Association for Community Living

JOINT SENATE/ASSEMBLY LEGISLATIVE HEARING ON THE 2013/2014 BUDGET February 27, 2013

Thank you, Assemblyman Farrell and Senator DeFrancisco for this opportunity to submit testimony. We would also like to acknowledge the participation and interest of the Senate and Assembly committee members present and welcome Senate Mental Health and Developmental Disabilities Committee Chair, Senator David Carlucci, and Assembly Mental Health Chair, Aileen Gunther. We look forward to working with you both this session and we hope for years to come.

The Association for Community Living represents over 110 not-for-profit community mental health agencies that provide mental health housing and other community-based rehabilitative services. Our member agencies operate over 25,000 housing units that are funded and regulated by the New York State Office of Mental Health. Virtually all of the people living in these housing units rely on Medicaid for mental health and other health related services.

We thank Governor Cuomo, the Division of Budget, Acting Commissioner Woodlock, and the OMH team for this budget proposal, which keeps level the funding for community-based services while looking to develop housing opportunities that have been proven to be cost effective in controlling overall Medicaid costs.

Supported Housing Development: We support the 2013-14 executive budget proposal for a multi-year commitment to build 8,400 new OMH supported housing units. This includes

funding for 2,234 units that will be operationalized by the end of 2014. These new units are targeted towards people in nursing homes, adult homes and individuals who are homeless.

The MRT has recognized that safe, stable, and affordable housing is paramount in reining in costs for the high users of Medicaid. Supported Housing is the most cost effective and community integrated form of housing New York State offers for people with a severe psychiatric disability.

DOH Supportive Housing Initiative: We also strongly support the $91 million of MRT savings that is in the DOH budget for Supportive Housing. This money will not only be used to create supportive housing slots throughout the state for high users of Medicaid, but fund new Housing demonstration projects that are designed to bring down the Medicaid costs for those served. Rigorous outcomes measures will be used so that we can identify cost savers that deserve to be replicated and brought to scale across the state. These pilots will guide the state toward the development of programs that save Medicaid expenditures in the future.

Funding levels: While new development is crucial in any plan to contain Medicaid costs, the level of funding must be sufficient to cover the costs of the program. Both OMH Supported Housing and OMH Licensed Housing are extraordinarily inexpensive programs when compared to the other alternatives.

The yearly rates for Supported Housing range from $7,675 to $14,493 per year depending on what region of the state the bed is located. Funding for these programs has not been increased for 5 years. If fact, over that 5 year period these programs absorbed a 1.1% cut. In down-state communities, where HUD Fair Market Rents range from $12,168 to over $14,000 per year, the current Supported Housing rate of $14,425 is often inadequate to just cover rent, let alone the 24 hour on-call, help with budgeting, landlord/tenant issues and other services that providers are obligated to provide.

Over the past 22 years, Fair Market Rents in the down-state area have increased approximately 63%. Conversely the OMH Supported Housing program has had increases of only 40%, leaving the down-state programs with a 23% shortfall in today's dollars compared to 1991. Increases for upstate regions have been even fewer. Upstate rates are now over 40% behind where they were

in 1991. The service dollars have all but disappeared as a result. As an example of the problem – one ACL member in NYC operates over 500 Supported Housing beds. This agency has had to decrease services by $250,000 per year to cover rental increases that have averaged 3% annually. Over the past 5 years this has resulted in a $1.25 million decrease in services for this agency alone. It is estimated that the service dollars in this program will be exhausted within 2-3 years.

Moreover, emerging expectations of the program has added to the general fiscal pressures. The Supported Housing program was originally designed to serve people with a severe mental illness that needed a minimal amount of supports to remain in the community; therefore, only minimal services were funded. However, during the past five years, the majority of development of OMH Supported Housing has been targeted towards emerging populations, in other words, people identified as high users of Medicaid services, those coming out of long-term stays at Psychiatric Centers, prisons and jails, those actively using drugs and alcohol, and the chronically homeless. This year's development is targeted towards only people coming out of nursing homes and adult homes, along with individuals that are homeless. These populations require more frequent and intensive services for behavioral as well as medical problems. However, as the populations being served become more challenging, the funding for OMH-Supported Housing continues to erode year after year. We have included as an attachment a chart that shows the county by county Supported Housing shortfall for all areas of the state.

