ANNUAL PERFORMANCE REPORT
Part 1: Agency Summary

Agency: Department of Human Services

Mission Statement:

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

Department of Human Services Goals

The January 1993, Department of Human Services Strategic Plan outlines the Departments goals organized in five theme areas consistent with *Minnesota Milestones."*

Health

- Program policies, funding, strategies and administrative procedures will promote early access to preventive and other services.
- Access to quality, affordable and non-stigmatizing health services will be developed and promoted.
- Health services will be prioritized to achieve to achieve maximum health outcomes with special emphasis on children.
- Long-term care and other services will maximize well-being and independence at the lowest level of service required, within affordable, integrated delivery systems.
- DHS health care policy and strategy will be positioned to respond to and influence national reforms and trends.

Children/Families

- The number of local,comprehensive, integrated service delivery systems (involving social services, education, health, mental health, and corrections) will increase.
- The number of children experiencing maltreatment will decrease.
- The use and abuse of alcohol and other drugs by Minnesota's young people and parents will decrease.
- The rate of adolescent suicide and other violent deaths of young people in Minnesota will decrease.
- The rate, length and frequency of out-of-home placements of children will decrease.

People Who Need Help

- The number of children living in poverty will decrease.
- The percentage of children receiving full payment of awarded child support will increase.
- The number of families receiving long-term public assistance without progressing toward self-sufficiency will decrease.
- The number of families on public assistance securing employment will increase.
- The percentage of persons with disabilities at risk of institutional placement will decrease.
- Regional Treatment Centers will provide competitive, effective and appropriate services.
- The percentage of older persons living in home and community-based settings will increase.

Respect for All People

- Programs and services will be available and accessible to all eligible persons regardless of sex, age, race, color, creed, religion, ethnic group, disability, marital status, sexual preference or economic status.
- Progress will be made in achieving affirmative action employment goals, maintaining an equitable workplace, and developing a diverse workforce.
- The number of discrimination and civil rights violations involving DHS programs, services and staff will be reduced.

Part 1: Agency Summary (Cont.)

Effective, Cost-Efficient Government

- DHS will make progress in gaining consensus on desired results of programs and services, and in utilizing evaluation methodology as appropriate.
- DHS will demonstrate continuous quality improvement focused on key process and priority areas.

Organization

The department is organized into 5 programmatic areas: Finance and Management, Family Self-Sufficiency, Community Mental Health and State-operated Services, Health Care and Social Services.

Finance and Management Administration: The Department of Human Services Finance and Management Program exists to provide overall direction and leadership to the department in accordance with a continuing quality improvement philosophy as well as to assure departmentwide policy and program coordination through regulatory, appeal, legislative, fiscal management, and administrative support activities. This program consists of the Executive Office and eleven support services divisions.

The major goals of the Finance and Management Program are:

1. To assure uniform and equitable administration of programs and expenditures of funds.
2. To assure that statutory and regulatory standards are established and implemented which protect the health, safety, and rights of the persons served and result in an integrated and cost-effective service delivery system.
3. To carry out the policy directives of the executive, legislative, and judicial branches of both state and federal government.
4. To implement state and federal laws.

Social Services Administration: The Department of Human Services, Social Services Administration exists to provide overall coordination, leadership and direction to serve the following consumers: 1) special needs children and their families; and 2) special needs adults and elderly persons. The areas of responsibility include children's services, aging services, deaf or hard of hearing services, chemical dependency, and services for the developmentally disabled.

Program goals are:

1. To ensure that children are protected from maltreatment and their special needs are met.
2. To ensure integrated community based services are efficiently delivered to special needs adults and elderly persons.

The Program also provides leadership to: 1) shape policy; 2) develop and test pilot projects; 3) conduct research and evaluation; 4) assure compliance with existing standards, rules and laws and; 5) develop and promote the use of performance indicators which can measure the efficient, effective use of resources. The Quality Services Division was formed in January of 1992 to serve as a focal point for carrying out these activities.

Family Self-Sufficiency Administration: The Family Self-Sufficiency Administration program exists to promote economic self-sufficiency of Minnesota families and individuals while providing for their basic needs.

The goals of the program are to:

1. Provide assistance adequate to prevent destitution to individuals and families in short-term need and those unable to become self-sufficient.
2. Provide a continuum of coordinated services to assist recipients toward self-sufficiency, including work and training, child care and child support.
3. Ensure program integrity and accountability.
4. Maintain and improve service delivery through automation and innovation with local agencies at stable or reduced costs.

Part 1: Agency Summary (Cont.)

Health Care Administration: The Department of Human Services' Health Care Administration exists to ensure that low income persons have access to quality medical care for both acute and chronic health-related conditions as well as for preventive and primary care services. This program manages major health care programs for the department. These programs ensure that payments are properly made to enrolled providers of medical and health care services for services provided on behalf of eligible persons of the state. These programs also develop policy for coverage of all services and rate setting policy for the MA, MinnesotaCare, and GAMC programs; for program integrity and efficient claims administration; for developing and managing cost effective LTC service systems and alternatives for persons requiring those services; and for interagency agreements with the Minnesota Department of Health (MDH) for survey, inspection of care, and case mix audits for nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), and review of prepayment capitation contracts.

Health Care Administration staff also provide program supervision to local agencies for implementation of these programs in the form of rules and instructions which are designed to maximize federal funding while ensuring that the needs of low income persons are met. In addition, Health Care Administration staff make payments to providers of medical and health services; conduct post-payment audits to detect abuse and/or fraud by recipients and providers of the MA, MinnesotaCare, and GAMC programs and secure recovery of expenditures where other third parties are liable. Local agency staff determine individual eligibility for the MA, GAMC, and Home and Community-based Waiver programs.

The major goal of this program is to provide appropriate medical benefits to all eligible persons in an effective and efficient manner.

Community Mental Health and State-operated Services Administration: The Department of Human Services' Community Mental Health and State Operated Services Administration exists to ensure an array of integrated services to persons with mental illness and to provide services to persons with chemical dependency and developmental disabilities who need the level of care available in the RTCs and SOCS. This administration works closely with the other parts of DHS and other agencies that have a role in serving these populations.

The goal of this administration is to make life as normal and productive as possible for individuals who have handicaps. This includes providing choices to clients regarding how and where to live, while maintaining appropriate accountability for public resources. This administration's role in relation to developmental disabilities and chemical dependency is primarily the administration of state-operated services. In relation to mental health, this administration's role is the overall development and implementation of a statewide mental health plan according to legislative directives in the Comprehensive Children's and Adult Mental Health Acts. This includes the development and maintenance of: 1) statewide community support programs; 2) statewide case management services; 3) statewide service standards; 4) statewide access to an array of basic services; and (5) a statewide mental illness information system.

The goals of the state-operated regional treatment centers (RTCs) and nursing home (Ah-Gwah-Ching) are to provide active treatment consistent with industry standards and state/federal regulations for persons with mental illness, developmental disabilities, chemical dependency, and for elderly persons who have complex medical conditions and challenging behaviors requiring a nursing home setting. The objective is to complement program alternatives in local service areas by assisting individuals to make documented progress toward personal habilitative or rehabilitative goals, that are necessary for their successful reintegration into normal community life. The major state-operated facilities include:

Ah-Gwah-Ching Center
Anoka Metro-Regional Treatment Center
Brainerd Regional Human Services Center
Cambridge Regional Human Services Center
Faribault Regional Center
Fergus Falls Regional Treatment Center
Moose Lake Regional Treatment Center
St. Peter Regional Treatment Center
Minnesota Security Hospital
Willmar Regional Treatment Center

Part 1: Agency Summary (Cont.)

All regional treatment center developmental disability programs operate community support services. These services include technical support for persons at risk of RTC placement. The technical support includes behavioral and psychological assessment, program development, hands on program implementation support, staff training, and emergency short term placement.

There are 7 state operated waiver residential programs and 15 intermediate care facilities for the mentally retarded residential programs in operation. These programs serve persons with developmental disabilities in 4 and 6-bed programs located in residential neighborhoods that allow for integration of the activities of daily living with non-disabled persons.

There are 3 state operated day training and habilitation program in operation. These programs are located in local communities that allow for integration of vocational activities with non-disabled persons.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Finance and Management
Program: Licensing

Program Purpose: The purpose of this program is to help assure minimum standards are met in programs licensed for children and vulnerable adults. To meet this purpose the division monitors, investigates and completes background studies in licensed programs. The division is the decision maker in work with county agencies, delegated inspection responsibility in foster care and family child care programs.

Performance Objectives and Measures:

The licensing division is able to work directly in two areas of the DHS mission:

- Protection
- Prevention

The division works with other agencies (e.g., law enforcement, county ombudsman) to complete investigations of allegations of abuse/neglect or maltreatment in licensed programs. This coupled with investigations of alleged licensing violations is the main effort characterized as "protection" activities. In these situations, there is an allegation of violation and/or that someone has been harmed and an investigation is necessary to determine the facts and make a recommendation for possible additional action.

Many activities could be characterized as "preventive" including the visits by licensors to monitor and inspect programs. The completion of applicant background studies is a known deterrent to some people, and does prevent individuals with a history of disqualifying behavior from working with children or vulnerable adults.

Objective 1. Programs will be licensed on time 80% of the time by June, 1995.

Measure: Number of programs licensed on time.

Objective 2. The backlog of investigations of abuse, neglect or maltreatment allegations will be reduced by 50% by June, 1995.

Measure: Number of backlogged investigations

Objective 3. Key indicator licensing practice will be implemented in family day care, adult day care, and training and habilitation programs for persons with developmental disabilities by October, 1993.

Measure: Rules that have key indicator development/implementation.

Objective 4. Review and piloting of alternative licensing of child care center programs with Montessori accreditation and residential mental health programs with Joint Commission for Accreditation of Healthcare Organizations (JCAHO) accreditation will be completed by January, 1994.

Measure: Number of license holders monitored with alternative methods.

Objective 5. A single rule containing all administrative licensing requirements will be developed and duplicate language in program rules will be eliminated. The rule advisory committee work will be completed by June, 1994.

Measure: Completion of rule advisory committee work

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Finance and Management
Program: Licensing

Objective 1. Programs will be licensed on time 80% of the time by June, 1995.

Measure: Number of programs licensed on time.

Definition: The number of programs that DHS licensing staff are responsible to inspect and monitor includes, as of September 1993:

Child Care Centers (Rule 3 -- 1,420
Child Plcmt/Adopt Agencies (Rule 4) -- 48
Institutions for Children with Serious Emotional Disturbances (Rule 5) -- 43
Maternity Shelters (Rule 6) -- 2
Group Homes for Children (Rule 8) -- 56
Semi-Independent Living Svcs (Rule 18) -- 92
Mental Health Centers (Rule 29) -- 92
Residential Svcs. for People with Developmental Disabilities (Rule 34) -- 380
Residential Chemical Dependency Services Rule 35) -- 105
Residential Mental Health Services for Adults (Rule 36) -- 85
Day Trng & Hab Svcs for People with Developmental Disabilities (Rule 38) -- 208
Home & Community Based Svcs for People with Developmental Disabilities (Rule 42) -- 406
Outpatient Chemical Dependency Services (Rule 43) -- 221
Adult Day Care (Rule 223) -- 75

Rationale: The Human Services Licensing act (M.S. 245A) authorizes the Commissioner to administer licensing functions in applicable programs. The Commissioner must inspect and monitor programs prior to issuing a license or re-issuing a license to an existing programs.

The outcome measure shows directly whether or not the Commissioner is meeting the time lines.

Note: In September 1993 the Commissioner began implementation of a change in general license terms. Previously licenses were issued up to one year. Licenses, as of September 1993, will be issued for up-to-two-years. Staff were reorganized and placed in higher priority division work.

Data Source: The number of programs that receive a license extension is tracked by licensing staff.

Factors Beyond Agency's Control That Affect Performance: The number of programs that apply for a license and must be inspected or re-inspected is beyond the agency control.

Objective 2. The backlog of investigations of abuse, neglect or maltreatment allegations will be reduced by 50% by June, 1995.

Measure: Number of backlogged investigations

Definition: The Commissioner is obligated to investigate allegations of maltreatment of children or abuse or neglect of vulnerable adults in licensed programs. The allegations are screened upon receipt and a determination made whether or not the allegation is within the jurisdiction of the Commissioner and appears to be a violation.

Part 3: Substantiating the Performance Measures (Cont.)

Note: In September 1993 the division reorganized staff to place more emphasis on this component of work. Less staff are now providing service under objective 1.

Rationale: The statutes that guide this activity include M.S. 626.556 (Maltreatment of Minors) and M.S. 626.557 (Vulnerable Adults Act). The Commissioner has authority to monitor and inspect programs from M.S. 245A.

Data Source: The number of investigations is tracked by the unit responsible for completion.

Factors Beyond Agency's Control That Affect Performance: The number and severity/complexity of allegations that require investigation.

Objective 3. Key indicator licensing practice will be implemented in family day care, adult day care, and training and habilitation programs for persons with developmental disabilities by October, 1993.

Measure: Rules that have key indicator development/implementation.

Definition: The key indicator option is a shorter checklist of the entire rule. It is developed with the assistance of various stake holders of the particular rule. The result is a set of "key indicators" that are reasonably able to predict compliance with the entire rule. The items selected are generally believed to be those critical items that consensus shows are serious and will help assure children and vulnerable adults are not placed at increased risk.

Rationale: It is shown in other rules already implemented to be a rationale way to reduce workload while continuing to maintain a presence in the licensed programs.

Note: The key indicator development is critical to be able to meet division goals and will be incorporated with up-to-two-year licenses.

Data Source: Division record of implementation.

Factors Beyond Agency's Control That Affect Performance: Staff are assigned this activity based on availability from other mandated work such as investigations or license visits. The number of those items is not under agency control and thus this activity is affected as those numbers change.

Objective 4. Review and piloting of alternative licensing of child care center programs with Montessori accreditation and residential mental health programs with Joint Commission for Accreditation of Healthcare Organizations (JCAHO) accreditation will be completed by January, 1994.

Measure: Number of license holders monitored with alternative methods.

Definition: Numerous professional organizations have developed accreditation standards for their particular industry. These organizations will be identified and materials reviewed prior to determining whether and how accreditation will be considered as partial compliance with licensing rules.

Rationale: The Human Services Licensing act provides for this type of alternative regulatory practice. The practice will help reduce the work of licensing staff because standards in rules and accreditation that are equivalent will no longer be reviewed by staff, as long as the accreditation is valid.

Data Source: Publication of the rule will be in the state register.

Factors Beyond Agency's Control That Affect Performance: Responses by affected parties cannot be predicted.

Part 3: Substantiating the Performance Measures (Cont.)

Objective 5. A single rule containing all administrative licensing requirements will be developed and duplicate language in program rules will be eliminated. The rule advisory committee work will be completed by June, 1994.

Measure: Completion of rule advisory committee work

Definition: A new rule (Rule 17) will be developed that combines all the licensing administrative requirements. Consolidating all requirements into one rule will enhance consistency in process, while also making applicability clearer, and modification in the future much more streamlined. Deleting duplicative language and unnecessary portions of rules will also enhance clarity and reduce the number of regulations.

Data Source: Publication of the rule will be in the state register.

Factors Beyond Agency Control That Affect Performance: Responses by affected parties cannot be predicted.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Social Services
Program: Family and Chidren's Services

Program Purpose: The following information reflects the results oriented format of the Social Services Administration (SSA). The SSA holds primary responsibility for developing and coordinating the requirements under Community Social Services Act (CSSA) [M.S. 256E] Because the SSA has philosophically adopted a client-focused outcome-based approach, the 1994-95 CSSA Plan Guidelines strongly urged each county agency to define their biennial service plans in a results oriented form. Each county agency was to incorporate client-focused outcome goals and outcome indicators (i.e., measures) for each target population as defined in Minnesota statute. For purposes of this report, we have defined program purpose in terms of mission statement or overview contained in the CSSA Guidelines for each program area. Using the client-focused outcome-based approach, we are defining program goals in terms of intended outcomes for client target populations. Prior to this year, programs were defined as a collection of services, and program goals reflected this service orientation. The examples of intended outcomes (goals) for clients have been identified through recent work with county agencies and are categorized by the target populations as defined in statute. The measures and performance objectives are specific to that population. Target populations and examples of specific goals are included below.

Program: Family and Children's Services

Program Purpose: In accordance with Minnesota Law, the Department of Human Services oversees the administration of services at the local county level to various target populations designated in Statute. One of the target populations served by the Family and Children's Services program is indicated below. The purpose of the Family and Children's Services program is to provide support to strengthen Minnesota's families so that they are better able to care for their children.

Target Population: Families with children under age 18, who are experiencing child dependency, neglect or abuse, and also pregnant adolescent parents under the age of 18 and their children.

Program Goal(s): (intended client outcome)
"Minor parents will parent their children appropriately." For more examples of goals, measures, and performance objectives for this target population, see Appendix I.

Performance Objectives and Measures:

1. "By 199_, ___percent of minor parents will parent their children appropriately."

Measure: "The number of minor parents who have an acceptable score on an instrument which assesses parenting practice."

Currently, the SSA is not collecting data related to the intended outcomes which have been identified for the above mentioned client populations. There are presently measurement instruments available which will yield reliable outcome indicators (i.e., measures). The SSA will continue to work with local county agencies to develop additional and more accurate measurement instruments. The outcome measure included on this page for this target population will establish a baseline for reporting future outcomes for this target population.

Over this biennium, the SSA will continue to provide individual county agencies with technical assistance for the purpose of developing data collection systems on a local level which will assist local agencies in managing program efforts. Information gathered on a local level will be aggregated to determine regional and even statewide trends. It is anticipated that present statewide information systems will also provide meaningful supplemental information to local agencies. The

Part 2: Program Information (Cont.)

Social Service Information System (SSIS) will be designed to collect and aggregate outcome data for the various target populations served by the SSA. If implemented, the information obtained from the SSIS will provide the basis for determinations regarding the success of our social service delivery system.

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Social Services
Program: Family and Children's Services

Objective 1. "By 199_, __percent of minor parents will parent their children appropriately."

Measure: "The number of minor parents who have an acceptable score on an instrument which assesses parenting practice."

Definition: Appropriate parenting practices, derived from instrument assessing parenting practice.

Rationale: A collection of services are provided to this population to improve parenting practice. The outcome measure indicates the progress towards the client goal for this population.

Data Source: Based on the above example, the data source would be the parenting practice instrument. Other instruments may be developed over time (i.e., observational tools, etc.).

