

Overview

The New York State Office of Mental Health (OMH) provides the following assessment of the legislatively-required survey of the Behavioral Health Community regulated by OMH (see §§ 13 and 14 of Chapter 130 of the Laws of 2010, as amended by §§ 3 and 4 of Chapter 132 of the Laws of 2010). The survey is intended to identify those functions, tasks and activities which are performed by staff in programs regulated by the OMH, in order to determine the use of licensed professionals and other staff to deliver restricted and unrestricted services. In addition, OMH provides its recommendation to make permanent the existing exemption from the “scope of practice” provisions for programs operating under the jurisdiction of OMH, while continuing to provide high quality and cost effective behavioral health services under the contractual and regulatory oversight of OMH.

Executive Summary

OMH and other affected agencies encouraged providers to participate in the survey, developed and circulated by the State Education Department (SED) earlier this year. Of the 426 mental health survey responders this sample represented a mix of residential and outpatient providers, comprising approximately 16% percent of impacted programs and services operated under the jurisdiction of OMH. The majority of those responding operate mental health programs that provide assessment, diagnosis, assessment based treatment planning, psychotherapy, and other services such as case management to a large cohort of individuals throughout the State.

The respondents to the survey identified 2,523 unlicensed individuals who provided one or more of the services that were defined as “restricted” in the survey instrument. Although the survey, shows an overlap of licensed and unlicensed staff performing the same functions, in reality, OMH programs perform “restricted” activities predominately in licensed programs under professional supervision, usually within the context of a treatment team approach consisting of multiple licensed professionals, and with multiple layers of programmatic oversight.

If the “scope of practice” exemption were to lapse, not only would there be inadequate numbers of licensed professionals to provide needed services, but the increased cost to replace unlicensed staff with licensed individuals would be approximately \$23.3 million annually, solely for the OMH providers who participated in the survey. Extrapolated to include all local providers and impacted staff, the total annual cost would be approximately \$46.6 million annually. If state-operated programs are included, the total cost of the elimination of the “scope of practice” exemption for OMH alone is estimated to be approximately \$85.9 million annually. (These estimated costs do not include any potential increase in fringe benefits, lost revenue to programs as new employees are hired and phasing in a new client caseload, costs for training or annualized costs.) The overwhelming reimbursement mechanisms for these services are funded by taxpayer dollars, including Medicaid, Medicare, and State deficit financing.

In addition, we believe that some of the survey respondents may have misinterpreted some of their activities as constituting the five restricted services, such as: confusing observation of symptoms with diagnosis; psycho-social or rehabilitation assessment with assessment based treatment planning or counseling; and advice giving and support with psychotherapy.

We are also unaware of any evidence that would support better client outcomes with increased licensed staff, given the multiple layers of protections that exist in OMH licensed and funded programs. OMH has a sophisticated regulatory apparatus that has been found to provide cost effective quality behavioral health services prior and subsequent to the enactment of the current exemption (see sections VI-IX below for greater detail and explanation).

I. Introduction

OMH submits this report after receiving the summaries of the SED survey of the field, as required by Chapters 130 and 132 of the Laws of 2010.

The OMH survey responders constituted **426** programs for purpose of this analysis or 16 percent of the **6,759** programs in the OMH service delivery system (see Attachment #1). The survey results corroborate and confirm information OMH previously supplied concerning the quality and cost effectiveness of the “scope of practice” exemption that currently exists in law. Indeed, given the continued efficacy of the exemption, the enormity of the increased costs and onerous fiscal impact on the State resources should the exemption be eliminated, and the potential to undermine the strategic plan to redesign the Medicaid program, the exemption should be made permanent.

The SED survey data indicate that if the exemption is eliminated, the cost to replace unlicensed practitioners would be at least \$23.3 million. This is consistent with previous estimates provided by OMH in 2008-09 in the amount of \$22.5 million to come into compliance in the first year. If the survey responders constitute a representative sample of providers (clinic programs comprised the majority of the responders), the extrapolated cost increase for the system would be **\$46,604,964** million annually. This amount is based on a CFR total of 11,000 – 12,000 FTEs (see Attachment #4) using the rate of penetration in the SED survey of non-licensed individuals. If state-operated programs are included, the total cost of the elimination of the “scope of practice” exemption for OMH alone is estimated to be **\$85,894,993** annually. Overwhelmingly, the financial resources to deliver the surveyed services are State resources paid through Medicaid, Medicare, and deficit financing from the State. Without any evidence of improved services or outcomes in this period of fiscal austerity, the wisdom of eliminating a cost effective exemption is questionable. To put this in perspective, for programs operated under the jurisdiction of OMH, the additional expense in the first year alone would completely eliminate the annual savings anticipated in fiscal year 2011-12 for the Medicaid Health Home initiative.

In addition to the likely increased personnel cost to both the provider community that is likely to be either borne by the State or result in substantially reduced services to our citizens, the cost of regulating both the licensed practitioners and the increased number of providers included through the waiver process can be expected to increase substantially. This regulatory scheme comes with additional expense, cost and/or likely dysfunction to healthcare for vulnerable populations at a time of great uncertainty and change especially in the State Medicaid program. Further, the SED would have to substantially increase the size and cost of its investigatory and prosecutorial function in the SED Office of Professional Discipline.

