

²⁷ New Initiatives Guidelines and Resource Materials Manual for FY 2000-2001, New York State Office of Mental Health, Section 2.2. Establishing Single Points of Entry for Case Management & Residential Services, 1999. (http://www.omh.state.ny.us/omhweb/new_initiatives/main_2.html)

It is unclear how SPOEs incorporate preference or choice of the individual in the process to select a case management agency. No SPOE representative interviewed for the study described using a process that involved the individual applicant and/or someone from the person's natural support network in any meeting when their case was discussed.

Service Dollars

“Be realistic when allocating service dollars.”

Case Management Survey response

Since mental health case management is a community support service intended to help people enhance their growth and independence to live and work within the community, the Commission's study also examined the use of service dollars by case managers. Service dollars, claimed to be a “primary component of case management,”²⁸ should be used for needs that are reflected in a person's service plan or for unanticipated, emergency service needs. Service categories included in the OMH guidelines for case management programs are: housing and related costs,²⁹ food and meals, clothing and personal needs, medical care, leisure, transportation, educational/vocational needs, escort,³⁰ crisis specialists,³¹ and lodging/respite.³²

All 11 agency program administrators confirmed that service dollars were available.³³ All of the case managers interviewed who served the people in the study sample accurately described what service dollars could be used for, and 97 percent (33 of 34) of case managers had used service dollars for people on their caseload. The one case manager who had not used this money had been employed less than three months.

As the following chart illustrates, case managers reported that they used service dollars to primarily pay for housing (80 percent of case managers), food (70 percent), clothing (67 percent) and medical care (45 percent). Interviews with administrators/supervisors and case managers stated that housing, substance abuse and transportation topped the list of service needs most difficult to meet. Additionally, Appendix III contains letters from stakeholders that identify similar barriers and concerns to providing case management services.

²⁸ Mental Health Medicaid Case Management: Program Guidelines and Resource Materials, New York Office of Mental Health, September 2001, Section X. Fiscal Guidelines, no page number.

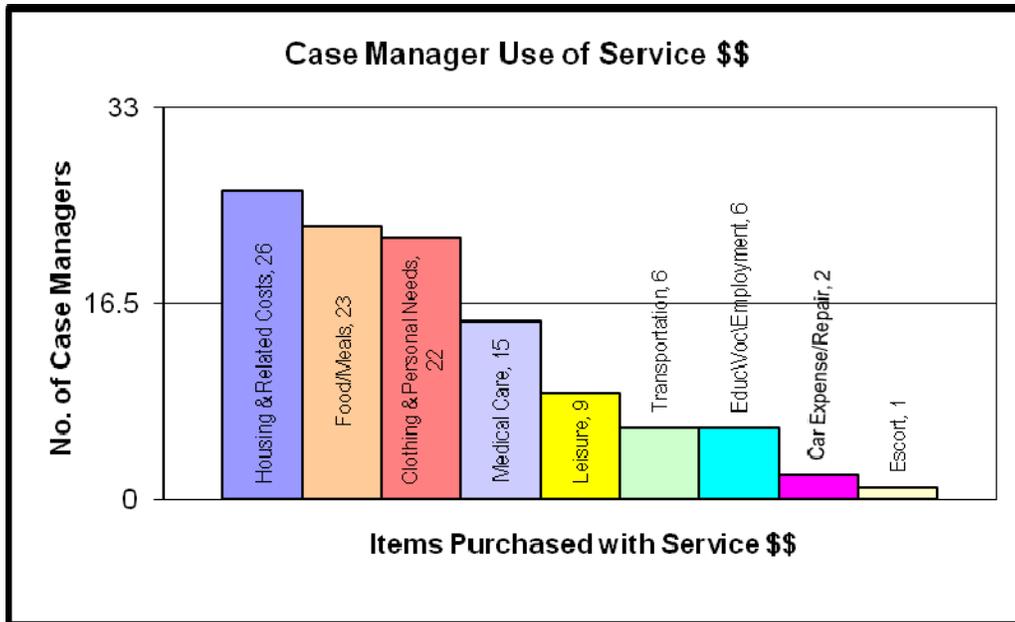
²⁹ For ease in reporting, the Commission staff grouped together housing (costs associated with securing appropriate housing such as security deposits, all or partial rent if a person is unable to pay due to illness etc.), and related housing costs (home furnishings including bedding, dishes), and the category of utilities.

³⁰ Escort services are costs associated with having assistance available to the person on a continuous basis and may be given in a person's home, emergency housing situation or day program etc..

³¹ Crisis specialists include per diem people to provide counseling care, companionship during a crisis period such as part time staff of community residences, respite providers or family care takers.

³² Lodging/respite is money used to purchase shelter.

