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BUILDING A MORE COHESIVE AND EFFECTIVE HUMAN SERVICE SYSTEM IN DUTCHESS COUNTY:

RECOMMENDATIONS TO THE COUNTY EXECUTIVE

Prepared by CGR on behalf of:
The Dutchess County Human Services Task Force

Robert Rosenkrantz, MPA
Project Director

One South Washington Street
Suite 400
Rochester, NY 14614
Phone: (585) 325-6360
Fax: (585) 325-2612

100 State Street
Suite 930
Albany, NY 12207
Phone: (518) 432-9428
Fax: (518) 432-9489

www.cgr.org

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EXECUTIVE SUMMARY

In August 2003, Dutchess County engaged CGR (Center for Governmental Research Inc.) to work with a Human Services Task Force on organizational and service delivery improvements that will result in more integrated and effective delivery of human services. The Human Services Task Force was composed of the Commissioners, Directors, and senior staff from the Departments of Health, Mental Hygiene, Probation and Community Corrections, Social Services, Office for the Aging, and the Youth Bureau and representatives from the County Executive's Office.

The study was divided into two Phases. During Phase I, CGR reviewed the organizational structure, functional statements, and annual reports of the six human service Departments, conducted interviews with over 150 County staff at all levels, and analyzed data and reported on 28 performance indicators selected by the Task Force. CGR then presented the strengths and issues that were raised during staff interviews and worked with the Task Force to identify nine priority issues based on the interviews and CGR's analysis. The Task Force members agreed that the best use of CGR would be to help the County develop recommendations on the three most important cross systems issues which have the greatest potential to improve program effectiveness, positively affect customers and the community, and show progress within the next 18 months. Based on these criteria, the Task Force selected the following three issues:

1. The County does not have a structure and process for high-level, cross-systems planning for health and human services.

2. County programs and operations are not routinely evaluated to determine what does and does not work; not all County Departments effectively evaluate contract agency performance.

3. There is a lack of coordination when an individual or family is served by multiple systems.

With the help of two Workgroups of senior staff from the health and human service Departments and insight provided by models

presented by CGR, The Task Force developed three major recommendations for consideration by the County Executive:

- **Create a County Health and Human Services Cabinet.** The Cabinet would provide the health and human service Commissioners a forum to hold open and frank discussion of issues, conduct cross-systems planning, develop strategies for maximizing county resources, and share information on best practices.

- **Strengthen the evaluation of programs through the comprehensive use of outcome measures.** Dutchess County should extend the use of outcome measures to all county-operated and contracted health and human service programs. Using outcome measures would help program managers assess which programs are most effective at improving the well being of individuals and families.

- **Improve the coordination of services to individuals and families involved in multiple systems.** The Task Force recommends the establishment of a new coordination strategy, the Multi-Systems Solutions (MSS) initiative. Through a strength-based team approach and more systemic review of high profile, high need cases, MSS would help eliminate duplication of effort by staff and improve outcomes for individuals and families involved in multiple services.

Section IV of this report presents these recommendations in detail, including the key elements and implementation steps needed to bring them to fruition.

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ACKNOWLEDGMENTS

CGR gratefully acknowledges the contributions of the members of the Human Services Task Force, whose commitment to this project was unwavering:

Bob Allers, Commissioner – Department of Social Services; John Beale, Director – Office for the Aging; Betsy Brockway, Executive Director – Youth Bureau; Earl Bruno, Assistant to County Executive; Michael Caldwell, Commissioner – Department of Health; Nancy Giordano, Assistant to County Executive; Kenneth Glatt, Commissioner – Department of Mental Hygiene; Bridget Goddard, Department of Social Services; Cathy Lane, Office of Probation and Community Corrections; Carole Lehrer, Youth Bureau; Irene Magalski, Deputy Commissioner – Department of Social Services; Jessica Mancuso, County Executive's Office\Budget; Sabrina Jaar Marzouka, Department of Health; Elizabeth Spross, County Executive's Office\Budget; Mary Ellen Still, Director – Office of Probation and Community Corrections; and John Storm, Department of Health.

Appreciation is also extended to the members of the two Workgroups, whose assistance was instrumental in the development of the recommendations included in this report:

Performance Evaluation Workgroup: Beverly Allyn, Department of Health; Betsy Brockway, Youth Bureau; Mary Kaye Dolan, Office for the Aging; Bill Fluck, Office of Probation and Community Corrections; Bridget Goddard, Department of Social Services; Benjamin Hayden, Department of Mental Hygiene; Carole Lehrer, Youth Bureau; and Elizabeth Spross, County Executive's Office\Budget.

Multi-Systems Coordination Workgroup: Toni Brewer, Department of Health; Kathy Jamison, Office for the Aging; Cathy Lane, Office of Probation and Community Corrections; Irene Magalski, Department of Social Services; Jill Michele Sawick, Youth Bureau; and Karen Troken, Department of Mental Hygiene.

Finally, we would like to thank the dozens of County staff who met with us and shared their perspectives about the current human service system and ways to improve it.

Contributing Staff

This project was staffed by Rob Rosenkrantz, MPA, Director of Integrated Services for Children and Families; Susan Lepler, MSW, MPA, Director of the CGR Albany Office; Chris Grill, PhD, Research Associate; Kimberly Hood, MPA, Research Associate; Rosanna Volpe and Heather Fralick, graduate interns.

SECTION I: INTRODUCTION

Overview and Project Objectives

In August 2003, Dutchess County launched a comprehensive review to determine the efficiency and effectiveness of its health and human service Departments as a unified and integrated system. The County Executive engaged CGR (Center for Governmental Research Inc.) to undertake this review and develop recommendations in partnership with a Human Services Task Force, composed of the Commissioners, Directors, and senior staff from the six health and human service Departments, and representatives from the County Executive's Office. CGR was established in 1915 as a non-profit organization to serve the public interest by providing objective research, analysis, and consultation to state, county, and municipal governments, businesses, and non-profit organizations.

The scope of this initiative included an assessment of the Departments of Health, Mental Hygiene, Probation and Community Corrections, Social Services, Office for the Aging, and Youth Bureau. Within the Department of Health, the review included only those units that, either directly or through contracts, provide services to individuals or families. During Phase I of this project, CGR facilitated monthly Task Force meetings, conducted dozens of individual interviews and seven group interviews with County staff, collected and analyzed operational and performance data, and shared our findings with the Task Force. During Phase II, we worked directly with two Workgroups of senior staff and members of the Task Force to shape the recommendations.

Organization of this Report

This report presents the methodology for this study, the strengths and weaknesses identified by both CGR and County staff, and the recommendations of the Human Services Task Force for improving the planning, management, and delivery of services.

This document is divided into four sections:

Section I: Introduction

Section II: Methodology

Section III: Key Findings

Section IV: Recommendations of the Task Force

SECTION II: METHODOLOGY

Focusing Our Efforts

CGR's charge was to explore avenues to create a more efficient, effective, and integrated human service delivery system in Dutchess County. Given this charge, Phase I of the project concentrated on gaining a clear understanding of the mission and operations of the health and human service Departments, their organizational structures, shared target populations, and interaction during planning and service delivery. During Phase II, CGR and the Task Force developed recommendations to address the most pressing cross-system issues identified during Phase I. Our foremost objective throughout the project was to pinpoint opportunities for greater collaboration, consolidation, or effectiveness in the human service delivery system while improving services for customers.

Conducting Stakeholder Interviews

CGR conducted interviews with more than 150 members of Dutchess County government, ranging from the County Executive and Commissioners to a host of supervisory and front-line staff. (see Attachment A). Based upon a standard set of protocols, these interviews were designed to elicit viewpoints about the overall functioning of the human service system; key issues within the individual Departments; barriers to effective service delivery and coordination within and across Departments; departmental strengths to build upon; and suggestions for how the County human service system could be improved. This process involved the following:

Individual interviews with County Leaders. Participants included the County Executive, Assistants to the County Executive, the Acting Budget Director, the Planning Director, and Commissioners and Deputy Commissioners from the Departments of Health, Mental Hygiene, Probation, Social Services, Office for the Aging and Youth Bureau.

Individual interviews with Program Directors and Supervisors. CGR conducted interviews with 37 program

directors and senior supervisors with operational responsibilities or administrative oversight in the six human service agencies.

Group interviews with County Staff. CGR conducted 7 group interviews with a total of 117 County employees. Each session involved a cross-section of frontline and support staff from a single Department.

Assessing Organizational Structure and Functions

In conjunction with the stakeholder interviews, CGR examined departmental budgets, program reports, planning documents, and current interdepartmental initiatives. CGR then followed up with the County Commissioners and their staffs to further clarify organizational structure and staffing, relations with contract agencies, and the interrelationships of programs within and across Departments. As part of this process, CGR prepared a set of functional organizational charts listing each Department's program responsibilities. These charts were presented to members of the Task Force for their review and final versions were distributed to Department leadership for their use.

Benchmarking Performance

As part of this review, CGR worked with the Task Force to identify performance measures that could be used as benchmarks of the efficiency or effectiveness of Dutchess County's human service system. Each Department was asked to identify outcome or process measures that reflect the impact of programs on the individuals that the County serves, either directly or indirectly through contract agencies. The measures had to: 1) include data over several years, or 2) be available from other counties to enable comparisons.

In preparing and evaluating these performance measures, it became clear to both the Task Force and CGR that data limitations were considerable. Some of the data were unobtainable. Other data elements were out of date or were available for only a single year. Nevertheless, after changing some of the measures and recasting others, the Task Force identified 28 indicators for analysis. CGR then prepared a report on how Dutchess County is doing on these measures and presented it to the Task Force in February 2004.

The report (attachment B) indicated that in over half of the areas for which data could be collected, Dutchess County Departments

were achieving success, meeting or exceeding their targets, or making improvements over time. Four of the measures revealed a downward trend, while the rest showed mixed or varying results. For the few indicators where comparison data were available, Dutchess County was generally doing as well as if not better than other comparable counties or the rest of New York State. While data limitations hindered our ability to develop a comprehensive set of performance benchmarks for the human service system, the difficulties in creating the report did underscore the need for better data collection on both county-operated and contract agency programs – a key issue which was selected for exploration during Phase II.

Model Research

During its work with the Task Force and Workgroups, CGR presented five models for restructuring or coordinating health and human services:

1. Albany County's Department for Children, Youth, and Families;

2. Erie County's proposed Department of Family Services and Community Health;

3. Stark County, Ohio's Family Council;

4. Monroe County's Child and Family Health Services; and

5. Monroe County's proposed Family Engagement and PINS Diversion Initiatives.

In addition, CGR invited Tobin and Associates, Inc. to present its On-Par Provider Management System to the Performance Evaluation Workgroup to demonstrate the possibilities and advantages of a web-based contract management and outcome measurement tracking system.

These models stimulated the thinking of the Workgroups and Task Force members and played a role in the development of the recommendations of this report. One model, the Monroe County Family Engagement and PINS and JD Diversion Initiatives, has already influenced the development of a Dutchess County

program, the Early Intervention Program, designed to better serve children involved in the juvenile justice system and their families.

SECTION III: KEY FINDINGS

This section presents the key findings from CGR's Phase I review of Dutchess County's human service system. Our stakeholder input process provided an opportunity to hear, first hand, about the strengths and challenges of the County's current human service delivery system from a wide range of vantage points. We first present a core list of strengths of the Dutchess County human service systems that were echoed by multiple staff at various levels (e.g. Commissioner, senior manager, supervisory, and frontline staff levels) and across Departments.

Strengths

Dutchess County has a dedicated and capable County workforce committed to delivering high quality services to those they serve. The most oft-cited strength of the County's human service system was the County workforce itself. Staff were described as talented, well-trained, hardworking, and compassionate individuals who "strive to do their best with limited resources" and exhibit a "willingness to adapt to new and challenging situations." Commonly noted was a strong commitment to serving individuals who would "otherwise fall through the cracks." Many staff also cited supportive supervisors who "stand behind their workers" as a strength.

Dutchess County's human service providers have embraced a spirit of collaboration and cooperation. The following initiatives were frequently cited as examples of successful cross-systems efforts: the PINS Task Force; Children's Services Council; Criminal Justice Council; Juvenile Justice Task Force; Coordinated Children's Services Initiative (CCSI); and Integrated County Planning.

In addition, staff noted that the County Commissioners and Directors interact well with one another and have worked together to identify common goals and ways to enhance service delivery. County Departments also have a history of collaborating with local non-profit agencies to improve service delivery.

Dutchess County offers a good depth and breadth of services for a county of its size. Staff emphasized that there is a wide

array of services and resources available in Dutchess County. Moreover, peer counties and state agencies have recognized that Dutchess County is innovative - willing to try new approaches and practices and embrace those that successfully improve services to its customers. Staff also recognized that many human service programs are provided at sites located throughout the county, which improves access for those residing in outlying areas.

Dutchess County cares about quality improvement and quality assurance. Staff acknowledged that this study, and in particular the examination of the human service system's strengths and weaknesses, was a reflection of the County leaders' commitment to providing high quality services to County residents.

Major Issues

The interviewees also commented on issues and made suggestions for improvement. Based on the insight provided by these comments and CGR's research, the Task Force identified nine critical issues for possible further exploration and development during Phase II. These nine priority issues were:

1. **The County does not have a structure and process for high-level, cross-systems planning for health and human services.** Commissioners do not regularly meet to discuss issues, identify and solve problems, set joint priorities, and develop strategies to maximize resources.

