ANNUAL PERFORMANCE REPORT

1994

MINNESOTA DEPARTMENT OF HEALTH

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Department of Health

AGENCY SUMMARY

AGENCY SUMMARY

AGENCY: **Health, Department of**

MISSION:

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

GOALS:

- 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 care from health care providers;
- to assure efficient and effective coordination of health related activities and services among state and local public health agencies;
- to improve decision making and health related planning and research at all levels of government and in the private sector; and
- to reduce the rate of increase in health care expenditures in Minnesota.

Table 1:

Program	Estimated Expenditures ($ in Thousands)	Percent of Total	FTE Staff Positions	Percent of Total
Community Health Services	$17,249	10.8	63.8	6.0
Family Health	77,063	48.3	153.2	14.4
Health Care Delivery Policy	4,669	2.9	60.5	5.7
Occupational and Systems Compliance	5,223	3.3	52.7	5.0
Facility and Provider Compliance	11,816	7.4	194.0	18.3
Environmental Health	13,344	8.4	192.9	18.2
Disease Prevention and Control	15,668	9.8	144.4	13.6
Public Health Laboratory	5,064	3.2	90.1	8.5
Administration	6,572,667	4.0	56.2	5.3
Management Services	2,952,370	1.8	52.6	5.0
Totals	$163,064,635	100	1060.4	100

ORGANIZATION:

The department is organized into 9 programmatic areas: 1) Community Health; 2) Family Health; 3) Health Care Delivery Policy; 4) Occupational and Systems Compliance; 5) Facility & Provider Compliance; 6) Environmental Health; 7) Disease Prevention and Control; 8) Public Health Laboratory; and, 9) Administration. Programs 1 through 3 make up the Bureau of Health Systems Development. Programs 4 and 5 are part of the Bureau of Health Quality Assurance. Programs 6 through 8 make up the Bureau of Health Protection. Administration is not part of a bureau. Services are delivered through a variety of direct prevention activities, educational services and state and local partnerships with county and city agencies.

WAYS TO IMPROVE PROGRAM OUTCOMES:

Organizational Structure: Over the past several years, the agency has grown significantly in both size and responsibility. Many new responsibilities result from the designation of the department as the lead agency in health care reform. These activities have, led to corollary responsibilities for defining and facilitating the achievement of new roles for public health in a reform ealth system.. In July, 1994, a new organizational structure was established to support these new responsibilities. This new structure emphasizes better integration of health care reform activities with other agency programs, and clarifies interdivisional linkages throughout the agency.

Systems Development: Health reform will drive changes to public health responsibilities in the future. The department, in concert with other health reform stakeholders, will be moving to complete and implement the recommendations required by Article 7 of the 1994 MinnesotaCare Act. The department will need to translate the core public health functions of "assessment, policy development and planning, and assurance" into operational terms and estimate the funding needs of meeting those operational requirements. It also must develop strategies for improving local capacity for meeting those requirements and further develop strategies for ensuring future financing and delivery of personal care services.

Capacity Building for State & Local Public Health: The department anticipates that state and local public health agencies will increasingly emphasize the core assessment, policy development and planning and assurance. Strengthening state and local government capacity to perform these core functions is a prerequisite to true reform of the health system. An important agency priority is to support MDH programs as well as local public health agencies in health assessment and policy development. Programs will emphasize the core public health functions of assessment of Minnesotans' health status on a population-wide basis and translate these assessments into policy development by supporting the development of integrated joint state-local information systems, research and technical capacity. Supporting the core public health functions for local agencies will be a major focus in the next year.

Data Initiatives: The department has focused on the issue of data, in terms of its effective collection, analysis and application to health programs as a major priority. Each program is taking on a significant responsibility in improving the quality and effectiveness of its data systems and support staff. The result of these efforts will be to improve the performance tracking and program evaluation associated with the objectives described in this report.

Linkages Between Programs: As part of the changes in organizational structure, a growing priority is on coordination among programs in the agency and across state agencies to achieve overall objectives. Within the agency, several key coordinating committees have been established to share information and assure consistency. The Management Information and Technology Advisory Committee, which has five years of experience in developing standards and policies for computer systems, has recently completed a Strategic Information Plan emphasizing public access to readily available data systems to enhance customer service. The Data Coordination Committee has been established recently to assure the coordination and quality of department data initiatives. Across state agencies, the department has had a long history of working collaboratively with other departments to achieve shared objectives. For example, in the area of children's issues, the department has been actively involved in Part H, Pew, ChITA, 1115 Waiver, Learning Readiness, Project Cornerstone, Children's Mental Health Integrated Funding. In the area of health care reform, the Department of Health as the lead agency has provided leadership in coordination across several state agencies. Finally, the department is strengthening a comprehensive ongoing coordination effort with the Department of Human Services to achieve objectives shared by both agencies.

WAYS TO IMPROVE PROGRAM OUTCOMES (continued):

Employee Development: The department currently has several activities that address various areas of program planning and performance outcomes. These include the biennial budget priority-setting process, a Quality Committee, 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. Some specific examples of supporting staff to achieve customer service efficiencies are telecommuting options, assessing ergonomic improvements in the workplace, implementation of the statewide accounting systems, and an automated 24-hour response system for nursing assistant inquiries. In addition, several divisions within the department are involved in developing strategic plans.

Administrative & Support Services: Although the specific objectives for administrative and support services are not addressed in this report, these services represent a crucial factor in the successful achievement of agency goals. Ongoing consultation by support services managers with program managers is a top priority. Using the results of consultations with programs, Administration & Support Services has developed strategic plans and specific objectives for customer service and efficiency.

SUMMARY

AGENCY: **Health, Department of**
PROGRAM: **01 - Division of Community Health Services**

EXPENDITURES AND STAFFING (F.Y. 1994)

	($ in Thousands)	
Total Expenditures:	$ 17,250	10.8% of department's budget
From State Funds	$ 16,093	
From Federal Funds	$ 1,090	
Number of FTE Staff: 63.8		6% of department's total

PROGRAM GOALS:

- To ensure that Minnesota's communities and local governments are able to meet their public health responsibilities under state law (M.S. 145A).
- To ensure that Minnesota's communities and local governments systematically assess health status and establish plans in order to improve public health.
- To support cooperative partnerships with cities, counties and local health organizations (M.S. 145A.12).
- To provide policy direction, leadership and information for the Department on Public Health and Health Care Reform activities.
- To support disease prevention, health promotion and health service delivery programs and strategies which address the gap in health status between minorities and non-minorities by collaborating with staff of the Department, local public health agencies, other relevant state and local agencies and community organizations so that the health status in minority populations is improved.
- To provide public health-related information, data collection, analysis, and reporting services to assist in identifying health problems and in carrying out the duties of the Office of the State Registrar of Vital Statistics (M.S. 144.211-144.227).

DESCRIPTION OF SERVICES:

The Community Health Services (CHS) activity is the primary activity ensuring that Minnesota's communities and local governments are able to meet their public health responsibilities under State law. The Department supports the infrastructure necessary to address this mission in a variety of ways:

- administers a $14 million subsidy program for (49) Community Health Boards covering the state that provides approximately 8% of total revenues available for local community health planning and activities. The Boards prevent and control communicable diseases; protect the health of persons suffering medical emergencies; improve and maintain

environmental health and safety; promote optimum human reproduction and child growth and development outcomes; and reduce health risk conditions or behaviors in order to prevent chronic diseases.

- provides training and consultation to Community Health Boards for local planning, provision and evaluation of community health services. Technical expertise is provided by various Department activities in the following areas: disease prevention and control, emergency medical services, environmental health, family health, health promotion, home health care, community assessment, program planning, administration, and program evaluation.

- maintains formal state and local public health policy development through the State Community Health Services Advisory Committee -- an advisory committee whose members are appointed by each of the state's 49 Community Health Boards. The advisory committee works with the commissioner and department staff to address joint state-local issues, to develop program guidelines and planning and reporting procedures, and to make recommendations regarding department policy, legislation and the continuing goals of the public health system.

- coordinates and supports efforts to improve the health status of Minnesota communit. :olor. The Office of Minority Health functions as a centralized mechanism to establish liaisons with communities lor, coordinate Departmental minority health activities, serve as a resource center, ensure the exchange of relev.. . information, pursue funding opportunities, and ensure the existence of consistent departmental policies in this area.

- administers grants to establish, operate, or subsidize clinic facilities and services to furnish health to two traditionally underserved populations -- Indians who reside off reservation and migrant agricultural workers and their families.

- provides necessary information for identifying health problems and assisting in the design of appropriate activities to address them. Data collected includes an ongoing statewide survey of over 2.000 households on behavioral risk factors. Much of the information collected is necessary to meet reporting requirements and program priority setting needs of external agencies and organizations.

BACKGROUND INFORMATION:

Public health in Minnesota is a complex collaborative process of shared responsibilities among state, local and regional agencies. Success in the system is often defined by what does not 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.

The collaborative process is also driven by data -- local, state, and national public health efforts are formulated using common data sources, data specific to the level of government or locality, and data specific to particular populations or sub-populations. Some of these data must be generated and maintained to meet obligations to our citizens as well as to state and federal government (birth and death records, for example). Other data help policy makers determine the best ways to address system changes (birth weight related to prenatal care, for example).

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994
	Documents Processed:		
W	Birth Certificates	67,000	68,000
W	Death Certificates	34,500	34,500
W	Marriage Reports	35,500	35,500
W	Divorce Reports	17,000	17,000
W	Abortion Reports	17,500	17,500
	Records Transmitted:		
W	NCHS	103,000	104,000
W	CDC	3,420	3,420
	Statistical Request:		
A	Routine and Custom Tabulations	2,500	2,500
A	Home Care Visits	1,100,000	1,200,000
A	Environmental Health Investigations	41,000	41,000
A	Disease Report Investigations	24,000	24,000
A	Family Health Visits	320,000	320,000

PROGRAM DRIVERS:

Health Reform. The working formula for health reform is:
(Health Reform = Health Care Reform + Public Health Reform). Health reform is driving the medical care and the public health systems to be accountable for new activities and for different populations. In light of massive system changes, local and state governments will need to redefine government responsibilities, particularly in the assurance function -- ensuring that personal health services and public health concerns are clearly delineated and appropriately delivered.

Capacity Building. Historically, many public health activities have been inseparable parts of personal care activities (nutrition education, for example, is often part of a medical care home nursing visit). Health reform requires state and local governments to distinguish among these activities and concentrate on traditional "core" public health functions -- assessment, planning and policy development, and assurance. As these core functions become more essential and visible, public health programs will need to develop better information systems and further research and technical capacity. Changing responsibilities -- assessment obligations to show which problems, approaches and programs matter the most as well leadership capacity to legitimize these findings in the arena of public policy discussion -- will be reflected in an increasing emphasis on support for core public health functions.

Demographic Changes. Minnesota's changing population requires new and more sophisticated program planning and delivery. While most health indicators for the general population of the state appear excellent, specific subgroups within the population do not share that standing. Communities of color are, by almost all indexes, less healthy than the white population of the state. Cultural differences in an increasingly heterogeneous population mean that traditionally successful public health methods no longer work. A growing population of the "old" elderly put additional strains on communities' health resources.

AGENCY: **Health, Department of**
PROGRAM: **Division of Community Health Services**

OBJECTIVE, MEASURE

Objective 1: 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.

Measure (1): Local prevention/mitigation program activities.

Actual Performance	F.Y. 1992	F.Y. 1993(e)	F.Y. 1994(e)	F.Y. 1995(e)	F.Y. 1996(e)	F.Y. 1997(e)
Home Care Visits	974,830	--	--	--	--	--
Target	1,000,000	1,100,000	1,200,000	1,2000,000	1,100,000	900,000
Environmental Health Investigations	39,353	--	--	--	--	--
Target	40,000	41,000	41,000	41,000	45,000	45,000
Disease Report Investigations	23,715	--	--	--	--	--
Target	20,000	22,000	24,000	24,000	28,000	30,000
Family Health Visits	324,397	--	--	--	--	--
Target	240,000	320,000	320,000	320,000	300,000	300,000

DEFINITION, RATIONALE, DATA SOURCE:

(Selected) local prevention/mitigation activities measure ongoing prevention activities provided locally, which fit into an overall state-local effort to preserve public health.

The performance measures chosen are local activities that support directly the prevention of disease or the mitigation of its effects. Community Health Boards (which are partially supported by a state subsidy) provide resources in two areas critical to the success of this local-state collaborative process; trained personnel and community assessment/planning. Trained personnel are critical 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 reform in Minnesota.

DISCUSSION OF PAST PERFORMANCE:

Minnesota has begun to implement health reform. As integrated service networks and other private providers begin to extend services to groups they have not served in the past, we anticipate that some services and responsibilities traditionally provided by government (particularly in the areas of home health care and family health visits) will shift to private providers. The extent of this shift will depend on the details of universal coverage available to citizens as well as on the extent of growth of the state's "high risk" population.

PLAN TO ACHIEVE TARGETS:

Collaborative efforts between the Department and local health agencies will provide increased capacity for agencies to provide the core public health functions. A major statewide conference/training session and follow-up assistance around tuberculosis control and immunization improvement is already underway; additional focus on community health assessment is also underway during late 1994 - 1995.

OTHER FACTORS AFFECTING PERFORMANCE:

Health reform will be changing the entire public health landscape as it is implemented. Local government provides the majority of direct support to public health programs. State or federal decisions to further categorize funds will put pressures on local government to respond only to "funded mandates." Unanticipated disease or environmental threats can cause a substantial shifting of resources from one program to another in order to respond.

Measure (2): Response to public health emergencies and to major initiatives

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Immunization status assessed - children		69,000				
TB Test/Circus		200				
Flood - Water test			1057			
Food-Borne Outbreak			1700			
School Enrollment Targets	N/A	N/A	N/A	N/A	N/A	N/A

DEFINITION, RATIONALE, DATA SOURCE:

Maintaining the public health system in a "state of readiness" to respond to initiatives and emergencies prevents death, disease and disability. In 1993 and 1994, 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. Sixty-eight circus employees were located and tested. Appropriate preventive follow-up, including therapy and treatment, was initiated for those with a positive mantoux test in order to prevent further infection of workers or the public. 3) The 1993 summer 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 well laboratory samples. Local health agencies distributed kits, responded to citizen inquiries, and did necessary follow-up work with the owners of wells that had been contaminated. 4) In a cooperative effort between the Department and the Anoka County CHS Agency, a disease outbreak was investigated and found to be *shigella sonnei*, a disease organism associated with the cafeteria in Fred Moore Middle School. Mitigation efforts were put in place to protect the three-quarters of the students and staff not yet affected by the outbreak.

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.

DISCUSSION OF PAST PERFORMANCE:

See immediately above.

PLAN TO ACHIEVE TARGETS:

Maintain the CHS system in a "state of readiness."

OTHER FACTORS AFFECTING 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, MEASURE

Objective 2: Implementing public health reform consistent with the changes occurring in health care reform -- particularly in the area of core public health functions.

Measure (1): Core public health functions--local use in planning

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
% use of assessment guidelines in plans	--	--	--	--	--	--
Target				100	100	100
% ISN/CISN plans reviewed for high risk	--	--	--	--	--	--
Target				50	60	70
% CHBs with all core function areas addressed	--	--	--	--	--	--
Target				30	45	60

DEFINITION, RATIONALE, DATA SOURCE:

Health reform is beginning to define governmental responsibilities in relation to private efforts to assure access to affordable health care by the entire population. Key to this delivery is to assess the need for prevention and emergency response activities, to develop incentives/regulations to respond to the assessment, and to implement community and statewide strategies to assure that public or private efforts to promote/protect health are in place.

Data are being gathered from Washington State, from the CHS Reporting System, and from surveys (of FTEs and costs to perform core functions, completed by 8 pilot agencies in July, 1994). Additionally, Community Integrated Service Networks (CISNs) and Integrated Service Networks (ISNs) are required to plan to meet the needs of high risk/special needs populations. These plans will be coordinated with/reviewed by local public health agencies.

DISCUSSION OF PAST PERFORMANCE:

Article 7 of the 1994 MinnesotaCare Act (Minn. Laws 1994, Ch. 625, Art. 7, §1) requires a report and recommendations to the Legislature on: implementing and financing local government public health functions and a series of other recommendations culminating in a recommended level of "dedicated funding" for local public health.

PLAN TO ACHIEVE TARGETS:

In determining the Legislative recommendations, the Department, in concert with the State CHS Advisory Committee, is concentrating on core public health functions (assessment, policy development and planning, and assurance). These functions should be reflected in future local public health plans and activities and in local public health authorities' review of CISN/ISN plans to meet high risk/special needs populations.

OTHER FACTORS AFFECTING PERFORMANCE:

Shifts in Medical Assistance (MA) dollars to managed care contracts will probably result in less third party revenue for assurance activities, especially if MA funds are used to expand the uniform benefits set to substantially more people. Local collaboration among several service providers will need to recognize the importance of core functions as part of an organized system that includes planning as well as service delivery.

OBJECTIVE, MEASURE

Objective 3: Timely processing of vital statistics on electronic media for federal agencies and an annual summary of health statistics.

Measure (1): Average number of days for preparing the transmission of the monthly data.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996(e)	F.Y. 1997(e)
Days Turnaround	95	100	95	90	--	--
Target	90	90	90	90	80	70

DEFINITION, RATIONALE, DATA SOURCE:

The number of days after the end of the month which that month's data would be transmitted to the federal agencies. 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, immunizations, outreach, etc. Data source come from internal management reports tracking the turnaround time.

DISCUSSION OF PAST PERFORMANCE:

Meeting the target turnaround time has been increasingly difficult with the existing manual system of a centralized data entry of paper birth and death certificates. The improvement in the turnaround time in FY 1994 and 1995 compared with FY 1993 has been a result of a pilot test of an Electronic Birth Certificate automated program.

PLAN TO ACHIEVE TARGETS:

The major plan revolves around the implementation of the Electronic Birth Certificate (EBC) system on a statewide basis. There will be legislation and a two-year appropriation sought for FY 1996 and FY 1997 to implement the EBC system at the state's 50 largest hospitals -- accounting for over 90% of all births.

A pilot for a Electronic Death Certificate (EDC) system is also going to be pursued. Once the results of the EDC pilot have been assessed in the next two years, a legislative proposal can be pursued for automated systems for death certificates.

OTHER FACTORS AFFECTING PERFORMANCE:

Developing new automated systems will require not only the support of Legislature, but also hospitals, physicians, other health providers, and mortuaries. A top priority is developing the cooperation and support by these professional groups.

Measure (2): Final report of the Summary of Health Statistics in terms of the number of months

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996(e)	F.Y. 1997(e)
Months to Publish	12	12	11	10	--	--
Target	12	12	10	10	9	9

DEFINITION, RATIONALE, DATA SOURCE:

The definition is the number of months following the end of the reporting year when the summary is published. 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 is an internal management report tracking the process of gathering and publishing the summary.

DISCUSSION OF PAST PERFORMANCE:

Making timely data available to policy makers has been an important priority, but is hindered by the manual processing of paper records and a data entry process near the end of the process. Processing time has remained stable at 12 months with FY 1994 being the first year to reduce the time to 11 months.

PLAN TO ACHIEVE TARGETS:

The more efficient use of automated systems will enable the data to be available for tabulation and publishing on a more timely basis. The Electronic Birth Certificate and Electronic Death Certificate will enable data to be processed in a more automated fashion.

OTHER FACTORS AFFECTING PERFORMANCE:

In addition to the need for more automated systems, there are key data items needed from the office of the State Demographer and other state agencies which are crucial to the timely publishing of the report.

OBJECTIVE, MEASURE

Objective 4: Accurate and useful statistical analyses for the Department of Health and other customers.

Measure (1): A percent level of completeness and accuracy and a percent satisfied with usefulness

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Accuracy & Completeness %	--	--	--	--	--	--
Target	--	--	--	--	--	--
Satisfied %	--	--	--	--	--	--
Target	--	--	--	--	80	80

DEFINITION, RATIONALE, DATA SOURCE:

The definition would need to be developed based on the nature of the three on-going studies performed each year. It is anticipated that the three studies would be developed so that they would be consistent in future years in order to be able to compare year-to-year changes. One study will most likely focus on the completeness of the birth certificate data to assure that all items are completed by the health care provider. The second study will measure the accuracy of the birth certificate data by a well-established methodology developed by the National Center for Health Statistics. The third study will look at the completeness of the death certificate. In all cases there will be a strong attempt to use methodologies developed by the National Center for Health Statistics, so that we could compare Minnesota results with other states as well as with national averages.

The rationale for accurate and complete vital statistics information is clear. The usefulness of vital statistics is based entirely on whether the information is complete and accurate. Their major concern across the country is that vital statistics information is inaccurate and sometimes severely biased, based on the response and accuracy of the health care providers completing the forms. The data source for these studies would be the vital statistics data and the methodologies developed to analyze the data. The satisfaction measure is the percent satisfied among customers of the Center for Health Statistics regarding the usefulness of reports and analyses. Satisfaction is defined on a routine survey of randomly sampled recipients of the Center's reports and analyses, the percentage who are satisfied with the usefulness of these materials generated by the Center for Health Statistics.

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 the reports should be able to report that these materials are useful on assisting them in improving health.

DISCUSSION OF PAST PERFORMANCE:

Minnesota has never vigorously conducted these studies in the past. There has been a reliance on the National Center for Health Statistics to conduct routine studies of this nature. Minnesota has tended to rank in the middle among the fifty states in terms of accuracy and completeness. Further analysis of the past performance will be a key initial step in the development of these accuracy and completeness studies in the future. There has not been a satisfaction survey of the customers of the Center's report.

PLAN TO ACHIEVE TARGETS:

The major activity will be to assess the nature and the scope of the accuracy in Minnesota. Once these analyses have been initiated, specific actions would be taken including the following:

- Build in edit checks into the electronic birth certificate and electronic death certificate automated systems
- Outreach to health care providers
- Evaluate the data that is collected for reasonableness to achieve accuracy standards.

A customer service program will be initiated to develop ways in which reports can be made more useful.

OTHER FACTORS AFFECTING PERFORMANCE:

The primary contributors to accuracy and completeness are the health care providers in hospitals and personnel in the medical examiners' offices who deal with birth and death certificates. There will need to be a significant collaboration with the Minnesota Medical Association, mortuaries and local registrars of vital statistics to improve accuracy and completeness of birth and death records.

AGENCY: **Health, Minnesota Department of**
PROGRAM: **Division of Community Health Services;**

OBJECTIVE, MEASURE

Objective 5: To develop a management plan identifying priorities and needs to address minority health issues.

Measure (1): To be determined in the future

DEFINITION, RATIONALE, DATA SOURCE:

The Department has recently hired a Director for the Office of Minority Health. In achieving the goal (see "Program Goals" in the summary), one of the crucial responsibilities will be to facilitate collaboration and communication among Department program staff, local public health agencies and community-based organizations in order to build capacity to address public health issues in minority populations.

DISCUSSION OF PAST PERFORMANCE:

New position.

PLAN TO ACHIEVE TARGETS:

The Director, in collaboration with an internal work group, will develop a management plan that identifies priorities and needs for specific program consultation/assistance on minority health issues. Using the plan as a basis, the Director and appropriate staff will provide consultation on implementing culturally targeted public health programs.

OTHER FACTORS AFFECTING PERFORMANCE:

There is a need to foster and ensure close working relationships among Minnesota's Minority Councils and the communities they represent and state and local public health staff. There is a need to extract, use and develop appropriately targeted demographic, health statistics and disease surveillance information.

OBJECTIVE, MEASURE

Objective 6: Prompt and courteous processing of birth and death records.

Measure (1): Copies of birth and death records turnaround time in days after request

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Days Turnaround	1	2	2	2	--	--
Target	1	1	1	1	1	.5

DEFINITION, RATIONALE, DATA SOURCE:

After a citizen has requested a copy of the birth or death record, the performance standard is the number of days before the copy is mailed out. In addition, when a citizen has requested a change in a b ›r death certificate due to name change or originally inaccurate information, the performance standard is the number of for a new birth or de: :ertificate with the new information can be processed.

The Vital Statistics Record Section is responsible for processing all copies of birth and death records for citizens who need them for passports, school registrations or other reasons. Prompt turnaround time is very important for the citizens who request the copies. Additionally, there are routine types of changes such as name changes requiring that new birth certificates be issued as replacements. Prompt turnaround time for these requests is also important to the citizens.

The data source is an automated internal fee accounting system developed in the past two years.