Factors Beyond Agency's Control That Affect Performance: Similar to all human behavior, control over other individuals is impossible. However, by focusing directly on agreed upon outcomes or results, potential for success is increased.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Social Services
Program: Chemical Dependency

Program Purpose: The following information reflects the results oriented format of the Social Services Administration (SSA). The SSA holds primary responsibility for developing and coordinating the requirements under Community Social Services Act (CSSA) [M.S. 256E] Because the SSA has philosophically adopted a client-focused outcome-based approach, the 1994-95 CSSA Plan Guidelines strongly urged each county agency to define their biennial service plans in a results oriented form. Each county agency was to incorporate client-focused outcome goals and outcome indicators (i.e., measures) for each target population as defined in Minnesota statute. For purposes of this report, we have defined program purpose in terms of mission statement or overview contained in the CSSA Guidelines for each program area. Using the client-focused outcome-based approach, we are defining program goals in terms of intended outcomes for client target populations. Prior to this year, programs were defined as a collection of services, and program goals reflected this service orientation. The examples of intended outcomes (goals) for clients have been identified through recent work with county agencies and are categorized by the target populations as defined in statute. The measures and performance objectives are specific to that population. Target populations and examples of specific goals are included below.

Program: Chemical Dependency

Program Purpose: In accordance with Minnesota Law, the Department of Human Services oversees the administration of services at the local county level to various target populations designated in Statute. One of the target populations served by the Chemical Dependency program is indicated below. The purpose of the Chemical Dependency program is to reduce the harmful impact of chemical use problems on Minnesota's citizens by increasing the cost effectiveness and quality of chemical dependency services.

Target Population: Persons receiving treatment for chemical use patterns which are either inappropriate and harmful or pathological.

Program Goal(s): (intended client outcome) "Persons treated for chemical usage which is inappropriate and harmful or pathological will be chemically free." For more examples of goals, measures, and performance objectives for this target population, see Appendix I.

Performance Objectives and Measures:

1. "By 199_, there will be a ___percent decrease in the number of persons experiencing recidivism over a ____ month period.

Measure: Number of persons experiencing recidivism over a ___ month period.

Currently, the SSA is not collecting data related to the intended outcomes which have been identified for the above mentioned client populations. There are presently measurement instruments available which will yield reliable outcome indicators (i.e., measures). The SSA will continue to work with local county agencies to develop additional and more accurate measurement instruments. The outcome measure included on this page for this target population will establish a baseline for reporting future outcomes for this target population.

Over this biennium, the SSA will continue to provide individual county agencies with technical assistance for the purpose of developing data collection systems on a local level which will assist local agencies in managing program efforts. Information gathered on a local level will be aggregated to determine regional and even statewide trends. It is anticipated

that present statewide information systems will also provide meaningful supplemental information to local agencies. The Social Service Information System (SSIS) will be designed to collect and aggregate outcome data for the various target populations served by the SSA. If implemented, the information obtained from the SSIS will provide the basis for determinations regarding the success of our social service delivery system.

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Social Services
Program: Chemical Dependency

Objective 1. "By 199_, there will be a ___percent decrease in the number of persons experiencing recidivism over a __ month period.

Measure: Number of persons experiencing recidivism over a ___ month period.

Definition: Number of persons experiencing recidivism after receiving treatment, assessed by repeat requests/referrals for subsequent treatment.

Rationale: The intended outcome for clients to remain chemically free as a result of services is not met if there is repeat need for treatment.

Data Source: The data source for this example would be client records indicating need for repeat treatment.

Factors Beyond Agency's Control That Affect Performance: Similar to all human behavior, control over other individuals is impossible. However, by focusing directly on agreed upon outcomes or results, potential for success is increased.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Social Services
Program: Developmental Disabilities

Program Purpose: The following information reflects the results oriented format of the Social Services Administration (SSA). The SSA holds primary responsibility for developing and coordinating the requirements under Community Social Services Act (CSSA) [M.S. 256E] Because the SSA has philosophically adopted a client-focused outcome-based approach, the 1994-95 CSSA Plan Guidelines strongly urged each county agency to define their biennial service plans in a results oriented form. Each county agency was to incorporate client-focused outcome goals and outcome indicators (i.e., measures) for each target population as defined in Minnesota statute. For purposes of this report, we have defined program purpose in terms of mission statement or overview contained in the CSSA Guidelines for each program area. Using the client-focused outcome-based approach, we are defining program goals in terms of intended outcomes for client target populations. Prior to this year, programs were defined as a collection of services, and program goals reflected this service orientation. The examples of intended outcomes (goals) for clients have been identified through recent work with county agencies and are categorized by the target populations as defined in statute. The measures and performance objectives are specific to that population. Target populations and examples of specific goals are included below.

Program: Developmental Disabilities

Program Purpose: In accordance with Minnesota Law, the Department of Human Services oversees the administration of services at the local county level to various target populations designated in Statute. One of the target populations served by the Developmental Disabilities program is indicated below. The purpose of the Developmental Disabilities program is to insure that Minnesotans with developmental disabilities have appropriate amounts, quality and types of supervision, support, training, and services as necessitated by the nature and severity of the disability and the individual life circumstances required to promote their full citizenship.

Target Population: Persons with mental retardation as defined in section 252A.02, subdivision 2, or with related condition as defined in section 252.27, subdivision 1, who are unable to provide for their own needs or to independently engage in ordinary community activities.

Program Goal(s): (intended client outcome)
"Each developmentally disabled consumer will have relationships with family members and others with whom they would like to have relationships." For more examples of goals, measures, and performance objectives for this target population, see Appendix I.

Performance Objectives and Measures:

1. "By 199_, ___percent of developmentally disabled consumers will have relationships with family members and others with whom they would like to have relationships."

Measure: "Number of developmentally disabled consumers who report that they have relationships with family members and others with whom they would like to have relationships."

Currently, the SSA is not collecting data related to the intended outcomes which have been identified for the above mentioned client populations. There are presently measurement instruments available which will yield reliable outcome indicators (i.e., measures). The SSA will continue to work with local county agencies to develop additional and more accurate measurement instruments. The outcome measure included on this page for this target population will establish a baseline for reporting future outcomes for this target population.

Part 2: Program Information (Cont.)

Over this biennium, the SSA will continue to provide individual county agencies with technical assistance for the purpose of developing data collection systems on a local level which will assist local agencies in managing program efforts. Information gathered on a local level will be aggregated to determine regional and even statewide trends. It is anticipated that present statewide information systems will also provide meaningful supplemental information to local agencies. The Social Service Information System (SSIS) will be designed to collect and aggregate outcome data for the various target populations served by the SSA. If implemented, the information obtained from the SSIS will provide the basis for determinations regarding the success of our social service delivery system.

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Social Services
Program: Developmental Disabilities

Objective 1. "By 199_, ___percent of developmentally disabled consumers will have relationships with family members and others with whom they would like to have relationships."

Measure: "Number of developmentally disabled consumers who report that they have relationships with family members and others with whom they would like to have relationships."

Definition: Responses to consumer satisfaction survey.

Rationale: Reliance on self-reporting by clients will provide one indicator of achievement. Additional information regarding this measure could be collected through examination of the case record and by case manager or interdisciplinary team.

Data Source: Based on the above example, the data source could be case records, self-reporting, and interdisciplinary team.

Factors Beyond Agency's Control That Affect Performance: Similar to all human behavior, control over other individuals is impossible. However, by focusing directly on agreed upon outcomes or results, potential for success is increased.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Social Services
Program: Aging and Adult Services

Program Purpose: The following information reflects the results oriented format of the Social Services Administration (SSA). The SSA holds primary responsibility for developing and coordinating the requirements under Community Social Services Act (CSSA) [M.S. 256E] Because the SSA has philosophically adopted a client-focused outcome-based approach, the 1994-95 CSSA Plan Guidelines strongly urged each county agency to define their biennial service plans in a results oriented form. Each county agency was to incorporate client-focused outcome goals and outcome indicators (i.e., measures) for each target population as defined in Minnesota statute. For purposes of this report, we have defined program purpose in terms of mission statement or overview contained in the CSSA Guidelines for each program area. Using the client-focused outcome-based approach, we are defining program goals in terms of intended outcomes for client target populations. Prior to this year, programs were defined as a collection of services, and program goals reflected this service orientation. The examples of intended outcomes (goals) for clients have been identified through recent work with county agencies and are categorized by the target populations as defined in statute. The measures and performance objectives are specific to that population. Target populations and examples of specific goals are included below.

Program: Aging and Adult Services

Program Purpose: In accordance with Minnesota Law, the Department of Human Services oversees the administration of services at the local county level to various target populations designated in Statute. One of the target populations served by the Aging and Adult Services program is indicated below. The purpose of the Aging and Adult Services program is to insure that persons age 60 or older and their caregivers have access to a coordinated continuum of community based services which: support wellness, maximize individual capacities, promote independent living, use both formal and informal support systems; are cost effective and least restrictive; allow choice; and are designed to meet the increasing demand projected for the future. It is also the State's mission to protect adults 18 or older who are particularly vulnerable to abuse or neglect or dependent on institutional services.

Target Population #1: Adults who are in need of protection and vulnerable as defined in section 626.557.

Target Population #2: Persons age 60 and over who are experiencing difficulty living independently and are unable to provide to their own needs.

Program Goal(s): (intended client outcome)

For Target Population #1 - "Clients will live in a setting that is free from abuse."

For Target Population #2 - "Persons age 60 or over who can and want to, will remain in their own home.

For more examples of goals, measures, and performance objectives for this target population, see Appendix I.

Performance Objectives and Measures:

For Goal #1 -"By 199_, there will be a ___percent decrease in the number of clients with repeat substantiated reports of abuse/neglect during a one year period."

For Goal #2 - "By 199_, ___percent of clients will live independently in their own home within one year of the Pre-Admission Screening."

Part 2: Program Information (Cont.)

Measure:

For Goal #1 - Number of clients with repeat substantiated reports of abuse/neglect during a one year period.

For Goal #2 - Number of persons who have an acceptable score on an instrument(s) assessing independent living in their own home.

Currently, the SSA is not collecting data related to the intended outcomes which have been identified for the above mentioned client populations. There are presently measurement instruments available which will yield reliable outcome indicators (i.e., measures). The SSA will continue to work with local county agencies to develop additional and more accurate measurement instruments. The outcome measure included on this page for this target population will establish a baseline for reporting future outcomes for this target population.

Over this biennium, the SSA will continue to provide individual county agencies with technical assistance for the purpose of developing data collection systems on a local level which will assist local agencies in managing program efforts. Information gathered on a local level will be aggregated to determine regional and even statewide trends. It is anticipated that present statewide information systems will also provide meaningful supplemental information to local agencies. The Social Service Information System (SSIS) will be designed to collect and aggregate outcome data for the various target populations served by the SSA. If implemented, the information obtained from the SSIS will provide the basis for determinations regarding the success of our social service delivery system.

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Social Services
Program: Aging and Adult Services

Objective 1.

For Goal #1 - "By 199_, there will be a ___percent decrease in the number of clients with repeat substantiated reports of abuse/neglect during a one year period."

For Goal #2 - "By 199_, ___percent of clients will live independently in their own home within one year of the Pre-Admission Screening."

Measure:

For Goal #1 - Number of clients with repeat substantiated reports of abuse/neglect during a one year period.

For Goal #2 - Number of persons who have an acceptable score on assessment instrument(s) re: independent living in their own home.

Definition:

For Goal #1 - Repeat substantiated reports of abuse/neglect over a one-year period as indicated by maltreatment reports.

For Goal #2 - Successful independent living by persons age 60 and over as indicated by assessment instrument.

Rationale:

For Goal #1 - Repeat substantiated reports of abuse/neglect are currently the best available measure for this goal.

For Goal #2 - An assessment which will effectively measure successful independent living using a scale, in conjunction with clients reporting level of satisfaction with independent living, will provide the best measures for this goal.

Data Source:

For Goal #1 - Maltreatment reports.

For Goal #2 - Independent living scale and reports of client satisfaction.

Factors Beyond Agency's Control That Affect Performance: Similar to all human behavior, control over other individuals is impossible. However, by focusing directly on agreed upon outcomes or results, potential for success is increased.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Work Readiness Employment and Training Services

Program Purpose: The purpose of this program is to provide employment and training services to recipients of Work Readiness cash assistance in order to help the recipients avoid or end public assistance dependency and become self-sufficient. As of January 1, 1993, Work Readiness eligibility is limited to six months per year (seven months for persons who are functionally illiterate).

The Work Readiness employment and training programs also serves as Minnesota's federal Food Stamp Employment and Training (FSET) program. The program operates under federal law and regulation, state law, and state administrative rules.

Employment and training services consist of orientation, assessment and employability plan development, job seeking training, group and individual job search activities, remedial literacy or English language training, child care and other supportive service payments, job placement, and limited training or educational opportunities. Services are provided in all 87 counties.

Work Readiness primary goals:

- To provide adult basic or remedial education in order to improve program participants' employability.
- To assist a significant number of Work Readiness recipients to become suitably employed through direct job placement or other services.

In 1992, over 30,000 individuals and families received Work Readiness or Family General Assistance. State statutes specify that county human service agencies and their employment and training service providers are required to provide Work Readiness employment and training services to all individuals and families who qualify for such services. The limited amount of funding available for the program and the short period of program eligibility do not permit extensive skill training or educational activities. Instead, the program provides basic education and direct job placement assistance at a very moderate cost.

Performance Objectives and Measures:

1. During each year of the biennium, at least 30,000 recipients will participate in Work Readiness employment and training services.

Measure: Number of recipients participating in Work Readiness services annually.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual				32,400	30,000	30,000	
Prior Objectives							

Part 2: Program Information (Cont.)

2. During each year of the biennium, at least 6,000 Work Readiness recipients will participate in adult basic or remedial education.

Measure: Number of recipients participating in adult basic or remedial education.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual				7,350	6,000	6,000	
Prior Objectives							

3. During each year of the biennium, at least 6,000 Work Readiness recipients will secure unsubsidized employment.

Measure: Number of recipients securing unsubsidized jobs following services.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual				5,200	6,000	6,000	
Prior Objectives							

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Work Readiness Employment and Training Services

Objective 1. During each year of the biennium, at least 30,000 recipients will participate in Work Readiness employment and training services.

Measure: Number of recipients participating in Work Readiness services annually.

Definition: The count of Work Readiness recipients participating in Work Readiness employment and training services during each state fiscal year.

Objective 2. During each year of the biennium, at least 6,000 Work Readiness recipients will participate in adult basic or remedial education.

Measure: Number of recipients participating in adult basic or remedial education.

Definition: The count of Work Readiness recipients participating during each state fiscal year in courses designed to educate adults to a minimum level of English, mathematics, or literacy proficiency.

Objective 3. During each year of the biennium, at least 6,000 Work Readiness recipients will secure unsubsidized employment.

Measure: Number of recipients securing unsubsidized jobs following services.

Definition: The count of Work Readiness recipients during each state fiscal year who have participated in Work Readiness employment and training services who secure unsubsidized employment.

Rationale: State and federal law specifies that the Department of Human Services, in partnership with the Department of Jobs and Training, is directly responsible for the provision of services designed to lead Work Readiness recipients to self-sufficiency. The provision of such services is intended to assist recipients to provide for themselves without needing public assistance.

These outcome measures directly demonstrate whether participants are being provided with sufficient job-seeking training, job placement assistance, adult basic education, and overall employment capabilities to enable them to become self-sufficient. Providing such services are expected to help ensure that the participant secures employment and reduces his or her reliance on public assistance. A direct comparison of the success of program participants compared to non-participants in becoming employed and moving off of public assistance would be preferable, but this type of evaluation of program effectiveness is very costly and requires a very high degree of program evaluation expertise. Until such an evaluation can be accomplished, the above measures are reasonable proxies for determining the effectiveness of Work Readiness.

Data Source: Department of Jobs and Training Management Information System, which county agencies or their employment and training service providers are required to provide data to at least monthly. The Department of Human Services accesses this data as needed.

Factors Beyond Agency's Control That Affect Performance: State, federal, and county human service funding levels directly affect the amount of services that may be provided, the number of Work Readiness recipients that may be served, and the overall comprehensiveness of program services. Additionally, the funding level and number of students served by local educational institutions directly impact the program's ability to place participants in education or training. Finally, the condition of the local labor market directly affects the ability of program participants to secure employment.

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Refugee Self-Sufficiency

Program Purpose: The purpose of the refugee self-sufficiency program is to provide culturally appropriate and comprehensive services to refugees which result in durable self-sufficiency and reduced welfare dependency.

Priority Clients:

Priority I: Refugee families receiving public cash assistance and residing in Minnesota.

Priority II: Singles and/or childless couples who are receiving public cash assistance and residing in Minnesota.

Program Goal: The self-sufficiency program is designed to assist refugees obtain the skills they need to become self-supporting. To do that, the program service design goals are to; a) provide family based services focusing on the entire family rather than on individuals; b) integrate services combining basic education, job skill training, employment and support services, and provide them concurrently rather than sequentially; and c) maximize resources by taking advantage of resources which exist outside of the Office of Refugee Resettlement (U.S. Department of Health and Human Services) refugee funding.

Performance Objectives and Measures:

1. 313 families will be removed from public cash assistance for a minimum of 90 days.

Measure:

	F.Y. 1992
Actual	299
Prior Objectives	313

2. 125 singles/childless couples will be removed from public cash assistance for a minimum of 90 days.

Measure:

	F.Y. 1992
Actual	157
Prior Objectives	125

3. Welfare savings of at least $1,095,877.00 or 50% of the total funding made available to the providers which was $2,191,753.00 for 1992.

Measure:

	F.Y. 1992
Actual	$1,400,530
Prior Objectives	1,095,877

It is important to note that of the 299 families removed from public cash assistance, 184 families or 62% were families with four or more members.

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Refugee Self-Sufficiency

Objective 1.

Measure:

Definition: The Refugee and Immigrant Services Section currently uses four standards as a measurement of a provider's performance. These standards are as follows:

a) The number of unduplicated families and childless couples/singles removed from public cash assistance for a minimum of 90 days on a quarterly and annual basis will correspond to the provider's proposed standards.

b) The actual average hourly wage of job placements will correspond to the provider's proposed standards on a quarterly and annual basis.

c) The 90-day job retention rate will correspond to the provider's proposed standards on a quarterly and annual basis.

d) Other outcomes proposed by the providers and agreed upon during the contract negotiation process to measure family movement toward self-sufficiency will correspond to the provider's proposed standards on a quarterly and annual basis.

Rationale: Self-sufficiency projects must consist of any combination of the following services:

- o promotion and recruiting
- o assessment and planning
- o job search and job placement assistance
- o basic education
- o job skill training
- o vocational training
- o short-term job training
- o on-the-job training
- o skills recertification
- o child care assistance
- o mental health services
- o transportation
- o translation and other interpreter services
- o incentive financial assistance
- o other services which demonstrate great creativity and potential for success

The services are essential in assisting the refugee family attain the goal of self-sufficiency and, hence, the provider's performance standard of families terminated from public cash assistance.

Data Source: In order to evaluate the performance of an agency a data network system was established for the Refugee Self-Sufficiency Program. The providers supply the data to the Refugee and Immigrant Services Section (RISS) through intake forms, enrollment/activity forms, job placement forms and job follow-up forms. In addition, RISS staff access the state MAXIS system to verify welfare grants received by each family when employment has occurred. All data is then keyed into the system and accessible to RISS staff to evaluate each provider's performance.

Factors Beyond Agency's Control That Affect Performance: The local and national economy can affect the availability of jobs.

