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# Assessment of the Dutchess County Department of Mental Hygiene

**August, 2008**

Prepared for:
**Dutchess County Executive and Department of Mental Hygiene**
Donald E. Pryor, Ph.D.
Project Director

1 South Washington Street
Suite 400
Rochester, NY 14614
585.325.6360

100 State Street
Suite 330
Albany, NY 12207
518.432.9428

www.cgr.org

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## SUMMARY

Dutchess County is blessed with a strong, diverse array of mental hygiene services. Over the years a number of changes have occurred which have reduced the County Mental Hygiene Department's direct control over major parts of the system, while making it possible at the same time to reduce the County payroll and direct salaries and benefits below what they would otherwise have been. Even as selected in-house services have been contracted out, the scope of the entire system has expanded over the years, and more people are served across the system now than was the case 10 years ago.

The scope and coverage of the system have also expanded over time, and a wide range of services are available and accessible on a decentralized basis throughout the county. On the other hand, much more attention is needed to investing in and providing expanded quality supervision, training and staff development support to the relatively less experienced line staff who now provide many of the contract agencies' clinic and case management services that represent the core of the MH service system.

CGR found no evidence of unneeded, inappropriate or redundant services or programs. There are opportunities to make better use of existing services and resources, and perhaps even to scale back some services, but we found none that warrant elimination—and some that may merit consideration for modest expansion under specific circumstances and guidelines.

CGR recommends that no changes be made in the current mixture of in-house, County-operated services and the services currently provided by contract agencies. There is a logic to retaining the services and programs currently provided directly by the MH Department, and no compelling logic suggesting that they should be outsourced.

CGR made a number of other recommendations designed to help the MH Department build on its many successes while at the same time developing new responses that will ensure that it continues to fulfill its historic mission in the future, in ways that balance quality provision of services with fiscal prudence and accountability.

# ACKNOWLEDGEMENTS

This study could not have been completed without the dedicated cooperation and assistance of a large number of individuals who serve Dutchess County through their work within the Department of Mental Hygiene's system of both County-operated and external programs and agencies.

We extend our appreciation to the more than 80 individuals who took the time to meet with us and share their experiences and insights. The information gathered in our interviews with these individuals (including considerable information and data supplied on a followup basis) is the backbone of this report. In addition, we would like to thank those members of the staff whom we did not interview but who welcomed us, responded to requests for information, and accommodated our space and scheduling needs.

Several individuals were particularly indispensable to us during this study:

Dr. Kenneth Glatt, Commissioner of the Department of Mental Hygiene, made himself and his staff available to us and provided invaluable history, perspective and deep insight into the organization. He was generous with his time, and we are grateful for his cooperation and his willingness to "let the chips fall where they may" as the study evolved. He set a tone throughout the Department of encouraging staff to be helpful, open and candid in their conversations with us, and that openness and candor were apparent in virtually all of our interviews.

Betsy Brockway, Director of the Dutchess County Health and Human Services Cabinet, provided leadership and support, and offered valuable insights and perspective on the larger County context in which the Department of Mental Hygiene operates.

Sonya Newman, Confidential Secretary to the Commissioner, seamlessly coordinated every aspect of our visits to Dutchess County and greatly simplified the logistical aspects of the study.

The Department's Division Chiefs and Office Directors all met with us for multiple and lengthy interviews and accommodated our requests for followup discussions and exchanges of information. We greatly appreciate their time, candor and willingness to share their extensive knowledge, experience and ideas. Their wisdom and insights are reflected throughout this report. We would also like to specifically acknowledge the leadership and key staff of the Office of Information Technology for their unfailing and thorough responsiveness to our multiple and never-ending data

requests, and the staff at Helpline, for allowing us to observe their operations during a busy shift.

## Staff Team

This report is the result of a team effort involving the project director and immense contributions from Maria Ayoob, who contributed her interviewing, analytic and writing skills to the project. Maria wrote drafts of many sections of the report, helped develop the recommendations, and added her editing skills to strengthen the final product.

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# CHAPTER I: INTRODUCTION

## Background

As the Dutchess County Department of Mental Hygiene (DMH) celebrates its 40th anniversary as a fully-functioning Department under the Dutchess County charter form of government, it is an ideal time to take stock of the Department's many achievements, as well as to address ways in which it can undertake productive changes to better prepare the Department and the County for the future. Accordingly, Dutchess County hired the Center for Governmental Research Inc. (CGR) to conduct a review of the Department of Mental Hygiene and the broader system of mental hygiene services it has helped create throughout the County. The objectives of the study were to review the current delivery of services within DMH and the larger mental hygiene system, to identify opportunities for increased efficiency, effectiveness and service enhancement, and in turn to suggest ways to strengthen the ability of DMH to meet future needs and continue to fulfill its mission in a fiscally prudent manner.

## Context

In the last several years a number of changes have affected DMH, its target population, and its service delivery system. In the late 1990s, County financial constraints and desires to downsize the County government workforce led the County Executive to promote the transitioning of certain services to not-for-profit agencies, thereby reducing the number of county employees in the mental hygiene system. This initiative coincided with desires to expand the array of mental hygiene services to address new issues, and the Commissioner of Mental Hygiene and the Department have been able to expand the system even as the County's MH workforce was being substantially reduced. Further efforts at cost constraint have included a hiring freeze in the County that has affected DMH's ability to staff some programs at levels deemed necessary by some.

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.

In addition to these changes in the external environment, a series of internal changes have occurred within the Department which have complicated ways in which staff perform their responsibilities, and which have, at least in the short run, compromised the Department's ability to

operate as efficiently and cost-effectively as in the past. The introduction of a comprehensive, complex and difficult-to-implement software system, loss of key experienced billing staff, and related changes in both Department and County financial practices and systems (accompanied by overlapping changes in State financial reporting requirements) combined to create the "perfect storm" of upheaval affecting all levels of staff activity, reporting, revenue generation and both clinician and support functions throughout the Department.

In this context of ongoing and more recent change, the County and the Department both understood the need to reevaluate the service delivery system within DMH and its contract agencies—and also understood the opportunity provided by this study to identify ways the Department can build on past successes to address and accommodate the environmental changes and develop responses to them that will ensure that it continues to fulfill its historic mission in the future, in ways that balance quality provision of services with fiscal prudence and accountability.

# Methodology

CGR used a number of methods in conducting this study:

## *Interviews*

CGR conducted more than 100 face-to-face interviews (including a number of followup interviews and phone discussions) with more than 80 individuals—members of the DMH leadership and staff at all levels, as well as leadership of key contract agency service providers. Through these interviews, CGR gained an understanding of the nature of services delivered, the processes involved in service delivery, staff roles and responsibilities, and numerous helpful insights about perceived strengths, challenges and opportunities for improvement within DMH and the overall mental hygiene system.

## *Review of Data*

CGR also reviewed and analyzed extensive background materials including internal Department reports such as minutes of Executive Council meetings, annual plans and Departmental goals and priorities, organizational charts, financial and program service reports, and policy and procedures manuals. In addition, along with our project partner CCSI, we analyzed relevant figures regarding budgeted and actual expenditures and revenues, service volume, demographics of those served, staffing and caseloads, and various productivity and outcome measures where available, for both internal Department-operated programs and services provided by contract agencies. We also discussed programs and best practices in place in other counties that might have future implications for Dutchess County.

### *Review of Contracts*

CGR reviewed a number of the contracts between DMH and the key agencies it funds to provide services to its constituency of clients. Contracts were reviewed to gain an understanding of performance requirements, services delivered and the funding relationships involved.

# CHAPTER II. STRENGTHS OF THE SYSTEM

Prior to describing and analyzing specific aspects of the Department of Mental Hygiene, its functions and its services (and those of its contract agencies) in subsequent chapters of the report, this chapter summarizes CGR's overview assessment of the overall strengths of the existing MH system as it has evolved over the past 40 years.

## 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. Because counties throughout the state offer, fund and monitor mental hygiene services in a variety of different ways—and differ widely in what they take credit for and the degree to which they hold various providers accountable to county taxpayers—it is difficult to make direct comparisons between counties concerning the scope and mix of MH services offered to county residents.

Nonetheless, based on the statewide experience of CGR and our partner, CCSI, it is our belief that Dutchess DMH offers as comprehensive a mix of services as almost any county of its size (and even including many larger counties) in the state. 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. This is particularly true in terms of broad accessibilityof services to county residents (see below). Moreover, Dutchess offers approaches to certain services that are distinct, if not unique, to the Department, compared to other counties. Those will be noted in subsequent sections of the report.

## Availability and Accessibility of Services

As discussed in more detail below, DMH has made conscious decisions over the years to decentralize service provision 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 Figure 1 on the 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. Bringing services to the community is a long-standing practice for services provided by the Department, and has been extended through many contract agencies as well. In addition, although DMH and its contract providers must attempt to maximize revenues and fees in exchange for provision of services, the Department also emphasizes 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 MH services.

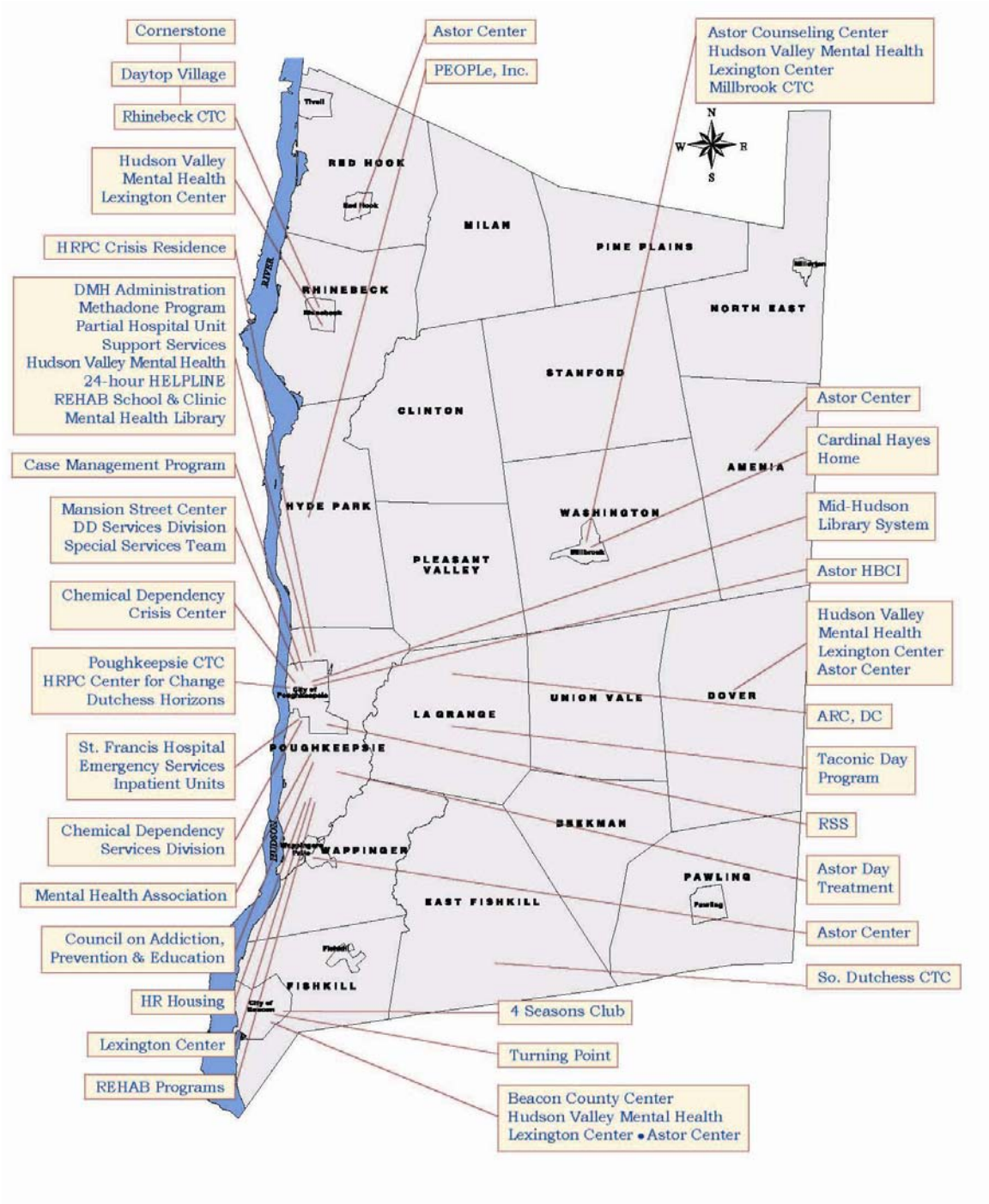
## Easy, Quick Entry to Service System

DMH is rare, if not unique, among New York State counties in that is 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 be 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. Ways to strengthen these core components of the system will be discussed later in the report.

## Commitment to a Culture of Quality

A theme emerged in nearly all our interviews, with both Department and contract agency leadership, and was confirmed via independent observation: That 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. While nearly everyone we talked with agreed with this assessment, some

**Figure 1: Dutchess County Department of Mental Hygiene, Locations of Services**




*Source: DMH Annual Report, 2007*

expressed the concern that this culture may be eroding over time, in part among more recent DMH hires and especially among contract agencies. In these agencies there appears to be a higher rate of employee turnover, and

the perception is that staff may not have the longevity to integrate the Department's culture into their own professional values and practices. Accordingly, several interviewees emphasized the need for increased efforts to re-emphasize and strengthen this culture. This will be addressed further in subsequent sections of this report.

## Committed, Caring Staff

Staff also spoke highly of their colleagues as skilled professionals with deep commitments to their jobs and to the people they serve. Within individual units and programs, many staff noted strong team relationships and support from their co-workers. In many cases staff have worked together for several years and feel strongly about their ability to cover for each other and work together as teams. However, as with the issue of quality of care, concerns were expressed in both Department and contract agency staff interviews that low salaries and benefits paid by most contract agencies make it increasingly difficult to find, hire and retain skilled staff with the same level of commitment and caring as has been the perceived hallmark of the MH system in the past. This issue will also be addressed in more detail below.

## Reputation

The staff at DMH is proud of having a strong reputation throughout the County and statewide. They feel that the Department is distinctive if not unique in its range of services and its commitment to its mission. Staff note that Helpline receives calls from outside the County and that other counties look to Dutchess as an example and for guidance around particular service-provision issues. Again, however, as more services have been contracted out, and the Department's ability to control the quality of services and staff has decreased, some see that reputation as slowly eroding and in need of increased innovation and leadership to offset this trend and restore the system's prestige and service quality throughout all sectors in the future.

## Longevity of DMH Staff

Many staff have been with the Department for a number of years—it was not unusual for us to speak with individuals who had worked in various areas of the public mental hygiene system for more than 20 years. 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.

## Vision and Leadership

Many of those interviewed, both employees of the County and of contracted non-profit agencies, described the Commissioner of Mental Hygiene 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 MH system. Similarly, the leadership team of Division Chiefs who report directly to the Commissioner have typically been in the Department for many years, work well together and are generally perceived positively by staff and contract agency officials alike.

The Department is also working towards the development of new leaders through the introduction of a Management Training Initiative. This Initiative provides a series of training sessions for executive staff, supervisors and others who have been identified as wishing to and/or having the potential to move into leadership positions. Sessions are designed to cover issues such as the culture of the organization, and training in supervisory issues such as employee evaluation and discipline.

## Accessibility of Department Leadership

The Commissioner and Division Chiefs generally received strongly positive comments from staff for being open, accessible and willing to talk to staff about any concerns. They are perceived as being good people to work for, caring towards their staff and open to staff ideas. On the other hand, as discussed in more detail below, some of the leadership openly proclaim that to some extent they are "dinosaurs." Although this is mostly tongue-in-cheek, it is recognized that the experience and longevity of DMH leadership can have the inadvertent or even subconscious effect of creating barriers to change. In that context, however, it is encouraging that the leadership of the Department, including the Commissioner, Chiefs, Directors and middle management levels, seems to have embraced and fully encouraged the full exploration of both strengths and improvement opportunities as part of this study.

## 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 Social Services on a new co-location grant and in an ongoing substance abuse assessment initiative, DMH is also involved in other cooperative ventures with other entities outside the traditional human services system. As will be discussed in more detail below, the Department plays a key

leadership role in broad County housing efforts, and it works very closely in partnership with Probation and jail officials, as well as other components of both the criminal justice and juvenile justice systems. The Department's leadership in these systems, while certainly not unique among its fellow Mental Hygiene departments, is exemplary and well ahead of many if not most of its peers.

## Contract Management and Accountability

The Department appears to be ahead of most 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. As part of Dutchess County's leadership focus on such measurement and careful contract monitoring within the human services arena, 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. As discussed further later in this report, more work needs to be done by the Department to strengthen the accountability process with both contractual and Departmental service providers, but DMH has taken significant steps to make sure its contract dollars are invested as wisely as possible.

# CHAPTER III: DEPARTMENT OF MENTAL HYGIENE STRUCTURE

## Overview

The Dutchess County Department of Mental Hygiene, established in 1968, is the County's Local Government Unit (LGU) within the New York State mental hygiene service delivery system. Its programs and services fall under the jurisdiction of the County Executive and County Legislature, and operate under oversight and regulations of (and receive partial funding from) the New York State Offices of Mental Health (OMH), Mental Retardation and Developmental Disabilities (OMRDD) and Alcoholism and Substance Abuse Services (OASAS). The Department operates under the following vision statement:

"The Department of Mental Hygiene, in fulfilling its commitment to ensure high quality patient care to the citizens of Dutchess County, will continue to improve, refine and expand the mental hygiene system, so that

all in need have access to prevention, treatment and rehabilitation services."[1]

To carry out the overall vision, the Department's stated mission is as follows:

"The Department of Mental Hygiene is the unit of county government that plans for, develops, oversees, and provides, in conjunction with allied agencies, a comprehensive and integrated array of services and programs to meet the mental hygiene needs of the Dutchess County community. In carrying out this mission, the Department strives to ensure that the resulting public mental hygiene system is responsive, accessible, affordable, cost-effective, patient-oriented and dedicated to continuous quality improvement."[2]

## Organizational Structure

Core services and programs are provided to County residents under three divisions within the Department: the Divisions of Developmental Disabilities Services, Mental Health Services and Chemical Dependency Services. A fourth division, the Division of Support Services, provides a variety of internal administrative support functions including billing; buildings and grounds support; personnel, purchasing and clerical support; safety and security programs, and other support functions. Each division is overseen by a Chief who reports to the Commissioner. Unit Administrators or Coordinators oversee clinical programs and report to Division Chiefs.

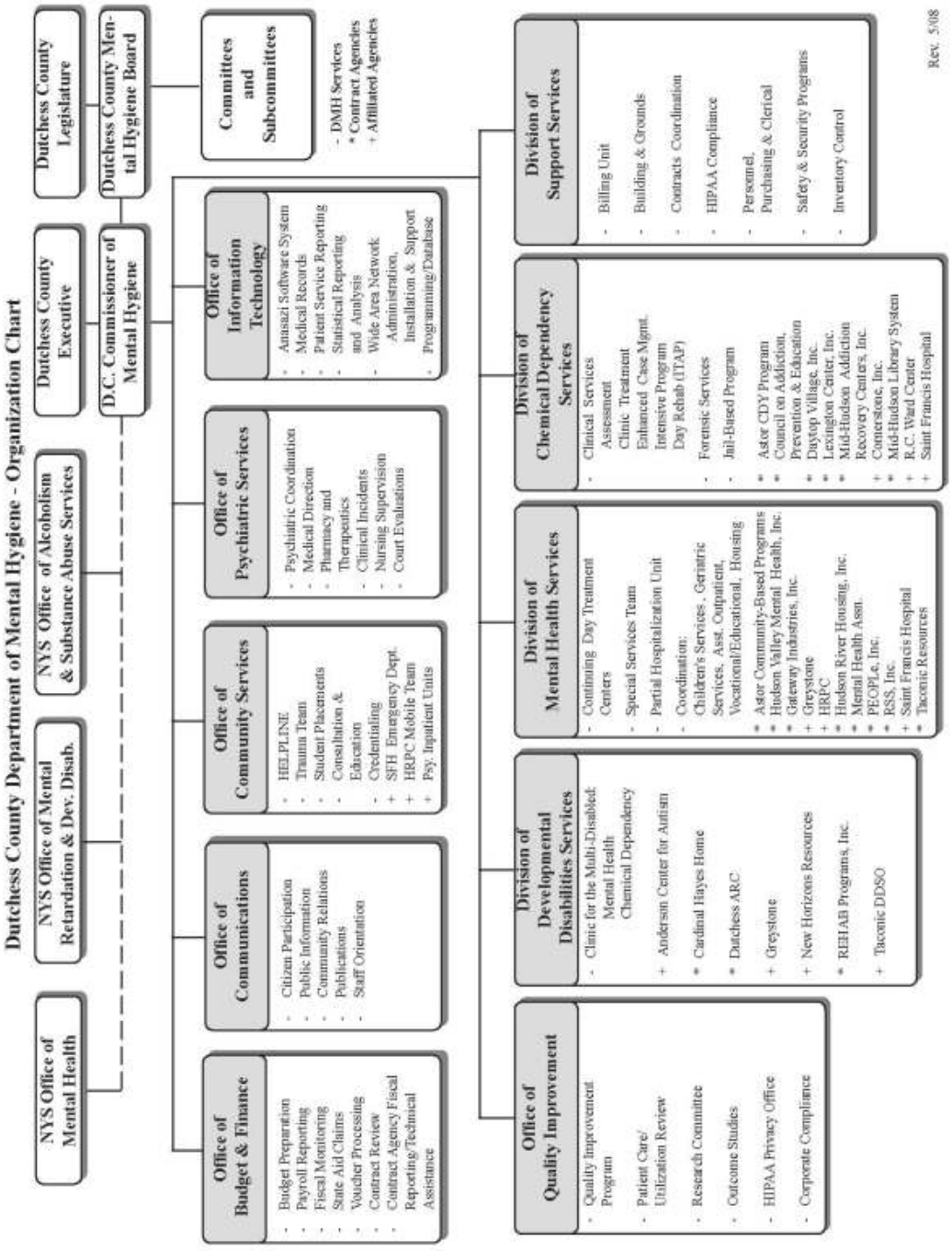
The Department is also served by six individual offices carrying out the following functions: Budget and Finance; Communications; Community Services; Psychiatric Services; Information Technology; and Quality Improvement. Each office Director also reports directly to the Commissioner.

The Commissioner, Chiefs and Directors all meet weekly as Executive Council, which discusses issues of importance to the Department and larger system, makes decisions on key issues, and provides guidance to the Commissioner.

Within the three clinical divisions, services are provided both directly, through in-house Departmental programs run and staffed by County employees, as well as through agencies contracted by the Department to

[1] Dutchess County Department of Mental Hygiene Policy and Procedures Manual, Part 200 – Departmental Purposes.
[2] Ibid.

**Figure 2: Dutchess County Department of Mental Hygiene, Organizational Chart, 2007**




*Source: Department of Mental Hygiene, Annual Report, 2007*

provide specific services. More detail on both in-house and contracted services is provided in the organization chart above, and in Chapter IV below. In addition to contract agencies, the Department also works with non-profits with which they have letters of agreement in place; these are

referred to as affiliated agencies and have varying relationships with the department but no funding or direct accountability relationship.

# CHAPTER IV. SERVICES OFFERED AND POPULATIONS SERVED

## Summary Profile of System

Prior to the late1990s virtually all County Mental Hygiene programs and services, with the exception of children's and youth services, were provided directly by the County ("in-house" programs), in programs run and staffed by County employees. Since then, in the effort to reduce costs and the size of the County payroll, three major core services have been removed from direct Department operations and control, and have been contracted out to non-profit agencies: mental health clinics, chemical dependency/substance abuse clinics, and case management services. In the process, the number of Department employees has declined from a peak in the range of around 325-350 to its more recent levels just above 200. According to figures supplied by the Department's Director of Budget and Finance, the number of authorized positions in the Department remained as high as 240 in 1999, and dropped to as low as 201 since then before inching back up to its current 2008 total of 209 authorized positions (several of which remain vacant). Thus, since its peak employment period, the number of Department employees has declined by between 35% and 40%.

### *Increases in Numbers of Persons Served by System*

During this period of in-house staffing declines, the overall numbers of people served and service volume throughout the system have grown or remained about the same. Paradoxically, service volumes have declined in the Developmental Disabilities Division, although it is the only Division not affected by any outsourcing changes. Service patterns reflecting changes from 1997 to 2007 are presented in more detail below in the context of discussing each type of service. Across all services provided directly by the Department or via contract agency, the total number of people served has 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. For more recent context, a summary of service patterns for the past four years is presented across all services in Table 1.

It is important to note any footnotes to the reported data on volume of services (units of services provided, rather than numbers of individual persons served) and to keep in mind the general caution that in recent years, changes have been made in the way units of service are coded and counted, particularly in non-clinic services. For example, in programs such as most Astor programs, the Clinic for the Multi-Disabled, and Partial Hospitalization, service volume totals in the past year or two are considerably lower than in previous years due in part to reporting changes. Thus, although the Department's 2007 reported figure of almost 537,700 service units is lower than the 1997 reported number of about 552,500 units, had comparable definitions and methods of counting been in place, the equivalent 2007 number would have been higher than the earlier 1997 number. The trends in service patterns are discussed in more detail below by type of service.

**Table 1: Dutchess County Department of Mental Hygiene, Service Volume, 2004-2008**

| | ANNUAL 2004 | | ANNUAL 2005 | | ANNUAL 2006 | | ANNUAL 2007 | |
|---|---|---|---|---|---|---|---|---|
| | PERSONS SERVED | VOLUME OF SERVICE | PERSONS SERVED | VOLUME OF SERVICE | PERSONS SERVED | VOLUME OF SERVICE | PERSONS SERVED | VOLUME OF SERVICE |
| **Mental Health Division** | | | | | | | | |
| **DMH PROGRAMS** | | | | | | | | |
| SPECIAL SERVICES | 180 | 3,769 | 208 | 3,731 | 158 | 4,025 | 157 | 3,379 |
| PARTIAL HOSPITALIZATION [1] | 300 | 8,424 | 264 | 4,470 | 277 | 4,345 | 273 | 4,768 |
| CONTINUING SERVICES PROGRAMS | 879 | 104,682 | 843 | 86,155 | 800 | 83,861 | 821 | 83,829 |
| **MHA CASE MGMNT & CMTY SUP.PROG.** | 1,770 | 52,304 | 1,849 | 51,383 | 1,820 | 47,410 | 2,145 | 45,567 |
| **HV MENTAL HEALTH CLINICS** | 3,327 | 39,996 | 2,831 | 39,933 | 2,251 | 38,419 | 3,116 | 37,380 |
| COURT EVALUATIONS | 37 | 37 | 48 | 67 | 87 | 87 | 69 | 69 |
| **ASTOR PROGRAMS** [2] | 2,248 | 73,259 | 2,138 | 60,159 | 1,786 | 67,033 | 2,150 | 54,641 |
| **TOTAL MENTAL HEALTH DIVISION** | **8,741** | **282,471** | **8,181** | **245,898** | **7,179** | **245,180** | **8,731** | **229,633** |
| **Division of Chemical Dependency Services** | | | | | | | | |
| **DMH CHEMICAL DEPENDENCY PROGRAMS** | | | | | | | | |
| ITAP DAY REHAB PROGRAM | 109 | 10,571 | 121 | 10,890 | 116 | 9,939 | 124 | 10,550 |
| CD CLINIC | 55 | 812 | 55 | 900 | 54 | 839 | 42 | 665 |
| ROAD TO RECOVERY | -- | -- | -- | 25 | -- | 187 | -- | 365 |
| VOCATIONAL CASE MANAGEMENT | -- | -- | -- | 66 | -- | 705 | -- | 652 |
| CD CASE MANAGEMENT | -- | 1,620 | -- | 1,435 | -- | 472 | -- | 971 |
| CD ASSESSMENT | -- | -- | -- | 317 | 899 | 899 | 1,126 | 1,126 |
| FORENSIC COORDINATION | 318 | 460 | 413 | 373 | 514 | 514 | 639 | 639 |
| JAIL-BASED SERVICES | 252 | 2,846 | 213 | 2,509 | 287 | 2,062 | 323 | 2,112 |
| **LCR CHEMICAL DEPENDENCY PROGRAMS** | | | | | | | | |
| CHEMICAL DEPENDENCY CLINICS | 2,259 | 32,650 | 2,493 | 40,173 | 1,782 | 42,775 | 2,131 | 44,347 |
| METHADONE CLINIC | 284 | 47,350 | 298 | 43,165 | 273 | 47,528 | 275 | 54,655 |
| **MARC** | 422 | 3,238 | 412 | 3,558 | 335 | 3,463 | 331 | 3,338 |
| **TOTAL DIVISION OF CHEMICAL DEPENDENCY SERVICES** | **3,699** | **99,547** | **4,005** | **103,411** | **4,260** | **109,383** | **4,991** | **119,420** |
| **Office of Community Services** | | | | | | | | |
| HELPLINE | -- | 14,609 | -- | 13,291 | -- | 13,956 | -- | 15,946 |
| HRPC CRISIS RESIDENCE | 241 | 3,742 | 254 | 3,825 | 274 | 4,122 | 279 | 3,920 |
| **ST. FRANCIS HOSPITAL** | | | | | | | | |
| INPATIENT | 1,632 | 19,415 | 1,755 | 19,727 | 1,819 | 20,193 | 1,781 | 19,566 |
| EMERGENCY DEPARTMENT | 3,641 | 3,641 | 3,526 | 3,526 | 3,665 | 3,665 | 3,860 | 3,860 |
| **TOTAL OFFICE OF COMMUNITY SERVICES** | **5,514** | **41,407** | **5,535** | **40,369** | **5,758** | **41,936** | **5,920** | **43,292** |
| **Division of Developmental Disabilities** | | | | | | | | |
| CLINIC FOR MULTI-DISABLED [3] | 426 | 8,866 | 428 | 8,917 | 428 | 5,484 | 431 | 5,145 |
| HABILITATION, TRAINING & VOCATIONAL PROGRAMS | 886 | 124,786 | 810 | 122,185 | 793 | 110,125 | 899 | 140,201 |
| **TOTAL DIVISION OF DEVELOPMENTAL DISABILITIES** | **1,312** | **133,652** | **1,238** | **131,102** | **1,221** | **115,609** | **1,330** | **145,346** |
| **TOTAL DC/DMH** | **19,266** | **557,077** | **18,959** | **520,780** | **18,418** | **512,108** | **20,972** | **537,691** |

[1] Decrease in service volume for 2004-2005 is due to change in reporting procedures: only Visits (code 60) are reported (excludes psych.svcs, groups, etc.)

[2] Astor to Anasazi as of 2007: Decrease in service volume for 2006-2007 is due to change in reporting procedures: only total sessions are counted, not number of recipients, as reported in the MIS system. N.B. For 2007, Persons Served is estimated, due to procedural issues related to the

[3] Decrease in service volume for 2005-2006 is due to change in reporting procedures as of 4/06: total sessions are counted, not number of recipients, and collateral services are excluded.

*Source: Dutchess County Department of Health.*

## County Dollars Support Many Services

A financial profile of the Department is presented in Chapter VI and expenditure and revenue profiles of DMH are discussed in more detail there. It is worth noting in this overview that the Department either provides directly, or oversees via contractual monitoring, more than $33 million worth of mental hygiene services to county residents. County taxpayers can expect to pay about 35% of these total costs, according to the 2008 budget, although the County share of actual expenditures in 2007 was slightly lower (33.6%), according to the 2007 DMH Annual Report.

***In effect, each County dollar invested in MH services leverages almost $2 in additional revenues represented by state aid and by Medicaid, Medicare, third party insurance and private pay fees.*** Furthermore, as noted in Table 2, most of the services for which the County contracts involve relatively small percentages of, and often no direct County investment, other than the important oversight and accountability role the County plays to ensure that the services are provided as efficiently and effectively as possible to county residents.

