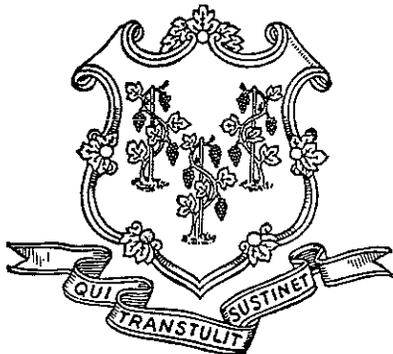


**CONSOLIDATION OF  
HUMAN SERVICES AGENCIES**

**Connecticut  
General Assembly**



**LEGISLATIVE  
PROGRAM REVIEW  
AND  
INVESTIGATIONS  
COMMITTEE**

**MARCH 1992**

**CONNECTICUT GENERAL ASSEMBLY  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

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**LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS  
COMMITTEE**

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## INTRODUCTION

In January 1991, the Legislative Program Review and Investigations Committee authorized a study to examine the consolidation of the state's human services agencies. While the study was in progress, the General Assembly passed P.A. 91-3 of the June Special Session, establishing the Commission to Effect Government Reorganization. One requirement of the act was for the commission to study possible agency mergers within the state's human services system. Noting the common purpose of the two studies, the committee suspended its review and loaned its staff to the reorganization commission.

The program review committee stayed abreast of the commission's efforts to reorganize the state's human services system through staff progress reports. After the Commission to Effect Government Reorganization completed its study, the committee reviewed the report and voted to adopt its recommendations. In addition to the approved recommendations, this final report of the program review committee includes work completed prior to the creation of the reorganization commission and additional analyses performed by the committee's staff in conjunction with staff from the Office of Policy and Management, the Office of Legislative Research, the Office Fiscal Analysis, and the Legislative Commissioners' Office.

The state agencies examined as a part of the study included the Department on Aging, the Department of Human Resources (DHR), the Department of Income Maintenance (DIM), the Department of Housing (DOH), the Department of Children and Youth Services (DCYS), the Department of Health Services (DHS), the Department of Mental Health (DMH), the Department of Mental Retardation (DMR), the Connecticut Alcohol and Drug Abuse Commission (CADAC), the Commission on the Deaf and Hearing Impaired (CDHI), and the Board of Education and Services for the Blind (BESB).

The findings contained in this report are similar to those identified in numerous other studies over the past 20 years. Specifically, the staff found an abundance of human services agencies operating programs that too frequently overlap in terms of either the services provided or the client group served. The staff's analysis showed that agency consolidations could produce administrative savings, but cautioned against the notion that substantial cost reductions could be achieved by merging agencies.

The recommendations of the Commission to Effect Government Reorganization adopted by the committee and contained in this report were developed by a task force composed of legislators, state agency heads, and citizens. The principal recommendations were to rename the Department of Children and Youth Services the Department of Children and Families and to consolidate 10 agencies into 3 as follows:

- a Department of Social Services to include the programs of the current Department on Aging, the Department of Income Maintenance, the Department of Human Resources (except for programs serving persons with disabilities and for Head Start, which would be transferred to the Department of Education), and the Commission on Hospitals and Health Care;
- a Department of Public Health and Addiction Services to include all public health programs of the current Department of Health Services and the Connecticut Alcohol and Drug Abuse Commission;
- a Department of Developmental and Rehabilitative Services to include the programs of the current Departments of Mental Health and Mental Retardation, the Commission on the Deaf and Hearing Impaired, and the Board of Education and Services for the Blind, together with the programs in the Department of Human Resources relating to services for persons with disabilities, including the Bureau of Rehabilitation Services.

This report of the program review committee is divided into four sections. Section I reviews the history of recent reorganization efforts in Connecticut. Section II analyzes budgetary, staff resource, and leased facilities data pertaining to the 11 human services agencies included in the reorganization study. It also contains an analysis of the overlap among programs administered by each of the agencies. Section III identifies and describes theoretical models for organizing human services agencies and applies the models to Connecticut. That section also outlines human service structures of selected other states. Section IV includes an edited version of the reorganization commission's report that was adopted by the program review committee.

## CHAPTER I

### REORGANIZATION EFFORTS SINCE 1971

**Etherington Commission.** The Etherington Commission was established through an executive order issued by Governor Thomas J. Meskill, on March 17, 1971. The commission was mandated to analyze the operation of all state agencies, boards, and commissions. Its final report, released in October of 1971, contained hundreds of recommendations aimed at increasing government efficiency and reducing costs.

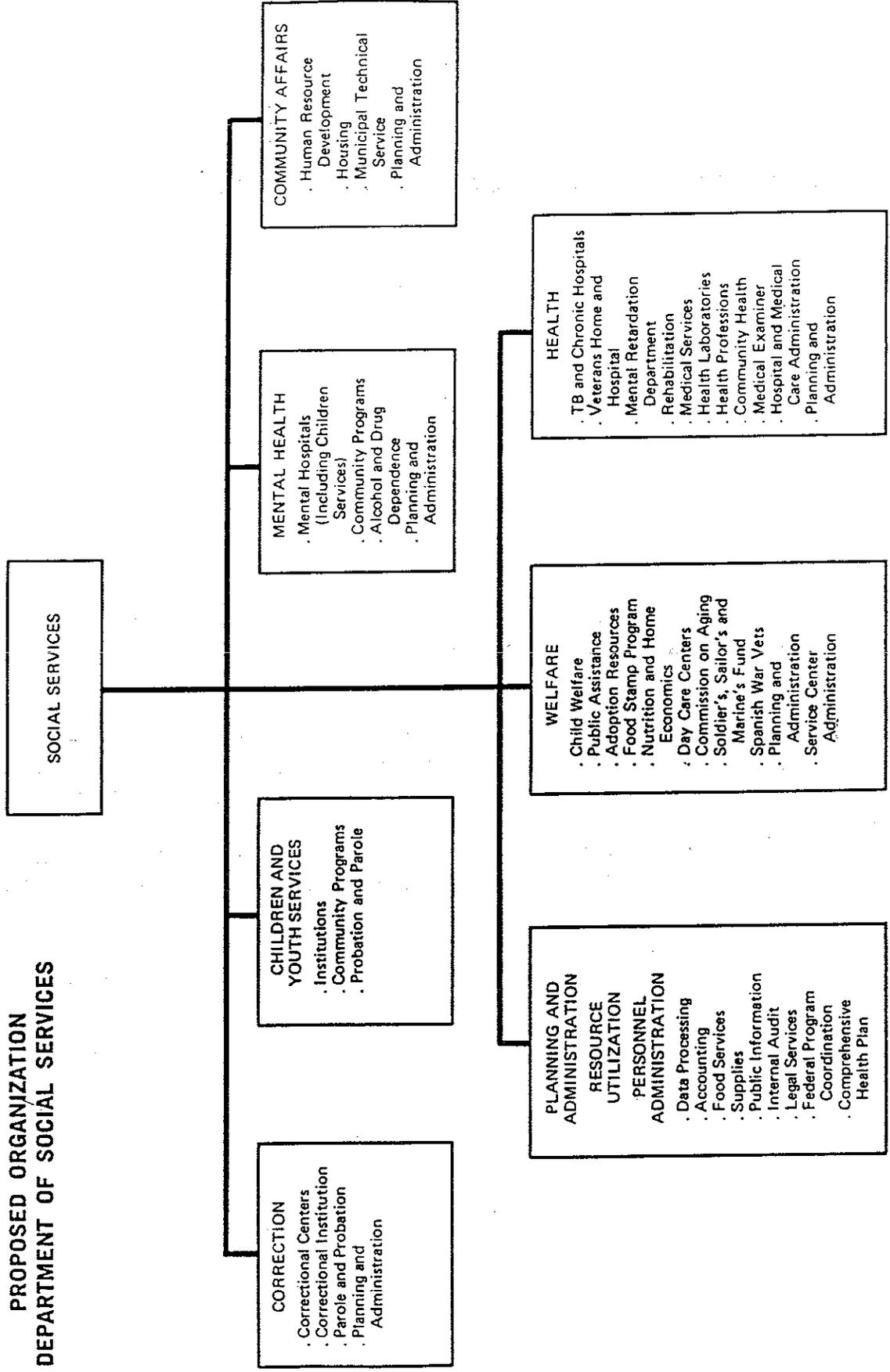
The recommendations directed specifically at human services agencies dealt primarily with streamlining procedures, increasing federal reimbursements, eliminating staff, increasing user fees, and making more efficient use of physical facilities. There were, however, a number of recommendations aimed at organizational issues. Typical of this group were proposals to transfer a function from one human services agency to another, or consolidate similar functions within the same agency.

The Etherington Commission also proposed a comprehensive restructuring of state government. A major feature of the reorganization was consolidation of several human services agencies including the Departments of Children and Youth Services, Community Affairs, Correction, Health, Mental Health, and Welfare into a Department of Social Services. (See Figure I-1.) The recommendation was in response to the commission finding that the existing structure of separate departments fostered duplication of internal support functions and discouraged coordination in the delivery of services.

Under the consolidation plan, duplicate functions such as personnel, data processing, record keeping, and financial accounting were consolidated into a single division. In addition to an administrative division, the proposal called for separate divisions to encompass the specialty fields of the formally autonomous departments. The director of each division would report to the head of the Department of Social Services, who in turn reported to the governor.

Rather than attempt to achieve the proposed reorganization through a statutory mandate, those responsible for implementing the Etherington Commission recommendations supported a bill introduced in the 1972 session of the General Assembly calling for the creation of a commission that would be responsible for designing a merger of human services departments. The heads of many departments identified for consolidation by the Etherington Commission testified in support of the bill. The only publicly stated opposition came from representatives of several human services groups.

Figure 1 - 1 Etherington Proposed Reorganization



Their chief complaint was their exclusion from membership on the study commission. The final version of the bill, which became Special Act 50, included the broader membership on the study commission requested by private human services agencies.

**Commission to Study Human Services.** The Commission to Study Human Services created by Special Act 50, passed in 1972, became known as the Zimmerman Commission. It was composed of 27 members including legislators, state agency heads, and private citizens. The commission was statutorily mandated to study the laws pertaining to human services provided by the state, and to plan and design a new department emphasizing coordination of services. The scope, size, and duties of the department were to be suggested by the commission.

The Zimmerman Commission, like the Etherington Commission, found the state's human services structure was composed of numerous independent agencies with narrowly defined missions. In the opinion of the Zimmerman Commission, the structure contributed to a fragmented service delivery system that was neither efficient nor capable of meeting the multiple needs of many of the system's clients. The report noted the separate planning, programming, and budgeting functions required by the state's system of independent agencies led to a focus on priorities within departments, thereby neglecting broader issues affecting the full range of human services. The commission also pointed out efficiency and coordination problems caused by duplication across department lines of such core services as outreach, intake, assessment, referral, and follow-up.

To resolve these problems, the Zimmerman Commission called for the creation of a comprehensive Department of Human Services. It recommended the department encompass the programs, services, functions, and legal responsibilities of the Departments of Aging, Children and Youth Services, Community Affairs, Correction, Health, Mental Health, and Welfare, the Office of Mental Retardation, and the Division of Vocational Rehabilitation. (See Figure I-2.) The commission proposed that the consolidated department be headed by a single commissioner in whom all powers would be vested.

The Zimmerman Commission recommended that the internal structure of the department not be mandated in statute and that the commissioner be given flexibility to organize the department. However, the commission report did outline its vision of the department's structure, which included:

- an administrative services division responsible for personnel, accounting, internal audits, data processing, grants management, and facility management;
- a planning, evaluation, and budgeting division;



- a community protection division responsible for statewide administration of licensing and inspections;
- a program development division composed of units corresponding to the separate departments;
- a designation of regional districts for planning, administration, and delivery of all human services; and
- a statewide advisory council and regional advisory councils.

A bill to implement the recommendations of the Zimmerman Commission was introduced into the 1973 session of the General Assembly. Strong opposition to the proposed Department of Human Services was expressed by many special interest groups including: private service providers; advocates for the retarded, aged, and children; and state employees. The size of the proposed department, the lack of details about the organizational structure of the department, the broad powers given to the commissioner, and the fear that attention and resources would be diverted from one constituency to another were the primary reasons cited for opposing the bill.

In place of the Department of Human Services recommended by the Zimmerman Commission, the bill that passed (P.A. 73-155) created a Council on Human Services. The council was composed of eight commissioners of human services agencies, the secretary of the State Board of Education, and six legislators; it was to be chaired by the governor. It was authorized to employ staff who were to be paid from the appropriations of the departments represented on the council.

The council was mandated to coordinate planning, policy, and resource utilization among the Office of Mental Retardation, the Vocational Rehabilitation Division of the Department of Education, and the Departments of Welfare, Health, Correction, Aging, Children and Youth Services, Mental Health, and Community Affairs. It was required to run demonstration projects among human services agencies to test alternative service delivery systems. The act also required the council report to the governor and General Assembly by January 1975 on its efforts and to recommend a system for regional districts, an organizational plan for a Department of Human Services, and a facility and resource allocation plan for existing human services agencies.

**Council on Human Services.** In its January 1975 report to the governor and General Assembly, the Council on Human Services submitted a plan for regional service districts; however, it did not present an organizational plan for a Department of Human Services, or a facility and resource utilization plan. Instead the council proposed that it function as the body responsible for setting priorities, developing

policies, and coordinating activities in the human services area. Given its composition and mandate, statutory authorization was not required for the council to play this role. The council remained in existence until it was terminated by the reorganization of state government in 1977.

**Filer Commission.** The Committee on the Structure of State Government, better known as the Filer Commission, was established in December 1975 by Governor Ella Grasso and issued its final report in December 1976. The commission was created to study the structure of state government as a whole and to make recommendations to streamline its operations.

In the human services area, the Filer Commission found that the existing programs were scattered and overlapping with responsibility for providing specific services to specific individuals often uncoordinated and accountability unclear. A fundamental problem was that each human services agency had its own narrowly defined set of services, its own client intake system, and its own method of client follow-up, with no standards to serve clients requiring services from multiple agencies and no way of assuring that referrals of clients to needed services would be accomplished.