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Quality Initiatives Division-Quality Control Section/Program Integrity Team

Program Purpose: Quality Control (QC) is responsible for conducting federally mandated quality control reviews on a statewide random sample of AFDC, FS and MA cases. This section reviews a statistically valid sample of cases to assess correct determination of eligibility. In cases determined to be in error, the reason for the error is determined. Based upon the review findings error rates are determined for each federal program. Each federal program has a limit of error above which a state will be sanctioned. Sanctions have the potential of amounting to millions of sanction dollars. Quality Control data is the basis for recommendations for corrective actions to reduce errors and identification of error prone activities to improve program administration.

In addition, the Quality Control function includes the selection, review and analysis of MinnesotaCare eligibility. MinnesotaCare quality assurance assesses correct eligibility determination on a random sample of cases pulled monthly from the universe of first months paid premiums. Review focus during the state fiscal year 1994, is concentrating upon MinnesotaCare residency requirements and exploring the potential of employee subsidized insurance among the selected population. In addition, the MinnesotaCare quality assurance activity generates data used in the determination of performance management of the MinnesotaCare eligibility function.

The purpose of the Program Integrity Team (PIT) is to control fraud and reduce overpayments in public assistance. New initiatives have centered on public awareness and fraud prevention investigations.

These initiatives utilize specific and focused methodologies:

- A well-advertised Hot Line which is available for complaints by the general public throughout the state.
- A fraud prevention component which investigates fraud referrals and allows for appropriate case actions at the earliest possible date.

By 1990 the public concern over welfare fraud was severely taxing the resources available to take complaints and conduct investigations. New initiatives were introduced to render program integrity efforts both more efficient and cost effective. Current goals include timely responses to cases identified by the general public and an investigative process where savings exceed costs.

Performance Objectives and Measures:

1. QC - A significant sample of selected AFDC, FS, MA cases will be reviewed, according to federal requirements, to assess the determination of eligibility.

Measure: Number of case reviews completed and analyzed.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	5000	5000	5000	4600	4600	4600	4600
Prior Objectives	5000	5000	5000	5000	5000	5000	5000

Part 2: Program Information (Cont.)

2. QC - Error rates will be determined for each federal program area.

Measure: Determination of error rates by program.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Medical Assistance							
Actual	1.16%	78%	.66%	NA	1%	1%	1%
Prior Objective	<3%	<3%	<3%	<3%			
AFDC							
Actual	2.67%	2.57%	3.19%	NA	3.0%	3.0%	
Prior Objectives	<4%	<4%	<4%	<4%			
Food Stamps							
Actual	9.0%	7.9%	10.4%	NA	10.0%	10.0%	10.0%
Prior Objectives	<10.4	<10.4	<10.6	NA			

3. QC - During state fiscal year 1994 a sample of MinnesotaCare cases will be reviewed to determine the correct assessment of residency and employer subsidized health insurance.

Measure: Number of MinnesotaCare reviews completed.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-0-	-0-	-0-	NA	1200	1400	2000
Prior Objectives	-0-	-0-	-0-	-0-	NA	NA	NA

4. PIT - Fraud prevention investigations will increase by at least 5% per year based on improved investigative methods.

Measure: The percentage of increase in Fraud Prevention Investigations.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual		1650	4950	6300	6800	7150	9125
Prior Objectives		1000	4500	6000			

5. PIT - For every $1.00 spent administering the Fraud Prevention Investigation program a return of at least $1.30 will be realized for the assistance programs.

Measure: The cost/benefit of administering the Fraud Prevention Investigation program.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual		1.25	1.43	1.30	1.33	1.35	
Prior Objectives		1.25	1.35	1.25			

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Quality Initiatives Division-Quality Control Section/Program Integrity Team

Objective 1. A significant sample of selected AFDC, FS, MA cases will be reviewed, according to federal requirements, to assess the determination of eligibility.

Measure: Number of case reviews completed and analyzed.

Definition: The completed review, according to federal requirements, of a significant number of cases as determined by the federal quality control statisticians in concert with the state Data Analysis and Reporting section.

Rationale: Federal law and regulation define the requirement for the existence of a Quality Control function to review and analyze a statistically significant sample of AFDC, FS and MA cases to assess the correctness of case eligibility. Based upon these reviews an error rate is determined for the state in each federal program. States are sanctioned if there error rate falls above a nationally developed tolerance level. Conversely, states receive enhanced FFP if their error rate falls below a figure determined by the federal quality control program.

Completion of the quality control reviews and the subsequent analysis of review findings produces data which not only is required by the federal agencies, but provides management analysis data to local agencies crucial to the efficient management of their assistance programs.

Data Source:

Factors Beyond Agency's Control That Affect Performance:

Objective 2. Error rates will be determined for each federal program area.

Measure: Determination of error rates by program.

Definition: Production of the state determined error rate by federal program. For food stamps the formula for calculation of the state error rate is as follows:

$$X/U = \frac{\text{Average error dollars per household}}{\text{Average benefit per household}}$$

Rationale: In order to analyze program error information nation-wide a nationally identified process for the determination of error rates by state has been developed. Production of the state error rate information and the analysis of the findings of the quality control reviews is an integral component of the quality control system nation-wide.

Data Source:

Factors Beyond Agency's Control That Affect Performance:

Objective 3. QC - During state fiscal year 1994 a sample of MinnesotaCare cases will be reviewed to determine the correct assessment of residency and employer subsidized health insurance.

Measure: Number of MinnesotaCare reviews completed examining residency and employer subsidized health insurance.

Part 3: Substantiating the Performance Measures (Cont.)

Definition: The number of random sample MinnesotaCare cases pulled and reviewed for eligibility determination regarding the factors of residency and employer subsidized health insurance.

Rationale: State legislation mandates the random selection of cases and determination of eligibility for a sample of cases for the state administered MinnesotaCare program. Beginning in state fiscal year 1994 the Quality Control section is beginning the determination of eligibility for a sample of MinnesotaCare cases under the auspices of MinnesotaCare Quality Assurance. For state fiscal year 1994 the eligibility factors to be examined are residency and employer subsidized insurance. As a result of these efforts MinnesotaCare management will receive critical information regarding eligibility determination of the MinnesotaCare program. In addition, the legislative body in Minnesota will obtain much needed eligibility information for use in determining future program direction.

Data Source:

Factors Beyond Agency's Control That Affect Performance:

Objective 4. Fraud prevention investigations will increase by at least 5% per year based on improved investigative methods.

Measure: The percentage of increase in fraud prevention investigations.

Definition: Annual increase in FPI investigations will increase a minimum of 5% per year based upon a base of 6300 per year in state fiscal year 1993.

Rationale: Fraud prevention investigations have proven an effective means of controlling fraud and reducing overpayments in the public assistance programs. New initiatives and expansion of FPI efforts will allow for the increase in investigations proposed.

Data Source:

Factors Beyond Agency's Control That Affect Performance:

Objective 5. PIT - For every $1.00 spent administering the Fraud Prevention Investigation program a return of at least $1.30 will be realized for the assistance programs.

Measure: The level of the cost-benefit ratio.

Definition: This measure is obtained by dividing the cost of the program by the projected savings as a result of fraud prevention investigation efforts.

Rationale: The fraud prevention investigation efforts have typically generated a savings return of approximately 130% of the costs of conducting fraud prevention investigation in the counties. Data from the fraud prevention investigation initiative indicate that anticipation of a continuation of this level of return is realistic at this time. The cost-benefit ratio of the fraud prevention investigation initiative has led to the continued interest and growth in fraud prevention investigation efforts statewide.

Data Source:

Factors Beyond Agency's Control That Affect Performance:

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Child Care Fund Assistance Programs

Program Purpose: The purpose of the Child Care Assistance Program is to assist low income AFDC and non-AFDC families in paying for child care costs. The program enables parents to pursue employment and/or education leading to employment so that the family can become financially self-sufficient.

There are five components to the child care assistance program. The components are:

a. AFDC employed child care,
b. STRIDE child care
c. the ACCESS child care program
d. Transition Year child care, and
e. Basic Sliding Fee child care.

Performance Objectives:

* families will receive child care assistance in FY 94
* families will receive child care assistance in FY 95

Measures:

Total number of families receiving assistance.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
# of families receiving assistance by 10/16/93	*	*	*	*	*	*	*
Avg. cost/ family	*	*	*	*	*	*	*

* to be supplied by reports and forecasts by 10/16/93

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Family Self-Sufficiency
Program: Child Care Fund Assistance Programs

Objective 1.

Measure: Approximately * families in 1994 and * families in 1995 will receive child care assistance in order to participate in employment or education and training which lead to self-sufficiency.

Definition: To maximize available funds so that all eligible AFDC families who are participating in programs that entitle them to child care assistance receive assistance and to fully implement the Basic Sliding Fee funding increase so that families currently on waiting lists will have opportunities to pursue employment, continue employment, or participate in education programs leading to employment.

Rationale: The ACCESS child care program for AFDC participants who are not eligible to participate in STRIDE will be at full enrollment at the end of FY 94 and the number of families who participate in Transition Year child care assistance will continue to increase. The number of families participating in the Basic Sliding Fee program will increase in FY 94 due to increase in available state and federal funds and will decrease slightly in FY 95 due to increases in the cost of providing child care and limitations on additional funds to cover the costs.

Data Source: Department of Human Services Reports and Forecasts Division

Factors Beyond Agency's Control That Affect Performance: The rate at which families choose to participate in the child care assistance program is influenced by many factors. Every effort will be made to advertise the availability of these opportunities to participate in education, job search and employment opportunities so that families may move to self sufficiency. Child care assistance program funds will be available for those who choose to participate. Local social services agencies administer the child care assistance program under state supervision.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Health Care Policy

Program Purpose: This activity manages the Medical Assistance (MA), General Assistance Medical Care (GAMC) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs and Human Immunodeficiency Virus (HIV) services in compliance with state and federal law. This requires the development and implementation of policies which are consistent with federal regulations without compromising the autonomy of Minnesota health care policy. This activity is involved in the following functions:

1. Developing rules and policies on recipient eligibility, and providing technical assistance, consultation, and training to local agency staff to ensure the effective local implementation of the respective programs.

2. Maintaining the MA state plan. The state plan incorporates all components of the MA program, including eligibility, medical services, administration, and payment mechanisms, and must be effectively maintained to prevent deferral or disallowance of federal funds.

3. Managing the health care services provided by the MA and GAMC programs, including interpretation of state and federal laws and regulations, development of health care services policies and standards, determination of community practice standards, promulgation of administrative rules, preparation of provider manuals and bulletins and other types of instructional materials, and professional reviews to determine disability status of program applicants.

4. Coordinating and prioritizing all requests for modifications to the Medicaid Management Information System (MMIS) including changes in federal and state law, regulation and rule changes, and new policies developed by the representative policy sections of the department. This includes analysis of the reason for the request, coordination of multiple modification system testing, setting of priorities for changes, and review and development of specifications for changes. This also includes the management of the price reference file for the MMIS.

5. Administering state and federal HIV service programs.

6. Assisting in the integration of MinnesotaCare with the MA program.

7. Establishing and maintaining rate methodologies for inpatient hospital services, review activities, and monitoring of utilization.

8. Applying for, monitoring, and providing technical assistance in securing federal Medicaid waivers.

Performance Objectives and Measures:

1. Reduce state and local health care costs by implementing federal options to shift coverage of certain categories of persons to MA.

Measure: Number of children receiving MA will increase.

2. Policy and standards for health services paid by MA, GAMC, and MinnesotaCare will be consistent and up to date with federal requirements.

Measure: MA policies and administration will be kept current with existing federal requirements.

Part 2: Program Information (Cont.)

3. Maintain and update MA/GAMC provider manual in a variety of mediums so that all service providers can be kept informed of changes in and the status of current policies, and costs can be minimized.

Measure: Number of mediums explored, costs of each analyzed, and viable options implemented.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
			Data will be available upon implementation				
Prior Objectives							

4. Develop and update administrative rules to clarify MA/GAMC coverage thereby providing improved legal basis upon which to make financial recoveries for program fraud or abuse and cost efficiencies generated as a result of having current legal authority to support policies.

Measure: Number of rules and rule sections amended to conform authority with policy.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
			Data not available				
Prior Objectives							

5. Insure that a comprehensive operation of the MMIS payment system assures positive and cost-beneficial effects, including:

1. Improved ability to respond to MA program changes thus avoiding retroactive provider charges and costly federal fiscal sanctions;

2. Better monitoring and calculation of payment rates for all providers as well as better information to providers on payments in process;

3. Improved access to management information for administrative and legislative decision making.

4. Current provider and recipient information;

5. Coordinating requests for modifications to the MMIS which result in timely and efficient modifications that complement each other and insure that the new MMIS will adequately address the needs of the MA/GAMC and other programs.

Part 2: Program Information (Cont.)

Measure:

Critical programming changes impacting health care programs will be made timely.

Improved customer responsiveness in status of claims and payment upon reaching a claims representative.

Number of pertinent management reports readily available to respond to internal and external requests.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
	Data will be available upon implementation						
Prior Objectives							

6. Insure that federal mandates affecting the MA program are implemented to minimize penalties for non-compliance and to insure that appropriate policies and rules are developed and communicated in response to such mandates.

Measure:

Service delivery between health care systems will be coordinated and operate smoothly.

Number of federal disallowances resulting from MA activities during this period will decline.

Activities relating to the MA program, GAMC program, Prepaid MA Program (PMAP), and managed care initiatives and MinnesotaCare are coordinated and operate in an efficient manner, thereby avoiding duplicative and competing activities.

7. Obtain federal grants for low income HIV infected persons who don't qualify for MA/GAMC.

Measure:

Evaluate current federally funded programs.

Develop new or expand existing programs that address the needs of HIV persons.

Prior authorization review of services will increase.

Number of grants obtained.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
	Data will be available upon implementation						
Prior Objectives							

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Health Care Policy

Objective 1. Reduce state and local health care costs by implementing federal options to shift coverage of certain categories of persons to MA.

Measure: Number of children receiving MA will increase.

Definition: The number of children receiving MA annually, in accordance with federal MA eligibility standards.

Rationale: Existing options are available to the state that will help to fully maximize federal reimbursement thereby reducing the state's financial obligation for the provision of special medical and other services to certain medically needy children.

Federal options expand the availability of special services under MA, thereby expanding the potential client base and alleviating state fiscal pressure.

This performance indicator measures the program's success of shifting a portion of the service cost to the federal sector.

Data Source: The Medical Management Information System (MMIS). Only MA recipients under the age of 21 will be counted.

Objective 2. Policy and standards for health services paid by MA, GAMC, and MinnesotaCare will be consistent and up to date with federal requirements.

Measure: MA policies and administration will be kept current with existing federal requirements.

Definition: Policies and standards will be reviewed and revised to maintain consistency with federal requirements. MA administration will be kept informed of the current status and necessary changes.

Rationale: Health services supported by policies and standards that are consistent with federal requirements are provided to recipients in a fair and constant fashion, and are less subject to disallowance.

Keeping the MA administration informed of necessary changes promotes prompt and consciousness response in legislation, rule, or general policy procedures.

This performance indicator ensures that critical congruity exists between federal requirements and current policy and standards.

Data Source: Federal Regulations, Regional Office Letters, Administrative Memos, Commerce Clearinghouse Publication, and State Medicaid Manual additions and revisions.

Part 3: Substantiating the Performance Measures (Cont.)

Objective 3. Maintain and update MA/GAMC provider manual in a variety of mediums so that all service providers can be kept informed of changes in and the status of current policies, and costs can be minimized.

Measure: Number of mediums explored, costs of each analyzed, and viable options implemented.

Definition: New mediums of information exchange will be explored to determine the most effective and cost effective methods. The costs of developing and implementing new strategies will be reviewed to determine cost-benefit ratio.

Rationale: This performance indicator measures the integrity of and costs associated with information dissemination to providers.

Data Source: Provider networks and organizations, Intertechnologies Group, Inc., private bidders

Objective 4. Develop and update administrative rules to clarify MA/GAMC coverage thereby providing improved legal basis upon which to make financial recoveries for program fraud or abuse and cost efficiencies generated as a result of having current legal authority to support policies.

Measure: Number of rules and rule sections amended to conform authority with policy.

Definition: Minnesota policy and rules will be researched to identify areas in which rules can be amended or created to provide a solid authority on which to base existing policy.

Rationale: Policy supported by enforceable rules presents a sound basis for recovering financial loss caused by program fraud or abuse, and policy that is current and in conformity with federal rules and regulations maximizes federal dollars and minimizes disallowance potential.

The need for enforcement will eventually decrease as those who defraud or abuse the medical system become aware of the consequences, thus reducing both the costs to the system caused by the fraud and abuse as well as the costs incurred by the legal enforcement of policy.

This performance indicator provides the measure of legal basis for enforcing policy.

Data Source: Minnesota Rules, Combined Policy Manual, Federal legislation and regulations

Objective 5. Insure that a comprehensive operation of the MMIS payment system assures positive and cost-beneficial effects, including:

1. Improved ability to respond to MA program changes thus avoiding retroactive provider charges and costly federal fiscal sanctions;

2. Better monitoring and calculation of payment rates for all providers as well as better information to providers on payments in process;

3. Improved access to management information for administrative and legislative decision making.

4. Current provider and recipient information;

5. Coordinating requests for modifications to the MMIS which result in timely and efficient modifications that complement each other and insure that the new MMIS will adequately address the needs of the MA/GAMC and other programs.

Part 3: Substantiating the Performance Measures (Cont.)

Measure: Critical programming changes impacting health care programs will be made timely.

Improved customer responsiveness in status of claims and payment upon reaching a claims representative.

Number of pertinent management reports readily available to respond to internal and external requests.

Definition: The new MMIS system will be monitored to ensure essential changes are made when necessary and without delay, provides immediate claims and payment status to claims representatives, and provide detailed data reports in a timely manner for administrative and legislative interests.

Rationale: By ensuring that modifications and updates to the MMIS are coordinated, timely, and effective, the most current claims and payment status and other information is readily available. Retroactive provider charges and federal fiscal sanctions can be avoided, improving provider relations and reducing the negative impact of unnecessary costs inflicted on both providers and the state.

Recipients and provider interests are better and more efficiently served when accurate and current information is readily accessible by claims representatives inquiring into the system regarding claims and payment status.

Providing accurate and timely reports assists administrators and legislators in effective decision making, benefitting recipients and providers.

This performance indicator measures the quality and responsiveness of the new MMIS system.

Data Source: MMIS. The new MMIS system, upon completion, will provide the information necessary to determine its effectiveness. Provider and user input.

Objective 6. Insure that federal mandates affecting the MA program are implemented to minimize penalties for non-compliance and to insure that appropriate policies and rules are developed and communicated in response to such mandates.

Measure: Service delivery between health care systems will be coordinated and operate smoothly.

Number of federal disallowances resulting from MA activities during this period will decline.

Activities relating to the MA program, GAMC program, Prepaid MA Program (PMAP), and managed care initiatives and MinnesotaCare are coordinated and operate in an efficient manner, thereby avoiding duplicative and competing activities.

