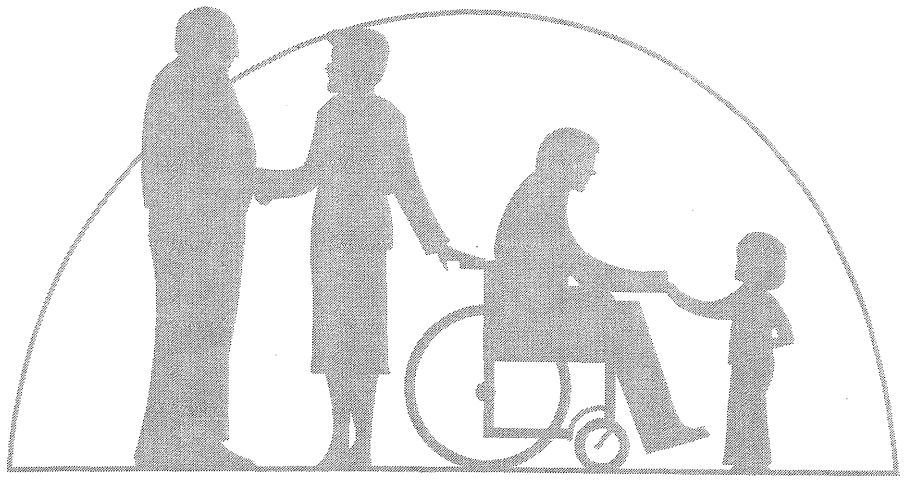
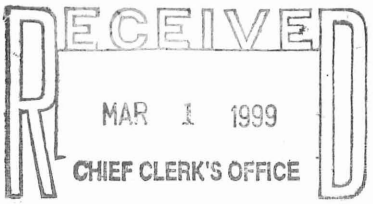


Minnesota Department of **Human Services**

1999 Performance Report

January 2, 1999



DEPARTMENT OF HUMAN SERVICES

SPECIAL PROJECTS OFFICE

Date: February 25, 1999

To: Performance Report Recipients

From: Michael J. McMahon

Phone: 651-297-2001

Subject: Erratum

We recently sent you a copy of the Department of Human Services ***1999*** **Performance Report.** The enclosed sheet describes an error in the report and includes the correct language for the report. Please insert this sheet into your copy of the report.

Kelly - Could you find
this report and staple
in the corrected information?
Thanks.
Bobbie

MINNESOTA DEPARTMENT OF HUMAN SERVICES

1999 Performance Report

ERRATUM

Page 10: One measure of performance is the "overhead cost" of doing business. DHS has set a goal of 5 percent or less for the costs of agency management. On page 10 of the ***1999*** **Performance Report**, data for this measure indicated that in S.F.Y. 1998, Agency Management was 5.8% of all expenditures. While this is true for the Agency Management budget category, this budget category includes pass through federal financial participation funds which are not part of the "overhead costs" of managing the department's programs. When these costs are removed, the expenditures for agency management in S.F.Y. 1998 were 4.4% of agency expenditures. The Performance Measures box is revised to read:

- **Agency Management is less than 5 percent of the agency's overall budget.**
  - In S.F.Y. 1998, Agency Management was 4.4% of all expenditures.
  - In S.F.Y. 1999, projected Agency Management costs will be 4.4% of all expenditures.

If you ask, we will give you this information in another form,
such as Braille, large print or audiotape.

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COST OF REPORT

The cost of this report is based on the costs of salaries and fringe benefits for Department of Human Services employees for the time spent developing and reviewing sections of the report, editing drafts and preparing the final text of the report. The cost also includes the cost of printing the report. No costs were incurred by other agencies or levels of government in the preparation of this report. The estimated cost of this report is $9,557.

Minnesota Department of Human Services
Performance Measures

Agency Management

- Agency Management is less than 5 percent of the agency's overall budget.
- At least 98 percent of payments will be made within 30 days of receipt of invoices.
- Staff composition will reflect the diversity of the human services client population.

Aging Initiative--Project 2030

- Decrease the average length of stay for older persons in institutions.
- Increase the proportion of older Minnesotans receiving public funding for continuing care who reside in the community rather than in an institution.
- Increase the average need level of persons residing in nursing facilities.

