Case Management Services for DSS/HRA/DHS Clients

Exploring the Incidence and Implications of Duplication

Angela Ghesquiere, Ph.D.

Office of Evaluation and Research

DSS OFFICE OF RESEARCH AND POLICY INNOVATION

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Background

The New York City Department of Social Services' Human Resources Administration and Department of Homeless Services (DSS/HRA/DHS) offer a wide array of services to meet the needs of low-income and vulnerable New Yorkers. One key service is case management. While "case management" has many definitions, which vary widely depending on service setting and population served, it typically involves assessment; connection to services; coordination between services; navigation assistance; goal-setting; and monitoring, delivered over multiple contacts (Luckersmith et al., 2016). For the purposes of the current report, we define "case management" as service delivery by anyone in a case-manager or similar role that covers multiple social service domains and is delivered in the context of an ongoing relationship (rather than brief, specific service delivery).

Some DSS/HRA/DHS clients receive case management from more than one of our agencies' programs, and/or from other City agencies and community organizations. Having more than one case manager can potentially result in time and cost inefficiencies due to duplication of services, client confusion about where to get support, and undue burden on both clients and case managers (Carey, 2015; Ragan, 2003). However, to date, there has not been clear information available on case management duplication among DSS/HRA/DHS clients or how staff and clients manage this. This study by the DSS Office of Evaluation and Research (OER) gathered information on these topics. It also sought to describe the scope of current case management services, and explored recommendations on how to reduce duplication, with the goal of informing efforts to improve the efficiency of case management delivery for agency clients.

OER's analysis sought to answer the following **research questions:**

- What kinds of case management services are clients receiving from DSS/HRA/DHS programs, and from whom?
- What is the scope and scale of duplication in case management receipt across programs (both internal and external to DSS/HRA/DHS)? Are there any clear patterns of duplication across programs?
- What are the benefits and challenges of working with case managers from multiple programs/agencies?
- Are there models of integrated social services case management or recommendations that could suggest best practices for DSS/HRA/DHS?
- What are some potential barriers and facilitators to better coordination and/or integration of case management services for DSS/HRA/DHS clients?

Key Findings

OER's DSS/DHS/HRA leadership interviews found that case manager activities range widely across DSS/HRA/DHS programs. Findings suggest that a minority of clients have more than one case manager, although case managers' specializations within the complex New York City social services landscape meant that having multiple case managers was often *not* associated with duplication of services. When duplication was problematic, the research literature, current program practices, and leadership recommendations offered a continuum of strategies that could potentially be implemented across DSS/HRA/DHS. Key takeaways from our evaluation include:

1) Many DSS/HRA/DHS programs offer case management services, which range widely, based on program focus, in their activities, scope, and frequency of contact with clients. The scope of activities varied from case managers primarily conducting assessments/reassessments to their simultaneously assisting with benefits applications, developing and tracking service plans, making referrals, and coordinating care.
2) A minority of DSS/HRA/DHS clients appear to have more than one case manager, though no programs tracked case management duplication consistently. Internally, case management duplication most commonly occurs among DHS shelter clients who are also served by HRA programs. Externally, DSS/HRA/DHS clients frequently have case managers at the other government agencies (e.g., Administration for Children's Services (ACS), Medicaid care coordination) or community-based organizations (e.g., mental health service providers, inpatient settings). Administrative data on DHS cases indicated that 27% were also Career Services cases, and that up to 17% of current DHS Family with Children families (excluding migrant households) have an active ACS case.
3) In most cases, multiple case managers meet different needs based on their individual specializations, and many case management activities are mandated. When case management service duplication does occur, challenges can result, including undue time and psychological burden on clients; client confusion over where to get services or what each case manager can provide; staff confusion over what client needs are being addressed elsewhere; and systems inefficiencies and service gaps. On the other hand, the increased choice and additional support offered by having more than one case manager could sometimes be beneficial to clients.
4) A large body of research has explored how to better integrate services. Models range along a continuum from minimal collaboration (e.g., information sharing) to full integration into a new joint entity. Some DSS/HRA/DHS programs are already using

some of these strategies, and recommendations for additional integration emerged from our interviews.

5) Better integrating or coordinating services has both barriers and facilitators, including organizational mandates, security and confidentiality considerations, infrastructure and technology, and funding.

Methods

OER conducted a mixed-methods evaluation that included semi-structured interviews with senior leadership, a scan of research literature, and analysis of administrative data. In interviews, we focused specifically on case management activities and efforts to reduce its duplication, understanding that there are many agency collaborative efforts outside of this narrow case management scope.

Interviews: OER researchers conducted a total of 14 in-depth interviews with 29 key informants in senior DSS/HRA/DHS leadership in 13 different program areas. From DHS, we interviewed leadership at Streets, as well as Families with Children, Single Adult, and Adult Families shelters. From HRA, we interviewed leadership at Adult Protective Services (APS), Career Services, Domestic Violence Services (DVS), the HIV/AIDS Services Administration (HASA), Prevention and Community Support (PCS) within the Homelessness Prevention Administration (HPA, who contract with community-based organizations to provide Homebase services)., the Home Care Services Program (HCSP), and the Wellness, Comprehensive Assessment, Rehabilitation, and Employment (WeCARE) program. From DSS, we interviewed leadership at the Health Services Office (HSO) and at NYCBenefits (within the Office of Advocacy and Outreach). We used a snowball sampling approach, adding key informants suggested by participants, as appropriate. We also considered conducting client interviews. Ultimately, we concluded that speaking with leadership across agency programs would provide a better sense of the full range of case management duplication incidences and implications, and we found that many leadership interviewees were able to speak to how clients navigate duplicate services. Future OER work could involve client interviews, although challenges identifying and reaching specific clients who are experiencing duplication of case management services across different programs and situations may limit our ability to generalize from findings.

Most interviews were conducted by video meeting between September 23rd and November 6th, 2025, with a final interview with Streets conducted on January 23, 2026. Each interview lasted approximately one hour and covered the key research questions. Interview questions are included in Appendix A. Six were individual interviews and 8 were group interviews of 2 to 7 people in the same program area.

Literature scan: This covered key studies published in peer-reviewed journals as well as reports from research and policy organizations. Literature was identified through searches of several scholarly databases, including Google Scholar, JSTOR and the Social Science Research Network (SSRN), as well as references from identified sources. We used combinations of relevant terms for searching, including "integrated," "collaborative," "social services/welfare," "case management/manager," "duplication," "multiple case managers," and related terms. While there is a large body of literature on care coordination in the medical field, our review focused specifically on social services.

Administrative data: The Office of Performance Management and Data Analytics (OPMDA) provided data on how many DHS clients also received services at Career Services, and how many also had active cases at the NYC Administration for Children's Services (ACS). Data was obtained from CARES, SEAMS, and an ACS feed that HRA has in place though a data sharing agreement with them. Data on DHS/Career Services overlap was available for single adults and eligible family households in shelter from January through June 2025. Data on DHS/ACS overlap was available for single adults and eligible family households in shelter on a single point in time of January 28, 2026.