**Table 2: 2008 Approved Budget and County Share by Program or Service**

| | Approved Budget Including Fringe Costs | County Share | |
|---|---|---|---|
| **In House Programs**[1] | | | |
| Central Administration | $3,915,629 | $3,031,901 | 77.4% |
| ITAP | $1,433,644 | $547,535 | 38.2% |
| Court Remands | $575,000 | $575,000 | 100.0% |
| Mental Health Clinics[2] | $2,534,910 | $192,902 | 7.6% |
| Continuing Day Treatment | $8,052,839 | $1,729,867 | 21.5% |
| Partial Hospitalization | $1,169,971 | $611,715 | 52.3% |
| Helpline | $1,168,485 | $1,005,258 | 86.0% |
| Division of Developmental Disabilities | $208,280 | $185,518 | 89.1% |
| Chemical Dependency[3] | $1,714,329 | $582,668 | 34.0% |
| *SubTotal* | *$20,773,087* | *$8,462,364* | *40.7%* |
| **Contract Agencies** | | | |
| Lexington Center for Recovery - Methadone | $268,926 | $84,063 | 31.3% |
| Taconic Resources for Independence | $37,326 | $0 | 0.0% |
| Mental Health Association | $2,965,412 | $33,944 | 1.1% |
| Hudson River Housing | $244,451 | $0 | 0.0% |
| Gateway | $622,236 | $0 | 0.0% |
| Lexington Center for Recovery | $1,843,582 | $660,551 | 35.8% |
| Hudson Valley Mental Health | $2,203,243 | $2,018,243 | 91.6% |
| Council on Addiction, Prevention and Education | $360,506 | $19,467 | 5.4% |
| Astor Home for Children - School Based Clinic | $1,114,892 | $160,882 | 14.4% |
| Rehab Programs, Inc. | $885,057 | $195,482 | 22.1% |
| Mid-Hudson Library System | $86,226 | $0 | 0.0% |
| DC ARC | $364,789 | $63,821 | 17.5% |
| Rehab Support Services | $1,363,198 | $0 | 0.0% |
| Cardinal Hayes Home | $90,385 | $1,800 | 2.0% |
| PEOPLe, Inc | $391,063 | $0 | 0.0% |
| *Subtotal* | *$12,841,292* | *$3,238,253* | *25.2%* |
| **Total** | **$33,614,379** | **$11,700,617** | **34.8%** |

1. Coordination Services are allocated to Central Administration; Mental Health Clinics; and Continuing Treatment Centers.

2. Includes Jail Based Services; Special Services; and Clinic for the Multidisabled.

3. Chemical Dependency includes all in-house Chemical Dependency Services, e.g. Assessment, Forensic Services, and a portion of Jail-Based Programs

*Source: Dutchess County Department of Mental Hygiene*

## Demographic Profile of Those Served

Across the programs operated by the County, plus the children's services operated by the Astor Home for Children and the mental health and chemical dependency clinics operated by Hudson Valley Mental Health and Lexington Center for Recovery, respectively, the demographic profile of service recipients has remained relatively consistent over the years, as reflected in Table 3 in the following proportions reported by DMH for 2007:

**Table 3: Department of Mental Hygiene, Patient Demographics, 2007[1]**

| **Gender** | |
|---|---|
| Female | 47% |
| Male | 53% |
| | 100% |
| Ethnicity | |
| African American | 19.6% |
| Native America | 0.4% |
| White | 68.2% |
| Asian | 0.6% |
| Hispanic | 7.4% |
| Other | 3.8% |
| | 100.0% |
| **Age** | |
| 0-17 | 14% |
| 18-21 | 6% |
| 22-29 | 15% |
| 30-39 | 17% |
| 40-49 | 23% |
| 50-59 | 16% |
| 60-69 | 6% |
| 70+ | 3% |
| | 100% |

1. Includes DMH Directly-Operated Programs; Hudson Valley Mental Health, Inc's. Mental Health Clinics; Lexington Center for Recovery, Inc's. Chemical Dependency Clinics; and Astor Community-Based Programs.

*Source: Dutchess County Department of Mental Hygiene, Annual Report, 2007*

Although consistently just over half of those served across the system have been males, the patterns have varied considerably by types of services. Almost two-thirds of those in the traditional mental health clinics have typically been women, in contrast to comparable proportions of men in the chemical dependency clinics. Typically, between 55% and 60% of those in the Astor programs and in the County's continuing day treatment centers are males. Racial/ethnic profiles are typically similar across types of services, except for the contracted mental health clinics, in which only about 12% of the participants have typically been African-Americans. About a quarter of all participants in continuing day treatment centers are 60 and older, compared to about 15% of mental health clinic clients; the majority of participants in the chemical dependency clinics are 39 and younger, compared to 15% to 20% of day treatment participants in that age range.

# Division of Mental Health Services

The Division of Mental Health Services (MH) is the largest of the three service-providing divisions of DMH, both in terms of dollars spent, revenues generated, programs offered (both in-house and contractual), numbers served, and County employees. The County directly operates four Continuing Day Treatment Centers (along with a satellite program affiliated with one of the centers), the Partial Hospitalization Program and the Special Services Team, and also provides system-wide coordination of Children's Services, Geriatric Services, Assisted Outpatient Treatment, Housing, and Vocational/Education Services. Contract agencies operate three major types of services which serve large numbers of clients: Outpatient Mental Health Clinics, Child and Youth Services, and Case Management Services. A number of other contract and affiliated agencies provide a variety of other services noted later in this section.

## *Individuals served: 1997, 2002, 2007*

Table 4 indicates the numbers of persons served and the volume of units of services provided by Department in-house programs and the major mental health contract agencies at five-year intervals through 2007. Programs are provided in-house unless otherwise noted. For the categories of mental health clinics and case management, the table notes the periods when the services were provided in-house, versus when non-profit agencies assumed responsibility for the provision of the services. Although units of service have fluctuated over the 10-year period across the Mental Health Division (in large part because of changing ways of counting the services, as discussed above), ***the actual numbers of persons served across the Division increased by 42% between 1997 and 2007.*** The greatest proportional growth was represented by the almost tripling of persons served by adult case management programs.

**Table 4: Services Provided, Division of Mental Health Services, 1997, 2002, 2007**

| | 1997 | | 2002 | | 2007 | |
|---|---|---|---|---|---|---|
| | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE |
| **MENTAL HEALTH CLINICS** | **IN-HOUSE** | | **SFH (1999-3/03)** | | **HVMH** | |
| POUGHKEEPSIE | 1,288 | 18,577 | 1,657 | 16,388 | 1,748 | 19,187 |
| MILLBROOK | 213 | 2,369 | 255 | 2,884 | 189 | 2,162 |
| BEACON | 662 | 6,625 | 739 | 8,134 | 680 | 9,688 |
| E. DUTCHESS COUNSELING CENTER | 252 | 2,788 | 239 | 3,014 | 235 | 3,064 |
| RHINEBECK | 274 | 2,868 | 304 | 3,510 | 264 | 3,279 |
| ***SUBTOTAL MENTAL HEALTH CLINICS*** | ***2,689*** | ***33,227*** | ***3,194*** | ***33,930*** | ***3,116*** | ***37,380*** |
| **CONTINUING SERVICES PROGRAMS** | | | | | | |
| DAY TREATMENT | | | | | | |
| BEACON/SOUTHERN DUTCHESS CDT | 250 | 15,663 | 269 | 29,098 | 283 | 25,960 |
| RHINEBECK CDT | 152 | 20,813 | 177 | 23,073 | 183 | 24,275 |
| MILLBROOK CDT | 134 | 18,166 | 147 | 19,184 | 123 | 14,438 |
| POUGHKEEPSIE CDT | 253 | 25,848 | 303 | 27,886 | 232 | 19,156 |
| ***SUBTOTAL CONTINUING SERVICES*** | ***789*** | ***80,490*** | ***896*** | ***99,241*** | ***821*** | ***83,829*** |
| **CASE MANAGEMENT** | | | | | **MHA (as of 1/1/03)** | |
| SUPPORTIVE CASE MANAGEMENT | 549 | 14,319 | 798 | 15,257 | 884 | 12,414 |
| BLENDED SUPPORTIVE CASE MANAGEMENT | | | 438 | 6,750 | 485 | 6,355 |
| COUNTY PRE-RELEASE/STATE | | 17,081 | | 13,396 | | |
| INTENSIVE CASE MANAGEMENT | | | 112 | 5,745 | 123 | 3,432 |
| BLENDED INTENSIVE CASE MANAGEMENT | 55 | 4,512 | 111 | 3,964 | 123 | 3,460 |
| GENERIC CASE MANAGEMENT | | | | | | 1,430 |
| HEDGEWOOD CASE MANAGEMENT | | | | | 170 | 2,039 |
| ***SUBTOTAL CASE MANAGEMENT*** | ***604*** | ***35,912*** | ***1,459*** | ***45,112*** | ***1,785*** | ***29,130*** |
| **ASTOR CLINICS - CHILDREN & YOUTH SERVICES** | | | | | | |
| POUGHKEEPSIE | 353 | 9,243 | 715 | 16,830 | 907 | 10,310 |
| RHINEBECK | 155 | 3,565 | | | | |
| RED HOOK | | | 394 | 8,680 | 271 | 3,570 |
| BEACON | 195 | 3,883 | 326 | 6,529 | 347 | 3,319 |
| HOME-BASED CRISIS INTERVENTION PROGRAM | 59 | 1,665 | 66 | 1,290 | 53 | 440 |
| SCHOOL-BASED CLINIC | 74 | 2,173 | 76 | 2,313 | 80 | 2,159 |
| FAMILY-BASED TREATMENT | 13 | 851 | 14 | 609 | 13 | 294 |
| PINS OUTREACH | | | 48 | 907 | 66 | 1,113 |
| INTENSIVE CASE MANAGEMENT - CHILDREN | 37 | 3,212 | 67 | 3,552 | 74 | 743 |
| CASE MANAGEMENT | | 864 | | 3,123 | | |
| SUPPORTIVE CASE MANAGEMENT | | | 72 | 1,567 | 58 | 457 |
| ADOLESCENT DAY TREATMENT | 170 | 15,659 | 173 | 19,312 | 184 | 20,303 |
| DAY TREATMENT CENTER | 99 | 10,983 | 94 | 10,501 | 97 | 11,933 |
| ***SUB-TOTAL ASTOR*** | ***1,155*** | ***52,098*** | ***2,045*** | ***75,213*** | ***2,150*** | ***54,641*** |
| **OTHER MH SERVICES** | | | | | | |
| SPECIAL SERVICES | 143 | 4,077 | 166 | 5,101 | 157 | 3,379 |
| PARTIAL HOSPITALIZATION | 358 | 6,390 | 397 | 8,449 | 273 | 4,768 |
| PART TIME MH CLINIC | | | 32 | 114 | | |
| COURT EVALUATIONS | 80 | 80 | 54 | 54 | 69 | 69 |
| DUTCHESS HORIZONS (MENTAL HEALTH ASSOC) | 326 | 17,800 | 312 | 19,032 | 360 | 16,437 |
| ***SUB-TOTAL OTHER*** | ***907*** | ***10,547*** | ***649*** | ***13,718*** | ***859*** | ***24,653*** |
| **TOTAL MENTAL HEALTH DIVISION** | **6,144** | **212,274** | **8,243** | **267,214** | **8,731** | **229,633** |

*Source: Dutchess County Department of Mental Hygiene*

## *In-House Services*

While other programs and services were being outsourced from DMH to community-based agencies, three primary programs have continued to be provided directly by County employees under the management of the Division of Mental Health Services: Day Treatment, Special Services, and Partial Hospitalization. In addition, Coordinators responsible for various systemic issues report to the Chief of this Division, although their responsibilities cut across all three divisions. Summary descriptions of these services follow:

### Continuing Day Treatment Centers

Four Continuing Day Treatment Centers (CTCs) are located throughout Dutchess County—in Hopewell Junction (Southern Dutchess CTC), Millbrook, Poughkeepsie and Rhinebeck. CTCs target adults with mental illnesses, many of whom live in community residences or supported or supportive housing. The Centers are open during the day and offer a range of individual and group therapy services. Groups address issues including coping skills, socialization, understanding illnesses and medications and skills needed to function on a daily basis. Medication management, individual therapy and recreational and vocational supports are among other services provided.

The Southern Dutchess CTC has a satellite that serves the Hedgewood Adult Home, a 200-bed facility in the City of Beacon. County staff, supplemented by case management staff from MHA of Dutchess County, provide services onsite at Hedgewood that include group therapy, medication management and responding to incidents and crises.

CTC programs collectively represent by far the largest in-house investment and service provided by the entire Department of Mental Hygiene, both in terms of expenditures and revenues generated, numbers served on a regular basis, and staffing. The annual budget for the Centers totals more than $8 million, and collectively the Centers account for about 90 of the Department's authorized positions—almost 45% of the total. Each year more than 800 county residents are served by the CTC programs across all sites. Most of the program participants are Medicaid enrollees, and Medicaid reimbursement accounts for nearly all of the fees/revenues generated by the program. Together, CTCs account for about two-thirds of the total client fees generated by the entire Department. Because of the fee-generating capacity of the CTCs, the County typically subsidizes between 20% and 25% of the total costs of operating the program—among the smallest County shares of any of the programs operated directly by the Department. A number of issues have been raised about the future operations of the CTCs, in part as a result of the uncertainty of the means of federal and state funding of such programs in the future. Issues related to the future of this major component of Department operations will be addressed in more detail in Chapters VII and VIII.

### Special Services Team

Special Services targets individuals who are resistant to treatment in traditional settings, many of whom are homebound. The Special Services Team (SST) responds to calls in homes and in various community settings, sees other patients in the program's office, and works to get patients either into a more traditional level of treatment or to an improved state with their illness. Some housebound patients are in situations that are not likely to change and are part of an ongoing caseload in the program. The program

staff provide individual, family and couples therapy, psychiatric evaluations and management of medications.

In recent years the program has served as many as 208 separate individuals in a year, but historically has averaged closer to the 157 served in 2007. Typically it has an active caseload of between 105 and 110 participants at a time. In addition to a Unit Administrator overseeing the program, it is staffed with three full-time clinicians, a full-time psychiatrist and a part-time psychologist and nurse practitioner. The program operates under the same license as the Clinic for the Multi-Disabled. The majority of its costs are reimbursed through Medicaid, supplemented with Medicare and other third party insurers. Data available to CGR did not enable us to separate County share of costs from those of the Multi-Disabled Clinic, but together they appear to cost County taxpayers only in the vicinity of about 10% or less of the total costs of the program. Issues concerning possible ways of strengthening the core SST program will be addressed later in the report.

### *Partial Hospitalization Program*

Partial Hospitalization is a short-term day program alternative to inpatient care for individuals who need intensive care but can live at home or in a crisis residence in the evenings and on the weekends. The goal of Partial Hospitalization is to prevent or reduce hospitalization by stabilizing patients and assisting them in avoiding hospitalization in the first place or transitioning from a hospital setting into the community, through medication management, individual and group treatment and case management.

The program is licensed to serve about 30 individuals per day. In recent years it has served an average of about 275 individuals per year, down from 300 or more in earlier years. Its 2008 budget is about $1.2 million. The PHP appears to have the highest amount of third party insurance payments of any Department program, and a high proportion of the Department's Medicare payments as well. But Medicaid payments make up a smaller proportion of reimbursements than most other programs, leaving a County taxpayer share of a bit over half of the total program costs—but presumably a lower share than the costs of hospitalizations that the program is designed to reduce. Additional issues related to the program are addressed in Chapters VII and VIII.

### *Coordination*

Full-time staff in DMH fill coordination roles in each of four areas: Children's Services, Assisted Outpatient Treatment, Vocational/ Educational Services, and Housing Services. In addition, a Unit Administrator in one of the Continuing Treatment Centers fills the role of Geriatric Services Coordinator part-time. Coordination services are overseen by the Mental Health Services Division Chief, although each of

these coordination services benefits individuals across the DMH system. Each coordination function is described briefly below, with additional comments and suggestions about the coordination functions to follow in subsequent chapters.

### *Children's Services*

The Children's Services Coordinator is the Department's primary advocate for children and youth in the County. The Coordinator oversees and coordinates a broad network of agencies that provide services to children (no services for children and youth are directly provided by the Department) and coordinates and develops relationships with other entities that involve children and youth, including schools, the juvenile justice system, social services and families. The Coordinator also directly monitors the contract agencies that serve youth, most notably the Astor Home for Children and selected respite and family support services provided by MHA of Dutchess County.

### *Assisted Outpatient Treatment (AOT)*

This service is based on NYS Kendra's Law legislation that calls for court orders for outpatient treatment and supervision for individuals who have a history of non-compliance that has led to at least two hospitalizations in the last 36 months or two dangerous acts (either to self or to others) in the last 48 months. The role of the Coordinator and an Intensive Case Manager is to identify and recommend appropriate treatment and monitor that treatment to ensure compliance. The Coordinator responds to all inquiries regarding AOT petitions that come to the County's attention and determines whether these meet the criteria for AOT. The Coordinator arranges referrals for those cases that do not. For those that do, the Coordinator is responsible for scheduling treatment plan meetings with any providers involved in the case, reporting on each case, and working with various agencies and entities involved in the AOT process. According to Annual Report data, the Coordinator initiated 25 investigations for AOT petitions in 2007, and 14 Court Orders involving six individuals were granted. An additional 23 individuals signed voluntary Enhanced Services Contracts as an alternative to more formal court orders.

### *Vocational/Educational Coordination*

This coordination function serves individuals across the DMH system and includes advocating for the educational and vocational needs of individuals in the system, including increased opportunities and supports for maintaining employment. The Coordinator functions as the liaison to community vocational providers on behalf of DMH. In addition to the overall coordination, planning, advocacy and educational roles of the Coordinator, the position also involves additional broad oversight and supervisory responsibilities of three vocational specialist positions

provided in the non-profit sector at Astor and Gateway—as well as supervising two County employees who have vocational/welfare-to-work responsibilities with the Department of Social Services and another County staff based at Lexington Center for Recovery as part of an OASAS grant.

### *Housing Coordination*

Housing is a major need and priority for the DMH population. The Housing Coordinator is responsible for assessing housing needs and advocating for those with mental illness, works to expand housing opportunities throughout the community, oversees the single point of entry (SPOE) system offering centralized access to various community living options in the mental health housing sector, and serves as a resource for housing providers for those with developmental disabilities. The Coordinator reviews applications for housing and coordinates with appropriate housing agencies based on the needs for specific levels of housing. In 2007, almost 350 applications for residential services were processed, and 119 received placements through the SPOE process. The Coordinator also plays key roles with the Dutchess County Housing Consortium and working with the County Planning Department to prepare the annual HUD grant application which generates several hundred thousand dollars worth of housing assistance each year. In both of these cases, the Coordinator plays larger community roles which go well beyond the MH function and therefore provide additional community return on the County's and Department's investment in this position.

### *Geriatrics Services Coordination*

The Geriatrics Coordinator is responsible for advocating for the needs of seniors across the system of DMH services, and for identifying special needs of this population and coordinating with other agencies that serve seniors, such as the County Office for the Aging. At this point, this position is provided on a part-time basis, with the functions carried out in addition to the responsibilities of the Unit Administrator of the Southern Dutchess Continuing Treatment Center.

## Contract Agency Services

The Mental Health Division has oversight responsibility for monitoring the performance of four of the five largest DMH contracts. Two of the four—Astor and Rehab Support Services—have consistently provided MH services not traditionally provided by the MH Department. On the other hand, the other two contracts—with Hudson Valley Mental Health and MHA of Dutchess County—involve monitoring clinic and case management services, respectively, that were formerly provided directly by the Department.

### *Mental Health Outpatient Clinics – Hudson Valley Mental Health*

In 1998, management of the County's Mental Health Clinics began to be outsourced to Saint Francis Hospital (SFH). Clinics in Beacon, Millbrook, Eastern Dutchess-Dover and Rhinebeck were transitioned that year, and Poughkeepsie followed in 1999. SFH managed these clinics until the end of March, 2003, when Family Services Incorporated took over. Since July of 2006, Hudson Valley Mental Health, Inc. (HVMH), a subsidiary of Families First of NY, has managed the five clinics.

The five outpatient clinics offer traditional MH clinic services such as diagnosis, treatment and referral services for adults with a range of disorders. Treatment modalities include individual, group and family therapy, evaluation and medication management; and referrals are available for case management, housing, and vocational services among other needs.

As indicated earlier in Tables 1 and 4, the mental health clinics in their various incarnations have fluctuated up and down in numbers served over the past 10 years, with the low of about 2,250 in 2006 apparently the aberration. With that exception, the clinics under various management organizations appear to have typically served as many or more persons each year under non-profit management as were served under County auspices in 1997. Issues of the quality of the services, and caseload and workload differences between the clinics, will be addressed in more detail in Chapter VII, but in terms of numbers alone, the transition from County-operated to non-profit-operated clinics does not seem to have reduced the numbers of county residents served by the five clinics.

HVMH represents the second-largest contract DMH has with any of its non-profit contract agencies. As shown earlier in Table 2, in 2008 the Department's budget includes a contract with HVMH of approximately $2.2 million. As the primary provider of core mental health services to the largest number of residents in the county (typically more than 3,000 served per year), it is not surprising that the contract amount in recent years has typically involved about $2 million per year. Because MH clinic services have typically been financial "losers" under reimbursement practices currently in place, it is also not surprising that, in order to cover the costs of these critical clinic services that often represent entry to the larger system of services, the County has subsidized nearly the entire share of the value of the contract with HVMH. While the County share of most of the Department's contractual arrangements has been less than a third of the contract's value, and often zero to 2%, the County typically supports around 90% of HVMH's deficit covered by the core clinic service contract in order to ensure that these services will continue to be in place for those in need of them. Issues related to the value received for that investment,

and implications for the future, will be discussed extensively in Chapters VII and VIII.

### Case Management – Mental Health America of Dutchess County

Case management is an integral part of treatment in many components of the DMH system. Case management services were transferred out of DMH and consolidated with an existing case management program at the Mental Health Association, recently-renamed Mental Health America (MHA), in 2003. Case management is a service intended to work closely with individuals to assist in accessing services in order to maintain independence and self-sufficiency.

MHA provides several types of case management, including Generic, Supportive, Intensive, and Blended Case Management. The type and level of case management are dictated by the needs of the clients. Services are provided to various programs within the DMH system, and the demand for the services, along with a few other community support services also provided by MHA, has continued to grow. As shown earlier in Tables 1 and 4, the County's data indicate that the number of adults using such services has almost tripled since 1997. In 2007, 1,785 adults used case management services, provided by about 60 MHA case managers, plus another 360 clients were involved in various other community support services under the Department's contract with MHA.

The contract with MHA is the Department's largest, involving almost $3 million in 2008. But the County tax levy share of that amount is minuscule, only about 1% of the contract's value. Moreover, typically some surplus funds are available at the end of the year for use by the County to supplement existing services where needed across the system. Other issues related to case management services are addressed later in the report.

### Children's Services – Astor Home for Children

From the early stages of the evolution of the Department of Mental Hygiene, children's services have been largely provided under the auspices of the Astor Home for Children, and DMH has never provided extensive direct services to children and youth. Nonetheless, the County role related to children and youth services has been significant, with a major planning, advocacy, coordination and accountability role played by the Children's Services Coordinator role described above.

In 2008, the Department is budgeted to purchase about $1.1 million worth of services in its contract with Astor. The County share of that total is about 14%, a reasonable investment for the range of services provided by Astor, and compared to what the County would need to be spending if it were providing such services directly. A wide range of services is

provided to children and families. As with other key services offered to adults in the MH service system, youth services are also provided in sites scattered throughout the county. Basic Astor counseling centers are located in Beacon, Poughkeepsie, Red Hook and Wassaic. Other programs are offered in schools and other sites. In addition to counseling services, a variety of day treatment, pre-school, case management, and home-based services are offered, as well as forensic Family Court evaluations and Coordinated Children's Services Initiative coordination to help reduce residential placements for children with emotional difficulties. Other issues related to Astor service provision and accountability, and implications for the rest of the service system, are addressed in subsequent chapters.

### *Rehabilitation Services – RSS, Inc.*

One of the Department's largest contracts is for about $1.4 million with Rehab Support Services, Inc (RSS). RSS provides job coaching supports and operates the Dutch Treat Café in the County Mental Health Center, while also providing a continuum of housing opportunities scattered throughout the county. Although a large amount of dollars are involved in the contract with RSS, the County spends none of its tax dollars on the agency. At least in part as a result, the County's monitoring of its performance is somewhat limited, with relatively little and questionable outcome measures systematically tracked and monitored, compared with the first three contracts noted above.

## *Additional Services*

Other agencies affiliated with or contracted by DMH provide a number of services to individuals treated by the Mental Health Division. These include advocacy, self-help and empowerment services; residential services; vocational rehabilitation and training; and information and education.

# Division of Chemical Dependency Services

The Division of Chemical Dependency Services (CD) provides services to individuals dealing with alcoholism and other chemical dependencies. In addition to operating several important internal programs and services (mostly related to the criminal justice system and vocational assessments), the CD Division works extensively with entities outside of DMH, including the Department of Social Services and the criminal justice system, and with contract and affiliated agencies that provide outpatient clinics, housing services, rehabilitation and detoxification services, prevention and education, and inpatient treatment. The range of services and program responsibilities, both internal and external, is summarized in Figure 1 in Chapter III, and described in more detail below.

## *Individuals served: 1997, 2002, 2007*

Table 5 below indicates the numbers of people served and the volume of units of services provided by chemical dependency clinics when they were still operated by the Department of Mental Hygiene, compared to when they were operated by St. Francis Hospital, and ultimately over the past five years by Lexington Center for Recovery. The table also indicates trends since 2002 in services provided in the County-operated ITAP and other criminal-justice, forensics and vocational assessment services, as well as via contract with MARC (all discussed in more detail below). Corresponding data were also presented earlier in Table 1 for the years 2004-2007. ***Both the 10-year perspective reflected in Table 5 and the more recent four-year trends indicate an overall steady growth in persons served and volume of services across CD programs and services, particularly within the Division's internal in-house assessment/ forensics/criminal justice services.*** The trends are discussed in more detail below by types of services.

**Table 5: Services Provided, Division of Chemical Dependency Services, 1997, 2002, 2007**

| SERVICE | 1997 | | 2002 | | 2007 | |
|---|---|---|---|---|---|---|
| | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE |
| **IN-HOUSE CD SERVICES** | | | | | | |
| ALCOHOL ABUSE CLINIC | 1,143 | 12,805 | | | | |
| BEACON ALCOHOL CLINIC | 204 | 1,711 | | | | |
| SUBSTANCE ABUSE CLINIC | 925 | 9,461 | | | | |
| BEACON SUBSTANCE ABUSE CLINIC | 138 | 767 | | | | |
| SAC/ EVENING INTENSIVE PROGRAM | 53 | 1,938 | | | | |
| METHADONE PROGRAM | 329 | 41,851 | 268 | 40,562 | | |
| ITAP DAY REHAB PROGRAM | 78 | 7,253 | 110 | 9,024 | 124 | 10,550 |
| ITAP AFTERCARE PROGRAM | | | 34 | 394 | | |
| ITAP INTENSIVE MODULE | | | 40 | 639 | | |
| HARLEM VALLEY OCFS CLINIC | | | 124 | 1,110 | | |
| RED HOOK OCFS CLINIC | | | 81 | 721 | | |
| PINS COORDINATION | | | 266 | 647 | | |
| FORENSIC COORDINATION | | | 340 | 532 | 639 | 639 |
| VOCATIONAL CASE MANAGEMENT | | | | 759 | | 652 |
| CD CASE MANAGEMENT | | | | | | 971 |
| CD ASSESSMENT/ENHANCED CASE MANAGEMENT | | | | 2,338 | 1,126 | 1,126 |
| JAIL BASED SERVICES | | | 349 | 3,788 | 323 | 2,112 |
| ROAD TO RECOVERY PROGRAMS | | | | | | 365 |
| CD CLINICS | | | | | 42 | 665 |
| ***SUBTOTAL IN-HOUSE CD SERVICES*** | ***2,870*** | ***75,786*** | ***1,612*** | ***60,514*** | ***2,254*** | ***17,080*** |
| **SFH CHEMICAL DEPENDENCY CLINICS (Through 3/31/03)** | | | | | | |
| MANCHESTER ROAD ALCOHOL ABUSE CLINIC | | | 815 | 10,205 | | |
| MILLBROOK ALCHOL CLINICS | | | 45 | 568 | | |
| BEACON ALCOHOL CLINIC | | | 316 | 2,119 | | |
| EASTERN DUTCHESS ALCOHOL CLINIC | | | 111 | 1,211 | | |
| RHINEBECK ALCOHOL CLINIC | | | 96 | 1,140 | | |
| MANCHESTER ROAD SUBSTANCE ABUSE CLINIC | | | 743 | 7,374 | | |
| MILLBROOK SUBSTANCE ABUSE CLINIC | | | 41 | 296 | | |
| BEACON SUBSTANCE ABUSE CLINIC | | | 109 | 465 | | |
| EASTERN DUTCHESS SUBSTANCE CLINIC | | | 101 | 996 | | |
| RHINEBECK SUBSTANCE ABUSE CLINIC | | | 46 | 351 | | |
| **LCR CHEMICAL DEPENDENCY CLINICS** | | | | | | |
| MANCHESTER ROAD CD CLINIC | | | | | 1,480 | 33,468 |
| MILLBROOK CD CLINICS | | | | | 66 | 688 |
| BEACON CD CLINIC | | | | | 271 | 5,159 |
| EASTERN DUTCHESS CD CLINIC | | | | | 153 | 2,812 |
| RHINEBECK CD CLINIC | | | | | 127 | 1,860 |
| METHADONE (10/1/04) | | | | | 275 | 54,655 |
| RED HOOK CD CLINIC | | | | | 34 | 360 |
| ***SUBTOTAL OUTPATIENT CLINICS*** | ***0*** | ***0*** | ***2,423*** | ***24,725*** | ***2,406*** | ***99,002*** |
| **MARC** | | | | | | |
| ALCOHOL CRISIS CENTER | 586 | 3,164 | 447 | 3,056 | 331 | 3,338 |
| **TOTAL DIVISION OF CHEMICAL DEPENDENCY SERVICES** | **3,456** | **78,950** | **4,482** | **88,295** | **4,991** | **119,420** |

*Source: Dutchess County Department of Mental Hygiene*

## *In-House Services*

Following the outsourcing of outpatient clinic services in the late 1990s from the County to the non-profit sector, the CD Division has increasingly focused on internal programs and services linked closely to criminal justice forensics and assessments, vocational assessments, and the ITAP treatment program which focuses primarily on persons involved with the criminal justice system. These services have been welcomed by the Department of Social Services and especially within the criminal justice system, where they are widely viewed as providing essential alternative-to-incarceration support.

Although reporting changes from year to year make direct comparisons and interpretation difficult, there is no question that together, these assessment, forensics and treatment services have expanded dramatically in their scope and reach in recent years. ***Just between 2006 and 2007, the two years where the data reported are most comparable, the numbers served via these internal services increased by 20.5% in just that short period***, and the collective numbers reached have grown by even greater amounts compared to earlier years, though incomplete data make the proportionate increases impossible to accurately calculate.

The CD Division has about 25 authorized positions allocated between ITAP and the various forensics and assessment services provided internally within the Division, including clerical support staff. In addition, two case managers are provided by MHA (not County employees) under supervision of CD staff to support the Division's Managed Addiction Treatment Services program. According to the 2008 budget, about $3.2 million was appropriated for CD administration, forensics and assessment activities, and the ITAP treatment program. County taxpayers were expected to pay about 35% of the total costs of these services, after state aid and various fees and other sources of income are applied. With the assumed value of the criminal justice-related services in helping to reduce the daily jail population, a portion of those County costs is likely offset by per diem daily jail costs the County would otherwise be paying to board jail inmates out to other counties, given the overcrowded conditions in the Dutchess jail.

Summary descriptions of various Division services follow:

## *Forensic Services*

The Division offers substance abuse assessments for individuals involved in the criminal justice system, with the goal of getting defendants into treatment where warranted rather than being incarcerated. Based on staff assessments, recommendations are made to the appropriate court for judicial action. Although the forensics unit occasionally works with sentenced prisoners, its primary focus is on finding treatment alternatives for unsentenced defendants which will make it feasible for them to remain in the community rather than being incarcerated at significant cost to County taxpayers.

Based on data from the Department's Office of Information Technology, ***the forensics unit has doubled the numbers of people it works with in just four years, going from 318 referrals in 2004 to 639 in 2007***. It now receives about 50 to 60 referrals a month from various components of the criminal justice system seeking assessments. Staff make recommendations and referrals for an average of about 350 cases per year. Referrals are made to a wide range of treatment options, including the Road to Recovery program, which targets non-violent multiple felony

offenders who are chemically dependent, and which Forensics staff also oversee. The number of service units for offenders in that program doubled in one year, from 2006 to 2007. Staff also work closely with drug courts in the cities of Poughkeepsie and Beacon and a Family Treatment and Juvenile Treatment Court in Family Court. Staff also refer appropriate misdemeanants in Poughkeepsie City Court to a Pre-Trial Diversion program, for which staff also provide follow-up monitoring of defendants diverted from incarceration. The unit is made up of a supervisor plus four other staff members.