Definition: Efficient coordination of effort and service delivery between health care systems is the result of developing, implementing, and maintaining compliance with federal requirements.

Rationale: Effective and efficient coordination and operation of service delivery between health care systems requires consistent application of federal requirements.

Federal disallowances occur when MA activity does not comply with contemporary or concurrent federal regulation.

Programs implementing federal and state mandates must be coordinated in order to prevent duplication of effort and promote efficiency in the provision of services.

This performance indicator measures the program's effectiveness in obtaining and disseminating changes in federal requirements.

Data Source: Provider manual, MA rules, Federal regulations

Part 3: Substantiating the Performance Measures (Cont.)

Objective 7. Obtain federal grants for low income HIV infected persons who don't qualify for MA/GAMC.

Measure: Evaluate current federally funded programs.

Develop new or expand existing programs that address the needs of HIV persons.

Prior authorization review of services will increase.

Number of grants obtained.

Definition: Federal funding for programs providing services to HIV infected low income persons increase base level funding available to the program for implementation of such grants and other service.

Rationale: There is an increased need for services available to low income HIV infected persons who are not eligible for MA/GAMC.

Increased prior authorizations are required to maintain the integrity of implementing new programs.

The number of grants obtained reflects the importance placed on the efforts necessary to secure funds for critical HIV programs.

This performance indicator measures the intensity of the administration's pursuit to obtain new critical funding.

Data Source: Federal funding received, current programs expanded or new ones created

perf-hc.301

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Coordinated Health Care

Program Purpose: This activity manages the coordination of and access to services under the Medical Assistance (MA), the General Assistance Medical Care (GAMC) and MinnesotaCare programs in compliance with the state and federal law. The activity develops rules and policies on coordinated care programs, which includes prepayment capitation programs, primary care utilization review (PCUR), prior authorization, volume purchases, and provides technical assistance, consultation and training to affected parties to ensure the effective implementation of the respective programs.

Responsibilities include initiation and administration of major managed care capitation contracts and volume purchase contracts, quality assurance program management, promulgation of appropriate administrative rules, and communication of these policies to health plans, contracted vendors, recipients, advocates and interested parties.

In addition, this activity is responsible for developing the managed care plan mandated by the MinnesotaCare Law. The department is required to present a plan to the Legislature by 1-1-93 for providing MA/GAMC/MinnesotaCare services through managed care arrangements.

This activity supports the goals of Minnesota Milestones to ensure access to health care for Minnesotans.

The following groups of recipients are enrolled in prepaid capitation programs:

Prepaid MA Program (PMAP)	GAMC
Hennepin County - aged, AFDC	Sole Source Model
Dakota County - aged, AFDC	Dakota
Itasca County - aged, AFDC	Itasca County
	Lake
MA voluntary	Multiple Plan Model
Lake County - aged, AFDC	Ramsey
Five County Metro Area - AFDC	Hennepin

Performance Objectives and Measures:

1. Health care services will be purchased in the most cost-efficient manner, assuring access to quality care.

Measure: Number of recipients receiving health care services through the Prepayment Mandatory MA program and Mandatory GAMC Prepaid Program.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon full implementation of MMIS II						
Prior Objectives							

2. A Long Term Care Options Medical Assistance Program (LTCOP) will be developed and submitted to HCFA.

Measure: Development of LTCOP plan that will be eligible to receive necessary waivers from HCFA.

perf-hc.204

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Coordinated Health Care

Objective 1. Health care services will be purchased in the most cost-efficient manner, assuring access to quality care.

Measure: Number of recipients receiving health care services through the Prepayment Mandatory MA program and Mandatory GAMC Prepaid Program.

Definition: The number of health care recipients receiving services through the Prepayment Mandatory MA program and Mandatory GAMC Prepaid Program

Rationale: The Prepayment Mandatory MA program and Mandatory GAMC Prepaid Program have been established to provide cost-effective health care services without sacrificing access to quality care.

Monitoring the number of health care recipients receiving services through the Prepayment Mandatory MA program and Mandatory GAMC Prepaid Program assists the program in establishing priorities for future goal setting and decision making.

This performance indicator establishes a benchmark measure on which to base future targets.

Data Source: DHS internal data regarding number of enrolled recipients.

Objective 2. A Long Term Care Options Medical Assistance Program (LTCOP) will be developed and submitted to HCFA.

Measure: Development of a LTOCP plan that will be eligible to receive necessary waivers from HCFA.

Definition: A comprehensive design for the enrollment of Medicare and MA eligible recipients will be developed by the program. Implementation of the first stage of the plan ensures that the process is instituted and can be monitored for necessary revision or changes.

Rationale: A comprehensive plan is essential for the program to obtain approval from HCFA and to successfully implement the LTCOP program.

This performance indicator measures the initial stages of the LTCOP program.

Data Source: Internal DHS data - status reports of LTCOP program

Factors Beyond Agency's Control That Affect Performance: HCFA approval of waivers.

perf-hc.304

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Health Care Operations

Program Purpose: This activity is responsible for administering centralized medical payment systems so that:

1. Health care services and long term care (LTC) services are provided to Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare recipients;

2. All liable third parties are required to pay for medical expenses if payment is made by government entities;

3. Medicare participation in the cost of LTC services is maximized;

4. The medical care surcharge is properly billed to nursing facilities and inpatient hospitals and complies with federal laws and regulations;

5. The new Medicaid Management Information System (MMIS) will be implemented with a minimum of disruption in claim payments to medical vendors;

6. Providers are oriented to the complexity of participating in the publicly funded health care programs;

7. Provider staff are trained on the correct submission of claims; and

8. Enrolled providers continue to meet federal and state requirements and are eligible to be reimbursed for services.

The systems administered in this activity annually process approximately 13,500,000 claims for 23,500 enrolled health care providers (physicians, dentists, hospitals, etc.) and 500,000 claims for long term care facilities and related services. The payment of these claims must meet the requirements of state and federal laws, rules, and regulations. The edit structure for the (MMIS) system consists of more than 900 system edits which are variably utilized depending on the type of service billed. The comparable edit structure in the LTC subsystem contains approximately 125 edits. These edits validate the information submitted, check for accuracy, determine appropriate coverage, compute reimbursement, assure that the claim has not been previously paid or does not conflict with another claim, and finally validate recipient eligibility. While claims that fail edits must be manually reviewed and corrected, claims which are clean can usually be processed and paid within 30 days of receipt. Prospective training efforts reduce the number of improperly submitted claims; thereby reducing the number of claims suspended or rejected for errors. A "clean" claim is adjudicated and paid faster with the result of lowering the provider's accounts receivable, which in turn, may partially reduce the impact of prevailing rate structures. The training activity involves all providers with focused training for dentists, outpatient hospitals and long-term care facilities. Training in long-term care has historically utilized live, cable broadcasts for facility and county staff. The broadcasts are coordinated at 18 area vocational technical institutes followed by a series of teleconferences to permit feedback by participants.

The data collected from adjudicated claims provides the base for management and operational reports, surveillance and utilization review, and the database for computing reimbursement rates. This database is the MMIS. The claims processing section operates a provider hot-line 8 hours per business day and receives in excess of 400 calls daily. Provider communications are coordinated through this activity to ensure that all claims processing related communication is consistent with department policy and responsive to the needs of the provider community. Information sought by providers includes types of covered services, proper procedure codes, reimbursement requirements, payment levels, and status of suspended claims.

Part 2: Program Information (Cont.)

Performance Objectives and Measures:

1. The operation of a centralized claims processing system for health care services (MMIS) provided to Minnesota recipients of MA, GAMC, and MinnesotaCare will meet federal certification standards and receive enhanced federal funding.

Measure: Percent of clean claims submitted to the MMIS system that are adjudicated.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon full implementation of MMIS						
Prior Objectives							

2. The operation of a centralized claims processing subsystem for LTC services provided to Minnesota recipients of MA will meet federal certification standards and receive enhanced federal fundi

Measure: Percent of clean claims submitted to the LTC payment system that are adjudicated.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon full implementation of MMIS						
Prior Objectives							

3. Maintain an accurate client information data base for all health care programs so that eligibility errors are reduced.

Measure: Claims rejected for eligibility errors.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon full implementation of MMIS						
Prior Objectives							

4. Ensure that MA, GAMC and MinnesotaCare expenditures are made according to federal and state requirements and secure recovery of expenditures where other third parties are liable or where fraud, abuse or misuse is established.

Measure: Recoveries and cost avoidance from liable third parties.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

5. Administer an appeal process that enhances Medicare participation in payment for LTC services, thereby maximizing federal funds.

Measure:

Monthly average of resident days required to be paid by Medicare.

Number of resident days successfully won on appeal.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

6. Ensure that health care providers experiencing difficulty with the claims processing activity are trained in the preparation and submission of claims.

Measure:

Number of provider training contacts for individual training.

Number of claims rejected for avoidable billing staff errors.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data will be available upon full implementation of MMIS				
Prior Objectives							

7. Implement the new MMIS efficiently, with minimum disruption to claims payment for health care providers.

Measure: Percentage of claims processed without manual intervention.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data will be available upon full implementation of MMIS				
Prior Objectives							

perf-hc.208

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Health Care Operations

Objective 1. The operation of a centralized claims processing system for health care services (MMIS) provided to Minnesota recipients of MA, GAMC, and MinnesotaCare will meet federal certification standards and receive enhanced federal funding.

Measure: Percent of clean claims submitted to the MMIS system that are adjudicated.

Definition: The percent of claims submitted to the MMIS system that are considered clean claims according to federal certification standards.

Rationale: Adjudicated clean claims do not need to be manually processed and reduce the period of time between claim and payment. Reduction of the time period lowers the providers' accounts receivable and may lead to a partial reduction in the impact of prevailing rate structures.

Enhanced federal funding is available to systems meeting federal certification standards.

This performance indicator provides a measure of compliance with federal standards thereby ensuring enhanced federal funding.

Data Source: MMIS

Objective 2. The operation of a centralized claims processing subsystem for LTC services provided to Minnesota recipients of MA will meet federal certification standards and receive enhanced federal funding.

Measure: Percent of clean claims submitted to the LTC payment system that are adjudicated.

Definition: The percent of claims submitted to the LTC payment sub-system that are considered clean claims according to federal certification standards.

Rationale: Adjudicated clean LTC claims do not need to be manually processed and reduce the time period of time between claim and payment. Reduction of the time period lowers the LTC providers' accounts receivable and may lead to a partial reduction in the impact of prevailing rate structures.

Enhanced federal funding is available to systems meeting or exceeding federal certification standards.

This performance indicator provides a measure of compliance with federal standards thereby ensuring enhanced federal funding.

Data Source: LTC subsystem of MMIS

Part 3: Substantiating the Performance Measures (Cont.)

Objective 3. Maintain an accurate client information data base for all health care programs so that eligibility errors are reduced.

Measure: Claims rejected for eligibility errors.

Definition: The number of medical claims that fail eligibility edits and are rejected due to eligibility errors.

Rationale: Claims that are rejected must be manually reviewed and corrected, increasing the time necessary to process the claim.

This performance indicator establishes a measure of claim system performance.

Data Source: MMIS

Objective 4. Ensure that MA, GAMC and MinnesotaCare expenditures are made according to federal and state requirements and secure recovery of expenditures where other third parties are liable or where fraud, abuse or misuse is established.

Measure: Recoveries and cost avoidance from liable third parties.

Definition: The amount of payments made by third parties on MA, GAMC, and MinnesotaCare eligible services in comparison to the total cost of the medical services provided under the programs respectively.

The amount of payment recoveries for MA, GAMC, and MinnesotaCare services from third parties for which they were liable.

Rationale: MA avoids unnecessary expenditures for clients with third party coverage by ensuring that all third party payments have been made for medical services prior to MA payment.

MA reduces expenditures by ensuring that all third party liability has been paid, avoiding additional costs that are incurred when MA pays the total claim charge first and must recover third party coverage after payment of the claim.

This performance indicator is a measure of the program's compliance with federal cost-avoidance requirements and the reduction of unnecessary expenditures.

Data Source: Benefit Recovery, MMIS

Objective 5. Administer an appeal process that enhances Medicare participation in payment for LTC services, thereby maximizing federal funds.

Measure: Monthly average of resident days required to be paid by Medicare.

Number of resident days successfully won on appeal.

Definition: The average number of resident days Medicare is required to pay.

The number of resident days that are successfully won through an appeal process.

Rationale: Monitoring the average number of resident days Medicare is required to pay and the number of resident days successfully won by appeal promotes maximization of federal funds.

This performance indicator is a measure of the degree to which federal funds of Medicaid and Medicare are maximized.

Data Source: Medicare Revenue Enhancement Project

Part 3: Substantiating the Performance Measures (Cont.)

Objective 6. Ensure that health care providers experiencing difficulty with the claims processing activity are trained in the preparation and submission of claims.

Measure: Number of provider training contacts for individual training.

Number of claims rejected for avoidable billing staff errors.

Definition: The number of contacts to the program requesting individual provider training.

The number of claims rejected due to failure of certain MMIS edits caused by billing staff errors.

Rationale: Monitoring the number of provider training contacts and the number of rejected claims for billing staff errors provides a perspective of the provider training needs and assists the program in developing the design and scope of necessary training efforts.

This performance indicator establishes the baseline criteria of needs for developing provider training initiatives.

Data Source: Customer Service Division data

Objective 7. Implement the new MMIS efficiently, with minimum disruption to claims payment for health care providers.

Measure: Percentage of claims processed without manual intervention.

Percentage of clean claims processed.

Percentage of claims received in electronic format.

Definition: The percentage of the automated claims processed by the new MMIS system without manual intervention.

The percentage of claims that are processed without edit failure.

The percentage of claims received from providers in an electronic - computer format.

Rationale: This performance indicator is a measure of the clean claims processed without manual intervention and is a measure of the cost-efficiency of the claims payment system.

Data Source: MMIS (new)

perf-hc.308

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Health Care Compliance

Program Purpose: This activity is composed of the Surveillance and Utilization Review (SURS) and audit sections which are federally mandated activities. The SURS section reviews 23,500 health care providers to determine if the incorrect payments were made as a result of fraud abuse or misuse. Potential fraud and abuse in Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare is identified through computerized practice profile reports from the Medicaid Management Information System (MMIS), recipient complaints and referrals from other providers, state agencies and divisions within the department. The new MinnesotaCare program will add an estimated 250,000 recipients to the state's fee for service population by the end of the biennium which will increase provider claim activity.

The audit section is responsible for the compliance auditing of 750 long-term care facilities (LTC) and 30 rural health clinic (RHC) and federally qualified health centers (FQHC). The on-site (field) audits are conducted in accordance with federal audit standards and are coordinated with other audit agencies to reduce duplication of effort. This section also establishes all payment rates for RHC, FQHC, and LTC facilities paid through the MA program. On a request basis, that audit section is responsible to conduct financial and compliance audits for over 200 grantees and contractors of the department.

Performance Objectives and Measures:

1. Ensure that the MA, GAMC, and MinnesotaCare expenditures are made to and utilized by providers according to federal and state requirements.

Measure:

Number of fraud and abuse investigations undertaken by SURS.

Total program expenditures cost avoided as a result of SURS activity.

Total program expenditures cost avoided as a result of LTC rate-setting activity.

Total program dollars recommended for audit adjustment as a result LTC compliance audits.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon implementation of MMIS II						
Prior Objectives							

Part 2: Program Information (Cont.)

2. Secure recovery of expenditures where fraud, abuse, or misuse is established.

Measure:

Total program expenditures recovered by SURS as a result of fraud and abuse investigations.

Investigative costs recovered from providers deliberately billed contrary to established policy.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

3. Establish RHC, FQHC, and LTC payments rates in accordance with state law and rules.

Measure: LTC Payment rates are set within timelines established in state law and rule.

4. Protect resident/client resources from misuse and abuse by providers.

Measure: Number of resident trust funds reviewed for misuse or abuse.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

perf-hc.209

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Health Care Compliance

Objective 1. Ensure that the MA, GAMC, and MinnesotaCare expenditures are made to and utilized by providers according to federal and state requirements.

Measure: Number of fraud and abuse investigations undertaken by SURS.

Total program expenditures cost avoided as a result of SURS activity.

Total program expenditures cost avoided as a result of LTC rate-setting activity.

Total program dollars recommended for audit adjustment as a result LTC compliance audits.

Definition: Recovered expenditures indicate those amounts improperly utilized by providers.

Rationale: This performance indicator is a measure of the degree to which federal and state requirements are met in paying MA, GAMC, and MinnesotaCare expenditures.

Data Source: Surveillance and Utilization Review System (SURS)

Objective 2. Secure recovery of expenditures where fraud, abuse, or misuse is established.

Measure: Total program expenditures recovered by SURS as a result of fraud and abuse investigations.

Investigative costs recovered from providers deliberately billed contrary to established policy.

Definition: Recovered expenditures from investigations are those amounts of MA payments made due to fraud and abuse in claims by providers.

Investigative costs are those costs incurred by SURS in the investigation of providers who have billed contrary to established policy.

Rationale: This performance indicator measures the viability of SURS investigation and recovery procedures for recovering expenditures incurred due to fraud and abuse of the program.

Data Source: Surveillance and Utilization Review System (SURS)

Objective 3. Establish RHC, FQHC, and LTC payments rates in accordance with state law and rules.

Measure: LTC Payment rates are set within timelines established in state law and rule.

Definition: Rates that are established both properly and timely insure maximization of federal financial participation.

Rationale: This performance indicator measures the compliance of payments to these providers with state law and rule.

Data Source: SURS subsystem

Objective 4. Protect resident/client resources from misuse and abuse by providers.

Measure: Number of resident trust funds reviewed for misuse or abuse.

Definition: Trust funds are established by LTC facilities for residents to maintain and control their resources for their personal and other needs.

Rationale: This performance indicator measures the program's capacity to deter provider misuse and abuse of resident resources.

Data Source: SURS subsystem

Factors Beyond Agency's Control That Affect Performance:

perf-hc.309

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Long Term Care/Providers Appeals

Program Purpose: This activity is responsible for the resolution of rate appeals filed by 445 nursing homes, 318 intermediate care facilities for the mentally retarded (ICF/MR), and 180 acute care hospitals. Appeals are resolved through either settlement or contested case hearings. Each year approximately 600 appeals are filed.

This activity serves as the final step in the rate setting process to assure compliance with law and policy. The activity is handled by staff attorneys who attempt to reach settlements with providers as an alternative to the more costly formal hearing process.

The activity also administers the expedited appeal review process and is involved with the acute care hospital appeals process in an advisory role.

Performance Objectives and Measures:

1. All appeals will be resolved or entered into the formal hearing process in a timely manner.

Measure: Number of appeals received annually compared to number of appeals resolved annually.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

perf-hc.210

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Long Term Care/Provider Appeals

Objective 1. All appeals will be resolved or entered into the formal hearing process timely.

Measure: Number of appeals received annually compared to number of appeals resolved annually.

Definition: The number of appeals resolved in a timely manner.