Findings

I. Case Management Services at DSS/HRA/DHS

Consistent with research literature that found a wide variation in case management models across settings and populations (e.g., Luckersmith et al, 2016; Frankel et al., 2018), DSS/HRA/DHS case managers' activities, scope, and frequency of interaction with clients varied greatly across programs. As noted above, we defined "case management" broadly, as service delivery by anyone in a case-manager or similar role that covers multiple social service domains and is delivered in the context of an ongoing relationship. Most DSS/HRA/DHS approaches differ from "traditional" case management, in that they are focused on specific program-related needs. For example, Career Services and WeCARE used a workforce case management approach, focused on employment and training, not on a wide range of service needs.

Across DSS/DHS/HRA programs, case management-related activities were provided by dedicated case managers, but programs varied in whether they were provided by DSS/DHS/HRA agency staff or contracted providers. Agency staff provided case management services at HSO, HASA and HCSP. Contracted providers provided case management services for DHS shelters and Streets, NYCBenefits, WeCARE, HPA/PCS, Career Services, and for some APS and DVS services. When case management was provided by contracted providers, leadership interviewees often reported a wider range in training and skills than among agency staff case managers.

The most limited range of activities, with the narrowest scope, and more minimal client contact, occurred at HCSP and APS. At HCSP, case managers primarily do initial assessments and yearly reassessments of eligibility for in-home services for Medicaid-eligible clients, with some referral and benefits access support. At APS, there are several tracks for services, with all having the goal of getting clients to stability in community settings and re-reestablishing their independence. Working on a different track from the case workers who investigate referrals to APS, "under care" case workers provider referrals, organize services to help stabilize clients (e.g., heavy-duty cleaning services, financial management services), and do monthly reassessments for service eligibility. Clients are rarely under care long-term, but when this occurs, it is usually because of a crisis or because they are under ongoing financial management or mandated court guardianship.

A slightly broader scope, with more types of activities and more frequent contacts, occurred at Career Services, WeCARE, HPA/PCS, and other DVS programs. For WeCARE and Career Services, case managers' scope of activities is centered on helping clients prepare for or obtain work through planning, referrals, and other supports. Both programs offer a range of tracks (VRS, Wellness and SSI, at WeCARE; PACE, PINCC, JobsPlus, CUNY Edge and several others at Career Services) depending on client needs and readiness, with case management services and intensity varying by track.

For HPA/PCS contracted providers who provide Homebase services, the scope of case manager activities is primarily focused on addressing housing instability and/or crisis, including support to avoid eviction, rental assistance voucher processing, and provision of or referrals to other services to help address housing stability-related issues (e.g., financial management skills, employment supports). Amount of and length of contact varies based on client needs. There are also length of service parameters as per federal funding, but HPA/PCS has set some exceptions related to subsidy processing time.

The DSS Health Services Office also provides case management services with a somewhat broader scope of activities, in this case with a clinical focus. Although leadership noted that their work is not exactly "true" case management, several of their programs for clients in DHS shelter include services that fall under our broad definition of the term: Nurses and Navigators in Shelter, Harm Reduction, and Complex Case Coordination. These programs work with clients in an ongoing way and try to connect them with a range of appropriate services; they also work closely with the client's DHS case manager. The Nurse and Navigator program is a pilot with NYU where nurse and navigator teams are embedded in and rotate through three different shelters, with the goal of both providing and connecting clients to healthcare-related services. The Harm Reduction team reaches out after all non-fatal overdoses at DHS shelters, based on weekly drug and alcohol incident reports, and connects to staff working with the client at the shelter to provide guidance around risk/harm reduction, safety planning, and resources. Staff also sometimes work directly with clients to

provide substance use and medical services. The program initially focused on single adults but recently expanded to families. The Complex Care Coordination team looks at DHS incident report data and identifies those in need of "high-level" care. They then work with providers to connect client with multiple needs to services when there are any gaps, and to address barriers to clients' gaining independence.

The broadest scope, with the widest range of activities and most intensive client contact, occurs at DHS Adult and Family Shelters, DHS Streets, HASA, non-residential DVS services, and NYCBenefits.[1] These case managers have regular, frequent contact with clients, complete service plans, check on progress towards plan goals, and make referrals. At HASA, case workers are additionally very involved in assisting with benefits and housing applications and generally "are a liaison to everything for clients and provide a 'one-stop' service offering system for clients." At DHS Streets, outreach teams for people experiencing street homelessness include case managers. Those case managers continue to work with clients and collaborate with their other case managers when clients enter DHS shelter, Safe Havens, supportive housing, or other transitional housing. Streets case management continues until they seem to be truly stable in the new setting (often for 6 months to a year). Streets case managers also provide more intensive services to "clinical caseload" clients, who are the most vulnerable, complex clients.

Finally, while NYCBenefits funds case managers at CBOs to support clients in submitting and reapplying for HRA benefits, a very narrow scope, in practice their scope can be far broader. Leadership noted that the program was designed to be flexible, and also supports these case managers to provide assistance applying to all Federal, state, and local benefits for which they are eligible. And case managers also often carry out a broad scope of case management activities as part of their regular CBO roles, including referrals, care coordination, and provision of grants at their own agencies. As NYCBenefits leadership put it, "They can address the whole person: childcare, learning English, job training, food pantry referrals. Everything."

II. The Scope of Case Management Duplication for DSS/HRA/DHS Clients

Fragmentation, and resulting duplication, of human services is not unique to DSS/HRA/DHS clients or New York City and is well-documented nationally. It is the result of a social services system that was created at different times by different organizing bodies. While over the course of the 20th century, services generally moved from independent, piecemeal efforts to government-coordinated services, many independent services remain (Waldfogel, 1997). As one researcher described back in 2003 (Ragan, p. 9):

[1] "Residential" case management in DVS shelters is separately contracted and is monitored separately by the state Office of Children and Family Services DVS staff cannot visit programs or review client case records and activities are managed autonomously by the shelter provider with state oversight.

> *"Human service system" is something of an oxymoron. In most locations, human services at the local level is not a system, but rather a patchwork of separate programs, each with its own goals, rules, bureaucracies, funding mechanisms, and service delivery processes…This is not a true system; it is a mix of …"silo" programs and services, many serving the same populations, but with little direct interaction, sharing of information, or coordination.*

We could not identify research on exactly how many social welfare clients have more than one case manager, but there is some older data on how many child welfare clients receive cash assistance from the large child welfare literature (e.g., Coulton, Korbin, Su & Chow, 1995). It found that close to half of all identified incidents of child abuse or neglect occurred in families receiving cash assistance, making it likely that they have at least two case managers (Pelton, 1994), and that about a quarter of new child entrants to TANF had contact with child welfare agencies during the preceding 5 years (Needell et al., 1999).

Consistent with these broader trends, most DSS/HRA/DHS leadership interviewees reported that some of their clients had more than one case manager, either internal to the agency or with external organizations. As none of the programs we spoke with explicitly tracked case management duplication, the exact rates of duplication are not often known. However, interviewees did not think that the majority of clients had more than one case manager, either internally or externally. Administrative data *was* available on DHS client overlap with one agency program (Career Services) and one external agency (the Administration for Children's Services (ACS)); see more detail below.