Children's Initiative

- Reduce the percent of child protection cases having a new maltreatment finding while case is open for child protection services.
- Reduce the percent of child protection cases having a new maltreatment finding within 12 months of case closure.
- Reduce the number of deaths and near deaths resulting from child abuse or neglect and child's living arrangement at time of death.
- Increase the percent of children who are residing in a permanent arrangement within 12 months of initial placement.
- Decrease the percent of children who have been in placement more than 12 months during the last 60 months.
- Increase the percent of children under guardianship who are adopted within 12 months of coming under state guardianship.
- Decrease the percent of children under guardianship of state who have not declined adoption, aged out of the system and are not adopted.

Continuing Care

- Decrease the use of institutional services to support persons with disabilities.
- Increase the utilization of flexible, cost-effective support models that allow individual needs to be met in a variety of community-based settings.
- Increase the number of adults utilizing continuing care supports which enable them to function independently, remain healthy or make contributions to their community.
- Maintain or increase the availability of family support and self-determination options.
- Provide ancillary services which enable special populations, such as low-income women and people of color, to access and benefit from continuing care services.

Economic and Community Support

- Increase in the percent of MFIP families with reported earnings.
- Increase in the percent of MFIP families who receive food assistance only.
- Increase in the average collection per open child support case.

Health Care

- Increase the monthly average number of individuals enrolled in MinnesotaCare.
- Increase the percentage of low birth weight babies delivered at facilities for high-risk deliveries and neonates.
- Increase the use of preventive dental services by managed care recipients.
- In managed care programs, increase the percent of two-year-olds with vaccinations completed in managed care programs.
- Increase the cost-effectiveness of purchased health care services while ensuring adequate access to services.
- Increase the proportion of MFIP recipients who no longer need publicly-funded health care.

Mission

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

DHS programs include Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, Minnesota Family Investment Program (MFIP), General Assistance (GA), child protection, child support enforcement, child welfare services, and services for people who are mentally ill, chemically dependent, or have physical or developmental disabilities. DHS also provides direct service through its regional service centers for persons who are deaf or hard of hearing and through its state operated services comprised of seven regional treatment centers, state-run group homes and the state nursing home.

Consumers include seniors who need help paying for hospital and nursing home bills or who need home-delivered meals, families with children who need help during a financial crisis, parents who need child support enforcement or child care money, and people with physical or developmental disabilities who need assistance to live as independently as possible.

Guiding Principles

The day-to-day work at DHS is carried out in accord with a set of ***core values*** and ***priorities for people*** which function as guides to helping Minnesotans who don't have the personal or family resources to meet their basic needs. Long-range planning for DHS services is carried out in accord with ***visions*** of the future.

Core Values

To serve Minnesotans in need more effectively, DHS adopted a set of core values to guide our work. These values are:

- We ***focus on people***, not programs.
- We are ***responsible for the common good***.
- We recognize and act upon our ***mutual responsibility to each other***.
- We provide ***safety nets and ladders up*** for the people we serve.
- We are ***partners with communities*** to mobilize supports that ***help people function and succeed***.

Priorities

With the help of Minnesotans from throughout the state, DHS developed five priorities to provide focus for achieving our mission. These priorities are:

- ***Health Care:*** Ensure affordable health care for families with children and purchase affordable long-term care for older Minnesotans and people with disabilities.
- ***Children:*** Promote the best interests of children in all agency services.
- ***Welfare Reform:*** Move more families to work and out of poverty.
- ***Technology:*** Make investments in technology to improve business standards and position for future demands.
- ***Workforce:***Attract and retain a diverse, well-trained workforce able to adapt to future needs.

Visions

In addition to the core values and priorities which guide the daily work of the department, DHS has adopted four visions of the future which provide focus to the long-range planning and policy development for achieving our mission. These visions are:

- ***Supporting Communities:*** Neighborhoods and communities are safe. People know each other, show interest in each other, and look out for each other's needs. Individual differences are respected; and there is a commitment to mutual values that make communities cohesive and strong.

