Task Force Report:
Review of The Tompkins County
Mental Health and Public Health Leadership Models 2019

Overview

This year marked the fourth year of a shared leadership model for the Tompkins County Mental Health and Public Health Departments. As stated in the December 2015 resolution (see Appendix A) which created this structure, County Administration was charged with reviewing the opportunities and challenges of the structure and providing a recommendation to the Legislature by the end of 2019 regarding how the departments should function in the future.

> *"RESOLVED, further, That beginning in early 2019, Tompkins County will conduct a 360 degree style performance review of the current arrangement to evaluate how well the interim administrative solution is working from the perspective of staff, boards, community members, and other stakeholders;*
>
> *RESOLVED, further, That in the same time period, Tompkins County will form a task force to examine the operations and consider the future directions of both the Health and Mental Health Departments, to include consideration of the advantages and disadvantages of an administrative partial or full merger, identification of the various aspects of their operations and any functions that might be combined, and any lessons that can be learned from other counties that have merged these particular functions;"*

To lead a thoughtful review, County Administration formed and supported a Task Force comprised of three members from the Community Mental Health Services Board, three members from the Board of Health, and the Chair of the Health & Human Services Committee of the Legislature (see Appendix B for the listing of Task Force members). The Task Force was asked to address the above charge and consider the advantages and disadvantages of:

> 1) an administrative partial merger (the current status quo and referred to as the "shared leadership model "in this report)
>
> 2) a full merger of leadership and operations
>
> 3) separation of the leadership and operations of the Mental Health and Public Health Departments

The Task Force was also asked to consider the various aspects of the operations, any functions that might be combined, and any lessons that can be learned from other counties that have merged these functions. The Task Force was not asked to evaluate individuals or their performance. After completion of the review the Task Force was asked to create a recommendation for submission to the County Administrator.

The Task Force weighed the significance of the term "merger" as used in the legislative resolution versus the term "integration," as they are often used interchangeably but at times without similar meanings. While the Task Force recognizes that the term "merger" can be defined as one entity completely consuming another, this is not how the Task Force viewed the term. Rather, the Task Force viewed the outcome of both terms similarly, in that the intention of either "merger" or "integration" in this instance leads to a similar outcome – the creation of one shared department with staff throughout responding to a single vision to serve the public health and mental health needs of Tompkins County residents.

Data Collection Process

The Task Force was formed in April of 2019 and began to meet on a bi-weekly basis in May of 2019.

Task Force members first identified the areas for review. The entire Community Mental Health Services Board and Board of Health were consulted to help define the review areas. The final areas identified for review and included in this report, are as follows:

- Departmental Vision, Mission, and Values
- Leadership Structures, Administrative Functions, and Current Overlaps
    - Organizational Charts
    - Departmental Direct Services Offerings
- Cross Departmental Projects/Programs
    - Electronic Health Record
    - Public Education and Outreach
    - Quality Assurance and Improvement
    - Departmental Planning
- Budget Management
- Legal Implications
- Departmental Advocacy
- Research from Other Communities
- Physical Location
- Client Satisfaction
- Employee Satisfaction
- Employee Turnover
- Community Partner Satisfaction

At each meeting the Task Force focused on areas for review, existing data and supporting materials related to each area, were shared by County Administration and discussed by the Task Force members.

In addition to reviewing existing data and materials, the Task Force also held in-person or phone interviews with the following individuals:

- County Attorney – Jonathan Wood
- Commissioner of Mental Health/Director of Public Health - Frank Kruppa
- Deputy Commissioner of Mental Health – Sharon MacDougall
- Public Health Administrator – Brenda Crosby
- Fiscal Administrator – Jeremy Porter
- Mental Health Medical Director – Gerard Lippert, MD
- Public Health Medical Director – William Klepack, MD
- Administrative Assistant – Shelley Comisi
- Director of Environmental Health – Liz Cameron
- Director of Children with Special Care Needs – Debbie Thomas
- Director of Health Promotions and Public Information Officer – Samantha Hillson
- Director of Community Health – Karen Bishop
- Livingston County Administrator - Ian Coyle, MPA
- Livingston County Director of Public Health/Commissioner of Mental Health – Jennifer Rodriguez, MPH
- Dutchess County Commissioner of Behavioral and Community Health - A. K. Vaidian, MD, MPH

The Task Force also conducted three anonymous surveys to gather feedback from: 1) community partners and Tompkins County legislators, 2) employees of both departments, and 3) the members of the Board of Health and Community Mental Health Services Boards.

A Review of the Information Gathered

This section of the report provides an overview of the data and materials reviewed as well as the Task Force's primary observations about this information.

Departmental Vision, Mission, and Values

The Mental Health Department and Public Health Department maintain separate departmental vision, mission, and value statements under the shared leadership model, although both are reflective of health and well-being for all of Tompkins County. These statements were created via internal teams in each department. The statements are as follows:

Mental Health (updated in 2017)

Our Vision: To be recognized by all members of our community as an innovative, welcoming, and reliable resource for effective mental health and wellness services.

Our mission is to support all members of our community in achieving and sustaining their mental, emotional, physical, and social wellbeing, and to help them reach their personal goals by providing a broad range of effective and individualized services.

Public Health (updated in 2013)

Our Vision: Your Partner for a Healthy Community.

The Tompkins County Health Department's mission is to strive to achieve a healthy community by protecting and promoting public health through education, training, advocacy, and the provision of services."

Our Values:

- We engage our community with compassion and respect.
- We value diversity, transparency, and fairness.
- We work collaboratively with integrity and competence.

Administrative Functions and Current Overlaps

The organizational chart under the current shared leadership model is included in Appendix C.

The organizational chart illustrates the primary areas of focus for each of the Departments, and also demonstrates that there was no integration of these areas of focus, or related direct services, under the shared leadership model. This limits the Task Force's ability to highlight particular areas or examples where services were integrated and the relative strength or weakness of such an approach. This does not mean that it could not be successful, but it is important to point out that there is not data available for the Task Force to assess with respect to direct service provision. The survey feedback and interviews with direct reports did yield insight though on many areas where staff, Board members, and community partners believed that more integration of service provision could occur, if permission was granted to do so. The possible opportunities afforded by integration was more often described in a positive manner, although there were a few who believed that integration of mental health and public health services was not possible or warranted.

The shared leadership model pilot provided more latitude to assess integration of several administrative support functions. Prior to the implementation of the shared leadership model in 2015, services such as State aid, budgeting, accounts receivable and payable, human resources, facility operations and financial management were provided independently in each department. Beginning in 2015, the shared leadership model provided a window of opportunity to develop a new administrative support model that could use existing resources to better meet the needs of both departments. Through attrition, a new structure was

created with an intent to span both departments and streamline common services where possible. For example, a new position of Fiscal Administrator was created upon the retirement of the Fiscal Coordinator at Mental Health that has the potential to be the senior leadership position guiding the administrative support functions of both departments. Currently, the new Fiscal Administrator works primarily in the Mental Health Department and provides assistance on a limited basis to Public Health.

Both departments provide evaluation and direct support services to community members, including therapies, counseling, and referral to community resources. Both departments support individuals and families with developmental disabilities. Both departments are involved in compliance monitoring for community entities and agencies. For a listing of Direct Services offered by the two departments please see Appendix D.

The Health Department's current Community Health Improvement Plan identifies "Promoting Mental Health and Preventing Substance Abuse" as priorities for the county.

Cross Departmental Projects/Programs

Electronic Health Records

At the end of 2014, before the shared leadership model began, a decision was made to pursue a single Electronic Health Record (EHR) for both departments. Each department was searching for a new EHR and it made sense from a fiscal and client-centered perspective to use a single EHR to share information and create a more holistic approach to serving clients.

The first attempt at a single EHR failed. After the failed implementation, the departments were able to secure outside funding from the Delivery System Reform Incentive Payment (DSRIP) Program under Medicaid to pay for the new system. With shared leadership, the departments were more effective in explaining the shared vision to the vendor.

The new EHR went live at Mental Health in April 2019 and in October 2019 the system went live at Public Health. Feedback so far is that the new EHR is more user-friendly and is also is more compliance-driven than the previous EHR, facilitating documenting compliance with regulatory requirements.

Public Education and Outreach

The Health Department has a Health Promotion Program that supports education, outreach, and public information by issuing press releases, maintaining social media accounts and the website, and creating outreach materials for public health initiatives. Mental Health currently does not have such a program. The Public Health Department has three full-time equivalents (FTE) assigned to education and outreach and Mental Health has none. Under the shared leadership, Health Promotion at Public Health began creating press releases and outreach material for Mental Health. This work is limited in scope due to the separation of budgets and time demands.

Quality Assurance and Improvement

Prior to 2015, neither department had a Quality Assurance and Improvement (QAI) staff in place. In response to the Office of Mental Health (OMH) recertification visits in 2016 which found significant deficiencies in the County's compliance with regulatory requirements for mental health services, the Mental Health Department established a QAI program. The Mental Health Department maintains a QAI Team comprised of 3 FTEs. The Public Health Department does not currently have QAI staff.

Each month the QAI Team presents the Mental Health Clinic leadership with data on key measures that are identified in the annual Quality Improvement Plan (QIP) as priorities. The intention is for leadership to be able to track progress and discuss changes that should be made and whether or not improvement occurs. More granular data will be provided to supervisors to share with their staff to implement front line-level changes that are needed to improve service outcomes. The Quality Assurance Team also leads the client satisfaction data collection. They are responsible for analyzing the results of ongoing surveys as well

as conducting focus groups to gather feedback from clients. As the data collection and analysis efforts become more robust over time, the results will then be used to implement change to improve the experience of clients.

It is important to recognize that the Clinic was re-reviewed by Office of Mental Health in 2019 and retained its certification with an indication of substantial compliance, exemplary standards of care and no significant deficits noted in any citations. This represents a significant milestone under the shared leadership model. There were some repeat citations noted, but it was because the same standard was not achieved but for a different reason. For example, during the previous review in 2015/16, the files were missing treatment plans. At the next review, the treatment plans were in place, but they may not have addressed adequately some clinical issues. The same standard was not met, but for a different reason.

There is no centralized quality assurance support in the Public Health Department similar to the Mental Health Department. The Health Department is therefore often left to the bare minimum resource support for quality assurance, which is typically focused on ensuring compliance with regulations that govern their work. There are limited or no resources to address broader quality improvement initiatives.