### *Jail-Based Program*

These services are targeted at incarcerated individuals and provide assessment and pre- and post-release planning and linkages to services and community resources. 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 team of a Unit Administrator and four staff members works within the jail, providing group and individual programs, and works to facilitate inmates' 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. One of the positions of this unit is used to staff the DMH/Probation Mental Health Outreach Program, in which a DMH licensed clinical social worker is located on-site at the Probation Department. This person assists Probation Officers in the recognition of symptoms, the assessment of mental status and of treatment needs, and the facilitation of referrals to appropriate inpatient or outpatient treatment.

The unit served 323 jail inmates in 2007, about double the number served in 2005. In the past two years, an average of about 250 per year were actually admitted for mental health, chemical dependency or release planning services.

### *Assessments*

DMH works with the Department of Social Services to provide drug and alcohol assessments for individuals applying for public assistance and evaluate their ability to participate in the Welfare to Work program mandated as part of eligibility for public assistance.

### *Enhanced Case Management*

Enhanced Case Management is a service targeted at single-parent individuals with chemical dependency issues. The program acts to get people into treatment and create self-sufficiency within the family. The program served 38 adults in 2007. As more individuals transition off public assistance rolls, referrals to this program have declined over the years. Thus the case manager who oversees this program also coordinates and supervises the case managers in the MATS program.

### Managed Addictions Treatment Program (MATS)

MATS is a pilot program based on a recent mandate by OASAS. The purpose of MATS is to identify, locate and work closely with individuals who have incurred $15,000 or more in Medicaid services related to chemical dependency services (i.e., repeated rehabilitation or detoxification program admissions). The program goal is to help these individuals access appropriate and effective treatment and ultimately lead to a reduction in Medicaid expenses for drug and alcohol services. A total of 72 cases were opened in the program's first full year in 2007. MATS is directed by a County employee, but case managers work for and are on the payroll of MHA. They work closely to track patient progress and assist in the supports needed for them to stay in recovery.

### ITAP (Intensive Treatment Alternatives Program)

The Intensive Treatment Alternatives program is a highly structured, supportive, long-term outpatient treatment program for patients with alcohol and substance abuse problems. ITAP works with the criminal justice system to provide an Alternative to Incarceration (ATI) program for individuals referred for assessment by Probation, courts or other entities. The program works with persons arrested for both felony and misdemeanor charges (an estimated two-thirds felonies), and thus can provide an alternative to both prison and jail sentences. The program is an OASAS-licensed outpatient day rehabilitation program involving a close linkage between ITAP/Chemical Dependency staff and two Probation Officers. The ITAP Unit Administrator supervises both DMH and Probation staff assigned to the program.

Ten years ago, ITAP served 78 persons; in more recent years it has served an average of about 115 per year, including 124 in 2007. The program admits about 100 new enrollees per year. The program also maintains an aftercare group for those who have successfully completed the core ITAP program.

The program budget for 2008 is about $1.4 million, almost half of which is expected to be covered by fees of participants (primarily Medicaid, but also with significant third party insurance coverage). State aid also covers a portion of the program costs, leaving an expected County share of about 38%, at least some of which should be offset by reduced jail costs resulting from the program.

## Contract Agency Services

The Chemical Dependency Division has oversight responsibility for one of the five largest DMH contracts—for the provision of outpatient clinic services. 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.

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

The County's outpatient chemical dependency clinics were outsourced to St. Francis Hospital in 1998 and then to Lexington Center for Recovery (LCR) in 2003. LCR currently operates clinics in five different locations throughout the county (Poughkeepsie, Beacon, Eastern Dutchess, Millbrook and Rhinebeck), serving adults, adolescents and families, with specialized programs targeting early recovery, relapse prevention, relationships, social supports, and parenting. Services include individual, group and family therapy. LCR also operates a Methadone maintenance and rehabilitation program. Four of the five clinics (all except the one in Poughkeepsie) are co-located in the same sites as the mental health clinics operated by Hudson Valley Mental Health.

Tables 1 and 5 suggest that the numbers of persons using the chemical dependency clinics may have declined somewhat on an annual basis since the initial transition from the County-operated clinics. As with the mental health clinics, numbers of persons served have fluctuated somewhat from year to year, but on balance, the numbers seem to have been typically lower in most recent years than pre-transition. However, although we believe that is an accurate conclusion, the data should be reviewed more accurately by DMH officials, given some concerns expressed to CGR that there may be some inconsistencies in LCR's reporting of more recent data. Other issues related to quality of services, caseload and workload differences between clinics, measures of performance and productivity, and other issues related to the operations of the clinics will be addressed in more detail in Chapter VII.

As shown earlier in Table 2, LCR represents DMH's third-largest contract. Including core clinic services plus the Methadone program, the County is contracting with LCR for just over $2.1 million worth of services in 2008, including about $269,000 for the Methadone program and more than $1.8 million for the basic clinic services. The County is expected to subsidize just over 35% of the total costs of these programs, which is similar to the overall County share of the entire DMH budget.

## Additional Services

Other services provided by affiliated or contract agencies to the Division of Chemical Dependency include crisis and community residences; detoxification and rehabilitation services; and prevention, education and counseling for youth and families. One of those agencies is Mid-Hudson Addiction Recovery Centers (MARC), which operates an OASAS-licensed chemical dependency crisis center in Poughkeepsie, as well as three licensed community residences. Although the DMH budget does not indicate that it directly contracts with MARC, it is worth noting that the reported numbers of persons served by MARC programs and services

have declined steadily over the years, according to data reported by DMH's Office of Information Technology, from a high in 1997 of 586 to 331 in 2007—a 43% reduction. If such conversations have not already occurred, it may be worth having DMH and MARC officials discuss the implications of these numbers in terms of whether they are likely to represent reductions in need for services, reductions in agency capacity to address the needs, changes in ways of recording data, or other reasons—and depending on the conclusions, considering any possible future actions that may be warranted.

## Division of Developmental Disabilities Services

The Division of Developmental Disabilities Services (DD) coordinates services for people with a range of disabilities, including mental retardation, autism, and cerebral palsy, among a range of other disabilities occurring before the age of 22. This Division currently is responsible for the operation of one in-house Unit (the Clinic for the Multi-Disabled) and for coordinating many relationships with 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 divisions within the Department, in large part a function of history. The region around and including Dutchess County historically housed large DD institutions. 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 a significant County presence in the DD service arena than has been the case in Mental Health and Chemical Dependency. It is difficult to tease out the DD share of the Department budget, since there is a DD administrative line but no ability to separate out the Clinic for the Multi-Disabled from the Special Services Team in a Mental Health Clinics segment of the budget. But based on previous reported Annual Report expenditure breakouts by division, it is reasonable to assume that about 3% to 4% of the overall DMH systems budget (in-house plus contracts) is allocated to the DD Division and its contractual agencies.

Although there are fewer in-house programs and contract agencies to monitor within DD than in the other two divisions, there is considerable coordination and planning needed with state, regional and local officials and bodies. In addition, in order to help spread the workload among the Division Chiefs, historically the responsibility for oversight of the Department's Office of Quality Improvement has been added to the tasks of the DD Division Chief. This allocation of responsibilities has

continued with the recent appointment of the new Division Chief earlier this year.

## Individuals served – 1997, 2002, 2007

Table 6 below, along with the earlier Table 1, provide indications of the changes over time in the numbers of people with disabilities who have been served by the County's Clinic for the Multi-Disabled and the DD agencies with which the Department contracts. ***The numbers of people served appear to have remained relatively constant or increased slightly in clinic and rehabilitation services over the past ten years, though the numbers served and units of service have declined substantially in the area of vocational services.*** These trends are discussed in more detail below.

**Table 6: Services Provided, Division of Developmental Disabilities, 1997, 2002, 2007**

| SERVICES | 1997 | | 2002 | | 2007 | |
|---|---|---|---|---|---|---|
| | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE |
| **DIVISION OF DEVELOPMENTAL DISABILITIES** | | | | | | |
| CLINIC FOR MULTI-DISABLED | 395 | 11,420 | | | | |
| CMD MENTAL HEALTH PROGRAM | | | 415 | 13,044 | 421 | 4,939 |
| MR/CHEMICAL DEPENDENCY PROGRAM | 13 | 319 | 8 | 213 | 10 | 206 |
| ***SUB-TOTAL*** | ***408*** | ***11,739*** | ***423*** | ***13,257*** | ***431*** | ***5,145*** |
| **REHABILITATION PROGRAMS** | | | | | | |
| DD DAY TREATMENT | 155 | 33,565 | 154 | 31,415 | 258 | 47,582 |
| WORK TRAINING | 408 | 55,491 | 408 | 48,000 | 319 | 40,414 |
| WARYAS RECOVERY HOUSE | 32 | 4,482 | 27 | 5,569 | 26 | 5,092 |
| ***SUBTOTAL*** | ***595*** | ***93,538*** | ***589*** | ***84,984*** | ***603*** | ***93,088*** |
| **ARC** | | | | | | |
| SHELTERED WORKSHOP | 240 | 40,330 | 149 | 20,768 | 141 | 18,540 |
| AMENIA SATELLITE WORKSHOP | 147 | 26,561 | 103 | 13,443 | 51 | 6,462 |
| PROJECT CHALLENGE | 77 | 9,198 | | | | |
| ***SUBTOTAL*** | ***464*** | ***76,089*** | ***252*** | ***34,211*** | ***192*** | ***25,002*** |
| **TACONIC** | | | | | | |
| TACONIC DAY PROGRAM | 136 | 23,613 | 106 | 21,848 | 104 | 22,111 |
| **TOTAL DIVISION OF DEVELOPMENTAL DISABILITIES** | **1,603** | **204,979** | **1,370** | **154,300** | **1,330** | **145,346** |

Note: Between 2002 and 2007, service reporting changes were made to reflect the number of visits or sessions provided, rather than the number of recipients served.
*Source: Dutchess County Department of Mental Hygiene*

## In-House Services

The Developmental Disabilities Division is the only one of the three divisions in the Department not to have outsourced any services it previously provided.

### Clinic for the Multi-Disabled

The Department-operated Clinic for the Multi-Disabled (CMD) provides a full range of multi-disciplinary mental health and chemical dependency services to mentally ill, mentally retarded/developmentally disabled individuals 15 and older. Services are provided on an outpatient basis at a main location and in five satellites around the county. The Clinic emphasizes an approach that involves a person's entire network of

supports and coordinating among various systems that can assist in the individual's treatment. For many of the persons in the program, the service involves receipt of primary support in monitoring their medications. Although we cannot be certain, CGR believes that this clinic may be the only one of its kind in NYS.

Over the past ten years, the Clinic has slightly expanded the number of people it serves, but most recently appears to have stabilized at a steady caseload of between 425 and 430 persons a year, served by an 8-person staff, including the Unit Administrator. The overwhelming majority of those served are people with primary mental health/DD needs. However, each year about 10 to 12 individuals receive direct chemical dependency services under a unit of the Clinic that is certified by OASAS to provide outpatient services to those 18 and older who are chemically dependent. A Licensed Clinical Social Worker on the staff provides focused attention to these individuals.

As noted above, the Department budget does not break out the Multi-Disabled Clinic from the Special Services Team in the more comprehensive Mental Health Clinic portion of the budget, but we do know that much of the funding for the Clinic is obtained through Medicaid and Medicare, as well as some state aid. Although we were unable to break out the Multi-Disabled Clinic separately, the budget suggests that across the Department's overall Clinic line, only about 10% or less of the clinic costs need to be covered by the County. Thus it appears that the County is able to provide this distinctive and perhaps unique service to its MH/DD dually diagnosed residents at relatively little cost to local taxpayers.

## Contract Agency Services

The Department contracts for selected DD services with three agencies:

### Dutchess County ARC

Dutchess ARC offers a range of services to residents with developmental disabilities, including service coordination, family resources, recreational services, clinical services, vocational services and residential opportunities. Pre-vocational training, vocational assessment and counseling, sheltered workshop, and job placement and on-the-job training opportunities are key services provided by the ARC. The County is contracting with ARC for about $365,000 in 2008, with County taxpayers covering about 17% of those costs.

With so much emphasis on vocational issues throughout the MH system, it is of concern that the data in Table 6 indicate a 45% decline over the past 10 years in the numbers of people served in the sheltered and satellite workshop settings. This was not an agency we were able to focus on in

this project, so CGR has no insights to offer concerning reasons for the decline, but it is worth County officials exploring, if they have not already done so, what more can be done through its contract with ARC to expand vocational services in the future.

### Cardinal Hayes Home for Children

The Cardinal Hayes Home for Children receives just over $90,000 in its contract with DMH to treat children and youth with severe disabilities. Services include residential services, respite care, service coordination, and recreational services. The primary focus of the DMH contract is to support respite care services for families caring for a developmentally disabled child at home. The County funds only about 2% of the contract amount.

### REHAB Programs, Inc.

DMH contracts with Rehab Programs, Inc. to provide work training centers which provide basic job skills training and skills development in a sheltered environment that ideally ultimately leads to a community job placement. The agency also provides children's education services, an outpatient rehabilitation clinic, and adult day habilitation services. The day habilitation program has grown in recent years in the numbers served. However, as with Dutchess ARC, there have been recent declines in the number of people receiving work training. The County is contracting with REHAB Programs for $885,000 in 2008, and should consider ways it can enhance the vocational return on investment in the future. County taxpayers directly subsidize about 22% of the contract amount with REHAB.

## Additional Services

The Taconic Developmental Disabilities Services Office provides a day treatment program and a behavioral support team that seeks to reduce psychiatric hospitalizations and provide effective discharge planning when hospitalizations do occur. The DD Division Chief coordinates closely with the DDSO, though there is no direct contractual relationship between the organizations.

# Office of Community Services

The Office of Community Services (OCS) provides a diverse set of services both to the larger community and internally within the Department. Most visible are the services provided through Helpline, the emergency hotline that also serves as the primary entry point for most users of the mental hygiene system of services. OCS also coordinates the County's Trauma Team and provides internal departmental support for staff training and development, credentialing of clinicians, student

placements, and consultation and education. It also provides various other coordination and monitoring functions summarized below.

## Individuals served: 1997, 2002, 2007

Table 7 summarizes some of the services monitored by the Office of Community Services. A more recent four-year profile was provided earlier in Table 1.

**Table 7: Services Provided, Office of Community Services, 1997, 2002, 2007**

| SERVICES | 1997 | | 2002 | | 2007 | |
|---|---|---|---|---|---|---|
| | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE | PERSONS SRVD. (EPISODES) | VOLUME OF SERVICE |
| HELPLINE | | 12,515 | | 16,584 | | 15,946 |
| BRIEF TREATMENT UNIT | 167 | 1,268 | | | | |
| HRPC CRISIS RESIDENCE | 266 | 3,493 | | 4,083 | 279 | 3,920 |
| ST. FRANCIS HOSPITAL | | | | | | |
| INPATIENT | 1,318 | 18,358 | 1,539 | 18,901 | 1,781 | 19,566 |
| EMERGENCY PSYCHIATRIC CARE CENTER | 2,868 | 2,868 | 4,248 | 4,248 | 3,860 | 3,860 |
| **TOTAL OFFICE OF COMMUNITY SERVICES** | **4,619** | **38,502** | **6,085** | **43,816** | **5,920** | **43,292** |

*Source: Dutchess County Department of Mental Hygiene*

## Helpline

Helpline is a 24/7 hotline that serves two critical functions for DMH—Helpline staff respond to emergency calls and also serve as a "single point of entry" for residents to access the DMH system of services. To the knowledge of CGR and our partner CCSI, this combined emergency hotline and pre-intake scheduling and entry point to the larger array of mental hygiene services is the only such system in the state.

Helpline takes calls from individuals seeking access to the County's services, and sets up initial appointments for in-house services and services provided by clinics run by Hudson Valley Mental Health, Lexington Center for Recovery, and Astor Children's Services—and occasionally other programs at the point of entry to the system. Pre-intakes consist of determining where in the system the individual should be directed, producing a pre-intake form of demographic information on the patient, and setting up appointments. Helpline staff can access schedules for each of the clinics in order to enter appointments; clerical staff in the clinics can then access this appointment information. The pre-intake form is printed and faxed to the clinic. (Variations of this basic procedure exist for people who call an agency directly or walk in to an agency for an appointment, but generally the system operates relatively seamlessly through the Helpline entry process. Once a person has accessed the system, internal referrals from agency to agency may not need to involve Helpline.)

In addition to the intake process, Helpline also takes calls from individuals in crisis situations, including those contemplating suicide. This includes calls from the County's Bridge Phones—located in a nationally-

recognized model on bridges across the county—and from the National Suicide Prevention Lifeline, which directs calls to various locations, including Helpline. Since joining the Lifeline, suicide calls to Helpline initially increased from 50 per month to 300 per month, though they have begun to decline to about half that level in recent months as the national system has begun to reconfigure its regions to even out the call load.

In addition to crisis calls involving individuals who may be a threat to harm themselves or others, Helpline also takes calls in crisis situations that are less urgent. Individuals may call who need to simply talk to someone; sometimes these are current patients who need support in between appointments, overnight or on weekends. A number of providers within the system, both internal and external, expressed the view that the support Helpline offers to current patients provides an important support that backs up the entire DMH system. In other cases callers may be individuals from within or occasionally outside the County who need support but do not subsequently need to become clients within the DMH system of services.

Helpline calls have increased substantially in recent years. ***Staff processed 20% more calls in 2007 than in 2005, and in the first month of this year calls were up an additional 30% over the first month of 2007***. Typically about 35% of all calls involve pre-intake processing.

Helpline is staffed in three shifts: a daytime shift of 8am to 4pm, an evening shift of 4pm to 12am, and a night shift of 12am to 8am. Typically there is an overlap person with the responsibility to cover the transition between the night and day shift from 8 to 9am, and between the day and evening shift from 4 to 5pm. In addition to a Unit Administrator, who oversees administration of the program as well as taking calls as a backup person when call volumes are high, there are three to four other staff on the day shift (one from 11 to 3 only), typically two on the evening shift, and typically one on the night shift. On weekends there is one staff member on at all times. Per Diem staff also are used to fill in as necessary.

These staffing patterns roughly mirror the call patterns. During 2007, 43% of the calls originated during the day shift, with 34% in the evening and 23% during the night shift. However, it should be noted that both evening and night calls increased substantially in 2007, while daytime calls declined slightly. The proportion of pre-intake calls during the evening shift also increased substantially in 2007. The implications of these shifts will be discussed in more detail in Chapter VII.

Helpline also is responsible for providing dispatch support for the County's Mobile Crisis Team. To help staff that support function, MHA provides Helpline staff coverage from 11am to 3pm five days a week. In

addition, three of Helpline's staff are involved in discharge planning from local hospitals and rehab centers.

The total costs of operating the Helpline function for 2008 are budgeted at $1.17 million. Some state aid is available to offset some of those costs, but the County is responsible for the vast majority (expected to be about 86% in 2008) of the unit's total operational costs.

More will be said about a number of issues related to the pre-intake process and Helpline in general in the report's last two chapters.

## Trauma Team

The Trauma Team is made up of senior clinicians from several County departments who are trained to respond to crises in schools, communities and homes and to provide crisis counseling and debriefing when needed. The team also serves DMH staff as well as emergency responders working in the community when members of these groups are in need of counseling following a personal loss or exposure to traumatic events. The Team has recently increased its focus on emergency preparedness, a growing priority since the events of September 11, 2001. Overall direction of the Trauma Team is provided by the Director of Community Services.

## Psychiatric Emergency Services

Services for psychiatric emergencies are provided by the St. Francis Hospital Emergency Department, an affiliated agency of DMH. In 2007 there were 3,860 face-to-face contacts in the ED, including 887 patients that were open cases in one or more programs in the DMH system. Typically about 55% of those open cases are referred back to a clinic or other program in the system, with the remainder being admitted to St. Francis. In 2007, the proportion of cases returned to clinics or other programs increased to 64%.

Psychiatric inpatient treatment is also provided by affiliated agencies, including St. Francis Hospital (acute inpatient care) and Hudson River Psychiatric Center (HRPC), a State-operated facility (intermediate and longer-term hospitalizations). Currently the number of beds available to county residents is insufficient to meet the needs, leading to 200 to 300 residents per year having to be transferred to hospitals for care outside the county. This issue is discussed further in Chapter VII.

HRPC also operates a crisis residence intended for individuals who need to be removed from their living situations but who are not in severe enough situations to warrant inpatient treatment.

# CHAPTER V. ADMINISTRATIVE FUNCTIONS

A number of internal offices and functions provide necessary support integral to the efficient operation of the Department and the entire system. These include one Division level—Support Services—as well as five offices (not including the Office of Community Services described in Chapter IV). The primary responsibilities and organization of these key internal support functions are briefly summarized below. Many of these units are also revisited in more detail in subsequent chapters, in the context of challenges facing the Department and potential ways these units can be strengthened and/or support changes and improvement opportunities the Department may wish to consider in the future.

These internal operations are jointly grouped for budget purposes under Central Administration, which is budgeted in 2008 at $3.9 million. This budgeted figure is consistent with recent years, as actual administrative expenditures have been contained within the $3.8 to $4.0 million range in each of the past two years, according to the 2006 and 2007 DMH Annual Reports. Although some fees and state aid are available to offset some of the administrative costs, the County share of the costs of administering the entire DMH system are budgeted at about $3 million, or 77% of the total administrative budget.

As mentioned earlier, the Chief and Directors responsible for the Division and Offices described in this chapter all report to the Commissioner of Mental Hygiene, who is ultimately responsible for all aspects of the MH system's operations. The Commissioner, Chiefs and Directors all meet weekly as Executive Council along with the Division Chiefs and OCS Director discussed in the previous chapter,

## Division of Support Services

Although administrative support functions are provided throughout the Department at many levels and within all units, the core of the Department's administrative support, including critical billing and clerical support functions, is provided directly by or with oversight of the Support Services Division. As with the direct service divisions described in Chapter IV, Support Services is headed by a Division Chief. Reporting to the Chief, with significant supervisory responsibilities, are the Billing Manager and the Support Services Manager, who is responsible for personnel, purchasing and clerical support functions.

## Billing Unit

The responsibilities of the Billing 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. A new Billing Manager was hired in October 2007, and since then two new hires have been made to fill Accounting Clerk vacancies, bringing the unit to full strength for the first time in several months (Billing Manager plus five Accounting Clerks). Clerks are responsible for reviewing a financial form that is completed for all new clients at intake to determine their eligibility for a payment source, and following up on missing information on these forms and setting up the client's financial data in the Anasazi software system. They deal with issues involving multiple payers (e.g., services where Medicaid and Medicare both pay a portion of the services), and for billing Medicaid spend-downs (which will be described in more detail in Chapter VI).

The Billing Unit uses the new Anasazi software (see below) to generate bills based on services entered by clinicians. The system has a billing logic that determines which party should be billed for a service for a particular client. Medicaid and Medicare claims are submitted electronically, while third party insurance claims are often submitted on paper. Self-pay statements are also generated on paper and distributed to clients. Billing's functions are intimately related to the roles of clinicians and the Office of Information Technology, and a number of related issues are discussed later in Chapter VII.

## Buildings and Grounds

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 of issues related to moving into new facilities or facility renovation often involve significant attention as well by affected Division Chiefs. Coordination may also be needed with the County Department of Public Works if County properties are involved.

## Contracts Coordination

The Division of Support Services handles contracts with vendors with which the Department does business; for example, contracts for cleaning and maintenance. Though all contracts are ultimately processed through the Support Services Division Chief, primary development, oversight and review of contracts involving the provision of services to clients (the contract agencies discussed in Chapter IV) are more the purview of the Office of Budget and Finance and the Division Chief or Coordinator responsible for oversight of the respective agencies.

### Personnel, Purchasing and Clerical

Employment paperwork, assistance in the development of job specifications, maintenance of personnel records, clinician credentialing, 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. A Support Services Manager oversees these functions and coordinates as needed with County Central Services (Purchasing) and Personnel functions. With the exception of "Confidential" clerical support staff, the Support Services Manager is also directly responsible for the efficient allocation of clerical support services to meet needs throughout the Department, including supervision of Support Services Assistants, who in turn supervise and organize the work of Secretaries within Divisions, programs and units. Support Services Assistants report dually to the Support Services Manager as well as to Division Chiefs; clerical staff are responsible both to Support Services Assistants and Unit Administrators. A number of issues related to the distribution and sufficiency of clerical support staff will be addressed later in the report.

### Safety & Security Programs

The Division oversees programs to ensure safety and security in DMH facilities, including fire drills and related facilities issues. The Division Chief has appointed one of the Support Services Assistants to serve as Environmental Safety Specialist, or Safety Officer, to be responsible for Department safety and security issues and work with a DMH Safety Committee to that end.

## Office of Budget and Finance

Major responsibilities of the Office of Budget and Finance include: annual preparation of the Consolidated Fiscal Report (CFR); preparation and monitoring of annual budgets; recording payroll and other payables and submitting these for payment by the County finance department; overseeing 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 seven professionals. Issues related to fiscal reporting, the impact of the new Anasazi software on Budget and Billing and the relationship between the two, and management use of financial information will be discussed in subsequent chapters.

## Office of Communications

The Office of Communications serves as the liaison between DMH and the public, organizing and providing a variety of public events, promotions

and reports for policymakers and the public. The Director of Communications (a one-person office) often serves as a behind-the-scenes voice of the Department, including drafting statements and documents on behalf of the Commissioner or other Department officials. Promotional events target both issues that affect the public who are outside of the mental hygiene system, addressing such broad issues as stress management, as well as increasing awareness of issues and services directly relevant to the DMH system. The Director helps write grant proposals, prepares news articles and promotional materials, plans and coordinates media campaigns, prepares advertisements, and is responsible for producing the Department's Annual Report and periodic internal communications celebrating the Department and its employees. The Director is also responsible for periodic review and updates of other internal documents such as the policy and procedures manual. The Office also is involved in developing and presenting materials related to the orientation of new staff, and helps oversee the citizen participation component of the DMH planning process.

## Office of Psychiatric Services

The Office of Psychiatric Services serves clinicians internally. The Department's Medical Director oversees and provides clinical supervision for psychiatrists on staff and is responsible for coordinating all medical and psychiatric services throughout the Department, including interpreting governmental mandates and regulations affecting the medical and psychiatric aspects of the programs of the Department. 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.

## Office of Information Technology

The Office of Information Technology (OIT) is broadly responsible for the support, installation, maintenance and training related to the Department's computer communications system and any related computer-based applications. OIT also operates to some extent as the research arm of the Department, monitoring patient satisfaction surveys and analyzing a range of data concerning performance and outcome measures related to internal and external programs and services. The Director of OIT supervises a staff of about 14, including programmers, research assistants, program assistants and office assistants.

Several years ago the Department purchased the Anasazi software system, designed to provide DMH with an integrated clinical, financial and billing system which would create staff efficiencies throughout the Department.

The lengthy evolution of this system, and related frustrations and implications across the Department, are discussed in Chapter VII. But suffice it to say here that since its introduction, a great deal of energy and resources within OIT have been devoted to customizing, implementing, and troubleshooting the system, along with related staff training and orientation. Meanwhile, even as these efforts have consumed large portions of OIT time and creativity, the Office has continued to be responsible for carrying out other routine ongoing functions, including:

- Client tracking - registering clients in the automated system based on copies of pre-intake forms received from Helpline;
- Producing monthly statistical reports on admissions, terminations, ratios of staff to patients, etc.;
- Reviewing data for the DMH Annual Report;
- Producing portions of the CFR, including census data from each unit, service data for each modality by site, and Medicaid services provided by site;
- Producing biannual OMH Patient Characteristics Survey results;
- Medical chart retention;
- Helpdesk support;
- Monitoring and analyzing data from key contract agencies;
- Ongoing staff consultation and troubleshooting individual and systemwide computer problems.

## Office of Quality Improvement

As indicated earlier, the overall responsibility for oversight of this office has historically resided with the Chief of the Division of Developmental Disabilities Services. That assignment of responsibilities continues under the newly-appointed Chief. Reporting to the Chief, and responsible for much of the day-to-day monitoring of quality improvement initiatives across the Department, is a Quality Improvement Coordinator.

### *Quality Improvement Program*

Quality improvement has been a longstanding priority for DMH—going back officially at least a dozen years to 1996, when the Office of Quality Improvement (QI) was created to develop and oversee an official QI plan for the Department. This initiative preceded an OMH regulation implemented in 2005 that offers a Medicaid enhancement to licensed

outpatient clinics implementing a mandated set of QI practices. DMH, Astor Children's Services and Hudson Valley Mental Health are all currently participating in this program. The components required include a QI plan, a QI committee with specifications regarding membership and meeting content, and at least one performance indicator (more were added after 2005).

The DMH Office of Quality Improvement monitors quality indicators throughout DMH, including contract agencies. Departmental leadership monitoring contracts, along with the QI Coordinator, include Division Chiefs and the Coordinators of Children's Services, Vocational/ Employment, and Housing. This group meets quarterly to review results of agency reports on performance indicators that are part of their contracts. Problems are investigated if they turn up in these reviews. The group also does occasional site visits and meets with agency staff. Agencies also are subject to site visits by their state licensing agency, with OASAS, OMRDD and OMH each requiring a different level of monitoring and involving DMH to varying degrees.

A standing Department Quality Improvement Committee oversees the overall QI plan, and also helps establish and oversee special ad hoc QI teams that address internal issues as they arise. Since 1996, more than 50 such QI teams have been created to address various issues related to improving quality across the Department. These teams have led to such results as improvements in the Patient Care/Utilization Review and format, development of family and agency satisfaction surveys, improvements in the approach to and consistency of new staff orientation, and improvement of language to help clients better understand why they are receiving certain medications.

## Patient Care/Utilization Review

This component of Quality Improvement monitors chart compliance in DMH in-house programs as well as all clinics and selected other contract agencies. Chart reviews look for compliance in regard to quality of intakes, careful monitoring of treatment plans and progress notes, as well as HIPAA compliance, among other things. The Billing Department also reviews charts to ensure consistency between clinical and billing events.

Following chart reviews, the Committee meets with program heads and staff to review findings and conclusions, followed by the generation of a formal report which is subsequently discussed with Executive Council.

## Outcome Studies

The Treatment Outcome Profile System (TOPS), a published measure of consumer assessment of quality of life, symptomatology, functionality and satisfaction with service, is used throughout the Department. It is updated

and monitored periodically as a means of tracking client levels of functioning over time. Data have been tracked across a number of units of the Department, although it is not clear that the results have been presented to management in ways that have clear implications for service improvement. The need for improving the use of TOPS and of making better use of additional outcome measures is discussed further later in the report.

### *Corporate Compliance Plan*

The Department began in 2006 to develop a Corporate Compliance Plan that outlines clear guidelines and standards of conduct and practices to be followed by staff and units of the Department in carrying out various functions and relationships with each other and with clients. A high-level Corporate Compliance Committee has been established to oversee and monitor the Plan, under the direction of the Department's QI Coordinator. In addition, a Corporate Compliance Specialist has been hired on a shared-staff arrangement with Hudson Valley Mental Health. The Specialist is responsible for reviewing clinical records to ensure that they meet Medicaid regulations, qualify for reimbursement and provide accurate reflections of treatment received.

# CHAPTER VI. FINANCIAL PROFILE

## 2008 Budget

For Fiscal Year 2008, the County approved a budget of $33,614,379 for the Department of Mental Hygiene. The detailed budget by major internal categories and contract agencies was presented earlier in Table 2 in Chapter IV. The budget is summarized below in Table 8, showing the totals for internal operations and programs, for contract agencies, and for the County share of each. Approximately 62% of the appropriated budget applies to in-house programs and services (50%) and central administration (12%). The remainder represents contracts with external agencies.

**Table 8: Dutchess County Department of Mental Hygiene, 2008 Approved Budget Summary**

| | Approved Budget | County Share | |
|---|---|---|---|
| **In House Programs** | $20,773,087 | $8,462,364 | 40.7% |
| **Contract Agencies** | $12,841,292 | $3,238,253 | 25.2% |
| **Total** | **$33,614,379** | **$11,700,617** | **34.8%** |

*Source: Dutchess County Department of Mental Hygiene*

As shown in more detail in the earlier Table 2, the largest line items in the in-house budget are, in order, Continuing Day Treatment Centers, Central Administration, and Mental Health Clinics (which includes the Special Services Team, the Clinic for the Multi-Disabled, and a portion of Jail-Based Programs). Together, these three line items account for about 73% of the in-house budget and nearly 45% of the total annual budget. Contract agencies with the largest budgets are, in order, Mental Health Association, Hudson Valley Mental Health, Lexington Center for Recovery, Rehab Support Services, and Astor Home for Children, which together account for about 75% of the contract agency budget and 29% of the total annual budget.