DISCUSSION OF PAST PERFORMANCE:

With the manual systems for processing birth and death records in Minnesota, we enjoyed an extremely outstanding record of prompt turnaround time. This has changed in recent years to some degree, because of increasing workload, staff reductions and most importantly, not identifying new or efficient processes within the unit. As a result, there has been the commitment to use more automated systems, such as the electronic birth certificate, electronic death certificate and an automated fee accounting system for processing citizens' requests. The initial implementation of the fee accounting system has gone more slowly than anticipated and has added to the challenge of turnaround time. In the long run it is anticipated that the fee accounting system will be a tremendous asset for improving turnaround time. Likewise, the same issues apply for the replacement of birth or death certificates.

PLAN TO ACHIEVE TARGETS:

The use of more automated systems such as the electronic birth certificate, electronic death certificate and a significantly-enhanced fee accounting system, as well as a statewide network linked to local registrars of vital statistics will significantly enhance customer service. These proposals are being developed as part of the legislative initiative in the 1995 session of the Legislature.

OTHER FACTORS AFFECTING PERFORMANCE:

The workload fluctuates fairly significantly throughout the year based on citizens' demands. These revolve around vacation times, beginning of school and other routine events when copies of vital records are needed. In addition, significant cooperation is needed from the local registrars of vital statistics..

SUMMARY

AGENCY: Health, Department of
PROGRAM: 01 - Family Health

EXPENDITURES AND STAFFING (F.Y. 1994)		
	($ in Thousands)	
Total Expenditures:	$ 77,063,404	(48.3% of department's budget)
From State Funds	$ 11,895,251	
From Federal Funds	$ 65,049,161	
Number of FTE Staff:	153.2	(14.4% of department's staff)

PROGRAM GOALS:

To promote optimal health and prevent diseases or conditions that are influenced by cultural norms and lifestyle choices (M.S. 144.391-144.393; M.S. 145.9265).

To assure statewide planning and coordination of maternal and child health services (M.S. 145.88-145.889; M.S. 144.07; M.S. 145.898; M.S. 145.90; M.S. 144.91).

To ensure that children are wanted, safe, and supported in leading healthy and productive lives. (M.S. 145.925, M.S. 145A.15).

To develop and implement a comprehensive state plan for the delivery of nutritional supplements and appropriate nutritional information as well as the development of adequate outreach activities to pregnant and lactating women, infants, and children. (M.S. 145.894)

To develop and promote family centered, community based, culturally sensitive comprehensive systems of care for children with special health care needs and their families. (M.S. 145.88-145.889; M.S. 120.1701; M.S.144.128; M.S. 144.146).

To inform residents of the need and the procedures required to register and donate bone marrow. (M.S. 145.927)

To establish and maintain a registry of persons who sustain a traumatic brain injury or spinal cord injury. (M.S. 144.661).

DESCRIPTION OF SERVICES:

The Division of Family Health's focus is on promoting and protecting the health of individuals and communities and on preventing chronic diseases, injury and other adverse health outcomes through population-based approaches to primary prevention and through the development and support of community-based systems of care that are comprehensive, coordinated and family-centered. Activities within the Division are accomplished through collaborative partnerships with Community Health Boards and other local, regional, or state entities.

The Supplemental Food Program provides standards, technical assistance, training, grants management, program and fiscal monitoring, and related support for two supplemental food programs: The Special Supplemental Food Program for Women,

A	No of SCI cases identified	95	310
UC	Cost per case	$45	$33
A	No of families in Home Visiting Program	15	77
	Minnesota Diabetes Control		
A	Clinics Conducting Quality Projects	5	5
UC	Cost per clinic	$4,000	$4,000
A	No of patients tracked	1,706	1,675
UC	Cost per patient	$12	$12
	Bone Marrow Donor Registry		
A	No of patients registered	11,529	13,040
UC	Cost per patient	$3.00	$2.50

PROGRAM DRIVERS:

Health Care Reform - Reforms of the health care delivery system including the financing of health care services and the integration of public health care programs have the potential to greatly affect the availability and quality of health care for women, children and children with special health care needs. The ability of Family Health programs to contribute to emerging reform discussions or to respond to system changes will vary dependent upon the level of experience of the program in these areas and the particular needs of the populations affected. Many performance indicators, including those related to infant mortality, family planning and access for children with special health care needs stand to be positively modified by improvements in the health care system, assuming that the goals of health reform are achieved.

Children's System Reform - Significant energy is being directed at redesigning how services are delivered to children and their families. This will affect how programs are administered and how services are provided. It is critical that integration and coordination activities within and outside agencies truly simplify the delivery system, result in a system that is understandable by families and easy to access, and does not result in gaps or duplicative services.

Increase WIC Participation - WIC is not an entitlement program and federal funds fail to meet existing needs. It is estimated that Minnesota is serving 68% of the eligible population and it is hoped through increased federal funding and building collaborative efforts with public and private agencies, that this caseload will expand. Increased participation will require that both the state and community agencies direct their attention to a significant increase in caseloads and reaching families who have traditionally been hard to reach - those whose incomes are at the higher range of eligibility. New outreach strategies as well as changes in program administration will be required to facilitate caseload increases.

Greater Interest in Lifestyle Factors - The importance of lifestyle factors, such as diet, physical activity, non-smoking, elimination or moderation of chemical use in preventing and/or reducing mortality and morbidity continues to receive strong support. More programs which encourage appropriate lifestyle behavior need to be developed and implemented to assure that Minnesota residents are aware of factors that may adversely affect their health.

Aging of Children with Special Health Care Needs - It is projected that due to medical advances there has been a 100 percent increase in children with a chronic illness or disability in the last two decades. For example, survival of children with cystic fibrosis has increase sevenfold and two times the number of children with spina bifida, leukemia, and congenital heart disease are now surviving. More than 85% of all children born today with a disability will now survive to their 20th birthday. As a result, more attention is being paid and efforts being directed to the special needs of children who are transitioning into young adulthood and independence.

Continuing Increase in Single Parenthood - In the United States, the percentage of births to unmarried woman of all races has increased in almost straight-line fashion from 10 percent of 1970 to 30 percent in 1991; for black births, the rate is 70 percent. This trend has not passed by Minnesota. Efforts to reduced unintended pregnancy, to promote male responsibility in pregnancy and parenthood and to support children in single-parent families will become paramount in future years. Without such support, we are likely to witness increases in children living in poverty with all of the health, social and educational problems that accompany single parenthood.

Increasing Awareness of Domestic and Community Violence as a Public Health Issue - as the public grows more aware, and less tolerant of violence and abuse within families or communities, there is an increasing call for primary prevention and a recognition that a public health approach to this problem is warranted. Family Health programs are in an excellent position to develop capacity in violence prevention around existing expertise in community prevention programs, home visiting, pregnancy and parenting support, child assessment, and public and provider education.

Increasing Numbers of Children Living in Poverty - Family income is considered a good indication of child well being. The 1990 census indicated that the percentage of children living in poverty has increased almost 22% since 1980. There is no reason to expect that this trend has changed. Poverty plays a significant role in inadequate nutrition, poor school performance, lack of access to appropriate health care, unsafe neighborhoods, and increased risk of child abuse and neglect. Children of color are much more likely to be raised in poverty. Over 45% of children of color live in poverty with almost 70% residing in the metro area. Effective strategies must be developed to adequately support children and their families, especially strategies that effectively reach communities of color.

AGENCY: **Health, Department of**
PROGRAM: **Family Health**

OBJECTIVE, MEASURE

Objective 1: Birth outcomes will be improved.

Measure (1): The percentage of pregnant women beginning prenatal *

Actual Performance	F.Y.92	F.Y.93	F.Y.94	F.Y.95	F.Y.96	F.Y.97
	78	80	82	85(e)		
Target			83	85	86	88

*care during the first trimester of pregnancy.

DEFINITION, RATIONALE, DATA SOURCE:

It is generally known that women who have early, continuous, risk appropriate prenatal care, as a group have better pregnancy outcomes then those who do not. 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 generally 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.

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

(live births for which prenatal care began in the first trimester) divided by (total live births)

DISCUSSION OF PAST PERFORMANCE:

MCH Block Grant funds have traditionally been used to strengthen outreach and educational efforts, to increase early initiation of prenatal care, to encourage compliance with prenatal care schedules based on pregnancy risk assessment, to support private providers in the areas of preparation for pregnancy education and prenatal education and to increase the adequacy of prenatal care utilization in accordance with national health objectives.

PLAN TO ACHIEVE TARGETS:

Steady improvement in this indicator is projected through the year 2000 due to the impact of the Maternal and Child Health Block Grant program coupled with the considerable attention to improved pregnancy outcome which is occurring in the private sector as part of health care reform activities.

OTHER FACTORS AFFECTING PERFORMANCE:

Participation in prenatal care is affected by many factors outside the Department's control. These include: the number and geographic location of specialty health care providers willing to provide high-risk prenatal care; financial resources to pay

for prenatal care; barriers to care, such as transportation, child care, and lack of translators; the lack of knowledge about the importance of receiving prenatal care, especially early in the pregnancy and the lack of recognition of signs of pregnancy and denial pregnancy has occurred.

AGENCY: Health, Department of
PROGRAM: Family Health

OBJECTIVE, MEASURE

Objective 1: Birth outcomes will be improved.

Measure (2): The percentage of pregnancies that are unintended.

Actual Performance	F.Y.92	F.Y.93	F.Y.94	F.Y.95	F.Y.96	F.Y.97
	48	46	44	42(e)		
Target			47	42	40	38

DEFINITION, RATIONALE, DATA SOURCE:

Effective family planning and the avoidance of unintended pregnancy can improve infant health. 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 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 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)] divided by (total pregnancies.)

DISCUSSION OF PAST PERFORMANCE:

Family Planning Special Projects grants are available to local communities to provide medical services, educational programs, parents as sex educator programs, non-directive family planning counseling programs, and outreach programs in the community.

PLAN TO ACHIEVE TARGETS:

Strong emphasis on outreach activities continues through educational materials, posters, billboards, radio spots and targeted mailings. Funding was made available this year for an additional staff position to assure necessary technical assistance to local communities.

OTHER FACTORS AFFECTING PERFORMANCE:

Unintended pregnancy rates are affected by many factors outside the Department's control. These include: lack of knowledge among sexually active people of options to reduce unintended pregnancies; 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.

AGENCY: Health, Department of
PROGRAM: Family Health

OBJECTIVE, MEASURE

Objective 2: All eligible 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 through the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Measure (1): The percentage of estimated eligible enrolled on WIC.

Actual Performance	F.Y.92	F.Y.93	F.Y.94	F.Y.95	F.Y.96	F.Y.97
	NA	66	68	70(e)		
Target			67	70	72	74

DEFINITION, RATIONALE, DATA SOURCE:

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. The percentage of estimated eligible enrolled is an appropriate way of monitoring the state's ability to meet the nutritional needs of its population.

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) divided by [{(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of pregnant women at nutritional risk) x (.75% of year a women 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% of year most women have completed breastfeeding)} + {(three-year average of births) x (percent of Minnesota women at nutritional risk) x .5% of year non-breastfeeding 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)}].

DISCUSSION OF PAST PERFORMANCE:

As funding has increased, outreach activities have been directed at assuring that available funding has been fully utilized. WIC has increased service to: pregnant women, infants and the working poor.

PLAN TO ACHIEVE TARGETS:

The WIC program develops standards for outreach activities and provides annual administrative workshops for local WIC staff. State and local agency multi-faceted outreach activities are conducted continuously throughout the year. Activities are targeted to the working poor, members of the minority communities, and program maintenance. The working poor is 10% of the WIC participants. Minority WIC participation is 10% black, 10% Asian/Pacific Islander, 5% Hispanic, and 5%

American Indian.

OTHER FACTORS AFFECTING 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.

AGENCY: Health, Department of
PROGRAM: Family Health

OBJECTIVE, MEASURE

Objective 3: Infant mortality rates for communities of color will be reduced to the current relatively low rate for white infants.

Measure (1): Disparities in infant mortality rates.

Actual Performance	F.Y.92	F.Y.93	F.Y.94	F.Y.95	F.Y.96	F.Y.97
African/American	2.3	2.1	2.0	1.8(e)		
Target			2.0	1.8	1.6	1.4
Native/American	1.9	1.8	1.7	1.6(e)		
Target			1.8	1.6	1.5	1.4
Asian/American	1.0	1.0	1.0	1.0(e)		
Target			1.0	1.0	1.0	1.0

DEFINITION, RATIONALE, DATA SOURCE:

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. Because the actual numbers of infant deaths for Minnesota in communities of color are small we propose using five year running averages for these measures.

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) divided by (births for that community)] divided by [(white infant deaths) divided by (white births)]

DISCUSSION OF PAST PERFORMANCE:

Local health agencies are encouraged to utilize their Maternal and Child Health Special Project Grant to target minority populations. Additional funds have ben made available to the cities of Minneapolis and St. Paul where the majority of the minority populations reside. These additional funds are used in large part to target reductions in poor pregnancy outcomes in minority populations.

PLAN TO ACHIEVE TARGETS:

The Infant Mortality Reduction Initiative's activities have been directed at the identification of preventable, causal and contributory factors related to mortality and the support and implementation of effective program interventions and public policy changes aimed at preventing future infant deaths.

OTHER FACTORS AFFECTING 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.

AGENCY: **Health, Department of**
PROGRAM: **Family Health**

OBJECTIVE, MEASURE

Objective 4: Adult smoking rates will be reduced.

Measure (1): Percentage of adults who smoke.

Actual Performance	F.Y.92	F.Y.93 1993	F.Y.94	F.Y.95	F.Y.96	F.Y.97
	23.6	22.4	21.0(e)	19.5(e)		
Target			20.0	19.5	18.8	17.5

DEFINITION, RATIONALE, DATA SOURCE:

Smoking related diseases, which account for more than 6,000 deaths each year, represent the leading cause of preventable mortality in Minnesota.

Measuring the percentage of adults (18 years and older), is an appropriate way of monitoring the overall impact of the combined state and federally funded program activities to reduce smoking rates. The national objective for this performance measure is 15% by the Year 2000.

Data is collected through questions contained in the Behavioral Risk Factor Survey (BRFS). The BRFS is a random telephone survey of 3,500 Minnesotans, age 18 years and older, which is conducted throughout the year by the Minnesota Department of Health. Data used for this measure is the percentage of persons 18 years of age and older who report being current smokers.

DISCUSSION OF PAST PERFORMANCE:

More than a decade ago in 1981, the smoking rates for all adults was 29.5 percent. Although men have historically smoked in larger proportions than women, this disparity has narrowed considerably in recent years as a result of the tobacco industry targeting of young women with special cigarette brands and sophisticated advertising campaigns. According to a 1989 survey of Minnesota women the smoking rate for women in the 18-30 age group is approximately 35% which is much higher than the overall adult smoking rate.

PLAN TO ACHIEVE TARGETS:

The major activity of the section is to work with state wide and community organizations to enable them to work with youth and community leaders in adopting public policy at the community level to create conditions in the community which are supportive of youth not smoking. Additionally the community groups work to reduce the influence of tobacco companies in their effort to promote tobacco products and to made these products readily available to youth in Minnesota Communities.

The section also develops and produces poster, T-shirts, etc with nonsmoking messages which assists in setting a community norm that smoking for youth is not acceptable and dissuades or delays youth from starting to smoke. These products are then made available to community youth groups to help them accomplish their objectives of dissuading youth from starting to smoke.

MDH personnel implement these activities through a combination of grants to community groups and providing technical assistance and training for individuals and community and state wide groups.

OTHER FACTORS AFFECTING PERFORMANCE:

Smoking rates are affected by a variety of factors not directly within the Department's control including the following: product pricing and advertising 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 such as the Cancer Society and the American Lung Association.

AGENCY: Health, Department of
PROGRAM: Family Health

OBJECTIVE, MEASURE

Objective 5: All children with special health care needs (CSHCN) will have access to family-centered, community-based, and culturally-competent coordinated health services.

Measure (1): The percentage of estimated eligible severely *

Actual Performance	F.Y.92	F.Y.93	F.Y.94	F.Y.95	F.Y.96	F.Y.97
	NA	39	52	60(e)		
Target			45	60	65	70

*disabled children receiving benefits from the Supplemental Security Income (SSI) program or the Children's Home Care Option (TEFRA) program.

DEFINITION, RATIONALE, DATA SOURCE:

Over 421,000 children in Minnesota are estimated to be affected by a chronic health condition with over 21,000 children considered to have a severe disability.

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

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)] divided by [(number of children under 18) x (.015)].

DISCUSSION OF PAST PERFORMANCE:

During the past two years the Department has directed significant attention through workshops, technical assistance and guidance to community resources, and the development of outreach materials to assuring children were enrolled in the most comprehensive and appropriate program available, thus, removing cost as a barrier to receipt of health care.

PLAN TO ACHIEVE TARGETS:

The Department will continue to inform families and referral sources of the availability of these programs and assist families through the application process.

OTHER FACTORS AFFECTING 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 to

determine eligibility from medical care providers and schools; the unwillingness or inability of families to seek out and accept public assistance or, in TEFRA, to make financial contributions to the cost of care.

AGENCY: Health, Department of
PROGRAM: Family Health

OBJECTIVE, MEASURE

Objective 5: All children with special health care needs (CSHCN) will have access to family-centered, community-based, and culturally-competent coordinated health services.

Measure (2): The percentage of Minnesota counties that document *

Actual Perfor	C.Y.92	C.Y.93	C.Y.94	C.Y.95	C.Y.96	C.Y.97
	84	84	85	89(e)		
Target			89	89	90	90

*providing services to children with special health care needs in their local maternal and child health plans.

DEFINITION, RATIONALE, DATA SOURCE:

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 Bock 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 number of counties in which Maternal and Child Health Block Grant funds are used in the Handicapped/Chronically Ill component is an appropriate way of monitoring community activity in this area.

Every two years, each Community Health Board in the state submits to the Department a Maternal and Child Health Special Project Grant application, documenting how the funds it received 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) divided by (87).

DISCUSSION OF PAST PERFORMANCE:

The Department's activity will be directed at the 1996 to 1997 grant applications.

PLAN TO ACHIEVE TARGETS:

The Department will be directing additional technical assistance and support to assisting community health boards to expand into this component.

OTHER FACTORS AFFECTING 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.

AGENCY: Health, Department of
PROGRAM: Family Health

OBJECTIVE, MEASURE

Objective 6: Severe periodontal disease and oral cancer will be reduced.

Measure (1): Percentage of dental health care workers who counsel*

Actual Performmance	F.Y.92	F.Y.93	F.Y.94	F.Y.95	F.Y.96	F.Y.97 1997
	29	NA	30	40(e)		
Target			NA	40	45	55

*patients about tobacco use.

DEFINITION, RATIONALE, DATA SOURCE:

Use of tobacco products is a primary etiologic factor in the development of serve periodontal disease and oral cancer. It is important that these significant public health problems be addressed. Currently, the percentage of dental health care workers who indicate that they provide some type of tobacco prevention and cessation activity for patients is less than a third.

Few dentists, hygienists and assistants have received formal training in tobacco cessation strategies and techniques. A majority do not believe they are adequately prepared to assist patients in quitting tobacco use. On the other hand, a large percentage of each group expresses a substantial willingness to be formally trained. These findings portray an opportunity to involve dentists, hygienists and assistant in clinical tobacco prevention and cessation efforts. By acquiring tobacco intervention skills, dentists, hygienists and assistants can take a leading role among health professionals in having a significant impact on the death and disability associated with use of tobacco products.

Data source is the 1993 Minnesota Tobacco Control Activity Survey of Dentists, Dental Hygienists and Dental Assistants.

DISCUSSION OF PAST PERFORMANCE:

The Dental Health Program has collected baseline data and promoted tobacco prevention and cessation activities with dental health care workers in cooperation with national, state and local professional organizations and government agencies.

PLAN TO ACHIEVE TARGETS:

The Dental Health Program will promote tobacco prevention and cessation services by initiating educational programs, distributing educational materials, conducting follow-up studies and working with all interested agencies, groups and individuals to increase dental health care workers' provision of these services to their patients.

OTHER FACTORS AFFECTING PERFORMANCE:

Dental health care workers provision of tobacco prevention and cessation services for patients is affected by a variety of factors that are not directly within the Department's control including the following: patient resistance and complaints; amount of time required; lack of reimbursement; resistance by staff; concerns about effectiveness; availability of patient education materials; and availability of adequate referral resources.

SUMMARY

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

EXPENDITURES AND STAFFING (F.Y. 1994)

($ in Thousands)

Total Expenditures:	$ 4,669	2.9% of department's budget
From State Funds	$ 3,932	
From Federal Funds	$ 283	
Number of FTE Staff:	60.5	5.7% of department's staff

PROGRAM GOALS:

- To control the rate of growth of health care spending (M.S. 62J.04, 62J.29, 62J.30 - 62J.46, 62P, 144.70)
- To improve the quality of health care services (M.S. 62J.30 - 62J.46)
- To improve access to health care services (M.S. 62N.23, 124C.62, 144.64, 144.1482 - 144.1487)

DESCRIPTION OF SERVICES:

The Data Analysis activity conducts data and research initiatives in order to improve the efficiency and effectiveness of health care in Minnesota. This activity includes the analysis of health care data; developing and disseminating health plan report cards, practice parameters, and hospital financial statistics; designing and implementing studies of health care outcomes; and cooperating with private sector initiatives in measuring consumer/patient satisfaction.

The Office of Rural Health and Primary Care activity administers grant programs to (1) 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; (2) assist financially troubled hospitals in isolated areas of the state to continue operating; (3) assure that at-risk hospitals would not close as a direct result of the 2% provider tax levied to support health care reform activities; (4) establish community health centers in rural areas of Minnesota that are underserved by health care providers, and (5) develop and implement an integrated service network technical assistance program. This activity is also responsible for developing and maintaining data bases on health care personnel; conducting special studies on rural health care access issues; providing technical assistance regarding federal and state health care programs to rural communities and providers; assisting rural communities with recruitment and retention of health care providers; administering a Nurse Practitioner Promotion Team Program; and overseeing the administration of a Summer Health Care Intern Program.

The Health Economics activity devotes effort to: surveying and analyzing conditions in the medical marketplace; researching and developing recommendations for state policies affecting the competitiveness of the market; and researching and monitoring trends in health care expenditures and prices. The role of the activity was expanded by the MinnesotaCare legislation to include the following activities: to define, measure and monitor health care expenditures for purposes of the

development, implementation and evaluation of growth limits and other health care reform activities; to conduct reviews of reports and maintain a data base of major health care expenditures in excess of $500,000; to evaluate and make recommendations regarding antitrust exceptions for cooperative arrangements involving providers or purchasers; to monitor long-term care costs in the state and make recommendations with regard to health care reform; to develop a risk adjustment mechanism for competing health plans; and to conduct special studies as mandated by the legislature.

The Health Care Policy activity is responsible for providing staff support to the six Regional Coordinating Boards and for conducting research studies and developing policy recommendations on health care reform issues. Current efforts of the Regional Coordinating Boards include the development of public health goals; monitoring the development of Integrated Service Networks and Community Integrated Service Networks; reviewing action plans developed by health plan companies; facilitating communication between the public and private health care sectors; and recommending appropriate structures for the organization of health services to achieve cost containment, quality of care and improved access to health care services. In addition to providing staff support for the Regional Coordinating Boards, the activity completed the Medical Care Savings Account Study in F.Y. 1994.

BACKGROUND INFORMATION:

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994
	Data Analysis		
W	Number of workgroups meeting on an on-going basis to obtain private sector input on data initiatives	10	22
A	Number of rulewriting projects in progress	N/A	4
	Office of Rural Health and Primary Care		
W	No. of health personnel for whom practice-related data is collected and maintained	N/A	40,484
W	No. of sites that receive direct technical assistance on applications, certifications, program benefits	N/A	200
W	Number of technical assistance workshops presented	N/A	11
W	Number of grant applications/loan repayment applications reviewed	30	64
A	Number of special studies conducted	3	5
	Health Economics		
A	Number of special studies conducted	3	3
A	Number of high cost expenditures reviewed	N/A	99
	Health Care Policy		
W	Number of educational presentations to the Regional Coordinating Boards	45	100
A	Number of special studies conducted	N/A	1
W	Number of statewide Regional Coordinating Board meetings to address cost, quality and access issues	N/A	3

PROGRAM DRIVERS:

- **Increases in Medical and Health Care Costs.** Health care costs have been increasing at 2-3 times the general rate of inflation, at about 10% per year. Minnesota trends are similar to the national trends in this area. In order for the state to be able to afford the increased access to care through state subsidized premiums and access programs, the increase in health care costs must be moderated. Cost containment strategies and approaches to constrain the increase in costs are dependent on the nature of the cost increases and the factors driving the health care markets.

