ANNUAL PERFORMANCE REPORT
Part 1: Agency Summary

Agency: Minnesota Department of Health

Mission Statement:

The mission of the Minnesota Department of Health (MDH) is to protect, maintain and improve the health of the citizens of Minnesota.

To achieve this end, the MDH conducts public health studies and investigations; collects and analyzes health and vital data; identifies and describes health problems; designs, implements and supports programs and services for reducing morbidity and mortality; establishes and enforces health standards; provides education and technical assistance; coordinates local, state and federal health programs and services; assesses and evaluates the effectiveness and efficiency of health service systems and public health program efforts; and advises the Governor and the Legislature on matters relating to the public's health.

The Department is currently located in five (5) metro area sites and seven (7) offices in Greater Minnesota, employs about 1,000 staff and has a $160 million annual budget from all sources, $37 million appropriation from the State General Fund including 200 positions.

The Department is organized into four programmatic areas: 1) Health Protection; 2) Health Delivery Systems; 3) Health Care Resources and Systems; and, 4) Health Support Services. These programs perform the functions listed above in order to achieve the following objectives:

- to prevent and control the transmission of communicable disease in Minnesota;
- to reduce the occurrence and severity of acute and chronic disease;
- to reduce the occurrence of disease and conditions that are environmentally induced, occupationally induced, and influenced by lifestyle choices and cultural norms;
- to ensure access to coverage for Minnesotans who are uninsured as well as ensuring financial, geographic and cultural access to quality health care for all Minnesotans;
- to safeguard and promote the health and safety of persons receiving services from health care providers;
- to assure efficient and effective coordination of health related activities and services among state and local public health agencies; and
- to improve decision making and health related planning and research at all levels of government and in the private sector.
- to reduce the rate of increase in health care expenditures in Minnesota.

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Health
Program: Health Protection

Program Purpose:

The Bureau of Health Protection exists to ensure that Minnesotans will have the best chance for a healthy life: by preventing the spread of communicable diseases through promotion of healthy behaviors, and by protecting the public from acute and chronic diseases, in ways in which they are unable to protect themselves, i.e., through improvements in the quality of air and drinking water, through disease surveillance and epidemiologic investigations, and through reduction of exposure to public health hazards.

Performance Objectives and Measures:

1. By the year 2000, the annual increase in AIDS cases will be three percent or less; the incidence of gonorrhea will be reduced to no more than 53 cases per 100,000 residents; the prevalence of chlamydia infection in women will be reduced to no more than 212 cases per 100,000 women; and the incidence of primary and secondary syphilis will be reduced to no more than 1.2 cases per 100,000 residents.

Measure: Number of reported cases of disease and incidence or prevalence rates

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual New AIDS Cases (% Increase)	228	263 (15%)	381 (76%)	346 (-9%)	356	367	FY 99 total plus 3%
Prior Objectives		235	271	392			
Actual Gonorrhea Cases (Incidence)	4430 (101)	3397 (78)	3361 (77)	2807 (64)	NA	NA	(53)
Prior Objective		NA	NA	NA			
Actual Chlamydia Cases (Prevalence) in Women	6479 (291)	6625 (297)	6779 (304)	6347 (285)	NA	NA	(212)
Prior Objectives		NA	NA	NA			
Actual Primary and Secondary Syphilis Cases (Incidence)	93 (2.1)	82 (1.9)	70 (1.6)	98 (2.2)	NA	NA	(1.2)
Prior Objectives		NA	NA	NA			

Part 2: Program Information (Cont.)

2. By the year 2000, the annual number of cases of: measles will be 0; mumps will be 10; and the number of cases of pertussis will be less than 20.

Measure: Number of cases of disease reported to the Minnesota Department of Health

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual cases of measles	559	17	29	3	10	10	0
Prior Objectives		509	459	10			
Actual cases of mumps	7	12	33	8	20	20	10
Prior Objectives		20	20	10			
Actual cases of pertussis	65	65	102	187	75	75	20
Prior Objectives		50	50	80			

3. By the year 2000, create a system that ensures that infants of all geographic areas, racial and ethnic groups, and socio-economic strata receive age-appropriate immunization against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, *Haemophilus influenzae* type B, and hepatitis B such that 90% are up to date when measured within two months of the date(s) on which they were to be vaccinated.

Measure: Review of all kindergarten children's medical records for school year 1992-93 for appropriate immunizations at 4, 6, 8, and 17 months

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
4 months	NA	NA	NA	86%	NA	NA	90%
6 months	NA	NA	NA	75%	NA	NA	83%
8 months	NA	NA	NA	64%	NA	NA	77%
17 months	NA	NA	NA	57%	NA	NA	74%
Prior Objectives	NA	NA	NA	NA			

4. By the year 2000, 94% (46 of 49) community health boards will have Communicable Disease Prevention and Control Cooperative Agreements in place.

Measure: Number of agreements signed and filed with the Minnesota Department of Health

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual (% signed)		36 (73%)	36 (74%)	37 (76%)	38 (78%)	39 (80%)	46 (94%)
Prior Objectives		65%	70%	75%			

5. By the year 2000, an average of 230 annual public requests for investigations of cancer concerns will be completed.

Measure: Number of cancer concerns investigated

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	49	106	112	121	133	146	236
Prior Objectives			NA	NA			

Part 2: Program Information (Cont.)

6. To reduce exposure to drinking water contaminants from public water supplies. This supports the Healthy People Year 2000, Goal 11.3, to reduce the outbreaks of waterborne disease from infectious agents and chemical poisoning to no more than 11 per year; and to the Minnesota Health Goals and Objectives for the Year 2000, Goal 5.2, to assure that all community public water supplies and 90 percent of all noncommunity public water supply systems will provide water that does not exceed the maximum contaminant levels established by the federal Safe Drinking Water requirements.

Measure: Percent of community and non-transient water supply systems in compliance with federal Safe Drinking Water Standards will be increased to 85 by the year 2000.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	92	92	92	92	80	82	85
Prior Objectives			NA	NA			

Measure: Percent of transient non-community water supply systems in compliance with federal standards of the Safe Drinking Water Act will be increased to 90 by the year 2000.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	*	*	75	80	80	80	90
Prior Objectives			NA	NA			

* Data Not Available

7. Modify and improve clinical laboratory methods to shorten the time it takes to produce accurate results for tests for certain infectious agents.

Measure: Percent of tests for organisms requiring culture which will be performed using more rapid state-of-the-art methods,i.e., time to result will be shortened from average of two weeks to two days.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Disease organisms identified /% using PCR or DNA probes			0	0	1000/1	9200/13	68,000/95
Prior Objectives			NA	NA			
Outbreaks organisms investigated /%usingDNA fingerprinting			0	0	400/17	1600/75	2100/90
Prior Objectives			NA	NA			

8. Reduce per test costs in chemical laboratory by improving staff and instrumentation efficiency

Measure: Decline in rate of increase of average hourly rate charged to perform tests and improved productivity rate.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual hourly rate		$75	$87	$84	$74	$75	$77
Prior Objectives		NA	NA	NA			
Actual average bench hours/FTE/month		60	62	66	70	72	80
Prior Objectives		NA	NA	NA			

8. Effectively administer the antitrust exception process to allow for collaborative arrangements between providers.

Measure: Written analysis and recommendation prepared for each application submitted.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995F.Y. 2000
Actual	n/a	n/a	n/a	n/a	100%	100%
Prior Objectives						

Measure: Percentage of applications analyzed

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995F.Y. 2000
Actual	n/a	n/a	n/a	n/a	100%	100%
Prior Objectives						

9. Maintain or increase the high quality of care provided to HMO enrollees.

Measure: Quality assurance examinations conducted

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995F.Y. 2000
Actual	n/a	n/a	7	4	7	7
Prior Objectives	n/a	n/a	7	4		

Measure: Number of enrollee complaints investigated

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995F.Y. 2000
Actual	n/a	n/a	738	815	900	900
Prior Objectives			800	800		

10. Ensure that unlicensed mental health practitioners and hearing instrument sellers conduct their business appropriately and in compliance with Minn.Stat. 148B.60 et.seq and 153A.13 et. seq.

Measure: Investigate complaints and take appropriate enforcement action against unlicensed mental health practitioners and hearing instrument dispensers.

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

Actual	n/a	n/a	738	815	900	900
Prior Objectives			800	800	n/a	n/a

11. Increase consumer awareness of consumer rights through the operation of a consumer information center for potential and actual purchasers of hearing aids and for consumers of mental health services.

Measure: Conduct consumer information programs

					Objectives	
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995F.Y.
2000						
Actual	n/a	n/a	15	20	25	30
Prior Objectives	n/a	n/a	n/a	n/a	n/a	n/a

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: HEALTH
Program: HEALTH CARE RESOURCES AND SYSTEMS

Program Purpose:

This Program includes implementation of the state's health care reform efforts in order to contain health care costs and increase access to health care, regulation of Minnesota's Health maintenance organizations and regulation of allied health occupations. The program is organized into five programs. They include: Data Analysis Program, Health Care Policy Program, Health Economics Program, Health Maintenance Organizations, and Health Occupations Program.

The purpose is also to safeguard and promote the health, safety and well being of health care service recipients by monitoring the quality of care provided by health care facilities and providers and requiring providers to take corrective action when needed.

Performance Objectives and Measures:

1. Develop an integrated data system that will be useful to purchasers, providers and payers of health care.

Measure: Aggregate surveys of providers, plans, insurers, hospitals and HMOs are conducted for financial and utilization data.

					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	n/a	n/a	n/a
Prior Objectives	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Measure: Number of claims collected through the data vendor and forwarded to the Department for analysis.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual					510,000	1,000,000	2,000,000
Prior Objectives							

Measure: Number of research projects initiated and reports issued

					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	3	5	n/a
Prior Objectives	n/a	n/a	n/a	n/a			

Part 2: Program Information (Cont.)

Measure: Number of practice parameters approved by the Commissioner and disseminated to providers.

					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	3	10	25
Prior Objectives	n/a	n/a	n/a	n/a	n/a	n/a	n/a

2. Provide health care consumers and purchasers with reliable responsible health care information through the establishment of an Information Clearinghouse. The information clearinghouse will disseminate information to consumers, providers, plans and others on health care reform and on health care costs, quality, and access.

Measure: Number of requests for information

					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	100	500	2000
Prior Objectives							

Measure: Percentage of requests completed

					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	100%	100%	100%
Prior Objectives	n/a	n/a	n/a	n/a			

3. Work with the public health subsystem to improve the health status of each region through the efforts of the regional coordinating boards.

Measure: Identify public health goals specific to each region.

					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	n/a	n/a	n/a
Prior Objectives							

4. Contain the growth of health care costs so that the rate of growth is decreased by 10% a year for the next 5 years.

Measure: Set and monitor growth limits on health care expenditures for the State of Minnesota.

					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	9.2%	8.1%	
Prior Objectives							

Part 2: Program Information (Cont.)

5. Effectively administer the antitrust exception process to allow for collaborative arrangements between providers.

Measure: Written analysis and recommendation prepared for each application submitted.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	n/a	n/a	n/a	100%	100%	
Prior Objectives							

Measure: Percentage of applications analyzed

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	n/a	n/a	n/a	100%	100%,	
Prior Objectives							

6. Maintain or increase the high quality of care provided to HMO enrollees.

Measure: Quality assurance examinations conducted

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	n/a	7	4	7	7	n/a
Prior Objectives	n/a	n/a	7	4			

Measure: Number of enrollee complaints investigated

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	n/a	738	815	900	900	n/a
Prior Objectives			800	800			

7. Ensure that unlicensed mental health practitioners and hearing instrument sellers conduct their business appropriately and in compliance with Minn.Stat. 148B.60 et.seq and 153A.13 et. seq.