As indicated in Table 8, the County is budgeted to cover about 35% of the total MH system budget in 2008. Because primarily of the high County shares of Central Administration and Helpline, the overall County share is considerably higher for in-house administration and services (41%) than for contract services (25%). As shown in the earlier table, the County contributes nothing to several of the contract agencies. The lowest County shares for internal programs are for Mental Health Clinics (about 8%) and Day Treatment Centers (21%).

Between 2005 and 2008, the total budget for the Department increased by approximately 17%, with the budget for internal programs and administration increasing by just over 21% and the contract agency budget increasing by nearly 12%.

## Revenue Sources

Revenue for the Department comes from three major sources: patient fees, including those paid by Medicaid, Medicare, other third-party insurance, and self-pay (patient out-of-pocket payments); State funding (e.g., from OMH, OMRDD, and OASAS), and County funding. The distribution of each of these sources in terms of *actual expenditures* (not budgeted amounts, as shown in the earlier table) for the past three full years (2005 – 2007) is shown in Table 9 below.

**Table 9: Dutchess County Department of Mental Hygiene, Sources of Revenue, 2005-2007**

| Year | Total Expenditures | Patient Fees* | | State Funds | | County Share | |
|---|---|---|---|---|---|---|---|
| **2005** | $28,542,758 | $6,955,653 | 24.4% | $10,059,315 | 35.2% | $11,527,790 | 40.4% |
| **2006** | $30,392,521 | $8,512,174 | 28.0% | $10,081,789 | 33.2% | $11,798,558 | 38.8% |
| **2007** | $31,080,426 | $9,158,731 | 29.4% | $11,466,853 | 37.0% | $10,454,842 | 33.6% |

* Patient Fees include revenue from Medicaid, Medicare, Other Insurance and Self-Pay

*Source: Dutchess County Department of Mental Hygiene, Annual Reports 2005-2007*

In 2007, the largest source of revenue was State aid at 37%, followed by County funding at nearly 34%. Patient fees represented just over 29% of the total. It is encouraging to note that between 2005 and 2007, while total expenditures were increasing by 9%, the revenues obtained from patient

fees increased by 32% (an increase of more than $2.2 million), and State funding increased by 14% (by more than $1.4 million). During this same period, the County share dropped by 9% (by more than a million dollars, and by more than $1.3 million compared to 2006). During that period, the County share of the actual costs decreased by almost 7 percentage points, from 40.4% to 33.6%.

## Patient Fees

While some services provided by the Department are non-reimbursable, others are funded through the collection of fees from various sources—Medicaid, Medicare, private third-party insurance, as well as fees paid out of pocket by patients. The largest source of all fees received comes from Medicaid, and 87% of patients currently being served by in-house programs have at least a portion of their fees paid via Medicaid.

Patients who are not insured are expected to pay for services through "self-pay"—a sliding scale based on individual or family income. The minimum self-pay amount that can be billed is $2.00. Patients who are eligible for Medicaid but have not yet applied, whose coverage has lapsed, or who are uninsured and not yet eligible for Medicaid may be required by the Department of Social Services to incur a "spend-down" before Medicaid will cover the person's remaining medical claims. In these cases self-pay bills apply to the spend-down amount and once Medicaid eligibility has been established, the patient is no longer billed a self-pay amount.

Self-pay amounts billed out but not paid within 90 days go into collections mode; if outstanding payments remain at the end of the year, these are reported to the Commissioner and may be written-off with his permission.

As mentioned, the vast majority of individuals served by the Department have Medicaid coverage. As of April 1, 2008, 87% of clients who were then being served were covered by Medicaid, either by itself (32%) or in combination with Medicare or another third party insurance type. About 8% of the Medicaid total involved Medicaid with spend-down payments. Just over half of the Medicaid total involved a combination of Medicaid and Medicare. Across all programs, only about 4.5% of the participants were considered strictly self-pay, with no insurance coverage of any type on file.

## State Funding

Many in-house programs and contract agencies receive funding through various State funding streams. In the case of contract agencies this funding is passed through the County and distributed to agencies in monthly installments via their annual contracts.

As reported in the County's Annual Reports and shown above, actual State Aid paid to the Department increased by more than $1.4 million between 2005 and 2007, representing about 37% of all expenditures in 2007. In the 2008 DMH budget, State Aid is budgeted at about $11.4 million, representing about 34% of total revenues.

## County Share

The County provides deficit funding to the Department to cover the portion of programs and services that are not covered by patient fees or funded by State agencies. This funding is of critical concern to the Department and to the County government. Rising County costs were one of the driving factors in the transition from services provided in-house to contracting with outside agencies, and the Department attempts to limit County costs through maximizing other sources of revenues to the extent possible.

Table 10 illustrates the trend in *budgeted or expected* County funding for the Department, using 2005 through 2008 Department budgets.[3] As noted earlier, in 2008, the County share of the Department's budget (including fringe costs) is expected to account for nearly 35% of the total revenues. The County share represents 41% of the cost of in-house programs and about 25% of contract agency programs.

[3] Budgets used for this analysis represented "almost final approved" budgets, as they contained the most useful breakdowns of sources of revenues for this analysis. The final budgeted figures were very similar to those shown in this table. For example, the 2008 approved budget contained about $20,000 less than what is shown in the table, a difference of less than one-tenth of one percent of the total budget.

**Table 10: Dutchess County Department of Mental Hygiene**
**Budgeted Appropriations and County Share of Funding**
**2005-2008**

**Appropriations - Without Fringe Costs**

| | | Internal Programs | Contracted Programs | Total |
|---|---|---|---|---|
| 2005 | Budgeted Appropriations | $14,832,699 | $11,496,673 | **$26,329,372** |
| | | $2,624,984 | $2,807,492 | **$5,432,476** |
| | County Share | 17.7% | 24.4% | **20.6%** |
| 2006 | Budgeted Appropriations | $15,698,021 | $11,192,940 | **$26,890,961** |
| | | $3,150,866 | $2,817,127 | **$5,967,993** |
| | County Share | 20.1% | 25.2% | **22.2%** |
| 2007 | Budgeted Appropriations | $16,596,898 | $12,079,048 | **$28,675,946** |
| | | $4,268,177 | $3,006,656 | **$7,274,833** |
| | County Share | 25.7% | 24.9% | **25.4%** |
| 2008 | Budgeted Appropriations | $16,996,935 | $12,841,292 | **$29,838,227** |
| | | $4,666,040 | $3,238,253 | **$7,904,293** |
| | County Share | 27.5% | 25.2% | **26.5%** |

**Appropriations - With Fringe Costs**

| | | Internal Programs | Contracted Programs | Total |
|---|---|---|---|---|
| 2005 | Budgeted Appropriations | $17,167,625 | $11,496,673 | **$28,664,298** |
| | | $4,959,910 | $2,807,492 | **$7,767,402** |
| | County Share | 28.9% | 24.4% | **27.1%** |
| 2006 | Budgeted Appropriations | $18,093,507 | $11,192,940 | **$29,286,447** |
| | | $5,546,352 | $2,817,127 | **$8,363,479** |
| | County Share | 30.7% | 25.2% | **28.6%** |
| 2007 | Budgeted Appropriations | $21,132,709 | $12,079,048 | **$33,211,757** |
| | | $8,803,988 | $3,006,656 | **$11,810,644** |
| | County Share | 41.7% | 24.9% | **35.6%** |
| 2008 | Budgeted Appropriations | $20,793,259 | $12,841,292 | **$33,634,551** |
| | | $8,462,364 | $3,238,253 | **$11,700,617** |
| | County Share | 40.7% | 25.2% | **34.8%** |

*Source: Dutchess County Department of Mental Hygiene*

Since 2005, based on budgeted appropriations, the proportion of the Department's budget covered by the County has increased from 27% of budgeted appropriations to 34.8% in 2008. The majority of this change is attributable to the change in the County share for in-house programs, which has grown from 28.9% of revenues to more than 40%.The County share for contract agencies has remained consistently at about one quarter of all appropriations in the 2005-2008 period.

A comparison of this *budget* table with the earlier table showing *actual expenditures* reveals that in 2005 and 2006, the Department significantly underestimated the County dollars that would be needed to balance the budget, i.e., they overestimated the other revenues that would be available to offset Department costs. In 2007, by contrast, it significantly increased its estimate of County funds needed to balance the budget, and the *actual* County dollars needed that year declined substantially. Hopefully the 2008 experience will be similar, with other sources of revenue exceeding the budgeted amounts.

The table is also revealing in suggesting the impact fringe costs have had on the County share of Department costs in recent years. If only basic operational costs are included, not including fringe costs, the County's share of the DMH budget would have accounted for only 26.5% of total budgeted appropriations in 2008, up from 22.2% of 2006 budget appropriations. But with fringes added to the totals, the County share rose by 6.2 percentage points during those years, from 28.6% in 2006 to 34.8% in 2008. Said another way, ***fringe benefits alone added more than $4.5 million in the budgeted County share of the Department's costs in 2007, and about $3.8 million in additional anticipated County costs in 2008.***

# CHAPTER VII. CHALLENGES, CONCERNS AND OPPORTUNITIES

## Context

As noted earlier in this report, the Dutchess County Department of Mental Hygiene has faced a number of challenges in the past several years. Trends in the environment, including financial constraints within County government, a changing service population, and organizational changes that have transferred several key services outside of the direct control of DMH have all presented challenges that have in many cases been difficult to completely resolve. In addition, internal staffing changes, the decision to transition to a new electronic billing and medical record system, and organizational structures and dynamics that in some cases limit efficiency and effectiveness combine to necessitate a closer look at selected current practices within the Department, and between the Department and external agencies.

The Department's priorities remain rooted in its long-standing mission—to serve individuals in the county with the highest quality services, to provide continuity of care, and to remain responsive to the needs of the population served. Maintaining the ability of the Department to continue to act on these priorities in the most cost-effective manner should be the foundation for any actions taken to address the challenges that have been faced to date and that may present themselves in the future.

Issues discussed below in many cases link back to discussions in earlier chapters. ***CGR believes that even those issues or concerns that may be problematic at this time have the potential to be converted into opportunities for productive change, given the openness to change which we believe exists—and that was often apparent in our interviews—within the County and Department, and within the contract agencies making up the larger DMH system***.

We begin with a discussion of internal issues and challenges currently facing the Department, followed by a series of concerns involving external agencies and forces. In Chapter VIII we then offer recommendations to address these challenges, building on existing strengths within DMH, to create improvement opportunities designed to enhance services in the most quality-focused, cost-effective, budget-conscious manner possible.

## Internal Issues, Concerns and Challenges

We begin with a discussion of the most pervasive internal issue that has dominated and influenced, both positively and negatively, virtually every

aspect of DMH operations in recent years: the introduction of the Anasazi software system.

## Implementation of Electronic Billing and Service Record: The Anasazi Software System

### Timing

Several years ago, DMH purchased a software package called Anasazi. The Anasazi software is designed as a "behavioral healthcare management"[4] system which offers an integrated linkage between billing, financial and clinical functions. The software is intended to track provided services and link them to a billing logic in order to simplify and expedite the process of billing out the cost of services to various payers. In addition, components of Anasazi allow clinical units to track progress notes and treatment plans. Over a lengthy period of time, Anasazi is being rolled out across the Department in phases, both in terms of components (Demographics, Assessment, Progress Notes and Treatment Plans) and in terms of sites or programs. For example, some sites are not yet fully using Anasazi but are instead sending service records to Office of Information Technology for entry into the Anasazi system; other sites have Anasazi up and running but are only using some of the components. In addition, some services continue to be recorded exclusively by hand by some clinicians and physicians, with data then entered electronically by clerical staff or OIT, while others have converted to routinely entering data electronically, avoiding any initial paper entry.

### Objectives

A key reason for the switch to Anasazi was the need to be compliant with HIPAA regulations, in order to meet reimbursement requirements. Security issues not met by the previous system were also to be addressed by Anasazi.

The software was also designed to simplify the process of billing under the new system and to make the processing and tracking of client progress easier for clinicians. It also ideally improves the County's ability to respond to audits by Medicaid, by storing service information and linking it directly to billing.

Anasazi has the benefit of an automatic billing logic; when services are entered in Anasazi by providers, the system is able to assign billing codes to those services, saving billing staff the time needed to look up and enter service codes. The system should therefore expedite billing and the tracking of receivables. However, there have been challenges in building

[4] Anasazi Website: www.anasazisoftware.com

the correct billing logic within the system, and this benefit has not been fully realized. When Anasazi was implemented, the billing process needed to be understood thoroughly in order for the billing logic to be written in the system. Apparently this was a difficult process, as many of the procedures in place in the billing unit were undocumented, and there has been a high level of turnover within that unit, thereby further complicating the transition and incorporation of the appropriate logic in the most efficient manner.

## Adapting to Change

Any change in the way things have "always been done" is bound to be difficult, but staff at all levels of the Department described the process of implementing and adapting to Anasazi as extremely difficult and frustrating—far exceeding routine levels of angst, disruption and discomfort normally associated with widespread change.

### *Insufficient Staff Input?*

A number of supervisory and line staff reported that a major problem with the implementation of Anasazi has been that differences among units and programs have not always been adequately taken into account. Procedures and reporting needs vary across units, and many staff feel that differences in functionality between these units were not always sufficiently factored in to the implementation process.

In general, staff reported that they did not have sufficient opportunity to raise questions that might have helped shape the initial decision to implement Anasazi, nor to provide meaningful guidance in implementation once the decision was made to go forward. On the other hand, the Department did establish an Anasazi task force made up of different levels of staff from many of the Department's units. This group in turn met with other staff and provided significant advice during the implementation process, but some of those we interviewed indicated that even that effort to seek input did not always represent operational concerns shared by many staff. CGR has no way to independently assess the validity of the various claims, except to say that there is no question that staff at all levels have been frustrated at the difficulties which have arisen in the full-blown implementation of the new system.

### *Inefficiencies Remain*

Staff noted that despite Anasazi being designed for electronic recordkeeping, items entered in the system are still being printed and filed in paper charts due to a distrust of the system and a fear that important records may be lost without the paper file backup. This adds further constraints on staff resources as well as on already-limited chart storage space. Rather than reducing the amount of paperwork involved in service delivery and recordkeeping, the perception is that the introduction of

Anasazi has increased the amount of paper; for example, each individual progress note must be printed and filed, as opposed to previously, when several notes may have been entered on one sheet of paper. Staff must be legitimately convinced that an adequate backup system is in place to eliminate the perceived need to backup data in hard copy. In addition, the system is seen as slow and staff complained that the system occasionally crashes. With limited time for paperwork to begin with, this interferes even more with the ability of clinicians to complete paperwork requirements.

Staff are not only used to keeping paper records, but many are not used to working on computers at all. As the Department gets closer to full implementation of the new software system, a number of staff members may need more training in the use of computers, and may need to be formally "urged" to make the adjustments needed to accommodate to the changing circumstances. However, many staff do feel that the change to Anasazi will ultimately have positive outcomes; younger, more computer-literate staff especially perceive fewer problems with the system than do some of the more veteran staff. Better recordkeeping and time-saving procedures are seen as potential outcomes once staff become accustomed to the system and remaining glitches are resolved.

### *Insufficient Initial External Support for Implementing Change*

In addition to perceptions of problems with the implementation of the Anasazi system, there is also a perception that, at least initially, national Anasazi staff were not sufficiently responsive to requests for system support. The Anasazi Website emphasizes: "We're always at your service and our industry leading support agreement backs up that promise."[5] Assumptions were made about such support that appear not to have fully materialized early in the implementation process, either because the support was not requested and insisted upon with sufficient urgency, or because it simply was not delivered upon request. As a result, OIT and the internal Anasazi task force were left to do extensive work in providing the support. Given the existing responsibilities of these two groups, and the complexity involved in implementation, it would have been helpful in the early stages to have had more external support—support that has been more available more recently. Staff noted that OIT staff have been quite responsive to requests for help with Anasazi-related problems, but that they have been asked to do too much with too few resources.

In retrospect, it appears that Anasazi may have been designed to work most effectively within a single agency, rather than an agency with multiple program types in multiple sites, along with external agencies with

[5] Anasazi Website, op. cit.

their own computer systems, policies and practices. There is also a question of how well-designed the basic Anasazi software system has been for relatively high-turnover, high-volume clinic settings.

Problems and issues continue to arise as Anasazi is implemented, and addressing these continues to be a priority for the Department. Currently OIT plans to have the treatment plan module rolled out completely by the end of this year and expects that all programs will be entering services in Anasazi, with no need for OIT to do any manual data entry, by the middle of 2009. Recommendations related to the remaining implementation process are explored further in the final chapter of this report.

## Billing and Insurance

A number of issues related to billing are directly connected to the implementation of the Anasazi software system, but there have also been other unrelated, or only partially related, concerns. Billing of services to Medicare, Medicaid, private insurance companies and self-pay patients has been an ongoing source of frustration across the Department. Retirement of a respected, long-term Billing Manager five years ago, other significant turnover and vacancies in the billing unit, the switch to Anasazi, delays in timely claim and statement generation, and uncertain and controversial divisions of responsibility around various billing-related matters are all cited as contributing to unresolved concerns in this area.

### Division of Responsibilities

The recently-produced draft of the DMH Billing Manual states: "Dutchess County Department of Mental Hygiene billing system requires the close coordination of Clerical, Clinical and Billing staff." It might well have added Office of Information Technology staff as well. Nearly everyone interviewed by CGR during the study argued that the current reality is far removed from such a desired state of coordination and cooperation. Indeed, the prevailing attitude has been more of distrust, of an "us versus them" mentality that contributes to clinicians and technicians working in opposition rather than in tandem to develop solutions to common problems. These problems have been exacerbated by the recent lack of leadership around development of common ground understandings and resolutions of long-standing issues.

Specifically, there is disagreement and confusion within DMH around where the responsibility for various billing and insurance functions should lie. Among the unresolved issues in contention are:

- Responsibility for data entry. Currently there is a mixture of clinician, clerical, billing and OIT entry responsibilities that varies by program, unit and even external contract agency in terms of what is entered by whom.

- Responsibility for obtaining patient financial information and calculating self-pay amounts at intake; checking patient eligibility for coverage at the time of service. Often the clinician obtains (and sometimes, but not always enters) this information, but responsibilities vary across units and agencies. At least one contract agency has assigned responsibilities for intake and initial gathering of information to a designated intake person or unit.

- Obtaining pre-authorizations and re-authorizations for services when needed. Many feel that this should be the responsibility of the billing staff (or perhaps clerical staff in some cases), unless a clinical interpretation is involved, in which case a clinician should be consulted. However, in many cases (especially in programs such as Partial Hospitalization, ITAP, and the Special Services Team), clinical staff are primarily responsible for these functions, and Unit Administrators frequently spend significant amounts of time on such activities that many believe would be more cost effectively handled by billing staff.

- Contacting payers regarding denied claims. Again, most feel that this is a process that should at least be initiated by billing staff, using clinicians or supervisors as backup as needed, but the latter are involved routinely in some units. Whether this is to some extent by design on their part, or by default, was not always clear, but the resulting frustrations and time constraints were apparent.

- Collecting out-of-pocket payment for self-pay clients and/or in Medicaid spend-down situations at the time of service, and completing and submitting payment paperwork to the billing unit. There is considerable disagreement between clinicians and technicians (and among many clinicians as well) as to who should be responsible for tracking down out-of-pocket payments from clients, many of whom have marginal ability to pay, even with small sliding scale fees in place. Some feel that holding clients responsible for payment of fees reenforces a sense of accountability that may be a component of their therapy and that"letting them off the hook" is enabling them to avoid responsibility. Others feel that clients should not be forced to pay, and that it is inappropriate, disruptive and overly time-consuming for a clinician to be expected to collect fees, any more than a medical doctor would be expected to do so.

- Monitoring of amounts of past-due client fees and expected actions to be taken. There appears to be no current clear policy on collection of spend-down amounts and the expectations of how much is to be collected, and by whom. CGR was not able to find evidence of any regular statements of private pay fees and spend-down amounts "charged" against clients versus how much has actually been paid against outstanding amounts. Often unpaid client fees are at least partially written off with approval of the Commissioner, though there

does not appear to be clear policy governing which items are written off, after what amount of collection efforts, if any, and after what amount of time. These decisions, amounts and timing all appear somewhat variable across clients and service units.

- Sending annual updates to the billing unit regarding financial, living arrangement or insurance changes. In some cases, clinicians or even Unit Administrators spend significant amounts of time tracking down current status information or signatures on an annual basis, sometimes from legal guardians who may be difficult to contact, simply to signify unchanged status. Medicaid does not require such updated information, but the perception is that the billing unit does in order to send out patient billing statements. Clinicians argue that the statements should continue to be sent out without the updated status or signatures, and any followup done only if the claims are contested, rather than wasting the time on multiple cases where there is no evidence of any change in status.

The issue with each of these concerns is not necessarily in determining a 'right' way that these functions should be performed. Legitimate cases can be made for a number of positions on each issue. The larger question is how to resolve these issues and how responsibilities should be divided to maximize the Department's resources, both in terms of staff time and expertise, and its goals in terms of revenue, billing, collections and related relationships with patients, third-party payers and among staff. A new billing manual has recently been developed for consideration by the DMH Executive Council, but it appears to mostly present circumstances as they are, without addressing ideally who should be responsible for what tasks in the future, or what changes in assumptions and working relationships may be needed. Too often, decisions about billing have been made without discussion about what makes most sense from the big picture perspective across units and functions. Before the billing manual is approved, these big picture issues need to be resolved and agreed upon across the Department. With a new Billing Manager in place for a few months and recognized as having good initial instincts, there appear to be significant opportunities for leadership around productive change and reaching out across units to build effective working relationships for the future.

### *Time Constraints on Clinical Units*

While staff in clinical units acknowledge that individuals communicating with insurance providers for authorizations and some claim denials need an understanding of clinical issues, they also feel that their time would be best used as a backup resource on what they perceive as a relatively small proportion of cases in which such issues are critical, and that in most cases a billing or clerical support person could handle the responsibilities, without taking time away from other valuable roles of staff clinicians and Unit Administrators.

As noted above, many clinicians also feel that dealing with financial issues can be disruptive to the therapeutic relationship between the clinician and client, although others feel it can be integrated with the therapy and that collections should be pursued more aggressively. In addition, some feel it is a waste of time to pressure self-pay clients regarding a minimum self-pay amount of $2, which is set for many self-pay patients, or for payment of spend-down fees. The clinical issues should be weighed against the value of the time spent to track down what appears to be a relatively small portion of revenues. An income and expense report from the Office of Budget and Finance indicated that through May, 2008, only about $23,000 of more than $11 million in expenses were attributed to patient fee revenues. It is not known how comprehensive a statement of unpaid fees this was, and how it would compare across a full year, but it suggests that from a revenue perspective alone, spending clinician time on fee collection would have relatively little impact on the revenue profile of the Department.

### *Delays in Billing*

Billing functions, and payment of bills, have at times been delayed due to the transition to the Anasazi system (see Financial section below). Initially, since the billing logic of individual Anasazi customers is not written into the product before the organization receives the software, the Office of Information Technology needed to work with the Billing Manager to write the Department's billing logic into the system. There were some initial delays in submitting claims while problems with the logic were resolved. Subsequently, there have also been delays in monthly and yearly closeouts, thereby leading to further billing delays and difficulties in enabling Budget and Finance to easily reconcile payments received against programs. Moreover, these closeout delays have contributed to the Department's delays in completing several years of Consolidated Fiscal Reports (CFRs), the state documents used by the County to claim state funding of MH programs. This in turn led to delays of up to several years in the release of state aid and some Medicaid dollars to the County. Some revenues over time have been foregone or written off as a result of these problems. Such issues have also on relatively rare occasions been compounded by not having appointments scheduled with credentialed, reimbursable staff. The Billing Manual addresses the need to be diligent about this issue, and supervisory staff need to also be careful to ensure that appropriately-credentialed staff are available and assigned as primary providers to maximize billing.

Fortunately, within the past two months, detailed Anasazi training has been provided for the new Billing Manager and new staff, which should help resolve billing and timeliness issues in the future. And, in recent months, the billing unit has been closing out each month within a few weeks of the next month. Once Anasazi and strengthened billing practices are fully in place, it is reasonable to expect increased fees in the future to

flow through the Department and its programs on a more timely basis, with the billing advantages of Anasazi triggering improved recovery of funds.

Chapter VIII includes several recommendations designed to strengthen the future role of the billing unit, and to strengthen efficient, productive and cost effective working relationships between billing and other units of the Department.

## Financial Reporting and Recovering Revenues

The Department's Office of Budget and Finance is responsible for monitoring adherence of DMH to its annual budget and provides fiscal reporting to that end, while also being responsible for claiming state aid to support County and contract agency programs.

### Reporting to New York State

As noted in the previous chapter, typically between 35% and 40% of the costs of the County's mental hygiene services are paid for through federal and state aid of various types (not including additional fee-based support through Medicaid and Medicare). The claiming mechanism for accessing state and federal aid distributed through the NYS OASAS, OMH and OMRDD systems is the state's Consolidated Fiscal Report (CFR), which must be filed annually.

The DMH Office of Budget and Finance is responsible for completion and submission of the CFR, with additional information for its submission supplied by the Office of Information Technology, which is responsible for portions of the CFR that concern: units of service by program modality and site; Medicaid units of service; and persons served by program and site. The process used for completion and timing of submission of the CFR document is outlined in the recently-updated Budget and Finance Manual.

### Delays in CFR Submission and Receipt of Revenues

As documented in a recent report by the County Comptroller, and as noted briefly in the section on billing, the Department experienced several years of delays in this decade in the submission of completed and certified CFRs, thereby leading to delays in payments of several million dollars in state aid to the County and some of its contract agencies, although the funds were ultimately released and paid. A number of factors appear to have accounted for the delays, including the aforementioned problems with the Anasazi software system and its implementation. Other contributing factors included loss of key staff in the Budget Office and within the billing unit, changes during the period in question to an accrual system of accounting by the Department, changes in the County Finance office's management system and direction, and changes in the state audit

certification process. In addition, there appears to have been a lack of effort within Department management to aggressively oversee and manage the process and to control more of the Department's destiny during these admittedly difficult changing circumstances.

For example, the Department leadership operated without monthly financial reports comparing budgeted to actual expenditures and revenues for several months (some of those we interviewed said up to three years). Problems with Anasazi and other contributing factors help explain the difficulties in producing such documents, but a delay of several months, without developing any interim solution to approximate a more traditional monthly financial report, seems hard to understand. Similarly, the Anasazi-created difficulties notwithstanding, it is not clear why it took several years to create sufficient sense of urgency to figure out a way to expedite closure of earlier CFR years. Perhaps a more comprehensive earlier intervention by the national Anasazi support team would have helped resolve these issues more readily.

### *Corrective Actions*

Admittedly, it is easy to suggest what might or should have happened to mitigate the issues discussed above. Currently it is of far greater importance to determine how to prevent further future delays. As the Anasazi system and billing practices have more fully developed, and better linkages with the County financial system have become more feasible, the DMH Budget Office has begun to put in place a series of helpful corrective actions and updated approaches which are designed to prepare the Department more effectively for managing the system's financial circumstances in the future. Among these practices is an updated Budget policy and procedures manual designed to capitalize on changes in Anasazi, DMH billing and County financial systems. This document may need to be updated periodically to keep pace with the evolving nature of Anasazi, but it appears to reflect recent updates in the software capabilities.

The Department is in the process of implementing better reconciliation practices to improve the ability to reconcile state aid revenue with County Finance data, which had been a problem before. It has also taken steps to expedite timely completion of the CFRs in future years, including tighter procedures to ensure timely reporting from contract agencies as well as internal updates.

The Budget Office has also developed a regular monthly income and expense summary report which is a "work in progress," but is beginning to reinstate the ability of Department management to monitor more carefully monthly financial progress against budgeted revenues and expenses. It is not clear from copies of this report shared with CGR whether this document will ultimately enable monitoring of progress against budget at

the unit level or not (e.g., individual clinic units, individual day treatment sites), but it at least provides useful information within overall categories such as day treatment centers, ITAP, Helpline, etc. The closer the monthly financial management system can get to tracking at the unit level, the better, but the current level of monthly reporting is a significant step in a needed direction. More will be said about financial reporting in the recommendations chapter that follows.

## Reporting of Service Data about Programs

For a number of years OIT has reported a variety of useful data about each internal program and the major external agencies on a "Monthly Statistical Summary." The data are tailored to the types of programs or services provided, so that the types of data presented for clinics are somewhat different from that which is presented, for example, for day treatment programs. Data focus on some variation of numbers served/program census; service volume; admissions; average daily attendance and, where appropriate, "no shows"; staff; and some type of ratio of persons served, or service units, per FTE staff. These data are presented at the unit and program site level.

### Basic Program Performance Data

In general, these indicators appear to provide useful management information for tracking basic trends in the services provided at each site, and basic performance measures for each site and type of service. However, there are opportunities for improvements in the types of data which could be considered in the future, and existing data must be used with caution, especially when making comparisons over time and across sites. For example:

- The transition of services to contract agencies. The involvement of several different agencies over a relatively short period of time in such services as MH and CD clinics has affected the accuracy and consistency of data and the ability to track certain measures because of changes in data tracking and definitions.

- Changes in definition of "service event" or "volume of services" over time. These definitions have changed across the system over the years, and from time to time within the same agency or program. Thus, even though the Department reports multi-year trends in service volume, the reader should be cautious in interpreting the trends, given variations in definitions from year to year and program to program. At the very least, presentation of these data in each year's Annual Report should be accompanied by explanations indicating how the definitions of the measure have changed over time.

- Patients staying on rolls while not in treatment. Data on program census, numbers served or caseloads may be inflated by open cases that have not been active or regular participants for some period of time. This is not an issue for many programs, but programs or services that have many potentially long-term clients, such as the core MH and CD clinics and day treatment programs, may find it useful to assess census/caseload statistics to see how accurate they are in reflecting realistic workloads of the respective programs and services.

- Because of differences in reporting approaches and comparability of measures, information from an agency such as LCR is not currently as useful, and does not contain some key indicators, compared with other clinic sites.

- Data for continuing day treatment centers provide useful measures of average daily attendance as a percentage of census, and in turn relate that measure to numbers of FTE clinical staff. However, such information would be even more useful if it could factor in the fact that many participants in various sites are only expected to attend three days a week, for example, rather than five. Factoring in not only the census and the average attendance, but relating those also to expected maximum aggregate days of attendance for the site, given individual schedules, would seem to provide an even more useful indicator of the adequacy of staffing per expected clients. At the same time, it could provide a more accurate way of tracking over time the extent to which attendance may be consistently high, or falling short of expected daily attendance over time, thereby providing management with information that could be useful if attention needs to be paid to either culling the rolls or taking steps to reach those whose attendance may have fallen off.

- It would seem useful to produce selected measures for each program showing point-in-time comparisons from quarter to quarter within a year, as well as comparing month-to-month or quarter-to-quarter from the current year to the comparable time the previous year. Comparing basic information on such measures as census, ratio of clients to staff, new admissions, no-show rates, and percent of census served and/or average daily attendance would enable management to spot variations from time to time, and "red flag" indicators that suggest changes are occurring, either in a positive or negative direction, that may suggest the need to raise further questions or consider corrective actions. A cursory review by CGR of selected monthly reports from 2007-2008 and 2003 indicated a wide range of measures and sites where little change has occurred over time, but others where data appear to have changed significantly, thereby raising potential questions for further investigation. It is our understanding that some limited measures such as persons served and volume of services are now beginning to be

tracked on a quarterly comparison basis, which appears to be a useful direction. Beyond that, we would suggest that a more comprehensive array of such indicators as those suggested above, or others that management deems most useful for assessing the performance of sites, be compared on a regular basis in going forward.

- There does not appear to be any consistent tracking of billable hours, or extent to which clinicians maintain certain proportions of their time as reimbursable. The value and appropriateness of such a measure would of course vary by type of program and staff position, but it might be worth considering for incorporation in the future, especially if it were tied to unit or individual goals. Such tracking might also help reveal the need for upgrading certification levels of certain staff in order to qualify for reimbursement from various funders.

- There also does not appear to be any current tracking of cost of service per persons served or units of service provided. This would of course mean linking service data with financial data from the Budget Office by unit and site. Care would need to be taken in the use of such information, to guard against making inappropriate comparisons across different types of services. However, using such information to compare across sites offering comparable services, or comparing data for the same site over time, could provide valuable feedback to programs and administrators to suggest opportunities for strengthening productivity and becoming more efficient.