³³ Although OMH guidelines allow ICM services to receive \$1,015 per individual and SCM services to receive \$6,090 per manager (or \$203 per person with 30 person caseload), 3 of the 11 sample agencies stated they use \$1,000 per individual, and two additional agencies reported \$1,200 per person, and the remaining 6 use some type of blended allocation.



Although OMH guidelines state that service dollars should never be interpreted as a client entitlement, three case managers interviewed upheld this statement but pointed out that many people on their caseload did not have enough money to pay for food or other necessities.

Coupled with the Commission finding that fewer than half of the sample individuals were assessed for educational or employment needs, only 18 percent, or six case managers, reported using service dollars for education or employment services, needs or programs.³⁴ Similarly, only 18 percent of case managers reported using service dollars for transportation costs associated with helping the individual use a bus, cab or other public transportation.

None of the case managers interviewed reported using service dollars for two categories included in the guidelines: crisis specialists and lodging/respice/hotel. It was not possible to determine, based on the data, why these services were not purchased with service dollars.

Natural Supports

Involvement of an individual's natural supports (family and friends, etc.) may also assist in promoting the person's choice and independence. While all case management programs had policies for emergency and crisis situations, only four had procedures for developing an individualized crisis prevention/management program that included natural supports. Most programs relied only upon existing crisis hotlines for use in emergencies. Although crisis hotlines are essential, identifying and including the person's natural supports where appropriate can bolster the person's choice and independence and create less of a reliance on institutional supports.

³⁴ Education service dollars can be spent on direct or related costs associated with education such as tuition books, supplies, and writer's workshops. Vocational/employment service dollars can be spent on any costs associated with securing or maintaining a job.

Commission Recommendation #3 – That OMH Enhance the Promotion of Independence and Choice 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 a minimum, allows the individual and their selected family/significant others (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 prevention 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 specialist categories and encourage the use of service dollars to help people attain their education and employment goals.**

3.D. Coordination and Linkage

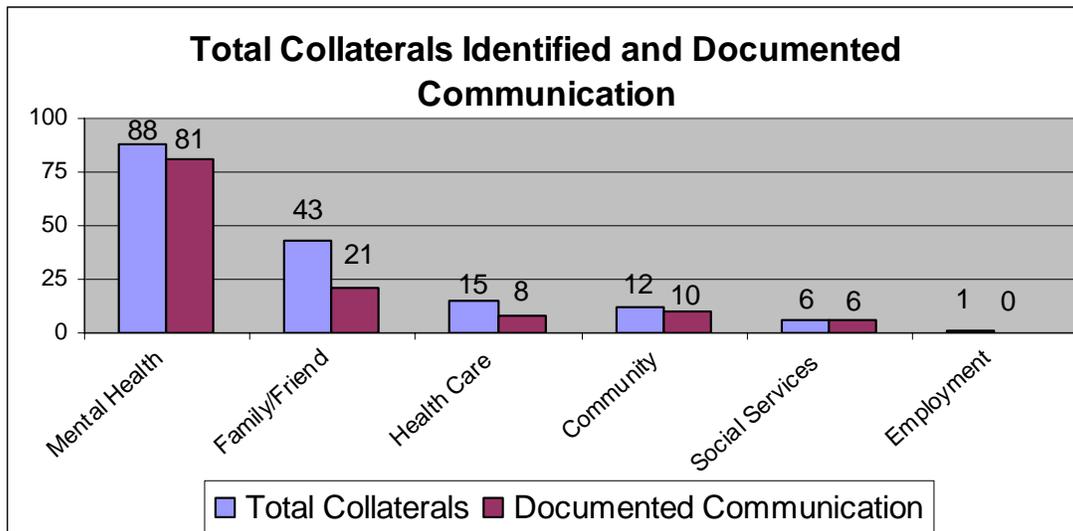
“Case management helped in a family custody issue, helped me get a community residence straight from prison and helped me to move to more independent living.”

Case Management Survey response

According to OMH guidelines, case management coordination requires collaboration with other service providers and informal care givers such as family and friends. The Commission reviewed case management records to see if “collaterals”³⁵ were identified, and if so, whether case managers communicated with collaterals including those associated with the individuals’ psychiatric hospitalizations. Case records confirmed that all 50 people had at least one collateral each, and 82 percent had more than two collaterals identified.

³⁵ Medicaid requirements for OMH Licensed Outpatient Programs define collaterals as members of a recipient’s family or household or significant others who regularly interact with the recipient, whereas an individual cannot be considered a “collateral person” based on his or her role as a staff member of the outpatient program, or any other mental health provider. However, the Commission purposely looked for case management linkages with these providers of service as well and considered them as “collaterals” in order to compare and contrast where most communication linkages were occurring.