Importantly, OMH has created oversight mechanisms for insuring that quality services are provided competently and safely, in a cost effective manner (see sections VI- IX below). If the “scope of practice” exemption were to be eliminated, it would result in enormous additional costs to the State, but would not provide any meaningful measure of increased safety or quality to our citizens as reflected by the survey results.

II. SED Workforce Survey Results for OMH Programs

Initially a total of **544 programs** responded that their programs were either operated, licensed (includes programs certified or regulated), approved, or funded by OMH. The data was further examined and refined, leaving **426** programs as survey responders for purpose of this analysis. Of the 426 programs that participated in the survey:

- Q5 97% answered (number providing assessment/evaluation in program)
- Q6 54% answered (number of licensed staff providing assessment/evaluation)
- Q7 45% answered (non-licensed providing assessment/evaluation)
- Q8 20% answered (re: other titles assessment/evaluation)
- Q11 83% answered (programs providing diagnosis)
- Q12 47% answered (licensed staff providing diagnosis)
- Q13 24% answered (unlicensed staff providing diagnosis)
- Q17 83% answered (number of programs providing assessment based treatment planning)
- Q18 53% answered (number of individuals providing assessment based treatment plan)
- Q19 40% answered (unlicensed staff providing assessment based treatment plan)

The overall response rate for answering one of the key questions that relate to the five survey services is approximately 55 percent. However, 87 percent of programs answered the question regarding the provision of three of the restricted services: assessment/evaluation; diagnosis; and assessment based treatment planning.

The self-selected sample represents **426** providers or approximately 16% of the OMH service delivery system, an under reporting of OMH's total of **6,759** programs (see attachment #1). State operated programs were under represented in this survey. In a previous analysis OMH identified State operated programs having **4,254** individuals in various titles that could be impacted. (See Attachment# 3)

III. The Five Survey Services

The survey attempted to capture a snapshot of services that the SED Office of Professions considers to be restricted to licensed individuals. Operating under the current extension of the exemption in the social work law, OMH and its affiliated agencies report they are providing the following services (references to the number of **individuals** engaged in any of the five services can be found in Attachment #2):

- **Assessment/evaluation** – Approximately **81 percent** of respondents stated that they provide assessment and evaluation. Assessment is provided by a mix of paraprofessional, professional, and licensed staff. Some type of assessment occurs in most all OMH funded services including: psychological evaluation, psychiatric evaluation, psycho-social assessment, or rehabilitation assessment.
- **Diagnosis** – Although **69 percent** of the respondents reported that their program provides diagnosis, only OMH licensed clinical programs perform diagnosis. The Article 163 licensees (licensed mental health practitioners) comprised only 4 percent of those staff providing diagnosis. While a total of **392** unlicensed individuals were reported as providing diagnosis, or 8% of the total, in each instance a physician must provide both the diagnosis and authorize treatment. Unlicensed individuals may be reporting on symptoms identification and not actually diagnosing an individual. (Note: the disparity between what was reported and what actually occurs in such programs raises questions regarding the accuracy of some of the survey reporting.)

- **Assessment based treatment planning/Service Planning – 82 percent** of providers answered the question that their programs provide assessment based treatment planning. This is one of those terms that, while defined in Article 154 of the Education Law applicable to licensed social workers, may be unclear to survey respondents. Assessment based treatment planning is primarily performed in licensed treatment programs and “service planning” is done predominantly in the case management, residential and rehabilitation programs. The survey **Case Processing Summary** (see Attachment #2) identified **4,757** licensed individuals and **1,795** unlicensed individuals engaged in “assessment based treatment planning.” As noted above, “assessment based treatment planning” is a defined term in the statutory provisions which describe the scope of practice of social work. Many services provided under the jurisdiction of OMH include similar activities such as screening for co-occurring disorders and gathering health information, but such functions are not “assessment based treatment planning.” In the performance of such activities OMH programs use a multi-disciplinary team structure that requires physician sign-off for treatment/service plans.

Of the respondents that reported licensed and unlicensed staff conducting “assessment based treatment planning” in their programs, more than half of the agencies responded they employed titles that can be “licensed or certified” however were reportedly filled with unlicensed staff:

- Psychologist (not licensed)
- CASAC
- Social Worker (not licensed)
- Certified Rehabilitation Counselor
- Vocational Counselor
- Recreation Therapist (not licensed)
- Mental Health Therapy Aide
- Case Worker, Service Coordinator, Social Work Case Manager
- Peer Specialist

For those programs with mixed staff, and particularly those that use a multidisciplinary treatment team approach, OMH does not find a material difference in the quality of services provided in programs which also employ unlicensed staff.

Psychotherapy – A total of **67 percent** of respondents reported that their program provides psychotherapy. A total of **5,613 licensed staff or 93% of the total reported** to provide psychotherapy; 9% were reported as interns. Clearly most staff providing psychotherapy in OMH programs are licensed individuals. However a total of **414** non-licensed staff were also reported as providing psychotherapy. The survey did not ask the percent of time the unlicensed individual engaged in psychotherapy or about their supervision. Here again it appears that because of the vague definition of psychotherapy many staff could assume to be providing psychotherapy while being engaged in crisis de-escalation techniques, counseling or behavior modification on a limited basis. In OMH licensed programs, no unlicensed individual performs psychotherapy without the supervision of a licensed professional. OMH’s licensed programs have been competently providing psychotherapy using a multi-disciplinary team model successfully prior to and after the enactment of the “scope of practice” exemption. It is interesting to

note that a large part of the licensed professional workforce receives their training in OMH programs.

