EVALUATION OF CASE MANAGEMENT MODEL

HENNEPIN COUNTY DEVELOPMENTAL DISABILITIES PROGRAM

2004-2005

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EXECUTIVE SUMMARY

In the summer of 2004, the administration of the Hennepin County's Developmental Disabilities Program of Community-Based Long Term Care requested an outside evaluation of the "new" case management model being used in the Division. They made this request of the Institute on Community Integration at the University of Minnesota, which is a federally-funded, internationally known Research and Training Center concerning the community integration of persons with developmental disabilities, and which has conducted many evaluations of case management in the past.

The new county case management model had been initiated in the Children's teams in 2003 and began to be implemented with the Adult teams in 2004. The Institute was asked to review case management literature and consult national experts about case management and support coordination, and provide an outside perspective concerning the design of the new case management model: whether the design was workable and effective to serve growing numbers of clients with fixed case management resources. We were specifically asked to address six questions concerning the new model, which are summarized below.

The team concluded that the design of the new model could work, and that several aspects of the new model are beneficial, but that there are several significant areas of implementation which need to be addressed in order to have the model work as effectively as possible. That is, most of the issues are not design issues of the new model itself, but rather implementation issues in changing to a new system.

Addressing these issues is critical to increase the assurance that client health and safety concerns are being adequately addressed, that potential county vulnerabilities are minimized, and that responsiveness to clients is assured. This report includes several recommendations regarding the implementation of and infrastructures for the new model. In addition, as the number of clients continues to grow, several larger directions will also need to be pursued by the county, including increasing avenues for consumer empowerment and control, as well as systems advocacy.

METHOD

In order to evaluate the new design, we:
- Reviewed case management literature
- Surveyed national experts to determine if other areas had used similar models
- Attended fourteen focus groups in the summer of 2004 which were attended by most Hennepin County case managers, supervisors, and aides
- Conducted a written survey of case managers, supervisors and aides in the winter of 2004-05
- Interviewed supervisors in the spring of 2005

The written survey was based on a stake-holder conference called "New Values, New Visions: Guidelines for Hennepin County Residents with Developmental Disabilities," which had been held in June 1997. This conference of stake-holders included many consumer and family statements regarding what was wanted from the case management system in Hennepin County and reflected many "best practice" recommendations.

DIFFERENT MODELS AND FUNCTIONS OF CASE MANAGEMENT

Case management itself evolved in the early 20th century, but has continued to evolve from the individual caseload design initially established, in which one case manager would have an individual caseload. At the time this model evolved in the 1970's, the case manager was intended to be a powerful monitor, advocate, and service coordinator. However, many aspects of the services system have limited case managers being able to fulfill the role intended for them. It is not that they are not well-intentioned or committed to fulfilling the roles envisioned for them, it is simply that many system aspects simply do not allow them or support them to do so.

In an evaluation of a case management system in the state of Ohio, the authors noted three myths which had evolved regarding case management. These myths are applicable in many places, as well as Hennepin County:

1. If someone is on a caseload, then there is a powerful person monitoring his/her situation and therefore he/she is safe.
2. The case manager is a powerful advocate and the primary one.
3. The case manager is a magic conduit.

These myths reflect the belief that there are substantial amounts of dollars available, many community resources, and that the case manager was key to unlocking these. These were part of the original assumptions or hopes in the original design of case management in the 1970's. However, what has happened is that the services system has evolved in such ways that case management as it was designed cannot guarantee these assumptions.

Newer models which have evolved since that time include support coordination, support brokerage, and models aimed at increased self-determination and consumer empowerment. Even these models are evolving as consumer self-determination continues to increase, and as it is recognized across the country that limitations in many aspects of the current services system require evolving designs and roles across every aspect of that services system. While implementation of the "best practices" may not always be possible, ways must be found to fulfill the interventions and resource allocations which are required, in the most unobtrusive and empowering ways possible.

We propose that the county must clearly address its role in five possible functions for a case management system:

1. administrative functions, including gate-keeping and monitoring
2. problem solving/crisis management
3. consumer empowerment
4. individual advocacy
5. systems advocacy

The first two of these roles are critical, necessary and foundational roles the county must fulfill. It is possible that the opportunity for individual advocacy has decreased in the new model. As the county moves toward a future of increasing numbers of clients and limited resources, the importance of consumer empowerment and systems advocacy will be critical.

EVALUATION OF THE NEW MODEL

There are both benefits and challenges in the new model. Many of the pervasive systemic challenges were also present under the old model of case management, and would persist no matter what system of case management was implemented. The county staff who responded to surveys indicated that many aspects of the new system took them farther away from the principles expressed by stake-holders in the "New Values, New Visions" conference, many of which statements were for a strong individual advocacy system.

Under the new system, benefits seen by focus group participants included the establishment of specialized teams, the calendar, and the central phone number. The challenges of the new model are addressed in different arenas of recommendations made. Responses to the six questions we were asked to address are summarized below:

1. Do the new models support and encourage client choice and control?

Client choice and control could be encouraged under either the old model or the new model. Elements of the new model which interfere with choice and control which need to be addressed include assuring that adequate information is being provided in real and useful ways to consumers and finding more avenues for consumer empowerment and self-advocacy.

2. Does the new model address county responsibilities?

The fundamental county roles of administration and crisis management can be adequately addressed in the new model. Individual advocacy has shifted for clients in the pool. The new model creates opportunities for increased consumer empowerment and increases the need for systems advocacy.

In terms of the county responsibility to manage limited resources as efficiently as possible, the "bugs" in the new system need to continue to be improved, including scheduling of meetings,

reducing duplication of effort, and determining ways to assure that the county responsibility of seeing individuals twice a year is fulfilled effectively.

3. Do we have any exposures of vulnerabilities under the new model?

There were several potential areas of exposure and vulnerabilities expressed during the focus group meetings which should be addressed, including: quality control, checks on providers (who may have increased power under the new model for individuals in the pool), variability in accountability of case managers, addressing potential "cracks" between different parts of the system, financial controls in CDCS, incorrect placement of consumers in the pool, increased risk for case managers dealing with clients unfamiliar to them, and "holes" when people are found in-eligible for services.

4. Does the new model lend itself to responsiveness to clients?

Some aspects of the new model increase responsiveness and some diminish responsiveness. Just as in the old system, the effectiveness of individual workers varies.   In terms of increased responsiveness, many clients like being able to get a live person on the phone, and to get an answer or services more quickly.

The ways in which the system reduces responsiveness can be addressed, including: clients having to tell the same story repeatedly to different workers, reduction in quality because of a number of different workers being involved with one consumer over time, and inefficiencies at the coverage desk and in procedures.   There is also a need to assure that quality and responsiveness can be maintained because the caseloads for those who do have individual caseloads are typically less balanced between more and less challenging caseloads as they used to be; an individual case manager now typically has more or almost all "intensive" cases.

5. Will the new model allow us to meet the growing numbers of clients with fixed case management resources?

For the long range future, there will likely be only increasing stress on the system, and growing numbers of clients.   In the short-term, efforts need to be directed toward doing everything possible to maximize revenue and increase cost-savings.   Longer range directions include increasing consumer empowerment and implementing new avenues of systems advocacy. Several specific suggestions in all these areas are included in this report.

6. Is the new model effective in assuring client health and safety considerations?

The new model could be effective in assuring client health and safety considerations, but there are several issues in the implementation of the new model which raised health and safety concerns.   Again, we think these are primarily a matter of working out the "bugs" in changing to a new system, rather than the design itself.   These include: fixing the "cracks" that cause delays and inconsistencies, assuring there is adequate and prompt follow-up on reported health and safety concerns, increasing consistency in documentation, and effective quality assurance and safety nets.

RECOMMENDATIONS

There are many specific recommendations made in the report in each of the six question areas described above.   In addition, specific suggestions in two broad arenas of recommendation are made:

I. Improving implementation of the new model:

1. Assure that the tools and information system necessary for the new model work
2. Standardize personnel at the coverage desk
3. Have consistent criteria, consistently applied, for membership in the "pool"
4. Establish consistency in expectations regarding the pool
5. Get parts of the system working more efficiently and effectively together
6. Promote ownership of the new model by case managers, supervisors, and consumers

A critical aspect of promoting ownership of the new model is that personnel in the position of "case manager" must understand the evolving nature of that role.   Several staff participating in the evaluation expressed a complaint like the following: "we're not doing social work." However, the role of case manager evolved 30 years ago from traditional social work models. It is not clear what the possible reasons are for this confusion.   At the same time, in the last decade, even case management has evolved into support brokerage and support coordination, and in the 21st century the services system has moved beyond even these models.   For example, the work in the Consumer-Directed Community Services team is several generations beyond social work.   These roles will continue to evolve.

II. Address Larger Longer-Range Directions

1. Focus on critical tasks
2. Be pro-active
3. Consumer empowerment
4. Systems advocacy
5. The broad county role

SUMMARY

In summary, the design of the new model can be an effective one to meet required county roles, but several implementation issues need to be addressed. For the long term future which the county faces: an increasing number of clients and fixed case management resources, the county is likely to need to increase and expand its roles in consumer empowerment and systems advocacy.

EVALUATION OF CASE MANAGEMENT MODEL

HENNEPIN COUNTY DEVELOPMENTAL DISABILITIES PROGRAM 2004-2005

The administration of Hennepin County's Developmental Disabilities Program of Community-Based Long Term Care requested an outside evaluation of the "new" case management model being used in the program. This model had been initiated in the Children's teams in 2003 and with the Adult teams in 2004.

This is our understanding of the essential elements of this new model:

1. People whose situations were fairly stable would no longer have an individually assigned case manager, but be assigned to what is commonly referred to as "the pool." In adult services, it is the Adult Resource and Response Team (ARRT) and in children's the Intervention Prevention Group (IPG). In the pool, work would be assigned by "task." Different workers from these teams would be assigned to attend any meetings about the person during the year, and to complete other needed tasks. If the consumer or their representative needed anything, they would call into a central number ("coverage desk") for the required information rather than call an assigned case manager. The individual could get the information from the coverage desk or the coverage desk worker would refer the request on and someone else would be assigned to get back to the consumer.

2. Individuals whose situations are not fairly stable are assigned to specialized teams or to teams in which case managers do have assigned caseloads. Once an individual's situation stabilizes, they could be assigned back to the pool.

Special teams were established around specific functions. On the adult side, these teams included:

    a. screening and assessment
    b. consumer-directed supports
    c. transition

On the children's side some of the teams at the time of the evaluation included:

    a. autism
    b. medically fragile
    c. parents with cognitive limitations
    d. dual diagnosis

One of the beneficial results of these special teams is that all case managers no longer had to have the specific information required to fulfill every specialized function, but could refer individuals to these special teams.

Evaluation Process

We were asked to provide an outside perspective on the design of the new case management model itself. We were especially asked to determine whether there was professional literature on the new type of model, and whether such a model had been implemented elsewhere in the country and if so, what support there was for this type of model. We were asked to focus on the feasibility and potential effectiveness of the model design itself – not on its implementation or how people felt about it. We were also asked to address six questions:

1. Do the current and proposed case management models support and encourage client choice and control?

2. Do the current and proposed case management models address county responsibilities?

3. Do we have any exposures or vulnerabilities under the current and proposed models?

4. Do these models lend themselves to responsiveness to our clients?

5. Will these models allow us to meet the needs of growing numbers of clients with fixed case management resources?

6. Will these models be effective in assuring client health and safety considerations?

There were three parts to our evaluation process:

1. Focus groups for different teams had already been set up by the county in the summer of 2004. We attended 14 of 16 of these focus groups.

2. A survey about the implications of the new model was distributed in December 2004.

3. Phone interviews with three supervisors were conducted in April and May, 2005

While we had initially planned a small number of focus groups and more interviews, the fact that the 16 focus groups were already scheduled by the county and that we were able to attend so many was serendipitous for our review and provided a far greater opportunity for data collection than the original plan. It has also been helpful to have a period of time in which to review the progress of the implementation – the focus groups were in July 2004, the surveys in December, and in the supervisor interviews in the spring we were able to get updated status reports on implementation.

In our evaluation, we did focus on the two primary arenas about which we were asked: professional and theoretical support for the model, and providing an outside perspective on the design of the model. However, we have also included comments on the implementation of the model, since that affects the outcomes of the model, no matter how well it is designed.

There are four parts to this report:

1. A summary of the professional literature and others' experience with this type of case management design.
2. A summary of the information gathered from focus groups, questionnaires, and interviews.
3. Summary responses to the six questions we were asked to address.
4. Recommendations.

I. SUPPORT FOR NEW CASE MANAGEMENT MODEL IN PROFESSIONAL LITERATURE AND OTHER SERVICE SYSTEMS IN THE COUNTRY

It is important to place the current changes in the Hennepin County case management system as one stage in a historical process of such changes. Some of the changes currently being experienced have a foundation in previous system evolutions.

A. RESEARCH ABOUT CASE MANAGEMENT AND CASE MANAGEMENT MODELS

The concept of case management has evolved from more traditional forms of social work, which itself evolved primarily during the 19th century. The earliest forms of social work were based in large groups and were almost completely dependent on charity. As a complex system of governmental funding and social services programs evolved for vulnerable individuals throughout the early part of the 20th century, both social work and individual case management evolved. Specifically, case management began in the anti-poverty programs of the 1960's, as a way to help people more thoroughly benefit from services, and then moved into the rehabilitation field (Spitalnik, 2000). The model evolved out of a need to address two functions: (1) that needy individuals receive the support and services they required but also (2) the need for gate-keeping. Funding agencies had a need for assurance that only eligible persons received services and that these individuals did not abuse the funding and programs available to them.

Case management was embraced for services for people with developmental disabilities in the mid to late 1970's as community integration became more common, and as people began to be placed less often in settings where a single agency was responsible for all aspects of their lives (as it had been in the institution). As a diversity of community services and programs became available, the need for coordinating complex packages of support became more common. The federal DD Assistance and Bill of Rights Act of 1978 established the policy rationale for case management by including it as part of the criteria for determining whether someone had a developmental disability, that it "Reflects the person's need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are life-long or of extended duration and... are individually planned and coordinated."