Rationale: Monitoring the time between an appeal being filed and resolved serves to insure that providers are treated fairly and equitably.

Data Source: Provider Appeals Division data

perf-hc.310

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Customer Service

Program Purpose: The purpose of the Customer Services Division is to enroll providers and provide training and technical assistance regarding Medical Assistance, General Assistance Medical Care, and MinnesotaCare policy to the 25,000 enrolled providers.

Performance Objectives and Measures:

1. Plan, develop, and implement a training plan for providers for conversion to a new MMIS.

Measure: Number of providers trained before MMIS implementation.

Number of DHS staff and county staff trained before MMIS implementation.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
	Data will be available upon implementation of MMIS						
Prior Objectives							

2. To provide technical assistance to providers regarding health care policies and procedures.

Measure: The number of providers successfully provided with technical assistance.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual		Data not available					
Prior Objectives							

3. Enroll all eligible vendors electing to participate in the publicly funded health care programs.

Measure:

Number of providers enrolled for each provider type.

Delay between application and actual enrollment.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual		Data not available					
Prior Objectives							

perf-hc.211

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Customer Services

Objective 1. Plan, develop, and implement a training plan for providers for conversion to a new MMIS.

Measure: Number of providers trained before MMIS implementation.

Number of DHS staff and county staff trained before MMIS implementation.

Definition: Training providers to use a new claims system ensures fewer errors and less time to achieve full implementation.

Rationale: Trained providers are critical to the successful conversion from the current MMIS to the new MMIS.

This performance indicator measures the scope of the training program established for providers.

Data Source: Customer Services Division data

Objective 2. To provide technical assistance to providers regarding health care policies and procedures.

Measure: The number of providers successfully provided with technical assistance.

Definition: The number of providers receiving accurate and timely technical assistance enhances the smooth operation of the MA/GAMC/MNCare programs.

Rationale: By providing prompt and accurate technical assistance, providers should experience fewer billing delays and/or recovery for erroneous billings.

Data Source: Customer Services Division data

Objective 3. Enroll all eligible vendors electing to participate in the publicly funded health care programs.

Measure: Number of providers enrolled for each provider type.

Delay between application and actual enrollment.

Definition: The number of providers enrolled under each provider type compared to the total number of potentially eligible providers.

The number of days from the time a provider applies for enrollment to the time the provider is actually enrolled.

Rationale: This performance indicator is a measure of the program's recruitment and enrollment procedures.

Data Source: Provider Enrollment

perf-hc.311

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Medical Assistance Grants

Program Purpose: Medical Assistance (MA) is the program authorized under Title XIX of the Social Security Act to provide health care services to eligible low income individuals and families. Most recipients of Aid to Families with Dependent Children (AFDC), Minnesota Supplemental Aid (MSA), and Supplemental Security Income (SSI) are eligible for MA. Eligibility is also available to the elderly, disabled, blind, and families with children under 21 years of age if income and assets are within MA standards. Pregnant women and infants are eligible with income under 185% of federal poverty guidelines. Children between ages 1 and 5 are eligible at 133% of federal poverty guidelines. Children between ages 6 and 18, born after 9-30-83, are eligible at 100% of federal poverty guidelines. Pregnant women and children are not subject to an asset test. Certain elderly and disabled people are eligible for Medicare cost-sharing paid by MA.

Persons with excess income may qualify through the spenddown provisions by incurring sufficient medical bills. Payments are made directly to health care providers, not to MA clients.

Performance Objectives and Measures:

1. During each year of the biennium, MA will provide medical care to eligible enrollees.

Measure: Average monthly number of MA recipients.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	(Available in forecast documents)						
Prior Objectives	Not Applicable						

perf-hc.202

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Medical Assistance Grants

Objective 1. During each year of the biennium, MA will provide medical care to eligible enrollees.

Measure: Average monthly number of MA recipients.

Definition: Each fiscal year the average number of MA recipients will be calculated on a monthly basis.

Rationale: This performance indicator measures the volume of clients receiving MA benefits during each year of a biennium.

Data Source: MMIS

Factors Beyond Agency's Control That Affect Performance: Economy, inflation, unemployment rates

perf-hc.302

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: General Assistance Medical Care Grants

ACTIVITY DESCRIPTION:

The purpose of the General Assistance Medical Care Program (GAMC) is to pay for medical services rendered to low income individuals who do not meet the eligibility categories of MA, such as age, disability, or family composition. Also persons who would be eligible for MA if they did not reside in an Institution for Mental Diseases (IMD) are eligible for GAMC. The majority of GAMC recipients are single persons, between age 21 and age 65. Persons eligible for General Assistance (GA) are eligible for GAMC without separate application.

Payments are made for inpatient and outpatient hospital care, drugs and medical supplies, physician services, prosthetic devices, dental care, eye care, chiropractic services, medical transportation and case management for persons who have a serious and persistent mental illness for persons who would be eligible for medical assistance (MA) but for the fact that they reside in institutions for mental diseases. Provider payment rates are specified in state law.

In F.Y. 1993, approximately 44% of total GAMC expenditures went to capitated payment plans, 24% of expenditures went to inpatient hospital services, and 12% into physician services.

Approximately 4% of GAMC costs in F.Y. 1992, on average, were attributable to residents of IMD's.

Performance Objectives and Measures:

1. During each year of the biennium, GAMC will provide monthly medical care coverage to applicants who meet eligibility requirements established by law.

Measure: Monthly average number of GAMC enrollees.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	(Available in forecast documents)						
Prior Objectives	Not Applicable						

perf-hc.203

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: General Assistance Medical Care Grants

Objective 1. During each year of the biennium, GAMC will provide monthly medical care coverage to applicants who meet eligibility requirements established by law.

Measure: Monthly average number of GAMC enrollees.

Definition: The number of active GAMC recipients will be determined each month of each year of the biennium.

Rationale: The average number of GAMC enrollees provide a tool for program decision makers to gauge the amount of GAMC activity.

This performance indicator provides a measure of the overall use of and demand for GAMC services.

Data Source: MMIS

Factors Beyond Agency's Control That Affect Performance: Economy, inflation, unemployment rates

perf-hc.303

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: MinnesotaCare Grants

Program Purpose: This activity exists to pay medical payments and subsidize premiums for the uninsured under the Minnesota Health Right Act of 1992. Beginning 10-1-92, enrollees will pay a premium based on a sliding scale of income and family size. Premiums are calculated on a monthly basis and may be paid monthly or quarterly. Premium payment is required before enrollment is complete. Nonpayment results in disenrollment. People disenrolled for nonpayment may not reenroll for 4 months. Children enrolled under the old Children's Health Plan, with its $25 annual premium, will be transferred to the MinnesotaCare sliding premium scale on 7-1-93.

Performance Objectives and Measures:

1. MinnesotaCare will provide covered medical care to all applicants who meet eligibility requirements established by law.

Measure: Average number of MinnesotaCare enrollees.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon full implementation of MinnesotaCare						
Prior Objectives							

perf-hc.212

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: MinnesotaCare Grants

Objective 1. MinnesotaCare will enroll eligible applicants who meet eligibility requirements established by law.

Measure: The average number of MinnesotaCare enrollees.

Definition: There is an average of 3+ individuals per household enrolled in MinnesotaCare.

Rationale: The average number of individuals enrolled in MinnesotaCare will is expected to grow in the biennium as the effect of expanded eligibility requirements established by law become effective.

This performance indicator measures the growth in the MinnesotaCare program and will establish a baseline for maintenance of the MinnesotaCare program once the eligibility requirement expansions are fully operationalized.

Data Source: MMIS

Factors Beyond Agency's Control That Affect Performance: Economy, inflation, unemployment rates

perf-hc.312

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Long Term Care Facilities Division

Program Purpose: The Long Term Care Facilities Division proposes legislation; develops rules, procedures and systems to reimburse 875 long term care (LTC) facilities which participate in the Medical Assistance (MA) program as required by M.S. 256B.41 and 256B.51. Facilities include nursing facilities, boarding care homes, intermediate care facilities for the mentally retarded, for day training and habilitation centers.

In carrying out these duties this section is responsible for rulemaking for Minnesota Supplemental Aid negotiated-rate facilities (group residential housing), for certification of facilities, for assuring compliance with federal requirements, and for policies related to nursing facilities, intermediate care facilities, and institutions for mental diseases. In addition, this activity oversees a major contract the Department of Human Services has with the Minnesota Department of Health (MDH).

Specifically, the major functions of this activity are:

1. Developing, reviewing, and analyzing methods of reimbursing institutional care services.
2. Analyzing cost and program data to contain costs and improve services.
3. Developing rules and implementing state and federal legislation.
4. Administering the MDH contract for federally mandated surveys of LTC facilities.
5. Coordinating and disseminating state LTC facilities policy.
6. Administering nursing facility property evaluations.
7. Maintaining automated rate setting systems.

Performance Objectives and Measures:

1. Adjustments in rates will be reflected in the automated rate-setting system.

Measure: The length of time required to change rates using automated system.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Data will be available upon full implementation						
Prior Objectives							

Part 2: Program Information (Cont.)

2. Requests of the Activities Information and Policy office will be handled in a timely manner.

Measure: The average length of time before requests for information and policy are filled.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

3. Reports due to federal administrations will be completed ahead of due date.

Measure: The average time ahead of schedule reports are filed with federal administrators.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data on Survey				
Prior Objectives							

perf-hc.207

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Human Services
Administration: Health Care
Program: Long Term Care Facilities

Objective 1. Adjustments in rates will be reflected in the automated rate-setting system.

Measure: The length of time required to change rates using automated system.

Definition: The number of days between the finalization of rates and the time the rates are installed into the automated rate-setting system.

Rationale: By maintaining a minimal number of days between the finalization of rate adjustments and updating the automated system, a responsive network is ensured for consumers and policy staff.

This performance indicator measures the effectiveness of the communication linkages between the division policy staff and the automated system programmers.

Data Source: Long Term Care Facilities Division data

Objective 2. Requests of the Activities Information and Policy office will be handled in a timely manner.

Measure: The average length of time before requests for information and policy are filled.

Definition: The number of days required for the division to provide information and policy upon request.

Rationale: Monitoring the length of time between request and response to the request for information and policy allows division staff an accurate and realistic measure of expectation to communicate to those requesting information.

More efficient means of corresponding with consumers and other divisions requesting information can be explored if necessary.

This performance indicator measures the average time period the division currently needs to communicate a response to a request for information and policy.

Data Source: Long Term Care Facilities Division data

Objective 3. Reports due to federal administrations will be completed ahead of due date.(Begin typing here.)

Measure: The average time ahead of schedule reports are filed with federal administrators.

Definition: The number of days reports to federal administrators are completed ahead of the scheduled due date.

Rationale: Completing and filing reports to federal administrations ahead of the scheduled due dates avoids crisis decisions and personnel time conflicts.

This performance indicator measures the effectiveness of the division in scheduling the time necessary for completing and filing reports ahead of schedule.

Data Source: Long Term Care Facilities Division data

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Long Term Care Home and Community-Based Services

Program Purpose: This activity is responsible for oversight and administration for home and community-based alternatives to institutional care for individuals in need of long-term care.

The programs administered fall under both medical assistance (MA) and alternative care funding and in addition to being the funding source to counties and providers, this activity develops rules for the providers of services.

Specifically, this activity performs the following functions:

- Administers the traumatic brain injury (TBI) program which provides case management and overall coordination TBI survivors.
- Administers the alternative care (AC) and preadmission screening program, including home health aid services, personal care, respite care, adult day care, case management, nutrition, and caregiver support.
- Oversees efforts to receive waivers within the federal guidelines in order to offer flexibility and efficiency within the state's Medicaid program and it administers and oversees waivered services. Such waivered services are community alternative care (CAC), community alternatives for disabled people (CADI), and the elderly waiver (EW).
- Maintains liaison activity with Department of Health staff to coordinate activities.
- Administers the Seniors' Agenda for Independent Living (SAIL) program. This is a major initiative set on a 20-year time line which has as it goal to create a new community-based care paradigm for long-term care in order to maximize independence of the frail older adult population and to maximize cost-effective use of financial and human resources. Components include: the Living at Home/Block Nurse (LAH/BN) program, coordinating activities under EW and alternative care, a public information campaign, and strategic planning.
- Administers MA home care prior authorization program which uses a staff of contract nurses to carry out advanced screening of potential PA participants for eligibility and determination of care needs.
- Develops long-term care policy related to the above.
- Carries out rulemaking related to the above.
- Administers the program and funding for group residential housing (GRH). This is a major initiative to move funding for GRH out of the GA and MSA programs so that the department can identify and shift certain costs to federally-matched home and community-based service programs.
- Administers the state's Caregiver Support Project and Resource Center, including state and federal grants for caregiver support and respite care projects

Part 2: Program Information (Cont.)

Performance Objectives and Measures:

1. The cost of preadmission screening will decrease.

Measure: The average cost per screening.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

2. The per client cost of private-duty nursing, skilled nursing, home health aide, and personal care services will decrease.

Measure:

The average cost per client for private-duty nursing and personal care services.

The average cost per client for home health aide services.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

3. The Seniors Agenda for Independent Living (SAIL) project will achieve awareness and use of low cost home care and other residential alternatives to nursing homes.

Measure: Number of Alternative Care grants and Elderly Waiver clients.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

4. The SAIL project will develop alternatives to nursing homes to service people needing long term care.

Measure:

Number of licensed Adult Foster Care homes of all types including frail elderly.

Number of frail elderly clients placed in licensed Adult Foster Care Homes.

Number of Alternative Care recipients and Elderly Waiver clients provided with assisted living or home respite services.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			Data not available				
Prior Objectives							

perf-hc.206

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Long Term Care Home and Community-Based Services

Objective 1. The cost of preadmission screening will decrease.

Measure: The average cost per screening.

Definition: Preadmission screening is done by a team consisting of medical and social services representatives. The team evaluates an individual's capacity to remain in a non-institutional setting and what services are required by that individual to remain out of a nursing facility.

Rationale: This performance indicator is a measure of the effort to continue the cost-effectiveness of home care alternatives to living in a nursing facility and the costs associated with making the eligibility determinations.

Data Source: MMIS

Objective 2. The per client cost of private-duty nursing, skilled nursing, home health aide, and personal care services will decrease.

Measure: The average cost per client for private-duty nursing and personal care services.

The average cost per client for home health care services.

Definition: MMIS

Rationale: This performance indicator measures the costs of providing private-duty nursing, personal care services and home health aide services that allow individuals to reside outside a nursing facility.

Data Source: MMIS

Factors Beyond Agency's Control That Affect Performance: Measure for SAIL Program

Objective 3. The Seniors Agenda for Independent Living (SAIL) project will achieve awareness and use of low cost home care and other residential alternatives to nursing homes.

Measure: Number of Alternative Care grants and Elderly Waiver clients.

Definition: Seniors are likely to request services that assist them in overcoming the difficulties of remaining independent when these services are available.

Rationale: The number of seniors requesting and receiving independent living services assists program developers with planning expectations and trends.

Data Source: Human Services Long Term Care subsystem

Part 3: Substantiating the Performance Measures (Cont.)

Objective 4. The SAIL project will develop alternatives to nursing homes to service people needing long term care.

Measure: Number of licensed Adult Foster Care homes of all types including frail elderly.

Number of frail elderly clients placed in licensed Adult Foster Care Homes.

Number of Alternative Care recipients and Elderly Waiver clients provided with assisted living or home respite services.

Definition: Elderly clients in need of alternative care services are occasionally placed in adult foster care homes which are licensed by the Department of Human Services (DHS).

Rationale: The percentage of frail elderly receiving services that assist them in remaining out of nursing facilities identifies the scope of need for alternative care projections.

Data Source: DHS SAIL project data, DHS Aging & Adult Services data

perf-hc.306

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Health Care
Program: Alternative Care Grants/Pre-Admission Screening

Program Purpose: This activity is the vehicle for distributing grants to counties to fund activities which provide alternatives to institutions at a lower cost than institutional care and which maximize options for independent living for people in need of long-term care services.

The activity is a state and county funded activity with counties acting as agents to provide direction to participants and providers. Payment is made on a fee-for-service basis and is made through the same process as that used by Medical Assistance.

Preadmission screening assures that individuals are provided with comprehensive information on their options while also adding responsibility to the funding system by encouraging individuals to seek and enter programs which provide the appropriate level of service in accordance with their needs.

Among the services provided through alternative care grants are the following:

- Respite care at both in-home and approved facilities
- Case management to assure care is provided as appropriate
- Adult day care
- Home health aide services such as assistance with medications
- Personal care services for assistance with needs of daily living such as hygiene
- Home-delivered meals
- Homemaker services to assist in assuring a save living environment
- Companion services to enhance quality of life
- Assisted living for those in need of greater assistance
- Caregiver training and education to provide family or friends with the knowledge and support necessary to adequately care for the participant while also preventing burn out
- Chore service
- Home health nursing for when medical needs require greater attention
- Transportation
- Nutrition services to assure dietary balance

Performance Objectives and Measures:

1. The percentage of light care or low care residents of nursing facilities will decrease.

Measure: Percentage of nursing facility residents who are case-mix A.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	Awaiting outcome of Long Term Care Commission						
Prior Objectives							

Part 2: Program Information (Cont.)

2. The number of pre-admission screenings will increase.

Measure: Number of screenings performed in the fiscal year.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
		Data not available					
Prior Objectives							

3. The alternative care grants activity will be a lower cost alternative at 75% of the costs of institutional care.

Measure:

Average fiscal year expenditure per client in alternative care.

Average length of participation in alternative care.

Average state share of fiscal year expenditure for nursing facility care.

Average length of residence in nursing facility.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual							
		Data not available					
Prior Objectives							

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Health Care
Program: Alternative Care Grants/Pre-Admission Screening

Objective 1. The percentage of light care or low care residents of nursing facilities will decrease.

Measure: Percentage of nursing facility residents who are case-mix A.

Definition: Residents requiring low or light care in facilities are given a case-mix code of A in a range from A through K, with K level patients requiring the most intensive facility service.

Rationale: In many cases, cost savings are realized when home care services are provided instead of institutional services, lessening the state and local financial cost of providing institutional care.

This performance indicator is a measure of the number of individuals who could potentially be admitted to a nursing facility without the provision of home care services.

Data Source: Nursing Facilities, Preadmission Screening data

Objective 2. The number of pre-admission screenings will increase.

Measure: Number of screenings performed in the fiscal year.

Definition: Preadmission screenings determine the potential of an individual to remain in the community in his/her current environment and the kinds and degree of services required by the individual to continue to live independently.

Rationale: This performance indicator is a measure of the intensity of the program focus on preadmission screenings designed to increase the numbers of individuals capable of remaining independent.

Data Source: PreAdmission Screening data

Objective 3. The alternative care grants activity will be a lower cost alternative at 75% of the costs of institutional care.

Measure: Average fiscal year expenditure per client in alternative care.

Average length of participation in alternative care.

Average state share of fiscal year expenditure for nursing facility care.

Average length of residence in nursing facility.

Definition: ACG funds insure the financial viability of a client being able to remain in the community.

