Haywood County
Health Department
and
Department of Social Services

Integration Study

Final Report
February 2013

Marty Stamey, County Manager
Julie Davis, Finance Director
Carmine Rocco, Director - Health Department
Ira Dove, Director - Department of Social Services

STUDY ON INTEGRATION OF
HAYWOOD COUNTY HEALTH DEPARTMENT AND HAYWOOD COUNTY DEPARTMENT OF SOCIAL SERVICES
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EXECUTIVE SUMMARY

This Task Force report provides an evaluation of the feasibility of combining the Haywood County Health Department and the Haywood County Department of Social Services into an integrated Human Services Agency. The study of the issue began with site visits to integrated Health and Human Services Agencies in North Carolina and included the following:

- Review of studies of Public Health from the UNC School of Government;
- Review of laws and policies related to other issues of integration, for example, the State Personnel Act and Governance;
- Facilitated discussion with interested parties; and
- Technical assistance from the UNC School of Government

After careful study, review and consultation, the Task Force concluded that Haywood County could benefit from integration in multiple ways, such as a focus on overall client needs and coordination of client services creating more efficiency and less duplicated effort.

With three options for governance included in the recently enacted NCHB 438, the Task Force considered the structure and makeup of Social Services and Health department's current boards, the benefit a variety of views would add, the time constraints of the Board of County Commissioners and the possible additional costs for training individuals regarding required board tasks. The Task Force concluded that presently both the Haywood County Social Services and the Haywood County Health Department have active boards and are well governed. Still, since the County could benefit from integration, and, after narrowing the choice to two preferred options, and researching the ramifications of each, the task force is recommending that Haywood County create a Consolidated Human Services Board that would maintain the powers and duties of the current health and social services boards.

Also, three crucial recommendations from the Task Force are (1) for development of a cross-training program for employees in order to sustain levels of service in the future, (2) revising the Haywood County Personnel Manual and policies to create a more substantially equivalent system capable of meeting all of the state and federal merit system requirements and (3) engaging the County's Indirect Cost Allocation Plan provider for suggestions on the most appropriate method of allocating or sharing expenses across the departments in order to maximize allowable reimbursement revenues.

Additionally, along with other recommendations included in this report, the Task Force recommends that any cost savings that may be realized in this integration should be placed back into the system in order that they may continue to increase efficiencies, improve meeting the benchmarks and serving the needs of the Agency, while lessening the long-term costs to the taxpayer. This concept has proven to be a crucial motivating factor in the Buncombe County plan and is suggested here as a way to facilitate a more successful integration.

ACKNOWLEDGEMENT

For several years, the employees and Boards of the Haywood County Health Department (HD) and the Haywood County Department of Social Services (DSS) have sought ways to innovate practice that improves both the lives of Haywood County's residents and the efficiency with which services are delivered to them. The Board of County Commissioners and County Administration have been supportive of these practice aims, as demonstrated by the beautifully renovated, and repurposed, Health and Social Services Building at Paragon Parkway. The lovely and well equipped building now houses both the HD and DSS. The Task Force Members acknowledge and thank all of those involved in the increase of best practices and provision of resources for our citizens. We also would like to thank Dr. Ramon Rojano and his management team in Wake County, and Mandy Stone and her team in Buncombe County. They have been longtime practitioners of best practices and have been most willing to share their findings. The groundwork set by all of those mentioned herein occurs at a time of seemingly ever increasing needs being met with diminishing State and Federal resources. Special thanks to Kathi McClure, Human Resources Director, for her willingness to assist the Task Force and for her contributions to this report.

BACKGROUND

On July 23, 2012, Mark Swanger, Haywood County Commissioner Chairman and Health Department Board Member; and Michael Sorrells, Haywood County Commissioner, Social Services Board Member on behalf of the Haywood County Commissioners formed a Task Force to study and make recommendations concerning the issue of whether or not Haywood County should integrate its Departments of Health and Social Services under the recently enacted NCHB 438, NCSL 2012-126 (Attachment 1).

Other members appointed to the Task Force include Marty Stamey, County Manager; Julie Davis, Finance Director; Carmine Rocco, Director of the Health Department; and Ira Dove, Director of Social Services.

On October 15, 2012 an interim report was submitted to the Commissioners stating the progress of the consolidation study. Portions of that report will be referenced in this final report; however it will not be duplicated here. The Task Force was charged with several duties to complete by the January 1, 2013 deadline.

A STUDY ON INTEGRATION

The Task Force has concluded its initial research at this time; however, this report recommends several points of further consideration, for both before and after integration, should the Commissioners decide to integrate HD and DSS.

On October 22, 2012, at Marty Stamey, Carmine Rocco, Mark Swanger and Ira Dove participated in a conference call with the University Of North Carolina School Of Government regarding receiving technical assistance from the School of Government around the integration issue. It was determined that members of the School of Government would travel to Haywood County and facilitate a conversation with the joint Boards of the Health Department and Social Services, and the Commissioners, and would cover issues such as governance, service delivery, the work force, fiscal impact and other such issues that would be part of integration.

On October 23, 2012, members of the Task Force conducted a site visit to the Buncombe County Health and Human Services in Asheville, NC. They met with Wanda Greene, County Manager of Buncombe County; Mandy Stone, Director of the Health and Human Service Agency; and key members of the Buncombe County staff. A brief report of this site visit is attached (Attachment 2).

On November 13, members of the UNC School of Government facilitated the conversation with the joint Boards regarding integration. A copy of the report prepared by the School of Government is attached along with an agenda from the meeting (Attachment 3).

November 28, 2012, the members of the Task Force and Human Resource Director, Kathi McClure, met to review the research to date, including independent research of the members, and to discuss the preparation of the final report and the recommendations that it would contain.

RECOMMENDATION AS TO WHETHER OR NOT TO INTEGRATE THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

After considering the different models of delivery of Social Services, the Task Force agrees that the County could benefit from integration of HD and DSS, if the integration is properly handled. Specifically, the Task Force members would cite the benefits that they have seen in the Buncombe County Health and Human Services Agency and in the Wake County Human Services Agency. These benefits include, but are not limited to, the following: a focus on all customer needs with coordinated service delivery; an increased ability to quickly shift resources to the greatest areas of need across former Department lines; potential administrative efficiencies

resulting from a workforce that can be cross-trained; a shared vision in Health and Human Services that can be articulated for the prioritization of resources and personnel; and greater communication among County employees and Management .

It is not accidental that one of the primary goals for service integration is to improve outcomes for clients. The trend is toward improving client outcomes and self sufficiency by providing timely and appropriate services aimed at helping the whole client, rather than just a need here and there; ultimately saving money as clients use either fewer or less expensive services. The philosophy and practice of the North Carolina Department of Health and Human Services (DHHS) exemplified in the DHHS Excels initiative is aimed at reshaping the culture of the Agency to achieve better outcomes and save money. The initiative stresses creating a Department that is customer-focused, anticipatory, collaborative, transparent, and results-based. DHHS Excels treats customers holistically and looks at services across traditional disciplinary and agency lines (http://www.ncdhhs.gov/excel/).

GOVERNANCE

Present Governance, Powers and Duties of HD and DSS Boards

The issue of governance should be carefully considered in the decision of whether or not to integrate, and if so how. Governance can be a complex topic, as the decisions and commitments concerning the relative powers and duties that should be assumed or delegated by the County Commissioners have real consequences.

The HD has an eleven member Board, which is appointed by the Board of County Commissioners (BOCC) and complies in composition with the professional disciplines as outlined in general statute. The Basic duties of the Board, as outlined in N.C.G.S. 130A-39 *et seq.*; N.C.G.S. 130A- 40 *et seq.*; and other General Statutes include: Appointing and supervising the Health Director; public health rule-making at the local level; adjudication of local rules and administrative penalties; setting local public health fees and recommending the budget to the Commissioners; meeting at least quarterly and satisfying the local health department accreditation requirements. As to the accreditation requirements, there are a number of benchmarks that the local Board of Health has met and must continue to meet (Attachment 4). Meeting these benchmarks requires substantial activity on the Board's part and is a multi-year process (Attachment 5). Meeting these requirements is mandatory and cannot be delegated.

Presently the local Board of Social Services (BSS) has five members, two of whom are appointed by the BOCC, two by the State Social Services Commission and one by the BSS itself. The basic powers and duties of the BSS, as outlined primarily in N.C.G.S. 108A – 9 et seq., include: appointing and supervising the Director of Social Services; advising the Director and other agencies on the social conditions in the County; inspecting the public service records; reviewing (or delegating review of) fraud cases in public assistance; meeting at least once a month; assisting the Director in planning the Social Services proposed budget; assisting in establishing County policies for programs that are consistent with Federal and State laws, rules and policies.

Presently, the BOCC has the ultimate authority and responsibility for the final budgets of both departments and the number of personnel positions in both departments.

Alternative Governing Options

In North Carolina, a BOCC could choose to leave the governance of the Departments as it is. Since there is presently no legal requirement to integrate the HD and DSS, there is no requirement to change the current governing structure. The BOCC can choose to change or assume the powers and duties of the Board of Health, the BSS, or both. Integration of the two into a Consolidated Human Services Agency (CHSA) is also an option (Attachment 6). If the BOCC elects to integrate the Departments, it can create either a CHS Board with full powers, or one that serves as an Advisory Committee. Examples of these options presently exist in other Counties.

Other Counties' Examples

Wake County has a CHSA model in which there is a board that exercises all of the powers and duties of the Social Services and Health Boards with the exception of the appointment and supervision of the CHSA Director. The County Manager hires and dismisses the Director, with the advice and consent of the CHS Board. The entire CHS Board is appointed by the County Commissioners and utilizes professionals as designated by statute to serve. Dr. Rojano, the Director, is a strong proponent of the model, wherein the CHS Board retains the powers and duties. One distinguishing item appears to be the level of commitment of the Board.

In 1984, the Mecklenburg BOCC assumed the powers and duties of the BSS. Presently, Mecklenburg appears to be having some very public issues concerning governance. Among the issues are Commissioners publicly denying knowledge of the workings of the Mecklenburg DSS, and their own responsibilities, and splitting Child Welfare off from DSS. (C.F. "DSS rift exposes deadly failures." *The Charlotte Observer*. October 21, 2012, p.1.)

Buncombe County has been in the process of integrating services since the mid-1990's. In September 2012, their BOCC formed the Buncombe County Health and Human Services Agency (BCHHSA). The BCHHSA Board has essentially the same statutory powers and duties as the Wake County Board. In addition, the BCHHSA oversees several advisory boards on targeted issues. (Attachment 7) According to Director Mandy Stone, a goal of the model is to increase participation on the Boards and to focus on community issues.

Recommendations as to Governance

After careful consideration, the Task Force initially narrowed the governance model choice to two options, should the BOCC choose to integrate. In the first alternative, the BOCC could assume all of the powers and duties of both Boards, those listed in the consolidation legislation (Attachment 1) and act as both Governing Boards. At the present time, the Commissioners are quite capable and could shoulder the additional burden. In essence, the Commissioners would be required to be familiar with actions and requirements of the Board of Health and BSS, in addition to the outlined powers and duties. Under this model, the BOCC would by law need to appoint an Advisory Committee that has members as outlined in N.C.G.S. 130 A- 35 and 153A-77 (a), but may include others. The Task Force would specifically recommend including other members representing the Social Services powers and duties, and having one larger advisory

committee. Although the larger advisory committee may have subcommittees, it is felt that some of the benefit of integration is lost without cross-section review of issues as the primary focus of the committee. In addition, should the County Commissioners choose to accept the responsibility to govern the Agencies, present and future commitments must be made and maintained. In addition to monthly reports, work session meetings should be scheduled to review the policies and performance of the Agency, and to work on the benchmarks for accreditation. Also, the lines of communication should be open and formalized. One benefit to BOCC governance is that individual Commissioners on the governing board would be more immersed in DSS and HD matters arising for a vote. However, this will take a larger time commitment and include handling several matters not normally brought before the full BOCC. Under this option, all Commissioners hereafter would be formally trained in the duties and responsibilities of the governance of Health and Social Services and acknowledge that they understand what is expected; both of these Departments have a substantial amount of Federal and State law, policy, regulation and funding, which impacts governance. It will be very important with this option that the role of the Advisory Committee is clearly defined and the operational expectations between the Advisory Committee and BOCC are specified.