Internal duplication

In DSS/HRA/DHS leadership interviews, having a case manager *both at DHS shelter and an HRA program* was most often cited as a source of multiple DSS-related case managers. As will be discussed below, duplication is often associated with mandates required by different programs. HRA's WeCARE, Career Services, NYCBenefits, and HASA programs all serve DHS clients. Notably, for HASA, the DHS group is quite small and HASA case managers coordinate directly with DHS to try to quickly transition these clients to HASA housing. HSO clients also have DHS case managers, as that is intentional as part of the design of HSO programs, and case managers work closely together. Administrative data was available on DHS client overlap with Career Services (Table 1). While data did not provide detail on case management receipt specifically, we know that all DHS clients are assigned case managers and that many Career Services clients are as well. About a third of Families with Children and Adult Families cases had a Career Services assignment, while about a quarter of Single Adult cases had one.

Table 1. Overlap of DHS cases with HRA Career Services, January-June 2025

	Total	With Career Services Assignment	
	#	#	%
Total unique eligible DHS cases	71,497	19,408	27.2%
Families with Children	26,769	8,418	31.5%
Single Adults	42,844	10,375	24.2%
Adult Families	1,884	615	32.6%

Source: CARES, SEAMS data from OPMDA

Note: Includes both DHS cases who were active on cash assistance (CA) from January to June 2025 and those who were inactive.

Within HRA, the program in which clients most commonly had a second HRA case manager was APS, with many APS clients also served by HCSP, HASA, and/or HPA/PCS. In these situations, APS is typically the primary case management program. Additionally, HCSP leadership noted that some of their clients also received case management services at HASA. Finally, within DHS, part of the model for DHS Streets outreach case managers (as described above) is that they continue to work with clients, and collaborate closely with their case managers, when they are in other DHS settings like Safe Havens.

External duplication

Program leadership also observed clients having case managers at a range of external agencies and organizations. As NYCBenefits leadership noted, "My sense from conversations with CBOs [Community Based Organizations] is that there's no one place to get case management…[There are] different programs with different funding sources and different spheres." Program tracking was limited by privacy issues, though, as medical records cannot be shared unless clients sign HIPAA agreements, and other records are not shared unless other release of information forms are signed, or there is a larger data sharing or collaborative agreement in place.

In our leadership interviews, a few external agencies or provider types were mentioned by multiple DSS/DHS/HRA programs.[2] Table 2 categorizes external services into two types: government agency and community-based organization (CBO) services. At government agencies, overlap with case managers at ACS was mentioned especially frequently. Indeed, administrative data from a single point-in-time pull on January 28, 2026 found that up to 17% of DHS Family with Children cases in shelter (excluding migrant households) had an active ACS case. Other government agencies where there was overlap with DSS/DHS/HRA programs were the NYC Department of Health and Mental Hygiene (DOHMH) and Medicaid care coordination (which includes health homes). On the CBO side, overlap with mental health case managers (through ACT (Assertive Community Treatment) teams, Incident

[2] This table should not be considered precise or exhaustive, as interviewees reported on overlap in response to an open-ended question, not a checklist.

Management Teams (IMT), or other community services), or case managers at inpatient settings (i.e., hospitals, inpatient mental health or substance use treatment, or correctional facilities) were mentioned most often. Note that the distinction between these two categories can be blurry, as many of the CBO services are contracted by government agencies.

Table 2. External organizations where DSS/HRA/DHS clients have additional case managers

	Government Agency						Community-Based Services			
Program:	**ACS**	**NYC Aging (DFTA)**	**DOHMH**	**DYCD**	**Medicaid care coord.**	**OPWDD**	**Mental health, (incl. ACT or IMT)**	**Inpatient services**	**Legal services**	**Substance use services**
HRA:										
APS						✓				
Career Services	✓	✓		✓						
DVS									✓	
HASA								✓	✓	
Homebase via HPA/PCS	✓							✓	✓	
HCSP	✓					✓				
WeCARE					✓		✓			✓
DHS:										
Families with Children shelters	✓		✓		✓					
Adult shelters		✓	✓		✓		✓	✓		✓
Streets			✓				✓	✓		✓
DSS:										
HSO			✓		✓		✓	✓		✓
NYCBenefits		✓		✓						

Notes: ACS=Administration for Children's Services; ACT=Assertive Community Treatment (ACT) teams; DFTA=Department for the Aging (now referred to as "NYC Aging"); IMT=Incident Management Teams; DOHMH=Department of Health and Mental Hygiene; DYCD=Department of Youth & Community Development); OPWDD: New York State Office for People With Developmental Disabilities

Source: Interviews with DSS/HRA/DHS leadership

Otherwise, DSS/HRA/DHS program leaders observed that clients had additional case managers at agencies/programs that served their unique populations. HSO and Streets leadership described how clients experiencing street homelessness work with Mobile Crisis Assisted Outpatient Treatment (AOT; which can include case-management-related activities), while those who are forensic clients are connected with Intensive Community Monitoring (ICM). DHS Streets leadership also shared that many clients are connected to SOS (Safe Options Support), which provides the evidence-based Critical Time Intervention (CTI) model developed for people experiencing street homelessness. DHS FWC leadership noted that children in shelters often see school social workers for case management-related work, although it is not clear how many have received ongoing case management at school. And for

HASA, the most consistent additional case manager is from the supportive housing provider for clients in that type of housing. Many HASA clients also have case managers at an HIV-related CBO (as NYC is particularly rich in HIV-related organizations). And Homebase clients also sometimes have case managers at several other entities that address issues related to housing instability (including DV providers, immigration services, and various non-profits). Finally, APS has an ongoing partnership with NYCHA, with regular meetings and check-ins to talk about case management.

Notably, at DVS, confidentiality and safety concerns for DV survivors and their families may limit the number of staff with whom clients interact. As DVS leadership described, "Typically, clients are in such a crisis…Since the nature of their situation is so personal, I don't think people are seeking out a lot of organizations…they don't want all of their information out [there]."

III. Challenges and Benefits of Service Duplication

The research literature OER identified focused on the impact of service fragmentation broadly, rather than case management duplication in particular, but many findings are applicable. Many of the themes from the literature were also described in interviews with DSS/HRA/DHS leadership. One key point identified in both sources was that (especially for complex cases) having multiple case managers was seen as a necessity to meet multiple client needs. Because most social services have specific criteria, procedures, and requirements, it is usually infeasible for one case manager to have the in-depth knowledge needed to navigate all domains (Ragan, 2003). And because some specialization has long been a feature of case management in the U.S., there are usually substantial differences across programs in caseworker training, knowledge, qualifications, caseloads, and policies and procedures that must be followed (Ragan, 2003; Waldfogel, 1997). As DHS FWC shelter leadership described, for example, "Our case managers are not trained in intervention. Case managers from ACS, DOHMH are trained in different things." As a result, despite some challenges from duplication that will be described below, many agency leaders felt that having multiple case managers did not necessarily mean duplication of services. As HASA leadership observed when HASA clients have more than one case manager, for example, "in most instances, all involved parties are serving very different roles. I don't think that there is much overlap in how different case managers serve their clients." Therefore, rather than focusing on eliminating duplication, interviewees emphasized the ways that coordination could be improved (see more in Section IV below).

