Feasibility Analysis for the Merger of the Department of Health and the Department of Mental Hygiene in Dutchess County, NY
Overview, Options and Recommendations

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Dutchess County

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SUMMARY

Dutchess County selected CGR (Center for Governmental Research, Inc.) based in Rochester, NY to assess the feasibility of merging the Department of Health and the Department of Mental Hygiene. Both Departments have experienced declines in recent years in personnel and funding, and the County has continued to struggle with a declining tax base coupled with ongoing pressure to provide both mandated and desired non-mandated services. County funding for the Department of Health has been increasing, while it has been declining for the Department of Mental Hygiene. Yet, because of overall large declines in the Mental Hygiene budget, the County’s share has actually increased.

With the changes in healthcare delivery beginning to take shape across the country due to the Patient Protection and Affordability Care Act (aka: Obamacare), and with the rollout of managed care for Medicaid in New York State nearing its final stages, there is a new paradigm taking shape within which counties must provide services. Old paradigms with traditional silos of service for various specialties are being challenged, and professionals are increasingly considering holistic, comprehensive care and treatment of individuals in an inter-disciplinary way. Counties will need to adapt in order to stay competitive, and it is in this context that this study was commissioned.

CGR’s approach to the project was multifaceted. We built a baseline of current services in each Department from which various options could be considered. The options were developed along a continuum of change that ranged from maintaining the status quo to full merger of the two Departments. In addition to the internal review in Dutchess County, CGR
also conducted an external scan of current structures and other counties’ and states’ approaches to running health and mental health departments. The learning from each of these models and the internal review was all factored into a final set of recommendations based upon the options that were developed.

To accomplish these tasks, CGR engaged in well over 60 interviews of individuals within the County: either employees of the County or elected officials, as well as interviews with nearly all of the contract agencies that partner with the County to provide services, and many other independent service providers. We collected and analyzed budget and staffing data for each Department, toured facilities, reviewed program data and outcome reports, examined policies, procedures, forms, manuals, laws and a litany of other data to learn about the two Departments. We interviewed numerous individuals outside of the County either in other counties, New York City, officials with New York State Regional offices (e.g., OMH), not-for-profit providers, or other states and professional organizations such as the Conference of Local Mental Hygiene Directors (CLMHD) and NYS Association of County Health Officers (NYSACHO).

**Highlights of Baseline Review**

Although there are certainly similarities between the two Departments, DMH and DOH are fundamentally different organizations. The differences start with the underlying roles they play in the community, but extend to organizational culture and operational approaches as well. Mental Hygiene services have evolved over decades, but the traditional focus has been on individuals receiving unique treatment based upon a person’s needs. Departments of Health, while providing some services to individuals, were developed primarily with the express purpose of monitoring community health trends and promoting preventive health agendas based upon documentable community-wide health concerns.

From the earliest interviews, it became apparent that these differences in orientation, with DMH more oriented toward providing or overseeing direct service to individuals and DOH more focused on big-picture trends, contributed to concerns about the potential for a merger between the two Departments. The primary objection raised by most DMH staff and many in the community about a merger was the possibility that the needs of those with behavioral health issues in the community would be lost and “get swallowed up” by the Department of Health. It was interesting, however, that those in DOH were surprised by that concern, instead considering the opportunity a welcome possibility due to the growing awareness of the need to leverage the expertise of the mental health system, particularly as it relates to the prevalence of substance abuse issues in the community.
The Department of Mental Hygiene, under stable leadership for three decades, has built a reputation for being an independent strong important advocate for some of the most vulnerable populations in Dutchess County, and for building a relatively robust network of behavioral health services. It is only natural that the consideration of broad, structural change would be viewed as potentially threatening to what has been established and potentially endangering those with mental health needs.

The needs of the mentally ill and those struggling with substance abuse or developmental disabilities need to be represented by someone with a passion for and expertise with mental health issues. That individual must be fully aware of the role of a Director of Community Services (DCS) as defined by the Mental Health Law (MHL), including meeting the demands of Section 9.45 of the MHL with regard to remanding individuals to emergency care as necessary. The DCS must be an advocate, and be knowledgeable about how to leverage resources in the community—serving as a leader and strategic partner in fulfilling the mission of the County to be the Local Governmental Unit (LGU) for the State. A strong DCS is vital to maintaining a robust system of care in the community.

Yet the traditional paradigm for achieving these goals is changing. Through a combination of external pressures, including changes in funding streams, internal restructuring and a greater reliance on external partnerships, the traditional departmental silos within which staff has operated are being challenged in an effort to leverage limited resources. Not only are there opportunities, but there are several inefficiencies and weaknesses in the two Departments that could be resolved and made stronger through partnership. All opportunities, however, need to be approached with the sensitivity that the strengths in each be maintained, even as opportunities emerge for greater collaboration.

Some noticeable cultural differences exist in the two Departments. DMH is far more centralized in its decision-making structure with leadership at the Commissioner level weighing in on decisions at all levels of the organization and the larger community-based service system. DOH appears to be more decentralized in its approach, in essence empowering staff at lower levels of the organization to make and implement decisions that are within their purview and control.

The culture extends to the operational philosophies in which DOH is structured leaner at the upper management levels than DMH. DMH upper management staff tends to be more hands-on in their responsibilities and in fact often do more than may be necessary, considering the grade and caliber of the staff that are in roles to support them. DOH has an operating philosophy that upper management should think about the big picture, focus on policy and planning and allow the implementation to happen at the staff level.
The Departments both carry out mandated functions. The DMH serves as the mandated Local Governmental Unit for the State Department of Mental Hygiene. This requirement for State aid also serves an essential function in the community by coordinating planning efforts to ensure people with mental health, substance abuse and developmental disability needs have access to care and are served with the highest quality treatment available. Beyond the mandated LGU function, most of the direct services provided or overseen by the County DMH are discretionary. The Department has increasingly provided fewer and fewer in-house services in recent years, forcing DMH leadership to coordinate an increasingly more decentralized array of services in fulfilling the LGU function.

By contrast, the set of services provided by DOH are all mandated, although the Department has discretion over some aspects of how they are provided, impacting budget and staffing. The largest programs by funding in DOH include the federally mandated Early Intervention and Preschool Special Education programs serving children birth to 5 with special needs. The County traditionally has served as a pass-through for funding for these programs. A recent change to the law has payments to providers coming directly from the State, shifting the County’s role and raising concern that costs may increase.

Programmatic overlap between the two Departments is quite minimal. Many of the mandated functions of the Health Department are not closely aligned with the programs and services offered or promoted by the Mental Hygiene Department. However, there are countless ways in which the needs and interests of the two Departments overlap, particularly considering that many of the people served by the Departments have co-existing physical and mental health issues. This may be nowhere more prevalent than in the case of substance abuse issues, which have now been identified by the Health Department as one of the top four public health issues in the County.

Aside from potential programmatic synergies, the administrative functions presented as another clear area where there is overlap, inefficiency and the potential for more collaboration and sharing of service. From budget issues to billing, to software to communications, the baseline review revealed several ways in which the two operations could be combined and yield a more efficient operation, should the County choose to move in this direction.

The combined budget of the two operations is approximately $59 million, 57% going to Public Health. The combined staff of the two Departments is approximately 203 FTE, with 59% in Public Health. Since 2009, Mental Hygiene has lost 60% of its staff, compared to a loss of 27% in Public Health over the same time period. Most of the losses in DMH (112 FTEs) came from closing the County-operated outpatient mental health clinics.
and the Continuing Day Treatment programs, in addition to reductions in Central Administration. Most of the FTE losses in Public Health came from downsizing the Public Health Nursing Division as home-health operations were sold, and streamlining Administration.

**Alternative Government Structures**

New York has a handful of combined health and mental health departments, most prominently in New York City, which joined its departments in 2002, but also in Suffolk, Ulster and Schuyler counties. Other counties, such as Albany, have considered merging the two departments without doing so. In a few other counties, mental health has been combined with a different department, such as the Department of Social Services; Broome, Putnam, Monroe and Chemung are examples of this approach, though these mergers are limited to one or a few combined positions rather than full departmental integration.

Some states have a combined health and mental health department, including Maryland (which has been combined since 1969) and Nevada, which is currently merging its departments under a recently adopted law passed by the state Legislature.

Combined health and mental health/hygiene departments offer the opportunity of a much more holistic, comprehensive approach to improving health in the community by appropriately recognizing and incorporating the importance of behavioral health. In some combined departments, this potential appears to be realized, at least partially, while in others, it remains more theoretical. The biggest threat to the success of a merged department appears to be what some constituents in Dutchess have voiced concerns about: the potential for diminution of either health or mental health needs and concerns. Our environmental scan did uncover cautions not only about how a consolidation could best be accomplished but also about negative impacts, including the diminution of one of the Departments. Without careful planning and messaging, and the selection of leaders who are not only knowledgeable about both disciplines but also open to letting others help lead and engage in decision-making, a merger can go seriously awry.

A defining factor in any successful transition of governance structures is the presence of a robust, transparent and well-communicated process. Whatever the structure under which mental health services are provided and overseen, mental health advocates in various counties emphasized the need for strong LGU leadership, a strong visionary and oversight function to be in place, mental health concerns to be effectively represented in key County decision-making discussions, and for a strong Community Services (Mental Hygiene) Board to also be in place to provide advocacy on behalf of a comprehensive network of services.
Four Options

After developing the baseline of services and conducting our environmental scan, we developed a series of options for the County to consider. The options were developed along a continuum based on impact to the organization and effort necessary to achieve the outcome, from maintaining the status quo, to combining administrative functions, to adopting a single commissioner model overseeing both Departments, to a full merger of the two Departments.

Status Quo

Maintaining the status quo does not imply that the two Departments will not change at all in the foreseeable future. As we define it, the status quo means that operational change will continue to be forced upon the two Departments as it has been in the recent past, with nearly annual evaluations of ways to trim budgets and staffing and do more with less. However, the two Departments could largely remain separate and continue to fulfill their mandated roles within this context. To accept this option is not unreasonable given the concern that changes could potentially diminish the prominence and integrity of the systems that have been established as independent entities. That said, it is not likely that the efficiency gains that could emerge from more wholesale change will be realized without a departure from the status quo.

Intra-Departmental Opportunities

As a variation of this option, we outline several possibilities for each Department to pursue internal improvement opportunities. Budget and staff impacts are outlined and are modest in scope.

Inter-Departmental Opportunities

A second variation of the status quo is ways the two Departments could work together more through shared services and enhanced inter-departmental collaboration. These possibilities involve changes to back-office and administrative functions, programmatic collaboration, and even relocation and co-location of certain staff members to improve communication and foster a more open, collaborative environment for the two Departments. These opportunities do not have significant budget implications but would require staff to work together in new ways and perhaps stretch their capacities.

Administrative Consolidation

The next step in the continuum of options is to consider fully merging the administrative functions of the two Departments. This started with reviewing the Administrator roles in each Department—the Administrative Division Chief in DMH and portions of the Assistant
Commissioner role in DOH—to find ways to carve out responsibilities for a potential single administrative role. All other administrative positions were similarly reviewed down through the various functions to achieve one consolidated administrative unit. A second combined position could be a single Budget and Finance Director for both Departments. The remaining positions would likely be necessary to fulfill the current responsibilities, though there is potential for some personnel to be reassigned to support other duties that may not currently be receiving enough attention.

Both interviews with staff and our own analysis conclude that most of the back-office functions are similar enough that they do not need to be self-contained in each Department. There is some degree of specialization required, but by blending existing staff and over time cross-training all staff, the specialization and expertise can be maintained and redundancy enhanced (allowing staff to cover for each other when needed). It is also important to recognize that certain strengths in one Department are weaknesses in the other, and leveraging the expertise in a collaborative fashion could make both better. For example, DMH is strong in both Corporate Compliance and Quality Improvement and billing relative to DOH, which hasn’t had as much focus or experience on either function. DOH has a strong communications operation, an area DMH has had to trim in recent years.

A challenge for this option is the reporting structure of the administrative unit and how to ensure that it is responsive to the Commissioners of both Departments. Shared service alternatives exist, but may significantly muddy the water so as to make this option untenable.

**Single Commissioner**

Another model to consider, and one that is being used by a few other counties in the state, is that of a single Commissioner overseeing both Departments. As noted in our environmental scan, there are few communities with a single commissioner over health and mental hygiene, but several that have a single commissioner overseeing similar departments, such as mental health and social services. A single Commissioner has the distinct advantage of allowing the County to pursue the merger concept in the long run while not disrupting existing services significantly in the short run. A single Commissioner can begin to plan for and implement shared service opportunities in the short and intermediate future while developing a longer term strategic plan that may or may not ultimately involve a more comprehensive merger of the two Departments.

**Without Administrative Consolidation**

A single Commissioner may be approved and put in place without any other changes in Departmental structure at the outset. Under this scenario,
the existing administrative functions within each Department would continue, as would programs and services, largely uninterrupted within the context of two separate departments. Again, this represents minimal disruption to service at the outset and allows for longer term implementation planning through a single leader.

**With Administrative Consolidation**

Another alternative scenario for this option is to consider installing a single Commissioner and simultaneously begin merging back-office and administrative functions. The distinct advantage in this option is that the new blended administrative department would have a singular person for reporting and leadership. This would streamline the reporting structure and allow for less confusion and fewer potential battles over turf as administrative personnel navigate the needs of both Departments.

A variation of this model would be to consolidate many if not all of the back-office and various administrative functions of the two Departments *over time*. In either case, the benefits outlined in merging the administrative functions would be realized in this model.

**Merger**

Our final option for consideration was a full merger of the two Departments. There are many considerations in this model, not the least of which would be our concern that a single Department not inadvertently, or even intentionally, divert resources and/or lessen the prominent role of the LGU and current Mental Hygiene system in the County. Strong leadership for a single Department that has a passion for addressing mental health issues, particularly in the context of a new paradigm of integrated services, is essential. In addition, the LGU function will need to be thoroughly understood with its various roles and responsibilities, including those around fulfilling Section 9.45 of the Mental Health Law.

With this primary caveat, the merger option offers the benefits of many, if not all of the other options, offering a mix of administrative efficiencies, potential cost savings, and the opportunity to significantly enhance the services being provided to the community. The extent to which the latter point becomes a reality will likely dictate the extent to which a full merger would be considered successful. Change for the sake of cost savings alone may not lead to the best outcomes in the community.

**Recommendations**

The primary goal of this study was to determine the feasibility of merging the DMH and the DOH in Dutchess County. Based on our understanding of the baseline of current services, and given the context of the changing landscape of the healthcare delivery systems, we believe that merging the
two Departments is not only feasible but in the long-term best interests of the County and preferable to the other options we have outlined in this report. However, we believe that the success of a merger cannot be defined by cost savings and efficiencies alone. A merger that does not at least maintain, and hopefully improve the level of service to individuals in the community will not ultimately be beneficial.

The new leader of a combined Department should be chosen carefully. This person would need to have not only the right background and set of qualifications but also the right temperament and soft skills to successfully spearhead major organizational change: high energy and commitment but also tact, diplomacy, excellent listening skills and ability to communicate a vision and bring others along in reaching for it. This also means acknowledging the complexity of the merger and acknowledging the cultural values of each organization and the need to preserve those values. A blended background of some type is desirable, with experience in both health and mental health and a good understanding of family and community systems.

The new leader should also be someone who is comfortable with shared leadership and letting others be out front at appropriate times and places. This will be needed to ensure that the nuances and details of both the health and mental health perspectives are fully represented in all appropriate settings, including at senior County leadership tables and out in the community in various planning settings.

The new structure and leadership of the Department should be developed with an eye toward preserving the priority and prominence of mental health. CGR would recommend a Department name that includes both the health and mental health disciplines (e.g., Department of Health and Mental Hygiene); a Commissioner title that refers to both Health and Mental Health or Hygiene; and a leader for the Mental Health division who is elevated in title above other division leaders, such as the Executive Deputy Commissioner title used in New York City.

There are a variety of options outlined in the report that could allow for a phased-in approach to merger. Practical realities may not allow a transition to occur quickly or all at once. Should the County decide that merger is not the most desirable option, we believe that the many options for shared services would remain good targets to improve efficiency and lead to better service for those served by or on behalf of the County.
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Staff Team

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INTRODUCTION

Dutchess County engaged CGR to study the feasibility of increased collaboration between its Department of Health and Department of Mental Hygiene, including but not limited to a full merger of the departments. The County seeks to strengthen delivery of services, maximize resources and increase efficiencies, and to understand the short- and long-term implications of any changes to the structure of the two departments, including the impact on services and clients, funding streams, regulatory requirements, and staffing.

This report provides background information and context on delivery of health and mental health services, the role of county governments within the larger systems, baseline information on both Dutchess County departments, and options for the County to consider in possibly restructuring the departments. CGR conducted high-level literature reviews; interviewed New York State and local policy experts as well as local stakeholders and dozens of staff members from each department; and analyzed the budgets, staffing, structure and facilities of both departments to inform this report and our recommendations.

LEGAL FRAMEWORK AND CHANGING LANDSCAPE OF HEALTHCARE IN THE US

Healthcare in the United States is rapidly changing due to emerging technologies and legislative mandates. The need to contain costs while at the same time expand access to the millions who find themselves without insurance has pushed reforms at the national, state and local levels. These reforms, such as the Affordable Care Act, are now being implemented, leaving a substantial number of questions about the ultimate impact they will have on states and localities. Certain aspects of change such as more people vying for fewer resources are already becoming painful realities, but it may take several more years before the many new initiatives wind their way through the courts and result in certainty for planning purposes.

One of the most important changes over the last two decades has been an increasing awareness of the interplay and connection between mental/behavioral health and physical health. In 1999 the Surgeon General’s Office issued its first report on mental health calling for the full
integration of mental health into the nation’s public health system.\textsuperscript{1} Since then organizations such as the National Centers for Disease Control as well as numerous other health professionals have concluded that physical, emotional and cognitive/behavioral health should be assessed and treated in a holistic manner in order for patients to have the best opportunity to lead healthy, productive lives. Empirical evidence is mounting demonstrating more associations between mental health and chronic diseases like cardiovascular disease, diabetes, obesity, asthma, arthritis, epilepsy, and cancer.\textsuperscript{2} The emerging paradigms continue to challenge the status quo and reshape the delivery of healthcare.

**Overview of Current Thinking on Integration of Health & Mental Health**

The emerging thinking of professionals in the healthcare delivery system is that they should provide holistic, comprehensive wellness, targeting all aspects of a patient’s physical, emotional, behavioral and psycho-social needs. The abundant connections between physical and mental health continue to reveal themselves, such that the World Health Organization famously declared in 2004 that “there is no health without mental health.”\textsuperscript{3} Chronic conditions in particular illustrate the importance of mental health to overall health, as poor mental health is not only a risk factor for chronic physical conditions, but people with chronic physical conditions are also at risk of developing poor mental health.\textsuperscript{4}

As science and research have continued to develop our understanding of those with mental illness, earlier interventions have been identified and the linkage between good mental health and good physical health has been documented. However, for many years, systems of care have isolated treatment of patients through reimbursement formulas, or well-intentioned emphases on providing the best care within specialties at the expense of more collaborative, holistic and integrated care.

The challenge has long been that treating physical issues and mental illness is very different. Mental illness can be invisible in many cases, often denied by those most in need and possibly even those around them—and is therefore perhaps less likely to result in needed treatment being provided in a timely manner. Nationally, people with mental disorders

\textsuperscript{3} http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
\textsuperscript{4} http://ontario.cmha.ca/mental-health/connection-between-mental-and-physical-health/
enter care on average nine years after the problems first appear, as a result of factors such as stigma, insurance barriers, and symptoms that reduce the ability to recognize problems. Physical matters are often more likely to be visible or felt, and are therefore more likely to result in seeking out immediate treatment.

Systems that were designed in previous generations to deal separately with the mentally ill are re-evaluating their roles. Treatment modalities are different, and as systems have considered more integrated solutions, fears have surfaced that those with persistent and chronic mental illness may not receive the level of care they require. While the dividing walls are coming down, they are by no means gone.

This lack of coordination magnifies the inherent challenges of solving behavioral health problems and contributes to poor outcomes cited by New York State’s Medicaid Redesign Team (MRT), including that people with serious mental illness die 15-25 years earlier on average than the rest of the population, often due to chronic physical illnesses that are not adequately treated. In addition, most preventable admissions to hospitals in New York are for people with behavioral health conditions, yet most expenditures for these people are for chronic physical health conditions.

New York State has initiated many changes recommended by the MRT aimed at encouraging or in some cases forcing practitioners and service providers to fundamentally address the lack of coordination in the service delivery system. One of the solutions the State is using involves redesigning the fee-for-service system in Medicaid that has traditionally paid for mental illness and substance abuse issues to one that mirrors trends in the medical community: a managed care reimbursement model. Instituting the concepts of Health Homes and Personalized Recovery-Oriented Services (PROS) and laying out a timeline to begin requiring Health and Recovery Plans (HaRPs) are all means toward raising the bar on accountability and promoting a systemic shift that leads to more integration and better coordination of care.

It is in the context of this landscape that many counties are coming to terms with their roles in caring for their most vulnerable and needy citizens. Compounding the problem, many communities have high incidence of people requiring services who have no financial means, or are under-insured and simply don’t know how to navigate a complex system of care. Striking a balance between fiscal prudence for cash-strapped

counties and appropriate care that better addresses needs and fulfills mandates imposed by State law has been a challenge that has no easy solution. Further, striking that balance within healthcare delivery systems that have evolved with competing goals and specialized services further complicates potential solutions. Nobody wants to compromise the quality of care, and yet fewer resources are available for that care, and those with the most chronic and persistent needs are often the most vulnerable. Without intentional and sensitive planning, it is the population of persistent and chronically mentally ill patients that could get lost in the cracks as the delivery systems change around them.

Organizations and structures are only a means to an end. With evolving research and greater understanding of the linkages between mental and physical health, opportunities are emerging for reconsideration of the systemic structures that support the delivery of services in communities. A commitment to quality of care and community awareness of the needs of mentally ill patients in particular will help key stakeholders in any community maintain traditional levels of service. Proactive strategic planning is a cornerstone to adapting to the changing environment and ensuring that new structures continue to meet high standards that lead to individual and community health.

**Centers for Disease Control (CDC)**

The CDC has been leading the way in promoting an integrated system of care for the physical and emotional/behavioral health of individuals. In 2011 the CDC published an Action Plan to integrate promotion and prevention of mental illness with the more traditional role of public health practitioners which includes chronic disease prevention. Citing the critical interconnections between mental health and physical health, CDC laid out a number of strategies to better integrate the two systems and disciplines, including supporting the integration of traditional public health, mental health promotion and services for the mentally ill at the local level. Their efforts yielded eight targeted strategies:  

1. Support collaboration of public health and mental health agencies to develop shared operational definitions;

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9 Ibid.
2. Support research into determinants and protective factors of mental health, antecedents and risk factors for mental illness and their relationships to chronic diseases;

3. Determine the importance of mental health or illness as factors in broader public health promotion and disease prevention programs;

4. Develop educational products that include appropriate cultural, linguistic, and developmental characteristics;

5. Develop educational plans that are appropriate for each professional audience;

6. Support the integration of traditional public health, mental health promotion, and mental illness services at the state and local levels;

7. Develop policies at all government levels for all audiences; and

8. Establish systems integration within CDC’s Division of Adult and Community Health to promote program and policy integration across multiple infrastructures.

These strategies are beginning to gain momentum around the country. The synergy between these disciplines is growing and so is the potential for systemic improvements.

### Affordable Care Act

The Affordable Care Act (ACA), remaking fundamental parts of the nation’s healthcare system, has put demands on local health departments, including Dutchess’, to help explain the requirements and impact to local constituencies. In addition, the act expands some aspects of mental health parity adopted in 2008 requiring insurers to cover mental health services on an equitable basis with physical healthcare. Under ACA, as 1 of the 10 essential health benefits, insurance plans can’t apply any annual or lifetime dollar limits on mental health or substance abuse treatment. Also, the Act requires all small group and individual market plans to comply with federal parity requirements. Health homes, discussed below, are another relevant reform in the act.

The many unknowns of the ACA include how many people will respond to the requirement and opportunity to sign up for insurance, what demands this will place on local healthcare delivery systems and what additional impacts this will have on local governments that often provide services to those who have heretofore been uninsured. Unfortunately, the ACA is still too new to fully evaluate the answers to these and numerous other questions. It is unlikely to be fully understood in the near future.
Electronic Medical Records

On Feb. 17, 2011, Congress and President Obama passed a $787 billion bill called the American Recovery & Reinvestment Act (ARRA) of 2009. Included in this law was $19.2 billion for the Health Information Technology for Economic and Clinical Health Act (HITECH) which was intended to improve individual and population health outcomes through the adoption of electronic health records (EHRs) and exchange of health information. EHRs allow for the systematic collection and management of patient health information in a form that can be shared across multiple health care settings. By providing easier access to patients’ medical records, EHRs can help improve healthcare quality, efficiency and safety. These systems can also promote use of preventive services, improve public health surveillance, and support research to improve population health.

New York State

New York State has been an early adopter of many of the healthcare reforms, preceding in many cases the mandates imposed by the federal government. In particular, NYS has been a leader in expanding Medicaid and increasing access to the uninsured for many years. As referenced earlier, Governor Cuomo appointed a Medicaid Redesign Team to review the State’s approach to Medicaid and come up with solutions for how to make the systems more efficient, more effective, and work with the Federal Government on key initiatives in an effort to improve the access to care for those who are in need. One of the key strategies of their effort was a plan to adopt a managed care model for reimbursement.

Managed Care

The provision of healthcare has been influenced for many years by managed care and limitations on the type of procedures and amounts of money that companies are willing to pay for reimbursement of care. While hospitals and healthcare professionals have been busy adapting for the better part of two decades, the emergence of managed care as a reimbursement strategy for mental health is a new phenomenon. Mental health facilities and programs are being forced to adapt and will increasingly become financially unviable if their models do not take into account the new payment structure.

Like most states, New York has been moving Medicaid recipients into managed healthcare plans in recent years to save money and better coordinate care. The State pays private-sector insurance plans a capitated rate (flat monthly amount) per Medicaid patient intended to cover nearly all their healthcare expenses. Medicaid recipients must see providers within the plan’s network and obtain a primary care provider’s referral to
access specialty care. Some behavioral health services have been “carved out” of the managed care package and continue to be provided on a fee-for-service basis, but this is changing as the State moves to offer integrated managed care plans that include mental health services. Managed behavioral health services will be offered to most Medicaid recipients via their regular health plan or a separate but linked behavioral health organization, while those with significant needs will be served under Health and Recovery Plans (HaRPs) providing expanded benefits.

For Local Governmental Units (LGUs) that are charged with assuring a comprehensive mental health system and access to care within counties, this transition is another pressure point in an already challenging and changing environment. LGUs (essentially county mental hygiene departments, as explained in more detail later in this report) will increasingly be asked to think outside the box and find ways to build collaborative partnerships with the medical community, hospital discharge planners, local practitioners and other public health officials. As the new paradigms become the new norm, it will become increasingly important to eliminate silos of thinking between mental and physical health.

**Health Homes**

Health homes are a further evolution of the efforts to provide better, more efficient care available to states under the Affordable Care Act. Health homes aim to coordinate and better integrate primary, acute, behavioral health and long-term services and supports for people with complex and chronic conditions. To be eligible for health home services, Medicaid beneficiaries must have (a) at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition and/or substance abuse disorder; (b) one chronic condition and be at risk for another; or (c) one serious and persistent mental health condition.

In New York, the State Health Department sent counties a list of Medicaid recipients who qualify for health homes; local providers could also suggest names. Health homes are providers or teams of providers; in Dutchess County, the federally qualified health centers Hudson River Healthcare and Open Door Family Medical Centers (as lead partner of the Hudson Valley Care Coalition) are the Medicaid health homes in charge of care management. They contract with an administrative provider, Hudson Center for Health Equity and Quality, to provide a streamlined administrative process. Both receive an enhanced monthly payment for coordinating care and work with behavioral health service providers, including Mental Health America and Hudson Valley Mental Health. However, rates being paid to health homes may not be adequate to pay for new staff, and there are some significant IT requirements.
Compared to the caseloads over those generally covered through managed care, care management is more intensive within a health home and caseloads are intended to be smaller, with the goal of saving money over time through better treatment and management of chronic conditions. The enhanced payments for care management, though, are temporary and slated to disappear in two years. The goal of smaller caseloads is not yet a reality, and there is some concern that as the temporary 90% matching funding received from the Federal Government sunsets and New York State is forced to reimburse at the 50% level, health homes may be challenged to fully realize their goals.

Similar to the challenges in general of the transition to managed care, the Directors of Community Services (county mental health directors) are being put in difficult positions relative to health homes. As more clients are referred to the health homes, there could be a demand for more services, thereby placing an added strain on the system. Traditionally counties such as Dutchess have been able to plan for these needs by expanding their internal capacity, but increasingly the pressure points are coming from external case managers and the system is becoming more decentralized. This not only challenges the Directors to be more engaged with the providers, but it potentially renders them less influential in the process, as they have less control over the mix of services and can only suggest the types and levels of service that will be demanded.

**Department of Mental Hygiene and Department of Health Funding**

The changes in funding systems are being accompanied by a greater degree of direct-to-provider funds. Thus, counties are likely to be faced with the potential for either reduced funding, or funding that comes with less discretionary control. The switch to managed care and health homes as well as the implementation of the ACA may constrain what the State is willing to pay for. There is no certainty regarding the future impact of these transitions on counties, but local leadership is going to have to remain nimble, wary and vigilant, paying close attention to the political and legislative environments at both the state and federal level in order to not get caught off guard by changes that get implemented.

**Dutchess County Context**

Dutchess County finds itself squarely in the middle of these changes in landscape and the systemic shifts occurring throughout the healthcare system. A new County Executive has established new goals to streamline County government in a smart and balanced fashion by incorporating best practices, shared services, and better coordination between departments. In the initial years of his administration, there have been dramatic reductions in staff across many departments. This has not always been in
the context of a loss of those services, but in many cases it has been accompanied by divesting of direct care models and building more public-private partnerships. Naturally, this has created fear for county staff both in relation to losing jobs, but also in the altruistic sense of concern over how changes will affect the treatment that individuals receive, particularly those who are mentally ill.

All of this has been exacerbated in Dutchess County which, like many throughout the state, has been profoundly affected by the state’s continuing shift away from providing inpatient mental health beds in large institutions, culminating with the closure of the Hudson River Psychiatric Center in 2012. New York has been an outlier among the states in continuing to operate two dozen state psychiatric hospitals and will continue to be, but to a lesser extent when the shift to “Regional Centers of Excellence” is complete. By 2017, New York will have gone from 24 to 15 state psychiatric hospitals, still more than the 8 in Texas and 5 in California. As a result of the changes, the nearest state psychiatric hospital to Dutchess will be in Orangeburg, Rockland County.

Like the other state hospitals, beds were closed and entire wings of Hudson River abandoned through the 1990s and early 2000s as mental healthcare evolved to embrace more community-based care and medication. At its peak in the 1950s, it housed some 6,000 patients; in 2003, the much smaller operations moved into one of the complex’s buildings, which housed patients until January 2012.

While few would argue for a return to large institutions, the closure has reduced the number of inpatient beds available in the county and put a strain on that part of the system, according to some providers. St. Francis is now the sole provider in Dutchess of inpatient care with 40 beds; not including an additional 60 beds dedicated for substance abuse rehab (50) and chemical dependency detoxification (10). The reductions in psychiatric beds has left the County with no beds for children and adolescents, creating a significant void that puts strains on families who have children that need help in the system.

The recent announcement by St. Francis Hospital that it filed for bankruptcy sent shockwaves through the health and mental health systems in the County. St. Francis is a vital partner in the public health services arena, and is also the only hospital in the county designated to receive mental health patients referred by the Director of Community Services. Any disruption in the cadre of services offered by St. Francis Hospital could significantly burden other parts of the provider network for both public and mental health services. Negotiations with the bankruptcy court and with the State agencies overseeing the hospital are in process at the time of this report and we discuss the potential impact in more detail later in the report.
The County’s Health and Mental Hygiene Departments are responsible in some similar and some different ways for navigating the community and its residents through these changes in service delivery systems and ways of thinking. The Health Department’s multi-faceted role is focused around promoting public health through education, analysis, monitoring and community planning and convening. The Department’s activities are varied, from setting priorities for health improvement activities to monitoring the community for disease outbreaks to carrying out regulatory functions such as safety inspections of restaurants and water supplies.

Although the Department interacts with the leading health institutions in the community around planning, priority-setting and specific initiatives, it does not have an oversight role over hospitals or other providers. The Department’s role in providing direct care is limited, now that it has sold off its certified home health agency, but it does maintain a Public Health Nursing Division that continues to provide an array of direct services within the community.

The Department of Mental Hygiene, by contrast, is more involved in shaping and, albeit to a lesser extent today than in the past, delivering care to patients/clients. Under the State’s Mental Hygiene Law, counties establish Local Governmental Units (LGUs) to develop in the community preventive, rehabilitative and treatment services for people with mental illness, developmental disabilities, alcoholism and substance abuse. The LGUs are to carry out a comprehensive planning and oversight process including all providers of services, and direct monitoring of contract agencies concerning quality of services. In many counties, particularly where there are few private-sector service providers, county governments continue to provide direct care, including outpatient clinic services. Dutchess has divested many functions but continues in some direct-care services, which will be discussed later in this report.

**Regionalization**

Another significant development in the fields of both health and mental health is a move towards regional thinking. The health community has a history of focusing on regional planning and it has some well-established regional health systems agencies and planning councils. However, the new initiatives, Regional Health Improvement Collaboratives (RHIC), are just emerging into the local lexicon.