Measure: Investigate complaints and take appropriate enforcement action against unlicensed mental health practitioners and hearing instrument dispensers.

	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	Objectives F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	n/a	738	815	900	900	n/a
Prior Objectives			800	800	n/a	n/a	n/a

Part 2: Program Information (Cont.)

8. Increase consumer awareness of consumer rights through the operation of a consumer information center for potential and actual purchasers of hearing aids and for consumers of mental health services.

Measure: **Conduct consumer information programs**

					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	15	20	25	30	
Prior Objectives	n/a	n/a	n/a	n/a	n/a	n/a	

9. Increase the quality of care for health care consumers.

Measure: Consistent interpretation of state and federal regulations by health care providers and Health Resources staff.

Make available the expertise of a medical director to provide training and consultation to the medical community and administration or health care facilities as well as the staff of Health Resources.

Federal funding will be requested for Resident Assessment Training for Consumers so that the process and requirements of the reident assessment instrument can be provided.

10. Regulating without creating adversarial relationships with providers and health care community.

Measure: Provide staff resources for provider organization education workshops to maintain and increase awareness of new quality of care requirements and survey process.

Development of rules and legislation that provide for an effective quality assurance program and establish a mechanism for the internal review of existing requirements, and a mechanism to incorporate industry and consumer advocate input into the process.

Continue on-going advisory committees which monitor changes needed in MDH rules such as Nursing Homes, Home Care, Supervised Living Facility, and Residential Care Home rules.

11. Meet Federal and State mandates in the most efficient and cost effective manner. This will be the most challenging objective for the division to accomplish as we anticipate declining state and federal funding for the quality assurance program, while experiencing increasing demands to protect the health care of the recipients of those services. In order to meet these demands we must be "market competitive" and strengthen our infrastructure to assurance our continued oversight of the federal program.

Measure: Support continuation of task force to create a "Uniform Client Identifier" to track individuals through the state system. This will reduce the time spent by county and state agencies to maintain accurate records. Consistency of the data across systems will provide the basis for longitudinal studies.

Finalize implementation of the Health Resources Information System which will enable the division to provide a "profile" for each health care facility.

Reduction of the more than 250 forms used in the certification/licensing program and streamline the processing activities.

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Department of Health

Program: Office of Rural Health

Program Purpose: The purpose of this program is to improve access to quality health care in rural Minnesota. To achieve this goal, ORH works cooperatively with public and private community organizations, educational organizations, and other government agencies to implement programs that promote the delivery of quality health care in rural Minnesota. ORH serves as a resource for education, community development, policy analysis, data collection, and research on rural health issues.

The Office of Rural Health was formally established in July 1992 as a result of the MinnesotaCare legislation.

Performance Objectives and Measures:

1.To maintain a rural health information clearinghouse that provides information on rural health care issues, research findings, innovative approaches to rural health care delivery, and grant opportunities to interested persons. (M.S.144.1482).

Measure: Number of information requests handled annually

					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	400	450	500
Prior Objectives	N/A	N/A	N/A	N/A			

2.To provide technical assistance regarding federal programs that affect rural health care, such as the Health Professional Shortage Area (HPSA), Medically Underserved Area/Population (MUA/MUP), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Community/Migrant Health Center (C/MHC) and National Health Service Corps (NHSC) programs. Technical assistance includes information about program eligibility and benefits, and assistance with application procedures. (M.S.144.1482)

Measure: Number of technical assistance requests on potential additional HPSA and MUA areas and on other programs handled. All HPSAs in state will be reviewed every three years and eligible areas recommended for redesignation.

					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	25	30	30
Prior Objectives	N/A	N/A	N/A	N/A			

3. To help maintain access to essential hospital services in rural areas of the state through the provision of grants to financially troubled rural hospitals in isolated areas of the state to continue operating. (M.S.144.1484)

Measure: Hospitals identified as essential to access that are in financial trouble will receive assistance to the extent of available funds.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	0	2	0	14	N/A	N/A	N/A
Prior Objectives	N/A	N/A	N/A	N/A	N/A		

4.To provide grants to assist rural hospitals and their communities in developing strategic plans for preserving access

to health services, or implementing transition projects to modify the type and extent of services provided by the hospital. (M.S.144.1482)

Measure: Number of hospitals eligible for, applying for, and receiving grants.

					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	9	10	10	10
Prior Objectives	N/A	N/A	N/A	N/A			

5.To develop a program to provide technical assistance and grants to rural communities and community organizations to establish community health centers in underserved rural areas of Minnesota. (M.S.144.1486)

Measure: Number of grants provided.

					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	2	2	2
Prior Objectives	N/A	N/A	N/A	N/A			

6.To provide timely and accurate data on health care personnel for state policymaking and analysis of shortages. (M.S.144.1485)

Measure: Databases will be developed and updated according to professional board relicensure schedule. Data will be collected, edited, and data entered annually on approximately 14,400 physicians, 200 physician assistants, 2500 physical therapists, 1000 respiratory care practitioners, 10,500 LPNs, 26,000 RNs, 5000 dentists and 5000 dental auxilary personnel.

					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	64,600	64,600	64,600
Prior Objectives	N/A	N/A	N/A	N/A			

7.To administer, with assistance from the Higher Education Coordinating Board, a federal and state funded loan repayment program for primary care physicians practicing in federally designated rural and urban shortage areas. State funding for this program was appropriated by the 1993 Legislature, federal funding comes from a National Health Services Corps grant. (M.S.144.1487-144.1492)

Measure: Number of loan repayment contracts administered annually

					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	4	8	8
Prior Objectives	N/A	N/A	N/A	N/A			

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Health, Department of
Program: Health Delivery Systems

Program Purpose: This program has seven primary purposes:

1. To encourage and support public policy which enables the population to avoid or delay the onset of chronic diseases (cancer, stroke, heart disease) and to promote positive health behaviors among Minnesotans.

2. To promote early detection and optimal follow-up care for Minnesotans at risk of diseases or conditions for which effective primary prevention measures are infeasible or nonexistent.

3. To ensure that Minnesota's communities and local governments are able to meet their public health responsibilities under state law.

4. To ensure that local, regional and statewide Emergency Medical Services (EMS) planning and activities are integrated into a working system and are consistent with current and appropriate medical practices.

5. To provide leadership and coordination for family health.

6. To further the efforts of organizations that deliver health services to families by assessing needs, developing standards, providing training and technical assistance, evaluating performance, and providing financial resources.

7. To deliver services directly to families when local capacity is not sufficient to meet needs.

The Health Delivery Systems Bureau program has five primary goals:

1. To promote optimal health and prevent diseases or conditions that are influenced by cultural norms and lifestyle choices.

2. To reduce disability and mortality associated with diseases or conditions for which effective primary prevention measures are infeasible or nonexistent.

3. Support and maintain a state-local public health infrastructure in a "state of readiness" that allows it to actively prevent disease, death and disability as well as to respond to public health threats.

4. Strengthen and support a system of cooperative partnerships among local, regional, and state organizations committed to protecting and promoting the health of the general population.

5. To ensure that children are wanted, safe, and supported in leading healthy and productive lives.

Part 2: Program Information (Cont.)

Performance Objectives and Measures:

1. Adult smoking rates will be reduced.

Measure: Percentage of persons 18 years of age and older who report being current smokers.

					Objectives		
	F.Y. 1981	F.Y. 1986	F.Y. 1990	F.Y. 1992	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	29.5	26.4	22.0	22.0	20.0	19.0	15.0
Prior Objectives							

2. Breast cancer screening rates will be increased for women 40 years of age and older.

Measure: Percentage of women age 40+ who report ever receiving a clinical breast exam and mammogram.

					Objectives		
	F.Y. 1989	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	74.6	78.1	78.0	79.0	80.0	85.0
Prior Objectives							

3. Cervical cancer screening rates will be increased.

Measure: Percentage of women age 18+ with uterine cervix who report ever receiving a Pap test.

					Objectives		
	F.Y. 1989	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	n/a	n/a	95.0	95.2	95.5	96.0	97.5
Prior Objectives							

4. State and local collaboration will maintain and improve the public health system's ability to address jointly public health issues.

Measure: Local prevention/mitigation program activities.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Home Care Visits	714,997	815,322	974,830	1,100,000e	1,200,000	1,200,000	800,000
Environmental Health Investigations	41,026	47,715	43,896	45,000e	45,000	45,000	50,000
Disease Report Investigations	17,412	16,311	23,715	22,000e	24,000	24,000	28,000
Family Health Visits	186,566	255,300	242,882	245,000e	250,000	250,000	190,000

Measure: Response to initiatives and to (potential) public health emergencies. (See Part 3, "Rationale" below).

a) Immunization Initiative -- Assessed immunization status of 69,000 public and private kindergarten children.
b) Tuberculosis -- Tested (screened and read) 200 circus workers as the circus passed through eight cities after a worker was hospitalized with infectious TB.

c) Flooding -- Through local health agencies in 49 counties, tested 1057 well samples and contacted the owners of the 567 positive (contaminated) wells for follow-up actions.

5. Reduce the death rate from unintentional traumatic injury.

Measure: Death rate from unintentional injury per 100,000.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual		33.0	32.67	31.13e	30.86	29.45	28.0
Prior Objectives							

6. Prevent poisonings (especially pediatric) and minimize the effects when they occur; promote home management of poison cases.

Measure: Poison exposure calls and information calls handled, persons reached by education programs, educational print materials distributed.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Exposure Calls		57,777	56,644	56,000e	56,000	58,000	60,000
Information Calls		61,927	60,490	61,000e	60,000	61,000	62,000
Persons Reached		56,250	105,361	100,000e	95,000	100,000	110,000
Materials Distrib.		687,764	668,602	660,000e	650,000	660,000	675,000

7. Birth outcomes will be improved, and unintended pregnancies will be prevented.

Measure: The percentage of pregnant women beginning prenatal care during the first trimester of pregnancy.

					Objectives		
	1980	1985	1990	1991	1994	1995	2000
Actual	73	69	76	77	83	85	95
Prior Objectives		85					

(National Health Objective for the Year 2000: 90 percent.)

Measure: The percentage of pregnancies that are unintended.

					Objectives		
	1980	1985	1990	1991	1994	1995	2000
Actual	47	48	48	50	47	40	30
Prior Objectives							

8. Infant mortality rates for communities of color will be reduced to the current relatively low rate for white infants.

Measure: The disparities in infant mortality rates between communities of color and the white population.

					Objectives		
	1980	1985	1990	1991	1994	1995	2000
African-American:White							
Actual	2.1	1.8	3.0	2.8	2.0	1.5	1.0
Prior Objectives			1.3				

Native-American:White							
Actual	1.7	0.7	1.9	2.1	1.8	1.5	1.0
Prior Objectives			1.5				
Asian-American:White							
Actual	1.3	0.6	0.6	0.7	1.0	1.0	1.0
Prior Objectives			1.0				

9. All Minnesota pregnant women, infants, and children will have access to adequate nutritious foods and their families will have access to nutrition education services designed to prevent the occurrence of nutrition-related health problems.

Measure: The percentage of estimated eligible low-income Minnesotans participating in the Special Supplemental Food Program for Women, Infants, and Children (WIC).

					Objectives		
	F.Y. 1984	F.Y. 1989	F.Y. 1991	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	53	59	75	66	67	70	85
Prior Objectives							

10. All children with disabilities will have access to family-centered, community-based, and culturally-competent coordinated health services.