In this period, most people who became case managers had been in more traditional social work roles. At a 1980 national conference on case management that was held by the National Association of Social Workers, four principal functions of case management were identified: assessment, planning, service linkage and brokering, and monitoring. At the conference, many newly designated case managers were uncomfortable with the service linkage function, saying they felt ill-equipped to perform the brokering and negotiating aspects of the role. They expressed that they missed the counseling functions of the social work role, which they considered very important and professionally satisfying (Spitalnik, 2000). Similar sentiments were expressed by several Hennepin County case managers at the focus group meetings in 2004; these case managers reported that under the new model they were no longer able to use their social work skills.

When case management was first starting and was becoming more wide-spread, many professionals and funding agencies raised significant questions about whether case management really made any difference. Although there were apparently virtually no controlled studies conducted with people with developmental disabilities, there were many rigorous studies concerning the efficacy and cost-effectiveness of case management with other population groups. For instance, in the 1980's there were a few well-controlled studies when case management systems for persons with mental illness were first established. These studies showed conflicting results as to the demonstrable efficacy of case management, both in cost savings and in improving outcomes for people (Franklin, Solovitz, Mason, Clemons & Miller, 1987; Bond, Miller, Krumwied, & Ward, 1988). In the 1980's, there were also many controlled research studies regarding the efficacy of case management for persons who were elderly, including random assignment to "case management" or "no case management" conditions. At least 14 community long-term care demonstration projects were studied, as well as ten National Channeling Demonstration projects in 10 states. The results of these studies indicated conflicting and generally rather negative evidence as to the cost-savings effects of case management in these numerous demonstration projects. However, many of these projects had other components in them, such as Medicaid waivers for the provision of additional services, so the use of case managers was not the sole intervention or factor in the results of these studies. Yet, despite these mixed and negative results, case management became a core function of numerous state and local Medicaid and other long-term care programs.

Zimmer and his colleagues (1990) noted that despite these conflicting results with these two different population groups, case management has been accepted as desirable, at least from the perspective of improving the quality and accessibility of care, so in that case is probably "cost-effective" if not cost saving. Furthermore, they note that despite the rapid growth and popularity of case management, there is little detailed and quantitative data available that describes which case management models have the greatest impact in making care more effective and efficient. In their study, they established a randomized trial comparing two models of case management for the chronically ill elderly with dementia – a neighborhood team model, with several professionals from different disciplines acting as a team, and a centralized individual caseload model. The team case managers provided much more intensive case management, had smaller caseloads, made more home visits, provided more counseling, and made more referrals for medical evaluation, respite and day care. While the team model resulted in cost savings in health care costs, specifically hospital and home health service use, there were no differences between the two models for functional and care need status, longevity, or in client or caregiver satisfaction.

In the developmental disabilities services system, in the 20-30 years since case management started, both the number of people eligible for case management and waiting lists have multiplied. Spitalnik (2000) has noted that this has in many instances resulted in the gate-keeping role of case management becoming even more important. In many systems, case managers have increasingly become gate-keepers, responsible for guarding the resources of the specialized service system. In these situations, they have less of a role as facilitators for individuals and families and more of a role as agents of the system.

CLASSIC MODELS OF CASE MANAGEMENT

Virtually all of the classic case management texts which we reviewed concerning models of case management assumed individual "caseloads." In Moxley's (1989) "The Practice of Case Management," for instance, case management is defined as "A designated person (or team) who organizes, coordinates, and sustains a network of formal and informal supports and activities designed to optimize the functioning and well-being of people with multiple needs." He states three goals of these case management activities:

1. To promote, when possible, the skills of the client in accessing and utilizing these supports and services.
2. To develop the capacities of social networks and relevant human service providers in promoting the functioning and well-being of the client.
3. To promote service effectiveness while attempting to have services and supports delivered in the most efficient manner possible.

Moxley lays out the five key functions of case management as:
- Assessment
- Planning
- Intervention
- Monitoring
- Evaluation

Note that Moxley indicates case management could be provided by either a person or a team. Both he and other sources have promoted the notion of work teams, but almost always the types of teams proposed are "self-directed work teams." There is a rich literature on such teams, which typically are required to be semi-autonomous and have shared leadership and control of the resources (Torres & Spiegel, 1990). However, in establishing the new model in Hennepin County for the work of case managers in developmental disabilities, it appears that the teams established were not based on this type of self-directed work team.

NEW DILEMMAS – MORE CURRENT AND EVOLVING MODELS

In more recent years, the impetus of increased self-determination, consumer-directed services and consumer empowerment has pressed case management in many places to evolve into the different role of "support coordination" or "support brokerage." These roles require different functions, including: more empowerment of individuals, developing a broad array of supports which arise from increased family and community connections, facilitating person-centered forms of planning, and viewing the individual and family as the directors of their own supports. These roles require case managers to be leaders in the transformation of the system of services, changing the balance of power and control, and giving up decision-making authority in favor of the consumer and their family (Agosta, 2000).

Moseley (2000) pointed out that over the past several years, the scope of case management has expanded to address an increasing number of competing goals. One key role is that case

managers have the responsibility for organizing the delivery of supports to an individual. However, they may also be expected to:

    a. act directly on behalf of the consumer, as an advocate, or friend
    b. work as part of the management of the agency to ensure resources are used in a cost-effective manner and to monitory quality and
    c. provide direct service, supporting an individual during times of crisis or other unplanned-for situations.

When the additional responsibilities for screening and case finding, assessment, development and implementation of the support plan, authorization of services, monitoring, referral and follow-up, the job truly becomes ambiguous (Kane, Kane & Ladd, 1998). Other new roles, such as training families to be case managers (Seltzer, 2003) also compound the complexity. All of this means that traditional social work and case management skills must typically be greatly expanded on, or in some cases might not even be the most necessary types of skills needed.

In summary, there are two major trends currently affecting the conceptualization of what case management is, could be, and should be. The first trend across the country is the one noted above: an increasing commitment to consumer empowerment. There has been a significant amount of questioning: in a system truly based on promoting self-advocacy and self-direction, is there an appropriate role for a "case manager"? If so, what would that be? The second trend is the one which Hennepin County acutely faces: increasing caseloads and fixed resources for case management. In such a dilemma, which increasing numbers of governmental entities across the country are or will be confronting, does a model of individual case management continue to make sense?

Attached in Appendix A is a resource list of references, sources and articles on case management for additional information.

B. OTHER EXPERIENCES WITH THIS TYPE OF MODEL

We searched the professional literature and contacted national key leaders across the country familiar with many different local and state systems to ascertain if there were other places which had attempted to use or were using a model similar to that implemented by Hennepin County, including the part of the model representing the "pool." We found two places that had used models with people with developmental disabilities that had elements similar to some of the elements in the Hennepin County model. (There might be others, but these were the only two we could identify.) One is in New Jersey and the second is in Ohio.

NEW JERSEY

The first model in New Jersey has three tiers of support that are designed to provide case management services that are proportional to the general needs of persons with developmental disabilities in different situations. While no services are "pooled" and there are still individual case loads, they have divided support into three levels or tiers. These three tiers are:

1. **Primary case management** is provided to people considered the most vulnerable.   Situations may include potential isolation and/or a need for special attention.   These persons include those who live in "skill development" (family foster care) homes, boarding homes, or who have been designated as having "urgent" status on the waiting list for services.   Because of the need for careful, ongoing monitoring, new Jersey has designated the "caseloads" for primary case managers to be 35 service recipients per case manager so that case managers can visit service recipients monthly with a face-to-face encounter.

2. **Program case management** is provided to people who are enrolled in structured service programs in which they experience regular oversight by a range of people. Individuals who receive program case management include people in group homes, supervised apartments, day programs, and people in the state's self-determination program. The caseloads for program case management are set at 90 service recipients per case manager.   Case managers visit service sites on at least a quarterly basis, but in reality case managers typically have a number of people on their case load served in the same service setting sot that they see people considerably more often than quarterly.   Indeed program case managers are often well-integrated into a provider agency's operations so that they see what is going on with fair regularity.

3. **Resource case management** is intended for people who do not need on-going traditional case management, but do need a source of connection to the system to identify and respond to problems they may be having with services received, to provide information and referral, and to attend to changing circumstances that may require more extensive services.   Typically the individuals receiving resource case management are school children receiving in-home services or adult children living at home who may receive respite care or some other support. Resource case management is vied as being for people for whom case management is really not needed or desired at the current time, so that "resource" caseloads are typically around 250 individuals per case manager.   Although limited support is needed by resource case management recipients at least one direct contact is made per year to monitor status and changing needs and to assure service recipients and families of ongoing-ready access to whatever information, advice, planning and service development they might need.

OHIO

 In 1995, Butler County, a small county in Ohio, was faced with the same dilemma as that currently faced by Hennepin County: increasing caseloads and a limited case management staff. The director of social services for persons with developmental disabilities for the county, said they faced a serious situation of being forced to look at "how to allocate a scarce resource." In their process of attempting to understand their dilemma and decide on the best courses of action, they took several steps back and asked larger questions about the whole system, including

questions regarding the very assumptions of case management and the assumptions under which the county social services system operated. Some of these questions were difficult ones, including: What is case management anyway? Who really benefits from it? Is there actually any real benefit people get from it? If we stopped doing it, would anyone miss it?

This county ended up establishing criteria similar to the "pool" criteria established by Hennepin County – that is, for individuals whose situations were relatively stable and who had sufficient advocacy from other sources, the amount of "case management" provided would be minimized. At that time (1995), the service configuration was different than it is there currently, and different than Hennepin County, in that few people had services through the Medicaid waiver and therefore case management was not mandated as part of waiver funding. Secondly, at the time, the ICF-MR services in Ohio were required to provide case management services to the people they were responsible for. So, the people receiving case management from the county primarily received other types of services, including what in Minnesota would be considered SILS, in-home support, and other locally and state-funded services.

In 1995, the existing case management system was reviewed by a three-person team which included a national leader in person-centered services, John O'Brien. The summary of the team's evaluation findings were reported in a document called "Case Management Evaluation 1995" (O'Brien, 1995). Many of the comments of this evaluation team are directly relevant to the current situation facing case management in most places, including Hennepin County, which has many features virtually identical to Butler County's situation, in issues if not in size. Therefore, these comments are more extensively reported on here. This summary evaluation was initially made as a presentation to the Butler County case managers and their supervisors, which was later turned into a transcribed report of the presentation (O'Brien, 1995). Consequently, some of the comments below have a more "conversational" tone.

The rationale for discussing these findings also includes one of the major questions we asked in conducting this study – which is, whether things were really any different for people under the old and new models of case management? We noticed a tendency for some county personnel to talk as if things were significantly better under the old model, compared to the new model. However, we suspected that many of the systemic problems which case managers deal with, in terms of issues which make real differences in the lives of people with disabilities, are exactly the same. That is, although the day to day work of case managers might be different, we were not sure that the daily lives of consumers were any different.

SYSTEM-CENTERED FRAMEWORKS

Part of the context for understanding the current crises in case management can also come from Beth Mount, one of the originators of Person-Centered Planning methods. She and John O'Brien have both contributed a great deal to understanding how "person-centered" work operates in sharp contrast to "system-centered" work. These ideas form a foundation for understanding that there will be pervasive systemic issues under any model of case management, and that there are some things which were probably not any better under the old system and would persist no matter what case management model was used.

In "Imperfect Change: Embracing the Tensions of Person-Centered Work" (1990) Mount and her colleagues describe a fundamental flaw in "system-centered" work. In system-centered approaches, control over decisions and actions is typically allocated to professionals, operating inside complex regulations and bureaucratic monopolies. Professional roles often distance workers from complex realities and rob them of the richness of sharing directly in people's dreams and disappointments. System-centered services rely on standardized designs for service delivery (e.g., SILS slots, SLS openings, etc.) that do not account for the interests of people or the resources in local communities. While many service systems aspire to be more person-centered, many current elements keep these services embedded in system-centered practices. One of the fundamental underpinnings of system-centered approaches is that there is an inherent or unspoken promise: that if there were simply enough funds, slots, beds, etc; enough staff, the right meetings; if all the paperwork and forms and checklists were filled out, then everything would be "perfect." "If they just get the paperwork done, meet the timelines, fill the quotas, then maybe things will get better." Mount calls this the "The Promise of Perfection" in system-centered work.

She contrasts this with "person-centered" approaches: "The desires of people often face workers with imperfection. People's lives may be filled with chaos and disorder. Workers may be confronted with their own helplessness in changing the quality of another person's life" (p. 11). The contrasts between these two systems are presented in her diagram in Appendix C. We thought this contrast applicable to the current situation in Hennepin County because in some of the focus groups' discussions there was almost an underlying implication that things would work in the case management system if there were simply enough case managers with the right number of people on their caseloads. If there were "enough," then everything would be "perfect."

This perspective also applied to the situation during the evaluation of case management in Butler County, Ohio. A startling realization by the evaluation team of the existing "overload" situation was that even if case managers had individual caseloads, reduced caseloads, and the number of case managers were doubled – the evaluation team concluded that this still wouldn't fix things. Even if you doubled the number of case managers, people would be relieved for a little while and then everyone would simply get overwhelmed again later. The team concluded that "It's not a matter of quantity, but rather of design. More wouldn't solve the problem."

OVERLOAD

The main finding of the evaluation team in Butler County was that the case managers were in a situation of "overload" -- having too many people to respond to effectively and the expectations about what their responses to people should be were unclear. One of the major consequences of overload was that case managers had to regularly deal with confused feelings of stress, defensiveness, anger and guilt – arising from their inability to help all the people on their "case loads."

Two other assumptions or expectations contributed to the "overload":

1. Case managers were believed or assumed by others in the system to be THE major defenders of people's rights.

However, rights-defense is clearly impossible in an overload situation.

A number of people acted as though that if there's a case manager there, then people's rights are taken care of. And if there's not a case manager, then it's the case manger's fault that people's rights are not taken care of. Along with this comes an expectation that "the case manager will tell us what to do" -- that is, in conflicting or difficult situations, others wait for and expect the case manager to decide what to do. The expectation is that it is the case manager's job to tell people what to do rather than to assist people in working together and figuring out together what needs to happen for someone.

Related to this was the phenomenon that case managers tended to be seen as the only people who have a sense of the whole person – so the whole person belongs to the case manager. It's as if providers were saying: "If we're having a problem in our program and someone isn't fitting in, it is the case manager's job to come and take the left over pieces – they're not ours, so they must be yours." This was a sign that the case manager had been handed the responsibility for the whole person instead of people trying to figure out, together, how to actually use the resources available to make the best in people's lives.

2. It was expected that case managers would be able to attend to and "fix" situations that are very complicated and difficult.