Licensed Residential Programs are experiencing similar fiscal and programmatic pressures. Licensed Programs include Treatment Apartments, Community Residences (CR), and Community Residence-Single Room Occupancy (CR-SRO) programs. None of these programs have seen increases for the past five years. The CR-SRO program was actually left out of increases the other licensed housing programs received in past years. All of these programs serve individuals with mental illness in the community who have the highest level of need. Most clients have multiple medical conditions, co-occurring substance abuse issues, need assistance in managing medications and money, and are not able to remain in the community without the intensive rehabilitative services they receive in these licensed programs. However, the staffing model in these programs was developed in 1984 and does not provide the funding or staff to consumer ratios necessary to serve all of the complex needs of those in the programs today.

We are requesting a 10% one-time correction to the funding of both OMH Licensed and Supported Housing. Without an immediate fix to these valuable and necessary housing programs, the ability to meet the service needs of people with severe mental illness living in the community will continue to be compromised. Although the state has promised that Health Home Care Coordination will fill the gap left by underfunding these programs, we know from early reports that this is not, and will not be, the case. ACL has written a report that shows savings related to turn-keying State Operated Community Residences to experienced non-profits would yield enough savings to pay for this. See report at http://www.aclnys.org/Libraries/ACL_Archives/SOCR_REPORT_FINAL.sflb.ashx

Community Reinvestment: The original Community Reinvestment program was crucial in ensuring access to quality community services for people with psychiatric disabilities when State Hospital wards and facilities were closed. However, little of what was promised ever made it into the community. We now have an inpatient census in our state operated psychiatric hospitals of approximately 2,800 but still have 17 state facilities. There is little room to continue closing only beds without facility closures as well. We ask that community reinvestment be strengthened to ensure that 50% of any savings generated by not only closing beds, but the consolidation and closing of facilities and the sale of properties be reinvested in community mental health. It currently costs over $377,000 to operate a bed in a state psychiatric center. As more beds are being closed, precious resources are being lost forever when the promise of community reinvestment is not kept

Exempt Income: Article VII language seeks to extend the state's authority to recoup a portion of income earned by providers that is over the state's approved budget for each program. These approved budgets were approved two decades ago with few adjustments to the rates along the way. Providers need every dollar that they earn and should be allowed to keep what they legitimately bill. All of these dollars would be re-invested into the programs for long needed repairs and upgrades, and/or with some creative financing, some of this money could be invested in new housing.

Social Work Exemption: The Executive Budget proposal includes legislation to make permanent the current long time temporary exemption for certain social work and mental health

professional licensure requirements of persons employed by a program or service operated, regulated funded, licensed, or approved by OMH and other State agencies. ACL supports this action. The potential fiscal impact to NYS and providers if this exemption is not made permanent could be as high as $265 million. We ask the legislature to support the permanent exemption in the Governor's budget proposal. We have attached a memo ACL sent to the State Education Department that further explains our positions as they specifically relate to our members. Among other things, the memo explains the problems for our members related to the scope of social work as defined in the statute as well as serious concerns related to the waiver.

Managed Care: The State is moving rapidly into Managed Care for behavioral health, however, effective treatments that lead to recovery depend on person-centered approaches to care, which are often difficult in a highly proscribed Medicaid environment. Also, although most people with a severe mental illness rely on Medicaid, there remain a large number of people dealing with a severe mental illness that do not qualify for Medicaid. Therefore, as we move forward into a managed care environment we must ensure that more flexible safety net mental health services remain available, not only for those without Medicaid, but for people with Medicaid that rely on these safety-net services. This can only be possible through the sustained availability of community based services and supports that Medicaid does not traditionally cover, and that are funded through local assistance dollars. We strongly urge that programs funded through local assistance remain out of Managed Care. We further recommend that any savings associated with Managed Care for the mental health system be reinvested in community based services and supports.

As the state moves all Medicaid programs into Managed Care we urge the legislature to help us keep the Medicaid component in residential programs out of the initial phase of Managed Care until we can determine the impact this dramatic shift has on community based services. It is unclear what will be in the managed care contracts, to what extent these services and the rates will be protected, if at all, and if people's housing stability will be impacted. Without stable and appropriate housing, other services for people with severe mental illnesses will be seriously compromised, and sometimes made meaningless, as they resort to emergency rooms and hospitals for services. We need to ensure that these rehabilitation programs that have a housing component remain stable and available for those living in the community working toward

recovery. The best way to accomplish this is to ensure that housing and housing services are initially carved out of managed care until the state has a better understanding of how it will all work.