Challenges of service duplication

When duplication of services did occur, DSS/HRA/DHS leadership interviews and the research literature identified several specific challenges, for clients, staff, and the social services system as a whole.

For clients:

Time and energy burden: The time and energy costs associated with having to visit different institutions, learn about procedures, and comply with administrative demands repeatedly can be high (Schnieder et al., 2025), particularly for clients with access challenges or complex needs (Waldfogel, 1997).

Confusion: Clients may be unclear on where to go for what service, creating confusion and overwhelm (Waldfogel, 1997). Indeed, interviewed DSS/HRA/DHS leadership observed that some clients became so overwhelmed that they became disengaged from all services. Another source of confusion for clients occurs in the instance that different case managers tell them conflicting or incomplete information, which agency leadership also observed.

Psychological burden: Especially for vulnerable groups, duplication can have psychological costs due to having to repeat the same information (Schneider et al., 2025); DSS/HRA/DHS interviewees particularly observed that having to repeat often traumatic histories and case information to multiple providers was challenging to clients.

Loss of trust: Having to navigate fragmented services can decrease clients' trust in both individual workers and the welfare system as a whole, as they can interpret this as a deliberate state strategy to deprive them of services (Schneider et al., 2025).

For staff:

Service quality: Duplication when there is no communication in place with the other providers can impact the effectiveness of their work and ability to advocate for clients (Carey, 2015), an issue also identified by DSS/HRA/DHS leadership. And when having multiple case managers limits client's engagement, it may lead to briefer and more superficial relationships with each case manager (Carey, 2015).

Confusion: Service duplication or fragmentation can lead to confusion and overwhelm in staff, contributing to a general sense of instability (Carey, 2015; Yeo et al., 2022). As Streets leadership noted, when case managers aren't communicating well with each other, "a lot can be missed."

For systems:

Inefficiencies: Duplication reduces efficiency for service delivery systems as a whole, through repetitiveness of tasks such as intake and assessment, history-taking, and diagnosis, as well as administrative inefficiencies (O'Looney, 1993; Carey, 2015; Waldfogel, 1997).

Service gaps: Service duplication often results in no one case manager overseeing the full range of client concerns. Then, if case managers do not have complete information about their shared clients and each other's care plans, clients can experience service gaps (U.S. General Accounting Office, 1992; Waldfogel, 1997). Leadership interviewees also observed that service duplication "could lead to the client not receiving services that would be beneficial [to them]."

Rubber stamping: When information *is* shared between duplicate case managers**,** 'rubber stamping' (i.e., the passing of adverse information about clients between institutions), has been found to be more prevalent in fragmented/duplicative institutional contexts (van Berkel & Knies, 2016).

Benefits of duplication

Despite these challenges, DSS/HRA/DHS leadership interviews and the research literature also identified a few potential benefits of case management duplication for clients and staff.

For clients:

Increased choice: Waldfogel (1997) has noted that having multiple service providers can allow clients more choice in both staff and providers, and this point also came up repeatedly in agency interviews. Sometimes the relationship with outside case managers is especially strong because they may have more cultural or community ties to the clients than at DSS/HRA/DHS. As NYCBenefits leadership noted about external CBO case managers: "CBO staff go to the same community center, house of worship, speak the language – clients feel more comfortable sharing information [with a CBO] when they're feeling very vulnerable." Similarly, several leadership interviewees observed that some clients used the choice provided by having multiple case managers to identify, and engage more, with the case manager they worked best with. That connection, in turn, could increase client engagement (and ultimately compliance, as applicable) with mandated HRA programs.

Additional supports*:* It can also be beneficial for clients to have several people that they can reach out to for help or advocacy. As leadership at HASA put it, "clients may feel comfort knowing that there are multiple people working on their case." This can also increase access to other services. At DHS Streets, where the case management model includes ongoing, close collaboration between outreach case managers and other case managers, leadership noted that "we definitely see benefits having case managers both on-site and on the outreach team...our outreach teams have spent a large amount of time getting to know clients…and trying to move to what's best for the client."

For staff:

Improved information: When case managers collaborate effectively, each can get information that the client might not share with the other and share it with each other (once privacy issues are addressed, of course).

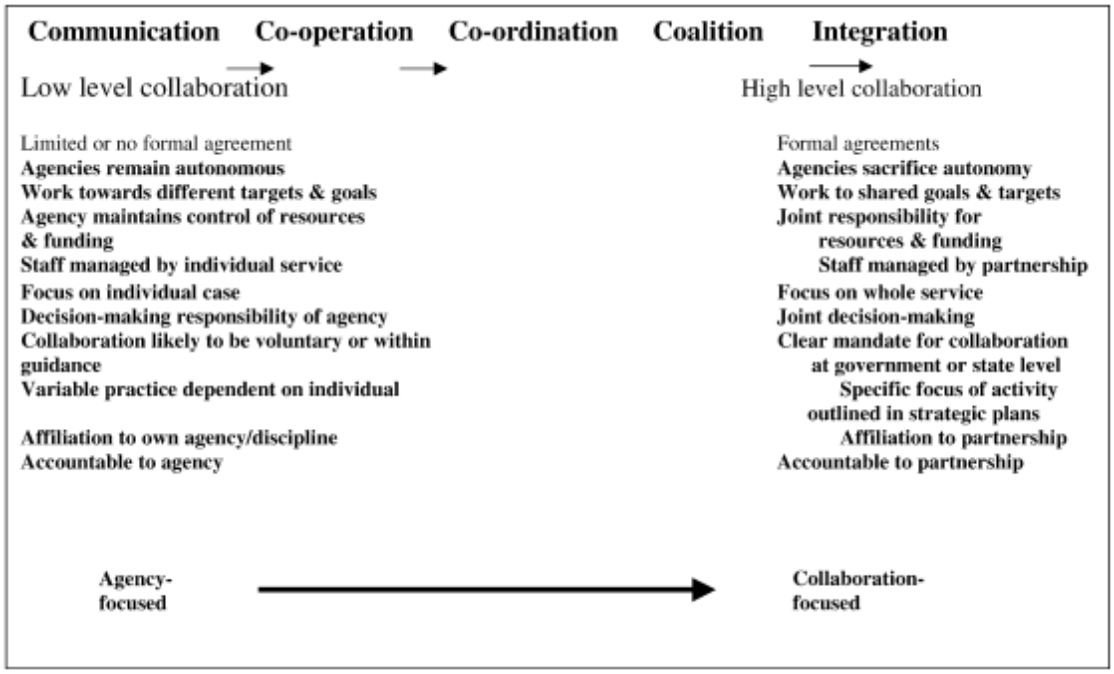
IV. Potential Solutions to Service Duplication

A large body of research, across many fields, has explored how to minimize service fragmentation, and generally ensure that clients are efficiently receiving services that address their needs. While this work does not focus on case management duplication specifically, it recognizes that duplication is a common result of service fragmentation, and proposed solutions can also address duplication. Most of the research we identified was older and followed the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as one of its goals was to increase integration and collaboration across welfare agencies (Ehrle et al, 2004). Many terms have been used to describe efforts to improve service delivery efficiency, including "cooperation", "collaboration," and "comprehensive service reform" (Waldfogel, 1997; Pindus et al., 2000; Ragan, 2003). One of the more common terms in the social services literature, which we will use in this report, is "service integration" (Kahn & Kamerman, 1992, in Waldfogel, 1997). The basic goals of service integration are to improve match between client needs and services provided and to create a more coordinated system for service delivery, therefore improving client outcomes (Waldfogel, 1997; Ragan, 2003).