A second option, and the one that has been adopted by Wake and Buncombe Counties, is the creation of a CHS Board that maintains the powers and duties of the other Boards.
Statute 153A-77(d) sets forth the powers and duties of the CHS Board as follows:

(1) Set fees for departmental services based upon recommendations of the human services director. Fees set under this subdivision are subject to the same restrictions on amount and scope that would apply if the fees were set by a county board of health, a county

board of social services, or a mental health, developmental disabilities, and substance abuse area authority.

(2) Assure compliance with laws related to State and federal programs.

(3) Recommend creation of local human services programs.

(4) Adopt local health regulations and participate in enforcement appeals of local regulations.

(5) Perform regulatory health functions required by State law.

(6) Act as coordinator or agent of the State to the extent required by State or federal law.

(7) Plan and recommend a consolidated human services budget.

(8) Conduct audits and reviews of human services programs, including quality assurance activities, as required by State and federal law or as may otherwise be necessary periodically.

(9) Advise local officials through the county manager.

(10)Perform public relations and advocacy functions.

(11) Protect the public health to the extent required by law.

(12) Perform comprehensive mental health services planning if the county is exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board under the consolidated human services board.

(13) Develop dispute resolution procedures for human services contractors and clients and public advocates, subject to applicable State and federal dispute resolution procedures for human services programs, when applicable.

Except as otherwise provided, the consolidated human services board shall have the powers and duties conferred by law upon a board of health, a social services board, and an area mental health, developmental disabilities, and substance abuse services board.

Under this model, many of the responsibilities are shouldered by the CHS Board, allowing the Commissioners to handle other community needs. As has been acknowledged in other Counties, there is a tremendous amount of expertise, experience and community voice on these Boards. Although an advisory committee may be committed and capable of giving good advice, many of the duties mentioned above may not be able to be assumed by them. This is just one of the benefits. There may be more ownership from Committee members. Also, due to term length and statutory composition of the appointments, a CHS Board that has some authority may provide a stabilizing effect.

For these reasons, the Task Force recommends that the formation of a CHS Board with full authority is the better option. To summarize, there are two possible options, and each offers particular benefits. It is the recommendation that there should be one CHS Board that covers both Health and Social Services issues.

By statute 153A-77(c), as the Haywood County CHSA would not provide mental health services, the composition of this board includes:

A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making and administrative board of the consolidated human services agency. The consolidated human services board shall be composed of no more than 25

members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

(1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem and two consumers of other human services.

(1a) Notwithstanding subdivision (1) of this subsection, a consolidated human services board not exercising powers and duties of an area mental health, developmental disabilities, and substance abuse services board shall include four persons who are consumers of human services.

(2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

(3) Two physicians licensed to practice medicine in the State, one of whom shall be a psychiatrist.

(4) One member of the board of county commissioners.

(5) Other persons, including members of the general public representing various occupations.

Although the statute requires that 9 of the 10 professionals appointed have expertise related to health in making a board, the majority of the work force and budget are directed at social services issues; therefore, this should be represented.

The Board should be trained and properly staffed. The Board should set a schedule to meet all of the benchmarks to maintain accreditation (Attachment 4) and have a formal plan to cover all of the duties outlined in the Federal, State and local policies, regulations and statutes.

If there should be a need to change the governance structure after establishing a CHS Board, the BOCC may elect to do so by following the requirements specified in NCGS 153A-77.

IMMEDIATE AND/OR LONG TERM BUDGETARY BENEFITS OF INTEGRATION

Both Wake County and Buncombe County realized a budgetary impact that has been attributed by their Directors to the integration of health and human services. Also, both Agencies were empowered from the beginning to allocate savings to produce better results for their customers. This last element is critical to their success; however, both Buncombe and Wake Counties' processes for integration began under different circumstances than those presently existing in Haywood. For example, both organizations started the process of integration in a better economy with more fully staffed agencies. Both Agencies also had independent, dedicated human resource staff. Also, the caseloads in economy sensitive services, Food and Nutrition, for example, were substantially lower. Conversely, Environmental Health permitting activity and fees generated were higher. Therefore, any immediate budgetary benefits that would otherwise be seen from integration have probably already been realized in Haywood County, where the Departments have smaller workforces than in 2009 and there is one central human resource

representative trained in Office of State Personnel Matters (OSP) for the County. Haywood County HD and DSS are already co-located, which is arguably both a cost and a savings. The cost savings initially, thought to be about two percent in Wake, are not likely to be great in Haywood County where reductions have already been made.

In the long run, by exploring efficiencies over the next few years, cost savings may be netted over what otherwise would be spent. In fact, this is how both Buncombe and Wake Counties demonstrated some of their cost savings. The savings are very real. Although all can be attributed to great management and proactive practice, not all can be attributed to integration. Buncombe claims $323,000 in savings from contracting with Southwestern Child Development. Haywood already does this. Buncombe has had significant savings when economic worker caseloads were able to increase over 270, in part due to better Information Technology (IT) and flexibility in moving workers. Haywood has also increased caseloads without adding workers (with admittedly a bit more pain, and less total capacity potential).

Some differences between the Counties still exist. Buncombe has saved money and reduced turnover by paying better salaries to a few targeted positions subject to turnover. This has netted savings. (*Buncombe County Health and Human Services 2011-2012 Workforce Plan: Analysis of Multifaceted Salary and Compensation Strategy.*) Buncombe also created a public-private partnership and no longer does primary care at the public Health Department, but rather at the Federally Qualified Health Center WNC Community Health Services. This resulted in savings. However, the access to medical care issue in Buncombe County is different than in Haywood. An in depth, broad based, multi-stakeholder, longitudinal study of access to care in Haywood should be conducted before a public-private partnership is contemplated.

Viewing the customer holistically in an integrated manner could account for savings, and certainly would be better for the customer. Dollars could be saved as the CHSA studies and implements cross-training and utilizes existing employees to minimize the need for additional positions. When such cost savings materialized, Buncombe County has put these into IT and other efficiency measures, which in turn generated more cost savings. BCHHSA has implemented technologies such as the Northwood's Case Management System and Q Flow, a customer routing system that is state of the art. When Haywood experiences long term budgetary benefit, then funds will be available to implement additional service efficiencies and do a better job of meeting Haywood County's Health and Social Services benchmarks. Reinvested cost savings would allow Haywood County to be able to improve the lives of their citizens, and slow the growth of budgets. Eventually, fewer services may be needed and savings in many areas might be netted.

COST OF INTEGRATION

The initial cost of integration would be moderate. There would be some legal fees. Buncombe County retained an attorney to draft documents concerning HIPAA, and various operating and confidentiality policies, and to consult on other matters. Consultation with an experienced labor attorney or attorney with great knowledge of the Office of State Personnel procedures would be beneficial, and Buncombe County retained a second attorney on these matters. Legal costs could reasonably run $5,000 to $10,000. In addition, the firm that handles the Haywood County indirect cost plan should be consulted to help ensure compliance with different standards. According to the North Carolina Social Services Director, Sherry Bradsher, the State DHHS Office of the Controller has several recommendations for Counties to consider (Attachment 8).

She advocated at the Western Director's conference the making of a financial plan for Counties planning to consolidate. There will be a substantial investment of personnel time to handle the studies mentioned herein and to possibly reconfigure offices within the existing structure. Some personnel would also need to be cross-trained. Further IT investment will also be needed, depending on the results of an information systems audit, which should be performed.

To net greater efficiencies, as time goes on, more costs may be incurred. A redesign of the front lobby and flow patterns in the building could be contemplated. The area is already wired for computer self serve kiosks. Rearranging the benches, adding a podium desk and kiosks for routing customers and self serve document drop off could be accomplished with minimum physical plant upgrades. However, Buncombe County spent around $250,000 on the Q-Flow routing system, which included the kiosks for that purpose, and software to track and manage clients getting multiple services. The program also allows clients to set appointments and check in from their home or smart phone. There was an additional investment in self serve document stations. Given their client volume and increased efficiency, they all agreed these investments were well worth it. The Task Force recommends that before any changes are made in the design or flow in the building, this would be carefully studied to see if they would net the return on the investment.

PROJECTED BUDGETS

Gazing into a crystal ball can be perilous. At the State and Federal level, there are many uncertainties as this report is written. How Health Care Reform will be addressed in North Carolina is uncertain and will be debated within the Legislature, and with a new Gubernatorial Administration, the final decision may have an impact on the department's budgets.

The primary items in the Department of Social Services that would be impacted over time by integration are in the 115310 Social Services line items (Attachment 9). Please remember, this is just a portion of the budget that is substantially larger. The total expenditures for these areas in FY 2011 were $7,166,482 and, in FY 2012, $7,148,607. The total line item in the 2013 revised budget is $7,389,063. These budgets include no new permanent full-time equivalent positions (FTE). The FY 2013 budget is also subject to change.

From both a Social Services and Public Health point of view, the big question as to budget in 2014 is Health Care Reform. Due to interpretations of the Supreme Court case as being implemented and litigated in other States, a change in management in the NC DHHS and the Federal Financial situation, none of the answers regarding Health Care Reform are certain. The 2014 Social Services budget for line item 115310 will most likely increase significantly. Barring other unforeseen circumstances, growth would be at about $110,000 to $120,000 per year to the overall budget due to average growth in personnel costs to maintain the present FTE's, a little more if others are added. In addition some service costs, such as foster care, may be expected to grow. However, as we speak, social service programs that citizens in our Country will receive are being heavily debated. This could lead to a change in the workforce.

The Health Department total budget for FY 2011was $4,494,833 and in FY 2012 the revised budget was $ 4,407,812 (Attachment 10). The slight decrease in budget was due to a change in State appropriations and grants and a reduction in fee revenue. It is expected that in 2013 the total budget will be approximately the same as the revised FY 2012 budget. The projected budget for 2014 is expected to-remain about the same due to trends in Fees for Services, grants

and Medicaid. However, these revenue lines could see changes quickly depending on the economy and Federal Appropriations. Beyond 2014, there are too many variables to accurately predict; however, it should be noted that over the past six fiscal years (FY 2006 – FY 2012) the budget has ranged between $4,196,896 and $5,228,077. It is also noted that in public health there is always the potential for substantial unanticipated expenditures in the event of emergency.

In both HD and DSS, over the next five years, the primary areas that would be impacted from integration include personnel in management support, IT, fiscal and management. It is not anticipated that any positions would be reduced. However, personnel in all of these areas could expect changes in duties that would create more efficiency and less duplicated effort. This could have a net gain over time of no need to increase the number of these kinds of positions as service demands increase. This has occurred in both Wake and Buncombe Counties. However this is a long term process and not likely to net savings in the first 2-3 years. However, it could net savings in the longer range that could be devoted to other areas, preventing position growth in those areas as well.

