AGENCY PERFORMANCE REPORT

1996

HUMAN SERVICES DEPT

Final Format **Prepared : December 24, 1996**

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AGENCY : HUMAN SERVICES DEPT

MISSION

The Minnesota Department of Human Services mission is to provide health care, economic assistance and social services to Minnesotans whose personal or family resources are inadequate to meet their basic human needs.

GOALS

- To create work-focused, anti-poverty welfare reform.

- To ensure affordable health care for families with children.

- To purchase affordable long-term care for the elderly and disabled.

- To promote the best interests of children in all public transactions.

- To make long term investment in workforce and technology.

- To promote the State's long-term financial stability through the promotion of strategies that will keep our human services affordable.

ORGANIZATION

The Department is organized into four major units for management purposes. These units are arrayed in 10 major budget programs. The management units are:

* The Children's Initiative which oversees Children and Families grant programs and promotes, cross-Department efforts to ensure positive outcomes for children.

* Finance and Management Operations which assures financial, legal and personnel accountability. This area houses financial operations, legal and regulatory operations and management operations.

* Economic and Community Support Strategies which provides policy leadership on DHS Welfare Reform Initiatives. The area houses all self sufficiency grants to families and children, operations of the MAXIS program, Aging/Adult Services and Deaf and Hard of Hearing Services.

* Health and Continuing Care Strategies which provides policy leadership on DHS Health Care Initiatives. The area houses the Regional Treatment Centers, Medical Assistance programs, MinnesotaCare, Mental Health, Developmental Disabilities, and Chemical Dependency Programs.

* The Aging Initiative oversees the Long Term Care Facilities unit and the Aging and Adult activity. The initiative will promote the development of policy options to address future state costs that will be driven by the increases in the elderly population that will accelerate as baby boomers age.

The Department's services are delivered directly and through county human services agencies, health care providers, jobs and training providers and private sector agencies.

WAYS TO IMPROVE PROGRAM OUTCOMES

The department anticipates several areas in which statutory changes will be put forward to improve programs. These include:

- Welfare changes that require and reward work

- Initiatives that invest in local solutions to Child Welfare issues

- Long term care initiatives that slow the growth of state costs

- Technology investments to enhance agency efforts and avoid cost.

EMPLOYEE PARTICIPATION

The Annual Performance Report development process was integrated into the department's Bienniel Budget development process, guidelines and timelines. Participation in the two processes included included staff from throughout the department.

Date : December 24, 1996

Agency Expenditure Summary

F.Y. 1996

NAME	(in thousands $)	% of $	FTE	% of FT
AGENCY: HUMAN SERVICES DEPT	$4,621,312	100.0%	6,043	100.0%
PROGRAM: AGENCY MANAGEMENT	$261,343	5.7%	367	6.1%
PROGRAM: CHILDREN'S GRANTS	$137,579	3.0%	23	0.4%
PROGRAM: CHILDREN'S SERVICES MANAGEMENT	$6,487	0.1%	43	0.7%
PROGRAM: BASIC HEALTH CARE GRANTS	$1,370,850	29.7%		0.0%
PROGRAM: HEALTH CARE MANAGEMENT	$43,037	0.9%	420	6.9%
PROGRAM: STATE OPERATED SERVICES	$247,715	5.4%	4,585	75.9%
PROGRAM: CONT CARE & COMM SUPP GRANTS	$1,930,509	41.8%	32	0.5%
PROGRAM: CONT CARE & COMM SUPP MGMT	$25,966	0.6%	252	4.2%
PROGRAM: ECONOMIC SUPPORT GRANTS	$541,742	11.7%	1	0.0%
PROGRAM: ECONOMIC SUPPORT MANAGEMENT	$56,084	1.2%	320	5.3%

Agency : HUMAN SERVICES DEPT

Program : AGENCY MANAGEMENT

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$261,343	5.66%
From Federal Funds	$155,130	
From Special Revenue Funds	$6,135	
From Agency Funds	$79,273	
General	$20,805	
Number of FTE Staff:	367	6.07%

GOALS :

- To manage the fiscal resources of the Department of Human Services so that policy objectives are furthered and stewardship of public funds is assured. (Minnesota Statutes 16A.10; 16A.103; 16A.11; 16A.124; 16A.127; 16A.1285; 16A.14; 16A.15; 16A.17; 16A.275; 16A.28; 16A.30; 16A.36; 245.03; 245.482; 245.765; 246.12; 246.50-55; 254B.02;253B.01-11; 256.01; 256.014; 256.011; 256.019; 256.025; 256.026; 256.82; 256.863; 256.9356; 256.9655; 256.9656; 256B.041; 256B.19; 256E.06; 256E.07; 256F.05; 256H.09; 246.50-.55; 253B.01-.11; 256B.)

- To provide legal and regulatory processes that promote equal access to services and ensure quality; to assure that statutory and regulatory standards are established and implemented which promote the integrity, integration and cost-effectieness of the services delivery system while protecting the health, safety and rights of persons served. (Minnesota Statutes 13; 14; 15; 16A; 16B; 245A; 256.045; 256B.50; 626.556-626.557.)

- To develop and maintain a workforce that is professionally competent, can meet new challenges quickly, reflects the diversity of our clientele, is technologically literate and operates at the highest level of integrity. (Minnesota Statutes 245.03)

DESCRIPTION OF SERVICES :

The Minnesota Department of Human Services, Agency Management's work can be organized into three areas: financial operations, legal and regulatory operations, and management operations. Two of the 5 department Priorities for People initiatives are found in Agency Management--the Technology and Information Access Initiative and the Workforce Development Initiative.

FINANCIAL OPERATIONS

The Financial Operations area forecasts entitlement expenditures and reports on all other expenditures and revenues, pays grantees and vendors, deposits department receipts, ensures that funds are received and spent within federal and state law, and manages the agency's biennial budget, annual operating budget and performance report. Human Services operates with an annual budget of approximately $10 billion. For it to operate within state and federal law, a huge variety of budgets forecasting, accounting, collections, and accounts payable and receivable must be managed. On top of the sheer size, the diversity of department programs and their related funding sources creates extensive accounting, budgeting, and forecasting complexity. Forecasting and reporting is critical to budgeting and estimating cost growth and fiscal implications of policy changes, to determining how well money owed to the department is being identified, recouped and managed as a resource, and to staying in compliance with federal and state laws.

In some cases, department programs are the payer or service provider of last resort, which means this activity must ensure that any other client resources are used first or recouped if a service has been provided. Making sure that private insurance policies or accident settlements, Medicare, or other federal benefits are tapped to cover their fair share is a priority. With significant reforms at the state level and new and pending federal reforms, managing budget development has become intense and virtually year round. As human services expenditures have risen, so have the stakes in making sure accounting is accurate, forecasts are realistic, and all resources that owe money to human services are tapped.

LEGAL AND REGULATORY OPERATIONS

The Legal and Regulatory Operations area activities include resolving disputes with clients, license holders, and long-term care facilities; providing data practices advise, legal support and rule making activities for all department services; overseeing litigation in collaboration with the Attorney General's Office; managing grants and contracts for department services; and licensing services and investigating complaints. Legal and Regulatory Operations also provides legal expertise to the department for management of developing legislation, intergovernmental relations and regulatory reform activities.

Administrative fair hearings are conducted in this area. They are appeals by recipients of service whose benefits have been denied, reduced, or terminated. Appeals of licensing decisions and long-term care rate appeals are also provided by the legal and Regulatory Operations.

Grant and contract management activities include providing technical expertise as service areas contract for specialized services. The department enters into over 1,000 contracts annually for professional technical services such as psychiatric and general medical services for Regional Treatment Center clients. The department also uses grant contracts for such services as prevention of substance abuse, violence and out-of-home placement, aid to maternal child health programs, training for child protection workers and

assisting adoption for special needs children.

Licensing and investigating services include responsibility for licensing, monitoring, and investigating child care centers, family child care homes, foster care homes for adults and children, group homes and residential treatment centers for children, day and residential programs for persons with mental retardation or related conditions, mental illness, chemical dependency or physical handicaps and mental health centers. This area conducts background studies on people who provide direct contact services in DHS and MDH licensed programs, and investigates reports of alleged or suspected maltreatment of children and vulnerable adults in DHS licensed programs.

MANAGEMENT OPERATIONS

Management Operations provides department leadership, human resources functions to manage agency programs, technology development to implement agency goals, management services such as leasing and facility management, and internal auditing to provide monitoring and evaluation of programs. Department leadership and direction includes priority setting for welfare, health care, and other service areas, policy development and direction for both day-to-day operations and the future, planning and implementation of public policies, accountability to the Governor and the Minnesota Legislature, and communication with clients, counties, tribes and the federal government.

Human resources services the entire agency. Over 7,000 people are employed by the Department of Human Services, including the State Operated Services providing direct services to clients throughout the state. Human resource functions include strategies for redeploying personnel to fit new priorities and changing business needs; recruitment, selection, compensation and classification services for 7,000 state employees and 3,700 county employees; labor relations, grievance arbitration and negotiation; affirmative action, diversity activities and civil rights enforcement and monitoring; health and safety training and workers compensation services; and training that promotes professional development, continuing education and cultural competencies.

Information and technology resources maintains current computer and technology investments and adapts them for the future. Information and technology resources help the department adapt its systems to meet new needs cost-consciously and identify ways to use new technologies.

Management services encompasses a variety of functions needed to ensure that basic business needs of the department are met. Management services functions include visual communications/video-conferencing; facility management and building security; voice technology services; inventory and property management; purchasing office goods; and mailing and printing services.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
		FINANCIAL OPERATIONS		
A	FY	Number of payment transactions	94,895	N/A
A	FY	Volume of checks deposited	315,988	468,445
A	FY	Number of draws on letter of credit.	3,676	2,992
O	FY	Percentage of checks received deposited within twenty-four hours.	68%	93%
		LEGAL AND REGULATORY OPERATIONS		
A	FY	Number of licensed programs directly monitored by DHS at the end of each year.	3,412	3,449
A	FY	Number of licensed programs monitored by counties and private licensing agencies at the end of each year.	22,715	23,143
O	FY	Number of negatiave licensing actions taken in DHS directly-monitored programs.	33	29
O	FY	Number of negative licensing actions taken in facilities monitored by county and private licensing agencies.	313	288
A	FY	Number of background studies completed by DHS on people providing services in DHS directly licensed programs.	59,865	42,933
A	FY	Number of background studies completed by DHS on people providing services for Minnesota Department of Health licensed agencies.	0	94,300
A	FY	Number of alleged maltreatment investigations completed by DHS.	958	903
A	FY	Number of alleged licensing violations (complaints investigated by DHS)	800	737
O	FY	Percent of orders in fair hearings that are issued within the 60 day limit.	88%	88%
E	FY	Percent of long term care rate appeal determinations issued within the one-year statutory deadline.	100%	100%
O	FY	Percent of long term care rate appeals for which providers do not require a contested case hearing.	90%	80%
		MANAGEMENT OPERATIONS		
A	FY	Number of computers installed, networked and supported in DHS Central Office.	1,709	1,925

OD	FY	Percent of areas in central office facilities determined meeting American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE) standards.	100%	100%
A	FY	Number of work station accommodations in DHS central office.	643	786
A	FY	Number of civil and human rights charges that are filed against human services providers.	9	12
O	FY	Number of job groups in DHS Central Office workforce adequately represented by protected class employees.	12	14
O	FY	Percent of job groups in DHS Central Office adequately represented by protected class employees.	50%	58%

PROGRAM DRIVERS :

Agency Management provides leadership and direction for the department specifically and human services generally and provides the support services required to enhance the productivity and effectiveness of the department's businesses and initiatives. Some program drivers can affect the direction of human services policies and programs, while others can affect support services for these policies and programs.

Welfare reform will have a significant effect in Minnesota. Federal changes affect eligibility of recipients, the length of eligibility for those who are initially eligible for assistance, amounts of federal funds available to the state, and the types of services federal funds will support. Sanctioning of clients is expected to increase as are appeals related to those sanctions. Federal and state reimbursement of administrative aid will be changing.

Health care reform may also have a significant effect in Minnesota. The overall health care system is changing in structure, financing and delivery based on reforms at both the federal and state levels, with a resulting ever changing health care marketplace and uncertainty as to how this dynamic environment will take shape.

As federal devolution occurs, more demands will be placed on staff, computer systems and other management services to design new programs, to understand how changes will affect people, and to cope with stress and uncertainty. Increased efforts may be needed to assist people to qualify for other sources of help in response to welfare reform, block grants and tightened federal eligibility criteria.

The department's clientele is becoming more diverse. Its staff must understand diversity issues and reflect that diversity in its ranks.

Technology is critical for the support of the department's purpose to manage fiscal resources, provide support for program implementation, and maintain a work place that is professionally competent and technically literate. Technology is used to address a rising workload and to meet rising customer expectations for quick, accurate transactions and information. The obsolescence of computers and their software is speeding up. As policies change, reprogramming is a given. Strategic planning is utilized to maintain the department's computer investment while adapting it to meet new needs and program changes.

Over time, there has been a change in the types of skills the department needs. There is a growing need for specialized services. More employees have to have basic and advanced computer skills. And more employees

have to be flexible in thinking of the impact of policies across areas of the agency and not just for their service division.

Staff are located around the state. To improve their ability to get the job done and get the training and information they need on new policies, telecommunications has come to the fore. Other types of training delivery using technological advances such as video-conferencing and video satellite must be used more extensively.

New privacy/data practices issues continue to be raised with the advent of new technologies such as e-mail and systems across agencies and jurisdictions. Technology in some cases is moving faster than the law that governs it. Sometimes it is difficult to categorize technology to fit existing legal standards.

More litigation is occurring due to reforms and legislative policy changes. The volume of lawsuits has increased as fundamental changes are made in entitlements and other major programs.

Goal 1 : To manage the fiscal resources of the Department of Human Services so that policy objectives are furthered and stewardship of public funds is assured.

Objective 1 : DHS payments will be made promptly at least 98 percent of the time.

Measure 1 : Percentage of payments made within thirty days.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of payments						
Actual	98.3%	98.7%	98.0e%			
Target				98.0%	98.0%	98.0%
Medical payments						
Actual	90.0%	90.7%	96.4e%			
Target				98.0%	98.0%	98.0%

DEFINITION :

The number of payments made within thirty days of receipt of invoice for those payments subject to the prompt payment target expressed as a percentage of the total subject payments. For medical claims this represents the percentage of clean, valid vendor invoices submitted to DHS as the primary payer of medical services.

RATIONALE :

Prompt payment of department obligations is an important customer satisfaction measure and a good indicator of the operational efficiency of the department. Vendors and providers will be more likely to deal with DHS and to extend cooperation to department staff if they are confident that they will be paid promptly and correctly.

DATA SOURCE :

The Department of Finance provides reports on prompt payment for non-medical payments. Medical payment data is taken from the MMIS system.

DISCUSSION OF PAST PERFORMANCE :

Department payment errors and late payments have been low despite increasing levels of transactions.

PLAN TO ACHIEVE TARGETS :

Target estimate is based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

Incorrect invoice amounts or inconsistent data (such as different "remit to" addresses or incorrect medical codings) on invoices can give the impression that a department error has been made that can affect prompt payment records. Implementation of the new statewide accounting system begun in fiscal year 1996 will impact payment performance in unknown ways.

Goal 1 : To manage the fiscal resources of the Department of Human Services so that policy objectives are furthered and stewardship of public funds is assured.

Objective 2 : DHS central office administrative costs will be less than or equal to 4.25% of total gross expenditures through 1999.

Measure 1 : Total DHS central office administrative costs as a percent of total gross expenditures

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of total expenditures						
Actual	N/A%	N/A%	4.27%			
Target				4.25%	4.25%	4.25%

DEFINITION :

This is a measure of DHS central office expenditures. It is defined as the central office expenditures recorded in the state accounting system for object of expenditure codes 1A0 through 2P0 (Administrative costs) divided by central office expenditures recorded for all object of expenditure codes (Total expenditures).

RATIONALE :

A low ratio of administration and management costs to total department costs indicates an efficient operation, a greater share of department resources going to clients, and a good value for the tax dollar. Comparison of the department administrative cost ratio to similar ratios of similar organizations used as benchmarks serves as confirmation of efficiency and value.

DATA SOURCE :

The cost figures are obtained from the state accounting system making them products of official state financial records. Department staff download financial data from the Information Access data warehouse into a series of DHS data bases and spreadsheets they have designed to produce customized DHS reports, including administrative cost management reports.

DISCUSSION OF PAST PERFORMANCE :

Total department expenditures have been increasing for a number of years. Department administrative costs have increased at a lower rate than program costs, which accounts for the decreasing administrative cost ratio.

PLAN TO ACHIEVE TARGETS :

Continue a strategic approach to application and implementation of computer technology, electronic transmission of data and information, and linking of department systems with each other and with other state and local systems will achieve a reduced duplication of work functions and decentralization of tasks to the lowest level possible. Coupled with continued management attention to cost control and efficiency this should provide a continued decrease in the administrative cost ratio.

OTHER FACTORS AFFECTING PERFORMANCE :

Significant one time start up costs of department automated systems could have a temporary effect on administrative costs. Program changes originating at the federal level may affect both service costs and administrative costs. Federal "off-loading" of work to states could lead to unavoidable increased administrative costs. To achieve greatest operating efficiency, assumption of costs at the state level may be necessary but should make it possible for local units of government to reduce or avoid increased costs.

Goal 1 : To manage the fiscal resources of the Department of Human Services so that policy objectives are furthered and stewardship of public funds is assured.

Objective 3 : Past due receivables will decline as a share of all receivables by 1999.

Measure 1 : Accounts receivable by length of time past due (in thousands).

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Not past due						
Actual	$65,182	$56,677	$52,448			
Target				$59,272	$59,784	$60,290
Past due 1-90 days						
Actual	$13,875	$30,149	$22,525			
Target				$22,219	$21,997	$21,777
Past due 90 days to 1 year						
Actual	$26,563	$31,596	$28,353			
Target				$28,931	$28,642	$28,355
Past due more than 1 year						
Actual	$63,550	$62,773	$79,149			
Target				$68,491	$43,898	$35,701
Total past due						
Actual	$103,988	$124,518	$130,027			
Target				$119,641	$94,537	$85,833
Total receivables						
Actual	$169,170	$181,195	$182,475			
Target				$178,913	$154,320	$146,123
Percentage past due						
Actual	61%	69%	71%			
Target				67%	61%	59%

DEFINITION :

Total department non-child support open accounts receivable as of the last day of each fiscal year, "aged" relative to its due date. A receivable is considered not past due, or "current", prior to the passage of its due date. When the due date passes without full payment, the receivable becomes "past due" and must be aged according to the number of days it remains outstanding beyond the due date.

RATIONALE :

It is generally accepted that as a receivable ages past its due date, the probability that the account will be collected decreases. Therefore, the ultimate goal of dealing with past-due accounts is to pursue all reasonable and appropriate actions to effect collection in a timely manner.

DATA SOURCE :

Minnesota Accounting and Procurement System (MAPS), Medicaid Management Information System (MMIS), and MAXIS accounting reports.

DISCUSSION OF PAST PERFORMANCE :

The department's accounts receivable are comprised of approximately 20 separate programs. Department-wide management and reporting of accounts receivable started in FY 1994 along with an initiative to consolidate the billing, collection, receipting and accounting of receivables. A vital element to the success of the initiative to consolidate was to reduce the many freestanding accounts receivable systems to the following three: MAPS, MMIS and MAXIS. This has been successfully completed on the majority of the department's accounts receivable systems.

PLAN TO ACHIEVE TARGETS :

The department's overall plan is to take all appropriate and cost-effective actions to aggressively collect accounts receivable and ensure firm, fair and consistent collection steps throughout the department. In the short term, the department will accelerate collection efforts and referrals to collection agencies as well as initiate accounts receivable procedural improvements. In the long term, department policies will be refined and more comprehensive accounts receivable reporting will be developed.

OTHER FACTORS AFFECTING PERFORMANCE :

Department policy/funding decisions regarding program operations may have an impact on revenue/collections by the department.

Goal 1 : To manage the fiscal resources of the Department of Human Services so that policy objectives are furthered and stewardship of public funds is assured.

Objective 4 : Collections costs will be maintained at or below 2.5 percent of the amount collected.

Measure 1 : Cost of collections as a percentage of amount collected

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Cost of Collections						
Actual	2.03%	2.31%	1.74%			
Target				2.10%	2.19%	2.29%

DEFINITION :

Department non-child support expenditures for the establishment, billing collection and accounting for its accounts receivable divided by department accounts receivable collections.

DATA SOURCE :

Minnesota Accounting and Procurement System (MAPS), Medicaid Management Information System (MMIS) and MAXIS accounting reports.

DISCUSSION OF PAST PERFORMANCE :

The department has consistently maintained the cost of collections at below 2.5 percent of the amount collected. During FY 1994, total actual collections exceeded the budgeted collections and proposed benefits for the accounts receivable project by $656,000. FY 1995 collections exceeded expectations by $1.2 million.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

Department policy/funding decisions regarding operations may have an impact on revenue/collections by the department.

Goal 2 : To provide legal and regulatory processes that promote equal access to services and ensure quality; to assure that statutory and regulatory standards are established and implemented which promote the integrity, integration and cost-effectieness of the services delivery system while protecting the health, safety and rights of persons served.

Objective 1 : All rules will emphasize both outcomes for people receiving services in place of prescriptive procedures, and the best uses of resources for the public.

Measure 1 : Percent of rules adopted that promote five or more regulatory reform values.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of rules						
Actual	100%	100%	100%			
Target				100%	100%	100%

DEFINITION :

The regulatory reform values of the department include:

Assure Consumer Protection
Tie Performance Measures to Outcomes
Maximize Flexibility
Support Community Partnerships
Minimize Administrative Burdens
Support Good Intergovernmental Relationships
Take Fiscal Responsibility
Do Not Duplicate Other Efforts

RATIONALE :

The Department core values of focusing on people not programs, being responsible for the common good, providing safety nets, mutual responsibility and partnering with communities is changing the regulatory role of the Department. The Department is moving away from a primary role and responsibility for quality assurance to basic standards with active consumer and family involvement, provider incentives for early problem identification and correction, and more information about services for consumers to make better choices.

The Department has established a mission to redesign enforcement mechanisms to meet the reform values through improved administrative rules, more effective licensing activities, increased use of contracting and modification of existing statutes There has been an over-emphasis on process and procedure in existing forms of regulation. Increasing competition for existing resources requires an examination of our regulatory methods.

DATA SOURCE :

Statements of Need and Reasonableness address the regulatory values on previously promulgated rules.

PLAN TO ACHIEVE TARGETS :

Targets can be achieved through education of consumers, providers, legislators, and state staff to the vision, mission and values of regulatory reform.

OTHER FACTORS AFFECTING PERFORMANCE :

Implications of federal welfare reform and possible health care reform could significantly impact the methods of regulations.

Goal 2 : To provide legal and regulatory processes that promote equal access to services and ensure quality; to assure that statutory and regulatory standards are established and implemented which promote the integrity, integration and cost-effectieness of the services delivery system while protecting the health, safety and rights of persons served.

Objective 2 : To remove all people from licensed programs who pose a risk of harm to children and vulnerable adults while affording due process rights to the individuals removed.

Measure 1 : Number of people who subsequently maltreat a child or vulnerable adult in a DHS licensed program whose disqualification had been earlier set aside.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
2(a) People disqualified						
Actual	497	587	462			
2(b) Number who requested reconsideration						
Actual	115	105	153			
2(c) Reconsideration disqualifications set aside						
Actual	77	70	116			
2(d) Number with a set-aside who subsequently maltreated						
Actual	2	0	0			
Target				0	0	0
2(e) Number with clean background study who maltreated						
Actual	NA	140	99			

DEFINITION :

Measures 2(a), 2(b), and 2(c) report on the activities that are the basis for the performance reporting in Measure 2(d). The above shows how often people are disqualified, how often they appeal their disqualifications, how often their appeals are granted, and the consequences of their appeals in terms of subsequent substantiated maltreatment. Measure 2(e) provides some perspective in that it shows the number of substantiated perpetrators for whom a background study revealed no disqualifying history.

RATIONALE :

Minnesota Statutes, section 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, require background studies on people who provide direct contact services in DHS licensed facilities. The statute and rule identify characteristics that, if in a person's history, cause the individual to be disqualified from providing direct contact services in licensed facilities. There is a rebuttable presumption that a history of these disqualifying characteristics predisposes the person to being a perpetrator of maltreatment of vulnerable adults or children in licensed programs. The disqualifying histories include a variety of criminal activities as well as substantiated maltreatment of a child or vulnerable adult.

After being disqualified, the individual may request that the Commissioner set aside the disqualification through an attempt to demonstrate to the Commissioner that, notwithstanding the disqualifying criminal history, the individual does not pose a risk of harm to the people receiving services from the licensed program.

The Legislature has limited the Commissioner's discretion to set aside disqualifications for certain foster care and family child care settings. This is a report on the outcome of some of the decisions remaining within the Commissioner's discretion, specifically those for programs directly licensed by the Division of Licensing.

DATA SOURCE :

Division of Licensing.

DISCUSSION OF PAST PERFORMANCE :

The current background study system has been in effect since 1991. In 1991, there was one individual with a set-aside disqualification who was later substantiated as a perpetrator of maltreatment of a vulnerable adult. There were no instances in 1992 and 1993 in which a person with a set-aside disqualification was substantiated as a perpetrator of maltreatment in a DHS licensed program.

PLAN TO ACHIEVE TARGETS :

Each request for reconsideration will be very carefully reviewed by a team of background study staff who will make a recommendation about the final decision.

OTHER FACTORS AFFECTING PERFORMANCE :

There are many forces in an individual's life that may contribute to the propensity to maltreat a child or a vulnerable adult in a licensed program where the person provides care. While an individual's prior history of criminal activity may demonstrate a past disregard for the well being of others, the situation presented at the time that a reconsideration decision is made may change over time. There is yet to be determined a fail-safe mechanism to predict human behavior, and as long as the Commissioner maintains some discretion to set aside disqualifications, there will be a risk that these people will commit maltreatment of children or vulnerable adults.

Goal 2 : To provide legal and regulatory processes that promote equal access to services and ensure quality; to assure that statutory and regulatory standards are established and implemented which promote the integrity, integration and cost-effectieness of the services delivery system while protecting the health, safety and rights of persons served.

Objective 3 : To increase the percent of grant contracts valued at $50,000 or greater to 75 percent by 1999.

Measure 1 : Percent of grant contracts of at least $50,000 in value.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of grants						
Actual		48%	48%	48%		
Target					60%	75%

DEFINITION :

The number of grant contracts over $50,000 divided by the total number of grant awards. The term grant contracts used here refers to cases in which the department funds services to be provided to clients. This definition does not include entitlement programs, professional-technical services contracts, annual plans or shared service agreements.

RATIONALE :

An analysis of the department's costs for administering grants in fiscal year 1995 showed that it costs approximately $2,500 to administer a grant contract regardless of the size of the current grant award. Even though a 10% rate for overall administrative costs for funding agencies which is DHS' rate for grants of $25,000, is currently an acceptable standard, many federal block grants and proposed federal reform measures call for the 5% administrative cost level. The average cost of $2,500 to administer a grant contract is 5% of an award of $50,000. Consolidation of small grant contracts into larger awards serving the same populations and functions will reduce the department's overall administrative costs. This objective would move the department in a direction that is consistent with the federal direction as well as increase the department's efficiency in grant contract administration.

DATA SOURCE :

Information to be used in determining this performance measure includes staff surveys, the number of grant/contract awards and the amount of each award.

DISCUSSION OF PAST PERFORMANCE :

This is a new initiative whose performance will be based on the overall cost of administering grants.