  We recognize many types of communities. We listen to them, ask questions and share information. Our responses are flexible, supportive and committed. Our goals and standards are not confused with sameness. We are a catalyst for solutions. We support local efforts, help eliminate barriers, fill gaps, and know when to stay out of the way. Our commitment is steadfast.

- ***Measuring Value:*** We learn how well people are being served and whether we are paying the best price for that service. We use what we know to serve people better and to make needed changes in how much we pay and in the ways we pay for services.

  We learn what will best help a person succeed. We accurately measure the results of these services in a person's life and are clearly able to show how well this person and others are doing. We learn from our measurements and improve our services. What we pay is connected to results. We learn how to spend enough, but not too much, to get what is best for people we serve.

- ***Accountable Local Delivery Structures:*** Services are delivered and accessed as close to the person as possible. The local agency and service providers are responsible and accountable

for meeting people's needs. They are flexible, creative, competent and highly motivated to perform well. They seek out measures to their performance and respond to constructive feedback. We monitor results, support what is working and change what is not.

- ***Integrated Services:*** People can go to one place near their home to learn about services that are available, to access those services and to receive assistance with ongoing service decisions. There is flexibility to receive the combination of services that best meet people's needs. Services may be funded from a number of different sources, but people receiving services are unaware of this because they just need to go to one place and talk to one person about their services. Services are available to fill gaps, but do not replace the help that is already provided by family, friends and community. Data are gathered and information is used to determine if the services are effective.

Minnesota Milestones

The core values, priorities and visions of the Department of Human Services are coordinated with objectives called "*Minnesota Milestones.*" *Minnesota Milestones* were developed by citizens as a statement of their best hopes for the state. DHS services support the following *Milestones*:

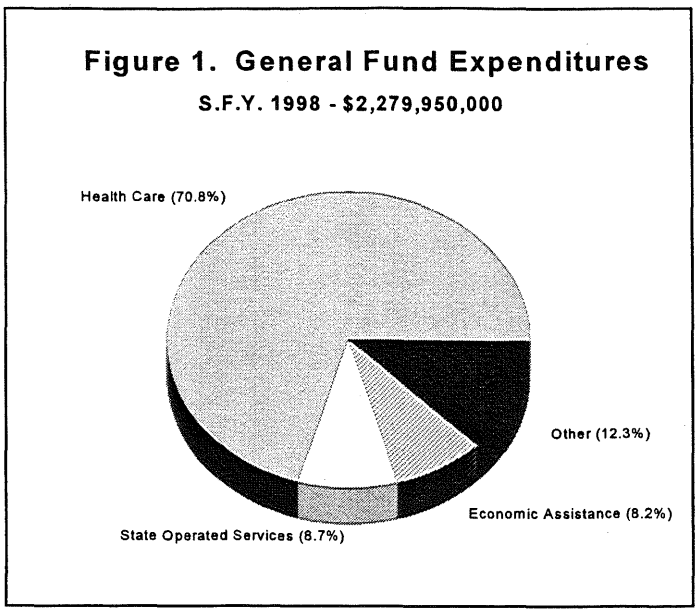
- Our children will not live in poverty.
- Families will provide a stable, supportive environment for their children.
- Minnesotans will be healthy.
- People who need help providing for themselves will receive the help they need.
- People with disabilities will participate in society.
- People of all races, cultures and ethnicities will be respected and participate fully in Minnsota's communities and economy.
- All Minnesotans will have the economic means to maintain a reasonable standard of living.
- Government in Minnesota will be cost-efficient and services will be designed to meet the needs of the people who use them.

In cooperation with other state and local agencies, the programs and services of the Department of Human Services will help to achieve these *Milestones.*

DHS Overview

The Minnesota Department of Human Services accounts for approximately one quarter of the State's General Fund budget. In fiscal year 1998, human services General Fund expenditures totaled about $2.3 billion.

Of these human services expenditures, 70.8 percent was used to pay for publicly subsidized health care services (see Figure 1). State Operated Services accounted for 8.7 percent of the expenditures,



while economic assistance programs used 8.2 percent. The remaining 12.3 percent of the expenditures were used for social services funding, children's programs and administration.