Prescriber Prevails: Prescriber Prevails language around atypical antipsychotics was added in last year's budget. However the Governor's budget proposal would remove it this year. We understand that this measure could potentially save the state approximately $19 million. The decision about medication should be between the prescriber and the individual and not the insurer. It can take years to find the appropriate type(s) of medication and dosage for an individual with a mental illness to start on the road to recovery. Included in the Governor's proposal is a plan to issue a "Gold Card" that would allow the prescribing physician to over-ride the limited formularies of the managed care prescription benefit. This Gold Card would be issued only to physicians that meet specific benchmarks in prescribing practice. We encourage the legislature to restore prescriber prevails until a time that there are details in place that assure the "Gold Card" system is not being so onerous, that physicians are tempted to only write prescriptions for medications on the limited formularies of the managed care prescription plans.

SUMMARY OF ACL's BUDGET PRIORITIES

1. **Housing Development**: Support the proposed new development in housing for people with mental illness and other high users of Medicaid. This includes the $90.8 million for supportive housing in the DOH budget and the development of 2,234 supported housing beds in the OMH budget.

2. **Funding Increase**: Provide an immediate 10% one-time correction to funding for all OMH residential treatment and housing programs.

3. **Community Reinvestment** : Strengthen the existing Community Reinvestment language in 41.55.to ensure that 50% of any saving from closing beds or closing and consolidating state operated facilities are reinvested into community mental health.

4. **Exempt Income**: Do not approve Article VII language to extend the state's authority to recoup income earned by providers that is technically more than a very outdated state approved budget allows.

5. **Social Work Permanent Exemption:** Support the Social Work permanent exemption

6. **Managed Care**: Keep the Medicaid component in residential programs out of managed care or delay it.

7. **Prescriber Prevails** : Restore Prescriber Prevails until a time that the "Gold Card" system ensures medication decisions remain between the consumer and a qualified Psychiatrist or treating physician.

OMH Funded Supported Housing - STUDIO APARTMENT
The Following Chart Computes an Adequate, Cost Based Funding Rate for each county

This chart was first compiled in 2002. Each year it is updated with new HUD FMR and SSI, as well as OMH increases to the actual rate.

A. **RENT**: Based on HUD Fiscal-Year 2013 Fair Year Market Rents for a **Studio apartment**

B. **RENT PAID BY RESIDENTS**: Residents pay 30% of income, typically the SSI living alone rate of $785/month, which is $236 per month or $2,832 per year.

C. **TOTAL PROPERTY COST TO AGENCY**: Column A minus column B.

D. **CONTINGENCY FUNDING**: Based on current OMH minimum of $500 per recipient annually made available to resolve housing situations that put the resident at risk of losing his/her housing including non-collectable rent payments due to various reasons, minor maintenance not the responsibility of the landlord, furniture storage, and any other housing related emergency problems that, if not addressed, could cause loss of housing. This number has not changed since 1991.

E. **OTHER THAN PERSONAL SERVICES (OTPS)**: Based upon a realistic estimate that includes travel, insurance, office supplies, telephone, etc. Three estimates have been made for OTPS; $1,000 is used for urban/metropolitan counties, $1,200 is used for urban/suburban counties, and $1,500 is used for rural counties. The different rates reflect the amount and cost for travel that is required (Public transportation is less expensive and more accessible in urban areas; greater travel distances are required in the more rural counties.) This number has not been changed since 2002.

F. **CASE MANAGER**: The salary in this formula for a supported housing case manager for a caseload of 15 (standard set in NYS-SH guidelines) is $25,000. An additional 15% was added to the base salaries in New York City, Long Island, Westchester county and Rockland county. The rate includes 30% for fringe benefits.

G. **SUPERVISOR**: The salary in this formula for a supported housing supervisor for a caseload of 75 consumers/ 5 case managers is set at $38,000. An additional 15% was added to the base salaries in New York City, Long Island, Westchester County, and Rockland County. The rate includes 30% for fringe benefits.

H. **ADMINISTRATION and OVERHEAD (A&OH)**; at 15% on columns D through G (property is excluded.)

I. **ADEQUATE SUPPORTED HOUSING RATE**: Total of cost columns C-H.

J. **CURRENT SUPPORTED HOUSING RATE**: This is the rate SOMH pays by region for each supported housing unit in each county as of January, 2012. This rate received a 1.1% **Reduction** in 2011.