- **Health Care Reforms in Other States and Nationally.** Health care reform efforts occurring at the state and federal level have a significant influence on health care reform within Minnesota. Whether Congress passes a health care reform bill will significantly affect the direction and financing issues in upcoming legislative sessions. For example, if Congress passes a bill that provides for a federally-subsidized health insurance program, this may redirect the Health Department's efforts toward new functions.

- **Standardization of Public and Private Data and Data Forms.** The collection of revenue and expenditure data is critical to effective implementation of growth limits and to monitor the impact of reform on the health care market. The federal government and private sector organizations are working on a number of initiatives to obtain, use and store data in a more standard fashion. As these efforts continue and organizations work to comply with Minnesota's administrative simplification legislation, the data available for measuring and monitoring the health care system should improve.

- **Development of Practice Parameters by National Organizations.** The practice parameters being evaluated by the Health Department are those parameters which have been developed by national health professional boards or associations. The more productive those organizations are in developing outcome-based practice parameters, the more productive the Health Department can be in evaluating practice parameters. Likewise, outcome measurement and case severity measurement techniques are in their infancy. As researchers and organizations around the country discover and learn the appropriate techniques for handling these issues, more valid and reliable health care information will be available for consumers.

- **Demographic Trends in Rural Communities and Underserved Areas.** Rural counties in Minnesota have a disproportionate share of the population over age 65, resulting in part from the outmigration of the younger generation. Troubled rural economies have also taken their toll on the health care system. Statewide income data indicates that the incidence of poverty is greater in many rural areas of the state. As this relates to health care, the percentage of individuals who are uninsured or underinsured are higher in rural Minnesota than in the metropolitan Twin Cities area. However, populations in the inner cities also continue to be characterized by high levels of poverty and poor health status indicators. These demographic trends result in a larger proportion of Medicare and Medicaid patients in rural and underserved urban areas of the state, as well as a greater burden of uncompensated care, consequently creating financial stress for the clinics and hospitals who serve these clients.

- **Shortage of Health Care Professionals.** Many rural and underserved urban communities are experiencing difficulty in recruiting and retaining primary care physicians and midlevel providers, and health care facilities report shortages of nursing and other health care personnel. Minnesota's current Health Professional Shortage Area (HPSA) designations reflect the need for additional primary care physicians to serve many rural areas of the state. Thirty-five of the 39 federally designated primary medical care HPSAs are rural, including eight entire counties and portions of 38 other counties.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

OBJECTIVE, MEASURE

Objective 1: To decrease the rate of growth of health care costs by 10% a year for the next five years.

Measure (1): Annual rate of growth of health care costs.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Overall rate of growth	11.4%e	10.2%e	9.4%e	8.3%e	--	--
Target	N/A	N/A	9.4%	8.3%	7.4%	6.7%

DEFINITION, RATIONALE, DATA SOURCE:

Growth limits are defined as the regional Consumer Price Index (CPI) for urban consumers plus a specified percentage as indicated in M.S. 62J.04, Subd. 1. 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 limits 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 general inflation. Historically, the rate of medical inflation has been as much as 2-3 times that of general inflation. For providers, the limits are based on revenues per the appropriate denominator (e.g. encounter, patient, stays, visits). For payers, the limits are based on expenditures per member per month. During the first year of enforcement, which is 1995, names of payers exceeding the growth limits will be published in the state register. The first year of enforcement for providers and the first year of monetary penalties for payers will be 1996 when the two year average limit will be determined. Overall growth limits will be determined based on an estimate of total health care spending developed from aggregate data surveys and other resources. The target performance measure outlined above uses the growth limits specified in legislation (62J.04) and are based on calendar rather than state fiscal years. Growth limits are set by January 31 of each year after the CPI for the previous year is available.

DISCUSSION OF PAST PERFORMANCE:

Data to set the growth limits were gathered in fiscal year 1993. Using public data from HMOs and voluntarily submitted data from commercial payers, the limits were set in statute in the 1993 MinnesotaCare Act. During fiscal year 1994, baseline data was collected from payers and hospitals to begin the process of growth limits enforcement. For other providers, audits will be the vehicle for enforcement of the limits. Audits will be conducted for all clinics that have over 100 providers and random audits will be conducted for the remaining providers.

PLAN TO ACHIEVE TARGETS:

Department staff are developing the data bases needed to monitor health care costs for both enforcement of the limits and other functions. The Department has also contracted with an actuarial firm to provide technical support and plans to consider contracting for audit services.

OTHER FACTORS AFFECTING PERFORMANCE:

Approximately 30% of Minnesota residents are covered under self-insured plans. The Employee Retirement Income Security Act (ERISA) prohibits states from regulating self-insured plans. Therefore, we cannot directly impact health care spending for almost one-third of the state's population.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

OBJECTIVE, MEASURE

Objective 2: To promote cost savings and improve quality of care and access through administration of the antitrust exception process.

Measure (1): To provide written analysis and prepare recommendations for each antitrust exception application submitted.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Applications reviewed	N/A	N/A	1	2e	--	--
Target	N/A	N/A	1	2	2	2

DEFINITION, RATIONALE, DATA SOURCE:

In creating the antitrust exception process, the Minnesota legislature intended to facilitate the goals of controlling health care costs and improving the quality of and access to health care services, by cooperative arrangements involving providers or purchasers that might otherwise violate state and federal antitrust laws if undertaken without government involvement.

M. S. 62J.2911 - 62J.2921 created an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality than would otherwise occur in the health care marketplace. An approval of an arrangement by the commissioner is an absolute defense against any action under state and federal antitrust laws, except as provided under M. S. 62J.2913, subd. 5.

The specific measures of cost savings and improvements in quality of care will vary depending on the unique situation for which an exception is sought. Therefore, we are only including the number of exceptions processed as our measurement indicator. The target of two each year represents an estimate of the number of exception applications that will be submitted to the commissioner.

DISCUSSION OF PAST PERFORMANCE:

To date, one application involving a major hospital merger, that resulted in the formation of HealthSpan Health Systems, has been reviewed by the commissioner under the antitrust exception process.

PLAN TO ACHIEVE TARGETS:

A detailed analysis is made of all materials submitted with an application including any comments that were made in connection with that application. Based on an initial analysis, a decision is made concerning the appropriate procedure to be used for review of an application seeking an antitrust exception. That analysis is based on the criteria established under M. S. 62J.2916. Subsequently, a detailed analysis is conducted to determine whether an application meets the criteria on cost, quality and access established under M. S. 62J.2917.

OTHER FACTORS AFFECTING PERFORMANCE:

The nature of the review and the level of analysis required is dependent on the number of applications and their content. To date, we have received one large, complex application which the commissioner has reviewed and issued a final order.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

OBJECTIVE, MEASURE

Objective 3: To promote the adoption of practice parameters by medical care practitioners which impact on the cost and effectiveness of health care.

Measure (1): The number of practice parameters evaluated (number approved for dissemination).

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Practice Parameter	N/A	N/A	N/A	7(2)e	--	--
Target	N/A	N/A	N/A	5(2)	5(2)	5(2)

DEFINITION, RATIONALE, DATA SOURCE:

A practice parameter is a statement which guides the clinical decision making of health care providers and patients and that is supported by the results of appropriately designed research studies. The number of practice parameters evaluated represents those practice parameters which have been developed by national health professional boards or associations and formally reviewed by the practice parameter advisory committee's expert review panels. The number of approved practice parameters are those approved by the commissioner of health for dissemination.

The Health Department is charged with developing, adopting, revising, and disseminating practice parameters, and disseminating research findings, that are supported by medical literature and appropriately controlled studies to minimize unnecessary, unproven, or ineffective care, so that a reasoned basis is provided for making medical practice decisions. The Health Department is currently seeking federal and private source grants to evaluate the effects of implementing practice parameters. However, until more cost-effective and sensitive methodologies for measuring outcomes and the effects of implementing practice parameters are developed, the number of practice parameters are proxies for evaluating the Health Department's ability to meet this objective.

DISCUSSION OF PAST PERFORMANCE:

The evaluation of practice parameters will begin in F.Y. 1995. Prior to F.Y. 1995, the Practice Parameter Advisory Committee selected the condition areas of investigation and developed a set of procedures for evaluating practice parameters.

PLAN TO ACHIEVE TARGETS:

Health Department staff are providing research and staff support to the practice parameter advisory committee, as well as to their expert review panels, to ensure that there is adequate technical support to reach the targets. Staff are also working to identify other condition areas that meet legislative requirements for practice parameter evaluation.

OTHER FACTORS AFFECTING PERFORMANCE:

The availability of practice parameters from national sources is a factor affecting performance. Current statute exempts the Health Department from rulemaking requirements when approving practice parameters from a number of national health professional boards or associations. All other practice parameters, including those developed through state and local efforts, require the Health Department to follow rulemaking requirements. Given the timeframe encompassed by the rulemaking requirements and the ever changing state of medical science, the Health Department cannot realistically consider practice parameters developed by organizations within the state. Therefore, the Health Department is limited by the availability of practice parameters that have been developed by some recognized national body.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

OBJECTIVE, MEASURE

Objective 4: To collect quality-of-care and access data from health plans to enable consumers and purchasers to make informed decisions.

Measure (1): The number of quality-of-care and access indicators collected (number of health plans represented).

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Number of Indicators	N/A	3(12)	3(12)	13(11)e	--	--
Target	N/A	3(12)	3(12)	15(11)	15(36)	20(36)

DEFINITION, RATIONALE, DATA SOURCE:

These quality-of-care and access indicators are measures designed to inform consumers about a broad spectrum of health services for which health plans are responsible. These indicators include information about health plans' delivery of preventive services, delivery and management of prenatal care, and management of acute and chronic illnesses. The number of health plans represented currently measures the number of state licensed entities providing these data.

The mere measurement and collection of data does not ensure that consumers and purchasers have sufficient or appropriate information to make informed health care decisions. However, this type of data has not been available in the past and represents the Health Department's initial efforts in collecting and reporting meaningful information for health plan comparisons. These quality-of-care and access indicators, along with utilization and cost data, will form the basis of the Health Department's "Health Plans Report Card." It is the "report card" which will ultimately provide consumers and purchasers with the data needed for informed health care decisions. The first report card will be released in the fall of F.Y. 1995. After the Health Department begins to release report cards, it will become appropriate to add a measure in future performance reports to record how effectively that information was distributed to consumers and purchasers. In 1994, a summary document will be issued to release data on Health Maintenance Organizations.

The raw data source for these indicators is an addendum to the health maintenance organization (HMO) annual information filing. The indicators along with explanations will be available every fall in the "Health Plans Report Card" and will be in the Health Department's Information Clearinghouse.

DISCUSSION OF PAST PERFORMANCE:

The Health Department has traditionally monitored HMO's financial and utilization performance for regulatory purposes. While this information is vital for maintaining a solid, stable market place, it is not useful to consumers in comparing the performance of HMOs. To provide consumers and purchasers with more useful information, the Health Department began working with the HMOs to define standard measures and indicators. These indicators are the initial results of those on-going efforts.

PLAN TO ACHIEVE TARGETS:

The Health Department, through the Minnesota Health Data Institute, is working jointly with private sector health plans (both HMOs and indemnity insurers), public programs, health care providers, consumers and purchasers to expand and define the number of useful quality-of-care and access indicators available. The work with these groups is designed to ensure that the "report card" formed from this collected data includes more health plans (public and private) and that the comparisons are fair and meaningful.

OTHER FACTORS AFFECTING PERFORMANCE:

The creation of standard health data sets, forms and measures is a factor affecting performance. Creating and constructing standard, uniform measures and indicators across the entire health care industry is a difficult process. In many cases it requires health plans to change how and what data they collect. As health plans better understand what data they will be required to collect for fair and meaningful performance measure, they will begin to change their data systems. The speed at which health plans are able to change their data systems will affect how quickly the Health Department will be able to collect and report more meaningful information.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

OBJECTIVE, MEASURE

Objective 5: To develop an integrated data system that will provide useful information about Minnesota's health care system to public officials, policymakers, providers, payers, and purchasers to assess the impact of health reform efforts in Minnesota.

Measure (1): Aggregate financial and utilization data collected from hospitals, providers, insurers, and third party administrators (TPAs) for understanding Minnesota's health care delivery systems.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
No. of Hospitals Surv Surveyed	153	153	151	150e	--	--
Target	153	153	151	150	150	150
No. of Providers Surveyed	N/A	N/A	7,500	14,000e	--	--
Target	N/A	N/A	7,500	14,000	14,000	14,000
No. of Insurers (TPAs) Surveyed	12	12	166(144)	82(65)e	--	--
Target	12	12	150(55)	82(65)	82(65)	82(65)

DEFINITION, RATIONALE, DATA SOURCE:

The Health Department asked hospitals, providers, insurers, and third party administrators to provide aggregate level data regarding administrative costs categorized by administrative function, medical expenditures, total paid premiums, and number of covered subscribers categorized by funding type. The number surveyed represents the number of acute care hospitals, physicians, HMOs, indemnity insurers, non-profit service corporations, and third party administrators that responded to the Health Department's aggregate surveys.

The data being collected presents a comprehensive view of financial dimensions within the state's health care system. The initial use of this data will be to allow public officials and policymakers to measure the impact of health reform. The revenue data will be used to monitor trends in total premiums across health plans and to monitor compliance with growth limits to ensure that savings are passed on to consumers. Health care expenditure data will be used to monitor spending trends over time, to monitor compliance with the growth limits, and to refine the methodology used to determine growth limits. The administrative cost data will be used to identify functional areas where administrative dollars are spent, areas where expenses are increasing or decreasing, and areas where opportunities for administrative savings exist.

Collecting and monitoring this data will allow policymakers to better assess the impact of health reform efforts in Minnesota. The data will identify areas within the state that require additional research and policy considerations. The data will also allow comparison between Minnesota's health care systems and national trends. When the data is collected over time the Health Department will be able to identify and report on trends in the data. These trends will allow individual hospitals, providers, insurers, and TPAs to compare themselves to the trends and to identify areas of differentiated performance.

These measures were calculated using the Health Department's MinnesotaCare-related data bases.

DISCUSSION OF PAST PERFORMANCE:

Most of the Health Department's legislative mandate to collect this data was provided in the 1993 MinesotaCare law. Prior to F.Y. 1994, this type of data was collected only for acute care hospitals and health maintenance organizations. Beginning in F.Y. 1994, all physician clinics, insurers, and TPAs were contacted and asked to respond to the Health Department's aggregate surveys. The Health Department is preparing to continue collecting this data on an annual basis.

PLAN TO ACHIEVE TARGETS:

To improve the quality of the data collected from each of the groups, the Health Department formed three workgroups, a workgroup of hospital representatives, a workgroup of providers, and a workgroup of health plan and insurance company representatives. These workgroups were formed to provide advice to the Health Department on changes and adjustments to the survey instruments. The workgroups' recommendations will be incorporated to ensure more consistent data definitions, more meaningful functional categories, less burdensome reporting requirements, and better overall data. The Health Department plans to continue working with the workgroups to assure that the surveys evolve to measure appropriate characteristics of an ever evolving health care market place.

OTHER FACTORS AFFECTING PERFORMANCE:

The standardization of Data and Reporting Methods is a factor affecting performance. In F.Y. 1994 the Health Department required hospitals, providers, insurers and TPAs to calculate and report information in ways that those organizations were not especially well equipped to handle. However, after working with those groups to improve the data collected, it is anticipated that a number of organizations will change and supplement how they record and store data. Organizations will also develop processes to ensure that they are capturing the type and form of data needed to improve their data reporting capabilities. The sooner organizations are able to make these changes and adjustments, the sooner the data reported to the Health Department will improve.

Agency: Health, Department of
Program: Health Care Delivery Policy

OBJECTIVE, MEASURE

Objective 6: To improve access to health care services by assisting communities to establish community health centers, receive enhanced Medicare/Medicaid reimbursement for their providers, maintain or modify hospital services, or form networks.

Measure 1:	Identification and provision of financial support to hospitals that meet the criteria of being essential to access, to the extent of available funds.

Actual	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Grants awarded	N/A	14	6	6e	--	--
Target	N/A	14	6	6	6	6

DEFINITION, RATIONALE, DATA SOURCE:

Under the auspices of the Sole Community Hospital Grant Program, the number of hospitals eligible for grant awards is annually determined using statutory criteria, and funding amounts are subsequently recommended to the commissioner. The data is maintained in the Office of Rural Health and Primary Care program files.

DISCUSSION OF PAST PERFORMANCE:

This program was established by the 1990 legislature. No funding was available in F.Y. 1992. In F.Y. 1993, the criteria were changed to more closely address the initial intent of the legislation, and the statute was amended to allow the commissioner to determine the amount of the award to be given to each eligible hospital based on financial need.

PLAN TO ACHIEVE TARGETS:

A proposed amendment will be submitted to the legislature in the 1995 session to codify the formula developed by the commissioner for determining financial need.

OTHER FACTORS AFFECTING PERFORMANCE:

The total amount of funding for 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 and need for services provided by rural hospitals are affected by many factors beyond the Office of Rural Health and Primary Care's control including Medicare, Medicaid, and private insurance reimbursement policies, as well as federal and state health care reform activities.

Measure 2:	Number of hospitals that plan and/or implement projects to preserve access to care or modify hospital services to better address local need.

Actual	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Grants awarded	N/A	9	10	10e	--	--
Target	N/A	9	10	10	10	10

DEFINITION, RATIONALE, DATA SOURCE:

The number of hospitals that are awarded State grants through the Rural Hospital Planning and Transition Grant Program defines the measure. The intent of implementing transition projects is to modify hospital services to more effectively meet the health care needs of the community. However, this result is difficult to directly measure due to the vast number of intervening variables that could affect such an outcome. The data is maintained in the Office of Rural Health and Primary Care's program files.

DISCUSSION OF PAST PERFORMANCE:

The program was not funded for the 1991-92 grant year. In the 1992 legislative session, the program was refunded as part of the MinnesotaCare legislation. Net income loss was removed as an eligibility criterion; the maximum grant award was $50,000; administration of the program was assigned to the Office of Rural Health and Primary Care; and the appropriation was increased to $250,000 per fiscal year. The 1993 legislature corrected an error in the statutory language, which had delayed contracts in the previous year, and the maximum award was reduced to $37,500. The grant program will be evaluated in 1995.

PLAN TO ACHIEVE TARGETS:

The Office of Rural Health and Primary Care continues to administer the program and will suggest policy changes pending results of the evaluation.

OTHER FACTORS AFFECTING PERFORMANCE:

The financial status of rural hospitals and the need for services provided by rural hospitals are affected by many factors beyond the Office of Rural Health and Primary Care's control including Medicare, Medicaid, and private insurance reimbursement policies, as well as federal and state health care reform activities.

Measure 3:	Number of community health centers and outreach projects established in medically underserved areas of the State.

Actual	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Grants awarded	N/A	N/A	10	4e	-	-
Target	N/A	N/A	10	4	4	4

DEFINITION, RATIONALE, DATA SOURCE:

The measure is defined as the number of communities/organizations that are awarded State grants through the state or federal Community Health Center Grant programs or the federal Rural Health Outreach Program. The Office of Rural Health and Primary Care awards grants through the State Community Health Center Program and provides technical assistance with preparing applications for participation in the federal programs. The Office does not have the research capabilities to measure increased access in the communities that establish these programs; however, the program criteria are oriented toward increasing access for underserved populations, and the assumption is made that establishment of locally governed community health centers and rural outreach projects will increase access to and improve quality of care. Data is maintained in the Office of Rural Health and Primary Care's program files.

DISCUSSION OF PAST PERFORMANCE:

The State Community Health Center program was established by MinnesotaCare legislation in 1992, with an appropriation of $250,000 per fiscal year. There was no grant activity in F.Y. 1993, and program funding was carried over to the next fiscal year, making $500,000 available in F.Y. 1994 and an additional $250,000 in F.Y. 1995. A total of $412,240 has been awarded through the grant process to date. In F.Y. 1993 and F.Y. 1994, the Office of Rural Health and Primary Care provided extensive technical assistance to entities applying for rural health outreach and federal community health center grants.

PLAN TO ACHIEVE TARGETS:

The Office of Rural Health and Primary Care will begin providing technical assistance for the state Community Health Center Program in F.Y. 1995. This program will also be evaluated in F.Y. 1995.

OTHER FACTORS AFFECTING PERFORMANCE:

The availability of federal and foundation funding to supplement state funds and federal and state health care reform activities will affect this program.

Measure 4: Number of rural health care service networks formed.

Actual	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Networks formed	N/A	N/A	N/A	25e	--	--
Target	N/A	N/A	N/A	25	10	5

DEFINITION, RATIONALE, DATA SOURCE:

The measure is defined as the formation of a physician-hospital network, community integrated service network, or integrated service network. The Integrated Service Network Technical Assistance Program (ISNTAP) is directed toward this end. Network formation is expected to improve health care delivery system infrastructure, thereby improving access to health care and ultimately health status. However, the number of intervening variables makes these results difficult to measure initially.

DISCUSSION OF PAST PERFORMANCE:

ISNTAP was established by the 1993 legislature. Four technical assistance seminars were presented across the state. In F.Y. 1994, legislation was enacted that allows the licensing of community integrated service networks beginning July 1, 1994 and enables the ISNTAP to begin providing technical assistance services to community integrated service networks.

PLAN TO ACHIEVE TARGETS:

The Office of Rural Health and Primary Care is in the process of developing a technical assistance manual and installing a toll-free line for site inquiries related to the formation of networks. Direct technical assistance is being provided, and further technical assistance seminars and workshops are being planned.

OTHER FACTORS AFFECTING PERFORMANCE:

The implementation of state and federal health care system reform will greatly impact rural Minnesota as rural communities attempt to meet the demands of the new managed competition model. Communities in rural Minnesota often lack the infrastructure for implementation of the integrated service network models. Furthermore, limited resources, such as expertise, time, and capital puts many rural and underserved urban communities at a disadvantage as they face the challenge of transforming their locally-based, relatively fragmented health care delivery systems into ones that meet the requirements of the reformed health care system.

Measure 5:	Number of sites that receive increased reimbursement for Medicare or Medicaid through participation in federal or state programs.

Actual	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Sites certified/ designated	N/A	N/A	15	20e	--	--
Target	N/A	N/A	15	20	15	15

DEFINITION, RATIONALE, DATA SOURCE:

The definition is the number of sites that receive increased reimbursement through federal designation or redesignation as a Health Professional Shortage Area or certification as a Rural Health Clinic or Federally Qualified Health Center. The Office of Rural Health and Primary Care provides extensive technical assistance for entities seeking to participate in these programs. Data is maintained in Office databases.

DISCUSSION OF PAST PERFORMANCE:

This technical assistance for this program is funded through a federal Primary Care Cooperative Agreement grant. The technical assistance program was expanded in 1994, when an additional staff member was hired. In addition, the Office of Rural Health and Primary Care developed a database for tracking requests in F.Y. 1994.

PLAN TO ACHIEVE TARGETS:

The Office of Rural Health and Primary Care continues to publicize the availability of technical assistance and to refine its tracking mechanisms. An additional staff member will be hired to provide technical assistance on reimbursement issues to community health centers.

OTHER FACTORS AFFECTING PERFORMANCE:

Availability of federal funding will determine staffing time for handling requests. State and federal health care reform has the potential for significantly changing these reimbursement mechanisms.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

Objective 7: To develop and direct a statewide recruitment assistance program that identifies and targets rural and urban shortage areas, and provides information and directs recruitment/placement services to assist communities in recruiting or retaining health professionals.

Measure 1:	Number of health care professionals placed in Community Health Centers, Federally Qualified Health Centers (or look-alikes), Rural Health Clinics, National Health Service Corps or State Loan Repayment Sites, or Health Professional Shortage Areas.

Actual	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Placements	N/A	N/A	32	40e	--	--
Target	N/A	N/A	32	40	45	50

DEFINITION, RATIONALE, DATA SOURCE:

The measure is as the number of health care professionals placed in federal and state Community Health Centers, Federally Qualified Health Centers (or look-alikes), Rural Health Clinics, National Health Service Corps or State Loan Repayment Sites, or Health Professional Shortage Areas. These entities are located in Health Professional Shortage or Medically Underserved Areas, and are prioritized for purposes of focusing recruitment assistance efforts. Although placements can be tracked, the results of increasing the number of health professionals in shortage areas on access to service is more difficult to directly measure. Data is maintained by an Office tracking system.