Health Care: Over 70 percent of the DHS General Fund expenditures are spent on basic and long-term health care through Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare. The purchase of basic health care fits within the mission to help Minnesotans whose personal or family resources are inadequate to meet their basic human needs. Basic health care services include physician visits, hospital care, eye glasses, medications, chiropractic and dental care. Long-term health care services, which account for most of the health care expenditures, include residential and nursing home care. In S.F.Y. 1998, over 500,000 Minnesotans were enrolled in one of the three health care programs:

- Medical Assistance served 399,881
- MinnesotaCare service 104,176
- General Assistance Medical Care served 33,688

State Operated Services: DHS operates facilities which serve persons who are developmentally disabled, elderly, mentally ill or chemically dependent, as well as persons with psychopathic personalities. This area includes services provided through campus-based regional treatment centers, community service programs and state-operated group homes. In addition, this area includes the Minnesota Sexual Psychopathic Personality Treatment Center, a facility which treats individuals committed as sexual psychopaths.

Economic Assistance: This area helps Minnesotans whose personal or family resources are inadequate to meet their basic needs by increasing the abilities of families and individuals to move out of poverty, to support themselves financially and to provide a temporary safety net for those people who cannot fully support themselves. The statewide Minnesota Family Investment Program

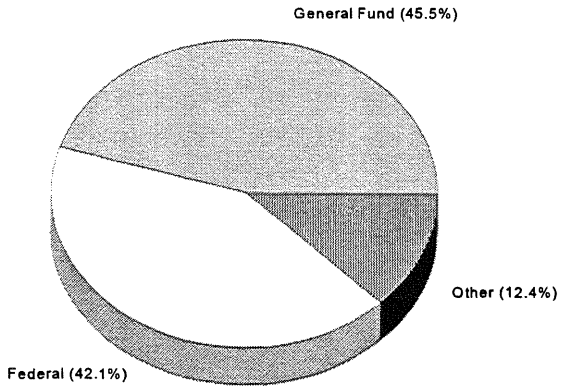
(MFIP) is the foundation for assisting families to move from welfare to work as the way to be financially independent. This area also includes Aid to Families with Dependent Children, General Assistance, Minnesota Supplemental Aid and Supplemental Security Income programs. Over 300,000 Minnesotans were served by these programs each month.

Other: This area encompasses a variety of social services and family and children's programs which are supported by the department, as well as the costs of managing human services programs.

During S.F.Y. 1998, the Department of Human Services spent a total of $5,229,366,000 on all services. In addition to General Fund appropriations, the primary source of funds was federal funds. General fund appropriations accounted for 45.5 percent of the expenditures, federal funds for 42.1 percent and other sources of funds for 12.4 percent (see Figure 2).

Figure 2. Expenditures by Fund

S.F.Y. 1998 - $5.2 Billion



The major programs funded by the federal government include Medical Assistance, AFDC, Temporary Assistance to Needy Families, Child Support Enforcement Administration, Foster Care and Adoption Assistance, Substance Abuse and Mental Health Services Administration block grants and the Title XX block grant.

1999 Performance Measures

The Department of Human Services supports and operates a variety of programs designed to provide health care, economic assistance and social services to those Minnesotans whose personal or family resources are inadequate to meet their basic human needs. Progress toward achieving this mission will be discussed in the context of six program areas in the department:

- Agency Management
- Aging Initiative--Project 2030
- Children's Initiative
- Continuing Care
- Economic and Community Support
- Health Care

Continuing Care, Economic and Community Support and Health Care form the three primary areas of service provided by the department. The Aging Initiative and the Children's Initiative are special focus programs which cut across the three primary areas. Agency Management is the management and support area for the department.

The following sections of this report will provide a description of each of these areas, its primary goal(s), performance measures for the goal, and performance results.

Agency Management

Agency Management provides the financial, legal and regulatory and management support for the department's programs. This area includes the commissioner's office and central administration for the department.