However, in fact, case managers work hard, but have few resources with which to attack difficult problems.

The evaluation team did not think that reduced case loads would reduce the overload problem. They recommended that the county workers get clear about the "must's" and the "have-to's" regarding case management. For instance, there are "must's that the county provides case management, that there are clear procedures for dealing with major incidents in people's lives and that case management has to be reported to the state. Also, case managers can't be case managers and provide other kinds of services at the same time. At a minimum, those were the musts. So that left a lot of room to think about: what is the RIGHT thing to do?

HARD QUESTIONS

During their evaluation, O'Brien and his colleagues tried to be quite honest and to bring a great deal of candor to their interviews with people. For instance, they asked clients would it be okay if they didn't have a case manager? Would it be a good thing if people with disabilities fired their case managers? The percentage of clients that responded that they didn't particularly care if they had a case manager or not was quite startling – and begged the question of the real usefulness of case management in people's lives.

A similar attitude was expressed by one of the Hennepin County children's workers in their focus group, "If we disappeared tomorrow, lots of families would be fine." The Hennepin County Consumer-Directed Support team also reported that some clients did not say their relationship with their social worker was important; in CDCS, this could be considered a desirable situation.

After the evaluation was completed in Butler County, some people on the county caseload were informed that they no longer had to have a case manager. Many of these people didn't care. People were also told "You can still call us (at the county) if you need something." After this point, service providers were as likely to call as the service recipients. It was reported that some of the consumers still called because they seemed to "like others to pay attention to them."

MYTHS ABOUT CASE MANAGEMENT

The evaluation team grounded their perspectives in three apparent myths, which are probably myths regarding case management in many places, including Hennepin County:

Myth 1: If someone is on a caseload, then there is a powerful person monitoring his/her situation and therefore he/she is safe.

This idea did not come out of nowhere – it came about in the 1970's or 1980's when case management started and came from a theory of what case managers were supposed to be. There is a myth that "My son or daughter is safer because they are on a caseload, and because they are on a caseload, you (the case manager) are on top of the situation and I don't have to worry." Of course there are many situations in which case managers have caused a positive difference, but that is different than thinking that everybody is okay because they are on a caseload. O'Brien and his colleagues noted that there is a great deal of attachment to this notion – it is a hard myth to deal with because people are attached to the idea and getting unattached means a big change.

Myth 2: The case manager is a powerful advocate and the primary one

This is the myth that if the case manager is the advocate, being the advocate gives them some kind of special privilege or special responsibility. If the case manager says something is okay, then it must be okay. But most stakeholders in the field, especially case managers, know the limitations of this notion and the limitations of power. Many case managers report: "I may be the advocate, but there is nobody listening about this particular situation."

Myth 3: The case manager is a magic conduit

There is a myth that the case manager is the accountable conduit to a place to live and to a whole lot of resources that nobody else knows about. It's like the case manager is a guardian of a treasure chest and that somehow others can seduce them or make them feel guilty or put the squeeze on and then the case manager will produce. This myth reflects a theory about what case management was going to do and a past condition long gone by – the past condition that there

were substantial amounts of dollars available. The current situation of far more limited resources will likely continue for several if not many years.

But even if there were a great deal more local investments in local services, it would still not be the case for consumers in relating to their case managers that: "All we have to do is get you to go the cupboard, and it will creak open and out will come all this good stuff." There is a notion that somehow or other there are all these community resources that case managers know about that ordinary consumers can not find about, and somewhere in the case manager's back pocket they have a doctor who will take Medicaid who's really good at this person's particular problem. "If I can just make you tell me, you'll come up with him." Again, however, this myth does not take away from the fact that sometimes there are indeed situations where the case manager does know someone or something and can help.

It is not a strange or unexpected situation if people believe any of these three myths – all of them were part of some basic assumptions or hopes in the original design of case management in the 1970's. However, what has happened is that, simply, the services system has evolved in such ways that case management as it was designed cannot guarantee these assumptions.   It is not that case managers are not well-intentioned and committed to fulfilling the roles envisioned for them, it is simply that many aspects of the system have and in some cases cannot be expected to allow them or support them to do so.   The "best practices" in case management in many cases simply cannot be expected.

O'Brien and his colleagues went on to note that underlying these myths is a common human service problem – that somehow or other people (including agencies, family members, people with disabilities, and case managers themselves) have been sent a strange kind of message that people actually NEED case management in the same way that they need a safe and decent place to live, some friends, some money and a reasonable job.

In Butler County they found that case management was an expensive service for what it actually delivered. The evaluation they conducted brought forth the question of whether case management had any real value or not. In most cases, it was not a "real" service – if you called an emergency room, you got a "real" service, but not when you called the case management office.

The reason that it is thought that case management is needed is that people assume that case management itself is the way to get those really necessary things – a home, a job, and friends. Any attempt to try to change the fundamental case management and services system will bump into these myths and beliefs. The system and people with disabilities and family members have a temptation to play a game in which they make the case manager the Wizard of Oz – the case manager could grant people's wishes if they wanted to. There's a big investment in nobody noticing that there is only a little man behind the curtain. Case managers and the system HAVE made good things happen for some people. But, the Wizard does not have access to big bags of gold. At best, case managers have access to little tiny bags of gold and that access comes with considerable difficulty.

The danger is that when Case Management is the place where others park "rights" and the place where they park "the whole person," the difficult issues get shifted to the case manager instead of being dealt with by the people who have them. There is an implied promise that the case manager will take care of various kinds of situations that they may not, in fact, be able to take care of. In terms of the assumptions that Case Managers can make services appear and can get things that other people can't, there are three problems:

1. Other people don't say: "What can we do to make better use of what resources we have, or hunt for some more?"
2. We absolve the system as a whole because we say case managers should figure it out. "We're sure you can make something happen here; you can make it work." That lets the system and the community as a whole off the hook, because it's the case manager's fault if something good doesn't happen for people.
3. People use the absence of a case manager at a meeting as the reason something better didn't happen. "How could we possibly do this? You were not there. You cancelled out at the last minute so now we have to reschedule the meeting in order to . . ." The trap door is "Case Managers are not there; things can't happen." This is a trap door that people can escape through instead of trying to figure something out.

The message that's been delivered in social services for about thirty years is that "case managers will be there to take care of it." However, that message must alter dramatically within the newer paradigm of consumer empowerment. The thirty-year old message evolved from a system that in the past was about comprehensiveness. The MR/DD system tried to expand and diversify so that it covered all possible needs for people with developmental disabilities in the community, and of course, it has been unsuccessful at doing that all of the time. One of the efforts of trying to cover all of the needs is that the system tends to dominate over OTHER ways of helping people with disabilities resolve some of their difficulties. Although there have been many positives for people with disabilities, the dominance of the local services system and its filtering its way into lots of sectors of peoples' lives have left people with developmental disabilities and their families in a situation in which they have little organized voice, little way of speaking for themselves. Consumers and families defer to the services system to try to resolve all of the situations that come up. There is a great cost to this deference. For instance, people with disabilities have few long term and stable human relationships with people without disabilities outside the services system; people find themselves alone. Families who have family members with developmental disabilities tend to relate mostly to other families in the same circumstances. This is an outgrowth of the thoroughness of the program in trying to assist people over the years. That thoroughness has had both good and bad effects.

WHAT DIRECTIONS WOULD BE WORTH PURSUING?

O'Brien and his colleagues looked at useful directions that would be worth pursuing. They recommended examining questions such as the following:

- When case managers are powerful for people in a positive way, what are they doing?
- What are the sources of their power?
- What good things should happen for people with disabilities because they have a case manager in their life?

The answers to questions such as these would help identify the PURPOSE of case management in an era of diminished resources for that role – what is case management really FOR? In addition, the answers would help focus the work of case management on that purpose. For example, in Butler County, they found that in reality case management was most useful as a service to people who were in "deep trouble."

The arenas of positive power which case managers had included the following:

1. the power of perceived authority
2. a great deal of knowledge about how things work in the service system
3. the trail to the money (e.g., the way to get at funds for residential supports) led thru case management
4. believable information about the performance of other parts of the system
5. the power of being in a position to try and address problems

We can utilize this perspective on recommendations for more focused work, as they apply to Hennepin County today:

1. Use the existing strengths to focus case management work on difficulties or problems experienced by people with developmental disabilities in Hennepin County communities and in the system.

This would include paying particular attention to crisis situations that MUST be responded to. Case loads should be formulated based on problem areas that matter, and case management itself should be primarily a service which is directed and focused on individuals' situations.

The county can be the office that stands ready and able to solve critical problems that people with developmental disabilities are experiencing. That expectation can be used to develop the community's and system's capacity to respond to people who are in crisis.

2. Engage in more systematic efforts to act carefully to help people with developmental disabilities and their families find an organized voice and have that voice be heard. This would include two directions:

a. Encourage more personal advocacy for/by people with disabilities.

b. If you tell people both inside the agency and elsewhere that "advocacy" is no longer on the list of services provided by case managers, that it is no longer the exclusive property of the case managers, and that it is no longer possible to see the case managers as the primary or sole advocates for people with developmental disabilities, then that raises the

question about who IS responsible for advocacy. This presents opportunities for others to determine their role and responsibility for advocacy.

3. Determine how to bring the strengths and the capacities of case managers and the county to bear on problems and issues that the community and the system see lying before them.

There are larger systems change issues which need to be addressed as services move into the future. Some of these issues are addressed below in the recommendations concerning systems advocacy.

C. POSSIBLE ROLES FOR CASE MANAGEMENT

Given this professional literature and thinking about models and model design, we concluded that in the early 21st century, a county social services agency could potentially have five roles or functions in case management for persons with the label of developmental disabilities. In the most simplistic conceptualization, these five roles could be seen as additive, going from the most basic and required functions to roles that are desirable but are beyond the minimum required ones.

1. ADMINISTRATIVE FUNCTIONS

This most basic role includes determining that individuals are eligible for services, authorizing services determined as needed, conducting required annual reviews of services, and fulfilling the required minimum monitoring functions. This is the most basic, needed and required function on the part of a county system which serves as a funding "gate-keeper." This also includes quality assurance and enhancement functions to ensure that public dollars are being used as intended and the monitoring and evaluation components to assure the health and safety of public service recipients.

2. PROBLEM SOLVING/CRISIS MANAGEMENT

When an individual is in crisis, when their services no longer meet their needs, or other emergencies or urgent situations arise, case managers must step in to provide the needed information, solve the problems, and address the crisis.

3. CONSUMER EMPOWERMENT – PROVIDING INFORMATION AND RESOURCES

Ideally, the case manager is oriented to empowering the consumer and his/her family or representatives in managing their own situation as much as possible. The case manager would provide people who receive support with the information they need to make their own decisions and empower them and committed others to solve problems together. Such information sharing could take two forms:

a. general information and notification of resources available – e.g., sponsoring provider fairs, letting people know about conferences, etc.

b. responding to person by person requests and providing needed information on an individualized, case by case basis

This third function is certainly less "mandatory" than the first two functions for a county agency whose primarily role is administrative, but is necessary to assist people as they age through the system and have evolving needs. It will also be more critical as the system continues to have increasing demands and limited resources. This importance is discussed below in the final recommendations section.

4. INDIVIDUAL ADVOCACY

In a complex human services system in a complex world, some of the most vulnerable individuals in the entire society are those with developmental disabilities. They are typically among the most devalued individuals in society, highly likely to be abused or neglected, often likely to have no one to advocate for them, and many are extraordinarily challenging in terms of their behavior.

Because these individuals often have the least amount of language and least ability to speak for themselves, they are least likely to be able to understand and/or negotiate the complex, costly services system which has evolved to provide for their needs. If they have caring family members, sometimes that family has become over-burdened or tired of the endless advocacy required of them. If the person has no family, typically someone else must be the advocate. Sometimes individuals require outside advocacy simply because their family members are the most likely to take advantage of them. Once an individual starts receiving formal services from an agency such as a group home provider which could keep that individual forever, often an outside advocacy voice is also needed.

If an individual had sufficient, knowledgeable advocacy from other sources, a county social services agency could minimize its role in individual advocacy. However, for those without such advocacy, the county role as advocate remains critical. It is also important for the county to continue to seek and expand outside advocacy.

5. SYSTEMS ADVOCACY

There are several major directions for the county to keep in mind as it heads toward the future. If case management resources remain fixed, and if the number of clients requesting services continues to grow, some of the only ways out of the "perfect storm" will be to address larger issues. These may include helping people with disabilities and their families to organize their voices in more powerful ways, using the changing expectations of families with younger children to change the capacity of the local system and communities, determining ways to expand consumer control of their resources, and expanding service alternatives for those in such control.

In the current situation facing the county and on into the future, it must define and continue to re-define how it sees its fulfillment of these five possible roles. One way in which we evaluated the

new model was from the perspective of which of these five roles are required, which are desirable but not required, which are impacted by and can be fulfilled in the current system, and which will be useful in moving forward into the likely future of the services system. Ideas and conclusions about these roles in the new model are contained in each of the next sections.

PART II

II. STAKE-HOLDER INPUT

This section summarizes the information and data collected during the evaluation process – the surveys, interviews, and focus group information.

A. WHAT DO HENNEPIN COUNTY CONSUMERS WANT FROM CASE MANAGEMENT?

In beginning this study, we had established that we would use the document called "New Values, New Visions" as the basis for our review of the current case management system. This document was generated out of discussions held at a conference on June 25, 1997 called the Hennepin County Conference on Self-Determination and Systems Change. Over 300 people attended this conference, in which many different types of stake-holders expressed what they wanted from many different areas of the services system, including community life, financial control, circles of support and other areas of self-determination. Several topics of discussion addressed service coordination.

If the areas related to support coordination and case management in this document are examined closely, it can be seen that most of what consumers want from case management are the third and fourth roles listed above – empowerment and individual advocacy. Many of the statements also reflect "best practices" in an ideal case management situation. Consumer preferences are reflected in such statements as:

"Service Coordination for people with developmental disabilities means:

- Caring about me as a person, not as part of a "caseload."
- Knowing me, listening carefully to me and understanding what I want
- Working for me and being on my side when I need help to get what I want.
- Teaching me ways that I can get things I want and need for myself."

While this was what consumers indicated in 1997, it is important to note that it is possible that since the growth of Consumer-Directed Services in Hennepin County in recent years, some of the consumer responses might be somewhat different if the same type of conference were held today.