PLAN TO ACHIEVE TARGETS :

Estimates are based on SFY 95 data and reasonably reflect the percentage of grant contracts that met the goal of a 5% administrative cost. The targets are our best estimate of the percentage of grant contracts that could be increased through consolidation. In 1996 the department established a Grants & Aids Project which made recommendations on how DHS could more efficiently and effectively administer some of their grant programs. One of the recommendations of this project was to consolidate similar grant programs and multiple grants to the same vendor as well as reducing the number of small grants. In SFY 1995 the department had approximately 666 grants, 52% of which were less than $50,000, each of which cost an estimated $2,500 to administer. This estimate is based on the average amount of staff time spent on each grant divided by the total number of grants administered. By consolidating similar grant programs, using existing funding structures, and consolidating multiple grants to single vendors, the department believes it could reduce the overall administrative cost of operations. This activity would be done without reducing funding for project activities or target populations.

OTHER FACTORS AFFECTING PERFORMANCE :

The addition of new grant programs or legislation could alter the total number of DHS grants.

Goal 3 : To develop and maintain a workforce that is professionally competent, can meet new challenges quickly, reflects the diversity of our clientele, is technologically literate and operates at the highest level of integrity.

Objective 1 : To decrease the frequency rate of work-related lost time injuries.

Measure 1 : Frequency rate of work-related lost time injuries.

	C.Y.1994	C.Y.1995	C.Y.1996	C.Y.1997	C.Y.1998	C.Y.1999
Lost time injury rate						
Actual	8.0	7.1	7.1e	6.8e		
Target					6.6	6.5

DEFINITION :

The number of lost work day injuries and illnesses, multiplied by 200,000 (a standard weighting scale) and divided by the total hours worked during the calendar year.

RATIONALE :

Frequency rate is one of the major nationally standardized indicators of safety and health program performance. It is used by the U.S. Bureau of Labor Statistics, the Minnesota Safety Council and the National Safety Council to compare the relative effectiveness of safety and health programs in similar industries. A frequency rate is also easy to calculate from readily available information. Note: This measure is based on a calendar, rather than fiscal year for federal reporting and industry comparisons.

DATA SOURCE :

The number of lost work day injuries and illnesses is obtained from the OSHA Logs (Form 200) at DHS Central Office and each regional facility. The total hours is obtained from payroll records.

DISCUSSION OF PAST PERFORMANCE :

Decreases in the frequency rate of work-related lost time injuries and illnesses are attributable to increased emphasis on safety practices and health promotion activities.

OTHER FACTORS AFFECTING PERFORMANCE :

Uncontrollable factors may include recordable injury and illness definition changes; formula calculation changes; judicial actions limiting violent crime interventions; and reduced funding for safety and health staff, equipment and initiatives.

Goal 3 : To develop and maintain a workforce that is professionally competent, can meet new challenges quickly, reflects the diversity of our clientele, is technologically literate and operates at the highest level of integrity.

Objective 2 : To connect all central office DHS employees to an internal Internet/Intranet by 1999.

Measure 1 : Percent of employees connected.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of employees						
Actual	N/A%	N/A%	N/A%			
Target				10%	50%	100%

DEFINITION :

The number of DHS Central office employees with physical connection to the internal Internet divided by the total number of DHS Central Office employees.

RATIONALE :

One of the more important uses of an Internet is the ability to share information among and with employees. Internal connections for all DHS central office would allow for group discussion, distribution of internal communications, sharing of databases, elimination of duplicate files and providing DOER information regarding working conditions, health insurance and other information impacting employees.

DATA SOURCE :

Internal network log files.

DISCUSSION OF PAST PERFORMANCE :

NA

PLAN TO ACHIEVE TARGETS :

Target is based on consolidated system budget and phased implementation planning.

Agency : HUMAN SERVICES DEPT

Program : CHILDREN'S GRANTS

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$137,579	2.98%
From Federal Funds	$87,419	
From Special Revenue Funds	$495	
General	$49,634	
From Gift Funds	$31	
Number of FTE Staff:	23	0.39%

GOALS :

- To reduce the number of children in out-of-home placement by 50% by the year 2005 by focusing on prevention and supporting families to keep children safely at home, reduce unnecessary out-of-home placement and reduce the need for out-of-home placement. (M.S. 256.871; M.S. 256F.06; M.S. 257.3571-3579, Social Security Act as amended)

- To protect children whose families are in crisis. (M.S. 256F.09, 256H.11)

- To promote permanancy. (M.S. 626.5591; M.S. 259.40; M.S. 259.44; M.S.626.5591)

- To promote wellness for newborns, infants, and childen and youth. (M.S. 254.17; M.S.256.01)

DESCRIPTION OF SERVICES :

The Minnesota vision for child welfare is a reformed system that provides supportive services to children and families in their communities to prevent them from entering the child protection and foster care systems. If, however, children do need to be removed from their homes, they will be protected, socialized, nurtured, and receive other services tailored to meet their individual needs. This program's purpose is to protect children and to provide counsel on making services across the agency effective and useful to families. This chapter of the DHS Performance Report encompasses two budget programs, Children's Grants and Children's Services Management.

Children's Services Grants is administered through the department's Family and Children's Services Division. This division administers 25 state and federal grant programs that are focused in three areas:

* Preventing families with children from experiencing a crisis by expanding integrated community services that provide a single point of access. Family visitation centers, crisis nurseries, and work with the Department of Children, Families and Learning are examples of strategies aimed at this result.

* Ensuring that the services are focused on positive outcomes for children by addressing the crisis in public confidence in child protection and foster care services. Examples of methods currently attempting to address this goal are comprehensive training, child abuse hot line and help line, family preservation grants, and Indian child welfare grants.

* Promoting permanency and stability for children who cannot live with their birth families. The adoption assistance program for children with special needs and the homeless adolescents programs are examples of current efforts to meet this objective.

Performance measures related to reducing unnecessary out-of-home placements, protecting children in crisis situations, and promoting permanency measure the impact of these grant programs.

In fiscal year 1996, Children's Services Management expended $6,487,000 and had staff resources of 43 FTE's. These represent 0.14% of the department's expenditures and 0.7% of its staff complement. Children's Services Management provides the lead program support for the department's Children's Initiative which supervises the activities of the Family and Children's Services Division and the planning and implementation of the Social Services Information System. The program's primary responsibility is to ensure that state human services policies and programs work for children at risk within the context of their culture and heritage, to promote the best interests of the child in all public transactions, and to create an awareness of children's issues between the public and all publicly funded agencies.

The Management program has three purposes. First, Children's Services Management seeks to reduce the number of children in out-of-home placements by working with counties and courts to develop placement prevention strategies which focus on the safety and best interest of the child. These strategies include improving the risk assessment process with the counties developing a continum of early intervention and family preservation programs, establishing a children of color task force, and developing an interdepartmental work group on alternatives to the current adversarial court process. Second, Management seeks to improve quality and increase public confidence in child protection and foster care services by ensuring that the services are focused on positive outcomes for children. Third, Management develops and implements state supports which assist the program in accomplishing its goals. A major effort currently being undertaken is the development and implementation of the Social Services Information System (SSIS), which will increase the time county children's services workers are able to spend with their clients, by reducing the time they spend on paperwork.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
W	FY	Number of Crisis Nursery clients.	2,300	2,400
A	FY	Number of children waiting adoption.	1,734	1,661
W	FY	Number of new adoption assistance cases.	108	184
W	FY	Number of Indian Child Welfare Act (ICWA) grant contracts.	20	19
O	FY	Child Welfare/Child Protection persons trained.	80	149

PROGRAM DRIVERS :

There are three significant program drivers affecting achievement of the Children's Initiative goals:

* The increasing rate and cost of out-of-home placement of children. Contributing factors toward this trend include chemical abuse, economic stress, familial stress, family violence and other factors.

* The need to move quickly to promote permanency for the child. There is growing recognition of the frequency with which the system allows children to languish in foster care placments without movement toward permanency. Corrective action will involve more effective family preservation efforts and, where that is not appropriate, more rapid termination of parental rights and adoption.

* Efforts to prevent child maltreatment before it occurs.

There are also three areas in which governmental initiatives at the federal and state levels will affect the Children's Initiative:

Welfare reform will have a significant effect in Minnesota. The Temporary Assistance to Needy Families block grant includes strong work requirements and incentives, which will result in a significant increase in the number of low income families needing child care assistance and experiencing parenting stress. Research has shown that low income families, regardless of the source of income, experience poor outcomes for children in the areas of health, nurturance, child development and learning readiness. The Children's Initiative will monitor child well being indicators for the effects of welfare reform on children.

Health care reform may also have a significant effect in Minnesota. The overall health care system is changing in structure, financing and delivery based on reforms at both the federal and state levels, with a resulting ever-changing health care marketplace and uncertainty as to how this dynamic environment will take shape.

As federal devolution occurs, more demands will be placed on staff, computer systems and other management services to design new programs, to understand how changes will affect people, and to cope with stress and uncertainty. Increased efforts may be needed to assist people to qualify for other sources of help in response to welfare reform, block grants and tightened federal eligibility criteria.

Goal 1 : To reduce the number of children in out-of-home placement by 50% by the year 2005 by focusing on prevention and supporting families to keep children safely at home, reduce unnecessary out-of-home placement and reduce the need for out-of-home placement.

Objective 1 : The number of out-of-home placements of children in Minnesota will be reduced.

Measure 1 : The number of out-of-home placements of children in Minnesota.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of children						
Actual	19,636	18,492	18,000e			
Target				17,000	16,000	15,000

DEFINITION :

The official annual count of out-of-home placements of children in Minnesota, based on reports of the counties to the Department of Human Services.

RATIONALE :

The number of out-of-home placements annually is one measure of success of family preservation efforts.

DATA SOURCE :

County reports to the Department of Human Services.

DISCUSSION OF PAST PERFORMANCE :

Out-of-home placement of children in Minnesota has been increasing generally for many years despite efforts to improve the situation. The Children's Initiative has taken leadership in bringing this issue to public attention and in working with counties to pursue alternatives to placement.

PLAN TO ACHIEVE TARGETS :

Many new approaches have been developed and implemented to address the situation. These approaches include incentives for collaboration among local governmental and private agencies, prevention programs, increased funding for crisis nurseries, development of more alternatives to out-of-home placement, and intensified efforts to safely reunite families as quickly and permanently as possible where out-of-home placement of children has already occurred.

OTHER FACTORS AFFECTING PERFORMANCE :

Poverty, the increase in single parent families, drug and alcohol abuse, educational outcomes, and court decisions all affect the need for out-of-home placement of children. Changes in legislation at federal and state levels, socioeconomic conditions or shifts in conditions, and policy changes at any level of government all can affect annual counts of out-of-home placements in ways that might not relate directly to the success of family preservation programs in Minnesota.

Goal 1 : To reduce the number of children in out-of-home placement by 50% by the year 2005 by focusing on prevention and supporting families to keep children safely at home, reduce unnecessary out-of-home placement and reduce the need for out-of-home placement.

Objective 2 : The number of out-of-home placements of American Indian children will be reduced.

Measure 1 : The number of out-of-home placements of American Indian children.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Placements						
Actual	2,176pre	2,034pre	1,950e			
Target				1,900	1,850	1,800

DEFINITION :

The official annual count of out-of-home placements of American Indian children in Minnesota, based on reports of the counties to the Department of Human Services.

RATIONALE :

The purpose of the federal Indian Child Welfare Act is to reduce out-of-home placements of American Indian children by providing child welfare and family preservation services to prevent the removal of Indian children from their tribe.

DATA SOURCE :

County reports to the Department of Human Services.

DISCUSSION OF PAST PERFORMANCE :

American Indian Children have historically been overrepresented in out-of-home placement.

PLAN TO ACHIEVE TARGETS :

Increased professionalization and expansion of capabilities of reservation-based, culturally-appropriate human services through Indian Family Preservation Grants should reduce the need for out-of-home placement. Increased statewide training of county workers to strengthen and improve compliance with the federal law should also reduce the number of Indian children being removed.

OTHER FACTORS AFFECTING PERFORMANCE :

Poverty, drug and alcohol abuse, educational outcomes, the increase in single parent families, and court decisions all affect the need for out-of-home placement of children. The federal Indian Child Welfare Act recognizes the sovereignty of tribes and places responsibility in states to prevent the removal of children from their tribes.

Goal 1 : To reduce the number of children in out-of-home placement by 50% by the year 2005 by focusing on prevention and supporting families to keep children safely at home, reduce unnecessary out-of-home placement and reduce the need for out-of-home placement.

Objective 3 : To increase the number of special needs children who are adopted.

Measure 1 : Adoptions of special needs children.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Children						
Actual	1,628	1,836	2,020			
Target				2,350	2,675	3,050

DEFINITION :

The number of special needs children who are adopted and receiving adoption assistance.

RATIONALE :

An increase in the number of children receiving adoption assistance demonstrates that children are being adopted who might otherwise have remained in foster care or institutionalized care.

DATA SOURCE :

Adoption assistance program reports of the Minnesota Department of Human Services, Family and Children's Services Division.

DISCUSSION OF PAST PERFORMANCE :

Children committed to the guardianship of the commissioner and in need of adoptive homes are increasingly more severely challenged. The children require more intensive use of various medical, therapeutic, and educational resources. The number of children who have been adopted has increased because of the availability of the supports offered by the adoption assistance program.

A collaborative cost analysis study was done in 1996 with Hennepin County Children and Family Services Division. For 98 children from Hennepin County who were moved on to Adoption Assistance in the past year, the documented savings averaged $3,648 per child per year (not including the savings of administrative, social work, and court expenses). This was the difference between the cost of keeping the child in foster care, and the cost of subsidizing the child in an adoptive home.

PLAN TO ACHIEVE TARGETS :

Privatization of adoption will result in an increase in the number of adoptions of special needs children, based on the experience of Pennsylvania and Kansas.

OTHER FACTORS AFFECTING PERFORMANCE :

The number of children whose parental rights are terminated and are made wards of the state is beyond the agency's control, and will affect performance on this quantified measure.

The social and psychological trauma experienced by these children, as well as the variety of congenital health problems, may be considered beyond the agency's control, and may affect performance on this quantified measure. Some children have problems so severe that finding placement is challenging.

Shifting date of initiation of adoption assistance to date of placement--dependent upon promulgation of date of revised adoption assistance rule. Anticipated date of promulgation is May 1997.

State law now requires permanency decisions to be made more quickly, resulting in increasing numbers of children in need of adoption.

The number of children requiring adoption assistance is directly related to the growing number of children in out-of-home placement.

Goal 2 : To protect children whose families are in crisis.
Objective 1 : Parents will not engage in family violence.

Measure 1 : Crisis Nurseries: Percent of parent clients who link with preventive services to which they are referred by a Crisis Nursery.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of parent clients						
Actual			65%			
Target				65%	65%	65%

DEFINITION :

The number of parent/clients who actually are served by a preventive treatment program to which they were referred by a crisis nursery program divided by the total number of parent/clients who were referred to the service based on a sample of outcomes for all crisis nursery clients.

RATIONALE :

Crisis Nurseries serve an immediate purpose in preventing child abuse. The long-term risk for perpetrating child abuse or neglect is considered a symptom of a treatable problem rather than a normal life condition. Therefore, parent/clients of Crisis Nursery programs routinely are referred to preventive treatment services to ensure that the risk for child abuse or neglect is reduced or eliminated.

DISCUSSION OF PAST PERFORMANCE :

Sample survey of outcomes for parent/clients of crisis nursery programs. More detailed and extensive evaluation data may be found in "Periodic Evaluation and Database Project for the Crisis Nursery Programs in Minnesota," 1996, available from DHS families and Children's Services Division.

OTHER FACTORS AFFECTING PERFORMANCE :

Stress-related abuse and neglect among client families might fluctuate in ways related to socio-economic factors beyond the control of the programs. Availability of other helping services also could affect the client population.

Goal 3 : To promote permanancy.
Objective 1 : Ensure a competent human services workforce statewide.

Measure 1 : Gain in knowledge of the approved Child Welfare/Child Protection Training curriculum (Likert scale self-report).

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent Change						
Actual	NA	NA	+16.4%			
Target				+17.0%	+18%	+19%

DEFINITION :

Percent improvement on Likert scale self-report of level of knowledge of curriculum covered by training.

RATIONALE :

Self report of level of knowledge/gain in knowledge is good and efficient proxy for prohibitively expensive detailed content-based pre- and post-testing.

DATA SOURCE :

Forms distributed to and collected from workers who attend child protection/child welfare training sessions.

DISCUSSION OF PAST PERFORMANCE :

This is the initial year of the training. Under the circumstances, as described below, a 16.4 percent gain in knowledge is very substantial.

PLAN TO ACHIEVE TARGETS :

The program expects to continue to improve performance as experience in doing the training grows.

OTHER FACTORS AFFECTING PERFORMANCE :

Current status of system development does not allow trainees to select training based on their Individual Training Needs Assessment (ITNA). When trainees are able to attend training based on their ITNA, they will be attending training designed to meet their highest training priorities, i.e., training on competencies self-defined as needing considerable development. The percent change should increase because knowledge regarding the competencies should be lower, so will allow for greater increase in knowledge gained after training.

Experienced workers have also noted an increase in motivation to do their job as a result of the training and this may improve performance.

Goal 4 : To promote wellness for newborns, infants, and childen and youth.
Objective 1 : The high-risk infant participants in the Maternal and Child program will show normal developmental advancement.

Measure 1 : Percent of infant participants in the program who advance developmentally.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent advancing						
Actual	75%	73e%	72%			
Target				70%	70%	70%

DEFINITION :

The count of infant participants in the program who advanced developmentally according to infant scores on the Bayley Scales of Infant Development, or on the Denver Developmental Assessment, divided by the total count of infant participants in the program.

RATIONALE :

The Bayley Scales of Infant Development and the Denver Developmental Assessment are highly respected and widely used measures of child development.

DATA SOURCE :

Quarterly and annual reports of programs to the Minnesota Department of Human Services, Family and Children's Services Division.

DISCUSSION OF PAST PERFORMANCE :

The majority of infant participants in the program have been shown to advance developmentally.

PLAN TO ACHIEVE TARGETS :

Programs continue to upgrade services of parenting skills training, parent/child interactive activities, and ongoing medical services designed to maintain positive outcomes in infant development.

OTHER FACTORS AFFECTING PERFORMANCE :

At this relatively early stage in program development, we still are not certain whether there will be any significant shifts in the characteristics of mother/caretakers, and/or the characteristics of infant participants at time of entry to the program. These, as well as economic, budgetary, funding, and/or policy changes are factors generally beyond the agency's control that could affect performance on the quantified measure.

Agency : HUMAN SERVICES DEPT

Program : CHILDREN'S SERVICES MANAGEMENT

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$6,487	0.14%
From Federal Funds	$4,132	
From Special Revenue Funds	$1,497	
General	$858	
Number of FTE Staff:	43	0.71%

GOALS :

The goals and measures for this program are found in the Children's Grants chapter which precedes this chapter.

DESCRIPTION OF SERVICES :

See Children's Grants Chapter

Agency : HUMAN SERVICES DEPT

Program : BASIC HEALTH CARE GRANTS

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$1,370,850	29.66%
From Federal Funds	$640,896	
From Special Revenue Funds	$65,264	
General	$664,690	
Number of FTE Staff:		0.00%

GOALS :

- To ensure that low income uninsured families and individuals will have access to quality, affordable health care within a defined budget. (Minnesota Statutes 256.936, Minnesota Statutes 256B, Minnesota Statutes 256D.01)

- To ensure access to high quality preventive health care with a special emphasis on maternal, infant, and child populations. (Minnesota Statutes 256.9353, Minnesota Statutes 256B, Minnesota Statutes 256B.0625)

- To improve consumer satisfaction with the accessibility, flexibility, and responsiveness of the Minnesota Health Care Programs. (Minnesota Statutes 256.9351, Minnesota Statutes 256B, Minnesota Statutes 256D)

- To provide Minnesota Health Care Program enrollees with preventive health care services in order to diagnose and treat potentially debilitating physical or mental health problems at the earliest possible state. (Minnesota Statutes 256.9351, Minnesota Statutes 256B, Minnesota Statutes 256D)

- To purchase acute care services for the disabled and elderly populations in a manner that support early identification of health conditions and interventions to preserve independence.

DESCRIPTION OF SERVICES :

Basic Health Care Grants ensure that low income people and people with special health care needs have access to quality medical care for acute health conditions and preventive and primary care services.

The department uses two approaches for the purchasing of health care: fee-for-service and managed care. The department has been engaged in managed care models over the past ten years Currently, as of November of 1996, the department has managed care contracts with 8 health plans operating in 16 counties. More than 165,000 people in MA and 15,000 people in GAMC are served through these managed care contracts. The

remaining recipients receive their health care services through the fee-for-service delivery systems.

This program includes the following grants, each of which are described below:

MinnesotaCare Grants
MA Basic Health Care Grants - Families and Children
MA Basic Health Care Grants - Elderly and Disabled
GAMC Grants

MinnesotaCare Grants: This grant activity exists to pay medical payments and subsidize premiums for the uninsured. MinnesotaCare health care coverage is funded by three sources. Enrollees pay a premium (deposited into the health care access fund) based on a sliding scale of income and family size. Health care providers pay a two percent tax. Funding is also supported by Medical Assistance (MA) funds generated by the implementation of the MinnesotaCare Health Care Reform Waiver, which allows MA reimbursement for health care coverage of Minnesota children and pregnant women formerly funded with state dollars only. MinnesotaCare-MA Grants are funded with approximately 54% federal dollars and 46% state dollars.

Health care benefits for MinnesotaCare enrollees who are non-pregnant adults cover inpatient and outpatient hospital care, drugs and medical supplies, physician services, prosthetic devices, preventive dental care, eye care, chiropractic services and medical transportation. Payment for inpatient hospital services is limited to $10,000 annually, with a 10 percent copay. Copays are also required for prescription drugs and eyeglasses.

Health care benefits for MinnesotaCare enrollees who are under the age of twenty-one or are pregnant cover all services listed above, and additional services including comprehensive dental care, personal care attendant services and access services. No copays are required and there is no annual inpatient limit.

During 1996, MinnesotaCare has moved from purchasing all health care under a fee-for-service approach to purchasing all health care through managed care. As of January 1, 1997, all MinnesotaCare enrollees will be receiving their health care through a health plan contracting with the program.

Medical Assistance Basic Health Grants-Families and Children: This grant activity exists to fund health care coverage for eligible low income individuals and families authorized under Title XIX of the Social Security Act. MA grants for families and children exist to support health care services to eligible low income individuals and families if income is within MA standards. Pregnant women and infants under age 2 are eligible with income under 275% of federal poverty guidelines. Children between the ages of 2 and 5 are eligible at 133% of federal poverty guidelines. Children who are ages 6 and older (born on or after October 1, 1993) are eligible at 100% of poverty. Children born after 10/1/83 are eligible at 133% of the Aid to Families with Dependent Children (AFDC) standard. Persons with excess income may qualify through the spenddown provisions if incurred medical bills exceed excess income over the MA standard. MA grants are funded with approximately 54% federal dollars and 46% state dollars.

Medical Assistance Basic Health Care Grants - Elderly and Disabled: This grant activity exists to pay medical payments for eligible elderly, disabled, and blind persons authorized under Title XIX of the Social Security Act. For performance measures relating the the MA grants for the elderly and disabled, refer to the Continuing Care and Community Support Grants chapter of this report.

General Assistance Medical Care (GAMC) Grants: This grant activity exists to fund health care coverage

provided to low income individuals who do not meet the eligibility categories of MA, such as age, disability, blindness or family composition. Also persons who would be eligible for MA if they did not reside in an Institution for Mental Diseases (IMD) are eligible for GAMC. The majority of recipients are single persons, between ages 21 and 65. Persons eligible for General Assistance (GA) and adult recipients of Family General Assistance (FGA) are eligible for GAMC. GAMC Grants are 100% state funded.

This Performance Report focuses on the accessibility to quality health care by the greatest number of recipients of Medical Assistance, MinnesotaCare, and General Assistance Medical Care within a defined budget. The Background Information consists of measures of activities for state fiscal years 1995 and 1996. The objectives and measures in this report focus on prenatal, infant, and child health services, consumer satisfaction with publicly funded health care and accountability of drug purchasing. The department is enhancing its capacity to extract data from its systems through installation of an executive information system. The next Performance Report will be able to reflect performance measures in more focused programmatic areas.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
O	FY	Total average monthly enrollment of Minnesota Health Care Programs enrollees	561,104	560,099
O	FY	Average monthly enrollment of recipients under the age of 21 in Medical Assistance (MA)	246,839	242,909
O	FY	Average monthly enrollment of recipients under the age of 21 in MinnesotaCare	135,031	131,823
O	FY	Average monthly enrollment of recipients under the age of 21 in General Assistance Medical Care (GAMC).	1,705	1,881
O	FY	Average monthly enrollment of recipients between the ages of 21 and 64 enrolled in MA.	135,031	131,823
O	FY	Average monthly enrollment of recipients between the ages of 21 and 64 enrolled in GAMC.	47,916	41,459
O	FY	Average monthly enrollment of recipients between the ages of 21 and 64 enrolled in MinnesotaCare.	31,718	40,097
O	FY	Average monthly enrollment of recipients over the age of 64 in MA.	52,030	51,617
O	FY	Average monthly enrollment of recipients over the age of 64 enrolled in MinnesotaCare.	43	109
O	FY	Average monthly enrollment of receipients over the age of 64 enrolled in GAMC.	197	214
O	FY	Average monthly enrollment in MA.	433,898	426,350

O	FY	Average monthly enrollment in GAMC	49,818	43,555
O	FY	Average monthly enrollment in MinnesotaCare	77,388	90,194
E	FY	Average monthly MA enrollment in managed care delivery system.	122,616	145,419
E	FY	Average monthly GMAC enrollment in managed care delivery system.	13,344	14,155
E	FY	Average monthly MinnesotaCare enrollment in managed care delivery system (effective 7/1/96)	N/A	N/A

PROGRAM DRIVERS :

Health Care Market Changes: The overall health care system is changing in structure, financing, and delivery based on legislative reforms and market changes driven by health care purchasing at both the national and state levels. Minnesota has been granted a waiver from certain federal requirements allowing significant flexibility for DHS to be an active purchaser in the market of health care commodities.

Program Administration Realignment: Aligning the health care programs more closely provides a ladder up for families and individuals as they move from a total health care subsidy to a premium-based system in which the enrollee's contribution gradually increases as income rises. Health and Continuing Care Strategies is in the process of realigning the administration of the three programs into a seamless system for the health care consumer. The current system of three health care programs with separate and sometimes differing policies often leads to dramatic changes in eligibility in response to fairly minor changes in a family's circumstances because of different methods of determining family size and income. Some families experience coverage gaps or unnecessary changes in health plan coverage as a result of shifting between programs. Integrating the administration of the three programs is the first step toward providing a more consistent health care package for uninsured Minnesotans and helps target limited resources to those most in need.

Disparity in Access: Consumers in some areas of the state who are covered under Minnesota Health Care Programs (MHCP) do not have sufficient access to health care services. Shortages of health professionals in rural areas and perceived differences in reimbursement contribute to the disparity in access to quality health care services. Managed care delivery systems can improve the situation if providers, health plans, and government agencies are willing to partner their efforts and resources to improve these basic access problems.

Goal 1 : To ensure that low income uninsured families and individuals will have access to quality, affordable health care within a defined budget.

Objective 1 : Reduce the number of Minnesotans who are uninsured and whose incomes are under 275% of the federal poverty guidelines.

Measure 1 : The number of individuals in families with minor children who are enrolled in MinnesotaCare and who have incomes below 275% of the federal poverty guidelines who would otherwise be uninsured.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Individuals						
Actual	45,500	51,800	54,500			

DEFINITION :

The number of MinnesotaCare enrollees in households with dependent children with incomes below 275% of the federal poverty guidelines who it is estimated would have been uninsured without the existence of MinnesotaCare.

RATIONALE :

The purpose of MinnesotaCare is to ensure access to health care for Minnesotans who are unable to obtain health care coverage through other public or private sector benefit plans. This measure is an indicator of the effectiveness of the MinnesotaCare program in reaching out to insure previously uninsured households and individuals. Providing health care services to the uninsured can save state dollars by making preventive medical treatment available, thus reducing the potentially devastating financial impact on both individuals and government and by offering health care coverage through a subsidized premium (based on income) encouraging individuals to enter, reenter, or remain in the work force.

DATA SOURCE :

Estimates of the uninsured population from Reports and Forecasts Division, DHS; MinnesotaCare enrollment data.