As the following chart shows, there was documented evidence that case managers identified and communicated often with mental health, community (mostly landlords and probation officers) and social services providers, however, communication with health care providers and family happened less frequently. Since case managers did not document communications with these collaterals approximately half the time, it appeared that case managers made less of an effort to work with health care providers and families.



Commission reviewers also learned through interviews with case managers, collaterals, and people receiving services, that there were 8 instances when communication occurred but was not documented, 11 instances where a person in the study sample requested that a specific collateral not be contacted, and 10 instances where contact with a collateral was not warranted at that time (e.g., no mental health symptoms, improved health or family functioning). However, none of this information was documented in the case record.

There were no substance abuse collaterals identified in any of the records reviewed, although 21 individuals had a need and 16 people had an active goal in this area. Only 4 of the 16 sample people (25 percent) with a substance abuse goal said their case manager was helpful in finding substance abuse services, and only 14 percent of the non-study people reported helpfulness of the case manager in this area of need.

Findings also showed there were no education collaterals identified and only one employment collateral identified and documented in one case record, which reflected the lack of documented coordination with the 11 people who had active education goals and the 21 people who had active employment goals.

“I wish there were more jobs for people with disabilities so I could be more helpful to my mom by earning money.”

Case Management Survey response

Similar to other people with serious psychiatric disabilities on a national scale, the employment rate for people served by the Commission’s sample agencies was low. The Surgeon General reported in 1999 that of those people with serious mental illness, only 10 percent are employed.³⁶ Employment related data from the Case Management Adult Program Annual Reports dated 2005 and 2006 submitted to OMH from all the Commission sample agencies showed that of the people³⁷ receiving mental health case management services by these sample agencies, only 10 percent were competitively employed with or without supervision. The annual reports also showed that 1,869 adults or 70 percent receiving mental health case management services were not in school or working.

These findings of low employment and few educational opportunities also mirrored responses the Commission received from 41 of the 50 sample people completing the Commission’s Satisfaction Survey, and from the non-study group of 488 people who currently receive case management or received it within the past two years from the date of completing the survey. Only 24 percent of the study sample and 17 percent of the non-study sample said their case manager was helpful to them in getting a job, and only 19 percent of both groups said their respective case managers were helpful to them in enrolling in school or classes. Given the low rate of employment of people in the sample agencies and the fact that people reported not being helped as often in getting a job or enrolling in school, it appeared case managers also made less of an effort to work with people on employment and education linkages.

Psychiatric Hospitalizations Linkage

Linkage and access to services for an individual during admission and at discharge from a psychiatric hospitalization are vital to the individual’s successful return to community living. Decreasing hospitalizations and reliance on emergency rooms is also a goal for case management services. The Commission examined the case manager’s and hospital’s communications with each other and how well the case manager communicated with the individual while the person was hospitalized.

Thirty four percent of sample individuals (17) had a psychiatric hospitalization during the period of the study. Overall, individuals with the highest number of hospitalizations were also enrolled in the most intensive case management services.

³⁶ *Mental Health: A Report of the Surgeon General, 1999*, p.293.

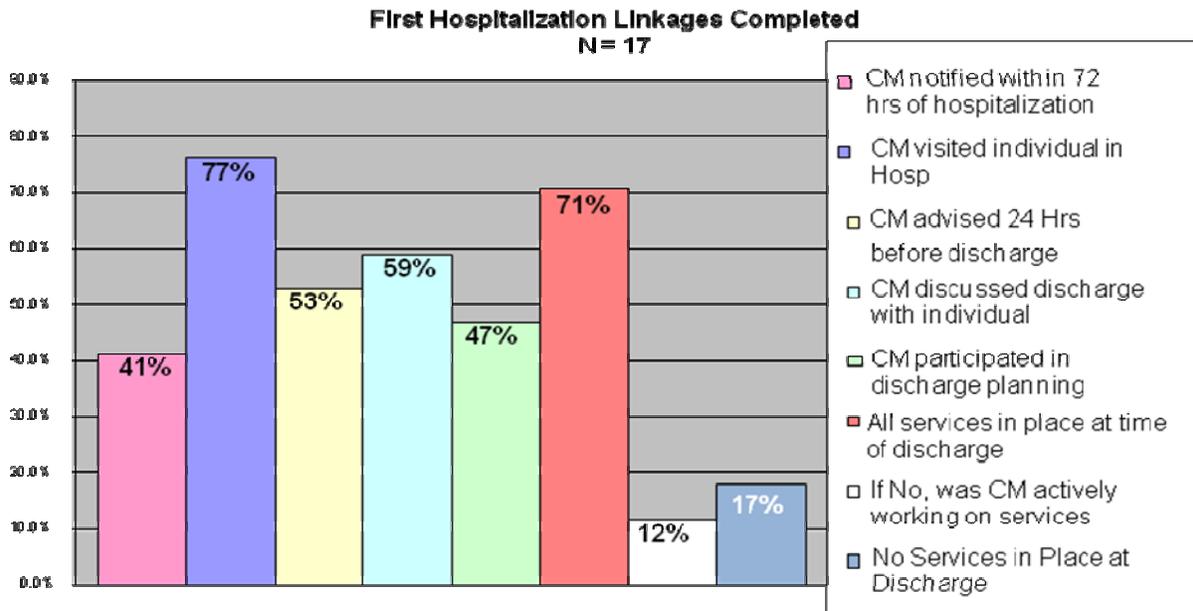
³⁷ 254 people from a total of 2,663 people