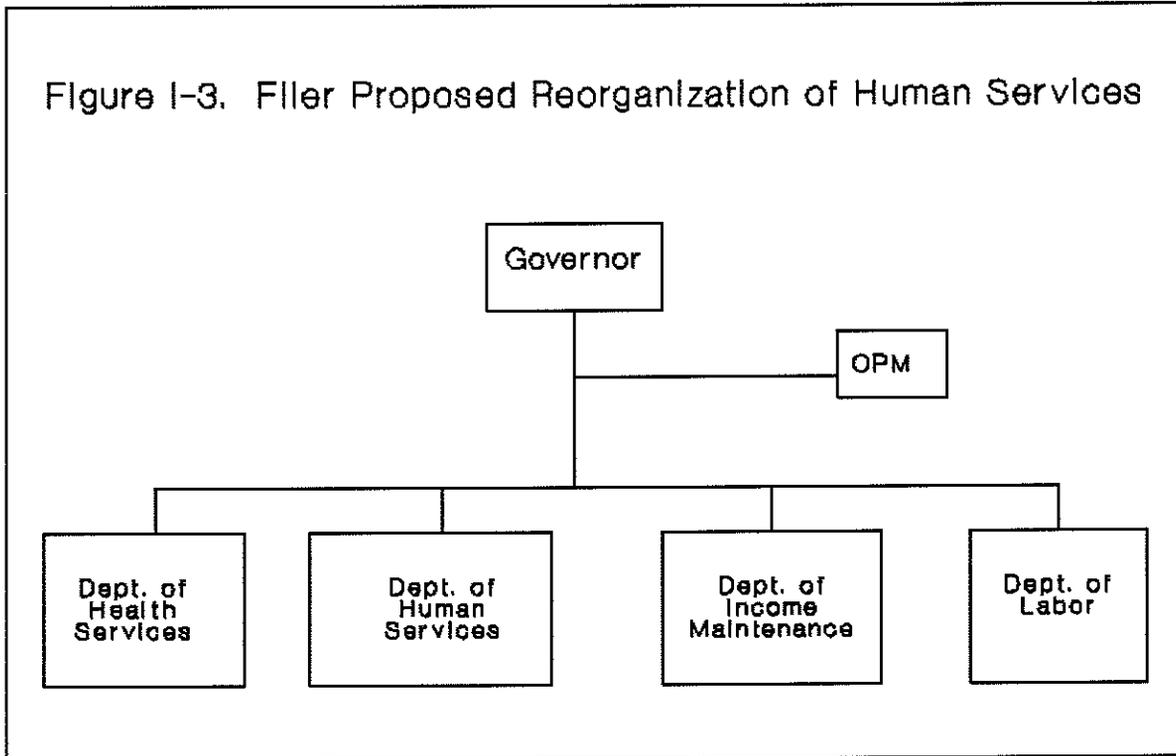
The commission also found that the plethora of human services agencies resulted in an inefficient use of resources including duplicative administrative support systems, multiple home visits by case workers, and duplicative paperwork.

The Filer Commission recommended that the existing Department of Social Services be disbanded and split into two new departments: a Department of Human Services and a Department of Income Maintenance. (See Figure I-3.) The Department of Human Services would consolidate the social service programs found in the existing Department of Social Services as well as merge a variety of other agencies involved in the delivery of services, including those responsible for day care, children and youth, aging, vocational rehabilitation, mental retardation, the poverty program, and manpower planning.

The new system would emphasize "one stop shopping" for human services and move all programs into common facilities wherever possible. Common forms would be used by all operating agencies, and there would be uniform client intake, diagnosis, referral, and case management processes. The rationale behind the commission's recommendation was to end the fractionalization of the existing social service delivery system.

The commission believed the income maintenance function should be separate from the delivery of human services. Therefore, the commission recommended establishment of a Department of Income Maintenance with responsibility for eligibility determination, benefit payments, and detection of fraud and errors.

Figure I-3. Filler Proposed Reorganization of Human Services



The Filer Commission also recommended the Human Services Council, created as a result of the Zimmerman Commission in 1973, be abolished. The commission recommended creation of a Department of Health Services led by a gubernatorially appointed commissioner of health services.

It proposed the new department include the Department of Mental Health, the Veterans Home and Hospital, and the existing Department of Health, which was responsible for a variety of traditional public health functions including maintaining health statistics, maternal and child health, laboratory services, and disease control. In addition, the new department would staff the Commission on Hospitals and Health Care, license health care professionals, and administer, in conjunction with the Department of Income Maintenance, the medicaid program.

Implementation of the Filer Commission recommendations was accomplished through Public Act 77-614, An Act Concerning the Reorganization of the Executive Branch of State Government. A Department of Income Maintenance was created with responsibility for administering all financial assistance programs. The act also created a Department of Human Resources to administer social services not related to income maintenance. However, the Departments of Aging, Children and Youth Services, Mental Retardation, and Mental Health were retained as separate agencies.

The act abolished the Human Services Council and instead established a bipartisan Human Services Reorganization Commission, responsible for drafting a State Human Services Plan. The plan was to be aimed at improving the coordination of services and achieving policy consistency in the human services area. The act further required the governor to submit the plan to the legislature by January 1979, to either adopt the commission's plan or formulate another plan.

Public Act 77-614 also created the Department of Health Services. In addition to the existing Department of Health, 19 professional licensing boards and commissions, with the Veterans' Home and Hospital attached for administrative purposes only, were consolidated under the new department.

**Human Services Reorganization Commission.** The 1977 Executive Reorganization Act established the Human Services Reorganization Commission. The commission was charged with the preparation and implementation of a State Human Services Plan that would achieve consistency of policy, integration of services, and accountability to the legislature and the governor.

Like the Etherington, Zimmerman, and Filer Commissions, the Human Services Reorganization Commission found that human services in Connecticut were uncoordinated and delivery of services to clients was fragmented. As a remedy, the commission offered recommendations in five policy areas including: service accessibility, service integration, focusing priorities, strengthening policy effectiveness, and improving human services management.

A leading recommendation made by the commission was the creation of a Human Services Cabinet, chaired by the governor, and composed of the secretary of the Office of Policy and Management (OPM) and the commissioners of the major human services agencies. The commission recommended a special assistant for human services be appointed, who would be located in the governor's office, and interdepartmental liaisons be designated within each agency. The cabinet would meet at least monthly. The commission envisioned the cabinet's role as the state's principal policy-making, planning, and coordinating body.

The governor's special assistant for human services would be responsible for coordinating development of human services policies and programs, providing staff support for the Human Services Cabinet, and ensuring follow-up activities were performed by OPM's Human Services Planning Unit and the interdepartmental liaison staff within each human services agency. Liaison staff would coordinate priorities, policies, and programs under the policy guidance of the cabinet, as well as provide interdepartmental communication. The Human Service Reorganization Commission also recommended expansion of the Human Services Planning Unit within OPM to provide: policy analysis for the governor; staff assistance to the cabinet; and policy and planning analysis for the budget-making process.

The reorganization commission also recommended creation of a Human Services Advisory Council. The council's role would be to facilitate communication among departmental advisory groups and address integration issues.

Another recommendation of the reorganization commission was that the governor, with the cabinet and OPM, create a Human Services Annual Agenda to guide the preparation of program plans and budget requests. The agenda would have a two-year cycle for implementation and evaluation, and would be at the center of the cabinet's comprehensive planning efforts.

Although the State Human Services Plan was submitted to Governor Grasso in December 1978, it was never presented to the legislature for approval. Instead, Public Act 79-31 removed the requirement that the 1979 General Assembly either approve the plan or failing approval, return the plan to the Government Administration and Policy Committee for adoption of a different plan.

Public Act 79-211 did require the governor, in conjunction with OPM and the human services agencies, to prepare an annual agenda to implement the plan developed by the Human Services Reorganization Commission. The agenda was to be prepared and implemented over a three-year cycle as part of the program and budget planning process. In developing the agenda, the act required the governor to consider service accessibility, service integration, provision of a comprehensive range of services, and coordination of services to assure accountability and policy consistency.

Although two annual agendas were developed in FY 82 and FY 83, Public Act 83-181 eliminated the requirement that the governor, OPM, and various human services agencies continue development of Human Services Agendas.

**Commission to Study Human Services.** In 1985 Governor William A. O'Neill proposed appointing a cabinet-level administrator with support staff, who would have overall responsibility for human services agencies in the state. The response of the General Assembly, through Public Act 85-546, was to establish a commission to examine human service coordination and delivery.

The Commission to Study Human Services, composed of a 12 member bipartisan group of individuals, was appointed by Senate and House leaders from both parties and the governor. Its mandate was "to examine the coordination and delivery of human services in Connecticut." Its final report was issued in January 1987.

The commission stated:

proliferation of federally funded and state-administered programs for categorically eligible groups (families with dependent children;

pregnant women, infants, and children at nutritional risk; the permanently and totally disabled, etc.) had provided an incentive for states to create separate administrative units to service each group. These programs had their own regulations with respect to administrative arrangements, reporting, and client eligibility. Such requirements made it difficult for an individual state to organize and coordinate its programs in an efficient and effective manner.

The commission found the budget process to be the primary driving force behind human services policies and formulation of programs. Like other study groups before it, the commission identified lack of coordination as a serious problem for the state human services system. Specifically, the absence of a formal structure requiring regular interaction between human services agency leaders limited opportunities for effective policy coordination, the commission noted. As a result, critical policy issues were addressed through the use of ad hoc legislative and executive branch as well as interagency task forces.

The commission recommendations focused on achieving maximum coordination in the areas of policy formulation and decisionmaking. The recommendations were in three areas: structural, policy, and operations.

The commission recommended the creation of a Human Services Cabinet, including all human service agency commissioners and chaired by the secretary of OPM, with staff to provide technical support and assist the cabinet in meeting its responsibilities. The cabinet's efforts were to focus on the formulation and coordination of policy and planning in human services programs across state agencies. The commission directed the cabinet to develop mechanisms to identify and address unmet human services needs and included a requirement that the cabinet issue an annual report outlining its goals, how it would meet the goals, and the results of its efforts.

Specifically, the commission recommended the cabinet address the following issues: development of a uniform case management system; integration and consistency of planning and policy; integration of health care, education, housing, transportation, job training, and economic development into the human services delivery system; standardization of grant application and audit procedures for grantees; common application forms for services; compatible database information systems that would maximize information sharing; improved program evaluation procedures and practices; and establishment of uniform human services districts.

No formal legislative action was taken on recommendations made by the Commission to Study Human Services. Instead, Governor O'Neill, in September 1987, established a Human Services Cabinet. This cabinet was composed of human services commissioners and chaired by the secretary of OPM with the responsibility

of advising the governor on human services issues and improving coordination of services and policies among the agencies. The cabinet continues in existence today; however, it is chaired by the lieutenant governor.

**Summary.** Over the past 20 years, all of the studies that examined Connecticut's human services delivery system identified common weaknesses and presented consistent views of systemic problems. The findings presented in the various reports are remarkably similar, each concluding that the system is fragmented, inefficient, and fraught with duplication. Similarly, recommendations centered on one of two approaches -- either consolidate various human services agencies or allow agencies to remain independent but create a high-level mechanism that would set interagency policy and ensure coordination.

Broad generalizations to support findings and recommendations were characteristic of the reports examined, with no evidence that conclusions were based on any hard data. For example, although three separate studies recommended a consolidated department because of fragmentation, there was no documentation concerning its effect on services, nor was there an explanation of how the consolidation would specifically improve coordination and provide better integrated services.

The reports tended to emphasize how the recommendations would improve services through the elimination of duplication and fragmentation, rather than reduce costs. One reason for this may be that the significant changes recommended in the reports can be achieved only through an initial increase in expenditures. The long-term savings that should occur by eliminating duplication and increasing efficiency are not given any emphasis. Plausible reasons for this may be lack of data or an unwillingness to raise the issue of staff cuts.

Finally, despite numerous attempts to reorganize the state's human services delivery system, the result has been the same. The recommendations have met with strong resistance from department staff and constituency groups. Reasons cited for the failure of past reorganization efforts included: a consolidated human services department would be too large and bureaucratic; fear that different constituency groups would be forced to compete for limited resources; and certain constituency groups did not want the stigma of receiving services from a department that was associated with providing public welfare. Thus, virtually none of the recommendations that proposed significant change have experienced great success.



## CHAPTER II

### DEPARTMENT EXPENDITURES, RESOURCES, AND PROGRAMS

During the first phase of the program review committee's study, the staff focused on obtaining and analyzing data descriptive of each agency's operations and resources. The information collected included mission statements, organizational charts, expenditure reports, personnel descriptions, physical facilities, and program descriptions. Although the information was collected on all of the state's human services agencies, the committee staff's analysis concentrated on the Departments of Income Maintenance, Human Resources, Aging, Housing, and Children and Youth Services.

Expenditure data for the five departments were analyzed to identify the size and cost of the administrative functions most likely to be directly affected by a consolidation of agencies. Personnel and physical facilities data were examined to gain an understanding of potential cost savings that could be realized through consolidating agencies. Agency programs were categorized by staff along functional lines to determine the extent of program overlap between agencies.

After the initial analysis was completed, the General Assembly passed Public Act 91-3, of the June Special Session, creating a commission to study reorganization of the state's human services system. The immediate impact on the committee was the assignment of two of its staff to the new commission. Working with the Task Force on Social Services and Services to Persons with Disabilities established by the reorganization commission, the program review committee's staff extended its data analysis to an additional six agencies. This was accomplished in conjunction with staff from the Office of Policy and Management, the Office of Legislative Research, the Office of Fiscal Analysis, and the Legislative Commissioners' Office.

**Expenditures.** State fiscal year 1991 General Fund expenditures by the 11 agencies in the reorganization study are displayed in Table II-1. The table shows that the agencies accounted for nearly 45 percent of the state's reported General Fund expenditures. The Department of Income Maintenance spent the most (28.4 percent of the state's total), followed by the Department of Mental Retardation (6.3 percent of the total). Of the remaining agencies, only the Department of Mental Health (3.8 percent) and the Department of Children and Youth Services (2.4 percent) accounted for more than 2 percent of the state's total. From this data, it appears that Connecticut has a large number of agencies each attempting to meet a small segment of the state's human services needs.

TABLE II-1. FY 91 GENERAL FUND EXPENDITURES BY SELECTED HUMAN SERVICES AGENCIES (1) (in thousands)		
Agency	FY 91	% of General Fund
DIM	\$ 1,883,803	28.4
DHR	104,621	1.6
AGING	44,298	0.7
HOUSING (2)	12,534	0.2
DCYS	158,517	2.4
DOHS	43,810	0.7
CADAC	43,157	0.7
DMH	254,365	3.8
DMR	420,229	6.3
BESB	11,904	0.2
CDHI	880	0.0
COMBINED	\$ 2,978,118	44.9
(1) Does not include federal reimbursements.		
(2) All of the department's expenditures are included, not just those for activities that would be included in a consolidation of human services agencies.		
Source of Data: Governor's Budget 1992-93.		

Although total expenditure data are indicative of the magnitude of an agency's operations, such data provide limited insight into possible cost savings that could be realized through merging human services agencies. Actual spending on personnel, programs, and other expenses is a much better indicator of the potential savings that can be realized from reorganization. Table II-2 presents these data for FY 91.