DISCUSSION OF PAST PERFORMANCE :

The August 1996 publication of "Minnesota Health Care Insurance and Access Survey, 1995," by the Institute for Health Services Research, University of Minnesota, provides the results of a follow up to a 1990 survey on uninsured Minnesotans. Among Minnesotans found to be uninsured for 12 months or longer, the proportion who were children declined from 28% in 1990 to 16% in 1995. Since there was no change in the overall percent uninsured in Minnesota over this five year period (6% in 1990 and 6% in 1995), this absolute as well as percentage decline suggests an impact for MinnesotaCare (and extensions in Medical Assistance) in reducing the number of uninsured children. In November 1996, the MDH's Health Policy and Systems Compliance Division released the document "Measuring Trends in the Number of Uninsured in Minnesota vol. 1, no. 05), citing the averaged uninsured rate at approximately 9% of the state's population in 1995. This release also emphasizes the stability of the rate of uninsured over time as does the University of Minnesota survey even though the specific percentages vary.

Also significant is that among Minnesotans of all ages found to be uninsured for 12 months or longer, the proportion who were in families with incomes less than 100% of the federal poverty level declined from 18% in 1990 to 11% in 1995; and those in families with incomes between 100% and 200% of the federal poverty level declined from 47% to 34%. Again, since there was no change in the overall percent uninsured in Minnesota over this five year period, these percentage declines also are absolute declines and suggest an impact for MinnesotaCare (and extensions in Medical Assistance) in reducing the number of uninsured who had low incomes. Finally, although the rate of insured did not decline over this period, for the nation as a whole there was a significant increase in total uninsured (from 13.9% in 1990 to 15.2% in 1994). Thus in Minnesota the constant rate of uninsured represents a better performance than might have been expected.

PLAN TO ACHIEVE TARGETS :

Outreach materials for MinnesotaCare are provided to community agencies and medical institutions for appropriate referrals. Persons exiting Medical Assistance, General Assistance Medical Care, or cash assistance programs are provided information regarding MinnesotaCare. Improved access to MinnesotaCare is essential. Efforts to expand information may include such enterprises as additional telephone lines for increased availability to the MinnesotaCare telephone information line or increased use of new and developing technology (e.g., kiosk, Internet).

OTHER FACTORS AFFECTING PERFORMANCE :

There may be significant changes in the number of uninsured Minnesotans independent of the impact of MinnesotaCare. Private health carriers and employers may change coverage and benefits in response to perceived economic threats that impact health care benefit packages.

Goal 1 : To ensure that low income uninsured families and individuals will have access to quality, affordable health care within a defined budget.

Objective 1 : Reduce the number of Minnesotans who are uninsured and whose incomes are under 275% of the federal poverty guidelines.

Measure 2 : The number of households without dependent children with incomes below 135% of the federal poverty guidelines enrolled in MinnesotaCare who otherwise would be uninsured.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Households						
Actual		1,400	3,000			

DEFINITION :

The number of enrollees in adult-only households with incomes below 135% of the federal poverty guidelines who it is estimated would have been uninsured without the existence of MinnesotaCare.

RATIONALE :

The purpose of MinnesotaCare is to ensure access to health care for Minnesotans who are unable to obtain health care coverage through other public or private sector benefit plans. This measure is an indicator of the effectiveness of the MinnesotaCare program in reaching out to insure previously uninsured households and individuals. Providing health care services to the uninsured can save state dollars by making preventive medical treatment available, thus reducing the potentially devastating financial impact on both individuals and government and by offering health care coverage through a subsidized premium (based on income) encouraging individuals to enter, re-enter, or remain in the work force.

DATA SOURCE :

Estimates of the uninsured population from Reports and Forecasts Division , DHS; MinnesotaCare enrollment data; and University of Minnesota Institute for Health Services Research.

DISCUSSION OF PAST PERFORMANCE :

The August 1996 publication of "Minnesota Health Care Insurance and Access Survey, 1995," by the Institute for Health Services Research, University of Minnesota, provides the results of a follow up to a 1990 survey on uninsured Minnesotans. Among Minnesotans found to be uninsured for 12 months or longer, the proportion who were children declined from 28% in 1990 to 16% in 1995. Since there was no change in the overall percent uninsured in Minnesota over this five year period (6% in 1990 and 6% in 1995), this absolute as well as percentage decline suggests an impact for MinnesotaCare (and extensions in Medical Assistance) in reducing the number of uninsured children. In November 1996, the MDH's Health Policy and Systems Compliance Division released the document "Measuring Trend sin the Number of Uninsured in Minnesota (vol. 1, no. 05), citing the averaged uninsured rate at approximately 9% of the state's population in 1995. This release also emphasizes the stability of the rate of uninsured over time as does the University of Minnesota survey even though the specific percentages vary.

Also significant is that among Minnesotans of all ages found to be uninsured for 12 months or longer, the proportion who were in families with incomes less than 100% of the federal poverty level declined from 18% in 1990 to 11% in 1995; and those in families with incomes between 100% and 200% of the federal poverty level declined from 47% to 34%. Again, since there was no change in the overall percent uninsured in Minnesota over this five year period, these percentage declines also are absolute declines and suggest an impact for MinnesotaCare (and extensions in Medical Assistance) in reducing the number of uninsured who had low incomes. Finally, although the rate of insured did not decline over this period, for the nation as a whole there was a significant increase in total uninsured (from 13.9% in 1990 to 15.2% in 1994). Thus in Minnesota the constant rate of uninsured represents a better performance than might have been expected.

PLAN TO ACHIEVE TARGETS :

Outreach materials for MinnesotaCare are provided to community agencies and medical institutions for appropriate referrals. Persons exiting Medical Assistance, General Assistance Medical Care, or cash assistance programs are provided information regarding MinnesotaCare. Improved access to MinnesotaCare is essential. Efforts to expand information may include such enterprises as additional telephone lines for increased availability to the MinnesotaCare telephone information line or increased use of new and developing technology (e.g., kiosk, Internet).

OTHER FACTORS AFFECTING PERFORMANCE :

There may be significant changes in the number of uninsured Minnesotans independent of the impact of MinnesotaCare. Private health carriers and employers may change coverage and benefits in response to perceived economic threats that impact health care benefit packages.

Goal 1 : To ensure that low income uninsured families and individuals will have access to quality, affordable health care within a defined budget.

Objective 2 : Reduce the ongoing reliance on publicly funded health care systems.

Measure 1 : The number of former Aid to Families with Dependent Children recipients who used MinnesotaCare to transition off public programs and have stayed off at least six months.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Former Recipients						
Actual	769	2,504	3,809			
Target						

DEFINITION :

The count of individuals who left MinnesotaCare in any fiscal year, after first being on AFDC (AFDC recipients receive full Medicaid coverage) before enrolling in MinnesotaCare, and did not return to a publicly funded health care program at any time during that fiscal year or the next six months.

RATIONALE :

MinnesotaCare is a publicly funded, subsidized health care program created to provide a stepping stone or "ladder up" for families and individuals as they move from total health care subsidy (such as that provided under AFDC) to a premium-based system in which the enrollee's contribution gradually increases as income rises (MinnesotaCare), and ultimately to full independence with no financial reliance on publicly funded health care systems. By reducing the number of individuals who have an ongoing reliance on the publicly funded health, more funding becomes available for individuals with greater need.

DATA SOURCE :

DHS database on enrollees of MinnesotaCare.

DISCUSSION OF PAST PERFORMANCE :

Statistical analyses undertaken by DHS staff indicate that the availability of MinnesotaCare has allowed some families on AFDC to leave public assistance and allowed other families not to start on AFDC. It is likely that many of these families (enabled by MinnesotaCare to enter the labor force or stay in the labor force) have acquired improved job skills and experience that in turn has allowed them to obtain jobs that offered employer-subsidized health insurance. For these cases MinnesotaCare can be said to have provided an important mechanism for achieving self-sufficiency.

PLAN TO ACHIEVE TARGETS :

As enrollment in MinnesotaCare increases, the number of families assisted can be expected to increase as well. As a result of federal welfare reform beginning July 1, 1997, Minnesota will begin implementing the alternative case assistance to the AFDC program, Temporary Assistance for Needy Families (TANF). The focus toward full independence from public assistance may increase MinnesotaCare enrollment, at least temporarily, as families move through the public assistance system toward full employment and receiving health care through private sources. DHS will use current enrollment data to set a baseline and carefully monitor the enrollment trends as part of an ongoing surveillance of overall expenditures by DHS.

OTHER FACTORS AFFECTING PERFORMANCE :

State and national health care reform
State legislation affecting covered health care services, eligibility, and reimbursement rates
Actions of private health carriers and employers
State of the economy
State and national welfare reform

Goal 2 : To ensure access to high quality preventive health care with a special emphasis on maternal, infant, and child populations.

Objective 1 : Increase the proportion of high-risk pregnant women and infants who receive appropriate care.

Measure 1 : Percent of pregnant enrollees assessed for high risk of poor birth outcomes.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of fee-for-service enrollees						
Actual	42%	39%	NA			
Target				70%	80%	90%
Percent of managed care enrollees						
Target				70%	80%	90%

DEFINITION :

This measure is the percentage of pregnant women enrolled in the Medicaid program who were screened for risk of a poor birth outcome. This measure is a proxy indicator for the quality of prenatal care provided to MA women. Although DHS has received more risk assessments than noted, these percentages are based on only those forms that were properly completed and entered into the system.

RATIONALE :

In 1988 DHS implemented a prenatal risk assessment process for pregnant women on Medical Assistance (MA) and collaborated with the Minnesota Department of Health (MDH) in providing extensive outreach and training to obstetric care providers. DHS uses this measure to continue the ongoing evaluation of the effectiveness of this prenatal program. The impact of interventions on identified risks will allow DHS to modify the prenatal program to better meet the needs of our population. The goal of the program is to reduce the number of poor birth outcomes to MHCP enrollees.

A standardized risk assessment is used to identify health related needs that can affect birth outcomes for low income pregnant women. Information from this assessment is used by providers to plan interventions (i.e. enhanced services, other related services) to minimize the identified risks. Women assessed and determined to be at increased risk for a poor birth outcome will have access to comprehensive prenatal care (enhanced services) resulting in lower rates of poor birth outcomes for this high risk group and a subsequent decrease in health care costs for child health care needs.

Poor prenatal care and lack of health education for high risk pregnant women are considered to be significant contributing factors of high costs incurred from poor birth outcomes. The risk factors identified on the prenatal risk assessment form can lead to complications during the prenatal period, labor/delivery, postpartum, the neonatal period or throughout a child's life. Impaired neonatal development as well as developmental delays during early childhood are possible adverse outcomes of inadequate prenatal care. The potential human and economic costs of these contributing factors will be significantly reduced by providing the preventive, enhanced services to high risk pregnant women.

In 1993 and 1994 there were approximately 12,500 births each year to women enrolled in fee-for-service MHCP. It is estimated that with managed care, MHCP paid for a total of 19,000 births in each of those years. In 1994 DHS had more than 5200 risk assessments on file. Of those on file, 45.5% of the pregnancies were high risk. In 1995 DHS had more than 4600 risk assessments on file. Of those, 43% were determined to be high risk pregnancies.

DATA SOURCE :

MMIS II claims; DHS database of prenatal risk assessments and the rates of referral for the enhanced services.

DISCUSSION OF PAST PERFORMANCE :

The data cited above consist of fee-for-service results only. Part of this section on past performance discusses managed health care results that, because of the nature of the data, cannot be used in conjunction with the fee-for-service data.

In 1993 the department participated in the Quality Assurance Reform Initiative (QARI), a two year demonstration project cosponsored by the Henry J. Kaiser Family Foundation, the National Academy for State Health Policy and the Health Care Financing Administration (HCFA). States participating in QARI were required to conduct a focus study on prenatal care using guidelines issued by HCFA in the "Health Care Quality Improvement System for Medicaid Managed Care - A Guide for States." The QARI study provided results that showed managed care health plans had a greater than 90% screening rate for risk of a poor birth outcome for enrolled recipients.

In a review of three years of the fee-for-service utilization, DHS has observed the following: The amount paid for enhanced services for calendar year (CY) 1991 was $659,877; CY 1992 was $690,406; and CY 1993 was $584,546.

PLAN TO ACHIEVE TARGETS :

In working with the HMO Council, MDH and several providers to develop a prenatal risk assessment for all pregnant women in Minnesota, DHS will expand the utilization of the Prenatal Care Program for our population through this project. With the introduction of the new risk assessment form, DHS will provide outreach to the provider community on the benefits of the enhanced services to MHCP recipients. DHS will continue to evaluate the impact of the enhanced services for our population.

OTHER FACTORS AFFECTING PERFORMANCE :

National and state health care reform
State legislation affecting covered services, eligibility, and reimbursement rates
Availability of health care providers in under served areas
Changing standards of prenatal care as determined by professional and regulatory organizations
State wide expansion of managed care for all enrollees
The willingness on the part of high risk pregnant women to accept and participate in enhanced services
Genetic, envirionmental and socio-economic factors outside the control of the medical service delivery system.

Goal 2 : To ensure access to high quality preventive health care with a special emphasis on maternal, infant, and child populations.

Objective 2 : Increase the proportion of high risk infants who receive appropriate care.

Measure 1 : Percent of low and very low birth weight infants born at special facilities for high-risk infants.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of Infants Fee-for-service						
Actual	65.3%	65.4%	67.6%			
Target				90%	90%	90%
Managed Care						
Target				90%	90%	90%

DEFINITION :

Numerator = Unduplicated count of level II or level III NICU claims with low or very low birth weight.
Denominator = Unduplicated count of hospital claims for newborn babies with low or very low birth weight.

RATIONALE :

Birth outcome may be an indicator of the quality of prenatal care a pregnant woman receives. Low or very low birth weight infants born in special facilities for high risk infants is an indicator that special needs are identified prior to birth and appropriate care provided. The provision of appropriate care of low or very low birth weight infants reduces high cost of special transportation of fragile infants at birth to appropriate facilities and decreases the incidence of costly developmental delays in early childhood by immediately treating identified problems at facilities best equipped to respond to intense needs of these fragile infants. The number of level II or level III neonatal intensive care unit (NICU) claims with low or very low birth weight diagnosis codes describes a subset of newborns requiring significantly higher levels of care. This subset is a proxy for poor birth outcome.

The meaningful measures of birth outcomes currently available to DHS come from claims data related to newborn deliveries. These data are complex and variable from year to year for several reasons including changes in coding and billing practices. The unduplicated count of hospital claims for all newborn deliveries is a relatively stable measure that can define and gauge the "universe" of all newborns covered by MHCP.

This objective and measure correlated with a recommended objective from "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" and certain measures contained in the Health Plan Employer Data & Information Set (HEDIS), version 3.0. The target reflects the Healthy People 2000 Objective (14.14%) to increase to at least 90% the proportion of infants who receive risk-appropriate care.

DATA SOURCE :

MMIS claims; hospital survey identifying level II and level III nurseries throughout the state.

DISCUSSION OF PAST PERFORMANCE :

The data cited above consist of fee-for-service results only. Part of this section on past performance discusses managed health care results that, because of the nature of the data, cannot be used in conjunction with the fee-for-service data.

In 1993 the department participated in the Quality Assurance Reform Initiative (QARI), a two year demonstration project cosponsored by the Henry J. Kaiser Family Foundation, the National Academy for State Health Policy, and the Health Care Financing Administration (HCFA). States participating in QARI were required to conduct a focus study on prenatal care using guidelines issued by HCFA in the "Health Care Quality Improvement System for Medicaid Managed Care - A Guide for States." One measure used in the study was birth weight as an indicator of quality prenatal care. The birth weight in grams of each live birth was reviewed as part of the prenatal care study.

The results for selected Minnesota health plans participating in the QARI project were consistent with the "Healthy People 2000" objective to reduce low birth weight to an incidence of no more than 5% and very low birth weight to no more than 1% of live births.

PLAN TO ACHIEVE TARGETS :

DHS is coordinating with the Minnesota Department of Health (MDH) to electronically link to the birth registry that is being developed by MDH. This link will provide to DHS the detailed birth data critical to maintaining a performance database on the MHCP neonatal population. DHS is undertaking efforts to implement the collection of data from managed health care plans that serve the MHCP populations. This data collection includes measures from the HEDIS. A comprehensive set of data on the whole of the MHCP populations is needed to fully measure the progress toward achieving performance targets.

OTHER FACTORS AFFECTING PERFORMANCE :

Implementation of a new statewide risk assessment protocol for all pregnant women
Statewide expansion of managed care for all MA enrollees
National and state health care reform
State legislation affecting covered services, eligibility, and reimbursement rates
Availability of health care providers in under served areas
Changing standards of prenatal care as determined by professional and regulatory organizations
Development of new databases at MDH

Goal 2 : To ensure access to high quality preventive health care with a special emphasis on maternal, infant, and child populations.

Objective 3 : Improve the rate of successful vaginal birth deliveries.

Measure 1 : The rate of births delivered by cesarean section for recipients of Minnesota Health Care Programs.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of Births by C-Section						
Fee-for-service						
Actual	16.4%	16.76%				
Target			15%	15%	15%	15%
Managed Care						
Target				15%	15%	15%

DEFINITION :

This measure is the percent of births delivered by cesarean section for pregnant women enrolled under the fee-for-services program.

*The actual 1994 percent is based on MMIS II Diagnosis Related Groupings reports. Potential for errors in reporting between the years does exist due to systems changes and changes in criteria for the reports.

RATIONALE :

Cesarean births increase the risk of complications to both mother and newborn. In some cases the need for cesarean section deliveries is to reduce the risk of complications to the mother and her newborn or to intervene during complications of labor and delivery. However, the national trend of increasing cesarean birth rates from 1965 through the 1980s has roots in several medical and social reasons. The most common reason for cesarean births are: repeat cesarean birth, failure for labor to progress, "fetal distress," and breech presentation. Throughout all of these reasons is the issue of malpractice litigation. The need to reduce the incidence of cesarean births is for improved pregnancy outcomes and lower financial expenditures. The target is based on objective 14.8 of the "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" to reduce the cesarean delivery rate to no more than 15 per 1,000 deliveries.

DATA SOURCE :

MMIS I CPT Codes report; MMIS II DRG reports, MDH Center for Health Statistics

DISCUSSION OF PAST PERFORMANCE :

There have been many statewide efforts to reduce the rate of cesarean births. Provider education has been crucial. The rates have decreased over the past few years with the anticipation that this will continue. As an incentive to reduce "repeat" cesarean births, DHS pays providers at a higher rate for patients who deliver vaginally subsequent to a previous cesarean delivery (Vaginal Birth After Cesarean or VBAC).

DHS has also reviewed the influence of race/ethnicity on cesarean birth rates. The ethnic group with the highest rate of cesarean births is the Hispanic population. The statewide statistics for the Hispanic population from 1989-1993 reflect a cesarean birth rate of 18.22% (MDH Center for Health Statistics). The statwide average for all population groups during 1989-1993 was 16.8% (MDH Center for Health Statistics). Under MHCP for the calendar years 1993 and 1994, the cesarean birth rate for the Hispanic population was 18.86%. These results show a significant difference in cesarean birth rates of the Hispanic population. Efforts are being made to understand and work toward reducing this difference.

PLAN TO ACHIEVE TARGETS :

Encourage providers to utilize the Prenatal Care Program for "at risk" pregnant women enrolled in Medical Assistance. By using this program to identify women at risk of poor birth outcomes, providers are encouraged to use prevention strategies outlined in the enhanced services offered through this program.

DHS will work with MDH in reviewing the factors contributing to elevated cesarean birth rates in the Hispanic community and identify ways to reduce those risk factors.

DHS, in consultation with MDH, will work with the provider community and professional organizations to encourage more providers to use VBAC guidelines as the standard of care for their individual practice, thereby reducing the number of repeat cesarean births.

OTHER FACTORS AFFECTING PERFORMANCE :

National and state health care reform
State legislation affecting covered services, eligibility, and reimbursement rates
Availability of health care providers in underserved areas
Changing standards of prenatal care as determined by professional and regulatory organizations
Statewide expansion of managed care for all MA enrollees

Goal 2 : To ensure access to high quality preventive health care with a special emphasis on maternal, infant, and child populations.

Objective 4 : Increase the percentage of Minnesota Health Care Program enrolled children under age 21 who receive age-appropriate preventive health care screenings.

Measure 1 : Percent of eligible children under 21 who participated in at least one preventive health care screening.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of children						
Fee-for service						
Actual	41%	46%	51%e			
Target	70%	80%	80%	80%	80%	80%
Managed Care						
Target	NA	NA	NA	80%	80%	80%

DEFINITION :

Numerator = Number of enrolled children who received at least one preventive health care screening service and are under 21 years old.

Denominator = Number of enrolled children who should have received at least one preventive health care screening service and are under 21 years old.

This measure reflects an unduplicated count over time of all MA eligible children who have received at least one periodic screening during the report period regardless of their participation in a managed care health plan. Federal requirements mandate a participation ratio of 80%. The participation rate is based on the ratio of the number of eligible children under the age of 21 who received at least one preventive or periodic health screening to the number of eligible children under the age of 21 who should have received at least one preventive or periodic health care screening.

RATIONALE :

Early detection of physical or mental health problems can significantly reduce or prevent potential problems and reduce the financial costs incurred in treating undetected problems. Children who are enrolled in Minnesota Health Care Programs have access to primary, preventive health care through outreach activities to families for well child health care services such as regular checkups, immunizations, developmental testing, and health education. This objective and measure correlates with the recommended objective from "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" to increase the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow up for necessary diagnostic, preventive, and treatment services, and with a combination of measures from the Health Plan Employer Data & Information Set (HEDIS), version 3.0.

DATA SOURCE :

MMIS claim files, Annual DHS report to HCFA, CATCH II - future years

DISCUSSION OF PAST PERFORMANCE :

Past performance for F. Y. 1992 = 39%; F.Y. 1993 = 41% participation. HCFA changed the reporting procedure beginning in F.Y. 1994, HMOs are required to report actual participation. Prior to F.Y. 1994; participation by enrollees in managed care was assumed to be 100%.

The 1994 and 1995 fiscal year's percentages reflect children receiving services under the fee-for-service option.

Although some data from the managed care plans are available from the child and teen check-up system (CATCH II), for F.Y. 1995 these data are incomplete and cannot be considered representative of all managed care plans.

Outreach to families and providers regarding child and teen check ups varies depending on the county.

PLAN TO ACHIEVE TARGETS :

Contracts with managed care health plans include 80% participation goals and standardized billing using one billing format. Outreach and follow-up contracts between local human service agencies and subcontractors include 80% participation goals.

Extensive statewide training for outreach workers. Provider training including the distribution of Provider Information Guide.

Obtain complete managed care data.

Revise reporting formats to standard health care data formats.

OTHER FACTORS AFFECTING PERFORMANCE :

Guidelines and recommendations from regulating agencies and practitioner organizations (e.g., Centers for Disease Control, American Academy of Pediatricians, and the American Medical Association)
Implementation of Rule 101 related to provider participation in Minnesota Health Care Programs
Statewide expansion of managed care for all enrollees changes reporting timelines
State and national health care reform
State legislation affecting covered services, eligibility, and reimbursement rates
Availability of health care providers in under served areas
Reporting form inadequacies may cause under-reporting.

Goal 2 : To ensure access to high quality preventive health care with a special emphasis on maternal, infant, and child populations.

Objective 4 : Increase the percentage of Minnesota Health Care Program enrolled children under age 21 who receive age-appropriate preventive health care screenings.

Measure 2 : Percent of eligible enrolled children under 21 who received preventive dental visits.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of children Fee-for service						
Actual	56%	40%	45e%			
Target				70%	75%	80%
Managed Care						
Target	NA	NA	NA	70%	75%	80%

DEFINITION :

Numerator: Number of enrolled children who received dental services.
Dominator: Number of enrolled children under 21 years old who should have received dental services according to the American Dental Association recommendations

RATIONALE :

The American Dental Association (ADA) recommends that children receive their first dental checkup by age 3. Early detection of dental disease, fluoride supplementation, diet counseling, and instruction about oral hygiene practices are necessary to maintain the oral health of children. Fluoride poisoning can cause death in young children. Dental exams at an early age are essential to improve the health status of children. Preventive dental care visits after the age of three should be maintained for good oral health throughout adolescence and into adulthood. Due to the increase of baby bottle mouth syndrome, the ADA is considering changing the recommended initial dental referral to age one. DHS tracks dental assessments for all children under the age of 21. This objective and measure correlate with several objectives from "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" and measures in the HEDIS, version 3.0.

DATA SOURCE :

MMIS claims file, HEDIS report

DISCUSSION OF PAST PERFORMANCE :

Fiscal years 1994 and 1995 percentages are based on the numbers of children enrolled under the fee-for-service option who received dental services. The decreased participation is mostly likely due to an error discovered in the logic of calculating the data for the 1994 report year.

PLAN TO ACHIEVE TARGETS :

Obtain managed care encounter data for complete reporting in future years.

OTHER FACTORS AFFECTING PERFORMANCE :

Provider outreach and training
Managed care encounter data is not available
Availability of providers
Statewide expansion of managed care
State and national health care reform
American Dental Association recommendations

Goal 3 : To improve consumer satisfaction with the accessibility, flexibility, and responsiveness of the Minnesota Health Care Programs.

Objective 1 : Increase consumer satisfaction with the publicly funded health care delivery systems.

Measure 1 : Percent of consumers satisfied/very satisfied with health their care.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
MA consumer satisfaction rate						
Actual	NA	83%	NA			
GAMC consumer satisfaction rate						
Actual	NA	88%	NA			
MinnesotaCare consumer satisfaction rate						
Actual	NA	91%	NA			
MHCP consumer satisfaction rate						
Target				to be	developed	

DEFINITION :

This measureis based on a consumer satisfaction survey of individuals enrolled in the Minnesota Health Care Programs conducted in 1995 by the Health Data Institute, MDH and reported in 1996.

*See Discussion of Past Performance below.

RATIONALE :

This measure will assess how well MCHP enrollees believe the publicly funded health care system is meeting their needs and fulfilling promises. Consumer satisfaction surveys are an important tool in determining quality of health care and developing performance plans.

Overall consumer satisfaction is a measure that correlates with a Satisfaction With the Experience of Care measure from HEDIS, version 3.0.

DATA SOURCE :

MHDI, see below.

DISCUSSION OF PAST PERFORMANCE :

The Minnesota Health Data Institute (MHDI), a public-private, nonprofit organization created by the Minnesota State Legislature in 1993, completed a consumer satisfaction survey in 1995 that included the MHCP populations. The survey results indicated a range of 83% to 91% of MHCP consumers who reported being very or extremely satisfied with managed care coverage; 83% for MA; 88% for GAMC; and 91% for MinnesotaCare. A major finding of the MHDI survey was that "overall satisfaction was higher for all public plan enrollees combined compared to all private plan enrollees combined. Public plan enrollees reported higher ratings for benefits and coverage, continuity of care, overall access, and medical services." The survey will unfortunately not be continued at this time using the same methodology due to the institute taking on new initiatives that do not include this survey.

PLAN TO ACHIEVE TARGETS :

DHS will design and implement a routine consumer satisfaction survey of its MHCP recipients that incorporates high standards of uniformity, quality, and accuracy. The results of this survey will be used to develop a performance plan with specific targets to be included in future reports.

OTHER FACTORS AFFECTING PERFORMANCE :

Lack of standard reporting guidelines that can be used to identify quality performance
Coordination with HEDIS reporting requirements

Goal 4 : To provide Minnesota Health Care Program enrollees with preventive health care services in order to diagnose and treat potentially debilitating physical or mental health problems at the earliest possible state.

Objective 1 : Increase the proportion of providers of primary care who routinely screen infants and children.

Measure 1 : Percent of providers who routinely screen infants and children for impairments of vision, hearing, speech and language, and assess other developmental milestones as part of well-child care.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual	89%	88%	90e%			
Target	70%	80%	80%	80%	80%	80%

DEFINITION :

Percent of all licensed pediatricians, family practice physicians, pediatric nurse practitioners, and family nurse practitioners who served children enrolled in MHCP.