Back in 1997 the seven counties in the Hudson Valley, recognizing the importance of communication and cooperation at the local and State level, organized the Hudson Valley Regional Health Officers Network (HVRHON). The group consists of the health commissioners of Westchester, Putnam, Dutchess, Rockland, Orange, Ulster and Sullivan Counties, facilitated by NYSACHO. The goal is to increase communication and cooperation at the local level to develop solutions to
common problems. In 2009, HVRHON received funding from NYSDOH through the HEAL NY Phase 9 grant for a Local Health Planning Initiative and conducted a regional community health assessment and improvement plan. That strategic planning project has guided the regional public health system since in meeting the needs of the residents in the Hudson Valley.

The mental health system is beginning to think in these terms as well, led by the Conference of Local Mental Hygiene Directors (CLMHD), a membership consortium of the County Community Services Directors (mental health directors) across the State.

The downsizing of the State psychiatric hospitals and transition to Regional Centers of Excellence has put a spotlight on the changing landscape as it relates to regional thinking in the mental health field. No longer can counties rely solely on the resources located within their borders. They must coordinate and communicate with those outside of their county to ensure that beds are available and that people can have access to the services that are required. Health homes are another example, because they are being managed by providers that cover regional territories not defined by traditional county boundaries.

The State recently approved a CLMHD proposal to develop Regional Planning Consortiums that will be tightly linked to the ongoing development of managed care. The consortiums will be phased in, with counties like Dutchess folded into the planning in July 2015. The goal is to develop linkages between behavioral health professionals and public health professionals to spur creativity and open up avenues for more coordinated and quality care. The impact on LGUs will be significant, but may be inevitable and is largely a reflection of the changing landscape. LGUs are already being asked to consider the ways in which they will address the needs of their community by tapping into resources that extend beyond county borders, and reciprocally, other communities will be looking to places like Dutchess to partner and extend their networks of care.

**Summary of Healthcare Context**

The changing landscape of healthcare is pushing medical and behavioral health practitioners toward a holistic model of patient care that incorporates mental/behavioral health concerns with physical health treatment plans. Developing and promoting a system of integrated healthcare does not necessarily mean that blending the structures of a Department of Health and Mental Hygiene within a County Government is a natural or required byproduct. Existing structures for County Mental Hygiene and Health Departments have been designed to carry out significantly different functions, with different philosophies and in some
cases different goals. There are significant considerations, including workplace culture, resources, commitment to patients and community, legal requirements, funding streams and the presence of strong leadership that will influence whether a transition in departmental structure will complement or detract from the overriding goals of improved health and wellness for individuals. If successful, however, a blended / merged department could result in the type of coordinated whole-person care envisioned in the modern context.

The sections that follow will outline the two departments in Dutchess County as a means toward laying the foundation of considering the implications of potential merger or other forms of increased collaboration between the departments.

**Departmental Reviews**

Dutchess County operates a separate Department of Health and Department of Mental Hygiene. Pursuant to State statute, health departments are mainly focused on detection and prevention of population-based physical health issues and identifying communitywide health trends to raise awareness and improve public health. Departments of Mental Hygiene are charged with overseeing, designing and ensuring open access to systems for the treatment of mental illness, substance abuse and developmental disabilities in a safe and high quality manner. Although there are certainly similarities between the two Departments, the inherent differences in orientation (e.g., prevention vs. treatment and emphasis on populations vs. individuals), in addition to the State laws that govern each Department, have led to differences in the types of programs and services that are offered within each Department.

Each County Department is governed by a different section of State Law. New York State Public Health Law and Mental Hygiene Law are both prescriptive of the types of services that are required, and the levels of service expected. The composition of programming, staff, and departmental structure is related to the legal requirements imposed by the state laws and local needs, and have thus resulted in unique operations. The sections that follow provide an overview of each Department.

**Department of Health (DOH)**

Dutchess County has established itself as a single County Health District. The Dutchess County Department of Health in conjunction with the County Board of Health oversees the health district and discharges responsibilities in accordance with the New York State Public Health Law, the State and local Sanitary Codes and numerous other local laws and regulations. Dutchess County has designated that its department is
headed by one Commissioner who is charged with monitoring and improving the public health in the community. Guided by the 3 Core Functions and Ten Essential Services\(^\text{10}\) of public health, the Dutchess County model has evolved into a comprehensive, proactive, organized and effective system.

**Budget**

The combined 2014 budget for the Department of Public Health is $33.4 million. Of this total, 64% is dedicated to federal programs for Early Intervention and Preschool Special Education programs. Combined, the two services are budgeted to spend $21.2 million in 2014. The remainder of the public health budget (36%) has been established at $12.2 million for 2014.

Approximately fifty-one percent (51%) of the DOH budget is paid for by the County tax levy. The State (along with some limited other sources) passes through federal revenue of $12.0 million (36%) to offset the cost of running the federal programs. Roughly $4.5 million (13%) is

\(^{10}\) The core functions and essential services are: Assessment (monitor environmental and health status to identify and solve community environmental health problems; diagnose and investigate environmental health problems and hazards), Policy Development (inform, educate, and empower people about environmental health issues; mobilize community partnerships and actions to identify and solve environmental health problems; develop policies and plans that support individual and community environmental health efforts), and Assurance (enforce laws and regulations that protect environmental health and ensure safety; link people to needed environmental health services and assure the provision of environmental health services when otherwise unavailable; assure a competent environmental health workforce; evaluate effectiveness, accessibility, and quality of personal and population-based environmental health services; research for new insights and innovative solutions to environmental health problems). See [http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm](http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm)
earmarked to offset the budget for the other health department functions including the medical examiner, weights and measures, and veterans affairs. The majority of that revenue comes from State Aid, though there are some grants that offset specific programs (e.g., Ryan White). The County’s net cost for public health services is budgeted for 2014 to be close to $17 million.

**Trends**
Department of Health non-tax levy sources of funding have been steadily declining since 2008, though since 2010 they have declined at a slower pace than they did in 2008 and 2009. The Department of Health expenditures have also been declining, but not at the same pace. Between 2008 (actual) and 2014 (budgeted), non-tax levy revenues are predicted to decline by roughly 36% (15% since 2010). However, expenditures over the same period are projected to only decline by 10%. The graphs below illustrate the point.
The overall trend in net County cost for the Department of Health has been on the increase as a result. The County cost for DOH jumped over 52% between 2008-10 and then experienced a 13% dip in 2011, due to stabilization funding following the Great Recession. Since 2011, however, the cost to the County has been up by 15%. In 2008, the County cost represented less than one-third of the overall DOH budget. Since 2012, the County cost has hovered at approximately 51% of the total DOH budget.

There are several reasons for the changes in the increases to the net County cost for the Department of Health. State and federal funding for all public health programming has been in decline. Though State reimbursement rates have remained steady for Early Intervention, Medicaid rates have been cut by 2% (impacting 20% of those served). Additionally retroactive Medicaid rate reductions dating to May 2011 caused further declines in funding during 2012 and 2013 as the State recouped their money. Costs have been trimmed but not commensurate to the losses in funding, thus increasing the net burden to the County.

More dramatically, the data provided to CGR revealed that revenue available for the Preschool Special Education program has declined while costs for running the program have increased. Part of this is due to delays in reimbursement making comparison of actual expenses and revenues incompatible for more recent years.

Grants for Ryan White and other mandated services have also been in decline. Some expenditures have been trimmed to account for the declines in funding, but mandated services cannot be eliminated and the cuts in funding have outpaced the County’s ability to trim costs. Small changes in the structure of the department, such as shifts that place Weights and Measures and Veterans Affairs under the Public Health Department,
contribute in small ways to the increase in net cost, but the larger factors remain the changes in available revenue.

**Staffing**

The Department of Health has experienced a dramatic reduction in staffing, losing over one-quarter of its FTEs since 2009. The biggest losses have occurred in the Administration and Public Health Nursing (PHN) Divisions. The PHN downsized due to the closings of the County Certified Home Health Agency (CHHA) and the Long Term Home Healthcare program (LTHHC) in recent years. The administrative services were trimmed as a result, while some other administrative positions went unfilled after vacancies emerged. In the table below, we include Weights and Measures and Veterans Services even though they were not part of the Department in 2009 because they are now and we want to facilitate the most accurate comparison over time.

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>2009</th>
<th>2014</th>
<th>Change</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examiner</td>
<td>5.0</td>
<td>6.0</td>
<td>1.0</td>
<td>20%</td>
</tr>
<tr>
<td>Administration</td>
<td>33.8</td>
<td>13.0</td>
<td>-20.8</td>
<td>-61%</td>
</tr>
<tr>
<td>Planning &amp; Education</td>
<td>16.0</td>
<td>10.8</td>
<td>-5.3</td>
<td>-33%</td>
</tr>
<tr>
<td>Water Lab</td>
<td>3.0</td>
<td>-3.0</td>
<td></td>
<td>-100%</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>40.0</td>
<td>43.0</td>
<td>3.0</td>
<td>8%</td>
</tr>
<tr>
<td>Pub Health Nursing</td>
<td>33.0</td>
<td>13.0</td>
<td>-20.0</td>
<td>-61%</td>
</tr>
<tr>
<td>Communicable Disease</td>
<td>18.8</td>
<td>15.0</td>
<td>-3.8</td>
<td>-20%</td>
</tr>
<tr>
<td>Pre School Special Ed</td>
<td>4.0</td>
<td>4.0</td>
<td>0.0</td>
<td>0%</td>
</tr>
<tr>
<td>CHHA</td>
<td>1.0</td>
<td>-1.0</td>
<td></td>
<td>-100%</td>
</tr>
<tr>
<td>LTHHC</td>
<td>2.0</td>
<td>-2.0</td>
<td></td>
<td>-100%</td>
</tr>
<tr>
<td>Early Intervention Program</td>
<td>4.0</td>
<td>8.0</td>
<td>4.0</td>
<td>100%</td>
</tr>
<tr>
<td>Weights &amp; Measure&lt;sup&gt;11&lt;/sup&gt;</td>
<td>5.0</td>
<td>4.0</td>
<td>-1.0</td>
<td>-20%</td>
</tr>
<tr>
<td>Veterans Service Agency</td>
<td>4.0</td>
<td>4.0</td>
<td>N/A</td>
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</table>

The Department of Health is projected to lose 5.75 positions in 2014 compared with 2013 staffing levels. This is consistent with continued declines in funding and trimming in the Department’s budget to account for the reductions. The reduction in personnel equates to a 5% reduction in salary costs, not including additional savings in fringe benefits and other long term Other Post-Employment Benefits (OPEB) obligations.

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<sup>11</sup> CGR included 2009 staffing for Weights and Measures because it was available. It was not part of the DOH in 2009. 2009 staffing for the Veterans Service Agency was not available at the time of this report.
<table>
<thead>
<tr>
<th>Department of Health</th>
<th>2013</th>
<th>2014</th>
<th>Change</th>
<th>Rate</th>
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<td></td>
<td>126.5</td>
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<tr>
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<td>15.00</td>
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<td>10%</td>
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<td>Pub Health Nursing</td>
<td>16.00</td>
<td>13.00</td>
<td>-3</td>
<td>-19%</td>
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<tr>
<td>Communicable Disease</td>
<td>16.75</td>
<td>15.00</td>
<td>-1.75</td>
<td>-10%</td>
</tr>
<tr>
<td>Pre School Special Ed</td>
<td>4.00</td>
<td>4.00</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Early Intervention Program</td>
<td>8.00</td>
<td>8.00</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Weights &amp; Measure</td>
<td>4.00</td>
<td>4.00</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>Veterans Service Agency</td>
<td>4.00</td>
<td>4.00</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

The largest division by staff count in the Department of Health is the Environmental Health division. There are 43 FTE (down from 44 in 2013) that are dedicated to this division. The Communicable Disease Division (15 FTE), Public Health Nurses (13 FTE) and Administrative Divisions (13 FTE) as the next largest divisions have less combined staff than the Environmental Division. Each of these divisions also lost staff in the 2014 budget. The Public Health Nurses lost three FTE (one FTE as a result of eliminating a vacant position), the Communicable Disease Division lost 1.75 FTE (one FTE was reassigned to the Medical Examiner), and the Administrative Division lost a net of two FTE (two FTE through elimination of vacant positions, one FTE to be reassigned outside of the DOH, and one FTE added). The only divisions in the Department of Health with net increases in staff for 2014 are the Health Planning and Education and Medical Examiner divisions which added one FTE each.

**The Board of Health**

New York State County Boards of Health are established and required by Public Health Law. The Dutchess County Board of Health (established locally in Section 7.03 of the County Charter) advises the County, including the County Executive, Legislature and the Department of Health, on health-related matters and is made up of physicians, nurses, attorneys and others who are appointed by the County Legislature. Its powers and duties are governed by the Dutchess County Charter, the Dutchess County Administrative Code, and the NYS Public Health Law Sections 347 and 350. The board does not appoint the health commissioner (that is done by the County Executive) nor does it have any direct role in managing the Department. It is responsible for updating the county’s sanitary code and for setting the fees charged by the Department for various services. As it brings together community expertise on various health issues, it is able to play an important role as a public voice.
advocating for a strong approach to improving public health throughout Dutchess County.

**Changes and Current DOH Context**

Over the last two years, the Public Health Department has gone through a significant transition. Relocation to the current site at the Poughkeepsie Journal Building (PJB) brought many welcome upgrades to offices and a new upgraded setting. However, the change in location produced some significant cultural changes that have taken time to work through. Formerly most staff had offices with their own door, and the layout of the space was a traditional closed door floor plan. It did not promote a sense of collaboration, openness, or support from colleagues across the many divisions of the Health Department, and leadership believes that this contributed to a less efficient and in many cases a less effective organization.

The new space in PJB was completely remodeled for the DOH with an open floor plan and very few closed-door offices. The open spaces are divided into cubicles and the floor plan is structured to promote collaboration between divisions, not just within divisions and specialty service areas. The clinic services were moved to the Family Partnership Center though some staff was given office space at the PJB. The official move was in the summer of 2013, and leadership report that while the transition was difficult, most have adapted and are experiencing the benefits of cross-pollination and collaboration for the various services they provide.

Several key positions are vacant in the Department of Health. The Acting Commissioner is also the Medical Examiner and at this time there is no plan to remove the Acting Commissioner title from the Medical Examiner. As such, the Commissioner and Medical Examiner positions remain shared under one person. Additionally, the key position of Budget and Finance Director for Public Health also remains in flux. With the start of the 2014 Budget year, the Department of Mental Hygiene (DMH) Budget Director was transferred to serve as the Budget Director for DOH for the first few months of 2014 in an effort to stabilize the financial operation of the DOH. The position will continue to share time with DMH, as much as 1.5 days per week. Several high level positions remain unfilled in the Environmental Health Division as well that will continue to strain the operations and ability to respond in a timely way to the pressing needs in that Division.

As part of an internal restructuring for the 2014 fiscal year, DOH has realigned several divisions to become more nimble and responsive to the changing environment. The realignment primarily affected the nursing and communicable disease divisions. The new structure creates a Public
Health Nursing Division (centrally located at the Poughkeepsie Journal Building) with clinic services (i.e. immunizations and testing for HIV and STDs) being operated almost exclusively from the offsite location at the Family Partnership Center owned by Family Services, Inc. Under the new structure the Public Health Nursing Division is responsible for Emergency Preparedness in addition to the more traditional clinic services, chronic disease prevention and treatment, maternal child health and lead safety. The Communicable Disease Division is separate from the other two in structure and is located at the main site in the Poughkeepsie Journal Building.

Recent changes in the Public Health Law\textsuperscript{12} have allowed for commissioners (or directors) of public health departments to oversee more than one department, provided they meet the minimum criteria for serving in the role. The minimum criterion includes being a board certified physician in the State of New York (i.e., MD) combined with some administrative experience (typically an MPH or some equivalent experience). As noted, the Dutchess County Health Department is currently working under the authority of an Acting Commissioner. While there are examples of other counties that have opted to have their commissioner serve in more than one role, the passage of this new provision in State Public Health Law further reduces the hurdles associated with making this type of transition.

The Department of Health oversees a diverse County with many parts reflecting a suburban and even rural character in addition to its few urban areas around two small cities. The demographics of the community have been changing partly from the effects of the Great Recession and partly from the outmigration of working-class people from the northern suburbs and more congested locations around New York City. There was a steady increase in housing values in the early 2000s, particularly in the southern part of the County, but that has tempered from the effects of the Recession. There was also a shift in the population demographics and per capita incomes within the County with higher and middle income wage earners filtering into the County in increasing numbers. The resulting disparities in the population (from north to south and urban to rural) are not causal to any particular public health issues, but they do create complexity for the department as it contends with the full array of needs presented in the broad diversity of individuals and needs within the community.

\textsuperscript{12} Article 6 of the PHL
Overview of State-Mandated Services

Public Health functions, described in more detail below, are a mixture of mandated services as proscribed by State Law, many provided with discretion by Dutchess County based upon its population and observed trends and needs, but some that are completely mandated by the State or Federal Government. The early childhood programs (Preschool Special Education and Early Intervention) are largely passing through federal funding allocations and both programs fulfill a mandated function. Most others are funded through State Aid and grants or in combination with County and outside County funding sources. The NYS Prevention Agenda\(^{13}\) published by the NYS Department of Health also helps drive the public health initiatives at the local level.

Article Six of the Public Health Law provides the most concise overview of the types of services that are both mandated and partially funded by New York State. Every public health department in New York State is required to provide the following services:

- Family Health Program
- Communicable Disease Control
- Chronic Disease Prevention
- Environmental Health
- Community Health Assessment
- Emergency Preparedness and Response

The Dutchess County Department of Health fulfills these requirements through a broad array of programs and services. As described on the department’s website and in several publications, the array of services includes (by State DOH topic area):

Family Health Programs

Maternal and Child Home Visits

Offered through the Division of Public Health Nursing, the maternal child health services are designed to support a healthy transition for new moms and their babies, and provide support for parents to improve the health of all children. Nurses provide support and help identify what services are needed for the mother or parent and also encourage well baby visits.

\(^{13}\)http://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse/index.htm
proper immunizations and other comprehensive well child and preventive care matters.

**Children with Special Healthcare Needs (CSHCN)**

Dutchess County participates in this statewide program designed to link families to appropriate healthcare alternatives that are responsive to primary or presenting health needs.

**Physically Handicapped**

Dutchess County offers a financial assistance program to families of children that are physically handicapped provided they meet certain eligibility requirements.

**Health Education Programs**

Dutchess County conducts numerous health education programs throughout the year. The programs are geared to specific age groups as necessary and are held on a range of subject matter. The County not only conducts programs for the public, but also is engaged in trainings and collaborative efforts with local healthcare providers to assure delivery of comprehensive primary and preventive care.

**Communicable Disease Control**

**Childhood, Adult and International Travel Screenings and Immunizations**

Pursuant to State Law, the County offers screenings and immunizations to those that require them. The County monitors the community for disease outbreaks and suggests interventions and potential immunization strategies as crises arise. While the County has been engaged for many years in offering flu shot clinics, increasingly flu shots are available commercially through retail outlets. The County works with the local healthcare provider community including all hospitals to assure that adequate attention is given to the prevention of diseases.

**Perinatal Hepatitis B Program**

The State requires Counties to address the prevalence of Hepatitis B in the community. The County offers case management and referral services to women who test positive for Hepatitis B and bear children.

**Tuberculosis**

The County is charged with monitoring, detecting and reporting on the incidence of tuberculosis. As necessary, the County also provides access to interventions and / or referrals to address cases that arise. Annually there are public health awareness messages that help inform the community of the risks associated with the disease or exposure to the disease.
Sexually Transmitted Infections and HIV
The County is engaged in monitoring, tracking and reporting on the incidence of STDs, and HIV cases. As part of the DOH charge, it not only captures the data, but designs interventions, including free testing and education on safe practices. The County has a clinic in the Family Partnership Center designed to offer these services.

Rabies Pre/Post Exposure and Vaccination Clinic for Pets
Clinics are held three times per year to help vaccinate animals / pets from the rabies virus. In the unfortunate event that a person is infected, the County will arrange for treatment for the infection.

Chronic Disease Prevention
Through its wide variety of programming, in addition to the data collection and analysis done through the community health assessment and community improvement plan, the County offers education, awareness and intervention plans to aide in the prevention of chronic diseases. As defined by the State, chronic diseases can include cancer, cardiovascular diseases, diabetes, asthma, obesity, and many others. This unit also promotes good nutrition recognizing the negative effects poor nutrition can have on the variety of other chronic diseases and overall health. One of the primary tools used by the County is the communication plan and public awareness campaigns that are designed annually to target high risk populations and promote healthier lifestyles. The County also offers education and training events around specific topics targeting high risk populations and prominent community health issues.

Environmental Health
Childhood Lead Poisoning Prevention
The Department is responsible to identify risk factors for lead poisoning in the community where childhood exposure is likely. The Department is also responsible to develop education and trainings and promote awareness of the issues around lead poisoning. The Department monitors laboratory lead testing results, and offers individual case management and follow-up to children with elevated blood lead levels as well as environmental investigations as requested or necessary.

Permits and Inspections of Public Facilities
The County inspects and permits all public facilities including but not limited to restaurants, hotels, realty subdivisions, children’s camps, temporary residences, mobile home parks, places with large gatherings (5,000 people or more), daycare centers, nursing homes, etc. The goal is to help reduce or prevent injury, particularly injury that leads to premature deaths.
Investigations of Complaints with Response

When complaints arise from food-borne illnesses, sewage failures, suspected rabid animals or a variety of other issues, the County is responsible to investigate those complaints and prescribe an appropriate response / intervention. The division also provides some non-mandated services such as testing for mold and responding to individuals who have had their heat turned off.

Engineering Services

The division recently experienced significant turnover in key leadership positions. After the 2012 fiscal year, more than 10% of the staff left, including many division leaders. The result was a tremendous loss of institutional knowledge and services that have become backlogged due to unfilled vacancies and a lack of staff able to perform the functions.

Engineers are responsible to ensure that sewage is properly managed. This involves inspections and approval of plans for sewage collection, treatment and disposal in both residential and commercial settings. The largest component of the division is the water program. There are over 700 public water supplies in the County, which ranks second across the country in terms of County-monitored public water supply responsibilities. Engineers conduct a NYSDOH-approved certification course for the water treatment plant and distribution system operators.

Environmental Health Assessment

The division conducts investigations and provides technical assistance regarding radon, asbestos, occupational health, hazardous and medical waste disposal sites, indoor air quality, environmental lead assessments, and potential exposure to chemicals and hazardous substances. The division also coordinates and facilitates response to radiation emergencies, and conducts West Nile Virus surveillance and control activities. New York State is instituting other regulations that the Counties will have to comply with, including those related to tattoo and tanning parlors.

Tobacco Control Programs

The County is required to permit and inspect local tobacco retailers to ensure compliance with State and local laws.

Community Health Assessment

In addition to the direct programs and services offered, the Department develops a comprehensive community health assessment (CHA) triennially. The goal of every CHA is to apply data and observe public health trends to develop a Community Health Improvement Plan (CHIP) targeting public health issues of greatest importance in the community. The State Department of Health also develops a prevention agenda to help guide the provision of services in local communities. Local departments
are encouraged to incorporate the State level initiatives into their planning efforts to ensure the State’s objectives are being met.

The Health Planning and Education Division (HP&E) of Dutchess County is responsible for this work. As defined by the strategic plan, the HP&E function:

- Monitors the health of the community
- Informs and educates
- Mobilizes communities to address health problems
- Develops policies and plans
- Links people to personal health services.

HP&E is responsible for the communication plan developed by the Health Department, which includes a 12-month strategy for outreach and targeted prevention or community health awareness campaigns. This division overlaps with many of the others in providing the health education trainings and seminars.

**Emergency Preparedness**

The functional needs of preparing a coordinated emergency response to public health-related crisis are handled by the Department of Health. Under the new structure, this responsibility falls under the Division of Public Health Nursing. The responsibility of the Department of Health is to consider rapid response to emergency epidemics and develop plans and trainings necessary to prepare the community for action. The overall 911 operation for the County works closely with the Department to assure that appropriate resources are marshalled and that proper planning has occurred to be responsive to anticipated problems identified in the emergency plans. Ideally this plan cuts across multiple departments, assuring continuity within the County for a coordinated response. In reality, it has been difficult to pull together resources and dedicate time across all departments to the emergency response plan. Fundamentally, there is a breakdown in many cases between developing a good plan and simply “having a plan” that meets criteria for funders and other mandated expectations. Department of Health officials are working to enhance the current emergency preparedness plan, but more needs to be done to ensure the level of coordination across the County is adequate.

**Federally-Mandated and Other Services**

The services provided below are not outlined in the NYS Public Health Law, but are mandated from other sources, mostly the Federal Government. In the cases of Weights and Measures and Veterans Services, the decision to place them under the DOH was an internal
organization structure decision and was not a result of synergies in funding streams or unique public health requirements. However, since they have become part of the DOH, synergies have emerged that were unanticipated that have elevated the level of service within those departments due to leveraging resources within DOH that were previously not considered accessible or were simply not considered at all. The most prominent example of this is related to the Veterans Affairs staff working more closely with the communications team of the DOH and becoming more proactive in reaching the veterans in the community. There has been collaboration on training events within the community for the veterans and DOH administration has found numerous ways to incorporate both the Veterans and Weights and Measures divisions into the health planning functions.

**Ryan White**

In fulfilling its federally-mandated responsibility to low income, uninsured or under-insured people living with HIV and AIDS, the County is mandated to provide services to eligible individuals. The program is funded exclusively through a federal grant and while funding has declined in recent years, through the end of 2013 the County still maintained an FTE that manages grant services.

As of March 2014 the Ryan White grant will expire. Due to changes in federal eligibility criteria, Dutchess County will no longer qualify for this funding as it does not have the required number of HIV/AIDS cases to be eligible.

**Early Intervention & Preschool Education**

The Early Intervention (EI) Program was officially established in 1993 in Article 25 of the NYS Public Health Law and stems from the 1986 IDEA Act of Congress. Administered now through the State’s Bureau of Early Intervention, the state subsidizes a significant portion of the programming required of the County, using pass-through funding from the Federal Government. To be eligible, children have to be age birth to three and have some presenting disability or developmental delay as established and defined by the State. The caseload of Early Intervention is close to 1,700 children / families with 7.5 dedicated staff and .5 FTE of a Director.

The Pre-School Special Education Program works closely in conjunction with the NYS Office of Special Education in addition to tapping into the funding streams that flow through the Department of Health. The program takes children who are ages 3-5 and provides a continuing source of support for children from the EI program until they reach school age. The Preschool program serves about 500 children. There will be 3.5 FTE in the 2014 budget and a .5 FTE Director. The one half FTE Director in both programs is the same person overseeing both.
The goal of both programs is to build networks to support children with special needs from infancy through the start of school. Intervening with the physical needs of children and supporting young/new parents builds a foundation that is invaluable in preparing them to be successful students. There is also abundant research that links social and financial returns on investments in young children to long-term systemic and community benefits. Returns such as higher employment, higher wages, less incarceration and other unwanted negative social activities (e.g., unplanned pregnancies, social deviancy) all result from early childhood investments.

Recent changes in the EI funding mechanism now allow providers to contract directly with the State. The County portion of funding for these services is now kept in escrow and drawn down over the course of the budget year as services are rendered and expenses incurred. There is concern that this change may over time lead to increases in costs that are outside of the County’s ability to control. It is unclear at this time whether that will occur.

**Veterans Service Agency**

The Veterans Service Agency is a mandated service that was recently brought under the supervision of the Department of Health. Staff reaches out to military service veterans particularly around health or mental health and re-entry issues. By bringing this service under the Health Department, it has allowed for improved public awareness, better outreach and a more supportive work environment for the four FTE assigned to carry out these duties, in part because the Department’s administrative staff have taken over some of the administrative duties that used to be handled by the director.

**Weights and Measures**

The Division of Weights and Measures is responsible for assuring fairness and accuracy in the various functions in the County that relate to merchant activity and fair trade. The overarching goal is to provide consumer protection. Currently there are four FTE assigned to this division, which was brought under the Department of Health in a recent restructuring in order to streamline staff supervision and assure synergy in the provision of service.

**Administrative and Back-office Roles**

The public health department provides several administrative support functions that are simultaneously required and in some cases help alleviate the burden on staff delivering services. In some cases the burden falls onto program staff, but in those specific cases the burden is uniquely suited to their role because of their expertise. The primary administrative services that support the DOH include budget and finance, grants and
contracts processing, compliance issues, communications, human resources and IT.

**Budget and Finance (Includes Payroll, HR, Accounts Payable, Billing, Purchasing)**

The Budget and Finance operation is overseen by one FTE Director (currently vacant though as of January 2014 this position is being served part-time by the Budget Director of DMH) and six FTE support staff (One Receptionist, 3 Accounting Clerks and 2 Principal Program Assistants). The division lost one FTE in 2014 when a Senior Accountant was transferred to another unit in the County.

In general the staff is responsible for review and approval of expenditures, monitoring revenues, assuring grant compliance for proper expenditures and payment, reporting, budget preparation and monitoring, reviewing changes in state and federal policies related to funding sources, purchasing, payables, processing payroll and human resources requests. Presently payroll includes a significantly time-consuming manual process of data entry based on paper timesheets. Some consideration has been given to transitioning to an electronic payroll system, but the transition has not been implemented.

Billing is primarily generated from the nursing division, though EI and Environmental Services also generate some limited billing activity. The new EI escrow system has changed the way billing traditionally works and the staff are adapting to “replenishing” the escrow as it gets drawn down from payments. The budget office is responsible for reviewing and approving the billing after it has been generated by the staff in the nursing division. The nurses use the McKesson System for billing. There is some discussion that this function may be growing as the State has opened up the potential to bill for more services in the clinics, particularly for those with Medicaid and those that might sign up for new health insurance under the ACA. There is some concern that institutional knowledge about the legacy billing processes will be lost over time, but this may be less important as newer systems come online and replace outdated manual processes.

There are several software systems that work across all the departments. The staff that need to engage them are all relatively proficient. The systems include Logos, Crystal Reports, Excel, and McKesson (for billing). The number of systems creates complexity, but there are few options that can handle the variety of billing and other reporting requirements comprehensively in the Department. The Assistant Commissioner has expressed interest in finding comprehensive billing software that would accommodate the variety of activity that is generated in the Department (and potentially across departments, though this may be less feasible given the numerous funder reporting requirements), and
discussions are currently in process with the County Office of Central and Information Services (OCIS) along those lines.

One important distinguishing feature of the Health Department finance function is the difference in accounting methods. State aid is processed on a cash basis while cost reports are developed on an accrual basis. Most grant reports are developed on the modified accrual basis. The fiscal year runs January through December with the exception of some grants that have their own life cycle.

**Grants/Contract Processing**

One FTE is dedicated to processing 169 contracts and 10 grants for the DOH. This includes annual contract renewals/updates, review of contract language, processing for signatures, pushing them through to the County Attorneys for approval, processing and sending/mailing upon approval from the County Executive, and maintaining good relationships with each of the contracted providers.

**Compliance Issues related to HIPAA, Medicaid, FOIL**

Several staff is responsible for this function as part of their other responsibilities. For instance, the Assistant Commissioner is designated as the FOIL officer for the DOH. When requests are made, she reviews the request and assigns certain staff to follow-up. Once information has been provided, she also reviews again to assure sensitive/personal information is redacted as allowed by law. Trainings are routinely conducted by one DOH staff person (as part of other duties) regarding HIPAA compliance. The Medicaid Compliance Officer is designated as the Director of Budget and Finance, though in practice currently the Assistant Commissioner fills this role. The Director of Nursing also plays a role in training around Medicaid Compliance.

**Communications**

Largely a function of the Health Planning & Education division, communications cuts across several divisions as it develops preventive and health awareness campaigns on an annual basis. The communication plans synergize with the health planning that is done through the CHA and the resulting health planning goals. There are sometimes crises in the community that require urgent responses, special activities, and community wide awareness, and the communications teams are responsible to get information published for those situations.

**Human Resources**

The human resources function is instrumental in developing annual reviews, assuring employee files are up to date, reviewing payroll, and assuring all union and civil service issues are managed appropriately.
Presently the responsibility is handled as part of a dual role for one FTE that manages payroll and HR together.

**Information Technology**

The DOH IT needs are managed by the OCIS. OCIS is the central internal countywide IT department for nearly all county IT services. All DOH data servers, email addresses and servers and infrastructure or hardware support needs are managed by OCIS. OCIS reports that there is not a good billing system in place within the DOH structure but that it is held hostage to a degree by the State because there has not been any leadership on adopting statewide standards. The State is in transition with its data center and as such has forced local departments to remain in flux while it irons out its approach. OCIS conducts daily backups on data and tests a disaster recovery process three times per year.

**Facilities**

The Department of Health operates out of six primary locations. Four are county-owned while the other two are rented.

One county-owned location services the needs of the Division of Weights and Measures and houses four FTE personnel. The needs of division relative to heavy equipment and larger vehicles, as well as the need for space for clients to come and do inspections on larger vehicles and equipment, forces the Division to locate at a separate location than the rest of the Department.

Two other county-owned locations serve as off-site locations for the Environmental Services Division. Beacon and Millbrook are satellite locations for the Division and are more efficient to operate than having all staff travel to and from Poughkeepsie to fulfill their duties. Five FTE from the Environmental Division are located at each facility.

The Medical Examiner (M.E.) has space in a separate county-owned location. The facility is brand new with state of the art equipment and amenities that have been significantly upgraded from the previous facility. The space is managed by the M.E. and is occupied by five additional FTE support staff.

As noted previously, the Department of Health relocated in 2013 into rented space at the Poughkeepsie Journal Building (PJB). As part of the relocation, clinic services were not located in the PJB but are mainly
housed in the Family Partnership Center owned and leased by Family Services, Inc. The PJB was completely remodeled and DOH occupies four floors of the remodeled space in the back half of the building. The design is an open air cubicle model with logistical considerations for which divisions would benefit from more collaboration. For instance, the Public Health Nurses occupy space on the second floor toward the front of the building and it allows them easier access to and from the building, as they are in the community more frequently than other staff. They are also co-located near the EI and Preschool programs on the second floor which offers some synergy in sharing information and learning from one another. Three staff occupies space at the Family Partnership Center Clinic four days per week. They also maintain office space in the Nursing area of the PJB. The third floor is geared more toward administrative functions and promotes collaboration between Health Planning and Education personnel (for communication plans and crisis response when necessary) and senior leaders. The first floor houses the Veterans and Environmental Services Divisions while the ground level has room for storage, files, break and training rooms.