Under the shared leadership model, there is limited sharing of quality assurance resources between the two departments and only when time permits. For example, the QAI Team at Mental Health helped the Public Health Community Health Services Division process map their services as they worked to develop and expand the maternal and child health program.

Departmental Planning

The Public Health Department is required to submit annual updates to NYS Department of Health on the current Community Health Improvement Plan (CHIP). The CHIP is informed by data collected through a Community Health Assessment (CHA) process. The CHA collects information and data on the health status of the community, identifies health disparities that exist, and establishes priorities aligned with the NYS Prevention Agenda. Similarly, each year the Community Mental Health Services Board develops a Priority Plan with the support of the subcommittees. The Priority Plan is intended to guide both the Mental Health Department and the State Office of Mental Health on how to direct resources in the community. The Priority Plan and the Community Health Assessments are aligned with the NYS Prevention Agenda.

Under the shared leadership model, there is more coordination between staff members within the departments on the CHIP. For example, the Deputy Mental Health Commissioner is on the CHIP steering committee and is using the Community Mental Health Services Board's Priority Plan to develop integration with the CHIP.

Budget Management

The Public Health Department budget has come in under the projected County local share for the past eight years. The Mental Health budget came in under budget in 2017 and 2018, for the first time in over a decade. In 2015/16 the Office of Mental Health noted the lack of compliance and adherence to regulatory requirements within the clinic and demanded that corrections be instituted or face closure of the clinic. The shared leadership model presented opportunities to address concerns raised by the OMH report including changes in budget practices, efficiencies, and additional resources for other activities. With improvements made by the billing team and increased training, the Mental Health Department has been able to gradually increase revenues through billing and maximizing their resources. In 2016, 30% of the clinician's time was used for direct service. By 2019, at least 60% of the clinician's time was being used for direct service. As a result of enhanced revenues, the Mental Health Department was able to reinvest in the department and the community by adding a Mobile Crisis Team and providing funding to the Mental Health Association.

Legal Implications

Since Tompkins County did not pursue a fully integrated/merged model in 2015, there were few legal implications that had to be immediately addressed. To operate currently as a shared leadership model, the Commissioner/Director and Deputy Commissioner worked with the Office of Mental Health, Office of Addiction Services and Supports, and Department of Health to address regulatory concerns related to the shared leadership under a single Department Head. A main interest of the regulatory bodies was ensuring that there were people within the leadership structure who met the legal requirements of both the Public Health Director and the Director of Community Services. This did not necessarily have to be the same person, nor did it have to be a single individual at the top of the leadership hierarchy. This was accomplished via the organizational structure as depicted in Appendix C.

Precedent exists for integrating/merging Mental Health and Public Health departments through the New York State regulatory bodies as multiple other counties have completed such a process (the Task Force had discussions with two of these counties which is described later in this report). The Task Force is not aware of any reason why legal responsibilities attributed to either the Mental Health or Public Health Department could not be met with an integrated/merged model.

As far as licensing, both departments are licensed by New York State under Public Health Law Article 28 and Mental Hygiene Law Article 31. This did not change under the shared leadership model. It is important to note that the regulatory systems are undergoing some change as New York State has become focused on improving care for the whole patient. There could be modifications to regulatory requirements in the future which will require changes on our part, regardless of the model used in Tompkins County.

The governing boards of both Departments – the Board of Health and the Community Mental Health Services Board – continue to function independently under the shared leadership model. A member of each Board tries to attend the meeting of the other; and the agenda of both Boards meetings now includes a report about what happened at the other's meeting. There is also demonstrated interest by both Boards to work together on issues of mutual interest that impact the health and wellness of the community. For example, during the statewide debate regarding the legalization of recreational marijuana, the two Boards formed a joint subcommittee and issued a joint letter.

It is important to note that while integration of the leadership and services of the Departments is legally allowable, the merging of the two boards is currently not allowable under law. Both boards must exist regardless of leadership structure.

Departmental Advocacy

Currently the Mental Health Commissioner/Public Health Director and Deputy Commissioner of Mental Health regularly attend State and Regional advocacy meetings including those held by the Department of Health, Office of Mental Health, Office of Addiction Services and Supports, and the New York State Association of County Health Officials, to name a few. Department leaders reported that the closer collaboration at the local level under the shared leadership model is driving more effective communication and awareness of opportunities at the State and Regional levels.

Research from other Communities

The Task Force met with the Director of Mental and Public Health and the County Administrator from Livingston County, which merged their mental health and public health departments in 2014. County Administration also spoke with the Commissioner of Dutchess County Behavioral and Community Health, which has operated with a merged model since 2016. Table 1 highlights the key points from these discussions. The Task Force found that approximately 35 of 62 counties in New York State operate a county mental health clinic.

Table 1: Discussions with other Counties

	Livingston County	Dutchess County
Advantages or Successes	Shared fiscal processes, streamlined staffing, expanded services, one focus on departmental goals of health for all, more power within both agencies to make changes at a community level. Multiple locations provided additional service opportunities.	Smaller workforce, increased efficiency, saved money, comprehensive approach, holistic services.
Challenges	Misconceptions and communication challenges about the integration process and outcome, health and mental health goals are not always aligned, operational/staff buy-in is important.	Some employees believe the departments should be independent of one another. Finding a mission and identity within units. Determining the strategic plan going forward for integrated departments. Creating buy-in from employees and maintaining standard of service.
Strategy	Created a transition team comprised of employees from both departments to help develop action items and to ease the merger. Started with one specific area (fiscal) as a pilot so that is wasn't overwhelming. Leadership met with each staff member to review the merger and to debunk any rumors.	Downsized mental health services administered by Director of Community Services (DCS), contracted these services out to organizations in the community. Downsizing made integration possible in this case. Commissioner provided latitude for the DCS to run the Mental Health side of the department.
Lessons Learned	Transparency is key. Regular communication so that staff feel involved in the process. To acknowledge and not minimize their program area by putting them under one umbrella. Ensure communication is bi-directional and that we leveraged the staff and organizational strengths in our department. Taking on strengths of each department to improve is very helpful.	The integration is an ongoing process that is 5-6 years in change. Scrutinize your programs for overlaps and efficiencies. Consider opportunities and challenges, like do we need 24hr services? Integration must be backed by solid, philosophical motivation (ex. believing in holistic health).

Physical Location

Currently the two departments are located in two separate locations. The Public Health Department offers a majority services at their Brown Road location in Lansing and the Mental Health Department offers a majority services at their Green Street location in the City of Ithaca.

Under the shared leadership model, the Director/Commissioner shares time at both locations, as does his Administrative Assistant. However, there is currently no co-mingling of departmental direct service provision.

Client Satisfaction

The Mental Health Department serves approximately 1,800 clients on an annual basis. In the past four years, the caseload was highest in 2016 with 1,998 clients compared with 1,963 clients today. There was some variation in 2017 and 2018, with the number of clients dipping to 1,748 in 2018, although that has since rebounded this year to 2016 levels. It is more challenging to count the total number of people served by the Public Health Department due to the nature of its programming, which is

not always in the form of direct service to an individual client similar to mental health. The annual number of clients served by public health programs where interaction is more "countable" include: Children with Special Care Needs, which sees 550 young people; Community Health Services, which sees 1,200 families through Women, Infants, and Children (WIC) programming and 150 families through Maternal and Child Health; and Environmental Health, which provides services to over 1,000 permitted facilities. Not included in this count are the broader populations that are served through communicable disease programming, health promotion programming, or lead prevention programs, as examples.

Due to differing regulations, client satisfaction is measured in different ways within the Mental Health and Public Health Departments. At Mental Health an annual client satisfaction survey is conducted among all clients. At Public Health, divisions collect information on a program-by-program basis using different scales and questions. The Task Force was not able to assess Public Health Client Satisfaction data due to small sample sizes and differences in how client satisfaction is measured. Therefore, at this time, it is not possible to compare client satisfaction at Mental Health with Public Health.

The Task Force reviewed the results from the 2016, 2017, and 2018 client satisfaction surveys from the Mental Health Department. Given the amount of data available from these surveys and that they were recently administered, the Task Force did not conduct additional surveys of clients.

The results of these surveys are available in Appendix E. The Task Force notes that the questions asked differ from year-to-year so there is some challenge in making comparisons across time. With respect to the Mental Health Department, the Task Force observed that the 2018 results reveal that clients are reporting that they "strongly agree" or "agree" with most of the metrics suggesting a positive experience in interacting with the Department. Some of the strongest positive responses were to the statements:

- I would recommend Tompkins County Mental Health Services to others.
- I feel safe in the building.
- I feel heard and understood by my clinician.
- Staff were willing to see me as often as I felt it was necessary.
- The appointment times offered are convenient for me.

The Task Force concluded that the level of satisfaction with the Mental Health Department under the shared leadership model has remained steady or improved.

Employee Satisfaction

The Task Force reviewed the 2018 Workplace Climate Surveys for both Departments, and compared these results to both the 2015 results as well as the 2018 county-wide results. The full results are available in Appendix F.

With respect to the Mental Health Department, the Task Force notes that the scores increased overall since 2015. The scores specific to leadership are lower than the County as a whole, but they too have increased over time. In summary:

- 82% of Mental Health Employees participated in the 2018 Climate Survey which is up from 58% participating in 2015
- 86% (43 questions out of 50) have scores that have increased since 2015
- 22% (11 questions out of 50) have scores higher than the County scores in 2018
- 50% of employees believe their performance evaluations provide meaningful information
- A lower percentage (down from 47% to 42%) of employees indicate that "The workplace is not seen as attractive to employees"
- However, 25% of employees don't believe a long-term career is available to them
- While improving, only 48% of employees believe the workplace is actively seeking to recruit to diverse people.