DISCUSSION OF PAST PERFORMANCE:

In F.Y. 1993, the Office of Rural Health and Primary Care produced and distributed a recruitment and retention manual and provided recruitment and retention technical assistance through a contract with the Minnesota Center for Rural Health. The Office also used federal Office of Rural Health Policy grant dollars to conduct: a statewide demand assessment for key primary care providers; two recruitment and retention workshops in rural Minnesota; and a survey of older physicians to determine their current level of medical practice and their plans for the future. In F.Y. 1994, the Nurse-Practitioner Promotion Program, which seeks to educate rural communities on the benefits of using midlevel providers, was established. The Office continued to oversee the administration of the Summer Health Care Intern Program, and the State Loan Repayment Program was implemented. Under the auspices of a 15-month planning grant from the Robert Wood Johnson (RWJ) Foundation Practice Sights grant program, a practice opportunity data base was developed and information disseminated to students, residents, and practicing health professionals. The Office also began collecting and entering data for the Health Personnel Database. Data on educational preparation, specialty, place of employment, and hour of practice are currently maintained on physicians, physician assistants, dentists, dental assistants, dental hygienists, licensed practical nurses, registered nurses, physical and occupational therapists, and respiratory care therapists to provide information to assist local communities and state government develop plans for the recruitment and retention of health personnel.

PLAN TO ACHIEVE TARGETS:

The Office of Rural Health and Primary Care is to receive an additional three years of funding through the RWJ program to: provide community-based recruitment and retention services; provide placement services to encourage primary care practitioners to choose rural and underserved areas; develop and implement programs to aid in the placement and retention of primary care practitioners; and promote the use of midlevel practitioners in the provision of primary care. The Office plans to expand the Health Personnel database to include chiropractic, podiatry, optometry, and pharmacy.

OTHER FACTORS AFFECTING PERFORMANCE:

The availability of state and foundation funds to support these activities will affect performance. In addition, state health care reform activities and the salary range, working conditions, geographical location of a health care facility, and numerous other factors ultimately affect success in the recruitment and retention of health professionals.

AGENCY: Health, Department of
PROGRAM: Health Care Delivery Policy

Objective 8: To promote the adoption of public health goals by the six Regional Coordinating Boards which impact on the cost and quality of and access to health care services.

Measure (1): The number of Regional Coordinating Boards adopting public health goals

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Adoption of Goals	N/A	N/A	4	6e	--	--
Target	N/A	N/A	3	6	6	N/A

DEFINITION, RATIONALE, DATA SOURCE:

The Regional Coordinating Boards are responsible for adopting regional public health goals, taking into consideration the relevant portions of Community Health Service plans, Minnesota Comprehensive Adult Mental Health Act plans, and Community Social Service Act plans. Effective July 1, 1995, all managed care organizations must file an action plan which describes the actions they are taking to achieve public health goals. The Regional Coordinating Boards are to collaborate with managed care plans in developing these activities.

In January 1994, the Regional Coordinating Boards initiated a pilot project to adopt public health goals. Preliminary activities included obtaining extensive information on the public health goals contained in Community Health Services and other required plans. The Boards evaluated these to determine if managed care plans could be held accountable for achieving the goals and, if so, what measures of accountability might be appropriate. They also explored whether or not any public/private collaborative could be initiated to achieve the public health goals.

PLAN TO ACHIEVE TARGETS:

The Health Department provides staff support to the six Regional Coordinating Boards, and it is anticipated that the number of public health goals adopted for each region will be increased in the following year. However, statutory authority for the Regional Coordinating Boards will expire at the end of F.Y. 1996.

DISCUSSION OF PAST PERFORMANCE:

The Regional Coordinating Boards first met in January 1993. Statutory language enacted during the 1993 legislative session directed the Boards to adopt public health goals. The pilot project to adopt the goals was initiated in January 1994. For purposes of the pilot project, the number of goals was limited to no more than three for each region.

OTHER FACTORS AFFECTING PERFORMANCE:

None

SUMMARY

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

EXPENDITURES AND STAFFING (F.Y. 1994)	($ in Thousands)	
Total Expenditures:	$ 5,223,394	3.3% of department's budget
From State Funds	$ 4,573,827	
From Federal Funds	$ 649,567	
Number of FTE Staff:	52.7	5% of department's staff

PROGRAM GOALS:

- To increase availability of competitive, managed care systems which provide quality, affordable and accessible health care (M.S. 62N)
- To ensure compliance with quality of care and financial standards for managed care systems (M.S. 62D, 62N)
- To protect the public health, safety and welfare of Minnesota citizens by ensuring the availability and accessibility of appropriate emergency medical response and competent care rendered by ambulance services (M.S. 144.802, 144.808)
- To improve the quality and availability of allied health care services and ensure that speech-hearing and unlicensed mental health practitioners conduct their activities in compliance with requirements in law and rule (M.S. 148B.60 et seq., 148C, 153A, 214.13)
- To protect the overall health, safety and welfare of the general public and those who are involved in the care and disposition of the dead human body (M.S. 149)

DESCRIPTION OF SERVICES:

The Managed Care Systems Program facilitates licensure of new competitive managed care plans and provides consumer protection to the enrollees of the health plans. Policy development and communications to interested communities and groups is achieved through reports to the legislature, promulgation of rules and interpretation of law to affected parties. Financial and quality assurance audits monitor the managed care entity's compliance with financial solvency and quality of care requirements. The investigative activity receives and investigates enrollee complaints about managed care problems and assists other consumers who have related inquiries about managed health care. Operating changes, including certificates of coverage, premium rates for certain products and management contracts, must be submitted for review and approval. Enforcement action is taken when there is evidence of violation of state law.

The responsibilities of the Emergency Medical Services (EMS) Program include licensing ambulance services, certifying EMS personnel, oversight of training and testing, administrating a financial data collection program on ambulance services, providing reimbursement for volunteer training, administering the volunteer incentive fund, administration of funding for the state's eight regional emergency medical services systems, administration of grants for poison information centers, and

serving as a technical assistance resource to individuals, agencies and organizations to ensure high-quality care through regulation and emergency medical system development. Recognizing the continuing struggle to maintain a sufficient supply of volunteer emergency personnel in the EMS system, the role of first responders in Minnesota needs identification and clarification. Another major factor is that an increasing number of communities and ambulance services wish to upgrade to advanced level licenses. Changes in the emergency medical technician training and curriculum are signs of the changing face of EMS nationwide and in Minnesota. Health care reform and the creation of Integrated Service Networks (ISNs) challenges the current system of emergency medical services in Minnesota. As well as identifying health care reform issues, Minnesota is in the process of identifying an organized, structured trauma system involving pre-hospital through rehabilitation services available in the state.

The Health Occupations Program exists to assure adequate numbers of allied health care practitioners and to protect health care consumers from incompetent practitioners. Quality and access to allied health care services are dependent in part on the competency and availability of practitioners qualified to provide health ...es. The program contributes to quality and access goals of health care reform efforts by engaging in four primary func... occupational policy analysis; credentialing of qualified health care practitioners; investigation of consumer complaints a... forcement actions against practitioners for unprofessional and illegal conduct; and consumer and public information an... ation.

The Mortuary Science Program ensures compliance with the current statute and rules relating to health, licensing, and disposition of the dead through the licensure of morticians, funeral directors, and mortuary science trainees; the registration and inspection of funeral establishments; the investigation of complaints and enforcement of regulations; and, the receipt, review and maintenance of pre-need trust fund reports. This activity was founded in 1898 by the Minnesota State Board of Health and is based on the concept fundamental to American society that the dead are properly cared for and the needs of survivors are met in a way that provides dignity to all. There are currently approximately 36,000 deaths per year in Minnesota. The Mortuary Science program issues approximately 1600 individual licenses and 500 funeral establishment permits annually.

BACKGROUND INFORMATION:

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994
	Managed Care Systems Section		
A	No. of Licensed HMOs	12	12
A	No. of HMO Enrollees (Thousands)	1,205,802	1,175,816
W	No. of Financial Exams conducted	7	7
W	No. of Quality of Care Exams Conducted	7	7
W	No. of Enrollee Complaints Received and Investigated	758	689
W	No. of HMO Operating Changes Reviewed	436	381
W	No. of Enforcement Actions	29	40
	Emergency Medical Services		
W	No. of Ambulance Service Licenses Issues	113	194
W	No. of Ambulance Vehicles Licensed	253	378
W	No. of Individuals Reached by Public Information Program	2400	2175
W	No. of First Responders Registered	5920	7203
W	No. of Emergency Medical Technicians (EMTs) Registered	5428	5690
W	No. of Written EMT Exams Administered by MDH	98	98
UC	Cost Per Written EMT Basic Exams, Including Retests	$90	$90

W	No. of Training Programs Approved	110	110
	Health Occupations Program		
A	No. of Credential Issues	1050	1040
W	No. of Complaints Opened/Closed	202/136	226/160
A	No. of Enforcement Actions Completed	3	3
	Mortuary Science		
A	Mortician, Funeral Dir. and Mort. Sci. Trainee Licensure	1,579	1,591
W	Funeral Establishment Permits	499	510
W	Pre-Need Trust Fund Reports	204	142
O	State Board Examinations	47	50
O	Endorsement Licensure Examinations	9	6

PROGRAM DRIVERS:

- State Health Reform. Since 1992, Minnesota has been involved in comprehensive reform of the health care system, in order to contain rising health care costs and increase access to affordable, quality health care and health care coverage.
- Federal Health Reform. At the current time, federal law primarily impacts health plan operations through Medicare and Medicaid participation requirements. There may be changes in federal law in the future which would change this relationship to grant either more or less authority for state alternative approaches.
- Credentialing Requirements. The marketplace evolution to more independent billing and a push towards the use of more allied provider services in large networks, appears to have generated a strong motivation for unregulated occupations to seek state credentialing. Unregulated occupation professionals are asserting that further state regulation will offer more choice and access in health care services.
- Injury Rates. The high frequency of traumatic injury to adult and pediatric populations, results in a demand to implement a statewide trauma system and initiate a statewide pediatric plan.
- Aging Population. The increase in our population of older citizens is increasing the demand for emergency medical services and access to health care services, along with a higher level of ambulance services provided to communities and health care facilities. At the same time, the increase in the aging population will also result in a greater number of deaths and the need for funeral services.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 1: To facilitate the licensure and ongoing regulation of community integrated service networks (CISNs) and integrated service networks (ISNs), as well as transition existing health maintenance organizations (HMOs) to CISNs and ISNs and continue regulatory activity.

Measure (1): Number of licensed CISNs, ISNs and HMOs, number of enrollees and regulatory activities.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Licensed CISNs/ISNs	N/A	N/A	N/A	6e		
Target				6	12	20
Number of Enrollees	1,193,802	1,205,802	1,175,816	1,200,000e		
Target	1,300,000	1,400,000	1,200,000	1,200,000	1,420,000	2,400,000
Licensed HMOs	12	12	12	12e		
Target	NA	NA	NA	12	8	0
% of St. Pop. Served	27	27	27	28e		
Target	NA	NA	NA	28	31	52
Changes Reviewed	306	436	381	400e		
Target	503	516	450	450	450	500
Audits Performed	13	13	15	14e		
Target	12	12	13	13	18	18

DEFINITION, RATIONALE, DATA SOURCE:

CISNs may start operation on January 1, 1995 and there will be additional new applicants as well as conversion of existing HMOs over the period of the next three years. During FY 1995 and FY 1996, new CISNs (smaller community networks) will be authorized to be licensed by Laws of Minnesota (1994) Chapter 625, Article 1. In FY 1997, the large, existing HMOs and health service corporations will need to convert to ISNs, in order to continue doing business. By measuring the number of licensed groups and regulatory activities, the Department will evaluate progress in making available competitive health care plan options which assure quality, affordable and accessible health care. Enrollment of these organizations is reported in quarterly and annual reports to the Department of Health. Regulatory functions are recorded internally on monthly status summaries. The cost to the State for reporting and using this data has been estimated at $6,000 per year, which is recovered through fees paid by health plans.

DISCUSSION OF PAST PERFORMANCE:

Minnesota has been the national leader in development of HMOs and the operating systems related to HMOs. Some of the first managed care systems in the nation were started in Minnesota approximately 50 years ago and during the past 22 years, Minnesota has been the heartland of managed competition. This nationally recognized past performance includes a regulatory environment which is receptive to innovation and change as long as the regulated organizations maintain fundamental legal principles which assure access to quality, comprehensive health care in a financially sound organization.

PLAN TO ACHIEVE TARGETS:

The MinnesotaCare Acts during the past three years have directed expansion of managed care systems through development of new CISNs for two years as well as a transition to ISNs by July 1, 1997. The agency is proactive in facilitation of licensure applications, assists development by providing public information on the law and models of operational systems and interprets laws so that the legislative purposes are achieved. Reports to the legislature, administrative rules and interpretations of law are done when necessary to reach program goals. During FY 1995 and 1996, two additional positions were allocated to the Managed Care Systems Section in order to promulgate comprehensive rules related to ISNs.

OTHER FACTORS AFFECTING PERFORMANCE:

In spite of any activity by the regulatory agency to facilitate development of CISNs/ISNs, managed care systems are still private corporations which operate in a very competitive marketplace. The viability of the managed care market is a function of many private economic variables which the regulatory agency cannot impact. A successful managed care market is dependent upon private physician and hospital participation in a business relationship which is workable for both parties. Similarly, there must be willing employers and individual purchasers in order for managed care systems to be successful. Some of the purchaser decisions are made by government through government employee benefit contracts, Medical Assistance contracts and Medicare arrangements. However, the largest portion of Minnesota health benefits are purchased by private employers. Employer decisions are affected by many factors including affordability of health benefit alternatives, collective bargaining agreements and employee morale considerations. Under current federal law, self-funded employee benefit plans are exempted from state health plan regulation.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 2: To investigate and enforce alleged violations of standards related to quality of care, access to care and eligibility for coverage provided to managed care enrollees.

Measure: Number of enrollee complaints investigated and enforcement actions undertaken.

Actual Performance	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
No. of enrollee complaints	741	758	689	750e		
Target	1229	1351	900	900	850	900
No. of Enforcement actions	24	29	40	28e		
Target	20	22	30	30	30	30
Percent of Enrollee Problems Resolved	38	37.5	40	40e		
Target	NA	NA	NA	40	40	40

DEFINITION, RATIONALE, DATA SOURCES:

Response to enrollee complaints is the core responsibility in successful consumer protection. Enrollee contacts by telephone include a wide variety of information requests, issues in need of referral to another authority and enrollee complaints which need investigation. Based upon the definition of an enrollee complaint in Minn. Rule 4685.1100, the complaints recorded for this purpose are a written expression of dissatisfaction with any aspect of health plan operations or enrollment provisions. Enforcement is any legal action taken by the agency to obtain enrollee satisfaction after investigation has determined that there is a potential violation of M.S. 62D. Data for measurement of this objective is recorded in the automated log of complaints with description of problems and results.

There are three primary results of investigation and enforcement: 1) enrollees involved are provided the needed services or paid for costs incurred; 2) corrective actions are taken so that in the future services are improved and no other consumers have the same problem, and 3) analysis of complaint trends helps to prioritize special examinations of key issue areas.

DISCUSSION OF PAST PERFORMANCE:

The agency has vigorously investigated allegations of violations of M.S. 62D and has worked with enrollees and HMOs to fairly achieve both a successful result for enrollees where possible and appropriate penalty against the HMO when necessary. Through the years, approximately one-half of the cases involve administrative, enrollment or billing issues while the other one-half involve medical care issues such as medical necessity determinations, emergency care disputes, access to care issues or provider competency problems. Trend analysis is done regularly so that special examinations can be conducted to ferret out systemic problems in need of correction. Medical necessity disputes and issues of investigational or experimental procedures are matters in which the medical expertise of agency staff, supplemented by medical consultants, is particularly important. Such matters are treated with urgency and objectivity so that prompt decisions can be reached for patients whose medical care is pending.

PLAN TO ACHIEVE TARGETS:

Current staff is well trained and experienced to investigate complaints. One additional staff position was added as a result of the 1994 legislative session. During FY 1995, particular emphasis will be given to developing an alternative dispute resolution system for CISNs and HMOs. This alternative dispute resolution method must be developed by January 1, 1995 and communicated to all enrollees. The system will maintain the investigative role of the agency and add new ways for

earlier negotiation, mediation and other methods to be used to avoid litigation and more prolonged disputes.

During the next several years new CISNs and ISNs will increase the number of managed care enrollees. While our initial licensure and ongoing evaluation will keep complaints to a minimum, there will be an unavoidable increase in complaints. This increased activity has been recognized in the increased staffing allocated to the Managed Care Systems Section.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 3: To ensure that all licensed ambulance services meet current Minnesota Statute and Rule requirements.

Measure (1): Number of ambulance services meeting full compliance on inspection for license renewal.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Ambulance Inspections	192	113	194	115e		
Target	NA	NA	NA	115	195	120
Correction Orders	NA	30	27	15e		
Target	NA	NA	NA	15	10	10
Summary Approval	NA	NA	1	20e		
Target	NA	NA	NA	20	20	10

DEFINITION, RATIONALE, DATA SOURCE:

Ambulance licensees are required by law to meet standards of Minnesota Statutes 144.801 to 144.8091 and Minnesota Rules Chapter 4690. Licenses are renewed biennially based on the EMS region in which they are located. This explains the rotation in services' inspections and licensing during "even" or "odd" years. Although the total number of ambulance services is not expected to change drastically, the types of services they provide is expected to rise to a higher level of care. Inspections and correction orders allow the EMS section to monitor the ability of services to meet current requirements. Ambulance renewal applications must be submitted biennially by each licensed ambulance service, thereby providing specific information as required by the Commissioner.

DISCUSSION OF PAST PERFORMANCE:

There is an increasing demand for higher level of emergency care, particularly in rural populations. Regulating through inspections and issuance of correction orders, while at the same time providing technical assistance, allows the Department to monitor quality performance standards.

PLAN TO ACHIEVE TARGETS:

In 1993 the EMS section, with assistance from other EMS persons and organizations, developed an EMS state plan that addresses concerns identified by the EMS community.

OTHER FACTORS AFFECTING PERFORMANCE:

Each ambulance service was issued a primary service area in the early 1980's. Since that time, many changes have occurred, perfecting the system which identifies a specific geographic area that each ambulance service operates. A summary approval process allows ambulance providers to change the geographical area in which they serve, thereby allowing services to improve coverage, improve coordination with the 911 system or improve efficiency of operations. The availability of trained personnel and the availability of continuing education directly affects the ability of providers to serve their constituents.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 4: To maintain the supply of qualified, registered persons as emergency medical providers.

Measure (1): Number of individuals registered as First Responder, Emergency Medical Technician (EMT)-Basic, EMT-Intermediate, and EMT-Paramedic level.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
First Responder	8040	5920	7203	8000e		
Target	NA	NA	NA	8000	8500	9000
EMT-Basic	5091	4695	5034	5100e		
Target	NA	NA	NA	5100	5100	5100
EMT-Intermediate	84	116	113	115e		
Target	NA	NA	NA	115	115	115
EMT-Paramedic	484	617	543	550e		
Target	NA	NA	NA	550	600	600

DEFINITION, RATIONALE, DATA SOURCE:

Minimum standards for personnel functioning on ambulance services have been established to assure the public of available minimally qualified individuals at all levels of care for responding in a tiered emergency response system. Registration of all levels is maintained on a database. All training program applications are reviewed to assure that necessary skills and knowledge are taught. This objective assures the same minimum skill and knowledge levels for all persons successfully completing an approved training program course.

DISCUSSION OF PAST PERFORMANCE:

The number of registrants per year is dependent upon the individual registrant meeting registration requirements. Some choose not to renew their registration every two years for a number of reasons. Currently there are 23,834 first responders, 18,233 EMT-Basics, 343 EMT- Intermediates, 1,288 EMT-Paramedics, and 226 examiners registered in the state of Minnesota.

PLAN TO ACHIEVE TARGETS:

The EMS Section will continue to encourage all currently registered personnel to renew their registration and provide technical assistance to training programs to help them meet needs of new curriculum,

OTHER FACTORS AFFECTING PERFORMANCE:

The need for, and the availability of, individuals interested in participating in emergency medical services in their community will affect the performance of this objective. Another major factor will be the availability of training programs. The effects of upcoming changes in the national training curriculum may affect the availability of state-approved training programs as well as the commitment expected of those participating. On a nationwide level, new curriculum guidelines are being developed. It is believed that in the next year, this will increase the number of training program reviews in anticipation of Minnesota adopting the new standard.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 5: To improve the overall competency and quality of allied health practitioners by establishing two credentialing systems in FY96 and FY97; register 1400 occupational therapy practitioners in FY96 and license 3000 chemical dependency counselors in FY97.

Measure (1): No. of applicants issued credentials for hearing instrument dispensing, speech language pathology, audiology, occupational therapy, and chemical dependency.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Hearing Instrument Dispensers	400	450	350	300e		
Target	NA	NA	NA	300	325	325
Speech Language Pathologists/Audiologists	500	600	690	700e		
Target	NA	NA	NA	700	710	720
Occupational Therapy Practitioners	NA	NA	NA			
Target	NA	NA	NA	NA	1400	1400
Chemical Dependency Counselors	NA	NA	NA	NA		
Target	NA	NA	NA	NA	NA	3000
Total Credentials Issued	900	1050	1040	1000e		
Target	1300	3000	2600	2600	2435	5045

DEFINITION, RATIONALE, DATA SOURCE:

Credentialing is one of two methods used in occupational regulation to affect the quality or competency of persons delivering health care services to Minnesotans. For example, imposition of competency testing as a pre-requisite to certification as a hearing instrument dispenser in Minnesota will assure that hearing aid sellers have a minimum level of knowledge and skill in the fitting and dispensing of hearing aids to predominantly elderly and vulnerable adults. The number of credentials issued is also data that indicates the relative availability of practitioners in Minnesota. Unduly restrictive credentialing requirements may reduce consumer access to services. Unduly lenient credentialing requirements may increase the supply of practitioners but reduce the overall competency of practitioners and quality of services. All information related to status of a credential is updated daily and organized by occupation in a computerized database.

DISCUSSION OF PAST PERFORMANCE:

Indicators of actual performance reflect the level of credentialing activity for occupations currently regulated by the Health Department. The Health Department discontinued a voluntary registration program for hearing aid sellers in FY93. Effective FY94 a mandatory permit system for sellers required conversion to certification regulation with a requirement that all sellers take and pass an examination. The conversion of the regulation will be completed November, 1994. As a result of implementation of new requirements for hearing instrument sellers, the occupational group appears to be shrinking. Speech-language pathologists and audiologists are gradually and slowly increasing in numbers.

PLAN TO ACHIEVE TARGETS:

Rules are being promulgated to establish uniform procedures and unique occupational standards that will be used to operate the credentialing system. Rules assure that all applicants and persons credentialed by the Program receive consistent and equal treatment. Following rule promulgation, resources must be planned, requested and acquired to implement the new credentialing systems.

OTHER FACTORS AFFECTING PERFORMANCE:

Establishment of credentialing systems and credentialing of occupational therapy practitioners and chemical dependency counselors is dependent upon promulgation of rules containing uniform and particularized credentialing procedures and standards.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 6: To increase the number of complaints investigated and successfully resolved relating to unlicensed mental health providers/Office of Mental Health Practitioners(OMHP).

Measure (1): The ratio of the number of complaints received compared to number of complaints closed each fiscal year for unlicensed mental health providers.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
No. of OMHP Complaints Opened	120	63	81	90e		
Target	NA	NA	NA	90	90	90
No. of OMHP Complaints closed	28	32	17	20e		
Target	NA	NA	NA	20	45	60
Ratio of Closed to Opened	.23	.51	.21	.22e		
Target	NA	NA	NA	.22	.5	.66

DEFINITION, RATIONALE, DATA SOURCE:

The ratio of closed to open complaints indicates the extent to which the number of complaints closed equal the number received in the stated time period. The program records complaint data daily, and monitors and reports complaint status weekly. Over time, the ratio may be a measure for evaluating whether each consumer complaint is resolved in a reasonable time, a measure of the extent to which the level of demand exceeds the level of program output, and an indicator of whether available resources may be adequate or not sufficiently effective. The measure shows that the output for mental health practitioners is far below the desired target of 1.0, which the program is able to maintain for hearing instrument dispensers.

DISCUSSION OF PAST PERFORMANCE:

The Commissioner of Health assumed authority to investigate complaints against unlicensed mental health practitioners effective FY92. Included in the complaint data for OMHP for FY92 are approximately 60 open complaints transferred to the Commissioner from the sunsetted Board of Unlicensed Mental Health Service Providers. In FY93, the program implemented a priority scheme for determining allocation of investigatory and enforcement resources, and a greater proportion of open mental health complaints were closed. However, of those remaining, only the most egregious complaints can be investigated, and a backlog of unresolved mental health complaints has been steadily growing. In FY94, the biennial appropriation to OMHP was cut 9 percent while the number of complaints increased approximately 29%.