Table 7: Assigned CM Type & Number of Hospitalizations

CM Type	% of Hospitalizations	One Hospitalization	Two Hospitalizations	Three or more Hospitalizations
ICM	41% (7)	3	0	4
SCM	41% (7)	4	2	1
FICM	6% (1)	0	0	1
BCM	12% (2)	2	0	0
Total	100% (17)	9	2	6

Nine of the 17 individuals had only one hospitalization during the time period covered by the study. This represents 18% of individuals in the overall study (N=50), and 53% of those who had hospitalizations (N=17). Two of the 17 had two hospitalizations, and 6 had three or more hospitalizations.

Upon the sample individuals' first hospitalizations during the study period, linkages with hospitals have room for improvement in terms of (1) the case manager being notified within 72 hours of person's hospitalization (41%); (2) the case manager being advised of individual's discharge 24 hours before the event (53%); (3) the case manager participating in discharge planning (47%), and finally; (4) the case manager discussing discharge planning with the individual (59%). Additionally, no services were in place upon discharge 17 percent of the time.³⁸



³⁸ Title 14 NYCRR Section 506.10 states that individuals who have been admitted to Article 31 and psychiatric units of Article 28 hospitals who have an anticipated discharge within 90 days, may receive case management services if such services are required to facilitate transition to community services and enable the individual to gain access to needed medical, social, educational and other services in the community. Therefore, the Commission believes the six criteria listed in the chart are the minimum requirements needed to ensure the proper communication between the hospital and case manager so that preparing for discharge, gaining community access and linking with the required services occurs.

With subsequent hospitalizations, some aspects of care got better and some got worse. As sample individuals experienced more hospitalizations, notification by the hospital increased, case manager involvement in discharge planning increased, and the case manager actively working on services increased. However, as hospitalizations increased, visiting the individual by the case manager decreased and services in place upon the individual's discharge decreased. Prior hospitalization by the individual did not seem to result in better linkages after discharge. This could be due to difficulty in planning a person's return to the community after experiencing so many challenges or the lack of services in the community.

Since the Commission found that the linkage and communication between case managers and hospitals was somewhat haphazard and inconsistent over multiple hospitalizations, a standard communication mechanism and working agreements would appear to be areas of needed improvement.

“Only one case manager out of four that I have had was really helpful to me. The other three did nothing to help me in my journey to get a job, find housing, and work toward recovery.”

Case Management Survey response

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

- A. requiring case management agencies to improve the 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.**

4. Are People Receiving Case Management Services Satisfied?

“With my case manager’s help, I feel more connected and can hang on.”

Case Management Survey response

The voluntary nature of case management and its mission to promote the independence and choice of the individual provide a unique opportunity for partnership between those receiving services and those providing services. Essential to this partnership is not only asking about a person’s satisfaction with services but also their opinions on improvements to help guide services. The Commission conducted an in-depth satisfaction survey that looked at both aspects.

This survey was conducted face-to-face or by telephone for 41 of the 50 individuals in the study sample who agreed to participate in the interview. Nine individuals or 18 percent did not complete the survey. Some did not want to participate, some had moved and could not be contacted, and one individual was deceased at the time of the review. The number of people interviewed in this study contrasts with the OMH oversight requirement³⁹ that at least two people receiving services and one case manager must be interviewed during a monitoring visit.

Additionally, the Commission solicited opinions from people outside the study sample who were currently receiving case management services at the time of the study or had received them within the last two years from the date of completing the survey.⁴⁰ The Commission worked with the New York Association of Psychiatric Rehabilitation Services (NYAPRS) and the Mental Health Empowerment Project (MHEP) to obtain this valuable information. Commission staff was invited to attend their regional meetings and conferences across the State to distribute surveys, conduct interviews, and additionally mailed surveys to members of these organizations. The Commission received 488 surveys⁴¹ from individuals living in 35 counties across the state.