K. **SHORTFALL**: This number is the difference between column I and column J: per bed.

L. **NUMBER OF SH BEDS:** The actual number of beds in each county. This number is from the September 2012, OMH Residential Program Indicators Report.

M. **TOTAL COUNTY SHORTFALL**: The shortfall per bed (Column K) multiplied by the number of beds in the county (Column L) equals the actual shortfall in dollars specific to each county.

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	HUD FAIR MARKET RENT	RENT PAID BY RESIDENTS	TOTAL PROPERTY COST TO AGENCY	CONTINGENCY FUNDING	O.T.P.S.	CASE MANAGER	SUPERVISOR	A&OH at 15%	ADEQUATE SUPPORTED HOUSING RATE	CURRENT SUPPORTED HOUSING RATE	SHORTFALL	NUMBER OF S.H. BEDS	TOTAL COUNTY SHORTFALL
	A	- B	= C	+ D	+ E	+ F	+ G	+ H	= I	- J	= K	x L	= M
ALBANY	7784	2832	4952	500	1,200	2190	659	1425	10,926	9285	1,641	240	393,876
ALLEGANY	6240	2832	3408	500	1,500	2167	659	1235	9,469	8426	1,043	32	33,379
BRONX	14,292	2832	11460	500	1,000	2492	757	2431	18,640	14493	4,147	3477	14,420,336
BROOME	6336	2832	3504	500	1,200	2167	659	1205	9,235	7675	1,560	149	232,366
CATTARAUGUS	6024	2832	3192	500	1,500	2167	659	1203	9,221	8426	795	99	78,675
CAYUGA	6408	2832	3576	500	1,500	2167	659	1260	9,662	7675	1,987	59	117,251
CHAUTAUQUA	6132	2832	3300	500	1,200	2167	659	1174	9,000	8426	574	70	40,173
CHEMUNG	5604	2832	2772	500	1,200	2167	659	1095	8,393	8426	-33	96	-3,197
CHENANGO	6372	2832	3540	500	1,500	2167	659	1255	9,621	7675	1,946	53	103,133
CLINTON	6168	2832	3336	500	1,500	2167	659	1224	9,386	7675	1,711	49	83,854
COLUMBIA	7860	2832	5028	500	1,500	2167	659	1478	11,332	9285	2,047	39	79,837
CORTLAND	6900	2832	4068	500	1,500	2167	659	1334	10,228	7675	2,553	51	130,208
DELAWARE	6432	2832	3600	500	1,500	2167	659	1264	9,690	7675	2,015	27	54,402
DUTCHESS	10236	2832	7404	500	1,200	2167	659	1790	13,720	12883	837	217	181,521
ERIE	6684	2832	3852	500	1,200	2167	659	1257	9,635	8426	1,209	914	1,104,752
ESSEX	6276	2832	3444	500	1,500	2167	659	1241	9,511	7675	1,836	28	51,394
FRANKLIN	6312	2832	3480	500	1,500	2167	659	1246	9,552	7675	1,877	38	71,322
FULTON	6420	2832	3588	500	1,500	2167	659	1262	9,676	7675	2,001	26	52,029
GENESEE	5628	2832	2796	500	1,200	2167	659	1098	8,420	8426	-6	42	-239
GREENE	7080	2832	4248	500	1,500	2167	659	1361	10,435	9285	1,150	28	32,203
HAMILTON	6420	2832	3588	500	1,500	2167	659	1262	9,676	7675	2,001	4	8,004
HERKIMER	6756	2832	3924	500	1,200	2167	659	1268	9,718	7675	2,043	28	57,190
JEFFERSON	8400	2832	5568	500	1,500	2167	659	1559	11,953	7675	4,278	50	213,905
KINGS	14292	2832	11460	500	1,000	2492	757	2431	18,640	14493	4,147	3,144	13,039,268
LEWIS	5904	2832	3072	500	1,500	2167	659	1185	9,083	7675	1,408	44	61,939
LIVINGSTON	6945	2832	4113	500	1,200	2167	659	1296	9,935	8426	1,509	38	57,336
MADISON	6588	2832	3756	500	1,500	2167	659	1287	9,869	7675	2,194	26	57,052
MONROE	6948	2832	4116	500	1,200	2167	659	1296	9,938	8426	1,512	380	574,674
MONTGOMERY	6912	2832	4080	500	1,200	2167	659	1291	9,897	7675	2,222	33	73,323
NASSAU	12168	2832	9336	500	1,200	2492	757	2143	16,428	14493	1,935	886	1,714,189