SURVEY PROCESS

Part of the evaluation study conducted for this report was to survey case managers, supervisors, and other staff of the division. The survey consisted of 24 statements selected from the "New Values, New Vision" document concerning service coordination, plus six general questions which the administration had asked us to address. A copy of the survey is contained in Appendix D. For these 30 items, respondents were asked about their ability to fulfill the expressed values

and preferences of consumers -- if they were better able to fulfill those preferences under the new model, less able to, or if it was the same under the new model as the old model.

In addition, respondents were asked to give specific examples of individuals for whom the new case management model was working and not working, and suggestions on improving the delivery of case management under the new model. The questionnaire itself is attached as an appendix here.

The survey was distributed internally by county administrators, in a packet with the survey and a cover letter from the university evaluators.

SURVEY RETURNS

We received questionnaires from 77 people, one of which was not useable. This return rate represented about half of the surveys which were distributed, and is an excellent response rate. Responses were grouped into three categories: case managers, supervisors, and "others." Fifty-three case managers responded, plus 8 supervisors and 15 others.

The 53 case managers included:
31 from adults,
13 from children's, and
  9 from CDO, specialized teams, transition, or both children's and adults.

The 8 supervisors included:
4 from adults,
2 from children's,
1 on the assessment team, and
1 from Quality Management.

The 15 "others" included:
10 financial aide workers,
2 planners,
1 assessment team member,
1 person who worked in resource management, and
1 member of the Parent Support Project.

For the people responding, the length of time which they had worked for the county covered the whole range, from 2 years to more than 31. In general, adult workers had worked for the county longer than the respondents from the children's area or in the "other" category. The children's area had no workers with more than 25 years, but adults had five respondents with more than 25 years at the county.

B. SURVEY RESULTS

The results of this survey indicate that most of the case managers felt that the new model of case management in the county took them farther AWAY from these values and preferences expressed by consumers in the "New Values, New Visions" document. That is, the new system does not bring the case managers and the division closer to the expressed preferences of consumers, but farther away. In this sense, then, the case managers and supervisors see the new model as disempowering their capacity to fulfill the empowerment and advocacy roles desired by consumers.

QUANTITATIVE RESULTS

The quantitative portion of the survey used the 24 statements from the "New Values, New Visions" document, plus the six topical areas which the administration asked us to review (See Appendix D for a copy of the survey and Appendix E for the mean scores). We asked the case management area staff to rate on a 1 to 5 scale whether case managers were better able under the new case management model to address the issues which consumers had expressed. Respondents could indicate whether the new model was about the same as the old model ("3"), or whether they agreed (scores 4 or 5) or disagreed (scores 1 or 2) that case managers were better able to address these issues under the new model. They could indicate they slightly or strongly agreed or disagreed on the 5 point scale.

As indicated above, most of the "New Values, New Visions" statements reflect a preference on the part of consumers and their representatives to be known, understood, have people interested in them, be cared about, have thoughtful and informed planning for a better life, have choices and flexibility. As a whole, the 76 respondents disagreed that the new model allowed them to better address these expressed preferences of stakeholders.   As shown in Appendix E, the mean average scores from all respondents ranged from a low of 1.62 to 2.67 – indicating disagreement that under the new model, case managers were better able to meet consumers' expressed preferences.

However, almost all of the supervisors' ratings were higher than the case managers' and other personnel. On 16 of 30 items the supervisors' mean scores were also below 3. On 14 of 30 items, however, supervisors' ratings averaged 3 to 3.67, which in general could be interpreted that on those items the new model was seen by the supervisors to be about the same or slightly better than the old model.

The following items were rated significantly differently between case managers and supervisors. The case managers gave all these items lower ratings than the supervisors, indicating they were more likely than the supervisors to feel that the new model was taking them away from their ability to:

1. Know individual consumer, listen carefully to them and understand what they want
2. Help consumer, family and service providers work together
3. Have enough time to visit each consumer and get to know them

4. Help consumers and their families have more choice and control over who provides service coordination to them
5. Be able to work with consumers and others to solve problems and get the results consumers need
6. Access information, ideas and experience that offer creative options and that support higher expectations for what individual consumers might experience and accomplish with their lives
7. Really help each consumer because they are not being asked to help too many people
8. Communicate more clearly to consumers and their families about the number and variety of choices available in services and in service coordination
9. Provide service planning, documentation and outcome reviews that are more meaningful and reflect more what consumers and families want and need
10. Rules that impede consumer control, financial flexibility and range of options are better able to be identified and reduced
11. Client choice and control are supported and encouraged

There were significant differences between the adult and children's supervisors on several items, but there were too few members in each of these groups (i.e., only 8 total supervisors) for these differences to be statistically meaningful.

When comparing children's case managers with adult case managers, there were significant differences in the ratings on the following issues. In every case, the adult case managers rated these items significantly lower than the children's case managers (that is, they were more likely to strongly disagree that the new model encouraged these principles):

1. Have enough time to visit each consumer and get to know them
2. Have enough interest to get to know each consumer
3. Have enough time to understand the changing and emerging needs of each consumer
4. Communicate more clearly to consumers and their families about the number and variety of choices available in services and in service coordination
5. Inefficiencies in the services system that drain off resources are better able to be reduced.
6. Client choice and control are supported and encouraged
7. County responsibilities are adequately addressed
8. County exposures and vulnerabilities are reduced

On the items of (under the new model) "Client choice and control are supported and encouraged" and "County responsibilities are adequately addressed," the children's case managers expressed the view that the new model was about the same as the old model. On all the other items, children's case managers disagreed that the new model encouraged these principles. Their ratings were on average higher (more positive) than the adult case managers, but they still disagreed.

QUALITATIVE ANALYSIS

On the survey, we asked 4 questions which called for written comments. These were:

1. any specific comments on the 30 quantitatively scored items
2. specific examples of individuals for whom the new model was working
3. specific examples of individuals for whom the new model was not working
4. suggestions for how the new model could be improved.

We conducted a content analysis of these replies, analyzing frequency and type of content in responses. What follows is a summary of all the responses to these four questions.

Question I - 31: Do you have any specific comments on any of the items in questions 1-30?

A number of respondents reported that they felt the survey was a waste of their time and that management should stop asking for their input if in fact their input was going to be ignored. A few respondents indicated that they were tired of being asked the same questions in different ways. Some indicated that they were told by their supervisors that they had to complete the survey (even though it was voluntary in nature). A general theme of there being a lack of trust that upper management would do anything with their comments and suggestions permeated the responses to the survey. Additionally a few respondents indicated that the survey was inappropriate for children's services (because of the nature of the questions) and a few newer respondents indicated that since they had not worked under the old system it was difficult for them to accurately complete the survey.

Question II -1: Please give specific examples of individuals that illustrate for whom the new case management processes are working well. Which aspects are working well for which people?

Some respondents reported that the new model works well for individuals and families with minimal needs that have good support networks (family, friends, advocates, service providers) who are able to handle day to day needs and trouble shoot and prevent crises from occurring.

Other responses to this question included:
- The assessment team had identified individuals who were not eligible for active treatment (ICF/MR level of care) who were able to receive more appropriate support services
- "Working well for people who used to be on a "bad" social worker's case load and never had their service needs adequately addressed"
- "Support goes to those with high needs, not just those who are most vocal"

One response summarized who it works well for – people who:
- "Have family or guardian actively involved in their life
- Are not looking to change day or residential placements
- Have teams that work well together (day and residence)
- Need minimal "active involvement" from a social worker
- Do not have county social workers as rep-payee
- Are doing well in placement and typically need only one meeting per year
- Client, family and guardian are happy with current services and want them to continue unchanged"

Question II - 2: Please give specific examples of individual situations that illustrate where the new case management processes are NOT working well. Which aspects are not working for which people?

Case managers reported that under the new model they have less time to spend with their clients. This is a result of, in some cases, increased caseloads and in other situations when the respondent is an ARRT (pool) worker having to review new files and trying to trace back and understand what a client's individual situation is each time they attempt to provide a service.

It was reported that the new model is difficult for individuals and families that have recently entered the system. A recommendation was made that new families not be allowed to go into the pool until after a 2-3 year period. Many respondents indicated that they did not have enough time to work on quality management issues and to ensure the health and safety of the people on their caseloads. A common theme was apprehension and anxiety reported by case managers because they were unable to perform much of the quality management role, the QM unit was not addressing and monitoring the needs of people on their case loads (because this FTE is divided among other population groups now and is not focused on the individual), and there simply are not enough case managers employed by the county in developmental disabilities to perform this function.

Several case manager responders indicated that when they are working with "pool" clients the families get frustrated because they have had to repeat their situation and story again to a new worker who is covering the "pool" that day. Family members and individuals have been frustrated with this and expressed their concerns to pool workers. Additionally many workers responded that they were still receiving phone calls from individuals and families who had been assigned to the pool because they wanted to talk to someone who knew them and to a person they knew as well.

Several individuals commented that one design principle behind establishing the "pool" was to make the case load of non-pool workers smaller and easier. Case managers commented that they have not seen their case loads reduced in size and that in fact the types of people on their caseloads have increasingly difficult needs (i.e. specialized health/medical, challenging behavior, mental health, criminal justice).

A common theme expressed by many respondents was that in the area of developmental disabilities the very nature of the disability indicates that the person will need lifelong supports and case management services. Unlike some other disability or acute care situations people with intellectual disabilities will rely on services throughout their life and the continuity of service is critical. The new model was reported to simply not take into account the lifelong nature of the types of people these case managers are working with. Additionally it was reported by many respondents that they have lost the ability to form relationships with their clients and this limits their ability to understand and problem solve to prevent crises. Almost all respondents indicated in some way that case load size is too large to meet the needs of their clients.

The issue of lack of accountability on the part of case managers was noted by several respondents. One example was that many individuals, parents and providers have reported that

there have been no case managers present at annual meetings since the re-organization occurred. This results in people not doing thorough work and taking their responsibilities as seriously because they are no longer seen as the accountable person. Several case managers indicated that some people have already fallen through the cracks because ARRT workers are not providing comprehensive services.

Question III – 1: However positive or indifferent you feel about the new case management model, you probably have some ideas about how it can be improved. Please share any of these ideas you feel might contribute to more effective organization and/or delivery of case management under the new model.

Respondents reported that many family members were satisfied and many were dissatisfied. A suggestion was made to provide the family/individual with a choice of individual or pooled case management and let them decide.

Many of the survey respondents indicated that the county simply undertook too many changes at one time. They reported that this has resulted in them being unable to evaluate the effects and efficiency of any one change because they are so intertwined and interconnected. Many indicated that the constant change resulted in none of the changes going smoothly and in many workers doing things inconsistently. One worker commented that there was not clarity about the desired outcomes of the redesign and that there does not appear to be any measurement in place for whether the county is achieving what they intended to achieve with the redesign. A suggestion was made that there should be an increase in evaluation efforts regarding the re-design to address issues of health and safety for people receiving services.

Some respondents reported that additional training and information dissemination was critical and that in particular providers and families needed to have a much better understanding of the redesign and its implications for communication, referral, modifying program plans, etc. Additionally, because case managers were being pulled in so many directions many reported that it would be appropriate to provide better training to individuals and families on where and how to access services and information. This was described as another time-saving opportunity.

Many respondents indicated that there was clearly a financial and cost savings reason behind the need to re-organize in the first place. Some provided additional ideas for cost savings. Increasing the use of private guardianship to reduce case manager time commitment to public guardianship cases was one example. This respondent went on to say that the county would need to make this a priority and assign staff to make it happen but if this occurred it would open case manager time to do other things. Other ideas provided by respondents for cost savings included ridding the case manager of representative payee roles and responsibilities regarding social security and Medicaid benefits. Many respondents indicated that these roles could be assigned to financial workers.

Several respondents indicated that many of the specialty units have "co-opted" developmental disability case managers into their units, thus distributing their FTE across other population groups and reducing the focused contributions to clients with developmental disabilities and

reducing the number of case managers working in this area. Additionally they report that they have personally seen little assistance to date from the specialty units. For example several indicated that the assessment team is so overloaded that they have had to continue to do assessments; many reported continued roles in quality management as well as with CDCS clients. In addition, several suggested that if specialty teams continue to exist they need to meet regularly and to share and discuss challenges and successes across units.

One worker suggested that having a case manager(s) that specializes in transition age youth and young adults is critical because these individuals are very time consuming. Another specialization area that was identified was the need to have specialized workers who can assist immigrants and others who do not use English as their primary communication method. Additionally a suggestion was made that there be a case manager(s) that handles crisis cases.

C. FOCUS GROUP RESULTS

Staff from the Institute on Community Integration attended 14 of 16 focus groups scheduled by the county administration in the summer of 2004 concerning the new model. These were facilitated by county personnel from the human resources department. These meetings were attended by a significant number of the case managers, supervisors, financial case aides and support personnel who worked in DD. These meetings gave us a great opportunity to understand the new model and the implementation issues related to switching to a new model. Participants saw both benefits and challenges in the new model. Some of the comments below are similar to what was written in the surveys, as described above. In this section, comments in quotes are directly from focus group participants. Comments in parentheses are notes on which team a participant belonged to.

Benefits of the New Model:

In the focus groups, the main benefit commented on the most frequently in the new system was the establishment of specialized teams, especially:

1. Assessment team
2. Specialized children's teams (autism, etc.)
3. Consumer-Directed Supports
4. Placement unit

The case managers appreciated not having to learn everything about assessment and consumer-directed supports, and that all these teams allowed for increased consistency in how standards were applied.

Other comments on what was working:

- "The calendar is working – we select what fits our schedule." (transition team)
- "The central phone number works well. Manning the phones frees up the workers"(transition team)
- "The Front Door is working well."

Challenges of the New Model

At the same time, while there were benefits in the new system, there was a great deal of vehemence against the new model. We felt that some of the vehemence of many personnel toward the new model was related to the model itself. However, it seemed that a significantly greater amount of the vehemence was related to the manner in which the model had been implemented. The implementation issues are critical to how well the new model itself will work, so they are important to address.

The complaints expressed during the focus groups were categorized into eleven primary areas. These were the main challenges noted in the focus groups related to the workability of the new model:

1. Too many changes had been going on at once

This includes: new HSIS system, new ISP form, etc.

2. Computer program and information system difficulties

There were programs that did not work, and were not effective in supporting the information-sharing necessary under the new model. "It's frustrating – they didn't put the technological pieces in place first."