The space is not overcrowded, leading to a comfortable work environment. In fact there are eight (8) vacant cubicles currently and space for 2-4 more between the two floors, not including the opportunity to co-locate some office space. For instance, by not allowing nurses to occupy space at both the Family Partnership Center and the PJB and instead permanently locating the few that have space at the FPC to the FPC full-time, there could be one more office and two cubicles made available at the PJB. This could allow for 13-18 additional spaces.

The Department of Health also uses and / or rents space in other parts of the County as needed for implementing their various clinic services. These sites include schools and Cornell for special immunization clinics and use remains ad hoc based upon the need.

**Community Boards and Coalitions**

The Department of Health facilitates several boards and/or coalitions in the community to coordinate public health services.

The Local Early Intervention Coordinating Council (LEICC) is mandated by State regulation and is comprised of community representatives and parents. Its role is to advise the Early Intervention Program in developing,

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14 The County maintained a clinic at this site prior to the relocation, and has consolidated nearly all clinic services to this location upon the move into PJB. The County still provides some clinic services at other locations throughout the County on a per diem basis.
maintaining and evaluating a system of early intervention services responsive to the needs of children birth through two with developmental delays and their families

The Professional Advisory Committee (PAC) serves as a quality control group for the Licensed Home Care Service Agency (LHCSA) activities. As required by law, each LHCSA must appoint a quality improvement committee to establish and oversee standards of care. The purposes of the PAC in Dutchess include:

- Review and recommend policies related to the delivery of service;
- Conduct a clinical record review of the safety, adequacy, type and quality of services;
- Submit a written summary of review findings to the governing authority; and
- Act as a liaison with other health care providers in the community.

The AARRMS Coalition (Affiliated Approach to Risk Reduction and Management of STDS) is a non-mandated network of providers that assists with prevention and disease control around the area of sexually transmitted diseases. The group meets quarterly to review the epidemiological trends in the community, changes in the regulations, gaps in services and ways to address these issues.

**Operational Insights**

The current organization and functioning of Dutchess County’s Department of Health represents some progressive systemic and organizational thinking, but CGR did observe and hear through interviews that it continues to struggle with maintaining a focus on its mission within certain divisions and is under significant pressure due to staff turnover and recent culture changes. We identified the following from our time with various staff throughout the organization.

- **Strengths:** There is a high degree of technical expertise within the Environmental Division. The various divisions are led by knowledgeable and committed staff, which provide excellent service and are committed to thorough and timely follow-up. The Early Intervention program is highly regarded and appears to not only serve its clients well, but also has a good handle on how to leverage services in other departments of the County to the betterment of its clients. The HP&E division is excellent and in touch with the trends and issues in the community. It and the DOH as a whole are adept at disease management and community health planning. Overall, the communications team and administration are creative in developing good communication and public education plans. CGR was very impressed with the willingness of
staff to embrace outside-of-the-box thinking as it relates to collaboration between divisions within the DOH and potential partnerships with other departments in the County.

- **Weaknesses:** CGR did not get to interview all staff, but from a few interviews we learned that there has been quite a bit of resistance to the organizational changes in location and structure. Some staff felt that certain leaders/staff prefer to defer to the status quo, and some are not as mission-driven, in the sense that they are caught up in managing day-to-day activities and perhaps lose sight of the bigger purpose and goals of the DOH. The Department continues to wrestle with declining funding but must continue to provide mandated services. Finding the right staffing levels in the midst of the changes is difficult, creating some overstaffing in certain pockets of the organization while other divisions struggle with understaffing. The County has already taken steps to address these issues in the 2014 Budget with some of the personnel changes noted earlier.

- **Threats:** The significant turnover in leadership over the last several years has left the County struggling to maintain essential services. There was a tremendous loss of institutional knowledge, particularly in the Environmental Services Division, and it may take several more years to get that division fully up to speed again. In the meantime, the critical elements of maintaining healthy drinking water, taking the time to assure adequate reviews are done for all permits and many other aspects of the services in that division are threatened by the short staffing.

Not uncommon to any DOH, the ever-evolving nature of Medicaid funding, mandated services and changes in the healthcare environment in general put strains on any Commissioner or local leader of public health in a community. Reductions of funding from the State will also continue to threaten the ability of the County to provide adequate or quality service.

- **Opportunities:** Culture change is happening with the relocation to PJB, new paradigms from new staff, and federal and state policies that are opening up ways to provide public health. The co-location of Veterans Affairs and other divisions has opened up ideas, spurred more creative potential, and allowed for better integration of existing services leveraging expertise in cross-division collaboration and decision-making. The increasing emphasis on integrated care, including needs related to mental health and substance abuse, opens up opportunities to help the community and offer treatment to individuals in a whole-person context rather than through silos. There appears to be a willingness to think
differently about the provision of public health services that opens up potential to rethink structures and systems within the County that weren’t possible in the past.

Department of Mental Hygiene (DMH)

The Dutchess County Department of Mental Hygiene operates under provisions outlined in Article 41, Local Services, of the New York State Mental Hygiene Law. Article 41 establishes the basis for local governments to “develop in the community preventive, rehabilitative, and treatment services…for persons with mental illness, developmental disabilities, and those suffering from the diseases of alcoholism and substance abuse.” (Section 41.01)

As outlined in Article 41, each county is to establish a local governmental unit to provide and oversee services, either provided directly or via contract. Each local governmental unit at the county level “shall have” a director (or county commissioner) who “shall be a full-time employee” unless the requirement is waived by the State Mental Hygiene Commissioner, and who “shall be a psychiatrist or other professional person who meets standards set by the commissioner for the position.” In Dutchess County, the director is called the Commissioner of Mental Hygiene, and is appointed by the County Executive, subject to confirmation by the County Legislature. Each county is also required to have in place a community services board with broad responsibility “for services to the mentally ill, the mentally retarded and developmentally disabled and those suffering from alcoholism and substance abuse.” (See Article 41, Sections 41.05, 41.07 and 41.09)

Changes and Current Context

The Dutchess County Department of Mental Hygiene (DMH) has a long and service-rich history of providing high-quality, innovative and patient-centered care to citizens struggling with mental health, chemical dependency, developmental disability and other related behavioral health issues. Key guiding principles have included a client-centered focus emphasizing virtually immediate access to all in need of services (little or no wait time), regardless of ability to pay. This long-standing commitment to strengthening high-quality treatment and patient-centered care remains a top priority for the key leadership and staff within DMH, as well as within the larger community-based network of mental and behavioral health service providers and advocates (mental and behavioral health is used throughout this chapter to broadly define and inclusively
refer to mental health, chemical dependency and developmental disabilities services).  

However, the environment within which this broad array of services is provided is rapidly changing, raising many questions about the delivery and funding of comprehensive mental/behavioral health services throughout the county in the future, and about how well the quantity, quality and comprehensiveness and broad accessibility of services will be able to be maintained going forward—both for DMH in-house services provided directly by County employees, as well as for contracted service providers. Changes in funding and service-provision strategies related to PROS (Personalized Recovery-Oriented Services) and health homes, the impact of managed care and of the Federal Patient Protection and Affordable Care Act (ACA), Medicaid Redesign initiatives, the trends toward contracting of services with external partners, the inpatient bed shortages created from the 2012 closure of the Hudson River Psychiatric Center and the transition to Regional Centers of Excellence all contribute to a turbulent, uncertain time for mental and behavioral health service delivery.

In addition, the characteristics of the population served by the Department and its contract agencies have changed, as the older and often previously-institutionalized population—which the system had become accustomed to serving—has been increasingly joined by a younger, often more aggressive and hard-to-serve cohort with a different set of diagnoses and treatment needs. Many of these individuals also wind up in the criminal justice, substance abuse and homeless shelter systems, creating new problems for those systems, as well as for the mental health treatment and service system.

Related to these issues, as more services have been shifted from direct provision by the County DMH to community-based service providers, there has been a significant trend in recent years of substantial reductions in internal DMH staffing levels, related shifting of responsibilities for those employees who remain, and changes in the DMH organizational structure.

But even as these changes have occurred, and even as County DMH staffing levels have been substantially reduced, it should be noted that the Dutchess County Commissioner of Mental Hygiene and his staff, working closely with a wide array of community-based service providers and

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15 For an earlier and more extensive historical perspective on the Dutchess County DMH about half a dozen years ago, see CGR, Assessment of the Dutchess County Department of Mental Hygiene, August 2008. Where appropriate, information from that report is referenced in this chapter.
community advocates, have been able to expand the overall service system and the network of broadly-defined mental and behavioral health services available at accessible locations throughout the county.

It should also be noted that the most significant concern expressed to CGR by mental hygiene advocates during this study is that mental hygiene not “get lost or fall through the cracks” among the priorities within Dutchess County government, and that appropriate resources and expertise continue to be leveraged for high quality intervention and treatment of mental health-related issues. Should any merger of Mental Hygiene and Health functions or full departments ultimately materialize from this review process, it is feared by some that mental health, chemical dependency, developmental disability and related services could be “swallowed up” by any newly-configured Department(s), with a resulting negative impact on the broader mental hygiene community and the service network that has been established over many decades. If mental health services lose funding and/or leaders do not have the same passionate voice advocating for the provision of high quality comprehensive mental health interventions, the expressed concern is that the most vulnerable in the community may suffer.

CGR has kept all of these directions and concerns in mind in outlining future options and recommendations later in this report.

**The Importance of the Oversight LGU Function**

Section 13 of Article 41 of the State Mental Hygiene Law outlines the extensive powers and duties of the mandated County Local Governmental Unit (LGU). These responsibilities include, among others, the oversight of a comprehensive needs assessment and planning process; development of a network of services to respond to identified needs; assurance of coordination and cooperation among service providers; supervising and monitoring the performance of all providers of services; promotion of the community’s awareness of and support for various mental disabilities.

As the Dutchess County Department of Mental Hygiene continues to adapt to providing fewer direct services, while overseeing the extension of a larger community-based service system, it prominently retains its mandated role as the State’s LGU within the County for policy oversight, systems leadership, community agenda setting, and monitoring/accountability for service providers under its purview. The continuing shift away from direct services will need to increasingly be accompanied by a greater emphasis on the LGU functions of leadership, total systems design, oversight and monitoring of the comprehensive mental hygiene system — creating gradual changes in long-established leadership paradigms.
Indeed, one of the major emphases in the 2012 Interim Report of the Health and Human Services Advisory Team appointed by the County Executive was to strengthen the role of the LGU and Commissioner of Mental Hygiene in “leading the vision, monitoring, evaluation and holding providers accountable for quality and outcomes” throughout the mental health network of services.¹⁶

Many long-term DMH staff continues to carry some responsibilities for direct care and provision of services that have long been a significant asset for the community, while also shifting greater attention to expanded oversight roles. Assuring that the skill set, experiences and competencies are in place within DMH to carry out these increasingly-important and expanded LGU/leadership/systems administration functions represents a key priority in planning for the future of DMH and those served by the system it oversees.

The Importance of the Community Services Board

The State-mandated Community Services Board is constituted in the Dutchess County Charter as the County Mental Hygiene Board. It is a 15-member advisory body appointed by the County Legislature. Working through four subcommittees, in consultation with the County Commissioner of Mental Hygiene, the Board advises on the creation of annual, intermediate and long-range plans for the County’s mental hygiene services and delivery system. It reviews and advises on community needs, services, budgets, policies and procedures, and various recommendations related to aspects of the mental hygiene system. It has the capacity to play an important role as a public voice advocating on behalf of a strong mental hygiene system throughout Dutchess County.

Staffing

We begin our analysis of the mental hygiene system by focusing initially on changes within the Department of Mental Hygiene staffing structure. Analysis of the numbers of authorized positions and FTEs in approved County DMH budgets from 2009 through 2014 confirms the significant decline that has occurred in this six-year period in the numbers of County employees engaged in DMH in-house programs and services. The numbers of authorized positions in the Department have declined from 209 in 2009 (and a slight increase to 211 in 2010) to 87 in 2014: a reduction of 122 authorized positions (-58.4%). Stated as FTE positions,

¹⁶ Dutchess County Health and Human Services Advisory Team, *Interim Report to the County Executive*, April 1, 2012.
the 82.76 positions in the 2014 budget reflect a reduction of 118.45 positions (minus 58.9%) from the 2009 total of 201.21, as indicated in the table below.

<table>
<thead>
<tr>
<th>Department of Mental Hygiene</th>
<th>2009</th>
<th>2014</th>
<th>Change</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Addiction Control</td>
<td>14.65</td>
<td>12.3</td>
<td>-2.35</td>
<td>-16.0%</td>
</tr>
<tr>
<td>Central Administration</td>
<td>40.5</td>
<td>28.0</td>
<td>-12.5</td>
<td>-30.9%</td>
</tr>
<tr>
<td>Mental Health Clinics</td>
<td>25.68</td>
<td>0</td>
<td>-25.68</td>
<td>-100%</td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td>84.52</td>
<td>0</td>
<td>-84.52</td>
<td>-100%</td>
</tr>
<tr>
<td>Partial Hospital</td>
<td>13.2</td>
<td>9.1</td>
<td>-4.1</td>
<td>-31.1%</td>
</tr>
<tr>
<td>Coordinated Services</td>
<td>0</td>
<td>17.0</td>
<td>17.0</td>
<td>NA</td>
</tr>
<tr>
<td>HELPLINE</td>
<td>10.16</td>
<td>5.16</td>
<td>-5.0</td>
<td>-49.2%</td>
</tr>
<tr>
<td>Diversion Program</td>
<td>1.5</td>
<td>11.0</td>
<td>9.5</td>
<td>633%</td>
</tr>
<tr>
<td>Chemical Dependency - MRDD</td>
<td>11.0</td>
<td>0.2</td>
<td>-10.8</td>
<td>-98.2%</td>
</tr>
</tbody>
</table>

As indicated in the table, these staffing reductions reflect the complete elimination of all positions associated with direct provision of clinic and continuing day treatment programs—representing the elimination of 110.2 FTEs. The Chemical Dependency/MRDD line reflects a reduction from 11 to 0.2 FTE positions, as a result of the elimination of the Multi-Disabled Clinic and inclusion of 0.2 FTE to oversee the developmental disability system. There has also been a 31% reduction in Central Administration positions, from 40.5 FTEs in 2009 to 28 in 2014 (with 4.8 of those FTEs eliminated between 2013 and 2014). The Partial Hospital program has seen a reduction in FTEs from 13.2 to 9.1 (a 31% reduction). Alcohol Addiction Control has also declined over this period from 14.65 FTEs to 12.3 (a 16% reduction).

Staffing in HELPLINE appears at first glance to have been reduced by almost 50%, from 10.16 to 5.16 FTEs in 2014. However, most of this apparent decline is attributable to the creation in 2013 of a new Coordinated Services cost center designed to capture costs related to services provided with or to other entities, such as the jail and courts. Some positions previously assigned to HELPLINE, such as two hospital discharge planners, were shifted from the HELPLINE budget line to the Coordinated Services line. This new Coordinated Services cost center also absorbed some positions previously allocated under other budget lines. In the process, the Coordinated Services line currently reflects a total of 17 authorized FTEs in 2014. Similarly, the Diversion line has expanded from 1.5 FTEs in 2009 to 11 in 2014, with the addition of new

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17 The services referenced in the staffing table are described in more detail in an expanded discussion of mental health services later in this chapter.
funding from the State Office of Mental Health to expand overall diversion services to help compensate for the closing in 2012 of the Hudson River Psychiatric Center.

The above staffing totals do not include 8.4 FTEs budgeted in temporary lines. Of those, 3.7 FTEs provide part-time support to help answer HELPLINE calls and another FTE supports the HELPLINE Texting for Teens program; two FTEs work in discharge planning; 0.7 supports the Partial Hospital program; and one combined FTE supports two programs in the Alcohol Addiction budget line.

A number of the positions lost to the County DMH have been absorbed in other provider agencies, as new positions have been added to community-based agencies picking up the coverage of many of the divested services. Some former County employees have chosen to accept positions with the agencies that absorbed many of the services previously provided by the County directly. At the same time, some responsibilities within DMH have been combined, so that some employees are now carrying expanded responsibilities compared to one or two years ago. Other responsibilities are being reconfigured—and some positions may need to be redesigned or perhaps combined, or even eliminated through attrition over time—to reflect the reductions in direct services provided by the Department and other evolving changes in the ways in which services across the mental hygiene system are and will be provided, funded and monitored in the future.

Given changing realities, it seems likely that the current number of DMH FTE positions will continue to decline in future years, depending on (a) reassessments of functions needed to meet the evolving needs of the Department in the future, (b) decisions about direct services to be either retained or contracted out, and (c) whether DMH remains an independent, autonomous department or is combined in some way with Department of Health functions. See the final chapters on options and recommendations for further discussion of these possibilities.

**Budget**

In 2008, the Department of Mental Hygiene’s approved budget called for expenditures of $33.6 million dollars across the entire mental hygiene system. Of that amount, almost $20.8 million (62%) applied to in-house administration and direct services provided by the Department, with $12.8 million (38%) allocated to contracted services.

Fast forward to 2014, and the fiscal pattern had shifted significantly. With major reductions in DMH staff, total approved budget appropriations for DMH have declined by $8.2 million since 2008, to $25.4 million. And in contrast to six years ago, with the latest round of shifts from in-house to
contracted services in place, the mix of in-house and contract agency appropriations had flip-flopped: Well over half ($13.6 million, or 53%) of the total 2014 DMH budget is now allocated for contracted services, with $11.8 million (47%) budgeted for in-house programs and administration.

Thus, between the 2008 and 2014 budgets for the overall Dutchess County mental hygiene system, total appropriations had declined by $8.2 million, a reduction of 24%. The in-house share of the budget had declined by $8.9 million (-43%), while the budget for contracted services had increased by about $734,000 (+6%).

During that same period of time, the total amount of budgeted County support or net cost for mental hygiene services has declined, with most of the decline attributable to the most recent round of elimination of direct County services during and at the end of 2012. In 2008, the budgeted County share or net costs of the total mental hygiene appropriations totaled $11.7 million, 34.8% of the total budget amount. By 2014, the budgeted County share had shrunk significantly to $9.4 million. Although this represented a higher proportion of the total budgeted appropriations (37.1%), that proportion was applied to a total budget that was significantly smaller than in 2008, and represented a $2.3 million reduction in budgeted County support from 2008 to 2014, a 19.5% decline over that period of time.

The above analyses are based on budgeted amounts. The graphs below reflect the trends, by year, in actual total expenditures, non-County revenues and amounts of County support for DMH services.
In the mid-2000s, patient fees accounted for 25% or more of the total mental hygiene revenues, with about 35% from state aid and 35% to 40% from County taxes. By 2014, with most fee-generating programs no longer provided by the County, budgeted patient fees were down to about $1.7 million (7% of the total DMH budget). The state aid portion of the total mental hygiene budget had risen to about 54% by 2014, the second straight year that proportion had been budgeted to exceed half of the total revenues.

Based on the 2014 DMH budget, the County covers 100% of all of the relatively small costs of the Court Remand and OMRDD budget lines (total appropriations of about $730,000), and 94% of the HELPLINE costs. The County also covers about two-thirds of the administration costs and of the Partial Hospital program, and about 58% of the costs of the various coordinated services. About 20% of the ITAP costs are borne by the County. On the other hand, 100% of the almost $2.2 million costs of the diversion program, including the Mobile Crisis Intervention Team and contracted diversion services, are covered by the state, with no County funds involved.

The only totally mandated service over which the County DMH has no control in what it must do and pay is Court Remand costs which, at $697,000, amount to 2.7% of the total DMH budget in 2014. An additional $460,000 (1.8% of the budget) is listed as mandated costs in which the County has control over how the services are provided. The latter include two positions in the 2014 budget identified as LGU Administration, one FTE identified as Assisted Outpatient Treatment (AOT) Coordination, and a .2 FTE position under the Developmental Disabilities line. Together, these mandated or partially-mandated costs
add up to less than 5% of the total DMH budget. The remaining services are provided at the discretion of the County.

**Network of Services Provided in Dutchess County**

As suggested above, there is an impressive array of mental hygiene services in Dutchess County. The service network includes services provided directly by the Department of Mental Hygiene (via County employees), services increasingly provided by various non-profit agencies via formal contract with the County DMH, and those provided via various affiliate agencies with less formal broad coordination with the Department.

Counties throughout the state offer, fund and monitor mental hygiene services in a variety of different ways—and differ widely in what they offer and the degree to which they hold various providers accountable to their county taxpayers. Increasingly across the state and within Dutchess County, many of those services are provided by community-based organizations and not directly under the auspices of County government and employees.

DMH has the obligation to plan for and oversee service provision throughout the system, but the State in its Mental Hygiene Law does not specify precisely what those services must be. Examining the overall network of services, irrespective of the mix of service providers, based on the statewide experience of CGR and discussions with experts knowledgeable about mental hygiene issues across the state, it is our belief that Dutchess County offers (directly and via contract and coordinated efforts) as comprehensive a mix of mental hygiene services as almost any county of its size (and even including many larger counties) in the state. Historically, these services have been broadly accessible to community residents, both geographically and without regard to the recipient’s ability to pay.

The overall mental hygiene system is directed, overseen and monitored by two divisions and three offices reporting directly to the Commissioner of Mental Hygiene, as indicated in the DMH organizational chart on the next page. Most direct and contracted services are overseen by the Chief of the Division of Clinical Services. In addition, a newly-created Office of Community Services includes responsibility for the HELPLINE and Mobile Crisis Intervention Team, provided directly by the Department, along with other functions noted in the organizational chart. This office is overseen by a Director who reports to the Commissioner, along with close coordination with the Chief of Clinical Services. The Chief of the Division of Administrative Operations oversees all internal administrative support functions; the Director of the Office of Psychiatric Coordination is
responsible for the management and supervision of all psychiatric and nursing services provided by the Department; and the Director of the Office of Quality Improvement oversees all quality improvement and corporate compliance activities of the Department and patient care and quality improvement measures of the Department’s contract agencies. Each of these functions and responsibilities is discussed in more detail below.

Dutchess County Department of Mental Hygiene

Service System Overview

Prior to the late 1990s virtually all Dutchess County mental hygiene programs and services, with the exception of children’s and youth services, were provided directly by the County, in programs run and staffed by County DMH employees. Between then and the end of the first decade of the new century, in the continuing effort to reduce costs and the size of the County payroll, three major core services were largely removed
from direct Department operations and control, and were contracted out to non-profit agencies: most mental health outpatient clinics, chemical dependency/substance abuse clinics, and case management services. More recently, in 2012, the County closed its Continuing Day Treatment program and its three associated centers, and simultaneously contracted with two non-profit agencies to provide a new recovery-oriented treatment service model, PROS (Personalized Recovery-Oriented Services). At the end of the year it also closed its three remaining mental health clinics and transferred their patients to other providers. Together, more than 1,000 patients previously registered in the clinics and Day Treatment programs were shifted in the past year or two from DMH-operated programs to other community providers. At the same time, the County DMH received state funds to expand diversion programming, including the creation of a new Mobile Crisis Intervention Team.

Through all of these changes in recent years, and the reduction in direct services provided by the County, the total mental hygiene system has continued to grow—with some services modified and expanded and new services added, while others changed providers. Moreover, during this period of transition, the overall numbers of people served throughout the system have grown. Across all services provided directly by the Department or via contract or affiliate agency, DMH data indicate that the total number of people served (episodes) increased significantly between 1997 and 2007, from 15,496 reported in 1997 to 20,972 in 2007—a 35% increase over the 10-year period. By 2010, that number had declined somewhat to 19,835 (a 5% decline), before growing again in 2011 (22,521) and 2012, even in the midst of the various changes in service provision that year (23,218). These numbers do not include those receiving services through HELPLINE.

The Mental Hygiene Service Report table shown in the appendix indicates data on total persons served (episodes)18, new admissions and overall volume of services provided by each program/service offered by either County-operated or contracted agency service providers in 2012. 2012 represents the most current data available for the entire mental hygiene system.

18 It should be noted that “persons served (episodes)” includes duplicate counts of individuals admitted more than once by a program during the calendar year. Thus each time a person is admitted to a program/service, he/she is counted separately each time. If there were no duplications or separate admissions during the year, the “persons served” would be identical to the number of “episodes.” It is not possible from the summary data provided by the programs and reflected in the appendix table to know for each program the extent to which separate admissions and duplicate persons are included.
service system, although in a few cases, 2013 data were made available to CGR as this report was being finalized.

Between 2010 and 2012, the numbers served (episodes) increased by 17%. The number of individuals served by the overall system in 2012—whether by DMH-provided services or via contract/affiliate agency, across the service areas of mental health, chemical dependency and people with developmental disabilities—was fully 50% higher than the numbers served 15 years earlier, in 1997. If people served in a St. Francis Hospital detox/rehab program, and residents referred from providers in Dutchess County to out-of-county hospitals for inpatient services are included in the totals, the total numbers served in 2012 grows to 25,613. It should be noted that these totals do not include numbers now being served by the two new health homes in the county. It is possible that these total numbers will increase in the future with the growth of health homes, new people covered under provisions of the Affordable Care Act, and the Department of Health’s Prevention Agenda 2013-2017, which includes expanded promotion of mental health and substance abuse prevention.

The remainder of this section summarizes the services provided across the mental hygiene system, broken down by type of service (mental health, chemical dependency, developmental disabilities, and coordinated services) and by in-house vs. contract service provision. These services are outlined in broad terms under the Division of Clinical Services and Office of Community Services sections in the organizational chart presented above. Until recently, mental health, chemical dependency and developmental disabilities each warranted its own division with its own chief overseeing all in-house, contract and related services within each. But as DMH restructured to more realistically reflect the reductions in services directly provided within the Department—and a greater emphasis on overall systems monitoring, collaboration and coordination across the various components of the system—the three previous divisions were combined under a single Division and Division Chief, plus the Office of Community Services.

Mental Health Services
With the closing in recent years of all County-operated outpatient clinics—the last ones closed at the end of 2012—and the closing in 2012 of all DMH Continuing Day Treatment programs, the vast majority of mental health services in Dutchess County are now provided by community-based not-for-profit agencies under contract arrangements with the County. Only a handful of direct services remain under the direct auspices and provision of the County Department of Mental Hygiene. The network of current mental health services is outlined below.
Direct In-House Services

The following mental health services continue to be provided directly by DMH staff:

**HELPLINE**

For many county residents, this 24/7 telephone operation is the entry point to the overall mental hygiene system. The service provides telephone counseling, information and referral, crisis intervention and suicide prevention. In 2012, HELPLINE responded to just fewer than 25,000 calls, about 40% of which were categorized as crisis calls. In 2013, those numbers declined to about 23,275 calls, but those included about a 5% increase in the number of crisis intervention services (almost 11,500). HELPLINE also provides centralized pre-intake and scheduling of appointments with providers around the clock. HELPLINE has 2014 staffing of 6 authorized positions (5.16 FTEs, including the administrator), with primary coverage on the day shift, and typically 1 or 2 persons covering the evening and overnight shifts. The 2014 budgeted positions are unchanged from 2013. In addition to the budgeted positions, as noted earlier, HELPLINE also receives services from 3.7 temporary professional and paraprofessional FTEs who help answer phone calls, and an additional temporary FTE who works in the HELPLINE Texting for Teens program.

The program currently operates at the core DMH administration building at 230 North Road in Poughkeepsie. This location has proved problematic in the past, with occasional flooding in its offices, and perceived vulnerability of single staff on duty overnight and on weekend shifts. The most recent flooding event in the fall of 2013 resulted in mold forming in walls of the room housing the HELPLINE and MCIT staff. Remediation is planned and a temporary relocation of the operation to the second floor board room is scheduled during the remediation process. Discussions have been occurring concerning the potential co-location of the operation with the County’s 911 operation. This issue is discussed further in the options and recommendations chapters of this report.

HELPLINE’s approved budget in 2014 was almost $922,000, up somewhat from about $892,000 in the amended 2013 DMH budget. More than $868,500 (94%) of the total HELPLINE budget in 2014 was to be funded by County taxes.

**Mobile Crisis Intervention Team**

In order to help compensate for the implications of the State’s closure of the Hudson River Psychiatric Center in 2012, the Dutchess County DMH received an ongoing commitment of $1.5 million a year in new revenues from the State Office of Mental Health to enhance local service programming, including expansion of overall diversion services. Chief
among these service enhancements was the implementation on April 1, 2012 of a new Mobile Crisis Intervention Team (MCIT). Operating 7 days a week, MCIT is designed to intervene with individuals in crisis in the community, to help reduce psychiatric hospitalizations and emergency department visits, as well as to provide supports in the community to help those discharged from an inpatient psychiatric admission or an emergency department contact to re-engage with family and local mental health and chemical dependency services as needed. MCIT works closely with HELPLINE, from which it receives many referrals, and with law enforcement and other community agencies.

One aspect of the MCIT initiative is its pre-trial diversion component, which links defendants in the criminal justice system with severe and persistent mental illness to services making it possible for the defendant to be released to the community, thereby avoiding jail time or reducing the length of stay in the jail.

Eleven positions are budgeted for the expanded diversion program in 2014, made possible by the additional OMH funding. Included within those totals are the positions allocated to MCIT, which includes a senior supervising social worker, a licensed mental health counselor, a registered community mental health nurse, three community mental health aides and a paraprofessional. In addition, two systems advocates were added to work with the discharge planning coordinator at St. Francis Hospital to enhance planned discharges to help facilitate engagement with community treatment and support services, and thereby to help reduce hospital lengths of stay. The systems advocates also work with Hudson Valley Mental Health clinics to provide support with their clients. In addition, two temporary paraprofessional FTEs work in discharge planning.

In its first year of operation (April 2012 – March 2013) the program responded to 635 referrals. Program statistics indicate that those referrals resulted in the prevention of 64 emergency room visits and 76 hospital admissions, the diversion of 62 persons from the criminal justice/courts systems, and 254 fewer inpatient psychiatric hospital admissions (a 13.5% reduction from the previous 12 months). This included a reduction of 168 admissions at St. Francis (-14.5%) and 86 fewer out-of-county psychiatric admissions (-11.7%). In the program’s first full calendar year of operation, in 2013, MCIT served 778 individuals, with a 37% increase in numbers of persons served per month between 2012 and 2013.

The total budget for the DMH diversion program, including but not limited to the MCIT program and not including diversion contract agencies, increased in 2014 to $1.577 million, up from $1.293 million in the 2013 amended budget. An additional $596,000 was budgeted for diversion contract agencies in 2014, down from about $740,000 the year before. All of the costs of this diversion program, both in-house and
contracted services, are covered by state aid, with no County funds involved.

**Partial Hospital Program**

The Partial Hospital Program (PHP) located at 230 North Road has been in place as a DMH program for a number of years, but was enhanced in 2012 by a close linkage with the MCIT and the addition of two new staff: a systems advocate and a PEOPLe peer specialist working closely with the program to help individuals develop skills to better manage their symptoms while living in the community. PHP’s goal is to help prevent inpatient admissions and to help individuals return to the community in a supportive environment upon discharge from an inpatient admission.

The program’s intensive, short-term (typically two weeks or less) outpatient day treatment is more concentrated than more traditional outpatient services and is credited with helping MCIT reduce hospital and ED admissions in its first year of existence, as MCIT made 51 referrals to PHP during that period. Overall PHP admissions increased 32% in the first year of the enhanced diversion initiative, contributing to the resulting improved outcomes referenced above, and numbers served by the program per month increased 17% between 2012 and 2013.

PHP staff has declined in recent years, from 14 authorized positions (13.2 FTEs) in 2010 to 10 authorized positions in the 2013 and 2014 budgets (9.1 FTEs in 2014, down .6 FTE from 2013).

The PHP approved budget in 2014 was $1.143 million, similar to the 2013 amount and up from $1.098 million in 2012. Two-thirds of the cost of operating the program are underwritten by the County (about $769,000 in 2014), with most of the remaining revenues provided by patient and other fees.

**Trauma Team**

Less a formal program than a group of clinical administrators trained to handle crises and traumatic events, this team of eight senior clinicians with other administrative responsibilities has the flexibility and training to respond immediately to such emergency situations as serious accidents, disasters, hostage situations, or other personal or public traumatic events. The team is trained in crisis counseling and provides emotional and psychological supports as appropriate. Trauma Team costs is not broken out separately in the DMH budget.

**Systems Advocacy**

Four mental health workers help individuals engage with treatment services they need to address their respective physical and behavioral
health issues. Whether working with the discharge planner at St. Francis Hospital or working in mental health and substance abuse clinics provided by Hudson Valley Mental Health and Lexington Center for Recovery, systems advocates assess patient needs for treatment, housing/residential support, medications and other health related issues, and assist in placing the individuals with the most appropriate outpatient services. More than 650 patients were served by the systems advocates in 2012. Systems advocacy costs are not broken out separately in the DMH budget.

**Contract Services and External Partnerships**
A growing variety of non-profit agencies has stepped up to provide a robust, wide range of services in response to Dutchess County decisions to reduce the County DMH footprint of direct mental health service provision in recent years. These contracted services focus primarily on replacements for outpatient clinic, continuing day treatment and case management services previously provided directly by DMH staff. These contracted services are now monitored by DMH staff as part of its Local Governmental Unit (LGU) function.

**Hudson Valley Mental Health – Outpatient Mental Health Clinics**
The Department of Mental Hygiene began to disengage from the direct provision of Mental Hygiene Law Article 31 adult outpatient mental health clinics in the late 1990s. Since 2006, Hudson Valley Mental Health (HVMH) has been responsible for providing core services in the five clinics previously operated by the County. Beginning in 2013, HVMH began to accept additional patients previously served by DMH’s Mansion Street and Hedgewood Mental Health Clinics, which closed at the end of 2012.