2. **County programs and operations are not routinely evaluated to determine what does and does not work; not all County Departments effectively evaluate contract agency performance.** County Departments do not systematically assess programs and strategies to determine if they are having their intended impacts. Not all County contracts contain outcome measures, and when such measures are included, some staff questioned whether they are always the right ones. Our interviews and effort to develop useful performance indicators revealed that it's often unclear to managers and front-line staff what to measure or how to assess effectiveness. At the same time, contractor payments are not closely linked to the achievement of outcomes; longstanding relationships and inertia are dominant forces in contractor selection and continuation. Finally, better staff training is needed for effective performance monitoring.

3. **There is a lack of coordination when an individual or family is served by multiple systems.** Outside of CCSI, Dutchess County does not have a formal process for identifying clients involved with multiple service systems. No interdepartmental protocol exists for joint assessments, information sharing, and service plan development and monitoring. Confidentiality issues and the lack of a common consent form further hamper information sharing.

4. **County services to adults and older adults are fragmented.** Five County Departments now serve adults and older adults: the Departments of Social Services, Mental Hygiene, Health, Office for the Aging, and Office of Veterans Affairs. Each service has its own narrow focus, with limited ability to comprehensively serve adults and older adults. Within the Office for the Aging, Community Alternative Systems Agency (CASA) and traditional Office for the Aging services are discrete. Even within CASA, nursing and case management functions are not well coordinated.

5. **Organization and delivery of DSS eligibility services, including Temporary Assistance, Food Stamps/HEAP, Medicaid, Child Support, and Day Care, are too categorical.** DSS has four separate divisions with multiple specialized units that are responsible for determining eligibility and re-certifying clients. This categorical service model limits the ability of County staff to comprehensively assess and respond to families' needs, resulting in multiple hand-offs, confusion, and frustration on the part of both staff and their clients. The impact of this problem is not confined to DSS; staff in other County Departments observed difficulties and delays when referring clients to DSS. While all DSS senior managers noted potential benefits of redesigning Department intake functions, the issues of what services to include and the extent to which integration is dependent upon software tools have not been addressed.

6. **County staff do not fully know the roles, responsibilities, and services offered within their Departments or in other Departments.** The County does not have a comprehensive directory or on-line resource available for identifying staff or describing programs. Moreover, few networking opportunities

exist for staff within and across Departments. The resulting lack of knowledge and understanding of other Departments can lead to inappropriate referrals, unrealistic expectations, poor service coordination, and confusion for clients. Over 50 frontline staff and senior managers identified this as a problem for the County.

7. **Questions remain whether the Health Department should continue to operate its Long Term Home Health Care Program (LTHHCP) and Certified Home Health Agency (CHHA).** The long-standing issue of whether Dutchess County should continue to directly provide LTHHCP services has yet to be resolved. While the Department of Health and Office for the Aging have issued a paper supporting divestiture of the Long Term Home Health Care Program, to date this policy direction has not been implemented. Similar questions have recently arisen about the County CHHA – should the Health Department keep it as is, scale it back, or eliminate its operation? (CGR is currently working on this issue and recommendations are expected this fall).

8. **The roles and responsibilities of the multiple County Departments and private agencies involved in serving high-need youth and their families are unclear.** A host of questions were raised, including the following: What is the appropriate role of the Youth Bureau in providing direct services? What should be the interface between PINS diversion, pre-diversion, Project Return, CCSI, and the Single Point of Accountability (SPOA)? What strategies can be used for increasing school involvement in these processes? How can the County increase the efficacy of SPOA and CCSI processes, particularly the ability to access intensive services in a timely fashion? What is the role of the PINS diversion multi-disciplinary assessment team in light of the Probation Department's implementation of the YASI assessment tool? And what role should DSS play in placement decisions related to PINS/JDs?

9. **Service gaps or insufficient capacity makes it difficult to effectively serve clients.** The most frequently noted service gaps were:

- Shortage of safe, suitable, and affordable housing generally and specifically for special populations (e.g., sex offenders, victims and perpetrators of domestic violence, the mentally ill, and chemically dependent individuals);
- Long waiting lists for Office for the Aging case management and children's mental health services;
- Mental health services for seniors;
- DSS foster family homes;
- Secure and non-secure detention;
- Inpatient psychiatric beds;
- Supervised independent living facilities;
- Transitional housing for youth ages 18-23;
- Residential/institutional placement options for youthful sex offenders;
- Parent support and education programs;
- Preventive services;
- Youth development programs;
- Respite care;
- Crisis residence; and
- Medical and dental services for Medicaid clients.

Setting Priorities: Phase II

After reviewing the models presented by CGR and the issues identified through the interview process, the Task Force considered and rejected the concept of a major structural reorganization of the Dutchess County health and human service Departments at this time. The Task Force believed that formal and on-going collaboration by the Departments would be the most effective, efficient, and achievable approach to better integrating systems and services while being the least disruptive to customers and staff. Instead, the Task Force decided that the best use of CGR would be to help the County develop a series of recommendations that would directly address the three most important cross-systems issues (i.e. recommendations that are

applicable for more than one Department or for clients across Departments). The Task Force members also agreed that the selected issues should have the greatest potential to: improve effectiveness; positively affect customers and the community; and demonstrate progress within the next 18 months.

Based on these criteria, the Task Force selected the following issues for development of recommendations during Phase II:

1. **The County does not have a structure and process for high-level, cross-systems planning for health and human services.**
2. **County programs and operations are not routinely evaluated to determine what does and does not work; not all County Departments effectively evaluate contract agency performance.**
3. **There is a lack of coordination when an individual or family is served by multiple systems.**

The Human Services Task Force formed two committees composed of senior staff from the six health and human service Departments - a Program Evaluation Workgroup and a Multi-systems Coordination Workgroup - to help develop its recommendations in these two areas. CGR facilitated eight meetings of these Workgroups over a three-month period and prepared a report on their recommendations to the Task Force. The Task Force members made some minor revisions to the recommendations, clarified the population to be initially served through a new multi-systems coordination initiative, and adopted the recommendations as their own. The Task Force then considered several options for creating a body to better coordinate health and human services and selected an approach to establishing a viable and effective Health and Human Services Cabinet. All of the recommendations of the Task Force, which were unanimously approved by its members, are contained in Section IV.

SECTION IV: RECOMMENDATIONS OF THE TASK FORCE

Recommendation 1:
Create a Dutchess County Health and Human Services Cabinet

Dutchess County should establish a Health and Human Services Cabinet composed of the Commissioners and Directors of the Departments of Health, Mental Health, Social Services, Probation, Office for the Aging, Office of Veterans Affairs, and Youth Bureau and a representative from the County Executive's Office. The Cabinet would serve as a high-level executive management team to tackle problems affecting multiple Departments, conduct cross system planning, share information on best practices, and develop strategies to maximize the County's resources. Through a schedule of monthly meetings, the Cabinet would provide an open forum for Commissioners and Directors to freely address issues and collaboratively plan for improvements in the County's health and human service system.

The Cabinet should be chaired by an Assistant to the County Executive who would take on a more visible role as the County's point person on policy development and cross-systems issues in the area of health and human services. The Assistant to the County Executive should have dedicated staff support for setting the agendas, preparing summaries of key decisions, and helping the Assistant implement Cabinet priorities. The Assistant to the County Executive may elect to secure the services of a neutral facilitator for Cabinet meetings that will address particularly difficult or controversial issues.

As a starting point, the Cabinet would oversee implementation and coordinate the two new cross-systems initiatives proposed below: 1) the development of a program evaluation system for all county-operated and contracted services and 2) the establishment of a service coordination mechanism for individuals and families involved in multiple systems. The Cabinet would also address the other cross-systems issues brought to the forefront by CGR's review (see Section III, above).

Recommendation 2: Strengthen the Evaluation of Programs Through the Comprehensive Use of Outcome Measures

Overview

The use of outcome measures to assess program performance has been embraced and encouraged by many state departments, federal agencies, and the United Way and has proven beneficial to many human service providers. In today's constrained fiscal environment, with growing demand for more cost-effective and efficient service delivery, program evaluation has become even more critical. A well-designed system of program evaluation can be used to demonstrate, in concrete terms, the value and effectiveness of programs to staff, funders, and the public. To this end, Dutchess County should implement a universal policy for program evaluation for its health and human service Departments by requiring outcome measures for all county operated and contract programs.

The major elements of the proposed program evaluation system are as follows:

Key Elements

Definitions

Outcome – identifies a change in the behavior or well-being of clients or customers as a result of the program or service.
Example – Youth are drug free.

Outcome Measure – quantifies the achievement of the outcome.
Example – Number of youth who graduated from a chemical dependency program and have not used drugs during the three months after graduating from the program.

Process Measure– identifies how well the program or service is being delivered.
Example – The percentage of applications reviewed within two weeks of submittal.

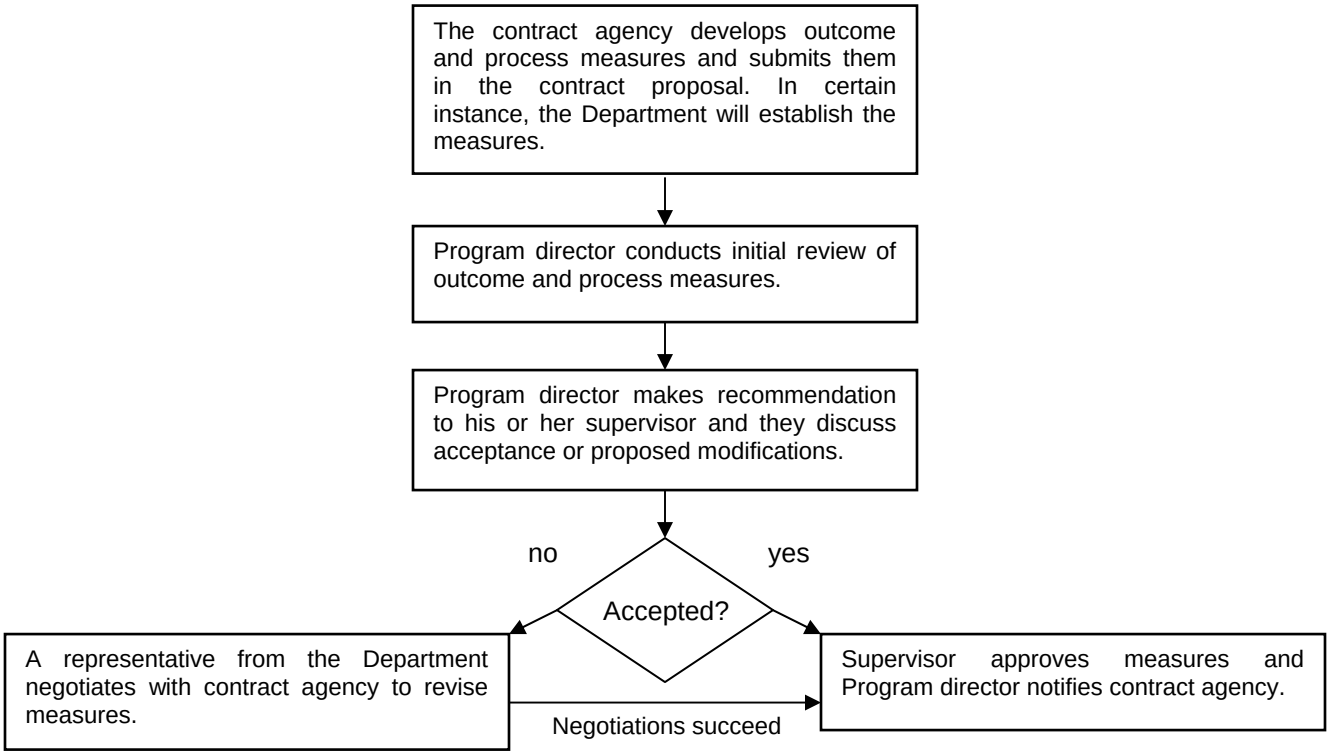
- **Development of outcome and process measures.** While some of the County Departments currently require that outcomes be included in at least some of their contracts, the goal of this initiative is to establish at least one outcome measure for every program, whether it is directly operated by the County or through a contract with a community agency. Each health and human service Department should also determine the extent to which it would mandate the use of process measures to evaluate how well a program or service is being delivered. The text box on the left provides definitions and examples of outcome and process measures to clarify how these measures differ.

Each Department should have flexibility in determining who in the Department has responsibility for negotiating outcome measures (and process measures, when included) with contract agencies: either a program director, supervisor, or an individual in the Department with overall responsibility for the program

evaluation system. In certain instances, such as when state or federal agencies require reporting on specific outcomes, the County Department may establish the outcome measure for the agency.

The flow chart, below, illustrates the proposed process for the development and approval of outcomes by contract agencies and county approval:

Outcome Process for Contract Agencies



For county-operated services, the program directors should develop the outcome and process measures for their programs. The supervisors of the program directors should be responsible for approving these measures and holding the program directors accountable for making progress in achieving the outcomes.

- **Reporting and monitoring of outcome measures.** Both county-operated programs and contract agencies should report on outcome and process measures at six-month and yearly intervals. Departments may elect to require more frequent reporting for specific programs, such as new programs or

programs which have a history of not making progress in meeting their outcomes. To facilitate reporting, the Workgroup developed a series of forms for this initiative based on those already being used by the Youth Bureau and some Department of Social Services' program managers. Reports have also been created to identify workload indicators and program activities, when a Department determines that this level of detail should be required.