- Inclusiveness is the lowest ranked category for the Mental Health Department
- Of concern is that less than 50% of the employees believe their opinions are part of decision making

The Public Health Department has seen similar improvements over time. More specifically:

- The number of survey participants increased from 2015 (n=30, 45%) to 2018 (n=43, 64%)
- 80% (40 questions out of 50) have scores higher than the County scores in 2018
- 78% (39 questions out of 50) have scores that have increased since 2015
- 20% (10 questions out of 50) have scores lower than the County scores in 2018.
- The categories of leadership, leadership effectiveness, accountability, and work satisfaction have all seen significant increases in their scores.
- Communication has improved across the department
- People from different departments work well together, but there have been some decreased scores in relation to diverse groups working together
- Employees would like to grow their careers within Tompkins County, but training opportunities are not seen as accessible to all employees

Employee Turnover

Each department employs approximately 65 employees per year. The Task Force reviewed the number of new hires (see Table 2) and reasons for employee turnover (see Table 3) in each Department. It is challenging to draw definitive conclusions from the data. For example, resignation from a position does not necessarily mean an individual is no longer employed by the Department or County. The Public Health Department has experienced more new hires as well as turnover than the Mental Health Department. The data demonstrates that the Public Health Department newly hired 50 individuals since 2015, but also lost 71 during that same time period. The Mental Health Department had 34 new hires, with 45 individuals separating from the Department. Turnover, as well as the reasons for turnover, has been relatively stable for both departments since 2015.

The following information is provided by the Tompkins County Human Resources Department with 2019 information consisting of information through October 2019.

Table 2: Hires at Public Health and Mental Health

New Hires

	PH	MH
2013	8	7
2014	10	6
2015	13	5
2016	14	13
2017	4	8
2018	13	6
2019	11	6

Table 3: Separations at Public Health and Mental Health

Separations

	PH							MH						
	'13	**'14**	**'15**	**'16**	**'17**	**'18**	**'19***	**'13**	**'14**	**'15**	**'16**	**'17**	**'18**	**'19**
Removal*	2	3	11	1	2	0	0	2	1	4	0	0	1	0
Retire	2	4	6	2	2	1	1	7	2	4	4	3	3	1
Resign	7	2	6	6	6	9	6	2	9	3	3	7	7	7
Deceased	0	0	0	0	0	0	0	1	0	1	0	0	0	0
Temp/Seas	0	0	1	5	3	3	2	0	0	0	0	1	0	0
Terminate	0	0	0	0	0	2	0	0	0	0	0	1	0	0
Layoff	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Totals	**11**	**9**	**25**	**14**	**13**	**15**	**9**	**12**	**12**	**12**	**7**	**12**	**11**	**8**

*Removal **

1. This is a temporary appointment such as project assistant and that appointment has ended. This is different than seasonal temporary appointments.
2. A person that did not successfully complete probation and was removed during the probationary period
3. It could, although unlikely, mean that they were terminated.

Employee Survey Feedback

In addition to the Climate Survey data described earlier that is collected by the County, the Task Force fielded an additional anonymous survey in August 2019 of all employees of the Mental Health and Public Health Departments. The response rate was approximately 48% with 63 of 130 employees of the two departments participating. We received responses from 31 Mental Health employees (from a staff of 63) and 32 responses from Public Health employees (from a staff of 67). The survey sought their input about which organizational structure they preferred, as well as the challenges and opportunities associated with integrating/merging or separating the two departments.

Table 4 summarizes the employee feedback related to the preferred organizational structure:

Table 4: Employee Feedback Regarding Organizational Structure

Response	All Respondents	Mental Health Employee Respondents	Public Health Employee Respondents
Unsure and/or had no opinion about the separation or integration/merger of the departments	38% (24 out of 63)	41% (13 out of 31)	34% (11 out of 32)
Departments should fully separate	21% (13 out of 63)	23% (7 out of 31)	19% (6 out of 32)
Departments should fully integrate/merge	41% (26 out of 63)	36% (11 out of 31)	47% (15 out of 32)

Table 4: Employee Feedback Regarding Organizational Structure

Response	All Respondents	Mental Health Employee Respondents	Public Health Employee Respondents
TOTAL	63 respondents	31 respondents	32 respondents

In addition, the survey included several open-ended questions regarding the opportunities and challenges presented by integration/merger or the separation of the two departments. Summary comments are included in Table 5 and represent common themes. A more detailed summary of survey respondents' comments is included in Appendix G.

Table 5: Summary of Employee Open-Ended Survey Responses

	Opportunities	Challenges
Integration/Merger	● Save money/effective use of resources ● More resources ● Greater coordination/increased synergy ● Sharing of information/communication ● Continuity of care ● Co-location and/or multiple locations ● Decreasing stigmas, particularly around mental health ● Holistic client care ● Shared record system ● Greater possibility for staff advancement	● Difference of mission/culture between departments ● Loss of focus ● More bureaucracy ● Two locations ● Combined budgets ● Integration of services ● Leadership spread too thin/focused on two jobs ● Increased workload ● Resistance to change, disruption ● Lack of time ● Poor communication/authoritarian decision making ● Finding a leader who is well-versed in both public and mental health ● Allowing equal attention to both public and mental health
Separation	● Dedicated, manageable leadership ● Greater access to leadership ● Director involved in day-to-day operations ● Better communication ● Clear focus on program responsibilities ● Specialization/enhancing skills ● Focused resources ● Clear planning ● Advocacy for specific issues ● Improving services for clients	● Communication issues ● Lack of comprehensive, holistic services ● Perpetuation of the idea that physical and mental health are mutually exclusive ● Continues stigmatization of mental health ● Implementing a new administrative structure ● Loss of momentum/separation of currently joined services ● Financial burden, inefficient ● Finding a new/appropriate leader ● Logistical issues with two locations ● Unsustainable model to be separated

Board Member Survey Feedback

The Task Force fielded an anonymous survey of all Community Mental Health Services Board (14 members total) and Board of Health (8 members total) members. The response rate was 68% with 15 of 22 combined Board members participating. We received survey responses from 10 members of the Community Mental Health Services Board and 5 members of the Board of Health. The survey sought their input about which organizational structure they preferred, as well as the challenges and opportunities associated with integrating/merging or separating the two departments.

Table 6 summarizes the Board member feedback related to the preferred organizational structure.

Table 6: Board Member Feedback Regarding Organizational Structure

Response	All Respondents	Community Mental Health Services Board Respondents	Board of Health Respondents
Unsure and/or had no opinion about the separation or integration/merger of the departments	20% (3 out of 15)	20% (2 out of 10)	40% (1 out of 5)
Departments should fully separate	13% (2 out of 15)	20% (2 out of 10)	0%
Departments should fully integrate/merge	60% (9 out of 15)	50% (5 out of 10)	80% (4 out of 5)
Departments should partially integrated for back office functions, but not services	6% (1 out of 15)	10% (1 out of 10)	0%
TOTAL	15 respondents	10 respondents	5 respondents

In addition, the survey included several open-ended regarding the opportunities and challenges presented by integration/merger or separation of the two departments as well as the current communications within the organization Summary comments are included in Table 7 and represent common themes. A more detailed summary of survey respondents' comments is included in Appendix H.

Table 7: Summary of Board Member Open-Ended Survey Responses

	Opportunities	Challenges
Integration/Merger	• Cost savings/effective use of resources • Interdisciplinary discussions • Improved communication/between boards • Increased ability to fight opioid epidemic • Addressing stigmas surrounding mental health and substance abuse • Holistic approach to health • Streamlining services	• Culture change/buy-in • Sharing leadership • Different reporting structures • Different regulatory structures • Not enough oversight • Logistics, location, staffing • Perception that one area is getting preferential treatment • Mental health not being paid attention to • Cross training would be expensive and time consuming
Separation	• Avoiding the stress of change • Leadership more available • Easy to remain in existing silos • Employees focus on one department • Potential to hire a Commissioner with a mental health background • Expert focus on best practices • More dedicated focus on mental health issues	• Duplication of effort in bookkeeping • High cost of management/costly to public • Not able to communicate/coordinate efforts as easily • Not as easy for departments to educate each other • Missed opportunity to better address health and social service needs • Barrier to holistic approach • Reinforcement of mental health stigmas • Turnover at the top • Lack of mental health expertise in Department Head • Competition for limited resources • Disruption again of work environment

Community Partner Feedback

The Task Force fielded an anonymous survey of nineteen agencies, organizations, departments and associations that compromise community partnerships with the Mental Health and Public Health Departments. The response rate was 14% with 6 of 42 invited community partners from these organizations (for a listing of the 19 organizations see Appendix I). The survey sought their input regarding which organizational structure they preferred, as well as the challenges and opportunities associated with integrating/merging or separating the two departments.

Table 8 summarizes the community partner feedback related to the preferred organizational structure:

Table 8: Community Partner Feedback Regarding Organizational Structure

Response	All Respondents
Unsure and/or had no opinion about the separation or integration/merger of the departments	33% (2 out of 6)
Departments should fully separate	0%
Departments should fully integrate/merge	67% (4 out of 6)
TOTAL	6 respondents

In addition, the survey included several open-ended regarding the opportunities and challenges presented by integration/merger or separation. Table 9 provides a complete summary of these comments.

Table 9: Summary of Community Partner Open-Ended Survey Responses

	Opportunities	Challenges
Integration/Merger	• Cost savings • Information sharing • Unified services • Collaboration • Shared resources • Neutralize and normalize stigmas surrounding MH • Cross-training • Greater efficiency • Co-location of services • Emphasis on wellbeing	• Organizational culture • Competing interests of leadership • Clearly defined roles • Removing silos • Physical building space • Resistance at individual/departmental level
Separation	• Creation of jobs • Clarity of roles	• Fragmentation of services • Lack of coordination • Difficult to connect mental and public health services • Finding a new Commissioner • Harder for staff to get to know each other • Added administrative layers

Interviews with Direct Reports

The Task Force conducted interviews with ten staff members that report directly to the Commissioner/Director. These were semi-structured interviews consisting of twelve core questions with additional probing questions and discussion as needed. Three of the direct reports are in Mental Health, six are in Public Health, and one is co-located, working in both departments. Currently three division heads, the administrative coordinator, and Medical Director in Public Health report to the

Commissioner/Director. In Mental Health the Fiscal Coordinator, Medical Director, and Deputy Commissioner report to the Commissioner/Director. An administrative assistant reports directly to the Director/Commissioner.

Eight of the ten direct reports (80%) shared that they believed that the benefits of moving toward a fully integrated/merged structure outweighs any challenges. Two of the ten direct reports (20%) did not believe that the benefits that may be achieved through an integrated/merged structure would outweigh the challenges and would recommend returning to two separate departments. Table 10 compiles a summary of the direct report comments, and Appendix J provides an additional summary of common themes of direct report interview responses.