Only **13 percent** of the licensed category fell under the “other” category, which include titles such as nurses, occupational therapists, and other licensees who may provide psychotherapy under the exemption but otherwise may not have psychotherapy as part of their scope of practice. Less than one percent of programs reported that they had either volunteers or contracts with 26 individuals who provided psychotherapy.

Of the unlicensed staff, 112 or **15 percent** of those with a case management/coordination titles reported providing psychotherapy. The total number of individuals in case management titles was 750. According to OMH data, there are **1,854** staff employed in case management programs and the survey captured 40 percent of the OMH case management workforce. Generally, case management programs are confined to linking clients to services and resources in the community. While case management may be part of the scope of practice of a licensed individual, it has not been seen as a restricted activity. In fact, “case management” is specifically listed among the functions that are exempt from the restricted practice of social work (Education Law section 7702 1. (g)).

- **Services other than psychotherapy** – The OMH service delivery system typically provides a wide range of services to individuals living with serious mental illness. Since services are provided in program settings, rather than an individual private practice setting, individuals can receive more comprehensive care, addressing impairments in key life domains.

Restricted Service	Unrestricted Service
<ul style="list-style-type: none"> • Nursing assessment • Psychiatry services, including: medication-treatment, medication management • Psychological testing • Case management 	<ul style="list-style-type: none"> • Assessment • Skill building • Supported education • Supported employment services • Recreational & socialization services • Discharge planning, advocacy, linkage to social and support services • Respite(short term child supervision)

IV. SED Survey Salary Data

The results of the SED survey salary data is described in the table below.

Title	Number	Mean Salary	Total
ABAS	4	\$37,250.00	\$149,000.00
CARECO	7	38,643.00	270,501.00
CASAC	47	35,996.00	1,691,812.00
CASEMGR	67	30,656.00	2,053,952.00
CASEW	11	34,365.00	378,015.00
CRC	20	41,112.00	822,240.00
CSRESAID	27	25,730.00	694,710.00
MHTA	16	36,633.00	586,128.00

NBCC__COU	4	27,000.00	108,000.00
Other -LI	84	52,014.00	4,369,176.00
Other 1	59	35,618.00	2,101,462.00
Other2	20	32,723.00	654,460.00
Other3	3	39,407.00	118,221.00
Other4	1	27,787.00	27,787.00
PREVCSLR	4	32,000.00	128,000.00
PSYCHGOV	16	59,973.00	959,568.00
RECTH	17	36,943.00	628,031.00
REHABTH	6	42,929.00	257,574.00
SERVCOOR	8	31,546.00	252,368.00
SW	109	40,386.00	4,402,074.00
SWCASE	12	36,859.00	442,308.00
SWCSEW	7	38,548.00	269,836.00
YOUTHCSL	21	23,507.00	493,647.00
VOCSLR	21	37,283.00	782,943.00
	591	\$874,908.00	\$22,641,813.00
Avg. Unlic. Salary		\$38,039.48	
Avg. of LMSW & LCSW Salary		\$47,275.50	
Salary Differential		\$9,236.02	
Unlicensed reported doing at least one of the five services	2,523	\$ 23,302,482.85	Salary differential to replace non-licensed staff with licensed staff

FISCAL IMPACT

The salary table above does not reveal which of the titles are providing the five restricted services or how often, however:

- A total of **2523 unlicensed** individuals were identified as providing any of the five restricted services.
- The total FTEs as reported on the **FY 2010 CFR** for non-hospital based programs is 32,000 with 11,000-12,000 FTEs listed in service titles. Hospital based programs and State operated programs were not included in this number (see Attachment #4)
- The salary differential between an unlicensed employee and a licensed employee identified in this survey is **\$9,236**. Based on the survey the salary replacement cost to replace unlicensed professionals with licensed staff would total approximately **\$23,302,482**.
- This cost does not include any potential increase in fringe benefits, lost revenue to the program as they are hiring new employees and phasing in a new client caseload, costs for training, or annualized costs.
- Based on this sample we estimate that there could be double the number of unlicensed individuals providing one or more of the restricted services, with a replacement costs upwards of **\$46,604,964**.

- In addition, if we include 4,254 positions in State operated programs using the salary differential identified in the survey there could be an addition cost of **\$39,290,029**.
- Total impact, without including fringe, lost revenue or other costs could be as high as **\$85,894,993**.

VI. Current Public Protection and Quality Standards in OMH

The articulated purpose of the New York State licensing law that created four new mental health practitioners professions was “to protect the public from unprofessional, improper, unauthorized and unqualified” practices (Legislative Intent of Chapter 676 of the Laws of 2002).

Programs operated, funded, and licensed by OMH have long been recognized for accomplishing this important purpose. Moreover, public behavioral health programs provide high quality services which are provided cost effectively and in underserved areas of the State. The current 2011 fiscal climate calls into question the imposition of additional restrictions on the operation of these programs.

Further, public protection by OMH is enhanced by multiple federal, state and county oversight including:

- Federal audits and review
- State control agency audits and inspections
- County oversight of mental health programs

OMH employs current complex oversight mechanisms to ensure that safe and effective quality services are provided within the various programs that the agency operates, licenses, funds or oversees. This oversight ensures that safe and effective services are provided to the population served whether licensed or non-licensed direct care personnel are providing such services.