Measure: The percentage of estimated eligible low-income and/or severely disabled children receiving benefits from the Supplemental Security Income (SSI) program or the Children's Home Care Option (TEFRA) program.

		Objectives		
	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	39	45	50	75
Prior Objectives				

Measure: The percentage of Minnesota counties that document providing services to children with special health care needs in their local maternal and child health plans.

		Objectives	
	F.Y. 1992	F.Y. 1994	F.Y. 2000
Actual	84	89	100
Prior Objectives			

ANNUAL PERFORMANCE REPORT
Part 2: Program Information

Agency: Minnesota Department of Health
Program: Health Support Services

Program Purpose: The purpose of this Program is to provide policy direction and leadership for the Department and the State on Public Health and Health Care Reform Activities. This Program provides Department-wide priority setting; Health Statistics collection analysis and retention; Information Systems and Technology Development; Financial Management; Human Resources Management and General Services (Facilities Management, Purchasing, Copy Services, Mailing and Library Services).

Performance Objectives and Measures:

1. Timely processing of vital statistics on electronic media for federal agencies and an annual summary of health statistics.

Measure: Average number of days for preparing the transmission of the monthy data set of vital statistics to the Social Security Administration and National Center for Health Statistics.

					Objectives		
	F.Y.1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	90	90	95	100	90	80	60
Prior Objectives	90	90	90	90			

Measure: Publish an accurate final report of the Summary of Health Statistics in terms of the number of months following the end of the year.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	14	13	12	12	9	9	6
Prior Objectives	12	12	12	12			

2. Accurate and useful statistical analyses for the Department of Health and other customers.

Measure: Percent satisfaction among customers of Center for Health Statistics regarding the usefulness of reports and analyses.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	-	-	-	80	80	95
Prior Objectives	-	-	-	-	-	-	-

3. Prompt and courteous processing of birth and death records.

Measure: Copies of birth and death records turnaround time in days after request.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	1	1	1	2	1	1	1
Prior Objectives	1	1	1	1			

Measure: Number of days for a replacement of a birth or death certificate to be processed.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	5	5	5	8	5	5	5
Prior Objectives	5	5	5	5			

4. Information technology resources development will meet the needs of agency program managers.

Measure: Percentage customer satisfaction survey of policies coordination and assistance.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	-	-	-	75%	80%	N/A
Prior Objectives			-	-			

Measure: Number of MDH Sites on Computer Network.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	1 of 10	2 of 10	4 of 11	12 of 12	11 of 11	N/A
Prior Objectives							

Measure: Percent of MDH Staff on MDH E-mail.

					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
Prior Objectives			-	-			

Measure: Voice Mail Installed at MDH Metro Sites.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	-	1 of 3	2 of 4	4 of 5	3 of 4	
Prior Objectives			-	-			

5. A records management program will ensure that mission critical information is available and that the disposal of information of no further value to the Department is performed efficiently.

Measure: Percentage records boxes going into inactive storage identified completely on the records container label.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	19%	82%	91%	97%	98%	99%	N/A
Prior Objectives			-	-			

6. Library clients will have access to library materials as needed.

Measure: Library materials circulated. (Books, journals, audiovisuals.)

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	13190	12349	11954	10363	10500	10500	11000
Prior Objectives	14400	13490	13490	13000			

Part 2: Program Information (Cont.)

7. Library clients have access to materials from other libraries.

Measure: Interlibrary loans are requested from other libraries and provided to cooperating libraries. (Books, journals and photocopies.)

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	7448	8280	9175	9752	9800	9800	9950
Prior Objectives	5000	7450	7450	9500			

8. Library clients are aware of journal literature required to do their job well.

Measure: On-line data base searches which produce bibliographies on subjects of interest to our clients are provided as requested.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	785	854	1052	1096	1075	1075	1075
Prior Objectives	500	800	800	800			

9. Programs will be provided the materials and services required to achieve excellence.

Measure: Number of purchases made for program requirements.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	4750	5047	5000	5100	5100	-
Prior Objectives	-	-	-	-	-	-	-

10. Programs will be provided safe and productive work space.

Measure: Square feet of leased space.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	195,000	195,000	210,000	230,000	230,000	
Prior Objectives		-	-	-			

11. Mailing and distribution services will be provided to meet customer communication requirements.

Measure: Pieces of outgoing mail processed.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual		934,000	885,700	900,000	900,000	900,000	N/A
Prior Objectives							

Part 2: Program Information (Cont.)

12. Payments will be processed on a timely basis to meet statutory requirements and obtain available discounts.

Measure: Percent of payments processed within thirty (30) days of receipt of invoice.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	98.2	99.2	98.7	98.5	98.0	98.0	98.0
Prior Objectives	98.0	98.0	98.0	98.0			

13. Customers will be satisfied with financial services provided by the Section of Financial Management.

Measure: Percent of customers with positive response to services provided.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	-	-	-	80	85	95
Prior Objectives	-	-	-	-			

14. Ensure an effective workforce through the maintenance of a comprehensive performance appraisal system.

Measure: Percent of employees with a completed performance appraisal on a timely basis.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			80%	85%	90%	95%	98%
Prior Objectives							

15. To improve employee performance levels in present jobs, to encourage individual development and to prepare employees for a changing workplace through an integrated training and development program.

Measure: Total number of hours of training.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	-	25,200	30,000	35,000	35,000	35,000	38,000
Prior Objectives							

16. To continue the Department's commitment to customer/client oriented service through training and work-group development.

Measure: Percentage of staff trained in Customer Service.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			60%	70%	85%	85%	95%
Prior Objectives							

Part 2: Program Information (Cont.)

17. To ensure that the Department's workforce is reflective of the local labor force and the Department embraces concepts of equal employment opportunity through an effective Affirmative Action program.

Measure: Number of Affirmative Action hires needed to reach goals.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual			35	30	30	25	10
Prior Objectives							

18. Provide quality support services with a minimum level of resources.

Measure: Indirect cost rate.

					Objectives		
	F.Y. 1990	F.Y. 1991	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 2000
Actual	15.6	14.3	14.0	14.6	15.0	15.0	15.0
Prior Objectives	14.2	-					

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Health
Program: Health Protection

Objective 1. By the year 2000, the annual increase in AIDS cases will be three percent or less; the incidence of gonorrhea will be reduced to no more than 53 cases per 100,000 residents; the prevalence of chlamydia infection in women will be reduced to no more than 212 cases per 100,000 women; and the incidence of primary and secondary syphilis will be reduced to no more than 1.2 cases per 100,000 residents.

Measure: Number of reported cases of disease and incidence or prevalence rates

Definition: The above diseases are required by law to be reported by health providers and institutions to the Minnesota Department of Health. Incidence rate is the number of new cases of disease occurring in a year for every 100,000 residents. Prevalence rate measures diseases that can be identified as both chronic (acquired at an unknown time) and acute (acquired recently) and is the number of cases reported in a year for 100,000 persons.

Rationale: Measuring the total number of cases of disease in a year demonstrates the actual frequency of disease occurrence. The cases of AIDS is used as that is a common measurement across the United States, although in Minnesota, positive HIV antibody tests (in the absence of AIDS) are also reportable.

The use of incidence and prevalence rates for sexually transmitted diseases allows monitoring of disease patterns and trends as populations change. It also allows for comparing sub-populations, such as teenagers and adults, or males and females, with a common measurement.

Data Source: Cases are reported to the Minnesota Department of Health by laboratories, health providers and institutions as required by law. In some cases, the Disease Prevention and Control Division uses active surveillance (MDH staff contacting reporting sources to identify new cases) and passive surveillance (reports submitted by reporting sources).

Factors Beyond Agency's Control That Affect Performance: The AIDS surveillance case definition changed as of January 1, 1993 to include persons with a suppressed immune system as measured by laboratory tests as well as the addition of other diseases such as tuberculosis and invasive cervical cancer in the presence of HIV infection. This change also applies to persons who had been previously reported as HIV infection alone, changing the totals for AIDS cases for previous fiscal years. If this change had not occurred, the total number of AIDS cases for FY 1993 would have been approximately 225 as compared to the 346 actually recorded. These additional cases are primarily those individuals who had previously been reported as having a positive HIV antibody test. The total number of persons reported to the Minnesota Department of Health who are HIV-infected without AIDS or have AIDS was 3,745 as of July 1, 1993 which is 544 over the total HIV infections or AIDS cases reported as of July 1, 1992 (3,201).

Diseases such as syphilis which have small numbers can vary greatly from year to year. HIV and STD prevention campaigns include MDH sponsored media campaigns, disease intervention activities, and community based organization outreach and programs. Preventing new cases of disease involves an interaction between individuals at risk, health care providers, and organizations who can inspire behavior change that reduces high risk behaviors. The ultimate choice about behavior change, however, remains with the individual.

Objective 2. By the year 2000, the annual number of cases of: measles will be 0; mumps will be 10; and the number of cases of pertussis will be less than 20.

Measure: Number of cases of disease reported to the Minnesota Department of Health
Definition: Cases of measles, mumps and pertussis are required by law to be reported to MDH by laboratories, health providers, and institutions.

Rationale: Historically, incidence of measles, mumps, and pertussis cases have had a direct relationship to the number of children

immunized and reduced incidence of disease is the ultimate goal of immunization programs.

Data Source: Cases are reported to the Minnesota Department of Health by laboratories, health providers and institutions as required by law. In some cases, the Disease Prevention and Control Division uses active surveillance (MDH staff contacting reporting sources to identify new cases) and passive surveillance (reports submitted by reporting sources).

Factors Beyond Agency's Control That Affect Performance: Diseases such as measles, mumps, and pertussis which have small numbers, can vary greatly from year to year for a variety of reasons. For example, a child with pertussis who is in a large day care could expose a large number of children, compared to a child in a family day care setting with limited exposure. Varying rates of immunizations also play a role in disease prevention. (See Objective 3.) In addition, approximately 5% of children who are appropriately immunized do not produce a protective level of antibody and can develop the disease if exposed. Only children under 7 years of age receive immunization against pertussis. Older children and adults have waning immunity against pertussis which may contribute to increases in transmission.

Objective 3. By the year 2000, create a system that ensures that infants of all geographic areas, racial and ethnic groups, and socio-economic strata receive age-appropriate immunization against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, *Haemophilus influenzae* type B, and hepatitis B such that 90% are up to date when measured within two months of the date(s) on which they were to be vaccinated.

Measure: Review of all kindergarten children's medical records for school year 1992-93 for appropriate immunizations at 4, 6, 8, and 17 months.

Definition: Through a cooperative arrangement with community health boards in 1992, all 69,000 kindergarten children's medical records were reviewed to determine actual dates immunizations were received. These dates were compared to the recommended dates for immunization to determine the percentage of children who received the recommended immunization within two months of the appropriate date.

Rationale: Immunization dates are not reported to the Minnesota Department of Health. In order to determine levels of immunization, several methods are used, including reviews of children selected from birth certificates. To prepare for the Immunization Action Plan initiatives, a more comprehensive set of information was needed, so that a review of all kindergarten children was conducted. This information reflects immunizations given to these kindergartners at least four or more years ago.

Data Source: To enter school, a kindergartner must supply the school with immunization records which become part of the child's permanent school health record. These records were reviewed by staff of community health boards or school nurses using a standardized report format. These reports were submitted to the Minnesota Department of Health for analysis, resulting in a report for all Minnesota children as well as reports by school district or zip code to identify areas needing additional resources or initiatives. The amount of resources required to review all immunization records prevents this strategy from being an annual activity. A second drawback to this method is that the review of immunization records of kindergartners reflects an immunization delivery system of four or more years ago. To evaluate the success of new initiatives to meet the above objective, additional record reviews will be done at intervals of approximately four years. Again, these reviews will reflect delivery systems of previous years so that records reviewed in FY 2000 will measure activities in the mid-90's and achievement of the year 2000 goal will be measured in 2005.