PLAN TO ACHIEVE TARGETS:

In view of the number of complaints, the current level of resources and the factors affecting performance described below, improvement in the ratio of closed to open OMHP complaints requires additional resources. The achievement of the target for OMHP complaints is dependent upon an additional appropriation to the base appropriation for the FY96-97 biennium. The FY94-95 biennial appropriation was cut by $20,000 by the 1993 legislature. An increase over the biennium will support additional investigative resources.

OTHER FACTORS AFFECTING PERFORMANCE:

Complex factors affect investigation and resolution of complaints in OMHP not present in HID complaints. First, about 50% of complaints allege client/therapist sexual contact. Second, evidence of violations primarily relies on client testimony as opposed to paper documents and contracts readily obtainable in hearing aid sale transactions. Third, because practitioners are not credentialed by the Department of Health, each complaint requires unique investigatory effort to establish that the Commissioner has jurisdiction of the practitioner involved. The multitude of titles used and types of training and education possessed by practitioners requires frequent OMHP contact with mental health licensing boards (social work, marriage and family therapy and psychology) to determine that jurisdiction is appropriate. Finally, unlicensed practitioners, who have not acknowledged the authority of the state to regulate practice by obtaining a credential, regularly challenge jurisdiction of the Commissioner to investigate and discipline their conduct. These factors make investigation and enforcement activity more labor intensive and time-consuming than HID disciplinary efforts.

AGENCY: Health, Department of
PROGRAM: Occupational and Systems Compliance

OBJECTIVE, MEASURE

Objective 7: To ensure compliance with current statutes and rules relating to examination and licensure of morticians, funeral directors, and mortuary science trainees.

Measure (1): Mortuary Science enforcement/compliance activities

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Inspections	252	204	142	300e		
Target	300	300	300	250	250	250
Investigations	11	12	9	10e		
Target	NA	NA	NA	10	10	10
Notice of Orders	15	29	20	20e		
Target	NA	NA	NA	20	20	20

DEFINITION, RATIONALE, DATA SOURCE:

It is the responsibility of the Mortuary Science Program to ensure that individuals and establishments have met the requirements mandated by statute and rule for licensure. Staff is responsible for conducting inspections, investigating complaints, and providing information to the general public and licensees on requirements and regulations. Establishing educational requirements consistent with national recommendations, development and supervision of a valid internship program, as well as the implementation and utilization of valid licensing examinations are methods used to ensure quality services to the citizens of Minnesota. Information is stored in the Mortuary Science data base and other records.

DISCUSSION OF PAST PERFORMANCE:

Minnesota is recognized as a leader in funeral services. The constant influx of individuals seeking licensure and a minimal number of complaints and/or violations indicate the program has worked well. The ongoing effectiveness of the program requires regular review of the statute and rule which regulates the industry and continuous consultation to the licensees and public. The number of applicants for individual and establishment licensure, combined with the renewals, dictates the program's activity.

PLAN TO ACHIEVE TARGETS:

Maintaining the health, safety and welfare of the licensees has become more complex with the addition of many new regulations, in the areas of itemization of charges, infectious waste, occupational safety and health, and blood-borne pathogens, all of which create an increased demand for information from the section. Compliance with these regulations is mostly facilitated through the establishments. Review and development of more consistent, comprehensive establishment permit requirements needs to be considered. With limited staff and other resources, the usual high level of service can be greatly impacted by a single factor such as a media investigation.

SUMMARY

AGENCY: **Health, Department of**
PROGRAM: **01 - Facility and Provider Compliance**

EXPENDITURES AND STAFFING (F.Y. 1994)

	($ in Thousands)
Total Expenditures:	$11,816,192
From State Funds	$1,568,787
From Federal Funds	$10,245,123
Number of FTE Staff:	194

PROGRAM GOALS:

- To assure individual payment for nursing home services is based on the care needed and received by each nursing home resident. (M.S.144.072)
- To assure the quality and quantity of care rendered to persons living in certified Intermediate Care Facilities for the Mentally Retarded, and Institutions for Mental Diseases (Regional Treatment Centers) is appropriate. (P.L. 92-603, 42 CFR 456)
- To assure a comfortable, sanitary and safe environment for patients and residents of health care facilities by ensuring compliance with state and federal physical plant requirements for health care facilities. (M.S. 144.50-56 & 144A.01-07, Titles XVIII (Medicare) & XIX (Medicaid) of the Social Security Act)
- To protect the public health and safety of patients and residents receiving services in licensed/certified health care providers by ensuring they conduct their activities in compliance with federal and state regulations. (MS 144.50-14456, & 144.51-144.653,144A.01-144A.16, 144.411-144.417, 626.557, Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act.)
- To educate health care providers and consumers so that quality health care standards are promoted and maintained.
- To receive, analyze, investigate and act upon complaints involving health care providers and nursing assistants.

DESCRIPTION OF SERVICES:

The mission of the Facility and Provider Compliance Division is to safeguard and promote the health and safety of the individuals receiving services from health care providers in regulated settings, and to assure health care expenditures reflect the services needed and provided. This division is regulatory in nature and is comprised of 5 sections: Licensing and Certification, Engineering Services, Case Mix Review, Office of Health Facility Complaints, and Management Services.

Case Mix Review (formerly Quality Assurance & Review) conducts annual reviews of all medicaid recipients and private pay residents in certified nursing facilities and intermediate care facilities for the mentally retarded. This activity is accomplished through onsite reviews, whose purpose is to assure the quantity and quality of services are appropriate to the individual needs of the residents. The program ensures that the daily rates charged by nursing facilities to residents care based on the actual care needed and received by each resident.

Engineering Services ensures that all new construction or remodeling of health care facilities complies with federal and state law. This action is accomplished through the review of all construction plans and the inspection of completed projects. By providing consultation and requiring approval of building plans, the Section ensures that facilities' expansion, replacement, or remodeling projects comply with applicable law. This benefits consumers and providers alike by assuring facilities' physical plants meet basic safety and health requirements, as well as by avoiding costly mistakes requiring correction after building projects are completed.

Licensing and Certification (formerly Survey and Compliance) provides assurance of quality care to recipients of health care services. This is accomplished by inspections and monitoring of health care providers. This program is also responsible for managing the federally mandated Nursing Assistant Registry which maintains eligibility information on 45,000 certified nurse aides in Minnesota, as well as reviews 104 training programs for nurse aides.

Office of Health Facility Complaints investigates complaints lodged against health care providers. Special investigators, conduct investigations and take regulatory action when violations are found. They also investigate complaints of abuse and neglect by nursing assistants, and report any substantiated complaints to the Nursing Assistant Registry, thereby precluding those nursing assistants from future employment in nursing homes.

Management Services coordinates the activities of the Division. Services include program and fiscal planning, information system management, promulgation of administrative rules, coordination of administrative appeals, and functions as liaison with other state agencies, the U.S. Department of Health and Human Services, consumer advocacy groups and providers.

BACKGROUND INFORMATION:

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994
Case Mix Review			
W	Audits	11,156	10,800
W	Reconsiderations	1,965	2,193
O	Savings (from Audits and Reconsiderations)	$8,779,695	$7,500,000e
W	Inspection of Care Recommendation	4,619	4,650e
Engineering Services			
W	Construction Plans Reviewed	150	172
W	Construction Inspections	200e	248
Licensing and Certification			
W	Licensing/Certification Surveys	2,150	1,525
O	Number of Violations	7,995	9,135
O	Number of Violations per Survey	3.7	6.0
W	Nursing Assistants added to Registry	7,853	7,988
O	Nursing Assistant abuse or neglect reported to Registry	26*	34*
	*excluding reports from other states		
Office of Health Facility Complaints			
W	Total complaints received	860	949
W	Investigations completed	659	880

PROGRAM DRIVERS:

Aging Population. The number and percentage of Minnesotans aged 65 or older is increasing, as is the level of medical care they require. This creates a greater demand for continued assessment of the needs of the individuals in long term care settings to assure they are appropriately placed, receiving services to meet their needs, and their payment rate reflects the level of services needed and received.

Increases in Medical and Health Care Costs. Increases in medical and health care costs have resulted in the creation of alternatives to traditional health care delivery services, such as outpatient surgical centers and community based residential long term care settings. As society looks for cost effective ways to deliver health care services, it is important that the quality of those services is not eroded.

Increased Emphasis on Enforcement. The increased federal emphasis on enforcement in long term care settings has resulted in a survey/investigative process demanding more detailed documentation capable of sustaining legal challenge.

Changing federal and state requirements. The Division is responsible for enforcing both federal and state requirements in these health care settings; therefore, as regulations change, there is a continuing need for training staff and providers. In addition, the Division's policymakers and rule writers must re-examine existing state regulations as federal regulations change to eliminate conflicting requirements, while maintaining Minnesota's standards for quality of care and services.

AGENCY: **Health, Department of**
PROGRAM: **Facility and Provider Compliance**

OBJECTIVE, MEASURE

Objective 1: To assure the quality and quantity of services provided to residents in certified long term care facilities are appropriate to their individual needs and the payment received by nursing facilities reflects care needed and provided to the individual resident.

Measure (1): Savings in long term care expenditures.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
# Assessments by NH	40,415	40,261	40,322	40,000e		
Target	40,000	40,000	40,000	40,000e	40,000e	40,000e
# Audits	11,287	11,156	10,800	10,750e		
Target	4,042	4,026	4,100	4,000e	4,000e	4,000e
Savings	$5,480,413	$7,431,506	$6,100,000e	$6,200,000e	$6,300,000e	$6,000,000e
# Reconsiderations	2,136	1,965	2,193	2,100e	2,000e	2,000e
Target	1,200	1,500	2,100	2,000e	1,900e	1,900e
Savings	$1,665,265	$1,348,190	$1,400,000e	$1,500,000e	$1,600,000e	$2,000,000e
Total Savings	$7,145,678	$8,779,695	$7,500,000e	$7,700,000e	$7,900,000e	$8,000,000e
Inspec. of Care Recs.	4,490	4,619	4,650e	4,650e		
Target	N/A	N/A	4,600	4,650e	4,650e	4,650e

DEFINITION, RATIONALE, DATA SOURCE:

The Case Mix Review Section has two primary functions: To assure the quality and quantity of services provided to residents in certified long term care facilities are appropriate to their individual needs and the payment received by nursing facilities reflects care needed and provided to the individual resident.

Minnesota requires that rates charged to nursing home residents are based on their care needs (M.S. 144.072). This classification process is known as "case mix" and applies to private pay residents and those receiving Medical Assistance. Residents' care needs are assessed at levels ranging from case mix level A (requiring the least care) to case mix level K (requiring the most care). The daily rate nursing homes charge to each resident is based upon this classification. Department staff regularly review the assessment levels and audit a percentage of the assessments performed by nursing home staff to ensure the payment levels reflect the care needed and received by each resident. These onsite audits have resulted in significant savings in rates paid by individuals and by Medical Assistance. The yearly savings (calculated by using a state wide average of nursing home rates) is shown above.

Onsite audits are conducted twice yearly by Department staff to verify the accuracy of the assessments. A minimum of 10% of the assessments are audited (shown above as targets) and up to 100% audits are performed if significant error is found. In addition, persons may request "reconsideration" of assessed case mix classification levels. Reconsiderations result in additional savings for individuals and Medical Assistance. The target number of reconsiderations is based upon averages determined from historical data.

Through Inspection of Care activities, a federally funded Medicaid program (Title XIX) (P.L. 92-603, 42 CFR 456), the Section reviews and interviews all residents and clients in certified nursing homes and intermediate care facilities for the mentally retarded to assess the appropriateness of the individual's placement and his/her care plan. Identified problems are

shared with the facilities in the form of recommendations for alternative placement or the need to review the plan of care. These activities are coordinated with the annual case mix reviews conducted by the Section.

DISCUSSION OF PAST PERFORMANCE:

Since 1985, Minnesota has used the case mix system for determining nursing home payment rates. This law was enacted to address increasing Medical Assistance costs. Minnesota is one of two states that has an "equalization" law requiring that rates for private pay residents are no higher than rates charged to Medical Assistance recipients. Therefore, all residents of nursing homes participating in Medical Assistance receive a case mix classification.

Under current case mix rule, residents are assessed on admission, annually by Case Mix Review Teams, semi-annually by the facility, after hospitalizations, 30 days post hospital, and when residents are transferred between different levels of care or facilities. Approximately 145,000 case mix assessments are processed annually. This level of activity is stable.

Over 4,600 individualized recommendations were written in 1993. In addition to addressing the need to reassess the current level of care, other areas of concern include medical, nursing, social service, dietary, rehabilitation, dental, activities, and care planning.

Trend analysis is an ongoing process in the Section. Data is collected and used for studies and identification of long term care issues such as restraint and psychotropic drug usage. Since the early 1980's the Section has maintained data on residents. This data collection allows for identification in trends in acuity of residents, drug useage, dependency needs and other indicators regarding the changing long term care environment.

PLAN TO ACHIEVE TARGETS:

The target of auditing 10% of the assessments is a minimum set by state law. The Department exceeds the minimum target whenever an error rate in assessments conducted by facilities is greater than 20%. The adjustments to case mix levels as a result of audits and reconsiderations produce significant savings for the State's Medical Assistance program and/or private paying residents. The Department conducts regular training for nursing home staff on how to assess residents' case mix level due to the constant turnover in facility personnel.

Revisions to the case mix system are currently being field tested. The purpose of the field testing is twofold: to address the increasingly complex care needs of today's nursing home population (e.g. persons discharged from hospital to nursing home sooner, persons with dementia who require more specialized services); and to prepare for proposed federal regulatory changes. Training will be conducted in conjunction with the provider organizations for final implementation of changes to the case mix rule. The medical director works closely with section personnel when addressing medical standards of care, consulting with primary physicians, medical directors, and the medical director's association.

OTHER FACTORS AFFECTING PERFORMANCE:

There is the continuing struggle to balance the demands of nursing home providers for adequate compensation to ensure quality of care with the public's demand for control of health care costs. The number and percentage of our population aged 65 or older is increasing, as is the acuity level of nursing home residents. This creates the need for a continuation of individualized assessments to assure appropriate placement and care which results in a correct level of payment.

The population in the intermediate care facilities for the mentally retarded continues to diminish as waivered services are developed for the clients. This may result in fewer mandated reviews for the Section. A major concern is that lack of oversight in these waivered facilities may result in diminished quality and quantity of care for a vulnerable population.

There is the expectation that a national case mix system will be implemented in the future, as such a system is now being field tested in four states. The Department must prepare for possible implementation of a proposed national case mix system while continuing to operate a successful state case mix system.

AGENCY: **Health, Department of**
PROGRAM: **Facility and Provider Compliance**

OBJECTIVE, MEASURE

Objective 2: Monitor construction and remodeling of health care facilities from initial design stage through project completion in order to ensure compliance with state and federal regulations.

Measure (1): Plan reviews and inspections of construction projects within established timeframes.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Const. Plans Received	200e	202	227	250e		
Target	N/A	N/A	N/A	250	250	250
Const. Plans Reviewed	200e	150	172	250e		
Target	N/A	N/A	N/A	250e	250	250
Construction Inspections	123	200e	248	300e		
Target	123	200e	248	300e	300	300

DEFINITION, RATIONALE, DATA SOURCE:

The Engineering Services Section exists to assure that hospitals, nursing homes, boarding care homes, supervised living facilities, and ambulatory surgical centers provide a comfortable, sanitary, and safe environment by assuring compliance with physical plant rules for state licensure and NFPA 101, Life Safety Code, standards for federal certification of these facilities. The Section reviews plans for health care facility construction and modifications, conducts inspections of completed projects, and provides information concerning physical plant rules and fire safety standards. It also reviews and processes Life Safety Code survey documentation for federally certified facilities. Activity in each of the performance criteria is recorded and tracked electronically.

DISCUSSION OF PAST PERFORMANCE:

There is an increasing demand for engineering services by health care providers. As the cost of health care increases, health care providers are re-thinking the methods used in providing this service in order to be more marketable and cost-efficient. This dynamic environment has resulted in new and innovative designs that in many cases are more complex. As existing facilities age, the physical plant, (structural, mechanical, and electrical systems) deteriorate even with regular maintenance. As applicable codes, rules, and regulations become increasingly numerous and complex, the Section is being asked to provide more technical consultation. In addition, innovative designs require increased interaction between Section staff and designers. In the past, these designs required both state and federal waivers from current regulations. Regulating through plan reviews and construction inspections, while at the same time providing technical assistance, allows the Department to assure a quality environment for users of these facilities.

The Department of Health contracts with the Department of Public Safety, State Fire Marshal Division, to perform fire safety surveys at hospitals, ambulatory surgical centers, nursing facilities, and intermediate care facilities for the mentally retarded. The Section reviews each Life Safety Code survey packet prior to submittal to the Health Care Financing Administration.

PLAN TO ACHIEVE TARGETS:

The Section must review 100% of plans received. Review and approval may not necessarily occur in the same fiscal year the plan was received. The variable is the length of time between plan submittal and final approval. This "turn-around time" is influenced by the size and complexity of the project, and the staff available to complete the work. The Section's "turn-around time" target is to review 80% of all plans submitted within 60 days of receipt by 1997. The ability to meet the 1997

target will be directly influenced by the accuracy of the estimated number of plans submitted and the resources available to complete the inspections.

The number of full Life Safety Code surveys in each fiscal year is determined by the number of recertification surveys conducted by the Licensing and Certification Section. The target is 100% of all recertification surveys.

Systems have been developed to increase consistency and efficiency, including: a construction checklist given to engineers and architects at the time of a preliminary plan review; a comprehensive set of letter macros for use by the Section's engineers in their written correspondence; all construction plans currently stored in traditional bulky paper form are being converted to microfilm; all correspondence currently stored in traditional file cabinets is being converted to electronic images; use of computer software by the State Fire Marshal; use of electronic communication systems to link the Section and State Fire Marshal; and, transfer of Life Safety Code data for each facility to an automated data base.

Microfilming of plan sheets will ease problems associated with review, updating and storage of necessary documents and will significantly improve the disaster recovery ability for both providers and the Department. Electronic imaging will improve accessibility and storage of these documents and will significantly reduce filing activities. The electronic communication system will enhance effective communications for rescheduling of inspections.

OTHER FACTORS AFFECTING PERFORMANCE:

Much of the Section's workload is dictated by external forces. The number of plans submitted and the month in which they are submitted is determined by health care providers based on their desires to expand and/or remodel. Plans are submitted as professional designers complete the designs; reviews must then be completed within a reasonable amount of time. The nursing home moratorium exception process and changes in the reimbursement formulas significantly influence the number of proposed construction plans that are received for review. The number of plans received varies each month, sometimes creating a surge in demand for engineering services. The innovative designs generally require additional time for review and approval in order to assure compliance with applicable codes. Construction inspections are required prior to occupancy. Facility owners demand service on a very short notice since the date of clearance for occupancy. In addition, changing regulations affect performance, as staff and the industry adapt to new standards.

AGENCY: Health, Department of
PROGRAM: Facility Provider and Compliance

OBJECTIVE, MEASURE

Objective 3: To monitor compliance by health care providers with federal and state requirements.

Measure (1): Number of regulated providers and regulatory activity.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Licensed Providers	1,182	1,175	1,781*	1,800e		
Target	N/A	N/A	N/A	1,800	1,830	1,850
Certified Providers	1,576	1,657	1,706	1,600e		
Target	N/A	N/A	N/A	1,600**	1,670	1,725
CLIA Laboratories	N/A	N/A	2,100	2,000e		
Target	N/A	N/A	N/A	2,000	1,900	1,800
NAs added to Registry	N/A	7,853	7,988	8,000e		
Target	N/A	N/A	N/A	8,000	8,000	8,000
Lic./Cert. Surveys	2,144	2,150	1,525	1,659e		
Target	N/A	N/A	N/A	1,740e	1,779e	1,779e
CLIA Surveys	N/A	N/A	234	306e		
Target	N/A	N/A	N/A	306	306	306
Follow-up Visits	1,316	1,400	742	1,400e	1,400	1,400
Target	100%	75%	50%	75%	75%	75%

* Increase due to licensure of home care providers

** Decrease due to the termination of the contract with HCFA to do Mammography surveys effective 10/1/94.

DEFINITION, RATIONALE, DATA SOURCE:

The Licensing and Certification Section provides assurance of quality care to recipients of health care services. This is accomplished through: (1) onsite inspections of licensed and certified health care providers; (2) issuance of correction orders and/or federal deficiencies; (3) followup visits to ensure correction of violations; (4) issuance of penalty assessments or initiation of other legal proceedings if compliance is not achieved; (5) complaint investigations of alleged unlicensed or improperly licensed care providers or referrals from the Office of Health Facility Complaints; (8) review and processing of all required documentation for provider licensure and Medicare or Medicaid certification; (9) administration of the Nursing Assistant Registry; and (10) collection and dissemination of information.

The direct clients are the 1,780 state licensed providers, 1,706 federally certified providers, and the 2100 clinical laboratories in Minnesota surveyed under the authority of the Clinical Laboratories Improvement Act (CLIA) of 1988. The licensed providers include 153 hospitals, 443 nursing homes, 83 boarding care homes, 463 supervised living facilities, 10 freestanding outpatient surgical centers, 8 state operated regional treatment centers and 621 home care providers. The certified providers include 492 skilled nursing facilities, 359 intermediate care facilities for the mentally retarded, 6 portable x-ray suppliers, 83 rehabilitation agencies, 96 physical and occupational therapists in independent practice, 218 home health agencies, 32 hospices, 43 end stage renal dialysis suppliers, 11 ambulatory surgical centers, 16 rural health clinics, 3 comprehensive rehabilitation facilities, and 17 community mental health centers. The indirect clients served are the consumers of services located throughout Minnesota.

The Nursing Assistant Registry is a federally mandated program which requires nursing assistants to meet minimal competency training requirements before working in a nursing home. Currently there are over 45,000 certified nursing assistants registered. In addition, 104 nursing assistant training programs in Minnesota are reviewed biennially to assure they meet quality standards.

DISCUSSION OF PAST PERFORMANCE:

Completing all surveys and follow-up visits as required will identify violations and provide for their correction so that patient and resident health care is improved. External factors influence the success of the program. There are uncertainties about federal funding priorities which cause shifting emphasis and make long range planning difficult. In 1993 a modified survey process with federal approval was utilized and 100% of survey goals were met. However, in fiscal year '94 the federal survey process reverted to utilization of the full survey protocols, per federal mandate, and resulted in a decreased number of surveys. The federal government is considering more changes to the survey process in fiscal year '95.

The Nursing Assistant Registry was automated in 1993, and has become a national model for efficiency and customer responsiveness. It effectively provides employers, nursing assistants, and the public with 24 hour, seven day a week access to employment data. Callers frequently comment on how surprised they are that state government can provide such responsive service. Many other states have inquired as to how to duplicate this system.

PLAN TO ACHIEVE TARGETS:

Federal funding has been assured so that vacancies created through attrition can be filled. Significant computer improvements in various program components have been made. Current staff is experienced and well trained to survey providers.

State home care licensure activities are expanding. This licensure program is new and is regulating providers unfamiliar with regulation. Thus, there is a large turnover of participating home care providers which necessitates continued clarification and explanations about licensure requirements to customers. This is different from other regulated providers such as nursing homes who are more familiar with regulatory processes. For example, in fiscal year 1993, 208 new home care providers were licensed, while 154 such providers closed.

With constrained resources, survey activity is prioritized based on history of complaints and compliance.

OTHER FACTORS AFFECTING PERFORMANCE:

There are changing federal and state program requirements and emphasis. The increased federal emphasis on enforcement has resulted in both the survey and investigatory processes demanding more specific, detailed documentation capable of sustaining legal challenge. The state has developed a new format of prioritization of workloads and numbers of providers surveyed based on federal funding levels. Federal funding is expected to stay constant, but the number of providers is projected to increase. It is anticipated that the number of medical laboratories in Minnesota to inspect will decrease due to laboratory consolidation.

AGENCY: **Health, Department of**
PROGRAM: **Facility and Provider Compliance**

OBJECTIVE, MEASURE

Objective 4: To increase health care provider compliance through enforcement and education.