If a program reports that it is not making progress in meeting its outcome or process measures, a Department should set in motion a series of escalating corrective actions. This could include the following steps:

1. A dialogue between program director and community agency staff (or between a supervisor and a program director in the case of county operated programs);

2. A written plan of corrective action and monitoring;

3. A discussion with senior Department staff or the Commissioner for repeated failure to meet outcome or process measures; and,

4. A consideration of funding or leadership changes for consistent failure to perform.

- **Oversight of the program evaluation initiative.** The Health and Human Services Cabinet should ensure that outcome and process measures are effectively integrated in all county-operated and contracted programs. To help in this process and ensure consistency both within and across Departments, each Department should assign one point person for program evaluation. The Department's program evaluation representatives would be responsible for:

  1. Reviewing and aggregating outcome and process measures;

  2. Reporting the status of outcome and process measures to the Commissioner and advisory boards;

  3. Meeting annually with the program directors in his or her Department to assess process and training techniques,

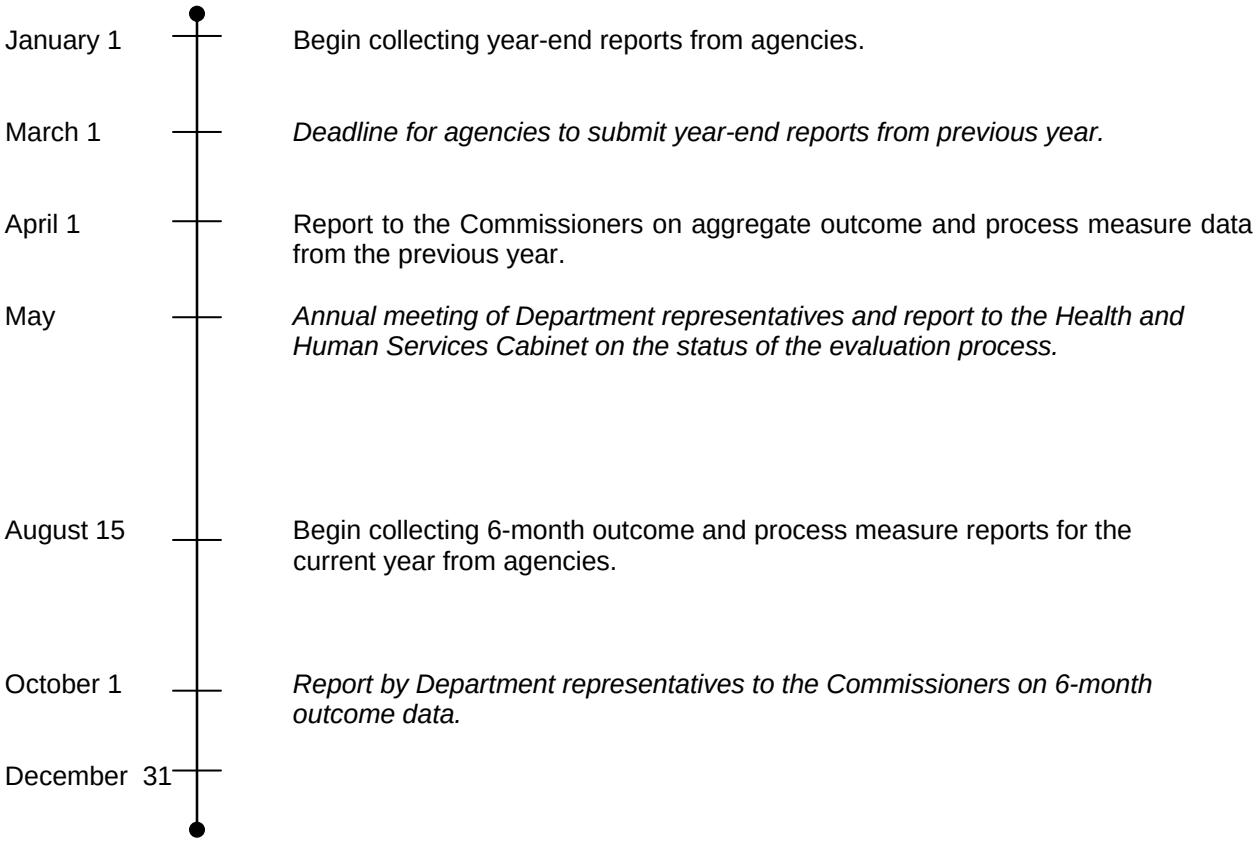
certify that reporting is being done, and ensure that plans are consistent with outcomes; and,

4. Work with staff in the Department to ensure that outcome and process measures correspond with existing Department-wide or County-wide plans and that these plans are updated based on progress or lack of progress on these measures.

The program evaluation representatives from all of the Departments should report annually to the Health and Human Services Cabinet on the status of the evaluation process and make recommendations for changes. This meeting should take place in May before the County budget process begins so that it can inform budgetary decisions.

A timeline depicting the program evaluation reporting and monitoring schedule is provided below.

Timeline for Program Evaluation Process



Implementation

Over a four-year period beginning in calendar year 2006, the County should aim to develop at least one outcome measure for every county-operated health and human services program and for every health and human services contract with a community agency. The target for the first year (calendar year 2006) is the inclusion of outcomes in 25% of all county operated programs and 25% of the approximately 100 contracted human services programs that directly serve clients. Once fully implemented by the health and human service Departments, the program evaluation initiative should be adopted and used by all County Departments.

To prepare for implementation in 2006, the following steps should be taken in 2004 and 2005:

1. Securing resources needed for this initiative, including: personnel coverage during training; professional staff time to conduct analysis of outcome and process measures of contract agencies; clerical support for collecting and aggregating data; and supplies and materials.

2. Communicating this new policy direction to the staff of the health and human service Departments and community agencies.

3. Conducting training for both contract agency and county staff and obtaining a common understanding of the terms and processes involved in the new evaluation system. The United Way has offered to provide a free training program for the County.

4. Identifying the program evaluation representatives and committees in each Department to support implementation.

Recommendation 3:
Improve the Coordination of Services to Children, Families, and Individuals Involved in Multiple Systems

The County should implement a new initiative to better coordinate services for individuals and families involved with two or more health and human service systems. This new approach to coordination, dubbed the Multi-Systems Solutions initiative (MSS) by the Workgroup and Task Force, is designed with three major goals:

1. To improve outcomes for individuals and families involved in multiple systems through better coordination and a more comprehensive approach to service delivery.

2. To reduce the need for more intensive services for individuals and families with complex needs.

3. To eliminate duplication of effort by staff.

While MSS should eventually be extended to all cross-system populations, the Task Force strongly recommends that it start with two populations to develop and refine the processes and test its efficacy. The first population is youth and families involved in the juvenile justice system's new Early Intervention program. Staff involved in this initiative are already trained in a strength-based team approach and routinely work with staff and providers from multiple systems. It would be a natural extension of the Early Intervention Program to infuse the other elements of MSS into this program. The other cross-systems population well suited for initial deployment of MSS is children and family members who are receiving Department of Social Services Preventive Services on a voluntary basis and involved in mental health, alcohol, or substance abuse services. These cases are often complex with the potential for poor outcomes and the need for high intensity and high cost services. The Task Force believes that this population

could clearly benefit from the MSS initiative's strategy for improved coordination of care.

The four main components of MSS are as follows:

Key Elements

- **A strength-based team approach to service planning and monitoring.** The cornerstone of MSS should be the establishment of a multi-systems strength-based team approach that fosters coordination and cooperation by all providers serving an individual or family. Through MSS, a county or contract agency frontline worker would be empowered, within guidelines, to form a Solutions Team composed of all staff providing services when an individual or family is being served by multiple systems. An individual or family being served may also request a Solutions Team meeting when they believe that it would be beneficial. The Solutions Team members, including the family, would jointly develop a plan of action, clarify roles and responsibilities, and identify ways to increase coordination. The Team would also decide on the frequency and type of interaction, depending on the complexity of a family's situation.

- **A new cross-systems information sheet and aggregate management reports to better inform both frontline workers and program managers.** The County should add a new cross-systems information sheet for use by all frontline workers involved in MSS. The information sheet would ask the customer to **voluntarily** provide information on all services that they and their family members are currently receiving and what services they believe that they need. Customers would be asked to sign release of information forms meeting all confidentiality requirements of the health and human service Departments so that collected information may be shared. Data from the information sheets could be periodically aggregated to provide valuable planning information to the Health and Human Services Cabinet on the number of individuals involved in multiple systems, the most frequent combination of services, the demographics of individuals and families served, and the common points of entry.

- **A pool of flexible funding to provide wraparound services.** Small amounts of flexible funding can go a long way in helping individuals and families meet their goals. The County should

establish a single pool of funds for Solutions Teams to access for individuals and families involved in MSS who do not have wraparound funds through existing programs. The funds would be made available for the purchase of services and items that cannot be funded through other means, but are essential to help customers meet their service goals. Services that might be funded through the pool include respite, camp membership, mentoring, babysitting, and transportation.

- **A cross-systems case assessment and planning process for recommending systemic changes.** Using existing County collaborative bodies, the County would identify and analyze high profile and high cost cases to determine if more needs to be done to improve outcomes. This body would also identify systemic changes to enhance overall coordination among health and human services and determine if more efficient methods of cross-systems service delivery can be deployed. The collaborative body would also be responsible for approving Solutions Team requests for wraparound funds and monitoring the use of these funds. During the initial development of MSS, the Task Force recommends that a sub-committee of the Health and Human Services Task Force work directly with the collaborative body to establish and carry out its responsibilities under this initiative.

The chart on the following page summarizes the organizational responsibilities under the MSS initiative.

Organizational Responsibilities - Multi-Systems Solutions Initiative

Health and Human Services Cabinet

- Designate an existing county interagency body to take on responsibility for cross-systems planning for the two target populations.
- Establish a single pool of funds for all cross-system individuals and families involved in MSS who do not have wraparound funds through existing programs.
- Designate one County Department to administer the wraparound funds, establish controls, and report back to the Health and Human Services Cabinet on the use of these funds.
- Approve guidelines to help frontline staff determine when a Solutions Team should be formed.
- Resolve issues if supervisors cannot resolve disputes among frontline staff on Solutions Team.

Sub-committee of the Health and Human Services Cabinet and the Interagency Collaborative Bodies

- Develop guidelines, for approval by the Health and Human Services Cabinet, for creation of Solutions Teams.
- Identify individual high profile or high cost cases and determine if more needs to be done to assist the individual or family to improve their outcomes.
- Ensure that the cross-information sheet is created and used by frontline workers, and that data collected is analyzed and reported to the Health and Human Services Cabinet.
- Highlight systemic changes that could enhance the overall coordination and service delivery for individuals and families.
- Establish guidelines for the appropriate use of wraparound funds for its target populations.
- Approve requests from the Solutions Team for the use of wraparound funds.

Frontline Supervisors

- Resolve Solutions Team disputes about responsibilities, appropriateness of the service plan, or Solutions Team procedures.

Frontline Staff

- Determine, within guidelines, which individuals and families should receive coordination through a Solutions Team.
- Call and coordinate a Solutions Team meeting when an individual or family member requests one.

As Members of Solutions Teams

- Develop a plan of action, clarify roles and responsibilities, and identify ways to increase coordination.
- Decide on the frequency and type of interaction, depending on the family situation.
- Communicate service plans and goals with other Team members, and notify Team members when services change or end.
- Document all Team communications in the individual service record.
- Request use of wraparound funds.

All policies and processes established through the MSS initiative should be guided by the following principles:

- **Coordinated:** Services provided are well coordinated with clear mechanisms for sharing information on goals, issues, and changes in the status of the individuals or families.

- F**amily-focused:** Services recognize that the family is the primary support system for any involved children.

- **In Partnership:** Individuals and families participate as full partners in all stages of the decision-making and treatment planning process.

- **Community-based:** Whenever possible, services are delivered in the individual's or family's home community, drawing on formal and informal resources to promote the individual's or family's successful partnership in the community.

- **Least Restrictive:** Services take place in settings that are the most appropriate and natural for the individual or family, and are the least restrictive and intrusive available to meet the needs of the individual or family.

- **Culturally Competent:** Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, practices, and characteristics of the individual's or family's ethnic group.

- **Individualized:** Each family member receives individualized services in accordance with his or her unique needs and potential, guided by an individualized service program.

Implementation

The Health and Human Services Cabinet would be responsible for overseeing and coordinating implementation of MSS. As one of the first steps, all frontline and supervisory staff involved in MSS should receive training on the purpose, principles and procedures of MSS; strength-based, family-focused service planning and delivery; and the availability of county-operated

and community services to serve individuals and families with multi-system needs. The Coordinated Children's Service Initiative is currently developing cross-systems training for frontline staff in county and contract human service agencies to provide information about Dutchess County services and strength-based service delivery. This training should be amended to include the MSS process and principles.

Other implementation steps include:

1. Identifying additional resources for wraparound funding, training, and collaboration by frontline staff.

2. Communicating the initiation of MSS and its goals to the staff of the health and human service Departments and community agencies.

3. Assigning responsibility for cross-systems case assessment and planning for the initial target populations. The Juvenile Justice Task Force should take on this responsibility for youth involved in the Early Intervention program. A sub-committee of the Children's Services Council could be formed to conduct case review and planning for youth and families involved in DSS Preventive and Mental Hygiene Services.

4. Establishing guidelines for the formation of Solutions Teams under MSS.

5. Developing the cross-systems information sheet, confidentiality release forms, and a Memorandum of Understanding. The Memorandum of Understanding would be signed by each health and human service Department and community agencies and identify the protocols for completing releases to enable the sharing of information.