- As an additional financial measure, consistent with the previous discussions concerning billing and financial reporting, it may be useful, if it is not already happening, to reflect in monthly financial reports the value of services being billed to various providers, versus the actual anticipated amount to be received, versus actual funds subsequently received. This may already be done, but we saw no indication of it in any of the financial materials provided to us. Such a presentation may suggest amounts potentially billable to other sources once initial payments are made, but beyond that, may provide useful information to present to the public and to policymakers concerning the value of the services being provided within the Department, versus what is actually covered by various insurance providers. Such information may be useful in establishing a rationale for how County support dollars are used to cover the costs of legitimate services not otherwise covered by fees.

- Similarly, it could also be useful to track the distinction between the value of services provided that are used to apply against Medicaid spend-down requirements versus the actual amounts paid against those spend-down amounts, and the amounts of the value of services charged against private-pay client fees versus the amounts actually collected.

- Because of the cost to train and orient new staff, and because as existing veteran staff begin to retire a number of new replacements will be needed in the future, it may become important to add a measure of staff turnover to those measures currently being tracked for programs. This may be an especially important measure to track within external agencies, where anecdotally it seems clear that there are concerns about this issue (see External issues discussed later in this chapter).

### Outcome Measures

Beyond basic performance measures of numbers served and other measures of what the programs do and how productively they provide service given existing resources, it is also important to ask various types of "so what" questions, i.e., so what difference do these resources in certain programs make? What impact do they have on those they serve? How well do they do in making progress against treatment goals, and how objectively can such progress be judged (rather than just via subjective observation)? What impact do various types of programs have on preventing psychiatric hospitalizations? What impact do the Department's various criminal justice programs have on reducing jail days or on other effects in the larger community? As discussed under External issues below, the Department has developed a process for developing and tracking a variety of performance and outcome measures for its contract agencies against logic models, but is only in the early stages of developing and monitoring such outcome measures, and holding programs accountable for performance against them, for its own in-house programs. These early efforts are to be commended, and we offer some suggestions for strengthening this initiative in the final chapter on recommendations.

## Internal Quality Improvement

### Increased Role in Using and Interpreting Data

In addition to overseeing the overall Quality Improvement efforts as spelled out in Chapter V—with heavy emphasis on QI teams, Patient Care/ Utilization Review processes, and monitoring of the Corporate Compliance Plan—the Quality Improvement Director (also the Chief of Developmental Disabilities) and the QI Coordinator are likely to need to spend a considerable portion of their time working with the Department to ensure full and expanded use of the types of data described above. Considerable emphasis will need to be placed on such efforts as strengthening performance and outcome indicators, working with OIT and the Budget Office to produce and analyze them, interpreting the results to management, and working with management and the units of the Department (as well as with contract agencies) to implement changes resulting from these analyses. The Commissioner and Executive Council will need to give their full blessing and support to this effort if it is to receive the attention it needs and deserves. Given the appropriate levels of attention, this expanding focus on effective use of data for management

purposes can have a significant impact on improving the services, internal operations and cost effectiveness throughout the Department and larger DMH system.

### *HIPAA Interpretation Regarding Previous Patient History*

One additional issue of significance was raised during CGR's DMH assessment that directly impacts the role of the QI Coordinator as Corporate Compliance and HIPAA monitor. A question was raised by a number of those we interviewed related to what information can be shared between agencies concerning the previous DMH history of a person seeking to access services within the system. The issue particularly pertained to individuals seeking to access services through Helpline, though it could apply in other situations as well. If a person attempting to access services is known (through real-time review of the person's medical record) to have previously been in treatment in another agency within the system, how restrictive must the new or intake agency be in passing that information on to the new agency or therapist? Can such information be transmitted to a new provider? Must the potential client give explicit permission for such information to be made known to the new provider? Or can the information be transmitted without asking the previous and potential prospective client? If the person denies previous contact, even though the previous contact/treatment is not in doubt, must the information be withheld?

It is CGR's understanding that up to this point, the County has taken a relatively restrictive or conservative approach to such an issue, choosing to err on the side of caution and not presenting the information unless it is expressly authorized by the person. CGR's understanding of the regulations and what the state would allow is somewhat less restrictive and would open wider the opportunity to pass on the previous history, regardless of whether the person does or does not provide his/her expressed approval at the time of intake. It is CGR's understanding that with appropriate privacy policies shared when patients first enter the system and privacy agreements signed by patients, the information in their charts should be able to be shared across programs and agencies under the DMH umbrella. This is a complex issue, but CGR suggests that a less narrow interpretation be used by the County in the interests of enhancing future services for the individual. It is our understanding that the County may be moving more in this direction, by allowing the intake or appropriate agency person to say something to the effect of "You've told us in the past about your substance abuse history and treatment," and with that introduction the person typically agrees, which is being interpreted, as we understand it, as being tantamount to agreeing to have the information passed on to an appropriate provider at the new program.

## Internal Communications and Decision-Making Processes

Internal communications and decision-making processes received mixed reviews across the Department, based on CGR's interviews and reviews of various documents. Among the major observations and conclusions:

- There is a general sense that communications have improved in recent years across the Department, and that decision-making has become more of a bottom-up rather than top-down process than in the past, with a greater sense of openness and encouragement of ideas from all levels throughout the Department. There appears to be an open-door, "walk-in or schedule an appointment as quickly as possible" willingness on the part of the Commissioner to make himself available to anyone. On the other hand, it is not clear how widely understood that invitation is, and there is also a sense of reluctance on the part of a number of staff to raise issues, either for fear of "challenging the status quo" or because of a sense that little will happen in response to any concerns that are raised. Thus, even though a number of QI and other ad hoc special committees have been established to address a variety of issues, the primary perception is that in general the decision-making process is not widely open to input from line staff, and that suggestions from individuals or special teams are often not taken seriously (or are rejected without the reasons being communicated). This discourages line staff from feeling they can implement or even seriously suggest innovative methods of working with clients or other changes, creates divisions between leadership and line staff, and has contributed to some of the divisive issues being faced by the Department currently, such as divisions between the Billing Unit and other staff, and the frustrations around the implementation of the Anasazi system.

- The longevity of many key staff throughout the Department is seen by most as an indicator of commitment, a contributing factor to the maintenance of a strong culture and sense of internal values, and a positive aspect of the Department. At the same time, many also see this as a "status quo" barrier to innovation and creative solutions, trying new therapeutic models, and changing procedures, practices and processes. Suggestions were made that to the extent possible, "fresh blood, fresh ideas and new people" should be added to Executive Council meetings.

- Partly in response to this mixture of both positive and downside effects of the experience of Department leaders, a succession plan has begun to be put in place, supplemented with opportunities provided for those interested in being considered for future upper management positions to be exposed to training and orientation around key issues and opportunities for development of skills related to important management dimensions. Staff appreciate that these efforts are being put in place.

- Many staff members commented on the perception that specific decisions, and the implications of those decisions for middle management and line staff, are often not clearly communicated. Better ways are needed of communicating key decisions and the rationale behind them to those who will need to assure that the decisions are effectively implemented.

- There is a clear sense of division, whether accurate or not, between the service-providing/clinician side of the Department and the more technician/technical support side, including Budget, OIT and Support Services with primary focus on Billing. This is further exacerbated by the sense that there are silos even within these splits, with insufficient communications between the various technical support areas and in some cases between different service-providing units. These perceived divisions and communications gaps appear to exist regardless of personalities or perceived support, as for example OIT is perceived to be helpful in responding to issues and direct service or information requests that are raised, even though problems are perceived as created and heightened by insufficient communications between OIT and other units around policy and "big picture" issues.

- Staff appreciate the fact that minutes from Executive Council have been posted for staff review. But suggestions have been made that they would be more widely read if they were sent to all staff via email attachments. Many staff commented that they often have no context within which to judge some of the issues mentioned in the minutes. By making them easily available to all staff via email, it would make it easier to raise questions about such issues in subsequent staff meetings within units or divisions, thereby enhancing the level of communications within the Department. Some noted that the most effective way to share information from Executive Council meetings would be through in-person discussions within departments or divisions, rather than simply expecting staff to feel adequately informed by reading the meeting minutes.

- As a further means of helping to ensure that there is better flow of information in both directions—with better explanations from the top down of reasons for decisions made by Executive Council, and better opportunities for issues to be communicated up from lower levels—suggestions were made by several staff that cross-unit middle management level meetings that used to occur should be reinstated on some type of regular basis.

- If such things as middle-management meetings are put in place, and supplement recent improvements in the initial orientation of new staff, as well as succession planning and training efforts, leadership of the Department will be viewed as taking important steps to inculcate the

critical existing values and culture of DMH to the next generation of staff and leadership. As veteran DMH leaders at top and middle management levels reach the point over the next few years of considering retirement, such improved communications and efforts to "pass the torch" will become especially important.

- With improved efforts underway to strengthen initial orientation and training of new staff members, if more regular staff meetings and improved communications are put in place, decisions made by Executive Council are likely to be more widely understood and appreciated.

- There are some indications obtained through the Patient Opinion Survey conducted annually among participants in Department programs, as well as among clients at Lexington Center for Recovery and Hudson Valley Mental Health clinics, that clients in selected units and programs do not always feel free to express their opinions within those programs. There may be reasons for this, including the nature of the clients themselves in particular programs, but the important point is that a review of the Patient Survey suggests that there are frequently important insights about particular issues within particular units or types of programs that should be carefully reviewed by top and middle-management, that go beyond the standard conclusion in recent survey reports that consistently show "patients reporting high levels of satisfaction in all areas."[6] CGR would not quarrel with the overall interpretation, as the findings are typically consistently positive, but a closer review of the more detailed data suggests that there are important opportunities to raise questions and consider improvement opportunities around selected issues within selected units.

## Facilities Issues

The Department has done an excellent job over the years of designing a decentralized service system, emphasizing access to residents throughout the county. This accessibility has been extended not only across the Department's in-house programs and services, but also through its major contract agencies as well.

However, as many of the numerous facilities throughout the DMH system age, often without sufficient resources to provide adequate upkeep and renovation, the Facilities client satisfaction ratings have declined in recent years. From 90% positive satisfaction ratings across the system's programs and clients as recently as 1994, the facilities overall positive

[6] Department of Mental Hygiene, "Patient Opinion Survey Spring 2008 Administration Presentation of Results," p. 1. The identical statement was also made in the Spring 2007 report.

rating fell to a low of 76.9% in 2007 (by contrast, the overall average positive ratings across all categories each year have never dropped below 87% since 1991). In particular, clients in Chemical Dependency programs (primarily those in LCR clinics) reported 72% favorable ratings on facilities in 2007, compared to 91% as recently as in 1999.

In addition to client declines in satisfaction with facilities, staff expressed a number of concerns related primarily to adequacy of space and health and safety concerns.

Various people noted concerns about having insufficient space to carry out group and other types of programs, including insufficient space for conducting confidential discussions with clients without displacing other staff members. Several examples were given of clinicians and doctors having to share offices, despite having their own clients and the need to meet individually with them. Ironically, there is insufficient space for staff involved in a recent co-location grant obtained jointly by DMH and DSS, with cramped conditions and insufficient space and equipment.

The system's main North Road facility received a number of comments related to concerns about issues of safety and health, including temperature control, leaks and mold in core buildings and adjacent trailer facilities.

In addition, the North Road facility, with its wide range of agencies co-located throughout the sprawling complex, can often be difficult for a client to navigate, and some staff expressed concerns about the ease with which anyone could wander unchecked throughout the facility. Signs are not always clear in directing traffic, and two switchboard operators are not necessarily in strategic positions to direct persons entering the building. The forthcoming move of Helpline to a different location within the building may create opportunities to do some renovation of space, to create a more open welcoming area and a central place where visitors can enter, check in, and be directed to the appropriate location.

Issues related to maintenance and repair, and upgrading and renovations of facilities owned by the County often seem to get caught up in buck-passing and issues falling through the cracks between the Department's Support Services Division, on-site administrators informally "deputized" by Support Services to manage building issues, and the County Department of Public Works. With significant facilities issues facing the Department, resolution of many of these issues will only be possible in concert with DPW in the future.

## Integration of Services: No Wrong Door Approach

The Department is currently engaged in efforts to move towards an Integrated Treatment approach. The goal of this approach is to allow clients to be served and treated for co-occurring disorders at their primary treatment setting and/or wherever they enter the system. This is viewed as a multi-year effort to fully implement, as staff cite a number of challenges and barriers to making this a reality, most specifically the current lack of cross-training for most staff to enable them to adequately deal with the disorder in which they do not currently specialize. The Department currently has a task force working to develop consistent policies, practices, procedures and assessment tools to make such an integrated, holistic approach workable across the system, including both internal and external agencies. Among the issues that will need to be resolved in making such cross-agency services and referrals possible is the ability to work around HIPAA restrictions on sharing of treatment information across service providers, consistent with the client's ultimate best interests in receiving appropriate services.

## Emergency and Psychiatric Inpatient Services

Dutchess County has for years had a problem with insufficient psychiatric inpatient beds to meet the needs of county residents. The DMH Commissioner has consistently pointed out the low ratio of available acute care psychiatric beds within the county, compared to other counties in the region, which has contributed to the need in recent years to transfer an average of 20 to 25 patients per month from the St. Francis Emergency Department to intermediate and long-term psychiatric inpatient care facilities outside the county. The need for more psychiatric beds within the county is a continuing significant problem, as sending some 300 patients a year to distant facilities complicates communications with local service providers, makes subsequent discharge planning more problematic, and creates problems for family members seeking to provide on-site support for the person who is displaced to a distant location.

Fortunately, a recent state grant has created 28 new support beds in the county, which is a positive development, but which continues to leave an unmet need for much more significant backup support to cover the insufficient number of beds available at Hudson River Psychiatric Center to meet the county's need for intermediate and long-term psychiatric inpatient treatment.

# Staffing and Training Issues

## Adequacy of Psychiatric Care

Contributing to the need for emergency and ongoing inpatient psychiatric care is the lack of sufficient numbers of psychiatrists in practice within Dutchess County. It is difficult to attract and retain psychiatrists under the best of circumstances, and agencies throughout the DMH system routinely report hiring problems, and resulting vacancies in psychiatrist positions. The County Department itself is in a difficult position hiring in competition with other MH agencies in the community. Although for most positions within the DMH system, the County pays higher salaries and benefits than is true for comparable positions in external agencies, the opposite appears to be the case for psychiatrists. For such positions, what the Department is apparently able to offer to new-hire psychiatrists is significantly lower than the salaries contract agencies are able to pay. The system's needs can only be well met if key psychiatric positions can be filled, at least at a basic level, in both in-house as well as contract agency services.

## Adequacy of Other Service-Providing Staffing Throughout Department

The Department's emphasis on decentralizing services has long been a core value enhancing access to a wide range of MH services to county residents, regardless of where they live. County government as a whole has also increasingly decentralized provision of selected core services to different locations. However, this valuable practice comes with a price, related to the need for additional staff to manage and supervise, provide, and offer clerical support for the services offered in these various locations. Without careful attention to census numbers and the resulting workloads and individual staff caseloads, staffing imbalances can occur across sites, and the ability to allocate clerical support staff equitably becomes a difficult logistical issue. That said, in general the Department appears to have done a reasonable job over the years of establishing an appropriate mix of staff in the various program locations sufficient to meet client needs, and without creating unmanageable caseloads in some locations compared with too-easy-to-manage caseloads in others. This issue of balance is addressed in more detail in the discussion of program-specific issues later in this section.

Perhaps as significant as the issue of balance and adequacy of numbers of staffing across sites is the question of the level and appropriate mix of staff. This is more of an issue with staffing in external contract agencies (discussed below), but it also has implications for in-house services. Anecdotally, staff spoke of the shift over time in some units from higher concentrations of certified social workers, with their more holistic training and focus, to more staff at specialty, less comprehensively trained levels.

This in turn may have increasing implications, as state and federal regulations related to reimbursements change, for the ability of the Department to fully bill services and time provided by less credentialed staff. Carefully assessing and maintaining the credentials and reimbursability of various levels of staff in the context of billing for various services will be an increasingly important part of Department management tasks in the future.

As noted further in the discussion of specific programs below, and in the recommendations in Chapter VIII, any assessment of the adequacy of staffing within the Department at this time is complicated by the transient, moving-target nature of the Anasazi software system, and the potential for changes in the way in which Billing interfaces with units throughout the Department in the future. The nature, needs and potential for expanded productivity of staff in many units, once Anasazi is fully implemented and possible Billing changes are in place, could be substantially different from current operations across the Department. Once these changes are fully in place, significant staffing adjustments may be in order, and/or increases may be possible in the numbers of people served with current staffing levels. These issues are discussed further below and in the concluding chapter.

### *Adequacy of Clerical Support Staff*

Similarly, the ability to make definitive decisions about the sufficiency of clerical support staff is limited by the uncertainty of the future. There appears to be general consensus among most staff that there is a current shortage of support staff in many units of the Department, in terms of existing tasks, which involve considerable data entry, entering information for many clinicians and doctors, and copying and filing large numbers of files and client charts. Furthermore, some new programs have been added without the accompanying clerical staff needed for the programs to operate effectively. However, many believe that overall workloads may change significantly with forthcoming expected changes, and that support staffing levels may become more reasonable under those circumstances. This issue is addressed in more detail in Chapter VIII. In the meantime, by design the Support Services Manager is responsible for juggling clerical support staff across sites in order to cover for shortages and peaks and valleys in workload. This creative flexible staffing support system, while not easy to manage from a logistical standpoint, has provided the Department with the ability to manage resources more efficiently than would have been possible with more traditional fixed assignments of positions to specific units, which would have offered little flexibility to move resources to meet changing needs.

### *Staff Orientation and Training*

The Department currently requires employees to receive 35 hours of formal training every two years, and each Friday, optional in-service

training sessions are offered on a variety of topics. Beyond that, the Department appears to have a relatively traditional approach to staff performance evaluation and staff development. Annual performance evaluations appear to be top-down from supervisor to person being supervised, with some focus on goals for the next year (though the level and specificity of those goals and the monitoring of them appears to vary considerably across supervisors and staff). The Department may wish to consider developing more formal evaluation guidelines for the future, with stronger emphasis on staff development and training, and with peers as well as supervisors encouraged to provide confidential input into the evaluation process.

As noted above, the Department has developed a focused comprehensive three-week orientation program for new employees, which has been positively evaluated by those who have gone through the program. It will be increasingly important to carefully orient and train new employees, and to continue to mentor and work with them in their early years, in order to help them absorb the important values and culture of the Department, while at the same time bringing their fresh ideas and perspectives to the workings of the Department and their respective units. Similarly, for hires in recent years who were not exposed to the new orientation program, it may make sense to attempt to build in ways to expose them to the program and to retroactively work with them to encourage their understanding of Department values and culture.

Currently, much of the on-the-job training received by new employees or staff shifting from one unit to another is done on an informal basis by the unit administrator to which the person is assigned. There appear to be few formal training guidelines for use with new employees, and little overall focus on cross-training to expose staff to issues and procedures that are common to different units, versus those that may vary from unit to unit. To the extent that clerical support staff in particular are shifted at times from unit to unit to cover shifting needs, such cross-training may prove beneficial in the future.

Several people within the Department appear to have some formal training responsibilities, in addition to the role various supervisory staff play in training their staff. The Community Services Director, Chief Psychologist and Quality Improvement Coordinator all have some levels of formal training responsibilities. With the increasing importance of staff training and development in the future, how these positions and responsibilities complement each other, and make use of other resources, will become an increasingly important issue for the Department. One of the issues likely to be important in the future will be increased ability to monitor data on performance and outcome measures, and to make informed management decisions to strengthen programs based on the data. Training issues are addressed further in Chapter VIII.

## Program-Specific Issues

In addition to the issues discussed above – which cut across all aspects of, and programs operated by, the Department—this final section of "Internal Issues, Concerns and Challenges" changes the focus to challenges and concerns facing specific in-house programs and services of the Department. Some common themes emerged across most if not all of the programs, including:

- Program or unit administrators spend far too much time on clerical and billing-related functions such as pre-authorizations, recertifications and dealing with insurance companies.

- Most Unit Administrators do not appear to be involved in budgeting for their units, or monitoring progress against their unit budget; they have typically not been asked to do so. Realistically, in recent years the information needed to do such ongoing financial monitoring has not been routinely available. Thus most reported having little understanding of how their units are doing against budgeted expenditures or revenues—and as a result few appear to have direct incentives, other than their own internal motivations, to manage unit costs, caseloads or staff productivity in the most efficient manner—and few appear to be held accountable by their supervisors for doing so. This is not to say that many are not very conscious and intentional in their efforts to operate efficiently. Most appear to be very committed to doing so; it is just that they are rarely asked to do so with the financial tools in hand to facilitate the process.

- Similarly, most administrators of programs or units seem to place relatively little focus on data as a management tool to help identify possible areas of improvement. Most are quite aware of their basic measures of performance such as numbers served, caseload size, etc., but most did not seem to have a detailed understanding of impact or outcome measures for their programs, or of what relationship such measures might have to the services they provide (e.g., reduction in hospitalizations, reduction in jail days, level of improvement on TOPS scales, improvement against treatment goals, obtaining of jobs, etc.).

- With some exceptions, administrators of programs and units seemed relatively content with current operations and did not seem to be aggressively pushing for change. On the other hand, when asked about opportunities to do things differently, most had insightful ideas about ways of making improvements in their operations or other aspects of the Department, and nearly all seemed quite open to productive change.

- Some administrators had suggestions for increased staff, some were content with existing staffing levels, and most were hopeful that full

implementation of the Anasazi software system and possible changes in billing practices could help free up staff time in the future.

Beyond these overall themes, other program-specific issues and challenges are summarized below, beginning with Helpline and the gateway to the MH system for most people. Recommendations related to the following challenges will be presented in Chapter VIII.

## Helpline and Pre-Intake Processes

Many counties around the state contract out their hotline functions to non-profit agencies. However, many of those are regional in focus, and few if any have such an ambitious integrated hotline/information and referral/ emergency services/pre-intake combination as Dutchess. In fact, CGR and CCSI are not aware of any other county that operates an integrated hotline and pre-intake operation such as Helpline. In addition, Helpline goes beyond some of the other hotline functions around the state in its expanded focus on suicide prevention, bridge phones, and processing of regional suicide calls—in addition to being responsible for a focus on discharge planning in conjunction with local inpatient psychiatric hospitals.

### *Who Should Provide This Service?*

A number of questions were raised during the study concerning whether this service should continue to be provided by the County or some other agency. Other questions were raised as to whether the pre-intake function should be centralized in the first place, or decentralized back to individual agencies. These issues are addressed further in the recommendations chapter, but it is fair to say here that there was significant support, even among most non-profits for County provision of the service, and for the notion of efficiencies in having a single well-known number available as a central means of entry to the system. Some support was, however, expressed in particular for decentralizing the pre-intake process for children to Astor, though others were concerned that two such systems could lead to confusion and potentially increases in overall intake staff in the system.

### *Increases in Numbers of Calls: Supervision and Staff Implications*

As noted earlier, Helpline calls were up 20% between 2005 and 2007, and up another 30% in the first month of 2008, compared to the first month of 2007. Furthermore, although about 43% of all calls in 2007, and half of all calls the preceding year, were processed during the day shift (8am to 4pm), and therefore the greatest concentrations of Helpline staff are assigned to that shift, the number of evening shift (4pm to midnight) calls increased by 39.5% in 2007 (up more than 1,500 calls to almost 5,400 in 2007). The number of night shift calls (midnight to 8am) also increased, by almost 350 (plus 10%) in 2007. More than a third of all calls involve

doing pre-intakes and initial scheduling, and those calls were also up by more than 800 (72%) during the evening shift in 2007, to more than 1,900 pre-intakes during that shift during the year.

Despite these increases, typical staffing during the evening shift remains at two persons, with only one on the night shift (and one on weekend shifts). Also, there is no direct supervision present during either of those shifts, or on weekends. The Unit Administrator is on call at any point as a backup or to respond to questions or emergencies, and often checks in at the end of shifts to see if any major issues emerged—as well as checking and commenting on notes left by staff from just-completed shifts. But such important efforts notwithstanding, this program which is integral to accessing the entire service system does not have any formal way of supervising or monitoring two growing shifts in which together, more than 9,000 calls were processed in 2007.

### *Unanswered Calls*

Currently, the Unit Administrator estimates taking about a dozen calls a day as backup for existing staff, when all lines are busy. In addition, estimates are that about 15 calls a day cannot be answered by anyone or must be put on hold or told to call back later. Some of these delay and overload issues should be addressed through the introduction later this year of a new phone system that will enable a "please hold" response if a call cannot be immediately answered, and a recorded "call back number" for staff to use to make a quick return call if the person hangs up. About a third of the intakes scheduled for Hudson Valley Mental Health clinics result in no-shows (only about 5% to 10% of those scheduled at Astor are no-shows, and the numbers aren't known for Lexington clinics). The no-show rate at HVMH suggests the need for followup calls to be made to increase those rates, and at this point it does not have the resources to make such calls, nor does Helpline. The combination of all these data suggests that more staff may be needed to address these increasing demands for service via Helpline.

### *Perceived Sensitivity and Accuracy of Calls: Training Implications*

Concerns were also raised about the quality and perceived sensitivity and compassion expressed by staff in response to some of the calls received by Helpline. Although new staff receive extensive training from the Unit Administrator and other staff, and from review of a Helpline manual, before making initial calls under supervision, there is little or no Helpline-specific ongoing in-service training beyond offerings to Department staff as a whole. No specific training is provided concerning phone manner and sensitivity to issues, and little training is provided concerning orientation to the services and programs to which Helpline staff make referrals, beyond brief descriptions in a summary of services in the Helpline manual. Little or no training is ever provided, other than the manual with

agency listings, and other than discussions among Helpline staff, of "who should be referred where for what services."

No calls are monitored for accuracy or sensitivity of responses, except by the Unit Administrator who is able to monitor indirectly via observation during the day shift. Consideration should be given to ways of providing expanded monitoring of a sample of calls from all shifts and staff, and ways of providing "call etiquette" training updates for staff.

These concerns should not in any way undermine the strong support expressed in most of our interviews for the concept and importance of Helpline, its pivotal role in the overall DMH system, and the critical work done by staff in dealing with often difficult crisis calls. But the perception is that these strong services can be improved, and that the critical nature of what Helpline does emphasizes the need to ensure that the services are provided consistently with the highest possible quality and sensitivity.

### *Forensic Services*

As noted earlier, the numbers of referrals to the Forensics unit doubled between 2004 and 2007. In addition, staff in this small unit serve the Road to Recovery program, and in the past few years, the unit has added responsibility for monitoring a new Pre-Trial Diversion program and assessments and staffing related to four new Drug Courts across the county. It is a respected unit responding to growing demands without recent changes in staffing. Despite the volume and importance of the unit, it continues to be headed by a Supervising Social Worker, and is considered a reporting sub-unit under the ITAP Unit Administrator. With its own significant responsibilities and its important unique role as a key County Alternative-to-Incarceration program, it is reasonable to consider whether the program should be independent of other programs, with its own unique focus, and whether it would benefit from added staff (and whether the jail and its daily census would also benefit from additional resources in this unit). Recommendations concerning these issues are offered in the concluding chapter.

In assessing the staffing issue, questions should also be posed to Drug Court administrators concerning whether there is a continuing need to have ongoing staff support from the Forensics unit for each of the four Courts, especially since Lexington Center for Recovery also provides staff support for the same Courts.

The Forensics Unit and the jail should also explore ways of documenting more precisely the assumption that this unit is instrumental in helping reduce the County jail population. Available evidence strongly suggests that the unit's efforts do have such an effect, but it would be more persuasive to funders, policymakers and criminal justice system officials if the case could be documented more clearly.

### Jail-Based Services

Level of staffing does not at this time seem to be an issue with this complementary service to the Forensics unit. The major concern appears to be for staff to determine how to help increase the proportion of those served by the program who actually are directed to and receive treatment from community providers. The impact of such treatment should ideally also be tracked over time. If more effective tracking can demonstrate the impact of the linkage of this program with Probation, to help Probation Officers focus more on treatment options for those they serve, consideration might in the future be given to adding a staff person to double the impact of liaison efforts with Probation.

### ITAP

This program has historically, by design and initial funding mandates, focused primarily on first-time non-violent felony offenders. As such, its primary initial focus was on reducing the prison population. However, over time it has expanded the proportion of its misdemeanor population to about 25% to 30% of all program participants. Success of the program with such misdemeanants would be more directly experienced through reductions in the local jail population. Suggestions have been made to expand the staff of this program, which also links effectively with Probation staff, to enable it to accept an additional 12 to 15 persons into the program during a year. Any consideration of such a request, discussed further in Chapter VIII, should also consider the mix of charges to be included in the profile of any additional entrants to the program. That is, consideration should be given to making any such staff increases contingent upon working with increased proportions of persons arrested on misdemeanor charges, in order to thereby increase the potential impact of the program on the local jail population and its need for expensive boarding-out of inmates to other counties.

This is one of the programs in which the Unit Administrator apparently spends considerable amounts of time doing pre-authorizations and related work that might better be assumed in the future by Billing unit staff. Freeing up some of that time could potentially increase further the impact of the program in the future.

### Enhanced Case Management/Managed Addiction Treatment Services Program

This combined service unit is notable for its model of using two case managers on contract from MHA, both of whom are supervised by County DMH staff. This is a model worth replication on a small project basis, as a means of providing needed services without expanding the County payroll, while maintaining Department control over the services.

The MATS portion of this unit is predicated on the assumption that it should be able to reduce Medicaid costs associated with high repeat users of chemical dependency services. Now that the program has been in operation for more than a year, it should begin to produce evidence of what impact it is having in being able to reduce Medicaid expenditures for the defined population.

### *Clinic for the Multi-Disabled*

To CGR's knowledge, this is the only focused, comprehensive program of its kind for dually-diagnosed persons with combinations of mental illness, chemical dependency and developmental disabilities. The program serves a relatively stable population of about 425 or so per year, with relatively little movement in or out of the program. It seems reasonably staffed, and is part of a clinics unit in the Department budget that costs the County nothing before fringes are entered in, and even with fringes has a County share of less than 10%. Although staffing in general appears adequate for the program, some advocates suggested the value in adding an additional MD/prescriber to help with the prescribing and oversight of medications for those in the program, with the additional person enabling more time to be focused on families of the clients in the program. An additional request was made to add a case manager to the program via contract with MHA to more effectively monitor progress against treatment plans for clients. While not essential for the program's success, such requests might be more readily considered in a program with minimal County costs compared to most other DMH in-house programs.

This is also one of the programs in which the UA spends more time than appears necessary or reasonable on various billing issues and tracking down signatures from families and guardians of those in the program to update information annually that is not required by Medicaid, but apparently has been in the past by Billing.

### *Special Services Team*

This program is also paired with the Clinic for the Multi-Disabled in a budget line that costs the County nothing for the straight costs of the program, with fringes not included, and goes to no more than about a 5% to 10% County share even with fringes included.

The program serves between 105 and 110 persons at a time, and could increase that total by as many as 10 if the Unit Administrator could be freed from several Billing-related tasks that should not be done by a clinic supervisor. Being able to increase the total served may bring in sufficient revenues to eliminate the County share completely, or at least reduce it to a miniscule level, as a result of additional revenues generated from the added time spent on cases by the UA.

Because the program is a community-based initiative that goes wherever the participants are, including their homes, rather than focusing on in-office treatment, the program staff spend large amounts of time in travel to and from meetings with the clients. As such, in the future it may make sense to decentralize some of the staff, perhaps with offices co-located with Continuing Day Treatment staff, and perhaps also to consider actually partnering more explicitly with selected CDT staff to have them help bring SST participants into Day Treatment locations to meet with SST staff and potentially to begin to introduce them to some of the CDT services.

In looking to the future, SST has been quite successful in covering most of its costs through existing forms of reimbursement. They were able to do this with limited numbers of reimbursable staff. Obtaining appropriate staff credentials for additional staff who could then become billable by Medicare could further increase fees paid to the program, which could potentially help underwrite the costs of other aspects of the Department's programs.

A similar program to SST is operated by NYS OMH, the Assertive Community Treatment (ACT) program. It focuses on somewhat similar cases who are resistive to traditional treatment approaches, though it is less assertive in its efforts to bring them into treatment than is SST. It also serves a smaller geographic area, has an overall caseload about half the size of SST's, and offers more intensive wraparound and financial services to those on its caseload, who are typically considered more difficult cases. SST maintains typical caseloads of about 28 per clinician, versus 1:10 ratios in ACT. ACT insists on providing 24/7 on call coverage for its clients, while SST uses Helpline to provide such backup coverage. ACT is more apt to use case managers to help support its clients, while SST thinks they may encourage unhelpful dependence. Despite these philosophical and practical differences in the programs, they are both meeting demonstrated needs within the county, and the SST Unit Administrator chairs the single point of entry for ACT. Although there are legitimate reasons why both programs have emerged and grown along parallel tracks, the question should at least be raised as to whether there are ways in which the programs can work more closely together in the future, perhaps sharing resources and reducing some costs that result from having two program infrastructures in place.