Table II-2 shows that the human services agencies included in the review spent 75.7 percent (\$2.253 billion) of their budgets on programs. While this is a large sum,

agency consolidations could only achieve substantial savings in this area if whole programs could be eliminated. However, such action could only be justified if it was found that an individual person was being provided identical services under separate programs. Given there is no overriding reason to believe that this type of duplication exists, cost reductions in the program area would be confined to savings resulting from increased operating efficiencies, which typically yield smaller amounts.

TABLE II-2. FY 91 GENERAL FUND EXPENDITURES BY FUNCTION FOR SELECTED HUMAN SERVICES AGENCIES (in millions)				
Agency	Personnel	Programs	Other	Total
DIM	\$ 58.8	\$1,777.6	47.4	\$1,883.8
DHR	17.6	79.9	7.1	104.6
AGING	2.2	41.4	.6	44.3
HOUSING (1)	2.9	8.7	.9	12.5
DCYS (1)	61.8	82.2	14.5	158.5
DOHS	23.4	11.5	8.8	43.8
CADAC	18.5	14.2	10.5	43.2
DMH	149.3	61.9	43.2	254.4
DMR	199.1	166.7	54.4	420.2
BESB	2.4	9.2	.4	11.9
CDHI	.7	0.0	.1	.9
<b>COMBINED</b>	<b>\$536.8</b>	<b>\$2,253.4</b>	<b>\$187.9</b>	<b>\$2,978.1</b>
(1) Includes all General Funds not just those associated with the programs that would be subject to a consolidation of human service agencies.				
Source of Data: Governor's Budget 1992-93.				

Table II-2 shows that the agencies expended \$536.8 million on staff in FY 91. The amount is important because staff reductions and the resulting decrease in personnel spending is the primary means of saving money through merging government agencies.

A good indicator of the potential savings in the personnel area is the amount of staff resources devoted to administration. Table II-3 depicts this information. The table was constructed by the program review committee staff using agency data submitted to the General Assembly's Appropriations Committee in March of 1991. It shows the number of staff engaged in administrative activities at the central office level.

TABLE II-3. DISTRIBUTION OF STAFF RESOURCES			
		Central Office	
Agency	Total Staff	Admin. Staff	Admin. as a % of Total
DIM	1,774	346	19.5
DHR	862	172	20.0
AGING	71	32	45.1
DCYS	1,704	164	9.6
DOHS	834	84	10.1
CADAC	514	72	14.0
DMH	3,941	101	2.6
DMR	5,376	114	2.1
BESB	117	18	15.4
CDHI	16	5	31.3
COMBINED	15,209	1,126	7.4
Source of Data: Appropriations Committee Survey--March 1991 and Office of Fiscal Analysis Position Data.			

The importance of the data in Table II-3 is that it helps to define the parameters for personnel reductions. If, for example, a goal of consolidating agencies is to reduce administrative staff by 15 percent, and assuming an average cost per staff person of \$50,000 (salary and fringe benefit costs), then the savings on central office staff alone can be estimated to be about \$8.5 million. Of course, more information on the distribution of staff within the category is needed before a detailed analysis can occur.

**Physical facilities.** Table II-4 presents data showing the current utilization of space by the 11 agencies involved in the consolidation study. The square-foot-per-staff statistic was calculated by dividing the amount of space credited to an agency in the 1991 State Facility Plan, by the number of staff assigned to the location. The number of staff at a location was determined from reports submitted to the General Assembly's Appropriations Committee in March 1991. Assuming the functions necessary to administer a consolidated human services agency are similar to those required by an existing agency, a rough estimate of the space needs of a consolidated central office would be about 200 square-foot-per-staff person. A similar amount of space would be required for a regional office.

TABLE II-4. OFFICE SPACE OF AGENCIES FOR SELECTED HUMAN SERVICES AGENCIES				
Agency	Central Office Sq. Ft.	Sq. Ft. Per Staff C.O.	Regional Offices Sq. Ft.	Sq. Ft. Per Staff R.O.
DIM	109,700	207.8	241,339	203.0
DHR	35,330	175.8	84,434	213.2
AGING	21,221	250.7	1,007	352.0
HOUSING	38,105	132.7	0	0
DCYS	44,600	247.8	116,086	176.2
DOHS	119,984	NA	7,000	NA
CADAC	16,357	NA	0	0
DMH	26,240	240.7	18,571	NA
DMR	27,790	243.8	94,443	NA
BESB	0	0	25,400	NA
CDHI	6,000	375.0	0	0
<b>TOTAL</b>	<b>445,327</b>	<b>205.4</b>	<b>588,280</b>	<b>198.9</b>
Sources of Data: State Facility Plan 1991-1996 and Appropriations Committee Survey--March 1991.				

Table II-5, which contains lease cost data, draws attention to the potential savings in facility costs that could result from staff reductions associated with agency

consolidations. If, for example, administrative staff was reduced by 15 percent (about 170 staff), then total office space requirements would decline by about 34,000 square feet (170 staff \* 200 sq. ft.). This would allow the state to eliminate at least one office (see Table II-4) and save up to \$400,000 annually.

Table II-5. COST OF SPACE OCCUPIED BY AGENCIES INCLUDED IN THE HUMAN SERVICES CONSOLIDATION STUDY				
Agency	Leased Central Office Space	Cost Per Sq. Ft.	Leased Regional Office Space	Costs Per Sq. Ft.
DIM	\$1,137,825	\$10.37	\$2,267,998	\$9.40
DHR (1)	355,875	10.73	793,484	9.40
AGING	189,435	10.95	49,982	10.14
HOUSING	417,250	10.95	0	0.00
DCYS	276,519	6.20	1,128,697	9.72
DOHS	1,234,366	10.29	56,000	8.00
CADAC	214,241	13.10	0	0.00
DMH	152,400	5.81	208,642	11.23
DMR	301,188	10.84	1,122,493	11.89
BESB	0	0.00	138,106	5.43
CDHI	67,200	11.20	0	0.00
Total	\$4,346,299	\$9.76	\$5,765,402	\$9.80
(1) Does not include the Division of Rehabilitative Services				
Source of Data: State Facility Plan 1991-1996.				

**Programs.** In order to examine the degree of program overlap between the 11 human services agencies, program review committee staff, working with staff from the Office of Policy and Management, established 8 functional classifications to categorize the agencies' programs. Using the Governor's FY 93 budget proposal, the staff identified 99 human service programs either directly operated by an agency or managed through contracts and grants with private organizations. An additional 15 programs were classified as management support.

Each program was placed into one of the eight functional categories based largely on the narrative description contained in the budget. A definition of each function follows:

- community-based social services - case management, client advocacy, legal services, information and referral, support for activities of daily living, nutrition, and community residential facilities;
- economic support - cash, vouchers, and direct or indirect payment for goods and services;
- employment - vocational rehabilitation, job training, and work programs;
- health services - medical services, psychological services, and treatment for persons with physical and mental disabilities;
- institutional care - 24-hour facilities providing room, board, and treatment for individuals with special needs (exclusive of correctional facilities);
- management - administration and operation of the department;
- protective services - prevention and protection of persons from abuse and neglect; and
- public health - licensing and regulation of facilities and professionals, monitoring of diseases, toxic substances, and environmental quality, and health promotion and disease prevention, information, education, and services.

Table II-6 indexes the 114 programs according to function. For each human services program listed, the table identifies the agency that operates it, the number of agency staff involved, the total dollars expended on the program in FY 91, and the type of population served. Five basic categories -- including age, income, hispanic, disabled, and all requests for services -- were used to identify the type of population served.

The table reveals several functional categories where human services programs overlap. This occurs primarily in one of two ways, either:

- different agencies offer a comparable program to the same or similar population groups (such as financial support for

energy assistance offered by both DIM and DHR, or employment programs in both of those agencies that are aimed at low income individuals); or

- different agencies offer the same program to dissimilar population groups (such as protection for abuse or neglect, which is located for children in DCYS, adults in DHR, and elderly in both DHR and Aging, or the child support enforcement program located in DHR for AFDC recipients and the Judicial Department for non-AFDC recipients).

Connecticut's history of creating agencies based on client characteristics rather than the type of service being provided has had a major impact on the state's service delivery system. A close examination of the data in Table II-6 shows program overlap in all of the functional categories. The most widespread, occurs in the area of community-based social services, where 8 of the 11 agencies offer services. The table also shows six agencies have employment programs, and six perform a health service function. Additionally, a total of four agencies administer economic support programs.

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
Community-Based Social Services	AGING	Community Services	7	\$3,386,061	Elderly
Community-Based Social Services	AGING	PIL (Frail Elderly)	2	\$8,877,745	Elderly
Community-Based Social Services	BESB	Adult Services	17	\$1,037,889	Persons w/ Disabilities
Community-Based Social Services	BESB	Orientation and Mobility	1	\$36,060	Persons w/ Disabilities
Community-Based Social Services	CADAC	Pretrial Alcohol Education and Treatment System (PAES)	0	\$1,586,945	Substance Abusers
Community-Based Social Services	CADAC	Prevention and Intervention	3	\$1,997,668	Substance Abusers
Community-Based Social Services	CADAC	Long Term Care and Shelters	0	\$1,149,133	Substance Abusers
Community-Based Social Services	CDHI	Interpreting Services	2	\$344,396	Persons w/ Disabilities
Community-Based Social Services	CDHI	Counseling Services	2	\$67,632	Persons w/ Disabilities
Community-Based Social Services	CDHI	Communications	0	\$31,800	Persons w/ Disabilities
Community-Based Social Services	DCYS	Youth & Community Development	0	\$2,947,829	Children & Families
Community-Based Social Services	DCYS	Youth Service Bureaus Counseling	0	\$1,263,134	Children & Families
Community-Based Social Services	DCYS	Community Living	10	\$8,879,730	Children & Families
Community-Based Social Services	DHR	Services to Persons w/ Disabilities	108	\$14,607,241	Persons w/ Disabilities

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
Community-Based Social Services	DHR	Housing Services	23	\$11,114,036	All Requests
Community-Based Social Services	DHR	Legal Services	0	\$90,460	Low Income
Community-Based Social Services	DHR	Food Distribution	2	\$716,047	Low Income
Community-Based Social Services	DHR	Family Planning	0	\$0	All Requests
Community-Based Social Services	DHR	Community Services	6	\$13,263,316	Low Income
Community-Based Social Services	DHR	Information and Referral	2	\$78,560	All Requests
Community-Based Social Services	DMH	Case Management	163	\$12,155,952	Persons w/ Mental Illness
Community-Based Social Services	DMH	Social Rehabilitation	8	\$6,263,279	Persons w/ Mental Illness
Community-Based Social Services	DMH	Residential Services	0	\$18,026,077	Persons w/ Mental Illness
Community-Based Social Services	DMR	Family Supports	29	\$2,262,615	Persons w/ Mental Retardation
Community-Based Social Services	DMR	Community Living Alternatives	958	\$144,238,494	Persons w/ Mental Retardation
Community-Based Social Services	DMR	Opportunities for Older Adults	40	\$5,588,779	Persons w/ Mental Retardation
Community-Based Social Services	DMR	Recreation/Social Development	42	\$4,919,887	Persons w/ Mental Retardation
Community-Based Social Services	DMR	Community Training Homes	10	\$4,129,854	Persons w/ Mental Retardation

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
<i>Economic Support</i>	AGING	CONNPACE	4	\$30,027,825	Low Income Elderly; Persons w/ Disabilities
<i>Economic Support</i>	DHR	Weatherization	6	\$2,752,333	Low Income
<i>Economic Support</i>	DHR	Fuel Assistance	8	\$15,764,338	Low Income not Receiving State Assistance
<i>Economic Support</i>	DHR	Child Support Enforcement	190	\$8,529,320	Low Income
<i>Economic Support</i>	DHR	Child Daycare	28	\$27,755,855	Low Income
<i>Economic Support</i>	DIM	Refugee Assistance	unavailable	\$0	Low Income Refugees
<i>Economic Support</i>	DIM	Aid to Aged, Blind, & Disabled	unavailable	\$108,040,520	Low Income Elderly; Persons w/ Disabilities
<i>Economic Support</i>	DIM	Energy Assistance	unavailable	\$0	Low Income Receiving DIM Cash Assistance
<i>Economic Support</i>	DIM	Food Stamps	unavailable	unavailable	Low Income
<i>Economic Support</i>	DIM	General Assistance	unavailable	\$114,084,077	Low Income not Receiving State Assistance
<i>Economic Support</i>	DIM	Medical Assistance	unavailable	\$1,195,818,480	Low Income
<i>Economic Support</i>	DIM	AFDC	unavailable	\$349,716,673	Low Income Child. & Guardians
<i>Economic Support</i>	DOH	Strategies for Affordability	1	\$9,068,022	Low Income
<i>Employment</i>	BESB	Workshop Programs	14	\$699,635	Persons w/ Disabilities
<i>Employment</i>	BESB	Small Business Enterprises	2	\$15,900	Persons w/ Disabilities
<i>Employment</i>	BESB	Vocational Rehabilitation	2	\$1,088,502	Persons w/ Disabilities
<i>Employment</i>	CDHI	Job Development and Placement	3	\$124,957	Persons w/ Disabilities
<i>Employment</i>	CDHI	Adult and Community Education	0	\$28,874	Persons w/ Disabilities

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
Employment	DHR	Refugee Assistance	2	\$97,291	Refugees
Employment	DHR	Opportunity Industrial Centers (OIC)	0	\$534,434	Low Income
Employment	DHR	Rehabilitation Services	6	\$8,126,749	Persons w/ Disabilities
Employment	DHR	Hispanic Employment Support	2	\$646,154	Hispanics
Employment	DIM	Job Connection	unavailable	\$16,551,377	Low Income AFDC & Food Stamp Recipients
Employment	DMH	Vocational Services	9	\$10,452,334	Persons w/ Mental Illness
Employment	DMR	Sheltered Employment	153	\$31,699,773	Persons w/ Mental Retardation
Employment	DMR	Supported Employment Programs	97	\$21,691,280	Persons w/ Mental Retardation
Health Services	BESB	Sp. Ed. of Vis. Handicapped Child	21	\$8,462,237	Persons w/ Disabilities
Health Services	CADAC	Treatment and Rehabilitation	429	\$36,130,259	Substance Abusers
Health Services	DCYS	Community Child Psychiatric Services	1	\$9,079,671	Children & Families
Health Services	DCYS	Private Day Treatment	0	\$2,362,958	Children
Health Services	DCYS	Unified School District #2	16	\$1,177,357	Children
Health Services	DMH	Outpatient Clinical Services	99	\$17,290,153	Persons w/ Mental Illness
Health Services	DMH	Emergency/Crisis Psy. Serv.	107	\$11,185,297	Persons w/ Mental Illness
Health Services	DMH	Partial Hospitalization	23	\$2,477,825	Persons w/ Mental Illness
Health Services	DMH	Compulsive Gambling Treatment	0	\$0	Persons w/ Mental Illness
Health Services	DMH	Community-Based Substance Abuse Serv.	9	\$27,215	Persons w/ Mental Illness
Health Services	DMH	Services for Mentally ill/Deaf	23	\$1,175,639	Persons w/ Mentally Illness
Health Services	DMR	Specialized Support & Health Svc.	78	\$18,707,400	Persons w/ Mental Retardation
Health Services	DMR	Case Management	232	\$8,818,304	Persons w/ Mental Retardation