The Task Force is confident that implementation of the recommendations in this report will establish a more coordinated and effective health and human service system in Dutchess County. The Health and Human Services Cabinet and Multi-systems Solutions initiative will promote coordination and teamwork at all levels – from frontline workers to Commissioners and Directors. The expanded use of outcome measures to all county-operated and funded programs will underscore the importance of measuring the success of programs by how they positively affect the lives of our customers. Taken together, these recommendations will lay a solid foundation for continuous improvement in the way the County plans, integrates, and delivers its health and human services.

APPENDIX A

Who CGR Interviewed

APPENDIX A

Who CGR Interviewed

51 Individual Interviews

- ❖ County Executive and Staff
- ❖ Commissioners and Deputy Commissioners
- ❖ Senior Managers and Supervisors

117 Staff in 7 Group Interviews

Department	# of Staff
Aging	13
Health	20
Mental Health	18
Probation	19
Social Services	40
Youth Bureau	7

APPENDIX B

DEPARTMENTAL PERFORMANCE MEASURES

CGR

Research to drive informed decisions.
Expertise to create effective solutions.

DUTCHESS COUNTY HUMAN SERVICES REVIEW

DEPARTMENTAL PERFORMANCE MEASURES

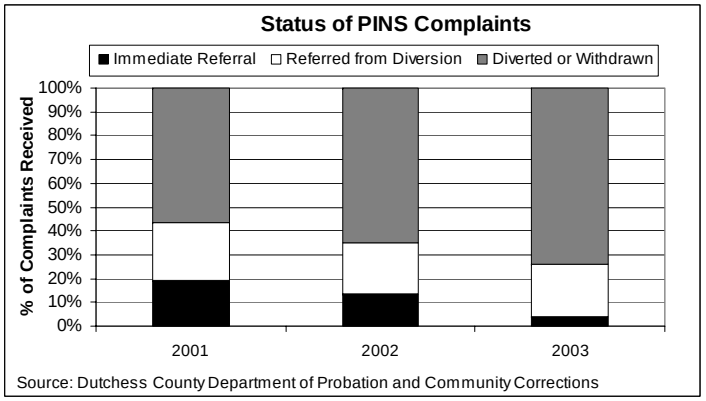
April, 2004

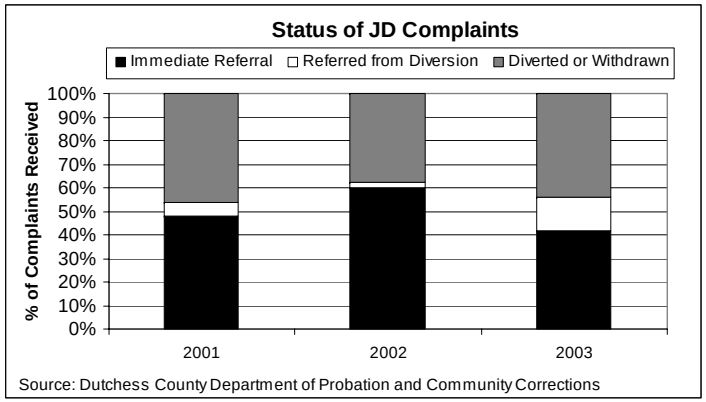
Performance Measure: PINS and JD Complaints Referred to Family Court

Description: The number of PINS and JD youth referred to Family Court, expressed as a percentage of total PINS and JD complaints received and opened by Dutchess County Probation. Referrals to Family Court are broken out by immediate referral (i.e., youth for whom Diversion is not attempted) and youth who attempt Diversion and are referred to Court from the Diversion Unit.

Findings: In 2003, Dutchess County Probation opened 958 PINS and JD complaints, a 23% increase compared to 2001. During this period, the number of PINS complaints referred to Family Court—both immediate referrals to Court and referrals from Diversion—declined from 43% to 26% of PINS complaints received. While the number of Court referrals from the Diversion Unit actually increased from 105 to 128, the overall decline occurred due to a significant 75% reduction in the number of PINS complaints immediately referred to Court.

A smaller proportion of JD complaints are diverted or withdrawn compared to PINS complaints (44% vs. 74% in 2003), however the vast majority of JD cases referred to Court are referred immediately without attempting Diversion. In 2003, 219 JD complaints were referred to Family Court, with nearly three-quarters referred immediately and about a quarter referred from Diversion.





	Complaints Received			Petitioned Immediately			Petitioned Following Diversion		
	PINS	JDs	Total	PINS	JDs	Total	PINS	JDs	Total
2001	439	340	779	85	163	248	105	20	125
2002	494	410	904	68	245	313	105	11	116
2003	568	390	958	21	162	183	128	57	185

Considerations: Included in the immediate referrals are youth for whom a missing persons report has been filed as well as JDs who are ineligible for Diversion due to the nature of the offense committed.

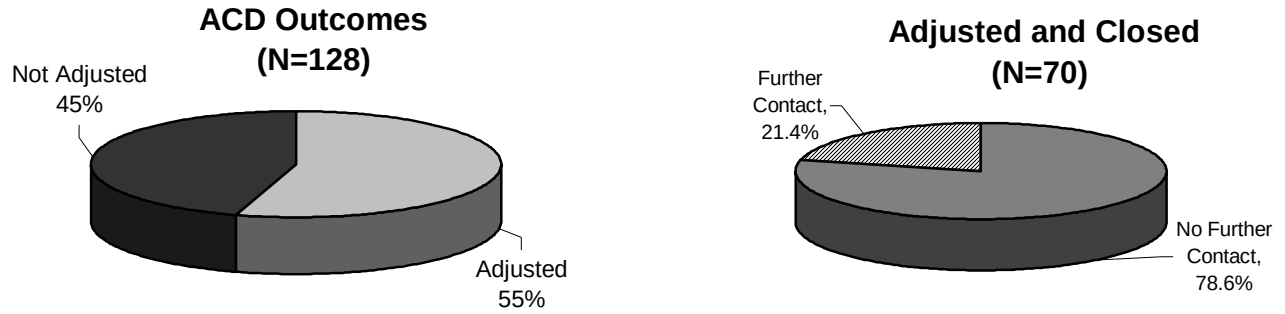
Performance Measure: PINS and JD Youth Successfully Completing Court-Ordered ACD

Description: Of PINS and JD cases referred to Court and subsequently adjourned in contemplation of dismissal (ACD), the proportion that are adjusted and closed and have no further contact with the juvenile justice system during the 12-month period following adjustment. Data for this measure could not be broken out by individual years and reflect an aggregate for the three-year period from 2001 through 2003.

Findings: During the 2001 to 2003 period, slightly more than half of all cases adjourned in contemplation of dismissal were adjusted and closed. Among these 70 cases that were adjusted, more than three-quarters (79%) had no further contact with the juvenile justice system during the 12-month period following adjustment.

Considerations: None.

Outcomes for PINS and JD Cases Adjourned in Contemplation of Dismissal

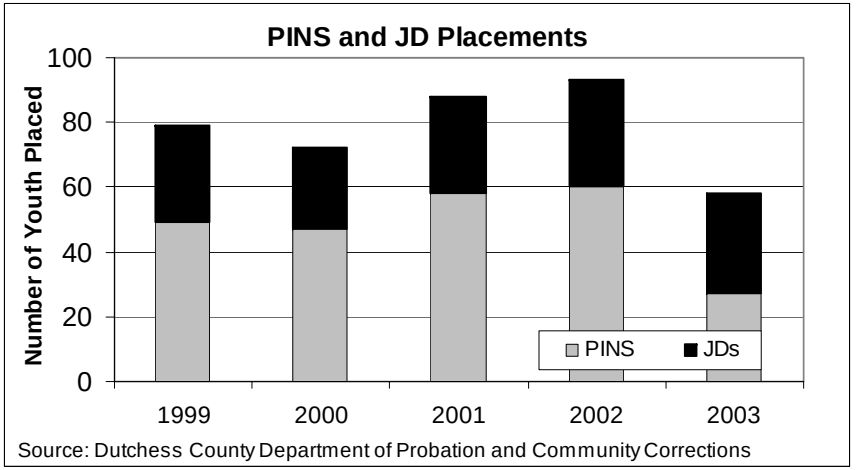


Source: Dutchess County Department of Probation and Community Corrections

Performance Measure: PINS and JD Youth Placed in DSS or OCFS Custody

Description: The number of PINS and JD youth placed in the care and custody of Dutchess County Department of Social Services or New York State Office of Children and Family Services as a result of a Probation referral to Family Court.

Findings: While the total number of youth placed out-of-home as a result of a Probation Court referral varied from year to year between 1999 and 2003, 38% fewer youth were placed in 2003 compared to just one year before, and 27% fewer were placed compared to 1999. Until 2003, on average, about two-thirds of youth placed in any given year were PINS youth. 2003 saw a dramatic decline in the number of PINS placements, and for the first time in the five year period examined, the number of PINS placements was below the number of JD placements (27 vs. 31). From 1999 to 2002, between 9% and 11% of PINS and JD complaints resulted in out-of-home placement. That proportion fell to 6% in 2003.



Source: Dutchess County Department of Probation and Community Corrections

Considerations: None.

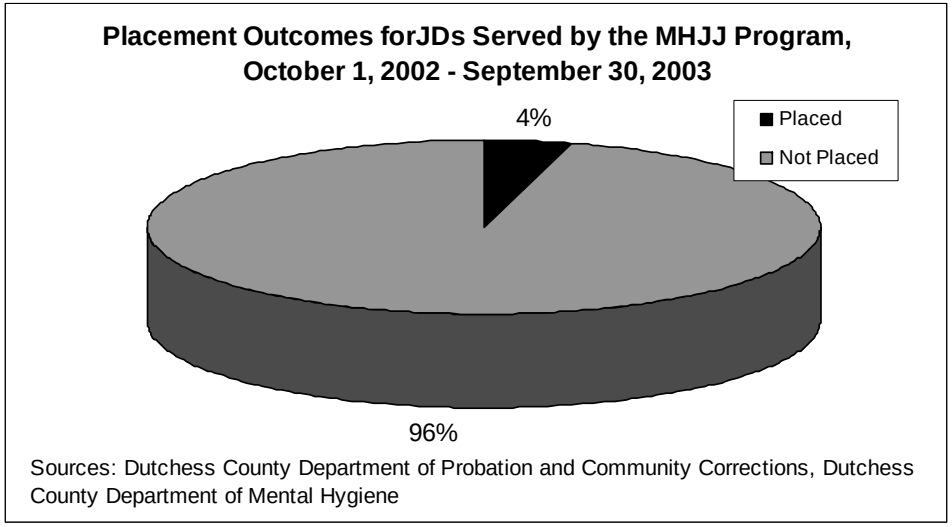
	Placements			Placements as a Percentage of Total Complaints Received		
	PINS	JDs	Total	PINS	JDs	Total
1999	49	30	79	11.7%	7.6%	9.7%
2000	47	25	72	10.4%	6.7%	8.8%
2001	58	30	88	13.2%	8.8%	11.3%
2002	60	33	93	12.1%	8.1%	10.3%
2003	27	31	58	4.8%	7.9%	6.1%

Performance Measure: Placements Outcomes for JDs Served by the Mental Health Juvenile Justice Project

Description: This measure presents baseline data on placement outcomes among JD youth receiving mental health counseling services provided through the Mental Health Juvenile Justice project (MHJJ).

Findings: During its initial year of operation, 47 JD youth and their families received mental health services provided through the MHJJ grant. The vast majority (96%) of youth receiving MHJJ services were not placed. In addition, 91% did not re-offend while receiving services.

Considerations: The MHJJ project began October 1, 2002; therefore no trend data are available.



Sources: Dutchess County Department of Probation and Community Corrections, Dutchess County Department of Mental Hygiene

Performance Measure: Pre-Trial Release Outcomes

Description: This measure has two components: 1) the number and percentage of defendants Probation recommends for pre-trial release but whose release is denied by the Court; and 2) the number and percentage of pre-trial defendants denied release by the Court and subsequently placed on probation. The first component indicates how often the Court disagrees with Probation's recommendation, and the second component indicates how often the Court, in effect, ultimately concurs with Probation's earlier recommendation for release into the community.

Findings: From 1999 to 2003, annually, Dutchess County Probation recommended between 930 and 1,049 defendants for pre-trial release. Typically, the number recommended for release was around 39% of the total jail population interviewed by Probation. In the past two years, the proportion of cases in which a Probation Officer has recommended an individual for release but the release was denied by the Court has increased. In 2002, in nearly one in ten of the cases in which Probation recommended release the release was denied, and while that proportion fell to 6.5% in 2003, these denial rates are substantially higher than they had been during the first three years of the study period when between 2.2% and 2.7% of Probation's recommendations were denied.
Data presented in the chart below also reveal that a substantial proportion of those individuals denied pre-trial release – anywhere from one quarter to one half—are later placed by the Court on probation.

Considerations: None.