VII. Overview of the OMH Community-Based System

The Office of Mental Health has the responsibility for the development, regulation, and funding of an organized community-based system of treatment, rehabilitation, and support services for individuals with serious mental illness and for children with serious emotional disturbances. This system serves more than 600,000 outpatients annually.

OMH classifies its programs into four major categories: Emergency; Inpatient; Outpatient; and Community Support. Programs may be operated by the State, county, municipality, or not-for-profit agencies.

- **Emergency** programs provide rapid psychiatric and/or medical stabilization while assuring the safety of the individuals who present risk to themselves or others. Programs include local emergency services and comprehensive psychiatric emergency programs (CPEPs).
- **Inpatient** programs are hospital-based psychiatric treatment programs providing 24-hour care in a controlled environment. These may be in State operated or non-State operated hospitals. Institutional programs often serve forensic or dually diagnosed populations.
- **Outpatient** programs include assessment, symptom reduction, treatment and rehabilitation in an ambulatory setting or in the community. Programs include Clinic,

Partial Hospitalization, Continuing Day Treatment; Day Treatment; Intensive Psychiatric Rehabilitation Treatment (IPRT); Assertive Community Treatment (ACT); and Personalized Recovery Oriented Services (PROS).

- **Community Support Programs** help individuals with severe mental illness with developing the skills and supports to live as independently as possible in the community. Community support services include: ICM/SCM/Blended case management, care coordination, outreach, clubhouse, sheltered work, affirmative businesses, supported employment, peer support, family support, respite, residential and other services.

VIII. Program Certification, Monitoring and Oversight Process

OMH's Bureau of Inspection and Certification reports that there are **6759 programs licensed, regulated, or funded by OMH**. This includes State and county operated, not-for-profit, and for profit programs. Programs licensed and funded by OMH are subject to oversight, monitoring, and regulation from numerous entities. These are described below.

Oversight is performed in several ways:

- **Regulation:** OMH has regulatory authority and has established regulations and/or guidance for all licensed programs (e.g., Clinics, CDT, Day Treatment, PROS, IPRT, Partial Hospital, and Residential) and many unlicensed programs (such as case management and supported housing). Links to regulations regarding licensed programs may be found at: http://www.omh.ny.gov/omhweb/policy_and_regulations/

OMH regulations require OMH licensed providers to:

- Perform comprehensive assessment;
 - Maintain individualized treatment plans;
 - Conduct periodic treatment team meetings and treatment plan reviews;
 - Provide supervisory professional oversight (as contrasted with private independent practitioners where no oversight is required); and
 - Maintain operating policies and procedures, including a staffing plan
- **Prior Approval and Review** or PAR process: Operators need PAR approval before establishing new programs or substantially changing existing programs. The PAR process includes a review of such areas as operator character and competence, fiscal viability, public need, and charities registration.
 - **Inspection and Certification:** OMH provides ongoing licensure oversight through on-site visits (announced and unannounced). Re-certification visits include a review of clinical practices, staffing credentials, supervision, service utilization, and quality improvement initiatives. The inspection and certification process reviews agency staffing and supervision plans to ensure staff are properly credentialed and trained. OMH policy precludes non-licensed clinical staff performing duties unsupervised.
 - The public sector has the regulatory apparatus that improve the quality and competence of services. The OMH [Balanced Scorecard](#) measures and reports on outcomes experienced by individuals served in our public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational

performance. The Scorecard is designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data to inform decision making and assess the service needs of the community.

- **Background Checks:** OMH requires providers to conduct background checks for criminal history and child abuse prior to hiring new staff.
- **Enforcement:** OMH Enforcement mechanisms include issuance of Monitoring Outcome Reports, Plans of Corrective Action, fines, license suspensions, and revocation of licenses. OMH may also withhold payments for an agency's lack of repeated non-compliance.
- **Fiscal Oversight:**
 - **Reimbursement** – OMH establishes Medicaid reimbursement rates for licensed programs and administers State Aid funding to local government. In return, OMH gathers data on services provided by mental health providers.
 - **Contract Oversight** – In addition to Medicaid reimbursement for licensed programs, OMH provides direct contracting & program oversight for many programs. All providers under contract must answer the following questions regarding:
 - The contract's intent and a justification of need. Explain how this contract is critical to health/safety, revenue collection, and/or core mission of OMH?
 - If this is for a renewal or amended contract, is the work plan remaining the same? If not the same, please explain modifications to the contract's scope and why they are necessary?

For further detailed contracting requirements, see:

<http://www.omh.ny.gov/omhweb/spguidelines/PDF/DirectContractFormsandInstructions.pdf> .

- **Accountability** – OMH promotes fiscal viability and accountability in the service delivery system through (a) fiscal reviews and audits and (b) OMH Field Office reviews of fiscal viability through the certification process.
- **County Oversight:** Section 41.13 of the Mental Hygiene Law establishes the powers and duties of local governmental units in administering local mental hygiene services through planning, oversight, quality assurance, and contracting with voluntary organizations. In regard to local oversight both under its general supervisory functions, and for LGU contracting, Subdivision 8 of 41.13 states:

The local governmental unit shall “make policy for and exercise general supervisory authority over or administer local services and facilities provided or supervised by it whether directly or through agreements, *“including responsibility for the proper performance of the services provided by other facilities of local government and by voluntary and private facilities which have been incorporated into its comprehensive program.”*”

Further, under 41.13, Subdivision 14, the oversight of local program services (including contract agencies) by local governmental units includes that the LGU “require the development of a written treatment plan as provided in the rules and regulations of the commissioner which shall included but not be limited to...appropriate programs, treatment or therapies to be undertaken...” This provision underscores the close involvement in individual programs' service delivery via contracts or other LGU oversight of programs.