In other program areas, cross training, better communication and cooperation can slow the growth of service costs as well. Both Buncombe and Wake have shifted persons across Department lines, either to fill gaps without adding new personnel, or to innovate practice. We met a Food and Nutrition Service worker who formerly worked in Inspections. Also, a nursing supervisor became a child protective services supervisor in a specialized unit devoted to working with families with infants and toddlers. The grant-funded Nurse-Family Partnership is the kind of integrated program that provides best practice and ultimately saves dollars as clients need fewer services in the long run. But those savings would not materialize in the first 4-5 years.

Haywood County is among the 20, Tier 3 (least distressed) Counties in NC and is part of the Metropolitan Statistical Area (MSA) including Haywood, Henderson, Madison and Buncombe Counties (considered for the most part an urbanized area). The impact of these designations limits grants and other funding based on economic well being or an urban versus rural focus. In addition to outcome of the Accountable Care Act (ACA), other external forces may affect the local budgets of both departments because of fewer revenue generating opportunities.

DETERMINATION OF WHAT EFFICIENCIES WILL BE GAINED THROUGH INTEGRATION

Before turning to future efficiencies, it should be noted that the HD and DSS have already taken several steps towards efficiency. These include, but are not limited to:

- Co-located facilities
- Installment of a Medicaid worker in the Health Department
- Increased cooperative work on Access to Care issues for the County
- Increased work together on Safety Task Force
- Approval of the Meals on Wheels menus by the Health Department Nutritionist
- Human Resources consolidation at the County level
- Increased Social Services participation in Healthy Haywood Initiative
- Increased Social Services participation in Rx for Safety Initiative
- Increased communication to clients regarding services offered by both Departments
- Increased referrals to Health Department Services such as Dental and WIC

After examining practice in other Counties, there are areas that should be looked at in depth:

- Information Systems
- Management and Support
- Document and File Management
- Finance, such as purchasing and billing

These areas are where resources are most likely initially to be netted. The ultimate goal is to improve customer support and provide a more seamless experience for customers. In Buncombe County's main lobby at the integrated office at Coxe Avenue, there is a great use of technology and a redefined front end work force that make for a much more efficient client flow. It should be studied to determine whether or not this could be replicated in Haywood County. The long term real benefit is to improve operational efficiency and client outcomes without increasing tax payer investment. One thing that could be done immediately to help ensure efficiencies is the creation of a Human Services Support Team (HSST). This team would cover Finance and Budget, Planning, Data Analysis, Information Technology, Staff Development and Training, communication, and operations. Attached is a sketch of the Buncombe model, created in 2005 as a first solid step toward integration. (Attachment 11)

IDENTIFYING THE NUMBER OF CLIENTS SERVED BY BOTH AGENCIES

Due to the Educational, Epidemiological, Environmental and Emergency Preparedness charges of Public Health, everyone in the County is a customer. Everyone also benefits from the safety net and emergency assistance provided by the DSS. A study was done on the number of common clients who applied or enrolled to receive services from both the HD and DSS (Attachment 12). A conservative estimate of the number of clients who actually applied and received services at

both the HD and DSS is about 7,000 people. If the rolls are considered for people who received services at one agency and could apply at the other but have not, at least 2,000 additional persons could be added. This is in keeping with Dr. Rojano's estimate that 50% of Human Services clients use three or more services. Currently 31% of the Health Department's caseload, excluding Environmental Health activity, is enrolled in Medicaid and the impact of ACA in the near future may increase that number.

ORGANIZATIONAL CHART

The Task Force created two possible organizational charts showing the upper administrative level. (Attachment 13) Because the Task Force recommends a Desk Audit of positions and, after this, the creation of an HSST, the Organizational Charts stop there.

SUMMARY AND NEXT STEPS:

The Task Force recommends that integration should be seriously considered as there could be benefits for the County in the long run as outlined herein. Initial steps for integration, some of which may be beneficial even if integration does not occur, are as follows:

1. Further discussion and sharing of this report with the Boards of Health and Social Services for additional feedback.
2. The Task Force should remain intact through the process of integration. The legislation should be reviewed by the group and the Commissioners with the County Attorney and the consultants form the School of Government.
3. The HD and DSS should continue to follow the steps to joint efficiency already accomplished and listed herein.

4. Legal experts should also be consulted as to the NC Office of State Personnel (OSP) guidelines and policy guidance on HIPAA, confidentiality and other items as needed.
5. The Haywood County Personnel policies and manual should be overhauled to create a more substantially equivalent system capable of meeting all of the state and federal merit system requirements. There are several policies that need review and updating. Until such time, the County should opt to remain under the OSP for the CHSA. After such time, the County could place all employees under the new system to treat everyone equally, which is what the Task Force would recommend.
6. The Indirect Cost Allocation Plan Provider should be consulted to help create a financial plan for these costs and for shared employee expenses.
7. There should be consultation with the State DHHS Budget office and local business liaisons for the State. Other outside consultants may be needed as well.
8. A Human Services Support Team should be created including representatives from IT, Human Resources, and Finance.
9. A Desk Audit of all the positions in the management support areas should be performed to determine how to best to redeploy/reassign persons in these areas as necessary.
10. A plan for cross training of employees should be developed.
11. An Information Systems audit between the Departments should be done concerning what are the cost and efficiencies of expanding the Laser-fiche system, which both Departments presently have. A solution should be found so that documents and information could be shared to more easily assist clients.
12. A study should be done as to whether or not Q Flow or another client routing model should be implemented.

13. After all of the other items, and the full implementation of NCFAST, a mutual client list should be made along with a plan to better serve clients who need multiple services.
14. Any initial cost savings that may be realized should be placed back into the system in an effort to continually increase efficiencies, improve meeting of benchmarks, and serving needs of the County, all while lessening the long-term costs to the taxpayer. The Task Force recommends a resolution on this point.
15. Establish a Nominating Committee to recommend members to be appointed to the CHS Board in accordance with NCGS 153A-77(c). The initial CHS board shall be appointed by the Board of County Commissioners based upon the recommendations of a nominating committee comprised of members of the pre-consolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board.
16. Develop CHS Board or Advisory Committee Bylaws, policies and procedures addressing operations and role definitions among or between the different governing bodies.

RESPECTFULLY SUBMITTED

Marty Stamey, County Manager

Julie Davis, Finance Director

Carmine Rocco, Health Director

Ira Dove, Director of Social Services

Index of Attachments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

SESSION LAW 2012-126
HOUSE BILL 438

AN ACT TO PROMOTE EFFICIENCY AND EFFECTIVENESS IN THE ADMINISTRATION OF HUMAN SERVICES AND TO STRENGTHEN THE LOCAL PUBLIC HEALTH INFRASTRUCTURE BY ESTABLISHING A PUBLIC HEALTH IMPROVEMENT INCENTIVE PROGRAM AND ENSURING THE PROVISION OF THE TEN ESSENTIAL PUBLIC HEALTH SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 153A-77 reads as rewritten:

"**§ 153A-77. Authority of boards of commissioners in certain counties over commissions, boards, agencies, etc.**

(a) In the exercise of its jurisdiction over commissions, boards and agencies, the board of county commissioners may assume direct control of any activities theretofore conducted by or through any commission, board or agency by the adoption of a resolution assuming and conferring upon the board of county commissioners all powers, responsibilities and duties of any such commission, board or agency. This ~~subsection~~section shall apply to the board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board ~~and~~or any other commission, board or agency appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners of said ~~county.~~county except as provided in G.S. 153A-76. A board of county commissioners exercising the power and authority under this subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the board through the imposition of civil penalties. If a public health rule adopted by a board of county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its violation a misdemeanor shall not be applicable to that public health rule unless the rule states that a violation of the rule is a misdemeanor. The board of county commissioners may exercise the power and authority herein conferred only after a public hearing held by said board pursuant to 30 days' notice of said public hearing given in a newspaper having general circulation in said county.

The board of county commissioners may also appoint advisory boards, committees, councils and agencies composed of qualified and interested county residents to study, interpret and develop community support and cooperation in activities conducted by or under the authority of the board of county commissioners of said county.

A board of county commissioners that has assumed direct control of a local health board after January 1, 2012, and that does not delegate the powers and duties of that board to a consolidated health service board shall appoint an advisory committee consistent with the membership described in G.S. 130A-35.

(b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

(1) Consolidate ~~the provision~~certain provisions of human services in the county under the direct control of a human services director appointed and supervised by the county manager in accordance with subsection (e) of this section;

(2) Create a consolidated human services board having the powers conferred by subsection (c) of this section;

(3) Create a consolidated county human services agency having the authority to carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners, including

the local health department, the county department of social services, ~~and~~or the area mental health, developmental disabilities, and substance abuse services authority; and

(4) Assign other county human services functions to be performed by the consolidated human services agency under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

(c) A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making, and administrative board of the consolidated human services agency. The consolidated human services board shall be composed of no more than 25 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

(1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.

(1a) Notwithstanding subdivision (1) of this subsection, a consolidated human services board not exercising powers and duties of an area mental health, developmental disabilities, and substance abuse services board shall include four persons who are consumers of human services.

(2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

(3) Two physicians licensed to practice medicine in this State, one of whom shall be a psychiatrist.

(4) One member of the board of county commissioners.

(5) Other persons, including members of the general public representing various occupations.

The board of county commissioners may elect to appoint a member of the consolidated human services board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

All members of the consolidated human services board shall be residents of the county. The members of the board shall serve four-year terms. No member may serve more than two consecutive four-year terms. The county commissioner member shall serve only as long as the member is a county commissioner.

The initial board shall be appointed by the board of county commissioners upon the recommendation of a nominating committee comprised of members of the preconsolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a four-year term. After the subsequent establishment of the board, its board shall be appointed by the board of county commissioners from nominees presented by the human services board. Vacancies shall be filled for any unexpired portion of a term.

A chairperson shall be elected annually by the members of the consolidated human services board. A majority of the members shall constitute a quorum. A member may be removed from office by the county board of commissioners for (i) commission of a felony or other crime involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii) violation of a written policy adopted by the county board of commissioners; (iv) habitual failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi) failure to maintain qualifications for appointment required under this subsection. A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners. The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(d) The consolidated human services board shall have authority to:

(1) Set fees for departmental services based upon recommendations of the human services director. Fees set under this subdivision are subject to the same restrictions on amount and scope that would apply if the fees were set by a county board of health, a county board of social services, or a mental health, developmental disabilities, and substance abuse area authority.

(2) Assure compliance with laws related to State and federal programs.

(3) Recommend creation of local human services programs.

(4) Adopt local health regulations and participate in enforcement appeals of local regulations.

(5) Perform regulatory health functions required by State law.

(6) Act as coordinator or agent of the State to the extent required by State or federal law.

(7) Plan and recommend a consolidated human services budget.

(8) Conduct audits and reviews of human services programs, including quality assurance activities, as required by State and federal law or as may otherwise be necessary periodically.

(9) Advise local officials through the county manager.

(10) Perform public relations and advocacy functions.

(11) Protect the public health to the extent required by law.

(12) Perform comprehensive mental health services ~~planning.~~planning if the county is exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board under the consolidated human services board.

(13) Develop dispute resolution procedures for human services contractors and clients and public advocates, subject to applicable State and federal dispute resolution procedures for human services programs, when applicable.

Except as otherwise provided, the consolidated human services board shall have the powers and duties conferred by law upon a board of health, a social services board, and an area mental health, developmental disabilities, and substance abuse services board.

Local employees who serve as staff of a consolidated county human services agency are subject to county personnel policies and ordinances only and are not subject to the provisions of the State Personnel ~~Act.~~ Act, unless the county board of commissioners elects to subject the local employees to the provisions of that Act. All consolidated county human services agencies shall comply with all applicable federal laws, rules, and regulations requiring the establishment of merit personnel systems.