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
Health Services	DMR	Non-Vocational Programs	176	\$18,399,073	Persons w/ Mental Retardation
Health Services	DMR	Early Intervention/USD#3	114	\$5,874,430	Persons w/ Mental Retardation
Health Services	DMR	School Age/USD#3 (DISCONTINUED)	38	\$1,578,350	Persons w/ Mental Retardation
Health Services	DOHS	Child & Adolescent Health	8	\$1,665,444	Children
Health Services	DOHS	Health Services for State Employees (DISCONTINUED)	0	\$215,476	State Employees
Health Services	DOHS	Chronic Diseases/Urban Rural Health	7	\$486,240	All Requests
Health Services	DOHS	Maternal & Child Health Programs	12	\$5,933,080	Low Income
<b>Institutional Care</b>					
Institutional Care	DCYS	DCYS Operated Institutions	792	\$34,583,143	Children
Institutional Care	DCYS	Private Facilities	0	\$34,493,325	Children
Institutional Care	DMH	Extended Care Facility	0	\$5,026,964	Persons w/ Mental Illness
Institutional Care	DMH	Forensic Services	276	\$13,904,395	Persons w/ Mental Illness
Institutional Care	DMH	Inpatient Services	2,834	\$129,719,284	Persons w/ Mental Illness
Institutional Care	DMR	Campus Units	2,258	\$113,674,595	Persons w/ Mental Retardation
Institutional Care	DMR	Other Private Residential Facilities	5	\$3,519,981	Persons w/ Mental Retardation
<b>Management</b>					
Management	AGING	Management Services	27	\$1,483,791	-
Management	BESB	Management Services	12	\$564,141	-
Management	CADAC	Management Services	40	\$2,293,445	-
Management	CDHI	Management Services	4	\$281,981	-
Management	DCYS	Management Services	194	\$10,831,906	-
Management	DHR	Management Support Services	104	\$4,829,997	-

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
Management	DIM	Program Operation and Support	unavailable	unavailable	-
Management	DMH	Education & Training	83	\$4,040,640	-
Management	DMH	Management Services	137	\$18,115,726	-
Management	DMR	Management (Field Operations)	573	\$25,869,058	-
Management	DMR	Management (Central Office)	116	\$7,418,492	-
Management	DMR	Staff Development & Training	29	\$1,839,029	-
Management	DOH	Management Services	49	\$2,245,568	-
Management	DOHS	Management Services	74	\$4,653,864	-
Management	DOHS	Center for Health Policy Dev.	33	\$3,839,390	-
<hr/>					
Protective Services	AGING	Ombudsman	13	\$522,406	Elderly
Protective Services	DCYS	Adoption Services	15	\$8,293,429	Children
Protective Services	DCYS	Community Child Protective	0	\$3,673,386	Children & Families
Protective Services	DCYS	Permanent Foster Family Homes	0	\$716,814	Children
Protective Services	DCYS	Foster Family Care	27	\$16,397,318	Children
Protective Services	DCYS	Children's and Protective Services	608	\$23,816,833	Children & Families
Protective Services	DHR	Victims of Household Abuse	1	\$1,512,240	Adults
Protective Services	DHR	Elderly Protective Services	24	\$2,329,874	Elderly
<hr/>					
Public Health	DMH	Consultation & Ed./Info & Refer	5	\$845,793	Persons w/ Mental Illness
Public Health	DMH	Research	42	\$3,658,127	Persons w/ Mental Illness
Public Health	DOHS	Community Nursing and Home Health	38	\$1,749,236	All Requests
Public Health	DOHS	Medical Quality Assurance Services	59	\$2,206,710	All Requests

**TABLE II-6. HUMAN SERVICE PROGRAMS.**

FUNCTION	AGENCY	PROGRAM	GF STAFF FY 91	GF DOLLARS FY 91	POPULATION SERVED
Public Health	DOHS	Environmental Health	53	\$2,685,061	All Requests
Public Health	DOHS	Emergency Medical Services	15	\$1,325,738	All Requests
Public Health	DOHS	Laboratory Services	201	\$8,501,228	All Requests
Public Health	DOHS	Hospital and Medical Care	40	\$1,210,583	All Requests
Public Health	DOHS	Comm. on Hospitals and Health Care	42	\$2,221,540	All Requests
Public Health	DOHS	Infectious Diseases	29	\$7,116,267	All Requests

Source: Governor's Budget 1992-1993.



## CHAPTER III

### ORGANIZATIONAL MODELS FOR HUMAN SERVICES

Based on a review of national literature and studies produced exclusively for Connecticut, the program review committee staff identified four basic models for organizing human services agencies. If placed on a continuum, the four models would range from a collection of single purpose agencies that focus on specific constituent groups (e.g., aged, children, and poor) to a single agency organized to deliver services functionally, rather than to client groups. The current structure in Connecticut most closely approximates the model described as a collection of single purpose agencies. The other three models emphasize coordination and integration of services.

The studies that describe the various models stress there is not one model structure that should be universally adopted. They note that in providing for the coordination and integration of human services, the most important factor is fixing responsibility in an entity that has the authority for decisionmaking and can be held accountable. In addition, the talent of the individuals involved in the management and delivery of services and the leadership provided by the governor contribute to increased efficiency. The basic features of each of the models, with the exception of the one currently used in Connecticut, are described below.

**Confederated model.** Under the confederated model shown in Figure III-1, an administrative umbrella agency is superimposed on the existing departments. It is given responsibility to coordinate the administrative activities of the underlying departments and, in cooperation with the departments, develop systemwide plans and priorities. Its powers with respect to the departments' operations are very limited, usually confined to reviewing and commenting on proposals originating in the departments. Under the model, real operating authority remains with the departments.

**Consolidated model.** Figure III-2 depicts a consolidated model. Under this approach, existing departments are merged into a single comprehensive agency. The agency is structured along traditional program lines providing services through divisions organized around client groups. Each program division maintains a limited administrative support capability to assist in day-to-day operations. The head of the comprehensive agency has authority over all departmental operations including budgeting, personnel, comprehensive planning, and data processing.

**Integrated model.** The integrated model, shown in Figure III-3, merges existing departments into a single comprehensive agency. All administrative support and program development functions are centralized and under the control of the agency head. Service delivery is organized around strictly functional categories, such as income, residential, or medical assistance. This allows traditionally separate services to be combined into one program unit.

Figure III-1. Confederated Model.

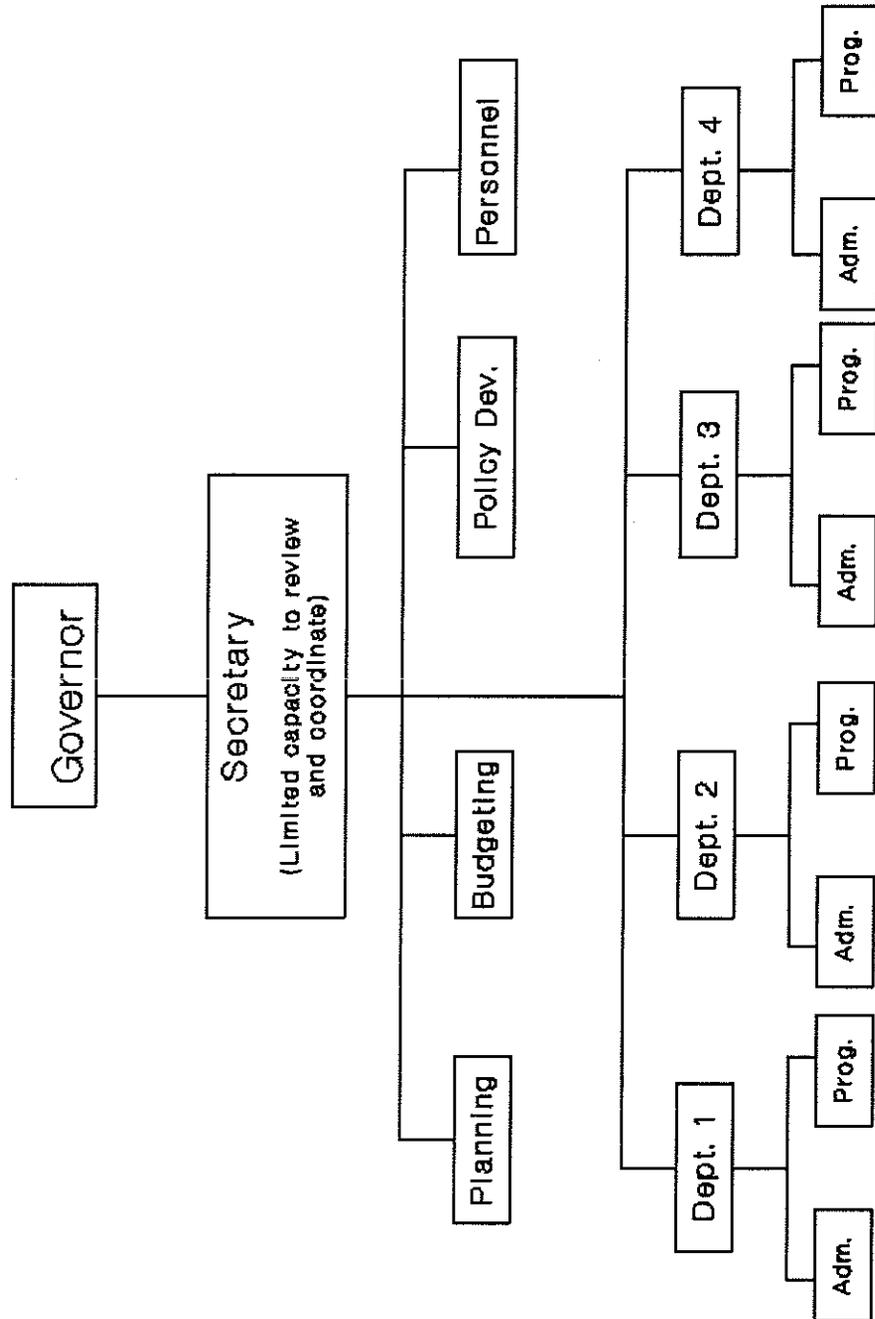


Figure III-2. Consolidated Model.