3. Inconsistency in application of "pool" criteria

Different supervisors applied different criteria to who did and did not belong in the "pool."

4. Inconsistency in accountability

Many participants expressed frustration that there were differences in how different case managers worked and their apparent sense of accountability. There were complaints that some fellow case managers were less conscientious than others. Without a designated caseload, some case managers felt other case managers were being less accountable. There was a complaint that other case managers would say, "I'm not doing that, it's not my job." Some felt that this led to an increased vulnerability of clients – that vulnerability was increased without there being one committed case manager.

5. Lack of recognition that a model developed for children's services would not necessarily fit for adults, and that not everyone fits in the pool

There was resentment related to the perception that what had worked as a pilot with children's was moved wholesale to adults, without recognition of the differences in adults. For many children, they have stable placements with stable family, and for many adults that is not true.

There was a perception that one model was trying to be imposed on everyone, without recognition that one model does not fit everyone. One supervisor said, "One size fits all kind of thing is a huge mistake."

Related to this are reflections that some individuals would never fit into a pool. These examples include:
- "Some people take a long time to build up trust."
- "(There are) clients who take two years to talk to you."
- "There are some people who will always need a worker – they need a consistent worker."
- "This works for some folks and for some it doesn't."
- "Part of the model needs to meet the needs of people who need to have their hands held."

6. Coverage desk

There were many reported "cracks" in the system related to calls into the coverage desk and incoming mail: reports of paperwork discarded with no follow-up, incoming mail not passed on to the appropriate team, and no follow-up from incoming calls and mail.

7. Clients and providers not informed of the changes

There had been complaints from some clients and provider agencies that they did not have one person to call.

8. Case managers' and supervisors' input and recommendations not listened to

There was a great deal of frustration over the fact that there had been many work-groups to come up with new models, and case managers had the experience that none of that was listened to.
- "We had so many meetings – in the end nobody cares. Our input never seems to make it. Your supervisor says, "I'm sorry but . . . or you're told why it can't happen."
- "A bogus process – we spent four to five hours a week for months (working on re-design)"
- "We weren't listened to – (we were) on committees for two years."
- "So many of our ideas don't go anywhere."
- "I'm seen as costing money when I give my viewpoint."
- "For what they pay me, you'd think they'd listen."

9. A hostile atmosphere

Besides the experience of not being listened to, focus group participants also experienced other aspects of a hostile atmosphere. One person characterized it as a "hostile take-over."

- "People who have dared to disagree -- not an open climate for speaking your mind"
- "No respect for what we do or who we are."

Other aspects included not understanding the rationale or agenda for the CBLTC merger, or for the new model. At least two workers mentioned that the new model was not consistent with a

county initiative to employ the "balanced score card" approach. Several workers were suspicious that the long-range plan was to get rid of all the county case managers in the future – that case management would be "farmed out to community agencies," that the county was trying to get rid of the DD program, that they would be "shoved into the corner" and lose their jobs. Part of the sentiment in reaction to the new model was that the "county is testing whether clients will go someplace else."

10. State wards

There was a concern that no one was being accountable for them and that they should all have private case management. We understand that since the time of the focus groups, all the state wards have now been assigned to an individual case manager.

11. The new caseloads: all the cases on a new caseload were "active" ones, rather than having a mix or balance of types of cases

The last section of this report contains some recommendations for addressing these and other implementation issues, as well as including additional comments from the focus groups.

III. SUMMARY ANALYSIS

In conducting this evaluation, we were asked to evaluate the model overall: could it work, did it work, was it a sound model?   During the process, based on responses and feedback about the new model, we also began to question whether things were really any better under the old system. Some people spoke as if they had been, but many problems seemed similar. That is, was part of the problem with the new design the fact that there are pervasive systemic issues which persist under any case management model? If so, then a useful question would be whether there are systemic issues which are made more difficult under this new model? Some of these questions were addressed in the first section of this report, and these issues are also taken into account in our responses in this section.

Our general conclusion is that the new model can work. However, there are major caveats to whether it can work or not, and in addition there have been significant implementation issues which must be addressed in order to have it work as effectively as possible.

First, there must be consistency and care regarding who can be served in "the pool." Obviously the pool works best for individuals who are in a stable situation and have a committed, knowledgeable guardian (whether family or professional) or knowledgeable advocacy. It is undetermined what proportion of Hennepin County clients really fit this criteria, or do so at any one point in time. Answers to both these questions would address the issue of how large the pool can really be. Given the variability in people's lives and situations, care must be taken about the process for coming into and out of the pool.

Secondly, we acknowledge as we noted above, that caseloads were too high under the old system and are still likely to be too high for effective case management for everyone. It is a myth to think that every individual will receive everything they could. As one supervisor noted, "We're trying to deal with an impossible situation." There are some alternatives to consider which are discussed below.

We were also asked to respond to six questions concerning the implications of the new model. This section contains our conclusions about these six questions. In this section, comments in direct quotes are from the focus groups conducted in July and August 2004. If the comments were made at a focus group for a particular team, those are noted in parentheses.

We found that focus group comments were of three categories:
   a.   implications regarding the new model itself
   b.   benefits or challenges related to how the model has been implemented
   c.   personal comments related to the process of change

We used the focus group information and other sources of information for our own understanding of the model design itself, separate from the other two categories of comments. Our comments below address our assessment of the model design itself, with separate comments about the implementation of the model.

1. Do the current and proposed (new) case management models support and encourage client choice and control?

In the nature of the design of the new model, it could be very effective at encouraging more client choice and control. However, we don't think it is the model itself that provides that avenue. More client choice and control could be provided under either the old model or the new model. As one of the children's workers expressed in their focus group, "You don't need a new model to have social workers promote self-reliance." In addition, certainly consumers and their families could be given a choice regarding being in the pool or on an individual caseload.

Inside a principle of consumer empowerment (in either model), the county and case managers could provide a great deal of information to consumers and support a decision-making process that is in the hands of the individual and their team.

Some of the children's workers who participated in the focus groups felt that they are supporting families to be more independent – teaching them how to be self-sufficient. They contrasted this with the previous system, which they perceived as creating dependency.

Some of their comments included:
- "Are you contributing to their dependence versus problem-solving for themselves?"
- "Parents network with each other. Parents could support each other. You really don't have to care-take so much."
- "Holds clients more accountable, which they don't like sometimes."

There were some responses from the surveys which indicated that respondents felt the new model diminished choice. So, the elements of the new model which interfere with increased client choice and control need to be addressed. These include assuring that adequate enough information is being provided to clients, in the different avenues available to do that in the new model. This will mean going beyond simply providing brochures, web-sites, or phone numbers; but avenues for more meaningful information sharing such as resource fairs, training opportunities (e.g., Partners in Policy Making), presentations, conferences, networking opportunities, active dialogues with providers and other families, and supporting more self-advocacy training.

With an increasing number of individuals coming to the county for support, we think that the encouragement of and development of client choice and control will be critical, as well as greater systems advocacy. The county must figure out additional avenues to provide people who are currently served and new consumers the greatest amount of information possible to empower them to make their own decisions and manage their services, as well as advocating for systems changes that will continue to expand the options for consumer control and for preferred services. These will be the key avenues to keep decreasing the amount of support needed from over-loaded case managers.

There have already been indications that this arena will require significant effort. For instance, one of the biggest complaints in the focus groups was that the consumers and families had not

been informed of the change in the case management model. In addition, it is clear that some case managers have not evolved even from a traditional social work model to being a case manager, much less evolving from more traditional case management to more of a support coordinator/support brokerage role. So moving to even greater and really meaningful consumer empowerment may be even more difficult.

There are two dangers in continuing to expand consumer empowerment:

a. tendency to simply withdraw (e.g., saying to consumers: "it's your decision", "That was up to you to take care of") without providing sufficient support and information.

b. "turning people over" – simply telling people to call the Arc or some other place, instead of doing the work which is really the responsibility of the case manager.

Both these dangers must be guarded against.

2. Do the current and proposed case management models address county responsibilities?

In the section above on Possible Roles for Case Management, we discussed five roles for county case management, in an ascending order of requirement:
   a. Administration
   b. Crisis management
   c. Consumer empowerment
   d. Individual advocacy
   e. Systems advocacy

The fundamental county responsibilities for the first two, administration and crisis management, can be adequately addressed in the new model. The role of individual advocacy has potentially shifted, especially for clients in the pool. The new model also creates opportunities for increased consumer empowerment, especially for those in the pool and of course in CDCS. In order to best meet the growing number of clients, it is indicated that the county needs to do even more with consumer empowerment and also with systems advocacy. Although individual advocacy for everyone may not be technically required in a very minimal understanding of county responsibilities, consumers and their families have expected it from case managers (as indicated by the "New Values, New Visions" conference and other sources). Consequently, if the opportunity for individual advocacy for everyone diminishes or changes under the new model, others must be empowered to take on that advocacy role where it is needed.

Another key responsibility to address is that as a publicly-funded agency, the county has the responsibility to manage limited resources as efficiently as possible. Several of the elements of the new model are designed to do that. For instance, some case managers indicated that scheduling meetings with Customer Service is far easier for consumers than under the old model.

However, the implementation of the new model has resulted in many examples of inefficiencies. These were some comments in focus groups:

- "We spend more time coordinating who goes to meetings, than going to the meeting"(transition team)
- "Half of my day is spent moving clients from one worker to another" (Supervisors)
- "(in triage) it took 2-3 hours to work on something"
- "People have to re-tell their stories. Staff effort is being duplicated."
- "It's frustrating to spend two hours chasing your tail"
- "Not efficient for providers – they have to do three or four calls" (Before, they just had to call one case manager)
- "We wish we had a point person – one with the same answers – on when to pull someone out of the pool. The five supervisors all have different thinking." (Transition team)
- "(When consumers call Front Desk, they're) Put on hold or they have to call back, and then they'll get a different person (example cited when someone had called 3 days earlier and gotten no reply)"
- "Before it was one call to the case manager, now it's harder"

It should be recognized that there is a reduced efficiency for a case manager in attending a meeting where they don't know the consumer. One case manager noted that when they had an individual caseload, they could do the annual much quicker. Others noted,
- "(You) spend more time than if it were on your own caseload."
- "We spend more time preparing."
- "Tons of confusion."

A second inefficiency is that at the time of the focus groups in July 2004 not all of the "bugs" had been worked out to have the system work efficiently. One comment in a focus group was "We haven't figured out where tasks go that come out of annual meetings."

Thirdly, in terms of meeting county responsibilities, there was concern expressed that, especially for pool clients, the county might not be able to meet the responsibility of seeing the person twice a year. It was suggested that more efficient ways of fulfilling this responsibility could be found, like seeing several individuals at once at the same day program or group residence.

These inefficiencies we felt were due to implementation stresses of changing models, rather than the model itself. That is, we agree that the "bugs" still needed to be worked out.

3. Do we have any exposures or vulnerabilities under the current and proposed models?

Several potential arenas of exposures and vulnerabilities were expressed during the focus group meetings:

A. Quality Control overall and checks on providers

One supervisor felt that the new system increased quality control since under the new model it's "Not just one case manager's eyes on a case, (we) have a few eyes on a case." Other supervisors acknowledged that quality of service was as much a problem under the old system as the new system – for instance, under the old system people got a different level of service "depending on who your case manager is." This variability continues to persist in the new model.

However, the new model raises at least three new concerns about quality control:

a. Increasing worker inconsistency

Different people going to different meetings could increase county exposure if unfortunate things happen to consumers that could have been prevented with a more knowledgeable or consistent worker.

Many individuals with developmental disabilities are in situations with a great deal of turnover in their support staff. Different case managers noted, "Many of us have been to meetings where we're the constant in the person's life." "If they have a private guardian or conservator, change of case manager is not that big an impact. When there is no family or state guardian, that's a very vulnerable individual."

A consistent caseworker in the old model could also anticipate "things going bad – before it fell apart." It is likely that working in the pool requires a particular kind of case manager, one with the flexibility to be able to go to ISP meetings for people they have never met before and, as one case manager expressed, "act like it's your client." Attentiveness to the type of case managers who work in the pool is at least one avenue to consider toward decreasing possible county vulnerabilities.

b. Variability in accountability of case managers.

Both in the focus groups in July 2004 and the surveys received in 2005, there were indications that the new model had decreased the sense of accountability on the part of some case managers. Again, this could potentially lead to increased vulnerability of clients -- vulnerability could increase without one committed case manager unless everyone else is being accountable for their role.   The new system which delegates different roles to different people is only as good as the weakest person on the team. It is also only as strong as the communication between those team members.

It was indicated that three things contributed to the increased variability in accountability:

1. a sense of frustration from having to rotate onto the coverage desk without fully knowing the job
2. resignation and frustration in being assigned to the ARRT team
3. resentment between pool teams and other teams

Some comments included:
- "resentment of people "not on board" including supposed sabotage"
- "You have to clean up what other people didn't do"
- "enables other people to NOT do things."
- "There's less accountability in this model – where do you find accountability. Who can see it through to conclusion?"

It should again be noted, however, that a range in the accountability of case managers was also present in the previous model. For instance, several workers gave examples of work that had not been done under the old system:

- "three-fourths of the caseload I inherited had no ISP, half a dozen clients who hadn't heard from a social worker in more than two years. I still get a lot of cases with no ISP's.")
- "(citing one case, there had been) no ISP for three years"

c. Several elements of the new model could potentially lead to providers having more power, which can set up vulnerabilities.

- One case manager noted it's "Being left to provider to frame the question."
- Another noted providers who want to "possess the client. We're not there to protect the private provider."
- For individuals in the pool, "No one really knows the client except the provider – there needs to be at least one other person."

This is a potential problem with some providers. There should be avenues in place to monitor for such problems, both through the teams as they are set up and the Quality Assessment team.

B. Cracks between parts of the system

There are at least two areas where people can "fall through the cracks."

First, there were numerous comments in the focus groups regarding the coverage desk, including that incoming mail had been thrown away or that calls had not been returned.

Secondly, there was concern expressed on several teams of people falling through the cracks: for example, between the pool and a specialized team, or between transition and an adult team. One transition team member felt that "A lot more families could fall through the cracks . . . . I'm fearful some of my clients will get lost."

With greater consistency at the coverage desk, and with more defined procedures regarding transferences between teams, both these issues could be resolved. Again, we know that people also fell through the cracks in previous county systems, but these are two particular areas to address due to the design of the new model itself.