**Occupations, Inc. – PROS Programs**
For years the Department of Mental Hygiene provided Continuing Day Treatment services (in four centers at one point, and then reduced to three). In March 2012 these centers were closed as part of the State Office of Mental Health’s decision to discontinue CDT programs and shift the focus to Personalized Recovery-Oriented Services (PROS).

The three centers previously offering CDT programming under the County reopened as PROS programs operated by Occupations, Inc. (OI), under contract with Dutchess County. These programs opened April 1, 2012, just after the CDT programs officially closed. PROS programs offer an array of rehabilitation and recovery services to assist those with mental illness in acquiring and maintaining skills and supports needed to live as independently as possible in their communities. The program typically places more responsibility on the program participant than did the previous CDT programs. While most agree with the PROS goals of
helping move people toward greater independence and integration into society, many question whether all of those previously in CDT programs were sufficiently ready for the transfer to and demands imposed by PROS, and others have raised questions concerning whether current staffing patterns are sufficient to meet the greater demands of the PROS program on its participants.

**Mental Health America of Dutchess County – Case Management and PROS Program**

Mental Health America (MHA) began in 2003 to provide case management services for county residents, under contract with Dutchess County, which had previously provided the services directly with DMH staff. MHA provides an array of generic, blended, supportive and intensive case management services. In addition, MHA is becoming the primary provider of care management services for those enrolled in the evolving health homes in the county.

As part of the transition from Continuing Day Treatment to PROS programs referenced above, a new PROS program was opened in Beacon in early 2012 by MHA.

MHA also provides a variety of additional services: e.g., to those with mental illness and/or substance abuse who are also homeless or at risk of homelessness; a variety of family support, respite, compeer and advocacy services to families dealing with mental illness; and various community education programs.

**Astor Services for Children and Families**

From the early stages of the evolution of the Department of Mental Hygiene, DMH has never provided extensive direct services to children and youth, as children’s services have largely been provided under the auspices of the Astor Home for Children, under contract with Dutchess County. The County DMH has played a significant role in planning, advocacy and coordination of children’s and youth services, but Astor has continued over the years to be the primary provider of a wide range of services to children and families in sites scattered throughout the county.

These programs include counseling provided in several centers; a variety of day treatment, pre-school, case management, and home-based crisis intervention services; adolescent partial hospital program; as well as forensic Family Court evaluations to help reduce residential placements for children with emotional difficulties. Astor also serves the Department of Health’s Early Intervention and Preschool Special Education programs.
Gateway Community Industries – Vocational and Residential Supports

Dutchess County contracts with Gateway to provide a community residence and other housing supports, along with vocational supports for individuals with psychiatric and alcohol/substance abuse issues.

PEOPLE, Inc. – Peer-run Support Services

PEOPLE, Inc. (Projects to Empower and Organize the Psychiatrically Labeled, Inc.) provides peer-run support services to help those with mental illness transition to mental wellness by enhancing their sense of hope and self-determination, and helping them achieve housing and employment goals.

PEOPLE has also been instrumental in the Imagine Dutchess project focusing on redesign of the County’s health and behavioral health systems (see further discussion below).

Rehabilitation Support Services, Inc. – Rehab, Housing and Vocational Services

One of DMH’s largest contracts has historically been with Rehab Support Services, Inc. (RSS). RSS provides a continuum of housing opportunities for those with mental health, substance abuse and developmental disabilities throughout the county. In addition, RSS offers case management and a variety of vocational training and services, such as job training and coaching supports, including follow-up employment placement support, via operation of the Dutch Treat Café.

Hudson River Housing

Hudson River Housing (HRH) offers 15 units of transitional housing at its Hillcrest House for adults with chronic, serious and persistent mental illness. It also offers various other supportive housing opportunities in the least restrictive settings possible for those with various special needs.

Affiliate/Coordinated Services

Although neither a direct County service nor a provider with a contract arrangement with the Department of Mental Hygiene, St. Francis Hospital is clearly closely affiliated with DMH and is a crucial provider of mental health services to the community.

St. Francis Hospital

St. Francis Hospital (SFH) plays an especially crucial role in the provision of inpatient psychiatric services in Dutchess County, given the closure of the Hudson River Psychiatric Center in 2012. SFH is currently the only
Mental Hygiene Law Article 9, Section 39 provider of acute, inpatient care for adults, with 40 beds available, and provides emergency psychiatric assessment for adults, children and adolescents. The hospital also offers 60 other beds for substance abuse services, including 50 rehabilitation beds and 10 dedicated to detox services. Although St. Francis closed its adolescent inpatient mental health unit in 2009, it has maintained an intensive outpatient clinic for adolescents.

St. Francis is also critical to the Department of Health, serving the Early Intervention and Preschool Special Education Programs. St. Francis is the only service provider in the community that offers services for hearing impaired children.

Given SFH’s integral role in the network of health and mental health services in Dutchess County, the recent filing for bankruptcy by the hospital sent shock waves through the community. Its closing would create a critical void in the local health service network, which will hopefully be staved off through purchase of the facility. Health Quest has already put in one bid to purchase the assets of St. Francis, and Westchester Medical Center of Valhalla and ArchCare connected with the Archdiocese of New York have also filed petitions with the bankruptcy court indicating interest to develop bids for the St. Francis assets. Representatives at St. Francis reported to CGR that New York State DOH, OMH, OASAS and OPWDD will be part of the review of the purchase of the facility and all have expressed that any purchase must include a commitment to maintain the hospital’s status as the “9.39” emergency psychiatric hospital within the community. At the writing of this report, indications are that Westchester Medical Center will become the new operator of the facility. The future impact of this development is uncertain.

**Chemical Dependency Services**

The array of chemical dependency services offered within Dutchess County, under the overall supervision and oversight of the Division of Clinical Services, has remained relatively stable in recent years, unlike the shifts in service provision that have occurred in the past two years within mental health and developmental disabilities services.

The chemical dependency services available to county residents are provided to individuals dealing with alcoholism and other forms of substance abuse/chemical dependencies. The County operates one primary direct program, ITAP (described immediately below), in addition to operating important forensic and jail-based services, which are summarized under the Coordinated Services section later in this chapter. Other chemical dependency services are provided by agencies under contract with the County. The range of services and program
responsibilities, both internal and external, is described in more detail below.

**Direct In-House Services**

Following the transition of chemical dependency outpatient clinic services in the late 1990s from the County to the non-profit sector, DMH direct in-house chemical dependency services have focused primarily on services linked closely to criminal justice/jail forensics and assessments, and the ITAP treatment program which also focuses primarily on persons involved with the criminal justice system.

**Intensive Treatment Alternatives Program (ITAP)**

Other than forensic and jail-related services described later under Coordinated Services, ITAP remains the only chemical dependency program operated directly by DMH staff. An alternative-to-incarceration program, ITAP is a state-licensed outpatient day rehabilitation program providing alcohol and substance abuse services for chemically-dependent persons needing more structured, intensive long-term treatment than can be provided in a clinic setting. Persons are referred to the program from various sectors of the criminal justice system, and participants are served by ITAP staff as well as by an ITAP Probation officer assigned to the program. Most program enrollees attend the program while also residing in a supervised community residence. About two-thirds of those in ITAP have a co-occurring mental health diagnosis. A growing number of those in the program are young adults with a primary substance abuse diagnosis of opiate usage (45% of those in the program in 2012 were between 18 and 24 with such a diagnosis).

Since the mid-2000s, the ITAP day rehab program has typically served a fluctuating number of people, ranging between about 115 and 135 persons per year, including 129 in 2013. ITAP’s related CD Clinic component typically served between 50 and 55 a year through 2011, before dropping to 41 each of the last two years. The third component of the ITAP program, the Transitions Treatment program, has steadily declined from serving 60 in its first year of operation in 2010 to about 15 per year in 2012 and 2013.

Numbers in this program may increase with the increase in opiate/heroin usage, which the County Department of Health has identified as a growing public health issue. The State Department of Health lists substance abuse among its top public health priorities in the context of its 2013-2017 Prevention Agenda.

The ITAP is staffed by an administrator plus five primary clinicians (two social workers and three CASACs), a nurse, a shared social worker, a Probation officer funded through Probation, one-third FTE nurse
practitioner, and .5 FTE temporary vocational counselor (at one point the program had three FTE vocational counselors).

The ITAP/Alcohol Addiction Control approved budget for 2014, $1.531 million, was about at the same level as in 2012. About 72% of the program’s costs are covered by participant and other fees, about 9% by state aid, and just under 20% (about $300,000) of the costs are funded by County taxes (about $225,000 less than the amended budget 2013 subsidy.

**Contract Services**

Other than services provided through the jail and criminal justice system, the bulk of the services provided through the DMH chemical dependency service network are provided by a handful of non-profit community-based agencies. Most of the services are provided in outpatient chemical dependency clinics. Until the late 1990s, all chemical dependency clinics in Dutchess County were provided directly by DMH, which subsequently oversaw the transition of the clinics to the non-profit sector. The County’s outpatient chemical dependency clinics were initially closed in 1998 with St. Francis Hospital filling the gap, and then Lexington Center for Recovery (LCR) adding more services in 2003.

**Lexington Center for Recovery – Outpatient Chemical Dependency Clinics**

Lexington Center for Recovery (LCR) has one of the largest DMH contracts—for the provision of outpatient clinic services. It currently operates six clinics serving adults, adolescents and families dealing with chemical dependency issues, including many with co-occurring disorders (dually diagnosed with substance abuse and mental illness). Services include individual, group and family therapy. In addition, LCR provides individual and group therapy to adolescents in a seventh setting, a secure Department of Children, Youth and Families residential facility. It also offers services for persons living in community sober residences.

LCR also operates a Methadone maintenance and rehabilitation program offering comprehensive treatment and counseling services (including vocational, educational and counseling services) for those addicted to opiates.

**Mid-Hudson Addiction Recovery Centers (MARC)**

DMH contracts with MARC to operate a licensed chemical dependency crisis center in Poughkeepsie and three licensed community residences. MARC services include short-term housing, counseling and support services for those under the influence of various substances who do not need hospitalization, and non-intoxicated persons at risk of relapse.
**Council on Addiction Prevention and Education (CAPE)**

Since the late 1980s the County has contracted with the Council on Addiction Prevention and Education to provide evidence-based prevention, education and counseling services to help reduce substance abuse among adolescents. Services include individual, family and group counseling sessions as well as educational presentations and information and referral services.

**Developmental Disability Services**

DMH coordinates services for people of any age with a range of developmental disabilities. Until the end of 2012, the Department was responsible for the operation of one in-house unit (the outpatient Clinic for the Multi-Disabled, which closed at the end of 2012), as well as for coordinating many relationships with contract and affiliated agencies that provide a range of services including vocational training and placements; clinical services; recreation opportunities; residential services; and case management.

This is by far the smallest of the three service-providing and coordinating units within the Department’s Division of Clinical Services, in large part a function of history. The region around and including Dutchess County historically housed large institutions for the developmentally disabled. As de-institutionalization occurred, the state encouraged the development of a number of community-based programs and regional Developmental Disabilities Service Organizations (DDSOs). Thus there was less need for direct County services for the Developmental Disabilities population than has been the case in Mental Health and Chemical Dependency.

Although there are fewer in-house programs and contract agencies to monitor within DD than in the other two service areas, there is considerable coordination, oversight, advocacy and planning needed with state, regional and local officials and bodies.

**Direct In-House Services**

With the closing at the end of 2012 of the County-operated Clinic for the Multi-Disabled (CMD), DMH no longer provides any direct in-house services for people with developmental disabilities. The clinic had previously provided outpatient mental health treatment services to developmentally disabled persons 15 and older who were also mentally ill and/or chemically dependent. As the CMD was closing, plans were made to accommodate those served through private therapists and various community agencies, most particularly ARC of Dutchess County.

**Contract Services**

In the absence of the Clinic for the Multi-Disabled, which had previously served more than 450 persons a year, the majority of county residents with
developmental disabilities are now served by community-based providers contracted with by Dutchess County.

**Abilities First – Vocational and Related Supports**

Abilities First (AF) provides a variety of vocational counseling and training, skills development, sheltered workshop and other vocational supports for those with developmental disabilities of all ages. Day treatment and residential services are also provided by the organization.

**Dutchess ARC – Multiple Services**

Dutchess ARC (Advocacy, Respect, Community) provides persons with developmental disabilities and their families a variety of services related to vocational, clinical and residential opportunities. It also provides consultation and service coordination for those who need help navigating the developmental disabilities service system.

With the closing of the Clinic for the Multi-Disabled, Dutchess ARC has expanded its clinic services to accommodate those affected by the clinic closing. It is now providing psychiatric services to many who lost services with the CMD closing, helping to ensure that they would receive continuity of care. The numbers of people served by ARC in future years should as a result be significantly higher than the historical totals served.

**Affiliate/Coordinated Services**

Although neither a direct County service nor a provider with a contract arrangement with the Department of Mental Hygiene, Taconic Developmental Disabilities Regional Office is clearly closely affiliated with DMH and is a crucial provider and coordinator of developmental disability services in the community.

**Taconic DDRO**

Staff of the Taconic DDRO, the regional office of the state Office of People with Developmental Disabilities, provide direct services, help with community placements, and help plan and coordinate services throughout the community. The Taconic Day Treatment program works with people in the DDRO’s various facilities and community residential alternatives.

**Coordinated Services**

In addition to the range of services described above which are directly provided or overseen and coordinated by the DMH, a variety of additional services are described by DMH as Coordinated Services. In one form or another, they involve significant coordination with systems beyond the mental hygiene system. In some cases the focus is primarily on coordination rather than direct service provision; in the case of jail and
forensic services, the focus is on both cross-system coordination and direct service provision.

**Assisted Outpatient Treatment (AOT) Program**

The AOT Program, otherwise known as Kendra’s Law, is mandated by New York State as part of the Mental Hygiene Law. It is aimed at mentally ill individuals who are not likely to survive safely in the community without supervision, based on their previous history and circumstances. Coordination of services and obtaining court orders where necessary to link residents to appropriate outpatient treatment is the responsibility of the Department and its AOT Coordinator (the Coordinator provides this service in conjunction with other responsibilities, such as also coordinating housing services). Thirty AOT investigations were initiated in 2012. MHA provides the case management for these individuals, involving the monitoring of compliance with court-mandated medications.

**Housing Coordination**

Shortages of housing are frequently mentioned as a significant service gap for those in the mental health, substance abuse and developmental disabilities systems. As stated in the Dutchess County DMH 2012 Annual Report, “The development and preservation of a full continuum of residential housing options for those with mental illness [and chemical dependency and developmental disabilities] is a priority for Dutchess County.” (p. 55)

The Housing Coordinator (formerly two positions were involved in this work, now shared with the AOT Coordinator) is responsible for assessing housing needs and contracts, advocating for those with mental illness, working to expand housing opportunities throughout the community, overseeing the single point of entry (SPOE) system offering centralized access to various community living options in the mental hygiene housing sector, and serving as a resource for housing providers and developers. The Coordinator reviews applications for housing and coordinates with appropriate agencies based on the needs for specific levels of housing. The Coordinator also plays a key role with the Dutchess County Housing Consortium, a group of government and community leaders working to address the needs of those who are homeless or at risk of homelessness. As such, the Coordinator plays a larger community role which goes well beyond the mental hygiene function and therefore helps provide an additional community return on the County’s and Department’s investment in this position.
Children and Youth Coordination

A Children’s Services Coordinator is responsible for the oversight of all system-wide services for children and youth. This involves coordination across a variety of services and systems that affect young children, adolescents and their families—e.g., mental health, substance abuse, disabilities, education, social services, juvenile and criminal justice and family support services. This coordination also involves the monitoring of contracts between DMH and contract agencies, including the major provider of services for children and youth—Astor Services for Children and Families (described above).

Forensic Services Coordination and Assessments

The Forensic Assessment Services (FAS) program is provided directly by DMH in-house staff. It is designed to provide a comprehensive mental health/substance abuse/criminal justice assessment for individuals involved in the criminal justice system, with the goal of getting defendants into treatment where warranted rather than being incarcerated. Referrals are received from judges, courts and offices throughout the criminal justice system. Based on staff assessments, recommendations are made to the appropriate court for judicial action.

Based on OMH data, the forensics unit continued to expand the numbers of referrals for assessments through 2011, before declining significantly in 2012. It went from 318 referrals in 2004 to 639 in 2007, and continued to increase its numbers to 858 in 2011, before declining to 563 in 2012 (with 457 completed evaluations) and back up to 651 (with 503 evaluations) in 2013 (it is not clear from the data if different ways of measuring the contacts might have been used in earlier years). The Forensics unit is staffed by a supervisor and two other staff, along with a 0.5 FTE psychologist assigned to Family Court. Evaluations were previously done by four staff, and now are completed by three. This reduction in staff may in turn be related to the smaller numbers of assessments the past two years, and to concerns expressed about longer waits to schedule appointments and complete evaluations.

In addition to its work for the courts, the Forensics unit also works closely with the County Department of Community and Family Services to meet the goals of the welfare-to-work program. It provides an assessment of individuals applying for public assistance, Medicaid and related programs to determine their ability to work or qualify for treatment. Two staff funded through the DCFS budget work with the Forensics unit to carry out these assessments (about 1,300 or more in each of the past two years).

The approved 2014 County budget appropriates almost $550,000 for forensic services, with portions reflected in the Alcohol Addiction Control
and Coordinated Services budget lines. There is no offsetting external revenue lines for these services, which are 100% paid for by County tax dollars. In addition, the 2014 County DMH budget allocates $697,000 from local tax dollars for Court Remands, which represents the State-mandated local 50% share of the costs for hospitalization in State facilities as a result of court orders for individuals in the criminal justice system that are ruled unable to participate in legal proceedings because of mental disabilities.

**Jail-Based Initiative**

These services, provided in collaboration with the Sheriff’s Department, are targeted at incarcerated individuals and provide assessment and pre-and post-release planning and linkages to treatment services and community resources for inmates with mental illness and/or chemical dependency issues. Inmates are referred to the program based on medical and corrections officer assessments when they enter jail and/or as they begin to approach release from the jail. The jail team, working with Correctional Medical Care (medical care provider on contract with the jail), works to facilitate an inmate’s transition out of jail and into the community, especially to ensure that individuals are set up with any needed treatment in place once they are released.

The unit served 323 jail inmates in 2007, about double the number served in 2005. The number served jumped significantly to 493 in 2010, before declining to 434 in 2011, 333 in 2012, and 277 in 2013, below the 2007 level.

The DMH jail-based staff team is composed of a Unit Administrator and four staff members (a Chemical Dependency Counselor, two social worker/case managers, and an activity therapy aide). The total budget for this service is about $612,000, all covered within the Coordinated Services line. About $146,000 of this amount is covered by an OMH grant and contract revenue from DCFS, with the remaining almost $466,000 the net County cost (about 76% of the total program budget).

**Community Consultation and Education**

The Director of the Office of Community Services is responsible for the Department’s provision of consultation, training and staff development education for the entire mental hygiene system. Beyond that, much of the education and training focus extends well beyond the DMH in-house staff and staff of contract agencies to also include key staff in the education system, domestic violence programs, key stakeholders in the criminal and juvenile justice systems, emergency first responders, DCFS staff involved in child and protective services, healthcare providers, etc. DMH staff provide much of the training directly, as well as making use of train-the-trainer approaches, coordination of training and development efforts.
provided by others in the system, and coordination of outside speakers and availability of various training and development opportunities on-line.

The importance of this training focus—particularly the train-the-trainer approach—is likely to be heightened during 2014 and 2015 as a result of a priority focus within DMH to implement a countywide Mental Health First Aid program. With $700,000 in one-time state funding over two years, the Department will be responsible for working with community partners as part of a national emphasis to develop best practices to increase physical and behavioral health awareness and wellness through increased focus on prevention. First aid is a key part of that prevention focus, through helping people throughout the community be better able to identify and respond to signs and symptoms and understand the key questions to ask in certain situations, focused particularly on mental health and substance abuse. The state funding will help create staffing to initially train 30 people in the train-the-trainer approach, reaching key DMH staff, faith-based groups, community-based organizations, schools, law enforcement personnel, etc. Focus will include anti-violence and anti-bullying messages and approaches to use. Once the initial groups are trained, they will reach out to other key community stakeholders. This effort will represent a major priority of DMH over the next two years, with anticipated benefits well into the future.

This community training and awareness role may provide opportunities for closer linkages with the broad Prevention Agenda 2013-2017 of the State Department of Health, with a variety of opportunities for cross-training and other types of collaboration between DMH and DOH.

**County Executive’s Health and Human Services Advisory Team**

In his 2012 State of the County address, County Executive Molinaro announced the creation of a Health and Human Services Advisory Team charged with providing an external independent assessment of issues related to the mental hygiene services delivery system and the development of diversion services. Two reports issued by the Team, in 2012 and 2013, emphasized, among other things, the need for a more holistic, integrated approach to service delivery; more collaboration between physical and mental health and the departments they represent; more focus on data-driven decision-making and the creation of better outcome measures to help make that possible; and a focus on more integrated prevention and early intervention approaches. The Team

19 Dutchess County Health and Human Services Advisory Team, *Interim Report to the County Executive*, April 1, 2012 and *Update to the County Executive*, February 28, 2013.
emphasized the need to build on the significant strengths of the existing system while creating a more community-based collaborative effort linking DMH, community stakeholders and representatives of the public and physical healthcare system.

One of the recommendations from the Advisory Team was to strengthen community support for the emerging Imagine Dutchess initiative. Imagine Dutchess describes itself as an asset-based community development project aimed at transforming how the healthcare system in Dutchess County serves people with mental illness and addiction so that it better supports their recovery and wellness. As described in its website, integrated, coordinated care should replace the common cycle of crisis intervention, hospitalization, homelessness and incarceration.

**Administrative Operations**

The previously-separate Division of Support Services and Offices of Budget and Finance and of Information Technology were combined in 2009 into one overall new comprehensive Division of Administrative Operations within DMH. This internal merger was consistent with the recent combining of the former separate divisions of mental health, chemical dependency and developmental disabilities services—along with the separate Office of Community Services—into one overall Division of Clinical Services, as indicated above.

This new Division of Administrative Operations provides department-wide administrative and technical support for such functions as billing and collections, budget and finance, buildings and grounds, contract information, information technology, purchasing, personnel and clerical support. As with the Division of Clinical Services, this Division is headed by a Division Chief.

DMH budget line 4310 is labeled Central Administration and primarily includes the positions that carry out the functions of the Division of Administrative Operations. Analysis of staffing patterns and trends within this Division is complicated by the fact that the budget line also includes the following high-level administrative positions not included within the Division: the DMH Commissioner, Clinical Chief, two directors and a nursing supervisor. Not counting these, the remaining positions assigned to the Division of Administrative Operations appear to be 23 FTEs, a sharp reduction from 36.5 FTEs as recently as 2009. See the broader discussion of staffing trends for this and other departmental functions in the Staffing section earlier in this chapter.

The following sections briefly describe the functions within the Division of Administrative Operations:
Budget and Finance
The Budget and Finance office is responsible for working with the Commissioner and Department’s Executive Council to prepare and monitor annual departmental budgets, including developing and tracking of spending and revenue projections for the Department—a difficult task made even more so in the context of the numerous policy, service configuration and funding environmental changes impacting on mental hygiene services, and County pressures to contain costs and limit County subsidies for the Department and the system it oversees.

Additional major responsibilities of the Office of Budget and Finance include: annual preparation of the Consolidated Fiscal Report (CFR); recording payroll and other payables and submitting those for payment by the County finance department; overseeing the money aspects of agency contracts; processing of vouchers; monitoring revenues against budgeted income and expenses; preparation of various federal and state aid claims; fiscal reporting and payments. To accomplish these tasks, the Budget Director supervises a staff of four other professionals (down from a budget staff of seven, including the Director, several years ago).

Among the issues facing this office is the continuing pressure to control costs and to limit the degree of County subsidies needed to maintain an effective mental hygiene system. An additional immediate issue being addressed by DMH and the Budget office at the time of this report is supporting the Department of Health’s vacant Budget and Finance Director Position. The DMH Budget and Finance Director will be spending a portion of her time in the early months of 2014 also serving as part-time interim budget director of the Department of Health.

Billing and Collections
The responsibilities of the Billing and Collections unit include maximizing revenues for client services by generating and submitting bills for services to Medicaid, Medicare, other third-party insurers and self-pay clients. The unit faces the constant challenge of keeping up with changes in programs and related payment mechanisms to cover service costs. For example, if more people receiving mental health services are covered by insurance in the future; increased time may be needed by the billing staff to work with insurance companies for pre-approval. But up to now, as a result of the closure of the DMH-operated clinics and of the CDT program, billing responsibilities have been reduced, leading to a reduction in the size of the billing unit from five to three in 2012. One of these positions is budgeted to ITAP with primary responsibilities for billing related to that program, and another is budgeted to and primarily responsible for billing for Partial Hospitalization. The Billing Manager oversees both and manages the unit. Thus far claims appear to continue to be processed for payment in a timely manner, despite the changes in staffing patterns.
Information Technology
The Information Technology (IT) office is broadly responsible for the support, installation, maintenance and training related to DMH’s computer communications system and any related computer-based applications. IT also operates to some extent as the research arm of the Department, monitoring patient satisfaction surveys and analyzing a range of data concerning performance, productivity and outcome measures related to internal and external programs and services.

Several years ago the Department purchased software from the Cerner Corporation (formerly Anasazi), designed to provide DMH with an integrated clinical, financial and billing system which would create staff efficiencies throughout the Department. Since its introduction, a great deal of energy and resources within IT have been devoted to customizing, implementing, and troubleshooting the system, along with related staff training and orientation, in order to address changes in the software and in billing and tracking procedures needed to meet frequent changes in service delivery and revenue generating processes. IT’s role in all this is complicated by the fact that not all of the contract agencies use the Cerner system in consistent ways, and some don’t use it at all, so IT must work around a variety of approaches for inputting and processing data from various providers.

Though most contracted agencies use the Cerner software, many still maintain data on other proprietary platforms. There is no requirement for what software to use, and neither the State nor County has mandated a particular platform for all agencies. The largest downside to this is the inability to seamlessly gather and share information for the purpose of tracking outcomes from interventions. This lack of coordinated data inhibits reporting and monitoring for County leaders and represents a hurdle challenging the overall effectiveness of an otherwise robust system.

IT oversees the creation of medical records including assigning unique case numbers to all pre-intakes across the County and all contracted service providers. It prepares the electronic chart for the County and for HVMH, adds the patient to the ePrescribe system, files or destroys completed charts and processes requests for information.

The Director of IT supervises a staff of seven other employees (3 in Medical Records, 3 in Service Reporting, and 1 in Technology), plus a programmer and supervisor from County OCIS. The two OCIS positions do not appear directly on the budget for Mental Hygiene, but DMH reimburses the OCIS for them. The size of this unit has been cut in half (down from 14 five years ago) with the improvements in technology such as moving to virtual servers, greater efficiency in the use of the software, and because as the Department has decreased in staff, the responsibilities placed on the OIT have declined.
Contracts Oversight
As noted above under the Budget and Finance function, the money aspects of contracts between the County and service providers are overseen within this Division of Administrative Operations. The Division also oversees contracts with vendors with which the Department does business. However, ultimately, primary development, oversight and review of contracts involving the provision of services to clients—and monitoring how well those provider agencies meet the goals and objectives of the contracts—are more the purview of the Division of Clinical Services which is responsible for oversight of the respective agencies, and of the Office of Quality Improvement (as discussed in more detail below).

Personnel, Purchasing and Clerical Supports
Employment paperwork, assistance in the development of job specifications, maintenance of personnel records, purchasing and other staff issues are handled through this Division. Issues related to hiring and various changes in personnel status are typically handled by Support Services, usually in collaboration with the appropriate division chief or office director. Various HR/Personnel and purchasing functions are undertaken within this Division, including coordination as needed with County Central Services (Purchasing) and Personnel functions. Support staff within this Division is often able to flex their time and shift responsibilities as needed to provide support through flexible allocation of staff to tasks as needs arise, without being locked into specific rigid assignments.

Moving to an electronic payroll system could yield potential efficiencies of up to 1 FTE. This may allow for a redeployment of staff to either support the existing Budget Director, or other needed clerical supports within the Department. There would be a cost in transitioning to electronic payroll, but it is possible that the one-time cost to purchase the software would be less than the current 1 FTE with benefits, and savings would accrue in future years through the staff reduction or redeployment.

Purchasing is a relatively small part of the overall administrative function and DMH has developed its own small in-house supply of common items such as paper, paperclips and other routine office items. There are likely synergies with the DOH purchasing process as most items are purchased through the County Central Services. The limited supply of office products and other DMH related products does not demand more than .2 FTE.

Finally, funding for staffing dedicated to communications has been reduced, so that the Department’s communications function is now provided somewhat “around the edges” by staff as available, primarily under the guidance of the Director of Diversion and Community Services. The communications function is an important one, involving liaison
between DMH and the public, organizing and providing a variety of public events, promotions and reports for policymakers and the public. Formerly provided by a dedicated staff person, the loss of funding and resources to proactively get preventive or essential service messages into the community detracts from the effectiveness of the Department. This type of function might best be provided in the future by a dedicated staff person again, focusing on shared messages between public and behavioral health functions.

**Emergency Preparedness**

The Director of the Office of Community Services oversees the limited role that DMH has in Emergency Preparedness in the County. The relationship has evolved over many years to the point that currently the Director has a seat at the Emergency Operations Center (EOC) to be present and participate in crisis management for emergency situations that arise in the community. The focus for participation is on how the emergency impacts the population that DMH services either directly or in partnership with the network of community service providers.

In addition to the direct role at the EOC during emergencies, the Director also coordinates mental health related training opportunities for the staff that man the 911 center as well as any volunteers that serve on the Medical Reserve Corp (MRC) for the County. The Director also participates on several committees including the PAC (discussed earlier under the DOH description) and the development of the Emergency Operational Plan. As necessary, the Director will coordinate the use or intervention of the Mobile Crisis Team and the Trauma Team during events that warrant such involvement.

**Psychiatric Coordination**

The Office of Psychiatric Coordination is under the guidance of the Department’s Medical Director who, along with the Nursing Supervisor, is responsible for the management and overall clinical supervision of all psychiatric and nursing services provided throughout the Department and mental hygiene system, including interpreting governmental mandates and regulations affecting the medical and psychiatric aspects of the DMH programs and services. The Director also provides backup as necessary for DMH psychiatrists, and supervises the Department’s Nursing Supervisor, who in turn is responsible for the supervision and training of the Department’s nursing staff. The office also handles issues related to pharmacy and therapeutics, clinical incidents, and court evaluations.

Because of the significant reduction in direct services provided by DMH in recent years, the number of psychiatrists/doctors and nurses needing direct supervision within the Department has also declined to a fraction of what it used to be. The Medical Director position is a half-time
appointment, which includes contract arrangements for medical supervision of clinic services operated by Hudson Valley Mental Health and Lexington Center for Recovery, Inc. Thus salary, time and direct supervision of staff are split between the County and these agencies, although the DMH overall role continues to include some responsibility for oversight of the overall quality of services for the entire system.

**Quality Improvement**

The Office of Quality Improvement (QI) is responsible for all quality improvement, corporate compliance and monitoring of quality improvement measures of both the DMH programs and all contract agencies. The office is headed by a person with the dual titles of Quality Improvement Coordinator and Corporate Compliance Officer, reporting directly to the DMH Commissioner. (In addition, a portion of this person’s time is spent as the Developmental Disability Services Coordinator, reporting in that capacity to the Division Chief for Clinical Services.) She is assisted in her quality improvement roles by a part-time nurse whose primary QI responsibilities involve review of charts and outcomes of contract agencies.

**Corporate Compliance**

Several times a year records are reviewed from each DMH program to identify compliance concerns related to areas of risk involving clinical documentation, especially with regard to billing. Issues are reviewed in the context of the DMH Corporate Compliance Plan, which outlines clear guidelines and standards of conduct and practices to be followed by staff and programs in carrying out various functions and relationships with each other and with clients. The Plan is updated as needed to reflect any important issues that surface from the reviews.

**Patient Care/Utilization Review**

Experienced members of the DMH staff from various disciplines meet twice a month to review randomly-selected patient records to ensure that effective treatment is taking place with appropriate documentation. Appropriateness of the admission and level of care are assessed, and fiscal issues are also monitored. The process monitors chart compliance in DMH in-house programs as well as all clinics and selected other contract agencies. More specifically, the clinical records of four of DMH’s largest contract agencies are regularly reviewed—Hudson Valley Mental Health, Lexington Center for Recovery, Occupations, Inc., and Astor Community-Based Services for Children and Families.

**Review of Performance Indicators: Contract Monitoring**

The Quality Improvement Director is available for consultation with both in-house programs and contract agencies to help develop effective performance outcomes. Periodic reviews monitor results of agency
reports on performance indicators. In addition to reviews of the performance and outcome measures of all programs, both in-house and contract, the Department prepares an “Annual Contract Performance Report” which focuses explicitly on progress made each year against stated targets and projected outcomes for each program and initiative of each of the DMH contract agencies. In general, DMH officials involved in contract review and oversight express concerns about the inconsistency of accountability and use of meaningful outcomes and performance measures across agencies. In addition, CGR’s independent review of the annual contract performance reports and specific measures used suggests that more use is made by contract agencies of process measures of such things as numbers served and “soft” measures of progress such as “connection to community resources” than of harder measures of real outcomes and documented real progress in achieving independence or other indicators of progress, though there are significant exceptions to that overall pattern, and increasing efforts are being made to focus more intentionally on outcome/impact metrics.