NEW YORK	14292	2832	11460	500	1,000	2492	757	2431	18,640	14493	4,147	3161	13,109,773
NIAGARA	6684	2832	3852	500	1,200	2167	659	1257	9,635	8426	1,209	119	143,835
ONEIDA	6756	2832	3924	500	1,200	2167	659	1268	9,718	7675	2,043	222	453,435
ONONDAGA	6588	2832	3756	500	1,200	2167	659	1242	9,524	7675	1,849	276	510,407
ONTARIO	6948	2832	4116	500	1,200	2167	659	1296	9,938	8426	1,512	68	102,836
ORANGE	10236	2832	7404	500	1,200	2167	659	1790	13,720	12883	837	228	190,722
ORLEANS	6948	2832	4116	500	1,200	2167	659	1296	9,938	8426	1,512	25	37,808
OSWEGO	6588	2832	3756	500	1,500	2167	659	1287	9,869	7675	2,194	51	111,909
OTSEGO	7284	2832	4452	500	1,500	2167	659	1392	10,670	7675	2,995	38	113,799
PUTNAM	14292	2832	11460	500	1,200	2167	659	2398	18,384	12883	5,501	57	313,551
QUEENS	14292	2832	11460	500	1,000	2492	757	2431	18,640	14493	4,147	1585	6,573,550
RENSSELAER	7884	2832	5052	500	1,200	2167	659	1437	11,015	9285	1,730	106	183,348
RICHMOND	14292	2832	11460	500	1,000	2492	757	2431	18,640	14493	4,147	442	1,833,129
ROCKLAND	14292	2832	11460	500	1,200	2492	757	2461	18,870	12883	5,987	143	856,191
SARATOGA	7884	2832	5052	500	1,200	2167	659	1437	11,015	9285	1,730	46	79,566
SCHENECTADY	7884	2832	5052	500	1,200	2167	659	1437	11,015	9285	1,730	130	224,861
SCHOHARIE	7884	2832	5052	500	1,200	2167	659	1437	11,015	9285	1,730	23	39,783
SCHUYLER	5784	2832	2952	500	1,500	2167	659	1167	8,945	8426	519	2	1,037
SENECA	5904	2832	3072	500	1,500	2167	659	1185	9,083	8426	657	33	21,671
ST.LAWRENCE	5820	2832	2988	500	1,500	2167	659	1172	8,986	7675	1,311	73	95,710
STEUBEN	5688	2832	2856	500	1,500	2167	659	1152	8,834	8426	408	107	43,688
SUFFOLK	12168	2832	9336	500	1,200	2492	757	2143	16,428	14493	1,935	1236	2,391,351
SULLIVAN	8232	2832	5400	500	1,500	2167	659	1534	11,760	9285	2,475	45	111,371
TIOGA	6336	2832	3504	500	1,200	2167	659	1205	9,235	8426	809	22	17,787
TOMPKINS	8184	2832	5352	500	1,500	2167	659	1527	11,705	8426	3,279	54	177,050
ULSTER	8916	2832	6084	500	1,200	2167	659	1592	12,202	9285	2,917	130	379,145
WARREN	6240	2832	3408	500	1,200	2167	659	1190	9,124	9285	-161	8	-1,287
WASHINGTON	6240	2832	3408	500	1,200	2167	659	1190	9,124	9285	-161	46	-7,401
WAYNE	6948	2832	4116	500	1,200	2167	659	1296	9,938	8426	1,512	56	84,689
WESTCHESTER	11760	2832	8928	500	1,200	2492	757	2082	15,959	14493	1,466	818	1,198,820
WYOMING	5736	2832	2904	500	1,500	2167	659	1160	8,890	8426	464	20	9,270
YATES	6036	2832	3204	500	1,500	2167	659	1205	9,235	8426	809	10	8,085
												19747	62,523,642

Jan. 2013 SUPPORTED HOUSING SHORTFALLS BY COUNTY – STUDIO APARTMENT

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Antonia M. Lasicki, J.D.
Executive Director

January 8, 2013

David Hamilton, Ph.D., LMW
Executive Secretary
The State Education Department
Office of the State Board for Social Work
89 Washington Avenue
Albany, NY 12234-1000

Dear Mr. Hamilton: David

I submit the following memo regarding the application of certain social statutes and regulations to non-profits that operate residential and housing programs funded and/or licensed by the NYS Office of Mental Health.