Rationale: This performance indicator measure the cost-effectiveness of maintaining individuals in their own homes or in noninstitutional settings by providing alternative home care services.

Data Source: Preadmission Screenings

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Mental Health Administration

Program Purpose: This program funds most of the staff and administrative costs of the Mental Health Division. The division is responsible for statewide implementation of the Comprehensive Adult and Children's Mental Health Acts, assuring high quality, cost-effective, and efficient services to persons with mental illness in Minnesota, with particular concern for the approximately 32,000 adults with serious and persistent mental illness and 57,000 children with severe emotional disturbance. The program performs five primary functions:

- Setting quality standards for mental health services,
- Developing and allocating resources to counties for provision of services,
- Monitoring key indicators of service provision,
- Providing technical assistance and consultation to counties and providers, and
- Planning a statewide system.

A key focus of these functions, which addresses one of the goals of the Department, is integration of service delivery systems.

To accomplish its responsibilities, the Mental Health Division works with counties, regional treatment centers, other state agencies, advocacy organizations, consumer groups, and a variety of community-based programs to assure provision of a quality array of services for persons with mental illness. The Division reviews and approves county mental health plans and grant applications, as required by the Comprehensive Mental Health Acts. The Division administers grants relating to community residential treatment, community support services, family community support services, and federal block grant funds, as well as special project grants. The division is also responsible for measuring effectiveness of grant programs, gathering and analyzing client outcome data, and working with counties and facilities to ensure fiscal accountability of grant funds. The Division actively seeks additional federal funding for mental health services.

The Mental Health Division has worked with other DHS divisions to develop an information system for monitoring mental health service delivery in the counties. The system reports a wide range of information, such as numbers of clients served and amount of mental health services received by particular groups of clients. This information system collects data from over 400 state-funded programs. All counties receive copies of the system's periodic reports for local planning and program evaluation purposes.

In addition to the Mental Health Division, the Residential Programs Management Division (for regional treatment centers and other state-operated services) and the Health Care Administration (MA/GAMC) also administer mental health funds. The Department has increased the extent of collaboration among these 3 divisions, in particular through joint projects, routine discussions of issues, and exchanges of data.

The Division also participates in numerous inter-departmental work groups to ensure coordination of its efforts with other affected parties. This includes the Departments of Education, Jobs and Training, Housing Finance, Health, Corrections, and others.

Part 2: Program Information (Cont.)

Performance Objectives and Measures:

{The following objectives assume no significant change in inflation-adjusted level of funding from year to year.}

1. A statewide mental health plan that meets federal requirements for funding and that reflects the goals and values of the Comprehensive Mental Health Acts.

Measure: A state mental health plan approved by the federal government (SAMHSA) for the years 1994 and 1995.

Plans approved for 1990, 1991, 1992, and 1993. Plan for 1994 will be submitted in January 1994.

2. Coordinated systems of care for adults and children in most counties, which include integration of mental health funding streams.

Measure: Number of counties with integrated funding for mental health services.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Adults	0	0	0	0	3	5	50
Children	0	0	0	0	0	5	50

3. Simplified state grant application process for counties.

Measure: Number of grants to counties for mental health services.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Adults	210	228	230	285	330	244	150
Children	0	53	53	162	194	103	100

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Mental Health Administration

Objective 1. A statewide mental health plan that meets federal requirements for funding and that reflects the goals and values of the Comprehensive Mental Health Acts.

Measure: A state mental health plan approved by the federal government (SAMHSA) for the years 1994 and 1995.

Definition: This objective aims to meet the planning expectations of both the federal agency that provides the state with its mental health block grant, and the state legislature. The plan must be updated by the Mental Health Division, and reapproved by the federal agency, each year.

Rationale: To meet this objective the plan must be approved by the federal agency. The state legislature does not approve the plan; however, it does monitor progress through an annual report it receives from the Division.

Data Source: The Division will receive a letter from the federal agency, which indicates approval or nonapproval.

Factors Beyond Agency's Control That Affect Performance: The Mental Health Division establishes plan objectives that take into account any foreseeable factors that could affect attainment of those objectives. Nevertheless, reductions in funding or staffing, or decisions by counties (local authorities) to not attempt to comply with state objectives, could result in lower attainment.

Objective 2. Coordinated systems of care for adults and children in all counties, which include integration of mental health funding streams.

Measure: Number of counties with integrated funding for mental health services.

Definition: Coordinated systems of care are defined somewhat differently for adults and children. Coordination in local adult systems means the unification of the mental health service delivery system by such means as integrated funding, case management, and single point of entry. In children's systems, coordination includes these factors, but also extends beyond the mental health system to the education, health, corrections, and social services systems. The Division relies on the demonstration approach to implementation, in which coordination mechanisms are tested in one or more counties before being expanded statewide through additional legislation or standards. Currently, there are five adult mental health demonstration projects, and applications from 21 counties to demonstrate children's mental health collaboratives.

Rationale: Although there may be differences from county to county in the form or function of coordination, one essential component is integration of funding that allows dollars to follow clients. For adult systems, most or all mental health funds should be integrated; for children's systems, mental health funds should be integrated with education, health, corrections, and social services funding for mental health problems.

Data Source: The Division will approve all coordinated systems through the local planning process.

Factors Beyond Agency's Control That Affect Performance: Funding reductions, or decisions by counties to not participate in coordination of services, could affect the rate of implementation of these systems. Health care reform could significantly affect the ways in which coordinated systems are configured, and could dictate the implementation schedule.

Part 3: Substantiating the Performance Measures (Cont.)

Objective 3. Simplified state grant process for counties.

Measure: Number of grants to counties for mental health services.

Definition: Along with integration of funding for local systems of care, applications for this funding will also be consolidated. Although this process was begun in 1993, with consolidation of several funds for community services, many counties were still developing their systems of care and were in need of additional grants. This expansion of the services system accounts for the rise in the number of grants from 1990 through 1994. The 1994 figures constitute the baseline for this objective of reducing the total number of grants through grant consolidation.

Rationale: Once all counties are receiving the grants they need to implement a full array of services, consolidation of grants will begin to be measurable in the overall count of awards.

Data Source: Grant award letters.

Factors Beyond Agency's Control That Affect Performance: Legislative decisions that continue categorical funding for certain mental health services could prevent accomplishment of this objective.

perf-so.301

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Adult Mental Health

Program Purpose: The purpose of the adult mental health program is to assist local public mental health authorities and local public systems of care in improving the mental health of their adult populations. This assistance takes the forms of funding, standard setting and policy development, planning, and technical assistance and consultation. Of particular interest is the mental health of adults with serious and persistent mental illness (SMI), who number approximately 32,000. A large percentage of this population needs mental health services through the public system.

(NOTE: Methods for estimating the size of the SMI target population are likely to change in 1994 or 1995, and this, in turn, is likely to affect future objectives. Also likely to affect objectives for the year 2000 are increases in general population size and health care reform. None of these factors are accounted for in the objectives given below.)

Other special populations for which this program provides services include: a) compulsive gamblers, b) homeless persons, c) nursing facility residents, d) racial and cultural minorities within the target populations, e) persons with dual diagnoses, and f) persons with psychopathic personalities.

FIGURE 1: Services to be Available in Each County

Mental Health Services to Adults

- Emergency Services
- Education and Prevention
- Outpatient Treatment
- Community Support Services
- Case Management
- Community Residential Treatment
- Day Treatment
- RTC Inpatient Treatment
- Acute Care Hospital Inpatient Treatment

The goal of the program is implementation of the Adult Comprehensive Mental Health Act (Minnesota Statutes 245.461 through 245.4861).

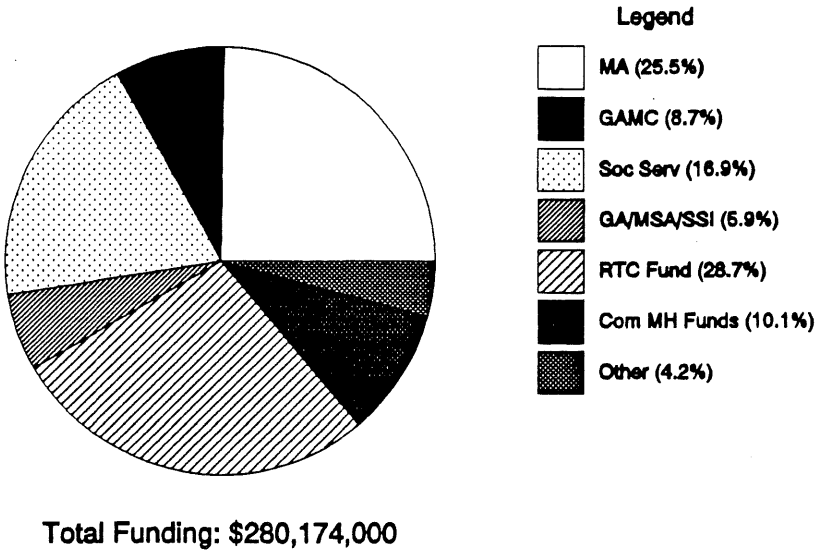
Accomplishment of this goal entails provision of a full array of quality mental health services to the residents of each county. These services are listed in Figure 1. The central intent of the Adult Mental Health Act is to provide the services people need, in settings that maximize personal independence and promote integration into the general community. This often means increased reliance on community-based services and decreased reliance on the more costly and restrictive inpatient and residential services. This reflects one of the Department's strategic goals: reduction in the number of persons with menal illness who are at risk of institutional placement.

Most of the services in Figure 1 are provided by organizations contracted by counties (the local mental health authorities); although some counties provide some of these services directly. The provider organizations include community mental health centers (CMHCs), state-operated regional treatment centers (RTCs), residential treatment facilities, and outpatient clinics. The majority of services are provided by the CMHCs.

The main sources of funding for adult mental health services are shown in the pie chart in Figure 2. These sources compose the "public funding" segment administered by the Department of Human Services and county agencies. The chart indicates the percentage of total funding coming from each source. About 57% of funding is for inpatient treatment, most of this in the RTCs; while about 40% is for community-based services, including residential treatment, outpatient treatment, and community support services.

In many counties, the adult mental health system is still in a developmental period, particularly in regard to nonresidential, community-based services. For this reason, some objectives are developmental in nature--in other words, they focus on development of the *system* of care rather than on client outcomes.

FIGURE 2: Percent of SFY 1993 Funding From Each Source: Adults



Total Funding: $280,174,000

Performance Objectives and Measures:

{The following objectives assume no significant change in inflation-adjusted level of funding from year to year.}

1. Adult services not yet available to the residents of each county will be available by 1995.

Measure: Number of counties providing each service.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Case Management							
Actual	N/A	82	85				
Prior Objective			87	87	87	87	87
CSP* or Day Treatment							
Actual	N/A	84	85				
Prior Objective			87	87	87	87	87
Emergency Services							
Actual	N/A	N/A	N/A				
Prior Objective			87	87	87	87	87

* Community support program services.

Part 2: Program Information (Cont.)

2. Adult services are provided at a level equal to the estimated level of need in the target population.

Measure: Number of adults with SMI receiving each service.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Case Management							
Actual	N/A	8,300	9,050				
Prior Objective				9,500	10,000	10,500	12,800
CSP* or Day Treatment							
Actual	8,500	10,100	11,200				
Prior Objective				12,000	12,500	12,500	12,800
Residential Treatment							
Actual	2,750	2,600	2,600				
Prior Objective				2,650	2,600	2,500	2,000
Community Inpatient Trmt.							
Actual	4,000	3,900	4,500				
Prior Objective				4,500	4,500	4,000	3,000
RTC Inpatient Treatment							
Actual	3,400	3,350	3,450				
Prior Objective				3,400	3,300	3,000	2,500

*Community support program services

3. Use of Medical Assistance to pay for adult community services will be maximized by 2000.

Measure: Percent of total public expenditures for each service that are paid by Medical Assistance.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Case Management							
Actual	11%	15%	16%	16%			
Prior Objective					17%	20%	40%
CSP/Day Trmt/PCA*							
Actual	N/A	N/A	26%	26%			
Prior Objective					25%	25%	25%

*Personal Care Attendant

4. Adult community support services achieve high levels of effectiveness.

Measure: Percent of CSP clients with program satisfaction, level of function, and quality of life scores of four or higher on five-point measurement scales.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Satisfaction							
Actual	N/A	N/A	N/A	N/A			
Objective					40%	50%	75%
Functioning							
Actual	N/A	N/A	N/A	N/A			
Objective					30%	40%	75%
Quality of Life							
Actual	N/A	N/A	N/A	N/A			
Objective					30%	40%	75%

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Adult Mental Health

Objective 1. Adult services not yet available to the residents of each county will be available by 1995.

Measure: Number of counties providing each service.

Definition: Although some of the array of services defined in the Adult Mental Health Act are already available in each county, some are not. This objective aims to ensure that the *full* array is available in all 87 counties.

Rationale: The measure is a straightforward count of the number or counties in which adults are receiving the specified service. The count, however, defines an "available" service as one that is being provided to at least 5 adults per 10,000 adult population. Services provided below this level are, in effect, not truly available.

Data Source: Data are taken from two sources: a) the Community Mental Health Reporting System (CMHRS), and b) the Medicaid Management Information System (MMIS). Data in the CMHRS are reported semi-annually by counties and providers, and are largely in the form of client-specific records. Data in the MMIS are from claims submitted by MA providers. Although the CMHRS contains some of the clients and services submitted with MMIS claims, it does not contain all of these clients and services; therefore, the MMIS data are used to supplement the CMHRS data where necessary.

Factors Beyond Agency's Control That Affect Performance: Because the mental health system is primarily a collection of local (county) systems, with supporting and supervisory functions at the state level, operational control is in the hands of counties, which at times elect not to abide by state mandates. Budget constraints are a commonly cited reason for lack of compliance. Although the state agency has statutory authority to compel compliance through withholding of funding, it is the clients who stand to lose most in such a situation. The state agency, therefore, relies on provision of technical assistance and consultation in trying to resolve compliance problems.

Limits on state funding also affect the extent to which these objectives can be achieved. Although the Legislature passed the Adult Mental Health Act that specifies requirements for local systems of care, it did not authorize all of the funding needed to fully implement this system. Accomplishment of objectives depends to a significant extent on shifting state funding away from regional treatment center (RTC) inpatient treatment into community-based services and on increasing federal funding.

Objective 2. Adult services are provided at a level equal to the estimated level of need in the target population.

Measure: Number of adults receiving each service.

Definition: A major goal or the Adult Mental Health Act is to increase reliance on nonresidential, community-based services and to decrease reliance on inpatient and residential services. These trends can be monitored by measuring the extent to which all major services are meeting estimates of need. The more of the serious and persistent mental illness (SMI) target population who are receiving quality community-based treatment and support services, the fewer will develop crises that require hospitalization or residential treatment. Table 1, below, shows estimates of need for each service. The levels of need are computed in various ways, which are further explained in the Department's annual *Mental Health Report to the Legislature*; however, the levels of need in that report pertain to current levels, whereas levels for the year 2000 reflect increases in population size and are subject to other factors such as health care reform.

Rationale: Since level of service need is defined as the number of persons receiving the service, based on prevalence rates, the measure is a simple count of these persons.

Part 3: Substantiating the Performance Measures (Cont.)

Data Source: The CMHRS and MMIS

Factors Beyond Agency's Control That Affect Performance: See discussion under Objective (1). Another factor that will affect these measures is new methodologies, mandated by the federal government, for estimating the prevalence of SMI. These methodologies are anticipated during 1994 or 1995, and they could result in either higher or lower estimates of need.

TABLE 1: Statewide Service Need, Utilization, and Unmet Need: Adults

Service	SMI Est. Need
CSP/Day Treatment*	12,800
Case Management	12,800
Outpatient Treatment	15,300
Community Residential Treatment	1,500
Community Inpatient Treatment	2,200
RTC Inpatient Treatment	2,500
TOTALS (unduplicated)**	24,000

*Community Support Program Services

**The SMI estimated need figure is based on 75% of prevalence being public sector clients

Objective 3. Use of Medical Assistance to pay for adult community services will be maximized by 2000.

Measure: Percent of total public expenditures for each service that are paid by Medical Assistance.

Definition: Use of Medical Assistance to pay for services has several effects. First, it increases overall funding for the system. Second, it increases the percentage of total funding that comes from the federal government rather than from state and local governments. Third, it provides an incentive for counties to provide the service, since it is paid by nonlocal funds. Fourth, it increases the funding for community-based services.

Rationale:

Data Source: MMIS

Factors Beyond Agency's Control That Affect Performance: See discussion under Objective (1).

Part 3: Substantiating the Performance Measures (Cont.)

Objective 4. Adult community support services achieve high levels of effectiveness.

Measure: Percent of CSP clients with program satisfaction, level of function, and quality of life scores of "four" or higher on five-point measurement scales.

Definition: In order for the shift toward community-based services to be justifiable, these services must meet client needs.

Rationale: Three ways of measuring whether client needs have been met are: a) the client's satisfaction with the personal changes that services have brought about, b) the client's level of functioning, and c) the client's quality of life. The Mental Health Division has developed (and validated) several measurement tools (client survey forms) for obtaining these measures and will implement these forms in 1994.

Data Source: New Consumer Outcome Survey.

Factors Beyond Agency's Control That Affect Performance: The state agency will rely on counties and providers to serve as intermediaries in the data collection system, and accuracy of measurement will depend on adherence to data collection procedures.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Children's Mental Health

Program Purpose: The purpose of the children's mental health program is to assist local public mental health authorities and local public systems of care in improving the mental health of children in their populations. This assistance takes the forms of funding, standard setting and policy development, planning, and technical assistance and consultation. Of particular interest is the mental health of children with severe emotional disturbance (SED), who number about 57,000. A large percentage of this population needs mental health services through the public system. Also of great interest is the integration of mental health services across the education, corrections, health, mental health, and social services systems.

(NOTE: Methods for estimating the size of the SED population are likely to change in 1994 or 1995, and this, in turn, is likely to affect future objectives. Also likely to affect objectives for the year 2000 are increases in general population size and health care reform. None of these factors are accounted for in the objectives given below.)

Other special populations for which this program provides services include: a) racial and cultural minorities within the target population and b) children with dual diagnoses.

The goal of the program is implementation of the Children's Comprehensive Mental Health Act (Minnesota Statutes 245.487 through 245.4887).