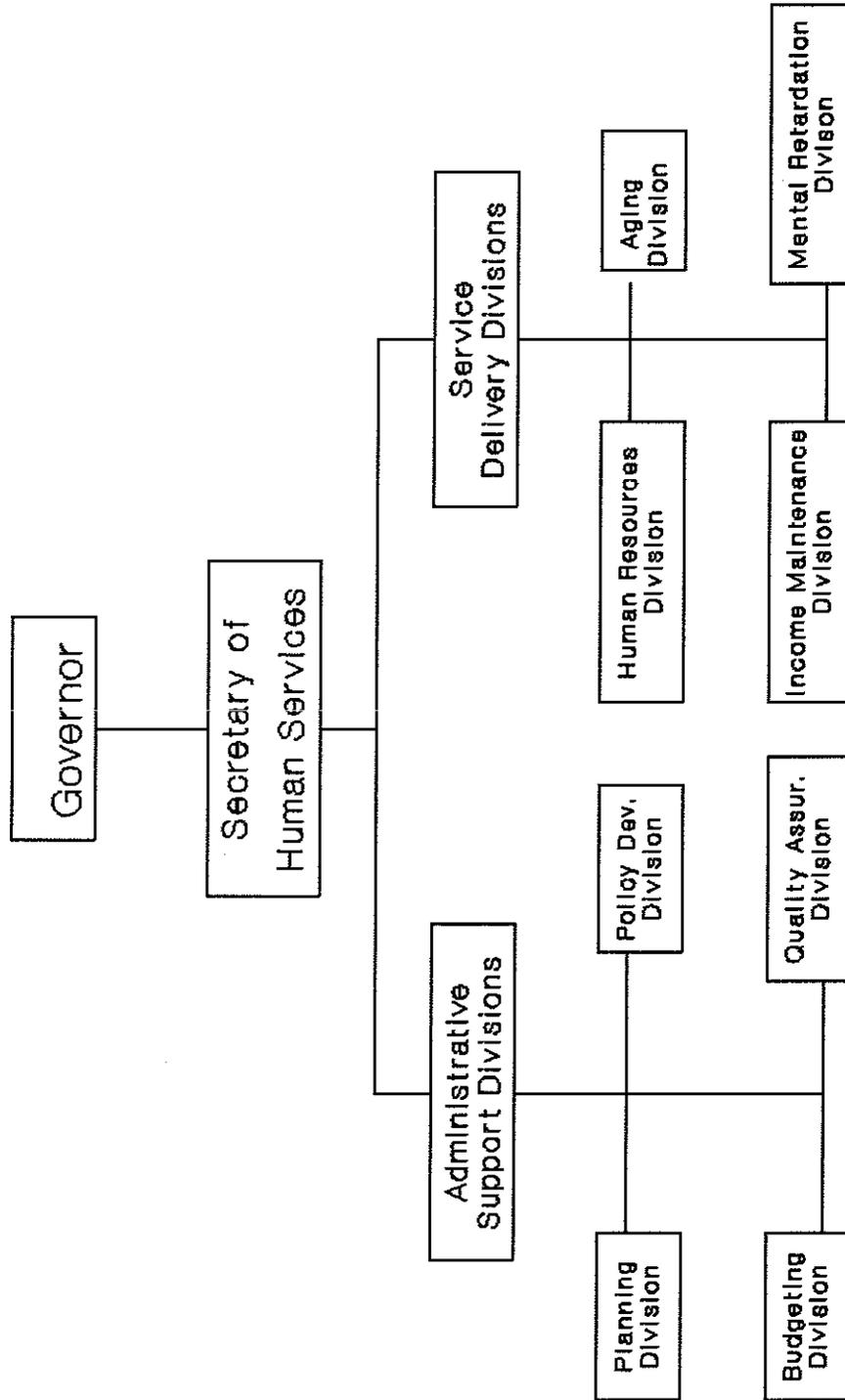
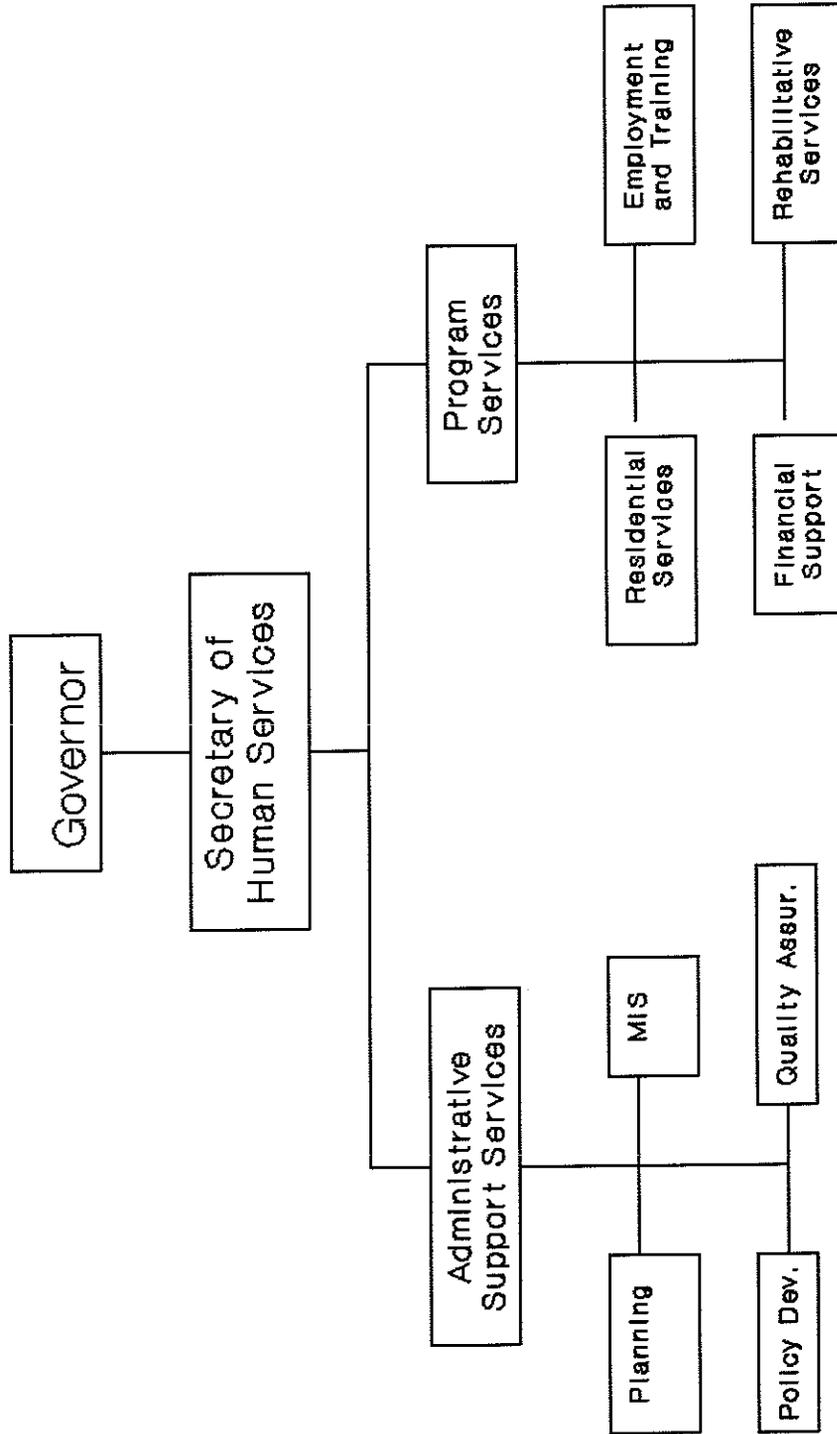


Figure III-3. Integrated Model.



**Reorganization options.** In analyzing the various models for reorganizing Connecticut's human services agencies, program review committee staff applied the three goals found in the act creating the Commission to Study the Reorganization of State Government (P.A. 91-3, June Special Session). The goals as stated in the act are:

- to improve the delivery of services to the people of the state;
- to increase the productivity of service providers; and
- to reduce the relationship of overhead costs to the provision of services.

Based on the goals, the confederated model was eliminated from further analysis since it does not merge existing agencies, but instead requires that an additional administrative structure be imposed to oversee activities and provide coordination between the separate agencies. By creating another layer of bureaucracy, this model would increase overhead cost and probably require an additional outlay of funds, both incompatible with the intent of reorganization under P.A. 91-3.

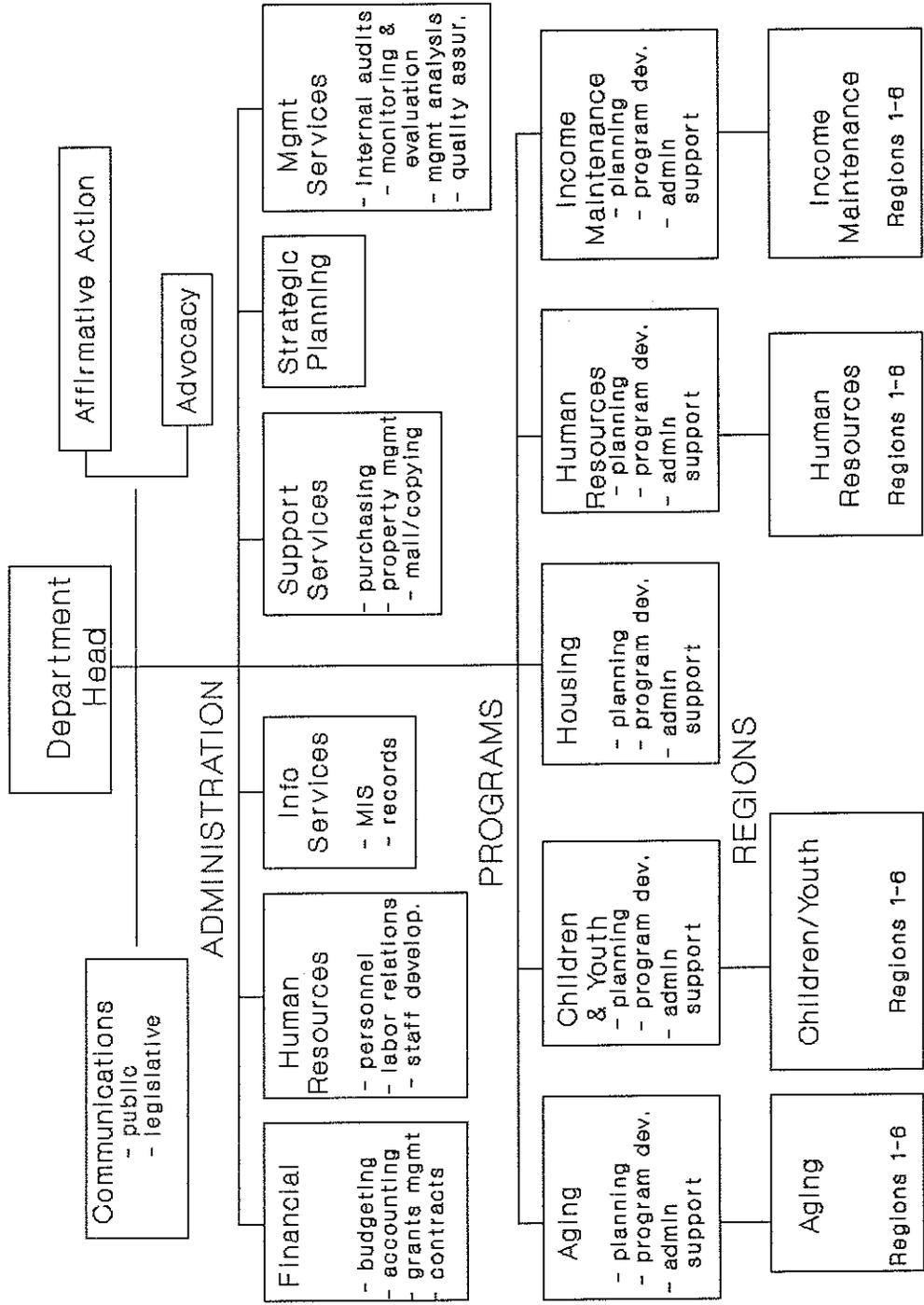
Program review committee staff found the consolidated and integrated models to be consistent with the goals identified in the act. Using these models, organizational structures involving selected human services agencies are presented below as viable options for reorganizing human services in the state. Although several variations on each model are possible, program review committee staff have diagrammed the basic conceptual framework of the two approaches.

As previously noted, although both models require the creation of a single department by merging existing independent agencies, the difference between the two is whether services are organized along functional or categorical lines. Functional services, as represented by an integrated model, are arranged around a particular need regardless of the characteristics of the population served (i.e. income, age, etc.). For example, financial or nutrition services delivered to any individual in need of these services would be considered a functional delivery system. Conversely, a categorical service delivery system, characterized by a consolidated model, is arranged around client groups and provides a wide range of services to specific clients who fall within the purview of the agency.

**Consolidated model application.** Figure III-4 shows one alternative for merging the current Departments of Aging, Children and Youth Services, Housing, Human Resources, and Income Maintenance, using a consolidated approach.

The figure shows the department's programs are organized around client groups paralleling the current Departments of Aging, Children and Youth Services, Housing, Human Resources, and Income Maintenance. The new divisions continue in the

Figure III-4. Consolidated Model for Connecticut.



tradition of the individual departments by delivering services through a regional system. The Division on Aging maintains a limited regional presence, with most of its operations centralized, as is the case under the current department. Although shown as a separate division in Figure III-4, the limited number of housing programs targeted for reorganization should probably be absorbed by the Division of Human Resources.

Under the consolidated model pictured in Figure III-4, common administrative functions from each of the existing departments are merged and staff consolidated. The new program divisions continue to perform functions unique to their operations. For example, the income maintenance division would remain responsible for meeting federal quality control requirements. The program divisions have limited responsibility for establishing basic priorities and planning within the scope of their operations, and, using a small staff, providing budgetary and other information to the department's administrative divisions.

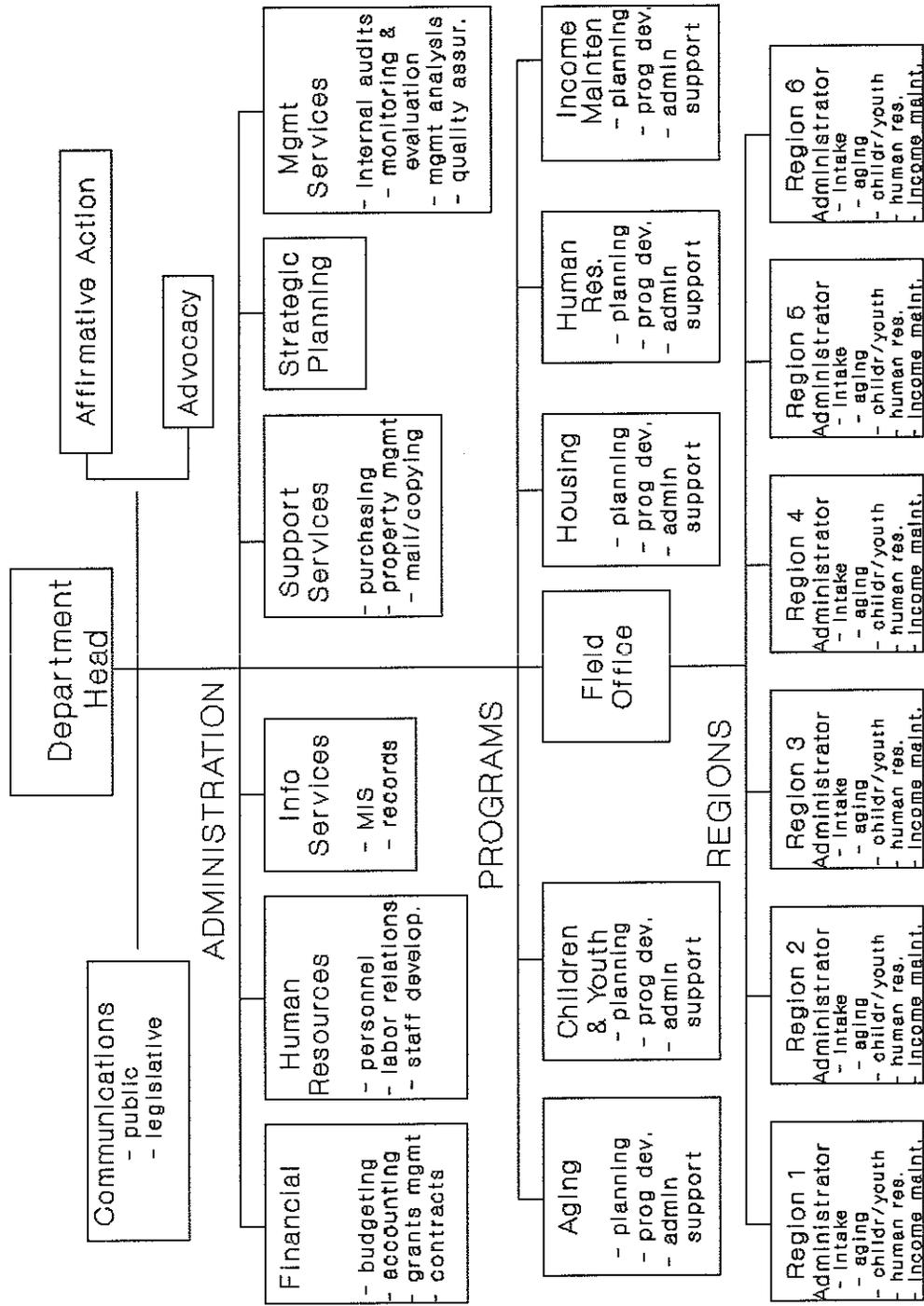
Under this version of the model, regional operations remain unchanged from the current system. Each region's three divisions (children and youth services, human resources, and income maintenance) operate autonomously, reporting directly to their program division's counterpart in the department's central office. This results in a cumbersome regional structure.

A drawback of this structure is the lack of a single point of entry for clients. Separate intake units must be maintained by each regional division since this organization lacks an overall coordinating mechanism.

Another option using a consolidated model is presented in Figure III-5. Although similar to Figure III-4, under this variation a limited consolidation occurs at the regional level. A single individual is responsible for the region's day-to-day operations and reports directly to the Field Office Division located in the central office. Although traditional program divisions are maintained for service delivery in each region, their consolidation under a single head allows for a common intake unit. At the department level, the Field Office Division is responsible for overseeing regional operations and assisting other central office divisions with information requests. Regional inquiries pass through the field office and are routed to the appropriate central office division for a response.