Table 10: Summary of Direct Report Responses

	Opportunities	**Challenges**
Integration/Merger	● Holistic approach ● Shared understanding, approach, and vision ● Competitive advantage especially related to value-based payment environment ● Shared resources (QAI, education, outreach, and other expertise) ● Learning culture ● Improved outcomes for clients ● Take advantage of different licensing models ● Co-location or multiple service locations	● Current physical separation ● Separate budgets ● Causes anxiety and uncertainty ● Differing regulations
Separation	● Focus on one department ● More access/time with Director/Commissioner ● Might be less expensive ● Ability to focus services ● Return to the “known”	● Backward step ● Short-sighted, will not benefit clients ● Will need to make investment in administrative team for both departments ● Creating shared vision across two departments with two leaders ● Both departments will need to build functional units - QAI, education and outreach, fiscal coordination, etc.

Task Force Recommendation

The Task Force relied on the above data to conduct a 360 degree-style evaluation on how well the interim administrative solution is working from the perspective of staff, boards, community members, and other stakeholders. The information was also used to further address the original charge to consider the future directions of both the Public Health and Mental Health Departments, including possibilities of merger or combination of functions, and any lessons learned from other counties that have merged these particular functions. The Task Force relied on all this data in considering the advantages and disadvantages of:

1) an administrative partial merger (the shared leadership model or the current status quo)

2) a full merger of leadership and operations

3) separation of the leadership and operations of the Mental Health and Public Health Departments

The Task Force does not recommend continuing with the status quo, with an administrative partial merger (the current status quo and referred to as the "shared leadership model" in this report).

This current structure leaves both Departments stuck in a state of paralysis and uncertainty. With the current model, the two Departments are primarily functioning on parallel paths with separate vision and mission statements as well as provision of services to the community. There are two budgets and two organizational charts. With this separation it is difficult to effectively move expertise from one Department to the other because of the restrictions on budget lines and missions. Both departments have delayed completing strategic planning because they do not want to move forward individually pending a final decision on organizational structure, and a shared mission or vision is not in place. While there are a few areas of integration, there are significant untapped advantages that could be achieved with more sharing and integration of operations and services. The current model does not permit leadership to move ahead as they have not been granted the ability or authority to do so. With this paralysis, a state of uncertainty persists, as staff do not know who they will be reporting to next, or if they are part of an experiment that will be undone. The shared leadership model has provided some stability, but there is still a fear of it all going away in the near future if another change occurs and the gains achieved at this time will be lost. Direct reports shared that they felt that the longer the department is under a shared leadership model there will be confusion of the goals of the separate entities and frustration over competing visions and priorities. Staff members also shared concerns that reverting to separate departments will erase important gains that have been achieved. It is important to recognize that the client and employee satisfaction surveys, budget management data, and compliance with regulatory requirements are trending in a positive direction under the shared leadership model. This suggests that further progression toward integration/merger is warranted and may yield additional benefits for Tompkins County residents.

Similarly, the Task Force does not recommend returning to the separate model of a stand-alone Mental Health Department and a stand-alone Public Health Department.

The Task Force acknowledges that some individuals interviewed and surveyed felt that this model would be better as it may result in more focus on each department and their sphere of work. Furthermore, separate leaders could come to their positions with more departmental focus and discipline-specific backgrounds. However, the Task Force believes that continuing to operate as separate departments is inconsistent with current health practice, which emphasizes more integration across services and providers and a holistic approach to caring for clients. We also believe that there are ways to compensate for needed topic-specific expertise within the Department leadership model in a way that does not require that two separate Departments exist. A separated model would reverse many of the efficiencies achieved to date in common activities, such as quality assurance and fiscal coordination. It would also eliminate the possibilities of future synergies that might be achieved with more integration,

for example around health promotion strategies or co-locating physical and mental health services. There would also be a need to replace either a Public Health Director or Mental Health Commissioner. Additional fiscal administration positions (2-3 FTEs) would be necessary at the Mental Health Department as, currently, the Fiscal Administrator is the only fiscal staff within the Department. Another EHR systems administrator would also need to be added to one of the Departments to support the EHR. This seems like a backward step that could potentially duplicate positions, unravel efficiencies achieved to date, and leave the County ill-positioned in the public health/mental health marketplace of the future.

The Task Force **unanimously recommends** that the Tompkins County Mental Health Department and Public Health Department begin the process to become one integrated/merged department, creating a system of collaborative services under a single umbrella.

This should occur throughout the department wherever appropriate, from leadership through service provision. One department will best meet the needs of the clients, staff, and community as public health and mental health will function not just as opportunistic collaborating partners but will be working side-by-side to support progress toward achieving one single vision. As a merged unit, staff members will operate under a shared vision to support clients in achieving better health-related outcomes, be it mental or physical, both at the individual and community level.

Integrating Mental Health and Public Health is not a new concept. As stated in the Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders of 2006:

> "Mental and substance-use problems and illnesses seldom occur in isolation. They frequently accompany each other, as well as a substantial number of general medical illnesses such as heart disease, cancers, diabetes, and neurological illnesses. Sometimes they masquerade as separate somatic problems. Consequently, mental, substance-use, and general health problems and illnesses are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. Moreover, mental and/or substance-use (M/SU) problems and illnesses frequently affect and are addressed by education, child welfare, and other human service systems. Improving the quality of M/SU health care—and general health care—depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients."

The importance of integration of physical and behavioral health was reconfirmed by the United States Department of Health and Human Services in their 2015 report on Innovative Medicaid Managed Care Coordination Programs for Co-Morbid Behavioral Health and Chronic Physical Health Conditions. The authors noted:

> "The prevalence of co-morbid chronic physical and behavioral health conditions is an established driver of spiraling costs and poor health outcomes among Medicaid recipients. States are increasingly deploying new managed care models to help control Medicaid costs and promote improved health outcomes."

The study identified six strategies that support improved health outcomes. The two most relevant to the charge of the Task Force are:

- supporting practice-based change for improved care coordination, and
- coordinating physical and behavioral health care management services.

While this study primarily focused on managed care environments the principles of integration between physical and behavioral health apply to broader health care practice. The Task Forces recognizes that this is important as we consider the future of Mental Health and Public Health in Tompkins County.

The Centers for Disease Control and Prevention (CDC) identifies the need for communities to recognize and address Social Determinants of Health (SDOH) as an overarching national goal, necessary to address pressing health concerns. SDOH include behavior, social support networks, physical and social environment (including violence prevention, communicable disease, substance use), and availability of physical and mental health care. An integrated/merged model is more likely to provide the County with the flexibility and structure to do this effectively than a siloed approach in two separate Departments. The Task Force also notes that historically, public interest and funding grow most quickly when medical issues are identified as public health issues, for example the opioid epidemic.

The Task Force believes that the staff of the two departments are best positioned to develop details of a new organizational structure. However, we do recognize that, besides the new department head, the senior leadership will need to include deputies with operational responsibilities and discipline-specific education, experience, and expertise in mental health and public health. These could evolve from deputy positions.

The Task Force sees the following opportunities with an integrated/merged model:

- **Shared vision of mental and public health for Tompkins County residents**. Staff will be better informed and aware of the departmental offerings and opportunities for services throughout public and mental health, resulting in consumers being able to be more broadly served. For example, a mental health clinician serving a soon to be mom may be better informed of the services provided by the Women, Infants, and Children (WIC) Program if a colleague from WIC is regularly working alongside the clinician sharing their programs' mission in meetings and other forums.

- **Reduced organizational silos.** One integrated/merged department will house all staff under one shared vision and mission, which is an important step in reducing organizational silos. While units may still maintain their functional operations, all staff will be focused in one client-centered direction. It will provide a structure within which we can shift the culture regarding how we approach supporting Tompkins County residents in need of physical and mental health services. For example, it would allow us to identify whether a client/family receiving Early Intervention Services from the Public Health Department might likely benefit from mental health/care management services from the Mental Health Department – and have a process in place for immediately connecting the family with those needed services. Or, a client being seen for mental health services may reveal that smoking is a concern for them or that they are concerned about their health because they have not been able to access needed physical health care services. An integrated/merged model, especially where services are co-located, could result in clients being able to walk down the hall to obtain such services rather than trying to schedule new appointments with different service providers at different locations. It may be especially beneficial for crisis situations where services can be provided immediately without waiting for referrals/transport/coordination.

- **Options for co-locating services**. While two locations may appear to be a challenge, it in fact presents opportunities for services to be provided in different locations to better meet the needs of the community. For example, clients do encounter barriers accessing mental health services in downtown Ithaca and may be more likely or comfortable to access services in an alternate location outside of the city. Regarding staff communication between the two locations, interviews with direct reports indicated that technology can adequately facilitate communication, including access to leadership.

- **Integrated planning services.** More integrated planning may result in common services and improved coordination across units that are currently housed in separate departments. For example, mental health services are discussed in the Community Health Improvement Plan and Community Health Assessments of the Public Health Department, but more could be accomplished with a closer working relationship with the Mental Health Department. Further integration

of these planning processes could be accomplished under an integrated/merged model, resulting in one plan that better serves community needs.

- **Enhanced succession planning.** One proposed administrative structure under an integrated/merged model would be to have four departmental leaders (a Commissioner/Director, two deputies, and a fiscal coordinator). The Commissioner/Director would serve as the strategic leader and visionary for the integrated/merged department. This position would be supported by a team with expertise in public health, mental health, and fiscal coordination. Such a model would improve upon succession planning since the deputies and fiscal coordinator could succeed as the Commissioner/Director in the case of turnover.

- **Increased efficiencies and revenues, which could be reinvested in mental health and public health services.** The Task Force did not assess the budgets under the shared leadership model, nor did we make predictions about what an integrated/merged model may entail with respect to expenditures. The Task Force cautions that assertions that an integrated/merged model will save money are likely incorrect – in fact, any of the models that we pursue are likely to cost more but for different reasons. It is worthwhile to note that over the past three years, the Mental Health Department and Public Health Department have both operated without a funding deficit. This is a result of efficiencies in both departments as well as improvements to the billing processes within the Mental Health Department. As revenues continue to increase, there will be an opportunity to reinvest the funding into the department to continue to enhance service provision.

- **Prepared for alternative payment models.** Partnership with services across the sectors may allow both mental health and public health to be better prepared to function in a value-based payment environment. This includes the potential to expand licensures or service partnerships, to provide additional mental health or primary care services.