Dutchess County Pre-Trial Release Outcomes							
	Defendants Interviewed by Probation	Defendants Recommended for Pre-Trial Release by Probation		Release Recommended by Probation and Denied by Court		Defendants Denied Release but Later Placed on Probation	
	Number	Number	Percent	Number	Percent	Number	Percent
1999	2,455	958	39.0	24	2.5	10	41.7
2000	2,351	930	39.6	25	2.7	7	28.0
2001	2,615	1,026	39.2	23	2.2	12	52.2
2002	2,678	1,049	39.2	109	10.4	41	37.6
2003	2,584	949	36.7	62	6.5	17	27.4

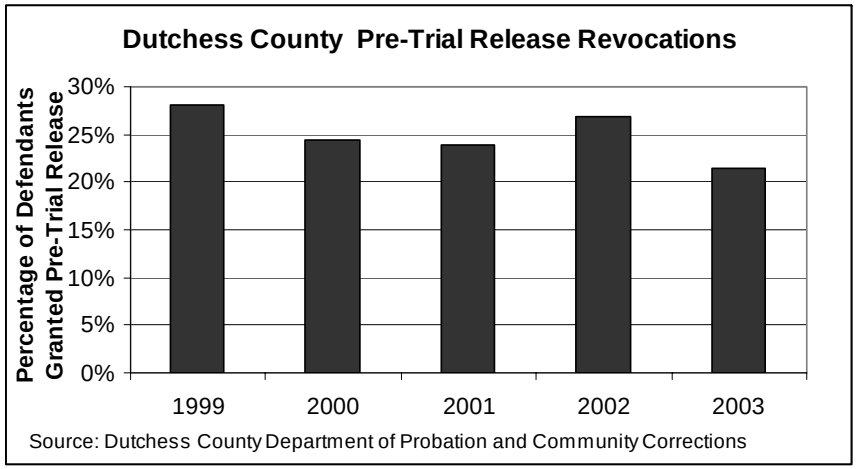
Source: Dutchess County Department of Probation and Community Corrections

Performance Measure: Violations of Pre-Trial Release

Description: The number of defendants participating in Dutchess County's pre-trial release program who violate the conditions of their release, resulting in revocation of release and a return to jail.

Findings: From 1999 to 2003, the proportion of defendants on pre-trial release whose release was revoked ranged from 22% to 28%. On average, annually, about one quarter of individuals placed on pre-trial release violated the conditions of that release and were returned to jail. While there were 20% fewer revocations in 2003 compared to 2002, additional data are needed to determine whether this represents a longer-term trend.

Considerations: Through its electronic monitoring and transitional housing programs, Dutchess County is able to place individuals at a higher level of risk on pre-trial release. These programs are also the most restrictive in terms of conditions for participation, and may be more likely to violate program participants who are not in compliance.



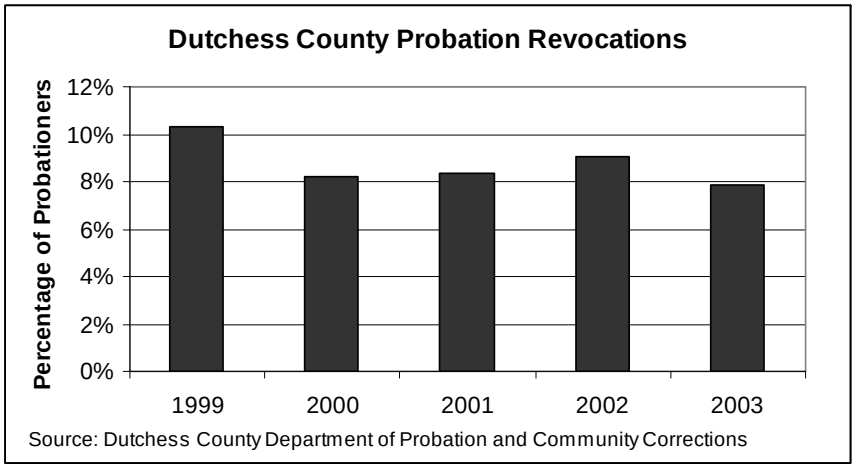
Dutchess County Pretrial Release Program			
	Released	Revoked	
	Number	Number	Percent
1999	935	263	28.1%
2000	908	222	24.4%
2001	1,027	246	24.0%
2002	971	260	26.8%
2003	961	207	21.5%

Performance Measure: Violations of Probation

Description: The number and percent of Dutchess County probationers who violate the conditions of their probation and whose probation is subsequently revoked.

Findings: While the total number of individuals on probation increased by 2% between 1999 and 2003, in 2003 there were 22% fewer probation revocations compared to 1999 (251 vs. 320). During this period the proportion of individuals whose probation was revoked varied only slightly from year to year, from a low of 8% to a high of 10% of the total probation caseload.

Considerations: None.



Dutchess County Violations of Probation			
	Number of Probationers	Probation Revocations	
		Number	Percent
1999	3,109	320	10.3%
2000	3,033	248	8.2%
2001	3,126	262	8.4%
2002	3,172	288	9.1%
2003	3,181	251	7.9%

Performance Measure: Improved Behavior in Children Served by the Youth Services Unit (YSU)

Description: The number of children served by the Youth Bureau Youth Services Unit's General Counseling Program whose behavior has improved, expressed as a percentage of all cases closed during a calendar year. The General Counseling Program offers counseling, advocacy, referral and educational services, such as anger management and social skills building, to troubled youth and their families.

Findings: The YSU's General Counseling Program appears to be exceeding its stated objectives. Between 1998 and 2003, rates of improved behavior for youth completing this program ranged from a low of 77% in 2000 to a high of 93% in 2003. Each of these figures surpassed the agency's annual target of 70% for cases closed. The average annual rate of improved behavior for this six-year period was 87%.

Considerations: The definition of improved behavior depends on the particular case and the goals involved, and can range from specific targets (such as fewer arguments related to grades or an end to skipped classes) to a more general perception that anti-social conduct has diminished. Behavioral parameters and objectives are established in conjunction with the family and are evaluated based on monthly family reporting.

Youth Bureau General Counseling Program			
	Number of Cases Closed	Youth Demonstrating Improved Behavior	
		Number	Percent
1998	136	120	88
1999	91	73	80
2000	85	65	77
2001	82	74	90
2002	151	134	89
2003	90	84	93
Total	635	550	87

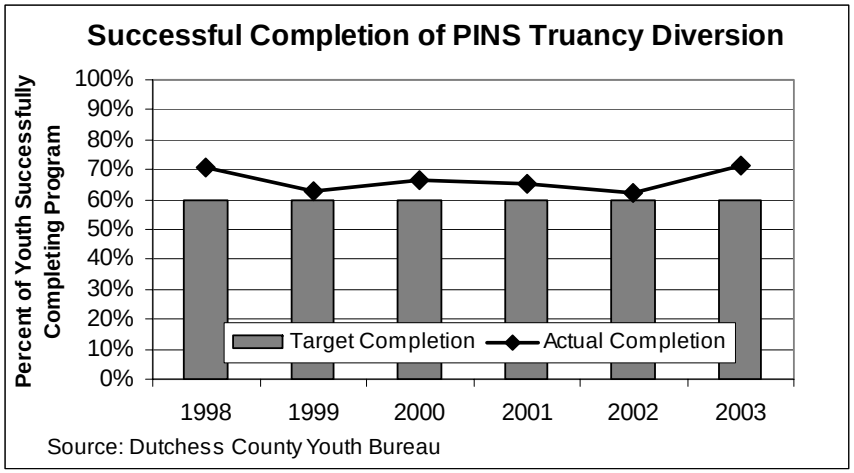
Source: Dutchess County Youth Bureau

Performance Measure: Youth Receiving PINS Truancy Diversion Services from the Youth Bureau Who are Diverted from Probation

Description: The Dutchess County Probation Department refers all truancy-related PINS applicants to the Youth Bureau for pre-diversion services in an effort to address family and school concerns and avert further involvement with the juvenile justice system. This measure reflects the number of youth who successfully complete the Youth Bureau's Truancy Diversion Services, expressed as a percentage of total cases closed by the program during a calendar year. PINS truancy diversion services include anger management, counseling, and other services for troubled youth.

Findings: On the average, two-thirds of the youth in the PINS truancy diversion program avoid being sent to Probation. The rate of successful pre-diversion has ranged from 62% to 71% over the past six years. These percentages surpass the agency's annual target rate of 60%. In addition, nearly 100% of those who successfully completed the Youth Bureau's truancy diversion program were not referred back to the Youth Bureau for additional services in the three month period following closing.

Considerations: None



Youth Bureau PINS Truancy Diversion Program			
	Cases Closed	Youth Completing Truancy Diversion	
	Number	Number	Percent
1998	79	56	71
1999	92	58	63
2000	123	82	67
2001	98	64	65
2002	71	44	62
2003	126	90	71
Total	589	394	67

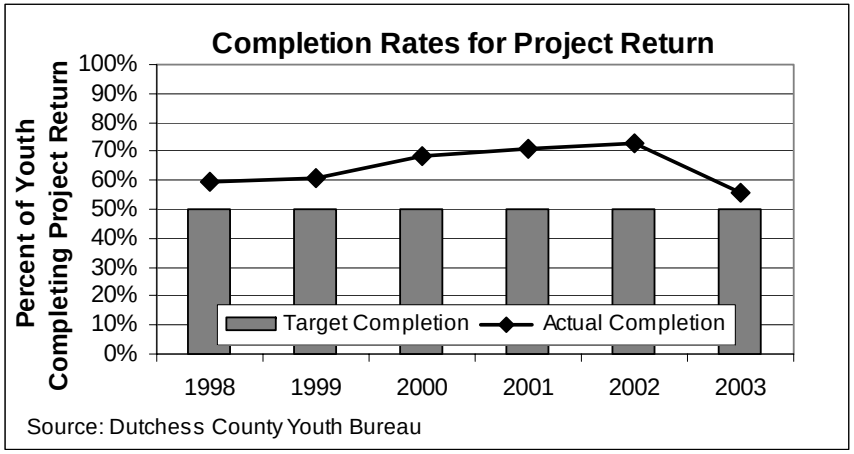
Source: Dutchess County Youth Bureau

Performance Measure: Program Completion Rates for Project Return

Description: The number of youth who successfully complete Project Return including those who are engaged in school or job activities, expressed as a percentage of all cases closed during a given year. Cases closed include those clients who are placed outside the home, fail to complete the program, or are considered uncooperative. Project Return is an intensive six-month program offering group life skills training, counseling, recreation, and other services to troubled youth either returning from residential care or at risk of an out-of-home placement.

Findings: The successful program completion rate for Project Return increased each year from 1998 to 2002, before dipping to a low of 56% in 2003. Each of these rates, however, still exceeds the YSU's annual target of 50% or more successful case closures. On average over this six-year period, nearly two-thirds of the children enrolled in Project Return were closed successfully and thus benefited from the program.

Considerations: None.



Completion Rates for Project Return			
	Cases Closed	Youth Successfully Completing Project Return	
	Number	Number	Percent
1998	27	16	59
1999	23	14	61
2000	22	15	68
2001	31	22	71
2002	26	19	73
2003	36	20	56
Total	165	106	64

Source: Dutchess County Youth Bureau

Performance Measure: Successful Discharge Placement Rates from River Haven

Description: The proportion of youth housed at River Haven who are reunited with their families or placed in otherwise appropriate long-term living situations when released from the shelter. River Haven provides emergency shelter, crisis intervention, case management, and advocacy services to troubled youth and their families. Children can be housed in the emergency shelter for up to thirty days, though extensions are sometimes granted. The shelter serves as a kind of respite care until the family crisis can be resolved or an alternative home placement can be arranged.

Findings: The successful discharge placement rate from River Haven has been quite stable over time, and has consistently met or exceeded the Youth Service Unit's target rate of 95%.

Considerations: River Haven was transferred from the YMCA to Hudson River Housing in 2000. Despite this transition, there was no significant disruption in services to the youth, including those provided by the emergency shelter.

Successful Placement Rates from River Haven			
	Youth Housed in River Haven	Youth Reunited with Families or Placed in Stable Living Situations	
	Number	Number	Percent
1999	149	144	97
2000	149	145	97
2001	157	151	96
2002	164	159	97
2003	160	154	96

Source: Dutchess County Youth Bureau

Performance Measure: Youth Bureau Contract Agencies Achieving 100% of Program Outcomes

Description: This measure reflects the percentage of all contract agencies funded by the Youth Bureau that meet 100% of their grant application outcomes in a given year. Beginning in 2000, municipal and non-profit agencies receiving program contracts from the Youth Bureau have been required to submit performance outcomes in their grant applications. Acceptable outcomes must specify a defined measure of progress, such as a newly learned skill, changed behavior, or a target percentage of children reaching a new achievement level, rather than simply report the number of children enrolled in or served by the program.

Findings: The percentage of contracted agencies achieving all of their program outcomes rose from 76% to 85% between 2001 and 2002.

Considerations: Although program outcomes language was introduced for grant applicants in 2000, contract agencies were not held to high outcome performance standards in that year because of this change and the transition to use of the Dutchess County Common Grant Application. The full shift to use of the Common Grant Application, including client outcomes with a documented verification process, was made in 2001.

Contract Agencies Achieving Program Outcomes			
	Contract Agencies	Contract Agencies Achieving 100% of Outcomes	
	Number	Number	Percent
2001	58	44	76
2002	59	50	85

Source: Dutchess County Youth Bureau

Performance Measure: Appropriateness of 7-Day CPS Safety Assessments

Description: Within seven days of receipt of a report, Child Protective Services (CPS) must conduct a preliminary safety assessment to determine whether the children named in the report and any other children in the household may be in immediate danger of serious harm. The New York State Office of Children and Family Services (OCFS) periodically conducts reviews of CPS performance at the county level. Most recently (August 2001), OCFS randomly selected 100 reports of alleged child abuse or maltreatment investigated by Dutchess County during the first half of 2001 to determine the adequacy of these investigations and the appropriateness of critical decisions and actions. Based on this report, this indicator reflects: 1) the proportion of cases in which a 7-day safety assessment was completed; 2) whether, in the reviewer's judgment, sufficient information had been gathered to make the safety decision; and 3) whether, in the reviewer's judgment, the safety decision was appropriate.