Scholars have identified a wide continuum of service integration models (e.g., Fine et al., 2005; Bryson et al., 2006; Grace et al., 2012; Nam, 2012). Horwath and Morrison (2007) have organized this continuum (Figure 1). At the low end of the continuum are organizations[3] that remain autonomous and hardly relate to each other when it comes to dealing with a common service, communicating only. The second-lowest level is "cooperation". This could involve working together on a case-by-case basis, more standardized information-sharing, the creation of inter-agency taskforces or advisory groups, and/or the development of consensus regarding good practice. The third level, "coordination," involves more formal joint efforts, such as formal inter-agency agreements or joint training programs. The fourth level, "coalition" (also called "collaboration" in some models), involves more joint structures with lower agency autonomy, where there are changes in agency, group or staff behavior to support shared goal. Finally, at the highest level, "integration," organizations are merged into a new joint entity. Here, there are seamless interagency service delivery teams and the adoption of a common identity, such that service users are unlikely to be able to identify with which agency they are interacting.

[3] We use the term "organizations" for simplicity, but that this term could refer to particular units and programs within an agency or institution, agencies or institutions as a whole, community-based organizations (CBOs), or even entire governments

Figure 1. Continuum of Service Collaboration



Source: Horwath & Morrison (2007), p. 57

There are two main approaches to service integration, with specific models falling along the continuum in Figure 1*: systems-oriented solutions* (also called "administrative" initiatives) and *service-oriented solutions* (also called "operational" initiatives) (Ragan, 2003; U.S. General Accounting Office, 1992; Waldfogel, 1997; Ehrle et al., 2014). We focus on (case management) service-oriented solutions here, although systems-level changes are often needed as a precondition to implement case management integration. Systems solutions can range from a formal agreement between two or more organizations (e.g., to integrate their services across organizational boundaries) to integrated budgets and consolidated governance (Cook, 1977; Wang & Wang, 2007; Becker et al., 2009; Borman, 2010; Nam, 2012; Gjersøe, 2021). The integration of HRA and DHS under the DSS umbrella is an example of government structure consolidation that provides a foundation for efforts to coordinate (or potentially streamline) case management services across the agencies' programs.

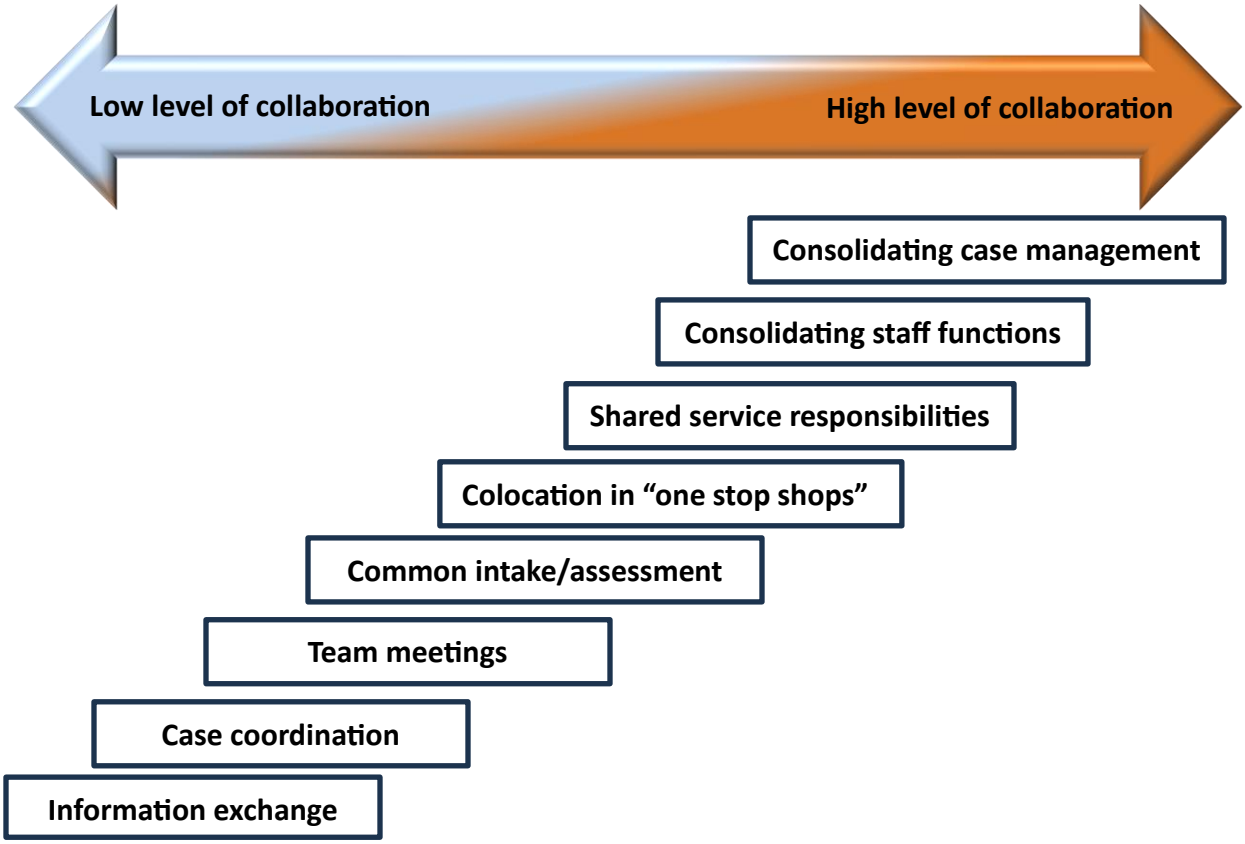
A common systems-level barrier to collaboration across social services are the restrictions in information sharing due to privacy concerns. One of the simplest approaches to allow for information-sharing, used by many programs nationally, is to ask clients to complete HIPAA and/or other release of information forms (Ragan, 2003). Legal data sharing agreements, to share large sets of administrative information across programs, are also common. Several DSS/DHS/HRA programs have utilized these approaches; for example, DHS adult case managers regularly have clients complete HIPAA authorizations so that they can share medical details and coordinate with other case managers. WeCARE created a system called

STARS (Substance use Tracking and Reporting System) where substance use providers can communicate with them on client compliance, schedules, program enrollment and related topics. They also have a contract (SuCAP) where substance use providers can upload/review various reports for clients in treatment. HSO has access to the New York State PSYCKES system, which allows them to identify clients with high use of psychiatric services, but noted that not all shelters have access to it. And DHS Streets is currently in the process of setting up an MOU between DHS and DOHMH to allow for data sharing for mutual clients.