- **Coordinated Board actions, where possible.** Coordination of the Community Mental Health Services Board and the Board of Health is a continued opportunity for community support and operations of the department, even though the Boards must operate as separate entities.

- **Elevated focus on mental health and public health.** An integrated/merged department communicates that the range of services provided by each of these departments is a priority for Tompkins County.

While the research points to the need for provision of services in an integrated care model, such integration does pose some challenges in practice. There are a few examples for how this can be done in New York State, but it has not been without challenges. Based on the information we received from our colleagues in other counties, the Task Force is aware that while challenges will exist, they are surmountable based on the experiences of these counties.

The Task Force sees the following challenges that will need to be addressed in a merged model:

- **Streamlined vision and mission statements**. The two departments must be united under a single vision and mission statement, and operate with a consistent set of values. While having a shared vision for mental and public health may reduce the stigma and permit clients to access both services in a more streamlined way, it is also possible that one service could be dwarfed by the other, i.e. the focus on physical health would mean there would be less focus on mental health and vice versa. It would also be important to recognize significant community concerns about stigma attached to mental health or public health services in such a model, and work diligently to combat such polarization. There may also be specific essential services that could feel dwarfed inadvertently. For example, the critical need for

environmental health services could easily be overshadowed by the large number of services that are focused on human relationships rather than engineering.

- **Redefined chain of command**. A more integrated/merged leadership model will require a formal redefinition of the chain of command, which should include further empowerment of divisional leaders to make key decisions. The leadership model must be clearly communicated to all staff, and clients where appropriate. A new leadership model will likely entail a change in "access" to certain leaders, although this should not be equated with a lack of expertise or an inability to make decisions. The Task Force is comfortable with the ability to structure an effective leadership hierarchy where sufficient visionary and strategic leadership exists coupled with other management team members who have specific expertise and decision-making authority.

- **Refined modes of communication**. Communication across the department and functional units may be more difficult since integrating/merging the two departments creates a larger organization. A concerted focus on how communication will flow will be needed.

- **Harmonized chart of accounts**. Mental health and public health are traditionally funded from different sources, all with their own rules and regulations. This impacts the fiscal chart of accounts and ways that reimbursements flow from the State agencies. This is a key challenge that will need to be addressed, however there is precedent set by other counties that could be followed as a template for success.

Next Steps:

The Task Force strongly recommends that a strategic workgroup of staff from both departments is formed as soon as possible to provide input and feedback regarding the integration/merger process. This should occur with deliberate speed to avoid prolonging the existing state of paralysis and uncertainty. In particular, the following topics will need to be addressed (not necessarily in this order) to move forward with integration/merger:

- Identify the name of the integrated/merged department and its brand in the community.
- Develop a shared vision and mission, as well as a consistent set of values, to guide services with goals of improved population health and holistic care for Tompkins County residents.
- Define and implement a new organizational structure to include a single department leader and associated management infrastructure with necessary expertise. This should include assessing individuals currently in these positions. Also, given some of the recent departures of staff in leadership roles, this will require hiring for certain positions.
- Institute clear communications of positional responsibilities and the chain of command for decision making.
- Determine the process for including broad representation from personnel, clients, and community partners in the decision-making process, as well as a mechanism for ongoing and transparent communication regarding decisions.
- Discuss with regulatory authorities the vision of the merged organization and any accommodations that may be needed in regulatory structures.
- Create a shared services culture, identifying areas where integration of physical and mental health services may be beneficial for Tompkins County residents.
- Review opportunities where "back-office operations" such as fiscal coordination, quality assurance, and education and outreach, might benefit from further integration/merging.
- Review opportunities provided by different licensing models and the service delivery provided to clients.
- Review opportunities and challenges provided by two physical locations, including the possibility of co-locating certain services at the two sites.

- Provide continuous opportunities for feedback and input on the planning and implementation processes, using feedback to make improvements.
- Provide regular briefings and updates to both Boards throughout the process.

Conclusion

The Task Force concluded that it would be a disservice to the residents of Tompkins County to continue to treat health in the silos of physical and mental health. The synergies created by the two departments becoming one, which will serve all clients as whole persons, are vital in supporting our community. The Task Force states unequivocally its support for the value of both mental health and physical health services. Pursuit of an integrated/merged model should not diminish the focus or relative worth of one service over the other. They are both integral to the health and wellness of Tompkins County residents and should be treated as such.

Change can be a challenge and has inherent risk, however the risk of change does not outweigh the benefits that could be achieved with a fully merged model. It is of the upmost importance that as this model is developed and implemented that the department and County leadership take many steps to plan for the success of our programs.

Given the Task Force's concern with the ambiguity associated with the shared leadership model, we recommend that the integration/merger process begin immediately with a goal of having a fully integrated/merged model by the Summer of 2021.

Appendix A: Resolution 2015-279

WHEREAS, since March 2015, a vacancy in the position of Tompkins County Commissioner of Mental Health has been filled on an interim basis by Tompkins County Public Health Director Frank Kruppa, and

WHEREAS, the efforts of Director Kruppa to simultaneously lead both the Health and Mental Health Departments have provided welcomed stability to the Mental Health Department, and

WHEREAS, a proposal has been made to extend the duration of this combined department head arrangement, and

WHEREAS, there are differing opinions as to whether joined or divided leadership of the Health and Mental Health Departments produce better outcomes or lower costs, and

WHEREAS, there are substantive differences in the fields of public and mental health but also opportunities for shared services and merged operations, and

WHEREAS, it has been recommended that a final decision on a permanent management configuration be deferred until more local experience and national data has been studied and evaluated, and

WHEREAS, it has been recognized that however this plays out that it is necessary to fill the position of Deputy Mental Health Commissioner and a two-month national search was begun in October 2015, now therefore be it

RESOLVED, on recommendation of the Budget, Capital, and Personnel Committees, That this Legislature authorizes the County Administrator to implement a plan for the responsibilities of the Public Health Director to be expanded to include the responsibilities heretofore granted to the Commissioner of Mental Health for the period December 1, 2015, through December 31, 2018, plus such additional time in 2019 as the Legislature deems necessary to evaluate the performance of the combined department head model, determine whether that model shall continue, consider other organizational alternatives, and accommodate any organizational transition required by the Legislature's decision,

RESOLVED, further, That during the course of the 2016-2018 period, the single department head plan be implemented on an interim basis in substantial compliance with the "Report to the Health and Human Services Committee regarding a proposal for combined leadership of the Mental Health and Health Departments" prepared by the County Administrator and entered into the record of this proceedings,

RESOLVED, further, That beginning in early 2019, Tompkins County will conduct a 360 degree style performance review of the current arrangement to evaluate how well the interim administrative solution is working from the perspective of staff, boards, community members, and other stakeholders,

RESOLVED, further, That in the same time period, Tompkins County will form a task force to examine the operations and consider the future directions of both the Health and Mental Health Departments, to include consideration of the advantages and disadvantages of an administrative partial or full merger, identification of the various aspects of their operations and any functions that might be combined, and any lessons that can be learned from other counties that have merged these particular functions,

RESOLVED, further, That based on the evaluation, the results reported by the joint task force, and other factors this Legislature may deem pertinent to its decision, a vote by the Legislature to re-authorize the combined department head model shall take place expeditiously, and by no later than December 31, 2019, with a majority approval of the Legislature required to re-authorize the combined department head model,

RESOLVED, further, That the salary of the Public Health Director shall be set at $119,180 effective December 1, 2015, and shall thereafter be adjusted by the same percentage increase or decrease, or by any change in benefit or benefit contribution, applied to other employees paid pursuant to the County's management salary and benefit compensation plan provided, however, that if the Legislature does not re-authorize the combined department head model, the salary shall return to the equivalent of the current Labor Grade for the Public Health Director on December 31, 2019, or such earlier time as the Public Health Director's responsibilities pertaining to the Mental Health Department conclude,

RESOLVED, further, That an Administrative Assistant 3 position be created in the Mental Health Department, and assigned to assist the Public Health Director in his dual departmental responsibilities, provided, however, that if the Legislature does not re-authorize the combined department head model, the Administrative Assistant 3 position will be abolished effective December 31, 2019, or such earlier time as the Public Health Director responsibilities pertaining to the Mental Health Department conclude.

SEQR ACTION: TYPE II-20

Appendix B: Task Force Members

Board of Health Representatives

President of the Board: Christina Moylan, PhD

Vice President of the Board: David Evelyn, MD, MPH

At-Large Member of the Board: Janet Morgan, PhD, RN

Community Mental Health Services Board Representatives

Chair of the Board: Khaki Wunderlich, JD

Vice Chair of the Board: Mary Hutchens, LCSW

At-Large Member of the Board: Sheila McEnery, MSEd

Representative of the Tompkins County Legislature

Vice Chair of the Legislature and Chair of the Health and Human Services Committee: Shawna Black