Measure (1): Number of violations and targeted area violation reduction.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Violations	9,692	7,995	9,135	8,350e		
Target	N/A	N/A	N/A	7,800	7,700	7,700
Violations per Survey	4.5	3.7	6.0	5.4e		
Target	N/A	N/A	N/A	4.7	4.6	4.5
Target Area Reduction						
NH w/ Res. Asmt. def.	N/A	N/A	264	258e		
Target	N/A	N/A	N/A	256	248	238
Education Session	25	25	25			
Target	N/A	N/A	25	26	32	32

DEFINITION, RATIONALE, DATA SOURCE:

The Licensing and Certification Section has targeted the area of "Resident Assessment" for improving provider compliance. Resident assessment was selected because it is the primary tool facilities use to determine the overall health status of residents, and it forms the basis for providing individualized care based on residents' needs. The target is to decrease the number of certified nursing homes with violations in this category. (If the number of nursing homes surveyed varies from year to year, the measure will be the percentage of surveyed facilities receiving resident assessment deficiencies.) The goal is to attain a 10% reduction from fiscal year 1994's figures by the end of fiscal year 1997 in the number (or percent) of certified nursing homes with deficiencies in resident assessment.

Recently the Department has developed the computer capability to track deficiencies and correction orders by category. This ability will assist the Licensing and Certification Section in measuring improvement in compliance and will help identify other areas for targeting.

DISCUSSION OF PAST PERFORMANCE:

Past performance has been impacted by the ability of the Licensing and Certification section to survey all the certified facilities and to provide the training and consultation necessary for improved facility compliance. The Division has developed an effective quarterly newsletter to provide ongoing information to facilities and has participated in ongoing educational programs.

PLAN TO ACHIEVE TARGETS:

Training in targeted areas to provider organizations is planned. Increasing provider and consumer knowledge of regulations should improve quality of health care. Also, increased access to federal training programs through video conferencing is proposed.

The Licensing and Certification Section will have available a newly hired physician and Registered Nurse Specialist as a resource for providers and division staff.

Currently, the Division's Nursing Home Regulatory Reform Project is revising the state nursing home regulations to be more consistent with federal regulations. This comprehensive overhaul of state rules should improve provider compliance and ease enforcement in the long term.

With an increase in the number of educational programs planned for provider and consumer organizations, this should result in increased compliance. Through automated access to data, the Division will be able to more readily share survey findings and trends with provider and consumer organizations.

OTHER FACTORS AFFECTING PERFORMANCE:

Changes in federal regulations regarding resident assessment and enforcement procedures will affect provider and survey agency performance. External factors affecting the ability to improve provider compliance are the knowledge and expertise of the providers; provider reimbursement; increased health care needs of residents; and changing interpretations of what constitutes quality care.

AGENCY: Health, Department of
PROGRAM: Facility and Provider Compliance

OBJECTIVE, MEASURE

Objective 5: To investigate complaints in health care settings in a timely manner.

Measure (1): Investigate 90% of all complaints within 90 days; 95% of NA/R abuse cases within 60 days by 1997.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
General complaints rec.	317	360	419	500e		
Target	N/A	N/A	N/A	410	550	600
VAA Complaints rec.	484	500	530	640e		
Target	N/A	N/A	N/A	550	720	800
*Investig. Completed	576	659	880	960e		
Target	N/A	N/A	N/A	960	1,020	1,100

* "Investigations Completed" may reflect complaints originating in prior year(s).

DEFINITION, RATIONALE, DATA SOURCE:

The Office of Health Facility Complaints (OHFC) is an investigative and regulatory office established under provisions of Minn. Stat. 144A.55 (1992) to receive, analyze, investigate and act upon 100 percent of complaints lodged against licensed or federally certified health care providers. Regulatory action is taken when violations are found to exist in order to assure the delivery of quality health care to the consumers of Minnesota. The Office assists residents of health care facilities in the enforcement of their rights, and works with administrative agencies, health care providers, and organizations representing consumers on programs designed to provide information about health facilities to the public and residents of facilities.

In addition to complaints of a general nature, OHFC has responsibility for investigating complaints of abuse or neglect of patients or residents of licensed health care providers in accordance with the Vulnerable Adults Act, Minn. Stat. Chapter 626.557 (1992). Also, this is the Office to which providers report incidents of suspected or known abuse or neglect under the Vulnerable Adults Act. Frequently allegations of abuse or neglect involve nursing assistants. Upon substantiation of abuse or neglect by a nursing assistant the Nursing Assistant Registry is notified. This notification could prohibit the nursing assistant from working in a nursing home in the future.

OHFC is responsible for investigating complaints against licensed home care providers and for ensuring compliance with the home care bill of rights by unlicensed medicaid exclusive personal care attendant (PCA) providers.

The number of general complaints and Vulnerable Adult Act investigations increased slightly in fiscal year 1994 from the previous year. Complaints against nursing homes are increasing in complexity. Investigation of nursing assistant abuse reports is projected to increase and as cases are substantiated they are submitted to the Nursing Assistant Registry. The number of nursing assistant abuse investigations is projected to increase. It is also projected that complaints involving home care providers will increase.

New computer tracking resources will allow profiles of providers, complaint trends, and timeliness of response.

DISCUSSION OF PAST PERFORMANCE:

Prior to 1991 OHFC was responsible for investigating potential violations of state law; in 1991 responsibility for investigating potential violations of federal law was added. Training and orientation was required to implement this federal complaint investigation activity. This had the effect of increasing the scope of many of the investigations thereby requiring additional

time for conducting the investigations. Also in 1991 the responsibility of investigating abuse or neglect by nursing assistants was required by federal regulations. Substantiated cases must be capable of sustaining a challenge in a contested case hearing, which is heard before an Administrative Law Judge.

Since 1992 several new processes have been implemented to reduce the backlog of complaints, including development of a system for prioritizing complaints, reduction in the length of reports, and regular meetings with investigators to set goal dates for completion. Even though these measures have helped in the reduction of the backlog, there remains a backlog of unresolved complaints.

PLAN TO ACHIEVE TARGETS:

OHFC expects a continued increase in the number of complaints received. OHFC's target is to complete 90% of the complaint investigations within 90 days of receipt by 1997. The figures shown above for 1995 and 1996 are based on a "90 day completion" rate of 75% and 80% of complaints received in FY'95 and FY'96 respectively. The ability to meet the 1997 target will be directly influenced by the accuracy of the estimated number of co[illegible]aints and the resources available to complete the investigations.

The program currently has a new computer database which allows each complaint to be recorded and will allow evaluation related to resolution of the complaint within the stated performance measure, evaluation of the relationship of the [illegible]mber of complaints received to the number of complaints resolved, and evaluation of adequacy and/or effectiveness [illegible] resources.

A new investigative report format has been developed and is currently being evaluated. This format provides for simplification of the documentation process and will be used for many of the investigative reports.

Changes in internal procedures and staff restructuring during the past year will assist OHFC in attaining this performance measure.

OTHER FACTORS AFFECTING PERFORMANCE:

A major factor which will significantly impact the realization of the objective is the accuracy of the estimated number of complaints received and the available resources. Another major factor which will affect the performance of this objective is the increased federal emphasis on federal enforcement, which may demand more specific, detailed documentation capable of sustaining legal challenge. Federal enforcement regulations may result in the need for additional training and the need for increased involvement of the Attorney General's staff.

Other factors which may affect the achievement of the objective include staff turn over and an increase in the nursing assistant abuse allegations. In addition, as consumers become more knowledgeable about the process for filing complaints it is anticipated that there will be an increase in the number of complaints received against home care providers. The home care providers were recently covered by state regulations and an anticipated growth in complaints is expected.

SUMMARY

AGENCY: Health, Department of
PROGRAM: 06 - Environmental Health

EXPENDITURES AND STAFFING (F.Y. 1994)	($ in Thousands)	
Total Expenditures:	$ 13,344	(8.4% of department's budget)
From State Funds	$ 9,989	
From Federal Funds	$ 3,239	
Number of FTE Staff:	192.9	(18.2% of department's staff)

PROGRAM GOALS:

- to protect the public health in the use and consumption of water in Minnesota, (M.S. 103I; 144.05; 144.383; 326.37-65).
- to protect the public health by reducing exposure to environmental health hazards, such as asbestos, lead, radon, environmental tobacco smoke, chemical releases, and other toxic agents by assessing health risks, communicating health risk information and regulation of abatement, (M.S. 103H.201; 116D; 144.05; 144.12; 144.411-417; 144.871-879; 326.70-81; 473.845).
- to protect the public health by reducing the incidence of foodborne and waterborne disease, communicable disease and assure sanitary conditions in Minnesota, (M.S. 144.71-144.76; 144.12, subd. 1-2; 145.02; 145A.07; 157; 214.13, subd. 1, 3).
- to protect the public health by reducing unnecessary radiation exposure to the public and users of ionizing radiation sources in Minnesota, (M.S. 4.035, subd.2; 12.13; 144.05; 144.121).

DESCRIPTION OF SERVICES:

The Environmental Health Division protects the public health and safety from threats in the home, community, and workplace environment. It provides this protection through enforcement of state and federal standards; provision of technical consultation with local health agencies, the regulated community, and other state agencies; evaluation of potentially health-threatening environmental conditions; and provision of health education materials concerning environmental health risks to the public, health care providers, and local health agencies.

The Drinking Water Protection Section: enforces the federal Safe Drinking Water Act and monitors public water supply systems; regulates wellhead protection plans for public water supply systems; regulates well construction, sealing, and maintenance; enforces the state plumbing code; and reviews public water supply construction plans, plumbing plans for public building construction, and swimming pool design plans.

The Environmental Health Hazard Section: regulates asbestos and lead abatement; ensures compliance with the MCIAA and standards for the indoor air quality of enclosed sports arenas; assesses human exposure to environmental contaminants near federal Superfund sites, clean-up sites, and metropolitan area landfills; analyzes health risks as part of the environmental

review process; develops health-based standards for groundwater contaminants; develops health effects advice related to eating sport fish from Minnesota rivers and lakes; and provides health education materials on radon, MCIAA, indoor air quality, lead, and health risks to the public, health care providers, and the regulated community.

The Radiation Control Section: regulates x-ray equipment and all sources of ionizing radiation; approves mammography screening programs; collects and analyzes milk, water, soil, and air samples to evaluate radiation levels and the effectiveness of radioactivity control procedures; and assures availability of trained staff to determine protective action guidelines in the event of a nuclear power plant emergency.

The Environmental Health Services Section: regulates food, beverage, and lodging establishments and other public facilities including manufactured home parks, recreational camping areas, childrens camps, migrant labor camps and mass gatherings; investigates foodborne and waterborne disease outbreaks; registers sanitarians; enforces the MCIAA in licensed public establishments; and evaluates delegated local food, beverage, and lodging programs to ensure sanitation and other environmental health standards are met.

BACKGROUND INFORMATION:

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994
	Drinking Water Protection		
A	# of public water suppliers	9,700	9,700
W	# of sanitary surveys	2,100	2,100
W	# of samples collected	80,000	115,000
W	# of water operators certified	2,000	2,000
W	# of plans reviewed for swimming pools, plumbing, sewage treatment, manufactured home parks, and camping areas	2,511	2,903
W	# of plumbing projects inspected	1,183	2,510
W	# of plumbers licensed	5,226	5,023
W	# of plumbers' apprentices registered	883 (est.)	996
W	# of water wells constructed	10,940	11,498
W	# of wells inspected	2,950	3,125
W	# of well disclosures processed	42,320	33,106
W	# of wells sealed	11,200	11,800
W	# of well contractor licenses issued	617	652
W	# of technical assistance requests for wells	25,000	25,000
	Environmental Health Hazard Management		
A	# of indoor air inquiries/complaints	5,000	16,000
A	# of MCIAA inquiries/complaints	1,200	8,900
W	# of total enclosed sports arenas/total inspected	160/160	168/170
W	# of asbestos abatement project permits issued	1,243	2,121
W	# of residential asbestos abatement project permits issued	0	873
A	# of asbestos abatement site inspections	297	445
W	% of asbestos abatement site inspections	24	21
W	# of asbestos abatement contractors licensed	132	169

W	# of asbestos abatement workers certified	710	935
W	# of asbestos abatement site supervisors certified	907	1,087
A	# of health risk limits (rules) for groundwater	89	121
	Fish Consumption Advisory		
A	# of lakes and rivers in advisory	458	543
A	# of advisories distributed	11,475	21,000
A	# of brochures and fact sheets distributed	13,086	26,074
A	# of lead-related telephone inquiries	9,000	13,000
A	# of lead-related presentations	35	50
W	# of lead-related educational items provided	165,600	159,200
W	# of reported patients tested for blood lead levels	4,766	18,272
W	# of reported blood lead analyses	6,252	21,503
W	# of lead abatement contractor licenses issued	N/A	107
W	# of lead abatement inspector licenses issued	N/A	175
W	# of lead abatement workers certified	N/A	43
	Environmental Health Services		
A	# of establishments regulated	Not avail.	6,274
W	# of inspections conducted	8,659	5,068
W	# of construction plans reviewed	477	516
W	# of food service training sessions provided	14	16
A	# of delegation agreements with local agencies	47	48
	Radiation Control		
W	# of environmental samples	250	250
W	# of x-ray facilities inspected	1,247	1,972

PROGRAM DRIVERS:

Federal regulation: The federal Safe Drinking Water Act continues to regulate additional drinking water contaminants at lower levels. Many of these contaminants are naturally occurring in water and are not necessarily the result of poor disposal or handling practices. Pollution prevention activities, therefore will not affect the levels of all contaminants in the water. An increasing number of public water supplies will exceed drinking water standards as EPA increases the number of regulated contaminants. Corrective action is often expensive and many systems, especially small systems, do not have the financial resources to take timely action and achieve compliance.

The 1992 federal Mammography Quality Standards Act now requires all facilities performing mammography to meet specific requirements including specially-trained personnel and the use of quality control procedures. Currently Minnesota law does not require trained personnel for x-ray machine operation.

The U.S. Occupational Safety and Health Administration is publishing draft rules on indoor air quality that affect most nonindustrial workplaces for general indoor air quality and affect all workplaces related to environmental tobacco smoke.

In 1993, the EPA classified environmental tobacco smoke as a human carcinogen.

Federal regulations and grants have a major impact on the asbestos abatement, lead abatement, and wellhead protection programs. Funding for grants are often dependent on ensuring states' regulations are equally as restrictive as federal regulations.

Lack of Funding for Mandated Activities: M.S. 144.871-879 requires residential inspections by local health departments and abatement by property owners when an elevated blood lead level is found in a child's venipuncture blood sample. Currently there is no funding available to the local health departments for inspections or to property owners for lead abatement.

Economic conditions: The well management, plumbing and asbestos abatement programs are entirely fee supported, and revenue generation is directly linked to overall economic conditions. Reduced numbers of transactions during periods of economic slowdown will drive the need to either reduce costs or increase fees to maintain current levels of service. Property development under times of economic growth has lead to the discovery of old landfills. Residents sometimes experience problems with landfill gases and groundwater contamination.

Increased risk of foodborne illnesses: The food industry is becoming more diverse and global in scope. The potential for foodborne illness is increasing due to global sources of raw foods, increased variety in food types, more extensive menus, new technologies in food processing and preparation, high turnover of food workers, and an extensive use of low paid food workers with limited education and training. Also, people now spends 40 percent of their food dollars eating away from home. The public has also become increasingly mobile for recreational, housing and travel purposes.

Improved scientific information and technology: Increased understanding of health effects of environmental contaminants has and will continue to fuel the public's demand for increasing service.

Increased demand for health risk information: The number of requests from state and local agencies for assistance or support on health risk assessment issues is increasing. There is also an increasing demand from the public, and rightfully so, for more information about hazardous environmental agents, and an increasing demand to be part of the risk management decision process.

AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To reduce public exposure to drinking water contaminants in Minnesota public water supply systems.

Measure (1): Percent of community and nontransient water supply systems in compliance.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	92%	92%	80%			
Target				82%	82%	85%

Measure (2): Percent of noncommunity transient water supply systems in compliance.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	75%	80%	80%			
Target				80%	82%	85%

DEFINITION, RATIONALE, DATA SOURCE:

Definition: Compliance with the Safe Drinking Water (SDW) rules means that a public water supply system meets all requirements of the rule including monitoring, maximum contaminant levels, record keeping, and public notification. Community and nontransient water supply systems in compliance with federal SDW standards will be increased to 85 percent by year 2000. Noncommunity transient water supply systems in compliance with federal SDW standards will be increased to 90 percent by year 2000. A public water supply is a piped water system that serves at least 25 persons per day for at least 60 days per year. A community public water supply serves year-round residents (municipalities, manufactured home parks). A nontransient public water supply serves the same nonresident population on a regular basis (business, schools). A noncommunity transient public water supply serves transient populations (restaurants, hotels). A primacy agreement refers to the delegation of enforcement authority from the United States Environmental Protection Agency (USEPA) to the state of Minnesota for federal safe drinking water standards. Safe drinking water standards (maximum contaminant levels) are established by the United States Environmental Protection Agency and adopted by reference and enforced by MDH.

Rationale: The percentage of public water supply systems in compliance with SDW rules is directly related to the services and enforcement activities provided by the Public Water Supply program. The program provides the systems with: monitoring, laboratory analysis, sanitary inspections, technical assistance, plan review, operator certification, training, and if necessary legal enforcement. This supports Healthy People Year 2000, Goal 11.3, to reduce the outbreaks of water borne 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 SDW requirements.

Data Source: Measures are calculated using information from the program's information database. Input to the system is provided by field staff and laboratories. As a condition of primacy, data from the system is used to make quarterly reports to the U.S. EPA Federal Reporting Data System.

DISCUSSION OF PAST PERFORMANCE:

As new rules and stricter requirements are imposed by the U.S. EPA, system compliance with SDW standards has decreased while the systems take action to remedy violations. A number of the proposed U.S. EPA rules due for promulgation over the next few years deal with contaminants that are naturally occurring in Minnesota groundwater. These rules could cause severe compliance problems for Minnesota public water supply systems. Compliance rates will again fall until systems can take remedial action and return to compliance.

PLAN TO ACHIEVE TARGETS:

The federal government has proposed a state revolving fund (SRF) to provide loans and grants to public water supplies to assist them in meeting safe drinking water standards. Minnesota has enacted legislation to set up the framework to manage the SRF funds, and the program has begun to formulate the structure to administer the SRF program. The program will be seeking renewed authority to administer the operator certification program.

OTHER FACTORS AFFECTING PERFORMANCE:

General aging of public water supply systems will impact their ability to meet compliance requirements. The requirement to develop wellhead protection measures for new public water supply wells should decrease potential for contamination. Lack of funding for developing and implementing wellhead protection plans will force measures to focus exclusively on new public wells.

AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To increase compliance with the plumbing code.

Measure (1): Percent of construction projects in compliance with the plumbing code.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	65	70	80			
Target				85	87	90

DEFINITION, RATIONALE, DATA SOURCE:

Definition: The program inspects plumbing and water conditioning system installations. The plumbing code refers to the Minnesota Plumbing Code.

Rationale: The percent of projects which comply with the code is an appropriate outcome measure because any single area of noncompliance could result in a health effect. The potential for adverse public health impact relates inversely to the percentage of projects which comply with the plumbing code.

Data Source: Data is obtained from the program's information database.

DISCUSSION OF PAST PERFORMANCE:

Measures taken to improve performance include: place plumbing inspector staff in district offices to improve efficiency; educate local inspectors on plumbing and code compliance; revise rules for licensure of plumbers; and enhance enforcement efforts.

PLAN TO ACHIEVE TARGETS:

Continue education and enforcement efforts; pursue legislation for statewide licensing of plumbers; and improve local enforcement. Continue to work with Plumbing Advisory Council.

OTHER FACTORS AFFECTING PERFORMANCE:

A major factor affecting the outcome statewide is inconsistent local enforcement which results in noncomplying work. Local units of government are responsible for about 80 percent of public-use projects in the state. Currently, licensed plumbers are not required to perform plumbing work in cities of less than 5,000 population. The use of unlicensed plumbers greatly contributes to unsafe installations and each of code compliance.

AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To protect public and private drinking water supplies by ensuring that water wells are properly constructed.

Measure (1): Percent of inspected new wells in compliance.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	92.6%	96.2%	96.0%			
Target				96.5%	97.0%	97.5%

DEFINITION, RATIONALE, DATA SOURCE:

Definition: The program inspects approximately 25 percent of all new wells constructed in the state. A "violation" means that one or more requirements of statute or rule, regardless of how small, was violated on the site of a newly-constructed well.

Rationale: Compliance with construction requirements is achieved by performing the combined activities of maintaining reasonable and comprehendible regulations, licensing and training contractors, inspecting new construction, enforcing consistently against violators, and providing technical assistance to licensed contractors. If the program is successful, the number of violations should be low.

Data Source: All violations are documented by field staff as an integral part of their surveillance activities. Violation reports are compiled by the program enforcement specialist in the central office. Violation rates are then compared to the total number of well inspections performed during the same period, and the percentage is calculated.

DISCUSSION OF PAST PERFORMANCE:

Regular field surveillance of well construction activities began during the latter part of the 1990 construction season. Initially, the violation rate was approximately 10 percent. As expected, significant decreases in violations occurred during the first two years of program operation. As repeat violators are addressed and educational programs take effect, the rate of decrease in violations is expected to tail off to some steady-state base level, yet to be identified. The Consolidated Health Enforcement Act of 1993 provides new enforcement tools that enable the program to bring violators into compliance through increased accountability and graded penalty assessment.

PLAN TO ACHIEVE TARGETS:

Recent program changes to improve compliance include an complete overhaul of the well code (M.R. Chapter 4725), effective May 10, 1993, to simplify, clarify, and better organize construction requirements. In addition, a new "Rules Handbook," which consolidates regulatory language, policy elaboration, graphics, and relevant excerpts from other referenced documents, will be distributed to licensed contractors in September 1994. Continue to work with Wells and Borings Advisory Council.

OTHER FACTORS AFFECTING PERFORMANCE:

Field surveillance of well construction activities is seasonal and weather dependent. Demand for program activities is directly related to overall economic conditions.

Objective 2: To protect groundwater by ensuring that unsealed abandoned wells are sealed.

Measure (1): Number of abandoned wells sealed.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	8,900	11,200	11,800			
Target				12,000	12,500	13,000

DEFINITION, RATIONALE, DATA SOURCE:

Definition: "Unsealed abandoned wells" are wells which are no longer in service, and threaten groundwater by serving as a channel for surface contaminants to travel deep into the ground, bypassing the natural filtration and attenuation provided when percolating water soaks through soil and rock.

Rationale: The number of wells sealed is a direct measure of the success of the well sealing program. Program activities which contribute to the outcome measure include contractor licensing, operation of the well disclosure program, inspections of well sealing activities, related enforcement actions, and public education. During periods of economic slowdown, the number of property transfers and the number of consequential well disclosures will decrease.

Data Source: Unsealed wells are primarily identified to the department through the "well disclosure" process, which requires any seller of property to disclose in writing the existence of any wells. All well sealings in Minnesota must be performed by a licensed contractor, to ensure that the job is done correctly. By law, a "Well Sealing Report" for each well sealed must be submitted to the department within 30 days. Sealing reports are entered into an automated data system, and reports are prepared from the data as needed.

DISCUSSION OF PAST PERFORMANCE:

Well sealing was stressed by the Well Management program staff for many years prior to the implementation of the Groundwater Protection Act, and consistent increases in the numbers of wells sealed can be seen throughout the 1980's (see attached table). Because the number of well sealings now relates directly to the number of property transactions, this measure will fluctuate directly with the economy.

PLAN TO ACHIEVE TARGETS:

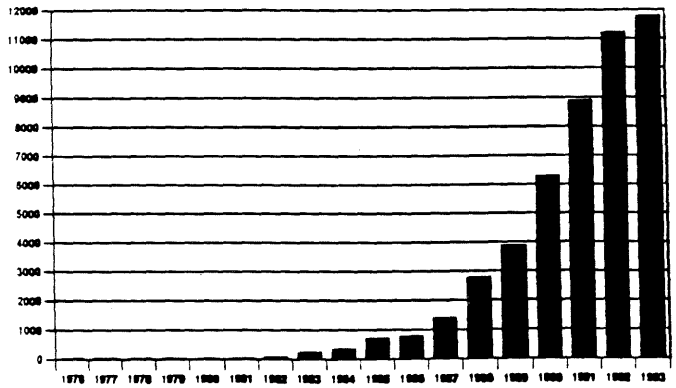
Program is still developing. The full implementation of a comprehensive data system to support the well sealing effort is a high priority. A new brochure on well sealing will be disseminated during FY95..

OTHER FACTORS AFFECTING PERFORMANCE:

The number of well sealings is directly related to the number of property transactions; this measure will fluctuate directly with the economy.

Minnesota Department of Health

Wells Sealed from 1976 through 1993



AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To reduce the percentage of children with elevated blood lead levels.