Numerator=Number of MHCP enrolled providers who provide preventive health care screenings for children under 21 years of age.

Denominator=Number of all licensed pediatricians, family practice physicians, pediatric nurse practitioners, and family nurse practitioners who are MHCP enrolled.

RATIONALE :

A federal mandate requires the MA program to annually document pediatric care provider participation. This measure is an indicator of accessibility of preventive health care for children. The target reflects the Healthy People 2000: National Health Promotion and Disease Prevention Objectives (#17.15) to "increase to at least 80 percent the proportion of providers of primary care for children who routinely refer or screen infants and children for impairments of vision, hearing, speech and language, and assess other developmental milestones as part of well-child care."

DATA SOURCE :

Annual State Plan Amendment: Obstetric/Pediatric Assurances Report to HCFA.

DISCUSSION OF PAST PERFORMANCE :

Beginning in FY 1994, a new database was used for reporting. The 1994 results counted four counties with no pediatric care providers. The previous years' database counted two counties with no pediatric care providers, causing the trend for FY 94 to appear downward. Target percentages were established using reports prior to the development of the new database.

In FY 1995, there were no counties with pediatric care providers. The downward trend in 1995 is due to errors found during a crosscheck completed manually. The percentage appears to have stabilized.

PLAN TO ACHIEVE TARGETS :

Extensive provider outreach and training.

OTHER FACTORS AFFECTING PERFORMANCE :

Statewide expansion of managed care for all enrollees
State and national health care reform
State legislation affecting covered services, eligibility, and reimbursement rates
Availability of health care providers in underserved areas

Goal 4 : To provide Minnesota Health Care Program enrollees with preventive health care services in order to diagnose and treat potentially debilitating physical or mental health problems at the earliest possible state.

Objective 2 : Improve the quality of health care by preventing or decreasing adverse drug-related incidents through the point-of-sale electronic decision assistance system.

Measure 1 : The percentage of potentially dangerous drug-to-drug interactions, incorrect dosage, overuse or abuse detected at point of sale that may have resulted in a change in the course of a prescribed treatment.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual	N/A	N/A	45%e			
Target				49%	52%	55%

DEFINITION :

This measure is the percentage of Drug Utilization Review (DUR) edits for Drug to Drug interactions, incorrect does, inappropriate use or abuse, resulting in a pharmacist assisted intervention that may prevent a potential drug related mishap and/or abuse of a pharmacy benefit.

Numerator = Total number of DUR edits on point-of-sale (POS) claims minus the number of claims resubmitted for payment with outcome and intervention codes resulting in an over-ride of the DUR denial.
Denominator = Total number of DUR edits.

RATIONALE :

In 1996, DHS implemented a computerized information system that would immediately notify a pharmacist of the possible adverse effects of a drug prescribed to a patient prior to dispensing the drug. The system consists of several on-line edits that indicate potential reactions with another drug, with a particular disease, or the possibility of over-prescribing.

Drug-drug: When an individual consumes two or more drug products, there is the possibility that unexpected health threatening events may occur, resulting in hospitalization or further physician visits.

Drug-disease: An individual with a chronic disease state is more likely to react in an unpredictable way to new prescription drugs resulting in hospitalitzation, physician visits, and greater health care costs.

Inappropriate use (incorrect dose, overuse, abuse): The consumption of drugs that appears to be above or below therapeutic ranges may result in negative events that will consume more health care resources.

DATA SOURCE :

Prospective Drug Utilization Review system (ProDUR): on-line real-time Drug Utilization Review.

DISCUSSION OF PAST PERFORMANCE :

This measure has not been done in the past. Prior to the development of a point of sale information system, DHS had to rely on retrospective review of recipient medical histories in order to detect anomalies in the prescribing of drugs.

PLAN TO ACHIEVE TARGETS :

Drug Utilization Review (DUR) interventions and educational outreach programs developed by DHS will help maximize the appropriate use of the ProDUR messaging system and produce greater cost savings.

OTHER FACTORS AFFECTING PERFORMANCE :

The ProDUR system requires active participation and professional judgment by pharmacy providers. These health care providers may not be motivated to utilize the ProDUR messaging to make good professional judgments on quality of care without maintaining or increasing the reimbursement rate.

Agency : HUMAN SERVICES DEPT

Program : HEALTH CARE MANAGEMENT

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$43,037	0.93%
From Federal Funds	$963	
From Special Revenue Funds	$31,504	
General	$10,558	
From Gift Funds	$12	
Number of FTE Staff:	420	6.94%

GOAL :

- To ensure the integrity of expenditures by guaranteeing that the health care system is efficient and fully accountable. (Minnesota Statutes 245.03, Minnesota Statutes 256B)

DESCRIPTION OF SERVICES :

Health Care Management exists to ensure effective and efficient management of the health care programs operated by the department, each of which are described below.

* Health Care Policy Administration: This administrative activity exists to manage the coordination of and access to services under the Medical Assistance (MA), the General Assistance Medical Care (GAMC) and MinnesotaCare programs in compliance with state and federal laws. This activity develops rules and policies on managed health care delivery, Minnesota Seniors Health Options, and eligibility. It oversees the utilization, quality improvement, and federal relations functions of health care administration.

Responsibilities include policy development and planning of new and innovative delivery systems; eligibility policy development; preparing and maintaining the MA state plan as required by the federal government; providing technical assistance in securing federal MA waivers and monitoring outcomes; and communication of these policies to health plans, counties, enrollees, advocates, and other interested parties.

* Health Care Operations: This administrative activity supports individuals in need of health care by providing the operation infrastructure necessary for effective and efficient delivery of health care. Specifically, this activity:
- administers centralized medical payment systems for the programs of Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare,

- administers major managed care capitation contracts under which contractors provide health services for a monthly per person rate paid on a prospective basis,
- conducts eligibility determinations,
- conducts quality improvement and data analysis program management, and
- communicates administrative procedures to health plans, counties, enrollees, advocates, and other interested parties.

This chapter of the report focuses on the management infrastructure of the basic health care grants: MA, GAMC, MinnesotaCare. The Background Information provides data on cost savings activities and the efficiency and effectiveness of the management component in meeting its operational obligations. Objectives and measures have been identified as indicators of performance toward meeting the above goals.

Note: The performance measures regarding programs for elderly or disabled persons are found in the Continuing Care and Community Support Grant and Management chapters of this report.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
O	FY	Amount recovered from other health care insurers	$66.2 mil	$81.6 mil
O	FY	Amount recovered from fraud and abuse investigations	$1.4 mil	$1.1 mil
E	FY	Number of claims completed by MMIS	20 million	23 million
O	FY	Average monthly percent of new claims held (did not pay or deny)	5%e	1.45%
E	FY	Percent of claims processed electronically	81%	85%
E	FY	Average time from receipt of claim to completion	15.0 days	9.0 days
E	FY	Percent of time the MMIS was available on-line to state and county users	97%	98%
E	FY	Percent of time the Eligibility Verification System (EVS) was on-line	NA	NA
E	FY	Number of individuals with differences in eligibility status between MAXIS and MMIS II for calendar months 9/95 and 9/96 (September 1995, September 1996).	7,484	2,899
E	FY	Number of recipients with other health care insurance (not Medicare)	51,679	48,839
E	FY	Number of recipients with Medicare coverage	80,966	83,116
O	FY	Percent of contracted health plans certified to submit encounter claims as of November 1996.	0%	100%

PROGRAM DRIVERS :

As a partner in Minnesota's health care reform effort, DHS directs certain legislatively mandated efforts such as changes to eligibility criteria, expansion of the managed care system statewide, and future realignment of the major health care program administrations (MA, GAMC, MinnesotaCare).

Implementation of federal and state legislation: Federal statutes and rules define the eligibility requirements for federal health care support and what services may be reimbursed through these programs. As the department moves to implement changes to federal eligibility requirements, the MMIS system must respond in a timely and accurate fashion without unnecessary delays or disruption to providers or recipients. As Minnesota moves toward statewide implementation of managed care and the realignment of the administration of MA, GAMC, and MinnesotaCare, changes within the department such as professional staff requirements and computer systems must be accomplished with a minimum disruption of daily activity.

Managed care expansion: Changes that affect both the health care consumer and the department's administrative responsibilities are created as Minnesota moves from a fee-for-service health care system to managed care. Expanding the managed care delivery system statewide for all MHCP participants presents a challenge in the face of the realignment of the major program administrations and federal and state reform activities. The large number of customers and the complexity of program information offer special challenges in keeping customers informed and satisfied with the department's response to their needs. MinnesotaCare enrollment in managed care will be completed by January 1997. As of August 1996, 47.9% of AFDC and other families with children had been enrolled and 36.7% of the aged population had been enrolled in managed care.

Changing environment: Changes in technology, health care purchasing strategies, and societal needs and demands have caused the department to develop and coordinate internal responses. To meet the challenges of this rapidly changing environment the department realigned its own infrastructure. The demand for large volumes of data for internal and external decisionmaking has prompted the department to enhance its capacity in data collections, creating a need for new skills and awareness of the technological environment. Program demand, budget and policy decisions are impacted by a variety of external factors, such as the job market and employer policies on employee benefits.

The department's capacity to measure performance will be enhanced by the development and implementation of the Executive Information System (EIS), incorporating MMIS, MAXIS and other large computer systems into a data warehouse. This EIS system will allow analysis of both fee for service and health plan encounter data. The EIS capacity is being phased in with the first phase scheduled for completion by 2/1/97. The development of a birth registry and an immunization registry at the Minnesota Department of Health (MDH) will allow a much improved ability to really measure our effectiveness in these service areas.

Goal 1 : To ensure the integrity of expenditures by guaranteeing that the health care system is efficient and fully accountable.

Objective 1 : Improve the timeliness of reimbursement to health care providers who submit claims to MMIS for payment.

Measure 1 : Percent of clean claims submitted to the MMIS system that are completed within 30 days.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of clean claims						
Actual	90%	90.7%	96.4%	97e%		
Target			90%	90%	90%	90%

DEFINITION :

The number of clean claims paid within 30 days of receipt divided by total claims received.

RATIONALE :

Federal certification, provider satisfaction, provider cash flow and compliance with the state prompt payment law are critical to the success of the MMIS system. Federal requirements state that 90% of claims are to be adjudicated (completed) within 30 days. When claims are properly submitted by providers, a quick reimbursement response encourages providers to remain enrolled in MHCP. Maintaining a sufficient number of enrolled providers is necessary to ensure adequate access to health care by the recipients of Minnesota's publicly funded health care programs.

DATA SOURCE :

MMIS management reports.

DISCUSSION OF PAST PERFORMANCE :

MMIS has historically complied with federal requirements to complete 90% of all clean claims within 30 days. Implementation of MMIS II, with enhanced edit capability and electronic claims, has enabled the department to achieve and maintain payment goals not previously attainable.

PLAN TO ACHIEVE TARGETS :

Further expansion of electronic claims activity from 85% to 90% and minimizing services that require manual pricing or other intervention will enable achievement of stated target.

OTHER FACTORS AFFECTING PERFORMANCE :

Quality of claims received and the medium of receipt, i.e., paper versus electronic.

Goal 1 : To ensure the integrity of expenditures by guaranteeing that the health care system is efficient and fully accountable.

Objective 2 : Decrease the cost of pharmacy-related health care services by getting the maximum federally approved rebates from drug manufacturers.

Measure 1 : Percent of drug rebate dollars collected from drug manufacturers.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of rebate dollars						
Actual	80%	80%	90%			
Target			90%	92%	93%	94%

DEFINITION :

Total drug rebate dollars collected within 6 months of invoice period divided by total invoiced drug rebate dollars.

RATIONALE :

The drug rebate program collects rebates from drug manufacturers for drugs purchased by Minnesota Health Care Programs. By federal law, manufacturers are allowed to dispute invoiced amounts, thus requiring extensive administrative review and dispute resolution. Improving the invoicing process diminishes disputes, reduces administrative intervention and expedites collections.

DATA SOURCE :

Drug Rebate Tracking System

DISCUSSION OF PAST PERFORMANCE :

Development of a state audit and negotiation process has increased the integrity of the rebate program. State experience with the process and improved relationships with drug manufacturers have increased successful, timely collections with reduced disputes and administrative interventions.

PLAN TO ACHIEVE TARGETS :

Refine the review and verification of pharmacy data base and provider billing activity to strengthen the integrity of rebate invoices submitted to manufacturers and to reduce the probability of disputes.

OTHER FACTORS AFFECTING PERFORMANCE :

Quality of claims data received from providers and accuracy of federal rebate tapes.

Agency : HUMAN SERVICES DEPT

Program : STATE OPERATED SERVICES

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$247,715	5.36%
From Federal Funds	$133	
From Special Revenue Funds	$851	
From Agency Funds	$3,866	
General	$231,345	
Revenue Funds	$11,492	
From Gift Funds	$28	
Number of FTE Staff:	4585	75.88%

GOALS :

- To return individuals to the community with the ability to cope with their disabilities and to successfully function in society. (Minnesota Statutes 253.016-.017)

- To reduce the need for admission to a regional treatment center. (Minnesota Statutes 254.275)

DESCRIPTION OF SERVICES :

The Department of Human Services (DHS) is a direct provider of services to people with mental illness, developmental disabilities, chemical dependency, or traumatic brain injuries and to elderly individuals needing nursing care. These services are provided through eight regional treatment centers (RTCs), community service programs and group homes. Additionally, DHS operates the Minnesota Sexual Psychopathic Personality Treatment Center in Moose Lake which treats persons committed as sexual psychopaths. Collectively, these are called State-Operated Services (SOS). The primary mission is to help clients get the treatment they need to function well in society and return to their communities.

RTCs are located in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, St. Peter, Willmar and Walker. Clients are referred to the RTCs by physicians, courts, county and community social services or directly by the client or a family member. The RTCs have different disability treatment programs. Some provide services to just one population, while others have more than one disability treatment program on campus. As treatment has changed over time, many have developed specialty programs such as those for adolescents with behavior problems and chemical dependency treatment programs designed specifically for women and Native Americans. The cost of client care is primarily paid through publicly funded programs like Medicare and Medical Assistance

(MA), with a small portion paid by private insurance and with personal funds.

Community services are being provided to persons with mental illness and individuals with developmental disabilities. Mental health services are being provided to residents of the Moose Lake catchment area through mobile crisis teams and a 15-bed in-patient unit as a result of the closure of the former Moose Lake Regional Treatment Center and transition of its mental health services into the community. Community services for the developmentally disabled include technical assistance, crisis intervention, state-operated residential and day-program services, supported employment, consultation and training.

A number of group homes are also operated by SOS. These group homes include Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) serving 6 individuals each, and Waiver Services homes serving 4 individuals each. These group homes provide the necessary supports to enable individuals with developmental disabilities to live in a community residence. Services include assisting individuals in activities of daily living, nursing care, and ancillary support services.

The following is a brief description of the services provided by the RTCs and Moose Lake Regional State-Operated Services Center:

AH-GWAH-CHING CENTER

Ah-Gwah-Ching Center (AGCC) is a 343-bed nursing home facility which also has 40 Rule 35 chemical dependency beds located in a free-standing unit on the AGCC campus.

Nursing Facility: AGCC serves as a resource for community nursing homes, hospitals and the Veterans Administration. It provides services for Minnesota's geriatric population with nursing care needs and severe behavioral problems. The behavior problems which clients show include physical and verbal assaultiveness, sexually inappropriate behavior and socially inappropriate behavior.

Chemical Dependency: Lakeside Chemical Dependency Treatment Center was opened in 1983. This program provides both inpatient and outpatient treatment for individuals with chronic chemical dependencies. Its goal is to help individuals who have been unsuccessful in previous treatment programs.

ANOKA METRO REGIONAL TREATMENT CENTER

The Anoka Metro Regional Treatment Center (AMRTC) provides services for persons with mental illness who are citizens of Anoka, Dakota, Hennepin, Ramsey, Sherburne and Washington Counties; inpatient and outpatient treatment for any chemically dependent person in Minnesota; and detoxification services for Anoka County residents.

Mental Health: The Mental Health Program provides active psychiatric treatment services on 7 inpatient units staffed by multi-disciplinary treatment teams. Currently 98% of the clients are admitted to the program under court order, primarily civil commitment. Most of the clients are admitted directly from community hospital mental health units, where they have received some acute care prior to court commitment.

AMRTC Mental Health Program provides specialized treatment services to persons with a Borderline Personality Disorder, clients with a dual diagnosis (mental illness and chemical dependency), geriatric or physically disabled individuals, and clients who need independent living skills training in order to make a

successful transition to the community. At the referral of the County Case Manager and the Inpatient Treatment Team, AMRTC staff provide limited transitional outpatient services to clients, whose needs cannot be met by existing community providers.

AMRTC also has established contracts with 3 local hospitals to treat committed clients who are eligible for MA and whose treatment can be completed in 45 days or less.

Chemical Dependency : The chemical dependency treatment program at AMRTC provides a structured, therapeutic environment for persons with chemical dependency. Services consist of diagnostic and overall needs assessment; group, individual and family counseling; education; aftercare services; referrals and follow up. AMRTC also provides CD treatment to clients on Methadone maintenance.

In 1993, AMRTC established a 12-bed, sub-acute detoxification unit. This program serves Anoka County under a contractual agreement. Detox clients also receive CD education, chemical assessments and information about AA meetings. Referrals are made for housing assistance, Rule 25 assessment for CD treatment, mental health and medical services and civil commitments.

BRAINERD REGIONAL HUMAN SERVICES CENTER

The Brainerd Regional Human Services Center (BRHSC) provides inpatient services to persons with mental illness, chemical dependency, developmental disabilities, traumatic brain injuries and the elderly in need of nursing care. Most clients are from the 12 counties of north central and northeastern Minnesota. The Adolescent and TBI programs serve clients from the entire state.

Mental Health: The Timberland Adult Program is a 110-bed inpatient psychiatric hospital serving individuals 18 years or older who require more intensive care than provided in an outpatient setting. Clients are referred through the courts, county and community social service agencies, mental health centers, physicians, or directly by the client or family members. The average length of stay is 95 days. The goal of treatment is to restore an individual to his/her optimum level of physiological, psychological, and social functioning so that he/she may return to the community, where he/she can resume independent living.

The Timberland Adolescent and Children's Program (TACP) provides inpatient services (25 beds) to adolescents between the ages of 12 and 18 with severe emotional problems. In March of 1996, a special 6-bed unit opened for clients who have cognitive deficits as well as emotional problems. Referrals to TACP are generally through the county juvenile justice system, community social service agencies and family members. Emergency services are provided for peace officer or physicians initiating 72-hour hold orders based on bed availability. The average length of stay is 94 days.

Developmental Disabilities: The BRHSC DD Program currently provides residential and medical services and habilitation training to 55 individuals. The majority of admissions are for temporary crisis care up to 90 days in length. BRHSC also operates 5 state-operated community services (SOCS) waiver homes and 2 day-training and habilitation programs off campus.

Nursing Facility: Woodhaven Senior Community (WSC) was opened on BRHSC's campus in 1989. WSC is a 28-bed nursing facility serving elderly persons who require nursing care and exhibit severe or challenging behaviors or require treatment for an underlying mental illness. It is a health care resource for elderly persons with disruptive behaviors which, in combination with health care needs, preclude their admission to private

nursing homes.

Chemical Dependency: The CD units at BRHSC operate specialized treatment programs. The Aurora Unit provides 28-day residential primary treatment, 96-hour outpatient primary treatment, 60-day extended care residential treatment, and 48-hour outpatient extended care treatment. In addition, the Aurora Unit provides chemical abuse/dependency services to Central Minnesota Juvenile Detention Center and the Minnesota Neurorehabilitation Hospital. The Four Winds Lodge Unit provides specialty primary residential and extended-care residential treatment to meet the unique cultural needs of Native Americans. This program has been recognized for outstanding contributions made to Minnesota's Native Americans. BRHSC also operates an outpatient program located on the Ojibwa Indian Reservation and at the Grand Casino in Hinckley.

Traumatic Brain Injury: Established in January of 1995, the Minnesota Neurorehabilitation Hospital (MNH) serves individuals with acquired brain injury who have challenging behaviors. The 12-bed program serves the entire state. The average length of stay is 300 days.

CAMBRIDGE REGIONAL HUMAN SERVICES CENTER

The Cambridge Regional Human Services Center (CRHSC) provides residential, habilitative, therapeutic and health care services for persons with developmental disabilities throughout the state. CRHSC operates specialized residential and day-training programs on and off campus for severely and profoundly mentally retarded persons who have additional functional problems such as physical disabilities or significant health problems, and for mildly to moderately retarded persons who have challenging behaviors or exhibit significant signs of mental illness. A significant number of admissions to CRHSC are committed through the judicial process. CRHSC operates 10 State-Operated Community Services (SOCS) Waivered Services homes, 2 ICF/MR SOCS homes for clients who have been discharged from the regional human services center and 2 day-training and habilitation programs. A Community Support Services team from CRHSC assists community facilities to serve difficult clients and prevent admissions to a regional center. CRHSC also operates a Community Health Clinic (Health Source) that provides medical, psychiatric and dental services to individuals with developmental disabilities who are unable to obtain these services in the community.

FARIBAULT REGIONAL CENTER

Faribault Regional Center (FRC) has a century-long history of providing services to persons with developmental disabilities. The population has steadily declined from its peak in 1955 to an average daily population of 126 during F.Y. 96. This decline in population is attributable to an increasing availability of programs in the community and a commitment to help individuals with developmental disabilities live less institutional lives.

The development of community-based living, training and habilitation services has become increasingly important in meeting the needs of persons with developmental disabilities. FRC provides community-based transitional services, community and facility-based residential and day-program services, crisis services, habilitation services, and medical, psychiatric and dental services for individuals with developmental disabilities from Southeastern Minnesota; including Hennepin, Dakota and Olmsted counties. By the end of the next biennium, all FRC clients are expected to be transitioned to community living.

FERGUS FALLS REGIONAL TREATMENT CENTER

The Fergus Falls Regional Treatment Center (FFRTC) provides inpatient and outpatient care, treatment,

rehabilitation, and habilitation services to persons with mental illness, chemical dependency, and developmental disabilities. The majority of clients are from 17 northwest counties of Minnesota, although client referrals to the CD program are accepted from throughout the state.

Mental Health: The Mental Health Division of FFRTC assists people to find mental health through a program of individualized professional psychiatric treatment services. MHD serves clients who are 18 years of age or older; elderly persons who have behavioral problems which are complicated by medical problems and physical disabilities; and, serious and persistent mentally ill adults with behavioral problems which makes community treatment difficult.

Developmental Disabilities: The Developmental Disabilities program at FFRTC provides residential and day-training and habilitation services. Services are based upon individualized assessments and directed by an interdisciplinary team. The Community Support Services program provides consultation, training, and on-site assistance to maintain persons in their own homes. The Community Services program also operates 4 SOCS waiver group homes, each serving 4 clients.

Chemical Dependency: The Drug Dependency Rehabilitation Center (DDRC) assists people to develop a healthy lifestyle, free from chemical dependency, through a program of individualized professional treatment, counseling and rehabilitation services. DDRC serves both adolescent and adults in its outpatient, primary and extended-care programs.

MOOSE LAKE REGIONAL STATE OPERATED SERVICES

In 1995, the Moose Lake Regional Treatment Center closed and the majority of the campus was turned over to the Minnesota Department of Corrections. As a result, its chemical dependency programs have been relocated, and its mental health and developmental disabilities services reconfigured. Mental health services are now being provided through mobile crisis teams and a 15-bed inpatient unit. Services for the developmentally disabled include a full range of community support services including technical assistance, crisis intervention, state-operated residential and day-program services, supported employment, consultation and training. These services are known as Moose Lake Regional State Operated Services and mainly serve individuals from Northern Minnesota.

Chemical Dependency: The CD Program is designed to treat clients not readily served in the private sector. The program offers 2 types of extended care for men: the Stabilization Model designed for "fragile" CD clients who have long-term withdrawal issues, cognitive deficits, and/or need monitoring/evaluation to stabilize appropriate medication for mental disorders; and the Relapse Model, designed to help the male client who has not maintained sobriety after primary treatment.

The Liberalis Program is designed specifically for women who are chemically dependent. The programming focuses on recovery needs and behavioral changes with emphasis on personal strengths. An aftercare component helps clients increase independence by learning how to mobilize personal and community resources. Liberalis offers primary and extended-care programming with varying lengths of stay.

Minnesota Sexual Psychopathic Personality Treatment Center: Individuals who have been committed under the Sexually Psychopathic Personality and Sexually Dangerous Person statute present an imminent danger of grave harm to others. The programming at Minnesota Sexual Psychopathic Personality Treatment Center concentrates on sex offender therapy and includes educational, industrial, and recreational treatment.

ST. PETER REGIONAL TREATMENT CENTER

St. Peter Regional Treatment Center (SPRTC) provides inpatient treatment and rehabilitation services to persons with mental illness, chemical dependency, and developmental disabilities.

Mental Health: The Mental Health Program at SPRTC provides high quality, comprehensive mental health services to adults in south central and southeastern Minnesota. The MH Program specializes in treating individuals with serious and/or persistent mental illness and geriatric clients with mental and physical problems and minimal self-care abilities. The program also offers comprehensive inpatient psychiatric and psychological services to clients who are mentally ill and hearing-impaired.

Developmental Disability: The Developmental Disability Program serves individuals who have a primary diagnosis of mental retardation and whose service needs are frequently complicated by additional physical, behavioral, and/or mental health disabilities. Staff also work with other human services agencies and community vendors to facilitate transition to community living and prevent readmission to an RTC.

Chemical Dependency: The Johnson Chemical Dependency Center (JCDC) offers an Alcoholics Anonymous-based CD treatment program for men and women 18 years and older. It has a licensed bed capacity of 58 and provides outpatient, primary care, extended-care and specialty programs for women and dual-diagnosed individuals. JCDC also includes a family program which provides education and support to a client's family members and significant other aftercare services to all clients who have completed treatment and a relapse program for clients who have completed treatment within the past 12 months but were unable to maintain sobriety.

Forensic Program: The Forensic Program, known as the Minnesota Security Hospital (MSH), provides multi disciplinary forensic evaluation and therapy services in a 214-bed secure setting. This facility serves male and female adults from all 87 counties of Minnesota, who are admitted pursuant to judicial or other lawful orders for assessment and/or treatment of acute and chronic major mental disorders.

The MSH has been praised by outside reviewers as one of the finest forensic hospitals in the U.S. It provides comprehensive court-ordered forensic psychiatric evaluations, including competency to stand trial, and pre-sentence mental health evaluations. In addition to evaluation services, MSH treats clients who are mentally ill and mentally ill and dangerous.

WILLMAR REGIONAL TREATMENT CENTER

Willmar Regional Treatment Center (WRTC) provides specialty health services, including inpatient treatment, rehabilitation, developmental services, community-based transitional services, community-based residential and day-program services, outpatient services, and crisis services for adults with mental illness, adolescents with mental illness, individuals with chemical dependency, and persons with developmental disabilities.

Mental Health: The Mental Health Treatment Program at WRTC provides active psychiatric treatment through multi disciplinary teams. Specialized services include stabilization services for persons needing short-term, high-intensity treatment; transition services for clients on the threshold of chronic mental illness; geriatric services for elderly clients and others who have organic and physiological illnesses which require significant additional medical and nursing care; behavior therapy services for persons with serious and persistent mental

illness; psychiatric rehabilitation services for persons who have regressive behavioral and vocational skills deficits; and, MI/CD services.

Willmar's Adolescent Mental Health Program serves 12 to 18 year olds with severe emotional disturbances. The adolescent program provides active inpatient psychiatric treatment for adolescents referred from throughout the state who have emotional problems which cannot be addressed with community-based services. They often have experienced longstanding multiple problems within the family, community and school. The Adolescent Mental Health Services utilize an interdisciplinary team approach to address the multiple treatment needs of the adolescents. A unique educational partnership with the local school district exists, resulting in innovative educational services while in treatment.

Developmental Disabilities: WRTC Developmental Disabilities Program consists of 6 SOCS residential programs and 2 day-training and habilitation programs. The goal of these programs is to teach individuals with DD skills they need to live as independently as possible and to provide experiences that will enrich their lives. WRTC also provides short-term crisis services and community-support services.