FIGURE 3: Services to be Available in Each County

Mental Health Services to Children

- Emergency Services
- Education and Prevention
- Outpatient Treatment
- Case Management
- Early Identification and Intervention
- Therapeutic Foster Care
- Professional Home-Based Family Treatment
- Family Community Support
- Community Residential Treatment
- Day Treatment
- RTC Inpatient Treatment
- Acute Care Hospital Inpatient Treatment

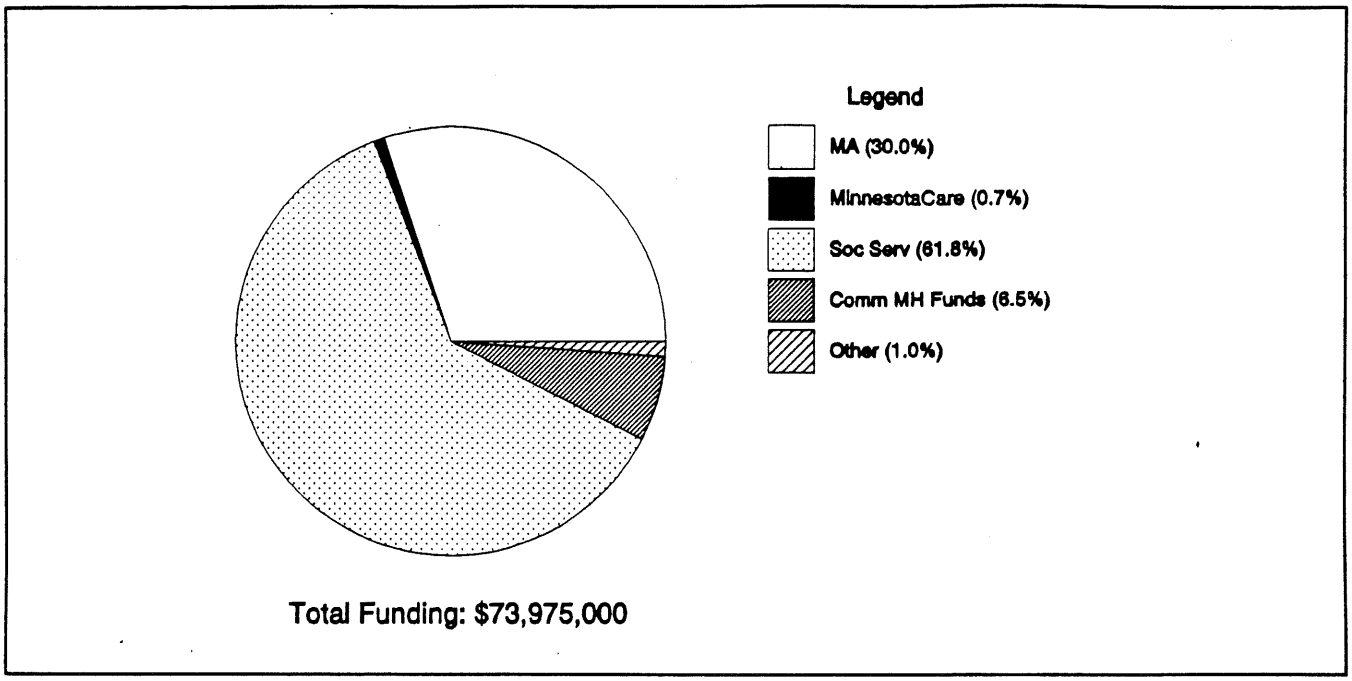
Accomplishment of this goal entails provision of a full array of quality mental health services to the residents of each county. These services are listed in Figure 3. The central intent of the Children's Mental Health Act is to provide the services people need, in settings that maximize personal independence and promote integration into the general community. This often means increased reliance on community-based services and decreased reliance on the more costly and restrictive inpatient and residential services.

Most of the services in Figure 3 are provided by organizations contracted by counties (the local mental health authorities); although some counties provide some of these services directly. The provider organizations include community mental health centers (CMHCs), state-operated regional treatment centers (RTCs), residential treatment facilities, and outpatient clinics. The majority of services are provided by the CMHCs.

The main sources of funding for mental health services are shown in the pie chart in Figure 4. These sources compose the "public funding" segment administered by the Department of Human Services and county agencies. The chart indicates the percentage of total funding coming from each source. The largest expenditure for children is for community residential treatment. Inpatient treatment accounts for only 19% of expenditures.

In all counties, the children's mental health system is still in a developmental period, particularly in regard to nonresidential, community-based services. For this reason, some objectives are developmental in nature--in other words, they focus on development of the *system* of care rather than on client outcomes. One focal aspect of development is toward integration of service delivery among all local agencies providing mental health services to children. This focus reflects one of the Department's strategic goals. The Department's emphasis on children's health is reflected throughout the objectives of this program.

FIGURE 4: Percent of SFY 1993 Funding From Each Source: Children



Performance Objectives and Measures:

{The following objectives assume no significant change in inflation-adjusted level of funding from year to year.}

1. Children's services not yet available to the residents of each county will be available by 1995.

Measure: Number of counties providing each service.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Case Management							
Actual	N/A	21	62	65			
Objective					75	80	87
FCSS* or Day Treatment							
Actual	N/A	17	52	65			
Objective					75	80	87
Emergency Services							
Actual	N/A	N/A	N/A	N/A			
Objective					87	87	87

*Family community support services.

Part 2: Program Information (Cont.)

2. Children's services are provided at a level equal to the estimated level of need in the target population.

Measure: Number of children with SED receiving each service.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Case Management							
Actual	N/A	320	750				
Prior Objective				1,000	1,200	1,500	4,000
FCSS or Day Treatment							
Actual	N/A	400	750				
Prior Objective				1,000	1,300	1,800	3,500
Home-Based Treatment							
Actual	N/A	N/A	300				
Prior Objective				500	600	800	2,000
Residential Treatment							
Actual	1,500	1,500	1,300				
Prior Objective				1,250	1,200	1,100	500
Inpatient Treatment *							
Actual	800	800	950				
Prior Objective				900	900	950	1000

* Includes both RTC inpatient and community hospital inpatient treatment.

3. Use of Medical Assistance to pay for children's community services will be maximized by 2000.

Measure: Percent of total public expenditures for each service that are paid by Medical Assistance.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Case Management							
Actual	0	2%	4%	6%			
Prior Objective					8%	15%	25%
FCSS/Day Trmt/PCA*							
Actual	N/A	N/A	28%	18%			
Prior Objective					20%	22%	25%
Home-Based Treatment							
Actual			NA	29%			
Prior Objective					30%	32%	35%

* Personal Care Attendant (decreased by $300,000 from FY92 to FY93).

Part 2: Program Information (Cont.)

4. Family community support services achieve high levels of effectiveness.

Measure: Percent of FCSS clients with program satisfaction, level of function, and quality of life scores of four or higher on five-point measurement scales.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Satisfaction							
Actual	N/A	N/A	N/A	N/A			
Prior Objective					40%	50%	75%
Functioning							
Actual	N/A	N/A	N/A	N/A			
Prior Objective					30%	40%	75%
Quality of Life							
Actual	N/A	N/A	N/A	N/A			
Prior Objective					30%	40%	75%

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Children's Mental Health

Objective 1. Children's services not yet available to the residents of each county will be available by 1995.

Measure: Number of counties providing each service.

Definition: Although some of the array of services defined in the Children's Mental Health Act are already available in each county, some are not. This objective aims to ensure that the *full* array is available in all 87 counties.

Rationale: The measure is a straightforward count of the number of counties in which children are receiving the specified service. The count, however, defines an "available" service as one that is being provided to at least 5 children per 10,000 child population. Services provided below this level are, in effect, not truly available.

Data Source: Data are taken from two sources: a) the Community Mental Health Reporting System (CMHRS), and b) the Medicaid Management Information System (MMIS). Data in the CMHRS are reported semi-annually by counties and providers, and are largely in the form of client-specific records. Data in the MMIS are from claims submitted by MA providers. Although the CMHRS contains some of the clients and services submitted with MMIS claims, it does not contain all of these clients and services; therefore, the MMIS data are used to supplement the CMHRS data where necessary.

Factors Beyond Agency's Control That Affect Performance: Because the mental health system is primarily a collection of local (county) systems, with supporting and supervisory functions at the state level, operational control is in the hands of counties, which at times elect not to abide by state mandates. Budget constraints are a commonly cited reason for lack of compliance. Although the state agency has statutory authority to compel compliance through withholding of funding, it is the clients who stand to lose most in such a situation. The state agency, therefore, relies on provision of technical assistance and consultation in trying to resolve compliance problems.

Limits on state funding also affect the extent to which these objectives can be achieved. Although the Legislature passed the Children's Mental Health Act that specifies requirements for local systems of care, it did not authorize all of the funding needed to fully implement these systems. Accomplishment of objectives depends to a significant extent on efforts to increase overall funding, which is far short of what is needed for full implementation of the Act; however, most additional funding has come in relatively small amounts from federal, not state, sources.

Objective 2. Children's services are provided at a level equal to the estimated level of need in the target population.

Measure: Number of children with SED receiving each service.

Definition: A major goal of the Mental Health Act is to increase reliance on community-based and home-based services, and to decrease reliance on inpatient and residential services. This trend can be monitored by measuring the extent to which the community-based and home-based services are penetrating the target population. The more of this population who are receiving quality community-based treatment and support services, the fewer will develop crises that require hospitalization or residential treatment.

The levels of need for each service are defined here as the number of children in the target population who need the service. These levels of need are shown in Table 2 below. The levels of need are computed in various ways, which are further explained in the annual *Mental Health Report to the Legislature*; however, the levels of need in that report pertain to current levels, whereas levels for the year 2000 reflect increases in population size and are subject to other factors such as health care reform.

(Note that inpatient treatment encompasses both RTC and community hospital inpatient. Children actually account for very few of the RTC patient population.)

Rationale: The measure is a straightforward count of the number of children with SED who receive each service. It is expected that the number of children in the system of care will increase significantly by the year 2000, so although the absolute number of children in inpatient treatment may increase, the percentage of child clients in inpatient treatment will decrease.

Data Source: The CMHRS and MMIS.

Factors Beyond Agency's Control That Affect Performance: See discussion under Objective (1). Another factor that will affect these measures is new methodologies, mandated by the federal government, for estimating the prevalence of SED. These methodologies are anticipated during 1994 or 1995, and they could result in either higher or lower estimates of need.

TABLE 2: Statewide Service Need, Utilization, and Unmet Need: Children

Service	SED Est. Need
Family Community Support *	2,800
Day Treatment	2,800
Case Management	5,100
Professional Home-Based Treatment	2,800
Therapeutic Support/Foster Care	1,100
Outpatient Treatment	20,000
Community Residential Treatment	150
Inpatient Treatment	1,000
TOTALS (unduplicated) **	26,000

* FCSS other than day treatment, professional home-based treatment, therapeutic support.

** The SED estimated need figures are based on 50% of SED prevalence being public sector clients.

Objective 3. Use of Medical Assistance to pay for children's community services will be maximized by 2000.

Measure: Percent of total public expenditures for each service that are paid by Medical Assistance.

Definition: Use of Medical Assistance to pay for services has several effects. First, it increases overall funding for the system. Second, it increases the percentage of total funding that comes from the federal government rather than from state and local governments. Third, it provides an incentive for counties to provide the service, since it is paid by nonlocal funds. Fourth, it increases the funding for community-based services.

Rationale:

Data Source: MMIS.

Factors Beyond Agency's Control That Affect Performance: See discussion under Objective (1).

Part 3: Substantiating the Performance Measures (Cont.)

Objective 4. Family community support services achieve high levels of effectiveness.

Measure: Percent of FCSS clients with program satisfaction, level of function, and quality of life scores of "four" or higher on five-point measurement scales.

Definition: In order for the shift toward community-based and home-based services to be justifiable, these services must meet client needs.

Rationale: Three ways of measuring whether client needs have been met are: a) the client's (or family's) satisfaction with the changes that services have brought about, b) the client's level of functioning, and c) the client's quality of life. The Mental Health Division is developing several measurement tools (client and family survey forms) for obtaining these measures, and will implement these forms in 1995.

Data Source: New Consumer Outcome Survey.

Factors Beyond Agency's Control That Affect Performance: The state agency will rely on counties and providers to serve as intermediaries in the data collection system, and accuracy of measurement will depend on adherence to data collection procedures.

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Regional Treatment Centers Administration

Program Purpose: The purpose of this program is to provide administrative and programmatic support for the 9 regional treatment centers (RTCs). The programs offered at each of these facilities are shown in Table 1.

Although there is a prevailing service philosophy favoring reduction of RTC inpatient treatment, a continuing role for the RTCs in community-based services is foreseen. The Moose Lake RTC Project, which involves a reduction in RTC MI beds in the Moose Lake region, along with other pilot projects in the state, represent a demonstration of the feasibility of this new role. Until this feasibility is established, *projections beyond 1995 are premature.*

(Note that although closure of the Moose Lake facility will occur in 1995, opening of a new facility for persons with psychopathic personalities during the same year will result in no net change in the number of licensed or accredited facilities.)

Performance Objectives and Measures:

(*These are "maintenance objectives," aimed at maintaining current levels of performance.*)

1. Uniform and effective management of human and fiscal resources.

Measure: Number of RTCs fully licensed.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	9	9	9	9	9	9	

2. Quality care.

Measure: Number of RTCs accredited through JCAHO or CARF.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
JCAHO	6	6	6	6	6	6	
CARF	1	1	1	1	1	1	

3. Timely Jarvis hearings.

Measure: Number of MI client Jarvis hearings occurring at the time of initial commitment hearing.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			100	200	200	200	

Table 1: Regional Treatment Center Programs

Regional Treatment Center	Programs
Ah-Gwah-Ching	Chemical Dependency Geriatric
Anoka Metro	Chemical Dependency Mental Health
Brainerd	Chemical Dependency Developmental Disabilities Mental Health Geriatric
Cambridge	Developmental Disabilities
Faribault	Developmental Disabilities
Fergus Falls	Chemical Dependency Developmental Disabilities Mental Health
Moose Lake	Chemical Dependency Developmental Disabilities Mental Health
St. Peter	Chemical Dependency Developmental Disabilities Mental Health Forensic
Willmar	Chemical Dependency Mental Health Developmental Disabilities

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Regional Treatment Center Administration

Objective 1. Uniform and effective management of human, fiscal, and informational resources.

Measure: Number of RTCs fully licensed.

Definition: This objective aims to establish uniform policies and procedures across all the RTCs, which ensure efficient and cost-effective use of resources, as well as comparable information.

Rationale: The measure is a global indicator of the quality of resource management. Each RTC is responsible for meeting licensing standards from a variety of sources, including the Department of Health and the Department of Human Services. Each RTC is expected to meet all licensure standards pertaining to the services it provides.

Data Source: Notification of licensure.

Factors Beyond Agency's Control That Affect Performance: (None specified.)

Objective 2. Quality care.

Measure: Number of RTCs accredited through JCAHO or CARF.

Definition: Persons admitted to an RTC program should expect the highest quality of care the state can provide. The JCAHO accreditation process involves assurances of quality care.

Rationale: Each RTC must obtain JCAHO or CARF accreditation where applicable.

Data Source: Notification of accreditation findings.

Factors Beyond Agency's Control That Affect Performance: (None specified.)

Objective 3. Timely Jarvis hearings.

Measure: Number of MI client Jarvis hearings occurring at the time of initial commitment hearing.

Definition: Jarvis hearings are to determine whether a person committed to an RTC for mental illness has a legal right to refuse medication. In the best interests of the committed patient, the Jarvis hearing should take place at the time of the initial commitment hearing.

Rationale: The measure is a straightforward count of the number of Jarvis hearings that occur simultaneously with the initial commitment hearing. This is a "maintenance objective," aimed at maintaining the current level of performance in future years.

Data Source: Jarvis coordinators at individual RTCs.

Factors Beyond Agency's Control That Affect Performance: (None specified.)

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ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Regional Treatment Centers Direct Services

Program Purpose: The purpose of the treatment program is to provide active treatment consistent with industry standards and state/federal regulations for persons with mental illness, developmental disabilities, chemical dependency, and elderly persons who have complex medical conditions and challenging behaviors requiring a nursing home setting. The objective is to complement program alternatives in the facility's service area by assisting individuals make documented progress toward personal habilitative or rehabilitative goals, which are necessary for their successful reintegration into normal community life.

In addition to inpatient treatment, the RTC system also provides crisis intervention services, transitional services, and community-support services. Objectives for these services are currently under development and will be added to future reports.

Representatives of the RTCs and the central office of the Department are currently developing a system for measuring performance in RTC programs. This effort has developed over 40 draft performance objectives that, when final, will apply statewide as well as to each facility. This year's performance report contains only seven of these objectives, those related most closely to client outcomes. However, the committee responsible for developing the RTC performance measurement system has agreed that these objectives alone are inadequate and potentially misleading, that multiple objectives and measures are needed to construct an accurate picture of performance. More objectives and measures will be added to this report in 1994.

Because these performance measures are new, there is *no data history*. Because there are no baselines, targets for 1994, 1995, and 2000 are not yet established. 1995 will be the baseline year for most objectives.

Performance Objectives and Measures:

1. Improved mental and behavioral functioning that allows geriatric patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 60 days of discharge.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
	N/A	N/A	N/A	N/A			

2. Improved mental and behavioral functioning that allows forensic patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 6 months of discharge.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	N/A	N/A	N/A	N/A			

Part 2: Program Information (Cont.)

3. Improved mental and behavioral functioning that allows patients with psychopathic personalities to live in a less restrictive setting.

Measure: Number of arrests and convictions per 100 discharge-months.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Arrests	N/A	N/A	N/A	N/A			
Convictions	N/A	N/A	N/A	N/A			

4. Improved mental and behavioral functioning that allows mentally ill patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 60 days of discharge.

				Objectives		
F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
N/A	N/A	N/A	N/A			

5. Long-term sobriety among chemical dependency patients.

Measure: Percent of discharges who report sobriety at 6 months post-discharge.

				Objectives		
F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
N/A	N/A	N/A	N/A			

6. Improved functioning that allows developmentally disabled patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 90 days of discharge.

				Objectives		
F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
N/A	N/A	N/A	N/A			

7. Improved emotional and behavioral functioning that allows child and adolescent patients to live in the home or other community setting.

Measure: Percent of readmissions to the RTC system within 60 days of discharge.

				Objectives		
F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
N/A	N/A	N/A	N/A			

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Regional Treatment Center Direct Services

Objective 1. Improved mental and behavioral functioning that allows geriatric patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 60 days of discharge.

Definition: The aim of treatment for this patient population is improved functioning that will allow discharge to the home or other community (non-inpatient) setting, with the prospect that the patient will be able to maintain that level of functioning and remain in the community for a significant period of time. The population to which this objective applies are discharges from inpatient treatment.

Rationale: A 60-day post-discharge period for identifying readmissions is chosen in part for practical reasons. Follow up data collection is costly, and contact with clients is more difficult to maintain over longer periods of time. Note that the measure refers to readmission to the *RTC system*, not readmission to any type of similar program, such as a nursing facility or community hospital. The percentage will be computed on the basis of the number of discharges for whom data are available, not on the actual number of discharges.

Data Source: HSIS (a uniform information system to be implemented in all RTCs by the end of 1994).

Factors Beyond Agency's Control That Affect Performance: Exposure to new, stressful events or circumstances outside the scope of treatment and other services offered by the system can result in readmission. Some forms of mental and behavioral disfunction are periodic in nature and are therefore likely to involve recurrent critical episodes, even in the absence of extrinsic factors. Absence of social supports, such as training in independent living skills, medication monitoring, etc. will increase the likelihood of readmission.