(e) The human services director of a consolidated county human services agency shall be appointed and dismissed by the county manager with the advice and consent of the consolidated human services board. The human services director shall report directly to the county manager. The human services director shall:

(1) Appoint staff of the consolidated human services agency with the county manager's approval.

(2) Administer State human services programs.

(3) Administer human services programs of the local board of county commissioners.

(4) Act as secretary and staff to the consolidated human services board under the direction of the county manager.

(5) Plan the budget of the consolidated human services agency.

(6) Advise the board of county commissioners through the county manager.

(7) Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.

(8) Act as an agent of and liaison to the State, to the extent required by law.

(9) Appoint, with the county manager's approval, an individual that meets the requirements of G.S. 130A-40(a).

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as a social services director, a local health director, ~~and~~or a director of an area mental health, developmental disabilities, and substance abuse services authority.

~~(f) This section applies to counties with a population in excess of 425,000.~~"

SECTION 2. G.S. 153A-76 reads as rewritten:

"**§ 153A-76. Board of commissioners to organize county government.**

The board of commissioners may create, change, abolish, and consolidate offices, positions, departments, boards, commissions, and agencies of the county government, may impose ex officio the duties of more than one office on a single officer, may change the composition and manner of selection of boards, commissions, and agencies, and may generally organize and reorganize the county government in order to promote orderly and efficient administration of county affairs, subject to the following limitations:

(1) The board may not abolish an office, position, department, board, commission, or agency established or required by law.

(2) The board may not combine offices or confer certain duties on the same officer when this action is specifically forbidden by law.

(3) The board may not discontinue or assign elsewhere a function or duty assigned by law to a particular office, position, department, board, commission, or agency.

(4) The board may not change the composition or manner of selection of a local board of education, ~~the board of health, the board of social services,~~ the board of elections, or the board of alcoholic beverage control.

(5) The board may not abolish nor consolidate into a human services agency a hospital authority assigned to provide public health services pursuant to Section 12 of S.L. 1997-502 or a public health authority assigned the power, duties, and responsibilities to provide public health services as outlined in G.S. 130A-1.1.

(6) A board may not consolidate an area mental health, developmental disabilities, and substance abuse services board into a consolidated human services board. The board may not abolish an area mental health, developmental disabilities, and substance abuse services board, except as provided in Chapter 122C of the General Statutes. This subdivision shall not apply to any board that has exercised the powers and duties of an area mental health, developmental disabilities, and substance abuse services board as of January 1, 2012.

(7) The board may not abolish, assume control over, or consolidate into a human services agency a public hospital as defined in G.S. 159-39(a) pursuant to G.S. 153A-77."

SECTION 3. Article 2 of Chapter 130A of the General Statutes is amended by adding the following new sections to read:

"**§ 130A-34.3. Incentive program for public health improvement.**

(a) In order to promote efficiency and effectiveness of the public health delivery system, the Department shall establish a Public Health Improvement Incentive Program. The Program shall provide monetary incentives for the creation and expansion of multicounty local health departments serving a population of not less than 75,000.

(b) The Commission shall adopt rules to implement the Public Health Improvement Incentive Program.

"**§ 130A-34.4. Strengthening local public health infrastructure.**

(a) By July 1, 2014, in order for a local health department to be eligible to receive State and federal public health funding from the Division of Public Health, the following criteria shall be met:

(1) A local health department shall obtain and maintain accreditation pursuant to G.S. 130A-34.1.

(2) The county or counties comprising the local health department shall maintain operating appropriations to local health departments from local ad valorem tax receipts at levels equal to amounts appropriated in State fiscal year 2010-2011.

(b) The criteria established in subsection (a) of this section shall be in addition to any other funding criteria established by State or federal law."

SECTION 4. G.S. 130A-1.1(b) reads as rewritten:

"(b) A local health department shall ensure that the following 10 essential public health services are available and accessible to the population in each county served by the local health department:

(1) Monitoring health status to identify community health problems.
(2) Diagnosing and investigating health hazards in the community.
(3) Informing, educating, and empowering people about health issues.
(4) Mobilizing community partnerships to identify and solve health problems.
(5) Developing policies and plans that support individual and community health efforts.
(6) Enforcing laws and regulations that protect health and ensure safety.
(7) Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable.
(8) Assuring a competent public health workforce and personal health care workforce.
(9) Evaluating effectiveness, accessibility, and quality of personal and population-based health services.
(10) Conducting research.

~~As used in this section, the term "essential public health services" means those services that the State shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North Carolina. The Departments of Environment and Natural Resources and Health and Human Services shall attempt to ensure within the resources available to them that the following essential public health services are available and accessible to all citizens of the State, and shall account for the financing of these services:~~

~~(1) Health Support:~~
~~a. Assessment of health status, health needs, and environmental risks to health;~~
~~b. Patient and community education;~~
~~c. Public health laboratory;~~
~~d. Registration of vital events;~~
~~e. Quality improvement; and~~
~~(2) Environmental Health:~~
~~a. Lodging and institutional sanitation;~~
~~b. On-site domestic sewage disposal;~~
~~c. Water and food safety and sanitation; and~~
~~(3) Personal Health:~~
~~a. Child health;~~
~~b. Chronic disease control;~~
~~c. Communicable disease control;~~
~~d. Dental public health;~~
~~e. Family planning;~~
~~f. Health promotion and risk reduction;~~
~~g. Maternal health; and~~
~~(4) Public Health Preparedness.~~

~~The Commission for Public Health shall determine specific services to be provided under each of the essential public health services categories listed above.~~"

SECTION 5. The Program Evaluation Division of the General Assembly shall study the feasibility of the transfer of all functions, powers, duties, and obligations vested in the Division of Public Health in the Department of Health and Human Services to the University of North Carolina Healthcare System and/or the School of Public Health at The University of North Carolina and submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services no later than February 1, 2013.

SECTION 6. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 21st day of June, 2012.

s/ Walter H. Dalton
President of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Beverly E. Perdue
Governor

Approved 12:20 p.m. this 29th day of June, 2012

Buncombe Site Visit

On October 23, 2012 the Task Force members visited the Buncombe County Health and Human Services Agency (BCHHS), and met with County Manager Wanda Greene, Director Mandy Stone, Human Resource Director Lisa Eby, Social Work Administrator Angie Pittman, Economic Services Administrator Steve Garrison and members of the Human Services Support Team. BCHHS has recently finished the process of consolidation after a multi-year process. They have learned many lessons and have a lot of ideas worth considering, that may or may not ultimately have applicability for Haywood. Some of these are as follows:

1. A Human Services Support Team that includes Finance, HR, Operations and a Planning and Evaluation team. Full time staffing around data and program analysis is a key to their success.
2. A common vision among Agencies with common themes. The BCHHS common vision is centered around citizen access to *core* health and human services; using the best IT; having a data analysis group and using the data; reinvesting and reallocating savings in order to provide better services; limiting the role of government to core services; strong communications; using a balanced scorecard management approach; and building public and private community partnerships and contract relationships to provide for other services, such as primary health care and Child Support Enforcement.
3. BCHHS put into place a Consolidated Health and Human Services Board that retains all of the powers and duties of the Board as conferred by law.
4. BCHHS, for now, has chosen to stay under the Office of State Personnel for its employees and may take the option of exempting a few positions. Buncombe also studied the cost of employee churn rates and targeted a few positions for increases.
5. BCHHS has done a fantastic job of remodeling and redesigning their Integrated Lobby on Coxe Avenue. There are several great features including: a self serve check in kiosk using Q-FLO; a self serve document scanning station and drop box; greeters who can help with the self check in process or scanning; a security guard; a number call system; income maintenance workers stationed upfront in the windows; and other features.

Overall it was a great visit and the door is open for further information sharing.

Haywood County DRAFT Agenda

November 13, 2012 4:00 PM – 8:00 PM

DSS/Health Department Building, 157 Paragon Parkway, Clyde, 28721

4:00 Call to order and opening remarks — Mark Swanger, BOCC Chair
Introduction of SOG team — Aimee Wall
Summary of events-to-date — Aimee Wall
Objectives for this evening — Margaret Henderson

- To assess the advantages/disadvantages of each option for change
- To create a timeline of next steps to take as we consider and/or implement change

Suggested guidelines for effective meetings
Introductions of participants
Name, position, and response to this question:
No matter whether or how we might decide to change our current human service system in Haywood County, one good thing we have now that I want to be sure we keep for the future is _____.

4:20 Presentation — Aimee Wall & Jill Moore
Background – summary of webinar
Status of other counties and their reasoning
Options for changes in structure and governance.
(Keep a list of the topics to research further or discuss in more detail later.)

5:30 Break - Dinner Served – will be a working dinner

5:45 Group discussion of the implications of each option in terms of: — Margaret Henderson

- Fiscal impact
- Service delivery
- Governance
- Workforce
- Public perception
- Other?

7:30 Next steps - including timeline — Margaret Henderson
Would it be useful to have another facilitated meeting?
Issues to cover
Special expertise required
Should anyone else be invited to participate or observe?
What should Haywood County staff be researching or sharing?
Potential dates for the next steps

- research, deliberation, public hearings, decisions, implementation, etc.

7:50 Self-evaluation and Concluding remarks from participants — Margaret Henderson

8:00 Adjourn

BENCHMARK 34

Benchmark 34: The local board of health shall exercise its authority to adopt and enforce rules necessary to protect and promote the public's health.

- 34.1: The local board of health shall have operating procedures which shall comply with state law.
- 34.2: the local board of health shall review its operating procedures annually.
- 34.3: The local board of health shall have access to legal counsel.
- 34.4: The local board of health shall follow the procedures for adopting rules in G.S. 130A-39.
- 34.5: The local board of health shall evaluate the need for the adoption or amendment of local rules.

BENCHMARK 35

Benchmark 35: The local board of health shall assure a fair and equitable adjudication process.

- 35.1: The local board of health shall assure it follows the procedures for adjudications in G.S. 130A-24.

BENCHMARK 36

Benchmark 36: The local board of health members shall be trained regarding their service on the board.

- 36.1: The local health department shall provide board of health members with a written board handbook developed or updated within the past 12 months.
- 36.2: The local health department shall assure new board of health members receive training and reference materials on the authorities and responsibilities of the local board of health within the first year after appointment to the board.
- 36.3: The local health department shall assure on-going training for board of health members related to the authorities and responsibilities of local boards of health.

BENCHMARK 37

Benchmark 37: The local board of health shall assure the development, implementation and evaluation of local health services and programs to protect and promote the public's health.

- 37.1: The local board of health shall assure that a qualified local health director, in accordance with G.S. 130A-40 or 40.1, is in place to lead the agency.
- 37.2: The local board of health shall approve policies for the administration of local public health programs.
- 37.3: The local board of health shall describe and define the knowledge, skills, and abilities that must be met by the local health director, consistent with the requirements in G.S. 130A-40.
- 37.4: The local board of health shall review and approve the job description of the local health director.
- 37.5: The local board of health shall conduct an annual performance review of the health director.
- 37.6: The local board of health shall approve policies for the recruitment, retention and workforce development for agency staff.

BENCHMARK 38

Benchmark 38: The local board of health shall participate in the establishment of public health goals and objectives.

- 38.1: The local board of health shall annually review reports provided by the local health department on the community's health.
- 38.2: The local board of health shall review community health assessment data and citizen input used to plan and monitor progress toward health-related goals.
- 38.3: The local board of health shall assure that individuals, agencies, and organizations have the opportunity to participate in the development of goals, objectives and strategies for community health improvement.