Findings: Ninety nine percent of the cases reviewed contained a safety assessment; however, in 10% of the cases the assessment was completed after the seventh day and therefore did not meet state standards. Reviewers determined that in 71% of the cases, sufficient information had been gathered to make the safety determination. In approximately half of the 100 cases (53%), the reviewer confirmed the appropriateness of the safety decision. According to OCFS, inappropriate safety decisions were made in 22% of the cases. OCFS' review concluded that Dutchess County tended to deem children unsafe when in the reviewer's opinion the children were safe.

Considerations: Data for this indicator are collected by OCFS and are not available annually.

CPS 7-Day Assessment of Safety		
Completion of 7-Day Assessment	**Number**	**Percent**
Assessment Completed within 7 Days	89	89%
Assessment Completed after 7th Day	10	10%
No 7 Day Assessment Completed	1	1%
Total	*100*	*100%*
Sufficiency of Information Gathered	**Number**	**Percent**
Sufficient Information Gathered	71	71%
Insufficient Information Gathered	21	21%
Unable to Determine Sufficiency	7	7%
No Assessment in Record	1	1%
Total	*100*	*100%*
Appropriateness of Assessment	**Number**	**Percent**
Decision Was Appropriate	53	53%
Decision Was Inappropriate	22	22%
No Decision Recorded	1	1%
Unable to Determine Appropriateness	24	24%
Total	*100*	*100%*

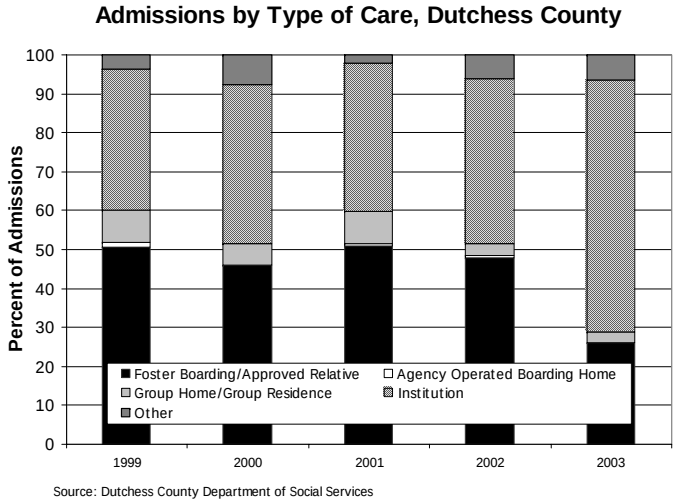
Source: New York State Office of Children and Family Services

Performance Measure: Admissions to Foster Care

Description: Admissions to foster care reflect the annual number of children placed in the care and custody of the Commissioner of the local Department of Social Services per 1,000 youth under age 22. These youth may be cared for in congregate care facilities, foster boarding homes, approved relative homes, or other facilities such as Supervised Independent Living Programs.

Findings: While there were 30 fewer admissions to foster care in 2003 compared to 1999 (138 vs. 168), both the numbers and rates of admission to foster care were otherwise variable during the intervening years, peaking at 225 admissions (2.6 per 1,000 youth under age 22) in 2002. Notably, the number of youth admitted to Institutional foster care increased approximately 50% from 1999 to 2003.

The graph at right shows a substantial decline in the proportion of youth admitted to foster boarding and approved relative homes and an increase in the proportion of youth admitted to institutional care from 1999 to 2003. In 1999, half of all admissions to care were admissions to foster boarding or approved relative homes. By 2003, this proportion had declined to 26%. In 2003, nearly two-thirds (64%) of youth admitted to foster care were placed in an institutional setting compared to 37% in 1999.



Source: Dutchess County Department of Social Services

Considerations: Capacity limitations and changes in policy (e.g., cost reduction policies or increased emphasis on keeping families together) may affect placement decisions and be reflected in a lower rate at which children enter foster care.

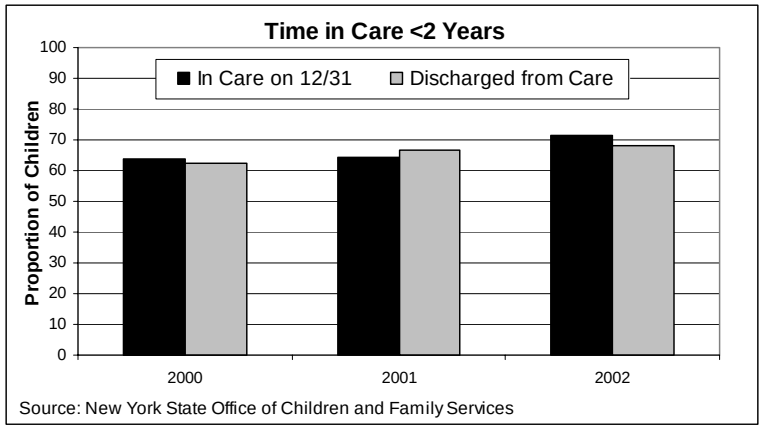
Dutchess County Admissions to Foster Care										
Placement Type	**1999**		**2000**		**2001**		**2002**		**2003**	
	Number	**Rate/ 1,000 Youth <22**	**Number**	**Rate/ 1,000 Youth <22**	**Number**	**Rate/ 1,000 Youth <22**	**Number**	**Rate/ 1,000 Youth <22**	**Number**	**Rate/ 1,000 Youth <22**
Foster Boarding/Approved Relative	85	1.0	73	0.8	98	1.1	108	1.2	36	0.4
Agency Operated Boarding Home	2	0.0	0	0.0	1	0.0	1	0.0	0	0.0
Group Home/Group Residence	14	0.2	9	0.1	16	0.2	7	0.1	4	0.0
Institution	61	0.7	65	0.7	73	0.8	95	1.1	89	1.0
Other	6	0.1	12	0.1	4	0.0	14	0.2	9	0.1
Total	168	1.9	159	1.8	192	2.2	225	2.6	138	1.6

Performance Measure: Time in Foster Care

Description: This measure reflects the length of time in care for two cohorts of youth, 1) those in foster care on December 31 of each year, and 2) those discharged from foster care during the three specified years. Achieving permanence in a shorter length of time is better for a child who has been removed from the home and is one of the goals of the federal Adoption and Safe Families Act (ASFA). ASFA established a 24 month timeframe to achieve permanency for a child who has been removed from the home.

Findings: While the overall number of youth in care on December 31 increased from 293 in 2000 to 384 in 2002 (a 31% increase), the first table below reveals that the proportion who had been in care for two or more years actually declined by 7.4% during this period.

About two thirds (68%) of youth discharged from foster care in 2002 spent less than two years in care. While this proportion has risen from 62% in 2000, nearly one third of the discharges in each of the three years reviewed here did not meet the ASFA goal of spending less than two years in foster care.



Source: New York State Office of Children and Family Services

Considerations: None.

Time in Foster Care – Children in Care on December 31									
	In Care on 12/31	Less than 1 Year		1-2 Years		2-3 Years		More than 3 Years	
	Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2000	293	117	39.9	70	23.9	54	18.4	52	17.7
2001	348	159	45.7	65	18.7	48	13.8	76	21.8
2002	384	178	46.4	96	25.0	38	9.9	72	18.8

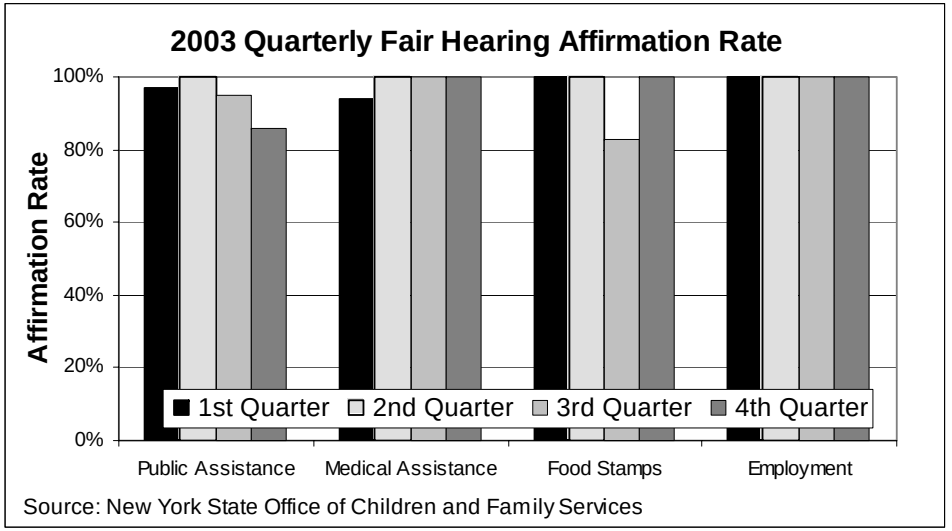
Time in Foster Care – Children Discharged from Foster Care									
	Discharged from Care	Time Spent in Care at Time of Discharge							
		Less than 1 Year		1-2 Years		2-3 Years		More than 3 Years	
	Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2000	193	61	31.6	59	30.6	41	21.2	32	16.6
2001	120	49	40.8	31	25.8	18	15.0	22	18.3
2002	173	89	51.4	29	16.8	24	13.9	31	17.9

Performance Measure: Fair Hearing Affirmation Rate

Description: This measure represents public assistance, medical assistance, food stamps, and employment fair hearing success rates, defined as the proportion of issues brought to a fair hearing for which the original DSS determination is upheld. Note: These data reflect the number of *issues* brought before an Administrative Law Judge and not the number of cases; i.e., an applicant or recipient requesting a hearing may be seeking review of multiple issues. The fair hearing affirmation rate measures a local social service district's ability to efficiently enforce administrative policy. These data are tracked on a quarterly basis by the New York State Office of Children and Family Services.

Findings: In 2003, DSS' decisions were upheld in 97% of the 372 issues for which a Fair Hearing was requested. Throughout the year, every one of the employment-related decisions was upheld. The affirmation rate for medical assistance issues was 98% (100% in the 2nd, 3rd, and 4th quarters), followed by a 97% affirmation rate for food stamps issues brought to a hearing. DSS' lowest affirmation rate was 95% for public assistance issues.

Considerations: None.



Source: New York State Office of Children and Family Services

2003	Public Assistance		Medical Assistance		Food Stamps		Employment		Total	
	Issues Heard	Affirmation Rate	Issues Heard	Affirmation Rate	Issues Heard	Affirmation Rate	Issues Heard	Affirmation Rate	Issues Heard	Affirmation Rate
1st Quarter	32	97%	34	94%	26	100%	9	100%	101	97%
2nd Quarter	29	100%	27	100%	30	100%	10	100%	96	100%
3rd Quarter	22	95%	28	100%	23	83%	5	100%	78	94%
4th Quarter	28	86%	26	100%	36	100%	7	100%	97	96%
2003 Total	111	95%	115	98%	115	97%	31	100%	372	97%

Performance Measure: Satisfaction with OFA Funded Programs/Services

Description: The percentage of respondents stating that they were very satisfied with Office for the Aging (OFA) funded services. The figures below were derived from OFA outcome and client satisfaction surveys conducted in 2001 and 2003. Data were selected from those surveys that asked respondents to rate their overall level of satisfaction with the program or service provided.
For the Expanded In Home Services to the Elderly Program (EISEP), the percentages reflect responses to a question asking participants to rate the overall quality of work performed by the home care worker (home care is one of the main components of the EISEP program). Response options for this question were excellent, good, fair, and poor.

Findings: In 2001 and 2003, overall satisfaction levels with OFA funded programs were fairly high, ranging from 86% to 100% of respondents reporting that they were "somewhat satisfied" or "very satisfied" with the services they received. For the Senior Exercise and Legal Services programs, approximately 90-95% of the respondents in both years expressed a high degree of satisfaction with the services provided. The number of those expressing a great deal of satisfaction with the Volunteer Caregivers Program increased from 70% to nearly 80% from 2001 to 2003. There was a slight drop in the proportion of those reporting that they were very satisfied with the Red Cross Medical Transportation program, although this rate was still a substantial 84% in 2003. The decline may be due in part to decreased County funding for this program which limited services. Between 89% and 95% of respondents served by EISEP home care workers reported that the quality of those services was "good" or "excellent".

Considerations: None.

Quality of Work Provided by EISEP Home Care Workers			
	Excellent	**Good**	**Fair/Poor**
1999	60%	35%	5%
2001	46%	43%	11%
2003	41%	51%	8%

Level of Satisfaction with OFA Funded Programs						
Program	**2001**			**2003**		
	Very Satisfied	**Somewhat Satisfied**	**Not/Not Very Satisfied**	**Very Satisfied**	**Somewhat Satisfied**	**Not/Not Very Satisfied**
Senior Exercise	94%	6%	0%	95%	4%	1%
Legal Services	87%	11%	2%	91%	9%	0%
Red Cross Medical Transportation	91%	9%	0%	84%	10%	6%
Volunteer Caregivers	70%	17%	13%	79%*	7%*	7%*
Nutrition Transportation	N/A	N/A	N/A	76%	22%	2%

Does not total to 100% because of 7% non-response rate.
Source: Dutchess County Office for the Aging

Performance Measure: Importance of OFA Programs in Helping Seniors Maintain Independence

Description: A primary mission of the Office for the Aging is to help seniors maintain their independence. As part of its periodic outcome and client satisfaction surveys, OFA asks its clients to assess the importance of the program or service they receive in assisting them to remain independent. The table below reflects responses to a question of this kind in the 2001 and 2003 surveys conducted for the following programs: EISEP; Volunteer Caregivers; Legal Services; Nutrition Transportation; Red Cross Medical Transportation; and Senior Exercise. The numbers in each column reflect the percentage of participants selecting that response option for the program involved.