Integration of data systems is much more complex, and has been described as a "long-held dream" that is hard to realize (Wouters et al., 2023). In interviews, DSS/DHS/HRA leadership often recommended creating integrated information systems to address case management duplication (while also recognizing the challenges of doing so given both privacy/confidentiality concerns and the complexities of setting up these systems). Within DSS/HRA/DHS, they felt that having *some* way of seeing if a program client is involved in other agency services would be very helpful. A shared database or spreadsheet were both suggested. Externally, several leadership interviewees suggested (and noted that external providers had also requested) being able to track what other services clients are receiving outside the agency, either through a common portal or additional data use agreements. NYCBenefits leadership highlighted the idea of a 'document wallet,' which would hold copies of birth certificates and other key documents and be accessible to clients as they meet with a range of service providers, and DHS Streets leadership proposed a similar idea, thinking it would be especially useful for all the documentation needed for supportive housing applications. The NYC Mayor's Office for Economic Opportunity has developed a document wallet called MyFileNYC that has been piloted at the DHS PATH family intake center; DSS may want to explore opportunities to expand our clients' access to this resource in other settings.

Turning more specifically to the deduplication and coordination of case management services, Figure 2 provides a rough approximation of where potential service-oriented solutions fall on the continuum from Figure 1. Notably, these strategies are not exclusive and often appear in combination. For example, information exchange can be combined with most of the other models (Andersson et al., 2011). Many of these solutions are currently used by DSS/HRA/DHS when clients have multiple case managers. Overall, agency approaches tended to fall on the left-hand side of the continuum in Figures 1 and 2, with a few exceptions. And when asked to recommend ways to address duplication, some leadership suggestions were for the solutions that are more on the righthand side of the continuum.

Figure 2. Service-Oriented Solutions for Collaboration



Source: Adapted from Horwath & Morrison (2007) and Andersson et al. (2011).

Information exchange. This is the simplest model of collaboration, and an example of "communication" in Figure 1. Exchange of information can be verbal or in writing, and can be supported by technology like video conferences. It is often based on informal, flexible contacts between professionals in different organizations who are working with the same client, but it can also be formalized into more systematic procedures for information sharing, referrals, or consultation on shared cases consultations. Accountability for services provided remains with each organization (SAMSHA, 2012). Interviewees indicated that this was one of the more common approaches used at DSS/HRA/DHS, and it was described by almost all programs. Typically, information exchanges were informal, not tracked consistently, and variable depending on the case manager's activity. However, at DHS shelters, information exchange is built into official guidance. As DHS Single Adult leadership explained: "[we put] emphasis on coordination and clear communication between all parties helping clients. The lack of clear communication usually falls on the case managers and shelter providers. We tell our providers that when communication fails, you need to escalate or check in on it to make sure things don't fall through the cracks."

DSS/HRA/DHS leadership interviewees also made recommendations to improve information exchange. To reduce duplication of case manager efforts internally, several

interviewees suggested having information more readily available about what each program can (and cannot) provide, perhaps in a summary sheet, along with eligibility criteria. HPS/PCS leadership especially emphasized this, since so many agency clients need assistance with housing. As leadership there noted, "No HRA staff should have questions regarding basic eligibility for CityFHEPS."

To reduce duplication of case management efforts externally, several other specific types of information exchange were suggested by leadership interviewees. A list of where to refer for what concern, a resource guide, or a portal that staff and clients could visit for case management resources would be extremely useful. As NYCBenefits leadership noted, "resources exist, [but] people don't know how to find them." Such a list could also potentially help avoid inappropriate referrals, where external providers think that programs can do something different or more than they currently do (a concern that was particularly common for both APS and HPS/PCS). Some leadership suggested that this such a resource also include clear, standardized protocols or guidelines for how to link services, define responsibilities for each agency and entity, or other ways to simplify the process of making connections. As HCSP leadership shared: "Right now, we can't even give a referral to certain agencies/support systems, only give clients information…It would be beneficial to have better coordination or linkage protocols."

Case coordination. In this model, organizations do not collaborate directly with each other, but through a person who coordinating their different services for a client. The case coordinator is often employed by one of the organizations, but works as an agent for the client, guiding them through the whole process. The case coordinator tries to balance the activities of the different organizations, trying to find a common plan for the client. Sometimes they meet (either regularly or informally) with staff from other teams to facilitate this process.

At DSS/HRA/DHS, HSO's complex case coordinators work with range of providers to get clients to the right services and avoid duplication. HSO leadership felt that their coordinators could be more involved with HRA programs that serve clients with high medical needs, such as HASA and APS. Notably, HASA staff also felt that they would benefit from having more clinical/medical staff available to their case managers as "a lot of questions that clients need to answer are medical/mental health related. We have a few social workers, but they don't necessarily have that level of knowledge." There may therefore be fairly straightforward opportunities for more integration across HASA and HSO.

Team meetings. In this approach, a group of professionals from different organizations who serve the same client populations meet regularly to collaborate on client needs. They might meet just with each other or include shared clients. One of the most common team models is the "multidisciplinary team" (MDT). In the MDT model, professionals from three or more

disciplines who have complementary competencies bring their unique expertise to discussing and making recommendations around client concerns (U.S. Dept of Justice, no date). MDTs have been used in a range of service types, from income support programs, to foster care (Palinkas et al., 2014) to Adult Protective Services (Ernst & Smith, 2012). Another team meeting model is the case conference, which is also attended by a variety of professionals but more directly focused on particular cases (Duggan et al., 2009).

Both types of team meetings were reported at DSS/HRA/DHS. For example, for DHS FWC cases, there is a mandated team conference with ACS within 72 hours of when a family is placed in shelter, "to make sure that they are adjusting to shelter and are receiving the services they need." APS has quarterly MDT meetings with a range of providers (e.g., mental health professionals, external providers, legal entities, financial providers) where they discuss shared cases in depth. Leadership noted that "this collaboration helps stabilize clients and move client cases along fairly quickly." DHS FWC cases also do MDTs on an as-needed basis, as well as case conferences with families. And HASA has quarterly workgroup meetings with third parties, including advocates. While they don't discuss specific cases, "the workgroup creates open communication around best practices for meeting client needs." HPA/PCS has regular conference calls with external providers to try and make sure everyone is on the same page around services delivered, referrals made, etc. And to reduce duplication of case management services with external providers, several leadership interviewees that didn't already have such meetings suggested regular, coordinated meetings with them. They thought that these meetings could include both a broader discussion of what programs provide and discussions of needs of shared clients.

The Coordinated Behavioral Health Taskforce (CBHT) Initiative managed by DHS Streets is another example of case-conference-like model. This initiative focuses on the most vulnerable clients experiencing street homelessness. Streets case managers meet weekly with other providers serving their clients to discuss their needs, including DOHMH, SOS, and other operational partners. The goal is to determine how to "move the needle" for shared clients. There are separate meetings for different groups of clients (e.g., clients on the subway, clients who are high utilizers of services).

Common client intake and assessment processes. Here, staff from multiple programs use a standardized intake or assessment tool to determine need for a wide range of programs and services. At DSS/HRA/DHS, joint assessments are conducted by HCSP. As noted above, their case managers' primary activity is conducting assessments and reassessments for home care services. Both internally (with HASA and APS caseworkers) and externally (with ACS caseworkers), when clients are connected to both programs, the external caseworker does most of HCSP assessment as part of their usual activities, and shares it with HCSP. HCSP then has their on-staff nurse do the medical portion of the assessment. Externally, HCSP also

shares their assessment with the State OPWDD, and OPWDD shares theirs with HCSP to make sure that all the information matches up.