Factors Beyond Agency's Control That Affect Performance: Approximately 80% of the immunizations received by Minnesota children are provided by the private medical sector. Influencing medical practice and delivery practice can be accomplished through cooperative working relationships with local community health agencies. Access to medical care, incomplete understanding by parents of the need for immunizations, problems in completing the series on time, and parent motivation are barriers to achieving this goal. Federal resources and priorities have been inconsistent in the past several years and could be a factor in being able to reach the goal established for the year 2000.

Objective 4. By the year 2000, 94% (46 of 49) community health boards will have Communicable Disease Prevention and Control Cooperative Agreements in place.

Measure: Number of agreements signed and filed with the Minnesota Department of Health

Definition: Communicable Disease Prevention and Control Cooperative Agreements describe the inter-relationships between local units of government and the Minnesota Department of Health in the areas of disease surveillance, disease intervention and control, and

management of disease outbreaks. A prototype of an agreement was developed by a workgroup of the State Community Health Services Advisory Committee and is used as the model for developing agreements to coordinate these activities. The Minnesota Department of Health provides group training and individual consultation in the development and implementation of the agreements.

Rationale: These agreements document the training, knowledge, and interest in community health, county boards, and city councils to provide comprehensive disease prevention and control services within their jurisdiction. A mutual agreement is a documentation of commitment by the local agency to take on responsibilities and describes the support available from the Minnesota Department of Health.

Data Source: Agreements signed by the Commissioner of Health and the local board and filed with the Minnesota Department of Health.

Factors Beyond Agency's Control That Affect Performance: Readiness of local boards to assume additional responsibilities depends on staff expertise and availability, local boards' interest in providing this service, and amount of need within the local area for disease prevention and control activities when compared to other priorities. Minnesota Department of Health staff provide assistance in defining roles and supporting the development of agreements but local boards must request this new responsibility.

Objective 5. By the year 2000, an average of 230 annual public requests for investigations of cancer concerns will be completed.

Measure: Number of cancer concerns investigated

Definition: Cancer concerns are reports of cancer (or other disease) clustering from anyone in the community that involve an observation of a number of similar illnesses, and the perception that the number is excessive.

Rationale: Investigations of these reports not only answer public concerns and questions and satisfy medical curiosity, but they also occasionally provide valuable information that helps us understand the reasons for perceived excesses and knowledge of specific disease etiology. Each investigation provides an opportunity to educate citizens, communities,a dn policy workers about cancer risks and to correct misimpressions about the importance of environmental exposures to these risks.

Data Source: Phone calls and letter from citizens throughout the State and the Minnesota Cancer Surveillance System.

Factors Beyond Agency's Control That Affect Performance: None

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: HEALTH
Program: HEALTH CARE RESOURCES AND SYSTEMS

Objective 1. Develop an integrated data system that will be useful to purchasers, providers and payers of health care.

Measure: Aggregate surveys of providers, plans, insurers, hospitals and HMOs are conducted for financial and utilization data.
Number of claims collected through the data vendor and forwarded to the Department for analysis.
Number of research projects initiated and reports issued.
Number of practice parameters approved by the Commissioner and disseminated to providers.

Definition: N/A

Rationale: The legislature directed the department to develop 11 different data bases in the MinnesotaCare 1992 law. These data bases encompass a variety of topics including outcomes, administrative costs, health plan comparisons, and health care expenditures. Various data elements within these data bases could be collected from a single source. Further the law directs the department to collect the data in the most cost-efficient and least burdensome manner. As a result, the department is developing an integrated data system.

There are two purposes behind the state's data collection efforts. First, the data will be used to provide health care consumers with the information they need to make wise health care purchasing decisions. Second, the data will be used for regulatory purposes. For example, the department was directed to impose growth limits on providers and payers of health care, yet the baseline data does not exist in the public sector to monitor these limits. Further, there are over 210 health care related data bases within state agencies today. Similarly, there are many data bases existing in the private sector. These data bases use a variety of data collection methodologies, definitions and strategies. Therefore, it is nearly impossible to compare these data in a responsible manner.

Through an integrated data system, providers, payers and purchasers of health care will have access to the information they need to improve their practice patterns, purchase more cost-effective health care, or compare ISNs on the basis of cost and quality.

Data Source: Existing MDH data bases, other state agency data bases, private sector data bases.

Factors Beyond Agency's Control That Affect Performance: It will be critical to this effort that the private sector cooperate fully. A public/private sector Data Institute has been created to help with the coordination of this effort and to provide direction to the department on its data collection activities.

Objective 2. Provide health care consumers and purchasers with reliable responsible health care information through the establishment of an Information Clearinghouse. The information clearinghouse will disseminate information to consumers, providers, health care plans and others on health care reform and on health care costs, quality, and access.

Measure: Number of requests for information
Number of requests completed

Definition: N/A

Part 3: Substantiating the Performance Measures (Cont.)

Rationale: Health care consumers and purchasers do not purchase health care as they do autos or groceries. For example, there is very little comparison shopping done on hospitals or other providers. One reason is that it is difficult to make these comparisons. The information clearinghouse will provide consumers with the information they need to make more rational health care purchasing decisions.

Data Source: Existing MDH data bases, other state agency data bases, private sector data bases.

Factors Beyond Agency's Control That Affect Performance: None

Objective 3. Work with the public health subsystem to improve the health status of each region through the efforts of the regional coordinating boards.

Measure: Identify public health goals specific to each region.

Definition: None

Rationale: The department divided the state into 6 regions for the purpose of creating regional coordinating boards as directed by the 1992 MinnesotaCare Act. The boards are responsible for a variety of functions, but specifically to provide advice to the commissioner on public health goals. Each board is comprised of 17 members from both the public and private sectors. Each region is vastly different from another and therefore, each region could have varying public health goals. These goals will not be set without the assistance of the community health boards and other public health agencies.

Data Source: Existing MDH data bases, other state agency data bases, private sector data bases.

Factors Beyond Agency's Control That Affect Performance: None

Objective 4. Contain the growth of health care costs so that the rate of growth is decreased by 10% a year for the next 5 years.

Measure: Set and monitor growth limits on health care expenditures for the State of Minnesota.

Definition: Growth limits are defined as CPI for urban consumers plus a specified percentage as indicated in 1993 Minnesota Chapter 345.

Rationale: The MinnesotaCare Act of 1992 directed the Minnesota Health Care Commission to develop a cost containment strategy to decrease the rate of growth of health care costs by 10% a year for the next five years. This strategy outlined three measures to achieve this goal: the development of integrated service networks, the design of the all payer system, and the imposition of growth rates on providers and payers of health care. The growth limits have been established to bring the rate of medical inflation more in line with that of inflation generally. Historically, the rate of medical inflation has been as much as 3 times that of general inflation. Should the growth limits achieve a 10% decrease in the rate of growth, Minnesotans could potentially save $7 billion over the next five years.

Data Source: Existing MDH data bases, other state agency data bases, private sector data bases.

Factors Beyond Agency's Control That Affect Performance: Conceivably, the state may not be able to obtain the necessary expenditure and revenue data needed to fully monitor compliance with the growth limits. Further, it will be nearly impossible to audit all providers and payers to ensure compliance with the growth limits.

Part 3: Substantiating the Performance Measures (Cont.)

Objective 5. Administer the antitrust exception process to allow for collaborative arrangements between providers.

Measure: Written analysis and recommendation prepared for each application submitted.
Percentage of applications analyzed

Definition: None

Rationale: In some areas of the state, particularly in the rural areas, there would be considerable advantages to providers collaborating. For example, it may be more cost-effective for 3 small hospitals to collectively purchase a mobile MRI unit than it would be for them to each purchase an MRI independently. As a result, the MinnesotaCare 1993 Act provided for an antitrust exception process for providers who wish to act in a collaborative manner. Existing state and federal antitrust laws pose some impediments to collaborative activities.

Data Source: None

Factors Beyond Agency's Control That Affect Performance: Three different review processes have been developed depending upon the complexity of the application. If all applications require the most thorough and time-consuming review process, achieving the targeted number of reviews may not be possible.

Objective 6. Maintain or increase the high quality of care provided to HMO enrollees.

Measure: Quality assurance examinations conducted
Number of enrollee complaints investigated

Definition: None

Rationale: Minnesota has a history of high quality health care. It is imperative that as the state's health care delivery system is reformed that quality not be eroded. Statutorily required quality assurance examinations will provide the state with some of the information necessary to ensure that quality standards are being met. Further, the department's HMO complaint telephone number is on the reverse side of each enrollee's membership card. Through the enrollee complaint investigation process, concerns with quality issues will be identified and addressed.

Data Source: None

Factors Beyond Agency's Control That Affect Performance: If enrollees do not file a formal complaint with the department, the department has no authority to investigate a particular situation. The department does have the authority however, to ensure compliance with the quality of care standards outlined in Minn. Stat. 62D and the corresponding rules.

Objective 7. Ensure that unlicensed mental health practitioners and hearing instrument sellers conduct their business appropriately and in compliance with Minn.Stat. 148B.60 et.seq and 153A.13 et. seq.

Measure: Investigate complaints and take appropriate enforcement action against unlicensed mental health practitioners and hearing instrument dispensers.

Definition: N/A

Rationale: Unlicensed mental health professionals are regulated through the Office of Mental Health Practice. It is a consumer complaint driven function as these practitioners are not credentialed. As these practitioners are unlicensed, the only means the department has to ensure compliance with the appropriate statutes is through a complaint process. In addition, as this is a relatively new function for the department, few law enforcement authorities are familiar with the department's responsibilities.

Currently, hearing instrument dispensers are regulated through a registration system. Prior to the 1993 legislative session two systems were in place - a permitting system for hearing instrument sellers and a registration system for hearing instrument dispensers. These systems were combined in an effort to create a more streamlined credentialing system. Hearing instrument dispensers are required to comply with both credentialing laws as well as consumer protection laws. In light of the fact that many of our hearing instrument users are senior citizens, it is imperative that the department aggressively investigate and take enforcement action against hearing instrument dispensers violating these laws.

Data Source: None

Factors Beyond Agency's Control That Affect Performance: Again, it is only through a formal complaint that the department may investigate an unlicensed mental health practitioner or a hearing instrument dispenser. However, fellow practitioners may bring complaints against a practitioner or dispenser.

Objective 8. Increase consumer awareness of their rights through the operation of a consumer information center for potential and actual purchasers of hearing aids and for consumers of mental health services.

Measure: Conduct consumer information programs

Definition: None

Rationale: Many consumers of hearing instruments are senior citizens who may not be fully aware of their rights. Similarly, consumers of mental health services may also be unaware of their rights with respect to the mental health practitioner. Through the consumer information programs hearing instrument users are informed of their rights. For example, state law requires hearing instrument dealers to provide consumers with a brochure outlining their rights as consumers. If a dealer does not provide this information to the consumer, that dealer is in violation of the law.

A similar problem exists with the responsibilities of the Office of Mental Health Practice. This is a relatively new function for the department and some law enforcement authorities and prosecutors are unaware of the department's authority. The consumer information programs provide a vehicle to convey the department's authority and responsibilities.

Data Source: None

Factors Beyond Agency's Control That Affect Performance: The department needs local organizations to sponsor these programs. Frequently, senior citizen centers sponsor informational programs. Programs on the Office of Mental Health Practitioners are more difficult to arrange as there is no likely sponsoring organization.