Demographic Information from People Responding

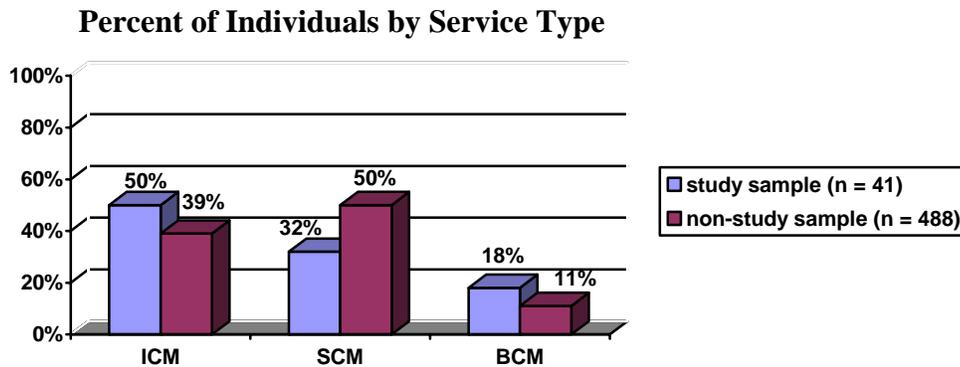
The following information reports the findings from the original study group (n=41) and the non-study group (n=488). In many instances, there were similarities between the two groups; however there were some interesting differences as well. Both groups had a fairly even split between male and female respondents (study group 54% male and 46% female vs. non-study group 50%-male, 49%-female and 1% unknown).

³⁹ The OMH “On-Site Case Management Monitoring Report” states the expectation that at least two recipients and one case manager will be interviewed during the monitoring visit or explain if not feasible. OMH regional offices reported to the Commission that they complete two to five interviews with people who receive services.

⁴⁰ Surveys were completed and submitted to the Commission from April through October 2007.

⁴¹ The Commission also received 100 additional surveys, but due to the extent of missing information, specifically identifying if the sample people receive (d) MH CMCM or case management as part of another certified program, these surveys could not be used.

Service types differed between the two groups. The graphic on the next page shows the percentage of participants in relation to their service type.



An important finding from the demographic information showed a majority of individuals in the non-study group reported that they have active family (72 percent) and close friends (76 percent) in their lives, but only 28 percent reported that family or someone else close to them was involved in developing their service plan. This finding is very similar to the study group where case record documentation showed 32 people (64 percent) had active family, in-laws or friends, yet 16 of these 32 people (50 percent) had little or no documentation indicating that family and friends were involved with case management service planning.

Overall Satisfaction with Case Management Services

Overall the vast majority of individuals in both the study group and the non-study group rated their case management services positively. The abbreviated table below reflects the nature of the responses. (See Table 10: Overall Satisfaction in Appendix II for a full listing of responses.)

**Table 10: Individual Satisfaction Survey
Overall Satisfaction**

	Study Group N=41	Non-Study Group N=488
Planned/discussed their case management services with their CM.	95%	87%
Overall, their case manager did a good job helping them obtain services.	92%	85%
Life is better because of their case manager's help	90%	87%
Met regularly with their case manager.	90%	87%
Case manager assisted them in engaging in community activities.	88%	76%
Determination of services needed or wanted are made with case manager.	88%	89%

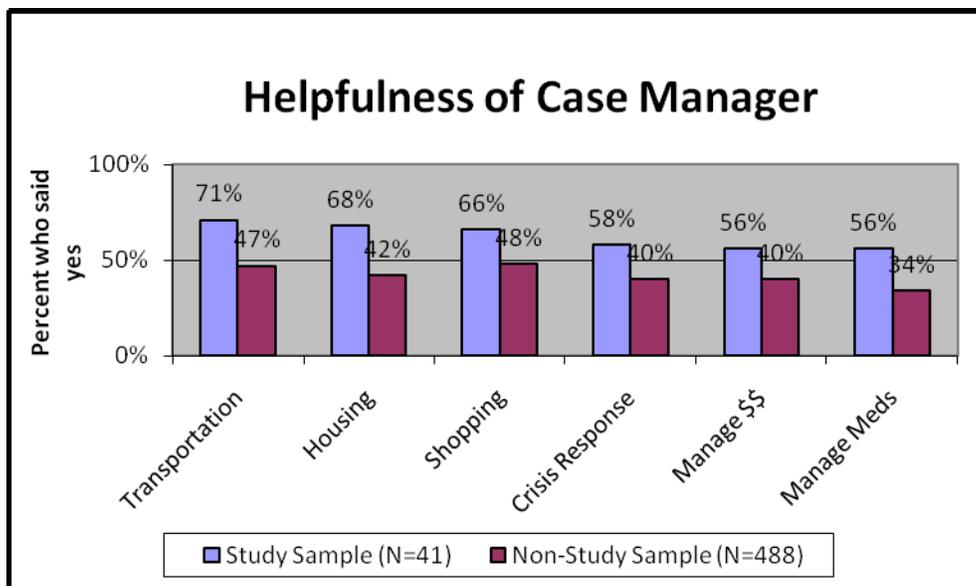
Helpfulness of Case Manager

Responses in this section seem to indicate that even though individuals are generally satisfied with their case manager, people are not finding case managers to be helpful in specific activities, especially those areas related to community involvement.