BENCHMARK 39

Benchmark 39: The local board of health shall assure the availability of resources to implement the essential services described in G.S. 130A-34.1(e)(2).

39.1: The local board of health shall communicate with the board of county commissioners, units of government and private foundations in support of local health department efforts to secure nations, state and local financial resources.

39.2: The local board of health shall review fiscal reports to assure essential services of public health are being provided in accordance with local, state and federal requirements.

39.3: The local board of health shall annually review and approve the local health department budget and approve fees in accordance with G.S. 130A-39(g).

39.4: The local board of health shall communicate with the board of county commissioners, units of government and private foundations in support of the development, implementation and evaluation of public health programs and a community health improvement process.

39.5: The local board of health shall assure that the proposed budget for the local health department meets maintenance of effort requirement in the consolidated agreement between the Division of Public health and local health department.

BENCHMARK 40

Benchmark 40: The local board of health shall advocate in the community on behalf of public health.

40.1: The local board of health shall inform elected officials and community boards about community health issues.

40.2: The local board of health shall communicate support for the enactment and retention of laws and rules and the development of public health interventions that protect health and ensure safety.

BENCHMARK 41

Benchmark 41: The local board of health shall promote the development of public health partnerships.

41.1: The local board of health shall take actions to foster community input regarding public health issues.

41.2: The local board of health shall take actions to foster local health Partnership-building efforts and staff interactions with community.

41.3: The local board of health shall take actions to foster the coordination of resources to enhance partnerships and collaboration to achieve public health objectives.

38.1	Annual review by Board of Health of local health department reports on the community's health				

39.3 Annual review and approval by Board of Health of local health department budget and fees

One year prior to Notification Date					
Activity	Between Cycle Work	Year 1	Year 2	Year 3	Year 4
2.2	Keep all copies of annual Immunization Assessment Reports since last site visit. Most recent is required for review.				
2.3	Keep all copies of Communicable Disease Report Records since last site visit. Reports for the past year are required.				
4.1	Maintain and present Surveillance Records for the 12 months prior to notification letter date				
15.5	Assure orientation and staff training for all new employees and create a list of all employees hired in the past 12 months				
17.3	Provide most recent annual summary of communicable disease control activity (e.g., isolation/quarantine orders, control measures etc.)				
36.1	Assure Board of Health members have a Board handbook developed or updated within the past 12 months.				
37.5	Conduct Health Director performance review each year since the last site visit - one completed in 12 months prior to notification date required				

Two years prior to Notification Date					
Activity	Between Cycle Work	Year 1	Year 2	Year 3	Year 4
7.7	Records of Preparedness & Response Team activity at least once in the two years prior to the notification date				
30.6	Monthly records of Cleaning & Maintenance for the 24 months prior to notification date				

37.1 Board of Health assurance of local health director qualifications within the past 24 months

NOTES:

A year can range from 12 to 15 months

See the Interpretation Guide for Full Explanation and Requirements

Note: This checklist lists *only those* activities that have requirements that must be met **annually** or **within one or two years** of the notification date. Review the entire HDSAI and HDSAI Interpretation Document to monitor and assure compliance with all activities.

Date Accredited_____
Date of Next Notification_____
Date HDSAI due_____

Activities with Annual Requirements

Activity	Performance Measure	Year 1	Year 2	Year 3	Year 4
1.2	Create SOTCH report each year since the last site visit, with exception of year CHA is conducted				
2.4	Analyze and note reportable events occurring within the community and report atypical incidence, if any, to the Division and the local board of health on an annual basis				
3.2	Records of Data System Evaluation & QI for each year since the last site visit				
4.2	EH Risk Reports & Follow-up for each year since the last site visit				
7.3	Records of EH Complaint logs for each year since the last site visit				
7.5	Conduct annual ongoing communication with local emergency managers				
7.6	Records of Preparedness & Response Plan Exercises for each year since the last site visit				
9.1	Dissemination records for local health issue information for each year since the last site visit				
15.1	Strategic Plan Implementation Records for each year since the last site visit				
15.3	Records of Policy Review for each year since the last site visit				
16.1	The local health director and unit directors, such as directors of communicable disease, nursing, clinical services and environmental health, shall receive ongoing training in current public health law and its application.				
19.1	Annual review of data of public health program use by underserved or at-risk populations				
26.3	Records of Cultural Sensitivity and Competency Staff Training for each year since the last site visit				
31.4	Conduct annual review and update of staff job descriptions				
31.5	Conduct annual performance evaluations for all staff				
34.2	Annual review of Board of Health operating procedures				
37.4	Annual review and approval by Board of Health of local health director job description				

Guidance

The Guidance will list advice given to LHDs in meeting evidence requirements of activities and in the interpretation of the activity, evidence or of specific words.

SVT Review and Guiding Questions

This section gives guidance and pointers for the SVT as they review evidence. This may list specifics they should see in the evidence. This section will also have questions the SVT may ask about evidence to show what is presented allows the activity to be met.

References

Specific references that support having this activity as one of the capacities the NCLHDA program measures are provided for each activity. Included will be the NACCHO operational definition of a local health department self-assessment matrix, reference to the consolidated agreement or specific agreement addendum, and to general statutes or NC administrative code.

Examples of Evidence (future development)

This section will list types of documentation that would meet evidence requirements of the activity. The evidence examples listed here are not required and do not rule out other evidence as being accepted.

General Guidance & Definitions

Definitions

Local Health Department

When the "local health department" is cited in activities, the reference is to the staff, including leadership positions and the health director. When the local health department is to fulfill requirements of an activity, work of the board of health is not required unless so specified. Agency, department, health department or LHD are all references and equate to "local health department".

Board of Health

When the "board of health" is cited in activities, the reference is to the membership of the board and the health director or other designee so determined by the board. If the board designates the work of an activity to the health director, the evidence should provide a specific designation to that activity or issue. The purpose of the governance standard is to show that the board of health is involved in the work of the agency and is fulfilling its role in being involved in the requirements of activities 34 through 41. Board or BOH are other references that equate to the "board of health".

Guidance

Below are some general guidelines in compiling evidence and for the site visit.

Standard: Agency Core Functions & Essential Services

The Agency Core Functions & Essential Services Standard is composed of 29 benchmarks and 93 associated activities. The activities assess the department's ability to deliver the 10 essential services of public health as categorized in the core functions of assessment, policy development and assurance. This standard looks at the basic capacity of the health department to provide key services and programs. It looks at the collaborative efforts of the department and how unmet needs are identified and met. This standard assesses the plans, policies and protocols of the department and their use in setting a foundation for consistent and effective operations.

Standard: Facilities & Administrative Services

The Facilities & Administrative Services Standard is composed of 4 benchmarks and 27 associated activities. The activities under this standard address the administrative oversight of the department's operations and facilities. This standard assesses facility cleanliness, maintenance and safety along with practices that protect customer confidentiality. It requires departments to have administrative policies, procedures and protocols to guide staff in the processes that address personnel and finances. This section sets an expected level of performance for overall department accountability and efficiency of business functions.

Standard: Governance

The Governance Standard is composed of eight benchmarks with 28 associated activities. This standard sets forth the expectations of the Board of Health and its role in guiding the local health department and it's involvement in the community. The BOH has powers and duties defined by statute as well as duties defined by these standards. The two combined create the basic design of how a BOH should operate. Any reference to a Board of Health within this standard refers to the governing board with oversight to public health activities and includes a single county health department board, a district health department board, a human services board, a public health authority board, or a public hospital authority board.

Organization and Governance of County Public Health and Social Services Agencies

	Public Health	Social Services
Single County Agency	• County health department with a BOH* • County health department with BOCC as BOH* • Public health authority with PHA board**	• County department of social services with a BSS* • County department of social services with BOCC as BSS*
Multi-county Agency	• District health department with a DHD board* • Public health authority with PHA board** • Interlocal agreement to create regional health department; retain county BOH* • Interlocal agreement to create regional CHSA with a CHS board‡	• County department of social services with a BSS; share a DSS director with another county* • Interlocal agreement to create regional department of social services; retain county BSS* • Interlocal agreement to create a regional CHSA with a CHS board‡
Consolidated Human Services Agency	• CHSA with a CHS board‡ • CHSA with BOCC as CHS board‡	• CHSA with a CHS board‡ • CHSA with BOCC as CHS board‡

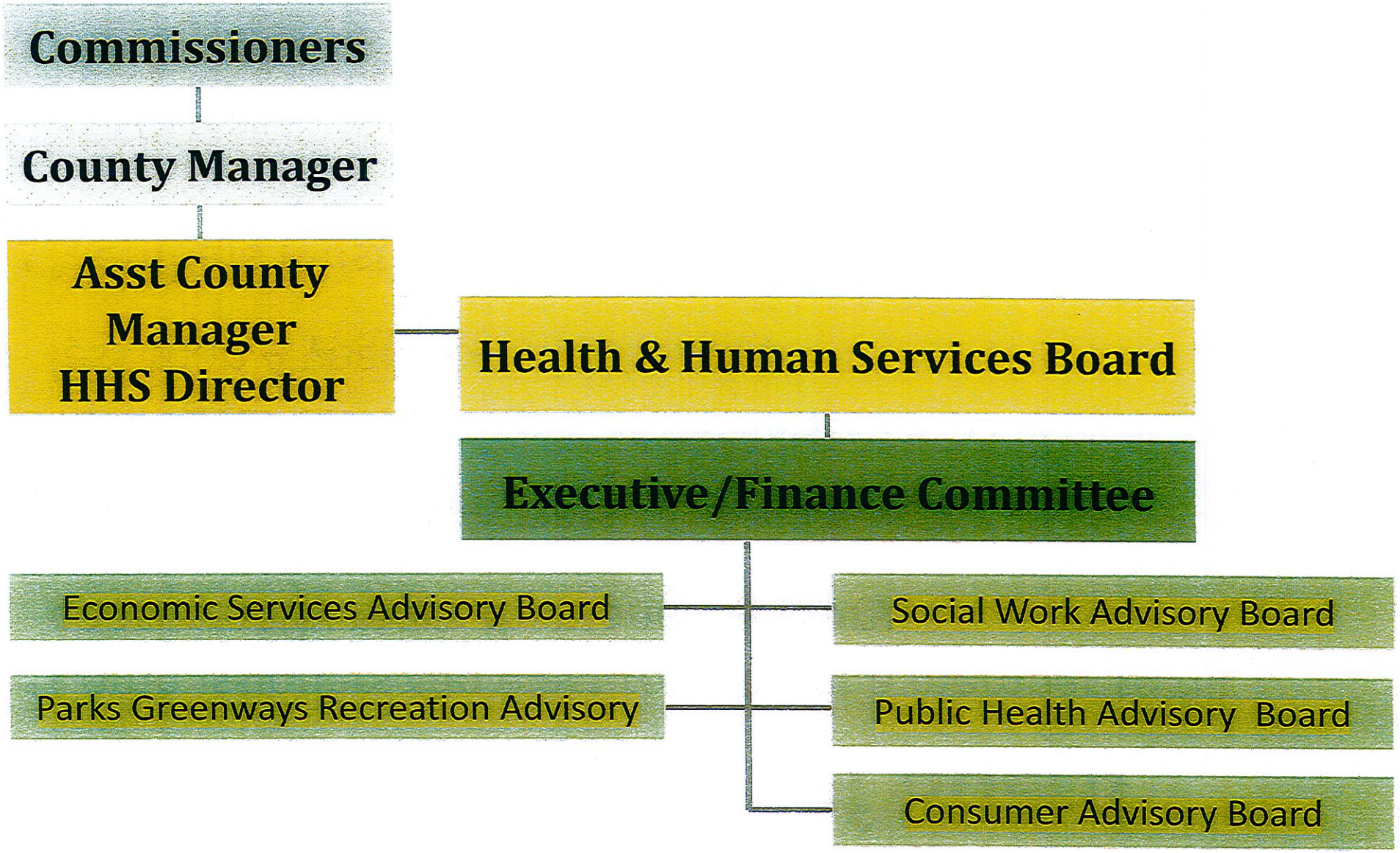
* Employees subject to the State Personnel Act

** Employees exempt from the State Personnel Act

‡ County chooses whether to exempt employees from the State Personnel Act

Acronyms: BOCC (Board of County Commissioners); BOH (Board of Health); BSS (Board of Social Services); CHSA (Consolidated Human Services Agency); DHD (District Health Department)

HHS Board Structure



North Carolina Department of Health and Human Services
Office of the Controller

2019 Mail Service Center •Raleigh, North Carolina 27699-2019
Tel: (919) 855-3700 • Fax: (919) 733-2604

Beverly Eaves Perdue, Governor
Albert A. Delia, Acting Secretary

Laketha M. Miller, Controller

December 3, 2012

TO: County DSS Directors

SUBJECT: County Reorganizations Impacting the County DSS

With the passing of House Bill 438, counties have the option to change the composition and manner of selection of boards, commissions and agencies, and may generally organize and reorganize the county government in order to promote orderly and efficient administration of county affairs. The DHHS Office of the Controller in conjunction with the Division of Social Services would like to provide items for consideration from a fiscal and reporting perspective as it relates to reporting expenditure data in the County Administration Reimbursement System (CARS).