Objective 2. Improved mental and behavioral functioning that allows forensic patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 6 months of discharge.

Definition: See Objective (1).

Rationale: A 6-month post-discharge period is selected for the same reasons cited under Objective (1).

Data Source: See Objective (1).

Factors Beyond Agency's Control That Affect Performance: See Objective (1).

Objective 3. Improved mental and behavioral functioning that allows patients with psychopathic personalities to live in a less restrictive setting.

Measure: Number of arrests and convictions per 100 discharge-months.

Definition: See Objective (1).

Rationale: The rate of arrests and convictions among this group of discharges is measured in terms of discharge-months, which is a more sensitive measure than percent of discharges who experience arrest and conviction.

Data Source: See Objective (1).

Factors Beyond Agency's Control That Affect Performance: See Objective (1).

Objective 4. Improved mental and behavioral functioning that allows mentally ill patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 60 days of discharge.

Definition: See Objective (1).

Rationale: See Objective (1).

Data Source: See Objective (1)

Factors Beyond Agency's Control That Affect Performance: See Objective (1).

Objective 5. Long-term sobriety among chemical dependency patients.

Measure: Percent of discharges who report sobriety at 6 months post-discharge.

Definition: Sobriety is widely viewed as a reliable indicator of successful treatment for this population.

Rationale: The length of time that a discharge remains sober following treatment is a quantitative measure of the success of the program of treatment. The six-month period of assessment is chosen because it represents a significant length of sobriety, and because follow up with discharges is still feasible.

Data Source: See Objective (1)

Factors Beyond Agency's Control That Affect Performance: See Objective (1).

Objective 6. Improved functioning that allows developmentally disabled patients to live in a less restrictive setting.

Measure: Percent of readmissions to the RTC system within 90 days of discharge.

Definition: See Objective (1).

Rationale: See Objective (1).

Data Source: See Objective (1)

Factors Beyond Agency's Control That Affect Performance: See Objective (1).

Objective 7. Improved emotional and behavioral functioning that allows child and adolescent patients to live in the home or other community setting.

Measure: Percent of readmissions to the RTC system within 60 days of discharge.

Definition: See Objective (1).

Rationale: See Objective (1).

Data Source: See Objective (1)

Factors Beyond Agency's Control That Affect Performance: See Objective (1).

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Developmental Disability

Program Purpose: This program supports the deinstitutionalization policy of the state for persons with developmental disabilities (DD). The program consists of three components:

- Community Support Services,
- State-Operated Community Residential Services, and
- State-Operated Day Treatment and Habilitation Services.

All regional treatment center developmental disability programs operate community support services. These services include technical support for persons at risk of regional treatment center (RTC) placement. The technical support includes behavioral and psychological assessment, program development, hands on program implementation support, staff training, and emergency short term placement.

There are 7 state-operated waiver residential programs and 15 intermediate care facilities for the mentally retarded residential programs in operation. These programs serve persons with developmental disabilities in 4 and 6-bed programs located in residential neighborhoods that allow for integration of the activities of daily living with non-disabled persons.

There are 3 state-operated day training and habilitation programs. These programs are located in local communities that allow for integration of vocational activities with non-disabled persons.

Closure of the Moose Lake RTC in 1995 will reduce the number of residential programs for persons with DD by one.

Performance Objectives and Measures:

1. All state-operated residential programs for persons with DD meet licensure requirements.

Measure: Number of residential programs licensed by the Department of Human Services.

				Objectives		
F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
7	7	7	7	7	6	

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ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Human Services
Administration: Community Mental Health and State Operated Services
Program: Developmental Disability

Objective 1. All state-operated residential programs for persons with developmental disabilities meet licensure requirements.

Measure: Number of residential programs licensed by the Department of Human Services.

Definition: All state-operated residential programs are to meet the licensure requirements of the Department of Human Services.

Rationale: This is a straightforward percentage computation: number of licensed programs (divided by) number of programs in operation.

Data Source: Notification of licensure.

Factors Beyond Agency's Control That Affect Performance: (None specified.)

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ANNUAL PERFORMANCE REPORT
Part 4: Improving Programs and the Reporting Process

Agency: Department of Human Services

Process Used:

An internal report development work group was established to prepare this draft report. The work group was coordinated by the Budget Analysis Division and included representatives from each of the five DHS Administrations. Work group representatives were given copies of the narrative from their administration's 1994-95 biennial budget including the "activity outcome objectives" and "performance measures" information from each administration's budget activities. Representatives also received the Department of Finance's forms and instruction packets. A majority of work group members attended the Department of Finance/Office of Legislative Auditor (DOF/OLA) mid-September project seminar.

Representatives acted as liaisons to their administration's program managers. In some cases, program managers were asked to review their 1994-95 biennial budget submissions and complete the information requested in the DOF forms and instructions. In other cases, work group members with special expertise developed the requested information themselves. Internal reviews were limited because of the short time frame for completion of the draft report.

All performance objectives and measures are considered to be in draft form. Some can be readily reworked for the annual report due next September. Others may take more time. For instance, the Residential Programs Management Division and the regional treatment centers have drafted over 40 measures, some that may be available for future reports. These measures are works-in-progress and need further refinement. Further, the administrative technology to implement and support performance measurement will need to be developed over time. There is a concern that further development of performance measurement technology is needed before performance reporting can be fully implemented. (see Appendix II)

Team members were advised to focus more on program than administrative activities as a way to make the scope of the task more manageable. Consequently, very few agency-wide support functions, such as accounting or budgets, were included. The Social Services Administration focused strictly upon client outcomes and used them as their primary organizing principle while the Health Care Administration aligned their response with Department budget activities.

Work group members were also asked to emphasize, where appropriate, efforts underway within their administrations that had a "results-oriented" philosophy. In that regard, the Quality Services Division in the Social Services Administration has been engaged in a project to bring a results orientation to its supervision of county social services agencies. Appendix I provides two exhibits descriptive of their activities.

Assessment of Performance Objective and Measure Development Needs

The sense of the work group was that the framework and time frame for development of performance objectives and measures needs to take into account an approach that was more reflective current state of practice in the field of results-oriented management. The published views of experts, views expressed in presentations such as the DOF/OLA conference in mid-September and our own experience (see Appendix I) in developing performance objectives and measures suggests a development framework that is highly process-oriented and staff and time-intensive. Given that framework, the work group needs to develop options to address how to accommodate the deadline for the first annual report in the most meaningful way. Our development plan would need to accommodate the differences among DHS administrations and address training, technical assistance and project staging requirements.

We are hopeful that the review by the Office of Legislative Auditor and the Department of Finance will be timely and useful in the development of the first annual report. The state agencies producing this draft report, while different in many ways, have many functional similarities that would make sharing of information valuable. For example, regulatory functions or

quality control functions may have similar types of objectives or measures. Similarly, agencies that supervise local-run programs may also find commonality. Review by the Department of Finance and Office of Legislative Auditor may take many forms. A key to the effectiveness of that review, however, will be its timeliness. The earlier that review occurs, the better.

The work group also feels that communicating with state agencies with similar clientele would be helpful. As one example, staff from the Departments of Human Services and Jobs and Training have jointly agreed that the two agencies must now create more specific program outcome measures. These measures are needed on two fronts: 1) at the state level where overall program goals and policies are formulated; and 2) at the local level where direct services are provided. The two Departments have initiated efforts to establish more specific outcome measures, as well as methods to implement such measures at the state and local level. These efforts will continue throughout the 1994-1995 biennium.

Within each administration the performance reporting process will be reflective of the quality movement to varying degrees. Ongoing examination of the processes used within the Department, using continuous quality improvement techniques, will assure the continuing improvement of performance. Training in and implementation of quality techniques and philosophy will complement the evolution of performance reporting.

Ways to Improve Program Outcomes:

The Department of Human Services will include some recommendations for improving program outcomes in its first annual performance report in September 1994. Other recommendations will be found in our legislative and budgetary packages submitted to the 1995 Legislative session.

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ANNUAL PERFORMANCE REPORT
Appendix I

CLIENT-FOCUSED OUTCOME EXAMPLES

Target Population	Desired Outcome (Goal)	Outcome Indicator (ratio)	Method	Performance Target
1) families with children under age 18, who are experiencing child dependency, neglect or abuse, and also pregnant adolescents, adolescent parents under the age of 18, and their children;				
(subgroup if necessary)				
Pregnant adolescents, adolescent parents under the age of 18 and their children Minor Parents	Minor parents will parent their children appropriately.	# of minor parents who have an acceptable score on an instrument which assesses parenting practice. --- Total # of minor parents in MP program (or receiving services)	Assessment instrument for parenting practices, (and frequency of administration)	By 1995, _____% of minor parents will parent their children appropriately.
Parents of children under age 18 who are in need of protection or services who are experiencing abuse or neglect.	Parents will provide a stable environment for their children.	# of parents who have been assessed as providing an acceptably stable environment for thier children. --- Total # of parents with children under age 18 who are in need of protection or services.....	•maltreatment reports •assessment instruments •plan reviews	By 1995 there will be a _____% increase in the number of parents assessed as providing an acceptable stable environment for their children.
Children under age 18 who have experienced abuse/neglect and are receiving CPS.	Children will be safe.	# of subsequent maltreatment reports in a _____ month period. --- Total # of children receiving CPS	maltreatment reports	By 1995 there will be _____% decrease in the number of subsequent maltreatment reports in a _____ month period.
2) persons who are under the guardianship of the commissioner of human services and dependent and neglected ward;				
(subgroup if necessary)				
Children under State Guardianship	Children under state guardianship will have an adoptive home placement	# of children under state guardianship placed in an adoptive home --- Total # of children under state guardianship	Case record review - completed adoptions	By 1995, _____% of children under state guardianship will have an adoptive home placement.

3) adults who are in need of protection and vulnerable as defined in section 626.557; **(subgroup if necessary)** Adult with substantiated reports of abuse/neglect clients	Clients will live in a setting that is free from abuse	# of clients with repeat substantiated reports of abuse/neglect during a 1 year period. --- Total # of adult clients with substantiated reports of abuse	Reports of abuse/neglect.	By 1995 there will be a _____% decrease in the number of clients with repeat substantiated reports of abuse/neglect during a 1 year period.
4) persons age 60 and over who are experiencing difficulty living independently and are unable to provide for thier own needs; **(subgroup if necessary)** Persons age 60 and over who want to remain in their own home and have been identified as experiencing difficulty living independently and are unable to provide for their own needs.	Persons age 60 or over who can and want to, will remain in their own home.	# of persons who have an acceptable score on assessment instrument(s) re: independent living in their own home. --- Total # of persons age 60 and over who have been identified as experiencing difficulty living independently and are unable to provide for their own needs.	Functional assessment (scale?) •PAS •Client Interview	By 1995 _____% of clients will live independently in their own home within 1 year of the PAS.
5) emotionally disturbed children and adolescents, chronically and acutely mentally ill persons who are unable to provide for thier own needs or to independently engage in ordinary community activities; **(subgroup if necessary)** Adults with SPMI - Mental Health	Adult clients with SPMI will effectively manage their mental illness.	# of adult clients who have an acceptable score on a functional assessment. --- Total # of adult clients with SPMI	Quarterly review of functional assessment	By 1995, _____% of adult clients with SPMI will effectively manage their mental illness.
Children with SED receiving supportive services in independent living skills.	Children with SED will function independently.	# of children who have an acceptable score on the functional assessment re: independent functioning. --- Total # of children with SED receiving supportive services in independent living skills.	Quarterly review of functional assessment	By 1995 there will be a _____% increase in the number of children with SED who are functioning independently.
Adults with Mental Illness	Clients will function effectively in the community.	O.I. #1 # of clients living independently appropriate to level of functioning --- Total # of clients receiving services O.I. #2 # of clients employed appropriate to level of functioning --- Total # of clients receiving services	Functional assessment, case plans Functional assessment, case plans	By 1995, _____% of clients will be living independently appropriate to level of functioning. By 1995, _____% of clients will be employed appropriate to level of functioning.

6) persons with mental retardation as defined in section 252A.02, subdivision 2, or with related condition as defined in section 252.27, subdivision 1, who are unable to provide for their own needs or to independently engage in ordinary community activities; **(subgroup if necessary)**	Each DD consumer will have relationships with family members and others with whom they would like to have relationships.	# of DD consumers who have relationships with family members and other with whom they would like to have relationships --- Total # of DD consumers.	•interviews with client during individual I.S.P. meetings •team process	By 1995, _____% of DD consumers will have relationships with family members and others.....
7) drug dependent and intoxicated persons as defined in section 254A.02, subdivisions 5 and 7, and persons at risk of harm to self or others due to the ingestion of alcohol or other drugs; **(subgroup if necessary)** Persons receiving treatment for chemical use patterns which are either inappropriate and harmful or pathological.	Persons treated for chemical usage which is inappropriate and harmful or pathological will be chemical free.	# of persons experiencing recidivism (time factor may be included - ex. over 6 months --- Total # in treatment	Case record - utilization of treatment DWI's	By 1995 there will be a _____% decrease in the number of persons experiencing recidivism over a _____ month period.
8) parents whose income is at or below 70 percent of the state median income and who are in need of child care services in order to secure or retain employment or to obtain the training or education necessary to secure employment **(subgroup if necessary)** Parents in employment and training program who have children in child care.	Parents will be employed.	# of parents employed after completing program --- Total # of parents completed program	records - utilization of CC funds	By 1995, _____% of parents will be employed after completing program.

COUNTY_____

CSSA COST PROJECTION TABLE

CHILDREN'S SERVICES PROGRAM AREA
CHILDREN IN NEED OF PROTECTION

SERVICE CODE	SERVICE TITLE	CHECK IF PROVIDED		TOTAL EXPENDITURE BY SERVICE CATEGORY	
		94	95	1994	1995
101x	Information and Referral			**ASSESSMENT AND PREVENTION**	
102x	Community Education & Prevention				
104x	Child Prot. Assess/Investigation				
105x	Nur. Home Pre-Admission Screening				
106x	CAC Assessment & Application				
107x	Child Welfare Assessment			$	$
115x	Language Interpreter			**FACILITATIVE**	
116x	Transportation				
117x	Interpreter-Hearing Impaired				
118x	Health-Related Services				
119x	Court-Related Services				
214x	Other Child Care			$	$

COUNTY_____

CSSA COST PROJECTION TABLE

PROGRAM AREA
CHEMICAL DEPENDENCY

SERVICE CODE	SERVICE TITLE	CHECK IF PROVIDED		TOTAL EXPENDITURE BY SERVICE CATEGORY	
		94	95	1994	1995
301x	Information and Referral			**ASSESSMENT AND PREVENTION**	
302x	Community Education & Prevention				
305x	Rule 25 Assessment				
307x	Rule 24 Financial Elig. Determin.				
309x	Pre-petition Screening/Hearing			$	$
316x	Transportation			**FACILITATIVE**	
317x	Detoxification Transportation			$	$
				SUPPORTIVE	
336x	Supportive Services			$	$
358x	Approved Pilot Projects			**REMEDIAL OUTPATIENT**	
359x	Consolidated C.D. Treatment Fund				
369x	Aftercare			$	$

COUNTY_____

CSSA COST PROJECTION TABLE

PROGRAM AREA
DEVELOPMENTAL DISABILITIES

SERVICE CODE	SERVICE TITLE	CHECK IF PROVIDED		TOTAL EXPENDITURE BY SERVICE CATEGORY	
		94	95	1994	1995
558x	Approved Pilot Projects			**REMEDIAL OUTPATIENT**	
564x	Supported Living Serv. - Adult				
565x	Supported Living Serv. - Child				
566x	Adult Day Training and Habilitation				
				$	$
572x	Regional Treatment Center			**REMEDIAL RESIDENTIAL**	
574x	Community Residential Facil. & Serv.				
589x	Respite Care				
				$	$
591x	Rule 185 Case Management - Waiver			**CASE MANAGEMENT AND RESOURCE DEVELOPMENT**	
592x	Rule 185 Case Mgt. - Non-Waiver				
594x	Case Consultation				
595x	Public Guardianship			$	$
TOTAL OF ALL SERVICE CATEGORIES				$	$

COUNTY_____

CSSA COST PROJECTION TABLE

ADULT SERVICES PROGRAM AREA
VULNERABLE ADULTS

SERVICE CODE	SERVICE TITLE	CHECK IF PROVIDED		TOTAL EXPENDITURE BY SERVICE CATEGORY	
		94	95	1994	1995
620x	Nutrition Services			SUPPORTIVE	
621x	Legal Services				
622x	Companion Services				
623x	Chore Services				
624x	Home Health Aide				
625x	Homemaking Services				
626x	Personal Care				
627x	Assisted Living				
628x	Home Delivered Meals				
629x	Congregate Meals				
630x	Caregiver Support				
634x	Semi-Independent Living Services				
637x	Employability				
638x	Extended Employment				
641x	Adaptive Aids or Spec. Equipment				
642x	Supplies and Equipment				
644x	Housing Services				
645x	Social and Recreational				
648x	Money Management				
649x	Adult Day Care			$	$

ANNUAL PERFORMANCE REPORT
Appendix II

MEMO

Minnesota Department of Human Services
Mental Health Division

TO: Natalie Haas Steffen, Commissioner

FROM: Jim Stoebner, Assistant Commissioner

SUBJECT: **The Department's Annual Performance Report**

DATE: October 15, 1993

The Community Mental Health and State-Operated Services Administration fully supports the Annual Performance Report as a method for determining how successful state government agencies are in meeting their goals and objectives. This administration has been engaged in developing the kinds of technology needed to support performance measurement for several years, and looks forward to this and all future opportunities to employ this technology.

Outcome-based performance measurement technology in mental health is, however, still in a developmental period. There are enormously complicated problems associated with defining outcome measures, and many technical issues involved in applying these measures. The Mental Health Division has developed measures in the areas of client satisfaction, level of functioning, and quality of life for some of its community-based services, but is only now beginning to field test these measures. A committee formed by the Residential Programs Management Division and the RTCs has drafted over 40 measures, but these, too, have yet to be demonstrated as "good" measures.

In the mental health field as a whole, the prevailing expertise in outcomes measurement argues for multiple measures, thus reducing the chance that a single measure will produce an erroneous finding in regard to program performance. Reliance on a single measure or a small number of measures is dangerous because there are many factors other than a program of treatment or a service that can that account for a given outcome. It is also dangerous because it is more subject to deliberate manipulation, sometimes at the expense of clients. A technology that uses a variety of measures, representing a variety of perspectives, provides a more complete, and fair, picture.

Most of the performance measures developed thusfar by this administration are not yet ready for implementation. This applies to all the measures developed for the Residential Programs Management Division. Nevertheless, the administration desires to participate in the Annual Performance Reporting process. Both divisions in this administration have submitted reports that include objectives and performance measures. In doing so, they have selected those measures that best meet the criteria put forth by the DOF, and they believe that these measures represent a good start to the performance reporting process. However, this administration must go on record as stating that use of these measures, and the statistical information they collect, to determine program effectiveness is premature. At this stage of the supporting technology, use should be limited to further development of that technology, and not extend to accountability issues.