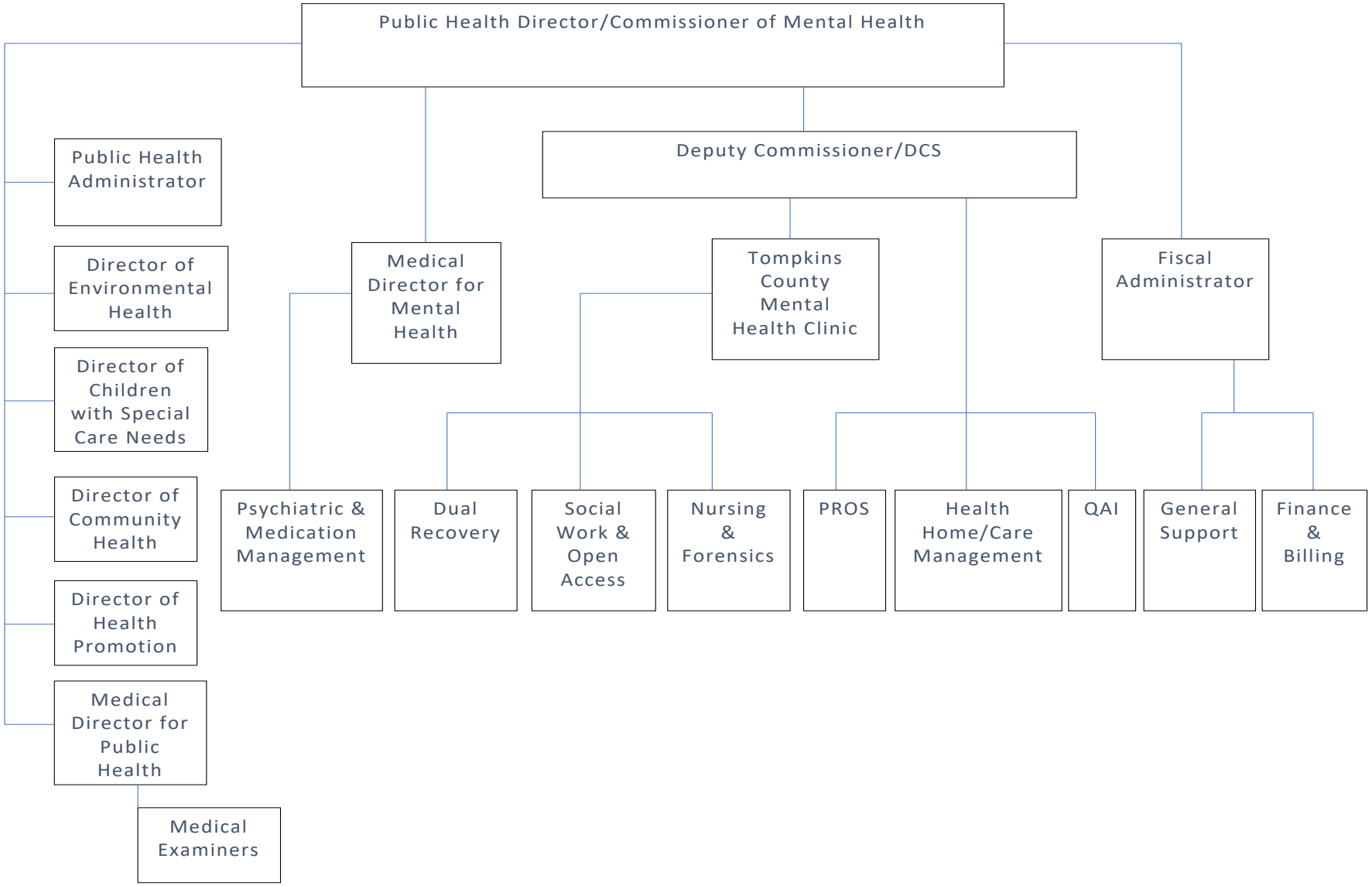
County Administration Staff

County Administrator: Jason Molino, MPA

Deputy County Administrator: Amie Hendrix, MSL

Administrative Assistant: Autumn Edwards

Appendix C: Shared Leadership Model Organizational Chart



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Appendix D: Direct Services Offerings of Both Departments

Public Health Offerings

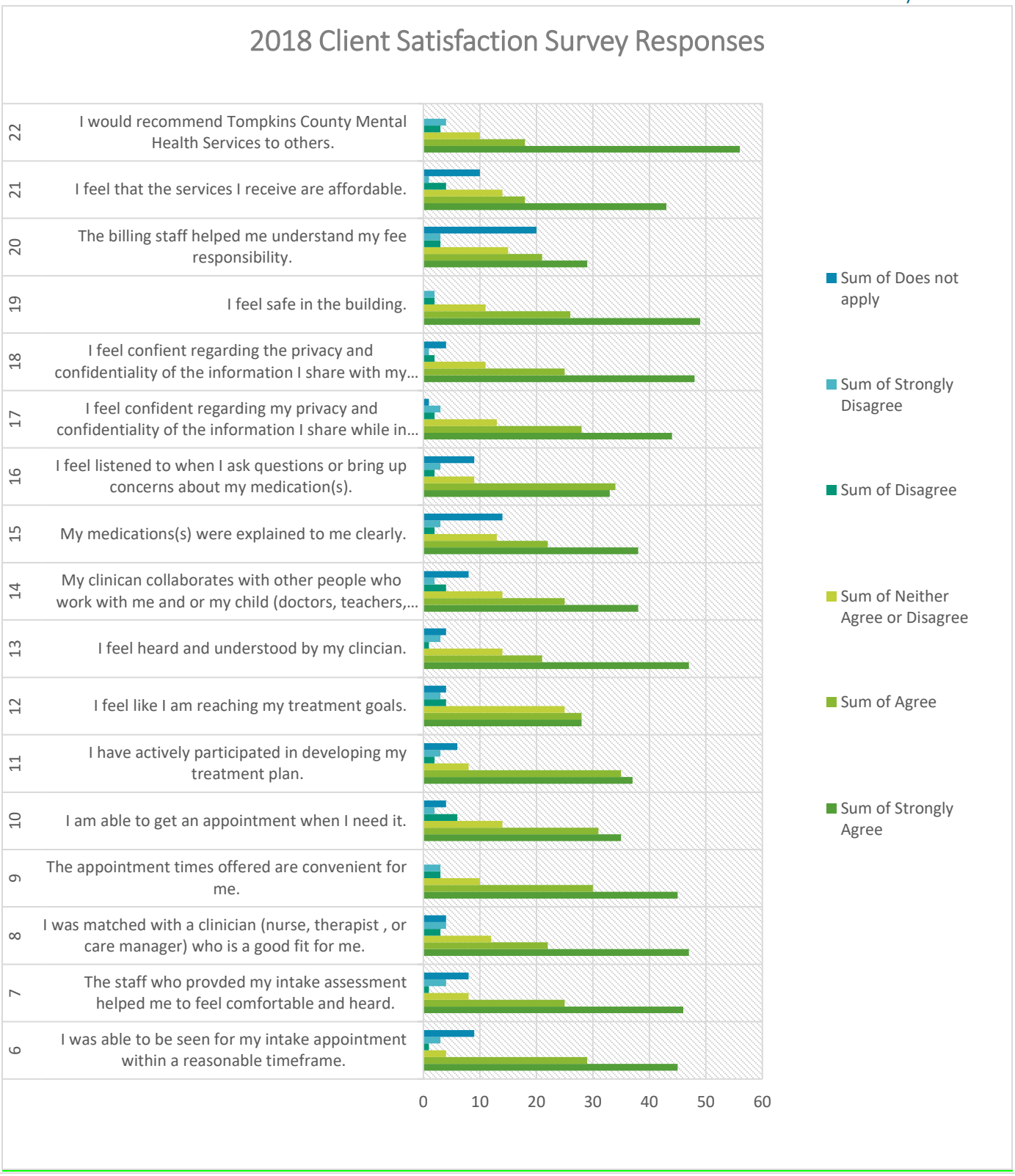
- Children with Special Care Needs
  - Early Intervention/Pre-K: provides evaluation and treatment for infants, toddlers and children needing assistance with feeding, speech, hearing, vision, other developmental delays
- Community Health Services
  - Communicable diseases: tracks the incidence of approximately 30 reportable diseases such as hepatitis B & C, Lyme disease, meningitis, pertussis
  - Immunizations : provides vaccinations at clinics held throughout the County
  - Medicaid Obstetrical and Maternal Services: serves Medicaid eligible pregnant women throughout their pregnancy and after delivery.
  - Lead Monitoring and Testing: provides information regarding lead poisoning, in-home assessments and treatment referrals
  - Rabies Prevention and Treatment: gives free rabies vaccinations for pets, tracks reports of animal bites, makes referrals for treatment
  - Women, Infants, and Children: holds clinics throughout the County to provide nutrition information and assistance for pregnant women and young children
- Environmental Health
  - Air Quality: provides information regarding mold, carbon monoxide and other air quality issues
  - Communicable Diseases: investigates incidences of food and water-borne illnesses
  - Food Safety: provides information regarding safe food handling; inspects restaurants and other food service operations throughout the County
  - Water Quality: ensures safe drinking water at public sites; makes sure sewage disposal systems protect neighborhoods and the County's water supply
  - Recreation Safety: inspects children's camps; ensures safety of public swimming areas
  - Residential Development: approves new residential developments, sewer and water extensions, and treatment plants to ensure safe and healthy communities.
  -
- Health Promotion Program
  - Public Information Officer: provides educational materials to the public, including health & safety alerts
  - Healthy Neighborhoods: makes free home visits to NYS designated areas to assess safety; provides smoke detectors and other materials for residents
  - Diabetes Prevention: teaches skills to make lifestyle changes that decease diabetes risk
  - Tobacco Prevention: provides information regarding risks of tobacco use; checks for tobacco sales to minors
  - Education and Outreach: provides health information in a variety of formats
- Planning and Coordination
  - Administration: oversees all activities of the health department; prepares budget, maintains compliance with NYS regulations
  - Emergency Preparedness: ensures the County is ready to respond to minimize risks in case of epidemics, severe weather events, or other catastrophic occurrences
  - Health and Safety: ensures internal Tompkins County workplace health and safety
  - Medical Examiner: verifies the cause of death
  - Vital Records: maintains birth and death records for the County

Mental Health Offerings

- Outpatient Clinic: provides evaluation and treatment for children and adults with mental health needs
- Children and Youth Therapy: provides evaluation and treatment to children in satellite clinics housed within local school districts
- Care Management (Health Homes): provides case management services to high need individuals with chronic mental illness
- Personalized Recovery Oriented Services (PROS): provides comprehensive recovery-oriented programming for adults with severe and persistent mental illness
- Re-entry Programming: assists formerly incarcerated individuals as they reenter into the community
- Emergency Outreach Services/Mobile Crisis team: provides services to individuals and families who have mental health crises.
- Contract Services: disperses state funding to local agencies to meet local needs related to mental illness, substance abuse, and developmental disabilities

Appendix E: 2018, 2017, 2016 Client Satisfaction Survey Summaries for Mental Health