Individuals in the study sample group were asked in what areas their case managers were helpful to them. The top three areas reported were using transportation (71 percent), getting housing or better housing (68 percent), and shopping for food and/or clothing etc. (66 percent).

Individuals in the non-study group were asked the same question. Their answers differed slightly from the sample individuals. The top three areas that individuals felt their case managers were helpful to them were: finding appropriate mental health services (52 percent), using transportation (47 percent) and helping to shop for food and clothing etc. (48 percent).

Even though well over 80 percent of both groups said that their case manager did a good job helping them obtain services and that their life was better because of their case manager’s help, as the chart below shows, when asked about specific activities both groups had lower rates of satisfaction.



When asked if their case manager assisted them in engaging in community activities, 88 percent of the study group and 76 percent of the non-study group answered affirmatively; however, as the bullets below illustrate, when asked about specific areas of community involvement both groups had lower rates of satisfaction.

- meeting new people (46% study group vs. 33% non-study group),
- finding interesting activities (32% study group vs. 33% non-study group),
- getting involved in self-help and support groups (27% study groups vs. 29% non-study group), and
- joining community groups such as church, civic groups etc. (27% study group vs. 18% non-study group).

As noted earlier in the report, a similar pattern was found for employment where only about one quarter (24 percent) of the individuals in the study group, and 17 percent of the non-

study group responded that their case manager helped them get a job. (See Table 11: Helpfulness of Case Manager Appendix II for a full listing of responses.)

Services Not Available in the Community

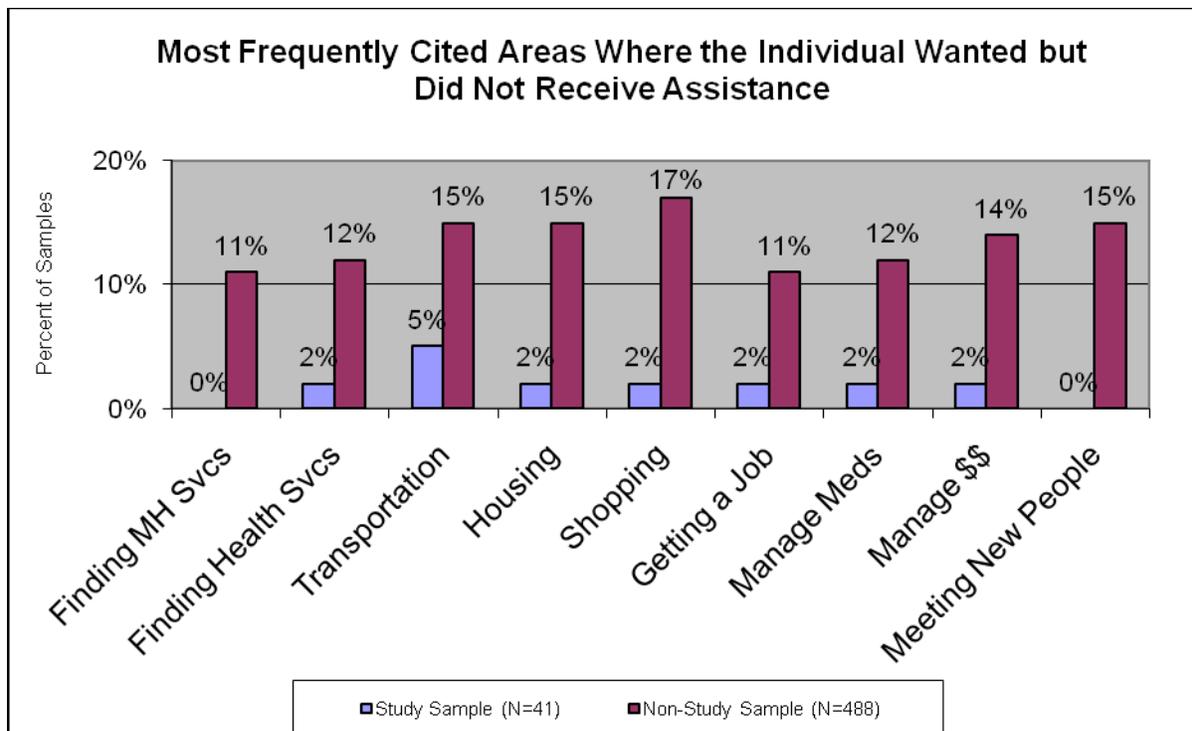
When asked if there were services that were not available in their community, there was a low rate of responses in any given area. Six individuals (15 percent) in the study group stated that they could not obtain housing or better housing despite the efforts made by their case manager, and 27 percent of the non-study group said they could not obtain housing or better housing. (See Table 12: Services Not Available in Appendix II for a full listing of responses.)