Representative examples of “process” metrics used by several contract agencies in 2012 include: attendance, participants screened, connected to community services, received case management service, involvement in an activity, participation in treatment, etc. These process measures typically gave no indication of whether any progress was made once an activity occurred.

Representative examples of “outcome” metrics used by several agencies in 2012 include: participants avoiding hospitalization, remaining in community setting and not requiring residential treatment, discharges to less restrictive setting, discharges with stable housing, discharges with discontinued substance abuse, discharges with reduced substance abuse, discharges with employment, increases in job skills, progress toward self-directed goals, participants with increased social skills, participants feeling less isolated. Many of these outcome measures were admittedly somewhat subjective in interpretation of progress, but they at least were attempting to provide an indication of some sign of progress beyond simple participation.

Using these rough characterizations of process versus outcome metrics, CGR examined the metrics stated in the contracts for 14 contract agencies in 2011 and 2012. The total number of process measures exceeded the number of outcome measures in both years, with the number of outcome measures declining considerably in 2012, compared to the previous year. Process measures were relatively unchanged in both years (134 in 2011 and 128 in 2012), while the number of outcome measures reflected in agency contracts declined from 127 in 2011 to 97 in 2012. As a proportion of total measures/metrics mentioned in contracts, outcome measures declined from 49% in 2011 to 43% in 2012.
Based on interpretations of whether the stated objectives were successfully met, success on process measures increased from 76% in 2011 to 84% in 2012, while successful achievement of outcome measures declined from 77% in 2011 to 73% in 2012.

CGR’s overview of the metrics used by the agencies, while admittedly not an in-depth review, tends to confirm the observations of several DMH officials that DMH and contract agencies need to collaborate more effectively in the development of more robust measures of program impact or outcomes, in order to better ensure the most cost-effective public expenditure of resources in the future.

**Facilities, Buildings and Grounds**

With the closure of several programs, the footprint of the Department has declined significantly. The main operation is housed at the facility on 230 North Road and the ITAP program is less than 2 miles away at a building on 82 Washington Street.

The Administration for the Department is primarily contained on the second floor of the North Road facility. Much of the first floor of the North Road building has been leased to other contracted agencies, including HVMH and Lexington, but the County still maintains the Partial Hospitalization Program, HELPLINE, AOT, Housing and other Coordinated Care programs, on part of the first floor. There is a large shared space in part of the first floor as well as a kitchen that is contracted out to an agency and provides daily meals for staff and caters some programs. Adjacent to this are some large classrooms, some of which are in use by Abilities First and at least one that is currently not in use on a regular basis. The OIT staff occupies a large office on the first floor, though the staff has declined over the last five years. Abilities First Inc. operates the other major first floor space for their programs to children with disabilities.

The facility at 82 Washington Street houses a large sitting room for group meetings, and has an open kitchen/dining area in the middle of its layout. The rest of the first floor is carved into offices and group meeting rooms for all the ITAP and Forensics staff.

After observing the location at 230 North Road where the Abilities First programs are in such close proximity to Lexington Center’s Methadone Clinic and other adult treatment programs run by the County and HVMH, CGR understands why some people expressed concerns about having these programs so close to one another. The facility is suitable for both programs, but the nature of the programs and the clientele does make it difficult to insure safety, and co-location may not be a good long term solution.
The building at 230 North Road is aging and there are concerns about asbestos and flooding that put staff and clients at risk. Certain classrooms were considered unsafe for use by the Abilities First leadership, leading to underutilized space within the facility. The flood in the fall of 2013 put HELPLINE in jeopardy and has since led to a mold infestation that will require remediation and a relocation of HELPLINE and MCIT during the process. HELPLINE will move to the second floor boardroom while MCIT will move to an open office in the A-Wing.

Buildings and Grounds functions are overseen by the Division Chief. Daily buildings issues are generally handled by Unit Administrators or other key staff in individual facilities, with major decisions involving, for example, major expenditures, referred to the Division Chief. Coordination may also be needed with the County Department of Public Works if County properties are involved.

**Overview of Strengths, Weaknesses, Opportunities and Threats to the Mental Hygiene System**

Based on our current understanding, we offer the following overall summary comments about the current status of the mental hygiene system, in no particular order of priority.

**Extensive Array of Services**

Between the services provided directly by the Department (via County employees), those services provided on a contractual basis between the County and various non-profit agencies, and those provided via various affiliate agencies with broad coordination with the Department, Dutchess County offers an impressive array of mental hygiene services across Mental Health, Chemical Dependency and Developmental Disabilities disciplines and service structures. Other counties may exceed DMH’s offerings for some selected services, but taken as a whole, our experience suggests that few can surpass Dutchess in its overall mix of available service offerings.

**Availability and Accessibility of Services**

DMH has made conscious decisions over the years to decentralize service provision (both in-house and contracted services) by offering services in numerous locations designed to make it as easy as possible for residents in all sectors of this large county to access services (see map with service locations on next page). In some cases, services are co-located, creating both efficiencies and ease of access for persons needing to avail themselves of more than one treatment modality. In addition, historically the Department has also emphasized the value of making all services broadly available regardless of the recipient’s ability to pay, thereby
helping to create a strong community safety net for those in need of various services. The extent to which this will continue to be the case as the County divests its direct services and funding mechanisms change represents one of the key issues facing the mental hygiene system going forward.
SERVICE LOCATIONS

- Actor Center
- Cornerstone
- Daytop Village Occupations, Inc.
- Hudson Valley Mental Health Lexington Center
- ROCKLAND PC Crisis Residence
- DMH Administration Methadone Program Partial Hospital Unit Mental Health Chemical Dependency Services: Divisions Hudson Valley Mental Health 24-hour HELPLINE Abilities First School & Clinic Diversion Program
- Mental Health America
- Chemical Dependency Crisis Center (MACF)
- OCCUPATIONS, INC. Rockland PC Center for Change Dutchess Horizons
- St. Francis Hospital Emergency Services Inpatient Units The Turning Point
- ITAP Forensic Jail-Based
- Hudson River Housing
- Lexington Center
- Abilities First
- Council on Addiction Prevention & Education
- Mental Health America Lexington Center
- SEASON County Center Hudson Valley Mental Health Actor Center

Revision 10-2012
**Easy, Quick Entry to Service System**
DMH is rare, if not unique, among New York State counties in that it has a single, well-publicized phone number that residents can use to obtain basic information about services, have access to an emergency hotline and suicide prevention services, receive referrals to a service provider, schedule a service appointment and have a pre-intake interview all at one time, thereby easing access to the service system. In addition, one of the principles historically and currently espoused by DMH leadership is that there are no waiting lists for services at any of the system’s providers, and that initial appointments are to be scheduled within a few days from the initial contact with the system. This intent is not always met as services become more decentralized.

**Commitment to a Culture of Quality**
DMH has a strong culture of commitment to serving the public through comprehensive services and high quality of care, with primary attention to putting the needs of the client ahead of all other concerns. This value and strong culture appears to be pervasive throughout the Department, and most especially among long-time DMH employees. However, the ability to maintain this culture may be eroding over time, especially among some contract agencies where the historic commitment to quality may be somewhat less pervasive, and there are often high rates of employee turnover, making it harder to develop and maintain cross-agency cultural patterns. However, the flipside of this is that some community members perceive a micromanaging approach on the part of the Department and a desire to prescribe specifics of external operations without always fully evaluating the big picture and pros and cons of proposed changes.

**Resistance to Change and Innovation**
In addition, DMH’s culture is perceived by some to be resistant to innovation and overly protective of the status quo, both the current way of doing business and affecting staff members. Some in the community describe a lack of access to top leadership, an approach to interacting with community members that stresses formality and hierarchy, an aversion at times to risk-taking, a lack of appreciation for learning from mistakes, and the centralization of decision-making authority within just a few top staff members. As one person put it, this culture hurts the Department’s overall effectiveness, as relatively few people are significantly engaged in solving systemic problems.

**Longevity of DMH Staff**
Many DMH employees have been with the Department for a number of years—often 20 or more years in various areas of the public mental hygiene system. This longevity is seen by many as an indication of commitment to the mission of the Department and as a contributor to the quality of services and the consistency of the culture of DMH. Others
noted that the flip side to this strength is that longevity can be a drawback, to the extent that it contributes to a “status quo” attitude and interferes with progress and innovative thinking, as described above.

**Vision and Leadership**

Historically the Commissioner of Mental Hygiene has been viewed as a person of great vision, as an architect of the culture and broad system of services, and as a committed advocate for high quality care for the population served by the mental hygiene system. Similarly, other persons in key positions of leadership within DMH, as well as key service system stakeholders and community mental hygiene advocates, have exhibited significant vision and leadership over the years.

Most recently, a committed group of advocates has come together as the Dutchess County Health and Human Services Advisory Team, at the request of the County Executive, to issue two reports urging that the County and DMH play an even more aggressive role in helping shape a more comprehensive, community-based mental health service system and integrated, holistic health and behavioral healthcare across the community. The opportunity would appear to exist for an exciting, vision-oriented collaborative effort between DMH and broader community leadership to forge new directions for County residents in response to the changing health and behavioral healthcare environment. The Imagine Dutchess effort which is emerging, and which the County is helping to support financially ($90,000 from County dollars in the 2014 DMH budget), may be one promising approach to further expand the mental hygiene system in ways that respond to changing community needs.

**Accessibility of Department Leadership in the Process of Making Needed Changes**

DMH officials have historically been perceived as being strong advocates for mental hygiene services in the larger community. They have had to manage significant change in recent years, and in some cases have been at the forefront of proposals to make needed changes within the system while maintaining the core principles that have helped shape the system in the past. However, the experience and longevity of DMH leadership, and their commitment to historical ways of doing things, can have the inadvertent or even subconscious effect of creating barriers to change or the perceptions by others in the community that they may not be open to change. In that context, it will be important that any efforts to create collaborative partnerships to explore possible changes in ways mental health services may be delivered in the future make absolutely clear the bedrock commitment to strengthening mental hygiene services, irrespective of any changes in organizational structures or delivery systems for doing so.
Coordination with Other Systems

Dutchess County has developed a robust system of sharing information and collaborating across its network of human services. DMH is an important part of this cross-systems endeavor. But it also goes considerably beyond collaboration within and across the traditional human service agencies. In addition to working closely with the Department of Community and Family Services in various collaborations, DMH is also involved in other cooperative ventures with other entities outside the traditional human services system, such as playing a key leadership role in broad County housing efforts, and in working very closely in partnership with Probation and jail officials, as well as other components of both the criminal justice and juvenile justice systems.

Contract Management and Accountability

The Department appears to be ahead of many of its peers in its emphasis on effective contract management through the use of logic models and adherence to measurable objectives, performance indicators and outcome measures. DMH has taken the lead, as part of its overall quality improvement initiative, to develop effective means of working with contract agencies and holding them accountable for their performance. However, as indicated earlier, more work needs to be done by the Department to strengthen the accountability process with both contractual and Departmental service providers, building on significant steps already taken to make sure its contract dollars are invested as wisely as possible.

CROSS-DEPARTMENTAL COMPARISONS

As previously discussed, the different roles that the two departments play within their spheres, with the Health Department more oriented toward monitoring, planning and convening, and the Mental Hygiene Department more involved in managing and overseeing direct services, make their culture and missions more distinct than they might otherwise be. The following section outlines other high-level comparisons between the departments, including recent budget and staffing trends and an analysis of areas of overlap within their functions.

Budget & Staffing Trends

Over the last several years, both departments have experienced contraction, though Mental Hygiene has lost far more staff members than Health, losing nearly 60% of its 2009 staff by 2014. Most of these losses (112 FTEs) came with the closures of the outpatient mental health clinics and Continuing Day Treatment, in addition to reductions in Central Administration. Health staffing declined 27% with most FTE losses
coming from Public Health Nursing and Administration. It is interesting to note that had the idea of a departmental merger been studied in 2009, Mental Health would have been the larger of the two departments.

From a budget standpoint, both departments have lost a significant share of the non-county revenue that they had in 2008: 36% for Health and 27% for Mental Health.

But declines in expenditures haven’t been as parallel, with Health spending down 10% compared to 24% for Mental Health.
As a result, the County share of the Health budget has risen from less than a third to about half of the total, or $17 million, in the 2014 budget. Over the same time frame, the County’s share of the Mental Hygiene budget has increased slightly to 37%, but since the total budget had declined 24%, that actually represented a decline in County spending on Mental Health of $2.3 million, to about $9.4 million budgeted in 2014.

The primary reason for more level spending in Health is federal and state mandates in areas such as Early Intervention and Preschool Special Education – even though state and federal support for these programs has declined, the County is still required to evaluate and serve children with special needs.
Cross-Functional Analysis

As might be expected due to the distinctions in the roles each Department plays, their primary functional areas have less direct overlap than might be expected. The following charts compare the functional areas of each Department side-by-side, with areas of similarity highlighted in gray. The first shows the entire divisions within each Department that have no direct counterpart or related functions in the other Department, while the second shows divisions that have some overlapping or related functions. Both charts are based on the 2013 departmental organizational charts, supplemented with information from interviews. Because each department groups and lists functions somewhat differently, we are missing some potential connections; for example, we know that both departments handle Health Information Privacy and Freedom of Information concerns, but only one of the departments may list these functions on its org chart. However, these examples are small in scope and do not significantly impact the finding that areas of directly overlapping functions are relatively few.

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<th>DOH Division</th>
<th>Distinct Functions</th>
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Even within the second chart, there are few clear-cut related or overlapping primary functions. The divisions with the most overlap are the administrative offices, where billing, budget, personnel and payroll, and contract administration among others all provide potential opportunities for collaboration, if not consolidation, which will be discussed in-depth in the Options section. In addition, the Early Intervention and Preschool special education functions within DOH’s Administrative Division might present some opportunities for synergy with DMH’s Developmental Disabilities unit and the Children and Youth Coordinator housed under the Clinical Service division. Similarly, infant/child health assessment and home visiting within DOH’s Public Health Nursing Division might have reasons to work with DMH’s Children & Youth Coordinator as well.

Other parts of both Departments might have similar or related functions, or unrelated functions that could benefit from working together – the Options section of this report will discuss those opportunities in more detail. This simple analysis was only meant to provide a high-level, graphical display of the level of overlap between the two Departments.

In CGR’s view, the lack of substantial overlap does not mean the two Departments cannot benefit from working together more closely or even merging; it does suggest the cost savings associated with consolidating services might be modest compared to the expenditures of the two Departments.

**CONSIDERATIONS FOR ALTERNATIVE GOVERNANCE STRUCTURES**

Despite so much agreement on the inter-relationship between physical and mental health, CGR did not find a plethora of combined health and mental health departments. Whether because of the different cultures and primary missions of the departments, or because of simple inertia, most local departments remain separate. We do not interpret this to necessarily mean that combining departments is not a useful idea; rather, there is simply little definitive experiential evidence available to either fully support or reject the notion. However, we do discuss below the cautions and caveats we draw from the experience of other local governments that have tried this approach.

**Overview of Merged Departments**

New York has a handful of combined health and mental health departments, most prominently in New York City, which joined its
departments in 2002, but also in Suffolk, Ulster and Schuyler counties. Other counties have considered merging the two departments without doing so: Albany concluded that it would need to revise its charter in order to move forward, and a charter review commission this year is considering the idea. Albany is moving in the same direction by creating a consolidated billing unit for health and mental health whose manager will report to the Commissioner of the Department of Management and Budget (county budget director) and/or his designee (budget analyst).\textsuperscript{20}

In a few other counties, mental health has been combined with a different department, such as the Department of Social Services; Broome, Putnam, Monroe and Chemung are examples of this approach, though these mergers are limited to one or a few combined positions rather than full departmental integration.

Some states have a combined health and mental health department, including Maryland (which has been combined since 1969) and Nevada, which is currently merging its departments under a recently adopted law passed by the state Legislature.

\textbf{Variations in Structure}

The variations we observe in how different communities have approached merging have to do with the prominence given to the mental health side and the degree to which the departments are truly combined. Many, though not all, of the combined departments preserve both health and mental health terms in their name: New York City has the Department of Health and Mental Hygiene, Ulster County calls it the Department of Health and Mental Health, and both Maryland and Nevada reference both disciplines in their departmental names (Nevada’s title is Division of Public and Behavioral Health). Some counties do not, instead folding the mental health/hygiene function under the Health Department; both Schuyler and Suffolk are examples of this approach.

Similarly, in some combined departments, the leader of the mental health part of the organization is given an especially prominent role. In New York City, the title is Executive Deputy Commissioner of Mental Hygiene and this position is elevated above Deputy Commissioners for Disease Control, Environmental Health, Epidemiology, and the like. In other communities, such as Suffolk County, the mental health function is carried out more as one of several functions of equal stature within the Health Department. The structure in Ulster County is a bit in-between these two ends of the spectrum, with a Deputy Commissioner overseeing mental

\textsuperscript{20} The new billing manager position resides in the Department of Mental Health’s budget but is funded equally by both departments.
health and another overseeing health, and directors taking responsibility for the specific functions under health (emergency preparedness, environmental health, etc.).

In both Broome and Putnam counties, linkages between the Departments of Social Services and Mental Health are limited to the consolidation of one or more senior positions. In Putnam, the commissioner and fiscal manager positions are combined under a single Department of Social Services and Mental Health and serve both functions under a single title (e.g., Commissioner of Social Services and Mental Health), but otherwise the Departments are largely separate. In Broome, one person serves in two positions, as Commissioner of Social Services and Commissioner of Mental Health. Otherwise, the two Departments operate as distinct units.

Chemung and Monroe Counties offer different combinations of departments involving mental health. In Chemung, the Departments of Social Services and of Mental Hygiene maintain their separate identities, and each report to a Commissioner of Human Services. In Monroe County, a Commissioner of Human Services oversees a broadly-defined Department of Human Services, which includes 10 separate divisions, including several pertaining to traditional Department of Social Services functions, plus Central Administration, Office for the Aging, Youth Bureau and the Office of Mental Health, which under a Director oversees a wide array of services via contracts with numerous community providers.

**Strengths & Opportunities**

Combined health and mental health/hygiene departments offer the opportunity of a much more holistic, comprehensive approach to improving health in the community by appropriately recognizing and incorporating the importance of behavioral health. In some combined departments, this potential appears to be realized, at least partially, while in others, it remains more theoretical.

In New York City, health, mental health and substance abuse providers engage in a fair amount of “cross-talk” bringing the information and strengths of their disciplines to bear on the current problems facing the residents of their city. Hepatitis C and HIV are examples of physical diseases that are tied to substance abuse in many cases, and New York’s approach to dealing with both is informed by discussions and expertise across the health and behavioral health parts of the Department. Interdepartmental collaboration leverages the expertise of both disciplines, which helps in implementing various programs. An example is the Screening, Brief Intervention and Referral to Treatment program that seeks to get workers in emergency departments and various primary-care settings to quickly assess the alcohol and drug use of all patients so they
can receive information and/or treatment if needed. The Bureau of Alcohol and Drug Use works with the Bureau of Primary Care Improvement to ensure this is occurring in an effective way.

In Maryland, having one department over both health and mental health is credited with bringing more focus on prevention to the mental health arena. Public health has traditionally been focused on education and prevention, while treatment of disease is handled by care providers. The preventive mindset has penetrated more deeply into mental health planning due to the merged department.

In Ulster County, the tone was set from the County Executive who believes that the needs of people with mental illness or chronic substance abuse are intricately linked to physical health issues. Building a holistic system of care became a top priority and facilitating the change through a new organizational structure was the means he employed to achieve his goal. Combining the departments of mental hygiene and health has resulted in improved collaboration, more community engagement, and more of a willingness to think creatively and holistically about individual and community health.

Sharing of various administrative functions is another potential benefit of a merged department, which seems to be more easily achieved with consolidation. In Schuyler County, which has had many challenges associated with its merger (discussed in more detail below); the merger of back-office/administrative support functions is seen as successful. The pooling of administrative and billing workers into combined units has provided more depth and combined expertise in some cases, as well as the simple ability to adequately cover vacations and other time off. The back-office units are also sharing equipment, such as a new color copier, thereby avoiding duplicative purchases of new items. A variation of the shared service/back-office concept has occurred in Broome County, via a contract arrangement. The Commissioner of the two Departments of Social Services and Mental Health has for several years contracted with an organization, Coordinated Care Services, Inc. (CCSI), to perform a wide array of high-level financial services, various data analyses, and monitoring of contracts and performance measures for mental health and some DSS purchase-of-service contracts. CCSI also plays similar roles for some other county mental health departments in the state.

Even in places such as Putnam County, where the mental health function is officially combined with the Department of Social Services yet operates largely on its own; there is benefit to having some joint positions for the purpose of increased communication and understanding. An example cited is the issue of providing anti-psychotic medications to young children in foster care, who are legally under the custody of the social services commissioner. The Putnam Commissioner of Social Services and Mental
Health, with a background in mental health and a formal role over the Department, was in a good position to increase his own understanding of the role of anti-psychotics and help other social services commissioners learn more about it as well. That illustrates the potential benefit to the care of children of having a shared position overseeing both mental health and child welfare.

**Weaknesses & Threats**

The biggest threat to the success of a merged department appears to be what some constituents in Dutchess have voiced concerns about: the diminution of either health or mental health needs and concerns. Interestingly, in Schuyler County, this occurred to the detriment of public health, rather than mental health. At the time of the consolidation in the late 1990s, there were performance problems in the leadership of the Health Department. That, along with a report on shared services by CGR, led to the consolidation, which put the Community Services director (the mental health leader) over both health and mental health. There were problems from the beginning with New York State not acknowledging the head of the Department as the public health director due to a lack of experience in public health. Instead, New York State Department of Health recognized the County’s deputy public health director as the supervising public health director, creating confusion at the local level.

In addition, a second leader of the combined Department with a background in mental health was perceived as inadequately representing public health concerns and issues to the County leadership or to the public. Although he represented the combined Department at all the relevant internal and external tables, public health was given short shrift and not included in vital planning efforts. “We became almost invisible to the community,” said the current head of the combined Department.

Since a public health nurse took over the leadership of the Department, public health has once again become prominent in community planning efforts, developing a diabetes class in the community and starting a committee to examine children’s issues. But the two parts of the Department, despite being co-located, really function as separate departments at this time. Before the Department divested itself of its home care agency, there was some collaborative clinical service, but since that time there has been little progress in integrating programs. The different funding streams, regulations and missions (direct care is primary for mental health, while public health is focused on planning, convening, and surveillance) inhibit more integration.

In fact, the Department may be split back into two again, which the current leader favors. She strongly believes it is too difficult for one
person to represent both mental health and health at planning tables and to have the necessary expertise to oversee both functions well.

In Suffolk County, years ago the mental health function was subsumed under the Department of Health Services. The Division of Community Mental Hygiene Services became one of several divisions under this large Department. The Mental Hygiene Division generally seems to function well, and offers a wide array of mental health and substance abuse services, but it is perceived by some as not always having an active singular voice at the table where decisions affecting behavioral health issues are made. The Commissioner of Health Services is viewed as an advocate for mental health services, and does not intrude on the day to day operations of the mental hygiene system, but at times the mental health voice needs to be represented on its own, rather than as just one issue among many being addressed by the Commissioner; and in this structure, that is not always possible. With the term “mental hygiene” not part of the Department’s title, and the division competing for attention with several other divisions within the Department, mental health issues are perceived as not always getting the attention they would have under either a stand-alone department, or a more prominent status within the existing Health Services Department.

Ulster County representatives stressed that in order to avoid a diminution of service related to either discipline the leader of a combined department must unequivocally have a passion for both disciplines. An attitude of support is essential and in their experience has resulted in a successful merger that is opening new opportunities in the community and among colleagues in the profession.

**Additional Considerations for Dutchess: The Importance of Process**

The health/mental health merger in New York City is one of the cases featured in a publication of Harvard University’s John F. Kennedy School of Government on making public sector mergers work. The author notes the importance of not moving too fast – the merger was discussed for years and presented to lawmakers and voters three times before it was approved – and of open communication among stakeholders in making the merger a success. Service providers in the mental health, disability and alcohol and substance abuse communities were the most concerned about the merger, for the same reasons Dutchess County service providers have cited – the possibility that the needs of their clients will be downplayed or overlooked in a larger department dominated by public health concerns.

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21 [http://www.businessofgovernment.org/sites/default/files/PublicSectorMergers.pdf](http://www.businessofgovernment.org/sites/default/files/PublicSectorMergers.pdf)
To allay their concerns, leaders were careful to talk about the change as a true merger, not an acquisition by the Health Department. In addition, the new leader of the merged department employed strategies used in private-sector mergers, such as achieving and publicizing early wins. An example was merging computer resources in order to produce data on both health and mental health issues at the zip-code level, which had not been possible before the merger.

Whatever the structure under which mental health services are provided and overseen, mental health advocates in various counties emphasized the need for strong LGU leadership, a strong visionary and oversight function to be in place, mental health concerns to be effectively represented in key County decision-making discussions, and for a strong Community Services (Mental Hygiene) Board to also be in place to provide strong advocacy on behalf of a comprehensive mental hygiene network of services.

**Options**

The departmental reviews of Health and Mental Hygiene highlight the high level of commitment Dutchess County government leaders have made to their community. While public health services are mandated, all services in both departments are provided with a sincerity and dedication to making Dutchess County one of the healthiest and most desirable communities to live and work and raise a family. However, commitment alone may not produce the most efficient and effective service delivery system to meet future needs.

Considering the changing landscape of healthcare delivery, changes in funding mechanisms (e.g., managed care) and a growing understanding of the interconnectedness of the health and mental health specialties, there are various options for systemic change that could be considered by the County, ranging from “tweaking” the current departmental structures at one end of a continuum to full departmental merger at the other. The struggling economic climate of the County, including a declining tax base and the slow national recovery from the Great Recession, will continue to put a strain on local government finances. As caseloads continue to rise, restructuring may not be optional in the near future.

The sections that follow outline the range of options that CGR has identified for the County to consider. We have identified four broad categories of options along a continuum that flow from little or no change to complete merger.
At one end of the range is the option to maintain the two current departments and continue with variations of the status quo. As noted below, the “status quo” does not necessarily mean “no change,” but merely a continuation of the current practices of responding to and planning for incremental change as necessary within the current structure and organization of the two departments. There are some variations within this general theme, including potential efficiencies and reconfigurations within the departments themselves, as well as enhanced inter-departmental collaboration and sharing opportunities that challenge the status quo slightly, but these would not be significantly disruptive to the current operations.

Moving along the continuum of options, the next option to consider is a consolidation of administrative and back-office functions. This acknowledges that there are some administrative services inherent in both departments that may benefit from the synergy and staff expertise of working together.

The next step in the continuum would be to consider combining the two Commissioners into one position, while maintaining essentially separate departmental operations. We observe this in several other counties, as noted in our section reviewing other governance structures, and we elaborate on the impact to Dutchess in this context. Once again, there are variations on the theme of having a single Commissioner, including maintaining two distinct departments with little overlap, and a second which includes maintaining two departments but consolidating some of the back-office functions under one Commissioner.

The final option we have outlined for the County to consider is a full merger of the two departments. This would inevitably involve some combination of all of the previous options, and we will identify the implications of this option in detail.

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Each option will be discussed with analysis provided for personnel, service and financial impact, as well as the merits and drawbacks associated with each. To the extent that any of the options fit into a timeframe (e.g., short-term versus long-term) that could aid in achieving its successful implementation, we discuss that as well.

### Option 1: Maintain Two Departments

The least disruptive path for the County to take is to retain the current operations of the Mental Hygiene and Health departments. This does not necessarily mean that there will not be any changes to the operations, staffing and budgets of the departments going forward, as there are many factors outside of the County’s control that influence those decisions. Rather, to adopt this option would be to acknowledge the assumptions that the operations as they currently exist are reasonably viable, that the services are typically reaching their intended recipients, that significant departmental reconfiguration may not substantially improve the quality and level of service to the public and recipients of care, and that large structural change may therefore not be in the best interest of the County at this time.

#### a) Status Quo

The status quo option is one that must be considered seriously. As we have documented throughout this report, Dutchess County has two well-developed, organized and committed departments that serve the community in a variety of ways. Significant portions of the services that are provided are not duplicative. Services provided by the Health Department cannot be eliminated or changed in any substantial way because of the legal constraints (i.e., mandates) that are associated with them, making blending the two departments not so much an exercise in cost-cutting and achieving savings as an opportunity to enhance the effectiveness of each department. Leveraging synergies, data and expertise across departments to improve services in either department is, at least in theory, possible without significant restructuring.

Another consideration in favor of the status quo is that it may avoid unnecessary distractions that ironically could detract from the ultimate goal of a potential restructuring. If the goal of the County is to become more efficient and/or effective at integrating services and serving people with mental and physical health needs, then realigning structures could divert necessary resources and attention away from the primary point of the process. Much of what needs to happen related to sharing information and improving collaboration between the departments could potentially happen without restructuring, so that maintaining two departments but focusing on the key areas where they currently are ineffective may be a better investment of time and resources. The time and attention it takes to
restructure—including the possibility of loss of staff, institutional knowledge, and the potential for complications inherent in any transition—has the potential to set the County back several years in the short term.

The obvious drawback to the departments working together more closely without restructuring is the existing reality: that not much collaboration currently occurs. In numerous interviews with those in the Health Department, we heard that there is very little understanding of what the Mental Hygiene Department is doing, and vice versa from Mental Hygiene employees. There is a lack of coordination, lack of communication, and difficulty in developing broad health and behavioral health prevention agendas and education materials. Mental Health officials have long been concerned that the needs of the chronically mentally ill could be “swallowed up” within a larger Health Department, leading to a diminution of services and a fear of degradation of the mental health system in the County in general. This reason, combined with a belief that the two departments have fundamentally different goals, has caused Mental Hygiene personnel to have a somewhat insular approach to working with the Health Department. Overcoming these traditional silos in the County operations may not be possible without a significant shakeup in the system.

It is obvious but important to note that the “status quo” does not in reality represent absolutely no change to the current cost and staffing of the two departments. Realistically in 2015 (or beyond) there could be some positions lost, budgets cut or changes to various programs. It simply means that no fundamental changes would be made in the two-department basic structure. However, funding from the State and Federal Governments will continue to be challenged by the difficult economy, and the County’s economic malaise may continue for the foreseeable future. This will lead to annual reviews of each department with the goal of streamlining, right-sizing and monitoring the programs for the most efficient delivery possible. While it is likely that this will occur, regardless of what option is pursued, current operations will not be exempt from future pressures and potential change.

Adopting the status quo could represent a temporary solution until some of the unknowns regarding managed care, health homes, ACA, regionalism and other changes in the larger environment become better known and understood. It would not be unreasonable to continue with the current operations knowing that all of these changes could lead to a vastly different system of care in the next five years. If the County wants to react to these changes as they unfold and wait to see how they will impact the quality and levels of care, then maintaining the existing operations could be a reasonable solution.
On the other hand, there may be opportunities to get out in front of some of the changes and help shape where those changes are heading. The downside to maintaining the status quo is the County may not be in the best situation to position itself for new funding streams, or not have as much influence with the leaders who are shaping the future of health and mental health service delivery. This argument is of course largely theoretical, and changes to the structure are not the only means to take advantage of being in positions of influence.

In our research and review of the external environment, CGR did not learn of any obvious incentives being offered to Counties that decide to make changes to their Health and Mental Hygiene Departments. As we stated earlier, there are very few counties currently combining their health and mental health departments, and virtually none in NYS that are in the process. Largely, those that have or are considering a health / mental health merger currently in NYS and in states around the country are making the transition for philosophical reasons (i.e., to account for the growing awareness of the interconnectedness of the two disciplines). To our knowledge, there are no incentives being offered by the State for merging the Health and Mental Hygiene functions, and no direct invitations to participate in forums or lead initiatives to explore merging these departments that would position Dutchess County for future influence and impact.

That said, in the recent State of the State address by the Governor, he reiterated his commitment to promoting consolidation as a cornerstone of his administration. He has developed a property tax incentive plan that is tied to the concept. While there are no direct incentives tied to merging Health and Mental Hygiene, to the extent that making changes in these departments would result in compliance with the requirements\(^{22}\) for the property tax incentives available in his tax plan, then the County may want to consider whether merging the two Departments might be viewed by the State as qualifying under the requirements of the proposed plan.

Finally, it is important to note that succession planning is an important consideration of the status quo given the tenure of several key staff, particularly in Mental Hygiene. There is a tremendous need to transfer knowledge and assure that a smooth transition occurs within the Department to avoid disruption in services, or any loss of influence in the community relative to the LGU role and the strong presence the Department has traditionally had in the community. In addition, the

\(^{22}\) The requirement for year one is that a municipality stays within its property tax cap. For homeowners to be eligible in year two, the municipality must not only stay within the cap, but proactively engage in a shared service or consolidation initiative.
Health Department will need to name a new Commissioner in the short term. Regardless of whether the County makes a formal structural change, leaders will have to manage significant amounts of turnover in the next three to five years, if not sooner, in key senior leadership positions. It is often during these times of transition that changes are received better by other staff and community stakeholders.

b) **Intra-Departmental Opportunities**

As mentioned in the previous section, maintaining two Departments and continuing with essentially no change to the current operations does not mean that there will not be any changes in the foreseeable future. In fact, one variation on the option is to proactively consider some changes within each Department that are currently available and should be considered regardless of any other structural changes that may or may not be instituted. We call these *intra-departmental* opportunities and outline some in each Department for consideration below.

**Department of Health**

Recognizing the need to adapt, the Department of Health has made several changes in recent years to improve its structure and align its resources for greater community impact. Some of the “low hanging fruit” options available within DOH (e.g., trimming staff in the Public Health Nursing Division and Budget and Finance Division) have recently been instituted within the 2014 budget. Most of these changes have been highlighted in our previous description of the Health Department. A few of the remaining options range from changes in software, to some other restructuring to address current needs.