Measure (1): Percentage of tested children whose venous blood lead levels are at least 15 ug/dL.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	18.7%	10.5%	5.9%	*	*	*
Target			15%	12%	5%	4%

*Data Not Available

Measure (2): Percentage of tested children whose venous blood lead levels are at least 25 ug/dL.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	7.3%	4.2%	2.4%	*	*	*
Target			4.5%	2.5%	2.0%	1.5%

*Data Not Available

DEFINITION, RATIONALE, DATA SOURCE:

Definition: Blood lead is measured as micrograms of lead per deciliter of whole blood. This is used as an indicator of body burden of lead and represents the last 3 to 4 weeks of lead exposure in most people. Lead follows the calcium stream in the body so it moves to soft tissues and ultimately most of it is deposited in the skeleton where it may remain for 20 to 30 years.

Rationale: "Healthy People 2000" and "Minnesota Health Goals and Objectives for the Year 2000" set goals for reducing blood lead levels in children under age 6 years. The baseline data is for calendar year 1992. In 1992, 7.3 percent of the children tested had blood lead levels of at least 25 micrograms per deciliter. The first goal is to reduce this to zero by the year 2000. Also, 18.7 percent of the children tested in 1992 had blood lead levels of at least 15 micrograms per deciliter. The second goal is to reduce this to 8 percent by year 2000.

Blood lead levels have been correlated with a wide range of adverse health effects including (dependent on dose) IQ loss, hearing loss, stunted growth, slowed nerve conduction, colic, anemia, kidney damage, liver damage, and brain damage, and death. Lead poisoning is insidious in that the first outward symptoms are very common and vague effects like irritability and headache so the child may not be taken to a physician. Children under 72 months of age are more susceptible to these adverse effects although anyone can get lead poisoning. A developing fetus receives essentially the exposure of the pregnant woman and is also susceptible to adverse health effects. It is possible to be born with lead poisoning.

Adult lead poisoning in Minnesota is largely due to occupational exposure. Reports of elevated blood lead levels in adults are referred to the Department of Labor and Industry's OSHA Section. (In one case, these reports led OSHA staff to a foundry that was poisoning its workers.)

Data Source: Medical laboratories are the primary source of data although reports are also received from clinics and physicians, especially if they send blood samples to an out-of-state lab. The volume of data being reported has increased dramatically since the 1991 Centers for Disease Control (CDC) document titled "Preventing Lead Poisoning in Young Children." The CDC document recommends blood lead levels at which medical and environmental interventions should take place. Although this is not a regulatory document, it is very widely followed by physicians and by health departments.

DISCUSSION OF PAST PERFORMANCE:

Although the percentage of children tested with elevated blood lead levels has been reduced, this is partly due to a large increase in testing. In FY93, there were 3,117 children tested of whom 326 had venous levels of at least 15 ug/dL, and in FY94, there were 9,695 children tested of whom 576 had venous levels of at least 15 ug/dL. The percentage of children tested with blood lead levels of at least 15 ug/dL decreased from 10.5 percent to 5.9 percent from FY93 to FY94, but the raw number of children with at least 15 ug/dL increased from 326 to 576. This effect of increasing numbers of children tested will continue until the rate of testing stabilizes.

PLAN TO ACHIEVE TARGETS:

MDH will aggressively seek federal funding to improve lead surveillance, expand health education and outreach, and facilitate conformance with federal lead-related laws. The Lead program has applied for several federal grants to expand its activities. These grant applications include: $135,961 from the National Institute for Occupational Safety and Health (NIOSH) for provision of lead abatement training courses in Spanish for the first year and assessment of the need for training in other languages in subsequent years; $270,376 from the Environmental Protection Agency (EPA) for the Lead Surveillance Initiative (increased reporting of blood lead levels and related data), for increased outreach with health education materials, and development of rules to be consistent with the EPA regulations on licensing lead abatement contractors; and $195,700 from the Department of Housing and Urban Development (HUD) for subsidized lead abatement courses to be presented around the state.

The Lead Surveillance Initiative will aggressively seek to improve the quantity and quality of the blood lead level reporting. This will hasten the stabilization of the rate of testing and will provide better quality data on which to base medical and environmental interventions.

OTHER FACTORS AFFECTING PERFORMANCE:

The distressed level of the overall state budget has precluded funding of many mandated activities, including the inspection duties imposed on the local health departments to respond to cases of elevated blood lead levels and the cost of abatement imposed on property owners. Residential inspections and lead abatements are triggered by an elevated blood lead level found in a child's venipuncture blood sample. Minneapolis and St. Paul have sufficient resources and workload to maintain the needed expertise for conducting the required residential inspections for children with elevated blood lead levels. However, most rural areas have neither the resources or the workload to maintain inspector expertise. Similarly, lead abatement contractors are much more available for lead abatement in cities than in rural areas. Many of the properties that become subject to lead abatement orders are affordable housing for people of low income, but the property may not support costly improvements. While the intrinsic value of the house is improved, this may not increase the rent that can be charged and therefore may not increase the resale value either. Currently no special funding is available to property owners for lead abatement, although some weatherization and housing rehabilitation programs can effectively be used for lead abatement. These programs are operated at the state level by the Minnesota Housing Finance Agency which has low-interest loan and grant money for housing rehabilitation programs. Local governments may also have low-interest loan programs funded through Community Development Block Grant (CDBG) funds. The housing weatherization programs are operated at the state level by the Department of Economic Security (DES, formerly Jobs and Training). DES operates the Community Action Programs that provide weatherization services.

Another financial issue is the high cost of liability insurance for lead abatement contractors and for landlords. The insurance industry has no experience with lead abatement so premiums for liability insurance for contractors start at $20,000. Insurance companies are writing exclusions for lead hazards. Landlords who have older properties are at risk if they don't have their property abated prior to a lead poisoning case and are at risk if they hire a contractor who does an improper abatement. Although the federal and state governments are moving toward in-place management of lead hazards as safer and less expensive, the insurance industry wants complete removal of lead so that there won't be any possible liability at a later date from lead left in the property.

The minority population of Minnesota has increased and will likely continue to increase. People of racial or ethnic minorities have more risk factors (older housing with leaded paint and soil, poorer diet, less health care, and cultural-related sources

of lead exposure) for lead exposure so this population shift may increase the number of children with lead poisoning in Minnesota.

Federal regulations and grants will increasingly drive the Lead program. The Federal Housing Act of 1992 includes Title X, Residential Lead-based Paint Hazard Reduction Act of 1992. Title X requires a plethora of activity by federal agencies, some of which will greatly affect how states lead programs operate. The EPA will be issuing draft regulations on licensing lead abatement contractors in September 1994 and final regulations in April 1995. States then have two years to adopt equally restrictive laws to remain eligible for HUD funding of lead abatement. Minnesota currently has a $2.8 million HUD grant for lead abatement. HUD grant regulations assume the existence of final EPA regulations. EPA was required by Title X to have issued final rules by April 1994. The failure of EPA to issue final regulations impedes states from adopting rules or amending them as technology or public policy changes. EPA must operate a licensing program for states that fail to do so. Minnesota adopted accreditation requirements effective in September 1993 and will have to amend them to be consistent with EPA's regulations. Provision of culturally sensitive material will become more difficult as the diversity of the population increases.

AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To reduce public exposure to asbestos through increased compliance with safe work procedures for asbestos abatement.

Measure (1): Percent of asbestos-related work projects found in compliance.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	65%	74%	>75%*			
Target				80%	82%	84%

* Percent compliance is not available due to ongoing processing of the inspection reports.

DEFINITION, RATIONALE, DATA SOURCE:

Definition: Compliance with the asbestos abatement rules means abatement projects meet all requirements of rules, including a review of asbestos fiber air monitoring and other records. The percentage of all inspections during which compliance was observed.

Rationale: Compliance with asbestos-related work procedures have a direct relationship with the success of the program in minimizing the exposure of workers and the public to asbestos. Compliance results from maintaining reasonable and comprehendible regulations, ensuring available quality training for individuals, enforcing consistently against violators, and providing technical assistance to the regulated community.

Data Source: The program's information database has record of all inspections and their outcomes. The presented numbers are the percentage of inspections found in compliance as a part of the total number of inspections performed by the program and inspector staff were added.

DISCUSSION OF PAST PERFORMANCE:

The program has been successful in increasing the compliance rate since FY91 as the program gained experience. The program's success in increasing compliance should increase when the final figures for FY94 are available primarily due to the use of enforcement tools now available under the Consolidation Health Enforcement Act of 1993. The new enforcement tools enable the program to bring violators into compliance through increased accountability and graded penalty assessment.

PLAN TO ACHIEVE TARGETS:

MDH will continue to evaluate inspection procedures and inspection report generation to insure the inspection activity adequately examines compliance. MDH will continue to gain experience using its new enforcement tools which became available in 1993 to ensure greater compliance. Fact sheets and educational materials will be developed and made available to ensure the industry and homeowners are aware of requirements and health hazards.

OTHER FACTORS AFFECTING PERFORMANCE:

The Asbestos Abatement program is directly linked to overall economic conditions. Reduced numbers of transactions during economic slow downs and increased numbers of transactions result from economic growth. Some asbestos abatement contractors fail to properly permit projects as required by law. This occurs at times because asbestos is encountered unexpectedly in building renovation projects or when contractors fail to obtain a project permit. The program learns about projects not permitted either from members of the public or local building inspectors. The program does not currently have the resources to establish a surveillance system for unpermitted projects. However, unpermitted projects are subject to penalty assessment.

AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To ensure that all facilities performing diagnostic x-rays meet all required quality control standards.

Measure (1): Percentage of facilities complying with quality control standards.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	35%	50%	60%			
Target				75%	85%	100%

DEFINITION, RATIONALE, DATA SOURCE:

Definition: Current state law requires that all diagnostic x-ray facilities meet quality control standards described in Minnesota Rules Chapter 4730, Ionizing Radiation Rules. Compliance with quality control standards ensures that x-ray equipment and x-ray film processing will minimize unnecessary radiation exposure. Quality control standards ensure high quality x-ray images that allow for accurate diagnosis.

Rationale: When a facility does not comply with the quality control standards, the facility is ordered to correct deficiencies. Failure to comply results in enforcement action.

Data Source: The compliance rates are available through the program information database.

DISCUSSION OF PAST PERFORMANCE:

The quality control standards for x-ray equipment were upgraded when the Ionizing Radiation rules was amended in 1991. Because of a legislatively imposed delay of part of the rule, it did not become fully effective until July 1993. Compliance with quality control standards improved between FY92 and FY94 as the regulated industry became better acquainted with rule requirements. Program staff conducted workshops and developed informational materials to assist operators to achieve compliance. Enforcement of the Ionizing Radiation rule requirements has improved since 1992. The x-ray inspection program is now fully staffed and trained to evaluate compliance with quality control standards.

PLAN TO ACHIEVE TARGETS:

Program staff will continue to see improved compliance rates as the x-ray facilities become more familiar with the quality control standards. The program will conduct annual inspections of mammography equipment for the Mammography Quality Standards Act under contract with the U.S. Food and Drug Administration.

Compliance of ionizing radiation rule requirements will continue to improve because more enforcement tools are now available. The legislature passed the Consolidated Health Enforcement Act of 1993. This act allows the commissioner of health to levy fines for noncompliance with rule requirements.

OTHER FACTORS AFFECTING PERFORMANCE:

Currently Minnesota has no training requirements for x-ray operators. The x-ray facility administrator is responsible for ensuring that x-ray equipment is operated safely. Facilities that use certified radiologic technologists have fewer deficiencies related to quality control standards than facilities with untrained x-ray operators. Trained operators help to ensure facilities comply with quality control standards and thus produce better radiographs. Minnesota has annually inspected facilities performing mammography. Media attention and public concern about breast cancer in women has focussed attention on breast cancer screening by mammography. The 1992 federal Mammography Quality Standards Act now requires that all facilities performing mammography must meet specific requirements including specially trained personnel and use of quality control procedures.

AGENCY: Health, Department of
PROGRAM: Environmental Health

OBJECTIVE, MEASURE

Objective 1: To reduce the potential for foodborne illness.

Measure (1): Average food and beverage service establishment score.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	85.3	88.6	88.0			
Target				87	84	85

Measure (2): Percent of food and beverage establishments in compliance with sanitation standards.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Actual	92.0%	95.9%	95.4%			
Target				95%	93%	94%

DEFINITION, RATIONALE, DATA SOURCE:

Definition: The U.S. Food and Drug Administration has established a standardized inspection and scoring system for food and beverage establishments. The average score of all scored inspections provides a summary of the establishments' sanitation status. For statistical purposes an establishment must score 70 or above to be in compliance with sanitation standards.

Rationale: The average score of all inspected facilities is reflective of the overall sanitation status of food and beverage facilities in the state.

Data Source: Data comes from facility inspection reports. It is maintained in the program's information database. It will be summarized on a quarterly basis.

DISCUSSION OF PAST PERFORMANCE:

The program's success in achieving compliance should increase primarily due to the use of enforcement tools now available under the Consolidation Health Enforcement Act of 1993. The new enforcement tools enable the program to bring violators into compliance through increased accountability and graded penalty assessment.

PLAN TO ACHIEVE TARGETS:

MDH has established a Blue Ribbon Advisory Task Force which is exploring ways to make the program more effective. In addition, another interagency task force has been established to review the new U.S. Food and Drug Administration Food Code to determine changes needed to Minnesota regulations.

OTHER FACTORS AFFECTING PERFORMANCE:

Program delegation to local health agencies has created some program service delivery inefficiencies when partial delegation occurs. MDH intends to follow the Blue Ribbon Advisory Task Force recommendation to only allow full delegation.

Performance measures are expected to decrease because the program plans to provide training on conducting standardized inspections. Typically when this is done, more orders are written per inspection and inspection scores go down. Over time, this is expected to lead to an improvement in sanitation and average establishment scores will go up.

Several trends support the need for an effective food, beverage, and lodging regulatory program including: increased number of imported food items; increased use of packaged meals; increased number of people who eat in restaurants; increased use of food prepared for consumption off site; increased use of salad bars; and increased availability of cold food items that do not receive further heat treatment before consumption.

SUMMARY

AGENCY: Health
PROGRAM: 07 - Disease Prevention and Control Division

EXPENDITURES AND STAFFING (F.Y. 1994)	($ in Thousands)	
Total Expenditures:	$15,688	(9.8% of the department's budget)
From State Funds	$ 4,494	
From Federal Funds	$11,061	
Number of FTE Staff:	144.4	(13.6% of the department's staff)

PROGRAM GOALS:

To analyze patterns of chronic disease occurrence in order to determine effective means for controlling these diseases in Minnesota (M.S. 144.671 - 144.691).

To prevent and control vaccine-preventable diseases (M.S. 144.4175, 144.4176).

To conduct surveillance for acute diseases so that outbreaks can be identified, investigated, and controlled; and so that trends in disease occurrence can be monitored for determining and assessing control strategies.

To conduct special epidemiologic studies of acute diseases to better define the epidemiology of such conditions and to assess control strategies or define pertinent clinical practice issues.

To provide and coordinate delivery of a full-range of infectious disease epidemiology services to communities/general public in greater Minnesota.

To prevent death and disability from human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) by providing statewide leadership to prevent transmission, and ensure the availability of prevention services for high-risk populations and health and supportive services for infected persons (M.S. 144.065 - 144.4186).

To increase the proportion of age-appropriate Minnesota women who are screened for breast and cervical cancer.

DESCRIPTION OF SERVICES: The Disease Prevention and Control (DP&C) Division focuses on the control or elimination of communicable and chronic diseases. This division maintains statewide surveillance of communicable and chronic disease; identifies and investigates outbreaks or unusual disease problems, assures that prompt and appropriate control measures are instituted to control or eliminate the spread of disease, provides epidemiologic consultation, training and information to physicians and other health workers; conducts specific programs for control of vaccine-preventable disease, STD (including HIV/AIDS), tuberculosis (TB), Lyme disease, cancer, and other conditions. An enhanced emphasis on immunization rate assessment, access to services, coordination with private providers, and development of plans to reach targeted populations has become a model for addressing other public health problems.

Chronic Disease and Environmental Epidemiology

Cancer Surveillance - Cancer occurrence in Minnesota is monitored through the Minnesota Cancer Surveillance System (MCSS). During the three-year period 1988-1992, a total of 108,995 new cancers were diagnosed among Minnesota residents. Cancer rates were higher in males than females for all but a few types of cancer. For both males and females, overall cancer rates in Minnesota were slightly lower than rates for other areas of the U.S.

Conwed Pulmonary Disease Screening Project - Since 1988, the MDH has been conducting the Conwed Screening and Notification Program. This program has identified, traced, and notified over 3,000 employees of the Conwed Corporation plant in Cloquet, Minnesota. Workers had potentially significant exposures to asbestos during the manufacturing of ceiling tile and other products.

Occupational Amputations Surveillance (Sentinel Event Notification System for Occupational Risks [SENSOR]) - SENSOR conducts indepth surveillance of Minnesota's share of the estimated 21,000 workers who suffered amputations. Amputations may greatly affect workers' job skills and reduce earning capacity. Almost one-fourth of the injured workers are under age 25 and about one-half are under 35.

Occupational Fatality Surveillance (Fatality Assessment and Control Evaluation [FACE]) - The purpose of FACE is to identify risk factors associated with fatal occupational injuries and to mitigate their occurrence in the future. The investigations are conducted mainly in the field through interviews of witnesses, employers, family members, etc.

Wadena City Health Study - National Institutes of Health (NIH) funding for the Wadena City Health Study supports a community-based study of carbohydrate metabolism and aging in individuals with non-insulin-dependent diabetes and a population sample of those without diabetes. This study has been a joint effort of the Medical School and the School of Public Health at the University of Minnesota, the Wadena medical community, and the MDH.

Indoor Air and Children's Health - This is a prospective cohort study, funded by the NIH, to assess the relationships between exposure to environmental tobacco smoke, nitrogen dioxide, wood smoke and respiratory illness in children under two years of age. Thirteen hundred (1,300) households are enrolled in the study and each is followed for two years.

Physical Work, Stress, and Pregnancy Outcome Study - Data analysis is underway for this prospective cohort study of pregnant women, funded by the March of Dimes to assess the relationship between physical workload and late outcomes of pregnancy, primarily birth weight and gestational age.

Acute Disease Prevention Services

Vaccine-Preventable Disease - Implementation of strategies to reach areas with low immunization rates are currently underway to improve preschool immunization levels and reach the goal of 90 percent immunization levels by the year 2000. These strategies include parental barriers surveys, immunization clinic enhancement, registry development, and outreach to families without health care providers. The Immunization Practices Task Force and workgroups address issues related to registry development, consumer education, and provider education.

Refugee Health - The MDH is the single point notification source for the pending arrival of new primary migrating refugees into the state. Accompanying their arrival information is a report of each person's overseas medical examination and, if from a camp in Thailand, their immunization record(s). A database is maintained on each refugee and immigrant, and the arrival forms are sent to the local Community Health Service agency in the county where the refugees are to be resettled. The number of Amerasian and other Southeast Asian refugees will decrease from previous years but similar numbers of Soviet, Bosnian, and African refugees will arrive. The public health problems that are found among the new arrivals are primarily focused on tuberculosis and hepatitis B. Additional health findings are of significance to the personal health of refugees, but do not pose a threat to the surrounding community.

Acute Disease Epidemiology

HIV/AIDS Epidemiology - The HIV/AIDS Surveillance Unit maintains active statewide laboratory, hospital, and clinic-based surveillance for AIDS cases and cases of HIV infection (regardless of clinical symptoms). As of August 1, 1994, 2,171 cases of AIDS (including 1,242 deaths) and 2,056 persons with HIV infection, but not meeting an AIDS clinical diagnosis, have been reported to the MDH. Data maintained by this surveillance system are analyzed according to exposure category, residence, age, and race/ethnicity. These data form the basis of monitoring trends in the AIDS/HIV epidemic in Minnesota.

The HIV/AIDS Epidemiology Unit also conducts special epidemiologic studies. This unit is involved in a national study to assess the completeness of disease reporting through evaluation of death certificates. It also maintains a program to evaluate HIV-infected health care workers to ensure that they do not pose a risk to their patients. This is a statewide program that includes all licensed health care providers. Finally, the unit provides technical expertise on AIDS/HIV-related issues to other sections and divisions of the MDH, to local health departments, and to service providers.

Surveillance and Disease Investigation - The Acute Disease Epidemiology Section collects data regarding cases and outbreaks of communicable disease, including vaccine-preventable disease. It is essential that reports of communicable diseases be followed up to identify outbreaks and to implement control measures in a timely fashion. Also, for a variety of diseases, monitoring incidence and trends in disease is essential in evaluating programmatic efforts and in assessing health status of the population.

Tuberculosis Control - The Tuberculosis Control Unit maintains surveillance for cases of active tuberculosis (TB) and monitors TB infection rates in various populations. The unit also provides medication to TB cases and assures that all cases complete an appropriate course of therapy. During 1993, 141 cases of active TB were identified and investigated. Tuberculosis occurs in Minnesota primarily in selected high-risk groups. In 1993 several TB cases necessitated complex contact investigations which were conducted by local public health departments with assistance from the MDH.

Epidemiology Field Services

Epidemiology Field Services (EFS) is responsible for carrying out policies and procedures related to the control of infectious diseases in greater Minnesota. District epidemiologists are located in Rochester, Mankato, St. Cloud, Fergus Falls, and Bemidji. This service includes disease and outbreak investigations related to reportable diseases. The district epidemiologists provide consultation to health care professionals throughout Minnesota on the control of communicable diseases. As part of this process, EFS has developed and manages agreements with local public health agencies (Community Health Boards [CHBs]) for the investigation and control of communicable diseases. Each agreement delineates responsibilities to assist the state in investigating reportable diseases, and helping in outbreak situations when a public health emergency or public health hazard is identified.

AIDS/STD Prevention Services

Prevention Programs - Provide: 1) grants and technical assistance to 21 community-based and governmental organizations which have demonstrated an ability to reach adults and youth whose sexual and needleuse behaviors place them at risk; 2) print and broadcast media as a supplemental HIV/STD prevention strategy; 3) survey research to collect information pertaining to priority target populations for which limited data are available; 4) the Minnesota AIDSLine, a statewide information and referral source (in addition, the MDH maintains a statewide HIV/STD prevention information, materials, and resource distribution system); and 5) HIV/STD Community Prevention Planning Project in which the MDH collaborates with the community to plan for HIV/STD prevention in Minnesota. Workgroups and regional meetings are held for citizens to generate prevention recommendations specific to their communities.

Disease Intervention Program - Serves to: 1) help people infected with HIV and other STDs understand the nature of their disease and how to prevent transmission to others; 2) inform unsuspecting partners of their exposure to HIV/STD, reducing the chance that if infected, they will transmit disease to others; 3) prevent the potentially serious complications of STDs by encouraging partners to seek STD testing and treatment; and 4) refer persons exposed to HIV for testing and treatment.

HIV Services - Involves the planning and delivery of services used by persons living with or affected by HIV disease. These services include financial assistance for HIV-related drugs; continuation of insurance; transportation; case management; home care; dental care; mental health services; financial assistance and child care; housing; and other services. Services are provided for persons with hemophilia, adolescents, families, and persons with HIV living in greater Minnesota.

STD Surveillance and Screening - Involves the collection and analysis of epidemiologic data on specific STDs including chlamydia, gonorrhea, syphilis, and chancroid. The data is used to target prevention resources and assist in the evaluation of STD interventions and risk factors. Surveillance data are summarized, and distributed to local public health agencies and other organizations. The medical epidemiologist provides expert medical consultation on the diagnosis, treatment, and epidemiology of STDs for clinical practitioners.

HIV Counseling and Testing Program - Provides consultation, training, and funds to support HIV/STD testing at eight STD clinics and 15 family planning/community clinics. Clients receive risk assessment and information about behavior change, test accuracy, and confidentiality issues. At the post-test counseling session, clients are given information about interpreting test results, and risk reduction. Training classes are offered at the MDH and can be arranged for private medical clinics, correction institution staff, chemical dependency treatment centers, and counseling and testing site personnel.

Investigations - Involves assessment and intervention with disease carriers who may pose a health threat to others, or who may pose an immediate and foreseeable risk of harm to others. Activities include: 1) identifying suspect cases as carriers; 2) investigating cases to independently verify and evaluate a carrier's status and behavior; and 3) implementing the Commissioner of Health's health directives, orders, and court orders to prevent and control communicable disease.