Ultimately, specific contractual oversight and supervisory authority over voluntaries will be determined, and vary based on contract terms. Such terms may also vary within and between counties depending on the needs of service recipients, the degree of third party (e.g., State agency) oversight, and the specific program. Examples of oversight of voluntary programs by a local governmental unit per a contract may include the following:

- Establishing and monitoring program process and outcome objectives;
- Require participation in local Community Service Board meetings to educate and encourage programs' service to specific community needs;
- Establish standards and procedure for addressing misconduct and disciplinary measures;
- Required appropriate non-profit corporate compliance plans; and
- OMH Field Office staff work with county/city government in order to assure adherence to the program model, documentation and meeting contract deliverables.

The **OMH County Profiles Home Page** <http://www.omh.ny.gov/omhweb/statistics/> offers consolidated, at-a-glance, and comparative views of key county community characteristics, mental health services expenditures, and outcomes. Its purpose is to enable planners and others to identify service gaps and disparities and plan improved service delivery. Under NYS Mental Hygiene Law, county governments and the City of New York must develop (in conjunction with local stakeholders) a local mental health Plan to address the mental health needs of individuals of all ages with serious mental illness or emotional disturbance. These Plans are reviewed by OMH annually. They must be approved by OMH in order for the State to provide funding through Medicaid reimbursement as well as local assistance funds. All mental health programs licensed or funded by OMH must participate in this process.

- **Other State, Federal and Certification Oversight** – In addition to OMH direct oversight, most programs operated or licensed by OMH receive additional oversight from:
 - NYS Department of Health
 - Federal Centers for Medicare and Medicaid Services (audits and inspections)
 - Federal Department of Justice
 - New York State Office of Medicaid Inspector General
 - New York State Office of State Comptroller (program audits)
 - New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD)
 - Private Certification Agencies including TJC, CARF and others

IX. Quality Control

OMH is focused on quality in addition to regulation, compliance and oversight. This is done through the use of multidisciplinary teams and standards of care.

- **Multidisciplinary teams** – Many OMH licensed and funded programs are structured to build in quality control through the use of multi-disciplinary teams. These teams are composed of a range of staff from psychiatrists to licensed and experienced therapists to

trained peers. The strength of the teams is enhanced by strong supervision and sign off by experienced and appropriately licensed team members. Teams use a multi-disciplinary approach to set the direction with the recipient for treatment. Professional staff on the team have overall responsibility for treatment plan implementation.

- **Standards of Care** – OMH has developed clinical standards of care which are essential for access to and quality of care for persons served by licensed clinics that provide mental health services. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State. The Standards of Care highlight expectations for:
 - Staffing
 - Caseloads
 - Training
 - Tracer Methodology
 - Screening
 - Assessment Domains
 - Best practices

Complaint Investigation: Complaints arrive at the Customer Relations Toll Free Line. The 1-800 Line receives approximately ten-thousand calls each year. The complainants can be mental health service consumers, providers of mental health services who are concerned with some aspect of service provision, family members of persons with mental disorders, or concerned citizens, among others. The Line is open to all. Complaints frequently arrive at the Customer Relations Line by referral from other agencies and organizations such as the Governor’s Office, police departments, the Department of Health, and the Office for Persons with Developmental Disabilities. The majority of the complaints come directly by phone. Complaints are also received at each OMH Field Office, at the Office of the Commissioner, and through the Office of Consumer Affairs. Many complaints come to the Office of Mental Health as letters, faxes, email, or from walk-in complainants, and are routed and resolved commensurate with the consumer’s needs. Simpler complaints are handled by staff of the Customer Relations Line. Complaints related to regional service provision are tasked to the Field Offices. All allegations of abuse or neglect are pursued by Clinical Risk Managers. Depending on need, complaints are also routed to other Agencies and Organizations, such as the Department of Health, Child Protective Services, or Community Mobile Crisis Teams, to name just a few.

Incident Reporting: NCCR 14 Part 524: Incident management regulations are intended to ensure the development, implementation and ongoing monitoring of incident management programs, by individual providers, which will protect the health and safety of clients and enhance their quality of care. QA 510 is the policy for State-operated programs. The following link will provide definitions for types and severity of incidents. <http://www.omh.ny.gov/omhweb/guidance/hcbs/html/DefinitionsForIncidentTypes.htm>

Mental Hygiene Legal Service (MHLS): The Office of Court Administration funds MHLS to represent, protect and advocate for the rights of people who reside in, or are alleged to be in need of care and treatment in, facilities which provide services for persons with mental disabilities.

X. Conclusion

To a large extent, OMH is able to shape and regulate community based services through its licensing, regulatory and funding authority. OMH agencies rely on a cadre of non-licensed professionals who provide, to varying degrees, the five services listed in the survey in addition also provide crisis, case management and counseling services within supervised and regulated programs.