C. Financial controls, especially in CDCS

There are some county vulnerabilities that increase with both pool clients and a coverage desk. For instance, clients who like to take advantage of the system may have a better avenue to do so given that in the new system they can call up frequently and potentially talk to lots of different workers.

There was also a concern expressed in the focus groups that if Consumer-Directed Supports clients were "pooled" that there was the possibility of them taking financial advantage of the

system – with different workers on the ARRT line every day, or different workers coming to different meetings. There was also a concern that fiscal intermediaries could more easily cause fraud.

However, since the time of the focus groups in July 2004 we understand that this has been changed and the CDCS clients have now all been assigned a primary worker. If the primary worker is familiar with each person's circumstances and needs over time, this accommodation would address that potential vulnerability.

D. Incorrect placement in the pool

Participants in focus groups expressed concerns about the inconsistency in pool placement, and that some individuals were in the pool that should not have been placed there. One example was an individual who poses community safety issues who had been placed in the pool -- it was reported that this person was a child predator who lives independently and has been picked up by police twice. The case manager noted,
- "We're going to be left in positions that are life-threatening."

E. Increased risk with unfamiliar clients

County vulnerability and exposure would increase if case managers were not adequately prepared for attendance at some meetings in which they do not know clients and those clients might be dangerous. An example was cited of a case manager being grabbed by a client. "If she had known him or had the information, she would have known not to sit down next to him."

F. "Holes" due to in-eligibility for services

The assessment team in particular reported on potential exposures and vulnerabilities concerning the individuals found not eligible for services. For instance, if people are found not eligible or no longer eligible for the waiver – where should they be steered? If people are not eligible for SILS, and with no more SILS funding, who do they go to? The assessment team felt that "no one is dealing with the people we find who are not eligible." Such individuals do leave the county vulnerable, if people's situations worsen in the future because they have no or minimal services. Under the old system, of course there were many individuals also found in-eligible for services. However, it seemed that what was being reported was that procedures to deal with such individuals in the new system had not yet been established.

4. Do these models lend themselves to responsiveness to our clients?

There are aspects of the new model which increase responsiveness and some aspects which diminish responsiveness. Again, we recognize that responsiveness under the old model also varied. In the old model, some people "complained they never saw their social worker, some wanted less intervention from their social worker (who was trying to be a therapist)." In the old model, the degree of responsiveness "probably depended more on the individual case worker." In the old model "there were people who never got two visits a year." As one supervisor

indicated, "it really depended on the worker. It was worker-dependent, if they didn't get back to people right away."

During the focus groups, the children's case managers reported that families said they liked being able to call in and get someone right away, and get the answer to their question right away, rather than having to wait to hear back from their own case manager.
- "They're able to talk to a live person at all times."
- "People say they're getting better service."
- One supervisor reported, "I had tons more complaints (in the old system) – workers not getting back to people."
- One of the QM team felt that under the new system "clients could get services faster, quicker," and that "processes were less bureaucratic, more simplified, less confusing."
- It was also commented in that focus group that "Things can go more quickly, react to consumer requests more quickly. Under old system (they) lost some time."

However, there are also several areas of decreased responsiveness. We think that these are areas that are a direct result of the design of the new model, and not an implementation issue.

1. Clients having to tell the same story repeatedly

With the new model, both with the coverage desk and the pool, it seems that consumers and families are more often in situations where they have to explain themselves and their circumstances repeatedly, to different people.

- "(They're) putting a DD person through talking to someone different every day. Our clients and providers are very upset."
- "There is a family complaint that they have to re-tell their story."
- "You don't have a commitment to families . . . You have to explain what's wrong with your child every time you call" (transition team)
- "Client is not used to having to explain every time."

Related to this is a sense of loss, which can make the system seem less responsive to clients.

- One adult team worker commented "(They) "don't understand why they lost their case manager."
- Another commented that a parent had said that under the old model, "I'm happy I have a social worker we can identify with. . . "
- One staff commented that the new model "eliminates individualization."

2. Responsiveness reduced at meetings

There have been issues in responsiveness related to different case managers assigned to go to different meetings. At the assessment team focus group in July 2004, there were reports of meetings in which 2 different case managers showed up, as well as meetings in which no case managers showed up. Case managers reported difficulties in their capacity to be responsive if they did not know the individual and their situation that well.

One assessment team participant noted that at meetings where a different case manager showed up, that other members of the interdisciplinary team acted toward the new case manager with the "Substitute Teacher Syndrome."

3. Different types of caseloads may reduce case manager capacity for responsiveness

Our understanding is that one of the results of the new model is that on the teams that are not "pool" teams and in which workers have regular caseloads, they are now more likely to have a caseload completely made up of more challenging cases, more cases in crisis. Our understanding is that previous caseloads had more of a mix or balance of clients. This change may mean that case managers may be able to be less responsive to individuals, and this change may more easily lead to burnout.

As one case manager noted, "Caseloads are too high to do effective case management either under the old or the new system . . . Under the old system, I knew enough about my families that I could prioritize."

4. Reduction in quality

In changing from a caseload model to a "tasking" model, there is a danger of quality being reduced. "The tasks can be completed, but quality is lacking." The case managers are not as likely to know the clients, their families, or the vendors. Just one example is noted by one case manager, "I don't know how I can responsibly make a decision on medications or placement." The Quality Management team commented, "There's no way they're getting better service."

Besides these above four issues that are model design issues that may reduce responsiveness, there are also two issues related to the implementation of the model that also may affect responsiveness:

1. Coverage desk

There were reports in lapses of responsiveness to calls coming into the coverage desk. The CDCS focus group reported that providers were complaining their calls were not being returned. There was a report that people calling in had been told by the coverage desk, "We don't do that" and were hung up on without being referred to another office.

2. Procedures

Certain procedures were missing that would assure responsiveness. One example was a client in a hospital, who needed to be signed off on 72-hour hold – the case manager did not know the procedures under the new system for getting a guardian and power of attorney. Another example was someone who needed a worker immediately, and it took two and a half months to get a worker assigned. Another example was a check that had been mailed to a wrong address, and the client had to call several times.

Both of these areas of implementation issues we felt would be improved upon as the new model was more consistently used and better procedures for having it work were determined.

5. Will these models allow us to meet the needs of growing numbers of clients with fixed case management resources?

 For the long range future, there will undoubtedly be only increasing stress on the system, and growing numbers of clients. It is highly unlikely that numbers of clients will be decreasing any time soon. Some focus group members were aware of the existing stress now on the "Front Door" in terms of referrals. There are at least two short-term issues which should be addressed, and a couple of longer range, larger perspectives to address if these models are to serve a growing number of clients in the future.

IN THE SHORT-TERM:

1. Maximize revenue

Several focus group participants brought up questions about whether everything was being done that could be to maximize revenue, such as maximizing billable hours. We are sure that accounting and other specialists are addressing ways in which continuous improvements can be made here.

2. Increase cost-savings

There are at least a couple of ways to examine how to increase cost-savings, how to reduce costs. These include improving monitoring processes, making initial placements as appropriate as possible, and determining how to improve services and support in potential crisis situations. The assessment team reported they have discovered situations in which people are able to function with less funding, in more cost-effective situations. One case manager noted, "It costs more for us to deal with a crisis if it hasn't been being monitored."

In addition, several case managers noted that when they were very familiar with a case or working with a person over time, they could figure out how to reduce costs:
- "I can reduce the costs if I'm working with my client better than in a team process. I can get the money down. I'm more capable of it."
- "I've been able to get cheaper, more efficient services."
- "We can find better services – used to work with a family for two weeks to get a better home – I can't do that anymore."
- "Waste of money – good placement not made initially."
- "I can work with the (client and whole family of relationships) to not cost the county anything – if I have it long enough."

Without going back to individual caseloads, it seems that procedures and processes could be implemented within the new model to better utilize the savvy knowledge of some case managers about how to effectively support the client as well as possible, at reduced or minimal cost.

Other cost-savings measures could include:
- increasing the use of private guardianship, especially for people currently under public guardianship.
- moving the roles of representative payee for social security and Medicaid to financial or other workers

We were not sure if technology was being used as effectively as possible on all teams, such as a computerized central task-management tool for all workers and needed tasks, including incoming items to the coverage desk, scheduling meetings, and timelines for annuals, quarterlies, etc. If this is not being used, or if the current system is not as effective as possible, we recommend this as another cost-savings measure.

LONGER RANGE DIRECTIONS:

Two more longer-range directions for the county to address and strategize about are two of the roles for case management and for the county as a whole, which were addressed above:

1. Consumer Empowerment

What would have to happen regarding empowerment of consumers and of other inter-disciplinary team members for the county to be able to reduce the ongoing time needed from case managers in their roles as advocates and problem-solvers?

Some possible directions include:

- Increased information and resource sharing – in meaningful ways
- Increased self-advocacy programs
- Better training to individuals and families on how to access services and information
- Increased training in such programs as Partners in Policy-Making
- Increasing parental and consumer attendance at information meetings and conferences
- Empowering other members of inter-disciplinary teams as informed advocates
- Increasing private guardianship

2. Systems Advocacy

What would have to happen in the service delivery system to increase people in the "pool" and to reduce crises (and therefore one of the major needs for case management services)?

Being able to legitimately increase the number of clients in "the pool" would be a result of increasing the number of people who are well-served, in stable situations, in situations they prefer and in which they flourish. Some directions may include:

a. Community involvement and empowerment in the situations of people with disabilities.

b. Serious efforts to increase the number of individuals who are in greater and greater control of their own situation. With no anticipated increases in and potential decreases in consumer-

directed support dollars, the county may have to determine other ways to increase consumer control without additional funding in that category – that is, within existing programs.

c. Increasing the flexibility of types of services able to be utilized with existing dollars, freeing up the system and people from fixed service options, and,

d. Finding more creative options to increase case management resources.

6. Will these models be effective in assuring client health and safety considerations?

The design of the new model could allow for effectiveness in assuring client health and safety considerations. One children's supervisor indicated, "We found out about situations where there are potential crises – by calls people made pro-actively. (We can) assign people to work with people more intensively."

However, at the time of the focus groups, there were several major issues in the implementation of the new model which raised health and safety concerns.

A. "Cracks" and Need for Promptness and Consistency

There were problems reported with people falling thru the "cracks." At the time of the focus groups, there were specific examples of calls coming into the coverage desk regarding serious health concerns. One example was someone who had apparently not been dealt with for five days. It was reported that a message had been left after hours on a Friday, the messages weren't checked, and the person went missing from Friday to the following Wednesday. By now, hopefully an adequate system has been established to deal with "cracks" such as this.

There is also a possibility of someone falling through "cracks" in the new model without the same county person receiving information from a person on several calls. For instance, if someone is calling in to report the third incident report of the week, where is the accountability and information located that allows recognition that this is the third incident in that week?

The transition team also felt that it might be easy for someone to fall through the cracks between children's, transition and adult teams. "If something had happened, we wouldn't have known."

There is a need to have an immediate and sole person assigned to be responsible for dealing with a health and safety issue when it is reported. For instance, one example cited was a woman who had fallen and cracked her hip – it was reported that she had to talk to speak to three different social workers and spend a total of six or seven hours getting the help she needed.

B. Adequate follow-up

It was not clear that there is an adequate system for following up once health and safety issues are reported. For instance, if there was a VA report on someone, who would be responsible for follow-up? If someone is found ineligible for the waiver or other services, where would they go?

Especially for the most dangerous or most physically vulnerable individuals, assuring that those concerns are addressed means assignment to an individual caseworker. "(With persons with health and safety issues,) involvement of one-to-one case manager was most important thing. I feel less certain about health and safety. We'd see things developing, be anticipatory to prevent crisis."

C. Documentation

Reported inconsistencies in documentation in records, phone calls, meetings, etc., left questions about whether health and safety concerns were being appropriately and adequately addressed. Apparently some health and safety issues have not been documented, or not documented appropriately.

D. Lack of knowledge on part of case manager

A case manager's lack on knowledge regarding a particular individual would be particularly problematic if health and safety concerns were an issue. There was a great deal of concern on the part of case managers about being asked to sign medical documents, such as forms from doctors or nursing homes, for an individual that they were not familiar with.

The issue of variability in case manager accountability previously noted can also contribute to health and safety concerns. While of course there were also problems with variability in accountability from case manager to case manager under the old system, the need for special watchfulness in the pool and in moving individuals with health and safety concerns between teams is called for in the new system.

If people with serious health and safety concerns were assigned an individual case manager who was quite familiar with the complexity of the issues over time, it is more likely that this concern would be adequately addressed.

E. Effective Quality Assurance

Adequate addressing of health and safety concerns may be very dependent on an effective quality assurance system. There were serious concerns expressed about the adequacy of the current quality assurance and quality management system:

1. Power of QA

There was a perception in the focus groups that the Quality Management team does not have the authority and power to be as effective as it should be.
- "QA has been impotent."
- "The QM team needs more teeth (for violations)."
With the current amount of responsibilities of this team, we did have a concern about this team's capacity to be effective.

2. Safety Nets

The Assessment team was concerned that they had nowhere to communicate the concerns they ran into. "We run into horrendous physical conditions. We should be able to bring this back. We approached the Quality Assurance team, they said 'we don't do that.' All we have is to fill out a form."

There needs to be an effective safety net set up when health and safety issues arise, which needs to be completely and clearly communicated, on the different teams and in the different avenues at which such issues may arise (e.g., time of assessment, on home visits, etc.).

IV. RECOMMENDATIONS

There are many specific recommendations in the above section of the six areas of concern we were asked to address.   In addition, given that there will continue to be an expanding number of people requesting services, and a likely future that case management resources will remain fixed, thi section contains two broader arenas of recommendations. First, there are specific arenas for assuring that the new model is working as effectively and efficiently as possible. Secondly, there are four larger arenas to consider for the longer-range future.

A. ADDRESSING IMPLEMENTATION OF THE NEW MODEL

While the design of the model itself could work, whether it is effective depends on many implementation issues. Since our initial contacts in July 2004 with those implementing the model, we appreciate that some things have changed and that personnel are learning to work more effectively in the new model. As one supervisor noted recently, "This is definitely a work in progress."

There are several areas to address to assure that the implementation of the model allows it to be as effective as possible. Some of these specific areas are discussed above in the responses to the six questions.   What follows are some of the main arenas which need to be addressed, some of which are not resource neutral:

1. Assure that the tools and information system necessary for the new model work

The information system necessary for the pool, coverage desk, front door, task management, and transfers between teams to work, must be effective.
As one supervisor noted, "We're only as good as our database."