Although some scope of practice definitions are unclear and too broad and are in need of revision, it is our belief that ACL members' licensed and unlicensed residential program activities are outside the existing social work scope of the practice.

We seek a decision by the State Education Department (SED) that makes it clear that activities performed in housing programs licensed and/or funded by the State Office of Mental Health and Local Governmental Units are not within the scope of practice contemplated in the laws and regulations related to Social Work scope of practice. We recommend that these non-profits be given permanent exemption from the ban on the corporate practice of social work. In the alternative, we recommend that a three year extension be granted.

In addition, the memo discusses the many unworkable aspects of the waiver.

Many non-profits that provide housing and residential services also operate clinic, PROS, CDT, and other services. This memo is not meant to address any social worker issues in those settings; however, these general arguments could be used to provide a framework for case management, social clubs, shelters, HUD and other special needs housing programs, or any program that provides paraprofessional counseling and supports.

Thank you for this opportunity to comment on these issues in depth.

Sincerely,

Toni

Antonia M. Lasicki
Executive Director

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1. SCOPE OF PRACTICE

Psychotherapy: The definition of psychotherapy in the context of licensed clinical social work practice is too broad. It is defined as *"the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behaviors which are intellectually, socially, or emotionally maladaptive".* CFR Section 7701 (2)(c). In addition, the guidance that the NYS Education Department (SED) recently distributed gives examples of psychotherapy that include the following – *"utilizing directive techniques to educate the consumer so that he/she can learn and understand their symptoms and the purpose and goals of their treatment of their mental illness or other condition and develop/strengthen coping skills and personal strengths to more fully engage in treatment and life activities."*

This definition and the example given do not separate the licensed clinical social worker who relies on higher levels of training based on the learning of underlying psychodynamics from the staff in paraprofessional positions working with people to modify behaviors that are maladaptive. In addition, the example given is actually an activity listed in the NYS Office of Mental Health (OMH) regulations as an activity that paraprofessional staff with as little as a high school diploma engages in routinely and for which the programs bill Medicaid. Section 595.4(b)(11) - symptom management - is defined as *"activities which are intended to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of residents' mental illness symptoms and response to treatment, interventions designed to help residents manage their symptoms and assisting residents to develop coping strategies to deal with internal and external stressors. Activities range from providing guidance around everyday life situations to addressing acute emotional distress through crisis management and behavior intervention techniques."* In addition Section 595.4(b)(10) – substance abuse services is defined as *"services provided to increase the individual's awareness of alcohol and substance abuse and reduction or elimination of its use: such services shall include verbal and medication therapies, psycho-educational approaches and prevention and relapse prevention techniques."*

This activity falls clearly within the guidance provided by SED as an activity that can only be done by licensed social workers when the OMH regulations specifically charge paraprofessionals with this activity.

Recommendation: Change the definition of psychotherapy and the guidance language referred to above.

Assessments:

The definition of the practice of social work is too broad. Even if the words "professional application of social work theory, principles and methods" effectively limit it, the subsequent phrasing is so broad that taken in parts, the definition includes all counseling activities.

Section 7701(1)(a) defines the practice of licensed master social work as the "professional application of social work theory, principles, and the methods to prevent, assess, evaluate, formulate and implement a plan of action based on client needs and strengths, and intervene to address mental, social, emotional,

behavioral, developmental, and addictive disorders, conditions and disabilities, and of the psychosocial aspects of illness and injury experienced by individuals, couples, families, groups, communities, organizations, and society".[1] Although staff in residential programs "prevent, assess, evaluate, formulate and implement a plan of action based on client needs and strengths, and intervene to address mental, social, emotional, behavioral, developmental, and addictive disorders, conditions and disabilities", their activities do not include the professional application of social work "theory, principles, and methods". Rather their activities fall under section 7702 (1) (j) where staff without a license may "assess, evaluate and formulate a plan of action based on client need" as well as under section 7702(1) (f) where staff without a license may "assist individuals with difficult day to day problems such as finding employment, locating sources of assistance...."