Rather than requiring all of our programs' direct care employees to be licensed professionals (and there are not enough licensed professionals to meet the needs of the public mental health system), our programs operate with all the above redundant protections. These multilayered protections better and more uniformly ensure safe, quality services than reliance upon the individual abilities, character and competence of each licensed professional in the State. Add to these the current enforcement by the Office of the Medicaid Inspector General (OMIG) and others there appears to be no need for further restrictions on the use of non-professional clinical staff in OMH licensed or sponsored programs.

Furthermore, if the exemption for OMH programs ends on July 1, 2013 financial consequences would be catastrophic. Minimally, and only for those programs which operate under the jurisdiction of OMH, there would be a need to either increase resources or decrease expenditures by as much as **\$85,894,993** annually in Medicaid, State Aid or a combination of the two in the first year.

XI. Recommendations

- Most importantly, the Legislature should establish a permanent exemption from “scope of practice” restrictions for programs operated, funded, licensed, or regulated by OMH.
 - All of the State mental hygiene (“O”) agencies agree that the Education Law Title VII regulatory apparatus has many benefits, and where appropriate, as in the recent OMH Part 599 clinic regulation (14 NYCRR Part 599), has been wholeheartedly endorsed. However, OMH and the “O” agencies also have instituted within the public behavioral health system substantial cost-effective public protections, and there is no demonstrated need for additional restrictions on the operation of these programs.
- The OMH has sufficient oversight mechanisms and program supervision in the service delivery system that makes conversion of unlicensed staff to licensed staff unnecessary.
 - Extension of the current exemption from the “scope of practice“ provisions will preserve the State statutory scheme for the provision of quality behavioral health services as defined in the State’s Mental Hygiene Law, as well as the important oversight role of the “O” agencies within the Department of Mental Hygiene.

ATTACHMENT #1

**Office of Mental Health
Bureau of Inspection and Certification
6/30/2011**

Number of Programs Licensed, Regulated, or Funded by OMH; by Auspice.						
Programs	Not-for-profit	State	For-profit	County	Total	
Licensed	1384	633	27	69	2113	
Non-licensed	3697	242	4	703	4646	
Total	5081	875	31	772	6759	

Source: CONCERTS database

Notes:

1. Licensed programs include residential, inpatient, outpatient, and family care.
2. Non-licensed programs include residential, non-residential/community support, and state PC inpatient.
3. State includes PC-sponsored family care homes (461).
4. Non-state-sponsored family care homes (13) are included under not-for-profit auspice.
5. County includes county-operated programs and NYCHHC municipal programs.

ATTACHMENT #2

SED WORKFORCE SURVEY ANALYSIS - OMH

Number of staff engaged in the 5 services

Licensed Practitioners	Assessment	Diagnosis	ABTX Plan	Psychotherapy	other services
Physician	1049	895	240	689	
Physician Assistant	21	18	7	6	
LMSW	1609	1120	1409	1321	
LCSW	1903	1361	1657	1976	
Psychologist	563	317	359	333	
Intern, resident	934	438	533	523	
Nurse Practitioner	200	158	158	125	
Article 163	384	185	301	274	
Other Professionals	0	37	93	366	
Total Licensed	6663	4529	4757	5613	
Unlicensed Practitioners*					
ABAS	13	3	6	3	
CASAC	126	101	154	45	
CASEMGR**	750	58	656	112	

CORRECLSR	0	0	0		
CRC	23	13	28	18	
CSRESAID	177	25	403	17	
MHTA	89	1	33	5	
NBCC	4	0	2	2	
OTHEREPE***	0	26	83	54	
RECTHER	41	5	31	13	
REHABTHER	32	2	23	5	
SW	269	144	198	102	
VOCSLR	128	2	103	12	
YOUTHCSL	56	0	56	7	
PSCCH GOV	52	12	19	19	
Total Unlicensed	1760	392	1795	414	
Contract titles or					
Volunteers	40	19	93	26	
Total ALL Staff	8463	4940	6645	6053	

*Omitted PREVCSLR which is typically an OASAS title

**CASEMGR includes similar titles such as:

CARECO, CM, CASEW, SWCSE, SWCAS, SWCES, SERVOOR

***Other Titles include: Director, Assist Director, Program Supervisor,

Sr. Counselor, Crisis Response Spec.
RN etc.

ATTACHMENT #3

Titles in OMH State operated programs that are believed to require licensure under the existing scopes of practice defined in the statutes.

OMH State Titles at Risk*

Title	Number at risk	Comment
Social Worker 1	41	Unless they met requirement or continue to be exempt they are at risk
Social Worker 2	0	no longer incumbents in these positions
Social Work Supervisor	0	All have their LCSW
Social Work Supervisor 3	1	One incumbent that does not have a LCSW
Licensed Master Social Worker	0	New draft standard sent to Civil Service
Community MH Nurse	0	nurses are exempt
Nurse 3 Psy	0	Nursed exemption prevents impact

Mental Hygiene Therapy Aides, SCTAs & SHTAs	3568	These direct care staff provide counseling, evaluation, crisis de-escalation
Social Work Assistant 1,2,&3	170	These direct care staff provide counseling, evaluation, crisis de-escalation
Rec. Therapist & Sr. Rec. Therapist	248	W/O exemption, this title would be re-allocated at a higher level e.g. Creative Arts Therapist
Rehab Counselor 1 & 2	188	exemption needed to cover counseling duties
Residential Program Counselor	38	functions overlap with LMHC
Total	4254	

* Original document generated in 2009

ATTACHMENT #4

OMH Local Provider Reporting for Mental Health Programs

The following a list of the Consolidated Fiscal Report (CFR) **Direct Care and Professional titles** reported by local, non-hospital providers that could be at risk should the extension of the Social Work exemption cease to exist for programs licensed, certified, funded or otherwise regulated by the Office of Mental Health. This list does not include Program Administration Staff titles. We estimate that there may be individuals working in program management and administration titles that overlap in scope of practice.