This adaptation of the model still permits consolidation of administrative positions at the central office level, while streamlining reporting lines through the creation of a field office and placing authority with a single individual in each region. An advantage of this approach is that it allows for a common intake unit for clients. Information about the client's needs can be collected and eligibility for any services offered by the region determined at a single entry point. Finally, this structure enhances program coordination at both the regional and administrative level by providing clearer lines of communication.

Figure III-5. Consolidated Model for Connecticut (Modified)



**Integrated model application.** Program review committee staff also examined the integrated model as a way of reorganizing human services agencies. As noted above, the integrated model advocates a functional, rather than categorical, approach to service delivery.

Figure III-6 shows the organization of the five agencies involved in the study using an integrated model. As the figure displays, the types of administrative functions performed in this model, and their location organizationally, is analogous to the consolidated model. However, the program divisions within the central office are organized functionally, not along traditional program lines. The Divisions of Financial Assistance, Protection from Abuse/Neglect, and Social Services are responsible for establishing basic priorities, planning and program development, guidelines and monitoring, interpreting policy, and providing limited administrative and budgetary support.

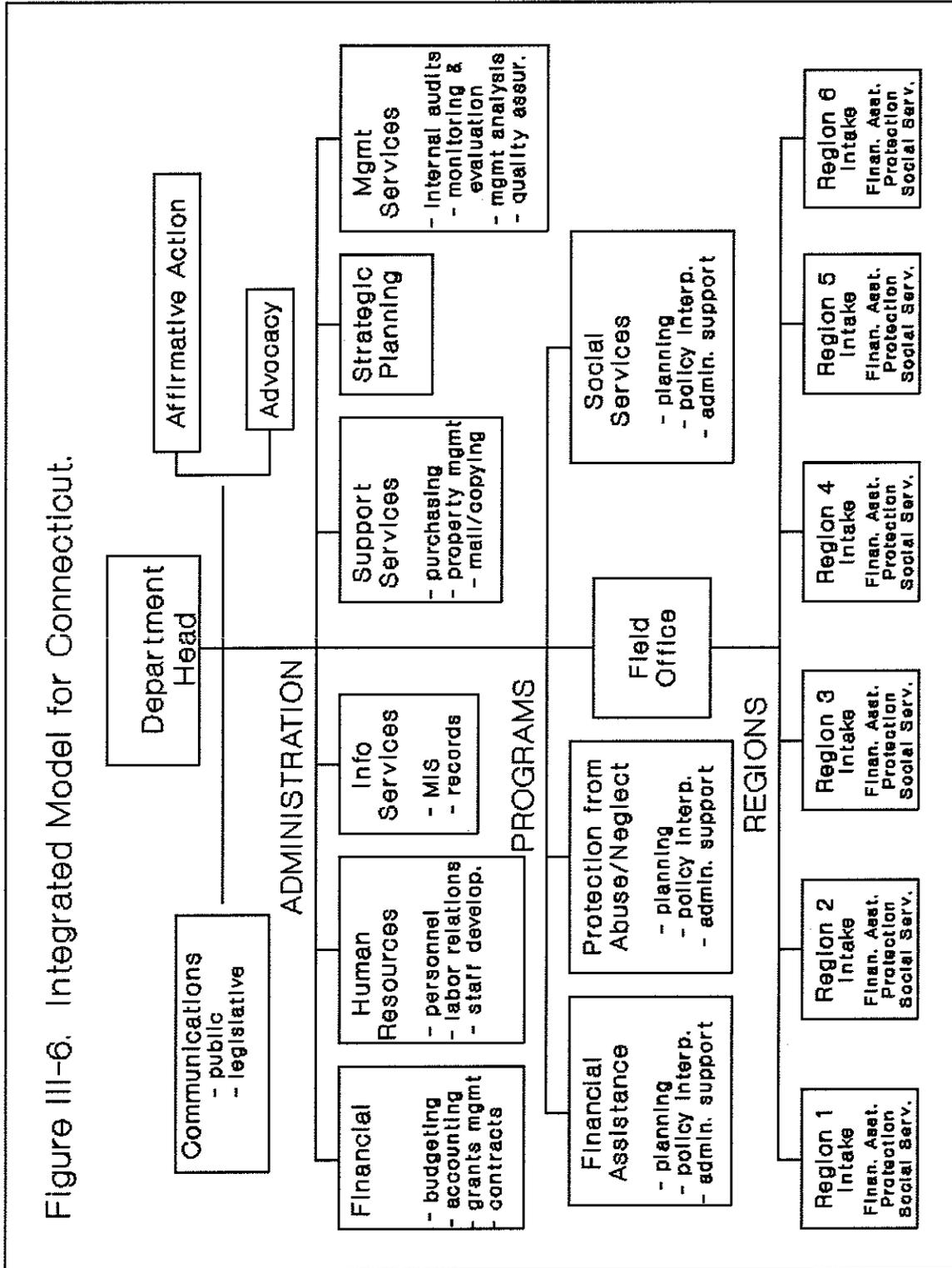
Program delivery is accomplished through a regional delivery system, corresponding to the program divisions within the central office. As Figure III-6 pictures, an individual manages each region, has direct authority over regional program staff, and is responsible for service delivery activities. This structure allows for a common intake unit to be established, permitting a single point of entry for clients and avoiding duplicative efforts in collecting client information by regional staff.

The fundamental difference between the two models is in the delivery of services. In the regions, the Financial Assistance Division operates programs that provide payment directly to a client or a vendor on behalf of the client, based solely on eligibility for any of the programs offered and not on particular characteristics of a client. An example of some of Connecticut's programs that would belong in this category are listed in Figure III-6. Similarly, the Protective Services Division directs programs for all individuals needing protection from an abusive or neglectful situation. The Social Services Division in the region is responsible for all other funded human service programs administered by the five agencies.

There are several modifications that could be made that would enhance service delivery and coordination within the department. Like the consolidated model presented in Figure III-5, a Field Office Division could be created to enhance coordination between the regional offices and the central office.

**Other states.** As part of the review of human services agency mergers conducted by the Commission to Effect Government Reorganization, staff from the Office of Policy and Management gathered information on the organization of the human services system in five other states. A variety of structures were found

Figure III-6. Integrated Model for Connecticut.



to exist across the country, ranging from a coordinated approach in Massachusetts to a single agency in Florida. The multiplicity of organizational configurations in other states lends credence to the notion that there is no ideal structure for organizing and delivering human services.

However, although these states may differ considerably organizationally, the staff found almost all have placed increased emphasis on developing a single application process, shared management information systems, and a common eligibility process in order to provide better coordinated services to clients. The assumption follows that better coordinated services will lead to improved planning, policy development, and management practices. A brief summary of the other states examined is presented below, and organizational charts of four of the states are provided in Appendix A.

Florida, categorically structured in 1979, has since undergone two reorganizations of their human services system. Currently Florida operates a single agency with the central office responsible for program policy, management, funding, and coordination. However, the delivery of services is decentralized, administered by 11 district agencies. The majority of services are operated by the public sector. Program areas are: Public Health, Economic Assistance, Job Training/Employment, Youth and Family Services, Medicaid, Mental Health, Mental Retardation, Alcohol/Drug Abuse, and Child Medical Services.

Massachusetts' health and human services system is based on a coordinated model. A secretary is responsible for policy and budget development; otherwise, the 15 departments are relatively autonomous. Each department has its own delivery system with separate district offices. There is no uniformity of intake, and no formal network for referral to other departments exists. Most human services in Massachusetts are delivered by private providers.

Wisconsin's health and human services agency is headed by a secretary, and is organized functionally into seven divisions, including community, care/treatment facilities, economic support, vocational rehabilitation, health, youth service, and management support. However, because Wisconsin delivers services through a county system, the state's role is primarily one of administrator. Actual service delivery varies by county.

The state of Indiana commissioned a study to reorganize human services agencies recently. Formerly structured to deliver services categorically, the study recommended that three agencies (public welfare, mental health, and human services) be consolidated, outreach and case management be standardized, and that providers of services be co-located. At this time, implementation of the recommendations is unknown.

A study of the Colorado health and human service system has recently been completed. Several recommendations resulted from the study, including a recommendation to consolidate the existing health and human service agencies into two separate departments: a Department of Health Services and a Department of Human Services. Implementation of the recommendations contained in the study have not yet been implemented.

## CHAPTER IV

### FINDINGS AND RECOMMENDATIONS

**Overview.** The Connecticut health and human services system is a dynamic and complex web of supports and services delivered to a diverse population in a wide variety of settings. The system is designed to serve the broad range of needs of Connecticut citizens. However, while serving many diverse needs and populations, Connecticut's human services are not always coordinated, flexible, or responsive to the client needs.

The fragmentation and inflexibility of the system is manifested in its bewildering array of workers, the applications and forms that must be filled out, and the regulations that must be followed in order to obtain even the minimal level of services. The disarray creates and sustains the widespread perception in the public mind that the system is unable to address the real needs and concerns of the state's citizenry in a responsive way.

In order to address such concerns about the Connecticut health and human services system, the Task Force on Social Services and Services to Persons with Disabilities of the Commission to Effect Government Reorganization was established to examine how to restructure and reform the system. One criteria for building a new structure was to better integrate services in order to respond to client needs and deliver services in a coordinated, unfragmented manner.

Presented below, in an edited version, is the report adopted by the Commission to Effect Government Reorganization on February 18, 1992. The Legislative Program Review and Investigations Committee approved the recommendations of the commission on February 21, 1992.

**Task force work.** As required by Public Act 91-3 of the June Special Session, the commission was charged with determining the feasibility of consolidating human services departments and programs in order to improve service delivery, increase productivity, and reduce the relationship of overhead costs to the provision of services. To carry out its mandate, the commission created a Task Force on Social Service and Services to Persons with Disabilities. The state agencies examined by the task force included the Department on Aging, the Department of Human Resources, the Department of Income Maintenance, the Department of Housing, the Department of Children and Youth Services, the Department of Health Services, the Department of Mental Health, the Department of Mental Retardation, the Connecticut Alcohol and Drug Abuse Commission, the Commission on the Deaf and Hearing Impaired, and the Board of Education and Services for the Blind.

The task force began meeting in November 1991 and continued meeting biweekly until February 1992. The early meetings of the task force were devoted to developing a scope of work and hearing presentations from human services commissioners on their agencies' current missions, organizational structures, statutory responsibilities, and programs. After gaining an understanding of the current health and human services system, the task force developed a mission statement, goals, and objectives for the delivery of health and human services in Connecticut.

To elicit ideas and suggestions regarding the structure of the health and human services system from individuals and organizations involved in the delivery of such services in Connecticut, the task force surveyed 250 state employees, clients, client advocates, and nonprofit service providers. One hundred responses were received, which provided valuable insight into the advantages and disadvantages of the current system. For more in-depth feedback about reorganization options, the task force held two focus group discussions on December 20, 1991, at which advocacy groups, state employees, clients, and service providers shared their expertise and contributed their ideas for human services reorganization.

After studying various alternatives, the task force developed a proposal for a single umbrella agency organized along functional lines. The task force held a public hearing on January 17, 1992, to solicit public comments on this proposal. At the hearing, concerns were expressed by consumers, advocates, and service providers that an umbrella agency would create additional bureaucracy and the benefits of the present categorical structure, especially related to persons with disabilities, would be lost.

The proposal was revised to address concerns voiced at the public hearing and resulted in the recommendations in this report.

**Vision and operating principles.** The starting point of the social services task force's work was to develop a new comprehensive vision for what a health and human services system should do. That vision, encompassed in a mission statement, is:

to promote the physical, social, and economic well-being of Connecticut's citizens and to empower citizens to achieve self-sufficiency while arranging an appropriate level of support for those who are unable to reach total independence.

Such a vision calls for the services of a health and human services system to be:

- accessible;
- responsive;
- well-coordinated;
- consumer and family focused;
- efficient and effective;
- respectful of the dignity of the individual client as well as the cultural and ethnic diversity of the state's citizenry; and
- supportive of shared responsibility and partnerships between clients and providers, public and private providers, and state and local providers.

Together, the mission and the operating principles form the foundation for rebuilding and restructuring a health and human services system that more directly addresses the needs of Connecticut citizens and more effectively and efficiently delivers the critical services and supports.

**Objectives.** The building blocks for the new system are a clear set of objectives to:

- expand the flexibility of services, ensure the provision of personalized and culturally relevant services, and effectively measure outcomes;
- ensure the involvement of consumers, families, providers, and communities in the planning, development, provision, and evaluation of human services;
- support citizens in their families and communities whenever possible;
- link state human services policy to economic development strategy in order to ensure that human services clients benefit fully from growth in the state's economy;

- decentralize authority and reduce the layers of decision-making within state agencies;
- channel funding to direct services whenever possible;
- facilitate access to nonstate supports and resources;
- establish uniform regional service delivery boundaries to improve coordination and reduce duplication and client confusion in the delivery of services;
- improve intake and eligibility processes by establishing a uniform system at the community level;
- establish uniform administrative functions related to the purchase of service system and designed to increase efficiency of that system as recommended by the Service Provider Network Task Force of the commission, including, but not limited to, auditing, contracting, licensing, and quality assurance; and
- continue to cooperate with the private sector in the provision of community-based services.

**Recommendations.** To restructure and reform the Connecticut health and human services system, 21 recommendations were adopted by the commission. Presented below in bold type are the recommendations and a short narrative explaining the intent of each.