Chemical Dependency: WRTC has provided treatment to persons with chemical dependency for 80 years. The Bradley Center houses WRTC's inpatient programs and offers an array of intensive treatment programs. The Bradley Center's Primary Residential Treatment Program uses a combination of individual and group therapy, educational and spiritual services. For clients who are prone to relapse and require a fully structured environment, Bradley's Extended Care Program deals with barriers to recovery and develops coping techniques to improve daily living skills. The Bradley Center has the state's only public Cocaine/Opiate Withdrawal and Treatment Program. The Bradley Center also offers a halfway house for men and women transitioning back into the community.

Willmar's other program, the Cardinal Recovery Center, operates a Primary Outpatient Treatment Program for adults who can maintain sobriety during treatment. The Cardinal Center also operates a Women's Day Treatment Program designed to be sensitive to the special needs of chemically dependent women. An outpatient program for adolescents, the Cardinal Youth Program, is designed to guide young drug and alcohol abusers, ages 13 to 18, to an understanding of their relationship with their chemical of choice. Cardinal's Prairie Youth Program is an adolescent program for adjudicated youths housed at Prairie Lakes Detention Center. Through a cooperative agreement with the detention center, this program is offered to male and female youth on a concurrent basis with their correctional program.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
O	FY	Average Daily Population (ADP) - RTC Adolescent Mental Health Programs	55	52
O	FY	Average Daily Population-RTC Adult Mental HealthPrograms	893	780
O	FY	Average Daily Population-RTC Developmental Disabilities Programs	622	419
O	FY	Average Daily Population-RTC Forensic Psychiatric Services Program (MSH)	197	178
O	FY	Average Daily Population- RTC Nursing Facilitiy Programs	263	257
O	FY	Average Daily Population-RTC Sexual Psychopathic Personality Treatment Program	68	85
O	FY	Average Daily Population-RTC Traumatic Brain Injury Program	4	11
O	FY	Average Daily Population- RTC Chemical Dependency Treatment Programs	218	183
OD	FY	Number of State Operated Group Homes and other Community Services.	74	87

PROGRAM DRIVERS :

A Community Support Services Program, that will ultimately be coordinated with county and private services under the Mental Health Pilot Projects, is currently being developed by the Mental Health Programs at the RTCs. The goal is to assist clients in the transition from hospital to community, and to remain in the community after discharge. This program includes both direct transitional aftercare services and consultation to community providers.

DHS is developing a new program at CRHSC designed to serve individuals who are both developmentally disabled and who present a safety risk to the public. This program, currently referred as the Minnesota Extended Treatment Options (METO), will provide both residential and outreach services and is slated to begin operations July 1, 1997. Bonding has been authorized for construction of 36 beds, with plans for an additional 36 beds. Minor remodeling of existing buildings for day training and recreational use is also authorized.

The number of individuals with developmental disabilities being served in the RTCs has declined over the years. As down sizing on the DD programs at the RTCs continues, it is anticipated that the only RTC inpatient DD population will be in the secure beds of the METO program.

In the past 12 months, the number of individuals admitted to the Minnesota Sexual Psychopathic Personality Treatment Center (MSPPTC) at Moose Lake has exceeded projections. In addition to committed individuals, the increase includes persons on hold orders and the commitment of 2 juvenile sexual offenders upon reaching the age of 19. The latter population represents a potential growth element and is in addition to the historic population projections.

Furthermore, public concern has heightened surrounding the development of therapeutic activities and discharge planning for those clients attaining the requisite treatment progress. It can be anticipated that this public concern will only increase with the sex offender community notification requirements which become effective January 1, 1997. These concerns are expected to result in increased lengths of stay and more staff-intensive efforts directed at client placements in the community.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 1 : Decrease the percentage of Long-term RTC in patient treatment stays.

Measure 1 : Percent of adolescent mentally ill clients discharged after 180 days of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Discharged after 180 Days						
Actual	38	44	32			
Total Number Discharged						
Actual	141	115	92			
Percent Discharged after 180 Days						
Actual	27%	38%	35%			
Target				32%	29%	26%

DEFINITION :

Total number of adolescent MI clients discharged from an RTC after 180 days of admission, each fiscal year, divided by the total number of adolescent MI clients discharged from an RTC during that fiscal year.

RATIONALE :

One of the indicators of effective treatment and program efficiency is length of time in in-patient treatment.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Length of stays has been declining due to change from residential care to active psychiatric treatment.

PLAN TO ACHIEVE TARGETS :

Continue emphasis on active psychiatric treatment to reduce length of stays.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of mental health services in the community for severe and emotional disturbed adolescents.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 1 : Decrease the percentage of Long-term RTC in patient treatment stays.

Measure 2 : Percent of adult MI clients discharged after 90 days of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Discharged after 90 Days						
Actual	1,091	1,058	947			
Total Number Discharged						
Actual	2,792	2,850	2,713			
Percent Dishcarged after 90 Days						
Actual	39%	37%	35%			
Target				33%	31%	29%

DEFINITION :

Total number of adult MI clients discharged from an RTC after 90 days of admission, each fiscal year, divided by the total number of adult MI clients discharged from an RTC during the fiscal year.

RATIONALE :

One of the indicators of effective treatment and program efficiency is length of time in in-patient treatment.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Length of stays has been declining due to change from residential care to active psychiatric treatment.

PLAN TO ACHIEVE TARGETS :

Continue emphasis on active psychiatric treatment to reduce length of stays.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of adult mental health services in the community including transitional and crisis services provided by the RTC/SOS system.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 1 : Decrease the percentage of Long-term RTC in patient treatment stays.

Measure 3 : Percent of individuals with developmental disabilities discharged after 90 days of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Discharged after 90 Days						
Actual	230	233	228			
Total Number Discharged						
Actual	304	298	285			
Percent Discharged after 90 Days						
Actual	76%	78%	80%			
Target				78%	76%	74%

DEFINITION :

Total number of individuals with DD discharged from an RTC after 90 days of admission, each fiscal year, divided by the total number of individuals with DD discharged from an RTC during that fiscal year.

RATIONALE :

One of the indicators of effective treatment and program efficiency is length of time in in-patient treatment.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Admissions have generally been for short-term stays (Respite and Temporary Care Stays of less than 90 days) and individuals are usually returned to their previous placement. Median length of stay for FY 95 and FY 96 admissions (as of October 1996) was 84 days and 61 days respectively.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on continued RTC in-patient DD downsizing and an increase in Community Support Services.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of community alternatives.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 1 : Decrease the percentage of Long-term RTC in patient treatment stays.

Measure 4 : Percent of MI&D clients discharged after 36 months of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Discharged after 36 Months						
Actual	26	15	14			
Total Number Discharged						
Actual	70	60	80			
Percent Discharged after 36 Months						
Actual	37%	25%	18%			
Target				16%	15%	14%

DEFINITION :

Total number of MI&D clients discharged from an RTC after 36 months of admission, each fiscal year, divided by the total number of MI&D clients discharged from an RTC during that fiscal year.

RATIONALE :

One of the indicators of effective treatment and program efficiency is length of time in in-patient treatment.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Community/County providers are often hesitant to have these individuals return to their communities because of the crime he/she has committed.

PLAN TO ACHIEVE TARGETS :

Continue to expedite the processing of client petitions for discharge and the scheduling of Special Review Board hearings when client is clinically able to return to the community.

OTHER FACTORS AFFECTING PERFORMANCE :

The Special Review Board oversees the disposition of MI&D clients.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 1 : Decrease the percentage of Long-term RTC in patient treatment stays.

Measure 5 : Percent of NF clients discharged after 180 days of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Discharged after 180 Days						
Actual	29	28	36			
Total Number Discharged						
Actual	54	51	65			
Percent Discharged after 180 Days						
Actual	54%	55%	55%			
Target				53%	51%	49%

DEFINITION :

Total number of NF clients discharged from an RTC after 180 days of admission, each fiscal year, divided by the total number of NF clients discharged from an RTC during that fiscal year.

RATIONALE :

One of the indicators of effective treatment and program efficiency is length of time in in-patient treatment.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Placement of NF clients in the RTC system was seen as an end stage placement.

PLAN TO ACHIEVE TARGETS :

Emphasize assessment, stabilization and return to the community of NF clients. Assist community providers by providing behavioral and psychiatric consultation with difficult behaviorally disturbed clients.

OTHER FACTORS AFFECTING PERFORMANCE :

Lack of available community alternatives.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 2 : Decrease the percentage of re-admissions to RTC inpatient treatment programs.

Measure 1 : Percent of adolescent MI clients re-admitted to an RTC within 90 days of discharge.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Re-admissions within 90 days of discharge						
Actual	11	11	2			
Total Number of Planned Discharges						
Actual	145	117	100			
Percent Re-admitted						
Actual	8%	9%	2%			
Target				2%	1%	1%

DEFINITION :

Total number of adolescent MI clients re-admitted to an RTC within 90 days of a planned discharge, each fiscal year, divided by the total number of adolescent MI clients given a planned discharge between the beginning of the fourth quarter of the previous fiscal year through the end of the third quarter of the current fiscal year.

RATIONALE :

If treatment has been effective and has addressed relevant clinical needs, there should be few complications resulting in the need for re-hospitalization within 90 days of discharge.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Not comparable due to use of residential program model and longer lengths of stay.

PLAN TO ACHIEVE TARGETS :

Develop child and adolescent psychiatric consultation and liaison services to enhance community based services.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of mental health services in the community for severe and emotionally disturbed children and adolescents.

The impact of the Children's Collaborative on integrated treatment.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 2 : Decrease the percentage of re-admissions to RTC inpatient treatment programs.

Measure 2 : Percent of adult MI clients re-admitted to an RTC within 90 days of discharge.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Re-admissions within 90 days of Discharge						
Actual	484	473	482			
Total Number of Planned Discharages						
Actual	2,791	2,798	2,791			
Percent Re-admitted						
Actual	17%	20%	17%			
Target				15%	13%	11%

DEFINITION :

Total number of adult MI clients re-admitted to an RTC within 90 days of a planned discharge, each fiscal year, divided by the total number of adult MI clients given a planned discharge between the beginning of the fourth quarter of the previous fiscal year through the end of the third quarter of the current fiscal year.

RATIONALE :

If treatment has been effective, and has addressed relevant clinical needs, there should be few complications resulting in the need for re-hospitalization within 90 days of discharge.

DATA SOURCE :

Human Services Information System (HSIS)

DISCUSSION OF PAST PERFORMANCE :

Hospital stays were longer with residential stay occurring predominately in the RTC system.

PLAN TO ACHIEVE TARGETS :

Expand transitional services programs and implement mental health pilot projects.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of adult mental health services in the community for the serious and persistent mentally ill.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 2 : Decrease the percentage of re-admissions to RTC inpatient treatment programs.

Measure 3 : Percent of individuals with DD re-admitted to an RTC within 90 days of discharge.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Re-admissions within 90 days						
Actual	21	21	27			
Total Number of Planned Discharges						
Actual	315	286	310			
Percent Re-admitted						
Actual	7%	7%	9%			
Target				7%	5%	3%

DEFINITION :

Total number of individuals with DD re-admitted to an RTC within 90 days of a planned discharge, each fiscal year, divided by the total number of individuals with DD given a planned discharge between the beginning of the fourth quarter of the previous fiscal year through the end of the third quarter of the current fiscal year.

RATIONALE :

If treatment has been effective and has addressed relevant clinical needs, there should be few complications resulting in the need for re-hospitalization within 90 days of discharge.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Residential care for individuals with DD was predominately RTC based.

In the past staff had no resources to assist in supporting community placements.

PLAN TO ACHIEVE TARGETS :

Early intervention in community settings through the further expansion of statewide Community Support Services.

OTHER FACTORS AFFECTING PERFORMANCE :

The RTC DD in-patient programs continue to downsize. The only planned RTC DD in-patient bed capacity will be those secure beds of the Minnesota Extended Treatment Options (METO) program.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 2 : Decrease the percentage of re-admissions to RTC inpatient treatment programs.

Measure 4 : Percent of MI&D clients re-admitted to an RTC within 90 days of discharge.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Re-admissions within 90 Days of Disharge						
Actual	28	20	30			
Total Number of Planned Discharges						
Actual	60	63	84			
Percent Re-admitted						
Actual	47%	32%	36%			
Target				32%	30%	28%

DEFINITION :

Total number of MI&D clients re-admitted to an RTC within 90 days of a planned discharge, each fiscal year, divided by the total number of MI&D clients given a planned discharge between the beginning of the fourth quarter of the previous fiscal year through the end of the third quarter of the current fiscal year.

RATIONALE :

If treatment has been effective and has addressed relevant clinical needs, there should be few complications resulting in the need for re-hospitalization within 90 days of discharge.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

State-Operated Services and the Special Review Board oversees the provisional discharge of MI&D clients.

PLAN TO ACHIEVE TARGETS :

Include MI&D clients in transition services programs.

OTHER FACTORS AFFECTING PERFORMANCE :

Medication changes and/or environmental changes in post discharge setting.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 3 : Decrease the percentage of RTC clients in residence over 365 days of admission.

Measure 1 : Percent of individuals with DD in residence over 365 days of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of individuals in residence over 365 days						
Actual	593	418	252			
Total Number of individuals in residence						
Actual	653	479	299			
Percent in Residence over 365 Days						
Actual	91%	87%	84%			
Target				80%	76%	72%

DEFINITION :

Total number of individuals with developmental disabilities in residence at an RTC over 365 days on the last day of each fiscal year divided by the total number of individuals with developmental disabilities in residence at the facility on the last day of that fiscal year.

RATIONALE :

Individuals who remain in treatment over one year are often hard to discharge and represent a very difficult to treat population.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

Development of Waiver Service homes has reduced the number of individuals in residence at an RTC over 365 days.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on continued DD downsizing trends and Waiver Service development.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of community alternatives.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 3 : Decrease the percentage of RTC clients in residence over 365 days of admission.

Measure 2 : Percent of NF clients in residence over 365 days of admission to an RTC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of individuals in residence over 365 days						
Actual	156	145	127			?
Total number of individuals in residence						
Actual	209	189	187			
Percent in Residence over 365 Days						
Actual	75%	77%	68%			
Target				63%	58%	53%

DEFINITION :

Total number of NF clients in residence at an RTC over 365 days on the last day of each fiscal year divided by the total number of NF clients in residence at the facility on the last day of that fiscal year.

RATIONALE :

Individuals who remain in treatment over one year are often hard to discharge and represent a very difficult to treat population.

DATA SOURCE :

Human Services Information System (HSIS).

DISCUSSION OF PAST PERFORMANCE :

In the past, NF was considered a permanent placement.

PLAN TO ACHIEVE TARGETS :

Emphasize assessment acute stabilization and return to the community of NF clients. Assist community providers by providing behavioral and psychiatric consultation with difficult behaviorally disturbed clients.

OTHER FACTORS AFFECTING PERFORMANCE :

Lack of available community alternatives.

Goal 1 : To return individuals to the community with the ability to cope with their disabilities and to successfully function in society.

Objective 4 : Increase the percentage of psychopathic personality clients participating in sex offender treatment programs.

Measure 1 : Percent of psychopathic personality clients participating in sex offender specific psychopathic personality program components during a one-week sample.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Clients attending sex offender therapy						
Actual	28	33	31			
Total Number of clients in residence						
Actual	57	60	52			
Percent Attending Therapy						
Actual	49%	55%	60%			
Target				62%	65%	67%

DEFINITION :

Total number of psychopathic personality clients attending sex offender therapy group during the week of assessment, each fiscal year, divided by the total number of PP clients in residence during that week. (Third week of May each year.)

RATIONALE :

Participation rate reflects active treatment.

DATA SOURCE :

PP program evaluation staff.

DISCUSSION OF PAST PERFORMANCE :

Clients were less likely to attend sex offender therapy as part of their treatment since there was a Supreme Court decision pending regarding the constitutionality of the PP commitment statute.

PLAN TO ACHIEVE TARGETS :

Continue offering sex offender therapy to all clients.

OTHER FACTORS AFFECTING PERFORMANCE :

The political/legal environment's influence on clients' hope of successful legal appeal.

Goal 2 : To reduce the need for admission to a regional treatment center.

Objective 1 : Increase the percentage of disabled individuals remaining in own home or other community setting.

Measure 1 : Percent of individuals with developmental disablies remaining in the community after 90 days of initial contact with community support services.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent Remaining in Community						
Actual	95%	95%	95%			
Target				97%	97%	97%

DEFINITION :

Total number of individuals with developmental disablies (DD) remaining in the community after 90 days of initial contact with community support services, each fiscal year, divided by the total number of individuals with DD receiving community support services between the beginning of the fourth quarter of the previous fiscal year through the end of the third quarter of the current fiscal year being measure.

RATIONALE :

If community support services are effective, admission to an RTC should be minimized.

DATA SOURCE :

Crisis Intervention Teams.

DISCUSSION OF PAST PERFORMANCE :

With the development of Community Support Services operated out of the RTCs, overall RTC DD admissions have decreased, and community capacity to serve individuals with DD has increased.

PLAN TO ACHIEVE TARGETS :

In the development of the Minnesota Extended Treatment Options (METO) program and statewide coordination of Community Support Services, we will be revising performance indicators in accordance with the new service model.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of community alternatives.

Agency : HUMAN SERVICES DEPT

Program : CONT CARE & COMM SUPP GRANTS

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$1,930,509	41.77%
From Federal Funds	$973,541	
From Special Revenue Funds	$61,328	
General	$895,623	
From Gift Funds	$17	
Number of FTE Staff:	32	0.53%

GOALS :

- To slow the growth of long-term care costs. (Minnesota Statutes 256, Minnesota Statutes 256B, Minnesota Statutes 256B.41, Minnesota Statutes 256E)

- To serve most medically needy first. (Minnesota Statutes 256B)

- To support persons in our target population in living as independently as possible. (Minnesota Statutes 237.50, Minnesota Statutes 254A, Minnesota Statutes 254D, Minnesota Statutes 256.971, Minnesota Statutes 256.975-977, Minnesota Statutes 256B.0911-.0916, Minnesota Statutes 256I)

- To reduce the negative effects on individuals, families, and communities due to behavioral, physical, and emotional disorders. (Minnesota Statutes 254A, Minnesota Statutes 254B, Minnesota Statutes 256E)

DESCRIPTION OF SERVICES :

A major desire for elderly, vulnerable and disabled individuals is to be safe, to live independently when possible and, when not possible, in places that are clean, friendly and caring, and to receive assistance in their communities close to friends and relatives.

The purpose of this service area is to fulfill that goal for the elderly, vulnerable and disabled when they need public assistance to pay for continuing care services like nursing homes, home care, mental health care, chemical dependency treatment and deaf and hard of hearing services.

Continuing care and community support strategies is composed of various grants. With these grants:

*Money is given directly to individuals to buy the services they need to stay independent; equipment or information is provided directly to individuals with the same goal in mind;

*Money is given to counties to purchase services for people or to develop the kind of services that keep people independent and out of institutions;

*Money is paid directly from the state to service providers for services rendered, including, when appropriate, long term residential care.

The specific grants in this service area are:

*Aging and Adult Services - Funding is provided to keep seniors independent through congregate dining and home delivered meals; Retired and Senior Volunteer Program (RSVP), Foster Grandparents Program, and Senior Companion program. Funding for these grants comes primarily from the federal Older Americans Act, with some supplemental state funds for congregate dining and home delivered meals, and from the Corporation for National and Community Services funded volunteer program.

*Alternative Care Grants - Funding is provided to seniors who have very little money and are at risk of going onto Medical Assistance (MA) to keep them independent and living in their homes for as long as it makes physical and financial sense. Alternative Care Grants are 100% state funded with counties acting as agents to provide direction to participants and providers.

*Chemical Dependency Entitlement Grants - Pay for chemical dependency treatment (fee-for-service payment) through the Consolidated Chemical Dependency Treatment Fund for individuals who are eligible for Medical Assistance or who meet the MA income limits.

*Chemical Dependency Non-Entitlement Grants - Pay for chemical dependency treatment (fee-for-service basis) through the Consolidated Chemical Dependency Treatment Fund for individuals who are not covered by the Chemical Dependency Entitlement Grants and whose income does not exceed 60% of the state median income who are pregnant, adolescent, or parents with minor children in the housheold. Non-Entitlement Grants also provide funds to American Indian Tribes and other organizations for prevention, education and training, intervention, assessment, and referral of American Indians; grants to local agencies and counties for prevention services, case management and other services for chronic alcoholics; detox transportation; research and evaluation, intervention with drug abusing pregnant women and services for children who abuse inhalants. Non-Entitlement Grants also receive funds from the federal Substance Abuse Prevention and Treatment Block Grant.

*Community Social Services Act (CSSA) - Funding is used by counties to prevent out of home placement for children; prevent chemical dependency among youth; supplement mental health services for children and adults; supplement child care or encourage its development; provide additional supports for developmentally disabled individuals to live in the community; and provide different, less formal supports for the elderly. CSSA funding includes state dollars and federal Title XX monies that are combined in a block grant to counties. Each county is required to levy an amount for social services at least equal to its CSSA allocation.

*Consumer Support Grants - Funding is provided to individuals and families to purchase what they need to help them live independently. This direct method of service funding enables consumer control over how and by whom supports are provided. Consumer Support Grants are funded entirely with the State's share of the cost of service(s) the consumer was receiving through their original/previous program.

*Deaf and Hard of Hearing Grants - There are three types of Deaf and Hard of Hearing Grants: Interpreter Referral Grants ensure access to services for deaf and hard of hearing individuals; Specialized Mental Health Services Grants are awarded to community based vendors to provide specialized mental health services to deaf and hard of hearing individuals and their families, enabling one-on-one therapy without the aid of an interpreter; and, Services to Persons with Deafblindness Grants are awarded to community based providers serving persons with deafblindness to provide specialized services to individuals and their families in gaining and maintaining

self-sufficiency.

*Developmental Disabilities Community Support Grants - Two programs are funded with Developmental Disabilities Community Support Grants: Semi-Independent Living (SILS) Grants program provides funds to enable persons with mental retardation or related conditions to live more independence in their communities by training individuals in money management, meal preparation, shopping, personal hygiene and other activities which are needed to support and improve a person's capability to live in the community; and Family Support Grants program enables families to purchase services and items above the ordinary care for their child's support in the home to prevent or delay the out-of-home placement of their child and to maintain their child in the family home.

*Group Residential Housing - This activity is charged with developing and administering the funding of housing supports, including the cooperation of service funding, in community settings as an alternative to institutional placement. This is primarily a state funded program.

*Medical Assistance Long Term Care Facilities - This activity funds over 1,000 long-term care facilities whose payment rates are established annually by the Department of Human Services. This includes nursing homes, intermediate care facilities for persons with mental retardation or related conditions (ICF/MR), and day training and habilitation services. Medical Assistance pays for these services for individuals who cannot afford them.

*Medical Assistance Long Term Care Waivers and Home Care - Funding is provided through Medicaid state plan and Waiver Programs to provide cost effective alternatives to institutional care for individuals in need of long-term care. These programs include Medical Assistance (MA) Home Care, Community Alternative Care (CAC) program, Community Alternatives for Disabled Individuals (CADI), Elderly Waiver Program, Traumatic Brain Injury Waiver (TBIW), Home and Community-Based Services for Persons with Mental Retardation and Related Conditions Waiver, and Alternative Community-Based Services Waiver.

*Mental Health Grants - State and Federal dollars are used to serve Minnesotans with mental illness, to spur development of non-institutional treatment options, to pay for mental health services for children and adults when they cannot afford to pay, and to set overall policy related to mental health services received by enrollees in publicly funded programs.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
OD	FY	Projected number of Minnesota seniors (ages 65+) - from the US Census Bureau	572,746	576,319
O	FY	Average monthly number of Medicaid-funded seniors residing in nursing homes.	27,029	27,707
O	FY	Average monthly number of Medicaid-funded seniors receiving elderly waiver services.	4,120	4,729
O	FY	Average monthly number of Medicaid-funded seniors receiving non-waiver services.	17,627	16,685

O	FY	Average monthly number of state-funded seniors receiving Alternative Care services.	5,214	6,312
UC	FY	Average monthly cost per senior recipient for Medicaid-funded nursing home care .	$2,490	$2,337
UC	FY	Average monthly cost per senior recipient for Medicaid-funded non-waiver services.	$652	$829
UC	FY	Average monthly cost per senior recipient for state-funded Alternative Care.	$491	$450
UC	FY	Average monthly cost per senior recipient for Medicaid-funded elderly waivered services.	$366	$390
E	FY	Nursing home occupancy rate (from LTC Facilities Report - 1994 & 1995)	95.3%	95.5%
O	FY	Number of pre-admission screenings conducted of Minnesota seniors.	22,289	23,330
O	FY	Percent of pre-admission screenings of seniors resulting in Nursing Home placements.	73%	72%
O	FY	Percent of pre-admission screenings of seniors resulting in Alternative Care placements.	14%	16%
O	FY	Percent of pre-admission screenings of seniors resulting in other care/no care.	13%	12%
O	FY	Number of adults with serious and persistent mental illness (SPMI) receiving publicly funded services	26,500	26,500e
O	FY	Number of adults with mental retardation or related condition receiving home- and community-based services.	4,102	4,802
O	FY	Number of children with serious emotional disturbances (SED) receiving public services.	25,500	26,000e
O	FY	Number of children with mental retardation or related condition receiving home- and community-based services.	617	701
O	FY	Number of individuals at risk of Medical Assistance (MA) paid institutional care, receiving home care or waiver services. (CAC, CADI, TBIW)	2,333	2,507
A	FY	Number of home delivered meals served to older persons, statewide.	1,674,942	1,684,049
A	FY	Number of persons served home delivered meals, statewide.	18,413	18,344
A	FY	Number of Senior Companion, Foster Grandparent and RSVP volunteers.	19,710	19,845
A	FY	Number of Senior Companion, Foster Grandparent, and RSVP volunteer service hours.	3,141,813	3,192,800

PROGRAM DRIVERS :

Since this is a collection of grant activities to promote community living and continuing care for the elderly, vulnerable, and disabled, each activity has its own history. However, the trends in all service areas are similar and have a lot to do with several of the Department's core values.

*People, not programs. In Continuing Care and Community Support Strategies, a greater emphasis over time has been on people's needs rather than program needs. For example, people with chemical dependency used to get placed in a treatment setting that was based more on what Medical Assistance would pay for than what their clinical needs were. This has changed, with money being pooled from various treatment sources and following the client to the more appropriate level of care. Alternative Care Grants grew up in response to seniors' desires to avoid Medical Assistance's rigidity when they need a little extra help to live at home. And the same people focus is guiding the experiment of providing grants directly to people and their families to purchase services without any government intermediaries.

*The common good. It would be easy to continue to do business as usual for the elderly and disabled. However, it would not be wise. If nothing is done, the current pace of spending for the Medical Assistance long term care alone would be a major contributor to health care costs exceeding available state revenue. Alternatives at that point would include dramatic cutting of eligibility with ironically fewer elderly and disabled being served at greater cost, eliminating most state government functions, dramatic tax increases or all three. The bottom line is that for the common good of all Minnesotans, to keep these services viable, we have to be bold now in figuring out different ways to purchase services for elderly and disabled. Broadly speaking, proposed changes in these service grants in this area are part of a strategy that fits the overall Health Care Initiative Priority to use the marketplace to give people choices and get good prices for taxpayers.

Mobilizing communities to help people function and succeed. Continuing Care and Community Support Grants are only one part of the equation of community living and community care. Families, churches, civic groups and friends are resources that government assistance can never replace. A trend within all these service strategies is to include and complement these natural human resources so that decisions and control can be closest to the individual and those who love him or her.

New state allocations, NAPISTrak implementation, and new contracting system.

Operating in a cross-cultural environment, the need for increased services to persons who are hard of hearing.

The need for increased independent living and long-term community services, requests for training on Deaf culture, the Americans with Disabilities Act (ADA).

There will be a 10% reduction in Minnesota's allotment for Title XX in the second year of the biennium. The source of community social services has been transferred from the local government trust fund to the state general fund.