**Electronic Payroll Process**

Currently one staff person oversees payroll and human resources for all DOH staff (approximately 120). The Department uses paper timesheets and manual data entry for payroll. Line staff is used to entering data for reports electronically, but there is no centralized system for processing payroll electronically. The DOH could consider purchasing centralized payroll processing software that may significantly reduce staff time associated with the process. It could also lead to fewer potential errors in the data entry process (though this is not currently a concern) and less paper storage. It could free up the person responsible for overseeing payroll to spend more time on the HR function. Freeing up line staff in the payroll process may improve productivity in other aspects of their jobs, and/or allow for opportunities to realign staff responsibilities between divisions or across departments over time.
Streamline Software Systems

The Health Department is multifaceted and as a result there are numerous software systems in place to record and track data for compliance with grants and for billing purposes. The fractured nature of the storage and management of this data results in no centralized source or database for information about the services that are offered, or the demographics of the people that are served. It also makes it impossible for the various divisions within the Health Department to share information about people they are serving and learn from their colleagues about issues that could be pertinent to their own specialty in real time. It is not impossible to pull this information together from the variety of sources, but the process is labor intensive, time consuming, and prone to error, and since it is not in real time, there is no assurance that the data will be current or relevant.

A software platform that could accommodate the many different needs of the Department in a centralized and coordinated manner would be a significant upgrade. OCIS has been consulted on this matter already and is currently reviewing options. There are no obvious “off-the-shelf” products available, meaning the solution may have to be developed. There would be a one-time cost associated with the development and installation, and transitions in software platforms always take time for training and debugging. Should the County pursue this option, it should take into account how to bridge the database and billing software associated with Mental Hygiene to allow maximum potential for future considerations of blending the IT and data tracking capabilities of both departments (discussed in more detail in Options 1c and 2 below).

Our interviews with staff from the OIT Department in DMH suggest that the Cerner software currently used by DMH staff could be adapted to manage the billing needs of the DOH. As DOH will be allowed to bill for more services now and in the future, adapting the Cerner platform may be a good solution and could prepare the two departments for future discussions of shared services or merger should they not materialize as part of this process. Adapting Cerner may not result in the full cross-disciplinary software platform that this option is suggesting, but in the short run it may fill a need to add capacity for billing that leverages the expertise and capabilities of the DMH in the process.

Add Capacity for Corporate Compliance with Medicaid and Quality Improvement

The Department of Health is operating without a dedicated staff person for Corporate Compliance for Medicaid. The function is being managed by the Assistant Commissioner of Health, among the many responsibilities currently assigned to her role. The DOH should take some steps to assign one FTE to be devoted to Corporate Compliance and Quality
Improvement in order to minimize potential threats posed to the County for potential non-compliance. There are no obvious candidates for reassignment to fill this function within DOH. However, DMH is particularly well-suited in this regard. We discuss as part of the option for 1c below a possible transition to sharing this function between DOH and DMH. However, we mention it here as the need exists independent of the DMH.

Emergency Preparedness

The Emergency Preparedness function is the statutory responsibility of the Department of Health. However, the need is one that transcends all departments across the County. Integral to this is the County 911 operation. While DOH is responsible to have a crisis response and intervention plan prepared relative to the public health of the community, County 911 must incorporate all aspects of this plan and its own required plan into a coordinated response that leverages all agencies in the County in the case of emergency.

The weaknesses of the current preparedness plan and planning process are a lack of adequate training, a lack of coordinated planning, insufficient focused and dedicated staff, and a culture within the County that is geared more toward “compliance” with Emergency Preparedness requirements for grants and contracts as opposed to a proactive commitment to proper planning that can lead to significantly better outcomes in the case of emergency. Contributing factors to this include multiple staff that touches the planning process, largely for grant compliance issues, and fairly regular and often unanticipated reorganizations of staff that causes information and critical planning steps to slip through the cracks.

Public Health officials proposed a plan within the current 2014 budget cycle to eliminate a secretary position and create a new Director of Emergency Preparedness position that would have been dedicated to Emergency Response planning and coordination. This position would have interfaced with all County agencies (reporting to the DOH Assistant Commissioner) and coordinated closely with the County 911 Director to raise the emphasis and awareness of the Emergency Preparedness needs throughout the County. There was no expected cost to this shift.

The plan was not approved, however, and partly as a consequence the key staff person overseeing the current emergency preparedness plan left for another organization. Not only does this leave a significant vacancy in the organizational structure, but filling the vacancy will not address the fundamental need for an elevating the importance of Emergency Preparedness.
After our interviews with those responsible for Emergency Preparedness, CGR believes a transition similar to the one that was proposed is not only warranted, but essential to the overall planning and preparation within the community. A single point of access for emergency planning would aid the community and improve the overall communication about the Plan. A single point person would also be focused on assuring compliance with Federal and State mandates and as noted in the position paper regarding this transition, learning from other experiences around the country and applying best practices to Dutchess County would be a significant benefit.

The challenge currently and going forward is that for an effort like this to permeate the culture of the organization (i.e., all County agencies), there has to be significant support/emphasis from the County Executive and his commissioners to challenge staff to devote the time and resources necessary to invest in training, preparation, planning and ongoing reviews of the Plan. Without strong advocacy by those in positions of influence, efforts such as this do not become a top priority. Having a dedicated staff person is a significant step in that direction, but that person must be sufficiently empowered to hold people accountable to the needs that will make an Emergency Preparedness Plan successful.

Add Capacity for Administrative Responsibilities

There are several administrative duties that have been consolidated under the Assistant Commissioner largely due to her skills and training to complete them that may not be ideal in terms of the checks and balances that should be in place. With the development of bids for instance (required for purchases over $20,000), the Assistant Commissioner supervises the Budget and Finance Director, meaning one person oversees procurement and payment. Billing and compliance matters are simultaneously an issue as well since the Assistant Commissioner also is currently the point person for Corporate Compliance. This puts the organization at risk and should be addressed through a realignment of responsibilities irrespective of the current Assistant Commissioner’s abilities to efficiently complete the tasks.

Department of Mental Hygiene

Regardless of whether the Department of Mental Hygiene remains a separate free-standing County Department, consolidates selected functions, or becomes part of a merged Department of Health and Mental Hygiene, a number of opportunities for productive change have presented themselves during this study that CGR believes are worthy of consideration by DMH and the County. These would need to be considered carefully, and implemented only after thoughtful due diligence, but we believe each has merit.
As suggested in the following summaries of each option, CGR believes that, following a careful review process, most if not all of the opportunities could be implemented—or the implementation process at least be well underway—within the next 12 to 18 months. It is also our assessment that most if not all would either save the County money, without detracting from the network of mental hygiene services available in the community, or would at the least enhance services without adding to the County’s costs of operating and overseeing the mental hygiene system.

Options for consideration include:

**Relocate HELPLINE and the Mobile Crisis Intervention Team to 911 Center**

As noted previously in this report, the current location of these programs at 230 North Road is problematic. The HELPLINE office has been flooded on more than one occasion, and there are perceived staff safety issues especially with single-staff coverage in the overnight and weekend shifts. There are clearly benefits to having these key programs and services located in the same facility with the overall DMH leadership, including the ability to efficiently review and manage about 60 Section 9.45 court orders per year, but such physical proximity may not be essential to the effective performance of either, and it may not be as useful as it once was as the County’s services become more decentralized.

Moving to the 911 Center would create some staff redundancy, thereby alleviating some pressure from staff that currently manages the call center alone during some shifts. Flooding would no longer be a concern, and the unit would be centrally located with other critical emergency services during a potential community disaster / crisis. Moreover, by relocating these programs to the 911 Center, which appears to have available space to absorb them (though this would need to be more carefully assessed), additional advantages of routine coordination with this and other important County call M in/emergency services, would become available.

Other than relatively minimal initial one-shot relocation and space reconfiguration costs, impact on ongoing annual operating costs of these services should be neutral at worst, and perhaps would save the Department and the County money over time, given the possibility of potential staffing efficiencies and reductions as new efficiencies become apparent and opportunities for staff backup coverage across functions can be explored. It will be important to assure a smooth transition for specialized services like the bridge phones used for suicide prevention, and transition planning is already well underway for that possibility.
Stop Renting Space at 82 Washington Street

Consideration should be given to consolidating most DMH employees into the vacant spaces in the North Road building. In effect, this would mean relocating the 18 staff currently deployed in the ITAP and related services at the 82 Washington Street location to available space at North Road. Although some question whether sufficient space exists for this to occur (without the possible relocation of Abilities First programs away from the building), CGR believes that there are currently spaces that could be available to accommodate this transition at least in part, and that with the potential relocation of the HELPLINE and MCIT programs and staff, additional space would become available. It may be best to view this option in conjunction with several of the other relocation options presented throughout this report rather than as just a single stand-alone option. If this option were to be pursued, it would in all likelihood require one-time renovation of space at North Road, but following that investment, annual savings of approximately $150,000 a year could be expected, as the County would no longer need to pay those annual rental costs to lease the Washington Street space. Savings would be reduced if for any reason Abilities First chose to relocate and the rent received for their space was lost.

Shift Partial Hospital Program Services to Non-Profit Provider

As made clear throughout the Mental Hygiene chapter of this report, DMH has been divesting numerous programs and services from the public to the private, non-profit sector for years, with the most recent changes occurring during and at the end of 2012. In the last two years, the DMH budget shifted for the first time to a preponderance of dollars spent on contract agencies, with in-house services and administration for the first time now accounting for less than half of the entire County Mental Hygiene budget. During this study, CGR considered whether some or all of the remaining in-house services should continue to be operated by DMH, or add to the growing list of external partnerships. We concluded that, with one exception, all existing services provided by the County should remain in-house.

We concluded that the following programs and services should logically remain as core DMH-operated entities:

- HELPLINE, which serves as the gateway or entry point to the entire mental hygiene system for many, and helps with scheduling many initial appointments with providers;
- Related diversion services, including the Mobile Crisis Intervention Team (MCIT), which is also an integral part of the system and interfaces with HELPLINE and with the criminal justice system; and
• Intensive Treatment Alternatives Program (ITAP), jail-based programming, and the forensics services team, all of which are closely linked to the criminal justice, jail and courts systems.

These form a logical core of in-house DMH-operated programs and services which are both interrelated to each other in most cases, and link effectively with the County law enforcement and justice systems in efficient ways that may be undermined if they were broken up and/or provided by external partners.

There is one possible exception to continuing the current core of in-house services. We believe an external partner may be able to provide a program with elements of the Partial Hospitalization Program (PHP), but incorporate a broader array of services to complement what the County offers. PHP is an important service that has been a key component of the recent diversion initiative, but it does not appear to have an essential need to be linked directly to the County the way other core DMH in-house services do, and it appears to be a program that could be provided alternatively by the non-profit sector as an option to the County DMH. We have not explored whether there is any potential interest among the larger provider community in taking over this program (St. Francis hospital may be an option once the current uncertainty about its future is resolved), but we believe it is worth a formal exploration by the Department with potential providers, either through direct conversations and/or through a more formal RFP process.

The PHP currently is budgeted at a cost of just over $1.1 million in the 2014 budget. The County share of the costs of operating the program is budgeted at $769,000, two-thirds of the program’s total costs. With 9.1 FTEs assigned to this program, and another .7 FTE part-time psychiatric support budgeted, it seems likely that the County could reduce its support costs for this important program by potentially contracting out PHP in the future. It would appear worth the effort to at least explore the possible interest among community-based providers in assuming the responsibility for this program in the future.

**Continue Strengthening the DMH Contract Review Process**

As noted in the Mental Hygiene chapter, DMH currently devotes considerable staff time to monitoring contract agencies and the quality of care they provide, as well as helping to ensure that agency goals and objectives are met. Staff also works with in-house programs and contract agencies in the process of developing the most appropriate metrics to assess the performance and impact of each of the services provided throughout the mental hygiene system. A gradual transition has been occurring away from process metrics and documentation of numbers served to a more outcome oriented assessment process.
CGR applauds current DMH efforts to push the providers throughout the system to place more focus on measuring performance and program impact on individuals served, and encourages even more intentional efforts to expand such metrics in the future. We suggest that expanded staff focus be devoted to working with service providers to develop more effective measures of program impact. We believe that this can be done by redirecting and reallocating some of the time of existing staff to this effort (supplemented in some cases with targeted staff training), without having to hire additional staff. We believe that devoting more targeted DMH staff investment in this effort would reap benefits in terms of helping ensure that services provided by all providers within the Mental Hygiene system are having the greatest possible impact and are providing the best possible return on the DMH investments of limited resources.

**Strengthen the LGU Leadership/Vision/Systems Development Role of DMH**

With fewer direct services to be provided and supervised, DMH roles are changing from heavy immersion in the direct service business to one of overseeing the larger mental hygiene system. This is likely to mean over time a changing skills set and changing competencies of staff to accommodate the changing role. The staff who remain will need to spend the predominant portion of their time and focus on visioning the future; planning for what the system will need to look like in future years; helping implement change; addressing issues related to changing ways of providing and funding services (e.g., working with managed care providers, linkages with health homes, training those in the system to keep pace with changing realities); carefully monitoring service providers and holding them accountable for effective performance and impact; working cross-systems to maximize resources and integrate preventive and treatment services between providers in the behavioral health and other systems; and educating the public and making people more aware of opportunities and the need for better prevention, early intervention and more integrated, holistic service provision.

All of these efforts to varying extents are part of the current portfolio of various people within the Department. No additional staff should need to be hired to carry out these targeted efforts. But shifting and reallocation of how staff time is spent, among those who remain within the Department as direct services decline, will be important in order to maximize the value of remaining staff, and to ensure that the overall mental hygiene system maximizes its potential to meet community needs. Making staff more targeted and efficient in their focus should help ensure that the system continues to be responsive to community needs and operates as cost-effectively as possible, while making the best use of the experienced staff that remains on the County DMH payroll.
Consolidate the Administrative Chief and Budget and Finance Director into One Position

As the DMH staffing and in-house service mix has declined dramatically in the last two years, and as the role of the Department becomes more focused on assuring programs and services are available in the community—and less on managing existing staff and programs—there will likely be less and less need for high level in-house administrative services. In CGR’s report from 2008, we recommended creating a senior level Administrative position because at the time there was a documented lack of coordination within the Department regarding various administrative issues. A Department with over 80 positions that occupies a building and works with contracts and grants still warrants an administrative coordinator, but we believe there may now be less need for both a Chief of Administrative Operations and a Budget and Finance Director. With proper support for the various roles, such as payables, purchasing, billing, payroll and the like (e.g. the Accountant recently hired can handle many of the duties currently handled by the Budget and Finance Director), some, but by no means all who are knowledgeable about DMH, believe that the Administrative Chief may be able to also act as the Senior Budget and Finance Director and adequately cover the duties of both. Given that during the early months of 2014, the DMH Budget and Finance Director is spending a substantial amount of her time as the acting Budget Director for the Department of Health on a shared basis, this interim arrangement may provide a realistic test of what adjustments need to be made to accommodate the reduced focus on DMH budget and finance matters by the Director, and whether this potential reduction of time can be absorbed within the Department.23

Were this transition to occur and the Budget and Finance Director position was eliminated, the savings would be $69,000 in gross salary. If benefits are factored in at roughly 50%, the total gross savings would be approximately $103,000. Net County savings may be less depending on the reimbursements and State Aid that help pay for this position, but it may also be possible to reallocate those resources to other needs in the Department.

Determine the Appropriate DMH Staff Configuration for the Future

Given the needs outlined in the previous LGU discussion, it may seem at first blush inappropriate to even raise the question of downsizing the

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23 This option might seem to contradict our suggestion in the Merger section (Option 4) that separate Administrator and Budget & Finance roles be created in a potential merged department, in part to enhance checks and balances. While we do view that separation as ideal, it’s not feasible in every smaller department due to lack of scale.
current DMH staff configuration. But despite the significant reductions in numbers of County DMH employees in recent years, staff remain whose roles are not as carefully defined as they once were when more services were being directly provided by the Department, and reallocation of staff time across different functions is likely to need to occur, as suggested above. Without knowing what support services might or might not be combined with the Department of Health in the future, and without the ability to undertake a more detailed intensive management study than was the focus of this project, it would be premature and inappropriate for CGR at this time to offer specific suggestions concerning the appropriate ultimate size and configuration of DMH staff in the future.

But our overall observation is that reassignments of staff will need to continue over the next year or two, and probably at an expanded pace, to best accomplish the changing realities noted above. And we expect that such reconfiguration will involve some downsizing over the next two to three years, probably through attrition. We expect that if PHP services are provided by external partners in conjunction with other programs and other changes in responsibilities occur going forward as suggested, there will ultimately be fewer people needed to carry out the more LGU-oriented functions of the Department than are on the current payroll.

The Department and County will need to engage in a careful process of making these decisions, and we anticipate that no one will need to lose their jobs in the process, but we suspect that some positions can be deleted over time through attrition and simply not be replaced, thereby saving the County future dollars without compromising the way in which the mental hygiene system operates.

During our interviews with various staff, we heard some perspectives that corroborated our view that staffing may not be optimally aligned for the needs that exist in the Department. One example that was provided was the need for more clerical support. Our review suggests it may be possible to reallocate the current payroll clerk to other clerical support roles in the Department. The size of the payroll has shrunk as the department has lost staff, and there is a possibility the Department may be moving to an electronic payroll process. Redeploying staff in this manner recognizes the changes that have occurred in the Department and could be a better use of staff resources.

Another position that could be reviewed is the current Support Services Manager. In addition to her supervisory responsibilities of support staff, her tasks include work as a Safety Liaison, asset/inventory management, telephone service requests and coordination of building matters, she also provides up to .5 FTE support for HR. As was noted in the DOH options, one person oversees payroll and HR for 120 employees in DOH. If DMH - where the ratio is 1.5 FTE for roughly 82 FTE - were to consolidate
payroll and HR into 1 FTE, the Support Services Manager may be freed up to provide other clerical supports or accomplish other duties as appropriate to her title. As primary support person for the Administrative Division Chief she could also be impacted by the consolidation discussed above of the Administrative Chief and Budget and Finance Director positions.

As part of this reconfiguration process, DMH may over time wish to employ a third party for monitoring contract agency performance and carrying out various fiscal and outcome analyses on behalf of the Department. Other counties have opted for this approach at varying levels of outside involvement, using organizations such as CCSI, and Dutchess may wish to investigate this possibility as it makes decisions about the future configuration of the Department.

**Budget Reorganization**

During our review it was difficult to compare the budgets of the DMH and DOH. The DOH budget allocates support staff (i.e. Administrative) into various programs to align staffing with appropriate cost centers. The DMH does this on a limited basis, but it was somewhat more difficult to disentangle the support staff for programs from those who serve in purely administrative capacities. This does not allow for an optimal understanding of the true costs of the programs and services and also makes it difficult to determine overlap and/or redundancy between Departments should that become necessary in the future. Budget reorganization could make analysis and monitoring of true costs more efficient and create a truer perspective on administrative costs and overhead for future analysis and planning.

**Culture Change**

Regardless of what happens between the two Departments, the operation of DMH could be more efficient if there was less centralized decision-making and more empowerment at lower levels in the organizational structure to make decisions and carry out responsibilities. Setting policy, tone and organizational goals and objectives, as already occurs with the development of the Local Government Plan, should sufficiently guide the staff to carry out their duties. This would improve efficiencies and lead to a cultural transition that could be beneficial to the overall staff morale and productivity.

**Regionalism**

Regionalism is likely to become more pervasive as a planning and organizing strategy at the State level. This could significantly impact the LGUs and force discussions about sharing resources that the DMH should
be prepared for. Many of those discussions are already being realized, for example with the lack of inpatient psychiatric beds for youth and the need to transport them out of the County. Reciprocal types of relationships have been occurring for years as well. In order to be a thought leader in this transition, Dutchess County DMH should proactively find ways to participate in the planning and development of these concepts. As the Conference of Local Mental Hygiene Directors (CLMHD) asserts, the LGU’s “cross-system expertise” is invaluable for helping ensure that people can find access to the full cadre of services that are needed.24

One opportunity that is emerging through the CLMHD is the concept of Regional Planning Consortiums. The goal is to bring together the leaders from the LGUs with the other key service providers in the region, and sit them together with the behavioral care and managed care organizations to help ensure the rollout of managed care provides the best outcomes for those served by the mental health system. State approval has been granted for the development of the consortia, whose roles will evolve and be shaped more explicitly in the near future as they formalize the process. Good, proactive policy will demand that DMH be an important part of the discussions, part of the planning, and factor the regional initiatives into their long-term plans.

**Strengthen Role of Community Services Board (CSB)**

This mandated advisory board is likely to play an even more important role in the future, responding to and helping shape changes needed in the mental hygiene system and its collaboration and integration with other systems such as public health. This important board should be encouraged to become more aggressive in advocating for needed changes. It may be especially helpful and timely for the CSB to work closely in conjunction with the Board of Health, the County Executive’s Health and Human Services Advisory Team and Imagine Dutchess to become integrated voices for more collaborative, holistic approaches to prevention and provision of services across systems in the future.

**Examine Outpatient Clinic Operations**

The County has historically set a high bar for treating patients with mental illness, seeking, for example, to eliminate or minimize waiting times for services to ensure that help is available when clients are open and willing to access it. This standard can be at odds with efficiency of operations. One place worth examining in this context is the outpatient clinics operated by Hudson Valley Mental Health. While it was beyond the scope

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24 [http://goo.gl/XQv792](http://goo.gl/XQv792)
of this project to do an in-depth review of clinic operations, CGR’s interviews and review of data suggest there may be opportunities to realize efficiencies or to reallocate resources to better meet needs within the clinic operations, to help ensure that each clinic’s hours are appropriate to meet needs while minimizing wait times and maximizing access within available resources. The County should examine clinic operations, including trends in patient visits and volume, at each location to determine if changes should be made.

**Both Departments Could Strengthen Collaboration**

Irrespective of whether the two Departments ultimately consolidate any functions or formally merge into one overall Department, opportunities abound for greater collaborations on a number of levels. Most of these are outlined below as part of the “Inter-Departmental” opportunities. However, short of formal sharing arrangements, both Departments could be far more intentional at including the other in relevant key decision-making opportunities. Collegial phone calls that occur by happenstance now, or chance encounters at meetings should morph into intentional communication and collaboration that fully recognizes the need of each Department to work closely together. Joint participation in community events and training activities, proactive planning as part of the community’s prevention agenda, joint focus on community education/awareness activities and physical and mental hygiene issues, joint advocacy efforts on matters of mutual concern, and collaboration on the communications plan published annually by the DOH are just some of the opportunities that exist for greater partnership. Limited resources may force some of this to happen, but proactive planning will pay dividends over time and open more avenues for collaboration that will have a positive impact on the community. For more detail on what expanded opportunities for collaboration might entail, see Option 1 (c) below.

**c) Inter-Departmental Opportunities**

Traditional public health agendas would be well served by including an emphasis on behavioral and mental health issues. The reverse is also true: people treated for mental illness often go undiagnosed for co-occurring physical health issues and delays in treatment for one or the other can be catastrophic. A Healthcare Reform Issue Brief published by the Bazelon Center for Mental Health Law cited numerous examples of how the needs of mental health and public health could be elevated through a shared vision and partnership. The Center cited the following

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25 [http://goo.gl/rTkOrM](http://goo.gl/rTkOrM)

26 Ibid.
as potential subject areas where cross-pollination would be both organic and beneficial:

- Community-wide education;
- Surveillance/epidemiologic surveys;
- Screening;
- Assuring and linking individuals access to care;
- Identifying underlying causes of disease burden;
- Promoting prevention and early interventions;
- Expanding electronic data systems and information exchange;
- Addressing social determinants of health, such as poverty and violence;
- Disaster response;
- Initiatives to connect people to services;
- Encouraging school health clinics to include mental health services; and
- Working with schools on mental health literacy and helping them engage in practices that strengthen social/emotional development and programs to foster a positive school climate.  

In some cases, Health and Mental Hygiene personnel in Dutchess County are engaging in these efforts. There has been some training between the departments regarding emergency preparedness and some discussion about the role that social workers can play in response to disasters and other crises either with County staff or victims of the disaster. The role of the Board of Health is sensitive to the issues of public health in schools and has been building linkages as they are able to bring more health awareness to kids.

A study completed in 2013 by the Epidemiology Division of the Department of Health reviewed the characteristics of mental health clients and mental health services used by Dutchess County residents to observe patterns and trends in the mental health delivery system. While the report was interesting, data were difficult to obtain, and no definable action plan emerged from the effort. There is no current process in place to make this type of activity more of a regular part of the collaboration between the Departments. Interestingly, and possibly contributing to the lack of follow-up action, the request did not come from the Department of Mental Hygiene, but from the Health and Human Services Advisory Team established by the County Executive, underscoring that collaboration between the departments is not typically a high priority of either.

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27 Ibid.
Broader evidence exists in the County that a collaborative environment can be successful in both the Health and Mental Hygiene Departments. Mental Hygiene works in a collaborative way sharing staff and space with the Jail, Probation and the Department of Community and Family Services (DCFS)—and maintains a good relationship with the courts, many contracted service providers and St. Francis Hospital. The Health Department works closely with DCFS and has proven that the reassignment and supervision of Veterans Affairs and Weights and Measures has yielded synergies regarding communications, trainings, and awareness that has made all services more effective. Mental Hygiene and Health already cross-pollinate in a limited way through serving on similar committees and participating in some high-level discussions around various community initiatives. It is in this spirit and context that other opportunities for shared services and collaboration could be considered. The opportunities include sharing more information, partnering together, integrating education and training events, diagnosing and referring on behalf of the other, and collaborating on the community prevention agenda.

Public Health Nurses

The prevalence of co-occurring physical and mental health issues for women and young children, particularly around childbirth, could be addressed far more proactively if public health nurses were adequately trained in diagnosing mental health issues. There are guidelines published to address this and the Department of Health has taken some steps to develop this as part of the initial intervention plan of their nurses (e.g. screening for post-partum depression). Some of the other issues include:

- Screening for substance abuse
- Integration of mental health expertise into home visitations or clinic services by public health nurses (cross-training, co-visitations of trained nurses and mental health professionals)
- Better coordination with other service agencies, which would include raising awareness and educating people throughout the nursing division on the various programs and services that are available within the mental health network of service providers.

The impact on current operations would be in the staff time that would have to be devoted to cross-training. However, folded into the regular training for public health nurses (whether for home visits or clinics), this would likely be minimal and pay large dividends on the quality and level of care that is offered through the program.
Shared Purchasing

CGR identified several purchases (and vendor contracts) occurring in both Departments that are unnecessarily duplicative. They are only handled separately because the Departments do not realize the overlap. One prime example is the purchase of the license for K-Checks (i.e., background and compliance checks). Both Departments have traditionally purchased this license ($675 annually) separately from the same vendor and for the same purpose. While the amount is not significant, the principle applies that processing two invoices to the same vendor is inefficient. Other examples include separate purchases for flu shots for clinics in the past and separate contracts for disposal of waste products using the same vendor.

At the lowest level, the opportunity to improve in this area involves staff from both Departments being intentional to evaluate every purchase in light of what the other Department is doing. This would involve regular communication and at least a quarterly review of each other’s purchasing history to determine potential overlap.

The most significant change would involve a consolidated purchasing function under one of the Budget and Finance Divisions that would be a single point of contact for all purchases and contracts for each Department. Purchasing does not take a significant amount of time in either DOH or DMH as most purchasing is done through Central Services. The function is part of a shared suite of responsibilities for staff in both, meaning the efficiencies gained from combining the purchasing function are mostly related to better coordination and lack of duplication in purchasing products or contracts.

Shared Data

The ability of either Department to extract and analyze data from in-house sources is limited. External sources are much more readily available, but whereas DOH is charged with mining these external resources and reviewing trends to develop preventive public health strategies, DMH primarily uses in-house program data for monitoring, reporting and billing purposes and does not devote extensive resources for more systemic data-driven planning exercises. Between the two Departments, DOH has an obvious advantage because analysis and planning are part of its mandate. There is a dedicated HP&E Division with an Epidemiologist and Biostatistician, devoting more time and expertise to data-driven efforts. DMH has no equivalent dedicated staff for this function, though staff from the OIT provide reports including trend analyses for various programs and services as requested.

The DOH could leverage its data-driven planning expertise on behalf of DMH in a more proactive and coordinated way. Within the legal
constraints of HIPAA, the two Departments could develop a regular data-sharing protocol that would open up access to data that could be used for planning purposes. DOH and DMH staff could also develop a regular meeting pattern to discuss what information would be useful for DMH in fulfilling its mission as the LGU. Integrated data would serve the HP&E function in pulling together the CHA and Community Health Improvement Plan (CHIP). DOH could also aid DMH in a transition to identifying more outcome-based measures to track and analyze in monitoring in-house and contractor performance. The ultimate goal is better utilization of data to inform planning and intervention. Greater collaboration between DOH and DMH may involve more of DOH staff time, but with planning and preparation for the transition, there is some capacity to absorb this enhanced service within the DOH at little to no extra cost.

**Shared Space**

Neither main departmental location, either the Poughkeepsie Journal Building (PJB) or 230 North Road, is overcrowded. There are many options for co-location of services. As noted earlier, the PJB currently has eight vacant cubicles already in the mix on the second floor, spread between the Finance, EI and Preschool and Nursing Divisions. Additionally, some of the nurses already occupy space at the Family Partnership Center (FPC) four days per week. The additional office and cubicle space they occupy at the PJB is unnecessary. If those nurses were permanently located at the FPC, it would open up 2 more cubicles and some office space at the PJB in the Nursing area.

On the third floor, there is some open area that could accommodate as many as two more cubicles, with some additional opportunities for co-located offices. In total, at a minimum there is space for 13 additional staff at the PJB, with the possibility that this could increase by 2-5 more depending on the formation of the cubicles and use of the open space.

There is less office space available at the 230 North Road facility, though there is considerable classroom space and open floor space for meetings and other activities, including a functioning kitchen. The design of the available space is not as conducive to open air cubicle arrangements, though specific classroom space could be carved into multiple cubicles were they needed. As noted earlier, that facility has some maintenance and remodeling needs that suggest relocation of staff or services to the facility may require more time and intentional planning. There is no obvious immediate need to move DOH staff to DMH, considering the open space available at the PJB. However, moving some DMH staff to the PJB may free enough office space at the 230 North Road Facility to warrant relocation of the ITAP program to 230 North Road, thus potentially freeing up rent from the 82 Washington Street facility.
Separately, there may be space available at the 911 Center for co-location of the MCIT and the HELPLINE (see above discussion). Relocating both of these services could free additional space within the 230 North Road Facility for other options such as space for ITAP staff, or contracting with other third party providers, whichever was more needed at the time.

**Partnership Opportunities**

There are many disciplines for which greater collaboration between the two Departments would potentially enhance the services of each. Several examples have already been mentioned, but there are others. The EI and Preschool Special Education focus brings the Public Health Department into contact with children and families at a very early age. The Children’s Coordinator in DMH fulfills a different role, particularly one that is geared toward more oversight of contracted agencies. There could be more intentional and proactive communication between these two areas to ensure that the families and children in the Public Health programs are receiving the quality of care they need inclusive of mental and behavioral interventions as necessary.

Issues such as corporate compliance, FOIL requests, and HIPAA trainings and compliance are ripe for cross-training and inter-departmental collaboration. For instance, there is expertise in the Public Health Department regarding HIPAA trainings and mental hygiene staff could benefit from sharing in the trainings with DOH. Similarly, DOH may learn about HIPAA rules and regulations related to counseling that would benefit their work in screening and interfacing with clients in the future. The cross-pollination of time together could generate new ideas as well.

The DMH corporate compliance officer is wearing that “hat” as part of a suite of services, but presently there is no equivalent in the DOH. DOH could benefit significantly from sharing the DMH expertise around Corporate Compliance and Quality Control to alleviate the Assistant Commissioner of DOH from managing the responsibility.

In many respects, the FOIL process is the same in each Department and represents a possible opportunity to transition to the general administrative services within the County. Short of that, having a single point of contact for FOIL requests within the DMH and DOH (i.e., a single FOIL officer meeting the needs of both) could streamline the process, ensure accuracy and protocol are followed, and create efficiencies elsewhere in the administrative structure.

**Communication**

The DOH and DMH could consider sharing their communications resources, leveraging the expertise of DOH to help spread messages and
themes on behalf of DMH. As noted previously, the DMH budget for communications has been drastically reduced, such that the role is now only part of a responsibility within the DMH staff. The DOH has an annual communication plan targeting different public health issues every month based upon the appropriateness of the theme relative to the time of the year, as DMH does around suicide prevention issues. For instance, a public awareness campaign for Tick-borne Disease is slated to occur in May with the onset of spring and summer.

DMH could tap into this communication system and utilize the resources to proactively spread messages targeting people in need of mental health, substance abuse or developmental disabilities services. Coordinating the themes for the communications calendar, combined with regular internal planning around communication needs, could strengthen the current work of DMH, and provide better service to the community.

**Planning as Part of the Community Health Improvement Plan (CHIP)**

The needs of the mentally ill and those with chronic substance abuse problems have not historically been a major part of the CHIP in Dutchess County. However, substance abuse issues have become so pervasive, particularly among young people that public health officials have begun to recognize them as some of the most pressing current public health problems today. For instance, the Dutchess County local community health assessment process identified the use of prescription drugs leading to overdose as one of the top four high-priority public health initiatives to target in the coming year.

As public health officials branch into the fields of mental health and substance abuse, they are going to need more support to develop appropriate, targeted and useful prevention campaigns, in addition to facilitating conversations about the system of care that is necessary to address these needs. The LGU is uniquely positioned to play this role, and thus improved collaboration, greater intentionality about planning, and assuring that the right target audiences are reached is essential. Public health officials will need to access more information from the mental health professionals, and the mental health professionals will need to avail themselves more to the DOH staff charged with building these awareness and prevention campaigns.