Findings: OFA programs appear to play a key role in helping senior clients maintain their independence. In both years, for all but the Senior Exercise program, at least three-quarters of the respondents rated the program as extremely important in helping them to remain independent, and for several programs this rate approached or exceeded 90%. The proportion citing the Volunteer Caregivers program as extremely important in maintaining their independence rose from 75% to 93% from 2001 to 2003.

Considerations: None.

Importance of Program in Helping Seniors Remain Independent								
Program	**2001**				**2003**			
	Number of Respondents	**Extremely Important**	**Somewhat Important**	**Not Important**	**Number of Respondents**	**Extremely Important**	**Somewhat Important**	**Not Important**
Volunteer Caregivers	29	75%	21%	4%	15	93%*	0%*	0%*
Nutrition Transportation	NA	NA	NA	NA	44	91%	2%	7%
Red Cross Medical Transportation	58	93%	7%	0%	70	90%	10%	0%
Legal Services	45	88%	9%	3%	24	87%	13%	0%
EISEP	101	84%	14%	4%	116	81%	16%	3%
Senior Exercise	423	64%	30%	6%	467	58%	32%	10%

*Does not total to 100% because of 7% non-response rate.
Source: Dutchess County Office for the Aging

Performance Measure: Dutchess County CASA Caseloads

Description: The table below presents caseload measures for Dutchess County's Community Alternative Systems Agency (CASA) program. The Office for the Aging compiles statistics on a monthly basis for the CASA program. The figures in the first column (total active cases) represent the average monthly number of active CASA cases each year. The data in the second column reflects the average monthly caseload for CASA workers per year.

Findings: From 2001 to 2003, the average monthly number of CASA cases increased by 9%, from 1,058 to 1,152. During this period, the average caseload per worker increased by 10%, from 78 to 86 cases per worker.

Considerations: None

Dutchess County CASA Caseload		
	Average Monthly Total Active Cases	**Average Caseload per Worker**
2001	1,058	78
2002	1,149	85
2003	1,152	86

Source: Dutchess County Office for the Aging

Performance Measure: Department of Mental Hygiene Patient Satisfaction

Description: This measure reflects patient satisfaction with services received from the Dutchess County Department of Mental Hygiene. Each year the Department administers a survey to patients at all program locations during a designated survey week. The data presented here reflect positive client satisfaction ratings, i.e., for questions that have a four-point response scale, the proportion of respondents providing ratings of "very satisfied" or "satisfied", "excellent" or "good", and "always" or "usually".

Findings: Overall, satisfaction ratings have been consistently high over time, with patients expressing the highest levels of satisfaction in response to the question asking "how would you rate the therapy you receive?" (see "Therapy Rating" in the table below). In 2002, 92% of respondents were either satisfied or very satisfied with the therapy they had received. On average, about 92% of respondents indicated satisfaction with clinic hours, and a slightly lower percentage, about 86% on average, were satisfied with their ability to make appointments at times that were convenient for them. While the vast majority, four out of five respondents in 2002, indicated that as a result of receiving DCDMH services they felt "better" or "much better" (see "Current Condition" in the table below), this percentage has slowly but steadily declined in each year since 1999.

Considerations: The data below do not include those served by the Department's Developmental Disabilities Division, which utilizes a separate survey instrument.

Percent of Respondents Indicating Satisfaction with DCDMH Services				
	(N=846)	(N=935)	(N=898)	(N=911)
	1999	2000	2001	2002
Facilities Rating	85.6	85.1	84.6	84.1
Clinic Hours	92.8	91.8	91.4	92.2
Appointment Convenience	86.0	83.8	87.3	87.2
Therapy Rating	93.7	93.9	94.1	92.4
Current Condition	84.2	83.7	81.4	79.9

Source: Dutchess County Department of Mental Hygiene

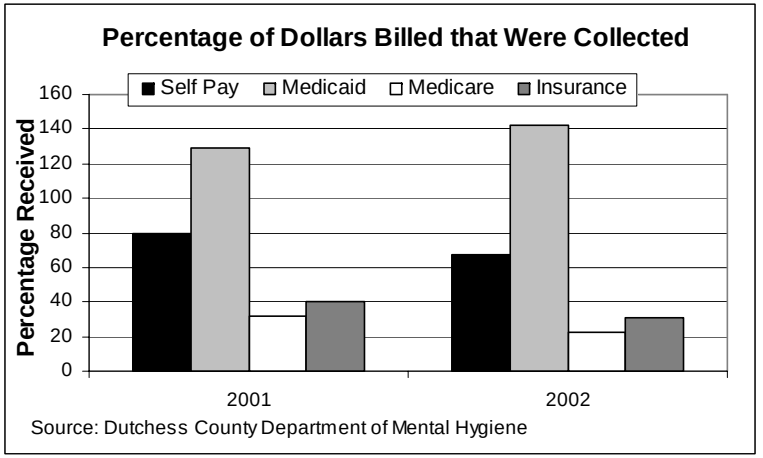
Performance Measure: Effectiveness of Revenue Collections for Mental Hygiene Services

Description: This measure reflects the dollar value of payments received for County mental hygiene services as a proportion of the total dollar amount billed for services. Services billed and payments received are broken out by the following payment sources: self-pay, Medicaid, Medicare, and third-party insurance.

Findings: While Medicaid is the largest revenue source for DCDMH with over $6 million in services billed in 2001 and 2002, the chart at right also reveals that Medicaid has the highest percentage of dollars billed that are actually collected. In fact, the Medicaid amounts received by the County exceed the amounts billed. Through the Comprehensive Outpatient Program (COPS) and Community Support Programs (CSP), the County receives an add-on to the standard Medicaid rate based on the number of services provided to seriously mentally ill individuals, and therefore the percentage collected exceeds 100%.

The second highest proportion of dollars collected relative to services billed is consistently the self-pay category. In 2002, approximately two-thirds of the amount billed under the self-pay category was received.

Medicare billings have consistently yielded the lowest percentage of payments received, ranging from 23% in 2002 to 36% during the first half of 2003.



Considerations: 2003 data are partial year only. The COPS and CSP revenue add-ons may mask the actual reimbursement percentage for billed Medicaid services.

Payment Type	2001			2002			2003*		
	Billed	Received	% Received	Billed	Received	% Received	Billed	Received	% Received
Self Pay	$217,130	$171,946	79.2	$244,626	$165,514	67.7	$140,310	$118,187	84.2
Medicaid	$6,049,610	$7,802,789	129.0	$6,559,111	$9,342,366	142.4	$2,901,444	$4,377,348	150.9
Medicare	$544,772	$172,200	31.6	$669,008	$152,924	22.9	$291,187	$105,558	36.3
Insurance	$706,086	$284,785	40.3	$943,109	$294,133	31.2	$332,091	$134,003	40.4

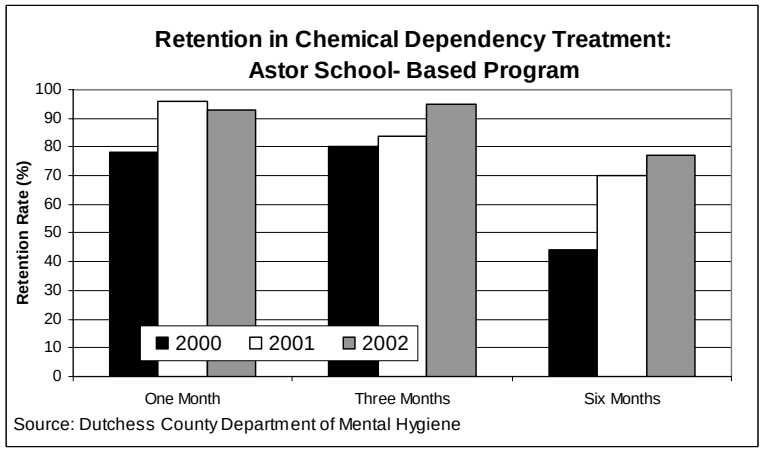
***Partial year data only: 1/1/03 - 7/31/03**

Performance Measure: Retention in Chemical Dependency Treatment

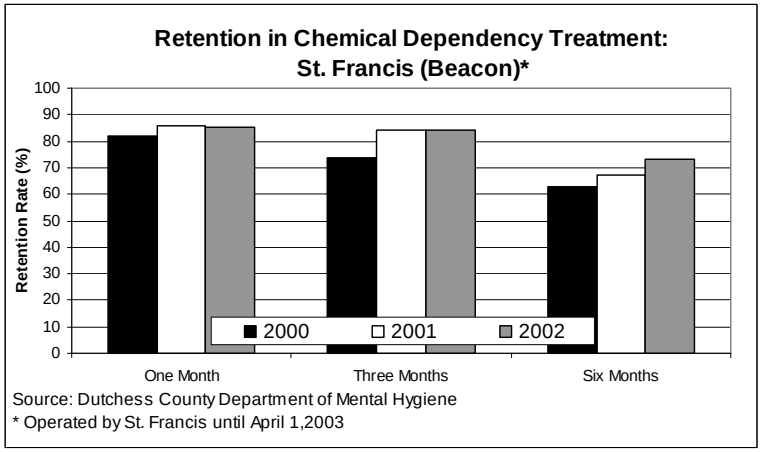
Description: The proportion of clients served by county-operated and county-funded chemical dependency programs who remain in treatment for one month, three months, and six months. Research shows that retention in treatment is an important factor in overall treatment success. Retention data are presented at the program level.

Findings: While the one-month, three-month, and six-month retention rates generally increased over time for the Astor School-based and Beacon programs, these rates generally declined for the Manchester/Satellite programs. Six-month retention rates increased at Beacon, from around 63% to 73% from 2000 to 2002, but dropped from 63% to 56% at the Manchester/Satellite programs during the same period.

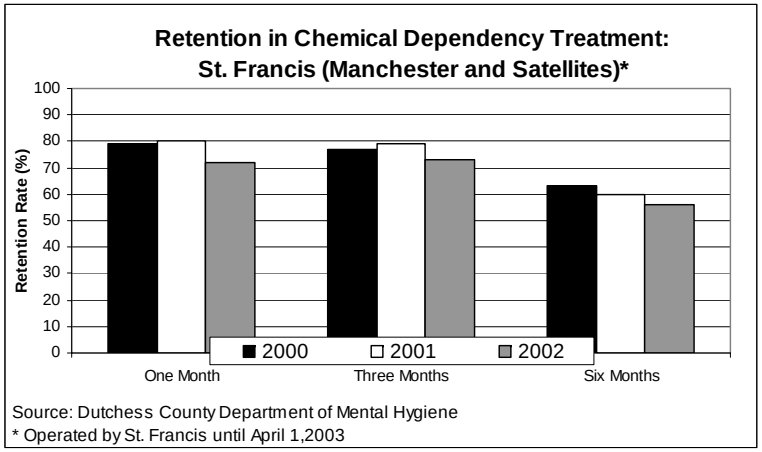
Considerations: St. Francis ran the Beacon, Manchester, and satellite programs below until April 1, 2003, at which point they were transferred to Lexington Center for Recovery. The Astor School-Based program serves a mixed population of mentally ill and chemically dependent youth, and is not directly comparable to other programs.



Source: Dutchess County Department of Mental Hygiene



Source: Dutchess County Department of Mental Hygiene
* Operated by St. Francis until April 1,2003



Source: Dutchess County Department of Mental Hygiene
* Operated by St. Francis until April 1,2003

Performance Measure: Children Receiving Early Intervention Services

Description: This measure reflects children age birth through two receiving Early Intervention (EI) services in Dutchess County, and has three components: 1) the number of children evaluated for EI during a calendar year, expressed as a percentage of all children age 0-2; 2) the number and percentage of those children found eligible for EI; and 3) children receiving EI services such as physical therapy, occupational therapy, and speech therapy, on December 1st of a given year, expressed as a percentage of children age 0-2.

Findings: Between 1999 and 2003, the number of children evaluated for, and participating in, Early Intervention programs in Dutchess County rose substantially. The number of children evaluated increased by 90% during this period, from 324 to 614, and on average, annually, about 90% of these children were deemed eligible for services. These factors lead to a concomitant rise in the number of Dutchess County's 0-2 year olds receiving services on December 1, and by 2003, this number was 70% higher than it had been in 1999 (603 vs. 354). These increases can likely be attributed both to the recent population influx in the southern part of the County and a growing interest in (and awareness of) Early Intervention services among parents and other care providers in the area.

Considerations: Rate calculations are based on the U.S. Census Bureau's 2000 population data.