Colocation in "one stop shops". In this approach, multiple services are located in the same place. Clients who visit these locations are able to have multiple needs addressed at once. There is "no wrong door" for the client, and staff can easily communicate with each other. While co-location was not common for case management services at DSS/HRA/DHS, HRA's Benefit Access Centers (BACs) are a good example of co-location of various benefits services, and APS's Center 80 is co-located with HRA SNAP and CA benefits. There was also one serendipitous example of co-location for NYCBenefits: they work with programs from 5 agencies in one small building. Staff often have lunch together, and cross-refer.

Shared service responsibilities. Here, staff from different organizations work closely together on cases, but still have separate responsibilities at their own sites (O'Looney, 1993). At DSS/HRA/DHS, when DHS Adult clients have signed HIPAA authorizations, shared case planning sometimes occurs with case managers at other organizations. HASA case managers often work closely with supportive housing case managers when clients are in those unit types. WeCARE leadership specifically encourages case managers to coordinate with case managers at external treatment providers because many external (OASIS) providers are obligated to help clients with job counseling/applications and they need ensure that everyone is on the same page. As a more formal arrangement internally, WeCARE and DHS planned to have a shared master spreadsheet and regular communications to share resources and client information, and coordinate services (while addressing confidentiality issues) so that they could more efficiently serve DHS clients who are also enrolled in WeCARE. This effort was cut short before implementation due to staffing issues. WeCARE does have a full list of DHS case managers, though, and they encourage their case managers to reach out to DHS case managers around housing placements and goals. And program leadership on both sides hopes to revisit the collaboration when staffing permits. As mentioned above, DHS Streets case managers work collaboratively with case managers in Safe Havens and supportive housing after their clients enter these settings, often more many months.

Consolidating staff functions. Sometimes staff responsibilities are changed to improve integration, combining what were previously separate roles. DSS/HRA/DHS leadership interviews did not identify any examples of this model or specifically recommend it.

Consolidating case management. In this model (representing the most integrated end of the collaboration spectrum in Figure 1), a single case manager is responsible for ongoing casework that traditionally would span case managers (such as for employment and housing supports; see an example in Box 1). Ragan (2003) has noted, however, that this is one of the most challenging service-oriented strategies because of all the knowledge needed to navigate the complex service systems involved, and he could find almost no examples of this in his scan of programs nationally. DSS/HRA/DHS leadership interviews did not identify any examples of this model.

Box 1. National example of service integration: Nebraska's N-FOCUS System

Motivated in large part by staff limitations in the many rural offices in the state, in the mid-1990's, Nebraska consolidated activities to create a new worker designation, Social Service Worker, with a higher salary. Case managers became responsible not only for a wide range of programs and services (e.g., TANF, Food Stamps, Medicaid, programs, the Children's Health Insurance Program, childcare subsidies, Emergency Assistance, and others), but also intake, eligibility determination and ongoing case management. To support this work, the state also created N-Focus, a fully automated eligibility determination and case management system that integrates twenty-seven human service programs (e.g., TANF, SNAP, Medicaid, and Adult Protective Services intake). In addition to assisting caseworkers in determining eligibility, the system has extensive case management functionality, includes information for referral-making, and is used to make payments to clients and providers. It also interfaces with other state and national systems, including Unemployment Compensation, the Internal Revenue Service, and the Social Security Administration (Ragan, 2003). While quite complicated, the system still seems to be functioning today (Nebraska DHHS, n.d.; Nebraska.gov, n.d.)

While fully integrated service models have many advantages in theory, researchers on this topic have emphasized several important caveats. The most often-iterated point is that context matters. Service delivery systems, including funding, organization, and staff skills vary widely by setting. Therefore, there is no "optimal" model of integration that can be applied everywhere (Ragan, 2003; Andersson et al, 2011). In a review of integration of medical and social services in the U.S. and U.K., Leutz (1999) argued that the intensity of integration should be determined by level of client need. Linkage/referral and some coordination would be the best options for the least severe needs, while more in-depth coordination (and perhaps full integration) would be best for those with the most severe needs. And certain services are better not being integrated, because their approach is so different that attempting to integrate them would make them ineffective.

Finally, beyond addressing case management duplication, interviewees commonly offered recommendations to improve programs' case management services overall (Box 2). These strategies might also indirectly address duplication by improving case managers' skills.

Box 2. Common interviewee recommendations to improve DSS/HRA/DHS case management services

Training: More ("robust, regulated, updated") case manager training was recommended by most interviewees. Training could address two common issues: there is a lack of standardization across contracted providers, and most case managers do not have to have related education or experience to enter the role, learning on the job. Trainings, standardized handbooks or manuals on "fundamental case management tools and techniques" were particularly recommended. Interviewees also felt that a quality assurance team that randomly audited case notes could be useful. HPA/PCS does this approximately quarterly, and their efforts could potentially serve as a model to other programs.

Hiring more staff and providing higher salaries was mentioned by almost all interviewees. Higher salaries were seen as key to increasing retention, reducing high case worker turnover, and filling vacant positions. All interviewees recognized that there were limited agency resources to address these recommendations, though.

Improved internal program communication. Some programs thought that there could be better communication within their case management own staff, to share best practices and other recommendations, though meetings or other efforts

V. Barriers and Facilitators to Reducing Duplication

When asked how current service integration models developed, leadership across programs said that they evolved organically through collaborative efforts over time. To make further changes, DSS/HRA/DHS leadership interviewees consistently recognized the challenges to implementing the service- and systems-oriented service integration models described above, and a large body of literature has described key facilitators and (conversely) barriers to doing so (e.g., Horwath & Morrison, 2007; Ragan, 2003; Nam, 2012; Ehrle et al., 2014; Palinkas et al., 2014; Waldfogel, 1997; Andersson et al., 2011). We briefly summarize four of the most common, actionable factors covered in this literature and our interviews.[4] Overall, the fragmented, siloed social services system in the U.S. is the greatest barrier, and the

[4] Other key barriers and facilitators, not discussed in detail here, include leadership style; membership of the partnership planning; organizational culture and structure; organizational goals, staff size and skill levels; planning processes; the history and dynamics of the organizations involved. It is also important to note there are many nuances discussed in the literature that are not covered here.

hardest to overcome (Ragan, 2003). Local resources contribute to this siloing; integration is most likely to be successful when a region is large enough to have services available to meet the local population's needs, but not too large as to involve an overwhelming number of service providers. NYC would certainly meet the latter criteria (and has an especially complex network of social services), and an older review by Ragan (2003) notably identified very few examples of service integration in large cities. Another consideration to keep in mind when planning for service integration is the time and resources involved. Some service integration examples in the literature took a decade or more (Ragan, 2003). This is in part because truly successful integration requires coordination on multiple levels: macro (i.e., government), meso (local services), and micro (individual staff and client (Waldfogel, 1997, Fine et al., 2005)).