Objective 9. Increase the quality of care for health care consumers.

Measure: Consistent interpretation of state and federal regulations by health care providers and Health Resources staff.

Make available the expertise of a medical director to provide training and consultation to the medical community and administration of health care facilities as well as the staff of Health Resources.

Federal funding has been requested for Resident Assessment Training for Consumers so that the process and requirements of the resident assessment instrument can be provided.

Definition: The federal health care regulations are unclear and many inconsistencies and often times confusion develops by providers, Health Resources staff, and consumers of health care services as to what is necessary to comply with the regulations.

Rationale: A focal point for the interpretation and training will be established by creating a medical director position in the Health Resources Division. This position will develop training seminars for the provider community, recipients of health care services, and for Health Resources staff. As quality assurance issues arise this position will develop and communicate the appropriate interpretation.

The medical director position replaces numerous independent medical consultants that provided services to the division. The medical consultants covered a specific geographic location and program area. These consultant services did not view the Health Resources Division as a whole entity, but focused on narrow issues. This position will centralize all of the previous consultant services and broaden the scope of the services the division is able to provide to the health care providers and to ourselves.

The medical director will ensure that the Resident Assessment Training for Consumers is provided so that consumers of these health care services understand the process and requirements.

Data Source: The Health Resources Division receives numerous requests for clarification of regulations and quality assurance requirements from health care organizations, health care providers, and consumers of health care services.

Factors Beyond Agency's Control That Affect Performance: No federal funding for Resident Assessment Training for Consumers will cause the division to seek alternatives in order to provide this information.

Objective 10. Regulating without creating adversarial relationships with providers and health care community.

Measure: Provide staff resources for provider organization education workshops to maintain and increase awareness of new quality assurance requirements and survey process.

Development of rules and legislation that provide for an effective quality assurance program and establish a mechanism for the internal review of existing requirements, and a mechanism to incorporate industry and consumer advocate input into the process.

Continue on-going advisory committees which monitor changes needed in MDH rules such as Nursing Homes, Home Care, and Residential Care Home rules.

Definition: The complexity and diversity of interests involved in establishing quality assurance standards requires greater inclusion in the development process.

Rationale: As the health care needs of recipients change to include more alternative care options than currently exist, these alternative care options need to be developed. As the demographics of Minnesota's residents change to include a more culturally diverse population, more accute care services, and more at home interim services being sought as alternative care sources, more inclusion in the development of standards is being sought to ensure that these varying interests are addressed.

Also the health care industry itself has changed significantly from the initial development of current quality assurance standards. New technology and improvements need to be reviewed and included when updating the standards. For instance, cleaning products currently available do not require that certain temperatures need to be reached or sustained while cleaning. These alternatives need to be addressed when reviewing current standards.

Data Source: As health care providers request "waivers" from current quality assurance standards, issues have been incorporated into the development of new requirements.

Factors Beyond Agency's Control That Affect Performance: None

Objective 11. Meet Federal and State mandates in the most efficient and cost effective manner. This will be the most challenging objective for the division to accomplish as we anticipate declining state and federal funding for the quality of care program, while experiencing increasing demands to protect the health care of the recipients of those services.

In order to meet these demands we must be "market competitive" and strengthen our infastructure to assure our continued oversight of the federal program.

Measure: **Support continuation of task force to create a "Uniform Client Identifier" to track individuals through the state system. This will reduce the time spent by county and state agencies to maintain accurate records. Consistency of the data across systems will provide the basis for longitudinal studies.**

Finalize implementation of the Health Resources Information System which will enable the division to provide a "profile" for each health care facility.

Reduction of the more than 250 forms used in the certification/licensing program and streamline the processing activities.

Definition: This measure focuses on the infastructure of the Health Resources Division and its ability to coordinate and streamline the resources within its domain.

Rationale: As the complexity of the federal and state quality assurance programs increased over time, the data systems and internal processing mechanisms have also increased in complexity. These systems need updating to ensure that the most efficient process is utilized. Coordinating with the DHS task force to create a "Uniform Client Identifier" to track individuals will increase the efficiency of HR staff by reducing the time needed to identify "flagged records" which cannot be matched by DHS for payment. The identifier will also allow HR to conduct longitudinal studies which will assist in the development of changing quality assurance requirements.

The Health Resources Information System has been in development for the past 12 months and is being incrementally implemented within the division. This system will be used not only as a management information tool but as a resource for identifying provider training and for identifying trends by geographic location. As funding resources decline, this system can be used to identify which provider types or individual providers to focus on to ensure that quality assurance requirements are met.

In reviewing our internal processing requirements when developing the Health Resources Information System it became apparent that tremendous amounts of staff resources at all levels of the division are devoted to ensure that processing requirements are achieved. The Health Care Financing Agency (HCFA) has been approached about streamlining the paper processing, reducing the number of forms, and about the possibility of electronically producing the forms "on-demand". HCFA is open to suggestions and did not realize the volumes of paper that states are required to prepare in order to meet their requirements and is open to suggestions for improving the process.

Data Source: Information collected while developing the Health Resources Information System.

Factors Beyond Agency's Control That Affect Performance: Recommendations to HCFA about systems changes are not approved.

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Department of Health
Program: Office of Rural Health

Objective 1. To maintain a rural health information clearinghouse that provides information on rural health care issues, research findings, innovative approaches to rural health care delivery, and grant opportunities to interested persons. (M.S.144.1482).

Measure: Number of information requests handled annually

Definition: The total number of information requests handled annually.

Rationale: ORH is required by state statute and as a condition of our federal Office of Rural Health grant to perform the rural health information clearinghouse function.

Data Source: During FY 1994 ORH will develop a database for tracking requests, and begin tracking them.

Factors Beyond Agency's Control That Affect Performance: Availability of federal funding will determine staffing time for handling requests.

Objective 2. To provide technical assistance regarding federal programs that affect rural health care, such as the Health Professional Shortage Area (HPSA), Medically Underserved Area/Population (MUA/MUP), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Community/Migrant Health Center (C/MHC) and National Health Service Corps (NHSC) programs. (M.S.144.1482)

Measure: All HPSAs in state reviewed every three years and eligible areas recommended for redesignation; technical assistance on potential additional HPSA and MUA areas and on other programs handled on a request basis.

Definition: Technical assistance includes providing communities and health care providers with information about program eligibility and benefits, and assistance with application procedures; reviewing applications, and working with the federal Office of Shortage Designation, Bureau of Primary Health Care, National Health Services Corps and other relevant federal agencies to ensure that all potentially eligible Minnesota organizations are assisted in qualifying for appropriate federal programs.

Rationale: ORH is required by state statute and as a condition of our federal Primary Care Cooperative Agreement grant to provide technical assistance on the these programs.

Data Source: During FY 1994 ORH will develop a database for tracking requests, and begin tracking them.

Factors Beyond Agency's Control That Affect Performance: Federal and state health care reform efforts may affect the number of requests for technical assistance, and the availability of federal funds affects the amount of staff time available for this effort.

Objective 3. To help maintain access to essential hospital services in rural areas of the state through the provision of grants to financially troubled rural hospitals in isolated areas of the state to continue operating. (M.S.144.1484)

Measure: Hospitals identified as essential to access that are in financial trouble will receive assistance to the extent of available funds.

Definition: ORH will determine the number of qualified hospitals annually using statutory criteria and recommend funding amounts to the Commissioner. This program was established by the 1990 Legislature and previously administered by the Health Economics Program in MDH. No funding was available in FY 1992. The eligibility criteria were changed in FY

1992 and again in FY 1993.

Rationale: ORH is required by state statute to administer this program.

Data Source: ORH program files.

Factors Beyond Agency's Control That Affect Performance: The total amount of funding in this program, $200,000 annually is quite small compared to the financial losses faced by rural hospitals in recent years. The financial status of rural hospitals is affected by many factors beyond ORH's control, including Medicare, Medicaid, and private insurance reimbursement policies, and federal and state health care reform activities.

Objective 4. To provide grants to assist rural hospitals and their communities in developing strategic plans for preserving access to health services, or implementing transition projects to modify the type and extent of services provided by the hospital. (M.S.144.1482)

Measure: Number of hospitals eligible for, applying for, and receiving grants.

Definition: Number of hosptials eligible for, applying for, and receiving grants. A formal evaluation of this grant program will occur in FY 1994.

Rationale: ORH is required by state statute to administer this program.

Data Source: ORH program files.

Factors Beyond Agency's Control That Affect Performance: The financial status of rural hospitals and need for services provided by rural hospitals are affected by many factors beyond ORH's control, including Medicare, Medicaid, and private insurance reimbursement policies, and federal and state health care reform activities.

Objective 5. To develop a program to provide technical assistance and grants to rural communities and community organizations to establish community health centers in underserved rural areas of Minnesota. (M.S.144.1486)

Measure: Number of grants provided.

Definition: Number of grants provided.

Rationale: ORH is required by state statute to administer this program.

Data Source: ORH program files.

Factors Beyond Agency's Control That Affect Performance: Availability of federal and foundation funding to supplement state funds and the impact of Federal and state health care reform activities will affect this program.

Objective 6. To provide timely and accurate data on health care personnel for state policymaking and analysis of shortages. (M.S.144.1485)

Measure: Databases will be developed and updated according to professional board relicensure schedule. Data will be collected, edited, and data entered annually on approximately 14,400 physicians, 200 physician assistants, 2500 physical therapists, 1000 respiratory care practitioners, 10,500 LPNs, 26,000 RNs, 5000 dentists and 5000 dental auxilary personnel.

Definition: Number of health personnel for whom practice status information is collectd, edited and data entered.

Rationale: ORH is required by state statute to administer this program.

Data Source: ORH program files.

Factors Beyond Agency's Control That Affect Performance: Cooperation from licensing boards and willingness of individual health professionals to complete data forms.

Objective 7. To administer, with assistance from the Higher Education Coordinating Board, a federal and state funded loan repayment program for primary care physicians practicing in federally designated rural and urban shortage areas. State funding for this program was appropriated by the 1993 Legislature, federal funding comes from a National Health Services Corps grant. (M.S.144.1487-144.1492)

Measure: Number of loan repayment contracts administered annually

Definition: Number of loan repayment contracts administered annually.

Rationale: ORH is required by state statute to administer this program.

Data Source: ORH program files.

Factors Beyond Agency's Control That Affect Performance: The need for loan repayment incentives to encourage practice in primary care shortage areas will be affected by federal and state reform efforts to increase the overall supply of primary care physicians and to encourage practice in shortage areas. The number of contracts for this program are directly tied to the continuing availability of federal and state funds for the program.

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Health, Department of
Program: Health Delivery Systems

Objective 1. Adult smoking rates will be reduced.

Measure: Percentage of persons 18 years of age and older who report being current smokers.

Definition: The percentage of persons age 18+ who indicate that they are current smokers when responding to questions asked in the Behavioral Risk Factor Survey.

Rationale: Smoking related diseases, which account for more than 6,000 deaths each year, represent the leading cause of preventable mortality in Minnesota. Although men have historically smoked in larger proportions than women, this disparity has narrowed considerably in recent years as a result of the targeting of young women with special cigarette brands and sophisticated advertising campaigns. The smoking rate for women in the 18-30 age group is approximately 35% which is much higher than the overall adult smoking rate. In 1985, the Minnesota Department of Health received approximately $1.6 million per year in state funding to establish a major statewide nonsmoking campaign. Unfortunately, state budget reductions have eroded these funds to a current level of approximately $200,000 per year. These reductions have been offset to some extent by the receipt of a federal grant (ASSIST) which supports the development of community-based coalitions to work on tobacco use prevention strategies. This performance measure is an appropriate way of monitoring the overall impact of the combined state and federally funded program activities which are intended to reduce smoking rates. The national objective for this performance measure is 15% by the Year 2000.