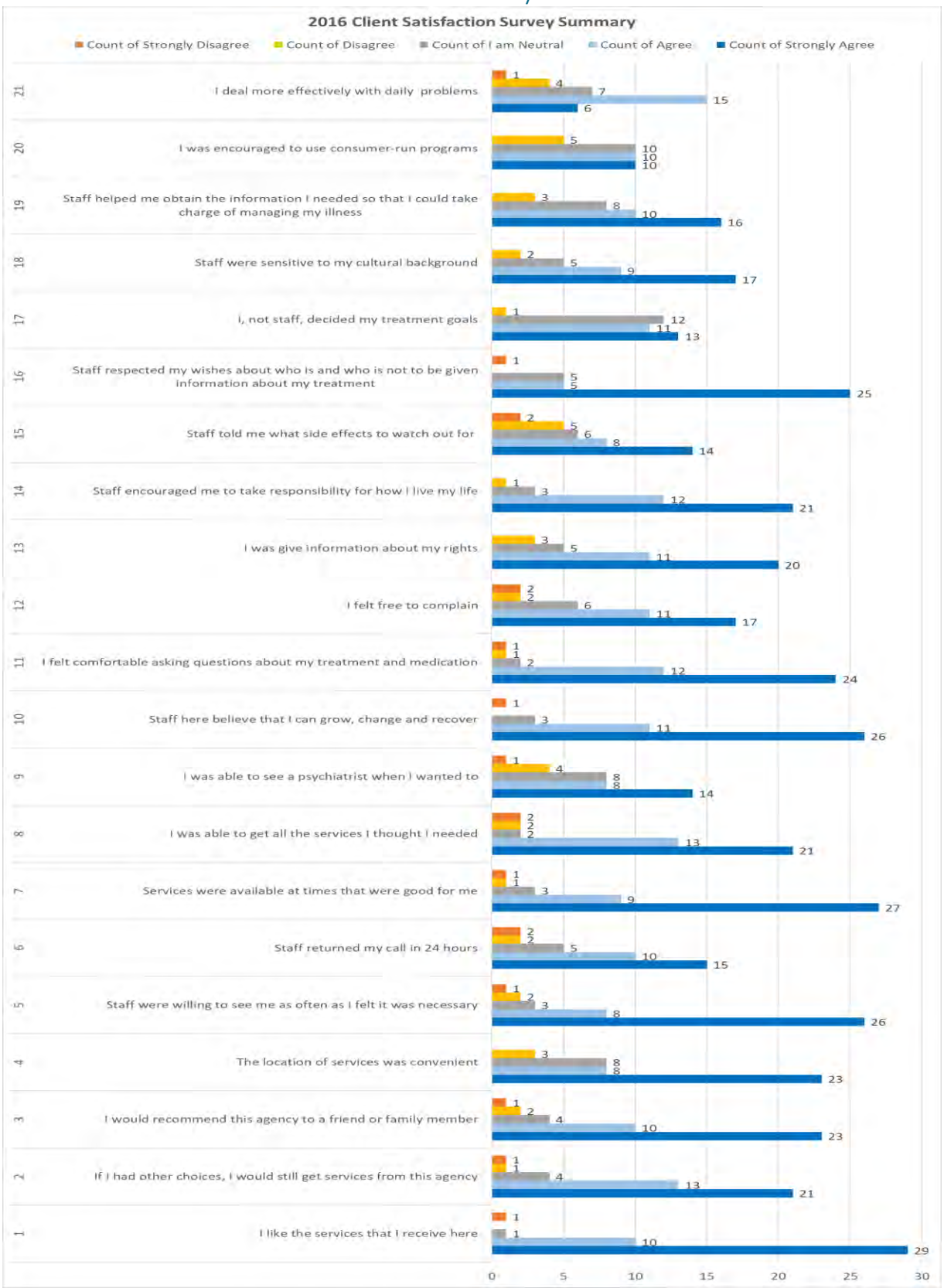
Mental Health Clinic Client Satisfaction Survey 2018



Mental Health Clinic Client Satisfaction Survey 2017

1= Excellent; 2= Very Good; 3= Good; 4= Fair

Mental Health Clinic Client Satisfaction Survey 2016



Appendix F: Climate Survey Summary

Mental Health Department Workplace Climate Survey Findings:

Key: Green = Increase score from '15. Red = Decreased score from '15.

Access to Opportunities	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
Employee performance is evaluated fairly.	54%	36%	51%
My performance evaluation provides meaningful information/my perspective	50%	53%	52%
Opportunities are available to grow career within the County	63%	N/A	58%
Employees have equal access to training opportunities.	60%	39%	62%
Workplace is attractive to all potential employees	42%	47%	66%
Workplace actively seeks to recruit people of diverse backgrounds	48%	39%	66%
Hiring practices are fair	73%	47%	66%
I desire to grow my career with the County	90%	75%	85%

Accountability	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
Department is held accountable to the same standards.	40%	22%	48%
Workplace has best interests of its employees at heart.	48%	33%	60%
Works to balance interests of constituents and employees.	58%	39%	63%
Can disclose suspected violation without fear of reprisal from co-workers	65%	N/A	67%
Can disclose suspected violation without fear of reprisal from supervisor	75%	N/A	72%
Workplace holds itself to a high standard of excellence.	67%	51%	83%
Serves citizens fairly/equitably.	83%	72%	87%

Communication	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
Does effective job communicating with employees.	61%	25%	62%
Department head does effective job communicating with employees in department.	54%	39%	62%
Department head is transparent about goals/objectives.	60%	39%	69%
Department head/supervisor routinely shares information about changes.	73%	51%	71%
Supervisor does effective job communicating with me.	69%	64%	76%

Commitment to the Organization	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
Long-term career is available to me.	75%	86%	76%
Employer problems are my problems.	88%	75%	71%

Diversity	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
People from different County departments work well together.	69%	47%	71%
In my department, different nationalities work well together.	71%	83%	77%
In my department, different religious backgrounds work well together.	77%	75%	79%
In my department, different races work well together.	69%	78%	79%
In my department, different sexual orientations work well together.	88%	89%	79%
In my department, different job levels work well together.	75%	61%	83%
In my department, different abilities work well together.	80%	81%	86%
In my department, different tenure work well together.	79%	64%	86%
In my department, different educational backgrounds work well together.	83%	66%	91%
In my department, different ages work well together.	90%	89%	92%
In my department sexes/different gender identities/expressions work well together.	98%	97%	92%

Inclusiveness	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
Preferential treatment to one person/group is not tolerated.	44%	33%	54%
Diverse perspectives are given appropriate weight in decision-making.	42%	33%	57%
Discriminatory, biased, or prejudiced behavior does not occur in the workplace.	44%	Negatively worded in 2015	58%
My ideas/opinions are a part of the workplace's decision-making process.	46%	50%	63%
Suggestions from people of diverse backgrounds are encouraged.	46%	44%	63%
Inappropriate behaviors are not tolerated/accepted.	60%	34%	67%
Everyone has opportunity to succeed without unlawful discrimination.	62%	64%	71%

Leadership Effectiveness and Accountability	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
Leaders doing effective job providing me mentorship.	50%	34%	57%
Leaders take action to address inappropriate behaviors	55%	N/A	59%
Leaders are doing effective job giving clear direction.	48%	25%	59%
Leadership does effective job giving feedback.	52%	22%	60%
Leaders exhibit inclusive behaviors in the workplace.	62%	50%	71%
Leaders demonstrate a commitment to diversity and inclusion.	54%	47%	72%

Work Satisfaction	2018 Favorable Participation: (n=51) 82%	2015 Favorable Participation: (n=36) 58%	County 2018 Favorable Participation: (n=517) 70%
I feel valued by my employer.	67%	50%	70%
I feel like part of the team at this organization.	83%	61%	79%
I am proud to work for the County.	90%	86%	86%
Skills learned on my job will be valuable to me in the future.	100%	86%	86%

Public Health Department Workplace Climate Survey Findings:

Key: Green = Increased score from '15. Red = Decreased score from '15.

Access to Opportunities	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
Employee performance is evaluated fairly.	74%	55%	51%
My performance evaluation provides meaningful information/my perspective	79%	47%	52%
Opportunities are available to grow career within the County	45%	N/A	58%
Employees have equal access to training opportunities.	58%	63%	62%
Workplace is attractive to all potential employees	56%	57%	66%
Workplace actively seeks to recruit people of diverse backgrounds	60%	57%	66%
Hiring practices are fair	60%	62%	66%
I desire to grow my career with the County	84%	80%	85%

Accountability	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
Department is held accountable to the same standards.	58%	53%	48%
Workplace has best interests of its employees at heart.	74%	50%	60%
Works to balance interests of constituents and employees.	70%	43%	63%
Can disclose suspected violation without fear of reprisal from co-workers	74%	N/A	67%
Can disclose suspected violation without fear of reprisal from supervisor	84%	N/A	72%
Workplace holds itself to a high standard of excellence.	93%	97%	83%
Serves citizens fairly/equitably.	91%	93%	87%

Communication	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
Does effective job communicating with employees.	72%	63%	62%
Department head does effective job communicating with employees in department.	74%	57%	62%
Department head is transparent about goals/objectives.	84%	62%	69%
Department head/supervisor routinely shares information about changes.	77%	67%	71%
Supervisor does effective job communicating with me.	91%	83%	76%

Commitment to the Organization	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
Long-term career is available to me.	86%	73%	76%
Employer problems are my problems.	74%	79%	71%

Diversity	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
People from different County departments work well together.	63%	69%	71%
In my department, different nationalities work well together.	60%	57%	77%
In my department, different religious backgrounds work well together.	79%	82%	79%
In my department, different races work well together.	55%	59%	79%
In my department, different sexual orientations work well together.	63%	79%	79%
In my department, different job levels work well together.	95%	79%	83%
In my department, different abilities work well together.	88%	86%	86%
In my department, different tenure work well together.	95%	93%	86%
In my department, different educational backgrounds work well together.	95%	86%	91%
In my department, different ages work well together.	95%	97%	92%
In my department sexes/different gender identities/expressions work well together.	86%	93%	92%

Inclusiveness	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
Preferential treatment to one person/group is not tolerated.	60%	55%	54%
Diverse perspectives are given appropriate weight in decision-making.	70%	52%	57%
Discriminatory, biased, or prejudiced behavior does not occur in the workplace.	65%	Negatively worded in 2015	58%
My ideas/opinions are a part of the workplace's decision-making process.	72%	53%	63%
Suggestions from people of diverse backgrounds are encouraged.	60%	45%	63%
Inappropriate behaviors are not tolerated/accepted.	88%	67%	67%
Everyone has opportunity to succeed without unlawful discrimination.	77%	73%	71%

Leadership Effectiveness and Accountability	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
Leaders doing effective job providing me mentorship.	65%	46%	57%
Leaders take action to address inappropriate behaviors	74%	N/A	59%
Leaders are doing effective job giving clear direction.	74%	59%	59%
Leadership does effective job giving feedback.	70%	53%	60%
Leaders exhibit inclusive behaviors in the workplace.	84%	60%	71%
Leaders demonstrate a commitment to diversity and inclusion.	70%	59%	72%