As an example, licensed residential program staff conducts a "functional assessment" upon which a "service plan" is created and followed by creating goals and objectives to strengthen functional areas of weakness, however, these do not constitute "treatment" as contemplated by the array of statutes and regulations that govern scope of practice.

Staff works with clients to fill out a functional assessment (Appendix A) that asks clients a number of questions related to their level of functioning in specific areas of daily living. This questionnaire exposes functional weaknesses that are addressed through the development of a "service plan" as well as "goals and objectives" that are designed to improve functioning. Clients take an active role in the development of the aforementioned items.

For example, a "community integration" goal may involve a staff person and client riding the subway together to make sure the client can learn to negotiate and travel within NYC. This may be necessary before a person can move on to an employment goal. An "activities of daily living goal" may involve a staff person teaching a client how to wash, dry, fold and put their clothes away or teaching them how to use a stovetop and oven. A "medication management" goal may involve the client reading their prescription each time they must take a medication – name of the medication and the dosage, - to the staff person so they can learn it. Some of these skills are necessary to move into an independent apartment. There are eleven areas of services in NYCRR Section 595.12 (b)(1-11) (Appendix B) that can be addressed in a service plan and in goals and objectives. Generally, four areas are chosen at a time. None of these activities rise to the level of the professional application of social work theory, principles or methods but rather falls under 7702(1)(f) and (j).

In addition, staffs in unlicensed supported housing programs conduct a "housing assessment" with each client. They then develop a housing plan that, when followed, helps clients move into their own

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[1] We assume that the regulation does not mean to say that social workers should "prevent ...a plan of action" although that is how the regulation reads. Also, assessing This should be corrected.

apartments and develop the skills necessary to keep those apartments. (See Appendix C for OMH Supported Housing Guidelines.) Staff activities include help with communication with neighbors, landlords, utility companies as well as help with money and medication management at a less intense level than in the licensed programs. (See sample job descriptions for a Supported Housing case manager and a supervisor in Appendix F.) These activities are outside the scope of practice because they do not include the professional application of social work theory, principles, and methods. Rather their activities fall under section 7702 (1) (j) where staff without a license may "assess, evaluate and formulate a plan of action based on client need" as well as under section 7702(1) (f) where staff without a license may "assist individuals with difficult day to day problems such as finding employment, locating sources of assistance...."

Appendix D provides sample job descriptions.

<u>Case Management In Licensed And Unlicensed Programs</u>

Although residential staffs do case management in both licensed and unlicensed programs, which is included in section 7701(1)(b) as a type of activity that master social workers engage in, section 7702 specifically includes "providing case management" as an activity that can be done without a license. Therefore, our case management activities in both the licensed and unlicensed programs are outside the scope of practice.

<u>Exempt Persons</u>

Even if activities in both the licensed and unlicensed programs are deemed to fall within the scope of practice, they are exempt persons under section 7706 (4), where it states that no part of these regulations may "prevent or prohibit the performance of activities and services within the scope of practice of licensed master social work as defined in subdivision one of section seventy-seven hundred one of this article by ...not-for-profit businesses which are providing instruction, advice, support, encouragement or information to individuals, families and relational groups." In fact, staff people in these programs operated by not-for-profits are providing instruction advice, support and encouragement within the parameters of a service plan, goals and objectives.

Recommendation: Make a determination that these non-profits are exempt persons and are not in need of filling out a waiver.

2. CORPORATE PRACTICE

Although it seems that the Senate, the Assembly and SED have not settled on one position regarding the following we have been told by SED that if we employ a social worker, even if that social worker is not practicing within the scope of practice, a waiver is necessary because it implies that we are holding ourselves out to the public as providing licensed practice. We respectfully disagree and ask that this policy be reconsidered.

Although there are social workers in these non-profits that do direct care work with clients and who may have supervisory roles it is our position that they are not practicing within the scope of practice nor are they practicing any of the licensed services listed in the waiver.[2] In addition, they do not hold themselves out as practicing licensed social work. For example, many Executive Directors have social work degrees, or a staff person may supervise hundreds of workers within a hierarchy where some staff in parallel positions has social work degrees and some do not. Although it is possible that some clients may interpret the job activities of a staff person with a degree as "counseling", or refer to that staff person as his or her "counselor", no-one would be under the mistaken notion that they were receiving psychotherapy, psychoanalysis, or some other form of professional counseling. Moreover, "the public" does not generally access these services in the way that the public might access a psychoanalyst's services. A person is usually referred by a clinician through a governmental single point of access. The person is deemed eligible or not, and then is moved through the application process. The person is generally aware that they are receiving housing with supports or services, with "housing" being the operative word.