The development of local multi-county initiatives to enhance/expand the community-based mental health delivery system to provide clients with a range of services as close to their home community as possible.

Children's Mental Health Collaboratives and Integrated Children's Mental Health fund give local authorities the flexibility to pool funds when necessary to serve a child's individual needs.

The Home and Community-Based Services waiver for persons with mental retardation and related conditions provides a resource to support people in their family homes, own homes, or other community settings. The waiver allows for flexible and creative service options to individuals who need a twenty-four hour plan of care and would be at risk of ICF/MR placement without waivered services support. The waiver provides a

mechanism for using federal and state funds to purchase services to prevent placements in state regional treatment centers and enables persons living in community ICFs/MR and regional treatment centers to move into community settings with individualized services. The legislature in 1995 authorized an alternative allocation structure for new waivered services recipients. The alternative allocation structure was designed to improve access to funding by allowing allocation of dollars to county agencies based on the need levels of the persons to be served; combined state and county managed waivered service programs for county management with greater flexibility and ability to meet changing consumer needs; streamlined and simplified administrative procedures; and gave greater latitude and decision-making support to the county agencies.

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), including state-operated regional treatment centers, continue to downsize and close. This activity is due partially to the availability of home and community-based waivered services. Also, the availability of community-based crisis and support services provide emergency supports to individuals, families, and service providers while decreasing the need for ICF/MR services and commitments to regional treatment centers.

Minnesota's elderly population continues to grow. At the same time, the costs of long-term care, including nursing home and community alternative care, grow. Therefore, MA LTC grants play a significant role in the department's Health Care Priority Initiative. A major push of the department and this service area is to develop better ways of purchasing care that are oriented toward performance and doing right by elderly residents and their families. Without a new approach which involves consumer feedback and invests in lower cost alternatives, long-term care will be the major contributor to health care costs, outstripping the state's total revenue by 2021.

Last year DHS began an important strategy in nursing facility care: contracting with nursing homes to set their payment rates. This contracting is less process prescriptive and its intent is to become more outcome-focused.

Alternative Care Grants (ACG) are a strategy that fits the overall Health Care Initiative Priority by providing cost-effective, consumer choices in long-term care. ACG reduce the overall tax burden paid by taxpayers. Because ACG pays for services that are less expensive than nursing home care, overall tax dollars that would have included state and federal funds are reduced. It makes more consumer sense and is less expensive to the taxpayer overall, but with 100% state funding, the state does pays full cost.

The expansion of prepaid plans has had only a modest effect on Consolidated Chemical Dependency Treatment Fund expenditures because, even in those counties where the transition to managed care is complete, the majority of Medicaid clients still receive CD treatment on a fee-for-service basis. This occurs because the initial 1 to 3 months of MA eligibility is paid for as fee-for-service; furthermore, any disruption of eligibility results in disenrollment from a prepaid plan. Any anticipated offset associated with prepaid plan enrollment would also apply only to the 61% of CCDTF expenditures spent on covered services (primary treatment).

The caseload for persons needing CD treatment has also increased over recent years, with no signs yet of leveling off. This increase is associated almost exclusively with cocaine abuse/dependence.

Goal 1 : To slow the growth of long-term care costs.

Objective 1 : Ensure that, for Minnesota seniors receiving publicly funded continuing care services, the average cost for community alternative care remains below the average cost of nursing home care, and as far below as possible for maximum cost-effectiveness.

Measure 1 : Community cost as a percentage of nursing home cost

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of cost						
Actual	24%	23%	29%			
Target				28%	30%	32%

DEFINITION :

Ratio of the monthly average cost per recipient for Minnesota seniors (defined as residents ages 65 and over) in community settings to the monthly average cost per recipient for nursing homes. A ratio of 100% means the average cost for the two settings is equal, and a ratio of 30% means the average cost of services for community residents is 30% of the average nursing home cost.

RATIONALE :

Community alternative services should meet their goal of being less costly than institutional settings, which usually include people with higher (and more costly) medical needs. Each program has a limit tied to the average nursing home cost: Alternative Care dollars per recipient must be less than 75% of the average nursing home cost per recipient and Elderly Waiver dollars per recipient must be less than 100% of the average nursing home cost per recipient.

DATA SOURCE :

MMIS, Encounter Data

DISCUSSION OF PAST PERFORMANCE :

Though this difference varies by service package, overall the cost of community-based alternative services is significantly lower than the cost of nursing homes.

PLAN TO ACHIEVE TARGETS :

Targets are based on projections from budget forecasts.

OTHER FACTORS AFFECTING PERFORMANCE :

Goal 2 : To serve most medically needy first.

Objective 1 : Use nursing home services only when necessary, and to use other less costly service options for those who are less needy.

Measure 1 : Average nursing home case mix weighted by resident day.

	F.Y.1991	F.Y.1992	F.Y.1993	F.Y.1994	F.Y.1995	F.Y.1996
Average case mix.						
Actual	2.36	2.38	2.41	2.44	2.45	na

DEFINITION :

Average case mix (weighted by resident day) for nursing homes statewide.

RATIONALE :

A department goal is for nursing homes to serve the most medically needy and for more independent persons to use less restrictive, community-based services. Changes in the average case mix indicate whether nursing home resources are being increasingly focused on those with the most need and least independence.

DATA SOURCE :

Long Term Care Facility Profiles; Impact of Case Mix Report (1995)

DISCUSSION OF PAST PERFORMANCE :

The increase in average case mix demonstrates the increasing service needs of people residing in nursing facilities. The amount of assistance that residents need with activities of daily living (such as dressing, bathing, grooming, eating, and toiletry) has increased over time. Fewer people have 0 to 3 dependencies and more people have 4 or more dependencies (comparing 1988 through 1994 data).

PLAN TO ACHIEVE TARGETS :

As community alternatives are developed for those seniors who are less medically needy, the department anticipates that this measure will increase; however, projections are not available.

OTHER FACTORS AFFECTING PERFORMANCE :

The measure of average case mix does not include the nursing homes participating in the Nursing Home Contracting pilot project.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 1 : Increase the percentage of adults with identified needs who are receiving community-based services.

Measure 1 : Percent of adults with serious and persistent mental illness (SPMI) who are receiving community support services.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of SPMI Adults						
Actual	34%	35%	NA			
Target				35%	36%	37%

DEFINITION :

The number of adults with SPMI who receive community support services is divided by the total number of adults with SPMI who are enrolled in the system of care.

The 30% target for community support services is a national standard (Healthy People 2000).

RATIONALE :

The state's principal strategy for assisting adults with SPMI in maintaining independent living in the community is through the provision of community support services. State law mandates provision of certain types of community support services in each county, such as medication monitoring and crisis assistance. Counties are also encouraged, and in some areas funded, to provide highly individualized support services.

DATA SOURCE :

The Community Mental Health Reporting System (CMHRS).

DISCUSSION OF PAST PERFORMANCE :

The state implemented community support services in the early 1980's and already exceeds national targets for this objective.

PLAN TO ACHIEVE TARGETS :

Continue current base funding for community support services, and increase use of regional treatment center (RTC) staff in providing these services.

OTHER FACTORS AFFECTING PERFORMANCE :

Achievement of this objective will in part depend on funding for special projects that enhance or expand the community service system and shift RTC non-fiscal resources from inpatient care to community support services. Dedicated (categorical) funds for these services are not expected to increase.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 1 : Increase the percentage of adults with identified needs who are receiving community-based services.

Measure 2 : Percent of adults with mental retardation or related conditions receiving home and communitiy-based services (MR/RC and ACS Waivers).

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of MR/RC adults						
Actual	NA	NA	30%			
Target				32%	33%	35%

DEFINITION :

Persons over the age of 18 receiving home and community-based services for persons with mental retardation or related conditions (MR/RC and Waiver) and alternative community-based services for persons inappropriately placed in nursing homes (ACS Waiver) divided by the total number of adults with mental retardation or a related condition.

RATIONALE :

Persons receiving services in the community are more likely to have a more intensive and valuable natural support system that will enhance the lives of the consumers and prevent more costly institutional placements.

DATA SOURCE :

MMIS II and the Developmental Disabilities Division waivered services tracking system.

DISCUSSION OF PAST PERFORMANCE :

The MR/RC and ACS Waivers have been effective vehicles for preventing institutional placements and/or ending institutional placements in a manner that is both cost effective for the state and quality enhancing for the person.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current level of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

Personal choice for waivered services versus ICF/MR services.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 2 : Increase the percentage of children/families with identified needs who are receiving community-based services.

Measure 1 : Percent of children with serious emotional disturbance (SED) who are receiving family community support services or home-based services.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of children						
Actual	9%	11%	NA			
Target				NA	12%	13%

DEFINITION :

The number of children with SED who receive family community support services or home-based services is divided by the total number of children with SED who are enrolled in the system of care.

RATIONALE :

The state's principal strategy for assisting children with SED in living at home with their families is through the provision of family community support services and home-based services. State law mandates provision of certain types of family community support services and home-based services in each county, such as crisis assistance and home-based treatment.

DATA SOURCE :

The Community Mental Health Reporting System (CMHRS).

DISCUSSION OF PAST PERFORMANCE :

These services were initiated in 1989 and in most counties have not yet reached their potential. However, radical growth in the services is not expected without additional funding.

PLAN TO ACHIEVE TARGETS :

Continue current base funding for family community support services. Integrate children's services funding within local children's mental health collaboratives, providing larger and more flexible sources of funds for these services. Improve coordination among state agencies in planning and monitoring services to children. Implement early identification of emotional disturbance among children entering the correction system. Expand children's mental health collaboratives to more counties.

OTHER FACTORS AFFECTING PERFORMANCE :

Achievement of this objective will in part depend on continued and increased funding for children's mental health collaboratives and the ability of these collaboratives to integrate children's funds.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 2 : Increase the percentage of children/families with identified needs who are receiving community-based services.

Measure 2 : Percent of children with mental retardation or related conditions receiving home and community-based services.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of MR/RC children						
Actual	NA	NA	14%			
Target				17%	20%	23%

DEFINITION :

Children under the age of 18 with mental retardation or related conditions receiving home and community-based services for persons with mental retardation or related conditions (MR/RC Waiver) divided by the total number of children with mental retardation or a related condition.

RATIONALE :

Children receiving services in the community are more likely to have a more intensive and valuable natural support system that will enhance the lives of the consumers and prevent more costly institutional placements.

DATA SOURCE :

MMIS II and the Developmental Disabilities Division waivered services tracking system.

DISCUSSION OF PAST PERFORMANCE :

The MR/RC Waiver has been an effective vehicle for preventing institutional placements and/or ending institutional placements in a manner that is both cost effective for the state and quality enhancing for the person.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current level of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

Personal choice for waivered services versus ICF/MR services.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 3 : Increase the percentage of children and adults, with identified health care needs at risk of Medical Assistance (MA) paid institutional care, receiving home and community-based services.

Measure 1 : Percent of disabled individuals who utilize home care and disabled waiver services to support community living.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of individuals						
Actual	45%	50%	52%			
Target				53%	55%	57%

DEFINITION :

The average monthly number of disabled individuals under the age of 65 using MA home care or disabled waiver services divided by those recipients (using MA home care or disabled waiver services) plus the average monthly number of individuals on MA under the age of 65 in nursing homes.

For purposes of this measurement, home care recipients are limited to those individuals who utilize Personal Care Attendant and/or Private Duty Nursing services and have a home care rating that is commensurate with being at risk of the level of care provided in a nursing facility or hospital (i.e., a "Q" rating or above). Disabled waivers in this measurement includes Community alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), and Traumatic Brain Injury (TBI) Waivers.

People who use these services include individuals with spinal cord injuries, developmental disabilities, brain injury, chronic cardiac, respiratory,or neurologic conditions, and so forth. Many of these individuals have long-term health care needs and will require on-going supportive care. The total population of persons with disabilities rises each year.

RATIONALE :

This measure tracks the proportion of disabled children and adults (under the age of 65) using home care and waiver services in the community in lieu of institutional alternatives.

DATA SOURCE :

MMIS II and DHS forecast. Due to a system change, home care data for 1994 and 1995 represent 11 and 13 months, respectively.

DISCUSSION OF PAST PERFORMANCE :

Growth in home care and waiver services are expected and encouraged as it: (1) is a cost effective alternative to institutionalization; (2) allows the state to continue the nursing facility moratorium established in 1983; and, (3) supports policy initiatives limiting the institutionalization of children and adults.

The number of persons served by disabled waivers has risen steadily. Growth of waivered services is projected to continue. Because waivers are not entitlement programs, an established number of individuals may be served. MA home care is an entitlement program. Any individual meeting the eligibility criteria may receive MA home care. There has been some fluctuation in the number of persons served by home care.

PLAN TO ACHIEVE TARGETS :

Prior to entering a nursing facility, individuals are screened by the local county agency. Whenever possible community based services are offered as an alternative to institutionalization. DHS staff provide technical assistance to counties and vendors to build local community capacity.

OTHER FACTORS AFFECTING PERFORMANCE :

State and federal regulations regarding eligibility; state budget; the identified number of individuals to be served on waivers; and, limited service availability in certain areas of the state.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 4 : Decrease the rate of out-of-home placements among children with serious emotional disturbances (SED).

Measure 1 : Number of children with severe emotional disturbance placed in residential treatment per 10,000 population.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Rate per 10,000						
Actual	16.8	17.2	N/A			
Target				17.0	17.0	16.8

DEFINITION :

Out-of-home settings for children with SED are defined as psychiatric hospitalizations (including RTCs), residential treatment facilities (Rule 5), foster care, group homes, and corrections. Not included are living with biological parents, relatives, legal guardians, adoptive parents, respite care. Children receiving mental health treatment in residential treatment facilities (Rule 5) are the focus under this measure.

RATIONALE :

Many children with SED experience mental health crises or problems at home that require hospitalization (intensive treatment) or other forms of institutional care, or some other form of out-of-home placement. Research shows that these placements can be minimized with adequate child and family support services, home-based treatment services, and collaborative relationships among local agencies serving children (mental heath, corrections, schools, etc.). Collaboratives will include integrated funding that permits greater flexibility in service delivery options.

DATA SOURCE :

Community Mental Health Reporting System.

DISCUSSION OF PAST PERFORMANCE :

There continues to be a perceived need for residential treatment services for children, as community and home alternatives are still insufficient in most counties. The trend in utilization was slightly upward in 1994 and 1995. Collaboratives have just began to form and to deliver services.

PLAN TO ACHIEVE TARGETS :

Continue support to counties to increase the use of home-based treatment services and family community support services. Implement children's collaboratives that integrate funds across local agencies serving children. Implement focused programs to divert adolescents with SED and violent behavior from out-of-home placement.

OTHER FACTORS AFFECTING PERFORMANCE :

Improved "case-finding," through services such as outreach services, results in more children with SED entering the system. This increase in caseload size tends to drive use of all treatment alternatives, including out-of-home placements, upward. Collaboratives may not have a noticeable statewide impact on out-of-home placement for several years. Courts must begin to recognize the effectiveness of alternatives to out-of-home placement, and to reduce such placements.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 5 : Decrease the percentage of Minnesota seniors who require publicly funded continuing care services.

Measure 1 : Percent of Minnesota seniors who receive publicly funded continuing care services.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of seniors						
Actual	9%	9%	10e%			
Target				10%	10%	10%

DEFINITION :

The average monthly number of Minnesota seniors (defined as residents age 65 and over) receiving publicly funded continuing care services (Alternative Care state-funded services and nursing home, Elderly Waiver, or non-waiver Medicaid funded services) divided by the total number of Minnesota seniors.

RATIONALE :

This measure ties directly to the core value of keeping people in community whenever possible, and of using public funding for the most medically needy people. It tracks the proportion of seniors who are able to use informal community supports rather than assessing public funding.

DATA SOURCE :

MMIS, Encounter Data, US Census Bureau

DISCUSSION OF PAST PERFORMANCE :

PLAN TO ACHIEVE TARGETS :

Targets are based on projections from budget forecasts.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 6 : Increase the percentage of Minnesota seniors, who require publicly funded continuing care services, living in community settings rather than in nursing homes.

Measure 1 : Percent of Minnesota seniors receiving publicly funded continuing care services who live in a community setting rather than a nursing home.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of seniors						
Actual	46%	50%	50e%			
Target				51%	52%	53%

DEFINITION :

Of the Minnesota seniors receiving publicly funded continuing care services, the percentage who do not live in a nursing home.

RATIONALE :

This measure ties directly to the core value of keeping people in the community whenever possible. It tracks the proportion of people who are able to live in the community cost-effectively and feasibly with public funding rather than being supported in higher-cost institutions.

DATA SOURCE :

MMIS, Encounter Data

DISCUSSION OF PAST PERFORMANCE :

PLAN TO ACHIEVE TARGETS :

Targets are based on projections from budget forecasts.

OTHER FACTORS AFFECTING PERFORMANCE :

The proportion of seniors in the community might decrease if the Department succeeds at increasing the number of seniors who develop natural supports in their communities that postpone or prevent their needing publicly funded continuing care services.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 7 : Decrease the number of persons who score "high" on the nutritional risk assessment.

Measure 1 : Number of persons at high nutritional risk, in both congregate and home-delivered meal programs.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of persons						
Actual	NA	NA	NA			
Target				30,687	30,380	29,772

DEFINITION :

Number of participants in congregate and home delivered meals program who scored "high" on the nutrition risk assessment.

RATIONALE :

Good nutrition is a health prevention strategy for older people in both congregate and home delivered programs. Starting in 1997, all participants in the nutrition program will be given a nutritional risk assessment at least annually. Nutrition providers can gauge the impact of the nutrition program on participants over a period of two years. According to a survey done of nutrition program participants in a significant part of Minnesota (1994), 27% of participants scored "high" on the risk assessment scale. Starting with a 27% of current participants as a baseline, the number of "high" risk participants will be lowered. Baseline may need adjustment after the risk assessment instrument is applied to the total population in 1997.

DATA SOURCE :

NAPISTrak

DISCUSSION OF PAST PERFORMANCE :

Not applicable.

PLAN TO ACHIEVE TARGETS :

Increase nutritional support services, like nutrition counseling, to improve scores of participants on the risk assessment.

OTHER FACTORS AFFECTING PERFORMANCE :

Information gathering is based on full and accurate implementation of NAPISTrak.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 8 : Increase the number of low income minority persons served by the Older Americans Act.

Measure 1 : Number of low income minority persons who are served by the Older Americans Act.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Persons Served						
Actual	5,618	6,031	5,371e			
Target				6,151	6,274	6,336

DEFINITION :

Number of persons served who are under 100% of poverty and in a minority group.

RATIONALE :

Services are targeted to low income minority populations.

DATA SOURCE :

NAPISTrak. F.Y. 1996 estimate will increase when revisions for the month of June are complete. Targets are based on F.Y. 1995 data.

DISCUSSION OF PAST PERFORMANCE :

Service programs are given targets to meet for serving low income minorities. These targets remain in place and programs are showing progress.

PLAN TO ACHIEVE TARGETS :

Continue targeting services.

OTHER FACTORS AFFECTING PERFORMANCE :

Measurement has been done using a reporting system that duplicates the number of recipients. Using an established methodology, the numbers are unduplicated. Introduction and full implementation of NAPISTrak, a client registration system, will minimize this problem, however another baseline may need to be established.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 9 : Increase the percent of deaf and hard of hearing interpreter requests filled by qualified interpreters.

Measure 1 : Percentage of deaf and hard of hearing interpreter referral requests filled by qualified interpreters.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of requests						
Actual	95%	96%	96%			
Target				96%	96%	96%

DEFINITION :

Total number of interpreter referral requests that the program is able to fill divided by the total number of interpreter referral requests each fiscal year.

RATIONALE :

Interpreter requests have risen steadily since the inception of the Regional Service Center program and are expected to continue to rise as awareness of the Americans with Disabilities Act (ADA) expands. The ability to fill requests for qualified interpreters is a direct outcome of efforts to match needs of deaf consumers with appropriately qualified individuals and is also reflective of RSC resource development activities.

DATA SOURCE :

RSC Services Report maintained by the Deaf and Hard of Hearing Division

DISCUSSION OF PAST PERFORMANCE :

Interpreter referral requests have risen steadily since the inception of the RSC program.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on past trends in referral requests.

OTHER FACTORS AFFECTING PERFORMANCE :

While Minnesota has several interpreter training programs, most graduates lack the skills necessary for freelance interpreting upon graduation. There is an inadequate supply of qualified interpreters to meet the demand for services, especially in greater Minnesota. In addition, interpreters receiving referrals through the RSC and contracting agency work as independent contractors and, as such, set their own rates and are free to deny referrals at will. This fact, paired with the scarcity of qualified interpreters, often make it difficult to fill jobs with the most qualified interpreter available.

Goal 3 : To support persons in our target population in living as independently as possible.
Objective 10 : Increase the number of deaf, hard of hearing, speech impaired and mobility impaired Minnesotans of all ages receiving specialized telephone equipment which will enable them to access the telephone system.

Measure 1 : Number of individuals receiving telephone equipment.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of individuals receiving telephone equipment.						
Actual	2,046	1,783	1,876			
Target				1,900	1,900	1,900

DEFINITION :

The total number of eligible individuals receiving equipment through the equipment distribution program who report increased independence as a result.

RATIONALE :

Historically people who are deaf, hard of hearing, speech or mobility impaired have had inadequate access to the telephone system. By providing appropriate equipment and training on using the equipment, consumers will have equal access and independence

DATA SOURCE :

RSC Services Report maintained by the Deaf and Hard of Hearing Division

DISCUSSION OF PAST PERFORMANCE :

Program has served approximately 2,000 individuals per year.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

Many individuals who could benefit from services are isolated and may not have access to information about the services available to them. In some cases, technology is not available to meet the unique needs of some applicants. The program is also responsible to repair and maintain equipment that is distributed; as equipment ages, more staff time and resources are needed to manage equipment returns.

Goal 4 : To reduce the negative effects on individuals, families, and communities due to behavioral, physical, and emotional disorders.

Objective 1 : Improve family and community functioning among adults with behavioral, physical and/or emotional disorders.

Measure 1 : Increase abstinence from alcohol and other drugs following chemical dependency treatment.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent abstinent						
Actual	NA	74%	66%			
Target				70%	70%	70%

DEFINITION :

Abstinence is defined as no use of alcohol or other non-prescribed drugs during the 6-month period following discharge from chemical dependency treatment.

RATIONALE :

The primary goal of chemical dependency treatment is the cessation or reduction of alcohol and other drug abuse.

DATA SOURCE :

The Drug and Alcohol Abuse Normative Evaluation System (DAANES) and the Treatment Accountability Plan (TAP). DAANES includes a standard descriptive minimum data set on each treatment episode. TAP includes comprehensive supplementary data and a 6-month posttreatment follow-up interview on a subset of 30 clients from each Minnesota treatment program.

DISCUSSION OF PAST PERFORMANCE :

Posttreatment abstinence rates are influenced by the characteristics of the population admitted to treatment, and can be affected by factors such as age, substance use history and previous treatment admissions, severity of psychological distress, and social stability. Changes in eligibility for treatment affect the treatment population base. During the years follow-up data were collected by treatment providers, posttreatment abstinence rates ranged between 65% and 70%, but the data were limited because follow-up samples were not representative of the treatment population as a whole, and interviews conducted by treatment providers may have elicited socially desirable responses.

PLAN TO ACHIEVE TARGETS :

The Treatment Accountability Plan is expected to provide an empirical basis for improving favorable treatment outcomes by identifying which services are associated with the most positive outcomes for different kinds of clients. In order to achieve improved outcomes, the results of the findings will need to be incorporated into the assessment, treatment placement, and service delivery systems.

OTHER FACTORS AFFECTING PERFORMANCE :

As more private- and public-pay patients are enrolled in managed care organizations, increased use of outpatient treatment, reduced lengths of treatment stay, and other changes in services provided may have an impact on treatment outcomes; such factors are outside the control of treatment providers.

Goal 4 : To reduce the negative effects on individuals, families, and communities due to behavioral, physical, and emotional disorders.

Objective 2 : Improve family and community functioning among children/families with behavioral, physical and/or emotional disorders.

Measure 1 : Decrease illegal behavior among adolescents after chemical dependency treatment.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent reduction						
Actual	NA	NA	NA			
Target				NA	80%	80%

DEFINITION :

The decrease in illegal behavior will be measured by comparing the days involved in illegal activities for the 30-day period preceding the 6-month posttreatment follow-up interview with the days involved in illegal activities for the 30-day period preceding admission to treatment. Alcohol and drug use will not be defined as illegal activities for purposes of this measure. An 80% reduction in average days of illegal activity is anticipated.

RATIONALE :

Reduction in criminal activity and antisocial behavior is one of the societal benefits of chemical dependency treatment.

DATA SOURCE :

The Drug and Alcohol Abuse Normative Evaluation System (DAANES) and the Treatment Accountability Plan (TAP). DAANES includes a standard descriptive minimum data set on each treatment episode. TAP includes comprehensive supplementary data and a 6-month posttreatment follow-up interview on a subset of 30 clients from each Minnesota treatment program.

DISCUSSION OF PAST PERFORMANCE :

This measure was not available in the past. The adolescent component of the Treatment Accountability Plan is scheduled to start in the spring of 1997. Preliminary posttreatment data will not be available until FY 1998.

PLAN TO ACHIEVE TARGETS :

The Treatment Accountability Plan is expected to provide an empirical basis for improving favorable treatment outcomes by identifying which services are associated with the most positive outcomes for different kinds of clients. In order to achieve improved outcomes, the results of the findings will need to be incorporated into the assessment, treatment placement, and service delivery systems.

OTHER FACTORS AFFECTING PERFORMANCE :

As more private- and public-pay patients are enrolled in managed care organizations, increased use of outpatient treatment, reduced lengths of treatment stay, and other changes in services provided may have an impact on treatment outcomes; such factors are outside the control of treatment providers.

Agency : HUMAN SERVICES DEPT

Program : CONT CARE & COMM SUPP MGMT

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$25,966	0.56%
From Federal Funds	$8,883	
From Special Revenue Funds	$1,298	
General	$15,780	
From Gift Funds	$5	
Number of FTE Staff:	252	4.18%

GOALS :

- To promote the highest quality of life and quality of care for consumers of health and long term care services. (Minnesota Statutes 256.974)

- To increase consumers' ability to make informed choices about health and long term care. (Minnesota Statutes 256.974)

- To provide easy access to the full range of human services. (Minnesota Statutes 256.971)

- To assist local county human service agencies with the implementation and ongoing utilization of a client-focused outcome-based approach to service management. (Minnesota Statutes 256E.05)

DESCRIPTION OF SERVICES :

The Continuing Care and Community Support Management program supervises the administration of the Continuing Care and Community Support Grants and provides central office support for the State Operated Services programs. The primary functions of this program serve vulnerable adults, the elderly and citizens with developmental disabilities, deafness or hard of hearing, emotional disturbances, mental illness, chemical dependency and long-term care needs.

The Management program exists to ensure the effective and efficient management of the continuing care and community support programs administered by the department and operated at state and local levels. Management activities can be categorized as policy administration, operations, and direct and support services.

Continuing Care and Community Support Policy Administration: This activity exists to coordinate the

development and implementation of policies and plans for community services and continuing care programs. Responsibilities include setting standards for services, developing and implementing policies, developing and implementing rules and regulations, coordinating department programs with relevant federal agencies, and statewide planning. This activity includes such functions as development of a long-range strategy to meet the long-term care needs of persons who are elderly and disabled, coordinating development of CSSA plans by the counties, and implementation of the transition of some Regional Treatment Center services into the community.

Continuing Care and Community Support Operations: This activity provides the infrastructure for the Continuing Care and Community Support Grants. Responsibilities include developing, allocating and managing state and federal grant resources, managing contracts, monitoring and evaluating programs, and providing technical assistance to counties and grant recipients. This activity also includes such functions as resolution of rate appeals filed by nursing homes, intermediate care facilities for the mentally retarded and acute care hospitals and implementation of federal (OBRA) requirements relating to nursing facilities and persons with mental illness and developmental disabilities, including Pre-admission Screening (PAS) and Annual Resident Review (ARR).