Work Satisfaction	2018 Favorable Participation: (n=43) 64%	2015 Favorable Participation: (n=30) 45%	County 2018 Favorable Participation: (n=517) 70%
I feel valued by my employer.	86%	62%	70%
I feel like part of the team at this organization.	93%	83%	79%
I am proud to work for the County.	88%	83%	86%
Skills learned on my job will be valuable to me in the future.	88%	80%	86%

Appendix G: Additional Summary of Common Themes of Employee Open Survey Responses

Opportunities provided by integration include:

- Cost savings
- Greater coordination between the departments
- Opportunities for sharing of information
- Continuity of care for clients
- Decrease of stigma
- A benefit of being co-located with other health care practitioners
- A holistic approach to client care
- A shared record system
- Fiscal savings
- More resources and tools for staff
- Increased synergy and understanding among the departments
- Greater opportunities for staff advancement

Challenges provided by integration include:

- More bureaucracy
- Difficulty with two locations
- A change in focus or loss of focus
- Leadership spread thin over two departments
- Increased workloads
- Resistance to change
- Lack of time
- Potential differences in mission and vision
- Poor communication
- Lack of staff
- Authoritarian decision making due to size of the organization
- Leadership versed in both public and mental health
- Two separation locations
- Integration of services that may not be able to be integrated
- Shared attention to Mental Health and Public Health
- Disruption through the change

Opportunities provided by a separation of departments:

- Focus on programmatic responsibilities
- Access to departmental leadership as the departments will be smaller
- Focus on specialization and enhancing skills
- Leadership focused on the day-to-day operations of one area
- Leadership will be more focused on one issue/department
- Clear planning for each department

- Each department will have a greater focus on their own goals
- Clearer focus on relevant issues related to programming by department

Challenges provided by a separation of the departments:

- Higher financial costs
- Perpetuation of the idea that physical and mental health are mutually exclusive
- Lack of communication between the two departments
- Logistical challenges of two locations/departments/leaders
- Obtaining a good leader
- Implementing a new administrative structure
- Loss of momentum in progress made
- Unsustainable model if they are separated; mental health and public health are related
- Lack of comprehensive, holistic services for our clients
- Continues stigmatization

Appendix H: Additional Summary of Common Themes of Board Member Open Survey Responses

Opportunities provided by integration include:

- Cost savings
- Shared staffing and coordination
- Holistic services to clients
- Potential for noting trends in the county involving areas that have not been considered together before.
- Interdisciplinary discussions and cross-pollination of ideas among personnel.
- Communication among the two boards and ability to address issues impacting the communities' health such as the opioid epidemic.
- Chance to re-think and re-direct how we will function moving into the future.
- Overlap in the activities of the departments. Where they do not overlap they are complementary (i.e. tobacco, drugs, alcohol, child welfare and wellness).
- The ability to push forward to the county and the state with a more unified voice from Tompkins County.
- The potential for less stigmatization and more integration of mental health as an aspect of overall health.
- Both Departments currently have plans that address holistic health. As we continue to work towards an approach based in social determinants, MH, SA, and disabilities are necessary parts of the conversation.
- Both sets of staff can best meet the needs of their clients by recognizing and helping to address behavioral and physical health issues.
- Both departments have strengths and weaknesses in support functions, bringing them together provides opportunities to better support the functions of both departments.
- Integration may also position the county for increased funding when we can show availability of coordinated, comprehensive care to meet Medicaid and Medicare VBP requirements, or at least more easily making the transition. Ability to provide some services at both locations making it easier for clients to access them.

Challenges provided by integration include:

- Staff and Boards understanding the "why" and facilitating the "how" of proactively delivering our services in different ways.
- People are loyal to their tribe and can resist doing something different. Both sides must see the benefits and feel they are on equal footing to be successful. This is a challenge.
- Different regulatory infrastructures.
- Two different cultures/service provision approach that will have to be merged.
- Different reporting structures that people will have to get used to.
- Leaderships time management.
- Administrators might find they are distracted and overloaded from the activities they need to get done within their respective areas. So, this would need to be monitored.
- Mental Health being swallowed up and not given enough resources or attention.
- Cross training in just the basics would be huge - expensive, time and productivity consuming.
- Logistics
- Leadership will need to be skilled in change management.
- Getting everyone on board with such a major shift in the way health is defined and the way in which health services are delivered.

Opportunities provided by separating the departments:

- Having two separate departments means avoiding change. Since change is, by its nature, stressful, separating the two would avoid stress for many county employees and possibly for recipients of services.
- Easy to remain in existing silos. Fewer challenges related to re-thinking administrative infrastructure. Things would likely continue just fine with the separation.
- A Mental Health Commissioner with a Mental Health background.
- More expert focus on needs, assistance, best practices, and funding for people with ID/DD disabilities, mental health disabilities, and substance use disabilities.
- More expert focus on public health needs.
- Both MH and PH should be at near to optimum function before consideration of the major upheaval of full integration.
- Focused leadership.
- One leader of the department instead of deputies.
- A return to mental health patient-centered approach and culture.
- Perhaps to make some staff feel more comfortable in how they're used to things being, but not a good reason to regress.

Challenges provided by a separation of the departments:

- Staffing and providing support functions.
- Developing the necessary mindset and services for staff in each department to best address needs of the whole client.
- Competition for limited resources.
- Continued stigmatization of mental health issues.
- It seems that we have always had a problem with finding candidates to head both of these departments. Keeping one person running both with supporting specialized staff may be a solution.
- Will we have the same issue as we have in the past if we go back to the old format?
- Isolation and working in silos on similar issues is not helpful to anyone.
- Turnover at the top.
- Higher cost, although if there were shared operational functions, these would be likely to offset that cost.
- Missed opportunities for better addressing health and social service needs of TC residents.
- The loss of current coordination and collaborations.
- Inefficiencies that are costly to the community.
- Waste of county dollars resulting from duplication of effort in bookkeeping, medical records, personnel management, and other areas.
- Cost of having top level directors with benefits vs. having only one.
- A barrier to a more holistic approach in meeting needs of clients.
- Reinforcement of stigma surrounding mental health.

Appendix I: Community Organizations/Partners Invited to Complete the Survey

Note that more than one individual from these organizations may have received the survey

Alcohol Drug Council of Tompkins (ADC)
Cayuga Medical Center (CMC)
Cayuga Addiction Recovery Services (CARS)
Cornell University
Excellus
Family & Children's Services
Finger Lakes Independence Center
Human Services Coalition
Ithaca College
Lakeview Mental Health Services
Mental Health Association of Tompkins (MHA)
National Alliance for the Mentally Ill (NAMI)
Racker Centers
Unity House
Tompkins County Department of Social Services
Tompkins County Health Planning Council
Tompkins County Legislature
Tompkins County Office for the Aging
Tompkins County Probation Department

Appendix J: Additional Summary of Common Themes of Direct Report Interview Responses

Benefits of an integrated/merged structure:

- A holistic approach to a person. An example of a holistic approach may be the child who participates in early intervention in Pre-K who may also need CTB mental health skill building. Under the shared leadership structure or two departments there are barriers between the two departments, including a lack of awareness and/or willingness to work with an outside department. If staff members are on the same team, they may be able to be brought together as one unit with a shared understanding, approach and vision.
- The ability to have a diverse portfolio as the billing system changes to Value Based Payments. As one organization when the department negotiates with health insurance companies there is a competitive advantage to having a diverse array of services available for the different types of integrated care.
- An expansion and focus of administrative staff support. Having an administrative team allow the burden of administrative functions to be taken off frontline staff.
- The expansion of Quality Assurance and Improvement unit for all of the various operations of the departments. This expansion provides a venue to show the work being done by all staff and ways to improve for the clients.
- An opportunity to expand education and outreach. Currently the Public Health Department has an education and outreach unit, working with this unit will allow the department to be proactive around Mental Health.
- Shared resources. There are resources and expertise within both departments. A merged department provides a golden opportunity to zone in with the mental health experts that will help public health better deliver care to our clients. In the interim phase, the Public Health department has incorporated mental health into various aspects of services, including emergency preparedness. Behavioral health being included in the drills and ultimately into care during emergencies allows for better services to clients.
- Creating a learning culture across the organization/both departments. Both departments provide opportunities for learning from their best practices. An example of this is the procedures and structure at the Health Department. The Health Department is very structured with many policies and procedures in place to provide consistency for employees. It is more loosely organized at the Mental Health Department. The administration structure from the Public Health Department can provide more structure to the Mental Health Department allowing for administrative consistency.
- Improved outcomes for our clients. There are advantages to the clients as one department focused on the social determinants of health. There are many opportunities to improve the general physical health and mental health of clients when the two organizations are moving together. The clients may have preventable medical conditions that when working together the departments would have a better understanding of what to look for, which would allow there to be better integration, thus allowing better treatment and early intervention.
- Opportunities to change licensing and provided better services. With merged services there are opportunities to change the licensing models and potentially recruit more staff with a new patient centered model which may include an Article 28 licensure expansion.
- Expanded locations and services.

Challenges of an integrated/merged structure:

- Physical separation is difficult but can be overcome. There may be opportunities with the two physical locations, such as satellite offices that improve access to care for clients in two locations.
- The budgets are currently separate which has its own challenges. Developing ways to integrate the budgets may be a challenge.

- Requires significant change in how each Department operates.
- Regulations in both DOH and OMH will need to be a priority if an integrated/merged model is to be achieved. Both organizations will need to continue to meet all the regulatory standards.

Benefits of a separated structure:

- The Public Health Director or Mental Health Commissioner would have more focus on one department. Allowing him or her to better document meetings and conversations.
- More hours of a person in the office, though you don't gain much growth.
- More time to focus on the departments as separate entities.
- More time with ground level staff or leadership by the Commissioner/Director.
- A lot of the same opportunities as integration may be available but the climb to get there would be a lot steeper.
- People have lived through two departments and it would feel like returning to the known.

Challenges of a separated structure:

- An investment to make an administrative team in both departments.
- A shared vision across two departments with two leaders.
- Public Health would need to build a stronger QA/I working team.
- Both departments will need to build their functional units – QA/I, Education and Outreach, Fiscal Coordination, etc.