Moreover, providers under licensure by the Office of Mental Health have many levels of supervision as well as regular state and provider level oversight so that there are adequate protections in place.

Recommendation: Not-for-profits incensed by the State Office of Mental Health should be permanently exempt for the ban on the corporate practice of social work. Short of that we recommend a 3 year extension until the myriad problems can be sorted out.

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[2] Licensed Master Social Work; Licensed Clinical Social Work; Licensed Mental Health Counseling; Licensed Marriage & Family Therapy; Licensed Creative Arts Therapy; Licensed Psychoanalysis; Psychology

Application for a Waiver

We have concerns about the waiver.

Question 2 states that a waiver must be issued for each setting in which the entity provides professional services. In OMH licensed and unlicensed residential settings, services are provided on-site in people's homes. In fact, the OMH license is attached to each licensed site whether it is a 1 bedroom apartment or a 48 bed congregate site. Providers would have to seek a waiver for every site.

- There are hundreds of congregate sites, more than 3,000 licensed apartment sites and nearly 20,000 Supported Housing apartments in the state. A typical provider may have 100 sites – some have 1,200 sites.

- The attestation requires that the waiver certificate be displayed at each site. Clients live in these sites, which are their homes – they are trying to learn to live normal lives. Therefore, we do not believe that clients will agree to the display. Staff would have little control over this, except to pull them out of hiding (or carry around copies of them for replacement purposes) and put them on display each time they visit a site. Moreover, to the extent that the waiver displayed makes it evident that the person residing in the apartment is a mental health client, it may run afoul of other confidentiality laws. Finally, clients should not have to announce to their house guests, by way of the apartment décor, that they are mental health clients.

- The attestation requires notification of any changes, including changes of sites. Because clients often move and apartments may come and go from the rent rolls of an entity, it is unrealistic to expect them to notify SED every time there is a site change. Even a very small Supported Housing provider may have 50 slots/apartments to manage.

Providers that were established after 6/18/2010 may have to provide information so that SED can establish whether or not there is a need for their services. These providers have all responded to Requests for Proposals (RFPs) from state and local governments that have already determined that there is a need for the services and have appropriated money to fund those services according to rigorous appropriations procedures.

Question 10 specifically asks the entity to check off any licensed activities for which it seeks the waiver. An entity that is required to seek a waiver merely because that entity employs social workers even though those social workers actually do not engage in any of the licensed activities listed cannot answer

the question because it does not currently engage in any of the listed activities nor does not seek to engage in any of the listed activities.

Question 11b asks if any program or service is under review by a variety of state and federal agencies. The attestation also requires notification of any changes to this answer. All OMH licensed programs are under review at times – state law requires OMH to review each site at a minimum twice a year. Reviews are unannounced. There are more than 3,000 licensed apartment sites in the state. Unlicensed Supported Housing programs are also reviewed on occasion. There are nearly 20,000 Supported Housing apartments in the state. Providers that honestly answer "no" at the time of the attestation because no program is specifically under review on that date would have to change that answer every time OMH or any of the myriad other state and federal entities with jurisdiction (e.g. NYS OMIG, NYS OIG, NYS Comptroller, Federal OIG, etc.) arrives at any one site.

Understandably, our providers are concerned about putting themselves under the jurisdiction of the Board of Regents and the disciplinary procedures and penalties set forth in sub article 3 of Article 130 of the Education Law. They operate programs that employ staff that do not engage in scope of practice activities as we understand them and so should not come under the jurisdiction of the Board or Regents. There is sufficient state and federal oversight. Adding this will require providers that are not practicing within the scope to develop policies and procedures that address all of the issues in sub article 3 of Article 130 of the Education Law, which will do nothing but confuse the staff who are trying to understand policies that are in effect but ....not really.

Finally, the attestation specifically requires providers to attest to the fact that they will ensure that adequate professional staff is available to provide professional services. However, they do not provide professional services so they cannot, and should not, attest to this.

Per the above, different parts of the waiver are just inapplicable or impossible to administer.