Breast and Cervical Cancer Control Program

Since 1990, the Cancer Control Section has been implementing two federal grants for breast and cervical cancer control. A National Cancer Institute-funded research grant has focused on two methodologies for increasing breast cancer screening among underserved women. **Outreach** targets women living in subsidized high-rise housing in Minneapolis and includes a promotional awareness campaign and assistance in making and keeping mammogram appointments. **Inreach** takes place at the Hennepin County Medical Center where charts are reviewed to determine women's breast and cervical cancer screening history. Women who are in need of screening are offered mammography and Pap smear at a special women's cancer screening clinic.

The second grant is supported by the Centers for Disease Control and Prevention. The goal of this five-year program, known as the Minnesota Breast and Cervical Cancer Control Program (MBCCCP), is to increase rates for breast and cervical cancer screening among all Minnesota women and to reduce avoidable mortality due to these diseases. MBCCCP has established screening sites in over 140 locations around the state to offer cancer screening, and tracking and follow-up services to eligible women. A tracking and follow-up system was developed and implemented which assures that women screened with MBCCCP funds receive timely care. A culturally sensitive public education program is being developed that will be based at the provider sites, as well as in the communities in which target populations of women reside.

BACKGROUND INFORMATION:

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994*
A	Number of cancers abstracted	50,151	45,129
A	Number of cancers registered	33,021	31,760
UC	Cost per cancer case entered	$29.41	$28.96
A	Number of OSHA consultations regarding workplace safety	60	60
W	Number of doses of vaccine distributed	288,520	258,720
O	Number of refugee arrivals	3,049	2,700

A	Infectious disease outbreaks investigated	147	150
A	Communicable disease case reports received and summarized	4,943	5,200
A	Communicable disease publications or abstracts	14	15
W	Issues of the *Disease Control Newsletter*	10	10
W	Number of birth packets distributed to date	NA	68,000
A	Field Services infectious disease case investigations	NA	854
A	Field Services consultations with health care professionals	NA	2,366
A	Field Services presentations to health care professionals	NA	144
A	Proportion of persons tested who return for HIV counseling	85%	85%
W	Number of HIV prevention contractors	21	21
W	Case management grantees	5	7
W	"Ryan White CARE" Act grantees	11	30
A	Number of mammography providers	62	128
A	Number of cervical screening clinical sites	60	143

* estimates

PROGRAM DRIVERS: The single greatest risk factor for development of cancer is age. The lifetime risk of developing a life-threatening cancer for children born today is about 50 percent and this proportion will increase even more over time. Identification of the true scope of specific work-related conditions is limited by the lack of complete and detailed information.

The implementation of the Vaccines for Children (VFC) Program will impact the delivery of immunization to children on Medicaid. The level of physician acceptance of the VFC Program will be uncertain given the current Medical Assistance reimbursement rate to physicians.

The Centers for Disease Control and Prevention (CDC) administers federal funding to assist states in refugee screening activities through a combined formula/competitive grant application process. Funding for Minnesota's program is based, in part, on the fact that the state currently receives 2.2 percent of the total U.S. arrivals.

The Acute Disease Epidemiology Section is involved in the collection of surveillance data for all communicable diseases listed in the Minnesota Rules Governing Communicable Diseases (MN Rules 4605.7000-4605.7800). Data are reviewed to ascertain outbreaks and to monitor trends in disease occurrence.

As consultants, EFS staff need to develop relationships with local public health staff, private providers, and other MDH staff. Differing patterns of acute disease influence the amount and type of work required in each district. Program priorities, such as vaccine-preventable disease, HIV prevention, and Lyme disease surveillance and prevention require involvement by EFS staff to educate local agencies and providers as well as provide input on issues. EFS staff also serve as grant monitors and assist local public health staff in program planning, implementation, and evaluation.

Factors affecting rates of STD and HIV infections include biological factors (duration of infectiousness, hormonal status, coexisting STDs); personal behavior factors (sexual behavior patterns, condom use, drug and alcohol use, health-related behaviors (early use of health care and compliance with therapy); and environmental factors (poverty, peer group influences, electronic media, access to medical services, travel, variable STD/HIV prevalence in different populations).

The activities of the MBCCCP are federally funded. Such funding is not always predictable and may change program activities. Reaching the target populations requires awareness of motivation factors, effect of media on knowledge levels, methods for reaching the hard-to-reach, and a message that encourages adoption of a health behavior resulting in medical care. Cooperation of private providers in this program has been excellent and is a large factor in the success of the program to date. It is uncertain the effect that health reform will have on this program.

AGENCY: Health
PROGRAM: Disease Prevention and Control

OBJECTIVE, MEASURE

Objective 1. By the year 2000, an average of 110 annual public requests for investigations of cancer concerns will be completed.

Measure (1): Number of Requests for Cancer Cluster Investigations and Cancer Data

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Cancer Cluster Requests	112*	121*	91	100(e)		
Target			133	146	100	100
Cancer Data Requests	*	*	40	44(e)		
Target			NA	NA	49	50

* Requests for investigations were not separated from data requests prior to FY 1994.

DEFINITION, RATIONALE, DATA SOURCE:

Definition: Cancer concerns are reports of cancer (or other disease) clustering or requests for data related to a cancer concern, from anyone in the community that involve an observation of a number of similar illnesses, and the perception that the number is excessive. An investigation of a cancer concern may range from collecting information over the phone from the caller to an extensive, scientific study.

Rationale: Investigations of these reports not only answer public concerns and questions and satisfy medical curiosity, but they may also 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, and policy workers about cancer risks and to correct misimpressions about the importance of environmental exposures to these risks.

Data Source: Phone calls and letters from citizens throughout the state and the MCSS.

DISCUSSION OF PAST PERFORMANCE:

Based on past experience, the number of phone calls have continued to increase slowly over the past few years. Callers have concerns about cancer in family members, co-workers, neighbors, communities, and geographic portions of the state. For most callers, information about general cancer rates, rates of the particular cancer they are concerned about, and national cancer information provides the assistance they were seeking. For the more complicated situations, in-person meetings, review of cancer surveillance information, review of current literature, and more extensive interaction between MDH staff and the caller(s). Occasionally, this more involved investigation identifies the need for an evaluation of the problem to determine if a special study around the concern is warranted.

PLAN TO ACHIEVE TARGETS:

Because of the continuing public interest and awareness of cancer, we anticipate that requests for assistance in evaluating cancer exposure will increase. We will provide varying levels of staff activity to respond to those requests as needed.

OTHER FACTORS AFFECTING PERFORMANCE: None

Outcome documents produced by the Chronic Disease and Environmental Epidemiology Section on cancer and other diseases are available by contacting the section at (612) 623-5216.

AGENCY: Health
PROGRAM: Disease Prevention and Control

OBJECTIVE, MEASURE

Objective 2: 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 immunizations against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, *Haemophilus influenzae* type B, and hepatitis B such that 90 percent are up-to-date when measured within two months of the date(s) on which they were to be vaccinated.

Measure (1): Proportion of children who received age appropriate vaccines in a timely manner

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
4 months	83%	90%	90%(e)	90%(e)		
Target					90%	90%
6 months	74%	81%	84%(e)	87%(e)		
Target					90%	90%
8 months	66%	73%	74%(e)	80%(e)		
Target					86%	90%
17 months	68%	76%	78%(e)	82%(e)		
Target					86%	90%
19 months	56%	52%	60%(e)	72%(e)		
Target					78%	84%

DEFINITION, RATIONALE, DATA SOURCE:

Immunization rates for fiscal years 1992-1994 are the result of surveys of birth cohorts conducted by the MDH. For 1994-1997, rates are projections of trends based on analysis of surveys of birth cohorts for 1984-1991. Rates are defined as the percentage of children up-to-date within two months of the date(s) on which they were to be vaccinated.

DISCUSSION OF PAST PERFORMANCE:

Minnesota was free of measles for the first time since 1982. The last reported case of measles in Minnesota had onset of illness in July 1992. This case was exposed to measles outside of Minnesota and serves as a warning of the ever present potential for imported measles. In contrast, 393 cases of pertussis and one death were reported in 1993; the highest number of reported cases since 1955. Nationally a similar increase in pertussis has been seen.

PLAN TO ACHIEVE TARGETS:

Based on the 1992-1993 retrospective data and needs assessment, local health departments are targeting their efforts to achieve the year 2000 objective. Efforts in 1995 will focus on the following activities:

Vaccine-Preventable Disease

Assessment - A thorough assessment of the current immunization delivery system, including needs and problems will be required. Data will include: number of births; distribution of births by area, race, ethnicity; number of private providers giving immunizations; number enrolled in VFC; number of public clinics; number of kids on MA/MnCare; number of kids on WIC; number of kids immunized in various settings; roles of other organizations/agencies; data from retrospective and other surveys which can highlight problems or barriers. Counties may decide to conduct surveys or other means to collect specific data. Interpreting the data must involve an IAP task force or other means of soliciting community input.

Policy Development - Involvement of key stakeholders (such as physicians, clinic nurses, schools, WIC staff) in identifying priority problems areas based on the assessment data and strategies to address those problems. The final product would be a written action plan for the community that specifies responsibilities and time lines.

Assurance - Work with key stakeholders to carry out the action plan. Involve the medical community and other stake holders. Local public health department staff may solicit input in other ways than a task force (e.g., one-to-one meetings, surveys, focus groups).

OTHER FACTORS AFFECTING PERFORMANCE:

Approximately 80 percent 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, incomplete understanding of the ever-changing and complex immunization schedule by parents and providers, problems in completing the series on time, and parent motivation are barriers to achieving this goal.

AGENCY: Health
PROGRAM: Disease Prevention and Control

OBJECTIVE, MEASURE

Objective 3: Reduce the spread of communicable diseases of public health importance.

Measure (1): By the year 2000, the incidence of tuberculosis (TB) will be 2/100,000 or less
Measure (2): By the year 2000, the annual cases of measles will be 0, mumps 10, and pertussis < 20
Measure (3): By the year 2000, the annual increase in AIDS cases will be 3% or less

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
TB incidence*	3.7	3.2	<3.0(e)	<3.0(e)		
Target					<3.0	<2.5
Measles Cases	12	0	<10(e)	<10(e)		
Target					<10	<10
Mumps Cases	26	2	<10(e)	<10(e)		
Target					<10	<10
Pertussis Cases	141	393	<350(e)	<300(e)		
Target					<200	<150
AIDS Cases	320	290(-9%)	<300(e)	<300(e)		
Target					<300	<300

* per 100,000

DEFINITION, RATIONALE, DATA SOURCE:

Definition: Cases of communicable diseases are reported according to Minnesota Rules Governing Communicable Diseases (MN Rules 4605.7000 - 4605.7800). Case definitions that are employed to define cases are those put forth by the Council for State and Territorial Epidemiologists in conjunction with the Centers for Disease Control and Prevention. Data are frequently validated by special surveillance studies or other validation methods to assure accurate case counting and identification.

Rationale: Measuring the total number of cases of disease per year demonstrates the actual frequency of disease occurrence. Maintaining surveillance for communicable diseases, conducting outbreak investigations to implement control measures, and conducting special epidemiologic studies to answer pertinent public health questions about these diseases, are all core public health functions.

Data Source: Data are collected from physicians, hospitals, laboratories, and other persons caring for patients with communicable diseases. Surveillance for HIV/AIDS is laboratory-based and also conducted through an active system of AIDS care providers.

DISCUSSION OF PAST PERFORMANCE:

In 1992, cases of TB increased in Minnesota. Tuberculosis cases have increased gradually over the last five to six years due to the resurgence of TB nationally and the occurrence of cases in hard-to-access populations, particularly foreign-born persons, homeless persons, and persons with other social issues such as chemical dependency. Cases declined somewhat in 1993, but have still remained higher than levels documented in the early 1980s.

In 1993, the numbers of cases of measles and mumps were extremely low (< 10 each). This may reflect recent efforts to increase immunization levels in the state. Pertussis (also known as whooping cough) case numbers were high and reflect increased activity for this disease. Of cases 2 months of age and older, 195 (67%) were age-appropriately vaccinated, indicating the limitations of currently available vaccines.

AGENCY: Health
PROGRAM: Disease Prevention and Control

OBJECTIVE, MEASURE

Objective 5: Reduce the incidence of STDs to meet Year 2000 Objectives.

Objective 6: Reduce the incidence of STDs in communities of color to meet Year 2000 Objectives.

Measure (1): Prevalence rate for chlamydia; incidence rates for gonorrhea and syphilis (see below)

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Chlamydia	193	168	NA	125(e)		
Target					125	125
Gonorrhea	77	57	NA	53(e)		
Target					53	53
Prim/Sec Syphilis	1.6	1.5	NA	1.2(e)		
Target					1.2	1.2
Chlamydia						
Females	301	259	NA	212(e)		
Target					212	212
15-19 y/o Females	1900	1,712	NA	1,230(e)		
Target					1,230	1,230
Gonorrhea						
Blacks	2,127	1,515	NA	1,505(e)		
Target					1,505	1,505
15-19 y/o	375	296	NA	242(e)		
Target					242	242
Women (15-14)		114	NA	95(e)		
Target					95	95
Pri/Sec Syphilis Blacks	72	50	NA	43(e)		
Target					43	43

DEFINITION, RATIONALE, DATA SOURCE: Physicians and laboratories are required to report cases of the above diseases to the MDH. Laboratory surveillance serves to increase the completeness of reporting. The rates are expressed as cases per 100,000 residents. The sexually transmitted disease (STD) rates are used to describe affected populations, measure progress toward Minnesota Detailed STD surveillance data are reported annually in the "Minnesota STD Surveillance Report." Copies are available from the AIDS/STD Prevention Services Section (612/623-5698).

Chlamydia is a bacterial infection which may involve the lower or upper genital tract in women and can lead to infertility and ectopic pregnancy. In both men and women, symptoms are often mild or absent. A child infected at the time of delivery may develop an eye infection or pneumonia. Chlamydia is measured by a prevalence rate.

Gonorrhea is a bacterial infection which may involve the lower or upper genital tract in women which can lead to infertility and ectopic pregnancy. A child infected at the time of delivery may develop an eye infection or bloodborne infection. Gonorrhea is measured by an incidence rate.

Syphilis is a bacterial infection which may cause symptoms of rash, enlarged lymph nodes, flu-like symptoms, and long term complications affecting the brain, heart, and other organs. Syphilis during pregnancy may lead to miscarriage and stillbirth. Syphilis is measured by an incidence rate. The above rates refer to primary and secondary syphilis which are the first two stages of syphilis, usually 6 - 9 weeks after infection.

Mammography rates increased greatly from 1992 to 1993 and will increase slightly for 1994. Significant increases are expected into the next two years as the program focuses on mammography utilization, and the number of sites and promotional activities increase. The program has been very successful in reaching women for whom health care access has been traditionally lower, most notably those from the communities of color. Over 20 percent of women screened have been non-white and over 10 percent have been Native American.

PLAN TO ACHIEVE TARGETS:

Targets will be met by giving increasing levels of support and technical assistance to our existing network of providers and by expanding our provider network. The increased support will take the form of a small grants program to CHS agencies through which they will publicize and perform other forms of outreach to women in the community. The increased technical assistance will be through new field staff who will assist providers with conducting their own outreach and publicity efforts. The size of the provider network will be expanded through an request for application.

OTHER FACTORS AFFECTING PERFORMANCE:

Both breast and cervical cancer screening is affected by a variety of factors not directly within the MDH's control including: policies of medical care providers and payers; lack of accredited mammography services and cervical screening clinics in rural areas; provider insensitivity to cultural barriers regarding breast and cervical cancer screening; and outreach activities of voluntary organizations such as the American Cancer Society.

SUMMARY

AGENCY: **Health, Department of**
PROGRAM: **01 - Public Health Laboratory Division**

EXPENDITURES AND STAFFING (F.Y. 1994)

	($ in Thousands)	
Total Expenditures:	$	5,071.9
From State Funds	$	1,971.
From Federal Funds	$	526.4
% of Total		3.2
Number of FTE Staff:		90.1
% of Total		8.5

PROGRAM GOALS:

- To meet the laboratory service needs of Department of Health Programs, including acute and chronic disease surveillance and control programs and environmental monitoring and programs, pursuant to M.S. Sec. 144.05 and Sec. 144.125;
- To provide laboratory services for the environmental program needs of other state agencies and local units of government, pursuant to M.S. Sec. 144.05 and M.S. Sec. 144.0742;
- To help assure the quality of tests performed for state environmental monitoring programs pursuant to M.S. 144.97-.98;
- To minimize increases in per test prices while maintaining data quality.

DESCRIPTION OF SERVICES:

The Public Health Laboratory (PHL) activity performs physical, chemical and radiological analyses on environmental materials such as air, water, sludge, wastewater, sediment, soil, tissue and toxic and hazardous substances for MDH programs, the Pollution Control Agency, Department of Transportation, Department of Labor and Industry, local units of government and several federal agencies; performs tests on human and animal specimens for infectious, chronic, and hereditary diseases as an integral part of the disease surveillance, prevention and control programs managed by the Department and local health agencies; performs selected clinical laboratory tests for private and public health care providers, including reference and verification testing; and manages a certification and quality assurance program for other laboratories which perform tests for Minnesota environmental monitoring programs. The Laboratory also develops new test methods, adapts existing methods to new laboratory sample and specimen types, and pursues the use of new and more efficient test technologies.

BACKGROUND INFORMATION:

MEASURES OF ACTIVITIES (A), WORKLOAD (W), UNIT COSTS (UC), OTHER DATA (O)

Type	Measure	F.Y. 1993	F.Y. 1994
O	Chemical Laboratory Programs Served	66	66
W	Chemical Laboratory Tests	73,124	70,010
W	Clinical Laboratory Tests	439,138	460,155
W	Environmental Labs Certified	210	222
W	Samples and Specimens Processed	210,991	215,468

PROGRAM DRIVERS:

The Laboratory workload is likely to increase for a variety of reasons: changes in the incidence of sexually transmitted diseases; emerging infectious disease problems, such as new organisms, parasitic organisms in public water supplies; redirection of federal resources away from providing or supporting laboratory services; public water supply monitoring increases. With health reform, we expect shifts in the Clinical Laboratory workload, as some screening tests may be done in private sector labs, while other types of tests, e.g., reference or confirmatory testing now performed in the private sector may come to MDH.

The Laboratory will need funds to purchase equipment to meet new standards for quality, to shorten time for producing and reporting results, or to measure at lower levels of detection.

Increasing costs of tests may cause some state labs to become regional centers of excellence to perform high cost, low-demand tests for neighboring states.

AGENCY: Health, Department of
PROGRAM: Public Health Laboratory Division

OBJECTIVE, MEASURE

Objective 1: Fulfill client expectations for the highest level and quality of clinical laboratory services achievable.

Measure (1): Use of state-of-the art methods to yield definitive clinical lab results in the shortest possible time.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
Percent of Outbreak Organisms	0	0	18	36	72	80

DEFINITION, RATIONALE, DATA SOURCE:

Definition: The measure shows the percentage of types of disease outbreak organisms, including TB, which the Laboratory will test using recently developed methods of identification which are more precise and rapid than those used in the past.

Rationale: DNA fingerprinting and DNA probes are new lab methods which help in the rapid identification and confirmation of species of micro organisms associated with outbreaks of public health significance, whether TB, or those related to food or other environmental contamination. The new methods allow for a test to be performed on a sample which heretofore was too small to be measured by conventional methods. The PHL provides the Department's disease surveillance program with analysis and identification of infectious agents responsible for outbreaks. The sooner the results are available, the sooner the epidemiologists can identify the source of the outbreak and proceed with appropriate treatment recommendations or control programs. With TB, the sooner the result is available, the sooner the physician can prescribe the appropriate treatment, thus reducing the potential for spread of the disease to others close to the patient.

Data Source: PHL is the source of this data.

DISCUSSION OF PAST PERFORMANCE:

Historically, laboratory techniques were largely limited to identifying foodborne outbreaks caused by *Salmonella*. The new methods allow testing for a much wider variety of organisms and for the results to be available in a few hours, rather than several days with the old methods. Use of the newer methods on TB can produce results in ~20 days, compared to 56 days with the old methods.

PLAN TO ACHIEVE TARGETS:

The proposed change in MDH rules will require that specimens of the more common food and waterborne disease outbreak causing organisms be tested by PHL using new methods for rapid identification and confirmation. For TB, further technological advances are expected to shorten the time to valid result to a few days. PHL will adopt these new methods just as soon as the FDA approves their use.

OTHER FACTORS AFFECTING PERFORMANCE:

Because these new methods require the use of expensive reagents and materials, significant reductions in funding may affect the rate at which the new test can come into widespread us in PHL.

AGENCY: **Health, Department of**
PROGRAM: **Public Health Laboratory Division**

OBJECTIVE, MEASURE

Objective 2: To help improve the quality of test results from labs performing environmental monitoring services in Minnesota.

Measure (1): Increase the number of laboratories which are certified.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
# of Labs Certified	186	207	221	230	N/A	N/A
Target	186	207	221	230	235	240
Estimated # of Labs Providing Services	300	300	300	300	300	300

DEFINITION, RATIONALE, DATA SOURCE:

Definition: The measure reflects the increasing participation of environmental laboratories doing environmental testing for Minnesota clients.

Rationale: Under M.S. 144.98 labs may participate in the certification program implemented by the Health Department. However, governmental programs which use environmental data can require the use of a certified laboratory. There are an estimated 300 labs in Minnesota providing environmental monitoring services. The certification of a laboratory raises the level of confidence in the data generated by that laboratory, since the laboratory must meet numerous process and quality standards and successfully pass an on-site inspection by the certifying agency. Encouraging programs within state and local government monitoring programs to require the use of the certified labs will help ensure that the data they receive meets state standards for quality.

Data Source: Laboratory certification program.

DISCUSSION OF PAST PERFORMANCE:

This program began in 1988. When the statute was first passed, rules were adopted which allowed the phasing in of test categories. The first labs began the application process in 1989 with approximately 50 enrolling in the first year. In 1993 all the test category requirements of the statute were met and 221 labs are currently certified.

PLAN TO ACHIEVE TARGETS:

The U.S. EPA will be expanding test categories to meet new program needs. As a result of training which PHL plans to provide in the next biennium on the benefits of certification and on the new EPA tests, the number of labs participating in the program is likely to increase.

OTHER FACTORS AFFECTING PERFORMANCE:

National certification/accreditation efforts currently underway by the U.S. Environmental Protection Agency (EPA) may cause the number of labs Minnesota certifies to decrease, if the federal standard only requires certification in the lab's primary business location.

AGENCY: Health, Department of
PROGRAM: Public Health Laboratory Division

OBJECTIVE, MEASURE

Objective 3: To satisfy Chemical Lab client needs for more timely test results at lower test costs.

Measure (1): Results reported within negotiated reporting times.
Measure (2): Average bench hour rate.

Actual Performance	F.Y. 1992	F.Y. 1993	F.Y. 1994	F.Y. 1995	F.Y. 1996	F.Y. 1997
(1) Percent	N/A	N/A	97.3	~99	~99	~99
(2) Average bench hour rate for Chemical Lab Tests ($)	94.18	90.71	89.18	89.18	~92.00	~93.00

DEFINITION, RATIONALE, DATA SOURCE:

Measure (1) shows the percentage of all test results (~90,000/year) which are reported to clients within the intervals negotiated with clients. Clients are notified ahead of time if a delay beyond the negotiated time is expected.

Measure (2) shows the bench hour rates used to calculate individual test costs. Test costs include all identifiable expenses related to testing, reporting of results and necessary support services.

Rationale: One factor to measure the Chemical Lab's ability to satisfy client needs is the timeliness of the data. The measures shown indicate that the Lab is making particular efforts to fulfill its contract obligation with regard to time for production of results and that cost control measures are effective. Clients expect the prices they pay to be based on maximally efficient operations, which the Laboratory is striving to achieve. On the other hand, state law requires that test prices must be set so as to generate the amount of revenue required to cover the costs of providing the services.

Data Source: Public Health Laboratory.

DISCUSSION OF PAST PERFORMANCE:

In the past the timeliness of data reporting needed improvement. Ever shorter turnaround times have been agreed to by the lab for each of the past few years. Since F.Y. 1991 the percent change in the average bench hour rate has actually decreased, due to ever more precise adjustments in staff levels to match the workload, rather than to adjust prices to match the staffing level.

PLAN TO ACHIEVE TARGETS:

Careful monitoring of the client's needs and a system which has the ability to react to workload changes is the core of the plan to improve timeliness figures to 99 percent for the entire Chemical Lab. In the future, the plan is to keep the average bench hour rate at or less than the rate of inflation. This will be accomplished by planning flexibility in staffing and updating equipment and methods for efficiency.

OTHER FACTORS AFFECTING PERFORMANCE:

Large, unplanned increases in workload can have a negative affect on the lab's ability to meet the time-line criteria. Larger than expected salary increases could cause prices to increase more than planned.