Currently, counties report their administrative and service costs based on a statewide federally approved cost allocation plan. Guidelines governing this plan and the reporting of costs are detailed in OMB Circular A-87. This plan assures that federal awards pay their portion of costs and establishes principles for determining allowable costs. It also outlines guidelines for developing required county-wide central supporting services cost allocation plan (indirect cost plan). For these reasons, it is important that changes in the structure of social services areas are examined to assure that OMB Circular A-87 guidelines are being followed.

Attached you will find a list of questions and considerations that is intended to aid you in discussions of your merger efforts and move you in the direction of developing a service delivery system that best meets local needs. We hope you find these helpful. If you decide to explore this further and need additional information, we would urge you to contact your DSS Local Business Liaison and arrange a conversation to discuss potential fiscal implications. Since some of these merger efforts may have significant financial impacts, we urge you to proceed deliberately and plan accordingly.

Sincerely,

Laketha M. Miller

Sherry S. Bradsher, Director
Division of Social Services

Attachment (1)

cc: County Finance Officers
County Managers
Jim Slate
Kathy Sommese
Jack Chappell
Curtis Crouch
DSS Local Business Liaisons
Debbie Hawkins
Myra Dixon

Excels
Services, Solutions, Success

Considerations for Developing and Reporting County Reorganizations

Some examples of possible reorganization scenarios are listed below: This is not intended to be an all inclusive list.

- Combining departments within the county-(DSS and Health, DSS and Aging, DSS and Veterans Affairs, etc.)
- Consolidating two or more county agencies across county lines-(county agencies completely merge. One county agency no longer exists)
- Consolidating like functions between two or more county agencies-(Regional model-e.g.-child welfare services from multiple counties combine into one)
- Sharing staff between agencies whose duties will encompass both agencies (Director, clerical staff, HR staff, etc.)

When contemplating any reorganization efforts, the following questions should be addressed:

1. Where will newly acquired staff be housed? Social services space, shared space or off site? Knowing this information will assist in determining whether staff should have overhead costs allocated to their positions. This will also affect how staff should be reported on the DSS 1571. There may also be a need to review and change the indirect cost plan.

2. Who will supervise newly acquired staff? How will FTE and salary/benefits of that person be cost allocated? All staff located in or supervised by the local social services, whose duties support the funding sources and/or programs of the departments shall be reported. If newly acquired staff is supervised by any DSS staff, this would affect how that supervisor's time should be reported. A supervisor may be required to keep a timesheet or some other method to differentiate how much time is spent supervising staff who work in social services versus staff who work in non-social services areas.

3. How are overhead costs handled, e.g. supplies, utilities, building costs, equipment, vehicles? Where space is shared with other agencies, the costs must be allocated on the basis of a reasonable pro rata share for all services; that is, on the basis of the amount of space occupied by social services in relation to the total building space. Counties should develop some methodology for segregating shared costs between merged entities so that only the social services portion of these costs are reported on the DSS 1571. This will prevent duplication of costs or unassociated non-social services costs reported.

4. How are county indirect cost plans affected and is there a need for revisions? Which costs are currently claimed through the indirect cost plan versus being directly reported on the DSS 1571? Counties must ensure that items included as indirect costs are not also charged directly to any service.

5. Are budgets of merged entities combined into one? From which budget are employees being reimbursed? This will affect what should be reported on the DSS 1571. If budgets are merged and costs are combined into one budget, all costs could potentially be reported

on the DSS 1571 as either reimbursable (funding administered through DSS) or non-reimbursable (funding from non social services programs)

6. How are shared costs and reimbursements tracked between merged entities, e.g. contracts or more informal agreements? If merged entities share costs, is there are mechanism in place to assure accurate calculations and billing for cost?

7. Counties should develop a mechanism for tracking revenues that are not reimbursed through the DSS 1571. How will these revenues be tracked, e.g. HCCBG, WIC?

8. Federal Regulations, General Statutes, Commission Rules and other licensing or billing/provider requirements must be met regardless of the organizational structure. Are there legal or audit considerations related to merging services?

000000HAYWOOD COUNTY DSS
EXPENSE TREND

		2011 YTD EXPENDED	2012 YTD EXPENDED	2013 REVISED BUDGET
115310 SOCIAL SERVICES				
115310__ 512100__ __	SALARIES & WAGES-REGULAR	4,494,776	4,588,084	4,685,966
115310__ 512100__ 99IVD__	SAL & WAG-PERM FT & PERM PT	5,225	-	-
115310__ 512200__ __	SALARIES & WAGES-OVERTIME	165	103	-
115310__ 512600__ __	SALARIES & WAGES-TEMP & PART	32,232	27,232	28,000
115310__ 512700__ __	SALARIES & WAGES-LONGEVITY	73,253	70,332	77,397
115310__ 517000__ __	BOARD MEMBER EXPENSE	731	610	3,600
115310__ 518100__ __	SOCIAL SECURITY CONTRIB	339,652	343,747	366,539
115310__ 518100__ 99IVD__	SOCIAL SECURITY CONTRIB	396	-	-
115310__ 518200__ __	RETIREMENT CONTRIB	296,451	324,652	321,051
115310__ 518200__ 99IVD__	RETIREMENT CONTRIB	339	-	-
115310__ 518204__ __	CO CONTRIB-401(K) SUPP RET INC	675	140	47,634
115310__ 518300__ __	HOSPITALIZATION INS CONTRIB	980,472	1,117,640	1,150,380
115310__ 518500__ __	UNEMPLOYMENT COMP CONTRIB	14,352	20,052	-
115310__ 518600__ __	WORKERS' COMP CONTRIB	106,321	80,637	80,760
115310__ 518900__ __	OTHER FRINGE BENEFITS-LIFE INS	4,640	4,286	4,518
115310__ 519100__ __	PROF SERVICES-ACCTG	-	4,200	5,000
115310__ 519200__ __	PROF SERVICES-LEGAL	13,500	5,872	13,500
115310__ 519300__ __	PROF SERVICES-MEDICAL	24,692	19,800	22,000
115310__ 519311__ __	PROF SERVICES-IV-D	1,661	2,019	5,000
115310__ 519311__ 99IVD__	PROF SERVICES-MED-IV-D	60,654	53,109	59,255
115310__ 519900__ __	PROF SERVICES-OTHER	3,511	3,196	5,000
115310__ 519900__ 11EF1__	PROF SERVICES-OTHER	8,089	3,440	-
115310__ 519902__ __	PROF SVC-OTHER-IN HOME AIDE	28,449	28,045	28,000
115310__ 523106__ __	SPECIAL PRGM MATERIAL - LINKS	1,572	3,530	3,750
115310__ 523106__ 06LNK__	SPECIAL PRGM MATERIAL - LINKS	9,802	16,543	28,899
115310__ 525002__ __	FUEL/GAS/DIESEL	948	4,993	3,000
115310__ 526000__ __	OFFICE SUPPLIES & MATERIALS	33,651	40,461	38,500
115310__ 526000__ 99IVD__	OFFICE SUPPLIES & MATERIALS	2,994	3,106	5,750
115310__ 526900__ __	NON-EXPENDABLE OFFICE SUPPLIES	22,323	3,627	5,000
115310__ 526900__ 99IVD__	NON-EXPEND.OFFICE SUPPL.-IV D	7,424	453	2,900
115310__ 529100__ __	DATA PROCESSING SUPPLIES	1,381	2,044	4,350
115310__ 529200__ __	DATA PROCESSING-SOFTWARE	832	14,762	1,500
115310__ 531100__ __	TRAVEL	58,090	79,439	62,500
115310__ 531100__ 99IVD__	TRAVEL	1,235	-	2,159
115310__ 532000__ __	COMMUNICATIONS	58,433	66,931	70,500
115310__ 532010__ __	COMMUNIC.-EE CELL PHONE	1,660	1,725	2,000
115310__ 534000__ __	PRINTING & BINDING	3,236	3,094	4,500
115310__ 535200__ __	REPAIRS & MAINT-EQUIP	17,005	16,076	30,300
115310__ 535300__ __	REPAIRS & MAINT-VEHICLES	3,304	4,390	3,600
115310__ 537000__ __	ADVERTISING	9,156	7,409	8,500
115310__ 539100__ __	LEGAL ADVERTISING	4,225	631	5,000
115310__ 539300__ __	TEMPORARY HELP SERVICES	3,603	-	-
115310__ 539500__ __	TRAINING-EMPLOYEE EDUC EXP	7,062	3,918	7,125
115310__ 539501__ 11EF1__	TRAINING-CLIENT EDUC EXP	4,440	-	-
115310__ 539906__ __	OTHER SVC-FOOD STAMP ISSUANCE	19,438	18,546	20,500
115310__ 539907__ __	OTHER SVC-BANK BALANCE VERIFY	2,052	2,422	2,250
115310__ 540000__ __	PURCHASED SERVICES-CHILD SUP	56,131	50,690	53,000
115310__ 543200__ __	RENT OF T/W, POSTAGE MTRS	2,655	2,140	2,800
115310__ 543900__ __	RENT OF EQUIPMENT	89,213	87,241	82,500
115310__ 545200__ __	VEHICLE INS	1,217	1,230	1,400
115310__ 549100__ __	DUES & SUBSCRIPTIONS	8,895	9,316	7,600
115310__ 552000__ __	C/O-DATA PROC EQUIP	241,619	1,696	25,600
115310__ 552000__ 99IVD__	C/O-DATA PROC EQUIP-IV D	2,649	-	-
115310__ 554000__ __	C/O-MOTOR VEHICLES	-	5,000	-
TOTAL SOCIAL SERVICES		7,166,482	7,148,607	7,389,083

115312 WORK FIRST -NCDOT TRANSPORTION

000000HAYWOOD COUNTY DSS
EXPENSE TREND

		2011 YTD EXPENDED	2012 YTD EXPENDED	2013 REVISED BUDGET
115312__ 531300__ __	TRANSPORTATION OF CLIENTS	35,988	19,005	19,538
TOTAL WORK FIRST -NCDOT TRANSPORTION		35,988	19,005	19,538