Data Source: Questions contained in the Behavioral Risk Factor Survey (BRFS) inquire into smoking status. The BRFS is a random telephone survey of 3,400 Minnesotans, age 18 years and older, which is conducted annually by the Minnesota Department of Health.

Factors Beyond Agency's Control That Affect Performance: Smoking rates are affected by a variety of factors not directly within the Department's control including the following: product pricing and adverting decisions of tobacco companies; state and federal excise tax levels; state and local regulations which restrict youth access to tobacco products; and, educational campaigns of voluntary associations (Cancer Society, Lung Association, etc.).

Objective 2. Breast cancer screening rates will be increased for women 40 years of age and older.

Measure: Percentage of women age 40+ who report ever receiving a clinical breast exam and mammogram.

Definition: The percentage of women age 40+ who indicate that they have ever received a clinical breast exam or mammogram when responding to questions asked in the Behavioral Risk Factor Survey.

Rationale: During the 3-year period of 1988-90, 2,227 women died from breast cancer in Minnesota. Survival is directly related to the stage of disease at the time of diagnosis. Women diagnosed with localized breast cancer have a 5-year survival rate of 90%, however, this decreases to only 17% with metastatic involvement. Therefore, early detection through mammography screening is an essential element in reducing breast cancer mortality. The Minnesota Department of Health receives federal funds to promote breast cancer screening and pay for the cost of mammography for low income women who are uninsured or under insured. While we maintain information on the number of women screened through the subsidized program administered by the Department, this performance measure is used in an attempt to measure the overall impact of the program including its efforts to increase age appropriate breast cancer screening for all Minnesota women. The national objective for this performance measure is 80% by the Year 2000.

Data Source: Questions contained in the Behavioral Risk Factor Survey (BRFS) inquire into breast cancer screening. The BRFS is a random telephone survey of 3,400 Minnesotans, age 18 years and older, which is conducted annually by the

Minnesota Department of Health.

Factors Beyond Agency's Control That Affect Performance: Breast cancer screening is affected by a variety of factors not directly within the Department's control including: policies of medical care providers and payers; geographic and cultural accessibility of screening services; and, outreach activities of voluntary organizations such as the American Cancer Society.

Objective 3. Cervical cancer screening rates will be increased.

Measure: Percentage of women age 18+ with uterine cervix who report ever receiving a Pap test.

Definition: The percentage of women age 18+ with uterine cervix who indicate that they have ever received a Pap test when responding to questions asked in the Behavioral Risk Factor Survey. Women who indicate that they have had a hysterectomy are not included in calculating the percentage.

Rationale: During the 3-year period of 1988-90, 140 women died from cervical cancer in Minnesota. Survival is directly related to the stage of disease at the time of diagnosis. Women diagnosed with localized cervical cancer have a 5-year survival rate of 88%, however, the decreases to only 14% with metastatic involvement. Therefore, early detection through Pap testing is an essential element in reducing cervical cancer mortality. The Minnesota Department of Health receives federal funds to promote cervical cancer screening and pay for the cost of Pap testing for low income women who are uninsured or under insured. While we maintain information on the number of women screened through the subsidized program administered by the Department, this performance measure is used in an attempt to measure the overall impact of the program including its efforts to increase cervical cancer screening of all Minnesota women. We have already reached the national objective for this performance measure which is 95% by the Year 2000.

Data Source: Questions contained in the Behavioral Risk Factor Survey (BRFS) inquire into cervical cancer screening. The BRFS is a random telephone survey of 3,400 Minnesotans, age 18 years and older, which is conducted annually by the Minnesota Department of Health.

Factors Beyond Agency's Control That Affect Performance: Cervical cancer screening is affected by a variety of factors not directly within the Department's control including: policies of medical care providers and payers; geographic and cultural accessibility of screening services; and, outreach activities of voluntary organizations such as the American Cancer Society.

Objective 4. State and local collaboration will maintain and improve the public health system's ability to address jointly public health issues.

Measure: Local prevention/mitigation program activities.

Measure: Response to initiatives and to (potential) public health emergencies. (See Part 3, "Rationale" below)

Definition: (Selected) local prevention/mitigation activities measure ongoing prevention activities provided locally, which fit into an overall state-local effort to preserve public health. Response to initiatives and emergencies measures how the state-local system is prepared to deal with unexpected emergencies or opportunities.

Rationale: Public health responsibilities in Minnesota are shared among state, local and regional agencies. Success in the system is often defined by what does <u>not</u> happen (a disease outbreak is limited by quick intervention, a well is not contaminated, a person does not have to go to a nursing home, a child is not born prematurely). The performance measures chosen are activities that support directly the prevention of disease or the mitigation of its effects; they have a reasonable nexus to events that do not occur but for these interventions. Community Health Boards (which are partially supported by a state subsidy) provide resources in two areas critical to the success of this collaborative process. Trained personnel are crucial to successful public health programs. Public Health Nurses, for example, provide a key link in both health and economic issues. (The Department of Human Services estimates that home care services have reduced Medicaid-supported nursing home patients from 50,600 [1987] to 39,300 [1990].) Community Health Boards also play a critical role in assessing local health needs and planning for meeting those needs -- a process that will be integral to the success of health care reform in Minnesota. As health care reform is implemented in Minnesota, we anticipate that the delivery of services (especially

home care and family health visits) to meet some of these needs will shift from local public health agencies to Integrated Service Networks (ISN) as the ISNs begin to assume more responsibility for preventive services. It is difficult to anticipate the speed of this shift.

Maintaining the public health system in a "state of readiness" to respond to initiatives and emergencies also prevents death, disease and disability. In 1993 three major events occurred to test this "state of readiness": 1) A major immunization initiative was undertaken to raise the immunization levels of all children in Minnesota. Local public health nurses and other staff quickly assessed the immunization status of the children in their area, formulated plans for universal childhood immunizations, and are now working with MDH (from those plans) to raise the state's immunization levels; 2) A worker in a circus travelling through Southern Minnesota was hospitalized with infectious Tuberculosis. The circus moved daily, which meant that the two-day lag between the TB screening and reading the results were done by several local public health agencies. All 200 circus employees were located, tested and found non-infectious. 3) The floods in Minnesota resulted in potential contamination of thousands of wells. Working with local health agencies the MDH distributed 3,000 sample kits and tested over 1,000 wells. Local health agencies distributed kits, responded to citizen inquiries, and did necessary follow-up work with the owners of wells that had been contaminated.

While these measurements are relatively "soft" they illustrate that positive outcomes occur through general readiness, not specific programs aimed at an infinite variety of eventualities.

Data Source: Program activities data come from the annual "Community Health Services in Minnesota: A Report to the Legislature" -- data based on the CHS Reporting System. Initiatives and health emergency data come from reports by specific programs within the MDH.

Factors Beyond Agency's Control That Affect Performance: The severity and distribution of a problem is often beyond local or state control or expertise -- a local food-borne outbreak can be part of an outbreak related to a national distribution of a product, local immunization levels may fall below safe levels because of the presence of a large religious community whose beliefs preclude immunization, planning the use of finite staff and fiscal resources for the most likely events cannot account for the unlikely or for "acts of God."

Objective 5. Reduce the death rate from unintentional traumatic injury.

Measure: Death rate from unintentional injury per 100,000.

Definition: Unintentional injuries, three-quarters of which are motor vehicle accidents or falls, comprise two-thirds of violent deaths in Minnesota (excluding suicides and murders).

Rationale: In 1991, there were 1,456 deaths due to motor vehicle accidents, falls, or other forms of unintentional injury. The Emergency Medical Services (EMS) system responds to ambulance calls over 350,000 times per year, including virtually all trauma incidents. The EMS system is one of a number of factors that will determine the outcome of an individual traumatic injury. Lacking more precise data of the effects of the EMS system on trauma, we believe that the death rate for unintentional injury serves as the best currently available interim proxy for EMS effect on trauma.

Data Source: Mortality data are drawn from "Minnesota Health Statistics, 1991," published by the MDH Minnesota Center for Health Statistics.

A further source of data may be developed in the near future. Minnesota currently receives a federal EMS Trauma grant. There is a strong possibility that one result of the grant will be a state commitment to develop and maintain a trauma registry which will contain precise trauma data based on the treatment of trauma patients throughout the state.

Factors Beyond Agency's Control That Affect Performance: The results of a trauma event can be influenced by several factors beyond the agency's control: use of seatbelts, equipment design, helmet (and other safety equipment) wear, speed of vehicles, height of falls, use of alcohol, time elapsed between the incident and treatment, distance of transport, training of emergency medical personnel (including those in the hospital emergency rooms), availability of trauma centers with specialized personnel and equipment.

Part 3: Substantiating the Performance Measures (Cont.)

Objective 6. Prevent (especially pediatric) poisonings and minimize the effects when they occur; promote home management of poison cases.

Measure: Poison exposure calls and information calls handled, persons reached by education programs, educational print materials distributed.

Definition:

Rationale: Poison exposure calls which result in home management of poison cases result in a two-fold benefit: quicker case interventions (with attendant improved patient outcomes) and decreased treatments at emergency departments or admissions to health care facilities (with consequent savings in health care expenditures). A recent study in Louisiana [*Southern Medical Journal*, June 1991] reported that some 63% of all poison ingestion cases self-refer to a local emergency department when there is no poison center to call for assistance. If 63% of the 56,644 exposure calls in Minnesota in 1992 had self-referred, 35,686 cases would have sought emergency room treatment. At a very conservative projection of $100 per visit, some $3,568,600 would have been expended--a figure that is more than 10 times the State of Minnesota's yearly $350,000 contribution to regional poison center operations.

Data Source: The annual reports from the Minnesota Poison Information Centers submitted to the MDH.

Factors Beyond Agency's Control That Affect Performance: Regional poison center operations enjoy a heavy financial commitment to support statewide poison control efforts from the Hennepin County and St. Paul Ramsey Medical Centers.

Objective 7. Birth outcomes will be improved, and unintended pregnancies will be prevented.

Measure: The percentage of pregnant women beginning prenatal care during the first trimester of pregnancy.

Definition: The percentage of women giving birth who report receiving at least one prenatal care visit during the first trimester of their pregnancy.

Rationale: To ensure optimal pregnancy outcomes, it is critical for prenatal care to start at the beginning of pregnancy. A risk assessment done at that time can identify potential problems that can best be addressed early in the pregnancy, and the pregnant woman can be given essential health education that will prevent problems from developing.

While the Department does not provide or fund prenatal care, through its Maternal and Child Health Block Grant it is charged with the responsibility of assuring access to prenatal care, providing outreach to high-risk and hard-to-reach pregnant women, assuring that financial arrangements are available for paying for prenatal care, and providing wrap-around services that enable women to participate in prenatal care. This performance measure is an appropriate way of monitoring the overall effect of this program.

Data Source: The number of births for which prenatal care began in each trimester of pregnancy is published annually in the *Minnesota Health Statistics* by the Minnesota Department of Health. The percentage of pregnant women beginning prenatal care during the first trimester is calculated as follows:

> [(prenatal care beginning in first trimester for legitimate live births) + (prenatal care beginning in first trimester for out-of-wedlock live births)] ÷ [(total legitimate live births) + (total out-of-wedlock live births)]

Factors Beyond Agency's Control That Affect Performance: Participation in prenatal care is affected by many factors outside the Department's control. These include: the number and geographic location of health care providers willing to provide prenatal care, especially to low-income women; financial resources to pay for prenatal care; barriers to care, such as transportation, child care, and lack of translators; and lack of knowledge about the importance of receiving prenatal care, especially early in the pregnancy.