Continuing Care and Community Support Direct Services: The Management program includes several unique , specialized functions:
* Regional Services Centers (RSCs) which serve as central entry points by which deaf and hard of hearing persons access community resources and the human services system;
* The Equipment Distribution Program (EDP) which provides funds for equipment, recurring expenses for equipment, and training for persons who are deaf, hard of hearing, speech impaired, or mobility impaired enabling their access to the telephone system;
* The Minnesota Commission Serving Deaf and Hard of Hearing People, which oversees a 15 member statewide advisory committee that advocates for their participation in and equal access to the full range of county and state services and programs;
* The Senior Agenda for Independent Living (SAIL), a major initiative designed to create a community-based paradigm for long-term care, maximizing the independence of frail and older adults and a cost-effective use of resources;
* The Minnesota Board on Aging (MBA) which is appointed by the Governor and is responsible for administration and implementation of the federal Older Americans Act; and
* The Office of the Ombudsman for Older Minnesotans which assists consumers in the resolution of complaints or disputes about their rights, quality of care, assess to care and access to government health care benefits.

This chapter provides goals, objectives and measures for determining the effectiveness and efficiency of Continuing Care and Community Support Management. Goals, objectives and measures for the grant programs themselves are in the chapter of Continuing Care and Community Support Grants.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR

Type	Based	Measure	1994-95	1995-96
O	FY	Number of complaints handled by the Office of the Ombudsman for Older Minnesotans	2,255	2,950
O	FY	Number of deaf and hard of hearing individuals served by the Regional Service Centers	42,199	43,084
O	FY	Number of deaf and hard of hearing individuals served by the Equipment Distribution Program	1,783	1,876

PROGRAM DRIVERS :

Health Care Reform: The overall health care system is changing in structure, financing and delivery based on legislative reforms and market changes driven by health care purchasing at both the national and state levels.

As federal devolution occurs, more demand will be placed on staff, computer systems and othe management services to design new programs, to understand how changes will affect people, and to cope with stress and uncertainty.

There will be a 10% reduction in Minnesota's allotment for Title XX in the second year of the biennium. The source of community social services funding has been transferred from the local government trust fund to the state general fund. Reduction in federal funds will put more pressure on state funding or reduce the resources available at the local level.

Minnesota's elderly population continues to grow. At the same time, the costs of nursing home care grow. A major interest of the department and its long-term care programs is to develop better ways of purchasing care for the elderly population. Without a new approach--one that results in cost-effective options for the state and for consumers and that invests in lower cost alternatives--nursing home care will be the major contributor to health care costs outstripping the state's total revenue by 2021.

Technology has become critical to the most basic functioning of the department. Technology has grown to meet a rising workload and to meet rising customer expectations for quick, accurate transactions and information. As policies change, reprogramming is a given. The department must plan for changes in the technological supports required for these programs.

New privacy/data practices issues continue to be raised with the advent of new technolgies, such as e-mail and systems across agencies and jurisdictions. Technology in some cases is moving faster than the law that governs it.

As resources become more restricted, the success of community services and continuing care programs may depend on developing and managing the roles of volunteers in serving Minnesotans in need.

Goal 1 : To promote the highest quality of life and quality of care for consumers of health and long term care services.

Objective 1 : To investigate and resolve consumer complaints about their health, safety, welfare, and rights.

Measure 1 : Percentage of complaints resolved to the consumers' satisfaction

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percentage of complaints resolved.						
Actual	78%	80%	89%			
Target				90%	90%	90%

DEFINITION :

Percentage of the total complaints handled which result in an improvement in care, services or quality of life as desired by the consumer.

RATIONALE :

Ombudsman complaints cover a variety of consumer concerns including matters that are not regulated and complaints that are not against a health provider. Consumers determine the outcome desired as a result of ombudsman intervention and whether or not the outcome has been achieved.

DATA SOURCE :

NORS/RASCAL database

DISCUSSION OF PAST PERFORMANCE :

Complaint resolution rates have been tracked since 1991. The successful resolution rate has increased each year.

PLAN TO ACHIEVE TARGETS :

Maintain ombudsman training/skill development. Maintain high level of consumer involvement in complaint resolution process.

OTHER FACTORS AFFECTING PERFORMANCE :

Major changes in standards for care and rights may make it more difficult to resolve consumer complaints.

Goal 2 : To increase consumers' ability to make informed choices about health and long term care.

Objective 1 : Increase the number of persons receiving education or consultation through the ombudsman program.

Measure 1 : Number of persons receiving education and consultation through the ombudsman program.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of persons						
Actual	23,631	30,475	27,242			
Target				28,604	28,604	28,604

DEFINITION :

The total number of persons given individual assistance or educational service.

RATIONALE :

Consumers who understand the delivery system and are aware of quality care standards will be more selective in choosing among providers and more assertive in their expectations for quality care and services.

DATA SOURCE :

NORS/RASCAL database

DISCUSSION OF PAST PERFORMANCE :

The ombudsman program maintains an on-going educational program offering 400-500 sessions each year. The number of sessions provided and thus participants has decreased as the number of complaints requiring resolution increased.

PLAN TO ACHIEVE TARGETS :

Increase use of volunteers. Increase program efficiency through NORS/RASCASL management information system.

OTHER FACTORS AFFECTING PERFORMANCE :

Increases in the number of complaints which need resolution may reduce the resources available for educational activities.

Goal 3 : To provide easy access to the full range of human services.
Objective 1 : Build the capacity of human service providers to serve deaf and hard of hearing persons.

Measure 1 : Number of individuals and agencies receiving training to serve deaf and hard of hearing people.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of individuals receiving technical assistance						
Actual	7,709	8,120	6,858			
Target				7,000	7,000	7,000
Number of agencies receving technical assistance						
Actual	796	1,055	983			
Target				1,000	1,000	1,000

DEFINITION :

Total number of participants and agencies in division sponsored training.

RATIONALE :

The Hearing Impaired Services Act (HISA), M.S. 256c, established the RSCs as a central entry point for deaf and hard of hearing individuals in need of assistance with accessing the statewide human services system. HISA also mandates the DHS to strengthen state and local services to deaf and hard of hearing people. The RSCs provide technical assistance and training as a means to build the capacity of local providers to meet the unique service needs of deaf and hard of hearing people.

DATA SOURCE :

RSC Services Report maintained by the division.

DISCUSSION OF PAST PERFORMANCE :

The program has generally trained 4,000-5,000 persons annually and has provided technical assistance to a minimum of 700 agencies per year.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

The division has no legal authority to mandate agencies to provide appropriate services to deaf or hard of hearing people.

Goal 4 : To assist local county human service agencies with the implementation and ongoing utilization of a client-focused outcome-based approach to service management.

Objective 1 : Increase the number of local county human service agencies demonstrating, through documentation, a working knowledge of a client-focused outcomes-based framework.

Measure 1 : Number of county agencies demonstrating a working knowledge of a client-focused outcomes-based evaluation framework.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of counties						
Actual	NA	NA	NA			
Target				37	44	53

DEFINITION :

The total number of local county human service agencies submitting an annual Community Social Services Act (CSSA) progress report which includes client focused outcomes and indicators (measures) that meet CSSA guideline criteria.

RATIONALE :

In order to effectively implement a client focused outcomes based social services delivery system at the local level, county staff must first have an understanding of the concepts, principles, and overall evaluation framework inherent in the utilization focused approach to outcome evaluation.

DATA SOURCE :

CSSA progress report

DISCUSSION OF PAST PERFORMANCE :

N/A

PLAN TO ACHIEVE TARGETS :

Community Services staff will provide consultation and assistance to county agency staff and contracted service providers to facilitate their understanding of a client focused outcomes development framework.

OTHER FACTORS AFFECTING PERFORMANCE :

Resource limitations, including funding and trained staff, at both at the state and local level.

Goal 4 : To assist local county human service agencies with the implementation and ongoing utilization of a client-focused outcome-based approach to service management.

Objective 2 : Increase the number of local county human service agencies utilizing a client-focused outcomes-based approach to service management.

Measure 1 : Number of county agencies using outcomes data to improve service management.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual	NA	NA	NA			
Target				13	15	17

DEFINITION :

The total number of local county human service agencies submitting an annual CSSA progress report which includes client focused outcomes, indicators and methods for data collection.

RATIONALE :

Once intended outcomes and indicators have been selected, there must be measurement instruments/methodologies specified for data collection. Assistance from Community Services (CS) staff will be provided, as requested, to build upon existing methodologies used by the department and county agencies. In addition, CS staff will work with local agencies and internal staff to determine which data currently being collected by the department will be of use at the local level.

DATA SOURCE :

CSSA progress report.

DISCUSSION OF PAST PERFORMANCE :

N/A

PLAN TO ACHIEVE TARGETS :

Continue to assist counties in their outcomes efforts through training, written materials, conference presentation, as well as acting as liaisons with other DHS staff with expertise in systems information, data collection, analysis and utilization.

OTHER FACTORS AFFECTING PERFORMANCE :

The development of new information systems, the accessibility of information within current DHS information systems, and advancements in various technologies will facilitate the effective transfer of data for county utilization.

Agency : HUMAN SERVICES DEPT

Program : ECONOMIC SUPPORT GRANTS

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$541,742	11.72%
From Federal Funds	$201,010	
From Special Revenue Funds	$19	
General	$340,708	
From Gift Funds	$5	
Number of FTE Staff:	1	0.02%

GOAL :

- To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community. (Minnesota Statutes 256.03, subd. 2 and subd. 4, Minnesota Statutes 256.484, Minnesota Statutes 256.72, Minnesota Statutes 256.736, Minnesota Statutes 256.979, Minnesota Statutes 256D, Minnesota Statutes 256D.051)

DESCRIPTION OF SERVICES :

Economic Support Grants provides for the basic financial needs of families and individuals, supporting the Minnesota Milestone goal that Minnesota's children will not live in poverty. This program is designed to increase the abilities of families and individuals to find ladders up, out of poverty, to support themselves economically, and to provide a safety net for those who cannot support themselves. This program includes seven types of grants.

Work Grants provide employment and training services to recipients of Aid to Families with Dependent Children (AFDC) to help recipients avoid or end long-term public assistance dependency. Work Grants are provided to all 87 counties and to 6 Native American reservations. Work Grants include:

* Success Through Reaching Individual Development and Employment (Project STRIDE) is Minnesota's primary welfare-to-work program. The primary purpose of STRIDE is to help participants become employed.

* Food Stamp Employment and Training (FSET) provides employment and training services to Food Stamp

recipients.

* Jobs Support Services funds direct service and technical assistance for Parents Fair Share, Injury Protection, Tax Credit Express and the Child Care Demonstration Project. These grants increase child support to families, assist job placement, provide injury protection coverage and expand child care options for working families.

* Self Employment Investment Demonstration (SEID) provides small business training for AFDC recipients.

The Minnesota Family Investment Program (MFIP) is a comprehensive reform of welfare for families. The MFIP grant replaces AFDC, Food Stamps, Family General Assistance and Project STRIDE grants. MFIP restructures the welfare system around three key values: working should be more profitable than welfare; the family must be supported; and the relationship of welfare to families served should be based on a social contract in which both the system and clients carry responsibilities. MFIP grants provide financial assistance and wage supplements to working families, child care assistance, and employment and training services to move families into the labor market as quickly as possible and to move them out of poverty through paid employment.

Aid to Families with Dependent Children (AFDC) provides support to children and the caretaker adults living with them. Without financial assistance, these families with children could not obtain the basic necessities of life: food, shelter, and clothing. Assistance is in the form of monthly grants to provide a basic safety net for families with children.

Child Support Enforcement Grants support the 87 Minnesota counties that administer the child support program in Minnesota. Services are provided to all Minnesota families upon request. Families receiving AFDC automatically receive services, and they are required to cooperate with Child Support Enforcement to qualify for public assistance. Child Support Enforcement services include child support collections, establishment of paternity, and conversion from Medical Assistance to private health insurance.

General Assistance (GA) Grants meet the monthly maintenance and emergency needs of Minnesota residents who are not eligible for other income assistance programs, but who have net income and resources below state limits, and who meet one of the categories of GA eligibility.

Minnesota Supplemental Aid (MSA) grants provide cash assistance to aged, blind and disabled persons who are in financial need. Federal law requires states to supplement payment made by the Supplemental Security Income program to aged, blind and disabled persons.

Refugee Services Grants provide for the effective resettlement and economic self-sufficiency of refugees in Minnesota. The primary services in this program are Refugee Cash Assistance/Refugee Medical Assistance, social services for refugees, and services for Asian youth.

Minnesota has maintained bi-partisan support for its core strategy, the Minnesota Family Investment Program. With federal welfare reform now a reality, Minnesota's challenge is to stay true to its principles and still meet ambitious federal performance expectations with fewer resources and less flexibility. In this environment, Economic Support Grants aims to ensure that:

* More parents will work, resulting in:
- Increased income
- Reduced welfare dependency

- Reduced child poverty
- More stable families
- A better environment for the health development of children.

*Non-working parents will be required to prepare for work or have grants reduced.

*Increased child support enforcement will ensure that both parents support their children.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
	FY	Number of STRIDE participants who secure employment following program participation.	3,740	3,793
A	FY	The average monthly percentage of AFDC-UP caretakers who work and count towards meeting federal work requirements.	21.8%	35.9%
	FY	Number of FSET participants who secure employment following program participation.	New 7-1-95	4,596
O	FY	Number of Refugee families terminated from income assistance	265	300
A	FY	Aid to Families with Dependent Children and Emergency Assistance general fund expenditures (thousands).	$136,164	$126,160
W	FY	Aid to Families with Dependent Children average monthly recipients.	181,687	172,234
A	FY	Minnesota Family Investment Program grant expenditures (thousands).	$28,849	$33,381
W	FY	Minnesota Family Investment Program average monthly recipients.	11,331	13,956
A	FY	General Assistance expenditures (thousands).	$49,496	$47,753
W	FY	General Assistance average monthly cases	14,568	12,904
A	FY	Minnesota Supplemental Aid expenditures (thousands).	$21,570	$21,043
W	FY	Minnesota Supplemental Aid average monthly recipients.	19,962	22,621

PROGRAM DRIVERS :

Welfare reform will have a significant effect in Minnesota. Federal changes affect the eligibility of recipients, the length of eligibility for those who are initially eligible for assistance, amounts of federal funds available to the state, and the types of services federal funds will support. For example, changes at the federal level will affect the composition and provision of employment and training services.

AFDC has been an entitlement. With entitlements, if a family fits the eligibility guidelines, they get help. Block grants enacted in 1996 mean an end to welfare as an entitlement. Based on a funding formula that considers a state's past caseload history, the federal government will fund the AFDC population. If more people are in need than money is available, Minnesota will face the choice of not serving some people or raising state money to fill the gap.

MFIP is Minnesota's welfare reform strategy. With regard to its goals of making work pay, reinforcing responsibility and supporting families, preliminary results from MFIP are very promising. In response to federal changes, MFIP is the proposed replacement for AFDC.

The Department is participating in the development of performance measures that will be used nationwide to assess state performance in meeting welfare reform goals. Those measures will be used in future performance reports.

As federal devolution occurs, more demands will be placed on staff, computer systems and other management services to design new programs, to understand how changes will affect people, and to cope with stress and uncertainty. Increased efforts may be needed to assist people to qualify for other sources of help in response to welfare reform, block grants and tightened federal eligibility criteria.

Technology has become critical to the most basic functioning of the department. Technology has grown to meet a rising workload and to meet rising customer expectations for quick, accurate transactions and information. As policies change, reprogramming is a given. Strategic planning is needed to make sure the department's economic support computer systems will be current with program requirements and eligibility criteria.

Goal 1 : To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community.

Objective 1 : More MFIP families than control group families will participate in paid employment.

Measure 1 : The difference between MFIP families and control families in the percent employed or off public assistance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
MFIP						
Actual	NA%	41.2%	*%	*%	*%	*%
Control Group						
Actual	N/A%	31.1%	*%	*%	*%	*%
Difference						
Actual	N/A%	10.1%	*%	*%	*%	*%

DEFINITION :

Percent of MFIP families and control group families participating in paid employment during each fiscal year.

For FY 1995, the data are provided by Manpower Demonstration Research Corporation (MDRC) and reflects a point in time during the applicable fiscal year for single parent recipient families randomly assigned to either MFIP or the control group between April and September 1994.

RATIONALE :

Employment directly relates to a family's ability to survive an economic crisis. Participation in paid employment is an indicator of family movement toward regaining or achieving their highest level of self-sufficiency.

This type of indicator may become one of the high performance bonus performance measures being developed by the states for use in their TANF funded programs.

DATA SOURCE :

Data will be provided by Manpower Demonstration Research Corporation. New data are expected in Spring 1997.

DISCUSSION OF PAST PERFORMANCE :

In F.Y. 1995 participation in paid employment for MFIP families exceeded that of control families by 10.1%.

PLAN TO ACHIEVE TARGETS :

Due to the fact that MFIP is a demonstration project, targets have not been set. One goal of the field trials is to gather information about establishing appropriate targets for a statewide program.

OTHER FACTORS AFFECTING PERFORMANCE :

To be identified by MDRC.

Goal 1 : To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community.

Objective 2 : More MFIP families than control group families will have total family income above the federal poverty guidelines.

Measure 1 : The difference between MFIP families and control families with total family income above poverty.

	F.Y.1993	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998
MFIP						
Actual					N/A	N/A
Control Group						
Actual		N/A	N/A	N/A	0	0
Difference						
Actual		N/A	N/A	N/A	0	0

DEFINITION :

Percent of MFIP families and control group families with total family income above the federal poverty guidelines.

RATIONALE :

Total family income above the federal poverty guideline is an indicator that a family is better able to survive an economic crisis. Family income is also an indicator of a family's movement toward regaining or achieving their highest level of self-sufficiency.

This type of indicator may become one of the high performance bonus performance measures being developed by the states for use in their TANF funded programs.

DATA SOURCE :

Data will be provided by Manpower Demonstration Research Corporation. The first data on this measure will be available in the spring of 1997.

DISCUSSION OF PAST PERFORMANCE :

Not available.

PLAN TO ACHIEVE TARGETS :

Due to the fact that MFIP is a demonstration project, targets have not been set. One goal of the field trials is to gather information about establishing appropriate targets for a statewide program.

OTHER FACTORS AFFECTING PERFORMANCE :

To be identified by MDRC.

Goal 1 : To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community.

Objective 3 : A thirty-five percent work participation rate is expected of families supported by Minnesota's TANF funded program by federal fiscal year (FFY) 1999.

Measure 1 : TANF work participation rate of all families.

	FED.1994	FED.1995	FED.1996	FED.1997	FED.1998	FED.1999
Work participation rate						
Actual	N/A%	N/A%	N/A%			
Target				25%	30%	35%

DEFINITION :

Percent of TANF families meeting the work participation rate. At least one parent in 35 percent of the families receiving TANF assistance must be working or participating in an employment and training program for at least 20 hours per week. The requirement increases to 25 hours per week in 1999 and to 30 hours per week thereafter. When determining if the state meets this requirement, all families receiving TANF are counted, except those with a child under age one and those in the first three months of being sanctioned for failure to comply with program requirements.

RATIONALE :

Federal requirements in the Personal Responsibility and Work Opportunity Reconciliation Act (PWORA) of 1996 specify that at least 35 percent of families receiving TANF must participate in employment and training activities for not less than 20 hours per week. These percentages and hours of work required increase until the year 2002 when 50 percent of families must be working in an approved activity for 30 hours per week.

DATA SOURCE :

Data will be obtained from the Department of Economic Security information system and the MAXIS system.

PLAN TO ACHIEVE TARGETS :

The nature of employment and training services is being reexamined and modified. Services which will create a rapid labor market attachment and which are more directly related to immediate employment are being emphasized. Sanctions for failure to cooperate are being examined and modified to help assure participant compliance.

OTHER FACTORS AFFECTING PERFORMANCE :

Major changes have occurred in the provision of public assistance. Recipients will only be eligible for cash assistance for a lifetime total of five years. In addition, recipients must be in employment programs or work after receiving benefits for two years. These factors are expected to have dramatic impacts on how long people receive benefits and on the number who become employed.

Goal 1 : To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community.

Objective 4 : During each year of the biennium, child support collections will increase by 10 percent.

Measure 1 : The amount of child support collected from non-custodial parents.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Millions of dollars of collections						
Actual	$250	$290	$323	$355e		
Target					$391	$430
Percent Change						
Actual	14%	16%	12%	10%		
Target					10%	10%

DEFINITION :

Child support collections are defined as court ordered child support and/or voluntary collections where parents have asked for services from the state or county or were required to participate as a condition of receiving state public assistance.

RATIONALE :

The amount of child support collected each year directly relates to the goal of providing support to children. The support collected on behalf of AFDC recipients directly reduces public assistance expenditures. Support collected for non-public assistance clients helps these families provide for their children and prevents many families from needing public assistance.

DATA SOURCE :

Monthly collection reports produced by the statewide Child Support Enforcement System (CSES).

DISCUSSION OF PAST PERFORMANCE :

Requests for child support services grow each year. Collections increase through case growth and through a process of both reviewing current support and/or a cost of living adjustment (cola) to the court order.

PLAN TO ACHIEVE TARGETS :

Target estimate is based on current levels of program funding.

Goal 1 : To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community.

Objective 5 : Paternity establishment rates for nonmarital children will increase by 7% per year.

Measure 1 : Percentage of nonmarital births who have paternity established.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Paternity establishment percentage						
Actual	62%	65%	69%			
Target				76%	83%	90%
Percentage Point Change						
Actual		3%	4%			
Target				7%	7%	7%

DEFINITION :

The percentage of nonmarital births in the child support caseload with paternity established is the ratio of paternities established as the numerator and nonmarital children requiring paternity establishment as the denominator.

RATIONALE :

Paternity establishment must occur before child support can be collected. Other benefits include family medical history information and the social benefits rightfully due the child.

DATA SOURCE :

Quarterly program data reports produced by CSES.

DISCUSSION OF PAST PERFORMANCE :

Child Support has increased this measure each year.

PLAN TO ACHIEVE TARGETS :

Target estimate is based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

New welfare reform legislation rewards states that increase paternity establishment percentages. States that do not improve this percentage may be penalized. Establishing paternity is required before child support obligations can be established.

Goal 1 : To reduce welfare dependency by assuring that economic support grants reward work and responsibility; creating reforms that are anti-poverty, responsive to economic realities and help families to help themselves; ensuring that noncustodial parents support their children, reducing public assistance costs and improving the lives of their children; and, improving policies to help people hold their families together and maximize support from extended family and community.

Objective 6 : Each year the average collection per child support case will increase by 10%.

Measure 1 : Average collection per child support case.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Average collections per child support case						
Actual	$1,398	$1,520	$1,617			
Target				$1,779	$1,957	$2,152
Percent Change						
Actual	7%	10%	6%			
Target				10%	10%	10%

DEFINITION :

Total collections divided by the average number of open child support cases, including cases with and without court orders for child support.

RATIONALE :

This baseline benchmark indicates improvement in rates of establishment and enforcement of court orders. The measure could be a proxy measure to indicate how child support collections compare to cost of living expenses.

DATA SOURCE :

Quarterly program data reports produced by CSES.

DISCUSSION OF PAST PERFORMANCE :

Child Support has increased this measure each year.

PLAN TO ACHIEVE TARGETS :

Target estimate is based on current levels of program funding.

Agency : HUMAN SERVICES DEPT

Program : ECONOMIC SUPPORT MANAGEMENT

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$56,084	1.21%
From Federal Funds	$1,547	
From Special Revenue Funds	$45,861	
From Agency Funds	$2	
General	$8,552	
From Gift Funds	$122	
Number of FTE Staff:	320	5.30%

GOAL :

- To assure efficient and effective delivery of services in order to reduce welfare dependency. (Minnesota Statutes 245.03, Subd. 2, Minnesota Statutes 237.70, Minnesota Statutes 256.9352, Minnesota Statutes 256.986)

DESCRIPTION OF SERVICES :

The Minnesota Department of Human Services, Economic Support Management supervises the county administered Economic Support Grants, the Food Stamp Program and the Child Support Enforcement activities of the counties. The purposes of this program include reducing or alleviating poverty for families and individuals; reducing the number of people who need public assistance for economic support; finding ladders up and out of poverty by expecting, rewarding and supporting work and responsibility; and providing a safety net for those who cannot work. The primary functions of this program promote progress toward economic self-sufficiency for families, children and individuals while providing for their basic financial needs. To carry out these responsibilities, Economic Support Management has two primary activities: Policy Administration and Operations.

ECONOMIC SUPPORT POLICY ADMINISTRATION

Economic Support Policy Administration performs a broad array of functions and services to enable county human services agencies and the Legislature to provide public assistance to the citizens of Minnesota. This program supervises the administration of basic economic support grants so that families and individuals are protected from falling into destitution. Policy Administration is responsible for statewide planning, setting standards for services and developing and implementing policies related to economic assistance. This activity seeks to improve policies to help people hold their families together and to maximize support from their

Technology has become critical to the most basic functioning of the department. Technology has grown to meet a rising workload and to meet rising customer expectations for quick, accurate transactions and information. As policies change, reprogramming is a given. Strategic planning is needed to make sure the department's economic support computer systems will be current with program requirements and eligibility criteria.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 1 : Policy and procedures for cash and food stamp and welfare reform programs will be developed and implemented by the effective date required by state and federal law.

Measure 1 : Percent of policy changes for cash and food stamp and welfare reform programs implemented by the effective date.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual		To be	developed			

DEFINITION :

The number of policy changes implemented by the effective date divided by the total number of changes required. This output measure will track the timeliness of implementing changes required by the state and federal law for the TANF, MFIP, FS, MSA, and GA programs. It will include the source of the change (e.g. public law number), a short summary of the policy changed by the law, the effective date of the law, the date the policy was implemented, and the method of implementation (e.g. combined manual letter).

RATIONALE :

PACT (Program Administrative Consultant Team) is responsible for developing program instructions so that county agencies can determine eligibility for program recipients. Correct determinations of policy ensure that program intent is carried out. Failure to make correct determinations may result in federal sanctions, court suits, and inaccurate conclusions being inferred from legislative initiatives. This measure will determine the timeliness by which instructions on policy and procedural changes are communicated to the county agencies that actually implement new law.

DATA SOURCE :

A data tracking record will be developed to record all state and federal welfare reform changes required each fiscal year. PACT staff required to provide instruction on program changes will enter data onto the tracking record. At the end of the year, implementation dates will be compared to effective dates to determine the percentage of changes implemented by the required effective date.

OTHER FACTORS AFFECTING PERFORMANCE :

Federal law and welfare reform have retroactive or same day effective dates that may require state statute change prior to implementation. Some federal and state law changes provide very short implementation times lines that are not realistic or may require rule promulgation before they can be implemented. New laws also often require programming of the statewide automated eligibility system and major changes to the system may require longer time lines to implement than those allowed by the law. Welfare reform has put the burden on the state to develop new laws and rules which govern the Food Stamp and cash programs.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 2 : Provide initial training to 95% of new county financial workers within two months of county request for training. Provide retraining of current financial workers on welfare reform within six months of request for training.

Measure 1 : The length of time from date of county request to the date training begins.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Months from request to training - Initial Training						
Actual			25 days e			
Target				2 months	2 months	2 months
Months from request to training - Welfare Reform						
Target				6 months	6 months	6 months

DEFINITION :

All new financial workers must attend the "Introduction to Public Assistance and MAXIS" (IPAM) course before they can attend any further training and/or receive log-on access to the statewide automated eligibility system (MAXIS). This measure will be the length of time from when the county requests training for a new worker to the first day the person attends IPAM training.

All current financial workers must be trained in changes that have occurred due to welfare reform. For current workers training will begin no more than six months after the county makes the training request.

RATIONALE :

Financial workers determine eligibility and benefit levels for persons in need of public assistance. In order to insure that people receive correct and timely benefits, financial workers need to be trained on both program policy and how to use Minnesota's MAXIS. Any delay in training new workers inhibits the ability of Minnesota counties to meet client needs and insure accuracy of benefits issued, which in turn, results in misspent tax dollars.