Financial Operations manages the fiscal resources of the department so that policy objectives are met and stewardship of public funds is assured. Human Services is an approximately $12 billion biennial budget activity. To operate within state and federal law, budget forecasting, accounting, collections, and accounts payable and receivable must be managed. The diversity of department services and their funding sources creates extensive accounting and forecasting complexity. Financial Operations is responsible for:

- Forecasting of entitlement program expenditures and reports on all expenditures and revenues
- Ensuring that funds are received from all required sources and are expended within the parameters of state and federal law
- Directing the development of the agency's biennial budget, supplemental budget and performance report.

Legal and Regulatory Operations provides procedures that promote quality and equal access to services; establish and implement regulatory/statutory standards based upon integrity and cost effectiveness; and assure protection of the health, safety and rights of people served by the department. Legal and Regulatory Operations is responsible for:

- Resolving disputes with clients, license holders and long term care facilities
- Providing 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
- Licensing services and investigating complaints
- Collaborating with other activities within the department to provide legal expertise.

Management Operations includes the commissioner's office and a variety of services necessary to the efficient operation of government programs. The purpose of this area is to develop a workplace that is professionally competent, can meet new challenges quickly, reflects the diversity of department clientele, is technologically literate and operates with ethics and integrity. Management Operations is responsible for:

- Agency leadership and public policy directions
- Human resource development to implement agency direction and manage services effectively
- Information and technology resources to maintain computer and technology investments and adapt them for the future
- Management services to meet the basic business needs including facilities, communication systems, inventory and property management and purchasing

- Internal auditing to provide an independent assessment of management and financial controls.

Agency Management activities are directly responsible for two of the five priorities: technology and workforce. Through its leadership, Agency Management is also directed toward achievement of the Milestone: Government in Minnesota will be cost-efficient and services will be designed to meet the needs of the people who use them.

Goal:

The primary goal for Agency Management is: Human Services will be cost efficient and designed to meet the needs of the people who use them.

Progress toward this goal can be measured by reviewing three activities within the purview of Agency Management. First, one measure of performance is the "overhead cost" of doing business. DHS has set a goal of 5 percent or less for the costs of agency management. Second, because a substantial portion of the administration of department programs involves the collection of receipts and dispersement of payments and because prompt payments to vendors are important to human service providers, another measure is the efficiency with which the department pays its bills. Third, providing a workforce which corresponds to the composition of our clientele is important.

Performance Measures:

- **Agency Management is less than 5 percent of the agency's overall budget.**
  - In S.F.Y. 1998, Agency Management was 5.8% of all expenditures.
  - This is a decrease from 6.4% in S.F.Y. 1997.

- **At least 98 percent of payments will be made within 30 days of receipt of invoices.**
  - In S.F.Y. 1998, 67,075 vendor payments were made through the Minnesota Accounting and Procurement System (MAPS).
  - 98% of the MAPS vendor payments were made within 30 days.

- **Staff composition will reflect the diversity of the human services client population.**
  - The percentage of minority employees in the central office has increased from 8.1% in 1996 to 10.1% in 1998.
  - The percentage of disabled employees in the central office has increased from 7.6% in 1996 to 7.8% in 1998.

Aging Initiative--Project 2030

The DHS Aging Initiative, established in 1997, encompasses all state-administered or state-funded supports for older Minnesotans. Direct supports range from nursing facility care to housing with services to home nurse or personal care to home-delivered meals. Also funded are indirect supports such as development of region-wide initiatives to coordinate service delivery and funding and develop infrastructures; development of coordinated health care systems that consolidate funding from multiple sources; exploration of "cash and counseling" provision to consumers to help them purchase their own services; operation of an ombudsman's office; and continuous improvement of systems and processes for accessing necessary services.

Project 2030 is a special effort by the Aging Initiative to promote widespread understanding of projected demographic trends and their ramifications for future elderly and their communities and to encourage development of local responses to an aging society.

Guiding Principles: In all its efforts the Aging Initiative is committed to:

- Focus on the whole person
- Provide meaningful choices
- Emphasize prevention and early intervention
- Create partnerships with private and public organizations to prepare for future demographic changes
- Promote appropriate competition, efficient management, quality, and innovation
- Encourage personal responsibility and accountability.