Measure: The percentage of pregnancies that are unintended.

Part 3: Substantiating the Performance Measures (Cont.)

Definition: The percent of pregnancies that were not wanted at the time of conception or that occurred earlier than they were wanted.

Rationale: Effective family planning and the avoidance of unintended pregnancy can improve infant health, because reducing the incidence of births to teenaged women and increasing the interval between births serve to reduce the incidence of low birth weight and infant death, and because women who plan their pregnancies tend to seek prenatal care earlier than women who become pregnant unintentionally. In addition, unintended pregnancies are an underlying cause of many social problems, such as child abuse and neglect, school difficulties, poverty, and juvenile criminal activity.

The Minnesota Department of Health receives $3.8 million annually in state funding for family planning grants. In addition, about $1 million in annual state/federal Maternal and Child Health Block Grant funding is spent on family planning. This performance measure is an appropriate way of monitoring the overall effect of these programs.

Data Source: The 1988 National Survey of Family Growth, conducted by the Centers for Disease Control, found that 32 percent of births occurring to married women and 55 percent of births occurring to unmarried women were unintended. The number of births and fetal deaths to both married and unmarried women is published annually in *Minnesota Health Statistics* by the Minnesota Department of Health, as are the number of induced abortions and the total number of pregnancies. The percentage of pregnancies that are unintended is calculated as follows:

> [(.32 x births to married women) + (.55 x births to unmarried women) + (.32 x fetal deaths to married women) + (.55 x fetal deaths to unmarried women) + (all induced abortions)] ÷ (total pregnancies)

Factors Beyond Agency's Control That Affect Performance: Unintended pregnancy rates are affected by many factors outside the Department's control. These include: lack of knowledge among sexually active people; failure to translate knowledge into behavior; the willingness of individuals to seek out and use family planning services; community norms regarding sexual activity, contraception, and child-bearing by teen-aged and unmarried women; and the availability of low-cost, confidential family planning services beyond those funded by the Department.

Objective 8. Infant mortality rates for communities of color will be reduced to the current relatively low rate for white infants.

Measure: The disparities in infant mortality rates between communities of color and the white population.

Definition: For each community of color for which birth and death records are maintained (African-American, Native American, and Asian-American), the ratio of that community's infant mortality rate to the infant mortality rate of whites.

Rationale: Infant mortality is an internationally-recognized standard for evaluating child health status. While Minnesota's overall infant mortality rate is one of the lowest in the United States, the disparity between the rate for white infants and the rates among communities of color is among the highest in the country.

Data Source: The number of births and deaths by race is published annually in the *Minnesota Health Statistics* by the Minnesota Department of Health. The disparity ratio for each community of color is calculated as follows:

> [(infant deaths for that community) ÷ (births for that community)] ÷ [(white infant deaths) ÷ (white births)]

Factors Beyond Agency's Control That Affect Performance: The Department does not directly control any of the factors that contribute to infant mortality; these include demographic, medical, physical, environmental, educational, behavioral, and attitudinal factors, as well as receipt and quality of medical care. However, the Department funds many activities that address these issues through prevention efforts such as family planning, improved pregnancy outcome, immunizations, childhood injury, and family violence, and funds reviews of infant deaths to determine the causes of preventable deaths and develop strategies to prevent future deaths.

Part 3: Substantiating the Performance Measures (Cont.)

Objective 9. All Minnesota pregnant women, infants, and children will have access to adequate nutritious foods and their families will have access to nutrition education services designed to prevent the occurrence of nutrition-related health problems.

Measure: The percentage of estimated eligible low-income Minnesotans participating in the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Definition: The number of participants in the Minnesota WIC program divided by the estimated eligible population.

Rationale: Nutrition is essential for sustenance, health and well-being. People who have adequate and appropriate nutrition are likely to be healthier and less in need of medical care. The largest program in the Department that addresses nutritional needs is the WIC program, which is targeted at the state's most vulnerable population, low-income pregnant women and children.

The WIC program serves several public health goals: it is a "drawing card" that allows local WIC agencies to connect families with other health services, and it promotes optimal birth outcomes and healthy child growth and development by providing nutritious foods and nutrition education. National studies have demonstrated that the infants of women who participate in WIC are more likely to be born healthy, and children who participate in WIC have better cognitive functioning. This performance measure is an appropriate way of monitoring the state's ability to meet the nutritional needs of its population.

Data Source: The number of participants receiving vouchers from the WIC program is reported to the Department by each local agency each month. The total for the state is calculated by the Department and maintained as an unpublished record. The number of persons eligible for WIC is calculated annually by Department staff using data from *Minnesota Health Statistics*, the Census, the U.S. Department of Agriculture, and WIC program statistics; it is also maintained as an unpublished record. The percentage of the eligible population served is calculated as follows:

> (WIC participation in the month of June) ÷ [{(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of pregnant women at nutritional risk) x (.75--percent of year a woman is pregnant)} + {(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (breastfeeding rate) x (percent of breastfeeding women at nutritional risk) x (.5--percent of year most women have completed breastfeeding)} + {(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (nonbreastfeeding rate) x (percent of nonbreastfeeding women at nutritional risk) x (.5--percent of year nonbreastfeeding woman is eligible)} + {(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of infants at nutritional risk)} + {(«population estimate of children under age 5» - «three-year average of births») x (percent of Minnesota population below 185% of poverty) x (percent of children at nutritional risk)}]

Factors Beyond Agency's Control That Affect Performance: WIC participation is affected by many factors outside the Department's control. These include: the amount of federal and state funding appropriated for the program; the amount of infant formula rebate the program is able to generate; the retail cost of the food products purchased by the WIC program; the capacity of local agencies to serve increased numbers of participants; and the willingness of families to avail themselves of WIC services.

Objective 10. All children with disabilities will have access to family-centered, community-based, and culturally-competent coordinated health services.

Measure: The percentage of estimated eligible low-income and/or severely disabled children receiving benefits from the Supplemental Security Income (SSI) program or the Children's Home Care Option (TEFRA) program.

Definition: The number of children enrolled in the SSI and TEFRA programs divided by the estimated eligible population.

Part 3: Substantiating the Performance Measures (Cont.)

Rationale: Access to medical care is critical to meeting the basic needs of children with special health care needs. The cost of medical care is a much more significant barrier for these children than for the general population because their medical needs are considerable and on-going. SSI and TEFRA are state/federal programs that have been created to address the special financial needs of these children. This performance measure is an appropriate way of monitoring the state's performance in assuring access to health services for children with special health care needs.

Data Source: The number of children enrolled in the SSI program is reported monthly by the Social Security Administration, and the number of children enrolled in Medical Assistance through TEFRA is reported annually by the Department of Human Services. The number of children in the state is obtained from the Census. Studies reported in the literature have estimated the prevalence of disabling conditions among children from 1 to 30 percent; the Department bases its estimate on a conservative study (Newacheck) that estimates that 1.5 percent of children have a condition that severely limits their activities. The percentage of the eligible population served is calculated as follows:

> [(number of children under 18 enrolled in SSI in a specified month) + (number of children enrolled on Medical Assistance through TEFRA in a specified month)] ÷ [(number of children under 18) x .015]

Factors Beyond Agency's Control That Affect Performance: Participation in SSI and TEFRA is affected by many factors outside the Department's control. These include: changes in eligibility criteria; delays in processing applications and determining medical eligibility; inadequate documentation from medical care providers and schools; inaccessibility of school records during the summer; and the unwillingness of families to seek out and accept public assistance or, in TEFRA, to make financial contributions to the cost of care for their children.

Measure: The percentage of Minnesota counties that document providing services to children with special health care needs in their local maternal and child health plans.

Definition: The number of counties in which Maternal and Child Health Block Grant funds are used in the Handicapped/Chronically Ill component divided by the total number of counties in the state.

Rationale: The purpose of community health boards under state statute is to "develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards." Through the Maternal and Child Health Block Grant, community health boards have access to funds that can be used to develop integrated systems of care for children with special health needs. The Maternal and Child Health Advisory Task Force has recently recommended to the Department that community health boards assume a much more active role in meeting the public health needs of this special population. This performance measure is an appropriate way of monitoring the Department's progress in delegating responsibility for developing community-based strategies for serving children with special health care needs.

Data Source: Every two years, each Community Health Board in the state submits to the Department a Maternal and Child Health Block Grant application, documenting how the funds it receives through a formula will be used in its geographic area. This information is logged by county and maintained as an unpublished record by the Department. The percentage of counties serving children with special health care needs is calculated as follows:

> (number of counties allocating funds to the Handicapped/Chronically Ill component) ÷ (87-- the number of counties in the state)

Factors Beyond Agency's Control That Affect Performance: Under state statute, the Maternal and Child Health Block Grant can be spent by most community health boards in any of four components, one of which is the Handicapped/Chronically Ill component; community health boards have complete discretion regarding which of the components they will fund. The Department's ability to affect the decisions made by the boards is limited to providing guidance and setting standards.

ANNUAL PERFORMANCE REPORT
Part 3: Substantiating the Performance Measures

Agency: Health, Department of
Program: Health Support Services

Objective 1. Timely processing of vital statistics in electronic media for mederal agencies and an annual summary of heath statistics.

Measure: Average number of days for preparing the transmission of the monthly data set of vital statistics to the Social Security Administration and Nation Center for Health Statics.

Definition: The number of days after the end of the month which that month's data would be transmitted to the federal agencies.

Rationale: The turnaround time is required by the contract with the National Center for Health Statistics and the Social Security Administration. In addition, having the vital records data in electronic media is very important in a timely fashion for other MDH programs to identify individuals for high risk births; immunization, outreach, etc.

Data Source: Internal management reports.

Factors Beyond Agency's Control That Affect Performance: Proposed legislation for the 1995 legislation will be needed to enhance turnaround time .

Measure: Publish an accurate final report of the Summary of Health Statistics in terms of the number of months following the end of the reporting year.

Definition: With each year having an annual summary of health statistics, the number of months following the end of the reporting year but the summary is published.

Rationale: The major report produced by the Center for Health Statistics is the annual report entitled Minnesota Health Statistics. This report has a series of key customers including local public health agencies, medical researchers and health program people. A major concern is the timeliness of the data being available in a final, accurate manner. By reducing the logtime in the availability of the data, health officials will be able to use the information in a more timely fashion.

Data Source: Internal management report.

Factors Beyond Agency's Control That Affect Performance: Reporting of data from other agencies.

Objective 2. To provide accurate and useful statistical data for the Department of Health programs and the Center for Health Statistics' customers.

Measure: Percent satisfied among customers of the Center for Health Statistics regarding the usefulness of reports and analyses.

Definition: On a routine survey of randomly sampled recipients of the Center's reports and analysis, the percentage who are satisfied with the usefulness of these materials generated by the Center for Health Statistics.

Rationale: The major impact of the Center for Health Statistics on improving health outcomes is the extent to which health officials can practically use statistical information to develop targeted and effective programs. The Center produces the annual summary of Health Statistics, the County Health Profiles, and Behavioral Risk Data on a statewide and regional basis and other special analyses. The customers or recipients of these reports should be able to report that these materials are useful on assisting them in improving health outcome.

Data Source: Special survey to be developed.

Factors Beyond Agency's Control That Affect Performance: Inherent challenge of making health data useful to health program staff.