Due to welfare reform and significant changes in the Food Stamp and cash programs policy and rules, new training curricula must be written and all financial workers must be retrained in order to inform them of these changes.

Training is mandatory for anyone requesting access to the system because of the need to ensure the integrity of the data entered in MAXIS. Training delays could negatively impact the integrity of the statewide eligibility system if these delays were to result in shared logs-on, etc.

DATA SOURCE :

The training registration software will track the date of each training request and the dates and types of training each county worker attends.

DISCUSSION OF PAST PERFORMANCE :

Since July 1994, training staff has been adequate to respond to requests to train new county staff within two months of receipt of a request.

PLAN TO ACHIEVE TARGETS :

Target goals for new workers will remain at two months. Current workers will now be trained in welfare reform within six months of a county request.

OTHER FACTORS AFFECTING PERFORMANCE :

Significant turnover, in both the department's training staff and county financial worker staff, plus unknown welfare reform changes could affect the department's ability to schedule sufficient training to meet this goal.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 3 : Within two days, the MAXIS Help Desk will provide county workers with resolution of critical difficulties and welfare reform changes during processing of cases in the statewide automated eligibility system.

Measure 1 : Percent of critical problems resolved within two days.

	F.Y.1993	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998
Percent of problems						
Actual			To be	developed		

DEFINITION :

The number of critical problems resolved within 2 days divided by the total number of critical problems referred to experts for resolution.

RATIONALE :

Although the majority of problems are resolved immediately by Help Desk staff, some problems require referral to other staff. It is important to research critical problems and respond to county agencies with the resolution in a timely manner. Problems are known or unknown technical systems difficulties that prevent the county worker from getting correct responses from the state-wide public assistance computer system. Failure to respond could result in incorrectly calculated and/or untimely issuance of client benefits.

DATA SOURCE :

"Trouble tickets" created by Help Desk staff are to be tracked through the use of automated software. E-mail received from county agencies is using MAXIS.

OTHER FACTORS AFFECTING PERFORMANCE :

Complex installations, new programming, welfare reform policy changes, and communication failures outside the control of the department, as well as increases in the number of users on the system all affect performance.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 4 : County agencies will receive responses to cash and food stamp policy inquiries within seven working days on average.

Measure 1 : Percent of cash and food stamp policy inquiries resolved within seven working days.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent resolved within 7 days						
Actual			63.5e%			
Target				80%	80%	80%

DEFINITION :

The number inquiries resolved within 7 working days divided by the total number of inquiries.

RATIONALE :

Counties request policy interpretation when available resources cannot be located or the policy and/or instructions need clarification. Failure to respond could result in incorrectly calculated and/or untimely issuance of client benefits. Some policy questions are resolved by county agencies through their own resources. However, welfare reform policy inquiries received at the policy center require extensive research due to their complexity. It is reasonable for county agencies to expect responses to inquiries within seven days.

DATA SOURCE :

Information on each policy inquiry is "logged," including the date of receipt and the date of response.

DISCUSSION OF PAST PERFORMANCE :

The percentage of correct policy answers within seven days is based only on person to person replies.

PLAN TO ACHIEVE TARGETS :

An RFP for a knowledge-based problem solving device is in progress. This tool will help to answer and track all policy inquiries coming into the department. It will take some time to get all the welfare reform changes programmed into the software.

OTHER FACTORS AFFECTING PERFORMANCE :

The number of complex legislative, policy, and welfare reform changes as well as turnover in staff at county agencies results in county workers with less experience and knowledge which results in increased policy inquiries.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 5 : Verify the continuing eligibility of 90% of those persons receiving the telephone assistance plan credit through the use of computer interfacing with the other state agencies.

Measure 1 : Percentage of recipients of the TAP credit recertified by computer interfaces.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent recertified						
Actual	18%	77%	77%			
Target				90%	90%	90%

DEFINITION :

The percentage of all persons receiving the TAP credit who are recertified to continue receiving the credit by interfacing with Public Assistance, Department of Revenue and Energy Assistance.

RATIONALE :

All recipients of the TAP credit must be recertified each year to ensure that they remain eligible for the credit. Recertification through computer interfaces reduces administrative costs by eliminating costly mailing of recertification forms. Clients are assisted as the elderly and disabled can be find it difficult and confusing to fill out forms. Also, this type of recertification helps ensure no interruption in the credit.

DATA SOURCE :

The section that administers TAP has its own database system that is capable of reporting and projecting counts and trends. These types of reports and statistics are also available from the Public Utilities Commission.

DISCUSSION OF PAST PERFORMANCE :

The percentage of recipients recertified for the TAP credit through the use of computer interfaces has increased significantly. This upward trend will level off as there are those recipients who cannot be identified through computer interfaces.

PLAN TO ACHIEVE TARGETS :

Target estimate is based on current levels of program funding and new interfaces with MAXIS and MMIS II. Interfaces with the Energy Assistance Program and the Department of Revenue will continue.

OTHER FACTORS AFFECTING PERFORMANCE :

This section is very dependent on other agencies to complete these interfaces. If other agencies have their own jobs to run, interfacing gets very low priority. Due to welfare reform and persons being taken off public assistance, it will be more difficult to do automated reviews because these persons will not be known to MAXIS.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 6 : Payment accuracy and administrative performance for each program reviewed or evaluated will be within the federal and state tolerance levels.

Measure 1 : Final payment accuracy rate by program.

	FED.1994	FED.1995	FED.1996	FED.1997	FED.1998	FED.1999
Food Stamp						
Actual	91.2%	93.3%	90e%			
Target				90%	90%	90%
AFDC						
Actual	96%	97.9%	96%			
Target				96%	96%	96%

DEFINITION :

Federal regulations require that states review a statistically valid, random sample of active AFDC and FS cases to determine the accuracy of benefit disbursement. This accuracy rate is the ratio of accurate (sample) dollars issued to total (sample) dollars issued. States determine an accuracy rate, which is adjusted by the federal agencies (via a regressed accuracy rate method). All rates are reported by federal fiscal year (FFY).

RATIONALE :

Federal regulations require that quality control reviews be conducted on a specific sample of AFDC, Food Stamp, and MA cases. In October of 1994 Minnesota was granted a waiver to conduct special research projects instead of conducting traditional quality control reviews on the Medicaid program. The accuracy of the benefit issued to the client is the data collected from this review. These data are then compiled using a specific methodology developed by the federal agencies administering the programs to establish a payment accuracy rate for each FFY. The program performance target for states is the tolerance level. The tolerance level for each program is established by the federal law.

DATA SOURCE :

Final federal accuracy rates are issued from the Health and Human services Agency and Food and Nutrition Service of the Department of Agriculture.

DISCUSSION OF PAST PERFORMANCE :

The federal tolerance level for Food Stamps is 1% below the national average. Minnesota has been above the national average for the time periods recorded and therefore has not been sanctioned. The federal tolerance level for AFDC is 96% or the national average, whichever is lower. Minnesota has been higher than the national average for the time period recorded. For FFY 1993, the most recent year the federal agency has issued a final AFDC payment accuracy rate, Minnesota ranked seventh in accurate issuance of benefits. There have been no federal sanctions imposed during this time period.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

The administration of AFDC, Food Stamps, and MA is conducted at the local county level. Each county is a government entity of its own and the state supervises each county, without the authority to set local administrative policy.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 6 : Payment accuracy and administrative performance for each program reviewed or evaluated will be within the federal and state tolerance levels.

Measure 2 : Quality assurance accuracy rates (by case) for MinnesotaCare (MNCare) enrollees.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Residency						
Actual	99.1	100.0				
Target			100.0	100.0	100.0	100.0
Current Insurance						
Actual	96.2	96.5				
Target			96.5	96.5	96.5	96.5
Employer Subsidized Insurance						
Actual	85.1	87.7				
Target			87.7	87.7	87.7	87.7

DEFINITION :

The initial measurement data were collected for FY1994 and included 737 cases. A subsequent sample of 430 cases were reviewed in FY1995. The sample universe included first time MinnesotaCare premium payers . A statistically valid random sample was selected and reviewed. Quality Assurance staff concentrated on three key criteria for each review. The criteria were: residency, current insurance, and employer subsidized insurance. Quality Assurance will continue to review these three criteria, unless other data collecting takes priority.

RATIONALE :

These three criteria were chosen for review due to the concern government bodies had in these areas when passing MNCare legislation. These critical areas could lead to misuse and abuse of the program. Therefore quality assurance emphasis on these three areas will enable policy and law makers to modify program policy language if necessary to administer a quality and effective program. Also, quality assurance reviewers collect additional data that are important to lawmakers and administrators of MinnesotaCare.

DATA SOURCE :

Minnesota Department of Human Services Quality Initiatives Division.

DISCUSSION OF PAST PERFORMANCE :

MinnesotaCare quality assurance (QA) data collecting began in October 1, 1993. Therefore there are no data prior to 1994. The total sample universe for these three measures in F.Y. 1994 was 737 cases. In FY1995 it was 430 cases.

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

MNCare is in the early stage of implementation. Additional and unanticipated rules, regulations, and legislation can affect the accuracy rate. Also, the application and enrollment rate has a significant impact on the department's ability to accurately administer the program.

Goal 1 : To assure efficient and effective delivery of services in order to reduce welfare dependency.

Objective 6 : Payment accuracy and administrative performance for each program reviewed or evaluated will be within the federal and state tolerance levels.

Measure 3 : The Fraud Prevention Investigation (FPI) program cost benefit ratio.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Cost-benefit of FPI program						
Actual	$5.03	$4.77	$5.31			
Target				$5.40	$5.50	$5.50
Costs per negative action						
Actual	$493	$488	$447			
Target				$445	$440	$440
Negative Case Action Rate						
Actual	49%	45%	44%			
Target				44%	43%	43%

DEFINITION :

Cost benefit compares program cost with savings (3 months) and overpayments. Negative action cost established per case costs in the context of successful investigations requiring and resulting in agency actions.

RATIONALE :

The department is making a concerted effort to confront fraud through prevention and early detection. New initiatives are combined with established efforts to improve both deterrence and fraud control.

DATA SOURCE :

FPI monthly activity reports (savings and overpayments) and Financial Management Form 2550.1 (Quarterly costs).

PLAN TO ACHIEVE TARGETS :

Target estimates are based on current levels of program funding.

OTHER FACTORS AFFECTING PERFORMANCE :

FPI was expanded in 1992 from seven to 20 counties. In 1995-96, the use of regional FPI coverage further expanded involvement to 50 counties. Maintenance and enhancement of performance has been sought in an ever-changing operational environment involving different mixes and types of counties, changing learning curves, increasing start-up costs and new program problems.

GLOSSARY

AFDC-UP	Aid to Families with Dependent Children-Unemployed Parent. In certain circumstances, a family can qualify for AFDC if the parent is unemployed.
AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)	Title IV-A of the Social Security Act authorized this public assistance program which provides financial assistance and social services to needy families with dependent children. (Replaced by TANF-Temporary Assistance to Needy Families-by welfare reform 1996.
ALTERNATIVE CARE GRANTS (ACG)	ACG is a home and community care program to pay for health care services in the home of an elderly individual who is at risk of requiring nursing facility care.
ALTERNATIVE COMMUNITY BASED SERVICES (ACS)	ACS is a home and community care program which pays for health care services in the home of an individual with mental retardation who was formerly inappropriately placed in a nursing facility. This is a Medical Assistance program approved by the federal HCFA.
AMERICANS WITH DISABILITIES ACT (ADA)	The ADA is a federal civil rights law for individuals with disabilities. The ADA gives civil rights protection to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national origin and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, state and local government services, and telecommications.
ANNUAL RESIDENT REVIEW (ARR)	Annual reviews relating to nursing facilities and persons with mental illness or developmental disabilities.
BIENNIUM YEARS (BY)	The two-year period for which state budgets are proposed and funds appropriated. The state biennium begins on July 1 of an odd-numbered year and continues through June 30 of the next odd-numbered year.
CALENDAR YEAR (C.Y.)	January 1-December 31. County budgets and programs are based on calendar years.
CATCH II	Child and Teen Check-Up System.
CCDTF	The Consolidated Chemical Dependency Treatment Fund (CCDTF) is a combination of funds used for chemical dpendency treatment. The CCDTF is a combination of General Assistance, General Assistance Medical Care, Medical Assistance, county funds, and state

	appropriations. It pays the costs of treatment for eligible recipients who have been assessed and placed in treatment by counties or reservations. This is a fee-for-service program. In counties with prepaid managed care, Medical Assistance funds are in the capitation to health plans instead of in the CCDTF.
CHEMICAL DEPENDENCY (CD)	Frequent or repetitive use of alcohol or other drugs which significantly impairs or adversely affects health, interpersonal relationships or employment on a continuing basis or when intoxication presents a clear and immediate danger of harm to self or others.
CHILD SUPPORT ENFORCEMENT SYSTEM (CSES)	A statewide computer system to manage child support cases and provide accounting for child support payments.
COMMUNITY ALTERNATIVES FOR CHILDREN (CAC)	CAC is part of the Medical Assistance waiver program intended to enhance the quality of life for children who are living or at risk of living in hospitals due to chronic illness. CAC serves eligible individuals in the community rather than in an institutional setting.
COMMUNITY ALTERNATIVES FOR DISABLED INDIVIDUALS	Community Alternatives for Disabled Individuals (CADI) is part of the Medical Assistance waiver program which provides funding for services that are alternatives to nursing facilities. Services are provided for screened, eligible individuals who can be cared for in the community less expensively than in a nursing or board and care home.
COMMUNITY SERVICES INFORMATION SYSTEM (CSIS)	A computerized social services tracking system. CSIS is a computer-based system designed to provide information on social services caseloads and to assist social service agencies in program planning and administration.
COMMUNITY SOCIAL SERVICES ACT (CSSA)	Minnesota Statutes, section 256E. This act extablished a system of planning for and provision of community social services administered by boards of county commissioners of each county in the state under the supervision of the Commissioner of Human Services.
DD	Developmental disabilities or developmentally disabled. DD refers to persons diagnosed with mental retardation or a related condition who have substantial functional limitations or deficits in adaptive behavior and who manfest these conditions before their 21st birthday.
DEPARTMENT OF EMPLOYEE RELATIONS (DOER)	Minnesota state employment agency.
DIAGNOSIS RELATED GROUP (DRG)	Classification of procedures used to sort hospital patients by discharge diagnosis into categories that are medically similar and have

	approximately equivalent lengths of stay. DRGs are used by MA and GAMC.
DRUG UTILIZATION REVIEW (DUR)	A review of the use of prescriptions to identify potentially dangerous drug-to-drug interactions, drug to disease incompatibilities and inappropriate uses of prescriptions (e.g., incorrect doses, overuse or abuse). ProDUR is a real-time, on-line drug utilization review system.
DSM-IV	Diagnostic Statistical Manual of Mental Disorders, 4th edition. American Psychiatric Association's official manual of mental disorders. The manual contains a glossary of descriptions of the diagnostic categories.
ELDERLY WAIVER (EW)	A federal Medicaid waiver program providing home and community-based services to frail, elderly persons in order to prevent their placement in nursing facilities.
ELIGIBILITY VERIFICATION SYSTEM (EVS)	A means of comparing elgibility determinations between MAXIS and MMIS.
EMERGENCY ASSISTANCE (EA)	Monies provided to eligible persons in crisis situations which receiving EA will resolve, provided that the individual is unable to resolve the situation on his/her own without EA and that the situation will result in severe hardship for the individual if not resolved. AFDC-EA helps families who face a crisis that will result in destitution if they do not receive immediate financial aid and are eligible for Aid to Families with Dependent Children. GA-EA provides assistance to persons who are in emergencies and are eligible for General Assistance.
EQUIPMENT DISTRIBUTION PROGRAM (EDP)	A program which funds equipment, recurring expenses and training to enable deaf and hard of hearing, speech impaired and mobility impaired individuals to access the telephone system.
FAMILY GENERAL ASSISTANCE (FGA)	General Assistance available to a family as defined in Minnesota Statutes, section 256D.02, subd. 5. A family must include at least one minor child and at least one of that child's natural or adoptive parents, stepparents or legal custodians.
FEDERAL FISCAL YEAR (F.F.Y.)	The period of October 1 of one year through September 30 of the next year. A federal fiscal year is identified by the year in which it ends, e.g., F.F.Y. 1997 is the period October 1, 1996 -September 30, 1997. Federal appropriations are made for federal fiscal years.
FEE-FOR-SERVICE	Method of purchasing health care services in which enrolled providers are reimbursed for services provided to enrolled recipients.

FISCAL YEAR (F.Y.)	Unless otherwise noted, the state fiscal year of July 1 of one year to June 30 of the next year.
FOOD STAMPS (FS)	Coupons used to purchase food and food products in approved stores. The Food Stamp Program increases the food purchasing power of low-income households.
FRAUD PREVENTION INVESTIGATION PROGRAM (FPI)	An investigative process based on a team approach involving financial workers and fraud prevention investigators. Its focus on timely resolution of issues involving questionable eligibility for public assistance prevents recipients from receiving or continuing to receive program benefits to which they are not entitled.
FSET	Food Stamp Employment and Training Program. The program which provides employment and training services to Food Stamp recipients, emphasizing quick employment and focusing on job seeking and job placement activities.
FTROP	Federal Tax Revenue Offset Program.
GENERAL ASSISTANCE (GA)	State program which provides financial assistance to eligible people who are unable to provide for themselves and dependents. Individuals must meet established criteria of eligibility.
GENERAL ASSISTANCE MEDICAL CARE (GAMC)	State-funded health care coverage program for individuals who are either General Assistance recipients or who do not meet the categorical requirements of Medical Assistance and whose financial situation prevents them from affording necessary health care. Typically these are adults under age 65 who are not disabled and are not caring for children in a family where one parent is absent, incapacitated or unemployed.
HEALTH CARE FINANCING ADMINISTRATION (HCFA)	The federal umbrella agency for the Medicaid program, an agency of the U. S. Department of Health and Human Services.
HEALTH MAINTENANCE ORGANIZATION (HMO)	An organization which provides an agreed upon set of basic and supplemental health maintenance and treatment services to an enrolled group of persons within a particular geographic area. The HMO is reimbursed for those services through a predetermined, fixed, periodic prepayment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amounts of actual services provided.
HEDIS	Health Plan Employer Data and Information Set.

HUMAN SERVICES INFORMATION SYSTEM (HSIS)	An information system used by the regional treatment centers to collect demographic, legal status and other general patient information.
ICF/MR	Intermediate Care Facility for the Mentally Retarded. A facility certified by the Minnesota Department of Health to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions who require active treatment. It must be licensed by the Department of Human Services.
INDIAN CHILD WELFARE ACT (ICWA)	The federal law which prescribes the process for addressing needs of Indian children for protection and placement.
INSTITUTION FOR MENTAL DISEASE (IMD)	Classification under Medicaid which denotes a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and other services.
IPAM	Introduction to Public Assistance and MAXIS (IPAM) is a training program for new county financial workers.
LONG-TERM CARE (LTC)	Facilities for persons who are elderly, physically handicapped or developmentally disabled who have lost some capacity for self-care and are expected to need care for a prolonged period of time. The LTC facility provides a wide range of medical and supportive services, most of which are paid for by Medical Assistance.
MAPS	Minnesota Accounting and Procurement System.
MAXIS	A master computer system which tracks, records and monitors all public assistance benefits activity (AFDC/TANF, MA, GA, GAMC), eligibility and payments. Originating from the Department of Human Services, this is a statewide system.
MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)	A mainframe computer system that processes provider invoices, edits for recipient and service eligibility, pays allowed charges and provides recipient payment history.
MEDICAL ASSISTANCE (MA)	Minnesota's Medicaid or Title XX program, a federal program which provides reimbursement to health care providers for health care services given to persons whose financial resources are insufficient to pay for needed medical care.
MENTAL ILLNESS (MI)	An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of

	Diseases (ICD-9) or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and that seriously limits a person's capacity to function in primary aspects of daily living such as relationships, living arrangements, work and recreation.
MENTALLY ILL AND DANGEROUS (MI&D)	As defined in Minnesota Statutes, section 253B.02, subd. 17, a "person mentally ill and dangerous to the public" is a person (a) who is mentally ill and (b) who as a result of that mental illness presents a clear danger to the safety of others as demonstrated by the facts that (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (ii) there is substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.
MENTALLY RETARDED (MR)	A person who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior and who manifests these conditions before the person's 22nd birthday.
MINNESOTA BOARD ON AGING (MBA)	A 25-member board appointed by the Governor and responsible for the administration and implementation of the federal Older Americans Act.
MINNESOTA FAMILY INVESTMENT PROGRAM (MFIP)	A comprehensive reform of welfare for families designed to simplify the structure and administration of the public assistance system in Minnesota. The focus is on using existing resources more effectively and efficiently and includes consolidating AFDC, GA and Food Stamps and helping promote recipients' transition to self-sufficiency. MFIP may be a model for implementation of Temporary Assistance to Needy Families (TANF).
MINNESOTA HEALTH CARE PROGRAMS (MHCP)	A general term for health care programs administered by the Minnesota Department of Human Services, including MA, GAMC and MinnesotaCare.
MINNESOTA HEALTH DATA INSTITUTE (MHDI)	A public-private, nonprofit organization, created by the Legislature in 1993, to collect, analyze and report on health care related data and trends.
MINNESOTA SENIORS HEALTH OPTIONS (MNSHO)	A federally approved waiver program which combines Medicare and Medicaid purchasing of acute and long-term care services on a capitated basis for persons eligible for both programs. (Formerly known as LTCOP--Long-Term Care Options Project.)
MINNESOTA	A state program which provides cash assistance to aged, blind and

SUPPLEMENTAL AID (MSA)	disabled recipients of Supplemental Security Income (SSI).
MINNESOTACARE	A state program which pays medical payments and subsidizes health care premiums for low-income, uninsured persons who are not eligible for MA or GAMC.
NURSING FACILITY (NF)	An institution certified by the Minnesota Department of Health to provide skilled nursing care.
PRE-ADMISSION SCREENING (PAS)	Pre-admission review a person must pass before being approved for an Alternative Care Grant, a Medical Assistance funded service which provides funding for services in the community for people aged 65 and older who have been determined to need a skilled nursing facility or intermediate care facility. Recipients must be eligible for MA and able to receive needed medical care and services in the community rather than in a nursing home for the same cost or less.
PRISM	Providing Resources to Improve Support in Minnesota (PRISM) is a statewide computer system now under development in child support enforcement that will be operational in 1997. It will further automate state child support case management and accounting and include features to improve customer services.
PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR)	An on-line, real-time drug utilization review system.
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Federal legislation which replaced traditional federal assistance programs.
PSYCHOPATHIC PERSONALITY (PP)	Refers to "sexual psychopathic personality" as defined in Minnesota Statutes, section 253B.02, subd. 18a.
REFUGEE CASH ASSISTANCE (RCA)	A program which provides cash assistance to refugees during their first eight months in the country if they are not eligible for AFDC.
REFUGEE MEDICAL ASSISTANCE (RMA)	A program which covers medical costs for refugees during their first eight months in the country if they are not eligible for MA.
REGIONAL SERVICE CENTER (RSC)	A central point of entry by which deaf and hard of hearing individuals access both community resources and the human services system.
REGIONAL TREATMENT CENTER (RTC)	An institutional facility providing 24-hour a day care and treatment for persons diagnosed as mentally retarded, mentally ill or chemically dependent. Regional treatment centers are administered by the

	Department of Human Services.
RETIRED AND SENIOR VOLUNTEER PROGRAM (RSVP)	A federal and state funded program in which older people volunteer for any kind of community service.
SEMI-INDEPENDENT LIVING SITUATIONS (SILS)	Residential program for developmentally disabled adults in which they can live semi-independently, such as in an apartment with a roommate, with follow-along services to help the client live as "normal" a life as possible.
SENIORS AGENDA FOR INDEPENDENT LIVING (SAIL)	A state-county cooperative program to develop alternatives to help senior citizens live in their own homes.
SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI)	The statutory name for persons diagnosed with a chronic mental illness.
SEVERE EMOTIONAL DISTURBANCE (SED)	"Child with severe emotional disturbance" is a child who has an emotional disturbance and meets the criteria of Minnesota Statutes, section 245.4871, subd. 6. The term "child with severe emotional disturbance" is used only for purposes of county eligibility determinations. In all other cases, this term should be replaced with "child eligible for mental health case management."
SOCIAL SERVICES INFORMATION SYSTEM (SSIS)	An information system being developed to provide uniform access to data on social services cases.
STATE FISCAL YEAR (S.F.Y.)	The period of July 1 of one year through June 30 of the following year. A state fiscal year is identified by the year in which it ends, e.g., S.F.Y. 1997 is the period of July 1, 1996-June 30, 1997. State programs, budgets and appropriations are made for state fiscal years.
STATE OPERATED SERVICES (SOS)	Programs operated by the Department of Human Services, including the nine regional treatment centers and a number of state-operated group homes in communities.
STRIDE	Success Through Reaching Individual Development and Employment (STRIDE) Project is Minnesota's primary welfare to work program which provides employment and training services to AFDC recipients to help them become employed.
SUPPLEMENTAL SECURITY INCOME (SSI)	A federal program which provides cash assistance under Title XVI of the Social Security Act to aged, blind and disabled persons to help pay their living expenses.
TEFRA	Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L.

	97-248). Also used to refer to a provision in this law authorizing the optional MA category of eligibility for disabled children who would be MA eligible if they lived in an institution, who require a level of care usually provided in an institution, and for whom care at home is less expensive for the MA program.
TELEPHONE ASSISTANCE PLAN (TAP)	A plan related to providing assistance in the use of telephones to deaf and hard of hearing, speech impaired or mobility impaired persons.
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	A new federal program of cash assistance which will replace AFDC.
TITLE IV-A	Section of the Social Security Act by which eligibility for AFDC is established.
TITLE IV-B	Section of the Social Security Act which provides funding and standards for establishing, extending and strengthing child welfare services.
TITLE IV-D	Child support for AFDC section of the Social Security Act which contains guidelines for establishing paternity and enforcing child support payments from fathers of children on AFDC.
TITLE IV-E	AFDC foster care section of the Social Security Act governing reimbursement for foster care (24-hour out-of-home subsitute care for children).
TITLE V	Maternal-child health (services to children with handicaps) section of the Social Security Act of 1939 which provides for maintaining, promoting, planning and evaluating maternal and child health. Provides health care services to low-income women and children.
TITLE XX	Social services section of the Social Security Act which provides block grants to states for social services. The state, in turn, passes these monies to the counties for the provision of community social services.
TRAUMATIC BRAIN INJURED (TBI)	An individual whose deficits in adaptive behavior or substantial functional limitations are caused by injury to the brain resulting in tissue damage and affecting functional abilities.
TREATMENT ACCOUNTABILITY PLAN (TAP)	A plan related to evaluating the achievements of chemical dependency treatment programs.
VACCINES FOR CHILDREN (VFC)	A statewide program administered by the Minnesota Department of Health in which vaccines are distributed without charge to the enrolled

APPENDIX

CHILDREN'S MANAGEMENT

Presented as part of Children's Grants

BASIC HEALTH CARE GRANTS

Refined goals and objectives

Retained 2 measures, developed 9, presented 3 as background, eliminated 27

HEALTH CARE MANAGEMENT

Refined goals and objectives

Retained 2 measures, presented 5 as background, eliminated 22

STATE OPERATED SERVICES

Refined goals and objectives

Retained and simplified 18 measures, developed 2, eliminated 10.

CONTINUING CARE AND COMMUNITY SUPPORT GRANTS

Refined goals and objectives

Retained 4 measures, developed 12

CONTINUING CARE AND COMMUNITY SUPPORT MANAGEMENT

Refined goals and objectives

Retained 3 measures, developed 2.

APPENDIX

ECONOMIC SUPPORT GRANTS

Refined goals and objectives

Retained 5 measures, developed 1, eliminated 30.

ECONOMIC SUPPORT MANAGEMENT

Refined goals.

Retained 7 measures, eliminated 15

Note: For Economic Support Grants and Management, future measures will be driven by Welfare Reform policy that will be implemented starting SFY 1998.