The OMH Office of Financial Planning determined that there are approximately **11,000 to 12,000** staff in many of these titles and other that could be impacted. Including all reporters of the CFR (OMH only), including the hospitals that reported, there are about 32,000 FTEs.

New York State Consolidated Fiscal Reporting and Claiming~ Manual	Subject: Appendix R - Position Titles and Codes Reporting Period: January 1,2010 to December 31, 2010	Section: 51.0	Page: 51.4 Issued: 10/10
CODE	DIRECT		
201	Mental Hygiene Worker (not for OMH CR) (Does not apply to SED)	All individuals engaged in providing non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or Rehabilitation. Job titles may include Habilitation Specialist, Residence Counselor, House Parents, ADL Specialist, Instructor and Trainer, Residence Staff, Relief Staff, House Apartment Worker.	
202	Residence Worker (Does not apply to SED)	All individuals engaged in supervising non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or Rehabilitation. Individuals in this position title do not perform any other administrative duties beyond the direct supervision of Direct	

		Care	If other administrative functions are performed, allocate that portion associated with these functions using position Code 501 or 502. Job titles may include Residence Director, Residence Manager, Hostel Manager, Residence Coordinator.
203	Counselor (OMH CR Only)		All individuals who perform this role as defined in the OMH Community Residence Program Model.
204	Manager		All individuals who perform this role as defined in the OMH
	(OMH CR Only)		Community Residence Program Model
New York State Consolidated Fiscal Reporting and Claiming Manual	Subject: Appendix R - Position Titles and Codes	Section: 51.0	Page: 51.5
	Reporting Period: January 1,2010 to December 31, 2010		Issued: 10/10

CODE NUMBER	POSITION TITLE! JOB TITLE(S)	DEFINITION
205	Senior Counselor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Mode.
206	Supervisor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
207	Developmental Disabilities Specialist QMRP - Direct Care (OPWDD Only)	All individuals not included within another listed title with at least a Bachelor's degree in an appropriate field or one year of experience working with developmentally disabled persons engaged in providing or supervising services to program participants and their families. Job titles ma include: Habilitation Specialist, Residence Counselor.
213	Paraprofessional - Social Services (SED Only)	All individuals under the immediate supervision and direction of a supervisor or caseworker and performs various support activities of case work services. Job title may include: Case Aide, Group Worker, Intern-Social Services, Family Advocate/Therapist.
215	Supervising Teacher (SED Only)	Provides for direct supervision of teachers. Certified Special Education teacher serving as supervisor of teachers less than 25 percent of assignment pursuant to Part 80 of the Regulations of the Commissioner of Education. If supervising more than 25 percent of assignment, see Code 518.
218	Teacher - Special Education	A certified teacher who provides specialized instruction to students with disabilities.
220	Teacher - Physical Education	Self-explanatory.
222	Teacher - Other	A teacher performing functions not otherwise coded. Job titles may include teachers of: Drama, Home Economics, Industrial Arts, Keyboarding. See codes 263, 269, 270, 271, 272, 273 and 274 for other specialized teachers.
224	Teacher - Substitute (SED Only)	Self-explanatory. This is not a permanent position but is maintained on payroll records.
225	Teacher - Speech Certified (SED Only)	Certified as Teacher of Speech and Hearing Handicapped or Teacher of Deaf and Hearing Impaired.
227	Teacher - Coverage/Floating (SED Only)	An individual who covers sick days on a regular basis as a permanent position or as an extra teacher.

228	Teacher Aide	Assists teachers in non-teaching duties such as managing records, materials and equipment, attending to the physical needs of students and supervising students.
230	Teacher Aide/Assistant-Substitute	An individual who covers sick days of teacher aide or teacher assistant personnel. This is not a permanent position but it is maintained on payroll records.
232	Teacher Assistant	An individual who, under the supervision of a certified teacher, assists in such duties as working with individual students or groups of students on special instructional projects, providing teachers with information about students, assisting students in the use of instructional resources, assisting teachers in the development of instructional materials and assisting in instructional programs.
236	Guidance Counselor (SED Only)	Self-explanatory. Job titles may include: School Counselor, Vocational Counselor.

New York State Consolidated Fiscal Reporting and Claiming Manual	Subject: Appendix R - Position Titles and Codes	Section: 51.0	Page: 51.6
	Reporting Period: January 1,2010 to December 31,2010		Issued: 10/10