**Better Integration of Diagnosis and Referral/Treatment Options at Single Point of Contact**

Alluded to several times throughout this section, there could be better collaboration and cross-training built into the DOH and DMH systems to assure that cross-disciplinary issues are addressed at a single point of entry. In the hospital, particularly in the emergency room, mental health
screenings could become increasingly routine parts of the initial physical diagnosis. Mental Health professionals need to be more accessible in those immediate and crisis moments when physical health appears to be the presenting matter but when individuals are accessible for mental health and substance abuse interventions. Similarly, for public health nurses that are screening for HIV, STD or other related issues, or for social workers interfacing with families and children, cross-diagnosis of physical and mental health matters could speed up access to care, making a critical difference in the life of a potential patient.

The Mobile Crisis Intervention Team (MCIT) has made a difference in this regard. There has been a marked improvement in finding alternative settings for those that come to the hospital setting. Hopefully this will continue to grow, though that could demand potentially more staff at some point in the future. Integrating this expertise into the DOH for the various ways it interacts with the community is a significant opportunity for the DMH to leverage its expertise and fulfill its LGU role.

**Combining OIT and OCIS**

The Office of Information Technology (OIT) within DMH and the Office of County Information Services (OCIS) could consider combining, which would streamline staff under the OCIS, and facilitate a more efficient IT system within the County. This is not to imply that there are significant inefficiencies in OIT personnel, as the OIT unit has been reduced significantly in recent years and is generally currently considered “right-sized” within the Department. The inefficiencies are more structural and somewhat unnecessary given modern technology. For instance, the DMH does not need its own email addresses and email system. Streamlining the email system would free up resources and put DMH on the same system as the majority of the rest of the County.

Monitoring and maintaining the Cerner software, supporting the remaining billing functions of the DMH, establishing and supporting the electronic medical records process, and supporting the work of contracted agencies for reporting purposes are all essential services that would need to continue. Nearly all of these services can be and currently are provided remotely, and the need for a physical presence at the DMH has significantly lessened. The OIT does not have as much responsibility for monitoring hardware as it once did, and all hardware facilitation needs could occur through OCIS. Hardware and software support for the contracted agencies at 230 North Road is largely provided by virtue of proximity, not necessity, with Lexington and Abilities First each having their own internal IT capacity to manage their own systems. Additionally, combining the servers with OCIS would help improve capacity, ensure the reliability of those servers and the data contained therein by improving redundancy and backup capabilities. While there may not be immediate
cost savings resulting from a possible combining of these offices, there are likely to be improvements over time that would lead to greater cost savings either through streamlining personnel, or technological advances that improve operations.

A more careful analysis of space availability at OCIS would need to be a critical part of any future assessment of the viability and potential value of the possible combining of these two offices.

**Emergency Preparedness**

The need for better coordination and planning was documented as a potential opportunity for the Department of Health. However, the benefits would also inure to the DMH and several other County agencies and thus bear mentioning in this section. For instance, the County would benefit from emergency staff and volunteers (e.g. MRC) that are trained in how to manage sensitive mental health related issues during crisis situations. This happens now irregularly, and without intentionality and expectation for participation it will not result in better service during crisis situations. Further, the DMH Continuity of Operations Plan could be significantly enhanced by having a more integrated plan with DOH and other County agencies, but this would require more dedicated planning and refinement of the current plan.

There are several areas that overlap in the Emergency Preparedness Plan, particularly the role for mental health professionals in support of County employees and/or community residents dealing with crisis. Supplies, materials, trainings and other preparedness components of the larger plan are all opportunities for greater collaboration and planning that should be leveraged for a better Plan.
## Option 1: Maintain 2 Departments

<table>
<thead>
<tr>
<th>Summary</th>
<th>Advantages</th>
<th>Challenges</th>
<th>Budget Implications</th>
<th>Staffing Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Status quo</td>
<td>No structural change</td>
<td>No disruption, time to see how ACA, managed care, health homes play out</td>
<td>Increased collaboration not likely to happen without structural change</td>
<td>Needed savings will continue to be found, including perhaps future downsizing</td>
</tr>
<tr>
<td>b) Recommended changes for each dept to consider</td>
<td>Key recommended changes listed below</td>
<td>Can achieve improvements, efficiencies in each dept with minimal disruptions</td>
<td>May lead to incremental improvements &amp; efficiencies rather than substantial</td>
<td>See specifics below</td>
</tr>
</tbody>
</table>

**DOH**
- Strengthen corp compliance
- Create Emergency Preparedness Director
  - None immediate
  - None immediate
  - Redefined role
- Adopt electronic payroll
  - 1-time cost/modest future savings
  - Increased efficiency of tasks
- Streamline software
  - 1-time cost/modest future savings
  - Increased efficiency of tasks
- Add administrative capacity
  - $55-75,000
  - Add 1 position

**DMH**
- Move HELPLINE, MCIT to 911 center
  - 1-time renovation, equipment costs
  - None
- Consolidate staff at 230 North Road
  - $150,000 in rental savings
  - None
- Outsource Partial Hospital Program
  - Unknown, expect some savings in $1.1 million
  - Eliminate 9 positions
- Strengthen contract review
  - None
  - None
- Strengthen LGU role
  - None
  - None
- Consolidate Administrative Chief and Budget/Finance Director
  - Annual savings of $103,000
  - Reduction of 1 position
- Reconfigure admin staff to realize efficiencies
  - Unable to estimate
  - Reduction of staff through attrition
- Examine outpatient clinics for efficiencies
  - Need further study to determine
  - Need further study to determine

**c) Inter-departmental collaboration**
- Key opportunities listed below.

| Cross-training: DOH Maternal & Child Health nurses and DMH staff | Better service to clients and community | May require staff to think/perform tasks differently | None | Investment of staff time |
| Cross-training: DOH Early Intervention and Preschool and DMH staff | Better service to clients and community | May require staff to think/perform tasks differently | None | Investment of staff time |
| Shared purchasing | Efficiencies & synergies | May require staff to think/perform tasks differently | None | Redeployment of staff time |
| Shared data | Efficiencies & synergies | May require staff to think/perform tasks differently | None | Investment of staff time |
| Shared space | Efficiencies & synergies/better messaging to community | May require staff to think/perform tasks differently | None | Investment of staff time |
| Shared communications | Efficiencies | 1-time costs to move staff, furnishings, etc. | Investment of staff time |
| Community Health Improvement Plan | Improved holistic planning | May require staff to think/perform tasks differently | None | Investment of staff time |
| Fold OIT into County IT | Efficiencies | May require staff to think/perform tasks differently | No immediate impact | No immediate impact |
Option 2: Consolidate Administrative Functions

The next option for possible consideration by the County involves formalizing a consolidation of administrative functions between the Health and Mental Hygiene Departments. CGR observed this option being used in limited ways in some other counties. In Albany, a consolidated billing unit for health and mental health is being created that will report to the County Commissioner of Management and Budget. In Putnam, a combined fiscal manager position has been created for the separate Departments of Mental Health and Social Services and reports to a single Commissioner of Social Services and Mental Health (no DOH involvement). In Broome and Monroe, various administrative functions are provided by external partners via contract involving Mental Health in both cases, and DSS in Broome and several other departments in Monroe. This option is distinct from a full merger in that both Departments would remain intact with separate Commissioners, but some or all administrative functions in both would fall under a combined administrative department.

As is evident from reviewing the inter-departmental opportunities above in Option 1(c), many (though by no means all) of the shared service (i.e. inter-departmental) opportunities are between administrative services and could lead to a formal consolidation of administrative operations. Many of the duties overlap, though disentangling them from staff that have multiple roles may take some time.

Redefine Roles of the DMH Administrative Division Chief and Assistant Commissioner of Health

The current Administrative Division Chief in DMH and the Assistant Commissioner of Health share several responsibilities that could be combined into one. As noted in the previous section 1b above, the Assistant Commissioner oversees many elements of the administration of the DOH that detract from her ability to serve at a higher level programmatically and support the Department as a whole. Some of the responsibilities also create conflicts of interest such as serving in both a procurement and oversight of payments role. Other responsibilities include building management, contracts oversight, telephone coordinator, asset management, and security to name a few.

The Division Chief for DMH oversees the DMH contracts process, building maintenance issues, budget and finance, asset management and many other similar responsibilities. The role of Administrative Chief at DMH has been significantly reduced, however, in the recent few years as the DMH transitions away from providing direct services.
A combined administrative function could consolidate several of these responsibilities under one administrator position. The benefit would be that the current Assistant DOH Commissioner could be freed up to focus on more programmatic and service related matters, coordinating the needs of various DOH divisions, and think more proactively about ways DOH and DMH could be leveraging resources between each other. The difficulty is that there might be conflicts between the needs of the two Departments if the Administrator were to become responsible for both. Staff time would have to be allocated in a shared fashion and clear time management would have to be exercised to make it successful.

Logistically, the Administrative Chief in DMH could be hired by DOH to serve part-time in the administrative capacity at DOH, and cut back to a part-time role in DMH. While this would have the effect of creating a new part-time position in DOH, cutting the position in DMH to part-time should make it cost-neutral. But there may be too many logistical problems with this option, including span of control issues, to make this a feasible option.

**Budget and Finance Directors**

Currently the position of Budget and Finance Director is vacant in the DOH, and the DMH Director of the same title is filling the role on a leave of absence from the DMH position. The Director still serves the DMH 1.5 days per week. The DMH Director position currently supervises four staff. The DOH position involves oversight of six staff.

If the two positions continue to be filled by one person, a single Budget and Finance Director would presumably be responsible, at least initially, for 10 immediate reports (not including three FTE DMH billing staff), though that number could be adjusted over time to the extent that efficiencies and shared responsibilities result. However, there are different rules and regulations for each Department that would need to be mastered in order to assure a smooth operation. Moving forward, such a joint office may include individuals who would retain specialized functions from Mental Hygiene and Health roles (e.g. billing), while others would perhaps be able to assume more shared generalist positions with responsibilities relatively common to both functions (e.g. payroll and HR).

Under this option, the combined position would continue to be a shared position of the two Departments. However, rather than having the position report to an administrator, a better option may be for the Director to report directly to the Commissioners in both Departments. This would create better checks and balances in the system, allowing the administrator to focus more on the procurement and corporate compliance and the Budget and Finance Director to focus on the payments, billing and budget.
Combining this function could lead to savings of the Budget and Finance Director position at the DMH. The DMH position is budgeted at $69,000 in salary and with benefits (roughly 50%) the gross annual savings would be approximately $103,000. The position on the DOH side is budgeted for $73,000 in salary, or roughly $110,000 with benefits. The roughly $7,000 differential may be a point of negotiation considering the expanded role of managing two Departments, and there is a possibility that the negotiation would come in higher than the DOH salary. Therefore, if we assume that the combined position would be $4,000 more than the current DOH position; the gross salary would be $77,000 not including benefits. This lowers the potential savings from the DMH position to $65,000. Therefore, an estimate of potential gross savings including benefits would be $98,000.

**Other Budget and Finance Functions**

Other Budget and Finance services, including purchasing, payroll, payables, revenue and billing are all functions that could be overseen by one central operation. Many of these functions are already part of the duties of the Budget and Finance staff in both Departments and would transition somewhat seamlessly. Payroll and HR for 120 FTE staff, for instance, are currently managed by one payroll person at DOH. In the DMH, there is one person doing payroll and one person doing HR for 82 FTE (102 individuals) staff. A combined unit could be handled by 2 FTE for payroll and HR for a combined staff of slightly over 200, which would free up 1 FTE in DMH to redeploy elsewhere (discussed below). A transition in payroll services would be aided by a transition to electronic timesheets and payroll software, which would facilitate offsite or remote location processing should it be required. Purchasing and payables are limited parts of the duties of the staff and there could be some synergies, as already noted with purchasing, by combining these functions with DOH.

Billing is another function that could be combined under a single operation. DOH is currently being allowed to bill for more clinic services, and the likelihood is that the Department will increasingly be able to bill for more services across other departments as well. The DOH has not traditionally had a high volume of billing activity and the function is currently just part of a portfolio of activity for one person in the Department. DMH has three people dedicated to billing and has a good system and good software supporting the function. IF DMH were to assume the responsibility for billing for DOH, there would be some synergies that would emerge in sharing the Cerner software and the expertise of the DMH would allow for a smoother transition for DOH as it grows its capacity to bill.
The staff of the combined operation could co-locate at the available space at the Poughkeepsie Journal Building. This would involve potentially 7 FTE moving from 230 North Road (4 FTE Budget and Finance and 3 FTE Billing) to the PJB freeing up space at 230 North Road for programmatic services.

There are two options for the position that is freed up from the combination of payroll and HR. The person currently oversees the limited purchasing function at DMH, so those duties would need to be consolidated under one of the remaining Budget and Finance staff positions. However, a need exists in DOH related to asset management and inventory control that could be a natural transition. This position would report to the Administrator and fill some duties that are currently handled in part by the Epidemiologist and Assistant Commissioner of Health, both of whom fill the roles by necessity and neither of which should be carrying the responsibilities directly. As the need exists at DOH, it is possible that this position would also relocate to DOH freeing up additional office space at DMH and consolidating all Budget and Finance and Administrative positions at the DOH.

Limited savings are possible from these transitions, as the volume of activity is unlikely to change and thus a similar staffing complement may be required. Over time, it is likely that synergies will be realized as the staff of both departments work together and realize ways things could be done more efficiently. That could lead to greater productivity, and possible redeployment of staff.

**Other Administrative Functions**

Other opportunities for administrative merger include corporate compliance, quality control, HIPAA compliance and trainings, FOIL requests, and grants and contracts management, which were all discussed previously as part of option 1c. All of these functions except for grants and contracts are partial responsibilities of existing staff and thus they are less easily defined for possible consolidation or co-location. Based on CGR’s limited exposure to the staff and to these issues, there is certainly synergy and overlap in the types of services that are being provided, but it is unlikely that a merger of these functions would lead to less volume of activity.

The most significant advantage identified earlier could be related to Corporate Compliance. It is an issue that is not getting the attention it needs in the DOH, while DMH has a dedicated staff position and expertise in this area. A combined administrative structure would promote the development of this position within the DMH/DOH system and potentially lead to improvements all around.
Greater coordination could improve efficiency, but as long as the volume of activity is the same, there is likely to be little to no savings initially from combining these functions.

**Location**

It is not evident that co-location would be required under this model. There are certainly efficiencies from co-location that cannot be discounted. However, provided there remain two Departments, there are some advantages to having a presence in both locations to keep the pulse of activity. If co-location is desired, for the reasons outlined above it makes sense to move them to the PJB. Combined with other alternatives, the move to the PJB frees up space at 230 North Road for other programmatic services.

**Opportunities**

The benefits of combining administrative functions are related to improvements in communication, coordination of services, the ability to specialize in certain activities with a larger staff, more redundancy in staffing to account for absences, possibly fewer staff or more efficiently deployed staff over time, and generally a greater level of efficiency in dealing with similar issues as part of a larger process. The obvious opportunity at this current time is the vacancy in the DOH Budget and Finance Director position which affords the two Departments a window to not rehire for one of the positions while potentially sharing the function across the two Departments. Other opportunities would likely present themselves once a transition was underway.

**Challenges and Considerations**

The most significant challenge to this option is the absence of a clear choice for accountability and supervision. If the operation were to co-locate in the available space at PJB, the natural tendency would be to assume that the administrative operation becomes the responsibility of the DOH with supervisory responsibility falling to the DOH Commissioner. This is problematic in that a fully functioning Mental Hygiene Department will have grant, contract and budget requirements and will need to have some authority over the positions which are responsible for those services. Supervision could fall to the Commissioner at DMH. This is considerably problematic if the services are co-located at the PJB. However, location aside, the same issues for the Department of Health will emerge in regard to accountability for billing and other finance functions that DOH will want to retain some control over.

Sharing the function between the two Departments is possible with the right complement of staff to support the roles. However, this may not be
ideal; over time the responsibilities of any one Department may need the attention of more than a part-time Director at either the Administrator or Budget Director Levels.

One other solution is that which is being pursued in Albany County. A shared budget and finance department, or portions within it (e.g. billing in the case of Albany County) could report to the County Budget Director rather than directly to the Commissioners, or Administrators in each Department. While this adds more responsibility to the County Budget Director, it would alleviate any concerns about who the personnel in the positions report to, should that become an issue.

There is no easy solution to building a consolidated administrative function in the context of two fully functional Departments. While the services are synergistic, the issue of supervision is problematic and not easily resolved with two separate Commissioners to report to.

Option 3: Adopt a Single Commissioner Model

Several counties in New York have figuratively “stuck their toes in the water” of departmental consolidation/merger by creating various forms of combined commissioner-ships, but have stopped short of fully merging departments. The four primary examples of variations of this approach, as discussed earlier in the chapter on governance structures, all involved the Commissioner of Mental Health/Hygiene, but none involved any linkages with their counterparts in the Department of Health. Instead, all involved some degree of linkage with the leadership of Social Services or broader Human Services departments. However, there appear to be no reasons why such an approach involving both Mental Hygiene and Health Commissioners could not be a viable option for consideration by Dutchess County.

This option is distinguished from a full merger (described in Option 4) by the fact that, while positions and titles at the Commissioner level may be combined, departments are not officially merged with other departments and thus retain their own independent identities. Not dissimilar to the sharing of administrative functions, allowing one Commissioner to serve both Departments splits the time of the position to provide oversight for both.

Combining commissioners—in effect, combining responsibilities for two departments under one person—has the potential fiscal value, under at least some permutations of this option, of saving the County money—while also helping to foster a culture of synergies, shared approaches to tasks, opportunities for efficient use of staff, and cross-systems linkages of service disciplines that can be beneficial for service recipients and the
public at large. Even without any formal consolidation of departments, having one person responsible at some level for thinking creatively and synergistically—and at a big-picture level—about both health and mental health issues, staffing, fiscal issues, administrative oversight, service delivery, public education/awareness and advocacy opportunities has the potential to open up possibilities for collaboration and decisions made in the broad public interest, that would be far less likely to occur with separate commissioners responsible only for their own independent departmental silos.

From Dutchess County’s perspective, consideration of this option offers the potential value of being relatively easy to implement, compared to a full-scale merger of two Departments, in the short run. Combining Commissioner offices under one person could create an opportunity to test the concept of working formally together across Departments under one leader, and exploring what advantages might accrue short of formally combining the Departments. Various opportunities for collaboration across Departments could be explored and evaluated. With such an opportunity serving as a test case, the County could then assess the potential value of taking the next step—potentially merging the two Departments and building on the learnings of the combined Commissioner option—versus whether simply combining responsibilities at the Commissioner level may be sufficient to accomplish the goals of strengthening both public health and mental hygiene systems, services and public awareness across the county.

In order for a County to be eligible to receive State Aid from OMH, it is required to have a full-time Director of Community Services (DCS) that oversees the Local Governmental Unit (LGU). As noted earlier, Dutchess County fulfills this requirement through appointment of a Commissioner of Mental Hygiene for the County. Directors of Community Services (i.e., the Commissioner) receive their statutory authority from Mental Health Law Sections 7.09 and 41.04. In order for a county to be in compliance with any alternative other than a full-time DCS, it must apply for a waiver, as other counties have successfully done. The waiver guideline is outlined in Part 102.8 of the Mental Hygiene Law. All approvals of all appointed DCSs and/or waivers are processed through the Inter-Office Coordinating Council (IOCC) representing the State Offices of Mental Health, Alcohol and Substance Abuse Services, and People with Developmental Disabilities.

An individual with a medical degree can fulfill the requirements of a DCS as outlined in Part 102 of the MHL, though there are other degrees and combinations of experience that meet the requirements as well. The
challenge in this discussion is that a Commissioner of health must have a medical degree. Thus, a single Commissioner of a combined Department would have to have a medical degree (MD) and the County would have to apply for a waiver to share a Commissioner between Mental Hygiene and Health because the DCS role would be less than full-time. Other counties such as Broome, Putnam and Ulster have a history of such approvals concerning Mental Hygiene, though not always involving linkages with Health. Public Health Law does provide that a Commissioner of Health can oversee more than one department, and the County would also have to seek approval from the NYS Commissioner of Health to achieve a shared commissioner model. In Ulster, under a Commissioner of Health and Mental Health, the Deputy Commissioner for Mental Health has been approved through the waiver process to meet the Commissioner of Mental Health requirements.

Should the County wish to explore the potential implementation of some variation of this option, this may be a relatively propitious time to do so, given the vacancy in one of the two existing Commissioner positions. We outline two variations of this shared Commissioner option: (a) combining Commissioners without any concomitant consolidation of any administrative functions, and (b) combining Commissioners along with some level of administrative function consolidation, but short of a full merger of Departments.

**a) Single Commissioner without Administrative Consolidation**

Under this scenario, in its purest form, one person would hold the title of Commissioner of two separate Departments. For example, in Broome County, one individual in effect splits his time between the Departments of Mental Health and Social Services, bearing the separate titles of Commissioner of each. He has a Deputy Commissioner under him in each department, responsible for much of the day-to-day operations of each organization, freeing the Commissioner to deal with big-picture policy issues. Since in all likelihood each Department would have a deputy under the Commissioner under normal circumstances, this arrangement affords Broome County the opportunity to save one Commissioner-level salary. Even if the salary for the shared-Commissioner incumbent is at a higher level than either separate departmental Commissioner would be

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28 We note that the NYS Sanitary Code laying out qualifications required of a county health commissioner does allow for a county to request approval of a commissioner lacking some of the educational or experience requirements. As the Dutchess County charter specifically requires a medical degree for the health commissioner post, this does not seem a likely path for the County, unless it chooses to amend its charter accordingly.
paid, the combined salary is still considerably less than the cumulative salary and benefits would be if two separate Commissioners were in office.

Although there is no shared administrative unit between the Mental Health and Social Services Departments in Broome, the Department of Mental Health does contract for some administrative services with Coordinated Care Services, Inc. (CCSI), which provides the services at less cost to the Department than if those same services were provided by County staff. A limited number of those services are also available to DSS, so in that sense, there is some indirect sharing of administrative services across these two models. Thus the Broome example in one sense is a bit of a hybrid between the “No Administrative Consolidation” sub-option, and the more formal “Administrative Consolidation” sub-option described below.

In Putnam County, a single person functions as the Commissioner of Social Services and Mental Health, ostensibly overseeing a single Department but, as noted in the earlier chapter, Social Services and Mental Health largely function as separate Departments, without a consolidated administrative unit, except for a shared fiscal manager, as described in more detail in sub-option (b) below.

Another variation of this scenario is found in Chemung County, in which the Departments of Social Services and Mental Health exist independently, but under one Commissioner of Human Services, who also doubles as the Social Services Commissioner, thereby enabling ideas and approaches to be shared across Departments, without any increase in costs to the County. In this case, no consolidated administrative unit has been formally created.

Should Dutchess County choose to consider adopting some variation of this option—with a single Commissioner of Health and Mental Hygiene, but no other consolidation of functions—with the right person as Commissioner, knowledgeable and passionate about both public health and mental health issues, the County could expect improved communications across these disciplines, with various opportunities to create informal shared services initially, and the potential to develop more formal administrative consolidations of functions over the first two to three years after the combined appointment occurred. Strengthened focus on integrated preventive approaches to public and behavioral health could be expected to develop over time, along with greater focus on community education and public awareness of both public health and behavioral health concerns.

In addition, a combined Commissioner, with a strong deputy overseeing each Department (equivalent positions for all intents and purposes already
exist), could potentially save the County money in salary and benefits by avoiding the costs associated with one of the Commissioners. The potential savings could be significant. The DMH Commissioner salary is currently $158,000 plus benefits, and the vacant DOH Commissioner salary is budgeted at $163,000 plus benefits.

For this combined Commissioner option to be viable for Dutchess County, including maintaining the strong and credible voice needed for both mental health and public health constituencies, the credentials of the person chosen to be the combined Commissioner would need to meet the requirements specified by the State for Mental Hygiene and Public Health Commissioners/ Directors, as outlined earlier in this option. Ideally the person would have credentials cutting across both disciplines, though this would not be required. Short of that, the respective deputies would need to be sufficiently empowered by the County to have the needed strong voice at decision-making tables. In addition, both disciplines would need to be prominently named and featured in the Commissioner title, e.g., Commissioner of Health and Mental Hygiene.

### b) Single Commissioner with Administrative Consolidation

Under this sub-option, any advantages resulting from implementation of sub-option (a) would continue to apply here, and presumably be enhanced by adding the potential advantages of also combining selected administrative functions under one consolidated back-office/administrative support unit reporting to the combined Commissioner. For more details about what such an administrative consolidation option might look like, see the earlier discussions of Option 1c and Option 2.

Having outlined the potential advantages in theory, CGR is not aware of any counties in New York that have fully adopted this option without full merger, though some have gone at least part-way toward implementing such an approach.

As noted above, Broome County has adopted a limited variation of this scenario via its arrangement with CCSI, whereby some administrative support functions are provided to the Department of Mental Health and, to a lesser extent, to the Department of Social Services, via contract with a specialized outside entity.

The Putnam County experience begins to suggest what this combined Commissioner/administrative consolidation option might look like if adopted in Dutchess County. As indicated earlier, one person functions as the Commissioner of Social Services and Mental Health. In addition, reporting to the Commissioner is a single fiscal manager who is
responsible for managing the fiscal affairs of both departments and oversees employees from each.

Another variation of this option occurs in Monroe County, where the Mental Health Department is one of several divisions responsible for providing and overseeing a variety of services that reports directly to a Commissioner of Human Services. The Department of Public Health is not one of those services reporting to the Commissioner, as it retains its own Director-level position and remains a free-standing Department within the county organizational structure. Among the divisions reporting to the Commissioner of Human Services is a central administration office providing various administrative supports to several departments and divisions such as DSS, Office for the Aging, Youth Bureau and Office of Mental Health. As with Broome County, some of those administrative support functions are provided via a contractual arrangement with CCSI.

If some variation of this combined Commissioner/administrative support consolidation option were to be implemented in Dutchess County between the Departments of Health and Mental Hygiene, it would presumably include the advantages inherent in simply combining the Commissioner function alone (sub-option 3a discussed above) and the pros and cons of consolidating administrative functions, as discussed under Option 2 above. Most importantly, it would address the issue raised in Option 2 of who would be in charge of such a consolidated administrative support function—i.e., to whom it would report. By linking a combined Commissioner of Health and Mental Hygiene with a consolidated administrative support unit, the responsibility and reporting relationship would presumably be clear—and any issues that need to be resolved resulting from combining staff from the separate Departments, with their separate histories and ways of carrying out tasks, would have a clear place and chain of command through which to resolve such issues.

Over and above the savings that would result from the elimination of one Commissioner position, additional financial savings from this option would be less likely, at least initially, other than potential savings from combining two Budget and Finance positions into one. As suggested in the Option 2 discussion, other savings from combining administrative support functions may be likely to occur over time, as efficiencies and sharing of functions evolve.

**Option 4: Merge the Two Departments**

A full merger of DOH and DMH would likely incorporate key aspects of several of the previously-outlined options: the combined Commissioner position, consolidation of administrative functions and increased collaboration among various parts of both Departments—as well as various intra-departmental options outlined in Option 1(b). In addition to
creating one unified structure under which these changes would take place, a merged Department would offer some additional opportunities, including co-location of some services and structures to foster conversation across appropriate parts of both Departments. We would expect that this continuing “cross-talk” would lead to the identification of additional synergies and opportunities for collaboration or consolidation of functions.

**Organization and Leadership**

A critical factor to the success of any merger would be careful attention to maintain the priority and emphasis on serving the community’s needs with regard to mental health, substance abuse and developmental disabilities. As this appears to be the chief, expressed objection to a merger, those concerns should figure prominently in plans to communicate about, engage conversations around and ultimately implement a merger plan. This means giving both staff members and the broader community and key stakeholders opportunities to express their concerns, providing answers and reassurance addressing these concerns, and listening to ideas for maintaining a focus on mental health, substance abuse and developmental disability-related needs in the community.

The new leader (i.e., the Commissioner) of a combined Department should be chosen carefully. This person would need to have not only the right background and set of qualifications but also the right temperament and soft skills to successfully spearhead major organizational change: high energy and commitment but also tact, diplomacy, excellent listening skills and ability to communicate a vision and bring others along in reaching for it. This also means acknowledging the complexity of the merger and acknowledging the cultural values of each organization and the need to preserve those values. A blended background of some type is desirable, with experience in both health and mental health and a good understanding of family systems and community systems.

The new leader should also be someone who is comfortable with shared leadership and letting others be out front at appropriate times and places. This will be needed to ensure that the nuances and details of both the health and mental health perspectives are fully represented in all appropriate settings, including at senior County leadership tables and out in the community in various planning settings.

The new structure and leadership of the Department should be developed with an eye toward preserving the priority and prominence of mental health. CGR would recommend a Department name that includes both the health and mental health disciplines; a Commissioner title that refers to both Health and Mental Health or Hygiene, and a leader for the Mental
Health function who is elevated in title above other division leaders, such as the Executive Deputy Commissioner title used in New York City.

The purpose of creating an Executive Deputy Commissioner for Mental Hygiene is to support our assertion that Mental Hygiene should maintain its prominent role within the County. Elevating the position above peers is partly symbolic, and partly practical to allow the LGU function to potentially be managed by the Executive Deputy in appropriate and coordinated ways. It would signify the commitment of the County to Mental Hygiene services and provide additional clout for the Mental Hygiene Division to have a strong voice with corresponding power to represent the needs of the Division.

The initial organizational structure could preserve much of each Department’s current structure, with a shared administrative division reporting to the Commissioner but serving both the Executive Deputy Commissioner of Mental Hygiene and the Assistant Commissioner of Health in collaborative ways. Two title changes may be required: one for the Executive Deputy Commissioner of Mental Hygiene (currently the Commissioner of Mental Hygiene and the Clinical Division Services Chief have the credentials to fill this role); and one for the Director of Emergency Preparedness (currently a Supervising Public Health Nurse).

The new Director of Emergency Preparedness position would be created to elevate the status of Emergency Preparedness within the organizational structure. As of January 2014 the role is partly handled by the Supervising Public Health Nurse in the Public Health Nursing Division and together with the EMS coordinator in the HP&E Division there is a shared responsibility to accomplish the tasks for developing and maintaining a plan. For reasons already described in previous sections of this report, this arrangement may not be dedicating the attention and prominence that it needs to accomplish the tasks necessary for a robust Emergency Preparedness Plan. Creating a direct report to the Commissioner may empower the position to work across a merged Department, including interfacing with other County Departments, to establish the framework and hold people accountable to the Emergency Preparedness Plan.

The other significant change we propose is that the position of Budget and Finance Director report directly to the Commissioner. Again, for reasons outlined previously, this change would allow for better checks and balances in the performance of duties, and would also elevate the position to one of equal partner in the executive team of the Commissioner. The practical matter is that this position is often already part of most significant discussions within each current Department and therefore the change in reporting structure in many respects only reflects the reality of current operations.
See a proposed organizational chart below. The Commissioner of the combined Department would report to the County Executive and would interface with and receive advice from both the Board of Health and the Community Services Board, preserving existing governance structures.

Down the line, there may be opportunities identified to merge other divisions or to link them in a meaningful way. CGR could envision, for example, synergies between the current DMH Quality Improvement division and DOH’s Health Planning and Education division, both of which use data to track trends and programs. Whatever structure is developed initially could evolve as opportunities for deeper collaboration are identified. (See additional discussion below.)

**Legal and Regulatory Considerations**

Unlike some other counties, Dutchess does not have any language in its charter that would interfere with a merger of Health and Mental Hygiene or that would prevent one Commissioner from overseeing both functions, so long as the Commissioner meets the qualifications required under New York State law. Dutchess would need to secure State approval in various forms to move forward with a full merger.
In order to satisfy the requirements of the Public Health Law, Article 6, the Commissioner would need to be a board-certified physician with administrative experience. However, there may be some flexibility here, given that the NYS Sanitary Code laying out requirements for a county health commissioner allows for a county to request State approval for waiving some of the educational or experience requirements for the position. Dutchess County, should it wish to do so, would also need to amend its charter accordingly if it were willing to waive the MD requirement.

In order to have a combined Commissioner for Health and Mental Hygiene, the County would also need to obtain a waiver from the State Mental Hygiene Commissioner from the requirement in New York State Mental Hygiene Law, Article 41, that each county have a full-time employee serve as the director or commissioner overseeing mental hygiene. Alternately, the Executive Deputy Commissioner for Mental Health (in our hypothetical model) could serve as the Director of Community Services for State purposes, rather than the Commissioner, as is the case in Ulster. CGR’s conversations with other counties that have adopted merged or shared leadership arrangements suggest that State officials are open to allowing such flexibility.

As of now, the Dutchess County Charter requires that a Deputy Commissioner of Health must have an MD degree, though that is not required by New York State. To retain existing staff, either the Charter would have to be changed to allow for a person without an MD to fill the Deputy position (a step the County may want to consider independent of other actions taken resulting from this report), or the position would have to be modified in title to accommodate the person. In the case of DOH today, the title of Assistant Commissioner and the person filling the role could continue without interruption. Similar issues must be considered for a Deputy Commissioner of Mental Hygiene. Either the current Commissioner or the current Clinical Division Services Chief would meet the necessary requirements of an Executive Deputy Commissioner of Mental Hygiene.

**Co-location**

Ideally, a merged Department would be centrally located, with most of the core functions and divisions in one space. This would foster the building of a shared vision and culture for the new Department and facilitate joint meetings and more informal conversations between staff members. As noted earlier there is additional office space available within the DOH offices at the Poughkeepsie Journal Building, but not enough to house all of DMH. A smart design and planning effort would need to be conducted that would allocate staff synergistically. These ideas have been discussed in previous options sections 1c, 2 and 3.
Structures to Foster Collaboration

With or without the natural benefits arising from co-location, the leadership of a merged Department should be intentional about developing structures to foster collaboration. Divisions and individual staff members with shared or related interests should be identified and encouraged (required, if necessary) to meet on a periodic basis. This might happen between the DMH Quality Improvement staff and the DOH’s Planning and Education staff, as mentioned earlier. DMH’s Clinical Services division and the Public Health Nursing division provide another common-sense connection; topics for discussion might include how to co-locate mental health services with STD clinics, for example, where it makes sense. Emergency response is a function within DOH that could benefit from a closer connection to mental health expertise, so that in times of emergency there is a process for drawing in mental health experts in places and ways that make sense.