Dutchess County Early Intervention Program					
	Children Evaluated	Children Eligible for EI		Children Receiving Services on December 1	
	Number	Number	Percent	Number	Percent of 0-2 Year Olds
1999	324	292	90.1	354	3.6
2000	456	416	91.2	451	4.6
2001	456	418	91.7	504	5.1
2002	582	515	88.5	558	5.7
2003	614	563	91.7	603	6.1

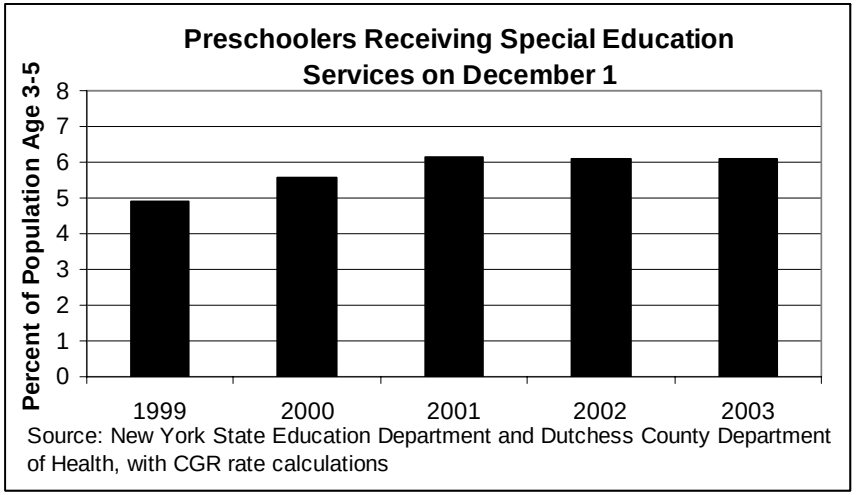
Source: Dutchess County Department of Health

Performance Measure: Preschoolers Receiving Special Education Services

Description: The number of preschool age children ages 3-5 with disabilities receiving special education services on December 1 of the given year, as authorized by a school district's Committee on Preschool Special Education, expressed as a percentage of all 3 to 5 year olds.

Findings: While the number of Dutchess County preschoolers ages 3-5 receiving special education services on December 1 was 24% higher in 2003 compared to 1999 (687 vs. 552), both the number and percentage receiving service have been fairly constant for the past three years. From 2001 to 2003, the most recent year for which data are available, about 6% of Dutchess County's preschoolers were receiving special education services on December 1.

Additional data provided by the Dutchess County Health Department reveal that 635 children were evaluated for preschool special education services in 2003.



Source: New York State Education Department and Dutchess County Department of Health, with CGR rate calculations

Considerations: Classification rates may vary between schools due to differing standards being applied by the various Committees on Preschool Special Education. Parents' roles, particularly the extent to which a parent may advocate for his or her child to be classified, and the district's responsiveness to the parent may also impact rates. Rate calculations for this measure are based on population data from the 2000 Census.

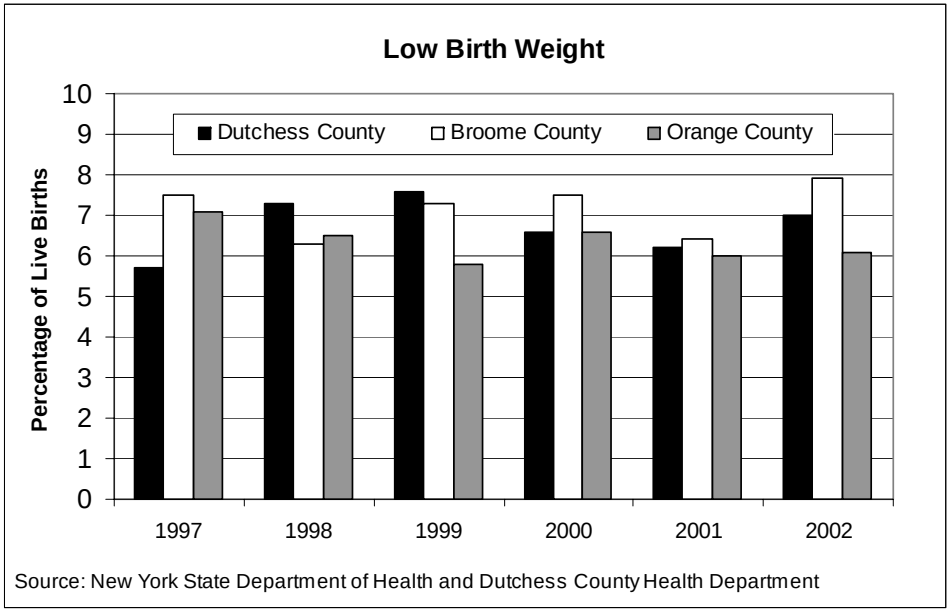
	Preschoolers Receiving Special Education Services on December 1	
	Number	**Percent**
1999	552	4.9
2000	625	5.6
2001	689	6.1
2002	686	6.1
2003	687	6.1

Performance Measure: Low Birth Weight Rate

Description: The number of babies born with low birth weight – less than 2,500 grams or about 5.5 pounds – in a given year, expressed as a percentage of all live births. Low birth weight is a leading cause of neonatal death. Low birth weight babies are also more likely than normal birth weight babies to experience long-term developmental and neurological disabilities.

Findings: Between 1997 and 2002, low birth weight rates fluctuated from 5.7% to 7.7% in Dutchess County (representing between 193 and 242 infants annually). While the proportion of low birth weight births declined for two years following a high of 7.6% in 1999, it increased once again in 2002. Overall, low birth weight rates in the County are similar to those found in Broome and Orange counties, although since 1998 the rates in Orange County have been lower than those in Dutchess in all but one year.

Considerations: 2001 and 2002 data are provisional at the county level.



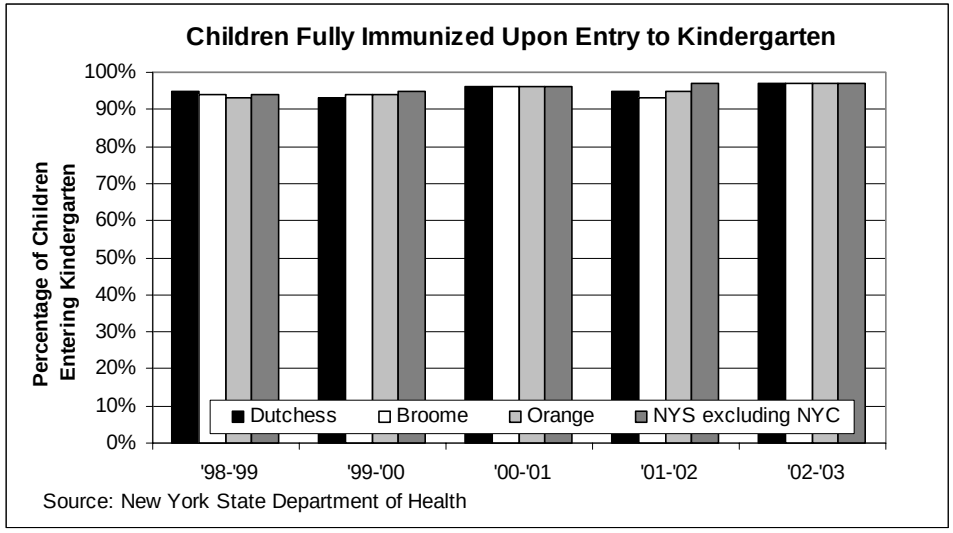
Source: New York State Department of Health and Dutchess County Health Department

Performance Measure: Immunization Rates for Children

Description: The percentage of all kindergarteners that have been completely immunized upon entry to school. The full schedule of age-appropriate immunizations includes the following vaccinations: DPT/DT/TD; Polio; Measles (2 doses); Rubella; Mumps; and Hepatitis B. Immunization levels reflect a community's commitment to preventive health efforts, and may reflect a family's access to and use of preventive care. Immunizations offer an effective means of reducing the risks associated with a variety of debilitating and sometimes deadly childhood diseases. Children must be up-to-date on their immunizations before they are permitted to enroll in public school.

Findings: Immunization levels among children entering kindergarten in Dutchess County have been high – 93% or better – and fairly stable over time. As the data also indicates, immunization rates have varied little within and across the three counties, and have consistently approached or equaled the statewide average. Each county did, however, attain its highest rate of 97% during the 2002-03 school year.

Considerations: None.

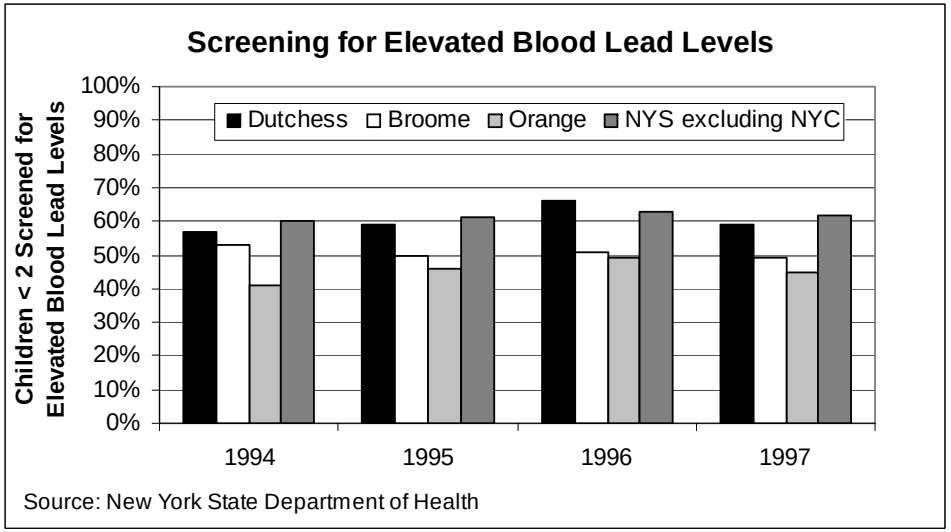


Performance Measure: Screening for Lead Poisoning Among Children

Description: New York State regulations require the testing of all children for blood lead levels before age two. This measure identifies the number of children screened for elevated blood lead levels at least once before age two, expressed as a percentage of the total birth year cohort. A birth year cohort includes all children who were born in a given year.

Findings: Blood lead screening rates ranged from 57% to 66% in Dutchess County for the 1994-1997 birth year cohorts. These lead screening rates approached and, in one year, surpassed the rate for the rest of NYS (excluding NYC). Dutchess County's screening rates were also well above the comparable rates for Broome and Orange counties. Nevertheless, the data still indicates that less than two-thirds of all children in Dutchess County are consistently screened for elevated blood lead levels.

Considerations: Data for birth year cohorts after 1997 is not yet available from the New York State Department of Health.



Performance Measure: Therapy Completion Rates for Tuberculosis Patients

Description: The percentage of all patients with active or latent tuberculosis (TB) infection that have successfully completed drug therapy treatment. Latent tuberculosis infection refers to individuals who have been exposed to TB but do not have the disease. The typical treatment period for both latent and non-drug resistant active strains of TB is six months; those infected with more resistant strains receive treatment for up to twelve months. In each case, the appropriate drug therapy must be administered within one year to meet the criteria for treatment completion. Tuberculosis remains a significant communicable public health disease threat in NYS, with an especially high incidence of infection among foreign-born residents.

Findings: Since 1998, the DCDOH has maintained a 100% therapy completion rate for patients with active TB infection and an 85% or higher completion rate for those with latent infection. Both of these figures are well above the relevant national and state averages. For example, the national therapy completion rate for active cases was 92% in 1999 (the most recent year for which data are available). Statewide, in 2001 the therapy completion rate for active cases was 81%, and only 62.5% for those with latent infection.

Considerations: None

Therapy Completion Rates for TB patients				
	Active TB Cases		Latent TB Cases	
	Number	Percent Completing Treatment	Number	Percent Completing Treatment
1998	9	100	N/A	*86
1999	9	100	N/A	*89
2000	10	100	N/A	*86
2001	5	100	165	84
2002	9	100	148	89
2003	11	100	98	85

Sources: Dutchess County Department of Health; *New York State Department of Health

Performance Measure: Identification and Notification of Patients Testing Positive for HIV

Description: The number of individuals testing positive for HIV who received their test results, expressed as a percentage of all individuals testing positive for HIV during a calendar year. HIV/AIDS remains a major public health concern in Dutchess County, posing a significant health threat to those infected with the disease as well as their sexual partners.

Findings: Dutchess County Department of Health protocol prohibits the release of HIV testing results (whether positive or negative) over the phone. In order to receive their results, clients must return to the clinic for a post-test counseling session, where they are advised about their test results, the risks of HIV transmission, proper methods of protection, and referrals for medical treatment and available social and mental health services. As part of this process, the department also attempts to identify all sexual partners of the clients and undertakes outreach efforts to bring them in for testing. Since 1998, the DCDOH has been largely successful in reaching and notifying clients who have tested positive for HIV. In four of the past five years, 100 percent of those testing positive have received their test results and post-test counseling. A client who does not return as scheduled for his or her results is contacted twice by mail, phone, or in person before a "lost cause" determination is made. However, post-test counseling rates for those testing negative (the vast majority of clients) have declined sharply over the past two years, reaching a low of 72% in 2002.

Considerations: None.

Dutchess County Department of Health HIV Testing and Counseling Program						
	Number Tested	**Number Receiving Post-Test Counseling**	**HIV Negative: Percent Post-Test Counseled**	**Positive Test Results**	**HIV Positive: Number Post-Test Counseled**	**HIV Positive: Percent Post-Test Counseled**
1998	931	790	85	14	14	100
1999	760	630	83	11	11	100
2000	780	645	83	7	6	86
2001	862	699	81	11	11	100
2002	930	674	72	5	5	100

Source: Dutchess County Department of Health