Received Services Not Needed or Wanted

A relatively small group of individuals stated that they believe they are receiving services from their case manager that they did not need: 12 percent in the study group and 15 percent of the non-study group.

Case Manager Did Not Assist in Obtaining Services

Some individuals responded that they needed or wanted certain services that their case manager did not assist them in obtaining as described in the chart below. (See Table 13: Case Manager Did Not Assist In Obtaining Services in Appendix II for a full listing of responses.)



General Comments

“If it weren’t for my ICM I would have dropped out of treatment completely.”

Case Management Survey response

“I accomplished more than I thought I could.”

Case Management Survey response

General comments regarding case management were written by 30 of the 41 (73 percent) study group. Nearly three-quarters (73 percent) of these individuals had very positive things to say about case management services when asked an open-ended question. A consistent theme was that people felt that their case managers were a big support to them, and viewed them as being friends or family when they do not have anyone else.

Of the 488 people in the non-study group, forty-five percent (217 people) wrote in general comments about case management. Similar to the study group, 69 percent (150 people) offered positive comments that also reflected the helpful, supportive nature of case management services in becoming independent and getting food, transportation, and volunteer work or a job.

Comments related to items needing improvement were written by 27 percent of the study group, and 31 percent of the non-study group. Similarly, both groups commented on the need for smaller caseloads, needing more help with transportation, and that they were unhappy with their case manager or case management services (i.e., case manager difficult to reach, not punctual, need more time to talk with case manager, encourages dependence, declines to assist with services, or lack of follow through).

Additionally, the people in the non-study group identified problems with case management services and improvements needed. These included improved training on: working with family members; cultural competency; self-directed goals and services; benefits and community resources; more service dollars and better access to this money; better and more timely help in getting housing; the lack of input into planning; and the job duties being too broad to oversee all aspects of life skills planning.

Commission Recommendation #5 - That OMH Expand the Satisfaction Survey and Us It to Help Guide Services By:

A. expanding its current requirement of interviewing at least two individuals per agency during a monitoring visit by also requiring case management agencies to 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 on their annual report to OMH.

“Many of us feel that we do not have any say over what services are offered, or over what changes should be made concerning those things in case management that apply to us.”

Case Management Survey response

Appendix I

Written Supervision Policies of Case Management Programs

Agency	Written Policies (Y/N)	Case Review Team Meeting (<i>OMH</i> Guideline: <i>M</i>)	Individual Case Manager Supervision (<i>OMH</i> Guideline: <i>B</i>)	Record Review by Supervisor (<i>OMH</i> Guideline: <i>S</i>)
<i>1</i>	Y	<i>W</i>	As Needed	Frequency Not Specified
<i>2</i>	Y	Frequency Not Specified	<i>B</i>	<i>M</i>
<i>3</i>	Y	<i>B</i>	<i>B</i>	Frequency Not Specified
<i>4</i>	Y	<i>M</i>	<i>W</i>	<i>S</i>
<i>5</i>	Y	<i>M</i>	<i>W</i>	Frequency Not Specified
<i>6</i>	Y	<i>M</i>	<i>B</i>	<i>S</i>
<i>7</i>	Y	<i>B</i>	As Needed	No Written Policy in this area
<i>8</i>	Y	<i>W</i>	No Written Policy in this area	<i>S</i>
<i>9</i>	Y	<i>W & B</i>	<i>B</i>	<i>W</i>
<i>10</i>	Y	<i>W</i>	<i>M</i>	<i>S</i>
<i>11</i>	N	No Written Policy	No Written Policy	No Written Policy

KEY: Semi-Annually *M*onthly, *B*i-weekly, *W*eekly

Appendix II

Table 10: Individual Satisfaction Survey

Overall Satisfaction	Study Group N=41	Non-Study Group N=488
Planned/discussed their case management services with their CM.	95%	87%
Felt that overall, their case manager did a good job helping them obtain services.	92%	85%
Stated that their case manager respects their right to make decisions for themselves.	92%	92%
Stated that they are able to contact their case manager when they need to.	90%	91%
Stated that they meet regularly with their case manager.	90%	87%
Stated they have enough information to make decisions about the services they receive.	90%	86%
Felt that their life is better because of their case manager's help.	90%	87%
Felt that they continue to need case management services.	88%	87%
Stated that their case manager explained their role.	88%	85%
Satisfied with the time it took for their case manager to return phone calls.	88%	85%
Stated that their case manager assisted them in engaging in community activities.	88%	76%
Stated that they determine what services they need or want with their case manager.	88%	89%
Thought their case manager helped them become more independent.	85%	86%