### *Partial Hospitalization Program*

This alternative to hospitalization program, aimed at preventing hospitalization for some and reducing its length for others, demands the highest ratio of staff to clients of any of the DMH programs. With an active caseload of about 30 to 35 at a time, and perhaps 20 of those in attendance on an average day, the active staff of eight clinicians/ professional staff (plus Unit Administrator) provide intensive coverage for

those in the program, including full team meetings at the beginning and end of each day to go over the events of the day for each client. Additional staff time could also be available for direct client services, except that one community mental health aide and the UA spend significant amounts of time focused on billing-related issues.

Several questions arise with regard to the program's staffing model, including: Is such a low ratio of clients to staff necessary for the success of the program, and could the team function effectively without as many full staff meetings? Could the same number of staff serve a larger caseload? Could additional persons be served if aide and UA time could be freed up from billing issues? Should the program be expanding, as some have suggested, to provide separate programming and a particular focus to the 18-25-year-old population in addition to its older current primary focus, and if so, could this happen to some extent at least with existing staff, or would additional staff be needed to cover the expansion? And, given that the County covers about half the costs of this program, are there ways to make it more reimbursable and/or to operate more efficiently and cost effectively in the future? Since some third party insurance payers only cover the first two to three weeks of a typically six-week program, are there ways to increase reimbursement levels for such cases? And are there data to demonstrate the impact of the program in reducing costly hospitalization days for those it serves?

This is broadly considered to be an exemplary program, but there are also questions about how it will proceed in the future that will need Department attention. Some of these questions are addressed with specific recommendations in the final chapter.

## Continuing Day Treatment Centers

The Department hopes to maintain this largest component of in-house programming in the future, both as a generator of substantial revenues and because of the substantial numbers of people served by the Continuing Day Treatment Centers (more than 800 per year in recent years). This is likely to happen only if significant changes are made in the program model over the next few years.

### *Changing Financial Benefits and Costs*

As of the Department's 2006 budget, the County's four Continuing Day Treatment Centers (and one satellite) were expected to cover all costs of program operation, minus fringes, actually returning a "surplus" to help cover other Department costs. By far the major source of funding for the program has consistently been Medicaid, with third party insurers also picking up a sizable minority share of the costs. But with funding changes in the Medicaid payment structure over time, this surplus has now turned into a County subsidy—still a modest 2% of total without-fringes costs, according to the 2008 budget. But of course, as shown clearly in Chapter

VI, fringes cannot be so cavalierly dismissed. With fringes included, and with no other sources of reimbursement to cover them, the County share of the total with-fringes costs of $8 million to operate CTC programs increased to 21% in the 2008 budget.

This rapid change in the recent financial viability of the Continuing Day Treatment Center model illustrates the uncertainty about projecting the future of this historically major component of the DMH service system. Some changes being discussed at the state and federal levels concerning Medicaid funding for such day treatment programs could turn the County's continued operations of the programs under the current model into even more of a financial loser in future years (OMH, for example, is not known to be a big proponent of the day treatment model). But other directions, such as the possible PROS model (Personalized Recovery Oriented Services), could force the Department to substantially restructure the current delivery model in ways that could be financially beneficial, while at the same time placing more emphasis on functional improvements and holistic recovery across participants. The reality is that no one at this point knows or has any reasonable prognosis for what changes will occur or when. Best bets are that little significant change will occur in Albany or Washington to dramatically affect the status of CTCs within the next three or four years. But the reality is that the Department is appropriately "dusting off" old models and reassessing the implications of moving in different directions under various scenarios. As the largest single program operated by the Department, it must be offered in a way that continues to be financially viable and limits the level of County funding as much as possible.

### *Changes Needed, and Occurring, in the Core Model*

The reality is that many think the Continuing Day Treatment Center model as currently operated within the Department should be changed, irrespective of changing financial realities. In some ways it has been gradually evolving in recent years, reflecting slightly different approaches and staffing patterns at each of the Centers, given differing profiles of clientele and needs at each. But the fundamental model of a range of individual and primarily group services offered on a daily basis to participants who typically come either five or three days a week has remained relatively intact. Many of the traditional users of this service have been older, in many cases previously-institutionalized persons for whom major changes in life status or skills were viewed as relatively unlikely.

Increasingly, however, across the system in general and within selected Centers in particular, the needs have begun to change, with higher proportions in some Centers of younger, more aggressive program participants, many of whom have realistic prospects of making progress around various issues, including the potential in many cases to obtain at

least some form of employment, given the development of certain job and coping skills. Thus the types of group sessions and training opportunities have begun to change across the network of Centers, and will need to continue to change over the next few years. In turn, the mix of staff skills and experiences is also likely to need to change, to a more professionalized, credentialed mix in some Centers to somewhat less credentialed staff designed to work with primarily "status quo" clients in others. Such shifts will need to occur carefully, to maximize skill sets and experiences of existing staff matched against the profiles of the primary clientele at each Center. This in turn may mean the need to shift staff across sites in the not-too-distant future, and also to replace current staff in some Centers through attrition with staff with different mixtures of skills and experiences—and interests and willingness to work with different types of people with differing needs.

### *Increasing Need to Use Data to Shape and Measure Changes*

Such changes will require perhaps more careful attention than in the past to defining the profiles of those being served in each Center, carefully identifying their needs and realistic expectations of changes possible with certain types of intervention, and ensuring that the appropriate mix of staff and services are put in place to address those needs and opportunities. For example, there are currently significant differences in the ratios of average daily attendance to defined FTE clinician staff levels. However, these ratios do not currently factor in what the actual *expected* average daily attendance would be if individual expected attendance patterns (e.g., three days a week versus five or some other pattern) were factored in. More realistic assessment of such factors, along with other understandings of clientele and needs, should enable a better fit of staffing to client characteristics and needs.

This will also mean building on and modifying existing performance and outcome measures, and tracking specific outcomes and types of progress of individuals more carefully, in order to ensure that new approaches are in fact able to produce the expected changes in behavior. Managers will need to carefully assess services, staffing mixes, and expenditure and revenue patterns against budgets and logic model-driven expected outcomes to ensure that the new or modified models are in fact producing anticipated outcomes within budget, and if not, to use the data to shape needed improvement opportunities. Each CTC site currently has a set of outcomes against which it is beginning to assess its performance. Some of these are appropriate outcome measures, while others will need to become much more measurable and tied to better goal statements to help Centers improve their performance. In addition, some system-wide measures (e.g., hospitalization rates) are likely to need to be developed and tracked consistently across all CTC sites, which has not been the case to date.

### *Hedgewood Adult Home Satellite*

The Department has allocated some of its staff from the Southern Dutchess Day Treatment Center to the Hedgewood Adult Home, supplemented by contracted case management services provided by MHA, to serve about 200 residents on site. Some questions have been raised about the value of providing such services directly to a for-profit home. Department officials indicate their belief that without the screening role they play there, the profile of the residents would be more problematic, and that without the core services provided to residents, the rate of costly hospitalization among residents would be substantially higher. Such data need to be consistently tracked in the future.

## Coordinator Positions

Specific recommendations are made in the concluding chapter concerning the Coordinator positions within the Department. For now, some brief indications of the questions that have been raised about these positions, which were briefly described in Chapter IV:

- The SPOA system within the purview of the Housing Coordinator is generally viewed as a helpful concept in creating access to housing throughout the county, but it is also viewed as a cumbersome application process that needs ideally to be simplified.

- A request has been made for creating a case management position to help carry out the function of the Housing Coordinator, perhaps as a joint position shared with the Assisted Outpatient Treatment Coordinator.

- Questions have been raised concerning whether the value of the AOT Coordinator position can be maximized through collaborating in new ways with other positions.

- The Vocational/Education Coordinator also provides a supervisory role over some vocation-related positions. The question is whether this combination of responsibilities enhances the role of the position, or possibly interferes with the ability to carry out the core coordination role.

- The Geriatrics Coordinator role is carried out on a part-time basis in conjunction with administrative responsibilities for a CTC unit. Does the position receive sufficient attention, given the current and projected needs?

- A number of suggestions were made concerning the possible creation of a new Transitions Coordinator position, to help create more effective transitions from the children and youth system to the adult system of services. Is this necessary?

These and related questions will be addressed in the final chapter.

# External Issues, Concerns and Challenges

Some of the issues raised above under Internal Issues and Concerns also apply to the External component of the DMH service system, but this External section focuses explicitly on the major concerns and challenges related to the Department's interactions with, and monitoring the impact of, the services provided outside the Department's direct control, by contract and affiliate agencies across the three Divisions of the service system (Mental Health, Chemical Dependency and Developmental Disabilities).

## *History of DMH Relationships with Contract Agencies*

As the Dutchess County government faced increasing financial constraints in the 1990s, the Department outsourced a number of its services to non-profit agencies in order to reduce the County payroll and lower the related costs of staff salaries and benefits. The Department had previously been affiliated with a number of service-providing organizations in the community in order to extend the continuum of services for its population of clients, but most core services (with the exception of those for children and youth) had up to that time been run within the Department, by County employees.

The transition of core clinic services (and a few years later, of case management services) to the non-profit sector was met with resistance and doubts by many Department employees. The DMH Commissioner addressed some of their fears by guaranteeing that anyone who wished to remain a County employee could do so, although in some cases they would have to accept new types of positions within the Department, or to be willing to take positions in other County agencies. At the same time, some employees were encouraged to take positions within the contract agencies, in order to help integrate the Department's culture, values and priorities within these organizations.

Since the transition, efforts have been made to maintain County control as much as possible over the expanded system of providers, mainly through requirements built into contracts between the County and an expanding array of non-profit contract agencies (monitored as part of the Department's Quality Improvement oversight process), as well as through limited training and orientation efforts involving the County interacting with contract agencies. However, many current Department employees, as well as some contract agency staff, feel that the outsourcing of critical

services has resulted in loss of quality and continuity of care in those services.

## Maintenance of Departmental Culture and Values

Initially, it was relatively easy to maintain the culture of the Department, as a number of former DMH staff did migrate to the new "parent" of the clinics, St. Francis Hospital. But as years have passed and the clinics were split to two new providers, Hudson Valley Mental Health and Lexington Center for Recovery—and new staff never before connected with the Department began to dominate the staffing mix within each organization—the ability of DMH to continue to have dominant influence within the clinics, and later the case management function, began to decline.

What once were consistent policies and practices, and a seamless ability to move clients easily from service to service and to track client progress across those in-house services, became a much more diverse array of programs and service delivery approaches, organizational cultures, and practices, as the new providers began to impose their own realities onto the system of care. Moreover, the realities of lower salaries the non-profit agencies could afford to pay, and the resulting difficulties in attracting and retaining high quality, experienced staff, further eroded the previous consistent set of culture, values, policies and practices.

## Staff Recruitment and Retention

Contract agencies generally have lower pay scales and benefits than is true of County government. This can and does lead to a higher level of turnover as well as a younger, less experienced and often less credentialed workforce. In addition, contracted clinics have fewer psychiatrists and psychologists on staff than when the County operated the clinics, since few can be attracted and retained with the salaries and benefits that contract agencies are able to pay. (And, realistically, the Department finds itself in a similar position of not being able to obtain sufficient numbers of psychiatrists and psychologists for its remaining programs as well.)

For a number of staff in these contract agencies, employment opportunities are the stepping stone to higher paying positions elsewhere. Although CGR was not able to obtain definitive data on turnover rates, we received consistent estimates from both County and contract agency staff of annual turnover rates among staff in major contract agencies of 20% to 25% or more. This can affect clients especially in terms of disrupted continuity of care and lack of consistency of services and primary providers. In terms of therapeutic relationships, consistency is often a key factor in patient progress and successful recovery. Because of the perceived quality gaps in staff services, a number of those we interviewed

indicated that they often think twice before making referrals to clinics that they need to be able to refer to.

There appear to be no data available which have attempted to compare client outcomes and improvement on various dimensions under the more seamless in-house provision of services versus under the ostensibly more disruptive shifts between clinicians/therapists under contract agencies. The closest information CGR could find related to the impact of changes of providers on clients came from examination of data from the Department's 2008 Patient Opinion Survey. As part of that survey, clients in both in-house and contract agencies are asked if they have changed provider staff in the past year, and if so, how they would characterize the effect of those changes on their treatment and progress.

In the recently-completed 2008 survey, 31% of the 961 persons surveyed indicated that they had experienced change among their primary service provider in the past year, and of those, 34% reported experiencing negative effects as a result, and another 12% reported both positive and negative effects. ***Thus almost half of those who experienced changes in their primary service provider reported at least some resulting negative effects. The reported impact was particularly noticeable within Hudson Valley Mental Health clients, where 38% of those surveyed reported at least one staff change in the past year, and of those, 55% reported either an exclusively negative effect (43%) or both positive and negative effects (12%)***.

## Need for Strong Training and Supervision

The core business model for the major contract agencies—including Hudson Valley Mental Health, Lexington Center for Recovery, Astor and MHA—appears to be clearly predicated on the assumption that they hire primarily relatively young, inexperienced staff at low salary and benefit ranges and anticipate that most will move on within two to four years. For those employees that are especially good and dedicated, the agencies attempt to find ways of providing incentives to retain them, but if they move on, it is simply considered the expectation, and that they will be replaced by the next round of relatively inexperienced clinicians.

For this model to work reasonably effectively, while meeting the needs of clients at least reasonably well, the mix of primarily inexperienced line staff must be supplemented by strong supervision, staff development and training support for as long as they remain on staff. Astor has developed the most effective model of providing such strong supervision and staff development support, while the other major contract providers appear, often by their own admission, to lag behind. All seem to subscribe to the same basic model, but Astor seems to be the only one of the major contract agencies which has figured out how to provide and retain a strong

supervisory infrastructure combined with a strong emphasis on extensive training and staff development support. This model, when well implemented, can go a long way toward empowering inexperienced staff and helping them to develop the skills and techniques needed to be effective in working with clients, despite their relative lack of experience.

Given the reality that available financial resources are not likely to expand significantly in the future among contract agencies, the likelihood is that the current pattern of inexperienced hires and subsequent high turnover rates will continue. Only if strong training, staff development and supervision can be put in place in each core contract agency is this outsourcing model likely to work effectively to the benefit of future clients. The affected agencies, with the support of the Department of Mental Hygiene, must find ways to develop this model more effectively in the future than has been the case to date. The ability to provide strong supervision and training, whether provided internally or through support offered in some way through the Department, must be considered an important part of the cost of doing business, if the "cheap hire" model is to work in the future.

## *Careful Monitoring of Contract Agencies*

In addition to the need for a strong supervisory and training component within contract agencies, the other key building block to ensure that outsourcing can meet County and Department objectives for quality service is the existence of a strong system in place to hold contract agencies accountable for meeting stated goals and measurable performance and outcome objectives. The Department has provided strong leadership in recent years in developing an effective, consistent model for monitoring contract performance and providing feedback on a regular basis to agency leadership. Contract agencies must develop logic models outlining what they plan to do in return for the Department's contract support, what outcomes they expect to result, and how they plan to measure the outcomes. They then must report progress on the outcomes on a quarterly basis to the QI Coordinator and internal Department QI review team. The Department is a leader among its peers in NYS in its emphasis on, and consistent process for monitoring progress against, performance and outcome measures.

One of the issues that is often a source of contention between the Department and contract agencies is the resolution between how much control the Department has, and should have, over the agencies and how they operate. Several contract agencies expressed appreciation for the professional way in which DMH conducts its review of contract performance, but some of the same officials also suggested that the Department tends to try to control too much of the agency's approach to service provision and administration. On the other hand, the County is

contracting with these agencies to deliver services, often with a significant investment of funds supporting the agency's operations. Thus it would seem to have the right to make suggestions and offer strong advice concerning improvement opportunities in return for its investment of funds, especially where there is evidence that the agency is falling short of its goals, or appears not to be managing its funds effectively.

CGR's observation is that if anything, the Department has been more cautious than it could or perhaps should be in offering advice and improvement opportunities when contract agencies appear to be experiencing problems in managing their operations effectively and/or appear to be having difficulties in meeting stated contract goals. In particular, more careful monitoring of agency financial, management and supervisory practices may be increasingly relevant and important roles for the Department to play in the future, as resources become increasingly scarce and important to maximize. For example, it would seem especially important to routinely assess the return each agency is providing on the dollars invested in its contract by the Department in terms of whether the dollars are being wisely spent for the outcomes received in return. Such careful assessment of dollars invested versus progress made against goals may yield insights that might lead in some cases to decisions to modify the goals or approaches used by a particular agency, in an ongoing attempt to make sure that available dollars are being used to the greatest possible effect, and where that does not appear to be happening, to work with the agency to make appropriate changes in goals and/or approaches for reaching the goals.

## *Timing of Approval of Contracts*

Several of the contract agencies expressed frustrations with the Department and the overall operations of the County concerning what they perceive to be unnecessary delays in the processing of the annual contracts and the activation of monthly payments following contract approval. The issue may have been exacerbated this year because of the accumulated problems with past CFRs, as discussed earlier, and the resulting holdup of release of some funds to the County and to some of the contract agencies. Hopefully more careful attention to billing and more timely closeout of monthly accounts will result in smoother and more timely release of contract funds in the future. On the other hand, there do appear to be unnecessary delays and inefficiencies built into the contract approval process that could presumably be expedited if the parties were interested in so doing.

Contracts appear not to be approved until well into the new year, even though in many cases there is little change from year to year in the core agreement. In most cases, the contract agency and the Department should be able to agree on the basic terms of the contract as soon as the County

budget is passed, and have the contracts forwarded to the County Attorney for review before the end of the year, in order for approval to be received as soon as possible thereafter, thereby paving the way for early release of monthly funds against the contract. An agreement to cooperate along those lines should be possible between the Department, contract agencies and County Attorney and/or County Executive's office to put such a more timely process in place.

Some of the agencies also expressed frustration at the holds they indicate are occasionally put on contracts while any adjustments or amendments are made in mid-year. It is not known how often this happens, but it apparently is perceived to be a significant enough occurrence that it was raised by several contract agencies in our discussions, even though CGR rarely if ever raised the issue on our own.

## Tracking of Contract Performance Measures

The aforementioned monitoring of agency performance against contract goals, and holding each contract agency accountable for its performance, are ultimately only as good as the quality and appropriateness of the performance and outcome measures used. With leadership from the County Executive's Human Service Cabinet and DMH, the contract agencies have worked with the Department to develop appropriate measurable targets, projected outcomes and indications of progress against each outcome for each program or service funded as part of the agency contract. Each of the contract agencies was responsible for assessing their progress against each goal and projected outcomes for 2007. The resulting progress statements across all the agencies were compiled into a recent report on "Annual Contract Performance Report" for 2007. A review of the report provides several insights and observations, including:

- A number of outcome statements have been carefully crafted, are clear, measurable and clearly reflective of the focus of the program or service being monitored.

- Probably the majority of the projected outcomes are not so clear, logical or indicative of the services being provided.

- A number of seemingly logical outcome statements that would seem to be appropriate to measure for a particular program are nowhere to be found.

- In perhaps the majority of cases, a simple statement was made under Progress simply stating something like "Target met" or "Objective met," with no supportive information to back up the claim. Perhaps the support was provided in separate documents and simply was

summarized in the report, but if not, careful scrutiny should be given to such claims to make sure they can be justified.

- In some cases, statements were made that outcomes were met, when the data that were reported directly refute such a claim.

- In a few cases, the projected outcomes made very little sense, or seemed to provide no basis for judging how well a program was doing, and therefore would appear to lend very little basis for determining whether a contract agency is justifying its investment or not. Several statements indicated that the outcome was to show less of something, with no basis for knowing less than what, over what period of time.

- In some cases, outcome statements were based on how well successful completers of a program did on particular measures. Ideally, it would also be important to know how many were not successful, and what happened to them.

- This report should provide a sound basis for the Quality Improvement Director and Coordinator and/or Division Chiefs to sit down with several agencies to begin to discuss ways of fundamentally restructuring their projected outcomes and progress statements for the future. Based on an admittedly-brief overview of the 2007 Contract Performance Report and its many outcome statements, it is reasonable to raise questions concerning what the County and Department are receiving in return for dollars invested in some of the agencies. That may not be a fair statement, as there may be much information that did not surface in the document that would clearly justify the funding, but based simply on what was presented in the report, it would be hard to review some of the agency reports on performance without wondering why so much money is being given to the agency, if the report provides the full story of what happens in response to the funding. The performance report in the future should be more definitive in demonstrating the clear connection between the funding and what happens as a result of the funds invested in these agency programs.

- Basically, in going back to the drawing boards in some cases, agencies and the Department should be attempting as much as possible to craft outcome statements that attempt to answer the question, “So what?” That is, given the activities and services provided within a program, so what are the outcomes or the impacts of those activities? If a certain number of people received a certain service, what was the result? What happened as a direct result of having received the service?

- In a number of cases, targets or goals appear to be much too conservative and easy to reach. The Department should, in the next iteration of these statements, work with the agencies to develop

aggressive goals and outcome statements that would reflect accomplishments that could justify the contract expenditures.

These observations and critiques notwithstanding, it is important and impressive that such a wide-ranging array of indicators has been compiled for tracking agency progress in a number of different types of programs. They may in many cases not be the best measures, or may not be stated as clearly as they could, and the degree of success against the outcomes and targets may not always be clear, but nonetheless the existence of this Contract Performance report is evidence of a positive direction. It is clear evidence of a demonstrated commitment to hold agencies accountable for their performance in providing a number of important services to county residents. If one considers that this is a work in progress, and an indication of a good faith effort to effectively track the impact of services provided by contract agencies across a wide range of programs, this should be considered to be an important foundation upon which to build and strengthen the effort as the next round of contracts is developed.

## Gaps in Male Staff

In clinical programs in most of the contract agencies, CGR was told repeatedly about small numbers of male clinicians and other levels of staff in most agencies. This becomes a problem partly due to the more physically demanding job of working with a younger, stronger and more aggressive population that many agencies report serving. Also, in a one-on-one clinical setting, clients who have a history of disturbed behavior towards women, or who are not comfortable speaking openly with a female clinician, may not be well served by the absence of greater numbers of male staff members.

## Agency-Specific Issues

In addition to the broad cross-cutting issues discussed above, this final section of "External Issues, Concerns and Challenges" changes the focus to challenges and concerns facing specific contract agencies with which we spoke or spoke about during the study. What follows is not meant to be an all-inclusive list of all challenges facing selected major contract agencies, but rather is a list of issues and concerns that appear to be significant, and that need some attention either by the agency and/or in conjunction with DMH.

### Hudson Valley Mental Health

HVMH is currently the largest provider of mental health services in the county, having provided clinic services to more than 3,000 individuals last year. But there appear to be legitimate questions about the quality of those services in many cases. By the agency's admission, it provides a high volume of cases with too few experienced staff (including few

psychiatrists or psychologists), often in 30-minute segments that are probably too short to be effective in many cases, and levels of supervision, staff training and agency high-level leadership are all deemed to be currently insufficient. The previously-noted "Patient Opinion Survey" suggested frequent discontinuity of services, with negative consequences for the many of the affected clients. Moreover, over the past several months, about a third of all referrals to the agency have missed their intake appointments, and about 20% of ongoing appointments appear to be routinely missed.

But on the more optimistic side, the agency has new leadership that appears to be aggressive in seeking to address these and other issues affecting the clinics; and HVMH's recent agreement with its parent First Families of NY to enable it to free up significant funds that can be used to upgrade high-level management staff to help address issues of training, the strengthening of supervision, and the development of standards and means of ensuring compliance, all auger well for the future of the agency and its clinics. There is also hope that purported changes in state reimbursement approaches, designed in part to help strengthen clinic services as the core of the system, will be implemented in such a way over the next few years that clinic funding will be increased significantly, thereby helping the agency strengthen its core services without needing additional support from the County, which already subsidizes the clinics at the highest level of any of the contract agencies.

HVMH officials reported wide discrepancies between numbers served and caseload sizes across staff in the five different clinics operated by the agency. They are concerned about sustained imbalances between caseload sizes and the effects they could have on staff in the various sites. Leadership of the agency is concerned about the need to resolve the imbalances across sites, but is reluctant to move staff from one location to another, fearful of resulting morale problems when there are already issues of insufficient pay, inadequate supervision and other issues to be addressed without adding a new issue to the mix.

### *Lexington Center for Recovery*

LCR is facing many of the same issues as HVMH. It has one large location, the Manchester Road facility in Poughkeepsie, that serves more than twice as many clients as its other four clinics combined. It has significant staffing imbalances and inequities in terms of caseloads across sites. Supervisory and upper level management staff are woefully overextended in attempting to deal with the overload of clients in one location while trying to figure out how to reallocate inexperienced staff in a cost effective manner across other sites. High staff turnover compounds the problems. Some of the sites have so few clients that consideration should be given to closing one or more, or offering services only on selected days. On the other hand, data problems within the agency make

the ability to make definitive judgments based on accurate data problematic.

In addition to these management issues, the agency has undertaken the development of a new location to alleviate overcrowding at the Manchester Road site, and has just been awarded two new grants that will add to the supervisory load and logistical problems facing the agency. The agency appears to be operating on a significant level of overload, yet appears to have the attitude that issues will be resolved with patience and time. It has added creative programming in the clinics that was not available in previous clinic incarnations. On the other hand, with gaps in supervision/management levels, and insufficient support for staff training or salary levels to attract highly qualified line staff, the agency appears to be operating at a level that makes it hard to be successful in meeting agency goals consistently. LCR officials seem to feel that the MH Department is overly controlling in many cases, yet CGR's perspective is that the Department may need to insert itself more forcefully in offering to help work out solutions to issues such as the staffing and client imbalances, and supervisory and management shortfalls.

Staffing and supervision shortages are exacerbated by requirements that LCR be represented at weekly planning and service team meetings for each of four Drug Courts which LCR has been asked to staff. These same Drug Courts are also staffed by Forensics staff within the Department. One way to reduce at least some of the current workload facing supervisory staff would be to be removed from the ongoing coverage responsibilities for these Courts, or to at least work out some type of shared arrangements with the Forensics staff, so they aren't offering overlapping coverage.

Agency staff also reported problems streamlining both the intake process so as not to further overload staff, while at the same time finding time to close old cases that currently give the appearance of contributing to large caseloads, when in reality some of the caseloads may be more manageable if the "deadwood" on them can be closed out.

Finally, the agency has double or triple duplication in data entry requirements that have significant implications for staffing workloads both within the agency and the Department's OIT. OIT and LCR are working to at least partially address this issue.

### *Mental Health America (MHA)/Case Management*

MHA took over the combined case management operations for the MH system about five years ago, consolidating what had previously been two separate systems. Since then it has made a number of changes in the philosophical approach to the delivery of such services, with an increasing focus on recovery and closing of cases as progress is made. In the process

it has become the Department's largest contract agency, with almost $3 million in services provided by MHA across a number of programs, including most prominently case management. Out of the large contractual amount, the County share is only about 1% of the total. Case management services were generally well reviewed by Department staff, with a few exceptions. On the other hand, it is plagued by the same issues of inexperienced staff with high turnover levels faced by other contract agencies.

From the perspective of service provision, one of the major issues facing case management staff involves HIPAA restrictions on the ability to have other agencies with which it is working share needed information with the case managers in order to enhance service provision and the development of appropriate service plans.

MHA has been innovative in working with DMH in developing staffing around one or two projects in which it provides needed staff support to the Department under Department supervision, without adding to the County payroll. This model has implications for possible replication across other programs in the future.

Case management services currently provide some surplus financial resources annually to the Department for use in covering needed one-shot support to enhance specific services or cover unanticipated shortfalls. However, the biggest issue facing MHA and the Department concerning its future is the uncertainty of what the funding model for case management will look like in the future. As soon as within the next couple of years, significant shifts in the funding rationale underlying case management services may not only wipe out the annual surplus, but call into question the financial viability of the service as it is presently constituted. DMH and MHA officials need to be diligent in planning for the future ability to maintain these essential services in a cost effective manner, without adding to the County's virtually non-existent costs of having such services in place.

### *Astor Home for Children*

Astor has long been the major provider of a wide range of children's services in Dutchess County. It has the reputation of being the contract agency with the most innovative approaches to offering evidence-based practices, and providing a strong infrastructure of training and staff development anchored by a strong management/supervisory staff offering support to its relatively inexperienced line staff. It has a history of bringing in outside resources to train staff, who in turn use what they have learned to train others. The agency has also brought in outside consultation to help resolve inefficiencies in the processing of information across units in the agency.

The agency is currently considering seeking a modification of its license to enable it to serve children and youth through the age of 21, to ease the transition of young people into the adult system. Astor could become a candidate for providing a Transition Coordinator role should that be recommended for implementation by the Department (see Chapter VIII), although there are questions as to whether such a function would be best carried out by Astor, with its immersion in children's issues, or under the auspices of the County.

Like LCR, Astor and the Department's OIT are engaged in duplicate data entry tasks which OIT is attempting to help resolve, with potential efficiencies and cost savings for both agencies.

Astor, with its experience in offering strong management and staff development support for its young staff, could potentially be a resource to the Department and the larger MH system to assist with training and staff and management development initiatives within other agencies. Astor officials have expressed a willingness to consider offering such support, should there be sufficient demand and resources available to cover the core staffing costs of providing the services.

# CHAPTER VIII. CONCLUSIONS AND RECOMMENDATIONS

## Conclusions

Dutchess County is blessed with a strong, diverse array of mental hygiene services. Over the years a number of changes have occurred which have reduced the County Mental Hygiene Department's direct control over major parts of the system, while making it possible to reduce the County payroll and direct salaries and benefits below what they would otherwise have been. Even as selected in-house services have been contracted out, the scope of the entire system has expanded over the years, and more people are served across the system now than was the case 10 years ago.

Generally outsourcing of services has worked, as core services have continued to be provided in multiple locations throughout the county, typically to as many or more individuals as pre-outsourcing (with the possible exception of chemical dependency clinics, where data uncertainties make direct comparisons over time somewhat non-conclusive). However, there are legitimate concerns about the consistency and quality of the services that are provided by some of the contract agencies that have assumed responsibility for previously-in-house services

and programs—and related questions as to how well clients benefit from services often provided by less experienced and less credentialed staff than existed when the County provided the services.

But to date, there are no definitive data indicating that any substantial harm has been done to clients, or that they are less likely to make progress under the current system than they would have previously, just as there are no data documenting that clients are any better off now than under previous treatment options. We simply do not know. What we do know is that substantial and often growing numbers of people are being served across the MH system, that the scope and coverage of the system have expanded over time, that a wide range of services are available and accessible on a decentralized basis throughout the county—and that much more attention will need to be paid immediately to investing in and providing expanded quality supervision, training and staff development support to the relatively less experienced line staff who now provide many of the contract agencies' clinic and case management services that represent the core of the MH service system.

CGR found no evidence of unneeded, inappropriate or redundant services or programs. There are opportunities to make better use of existing services and resources, and perhaps even to scale back some services, but we found none that warrant elimination—and some that may merit consideration for modest expansion under specific circumstances and guidelines.

The recommendations that follow are designed to reflect the political reality that places limitations on the extent to which any major growth in County staff or programs is likely to occur. But that reality is balanced against the legitimate concerns of not wanting to add any substantial services within existing contract agencies, which by their own admission offer services of somewhat inconsistent quality provided by, on balance, less credentialed and experienced staff than was the case pre-outsourcing.

## Recommendations

Many of the recommendations that follow were hinted at and grow logically from issues discussed in the previous chapters, particularly Chapter VII. A few may not have a specific antecedent in the earlier chapters, but simply make sense to include here anyway. In some cases, it may be helpful for the reader to refer back to an earlier discussion to flesh out some useful details to help implement a recommendation made below (e.g., comments about various types of performance and outcome data in earlier chapters may help amplify some of the data-related recommendations below).

Our recommendations are based on our current understanding of political, funding and regulatory realities in Washington and Albany at this point and in the foreseeable future. We have not made any recommendations that we believe would be in funding jeopardy, or that would knowingly increase the financial support levels required from the County, unless the rationale is spelled out as part of the justification for implementing the recommendation. That said, as anyone involved in planning for, administering or funding mental hygiene services knows, trying to plan responsibly for the future can be a frustrating exercise in trying to hit a moving target or playing a guessing game, based in part on attempting to anticipate the "unknowable" at the state and federal policy levels. Various MH funding proposals have been swirling around for years, with no final resolutions. Our best information and judgment are that no major changes in funding or regulations are likely in the next two or three years that would undermine any of our recommendations, but we have attempted to indicate any recommendations where particular caution and due diligence may be in order to further assess the political and regulatory landscape before taking any actions.