**1. In order to improve the coordination, accountability, and cost effectiveness of the health and social services system, the state's responsibilities for health and social services programs, policy, financing, and management should be consolidated into four departments. These four agencies together shall be charged with implementing the single mission of the Connecticut health and human services system, which is to promote the physical, social, and economic well-being of Connecticut's citizens and to empower citizens to achieve self-sufficiency while arranging an appropriate level of support for those who are unable to reach total independence.**

**A new consolidated Department of Social Services shall include:**

- **all programs of the Department on Aging and the Department of Income Maintenance, including Medicaid policy and operations;**
- **all programs of the Department of Human Resources, including day care purchase of service, registration, and training of providers, but excluding:**
  - **all services to persons with disabilities such as the Bureau of Rehabilitation Services, and**
  - **the Head Start program, which will be transferred to the State Department of Education;**
- **day care licensing of the Department of Health Services;**
- **the state rental assistance program and the federal Section 8 certificate/voucher program of the Department of Housing; and**
- **the duties and the responsibilities of the Commission on Hospitals and Health Care (CHHC).**

**A new consolidated Department of Public Health and Addiction Services shall include:**

- **all programs in the Department of Health Services, including Medical Quality Assurance, Nursing, and Home Health (but excluding Day Care Licensing), Environmental Health, Emergency Medical Services, Hospital and Medical Care, Laboratory Services, Infectious Diseases, Chronic Diseases, and Maternal/Child/Adolescent Health (including Rape Crisis, Genetic Diseases, Community Health Centers, the WIC Program, and School Based Health Clinics); and**

- **all programs of the Connecticut Alcohol and Drug Abuse Commission, which is currently assigned to the Department of Mental Health for administrative purposes only, including all substance abuse prevention, intervention, and treatment programs and the statewide substance abuse coordinating function.**

**A new Department of Children and Families shall include:**

- **all programs of the Department of Children and Youth Services.**

**A new consolidated Department of Developmental and Rehabilitative Services shall include:**

- **all programs of the Departments of Mental Health and Mental Retardation, the Commission on the Deaf and Hearing Impaired, and the Board of Education and Services for the Blind; and**
- **all programs in the Department of Human Resources relating to services to persons with disabilities, including the Bureau of Rehabilitation Services.**

**(See Appendix A for the composition of the new departments.)**

The consolidation of these health and human services agencies reduces the 11 presently autonomous state agencies into 4 new departments. This change will serve to coordinate the system by improving the ability of the commissioners of these four agencies as well as key personnel in each of the agencies to work collaboratively on the delivery of health and human services.

All too often agency lines and turf battles are barriers to communications among and within agencies and impede the integration of services. These barriers occur not only at the highest level of policymaking, but also at the programmatic level in the delivery of services where staff sometimes have little knowledge of what other independent state agencies could provide or deliver to the same client. As a result, the client may not receive needed services.

In each newly consolidated department, priorities among programs and funding would be made in a single, interdepartment forum united under common agency goals.

The commissioner of each agency will have authority over the program, budgeting, planning, and operations of that agency. This delineation of authority will reduce the fiscal and programmatic conflicts that previously occurred among independent and autonomous state human services agencies, each of which pursued its own mission and goals.

Each of these consolidated departments will also be more cost efficient given economies of scale and reduced administrative costs. Additional savings can be achieved with the subsequent coordination and uniformity to be achieved in the purchase of services activities in these agencies as recommended by the Service Provider Network Task Force of the Commission to Effect Government Reorganization.

**2. The new Department of Social Services shall develop, monitor, evaluate, and contract for or deliver services, in most instances, structured along a "functional" line. In the department, the program areas will be divided into the following divisions, which will be headed, as appropriate, by a deputy commissioner:**

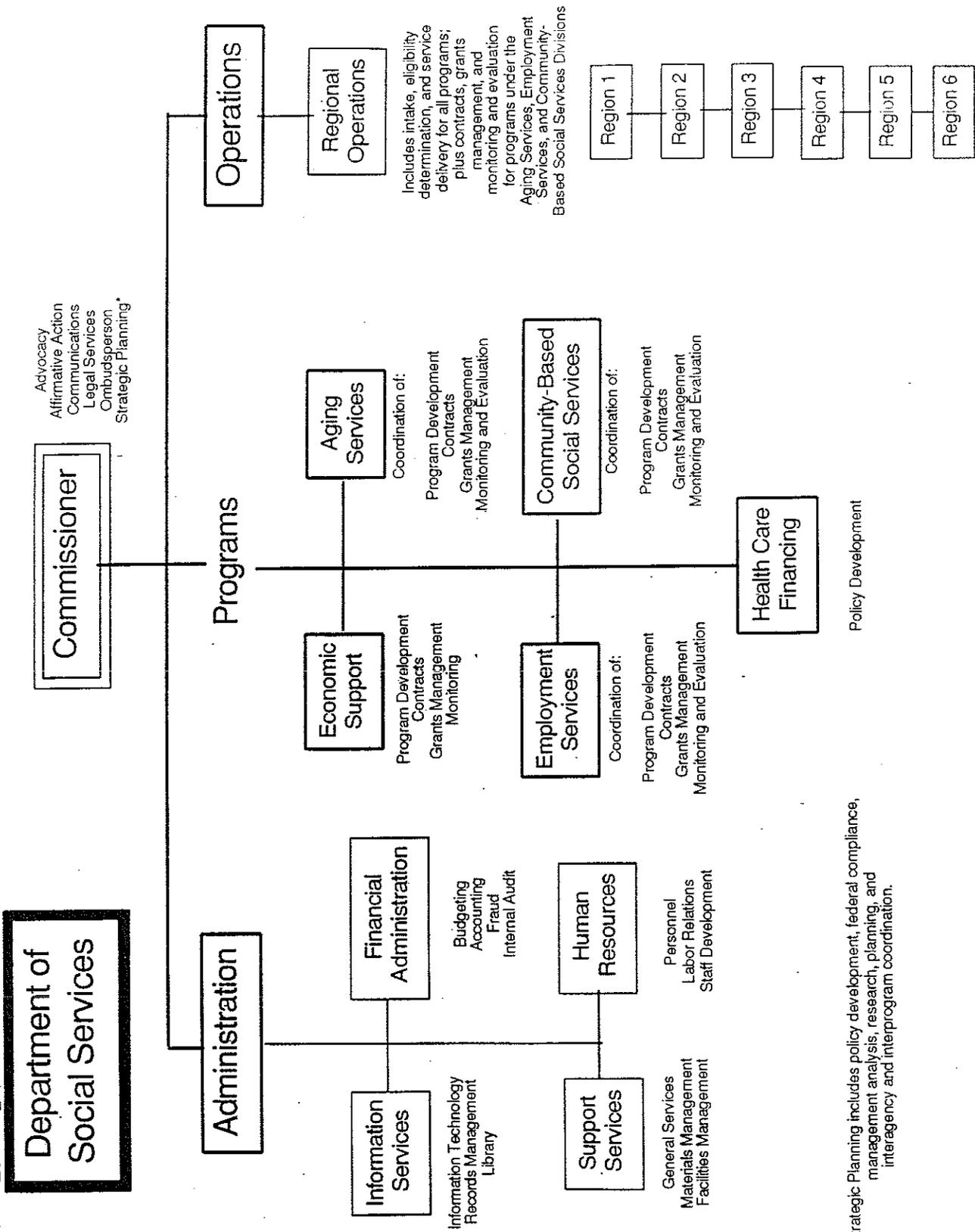
- **Economic Support,**
- **Community-Based Services,**
- **Employment Services,**
- **Aging Services, and**
- **Health Care Financing.**

(See Figure IV-1 for a graphic display of the above structure.)

Three of the divisions identified above are structured functionally, in contrast to an organization of services along purely categorical lines. This structure encourages efficiencies by creating more uniform programs that may serve many different clients who have similar service needs. It allows the investment of a critical mass of staff skills and expertise in the nature of the service being provided, resulting in better quality, state-of-the-art programs for the clients who seek those services.

Aging services in this new consolidated agency will be maintained along a categorical line. In part, this structure is to satisfy federal requirements for an identifiable unit on aging in order to qualify for federal funds for elderly services. The major purpose of setting out aging services as a separate division, however, is to provide strong advocacy for the improvement and enhancement of services to the elderly in this state as well as a coordinating function with other state agencies on such issues. The Division of Aging Services will also ensure that the needs of elderly citizens are addressed in a holistic way and that the array of services is effectively managed and accessible to this particular client group.

Figure IV - 1



\*Strategic Planning includes policy development, federal compliance, management analysis, research, planning, and interagency and interprogram coordination.

The function of health care financing is a critical and key one in the new Department of Social Services. As the costs of health care and the demands for increased access to health care continue to escalate, it is essential that the new Department of Social Services address this formidable financing dilemma on both the state and national level.

Placing these critical responsibilities for health care financing in a separate, visible division of this new consolidated department emphasizes the importance of these activities to the department's overall work and integrates it with work of other divisions so that issues of health care financing will be factored into broader human services policy decisions.

This division will merge the present functions of Medicaid policy development and efforts for maximizing federal revenues in the Department of Income Maintenance with the current rate setting and certificate of need activities of the Commission on Hospitals and Health Care.

**3. In order to ensure effective enforcement of child support payments to Connecticut's children, the new Department of Social Services shall be the lead agency in which such efforts will be consolidated and coordinated. There shall be an implementation plan to combine the child support enforcement efforts of the current Departments of Human Resources and Income Maintenance, the Judicial Department, the Bureau of Collection Services in the Department of Administrative Services (DAS), and the Office of the Attorney General.**

This consolidation and coordination of child support enforcement efforts is based on the principle followed by the task force, that similar functions in state government should be combined in order to deliver better services to clients. An application of this principle in the child support enforcement arena would eliminate the practice of providing similar child support enforcement services through separate agencies depending on whether the client is a recipient or nonrecipient of Aid to Families with Dependent Children (AFDC).

**4. The newly consolidated Department of Developmental and Rehabilitative Services shall develop, monitor, and contract for or deliver services for persons with disabilities in order to coordinate more effectively the delivery of these services in the state. In the department, the program areas will be divided into the following divisions, each of which will be headed, as appropriate, by a deputy commissioner:**

- **Mental Health,**
- **Developmental Services,**
- **Vocational Rehabilitation, and**

- **Physical and Other Disabilities.**

**Mental Health includes all programs of the current Department of Mental Health and any other programs that are deemed appropriate.**

**Developmental Services includes all programs of the current Department of Mental Retardation and other programs that are deemed appropriate.**

**Vocational Rehabilitation includes the Bureau of Rehabilitative Services of the Department of Human Resources. This division shall have such duties and responsibilities as are required by federal law or regulation, and any other programs that are deemed appropriate.**

**Physical and Other Disabilities includes services to persons with visual impairment, hearing impairment, traumatic brain injury, autism and learning disabilities, and all other programs deemed appropriate.**

(See Figure IV-2 for a graphic display of the above structure.)

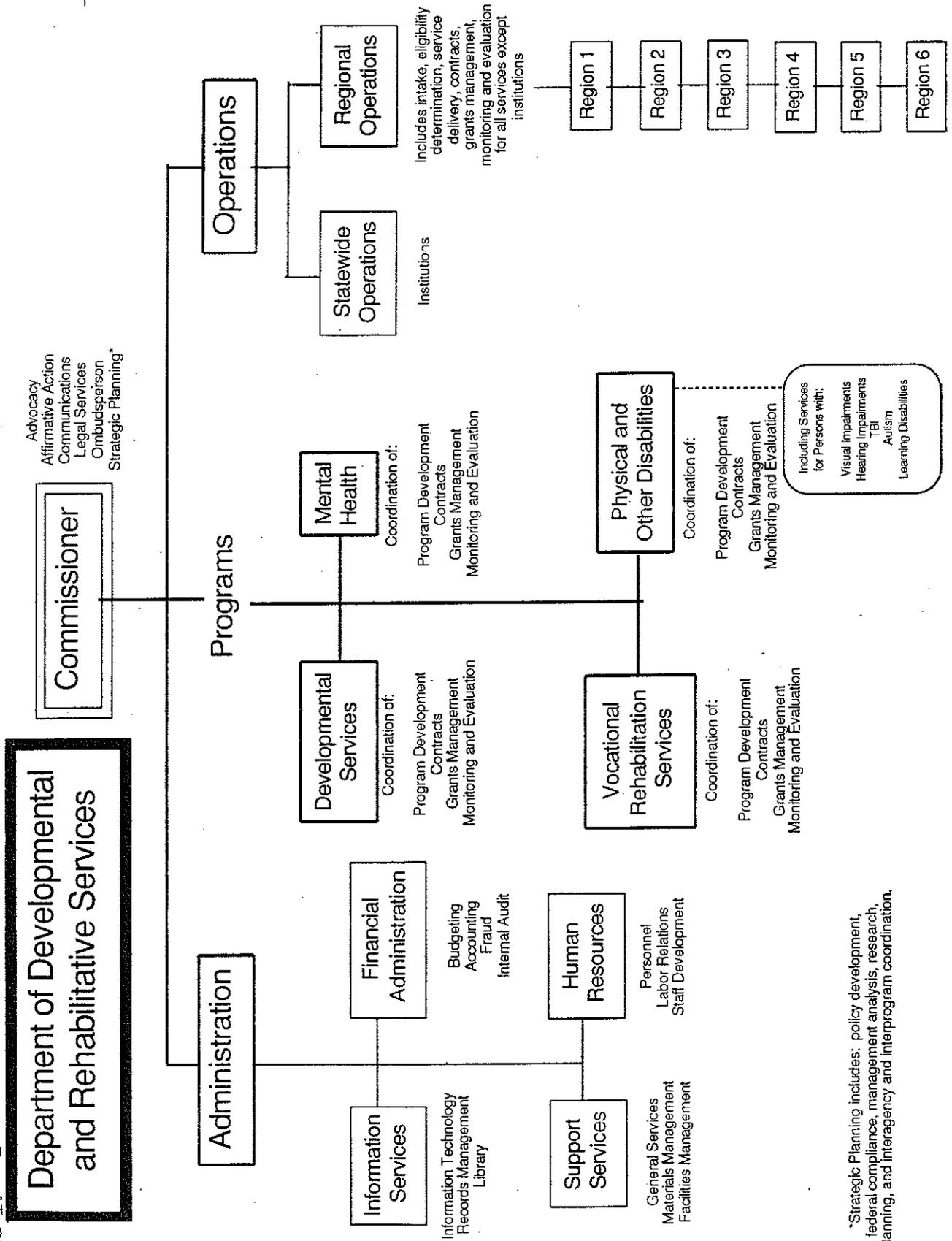
The structure of this newly consolidated department is designed to assure that all types of disabilities will be addressed. Some programs will be organized along "functional" lines, such as vocational rehabilitation, and others more categorically, such as mental health. This structure will continue to allow specialized services to be developed that will promote innovation and state-of-the art advances.

This consolidation of services to persons with disabilities is also designed to coordinate these services and to assure that clients with multiple needs will not fall between the cracks of independent, autonomous state agencies, particularly those clients who have dual or multiple diagnoses.