CODE NUMBER	POSITION TITLE! JOB TITLE(S)	DEFINITION
237	Curriculum Coordinator (SED Only)	A certified administrator or certified Special Education teacher with five years teaching experience who is knowledgeable about the New York State Learning Standards and responsible for ensuring that the program's curriculum is developed and aligned to such Standards. Monitors implementation of the curriculum, Oversees curriculum training, and any curriculum adaptations.
238	IEP Coordinator (SED Only)	A certified or licensed individual in one of the job titles below who is responsible for ensuring that IEP recommendations are implemented and that each service provider responsible for implementation of a student's IEP is aware of his or her IEP responsibilities, including specific accommodations, program modifications, supports and/or services for the student, prior to implementation of such program. Serves as a liaison to the school district Committee on Special Education. Job Titles: Certified Special Education Teacher, School or Licensed Psychologist, Social Worker (Licensed or Master's Level), or Certified Administrator.
243	Behavioral Support Staff (SED Only) Replaces Crisis Intervention Worker	An individual with less than a Master's degree who assists in the implementation of positive behavioral interventions, supports and services.
254	Job Coach/Employment Specialist (OMH & OPWDD Only) (SED- See Codes 255 and 257)	An individual who is responsible for the provision of intensive or extended training related services and supports necessary to obtain employment in the community or for the development of employment opportunities with business and industry.
255	Transition Coordinator (SED Only)	Conducts Level 1 Vocational Assessment, participates ¹⁰ development of transition plans, coordinates school and local resources to provide vocational opportunities, develops post-secondary linkages, and works with VESID' Vocational Rehabilitation Offices to coordinate vocational assessments beyond Level I.
257	Transition Specialist (SED Only)	Conducts and monitors implementation of transition services on a student's IEP, such as training, education, employment, and where appropriate, independent living skills. May include direct assistance to persons in supported employment placements or other job experiences and to their employer, under the direction of a special education teacher, social worker or psychologist.
260	Teacher - Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs).
263	Teacher - Blind and/or Deaf (SED Only)	Teacher who provides special education services to students with disabilities who are blind and/or deaf. Job titles include teachers certified as Teacher of the Blind and Partially Sighted, Teacher of the Visually Impaired, Teacher of the Deaf, Teacher of the Hard of Hearing, or Teacher of the Deaf / Blind.
265	Paraprofessional - Non-Disabled (SED Only)	Self-explanatory . (For use in Preschool Integrated Programs). Includes Non-Disabled Teacher Aides and Assistants.

New York State Consolidated Fiscal Reporting and Claiming Manual	Subject: Appendix R - Position Titles and Codes	Section: 51.0	Page: 51.7
		Reporting Period: January 1,2010 to December 31,2010	Issued: 10/10
CODE NUMBER	POSITION TITLE/ JOB TITLE(S)	DEFINITION	
266	Peer Specialist (OMH Only)	Peer Specialists work with residents to facilitate the individual's recovery process.	
267	Counselor - Alcoholism and Substance Abuse (CASAC)	An individual credentialed by the New York State Office of Alcoholism and Substance Abuse Services.	
268	Counseling Aide/Assistant - Alcoholism and Substance Abuse (Does not apply to SED)	An individual functionin as defined for Alcoholism and Substance Abuse Counselor under supervision but who does not have a credential issued by the Office of Alcoholism and Substance Abuse Services.	
269	Teacher - Art	Teacher who is certified to provide art education to meet Part 100 program and units of credit requirements.	
270	Teacher - Music	Teacher who is certified to provide music education to meet Part 100 program and units of credit requirements.	
271	Teacher - Technology	Teacher who is certified by SED to provide technology studies to meet Part 100 program and units of credit requirements.	
272	Teacher - Foreign	Teacher who is certified by SED to provide foreign language to meet Part 100 program and units of credit requirements.	
273	Teacher - Resource Room	Certified special education teacher that provides resource room services consistent with a student's Individual Education Program (IEP).	
274	Teacher - Reading	Teacher who is certified in reading by SED to provide reading instruction.	
290	Other Direct Care Staff	Anyone not listed in the 200 series engaged in providing direct care services.	
CLINICAL STAFF			
301	Case Manager (Does not apply to SED)	Supervises the implementation of each individualized program, monitors services received, records progress and initiates required periodic reviews. Job title may include: Client Coordinator.	
305	Counselor - Rehabilitation (Does not apply to SED)	All individuals who have a degree in rehabilitative counseling from a program approved by the State Education Department or with current certification by the Commission on Rehabilitation Counselor Certification.	
309	Developmental Disabilities Specialist Habilitation Specialist QMRP - Clinical (OPWDD Only)	All individuals not included in otherwise listed titles with at least a Bachelor's degree in an appropriate field from an accredited program and specialized training or one year experience working with developmentally disabled persons engaged in providing or supervising services to program participants and their families.	
312	Emergency Medical Technician (Does not apply to SED)	An individual certified by the New York State Department of Health for a period of three years as being qualified in all phases of medical emergency technology including, but not limited to communications, first aid, equipment maintenance, emergency room techniques and procedures, patient handling and positioning, and "knowledge of procedures and equipment used for obstetrics, respiratory and cardiac emergencies who has passed an examination in the regular and advanced American Red Cross first aid courses and other training as required by the Commissioner of Health.	

New York State Consolidated Fiscal Reporting and Claiming Manual	Subject: Appendix R - Position Titles and Codes Reporting Period: January 1,2010 to December 31,2010	Section: 51.0	Page: 51.8 Issued: 10/10
355	Student (OMH Only)	Student who is participating in a program approved by the NYS Education Department that lead to a degree or license in one of the Professional Disciplines. Must have a signed agreement and policies And procedures for placement & supervision.	
390	Other Clinical Staff (Does not apply to SED)	Student who is participating in a program approved by the NYS Education Department that lead to a degree or license in one of the Professional Disciplines. Must have a signed agreement and policies And procedures for placement & supervision.	