000000HAYWOOD COUNTY DSS
EXPENSE TREND

			2011 YTD EXPENDED	2012 YTD EXPENDED	2013 REVISED BUDGET
115340 PUBLIC ASSISTANCE					
115340__ 549905__ __		MISC CHARGES-GEN ASSISTANCE	3,217	1,543	4,000
115340__ 549906__ __		MISC CHARGES-WRK 1ST & EMERG	405	-	500
115340__ 549907__ __		MISC CHARGES-FOSTER CARE IV-E	431,332	633,562	439,984
115340__ 549908__ __		MISC CHARGES-MEDICAID	(828)	(592)	430
115340__ 549909__ __		MISC CHARGES-AA & AD	483,215	498,848	510,000
115340__ 549910__ __		MISC CHRG-CRISIS INTERV-FUEL	311,713	472,478	200,875
115340__ 549910__ 8ADMN__		MISC CHRG-CRISIS INTERV-FUEL	28,500	35,901	35,900
115340__ 549910__ LIEAP__		LOW INCM ENERGY ASSIST PRGM	-	126,799	149,381
115340__ 549911__ __		MISC CHRG-STATE FOSTER HOME	454,707	359,432	467,100
115340__ 549912__ __		MISC CHRG-FOSTER CHILDREN-CNTY	19,316	17,342	36,100
115340__ 549913__ __		MISC CHARGES-AID TO BLIND	6,974	5,636	6,500
115340__ 549914__ __		MISC CHRG-ADOPTION ASST IV-B	27,344	22,514	48,655
115340__ 549916__ __		MISC CHRG-MEDICAID-TRANSPORT	560,199	481,638	422,258
115340__ 549918__ __		MISC CHRG-CP&L ENERGY NEIGHBOR	31,690	11,702	32,662
115340__ 549918__ 7HEMC__		CRISIS ASSIST.FOR HEMC CUSTOMR	56,831	68,131	59,361
115340__ 549919__ __		MISC CHRG-FOSTER CARE GIFTS	3,970	3,513	15,600
115340__ 549919__ 0HOPE__		MISC CHRG-HOPE COLLABORATIVE	-	1,236	9,875
115340__ 549924__ __		MISC CHRG-IV-E FOSTER CARE	34,801	38,837	42,500
115340__ 549926__ __		DOMESTIC VIOLENCE	25,349	24,973	-
TOTAL PUBLIC ASSISTANCE			2,478,736	2,803,492	2,481,681
115350 MEALS ON WHEELS					
115350__ 512100__ __		SALARIES & WAGES-REGULAR	107,193	105,835	112,341
115350__ 512600__ __		SALARIES & WAGES-TEMP & PART	-	2,934	2,700
115350__ 512700__ __		SALARIES & WAGES-LONGEVITY	959	967	999
115350__ 518100__ __		SOCIAL SECURITY CONTRIB	7,973	8,065	8,877
115350__ 518200__ __		RETIREMENT CONTRIB	7,025	7,446	7,639
115350__ 518204__ __		CO CONTRIB-401(K) SUPP RET INC	-	-	1,133
115350__ 518300__ __		HOSPITALIZATION INS CONTRIB	35,350	41,580	41,580
115350__ 518600__ __		WORKERS' COMP CONTRIB	3,724	2,680	2,696
115350__ 518900__ __		OTHER FRINGE BENEFITS-LIFE INS	163	152	162
115350__ 519900__ __		PROF SERVICES-OTHER	2,200	2,400	2,400
115350__ 522000__ __		FOOD & PROVISIONS	68,644	63,919	114,100
115350__ 522001__ __		VOLUNTEER RECOGNITION - FOOD	579	1,250	1,250
115350__ 525000__ __		VEHICLE SUPPLIES & MATERIALS	-	-	250
115350__ 525002__ __		FUEL/GAS/DIESEL	3,212	3,892	2,900
115350__ 526000__ __		OFFICE SUPPLIES & MATERIALS	748	148	750
115350__ 526900__ __		NON-EXPENDABLE OFFICE SUPPLIES	-	80	500
115350__ 529900__ __		MISCELLANEOUS SUPPLIES	119	-	250
115350__ 532010__ __		COMMUNIC.-EE CELL PHONE	287	288	300
115350__ 535200__ __		REPAIRS & MAINT-EQUIP	658	1,662	3,425
115350__ 535300__ __		REPAIRS & MAINT-VEHICLES	183	1,234	1,500
115350__ 537000__ __		ADVERTISING	1,574	1,125	2,000
115350__ 539500__ __		TRAINING-EMPLOYEE EDUC EXP	90	125	475
115350__ 545200__ __		VEHICLE INS	1,217	1,266	1,440
115350__ 545400__ __		PROF LIABILITY INS	1,485	437	1,530
115350__ 549100__ __		DUES & SUBSCRIPTIONS	85	150	150
TOTAL MEALS ON WHEELS			243,468	247,635	311,347

000000HAYWOOD COUNTY DSS
EXPENSE TREND

			2011 YTD EXPENDED	2012 YTD EXPENDED	2013 REVISED BUDGET
115372 WORK FIRST					
115372__ 518303__ SWCDC_	SWCDC-ADMIN COST	****	-	90,425	80,000
115372__ 525002__ __	FUEL/GAS/DIESEL		13,095	17,089	14,800
115372__ 531300__ __	TRANSPORTATION OF CLIENTS		79,962	79,786	80,000
115372__ 535300__ __	REPAIRS & MAINT-VEHICLES		1,350	629	2,000
115372__ 539500__ __	TRAINING-EMPLOYEE EDUC EXP		234	783	-
115372__ 539907__ SWCDC_	DAY CARE REIMB TO SWCDC	****	-	3,108,589	1,932,464
115372__ 539909__ __	OTHER SVC-PARTICIPANT ASST		13,931	9,895	-
115372__ 539911__ __	CONTRACTED SERV-ESC-JOB DEVEL		151,615	159,215	104,000
115372__ 539911__ 9WFFA__	CONTRACTED SERV-ESC-JOB DEVEL		8,333	-	-
115372__ 545200__ __	VEHICLE INS		4,259	4,306	4,900
TOTAL WORK FIRST			272,780	3,470,717	2,218,164
115389 FOOD ASST-EMP & TRAINING					
115389__ 549900__ __	MISCELLANEOUS CHARGES		4,906	2,525	-
TOTAL FOOD ASST-EMP & TRAINING			4,906	2,525	-
115392 ADOPTION AWARENESS					
115392__ 529905__ __	MISC-ADOPTION AWARENESS		250	475	5,525
TOTAL ADOPTION AWARENESS			250	475	5,525
115401 ADULT DAY CARE - DSS					
115401__ 512100__ 06ADC__	SAL & WAG-PERM FT & PERM PT		82,503	94,391	94,835
115401__ 512200__ 06ADC__	SALARIES & WAGES-OVERTIME		-	-	399
115401__ 512600__ 06ADC__	SALARIES & WAGES-TEMP & PART		2,158	916	2,500
115401__ 512700__ 06ADC__	SALARIES & WAGES-LONGEVITY		-	1,052	1,095
115401__ 518100__ 06ADC__	SOCIAL SECURITY CONTRIB		6,147	6,965	7,560
115401__ 518200__ 06ADC__	RETIREMENT CONTRIB		5,370	6,653	6,493
115401__ 518204__ 06ADC__	CO CONTRIB-401(K) SUPP RET INC		-	-	963
115401__ 518300__ 06ADC__	HOSPITALIZATION INS CONTRIB		29,400	36,960	36,960
115401__ 518600__ 06ADC__	WORKERS' COMP CONTRIB		329	912	888
115401__ 518900__ 06ADC__	OTHER FRINGE BENEFITS-LIFE INS		133	144	144
115401__ 519900__ 06ADC__	PROF SERVICES-OTHER		29,076	30,811	35,700
115401__ 522000__ 06ADC__	FOOD - MEALS ON WHEELS		21,474	16,642	18,500
115401__ 523900__ 06ADC__	MEDICAL&NUTRIT.SUPL.FOR CLNTS		6	-	500
115401__ 525002__ 06ADC__	FUEL/GAS/DIESEL		5,132	6,464	5,600
115401__ 526000__ 06ADC__	OFFICE SUPPLIES & MATERIALS		1,641	1,618	1,700
115401__ 526900__ 06ADC__	NON-EXPENDABLE OFFICE SUPPLIES		777	-	500
115401__ 529100__ 06ADC__	DATA PROCESSING SUPPLIES		-	108	200
115401__ 529900__ 06ADC__	MISC DEPT'L SUPPLIES		1,005	874	1,100
115401__ 531100__ 06ADC__	TRAVEL		70	220	300
115401__ 532000__ 06ADC__	COMMUNICATIONS		1,909	2,981	3,400
115401__ 532010__ 06ADC__	COMMUNIC.-EE CELL PHONE		780	847	750
115401__ 533000__ 06ADC__	UTILITIES		2,934	2,092	2,700
115401__ 535300__ 06ADC__	REPAIRS & MAINT-VEHICLES		51	1,064	1,800
115401__ 539500__ 06ADC__	TRAINING-EMPLOYEE EDUC EXP		300	-	300
115401__ 541200__ 06ADC__	RENT OF BUILDING		9,480	9,480	10,500
115401__ 545200__ 06ADC__	VEHICLE INS		1,217	1,266	1,270
115401__ 549100__ 06ADC__	DUES & SUBSCRIPTIONS		40	-	240
TOTAL ADULT DAY CARE - DSS			201,932	222,459	236,897

000000HAYWOOD COUNTY DSS
EXPENSE TREND

			2011 YTD EXPENDED	2012 YTD EXPENDED	2013 REVISED BUDGET
115402 CAP-COMMUNITY ALTERNATIVE PRGM					
115402__ 512100__ 06CAP__		SAL & WAG-PERM FT & PERM PT	230,599	233,801	235,760
115402__ 512700__ 06CAP__		SALARIES & WAGES-LONGEVITY	1,557	3,277	3,359
115402__ 518100__ 06CAP__		SOCIAL SECURITY CONTRIB	16,905	17,375	18,293
115402__ 518200__ 06CAP__		RETIREMENT CONTRIB	15,082	16,554	16,117
115402__ 518204__ 06CAP__		CO CONTRIB-401(K) SUPP RET INC	-	-	2,391
115402__ 518300__ 06CAP__		HOSPITALIZATION INS CONTRIB	48,650	55,440	55,440
115402__ 518500__ 06CAP__		UNEMPLOYMENT COMP CONTRIB	6,032	-	-
115402__ 518600__ 06CAP__		WORKERS' COMP CONTRIB	8,415	6,241	6,366
115402__ 518900__ 06CAP__		OTHER FRINGE BENEFITS-LIFE INS	232	215	216
115402__ 519900__ 06CAP__		PROF SERVICES-OTHER	17,196	14,734	18,600
115402__ 523900__ 06CAP__		OTHER MEDICAL SUPPLIES	55,573	70,988	54,000
115402__ 526000__ 06CAP__		OFFICE SUPPLIES & MATERIALS	1,553	578	2,090
115402__ 526900__ 06CAP__		NON-EXPENDABLE OFFICE SUPPLIES	-	-	300
115402__ 531100__ 06CAP__		TRAVEL	8,136	7,958	9,360
115402__ 532000__ 06CAP__		COMMUNICATIONS	1,176	1,330	1,350
115402__ 532010__ 06CAP__		COMMUNIC.-EE CELL PHONE	-	-	150
115402__ 533000__ 06CAP__		UTILITIES	5,194	3,442	4,500
115402__ 539500__ 06CAP__		TRAINING-EMPLOYEE EDUC EXP	-	-	250
115402__ 543900__ 06CAP__		RENT OF EQUIPMENT	1,539	750	1,425
TOTAL CAP-COMMUNITY ALTERNATIVE PRGM			417,839	432,681	429,867
115403 COMMUNITY CONNECT.RWJ.MTN.PRJS					
115403__ 569900__ __		OTHER CONTRACTS, GRANTS, ETC	65,000	110,664	120,000
TOTAL COMMUNITY CONNECT.RWJ.MTN.PRJS			65,000	110,664	120,000
115412 COMMUNITY CRISIS MANAGEMENT					
115412__ 549900__ __		MISCELLANEOUS CHARGES	5,997	4,016	-
TOTAL COMMUNITY CRISIS MANAGEMENT			5,997	4,016	-
115471 ADOPTION PAYMENTS					
115471__ 549900__ __		MISCELLANEOUS CHARGES	202,371	213,927	223,500
TOTAL EXPENSES			11,095,748	14,676,202	13,435,602
Adjust for SWCDC Expenses			-	(3,199,014)	(2,012,464)
ADJUSTED TOTAL EXPENSES			11,095,748	11,477,188	11,423,138