**5. Maintain in the new consolidated Department of Public Health and Addiction Services, a strong coordinating function for substance abuse prevention, intervention, and treatment programs across agency lines and among the branches of state government. With an identifiable Division of Alcohol and Drug Abuse Services, this coordinating function will take place within the department and will involve other human services departments, particularly the Department of Children and Families and the Department of Developmental and Rehabilitative Services and criminal justice agencies in the executive and judicial branches of state government.**

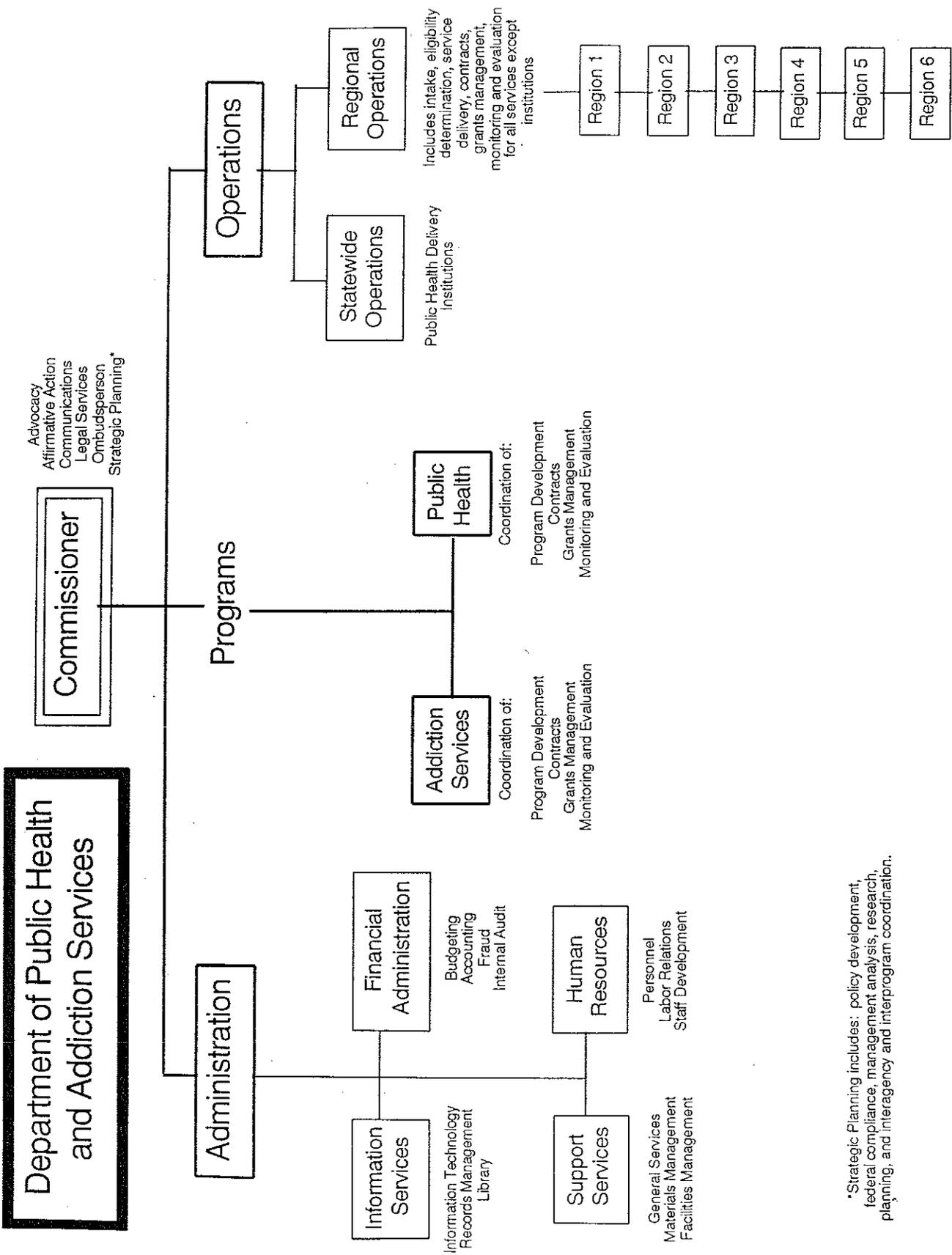
(See Figure IV-3 for a graphic display of the above structure.)

Figure IV - 2



\*Strategic Planning includes: policy development, federal compliance, management analysis, research, planning, and interagency and interprogram coordination.

Figure IV - 3



\*Strategic Planning includes: policy development, federal compliance, management analysis, research, planning, and interagency and interprogram coordination.

This recommendation is consistent with the work of the Substance Abuse Task Force of this commission, which recognized that Connecticut needs a coordination of substance abuse services in order to eliminate duplications, fill service gaps, and assure efficiency and effectiveness of these critical programs.

**6. In each of the consolidated departments, a commissioner, appointed by the governor, will oversee three functions: administration, operations, and programs. Deputy commissioners will head the administration and operations functions and work with the commissioner to assure that each function works in concert to support the day-to-day operations of the department, in particular the delivery of services to clients in the field. As described in recommendations 2 and 5 above, deputy commissioners will head the separate program divisions, as appropriate.**

**7. The commissioner's office in each newly consolidated department shall be responsible for the overall management of the department. The office's focus shall be on developing policies and procedures to guide the department, coordinating the program divisions and various functions of the department, ensuring compliance with federal and state mandates, and communicating with the public, the governor, and the legislature. The office will have responsibility for strategic planning, advocacy, affirmative action, communications, and legal services. An ombuds-person will also be located there to ensure client access to and availability of services.**

**8. A Strategic Planning Unit is a critical activity in the commissioner's office of each newly consolidated department. This unit will coordinate and centralize policy development and planning among all the administration, operations, and program functions of each department. The unit will also promote interprogram and interagency coordination.**

Interprogram coordination is essential to fully achieve the benefits of the design of programs in each department. For example, in the new Department of Social Services, the full benefits of organizing social services programs along functional lines will only be reached if the program development is coordinated so that links are forged among the program areas. Likewise, interagency coordination is critical, particularly to bring together health and social services programs with those that serve children and families and persons with disabilities.

**9. The administration function of these newly consolidated departments will provide centralized management and support to the programs and operations of the department. This function shall be constructed from a consolidation of administrative functions performed in the merged**

**agencies and should support regional operations, not duplicate or create new layers of bureaucracy in the operations of the department.**

The administration function will be responsible for: the financial administration of the agency including budgeting, accounting, fraud, and internal audit; human resources including personnel, labor relations, and staff development; support services including general services, materials management, and facilities management; and information services including information technology, records management, and the library.

In preparing and presenting the budget for each newly consolidated agency, the commissioner shall show each program division's budget as a separate item in order to maintain an identity of programs in each area while managing the budget of each department as a whole.

**10. The operations function will consolidate the service delivery systems of the merged agencies into a regional structure that will provide, to the greatest extent possible, "one-stop shopping" for clients in each newly consolidated department. The goal is to have a single point of entry for information and referral, screening, intake, and eligibility determinations and service delivery. The primary purpose of the operations function will be to coordinate the department's regional service delivery system and oversee statewide operations for any client services not delivered through the regional offices.**

**11. Among the critical components of the service delivery system in and among each of the newly consolidated departments will be the development of a single application form for client intake and eligibility determinations. There should be a common client identifier and a commonly linked computerized management information system that has the capacity to track clients and determine eligibility across programs.**

**12. In each newly consolidated department, the service delivery system will be decentralized into regional administrative offices that will be as autonomous as possible. In most instances, the regional offices should have the ability to contract for services, manage grants, and monitor and evaluate programs delivered in that region. This decentralization of authority to the regions will empower staff in those agencies to respond to the particular service needs of each region. However, centralized control and programmatic direction will remain in the programs function in order to assure consistency and uniformity among the regions in the development and provision of services.**

Some programmatic areas may not lend themselves to regional decentralization. For example, in the new Department of Social Services, the economic support programs may need to be operated in a more centralized manner due to the need for uniformity in interpreting and applying a myriad of federal rules and requirements in such programs as Medicaid, Aid to Families with Dependent Children, and Food Stamps.

**13. In the regional delivery of services, the four newly consolidated departments will have no more than six uniform regional service delivery boundaries in order to ensure maximum coordination of services among these agencies, to eliminate confusion and duplication of effort, and to promote better regional planning efforts. The service delivery offices of these four departments should be co-located to the extent possible.**

**14. The newly drawn regional boundaries for the Departments of Social Services, Public Health and Addiction Services, Children and Families, and Developmental and Rehabilitative Services should be drawn in light of criteria that are most important to ensure effective delivery of health and human services to clients. Geographical size is a key criterion. Other criteria include but are not limited to:**

- general population distribution,
- agency target population distribution,
- agency case load,
- placement of department facilities,
- transportation accessibility for clients to service delivery offices and for workers to clients, and
- any federal requirements as to placement of boundaries.

**15. The regional service delivery boundaries of the newly consolidated departments shall coincide to the greatest extent possible with those of other agencies that provide health or human services related programs. These agencies may be state agencies or private providers who receive grants from the state or are federally mandated to deliver services regionally. The state agencies include, but are not limited to, the Departments of Labor, Correction, Education, Economic Development, and Veterans' Affairs. All regional boundaries should coincide, wherever possible, with the current regional boundaries of the previous**

**departments in order to minimize expense and disruption of current regional service delivery.**

The majority of the current human services agencies have either five or six service delivery regions. With the exception of the coterminous boundaries of the Departments of Income Maintenance/Department of Human Resources and the Department of Mental Health/Connecticut Alcohol and Drug Abuse Commission, none of these current boundaries are uniform.

The fact that many of state's human services agencies use different regional boundaries for service delivery has not gone unnoticed by several commissions that have studied the structure of state government in the past 20 years. These commissions have all recommended uniform boundaries: Commission on Human Services (Zimmerman) (1972), Connecticut Council on Human Services (1975), Human Services Reorganization Commission (1978), and Commission to Study Human Services (1986).

The commission reports have generally focused on three concerns that result from non-coterminous boundaries. One is that without uniformity, clients served by more than one agency are confused about where to go for services, and they sometimes have to go to more than one office to receive the services they need. This issue can be addressed by uniform regional boundaries and co-location of offices so that clients will have "one-stop" shopping.

Another concern is the difficulty line staff have in negotiating the system for clients when regional service delivery boundaries are not uniform. The referral to another public or private provider agency for services becomes a two-step process -- first, the worker must determine which region the client lives in for that agency, and second, a referral to the appropriate regional service office must be made. A final concern is that non-coterminous boundaries limit the ability to gather data and plan for services in a given geographical area. With uniformity, all agencies will gather data and information about the same geographic areas in order to aid them individually and jointly to plan for services to meet the particular needs of citizens of each region.

**16. The programs function of the newly consolidated departments will provide a centralized coordination of the development, monitoring, evaluation, delivery, or purchase of programs and services in each specific area, such as aging services, employment services, and vocational rehabilitation. The primary purpose of this function is to establish uniform departmentwide policies and procedures so that there is consistency and uniformity among the regions in contracting, grants management, and monitoring and evaluation in each program. Maximum regional autonomy will be allowed, however, to address specific regional needs and empower staff at the field operations level.**

This structure will also ensure that information is available on a statewide level on programs that are delivered or purchased in each region.

**17. The programs of these new consolidated departments should emphasize prevention and early intervention and be family focused.**

**18. There shall be boards and advisory groups in each newly consolidated department that will provide, in a coordinated manner, input, and expertise from consumers, advocates, and other interested parties.**

**19. Continue a Human Services Cabinet and other interagency coordinating mechanisms for the four newly consolidated departments to work with other state agencies whose programs are critical to the delivery of a complete range of services to clients of the health and human services system.**

While the four newly consolidated departments have responsibility for a majority of the health and human services programs in Connecticut state government, other agencies will need to interact and coordinate with these departments. These departments include correction, veterans' affairs, labor, housing, education, higher education, and consumer protection. It is also essential to forge links between human services and such issues as transportation and economic development.

A Human Services Cabinet has been in use for several years in the executive branch of state government, which provides commissioners with an interagency forum to coordinate policy development and to communicate openly on common administrative and programmatic issues. The cabinet, under the direction of the lieutenant governor, will need to be reconstituted in light of the consolidations in the above recommendations, but should continue to provide this important interagency forum on health and human services issues.

**20. Encourage collaborations that will foster the development and maintain the client-focused structure of a Connecticut health and human services system and that will involve partnerships between clients and their service providers, both state and local, public and private.**

The purpose of the partnerships is to complement state agencies' work with local communities, which provide services as part of their responsibility to their residents, and to ensure the integration and coordination of those local services with state-funded and operated programs. These partnerships are designed to eliminate duplications, address service delivery gaps at the regional and local levels, and promote dialogue between public and private service providers.

**21. Implement the structural changes that are required to create the newly consolidated Departments of Social Services, Public Health and Addiction Services, Children and Families, and Developmental and Rehabilitative Services. In the implementation process, provide legislative and executive branch oversight and monitoring to assure that the new departments are set up in adherence to the operating principles, objectives, and recommendations above. The process should also allow for flexibility in fashioning these departments so that they are manageable, become operational with minimal disruption to the system, and are ultimately successful in accomplishing the mission of the health and human services system.**

## APPENDIX



## APPENDIX A

### Composition of New Departments

#### DEPARTMENT OF SOCIAL SERVICES

Merger of:

- DIM - all current programs including Medicaid policy and operations
- DHR - most current programs, including day care purchase of service, registration, and training of providers; excluding services to persons with disabilities
- SDA - all current programs
- DOH - Rental Assistance Program (RAP) and federal Section 8 Certificate/Voucher Program
- DHS - day care licensing
- CHHC - all functions

Organize into five Program Divisions: Economic Support, Employment Services, Aging Services, Community-Based Social Services, and Health Care Financing, combining the Medicaid policy and operations of the Department of Income Maintenance and the activities of the Commission on Hospitals and Health Care.

Include Child Support Enforcement consolidation and coordination in DSS.

#### DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

Merger of:

- DHS - all programs including Medical Quality Assurance, Nursing and Home Health (but excluding day care licensing), Environmental Health, Emergency Medical Services, Hospital & Medical Care, Laboratory Services, Infectious Diseases, Chronic Diseases, and Maternal/Child/Adolescent Health (includes Rape Crisis, Genetic Diseases, Community Health Centers, the WIC Program, and School Based Health Clinics)

CADAC - all programs including substance abuse prevention, intervention and treatment and specifically, statewide coordinating function.

DEPARTMENT OF CHILDREN AND FAMILIES

DCYS - all current programs, including prevention, protective services, juvenile justice, mental health, and substance abuse

DEPARTMENT OF DEVELOPMENTAL AND REHABILITATIVE SERVICES

Merger of:

DMR - all current programs

DMH - all current programs

DHR - all programs that serve persons with disabilities including Bureau of Rehabilitation Services (BRS)

CDHI - all current programs

BESB - all current programs

Organized into four Program Divisions: Mental Health, Developmental Services, Vocational Rehabilitation, and Physical and Other Disabilities.

STATE DEPARTMENT OF EDUCATION (SDE)

- Transfer Head Start from DHR
- Maintain SDE Early Childhood Education Standards/Policy