Objective 3. Prompt and courteous processing of birth and death records.

Measure: Copies of birth and death records turnaround time in days after request.

Definition: After the citizen has requested a copy of a birth or death record, the number of days before the copy is mailed out.

Rationale: The Vital Statistics Records Section is responsible for processing all copies of birth and death records for citizens who need them for passports, school registration and many other reasons. Prompt turnaround time is very important for the citizens who request the copies.

Data Source: Internal Fee Accounting system.

Factors Beyond Agency's Control That Affect Performance: Volume of requests by citizens.

Objective 4. Information technology resource development will meet the needs of agency program managers.

Measure: Number of regular Management Information Technology Advisory Committee (MITAC) meetings.

Measure: Percentage customer satisfaction survey of policies and coordination.

Rationale: The intent is to institute an annual survey of customers beginning in 1994. The survey may include selected in-depth interviews. The intent is to find out the level of satisfaction and where to change or improve the IS&T leadership role or the MDH method. The customer survey will measure how well the method for departmental control and coordination of information technology resources continues to support accomplishment of program objectives.

Measure: Number of MDH Sites on Computer Network.

Measure: Percent of MDH Staff on MDH E-mail.

Measure: Voice Mail Installed at MDH Metro Sites.

Rationale: The above three indicators measure the universality of the technology productivity tools. It indicates how widespread these basic tools are available to support program objectives.

Data Source: IS&T inventory records.

Rationale: Quality means meeting the needs and expectations of the customer. The intent is to institute an annual survey of customers beginning in 1994. The survey may include selected in-depth interviews. The intent is to find out customer satisfaction with the quality of the IS&T telecommunications services and how helpful the services are to programs to carry out their program objectives.

Objective 5. A records management program will ensure that mission critical information is available and that the disposal of information of no further value to the Department is performed efficiently.

Measure: Percentage records boxes going into inactive storage identified completely on the records container label.

Rationale: The labels being filled out accurately shows that the employees working with the records are aware of the records' data privacy classification, its value to the Department (disaster recovery category), and proper retention period. This is an indicator that all record series are identified on approved records retention schedules. This shows that all the mission critical records in the Department have been identified and that the procedures for handling them (such as data privacy classsification, retention period and disposal method) have been reviewed and approved.

Data Source: IS&T record management storage activities file.

Objectives 6, 7 & 8. Library clients will have accessible MDH library materials from all libraries plus be knowledgeable as to other libraries' literature.

Definition: All library outcome measures are indications of actual work done for clients. These units or types of work are counted and compiled monthly.

Rationale: The measures used here are indications of work performed by the library staff and usage patterns of our clients. The changes in usage patterns might be a reflection of staff needs, staff relocation, the current library collection, or changing direction of the department. There has been no attempt to ascertain why the patterns have changed. The librtary will be using a survey of clients to gauge quality of service, outcomes for which information is being sought and potentials for improvement. The coming calendar year a Library Committee will be established to assist the library director in establishing direction and future goals.

Objective 9. Programs will be provided the materials and services required to achieve excellence.

Measure: Number of purchases made for program requirements.

Definition: The total number of purchase orders and their product value that were negotiated and issued to vendors in order to meet program demands. The number of stocked items indicates the total number of products that are maintained in a store as a buffer between immediate customer needs and vendor ability to supply.

Rationale: This outcome measure demonstrates the number of customer requests that were made and met during the year, and their associated dollar value. Stocked items represents those items that there has determined to be a repeated and on-going need for and is more efficient to purchase a greater number at one time rather than purchasing directly each time a small quantity is needed.

An improved measure of performance would be the number of times a need was anticipated and thus reducing the need to issue a purchase order for a particular item. In effect, a purchase that is not made to replenish stock represents a failure to anticipate customer requirements. No effective way has been found to collect this information, however, discussions are on-going to develop improved measurement methods.

Data Source: Purchasing and materials management systems are computerized and provide regular reports on number of puirchases, their value, and number of stocked items.

Factors Beyond Agency's Control That Affect Performance: The agency relies heavily on material contracts negotiated through the Department of Administration. Failure to provide effective or timely contracts has a negative affect on meeting customer requirements.

Objective 10. Programs will be provided safe and productive work space.

Measure: Square feet of space proved for employees.

Definition: The total number of office, laboratory, and storage, space leased or owned for use in support of Department programs.

Rationale: This outcome measure demonstrates the square footage made available to support Department programs.

Alternate measures of performance could include the number of metropolitan or non-metropolitan locations that have been developed or provided for use in support of programs. An additional measure could include theft rates or other security incidences to measure the effectiveness of security practices. These measures could be reasonably available; however, an improved measure would be the level of satisfaction employees experience in the work space that has been provided in relation to the cost of providing this space. A hight level of satisfaction could be achieved if cost were not considered important; however, current efforts require a high degree of cost effectiveness.

Data Source: Square footage information is readily available and compiled from lease information.

Factors Beyond Agency's Control That Affect Performance: The agency relies on real estate and negotiation services by the Department of Administration.

Objective 11. Mailing and distribution services will be provided to meet customer communication requirements.

Measure: Pieces of outgoing mail processed.
Packages Shipped.

Definition: The total number of pieces of outgoing mail that was processed for mailing for Department programs and the total number of packages that were prepared for shipping.

Rationale: This outcome measure demonstrates the volume of outgoing mail required to be processed in order to meet customer requests during the year. The number of packages processed for shipment demonstrates customer demand for materials to be shipped outside of the Department in support of Department programs.

An alternative measurement would provide information on the ease with which programs can make use of this service; however no effective means has been developed at this point to economically provide this measure.

Data Source: Piece counts are recorded as a necessary step in the replenishing of postage funds and are readily available.

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

In the past, focus groups, surveys, and other means of generating customer information have been used to help determine customer requirements and opportunities for improvement. These forms need to continue and be expanded as ways of generating customer feedback to drive continuous improvement and re-engineering efforts. In addition, work on a strategic plan in beginning to help better identify key goals, and develop improved performance measures.

Objective 12. Payments will be processed on a timely basis to meet statutory requirements and available discounts.

Measure: Percent of payments processed within thirty (30) days of receipt of invoice.

Definition: Self explanatory.

Rationale: This is a key indicator of efficiency as well as customer service.

Data Source: Monthly reports provided by the Department of Finance.

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

Objective 13. Customers will be satisfied with financial services provided by the section of Financial Management.

Measure: Percent of customers with positive response to services provided.

Definition: Self explanatory.

Rationale: The level of customer service needs to be improved for both internal staff within the agency as well as external customers outside of the agency.

Data Source: A survey process will be designed to measure this outcome.

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

Part 3: Substantiating the Performance Measures (Cont.)

Objective 14. To ensure an effective workforce through the maintenance of a comprehensive performance management system.

Measure: Percent of employees with a completed performance appraisal on a timely basis.

Definition: A comprehensive performance management system includes regular feedback on individual performance, recognition of excellence and a plan that addresses ways to strengthen identified weaknesses. This measure is the written performance review that serves as documentation for the system.

Rationale: A strong performance management system contributes significantly to the ability of the MDH to meet or exceed its goals by regularly encouraging and recognizing outstanding employee performance and developing strategies to strengthen areas where performance is weak. This measure is a proxy of the use of the system.

Data Source: Human Resources Management Section records.

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

Objective 15. To improve employee performance levels in present jobs, to encourage individual development and to prepare employees for a changing workplace through an integrated training and development program.

Measure: Total number of hours of training.

Definition: The total number of hours of training is the summation of the number of hours for each training activity multiplied by the number of employees attending.

Rationale: This measure serves as a proxy for training that supervisors and employees have identified as necessary for excellence in performance.

Data Source: Training records located in the Human Resources Management Section.

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

Objective 16. To continue the Department's commitment to customer/client oriented service through training and work-group development.

Measure: Percentage of staff trained in customer service skills.

Definition: The percentage of current MDH staff who have received customer service training, either through MDH's training program or another documented trainer.

Rationale: This measure is a proxy, based on the assumption that employees who have been trained in customer service skills will utilize them in serving their customers and clients..

Data Source: Training records located in the Human Resource Management Section.

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

Part 3: Substantiating the Performance Measures (Cont.)

Objective 17. To ensure that the Department's workforce is reflective of the local labor force and the Department embraces concepts of equal employment opportunity through an effective Affirmative Action Program.

Measure: Number of hires needed to meet MDH's established goals for each protected group.

Definition: The MDH Affirmative Action officer, in cooperation with the Equal Opportunity Division staff of the Department of Employee Relations, established goals for the agency. These goals are based on 1990 Ecnsus data regarding the availability in particular geographic areas of protected group members in specific occupational categories..

Rationale: These percentages ensure that the MDH employee population is at least reflective of the protected group populations in the local labor market. To that extent, it serves as a proxy for commitment to ensure a diverse workforce..

Data Source: MDH Affirmative Action reports.

Factors Beyond Agency's Control That Affect Performance: Beyond Agency's Control That Affect Performance: The absence of protected group members in several of the scientific or technical job classes that are needed by the MDH.

Objective 18. Provide quality support services with a minimum level of resources.

Measure: Indirect cost rate.

Definition: Indirect costs are specifically defined in federal management circular 74-4 (88 pages), and are required pursuant to M.S. 16A.127. Summarily, they represent those costs not generally paid directly by federal and state programs. They include such things as the costs of accounting, budgeting, financial control, administrative services, personnel, space rental, telephone services, etc.

The Department is required by state and federal law to negotiate an indirect cost rate with the federal Department of Health and Human Services on an annual basis and to charge this rate to all programs unless specifically exempted by law.

It should be noted that indirect costs are only charged on "applicable direct costs" which exclude such things as grants, equipment, contracts over $25,000, etc. The purpose of the indirect cost rate is to ensure that all programs pay their fair share of total costs. The option would be to set up duplicative direct cost activities for each program which would result in inefficient management of resources.

In addition to the indirect costs of the Department of Health, the statewide cost allocation of the Department of Finance (DOF) is included in the various state agency rates which requires that a portion of the indirect costs collected by the Department of Health be transferred to the state's General Fund.

Rationale: The indirect cost rate can be used as a proxy measure of the efficiency of providing support services to Department program activities.

Data Source: Annual indirect cost rate proposed as negotiated with the Federal Government.

Factors Beyond Agency's Control That Affect Performance: The share of the agency rate attributed to control state agencies such as Department of Finance, Employee Relations and Administration are not within the Department's control.

ANNUAL PERFORMANCE REPORT
Part 4: Improving Programs and the Reporting Process

Agency: Minnesota Department of Health

Process Used: The Minnesota Department of Health has involved the Division Directors and Assistant division Directors in preparing this report. The process included Division and Executive Office staff reviewing the performance indicators in the 1994-95 biennial budget and determining which of these existing indicators and newly developed indicators should be included in the report. There was an emphasis made on using indicators which can be rigorously measured. Newly developed indicators will emphasize outcomes measures, both "intermediate" and "end-stage" out comes. The final review and editing of these indicators occurred with the Executive Office in consultation with division staff.

Ways to Improve Program Outcomes: The agency wil undertake a planning process in November, 1994 - February, 1995 to determine the process for improving program outcomes.

Employee Development: The department currently has several activities that are addressing various areas of program planning and performance outcomes. These include a quality management group, the Biennial Budget priority-setting process, a Customer Service Training program, a management group to address the department's goals for the year 2000 and the statutory "Worker Participation Committee" established by the 1993 legislature.

These activities and groups will participate in the design of an ongoing system for development of outcome measures and a performance reporting process.