Summary of HCHD's Budget Request for FY: 2007-2013

2/18/2013

	Actual FY: 2006-2007		Actual FY: 2007-2008		Actual FY: 2008-2009		Actual FY: 2009-2010		Actual FY: 2010-2011		Actual FY: 2011-2012		Budget FY: 2012-2013	
State Appropriations & Grants	$1,184,120.66	24.43%	$1,289,376.44	24.78%	$1,314,769.02	25.15%	$1,574,574.79	31.32%	$1,202,959.13	26.76%	1,023,189.81	24.38%	1,132,555.00	25.69%
Fees	$740,137.28	15.27%	$707,748.52	13.60%	$727,525.75	13.92%	$516,808.25	10.30%	$581,423.00	12.94%	429,807.96	10.24%	487,053.00	11.05%
Medicaid Expenditures	$934,854.28	19.28%	$990,152.29	19.03%	$1,001,469.88	19.15%	$1,042,927.79	20.75%	$943,364.74	20.99%	952,454.55	22.69%	954,138.00	21.65%
Haywood Co. Appropriations	$1,988,048.92	41.02%	$2,215,801.78	42.59%	$2,184,312.77	41.78%	$1,892,216.17	37.63%	$1,767,085.72	39.31%	1,791,443.41	42.68%	1,834,066.00	41.61%
Total	$4,847,161.14	100.00%	$5,203,079.03	100.00%	$5,228,077.42	100.00%	$5,026,527.00	100.00%	$4,494,832.59	100.00%	4,196,895.73	100.00%	4,407,812.00	100.00%


• Accounting
• Contract Management
• Monitoring
Finance & Budget
Human Resources
• Leadership Development
• Staff Training
• Media & Communication
• Personnel
Human Services Support Team
Implemented in 2005
• Data & Analytics
• Program/ Fiscal Analysis
• Team Facilitation
Planning & Evaluation
Operations
• Supplies
• Building Management
• Safety & Security

2005

STUDY FOR UNDUPLICATED CLIENT LIST

Client Services Data Warehouse queries were performed from the Health Department and Social Services to compile unduplicated lists of common clients that both agencies serve for Fiscal year 2011-12. Earlier single day client lists have been pulled for Social Services.

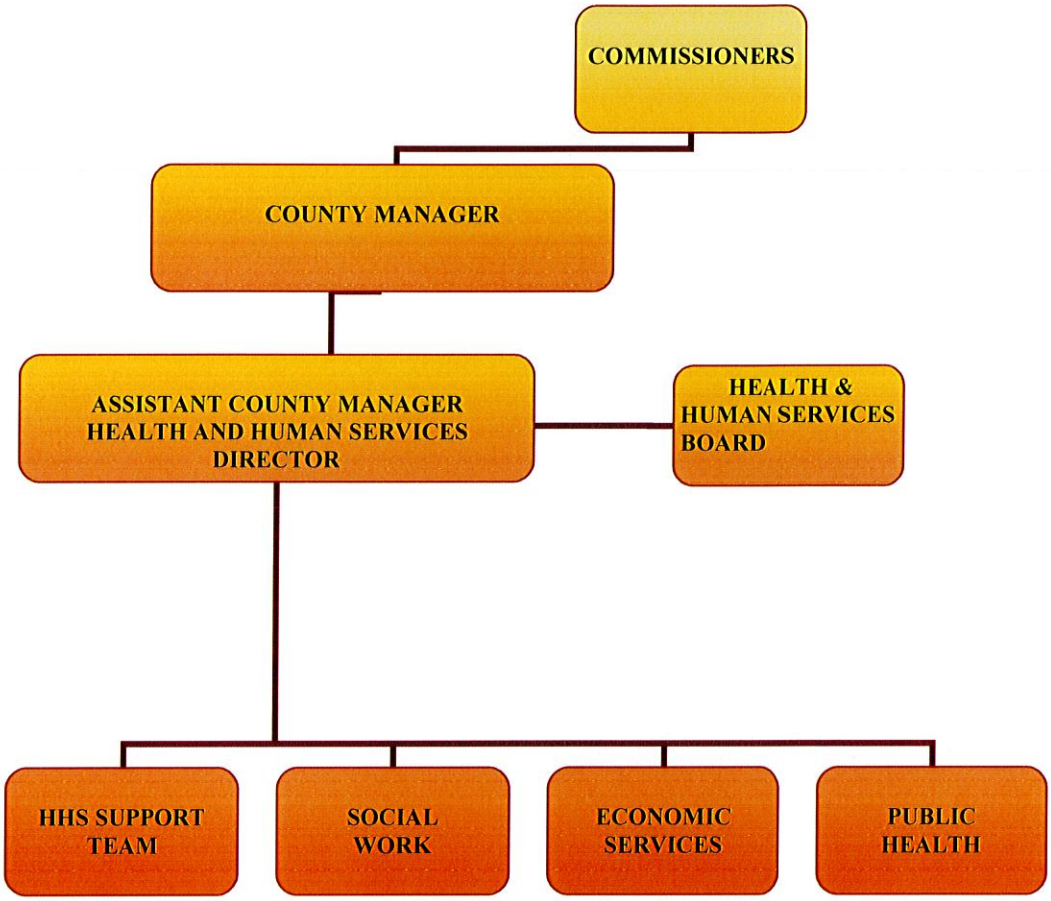
Social Services was able to pull the report, however upon review, duplications were evident on initial data entry levels. For example, a client might be in the report several times when they have been entered by different programs where one might put the middle initial and the other did not. That client will show as two separate clients. The report pulled from DSS resulted in 587 pages, approximately 22,000 clients. The report would have to be manually reviewed to ensure accurate numbers. A report from each separate program would have to be run and then manually matched to avoid duplication within DSS itself, for example services provided by two programs within the agency for one client.

The Health Department found the same duplications to be true in their queries. Their query resulted in 287 pages, 6820 clients served within the same fiscal year. As a result, some clients showed up twice because they were initially entered in the computer system differently, for example, one time they were entered with a social security number and the next time they did not have a social security number entered. These clients showed up as two separate clients. They also found that even though a client might be shown as having a Medicaid number, they would have to go manually into each client case to make sure that client actually had Medicaid during that time period. Also, some of their clients might have Food and Nutrition Services, but are not on Medicaid. The WIC program sees approximately 1500 clients per month. These same clients will be seen every three months. Inclusive in these 1500 are children and mothers. These mothers are also included in DSS data in Medicaid.

We were able to pull some separate reports with the following results: ("Cases" are reported, these might contain more than one client per case.)

Food and Nutrition Services – 4959 open cases (over 10,000 individuals)
Adult Medicaid Cases – 3670 open cases
Family and Children Medicaid Cases – 5105 cases
CIP – 453 approved cases
LIEAP – 33 when applications were starting to be accepted in the first day
Child Support – 1541 open cases
Child Welfare – 1383 children in fiscal year 2011-12
MOW – 197 people currently served

The two departments currently operate with more than 19 legacy computer systems. Because of this, data is processed differently and the results are not the same. We spoke with a data expert from Policy Consulting Group, and it was confirmed that until these are integrated into the NCFAST system and HSIS, the one common result will be unobtainable in one report. However, because of the research that both departments have done working together over the past four days, we feel comfortable in saying that we serve conservatively 7000 common clients.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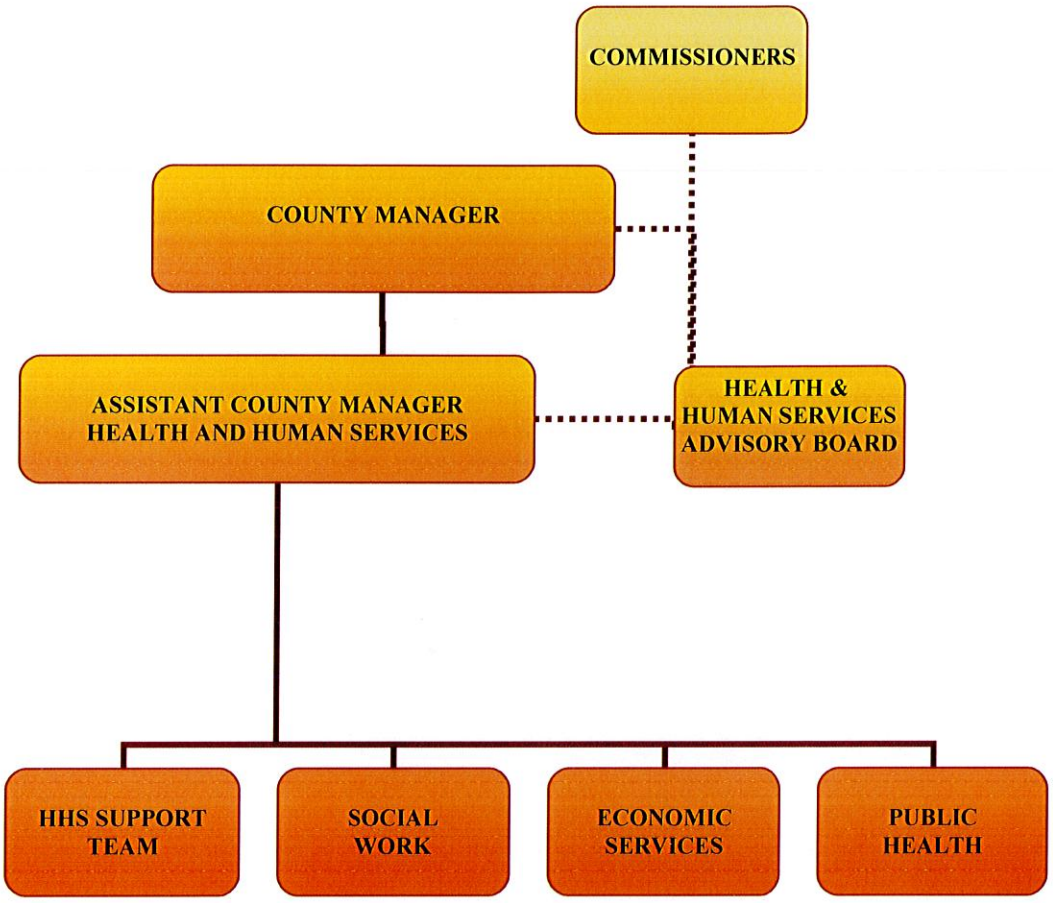
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