Organizational mandates: Mandates across involved organizations impact integration and collaboration, and in this context refer to the "need, authority or requirement for collaboration" (Horwath & Morrison, 2007, p. 60). Government agencies are subject to a range of constraints that influence their mandate, such as legislative directives, funding specifications, and political support (Meyers, 2003; Horwath & Morrison, 2007). In interviews, leadership described how many programs' case managers must follow City/State/Federal policies and agency procedures (and for contracted providers, City contracts) and complete required activities regardless of whether clients are receiving similar services from someone else. For example, offering HASA case management is mandated under local law (though clients can refuse), and Career Servies or WeCARE case management assists clients to meet work/training requirements that are mandated in order for them to receive cash assistance. Case management in these programs is directly linked to benefit receipt and could lead to loss of benefits if a client disengages. As Career Services leadership put it, "[our] PACE [program] is rooted in compliance…Having multiple case managers doesn't change the work that Career Services case managers are doing." Or, similarly, as HASA leadership said, "Our staff do whatever they are mandated to. They don't change their approach because third parties may be involved, even if parts of the service delivery may be redundant." For the most part, though (as described above) leadership felt agency case managers did work that other case managers could not.

Security and confidentiality: As Ragan (2003, p. 40) put it, "no discussion of service integration seems to occur without issues related to perceived barriers to sharing client information being raised." And of all of the barriers to collaboration, security and confidentiality concerns were mentioned most frequently and consistently in DSS/HRA/DHS leadership interviews. These concerns can become particularly complicated when different levels of government are responsible for program administration (e.g., state vs. city government). If investment and sustained efforts are made on both sides, however,

agreements can be reached and necessary procedures put in place that allow for secure information sharing (Ragan, 2003).

Infrastructure and technology: Even once security and confidentiality issues are addressed, systems and resources can either facilitate or limit the exchange of information between organizations. In government, technological systems are often built over decades to meet state or Federal requirements, and can be antiquated, inflexible, and limited in what they can collect (Ragan, 2003). The limitations of existing data systems were also brought up frequently in interviews. To make changes, one must consider the architecture of any systems where storage is considered, the compatibility of data standards and technical standards, issues of data ownership, the flexibility of legacy systems, the ability to standardize platforms and applications, and privacy and security issues. There must also be the technical expertise to implement these changes (Ehrle et al., 2004).

Funding: Both the existence of appropriate funding and clarity about how funding is distributed is key to integration, and limited funding is a key challenge (Nam, 2012). While one of the goals of deduplifying case management services is to save resources, the literature suggests that new funding may be needed to support start-up costs for a new collaboration (Leutz , 1999). Consistent with this, in a review of collaborations nationally, Ragan (2003) found that resources beyond federal and state funds (such as from local foundations or county levies) were needed to initiate and support integration efforts. Sometimes there are also costs for new staff, as some organizations have hired managers to oversee collaborative efforts (Ragan, 2003). Funding streams sometimes acted as a barrier for DSS/HRA/DHS programs as well. Existing funding (e.g., for Medicaid vs. TANF) support certain services being separate, even if they are duplicative. The contract structures in place also prioritize certain tasks that have to be reported upon and are incentivized. As NYCBenefits leadership noted, “even if an agency wants to prioritize holistic care, it still needs to report on contract metrics.”

Concluding Thoughts

Many DSS/HRA/DHS programs offer case management services, which range widely in their focus and scope. Leadership indicated that a minority of clients have more than one case manager, and there can be challenges when this occurs, including client and staff overwhelm and undue burden on clients. However, duplication was not viewed as extensive, and leadership emphasized that duplication of case managers often did not result in duplication of services given case manager specializations. Moreover, many case management services are mandated by local, state or Federal policies. That said, since programs did not track case management duplication consistently, interviewed leadership may not be fully aware of its scope or consequences. When they were aware of duplication, programs used a variety of strategies to coordinate services, from informal communications to formalized

collaborations. Many of these approaches are reflected in existing models that have been used in other jurisdictions. DSS/HRA/DHS might consider some existing models for future efforts to improve communication and coordination, while also taking identified challenges into account. Among the most complicated issues to be addressed are privacy and confidentiality concerns, the time and expense involved initially, and the larger context of the rich but fragmented social service system both locally and nationally. Future OER work could focus on obtaining client insights into this issue, although the variability in experiences may limit our ability to generalize from our findings.

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Appendix A. Leadership Key Informant Interview Guide

Introduction:

Thank you for taking the time to speak with us today. We're with the DSS/HRA Office of Evaluation and Research. We are working on a study requested by the Commissioner to better understand case management services received by DSS/HRA/DHS clients. We're especially interested in what specific kinds of case management services clients receive, the extent to which clients may receive case management services from multiple programs at the same time, and any recommendations you might have to improve case management—and coordination across case managers—for your unit/department's clients.

The insights you share with us will inform an internal agency report, and we'll take notes to make sure we don't miss anything important. but we won't disclose your name or other identifying information. Anything you say won't affect your employment in any way. Our conversation should take 45-60 minutes. Do you have any questions before we start?

Current Case Management Services:

1. First, please tell us about case management services in your unit/department. What specific services are provided? For how long?
   (Define as needed: We define "case management" as service delivery by anyone in a case-manager or similar role that covers multiple social service domains and is delivered in the context of an ongoing relationship, rather than brief, specific service delivery (e.g., food or rental assistance or job training)).

2. Who provides case management services (i.e., are they provided by a dedicated case manager, or someone else)? What is the typical caseload size?

3. How do clients become eligible for case management services? *(Probe for: all clients receive services, vs. only received by some based on specific criteria).*

4. What outcomes do you track (if any) for your case management services?

Duplication of Case Management Services:

5. Some DSS/HRA/DHS clients receive case management from more than one place at the same time. For example, from more than one of DSS/HRA/DHS' programs, or from our agency and another City agencies or community organizations. How common do you think this is among clients receiving case management from your unit/department?
   If never: SKIP TO QUESTION 11
   Else: ASK REMAINING QUESTIONS IN THIS SECTION

6. Are there any common trends in where else clients receive case management (e.g., from DHS shelter, WeCARE, Career Services providers, ACS, particular CBOs)?

7. Do you have a sense of how clients engage/interact with their case managers in your program compared to case managers at from other programs? *(Probe for variations in meeting frequency, services received, relationship quality).*

8. How does having more than one case manager affect the client's services and outcomes? *(Probe for both challenges and benefits).*

9. Thinking about staff working with clients who have more than one case manager, how does that change their approach to the work? What impact does it have overall on the work of your unit/department? *(Probe for both challenges and benefits).*

10. What are the pros and cons of having multiple case managers for DSS/HRA/DHS clients?

Recommendations and Concluding Questions:

Finally, we'd like to ask for your recommendations.

11. What would help improve case management services in general at DSS/HRA/DHS, if anything? *Probe for: increased staffing, training, other support*

12. What do you think would help improve service delivery when DSS/DHS/HRA clients have more than one person providing case management?

13. What policies could DSS/HRA/DHS implement to improve case management efficiency across programs? Across agencies?

Those are all of our questions. Do you have any other comments, suggestions or questions about anything we've discussed today? Thank you so much for taking the time to speak with us!