## Retain the Current Mix of In-House vs. Outsourced Services

- ***CGR recommends that no changes be made in the current mixture of in-house, Department-operated services and the services currently provided by contract agencies.***

There is logic to retaining the services and programs currently provided directly by the Department, and no compelling logic suggesting that they should be outsourced.

Indeed, at this point, the compelling logic argues that the County and DMH should be very cautious about attempting to contract out any additional services, given the myriad problems noted above concerning the lack of sufficient resources to consistently hire and retain experienced, credentialed professionals interested in making a career within local non-profit, mental hygiene service-providers. Although the agencies are well-respected, typically well-run organizations, most are currently experiencing difficulties not only in finding and keeping experienced line staff, but are also finding it difficult to retain appropriate supervisory oversight, training and staff development supports to maximize the value of the line staff who have been hired. The agencies are quite aware of these concerns, and are actively attempting to find the resources to address and solve these problems.

In the meantime, it would seem to make little sense for the Department and County to compound the existing problems by potentially adding additional staffing and programming issues to the current ones. The

system is currently functioning and meeting service needs in spite of the resource questions it faces, but until the contract agencies can find ways to retain a higher proportion of talented professional staff, and to provide them with adequate levels of supervision and training, it would make little sense to add to their current burdens by asking them to take on additional services.

But our recommendation is not premised primarily on what *not* to do. Our reasons for recommending that current in-house programs remain within the Department are based primarily on positive reasons to keep them within the County operations. County programs, backed by the experience, knowledge and advice of the Department's leadership and veteran staff, remain in the best position to be able to link clients across the service network and efficiently direct them to the services they need. This becomes especially important in programs such as Partial Hospitalization and Special Services Team, where making connections to other services and understanding what is best for a given client are key to the ability to meet clients' needs. It is likely that the highly professional teams in these and other specialized programs such as the Clinic for the Multi-Disabled would be harder to recruit and retain outside County government.

In addition, the various programs operating within the criminal justice system have developed the trust and confidence of those within key components of that system, and it makes no sense to attempt to tamper with those relationships that seem to be working so well at providing alternatives to traditional approaches to processing defendants and offenders with mental health and substance abuse problems. Helpline makes good use of its connections to Anasazi and the Department's computer resources, as well as the strong support of the rest of the Department's leadership, to provide a unique integrated hotline and pre-intake system that enhances the Department's connections to and understanding of the entire system—which is a critical component of its ability to effectively fulfill its coordinating, planning and advocacy functions. As noted below, there are issues that need to be addressed within all of these Department programs, but we believe the county's residents with various mental hygiene issues, and the county's taxpayers, are all best served by keeping the programs where they are organizationally and addressing their challenges internally, rather than compounding them by considering contracting them out at this time and potentially compromising the quality of their programming.

## *Reorganize the Structure and Functions of Department's Executive Council Team*

CGR proposes to eliminate one top level position, add a new one, add an additional existing position to the Executive Council, and change some

other responsibilities of current positions. The proposed changes should have limited or no net financial impact on the Department, while strengthening its overall strategic planning, quality improvement, and oversight functions both internally and across the DMH system.

- ***The Department should eliminate the Support Services Division and the position of Chief of the Division, and should create a new Division of Administrative Operations, headed by a Chief, who might also be thought of as the Chief Operating Officer.***

The pending retirement of the current Chief of the Support Services Division, Terry Stuart, and the years of experience he takes with him, provides an opportunity to rethink the way in which the Department's administrative support and technical support functions are and should be organized in the future.

- ***We propose that the Division of Administrative Operations would include the Office of Budget and Finance, the Billing Office, and the Office of Information Technology. The Directors of Budget and OIT and the Billing Manager would report directly to the Chief of the Division, or COO. In addition, the Support Services Manager would report to the COO.***

The Budget, Billing and IT offices would continue their current critical technical support operations and responsibilities, and their respective staffs would continue to report to their Directors and Managers as they do now. Their grade and pay levels, and levels of responsibilities would remain unchanged. Budget, OIT and Billing are all technical support functions that need to be of service to the overall management structure of the Department. Bringing them together under one overall coordinated Division would, we believe, facilitate this support relationship.

The point of the creation of the new Division and the new Chief/COO position is in no way to diminish the importance of the functions and individuals that would report to the position, or to cast any aspersions on the quality of their work. Rather, it is to heighten their impact and increase their future value, by helping to break down the "silos" that currently exist within the Department. Although the affected offices communicate as needed and often work collaboratively, it is not their normal style, nor have they typically been asked, to think strategically or to look for ways to create solutions that transcend individual offices or units. The role of the proposed new Chief would be to do that: to break down barriers and to think strategically about how the important technical support functions of the Department can work best to support each other and the management team, and to better support and serve the clinical side of the Departmental operations.

An alternative to the proposed structure would be to have OIT remain outside the new Division and continue to report directly to the Commissioner, given that the office is so integral to the functioning of each unit throughout the Department. But we believe that if this new structure is to work, and if the new Chief is to be most effective in helping to change the way in which technical support functions work together and with the remainder of the Department, the OIT Director should report to the Chief.

The Commissioner should decide, under this proposed structure, whether the OIT and Budget Directors would continue to be a part of Executive Council, as they have been in the past, or whether they should simply be represented on Council by the Chief. There could be a logic to either approach, but we would suggest that both be "grandfathered" in and continue to meet with the Council, particularly during these pivotal next few months when new financial reports and procedures are being developed and tested, and as Anasazi's final rollout schedule approaches. At some point in the future it may make sense to not have those positions regularly attend Executive Council, but for the foreseeable future, it makes sense for them to continue to attend and fully participate, even after the new Chief/COO is in place.

- ***The remaining functions of the current Support Services Division must be reassigned and distributed to various units within the Department. We suggest that the current position of Support Services Manager continue within the Division of Administrative Operations, reporting to the Chief.***

The Manager position would retain responsibility for personnel, purchasing and clerical support functions, as now exists under the current Support Services Division. Building and Grounds and Inventory Control might also be folded under the Support Services Manager's responsibilities. The new Chief could decide, in conjunction with the Commissioner, how to deal with safety and security issues, but they would presumably continue at some level under the overall guidance and oversight of the new Chief. As an alternative, Buildings and Grounds might be placed with the Budget Director, since that position may need to become involved if financial matters need to be addressed. Otherwise, most Buildings and Grounds issues are currently addressed at the building manager/Unit Administrator level anyway. Contracts coordination (for non-client service contracts and overall contract initiation, such as with vendors) might also be assumed under the Budget Director, who already has responsibility for review of the contracts involving services to clients.

- ***The Quality Improvement Coordinator role should be strengthened, and the Coordinator should become an official member of Executive Council.***

Further recommendations are made below concerning ways in which this function should be strengthened, particularly with regard to enhanced roles in monitoring and working closely with contract agencies, but in the context of this discussion about strengthening the Department's leadership structure, it is enough at this point to say that it is important to have a fresh, independent voice speaking to Council on a regular basis about the importance of quality improvement throughout the system, improved measurement of outcomes and their value as a management tool, corporate compliance issues, HIPAA issues and how they can be resolved in a way that does not interfere with enhancing services. The Coordinator technically reports to the Chief of Developmental Disabilities, who also doubles as the Director of the Office of Quality Improvement, but we believe the Coordinator role to be important enough in its own right, with sufficient responsibilities unique to the position, that the role and the issues addressed by the Coordinator should be visibly represented at Executive Council each week, and not just when Patient Care/Utilization Review reports are on the agenda.

- ***The role of the Office of Community Services should be restructured to place more focus on training, orientation and staff development, both for internal and external staff.***

This Community Services office already has, among other functions, responsibility for credentialing of staff and student placement coordination. CGR recommends that the Department assume greater responsibility for training and orienting staff throughout the system, with the Director of Community Services taking the lead, supplemented by efforts of the Quality Improvement Coordinator, Chief Psychologist and possibly the Director of Communications (see below). The incumbent Director could begin this focus, and at such point as she retires, a person with direct training experience could be hired as her replacement. A more detailed recommendation is presented later in the chapter concerning the expanded role the Department needs to play to ensure a stronger focus on training and staff development and retention throughout the system

- ***The role of the Office of Communications should be reassessed.***

To our knowledge, Dutchess is one of the few counties to have a full-time Communications Director within the Mental Hygiene Department. As a one-person operation, the current Director has played an instrumental role in building public visibility for the role and services of the Department, and putting a public face on the importance of mental health services. Given the success of the Office in helping strengthen the public image of mental illness and mental health services, and given the fact that the veteran Director of the Office is likely to be seeking retirement at some point in the not-too-distant future, it is worth assessing how the role of this position might change in the future.

At this point, the Director has developed such an impressive array of public service announcements and designs of press releases and other media guides that her replacement will have much to work with from the beginning. Moreover, documents such as the Annual Report are relatively straightforward to update each year, as the basic format remains consistent from year to year, mostly involving updating annual data. The Director has also made internal communications and celebration of Department employees a value, and produces periodic documents showing summaries of key events during the year, with numerous pictures of many staff involved in these events. These documents have been wonderful for staff morale over the years.

Among the questions that might be asked at this time of opportunity to assess the future value of this position are: As important as a large, semi-glossy Annual Report may have been in building support and credibility for the Department over the years, how important is it now to have a major 60-70 page Annual Report replete with pages of pictures, and who is the primary audience for the report? How widely read is it? For it to have full value, is more analysis of data and trends important in future editions? Are the several-times-a-year internal reports still widely anticipated and used by staff, and in particular are the pictures worth their inclusion for morale purposes? Should more focus in the future of the position be on website enhancement? Could the job be done effectively on a shared basis as part of a different position, or can it only be done effectively full-time? However significant the value of the position, in a tight economy, can it be justified as a full-time position in the future? Are there other tasks that could be added to the historical responsibilities of the position to more fully justify continuation of the position in the future in a tightening economic climate?

CGR suggests that if the Department perceives there to be continued public relations and educational value to the various publications, announcements and documents produced by the Office over the years, the position should be continued. If the view is that many of these past activities that were so important to building awareness in the county no longer have the same value, and that that the work has been done so well in the past that the Department can “coast” for a while without producing as much public educational materials in the future, then it may be worth assessing whether a scaled-down version of the previous work could be done by a part-time or shared position.

If the decision is to continue with a full-time position, CGR suggests that a major focus of the position in the future be on developing and presenting orientation materials to new employees throughout not just the Department but among major contract agencies as well. The Director could also be instrumental in helping with the development of related

materials to help train new hires and supervisors both internally and in contract agencies (see increased focus on training below).

- ***The Department should reconsider whether to continue having the supervisory and followup responsibilities of all the Coordinator positions concentrated under the Chief of the Mental Health Division.***

Historically, this concentration has made sense, as the focus of the Coordinators, while cutting across all the divisions, has been primarily on mental health issues. From that perspective, it makes sense to continue to have each Coordinator report to the Mental Health Chief. On the other hand, from a budgetary, programmatic and planning perspective, the MH Chief has a disproportionate share of the workload and responsibilities compared with the other Chiefs, so there is some value to finding ways to redistribute the workload related to the Coordinator functions, as the work they generate can lead to substantial involvement at times for the Chief as well.

It may not be necessary in going forward to always have all Coordinators report to one Chief. Certainly there is logic to the argument that the primary focus of each is more on mental health than on other areas, but there may be alternative factors to consider in making the decision about reporting relationships. For example, the current Developmental Disabilities Chief was previously Children's Services Coordinator, so it may make sense to have her successor as Coordinator report directly to the DD Chief at this point in time. The transition would be a seamless one, and there would be no need for a learning curve period of "getting up to speed" on the issues. In addition, the Vocational/Education Coordinator currently spends considerable time focusing on both DD and Chemical Dependency issues, and in fact also has supervisory responsibilities for programs within the CD Division. Thus a strong case could be made to have this position report to one of those Chiefs, perhaps most likely the CD Chief because of the supervisory relationships. CGR recommends that serious consideration be given to both of these shifts, both as a means of better balancing the Chief workloads and as a means of helping to ensure that both of these Coordinator functions receive as much supervisory attention for their work as possible.

## Strengthen the Role of Orientation, Training and Staff Development Support Across MH System

- ***The Department should place an increasing emphasis on providing training and staff development support for both line and supervisory staff throughout the system, with particular focus on the major contract agencies.***

With so much staff turnover across the primary contract agencies, agencies struggling to provide training and supervisory support for new hires and existing relatively inexperienced staff, and the Department itself recognizing the need to more carefully focus on orientation of new staff concerning the culture and values of the Department, there is an urgent need for the Department to make training and staff (including supervisory staff) development a major priority over the next few years, both internally and especially externally, in an effort to help reduce staff turnover and strengthen the skills of relatively inexperienced staff and overworked supervisors in the major contract agencies.

This is likely to mean a significant investment of Department staff time and perhaps additional system resources to provide the required focus on initial orientation, ongoing training and staff development supports within major contract agencies as well as within the Department. It appears as if, at least initially, the Department needs to be willing to provide the leadership and the resources to jumpstart this effort, as it is not likely to happen in any comprehensive and consistent way if left to the contract agencies to initiate.

This effort may require both significant staff time and perhaps also the purchasing of additional training support from outside the Department to be successful. ***This may need to be thought of by the County and the Department as one of the prices, belatedly, of getting out of the clinic and case management businesses, or as an investment in playing catchup for the past, i.e., to help underwrite the costs of addressing staffing and supervisory problems that are the direct result of contract agencies paying less for staffing these positions than the County would have paid had the programs remained within the Department.***

We considered recommending the creation of a new Director of Training position within the Department to serve both internal and external staff and programs. But we decided instead to recommend that, at least initially, this effort be made a priority of three or four key internal staff who already have related assignments that we believe can be readily adapted and expanded to meet this immediate and ongoing need. As noted above, our recommendation is that the position of Director of Community Services be charged with the primary responsibility for developing plans, strategies, materials and agency linkages to get this training effort off the ground and sustain it over the next few years. This leadership effort would be supplemented by priority commitments from the Quality Improvement Coordinator, Chief Psychologist, and possibly Communications Director.

- ***The Department may also wish to contract out part of the responsibility for this effort, perhaps with Astor Home for Children.***

By all accounts, Astor has found a way to find the balance between hiring inexperienced staff, many of whom will leave within three or four years, and providing them sufficient training, supervision and related incentives that staff are able to be effective for as long as they stay, with some choosing to stay to take advantage of the culture and opportunities for growth within the agency. It may make sense for the Department to contract with Astor to develop approaches based on their training and supervision experiences that can be shared with and used to train other agencies concerning practices that have been proven to work in the Astor and/or other settings. Astor officials have indicated a willingness to consider involvement in such an initiative if the Department is interested in pursuing the possibility. We would envision the role of Astor, and/or DMH staff as essentially developing approaches designed to help others help themselves, i.e., using something along the lines of a train the trainer approach.

- ***Internally, the Department should continue its recent initiative to provide a comprehensive orientation on the Department, its full range of services, and its culture to all new hires. It should also expand its coverage to new hires throughout the major contract agencies. On an ongoing basis, it should provide as much cross-training as possible to staff within the Department, especially among clerical support staff.***

The internal orientation has proved to be successfully received by new hires, based on followup evaluation done by the Department. It should be helpful, with perhaps some modifications, within contract agencies as well, if scheduling can be worked out. Exposure to the scope of the system and its core values and components should prove to be a useful introduction to new hires, who can put what they will be doing into a larger context as a result.

The notion of cross-training was raised by several of those we interviewed within the Department, who advocated for clerical support staff in particular to be exposed to the different types of expectations and approaches used in various divisions and units concerning types of services provided, what information needs to be maintained, how things are filed, etc., so that they will have enough core understanding of different units to be able to "hit the ground running" if they are assigned to a new unit for a short period of time to help with an emergency or cover for a person on leave.

- ***From a staff development perspective, the Department is encouraged to place more emphasis on the importance of providing thorough annual written evaluations, emphasizing the development and review of annual personal and unit goals. Ideally, evaluations would include opportunities for peers to evaluate their colleagues.***

CGR's impression from our interviews is that performance evaluation of staff is not always consistently undertaken within the Department, with some staff and supervisors taking it more seriously than others. Performance evaluation is a key part of the organizational culture, but there does not always appear to be a consistency of quality, or a consistent focus on setting and monitoring annual performance goals. For effective staff development to occur and improvements to be made on an ongoing basis, annual performance evaluations must be taken seriously, and emphasized from top to bottom of the Department. CGR's experience is that such an evaluation process is enhanced if peers are also invited to participate by providing assessments of their peers to their supervisors, for anonymous inclusion in the supervisor's overall written evaluation. Staff may also be given the opportunity, to the extent practical, to provide evaluation of their own supervisor to the person evaluating the supervisor. This may be harder to do the higher up the organization one goes, because of the sheer volume, but at least within units, such an approach, often called "360-degree evaluations," can provide the opportunity to offer helpful positive and improvement opportunities on all staff, and place the focus on ways of strengthening individual as well as team performance.

- ***Management should ensure that staff are eligible for all appropriate billing by maintaining the appropriate levels of credentials.***

In order to avoid delays in payment of revenues, and as part of a strengthened focus on staff development and on a more comprehensive and systematic approach to billing within the Department, management should ensure that within each unit, care is taken to make sure that all professional staff are current with their appropriate certification levels.

- ***The Department should develop an internal mentoring program, through which new staff could be assigned to a mentor with whom he/she would work and/or be available to go to for advice as issues arise early in the new employee's career.***

This program could be designed and implemented without additional cost to the Department. Someone would need to be assigned the responsibility of developing guidelines for the program, which could then be implemented by heads of units as new people are hired into their areas.

## Maintain Current Staffing Levels, Add Selected Positions, and Reassess Post-Anasazi

- ***At this point, no reductions in Department staff are recommended based on the study. Staffing levels should be reassessed following the full implementation of the Anasazi system and any changes in the relationship between Billing and other units.***

It is simply not the time to make a fair assessment of future staffing adjustments, given the assumption that today's workloads look very different from what they may look like a year from now, with hoped-for efficiencies in place. CGR anticipates that once the Anasazi software system is fully in place (anticipated in 2009) and once changes are implemented in the way in which the Billing unit interfaces with other units throughout the Department (hopefully such changes will be in place later this year; see recommendations below), the staffing landscape will be much clearer, and more effective decisions about future staffing needs will be possible. It is simply not feasible, based on current circumstances and workloads, to make informed decisions about whether any staff reductions or reallocations may be possible without affecting unit performance. There is no way at this point to make realistic judgments about what efficiencies and productivity improvements are likely to occur, and in what units.

We assume that a year from now as the 2010 budget is being prepared, once Anasazi is fully implemented and possible Billing changes are in place, significant staffing adjustments may be in order. We assume that there will be opportunities to reassess staffing at that time and to consider either (1) possible elimination or combination of some positions (perhaps through attrition), (2) potential reallocation or redistribution of functions, or (3) opportunities to increase caseload or make other workload adjustments with the same levels of staff as a result of increased productivity. In the meantime, we believe it would be unfair either to employees or their units to attempt to downsize or make other significant staffing changes while so much remains uncertain within the Department.

Concerning clerical support staff, if a decision had to be made today, and no changes in work environment were anticipated, CGR would recommend some increases in full-time clerical positions. However, today's reality is not the reality that should be used to make future staffing decisions about more permanent support staff levels. We assume that efficiencies, including anticipated reductions in duplicate data entry, reductions in copying and lowered filing demands, will occur when anticipated changes are fully in place, but how exactly those will play out for specific positions and units cannot be anticipated at this time. Fortunately, in the meantime, the team of support staff under the overall authority of the Support Services Manager is available to be assigned as needed to meet the ebbs and flows of workload across different units, based on the design created by the Department to maximize flexibility of the clerical support staff.

However, all that being said, we do make one recommendation at this time to increase that level of flexibility.

- ***The County should authorize the Department to hire up to two per diem "floaters" at the clerical support level to provide greater flexibility to meet support staff needs across units.***

Because there are current needs that cannot wait for promised future efficiencies, and because added flexibility in meeting those needs is limited with the inability to hire any additional staff at this point, we recommend the creation of these new per diem "floater" positions for use as needed by the Department. At least one such position did exist in the past, so there is a precedent for it. CGR believes creation of up to two such positions is justified during this period, for use in emergency or unplanned shortfall situations.

- ***In addition to the "floater" positions, CGR recommends that the following new positions be created:***
  - ***1 full-time and 1 per-diem position within Helpline***
  - ***1 or 2 full-time positions between the Forensics and ITAP units***
  - ***1 full-time Geriatrics Coordinator***
  - ***1 full-time Transitions Coordinator (potentially hired through a non-profit agency, and not on the County payroll)***

The rationale for each of these proposed additions is spelled out in the context of more specific program area recommendations below. These represent the sum total of any additional positions proposed on the basis of CGR's analysis. *It does not mean that other new positions may not be justified, or should not be recommended in the Department's submission of its 2009 budget requests. But these are the new positions that are clearly justified based on our assessment of the Department and its needs*, and the needs as we assess them of the larger community.

Frankly, we almost recommended an additional position to provide further support within OIT, but we decided against it for three primary reasons: a rare new DMH position was added in 2007 in OIT; the OIT Director has speculated that once Anasazi is more fully implemented next year, an additional person may be less needed; and perhaps most important in our thinking, if a new position is created at this time, it will create less of a sense of urgency for aggressively seeking the assistance of the Anasazi national support team to provide support as the rollout continues and practical problems arise. As noted earlier, and recommended more explicitly below, CGR strongly believes that the Department should be insisting on a much more substantial on-site presence of the promised support team from the national office to supplement OIT's work in making final adjustments in the software system and its final rollout. We believe this support should be insisted upon and forthcoming, and

therefore have not recommended the creation of an additional OIT position as an option.

Finally, we believe not only that the costs associated with adding these proposed new positions are justified (as discussed further in their respective rationales below), but that they are likely to be at least matched, if not more than offset, a year from now when offsetting reductions or adjustments in other positions are likely, based on Anasazi and billing-related efficiencies, and/or when increased productivity and revenue generation are made possible by the same efficiencies.

## Maximize Effectiveness of Anasazi System

Although many staff expressed frustration that Anasazi was chosen and implemented, most acknowledge that now that it is being implemented, it has value and needs to be used as effectively as possible. Many staff expect that eventually, it will increase efficiency and be a useful tool for them. However, CGR recommends that, although implementation is in full swing, it is not too late to take actions to ensure that the remainder of the implementation process, and ultimately the ongoing use and maintenance of the system, occur as seamlessly and efficiently as possible, and maximize the utility to all users. In order to maximize the system's effectiveness, we recommend the following action steps:

### Action Items

- ***Before final implementation of Anasazi, survey unit staff more explicitly than heretofore, soliciting any final suggestions for improving the software. This should be done as systematically and thoroughly as possible***.

This final emphasis should be on understanding the nuances of each program and unit to make Anasazi the best possible tool for each of these entities.

- ***Make sure that any restructuring in functions such as Billing occur first and be completed before final decisions are made about Anasazi, rather than continuing to build system functionality around a system that is in progress.***

- ***To the extent that it would be helpful, consider ways of using a support team or teams as necessary from the national Anasazi office to supplement the OIT efforts to rollout the system, to meet with unit staff to hear and respond to suggestions, and to help troubleshoot any major concerns that arise.***

To the extent that it would be helpful as a supplement to OIT efforts to ensure the most effective possible rollout of the final aspects of Anasazi,

national resources should be brought on-site to work in conjunction with OIT to help expedite final implementation of the system and to address any final issues that may emerge. This has happened more effectively in recent months than in the initial implementation stages of Anasazi, but may need an added push "down the stretch." OIT should ideally meet initially with selected units to obtain an early indication of any remaining key issues that will need to be addressed, and develop an appropriate work plan in response to frame any followup work to be done with the support team, both in advance of any trips and while actually on site.

- ***Consider what is realistic in terms of what functions can be performed once Anasazi is fully rolled out and anticipate what other functions may still need to be addressed further at that time.***

For example, if Anasazi cannot be made compatible with OASAS reporting, consider and plan for what other procedures need to be put in place in order to create efficiencies around such reporting. This will involve team-based input and problem solving.

- ***The Department should set clear deadlines and expectations concerning when all units and affected staff will be expected to be fully functioning consistent with Anasazi performance expectations, and hold unit administrators accountable for ensuring that all staff are ready and trained by the appropriate time.***

The goal should be that by the appropriate date, all staff are appropriately trained and ready to be fully computer literate and able to function under the new system, and that everyone is able to enter the appropriate information consistent with her/his position. (It is recognized that some exceptions may be needed for reasons deemed acceptable by management, with such cases "grandfathered in," but these exceptions should be quite rare, and should be completely phased out through attrition.)

- ***Guidelines should be developed in conjunction with unit inputs concerning when paper copies are needed and when they can be eliminated. These guidelines must reflect reasonable concerns from staff about needed backup, but also accommodate to OIT assurances of system backup capabilities and protections, while also factoring in overall efficiency issues such as time lost in making and filing copies, and insufficient space to store unneeded paper files.***

Once guidelines are developed and agreed upon, managers and unit administrators should hold staff at all levels accountable for operating in concert with the guidelines, and the effect of such implementation on any freeing up of staff time should be monitored.

## Restructure Billing Functions

Creating a shared understanding of billing and insurance procedures and moving towards greater efficiency and effectiveness in this area is critical. The perception of many staff is that they don't understand what the Billing unit does and why, and that Billing doesn't understand what clinical staff do and why. Many staff suggested that having Billing staff on-site or assigned to units would help alleviate the strain on clinical resources now devoted to billing and insurance issues, and would allow the Billing unit to evaluate its procedures on an ongoing basis to ensure that the unit is up to date on the needs of the various programs and services. But before such ongoing links can occur with a level of comfort, some preliminary work seems needed.

- ***As an immediate step, there should be an in-depth (possibly mediated) discussion or discussions between Billing and OIT, Budget and Finance, representative clinicians and clerical support staff from various units, and Division Chiefs.***

The issues that exist across the various functional areas need to be discussed outside of Executive Council, with all levels of affected parties, and with a positive approach and the goal of greater efficiency for the greater good.

### Evaluate Workflow Related to Billing and Other Units: Action Step – Create a Matrix of Function and Responsibility

- ***In conjunction with the proposed discussion(s), CGR recommends that the Department and Billing unit examine in-depth all functions related to billing and insurance, and who is now or should be responsible for various tasks under what circumstances.***

This will allow for an opportunity to break down the "silo" mentality that has shaped previous discussions about billing, and should help result in a shared understanding of this key function that affects the entire Department, while engaging staff across units in creating opportunities for improvement.

1. Inventory all functions, processes, informational, data entry and paperwork needs related to billing and insurance. Compiling such a list will need to involve all staff that are involved in billing in any way.

2. Indicate current responsibility for functions, location of information and flow of paperwork. This could also be the basis for a discussion of how to determine the most cost-effective approaches for the good of the overall Department to assigning responsibilities for the functions under certain circumstances.

3. Document areas of duplication and inefficiency. Examples of such areas may include: Functions that are being performed by persons with less information (or, alternatively, more information) than needed to perform the function; functions that could take less time if performed in another location or by another person; functions that would be less costly if performed by someone else; information that is data entered more than once; paper forms that could be automated; or forms that cross one person's desk several times.

4. Allow staff to suggest improvements in work flow and in who should do what under what sets of circumstances.

5. Prioritize and implement improvements.

- ***These steps should become the basis for updating the current draft Billing Manual, which would be far more useful with such understandings and assumptions included.***

## *Action Step – Implement Increased Billing Staff Support to Units and Programs*

- ***Following the evaluation of current workflow, the Department should approve more active support of units and programs by the Billing unit.***

It is clear that billing and insurance issues are currently taking up a great deal of time that clinicians and other line staff—as well as several Unit Administrators—could be using to work more closely with clients, generate revenue, expand caseloads and carry out other daily functions. It appears that at least some of the push to have clinical staff take on a greater amount of responsibility in this area was an artifact of high levels of turnover in the Billing unit; if so, this trend can be reversed as the Billing unit becomes more stable, and attitudes improve between different segments of the Department. In order to further break down barriers and increase the efficient use of both Billing and unit staff, the following recommendation is made:

- ***Have each Billing Clerk assigned to specific programs or units to allow Clerks to become specifically and thoroughly familiar with the needs of the assigned units.***

In most cases, any issues needing discussion or resolution could be addressed via email or phone, but in some cases, direct onsite visits to the units would be critical to building relationships between Billing staff and the units. This would allow specialties to develop between Clerks and "their units," while also enabling clinicians and supervisory staff to develop trust relationships with "their Clerk." Much time and frustration on both ends could be avoided by the development of these relationships, thereby making it easier to work through conflicts and disagreements

when they do occur, rather than just having frustrations fester, as has often been the case in the past.

Some of the questions that will need to be answered in order to effectively restructure the current relationships between Billing and units include:

1. Can certain paperwork be handled one day a week instead of dealt with on an as needed basis? For example, if a Billing staff person spent one day on a unit, could certain paperwork, investigations or data entry be reserved for that day?

2. Which tasks require clinical expertise and therefore must be handled by a clinician, and if so under what specific circumstances?

3. Are current software systems compatible with any changes that would be necessary to facilitate a greater Billing presence within units?

## *Strengthen Fiscal Controls*

Since the 2007 Dutchess County Comptroller's audit report on DMH's finances for the years 2003-2006, the Department has taken steps to update its Office of Budget and Finance (OBF) policy and procedures manual and to institute practices that appear to provide a better and more timely capability than existed before to reconcile state aid revenues with data in the County Finance system. The policy and procedures document also outlines the primary responsibilities of each staff position within the Budget Office, and provides a clear timeline of what needs to happen with regard to the completion of the Consolidated Fiscal Report (CFR). The language spells out financial consequences for contract agencies which are delinquent beyond a particular date in their submission of CFR materials. CGR does not know whether such consequences were identified in previous editions of the model, but if not this appears to be a useful addition.

It is important that a clear understanding exists in writing, both to identify tasks that need to be completed by specific staff within the Budget Office, and for awareness of the Department's management team, to ensure that policies and practices are in place to enable the Budget Office to handle immediate issues and to plan for tighter controls and fiscal management going forward, both internally, from the Department to State agencies, and from contract agencies to the Department.

CGR's review of the draft policy and procedures manual shared with us suggests that it is thorough in outlining responsibilities and technical tasks that need to be completed by OBF staff, although as a highly technical document it is not clear how helpful it would be for policymakers and management staff seeking a clear understanding of the controls that are in place and what protections are offered against the problems identified in

the Comptroller's audit report. On the other hand, more rapid monthly closeouts by the Billing unit (now occurring within a few weeks of the close of the previous month) should go a long way toward providing at least some important reassurances.

What did not seem to be addressed at all in the draft manual was how data would be presented, with what assumptions and caveats, on a monthly basis for management review, in order for the Commissioner and Executive Council to assess how the Department is doing month to month and year to date in terms of its financial position concerning expenditures and revenues against each other and against budget. Such a section may have been added subsequent to the draft CGR received.

In order to ensure that there is a healthy cash flow, collection of revenues, compliance with reporting requirements, and the ability of Division Chiefs and Unit Administrators to manage the budgets of their programs, it is important that key fiscal procedures are well understood by the DMH leadership, and that expenditures, revenues and accounts receivable can be summarized in easily-understood reports on a regular basis. To that end, we offer the following suggestions:

- ***A group made up of the Commissioner, Division Chiefs, selected Unit Administrators, Billing Manager, OIT Director and Budget Director should be convened to review the policy and procedures manual and the current draft of the monthly income and expense summary report to determine how well they meet the needs for transparency and understanding, and how well they appear to provide the information needed to effectively manage the financial affairs of the Department and its respective divisions and programs/units.***

This group would also be charged with identifying any additional financial measures they would like to access; would help determine how feasible it is to access all such measures; and would decide what would be minimally acceptable given realistic constraints in accessing such measures

- ***A priority in the financial accounting of expenditures, revenues and accounts receivable should be to have the agreed-upon data available at the individual program unit level to enable both Division Chiefs and Unit Administrators to monitor performance at the unit level.***

Such small-unit management oversight is consistent with goals stated in other sections of this report that UAs need to have detailed financial as well as performance and outcome measures available in order for them to be better able to manage their programs and to have incentives and accompanying information to make adjustments to enhance program quality, outcomes and financial viability. In the past they have not had

such information, so a move in this direction this year is a very positive development.