The information system should have at least the following four characteristics:

A. Workability

There were numerous complaints that the system was not workable:

- "Problem entering ISP: they have disappeared after they have been filled in."
- "The ISP – (I had to) completely re-enter it."
- "Database at Ridgedale was a problem."
- "Some info in HSIS is not in the client database, like phone number and list of financed services the client has."
- "The MR files in MMIS/CSIS – some won't open, assessment team couldn't look at ISP."
- "Can't get social history on some clients."
- "The ISP needs to be simpler, with drop down boxes."
- "I would like to see a user-friendly document available on computer."
- "Computer should be more user-friendly (we have to pull up too many screens)"

- "The billing and case-files – get it working."

Another type of suggestion was "We should have a triplicate form we can fill out at the meeting."

We don't know how many of these computer and database problems have already been addressed, but for the new model to work the information system is critical.

B. Access

There were problems for telecommuters, who could only access HSIS and not the data-bases.
- "We need to have files work, shared access."
- There were also complaints about access at the main office: "Can't access computer system – try to get IT to help, they can't always."

Access would also be improved with increased use of portable laptops that would allow access to the database from any meeting, anywhere. In the future, technological advances should also be utilized to streamline the system and case manager's work as much as possible, such as on-line shared plans and reports between service providers (e.g., residence, day program) and the county.

C. Systematic approach to entering data

There should be standardization and sound guidelines for how files are arranged and consistency in how case notes are formatted, both in HSIS and in the database. One example was a case manager who said that psychiatric medications weren't being added to files. "(The system) works as good as your notation is."

D. Flexibility

There were numerous complaints that changes during the year could not be noted on the ISP. Software should be able to be updated.
- "Can't change ISP during the year – couldn't go in and edit."
- "When you want to edit, it freezes you out. No update allowed in six months – have to handwrite and put in chart."

2. Standardize personnel at the coverage desk

There were numerous complaints at the focus group meetings from the adult teams about the need for a regular back-up person at the coverage desk. We understand that this has been changed and there is no longer rotating staff. However, there is still a need for consistency and probably a need for at least three regular staff if not four, to assure vacation coverage, etc.

3. Have consistent criteria, consistently applied, for "pool" membership

A great number of complaints about the implementation of the pool for adult services concerned the inconsistency in application of criteria of who belonged in the pool and who did not. There

was also apparently inconsistency in the amount of work completed on a case and on case files before someone was moved to the pool. Other personnel need to be able to "read the transfer summary." There were complaints that the caseloads of workers who had left the county were simply all moved into the pool, or that cases were moved into the pool that had not been reviewed by the supervisor. (We do not know the accuracy of these complaints, but these were reported perceptions of what had happened.)

There should be periodic review of every individual in and out of the "pool" for consistency in membership. There should be specific criteria for the amount of stability in a person's situation before they are moved into the pool and for the degree of need before they are moved out of the pool. If a screening or sorting instrument with consistent criteria is not being used, it should be developed. If one has been being used, it should be periodically reviewed for usefulness, effectiveness, accuracy and consistency between teams and team members.

- "No one has the same set of rules or requirements to move (an individual) from one area to another (CDCS team)"
- "People languish in-between teams, especially (in cases of) homelessness, aggression."
- "What 'low maintenance' is, is interpreted differently. (There are) different interpretations of 'done.'"

4. Establish consistency in expectations regarding the pool

For the "pool" (ARRT and IPG) teams, it probably takes workers with certain types of skills to be able to maintain a strong sense of accountability while rotating to different meetings or rotating tasks and responsibilities on clients that are not that well known to the individual worker. We trust that careful consideration has been given to who should be assigned to the pool teams to maintain that strong sense of accountability with every client.

In July 2004, case managers felt there was a need to clarify the roles of the pool with everyone – clarification was needed of expectations and of how things were to be done.

There has also been inconsistency in how model has been articulated to families. Individual workers have explained it in very different ways – there is a need to "get everyone on the same level."

5. Get parts of the system working more efficiently and effectively together

There were specific examples of ways in which the different parts of the system were not working together that could be addressed.

More streamlining of processes between teams and within teams would also increase effectiveness. For instance, one of the comments at the Quality Management team focus group was that "It is not possible to do everything with the number of social workers they have. (It needs be figured out) what things do they NOT have to do anymore and still meet the intent. They're trying to do business the same with fewer resources.... Work (has been) added without letting anything go."

Another case manager noted that under the new model, "I have to learn good short-cuts (which I haven't done yet)." If these can be learned, they can be passed on to everyone.

Other suggested ideas for more efficiency included:

1. a better system to find out where openings were in residential and other programs, and a better system to communicate that information more effectively to all the case managers who need it
2. specialized experts in DTH, SILS, transportation, guardianship/conservatorship, immigrants, and crises
3. more streamlined system for how to deal with consents and medications
4. regular meetings of the specialty teams with the other teams – sharing and discussion of successes and challenges by the assessment, QM and CDCS teams with the other caseload and pool teams (this would increase understanding of the whole system by everyone)

There were other examples of parts of the system that needed to work better together. For instance, the QM team said "We need to provide better feedback to the case managers about how we follow up." The Transition team complained that cases were sitting on supervisor's desk for four or five months without being passed on to them. It is also likely that many of the reported disagreements between adult teams and "pool" teams can be addressed, if they have not already been.

Under the old model, there had apparently been inconsistency in determining if someone met the ICF/MR eligible level of care. However, while under the new model there is a specialized assessment and screening team which should address these inconsistencies, this team admitted that their team members had not sat down together and gone through the screening document together to assure their own consistency as a team. This team also felt that they had passed cases on to other teams with specific requests that have been ignored.

The management and overall organization should also be periodically reviewed to ensure the strengths of different supervisors and managers are being allocated in ways to maximize the provision of supervision as efficiently and effectively as possible.

6. <u>Promote Ownership</u>

Almost every focus group expressed a lack of ownership of the new model and that the work culture was not one in which employees were listened to. This was perhaps most powerfully expressed in the supervisors' focus group. They expressed that the management is not listened to by the directors, the supervisors are not listened to by management, so why would the case managers believe their supervisors are listening to them, or the clients believe they are being listened to? "The Area Directors never come on the floor."

There are many, many ways to promote more ownership of the model and to have the work culture be as respectful as possible. Four avenues were suggested in the focus groups and interviews:

A. A sense of progress and of making a difference

Case managers, like all human beings, need to experience that their work makes a difference. Since these professionals are typically in this field because they have a deep sense of caring, it is important to see progress. In a task model, it is much more difficult to see progress for individuals. It will be important to determine ways to figure out how to have workers see and share about progress for the individuals who receive services, even for individuals in the "pool."

It is also difficult to have that experience of progress and of making a difference without feedback from one's supervisor. Case managers want to improve their skills and many may need more interaction with their supervisors than they were having at the time of the focus groups.

B. Listening to suggestions about the new model

Although there were many complaints about the new model and wishes to go back to the old model, many of the suggestions we heard were legitimate and creative ideas about how to get the new model itself to work better. These suggestions might get buried under more vehement outcries about the model itself, or under the expressed resignation of "not being listened to." Ways could be found to solicit, reward and implement these ideas for improving the new model.

C. "We're not doing social work"

We found it intriguing how often a complaint something like the following was expressed during the focus groups: "We're not doing social work." While we don't understand the whole history of the evolution of the DD department in Hennepin County, as noted above in the first part of this report, "social work" should have gotten left behind in a "case management" system more than 20 years ago. We are not sure if workers never had that distinction that case management is different than social work, if case managers have been told they need to use their social work skills as a case manager, if the two have been treated as if they are the same within the county, or what. However, it is clear that in the 21st century the services system itself has moved beyond even case management. The skills needed require broader, inter-disciplinary approaches; in some positions, traditional social work skills may not even be needed.

Newer models across the country include many different functions such as support brokerage and support coordination, which are very different from both social work and case management, and in Hennepin County certainly much of the work that must be done is not "case management." For example, it is likely that the work in the CDCS team is several generations beyond social work.

While some individuals may still operate from what they were professionally trained in, or old expectations, it would be useful to generate ideas for how to deal with and get past this issue. That might include

a. Promoting better understanding of the history and contexts of different frameworks;
b. Doing a survey of how many clients would like to not have any "case manager" and find out what they really want from the county, if anything.
c. Delineation of the different types of functions and skills needed, and the differences between these functions and skills and those of social work or case management

It should also be noted that under the new system, case managers and other team members are sometimes being asked to take on very different roles than ones they previously had. These new roles require supervision, training and support. For example, some training and working with under-performing members may need to be provided, in order to enhance performance as much as possible. The new model in many cases requires interdependency among team members; if some members are not doing their part of the task, this can be upsetting to more high performing members

D. Recognition that adults with developmental disabilities are often very different from and in very different situations than children

It is likely that the adult division has and is setting up its teams and work to deal with the fact that adult situations are often very different than children's, and that adults with DD often have significantly different needs than children. Of course some administrative and other structures can be the same with all ages. However, if this is not already being done, we recommend that the differences between adults and children, and between their situations, are consistently and continually acknowledged and that the parts of the model which need to be different because of different ages and different types of services are taken into account. It might be useful to have a small number of case managers and/or supervisors from both children's and adult's units come together to clarify which model elements are applicable across the board, which must have special adaptation, and which elements must be different between the two groups. Efforts to work together across the two groups may also assist in promoting more "ownership."

B. ADDRESS LARGER LONGER-RANGE DIRECTIONS

There are five arenas which are "big picture" types of approaches we feel would be helpful or necessary for the long run.

1. FOCUS ON CRITICAL TASKS

It helps to ask and focus on what is really critical for county case managers to do. What is the purpose of case management now, in this era? Yes, the social work model no longer applies, but also many aspects of traditional case management, support coordination and support brokerage do not apply, either. It is apparent that the administrative, gate-keeping and monitoring aspects are critical ones for county case management, as well as the role of supporting people in crisis. It is possible there are other tasks and aspects which county personnel can also identify as the critical ones, and need to identify, review and change periodically as the system continues to evolve.

2. BE PROACTIVE

Under the individual caseload system, individual case managers could be pro-active regarding particular individuals they were familiar with. Under the new model, many case managers have not yet figured out ways to be pro-active. As one children's case manager expressed, "When I knew my caseload, I could send information on new resources – it bothers me we can't be proactive." Another said, "If we really want to assure longer-range results, we need to be more proactive. Some could be easily done, we have real stuff to give people. Just get out and pass it out – guardianship stuff, camp stuff, etc."

Under the new model, it would be useful to find as many ways as possible for both the county and case managers to be as pro-active as possible, in several directions: assuring initial placements are the best possible, having a system to be aware of and identify impending crises, determining more effective services, and determining less costly service packages.

Other ways to think about how to be more proactive include asking the questions:

- For the people who need our assistance, how do we spend more of our money on what we want, and less on what we don't want?
- How can we unfreeze the limited structures of currently available service options, to improve people's support situations and decrease the need for our services?

The county should continue to seek assistance regarding new service models, such as more creative ways to provide employment and day program support, respite, etc.

3. CONSUMER EMPOWERMENT

As mentioned in the first section of this report, the capacity to have an increasing number of people served with fixed case management resources will take an increase in empowerment of others – not just consumers, but their families, care-givers, and committed others.

Several models exist. The university had a Parent Case Management project for many years. A model of "the team being case management" was mentioned by the customer service team. Principles of consumer empowerment learned in consumer-directed services can be applied to others, even without increases in that specific funding stream. For instance, an approach that can be implemented is an overall one of self-determination; a possible direction which could be taken is, "We're going to treat the resources for each consumer as if they're people's own." Larger questions to engage in include, "How can we get control of scarce resources directly in the hands of consumers as much as possible?" "How can we use this control to help people un-freeze the current service system structures in which people are trapped (as several CDCS families have done)?"

For some families, consulting with the county only once a year is the time-table that works. Self-advocacy programs can be increased and better supported. The Quality Management team can probably find ways to better educate groups of providers at once.

Consumers can be better educated in such areas as who to contact for what, where to get signatures, etc. Families can be encouraged to join ARC and use other resources for information. Technology can be better utilized, such as computerized information lines and consumer-friendly web-sites.

Of course consumer empowerment must be balanced with adequate and needed support. People cannot simply be told, "you're empowered now – you're on your own now," and support cannot simply be yanked away. In addition, the county will be faced with new issues such as a likely increase in non-English speaking clients who will need a great deal of support. There will always be families with trust issues, and always over-protective or harmful families and providers.

At the same time, in the name of empowerment or for any other reason, the county cannot simply expect providers or advocacy groups like Arc to do things the county must do – since both Arc and providers also face the stresses of limited resources. With high staff turnover in many provider agencies, there can be an even greater need for the county to address the issue of constancy of relationships in consumers' lives.

Between the two extremes of leaving people on their own and the other extreme of over-dependency, there will still have to be a middle ground as ways to increase consumer empowerment are employed.

An important avenue to incorporate is to have consistent plans for collecting information from the people who use the county services. While surveys and questionnaires can be helpful, they sometimes do not yield the quantity or quality of response which would be most needed. More feedback could be gathered at individual meetings with consumers or families, or in larger stake-holder meetings such as the "New Values, New Visions" conference in June 1997. Finding out both what people need, what they want, and what they expect from the county can be asked in many ways. Many of the questions originally used in New Values, New Visions were useful, but they often yielded responses that might be considered "ideal" answers – that is, if everything were working ideally, what would people be getting? In our current era, it might be useful to find out what the minimum is that people really need or expect – consumers themselves can be responsible for the current situation of more reduced funding. Then questions can center more around: "Given the current reductions in service funding which we are facing in the county, state, and country, what would be the best ways to proceed?" What do people really need, at a minimum? What must the county be accountable for providing you, at a minimum? How can we provide for the increasing numbers of people who need support, with the same amount of resources?" Consumers themselves can often provide useful and even brilliant solutions, and can have more of a role of real partnership with the county.

4. SYSTEMS ADVOCACY

The county can explore ways to influence the system in general so that individuals do not need to be so dependent on case management. For instance:

1. What has to happen in what aspects of the services system to minimize preventable crises?

2. For consumers who just want someone to listen, how does the system need to change so there are more people in someone's life and the case manager does not have to be the only person they depend on?