Table 11: Helpfulness of Case Manager

Helpfulness of Case Manager In:	Study Group N=41*	Non-study Group N=488
Using transportation.	29 (71%)	229 (47%)
Getting housing or better housing.	28 (68%)	203 (42%)
Shopping for food/clothing etc.	27 (66%)	230 (48%)
Responding in a crisis situation.	24 (58%)	190 (39%)
Managing money.	23 (56%)	192 (40%)
Managing medications.	23 (56%)	165 (34%)
Finding appropriate mental health services.	23 (56%)	247 (51%)
Finding health care services (MD, den., etc.)	22 (54%)	185 (38%)
Meeting new people.	19 (46%)	162 (34%)
Finding interesting activities.	13 (32%)	161 (33%)
Getting involved in self- help/sup groups.	11 (27%)	139 (29%)
Joining community groups (church, civic, etc.)	11 (27%)	89 (19%)
Getting a job.	10 (24%)	85 (17%)
Enrolling in school/classes.	8 (19%)	94 (19%)
Finding help for substance/alcohol abuse.	6 (15%)	66 (14%)
Finding volunteer work.	5 (12%)	64 (13%)
Finding help for domestic violence issues.	3 (7%)	30 (6%)
Finding child care.	2 (5%)	16 (3%)
Finding parenting classes/support.	2 (5%)	16 (3%)
Other	13 (32%)	58 (12%)

Table 12: Services Not Available

Services Not Available in the Community	Study Group N= 41	Non-Study Group N=488
Housing or better housing.	6 (15)	132 (27)
Vocational services/Job.	2 (05)	66 (14)
Mental Health Services	2 (05)	64 (13)
Health Care Services (MD, dentist.)	2 (05)	53 (11)
Child care	1 (02)	13 (03)
Education	1 (02)	48 (10)
Money management assistance	1 (02)	59 (12)
Transportation	1 (02)	84 (17)
Volunteer work	1 (02)	35 (07)
Domestic Violence services	1 (02)	12 (02)
Interesting activities	1 (02)	72 (15)
Community/church groups	1 (02)	29 (06)
Substance/alcohol abuse services	0	20 (04)
Self-help/support groups	0	44 (09)
Parenting classes	0	10 (02)
Medication management services	0	49 (10)
Crisis services	0	35 (07)
Other	2 (5)	29 (06)

Table 13: Case Manager Did Not Assist In Obtaining Services

Case Manager Did Not Assist In:	Study Group N=41	Non-Study Group N=488
Finding health care services (MD, dentist.)	2 (5)	56 (12)
Responding in a crisis situation.	2 (5)	30 (06)
Using transportation.	2 (5)	70 (15)
Shopping for food/clothing etc.	1 (2)	81 (17)
Getting housing or better housing.	1 (2)	74 (15)
Getting a job.	1 (2)	52 (11)
Finding parenting classes/support.	1 (2)	20 (04)
Finding volunteer work.	1 (2)	45 (09)
Managing money.	1 (2)	66 (14)
Managing medications.	1 (2)	58 (12)
Becoming involved in self-help/support groups.	1 (2)	43 (09)
Finding interesting activities.	1 (2)	57 (12)
Finding appropriate MH services.	0	52 (11)
Finding help for substance/alcohol abuse.	0	33 (07)
Enrolling in school/classes.	0	49 (10)
Finding help for domestic violence issues.	0	22 (05)
Finding child care.	0	16 (03)
Meeting new people.	0	72 (15)
Joining community groups (church, civic)	0	43 (09)
Other	4 (10)	28 (06)

Appendix III

Suggested Improvements to Case Management Received by CQCAPD⁴²

Suggestion	<i>Case Management Administrators</i>	<i>Case Managers</i>	<i>SPOE Coordinators</i>	<i>NYS Conference of Local MH Directors</i>	<i>Suffolk Coalition of MH Providers</i>
Smaller/more flexible caseloads	X	X		X	X
Improve Medicaid (disallowances, eligibility)	X	X			
Better/more housing options	X	X		X	
Provide reimbursement for collateral visits for adults	X				
Improve services for people with co-occurring mental health and substance abuse disorders	X			X	
Increase telemedicine	X				
Address HIPPA information sharing problems	X				
Integrate outpatient and case management services	X				
Improve transportation	X	X		X	
Add individual & referral source to SPOE meetings			X		
Develop Electronic Applications for SPOE			X		
Provide add'l non-Medicaid funding				X	
Improve training				X	X
Case mgmt specialists in employment and education				X	
Increase use of peer specialists					X
Improve salaries for case managers					X

⁴² Source is interviews conducted with sample agencies and SPOEs. In addition, the Commission received letters from the NYS Conference of Local Mental Hygiene Directors and the Suffolk Coalition of Mental Health Directors.