- ***To ensure timely and accurate completion of future CFRs, the Budget Office should make sure it has timelines and checkoff procedures in place to ensure that the following list of actions has been taken or set in motion. Most if not all of these appear to be addressed in some fashion in the draft manual we received, but DMH leadership should ensure that each of these is comprehensively covered.***

- Document each component of the CFR and the data needed to complete it;

- Document the location of, or the procedure for accessing those data;

- Document current responsibility for each component of the CFR;

- Identify areas of duplication, areas of uncertainty, areas where data are not easily accessible or have not been accessible for timely completion of the CFR;

- Create a matrix of the data and tasks above, responsibility for each and due dates for each component;

- Assign a project manager to oversee completion of tasks as designated above;

- Cross-train each staff person with responsibility in regard to the CFR on the other components of the CFR for backup purposes.

## Strengthen Focus on Data Tracking and Monitoring

Tracking and monitoring data on various measures helps any organization manage day-to-day functions and strategically and systematically plan for the future. While data tracking occurs at some capacity within the Department and across contract agencies, as emphasized in Chapter VII, there are many issues that are tracked informally, are reported anecdotally, or are not tracked at all.

### Action Step – Strengthen Metrics

- ***CGR recommends that the Quality Improvement Director and Coordinator, Director of OIT and Division Chiefs carefully examine current metrics that are being used in internal programs and external contract agencies to measure finances (discussed earlier), client progress and other measures of community impact, program performance and outcomes. Although the Department has taken***

***strong leadership in putting performance and outcome measurement front and center in the conversation about how to hold programs accountable, the measures currently in use for most programs still need considerable strengthening, as indicated for both internal and contract agencies in the previous chapter***.

A few specific issues that need to be raised in regard to metrics currently being used include:

- Minimizing waiting times for appointments is a major priority in the Department. Are these a realistic measure for clinics? Do they measure the start of treatment or simply the time from pre-intake to first appointment, without taking into account no-shows? Are they realistic given staff constraints in clinics?

- Is TOPS being used effectively? Several staff "in the trenches" reported that TOPS is administered but the results are not examined often, thoroughly, or with any clear link to continuous improvement opportunities. Measures in treatment plans are monitored, on the other hand, but these are more difficult to quantify. Is there a need for additional quantitative measures to track client progress, or does TOPS data need to disseminated and used more effectively, such as being tracked from year to year within each program and site? Are treatment plan measures adequate to assess the effectiveness of programs?

- What measures could be used to assess the impact the Department has on the larger community in Dutchess County? For example, programs that work in conjunction with the criminal justice system are perceived as saving the County money: Is there a clear way to quantify this? Similarly, for programs designed in part to prevent or reduce hospitalization, can such data be tracked and linked to people served within specific programs?

- Are there ways to quantify the differences between the Department's performance and that of contract agencies? For example, are client performance measures compared? Are comparisons justified given different clientele in different programs? Are staff turnover rates quantified? Could such measures provide additional opportunities for focusing more systematically on solutions to problems within programs?

- Could Patient Opinion Survey findings be used more effectively and consistently to compare internal versus contract agency performance, at least as perceived by the clients? And should these data be used more intentionally by program administrators as data to help spark discussions of program improvement opportunities? Could the data be broken out and compared in terms of satisfaction on various measures for those clients retaining the same clinician during the year versus those for

whom changes in clinicians occurred? Could such data prove useful in suggesting change strategies for the future?

In addition, numerous other questions about the performance measures currently in use were raised separately in discussions of internal programs and external contract agencies in Chapter VII. A careful review of the measures currently in use in both contract and in-house programs should lead to substantial improvements in making the measures more useful tools for tracking performance of programs in the future.

### *Action Step – Link Performance and Outcome Monitoring to Program Improvement Opportunities*

- ***The Quality Improvement Director and Coordinator should take the lead, with support from the Division Chiefs and Unit Administrators, to develop better measures that are more direct reflections of program goals and targets, and to compare progress on those measures from quarter to quarter and year to year to document the degree of progress made in improving outcomes, and putting into place improvement strategies where goals or targets are not consistently being met.***

To be effective as a management tool, the outcome and performance indicators being tracked must represent reasonable measures of what a program can realistically expect to accomplish with its clients, given their needs and potential for growth. The measures must set realistic targets for improvement, and they must focus, as much as possible, on the types of progress program administrators work to attain in their programs. Assuming that true outcomes are being tracked, program administrators—and their supervisors—should be able to honestly look at their data and know how well they are doing from time to time in accomplishing their goals, and to use the data to take corrective actions and initiate changes if sufficient progress is not being made over time.

Having access to such outcome and performance measures, being able to track the data consistently over time, and being able in turn to link outcomes to financial expenditure, revenue and staffing data, such as discussed in the previous section, should provide program management with much more effective tools than they have had in the past for assessing how they are doing, and suggesting where they need to begin to make changes to be more effective in the future.

Similar approaches should be taken with QI staff and Chiefs in their interactions with contract agencies, who should also be encouraged to identify those measures that best reflect what they are attempting to accomplish in their programs. The key is not letting them, nor internal programs, settle for easy measures such as how many are served, or a small percentage reporting progress on a particular measure or indicating they learned something from a group. To the extent possible, harder, more

empirical data should be used to track actual progress, or avoidance of something such as hospitalization or jail days, that can be attributed to intervention by the program.

## Expand the Role and Impact of Quality Improvement Throughout the MH System

- ***Department leadership should provide strong support and backing, both internally and in discussions with contract agencies, for the expanded role the QI Director and Coordinator will be expected to assume in focusing on monitoring program performance and impact against outcome measures, and on working with program administrators to help them understand how to use such data as a management tool to identify opportunities to improve their programs.***

Along with Division Chiefs, the QI Director and Coordinator would, if our recommendations are followed, become the point persons in a system-wide focus on making programs, both those operated internally and by contract agency, more accountable for their performance, and for taking corrective actions where the performance is not matching up to expectations. This emphasis is also consistent with QI's increased focus, suggested earlier, on orientation, training and staff development and supervision supports for contract agencies. The use of data can be instrumental in efforts to strengthen staff and supervisory development across agencies. Adding the QI Coordinator to Executive Council would also send an important signal that the Department is serious about these interrelated efforts, and is providing the QI focus with a strong voice at the table where policy decisions are made, as well as providing a forum for QI initiatives to be discussed and disseminated throughout the system.

- ***The QI Coordinator, as key to the process of the Patient Care/ Utilization Review process and the quarterly review of contract indicators, should emphasize the value of integrating financial reviews into the discussions of performance and outcome reviews, and tracking of client progress. It would seem to make sense to have financial reviews become a key component of any agency review, so that performance on various measures can be explicitly linked to the financial and management status of the contract agency.***

Fiscal reviews are occasionally built in to some of the QI review processes, but they do not seem to have a consistent role. Holding programs accountable for their performance, whether an in-house program or an external agency, should by definition have a financial component to complement the performance progress review.

## Improve Communication Across the Department and Contract Agencies

- ***The Department should provide leadership around strengthening communications in various ways designed to help rebuild a common culture of continuity across programs and services, and across Department and contract agencies, to the extent possible. A number of possible opportunities for strengthening communications cross-units and/or across agencies have been suggested, including Anasazi and billing task forces, more extensive orientation of new employees, development of mentoring opportunities for new staff, cross-program middle management meetings, and improved dissemination of information from Executive Council***

### Action Step – Explore HIPAA Regulations

- ***HIPAA regulations should be explored and discussed more thoroughly across staff to ensure they are not being interpreted in an overly stringent manner and are not creating barriers to more multi-disciplinary and continuous approaches to treatment and cross-program communication***.

### Action Step – Inter-Department Communication Opportunities

- ***Staff spoke of their desire to have a better understanding of how other programs work, how similar units operate, and to share information about treatment modalities, innovations and other appropriate issues. Knowing and working more closely with practitioners in other programs, sharing ideas, and sharing information about approaches to client care, could help break down some of the barriers and build a new sense of continuity. While time is recognized as a barrier to any such efforts, CGR recommends that the Department seek feasible and realistic, yet consistent means to address this need.***

### Action Step - Involve Line Staff in Decision Making and Change Implementation

- ***Efficiencies can often be created when line staff are allowed to participate in identifying them. They often have insightful ideas about useful change, if only they are asked. CGR heard many of those insights. Procedures should be put into place and encouraged to create a culture where two-way communication is a major priority, staff have specific and trustworthy ways of weighing in with their suggestions, and they can see that their suggestions are being taken seriously.***

A culture of increased efficiency and ongoing quality improvement can and should be disseminated throughout the Department. Most staff, it

seems, could be expected to embrace efforts to increase efficiency and lower costs, and also to be creative in meeting the needs of clients and of employees. However, for this to become a reality, employees at all levels need to feel that they are truly listened to and part of the process.

## Strengthen Internal Programs and Services

A number of suggestions and recommendations are made to strengthen and improve the performance and efficiency of internal Department-operated programs, based on issues and challenges raised in Chapter VII. Some cross-cutting recommendations are presented first, followed by program-specific suggestions.

- ***To the extent possible, program administrators and clinical staff should be removed from all responsibilities for billing contacts with insurance companies and from pre-authorization and recertification activities, except to the extent that clinician-specific information is required.***

This recommendation is consistent with earlier recommendations to develop approaches that emphasize the desire to have billing and clinician staff focusing on what each does best for the common good of the Department and the people it serves.

- ***Unit Administrators should be encouraged to take more responsibility for the performance, cost effectiveness, efficiency and improvements of their units; should be provided with the financial, performance and productivity data needed to monitor such matters; and should then be expected to be held accountable for the successful operation of their units***.

Heretofore, program administrators, and in many cases even Division Chiefs, did not have the necessary information to make effective, data-driven decisions about individual programs and services. They are beginning to have access to such information, though full implementation has not yet been achieved. If new initiatives that have begun to be set in place, and recommendations made in this report, are faithfully implemented, it should become a reasonable expectation that program administrators can be held accountable for improved performance of their operations as they will, for the first time, have the management tools to do so. Most have had the desire to operate as efficiently and effectively as possible, but had no quantitative, objective means of assessing the results. In the future, such information should be available, and the Department's programs and services should be improved in quality, cost effectiveness, productivity and outcomes as a result.

### *Helpline*

As noted earlier, CGR strongly recommends that Helpline remain a County-operated function, and that it receive additional staff to help strengthen its operations. But in order to justify the faith in the program, and to justify the expansion of staff, the Department should implement a number of recommendations outlined below:

- ***The County should authorize the Department to hire one additional full-time staff and one additional per diem position to keep up with the increasing volume of calls received by Helpline, to strengthen the quality of the services, and to reduce or eliminate the need to tell callers that someone will have to call them back***.

Although these positions will be heavily County-subsidized (about 85% of the costs of Helpline are paid for by County dollars), CGR believes that it is a good investment in strengthening this cornerstone of the entire mental hygiene system in the county. To not maintain sufficient staff to keep up with the increasing volume of calls would eventually put the credibility and value of the Helpline operation at risk by weakening the ability to respond to emergencies and crisis calls, and also by reducing opportunities to link callers with needed services at the time of the call. We recommend these positions without reservation, in order to increase the ability of the Unit Administrator to provide adequate staff coverage, especially to cover evening and night shifts that are experiencing rapidly-growing call volumes. The goal, between added staff and the forthcoming new phone system, should be to cover all calls without ever having to tell a caller to call back, as now happens approximately 15 times a day.

- ***The Unit Administrator should find ways to provide more active oversight and supervision of the evening and night shift operations. The most rapid expansion in call volume in recent years has come during those two shifts, yet there are few staff deployed at these times and no supervision present. Occasional visits to observe during the evening and night shifts, combined with ways to monitor and listen in on calls made during those two shifts, are two suggested ways of providing more direct supervision on these growing shifts. It simply is not good business, nor is it fair to the evening and night shift staff, to have no formal supervision during these two shifts.***

It is admittedly difficult to expect the UA for this 24/7 operation to need to appear at the facility to monitor staff performance in the middle of the night, but at the same time it is simply not tenable for such a high-visibility operation to be functioning with no practical ability to monitor its performance during increasingly-high-call periods of the evening and night. The UA must flex his hours occasionally or in some way on a sample basis spend some time on site in the evening and night shifts. Not only would it provide needed supervision and observation opportunities,

but would also send an important signal that the staff on those shifts are considered important enough to be observed, no matter what the hour, by the Unit Administrator. In addition, presumably the new phone system to be unveiled this fall will provide the opportunity, either from home or on an after-the-fact basis, to occasionally monitor samples of calls to make sure that the calls are being handled properly.

- ***Training on selected issues must routinely be provided to all Helpline staff on an annual basis. In particular, several of those interviewed during the study mentioned the need for more sensitivity and compassion to be expressed by particular staff in response to callers***.

How accurate a perception this criticism is cannot be independently judged, but this is something that could be assessed by the UA with more monitoring of calls on each shift. Regardless of the validity of the critiques, the reality is that the only training routinely provided to Helpline staff at the current time is generic training provided to all Department staff. Clearly various types of mandatory training unique to Helpline and the nature of the calls they receive should be provided for both new and experienced staff on an annual basis. These dedicated staff provide a critical and difficult function for county residents, and they deserve to have regular training updates as a mark of the respect the County has for them, as well as for those they serve.

- ***The Department should also update its information on the services to which staff make referrals as part of its I&R and pre-intake responses to callers. The narrative information about each human service provider is relatively brief, and staff wind up making referrals based on their historical understanding of the nature of each service. Those understandings may or may not be based on accurate and current information, and should be updated by formal training and more current information to make sure that all staff have consistent understandings of the range of services available in the county, and that they are using similar criteria and guidelines as the basis for making referrals***.

## Forensic Services and ITAP

These two units of the County's Chemical Dependency Division's services within the criminal justice system provide crucial services that, by all indications, help to reduce the jail population below what it would otherwise be. Since every jail day saved represents significant dollars saved by the County in terms of the cost of boarding out and transportation, these are not services where the County should be attempting to economize.

Referrals processed by the Forensics unit doubled between 2004 and 2007, and during that period of time the unit has expanded responsibilities by

adding monitoring for a new Pre-Trial Diversion program and assessments and staff coverage for four Drug Court programs in various local and County courts. It is not realistic to expect this unit to continue to operate with the same level of staffing as in the past. Furthermore, its supervisor reports directly to the ITAP Unit Administrator, when the nature of the two services, and the volume and variety of what they both do, suggests that they should each be their own units.

The ITAP program has gradually evolved from one strictly focused on first-time non-violent felony offenders, and thereby primarily impacting on state prison days avoided, to one in which now about 25% to 30% of its participants were arrested on misdemeanor charges, and are therefore subject to County jail time in the absence of the program's intervention. Another staff member could help the staff expand its coverage by an estimated 12 to 15 persons during a year.

- ***CGR recommends that these two programs should be expanded by a total of one or two full-time positions effective with the implementation of the 2009 budget. We believe two are justified, one per program, but believe a reasonable compromise, if that becomes necessary, would be to add one in 2009 to be shared between the two programs, with an implied commitment to add the second position in 2010 if data justify the further expansion, as we anticipate would occur. In that case, each program should at that time each have one additional full-time staff compared to now. Whichever approach is determined, any increase in the ITAP staff should be predicated on an agreement that increased cases brought into the program with the added staffing would be misdemeanor cases, in order to ensure that the return on the investment in funding increases in both Forensics and ITAP staff, whether full-time or part-time, would both accrue directly to the local jail and thereby save local tax dollars with every resulting jail day saved.***

In CGR's estimation, to not expand these two programs, at least by adding one shared position, and preferably both, would be a classic case of "penny wise, pound foolish."

- ***Because of the increasing role and responsibilities of the Forensics unit, it no longer makes sense to have the unit headed by a supervising social worker who in turn reports to the UA of ITAP. The responsibilities of the Forensics unit are such that the unit should be made into its own independent unit, and the head of the unit should be promoted to the UA position.***

- ***Although this would need to be tested, CGR believes that the UA of ITAP could pick up a small caseload under two assumptions: that he no longer supervises the Forensics unit, and he can be freed up from***

***pre-authorization responsibilities that hopefully will be absorbed by the Billing unit. If those two events occur, we recommend that the UA at least experiment with the assumption of a small caseload, which could further expand the impact of this program on the criminal justice system.***

- ***Although not actually part of the Forensics unit, we will add a recommendation here related to a similar program within the Chemical Dependency Division. We suggest that it may be possible to free up some of the time of the UA of the Jail-Based Team so that additional time can be devoted to providing more direct followup to the cases referred to this program in order to maximize the proportion of cases that actually enter a direct treatment service, thereby helping to increase the probability of having a long-term impact on criminal justice recidivism and subsequent reduction in jail time.***

## Special Services Team

- ***This program costs the County very little money, and it could probably cost even less if the Unit Administrator for the SST could be freed up from significant Billing-related tasks and as a result, add a partial caseload of as many as 10 persons, thereby expanding the program's active caseload by about 9%. Since the UA's salary and benefits are already included as costs against the program, any additional reimbursable cases that she could supervise would just add to the program's revenues, with no marginal increases in costs. We recommend such a caseload expansion, assuming that the Billing-related tasks can be absorbed by the Billing unit, which we believe is feasible***.

- ***The program should consider co-locating some of its staff with one or more of the County's continuing day treatment programs in an effort to minimize the program's growing transportation costs resulting from its focus on going directly to the clients, who are scattered throughout the county. If this happens, it may also be possible to develop a partnership with day treatment staff who would help with some of the program's outreach efforts.***

- ***The County and Department should explore ways that the SST might consider a fruitful partnership with the NYS Regional Assertive Community Treatment (ACT) program, which has a somewhat similar mission and target population.***

As noted in Chapter VII, there are, despite the apparent similarities of the two programs, also many differences that may preclude a formal partnership or merger in the future. On the other hand, if there are possible opportunities to share resources and reduce administrative costs in some way, they should at least be explored.

## Partial Hospitalization Program

This program appears to be viewed by a number of people, as noted earlier, as being an exemplary program that meets an important need to prevent hospitalization for about half its clients, and reduces the length of hospital stays for the other half. As such, even though the County covers about half its costs, many of those costs may be offset by reductions in hospitalization costs. We were not able to determine the magnitude of such savings. In addition, the numbers associated with the program raise various questions that need resolution in order to make sound decisions about its future. Accordingly, our recommendations for this program have to do more with questions to raise rather than definitive proposals.

- ***The Department should attempt to determine the best estimates possible, on a conservative basis, of the number of hospital days that the program helps avoid per year, and of the dollars saved to taxpayers as a result.***

- ***The program should estimate how much time would be saved if all Billing-related tasks now performed by the UA and a community mental health aide could be performed by the Billing office, and how that time could be productively rechanneled within the program. For example, could the program expand and cover more people, meeting more needs, and generating more revenues with the same staffing level if this were to occur?***

- ***Does the program need to have such a very low client-to-staff ratio to be successful, and are all the team meetings to review client progress each day necessary? Could the same number of staff serve more people, or are the needs of the clients such that this intense staffing model is crucial to program success?***

- ***Could the program expand to a younger 18-25 year-old population, as some have suggested, and if so, could it do so with modifications in the existing model with existing staff, or would entirely new staff be needed, in effect establishing a new program? Could services to a sample of potential clients in this age group be piloted for a short period of time with this program staff to begin to assess the applicability of the model and staffing mix to that age group?***

## Continuing Day Treatment Program

Because of uncertainties as to future funding surrounding day treatment programs, this remains perhaps the most vulnerable of the programs still operated directly by DMH. As recently as the mid-2000s, the CDT programs were generating a net surplus for the County, but that has changed, and there is the possibility that the financial supports for such programs, at least in their current configuration, may erode further in future years. Changes in Medicaid funding approaches to day treatment

could affect the program's future, as could the possibility of PROS funding (Personalized Recovery Oriented Services), and how it is structured and what it does or does not cover. Whatever happens in the future, it is likely that the day treatment programs will undergo some level of change in the future, moving toward a model that places even more emphasis than today on recovery, rehabilitation and functional improvements for the majority of participants in the program. With that context and expectation, we offer the following recommendations:

- ***The Department of Mental Hygiene must continue to be vigilant about the future of CDT programs, keeping in mind the uncertainty of future funding. The Department must continue to do what it is currently doing, assessing different options such as reviewing what a model might look like under a PROS license. It must be prepared to make significant modifications in the model as needed in the future, to adapt both to changing needs of participants and to potential changing financial realities. The Department appears to be on top of this issue and is carefully monitoring the political, funding and regulatory landscape that will ultimately drive the future funding models that will be offered to counties.***

- ***Even without the forced incentive of funding changes, DMH should consider changes in the existing model. It has gradually evolved in recent years, particularly in some of the day treatment sites, but further changes are likely to be needed to place greater emphasis on rehabilitation and seeking personal progress wherever possible in job, independent living, life skills and housing dimensions of life. In particular, it is likely that the programs will need to position themselves to be more relevant to a younger, more aggressive population of participants, for whom rehabilitation, recovery and functional improvements are viable options. This in turn is likely to mean changes over time in the skill sets and credentials of staff in the day treatment centers, and to the possibility of shifting existing staff across centers to meet changing needs and concentrations of program participants in different locations. This may also mean different future hiring patterns in terms of needed skills, experiences and credentials as new staff are hired to replace existing staff as they retire.***

- ***The Department should remain open to the future possibility of contracting out its day treatment centers, or even selected centers, depending on the combination of needs and characteristics of the census from center to center, compared with what future funding models will cover. CGR does not believe that there is justification for such a decision to be considered at this point, for reasons outlined early in this chapter, but it should remain open to the option in the future, should funding options become so restrictive that the County's***

***needs, and the needs of those served by the CTCs, might become better served under a contract model. Should that scenario unfold as a viable option to consider in the future, the Department should do everything it can to ensure adequate funding support for any outsourced programs to minimize problems that have occurred in outsourced clinics to date, e.g., low pay, high staff turnover, inadequate supervision and staff development, perceived lower quality of care.***

- ***The Department should make more careful use of data to define the characteristics of participants and their needs and realistic expectations for improvement and progress in each location, including their expected days of attendance. Better use of such data in the future should enable the Department to best position itself to have in place the most appropriate staffing models and mix of skills to most efficiently and cost effectively meet the client needs site by site. Improved performance and outcome measures must also be developed for the day treatment centers in general, but also on a site-specific basis, in order to best track the measures most reflective of the needs and realistic growth expectations of the clientele and census of each center. The centers have begun this process, but continuing improvements are needed to refine and add to the measures currently in place in each center.***

- ***On balance, CGR believes there is merit to continuing to offer day treatment-related services to residents at the Hedgewood Adult Home. We believe the County receives more benefits from the Department's presence there than would be the case if it were to walk away from involvement at that satellite operation. However, we encourage the Department to be more aggressive in attempting to obtain some financial support or assistance in such things as covering costs of transportation for accessing selected off-site services facilitated by program staff on behalf of residents. It is not unrealistic for the Department to seek at least modest contributions from the home, as a for-profit entity, to offset some of the program's legitimate direct costs.***

## Service Coordinators

In addition to suggested changes in the supervisory reporting relationships of two of the Coordinator positions that were outlined earlier in the chapter, we also recommend the creation of two new full-time Coordinator positions, as follows:

### *Create New Geriatrics Coordinator Position*

- ***The Department should recommend, and the County should approve, the creation of a full-time Geriatrics Coordinator position. As the***

***population continues to age, the needs of the older population are likely to need full-time attention.***

The Coordinator position currently exists on a part-time basis, covered by the Unit Administrator of the day treatment center that also operates the satellite program at Hedgewood. While by all accounts the UA appears to be managing both responsibilities effectively, both jobs should be full-time endeavors. Population projections for Dutchess County forecast significant growths over the next two decades in the senior population, and the likelihood is that growing proportions of that expanding population are likely to need mental health and substance abuse support services. The proportion of older persons currently served by existing mental hygiene programs lags behind their proportions in the total population, suggesting that there is work to be done to reach out to, and better educate, seniors and their caregivers concerning a variety of mental health-related services they should be aware of. The proposed new Coordinator should be expected to focus on strategic planning efforts and to cultivate close working relationships with the County Office for the Aging and other agencies serving the county's older population.

### *Create New Transitions Coordinator Position*

- ***The Department should also create a new full-time Transitions Coordinator position to focus attention on the needs of the population of young adults aging out of children's services and needing to merge into appropriate adult services. The County could opt to create this position as a County employee, or may choose to contract it out.***

In an overwhelming number of our interviews, people in both the Department and in contract agencies emphasized the growing needs to expand services for the 18-25 year-old population aging out of the children's services network of services and seeking services in the adult system. Too often, needed services are not readily available, or the young adult experiences difficulty accessing the services, or the services involve moving into what can be an uncomfortable mix of aggressive young adults with more passive older adults who are more set in their ways—or worse, a mixture of all of the above. There is simply no good system in place to help the young adult navigate this difficult transition from one system to the other. Nor is there a full-time advocate for the service needs of this in-transition population. Both are needed, and both would be addressed by the creation of this proposed new position.

There appear to be two, or even three viable options for the creation of this position. One could have the position be essentially a case manager position funded through MHA to focus on individuals on a case by case basis as they make the transition. We believe this to be the least viable option because of its somewhat limited focus.

There appear to be strong reasons to support either of the second or third options. The second would be to contract with Astor to provide the transition services, with focus both on individual transfers but also the larger systems change/advocacy role. This option would not add a position to the County payroll, but would enable the function to be carried out under a part of the Department's contract with Astor. Because Astor already works with most of the young people who would be affected, there would be an existing relationship and trust level between the provider and the population, thereby helping to facilitate transitions and the development of transition plans on a case-by-case basis. Furthermore, Astor officials have a good understanding of the systemic issues involved and could therefore carry out the systems change/advocacy role well from the beginning.

On the other hand, there is merit to having the Coordinator function provided in-house within the Department, reporting to a Division Chief, as do the other Coordinators. Having the power and authority of the County behind a request for services or a proposal for changes in the system and/or creation of a new program could be helpful, as has been the case with other Coordinator positions. Certainly if this option were to be adopted, the County Coordinator would need to immediately develop a close working relationship with the experienced staff at Astor, thereby ensuring that Astor's role in transition planning would be factored in to anything a County Coordinator would do. The decision may come down to how strongly the County desires to avoid adding a position to the payroll. If that is the case, the Astor contract option would be a very strong alternative, and its long experience and credibility could be enough to help offset not having the position lodged within the County. On balance, however, CGR believes there is a slight advantage to having the position be a County position of equal stature with the other Coordinators. The important point is to get the position funded and in operation as quickly as possible under either option.

### *Other Issues Related to Coordinators*

- ***The Department should assess the future structure of the Assisted Outpatient Treatment (AOT) Coordinator position. It is a mandated position, and appears to be effectively carried out with passion by its incumbent, but suggestions were made during the study suggesting that this might be a position, given the relatively small number of cases opened during each year (albeit intense cases needing extensive attention and coordination), that could in some way be coordinated or merged with another position. We encourage the Department to consider whether such viable collaborative possibilities exist.***

- ***The intense, cross-systems work of the Housing Coordinator could, we believe, be simplified if ways could be developed to simplify the application process and paperwork involved in applying for housing***

***options through the County's single point of access system. The process is over seen by the Housing Coordinator, and we believe the process could be expedited, and her workload made more efficient, if the application process could be simplified. We encourage efforts to make the process less cumbersome, to the benefit of all involved.***

## Strengthen External Programs and Services

A number of suggestions and recommendations are made to strengthen and improve the performance and efficiency of external programs operated on a contract basis by various agencies, based on issues and challenges raised in Chapter VII. Some cross-cutting recommendations are presented first, followed by agency-specific suggestions.

- ***The County Department of Mental Hygiene should place the highest priority on strengthening its oversight and collaborative working relationships with its contract agencies, in order to strengthen this key component of the overall MH service system.***

Because many of the contracted services are critical cornerstones of the overall system (e.g., mental health and chemical dependency clinics, children's services, case management services), it is crucial to the success of the system that they offer services of the highest possible quality. This report has presented evidence that that is not always currently the case, due to resource limitations which lead to less experienced, less credentialed clinician staff in key positions serving large numbers of county residents; high staff turnover rates; and insufficient focus on training, staff development and supervisory support for line staff.

To help address these issues, CGR has suggested earlier in this chapter a number of initiatives that the MH Department should take to strengthen its support of, and investment in, the key contract agencies. Those include:

- strengthening DMH staff and possible contractual support to provide expanded orientation, training and staff development resources directly to contract agencies, effective at the earliest possible time such services can be coordinated and put into practice;

- a strengthened presence of the Department's Quality Improvement staff to work with agencies to improve their internal focus on quality improvement and to provide direct assistance in helping agencies to identify and act on improvement opportunities to strengthen their core services; and

- the use of improved outcome and agency performance measures to help identify improvement opportunities and to enable the Department to more effectively hold contract agencies accountable for returns on the investments being made in their services.

The County over the years has made conscious choices to downsize its direct service provision within the MH Department. In general, the transition to contract agencies has worked effectively and has reduced County costs to less than they would have been had the services remained within the County. However, the price of these decisions has been some apparent reductions in the quality of care, and in the levels of experience, credentials and skill sets with which that care is being delivered. In order to make up for lost time and cumulative issues that have emerged as the transitions have gone through various iterations, ***the County must now be willing to invest resources into shoring up the core contractual services—perhaps including increased financial support for contract services—while at the same time insisting on receiving a payback in terms of improved services and outcomes in return for those investments. To do less is to undermine the very strengths of the system that the County and DMH have worked hard to put in place over many years.***

- ***The County and Department are encouraged to develop a more timely streamlined process for the approval of contracts between the Department and contract agencies, in order to facilitate the release of state funds filtered through the County to the agencies beginning as early in the year as possible. With the historic problems of CFR delays resolved, and better financial and billing practices being put in place, it should be possible to work out agreements whereby the contracts get worked out between the agencies and DMH early enough at the end of one year that approvals can be processed through the County Executive and Attorney's offices in a timely enough fashion that contract agencies should not have to experience severe cash flow problems awaiting agreed-upon funding.***

We understand that discussions may already be underway in support of resolving this issue, and we encourage them to continue to go forward.

## Hudson Valley Mental Health and Lexington Center for Recovery

- ***The Department should consult with HVMH and LCR officials concerning ways to strengthen their core management and supervision infrastructures. Both have reported difficulties in providing the management supports necessary to effectively manage the agency clinic services. DMH advice about what might make sense, with what resources, and with what accountability expectations, may prove helpful, especially as supplemented by the other supports being offered to contract agencies.***

- ***Both agencies also have significant imbalances in censuses across their respective clinic sites, and imbalances in sizes of clinician***

*caseloads. Both may need to consider shifting staff to create more equitable workloads, as well as considering the possibility of consolidations of services, or reductions of some services to less than five days a week. With clinics typically co-located in the same buildings between LCR and HVMH, joint planning and decisions may be possible that would result in efficiencies of benefit to both, while saving the system overall dollars and still maintaining decentralized services at an appropriate and sustainable level, commensurate with current and projected levels of demand. The Department should provide advice in terms of the impact of any possible changes on contract expectations, and any adjustments that may need to be made.*

- *LCR and the DMH Forensics unit should collaborate on a proposed plan to reduce the level of staff support they both provide to four Drug Courts. Both have numerous other staff demands that make it difficult to also accommodate weekly Drug Court meetings. The two are encouraged to develop a plan to present to the respective judges that provide the courts with needed support services but without placing unrealistic staff demands on these two entities that in turn interfere with other needed staff functions.*

- *LCR and OIT need to find ways to reduce the duplication of data entry that have grown out of separate Anasazi and OASAS system demands. OIT officials have indicated that discussions are underway to resolve the issue, and that at least a partial solution should be possible, with potential significant staff time being freed up as a result.*

### *MHA – Case Management Services*

- *MHA and DMH top officials should develop alternative scenarios to cover various contingencies, should significant modifications be made in the funding formulas affecting provision of case management services. These services at this point are provided at very little direct cost to the County, with even some "surplus" funds returned to the system for one-time additions at the end of most years. The Department should be planning for potential State-level policy changes that may be forthcoming over the next two or three years.*

### *Astor Home for Children*

- *Astor and OIT, like LCR, need to find ways to reduce the duplication of data entry that have grown out of separate system demands. OIT officials have indicated that discussions are underway to resolve at least portions of the issue, and that at least a partial solution should be possible.*

- *As suggested above, DMH should discuss with Astor the possibility of contracting with Astor to provide various types of training or staff*

***development or "train the trainer" types of activities for other contract agencies concerning ways they can each address staff training and development issues more effectively. Astor has expressed a willingness to discuss this matter further, and as DMH considers ways of meeting the proposed investment in training for contract agencies, it should determine early on whether Astor may be interested in being part of the educational and training process.***