3. What can be figured out to build up organizational structures so more basic relationships happen for people?

4. How can more political activity be encouraged on the part of younger families to expand the service options available?

These larger system questions will need to be addressed if the county continues to have limited resources for case management. The service system itself will need more significant changes to assure that people are adequately supported and that the necessity for certain case management functions can decrease.

5. THE BROAD COUNTY ROLE

It is also important to recognize that case management for persons with developmental disabilities fits into a much larger role of the entire county. There are significant trends both in Minnesota and in the country toward unifying supports and models for many different types of groups who need long-term support. The county Quality Assurance team, for instance, is taking on responsibility for many different types of individuals and disabilities. In an era of reduced resources for human services, the unification of effort and alliance between different groups is critical. It is a likely future that developmental disabilities will not be able to sustain the distinct and separate identity it has had in the past. It is possible that models for individual service and individual case management may be reduced in the future. It is also possible that the case management expertise of developmental disabilities professionals may be of significant contribution in mental health, aging, and other groups.

IN CONCLUSION

We found that the design of the new model of case management could be effective at allowing the county to manage growing numbers of clients with fixed case management resources. In particular, it allows the county case management system to fulfill its required administrative, gate-keeping and crisis management roles. Some elements of the design are more beneficial for clients and for the necessary work being accomplished than the previous model. At the same time, the new model can in several ways potentially diminish the case management role of individual advocacy.

In order for the implementation of the model to be as effective as possible, there are several arenas which must be addressed. In addition, in the long run the county will have to continue to explore ways to manage increasing numbers of clients. Finding ways to increase real consumer empowerment, advocacy by others, and systems advocacy to expand service systems options are ways in which potentially more individuals can receive the support they need with limited case management resources.

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APPENDIX B

Beth Mount chart: System-centered versus Person-centered

Contrasting Realities: No Wonder There is Tension!

- PROGRAMS
- CONFERENCE ROOMS
- MANDATES
- FORMS
- POLICIES
- COMMISSIONERS
- PROCEDURES
- PAPERWORK
- CENTRALIZED
- STANDARDIZED
- PROFESSIONAL CONTROL
- CHECKLISTS
- CONTROL
- LARGE
- EFFICIENCY
- LAWS
- DETACHMENT
- PRODUCTION
- IMPERSONAL
- COURTS
- ORDER
- STATUS
- BEDS
- SLOTS
- OBJECTIVES
- LABELS
- FUNDERS
- QUOTAS
- REGULATORS
- CLIENTS
- MISSION STATEMENTS
- WAITING LISTS

THE PROMISE OF PERFECTION

SYSTEM-CENTERED WORK

PERSON-CENTERED WORK

WHAT'S A PERSON TO DO?

THE ART OF IMPERFECTION

- DREAMS
- HOPE
- IMAGINATION
- SPIRIT
- DETERMINATION

- PEOPLE
- LIVES
- EXPERIENCE
- RELATIONSHIPS
- DIGNITY

- VALUES
- FEELINGS
- PAIN
- JOY
- DEPRESSION

- RESPONSIVENESS
- PERSONAL
- CARING
- FRIENDS
- LIVING ROOMS

- NETWORKS
- CIRCLES
- TRUST
- GATHERINGS

- SMALL
- FLEXIBLE
- DIVERSE
- COMMUNITY
- SUPPORTS

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COPY OF SURVEY

HENNEPIN COUNTY CASE MANAGEMENT SURVEY

PLEASE RETURN BY JANUARY 20

1. Date Completed: _____
2. Role in County (Mark one): a. Case Manager ___   b. CM Supervisor __
                c. Other (describe) _____
3. Primary group supported (Mark one): a. Adults _____   b. Children's _____
                c. Other (describe) _____
4. Name of your team (optional): _____
5. How many years you have worked for Hennepin County (Mark one):

   _____ a. 0-1 year _____ f. 21-25
   _____ b. 2-5 years _____ g.26-30
   _____ c. 6-10   _____ h.31 or more years
   _____ d. 11-15
   _____ e. 16-20

PART I: IMPRESSIONS OF NEW CASE MANAGEMENT MODEL
The following statements are from the document "New Values, New Visions: Guidelines for Hennepin County Residents with Developmental Disabilities," a stakeholder conference held on June 25, 1997. Please indicate the degree to which you agree or disagree with the following statements, or the degree to which you think that the new model is about the same as the old model, by circling one number in each item. Please feel free to write in comments on any specific question or issue.

UNDER THE NEW CASE MANAGEMENT MODEL, CASE MANAGERS ARE NOW BETTER ABLE TO:	Strongly Disagree	Slightly Disagree	About the Same as Old Model	Slightly Agree	Strongly Agree
1. Know each individual consumer, listen carefully to them and understand what they want.	1	2	3	4	5
2. Develop an interpersonal relationship with and care about each consumer as a person, not as part of a "caseload."	1	2	3	4	5
3. Help each consumer, their family members and their service providers to work together.	1	2	3	4	5

UNDER THE NEW CASE MANAGEMENT MODEL, CASE MANAGERS ARE NOW BETTER ABLE TO:	Strongly Disagree	Slightly Disagree	About the Same as Old Model	Slightly Agree	Strongly Agree
4. Have enough time to visit each consumer and get to know them.	1	2	3	4	5
5. Have enough interest to get to know each consumer.	1	2	3	4	5
6. Have enough time to understand the changing and emerging needs of each consumer.	1	2	3	4	5
7. Be more effective and committed to standing up for each consumer to get what that consumer needs, wants and deserves.	1	2	3	4	5
8. Help consumers and their families have more choice and control over who provides service coordination to them.	1	2	3	4	5
9. Be able to work with consumers and others to solve problems and get the results consumers need.	1	2	3	4	5
10. Access information, ideas and experience that offer creative options and that support higher expectations for what individual consumers might experience and accomplish with their lives	1	2	3	4	5
11. Have meaningful opportunities to invest the time and resources needed to provide the help that consumers need from their case manager	1	2	3	4	5
12. Really help each consumer, because they are not being asked to help too many people	1	2	3	4	5
13. Communicate more clearly to consumers and their families about the number and variety of choices available in services and in service coordination.	1	2	3	4	5

UNDER THE NEW CASE MANAGEMENT MODEL, CASE MANAGERS ARE NOW BETTER ABLE TO:	Strongly Disagree	Slightly Disagree	About the Same as Old Model	Slightly Agree	Strongly Agree
14. Provide service planning, documentation and outcome reviews that are more meaningful and reflect more what consumers and families want and need.	1	2	3	4	5
15. Provide services and supports that are based on person-centered approaches of discovering what's important to the individual and in monitoring people's personal satisfaction and happiness	1	2	3	4	5
16. Ensure that the services provided are what were promised to individual consumers and are what consumers need	1	2	3	4	5
17. Know and clearly define their own specific role in assisting each consumer.	1	2	3	4	5
18. See their own job as working for the consumer, more so than seeing their job as working for the county.	1	2	3	4	5
19. Be held accountable for their individual performance.	1	2	3	4	5
20. Be flexible and available to individual consumers at the times and places when they need help.	1	2	3	4	5
21. Achieve a reasonable balance between the amount of time spent on paper and rules and the amount of time available for individual consumers	1	2	3	4	5

UNDER THE NEW CASE MANAGEMENT MODEL:	Strongly Disagree	Slightly Disagree	About the Same as Old Model	Slightly Agree	Strongly Agree
22. Consumers are given more choice in their services, agencies and the individuals who provide them, including service coordination	1	2	3	4	5

UNDER THE NEW CASE MANAGEMENT MODEL:	Strongly Disagree	Slightly Disagree	About the Same as Old Model	Slightly Agree	Strongly Agree
23. Rules that impede consumer control, financial flexibility and range of options are better able to be identified and reduced	1	2	3	4	5
24. Inefficiencies in the services system that drain off resources are better able to be reduced.	1	2	3	4	5
25. Client choice and control are supported and encouraged.	1	2	3	4	5
26. County responsibilities are adequately addressed.	1	2	3	4	5
27. County exposures and vulnerabilities are reduced.	1	2	3	4	5
28. Responsiveness to individual consumers is increased.	1	2	3	4	5
29. Growing numbers of individuals and families are able to have their needs met (within fixed case management resources)	1	2	3	4	5
30. The health and safety supports and protections needed by individuals are in place and health and safety considerations are effectively met.	1	2	3	4	5

29. Do you have any comments on any specific questions above? (Please indicate which item your comment refers to)

PART II: EXAMPLE OF EFFECTS OF THE NEW CASE MANAGEMENT MODEL

1. Please give SPECIFIC examples of individuals that illustrate for whom the new case management process are working well. Which aspects are working well for which people? (Please tie to a specific question number above, if you wish.)

2. Please give SPECIFIC examples of individual situations that illustrate where the new case management processes are NOT working well. Which aspects are not working for which people? (Please tie to a specific question number above, if you wish.)

PART III: SUGGESTIONS FOR CASE MANAGEMENT

1. However positive, negative or indifferent you may feel about the new case management model, you probably have some ideas about how it can be improved. Please share any of these ideas that you feel might contribute to more effective organization and/or delivery of case management under the new model.

If you wish to be contacted for additional information, please provide your name, phone number and email:

Name _____ Phone Number _____ Email Address _____

Please return this survey in the enclosed envelope by JANUARY 20 to:

Dr. Angela Novak Amado   If you wish to contact us:
Institute on Community Integration   651-698-5565
University of Minnesota   amado003@umn.edu
204 Pattee Hall
150 Pillsbury Drive SE
Minneapolis, MN 5545

Survey Questions and Frequencies
HENNEPIN COUNTY CASE MANAGEMENT SURVEY

1. Date Completed: **January 2005**
2. Role in County (Mark one):
   - a. Case Manager   53
   - b. CM Supervisor   8
   - c. Other   15
3. Primary group supported (Mark one):
   - a. Adults   35
   - b. Children's   15
   - c. Other or multiple   26
4. Name of your team (optional): _____

		Total (St. Dev.)	Mean N=76	Case Managers Mean (St. Dev.) N=53	Supervisors Mean (St. Dev.) N=8	Other (St. Dev.) N=15	Mean
V1	Know & listen to each individual consumer	1.68 (.941)		1.74 (.923)	2.29 (1.380)	1.17 (.389)	
V2	Develop personal relationship with each consumer	1.60 (.954)		1.57 (.910)	2.14 (1.345)	1.50 (.905)	
V3	Help everyone to work together	2.15 (.981)		2.04 (.876)	3.00 (1.155)	2.25 (1.138)	
V4	Have time to visit each consumer & know them	1.62 (.892)		1.62 (.945)	1.57 (.535)	1.67 (.888)	
V5	Have interest in knowing each consumer	2.26 (1.138)		2.24 (1.106)	2.50 (1.378)	2.33 (1.231)	
V6	Have time to understand changing needs of consumer	1.70 (.967)		1.62 (.945)	2.71 (1.113)	1.59 (.674)	
V7	Be more effective in standing up for consumer	1.90 (1.148)		1.72 (.907)	2.43 (.787)	2.60 (2.011)	
V8	Help consumer & family have more choice in services	2.25 (1.058)		2.08 (.904)	3.43 (1.512)	2.25 (1.055)	
V9	Be able to work with consumer to solve problems	2.21 (1.027)		2.08 (.976)	3.1 (1.069)	2.25 (1.055)	
V10	Access information for creative options	2.26 (1.035)		2.13 (1.020)	3.29 (.951)	2.18 (.874)	
V11	Have meaningful opportunities to invest time & resources	1.93 (1.117)		1.83 (1.122)	3.00 (1.265)	1.75 (.754)	
V12	Able to help as caseload is not too large	1.76 (1.028)		1.70 (.992)	2.83 (1.329)	1.50 (.798)	
V13	Clearly communicate with consumers re service options	2.46 (1.100)		2.40 (1.025)	3.67 (1.506)	2.08 (.900)	
V14	Provide service documentation that is meaningful	2.19 (1.194)		2.08 (1.124)	3.50 (1.517)	2.00 (1.044)	
V15	Provide PCP based services & supports	2.04 (1.164)		1.94 (1.092)	3.00 (1.095)	2.08 (1.379)	
V16	Ensure that promised services are provided	2.18 (1.086)		2.12 (1.060)	3.00 (1.265)	2.00 (1.044)	
V17	Know & define specific role with consumer	2.39 (1.228)		2.42 (1.232)	2.83 (1.329)	1.92 (1.084)	
V18	See their job as working for consumer vs county	1.92 (1.017)		1.85 (1.045)	2.33 (.816)	2.08 (.996)	
V19	Be held accountable for individual performance	2.67 (1.151)		2.70 (1.119)	3.50 (1.378)	2.25 (.965)	
V20	Be available to consumers when they need help	2.26 (1.061)		2.17 (.995)	3.00 (1.265)	2.42 (1.165)	
V21	Achieve balance between paper, rules & consumer time	1.99 (1.055)		1.92 (1.053)	3.00 (.894)	1.83 (.937)	
V22	Consumers are given more choices in services	2.56 (1.016)		2.35 (1.016)	3.33 (.516)	2.92 (.900)	
V23	Impeding rules are more easily identified & reduced	2.41 (1.028)		2.24 (.951)	3.33 (.816)	2.58 (1.165)	
V24	System inefficiences are better identified & reduced	2.07 (1.150)		1.96 (1.171)	2.83 (.753)	2.17 (1.193)	
V25	Client choice & control is supported & encouraged	2.61 (1.115)		2.40 (1.107)	3.67 (.516)	2.83 (1.030)	
V26	County responsibilities are adequately addressed	2.38 (1.033)		2.40 (1.034)	3.33 (.816)	1.83 (.835)	
V27	County exposures & vulnerabilities are reduced	1.99 (1.105)		1.94 (1.121)	2.17 (.983)	1.91 (1.044)	
V28	Responsiveness to individual consumers is increased	2.01 (1.123)		1.98 (1.140)	2.83 (1.169)	1.75 (.965)	
V29	Growing numbers of consumers are able to have needs me	2.37 (1.551)		2.19 (1.205)	2.83 (.983)	2.92 (2.746)	
V30	Health & safety supports are effectively met	2.19 (1.081)		2.14 (1.132)	2.67 (1.211)	2.08 (.793)	

1 "Strongly Disagree"; 2 "Slightly Disagree"; 3 "About the Same as Old Model"; 4 Slightly Agree"; 5 "Strongly Agree"