The importance of informal conversation should also be appreciated and taken into account when planning the configuration of the office, so that health and mental hygiene employees ideally have plenty of opportunities to cross paths. Shared lunchroom space and other common areas are also places that should reflect both disciplines and encourage cross-talk.

Payroll, HR, Billing and other Budget and Finance functions all would benefit from a shared location and vertically integrated structure that accounts for both the DOH and DMH needs. The ability to streamline some administrative functions such as building maintenance, inventory, infrastructure needs (telephone and security), and many other issues are possible additional outcomes of a merged department.

Implications

Initially, the financial and staffing implications of a merged department will be the same as the shared commissioner and shared administration models. Combined savings would include eliminating one Commissioner, one Budget Director, and possibly relocating all ITAP services back to the 230 North Road facility. Annually this would sum to around $485,000.

- Commissioner salary and benefits - $237,000
- Budget and Finance Director salary and benefits - $98,000
- Rent for 82 Washington Street - $150,000

Over five years, this would add to over $2.4 million. Most, if not all other staff, would be likely to be reallocated among the two Departments to account for gaps in the system. However, as the combined Department takes shape in its first 1-3 years of operations, and as the merger becomes a daily reality, additional opportunities for efficiencies may be identified.
It is important to note that there will likely be one-time costs associated with the realignment of staff, adaptive reuse of the 230 North Road facility, and other possible transitional costs that will reduce the potential immediate savings from these transitions. However, once those one-time costs are expended, the annual savings outlined above should accrue.

As important as the cost savings, however, may be the opportunities to streamline operations resulting in enhanced services and better division of labor. As discussed, this could include a better emphasis on Corporate Compliance for Medicaid for DOH, or more efficient management of HIPAA compliance trainings between the two Departments. More checks and balances within a different structure would be likely to better align the system for improved outcomes and strengthen the operation moving forward.

As discussed earlier, these issues are less important than providing quality service to clients and the community. There is no guarantee that a merged Department achieves this goal any better than the current operation. However, we believe there is significant opportunity to improve operations and the provision of integrated holistic services by using existing staff to augment services that are not currently getting sufficient attention, and in the process devote more staff time to programs, oversight, and building linkages and communication between the two Departments that are likely to lead to better outcomes for people in the community. The success of that depends on the extent to which a new leader can galvanize the interests of both Departments and lead a new merged Department in a direction with a shared vision for a new future that effectively strengthens and expands community awareness of both mental hygiene and public health issues.
CONCLUSION

Underlying Assumptions

CGR’s conclusions and recommendations for the County Executive and his leadership team are fueled in large part by several underlying assumptions about the County Executive’s philosophies and goals for County Government. To the extent that the County Executive or members of his team disagree with or place different emphases on various assumptions, or other factors influence decision-making that counteract these assumptions, a different set of conclusions or recommendations may result. The assumptions include that the County Executive:

- Supports the body of evidence that an integration of holistic physical health and mental health services is in the best interest of those who are being served;
- Wants to strengthen the delivery of services; any changes should maintain the strongest possible network/system of services;
- Believes that the County must think beyond the status quo in order to be competitive in the future;
- Wants to save dollars as much as possible, particularly limiting County net funding for DOH and DMH services, consistent with maintenance of a strong service system;
- Wants to maximize the use of available resources, operating as efficiently and cost-effectively as possible;
- Wants the best organizational structure to prepare for the future and the changing landscape of health/mental healthcare locally, regionally and nationally;
- Believes that streamlining departmental structures is beneficial;
- Wants to be cutting edge and be a thought leader to help shape approaches locally and in other counties around the state; and
- Is willing to act judiciously but aggressively if warranted to make changes that fulfill all of these assumptions.

Our conclusions are also fueled by a desire to ensure that the strong commitment to providing mental hygiene services in the County is not diminished by any outcome we might recommend. We have stated in several places throughout this report and reiterate here that any change to the current operations of the Mental Hygiene Department must be done with the utmost concern for keeping the needs of people with mental illness, substance abuse and developmental disabilities at the forefront of planning and service delivery models. Mental health professionals in the County and at the State level have made significant strides in both raising awareness and encouraging comprehensive access to quality care for some of the most vulnerable individuals in the community. While the system and the environment in which care is provided and funded are changing, and DMH continues to transition its primary role from direct service provider to overseer of a comprehensive system of care, the DMH staff and the system of care providers they oversee will and should continue to expect that the needs of the people they serve will be addressed with the highest caliber of service and to the extent possible will not be marginalized because of resource constraints or diminished emphasis on, or leadership of, mental hygiene services.

In fact, we believe that, done well, a merger can have the effect of elevating the prominence and importance of behavioral health issues by bringing them more directly into the planning, monitoring and convening functions of the public health department. Our conversations with DOH leaders and staff members, as well as members of the Board of Health, indicate that, almost to a person, they recognize the critical, inseparable role that behavioral health plays in overall health and would like to see
systems and staff members work more closely together in order to reflect that reality and improve health for the community.

We have reiterated throughout this report our strong belief that both DMH and DOH have long histories of impressive services rendered to the residents of Dutchess County. Both Departments have been blessed by, and strongly benefited from, strong leadership over the years at the Commissioner and top management levels. Nothing in our conclusions and recommendations should be interpreted as in any way diminishing our respect and admiration for this history of strong leadership, vision, caring and commitment to the highest quality of services.

But this study is about the future, and how the County best positions itself to meet the changing needs and realities that future will bring, when current incumbents will no longer be present. It would be inappropriate for us to make suggestions about who should serve in what capacities in our recommendations. Our intent has been to help design a structure that will enable the County to best meet the changing health and behavioral health environment of the future, looking beyond the tenure of present leadership. The proposed structure is designed to preserve and build on the strengths of the current DMH and DOH systems, while ensuring that strong governance structures and leadership will be in place to ensure the best possible delivery and oversight of public health and mental health services when the current leaders are no longer serving the County.

**Recommendations**

With these assumptions in mind, and considering the analyses we have conducted and outlined throughout the body of this report, CGR developed a set of recommendations around a series of questions.

**Is a merger of DOH and DMH feasible?**

CGR’s conclusion is that merger of the DOH and DMH is feasible, reasonable, and would result in short-term modest cost savings, and perhaps further efficiencies down the line as staff from the two Departments increasingly figure out how to work with each other. The benefits go beyond financial – there is real value to getting some of the staff working together and thinking about their work from a broader integrated perspective.

Merger is consistent with the changing landscape of healthcare delivery in New York State and nationally. There are numerous forces driving toward more holistic integration of services in the physical and behavioral health professions, and a merger would position these two Departments to proactively adapt to the changes that will likely be required.
Though we believe merger is feasible on its merits, there is a strong set of additional assumptions that are important to acknowledge. In order for merger to elevate the delivery of service and ensure those served by the current DMH are not marginalized in any way, the leader of the merged Department will have to be a strong advocate for mental hygiene services. The leader will have to have a good understanding and appreciation for the role of a Mental Hygiene Commissioner, including the legalities of fulfilling the requirements of Section 9.45 of the Mental Hygiene Law and providing strong leadership to fulfill the LGU role within the County. There is a degree of independence that is essential for the mental hygiene function to maintain a respected voice in the community, and that has the potential to be lost in a merger. The extent to which a combined Department can preserve the independence and prominence of the mental hygiene function while building on the opportunities for collaboration, communication and leveraged resources may dictate whether a merger should be implemented and, if so, how successful a merger can be.

Success must also be clarified. We use the term success to mean a new, merged system that results in cost savings, more efficient services, and an overall improved level of care and access for those needing support from either the public health or mental hygiene system. Change for the sake of cost savings alone may be compelling for budgetary reasons, but should not be the sole criterion by which success is measured.

**Is a merger of DOH and DMH necessary?**

Given that a merger is feasible does not satisfactorily answer whether a merger is necessary. Necessity can be defined in several ways. Using one of the assumptions outlined above, that the status quo is potentially unsustainable, change is likely required in both DOH and DMH in some capacity. Our report outlines numerous options for changes with potential for improvement within and between the two Departments. Merger is not the only change that will yield efficiencies, cost savings or improved levels of service, and therefore a merger is not an absolute necessity to achieve some of the desired results.

**Is merger preferable to the status quo?**

Based upon our analysis, a merger is preferable to the status quo for several reasons.

- It will save money. As noted in the previous summary of the merger option (Option 4), we anticipate that, following initial one-time transition costs, nearly $485,000 in gross annual savings could accrue from the merger if implemented according to the design we outline. This is likely conservative, given the numerous
other options that we believe should also be implemented that should lead to additional cost savings.

- There are currently opportunities for increased efficiency in the programmatic, operational and oversight systems in each of the Departments. We have outlined these opportunities in detail in the other sections of this report; they span overstaffing, and ways of improving coordination and communication. Although some of these opportunities can be addressed short of merger of the Departments, on balance we believe that they can best be addressed through the combined efficiencies that can only occur through merger.

- There are currently services that are suffering from insufficient resources and / or manpower available within one Department. Several were cited in DOH, for example, including a lack of capacity devoted to corporate compliance, quality improvement and several other key administrative tasks. Each Department has strengths or resources (i.e., manpower) it could leverage on behalf of the other that would alleviate some of these issues.

- A merger is consistent with a philosophical move toward integrating the two physical and mental/behavioral health disciplines in theory and practice.

- Mental health and physical health needs are increasingly intertwined and some, such as substance abuse, are becoming significant public health concerns. The NYS Prevention Agenda and Dutchess County Community Health Improvement Plan (CHIP) both identify substance abuse issues as a paramount public health matter that needs to be addressed in a comprehensive, holistic, integrated manner across disciplines.

- There needs to be better collaboration between the two Departments. From small issues like purchasing the same things from the same vendors, to larger issues like not coordinating on the broader communication plan developed by the DOH, there are potentially many opportunities to collaborate more proactively.

- The evolving landscape of healthcare and funding requirements related to managed care are going to force some change, and being proactive will put the County in a better position to handle the changes as they come.

**Could the benefits of merger be achieved without it?**

The next question we posed is whether merger is the only answer to achieving many of the outcomes listed above. The shared services approaches outlined above in Option 1c, the combined administrative structure of Option 2, or even the combined Commissioner approaches
outlined in Option 3 all represent potential for change. There are good points in favor of any of these options, as most of them could achieve some level of the savings, efficiencies and potential service integration and improvements bulleted above.

The issue in our estimation that tips the scales in favor of full merger is the significant organizational and cultural differences that currently exist between the two Departments. It is our concern that if most of the suggested options were to be implemented in the context of the current structures and organizational paradigms, few if any of the broad collaborative recommendations would ultimately succeed. In order for there to be a significant change, we believe that the organizational model must shift to help force change throughout the staff and programs of the two current Departments.

Organizational change is difficult in the best of circumstances, including when fueled by energetic leadership with vision and passion and a strong base of support from key influencers all around the organization. When there is a difference in philosophy between leaders that is rooted in historical paradigms, including perceptions that change often means a degradation of service rather than an improvement, the hurdles are often too great to overcome and inertia becomes the dominant force. CGR believes that bypassing those hurdles through wholesale structural change may be essential and beneficial to achieving some immediate wins and long term organizational change.

It is also a fair conclusion that cost savings will likely be minimized the less dramatic the change becomes. For instance, the options associated with shared services (Inter-Departmental) change are geared more toward improved efficiencies, and only a few would result in cost savings opportunities by themselves. They will promote improvements in service and lead to better outcomes for people that are being served, which is enough reason to pursue them. However, since cost savings is one of the County’s goals, those options even if pursued successfully may not produce the budget outcomes that are necessary to keep the County competitive, unless they are part of a merged approach.

**Does merging the two Departments need to be done all at once?**

The short answer to this question is no. There are many steps that could be taken to phase this process in over time. We outline several of those alternatives below. We understand some of the cost savings and efficiency benefits of full-scale merger to be closely linked to having a single Commissioner and consolidating administrative services. We don’t limit our recommendations to these incremental changes for the reasons already stated about organizational culture, believing the best possible outcome for the County and the people receiving services rests in the ability to fully
bridge the culture of the two Departments. Short of that, we believe the likelihood of success as we define it would be significantly reduced.

**Alternatives**

Though we recommend complete merger from the outset, there are other paths to the same end that the County could adopt to ease the transition. We outline two scenarios in Option 3 that could start the County on the path towards full merger. If the County wants to take a slower path and start with maintaining the two Departments, but under the leadership and direction of a single Commissioner, we would recommend that Option 3a be pursued. As evidenced by several counties, this option results in savings at the Commissioner level, but largely leaves existing structures and services in place in each Department. We have outlined the advantages of moving to a single Commissioner as largely allowing for one person to help guide a transition toward better integration of services as well as identification of inefficiencies and incremental implementation of many of the other options that we have identified.

A next logical step would be to consolidate the administrative functions under a single Commissioner (Option 3b). However, consolidating administrative functions would not be required under the single-Commissioner option. What we *would* discourage would be the consolidation of administrative functions without at least moving to a single Commissioner model. We defined this in Option 2. We believe that the shared administrative model we developed as an option is potentially fraught with problems if the administrative duties are not linked to a single Commissioner for reporting purposes. The problems include defining appropriate reporting and supervisory responsibilities, determining how to share time, space and location considerations if staff report to two people, and a host of other matters.

Whether or not a full departmental merger is implemented by the County, CGR believes a number of the options outlined in the earlier discussions of options 1b and 1c should also be implemented (or at least be seriously considered) by the County. We offer the following recommendations concerning each of these options for the County’s consideration.

**Recommended Options**

- Strengthen Corporate Compliance
- Create a position of Director of Emergency Preparedness
- Adopt Electronic Payroll and streamline other software systems as possible
- Consider alternatives for Partial Hospitalization Program
- Strengthen Contract Review
- Strengthen LGU Role
• Reconfigure DMH Administrative Staff
• Reconfigure the DMH budget to better allocate administrative positions
• Cross-train Public Health Nurses, EI and Preschool Staff to diagnose mental health issues
• Share purchasing, data, space, and develop more comprehensive communications strategies
• Collaborate on the Community Health Improvement Plan
• Take steps to fold DMH OIT into OCIS

Not Recommended

• Option 2 – Administrative merger in the absence of other structural changes is not recommended. In order to be clear, we do recommend merging administrative functions as appropriate, but only in the context of a single Commissioner or full merger where lines of reporting and supervision are clearly delineated. Issues like sharing purchases and other small collaborative efforts are possible within the structure of the two Departments that currently exist and would not require a full administrative merger.

Recommended Only With Further Investigation

Several of the options identified may not have enough detail to implement without further investigation. Additionally, some of the options only make sense if other options are implemented simultaneously, or precede the options listed below.

• Add administrative capacity at DOH – Through our review of current operations it appears there is a need to add some administrative capacity in the Department of Health. This may be accomplished in the context of a full merger where staff could be optimally redeployed. However, the need may become acute without a merger and there could be a position that is required to be added to DOH. Whether this position comes from elsewhere in the DOH or from another Department in the County is unknown.

• Move HELPLINE and MCIT to the 911 Center – There appears to be synergy to make this move between the space and security issues at 230 North Road and the availability of space at the 911 Center. The move may not result in better or worse service, but may improve work conditions for employees, and build in redundancies for staff that are on shift alone. Whether a move geared toward improving work conditions for the employees warrants enough consideration to merit a move is unknown.
• Consolidate DMH staff at 230 North Road – Relocating the ITAP program and consolidating several DMH programs into the 230 North Road is likely only feasible if other relocations of staff occur. For instance, if the HELPLINE and MCIT were to move to the 911 Center, and if Budget and Finance staff were consolidated at the DOH main facility, and if DMH pursued a right-sizing strategy that yielded some efficiencies through staff reductions, then consolidating staff at 230 North may be feasible. On its merits, it is likely not an ideal option absent some of these other “dominoes.” That said, 230 North Road does have some free space and options should be considered for how to utilize that free space more judiciously.

• Examine outpatient clinics for more efficiency – Whether contracted agencies are optimally staffing various clinic locations should be reviewed in light of demand data and outcome measures for each location. There is not enough information at this time to formally recommend any changes.

Implementation Plan

Our recommendation to merge the Departments of Mental Hygiene and Health can be achieved in a variety of ways, including implementing many of our options over time as described above. However, if the County adopts our premise that merger is the best solution, then the process ideally will begin with that goal in mind. We have outlined a hypothetical timeline and implementation plan in the following paragraphs as one approach to achieving full-scale merger.

Months 1-3

During this phase we believe that conversations regarding this report should start between the County Executive’s office, the Acting Commissioner of Health and the Commissioner of Mental Hygiene, the Clinical Division Chief and the Administrative Division Chief of Mental Hygiene and the Assistant Commissioner of Health. It may also make sense to involve at some level representatives from the Community Services Board and the Board of Health, along with perhaps representatives from Imagine Dutchess, the County Executive’s Health and Human Services Advisory Team, and the Health and Human Services Cabinet Advisory group. The purpose of these discussions should be to frame the new paradigm and intended goal and outline the issues going forward. A formal plan will need to define what makes sense and is achievable and in what sort of timeline.

Toward the end of this initial 3-month timeframe, the County should begin in earnest the formal identification of a single Commissioner. The
Commissioner should meet all the established criteria as set forth throughout this report, including having a strong commitment to mental health and a willingness to empower the needs of the mental hygiene staff and leadership as necessary to ensure the LGU function is fulfilled in a robust manner.

It will also be essential to create a plan for communicating changes to the community and provider networks throughout this timeframe. Working closely with the group of representatives previously listed should allow for open and transparent dialogue and facilitate necessary feedback loops to ensure a transition is as smooth as possible within the local government and the larger community.

**Months 3-6**

As the process unfolds, attention should turn to identifying shared service opportunities, some of which will come from this report, and others which will emerge as the two Departments begin to work together and identify opportunities. Out of this will emerge tentative plans for the 2015 budget preparation, including reassignment of staff, reallocation of resources, and possible relocation of some programs, services or personnel.

**Months 6-12**

Significant steps should have been made by this timeframe to begin merging the Budget and Finance staff from both Departments. This will involve some reassignment of responsibilities, possible relocation of offices to a merged office environment, and a delineation of duties to account for the specialization required in each function. By the end of this timeframe, the two budget divisions should be operating as one unit. The 2015 County budget should reflect a combined operation.

The transition of OIT to OCIS could occur during this timeframe, allowing for enough preparation to fully integrate into OCIS before all operations are fully merged.

During this time frame, assuming this is the last part of 2014, restructuring of staff and titles for 2015 should be well along in process, and the County should take formal action to adopt the new organizational chart as the guiding model for the integration of the services. We would expect that any authorizing legislation or act of the County Legislature would have to take place during this timeframe in order to ensure the Department could be operational as a single entity in 2015.

**Months 12-24**

If a single Commissioner has not been identified and installed during the first year, the process should be completed within this timeframe. The new
Commissioner will continue to act on implementing shared service opportunities and refine the integration of the two Departments. Any relocation of programs or services could occur in this timeframe once the relocation of other shared administrative support staff has occurred and the available space is identified.

During this time, department leaders should address the need to intentionally develop structures to foster collaboration, including regular meetings between and among divisions and individual staff members with shared or related interests, as discussed in more depth in Option 4.
APPENDIX
**DUTCHES COUNTY DEPARTMENT OF MENTAL HYGIENE SERVICE REPORT JANUARY - DECEMBER 2012**

<table>
<thead>
<tr>
<th>ON ROLLS</th>
<th>ADMITS</th>
<th>TERMS</th>
<th>ON ROLLS</th>
<th>PERSONS SERVED</th>
<th>VOLUME OF SERVICE</th>
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<td>7459</td>
<td>8183</td>
<td>8660</td>
<td>6982</td>
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**DIVISION OF MENTAL HEALTH SERVICES**

**DMH PROGRAMS**

- **MOBILE CRISIS INTERVENTION TEAM (A)**
  - On Rolls: 0
  - Admits: 482
  - Terms: 222
  - On Rolls: 260
  - Person Served: 482
  - Volume of Service: 3820

- **SPECIAL SERVICES/ MANSION ST. MHC (B)**
  - On Rolls: 327
  - Admits: 58
  - Terms: 385
  - On Rolls: 0
  - Person Served: 385
  - Volume of Service: 4632

- **PARTIAL HOSPITALIZATION**
  - On Rolls: 22
  - Admits: 358
  - Terms: 355
  - On Rolls: 25
  - Person Served: 380
  - Volume of Service: 3779

- **HEGDEWOOD MENTAL HEALTH CLINIC (C)**
  - On Rolls: 158
  - Admits: 23
  - Terms: 181
  - On Rolls: 0
  - Person Served: 181
  - Volume of Service: 3453

- **COURT EVALUATIONS**
  - On Rolls: -
  - Admits: -
  - Terms: -
  - On Rolls: -
  - Person Served: 83
  - Volume of Service: 181

**CONTINUING SERVICES PROGRAMS**

- **Day Treatment Centers (D)**
  - On Rolls: 337
  - Admits: 23
  - Terms: 360
  - On Rolls: 0
  - Person Served: 360
  - Volume of Service: 9542

  **SUB-TOTAL**
  - On Rolls: 844
  - Admits: 944
  - Terms: 1503
  - On Rolls: 285
  - Person Served: 1871
  - Volume of Service: 25407

**OCCUPATIONS, INC.**

**PROS PROGRAMS (E)**

- **RHINEBECK PROS**
  - On Rolls: -
  - Admits: -
  - Terms: -
  - On Rolls: -
  - Person Served: 93
  - Volume of Service: 24381

- **MILLBROOK PROS**
  - On Rolls: -
  - Admits: -
  - Terms: -
  - On Rolls: -
  - Person Served: 140
  - Volume of Service: 18844

- **POUGHKEEPSE PROS**
  - On Rolls: -
  - Admits: -
  - Terms: -
  - On Rolls: -
  - Person Served: 232
  - Volume of Service: 30299

  **SUB-TOTAL**
  - On Rolls: 465
  - Admits: 73524

**MENTAL HEALTH AMERICA**

- **SUPPORTIVE CASE MANAGEMENT**
  - On Rolls: 559
  - Admits: 445
  - Terms: 393
  - On Rolls: 611
  - Person Served: 1004
  - Volume of Service: 14348

- **BLENDED SUPPORTIVE CASE MANAGEMENT**
  - On Rolls: 231
  - Admits: 209
  - Terms: 265
  - On Rolls: 175
  - Person Served: 440
  - Volume of Service: 5039

- **GENERIC CASE MANAGEMENT (D)**
  - On Rolls: -
  - Admits: -
  - Terms: -
  - On Rolls: -
  - Person Served: (D)
  - Volume of Service: 1377

- **INTENSIVE CASE MANAGEMENT**
  - On Rolls: 54
  - Admits: 69
  - Terms: 65
  - On Rolls: 58
  - Person Served: 123
  - Volume of Service: 2304

- **BLENDED INTENSIVE CASE MANAGEMENT**
  - On Rolls: 67
  - Admits: 69
  - Terms: 54
  - On Rolls: 82
  - Person Served: 136
  - Volume of Service: 3554

- **HEGDEWOOD CASE MANAGEMENT**
  - On Rolls: 115
  - Admits: 26
  - Terms: 28
  - On Rolls: 113
  - Person Served: 141
  - Volume of Service: 2810

- **BEACON PROS PROGRAM (F)**
  - On Rolls: -
  - Admits: -
  - Terms: -
  - On Rolls: -
  - Person Served: 146
  - Volume of Service: 32330

- **COMMUNITY SUPPORT PROGRAMS (G)**
  - On Rolls: 129
  - Admits: 15
  - Terms: 32
  - On Rolls: 112
  - Person Served: 144
  - Volume of Service: 1503

  **SUB-TOTAL**
  - On Rolls: 1155
  - Admits: 833
  - Terms: 837
  - On Rolls: 1151
  - Person Served: 2134
  - Volume of Service: 63265

**HVMH MENTAL HEALTH CLINICS**

- **POUGHKEEPSE**
  - On Rolls: 930
  - Admits: 802
  - Terms: 613
  - On Rolls: 1119
  - Person Served: 1732
  - Volume of Service: 16932

- **MILLBROOK**
  - On Rolls: 126
  - Admits: 91
  - Terms: 72
  - On Rolls: 145
  - Person Served: 217
  - Volume of Service: 2325

- **BEACON**
  - On Rolls: 488
  - Admits: 409
  - Terms: 370
  - On Rolls: 527
  - Person Served: 897
  - Volume of Service: 13366

- **EASTERN DUTCHESS**
  - On Rolls: 223
  - Admits: 101
  - Terms: 126
  - On Rolls: 198
  - Person Served: 324
  - Volume of Service: 3562

- **RHINEBECK**
  - On Rolls: 113
  - Admits: 141
  - Terms: 114
  - On Rolls: 140
  - Person Served: 254
  - Volume of Service: 3130

  **SUB-TOTAL**
  - On Rolls: 1880
  - Admits: 1544
  - Terms: 1295
  - On Rolls: 2129
  - Person Served: 3424
  - Volume of Service: 39315

**TOTAL MENTAL HEALTH DIVISION**

- On Rolls: 3879
- Admits: 3321
- Terms: 3635
- On Rolls: 3565
- Person Served: 7894
- Volume of Service: 201511

**TOTAL DC / DMH 2012**

- On Rolls: 7459
- Admits: 8183
- Terms: 8660
- On Rolls: 6982
- Person Served: 23218
- Volume of Service: 547027

(A) PROGRAM BEGAN APRIL 2012.
(B) PROGRAM CLOSED DEC 2012.
(C) PROGRAM CLOSED DEC 2012.
(D) THE THREE DMH DAY TREATMENT CENTERS WERE CLOSED ON MARCH 30, 2012.
(E) THE OI PROS PROGRAMS BEGAN APRIL 1, 2012.
(F) THE MHA BEACON PROS PROGRAM BEGAN JAN 2, 2012.
(G) INCLUDES COMPEER ONLY. EFFECTIVE 12/31/2011, DUTCH.HORIZONS, BEACON PSYCH. CLUB & YOUNG ADULT PROG WERE CLOSED.
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<th>PERSONS</th>
<th>VOLUME OF SERVICE</th>
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## DUTCHESS COUNTY DEPARTMENT OF MENTAL HYGIENE SERVICE REPORT JANUARY - DECEMBER 2012

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<th>PERSONS SERVED (EPISODES)</th>
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### OFFICE OF COMMUNITY CONSULTATION & CHILDREN'S SERVICES

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### ST. FRANCIS HOSPITAL

| INPATIENT | 172 | 1023 | 1024 | 171 | 1195 | 14185 |
| EMERGENCY DEPARTMENT | -- | -- | -- | -- | 5290 (B) | 5290 |

### ASTOR PROGRAMS

| POUGHKEEPSIE COUNSELING CENTER | 373 | 606 | 524 | 455 | 979 | 9730 |
| RED HOOK COUNSELING CENTER | 259 | 275 | 124 | 410 | 534 | 5917 |
| BEACON COUNSELING CENTER | 198 | 199 | 177 | 220 | 397 | 4374 |
| DOVER ASTOR CLINIC (C) | 99 | 107 | 68 | 138 | 206 | 1784 |
| HOME-BASED CRISIS INTERVENTION PROGRAM | 11 | 90 | 84 | 17 | 101 | 697 |
| INTENSIVE CASE MANAGEMENT | 31 | 43 | 54 | 20 | 74 | 857 |
| SUPPORTIVE CASE MANAGEMENT | 13 | 37 | 36 | 14 | 50 | 442 |
| DAY TREATMENT CENTER | 62 | 35 | 34 | 63 | 97 | 13168 |
| ADOLESCENT DAY TREATMENT | 117 | 44 | 54 | 107 | 161 | 16070 |
| PARTIAL HOSPITAL (D) | 16 | 128 | 125 | 19 | 144 | 1615 |

**SUB-TOTAL** 1179 | 1564 | 1280 | 1463 | 2743 | 54654 |

### TOTAL COMMUNITY CONSULT. & CHILDREN'S SRVCS

| TOTAL COMMUNITY CONSULT. & CHILDREN'S SRVCS | 1367 | 2822 | 2531 | 1658 | 9479 | 102365 |

### DIVISION OF DEVELOPMENTAL DISABILITIES

#### CLINIC FOR MULTI-DISABLED

| CMD MENTAL HEALTH PROGRAM | 437 | 18 | 455 | 0 | 455 | 2570 |
| CMD CHEMICAL DEPENDENCY PROGRAM | 2 | 0 | 2 | 0 | 2 | 12 |
| **SUB-TOTAL** | 439 | 18 | 457 | 0 | 457 | 2582 |

### ABILITIES FIRST

| DAY HAB | 319 | 20 | 22 | 317 | 339 | 53169 |
| WORK TRAINING | 221 | 8 | 8 | 221 | 229 | 32445 |
| WARYAS RECOVERY HOUSE | 8 | 5 | 5 | 8 | 13 | 2953 |
| **SUB-TOTAL** | 548 | 33 | 35 | 546 | 581 | 88567 |

### ARC

| SHELTERED WORKSHOP | 129 | 9 | 6 | 132 | 138 | 20095 |
| AMENIA SATELLITE WORKSHOP | 29 | 0 | 4 | 25 | 29 | 2274 |
| **SUB-TOTAL** | 158 | 9 | 10 | 157 | 167 | 22369 |

### TACONIC

| TACONIC DAY PROGRAM | 111 | 3 | 4 | 110 | 114 | 20843 |
| **TOTAL DEVELOPMENTAL DISABILITIES DIVISION** | 1256 | 63 | 506 | 813 | 1319 | 134361 |

### TOTAL DC / DMH 2012

| TOTAL DC / DMH 2012 | 7459 | 8183 | 8660 | 6982 | 23218 | 547027 |

(A) DUTCHESS COUNTY RESIDENTS ONLY.

(B) DATA PROVIDED BY SFH. DUE TO PROCEDURAL CHANGES AT SFH, THIS FIGURE NOW REPRESENTS ALL MH EMERGENCY VISITS.

(C) DOVER ASTOR BECAME A LICENSED CLINIC IN 2012

(D) ASTOR PARTIAL HOSPITAL PROGRAM BEGAN 2/2011

(E) PROGRAM CLOSED DEC 2012.
Dutchess County
Health and Human Services Advisory Team

Input to the County Executive on the

CGR Feasibility Analysis for the Merger of the Departments of Health and Mental Hygiene

February 2014
Dutchess County Health and Human Services Advisory Team Membership

Chairman, Dr. James McGuirk,
Astor Services for Children & Families, Executive Director/CEO

Staff Liaison, Mary Kaye Dolan,
Dutchess County Health and Human Services Cabinet Chair

Jacki Brownstein – Community Advocate
Renee Fillette – Grace Smith House
Don Hammond – United Way of the Dutchess-Orange Region
Kevin Hazucha – Hudson Valley Mental Health
Lorna Johnson – Hudson River Health Care
Trish Luchnick – Astor Services for Children & Families, Consumer Advocate
John E. Mack, PA – Health Quest Medical Practice, PC
Steve Miccio – PEOPLe, Inc.
Ed Murphy – Hudson River Housing
Andrew O’Grady – Mental Health America of Dutchess County
Dr. James Regan – Marist College

Carole Lehrer,
Confidential Secretary
Dutchess County Health and Human Services Advisory Team

Input to the County Executive

On the CGR Feasibility Analysis for the Merger of the Departments of Health and Mental Hygiene

The Health and Human Services Advisory Team offers its thanks to Scott Sittig, Don Pryor and Erika Rosenberg of CGR for a thorough and thoughtful analysis and the detailed report which resulted from their work.

The Team appreciates being afforded the opportunity to provide input into this important decision to be made by the county and also acknowledges the willingness of the county government and its departments to openly engage in the process of self-examination.

Initial Recommendation:

The Health and Human Services Advisory Team finds that the CGR Report and its recommendation for a full merger is consistent with the input previously provided to the County Executive, particularly as it relates to the integration of physical and mental health, the current and ongoing impact of Health Homes, the Affordable Care Act, and the need for data based decision making. The Team supports CGR’s recommendation of “Option 4,” the full merger of the Departments of Mental Hygiene and Health and recommends the county pursue that option.

Related Recommendations:

In order to make a merger successful for the county itself, the overall community and individuals served, the Team requests the county give consideration to the following related recommendations as its proceeds:

1. Mission Statement and Value Set – A mission statement and a set of values should be constructed early on in the merger process. The Health and Human Services Team, or representation from the Team, should be included in the development of the mission and values.

2. A merger should seek to protect and maintain the level of service currently provided with a focus on quality and accountability. Efficiencies should not focus only on dollars, but on quality as well. Service delivery decisions should be based on and address the
social determinants of health. The merger should go beyond collaboration and actually align services to improve them.

3. The county should provide for a consumer voice in the merger process as well as in the operation of the merged department. One possibility during the process would be small town-hall style meetings, perhaps facilitated by Imagine Dutchess.

4. The Board of Health and Community Services Board should be examined and reconstituted with a goal of providing greater emphasis on consumer input as well as a greater role for the Boards in the planning, monitoring and service delivery process. This should include an epidemiological view of these three areas.

5. The selection of a Commissioner for the merged department who strongly reflects the values and mission developed is key. The Team believes the selection of the right person as Commissioner is critical to the successful transition to a merger. While we believe the person should ideally be part of the process in the early stages of the merger, it is more important to find a person who will be a strong leader and reflect the mission and values established for the department.

6. As the county goes through the merger process, it should keep in mind any opportunities to work toward greater integration or synergies of the merged department with the Department of Community and Family Services and Department of Probation due to the large numbers of shared clients.

7. The Health and Human Services Advisory Team should have a role in the transition planning process.