Funding: The Aging Initiative meets older Minnesotans' needs through a variety of funding mechanisms:

- Funding is made available to counties to purchase services for individuals or to create services to meet specific local needs
- Payment is made directly by the state to service providers for services rendered
- Grants are provided directly to individuals to buy the services they need
- Services are provided directly by the state.

Services: Services and supports funded by the Aging Initiative include:

- Congregate dining and other nutritional services
- Home care and skilled nursing and other services which allow persons at risk of nursing home placement to live at home
- Nursing home payments
- Group residential housing
- Social services, adult and child foster services
- Ombudsman services for the elderly.

Goal:

The Aging Initiative's primary goal is to promote independent living for older persons by funding or providing a broad range of residential care and social services close to home communities, instead of in institutional settings. DHS also emphasizes developing services and supports that accomplish the following goals:

- Have decisions made at a level which is closest to the person
- Promote self-determination and self-reliance
- Build informal supports from family, friends and community
- Allow flexible purchasing to meet individual needs
- Purchase supports on a performance rather than a cost basis
- Coordinate long-term and acute care services
- Encourage local innovation, efficiency and accountability
- Assure a statewide safety net.

Performance Measures:

- **Decrease the average length of stay for older persons in institutions.**
  - The mean length of stay of older Minnesotans in nursing facilities decreased from 513 days in F.Y. 1995 to 493 days in F.Y. 1996 (see Figure 3).
  - The median length of stay of older Minnesotans in nursing facilities decreased from 99.5 days in F.Y. 1995 to 67.5 days in F.Y. 1996.

- **Increase the proportion of older Minnesotans receiving public funding for continuing care who reside in the community rather than in an institution.**
  - Of older Minnesotans who received public funding for continuing care, the proportion who reside in the community rather than in an institution increased from 36.9% in F.Y. 1996 to 39.4% in F.Y. 1997. [1]

- **Increase the average need level of persons residing in nursing facilities.**
  - The average case mix score (weighted by resident day) for nursing facilities statewide has steadily increased from 2.36 in F.Y. 1991 to 2.44 in F.Y. 1996(see Figure 4).[2]

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[1]The proportion of older Minnesotans who received public funding for continuing care in F.Y. 1997 was 8%.

[2]A case mix classification from A to K is assigned to each nursing facility resident to represent the assessed need level of the person. Case mix classifications are weighted, and the weights range from 1.0 for case mix A to 4.12 for case mix K. Higher weight represents higher service need.

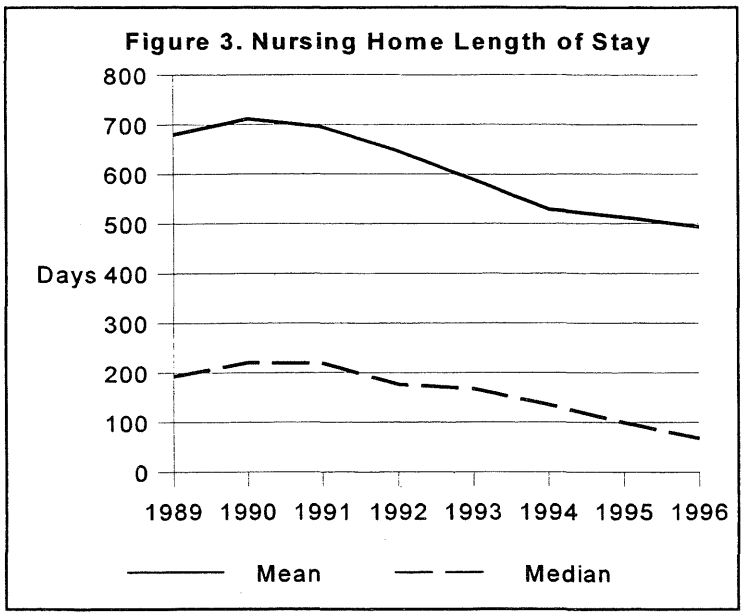


Figure 3. Nursing Home Length of Stay
800
700
600
500
Days 400
300
200
100
0
1989 1990 1991 1992 1993 1994 1995 1996
Mean
Median

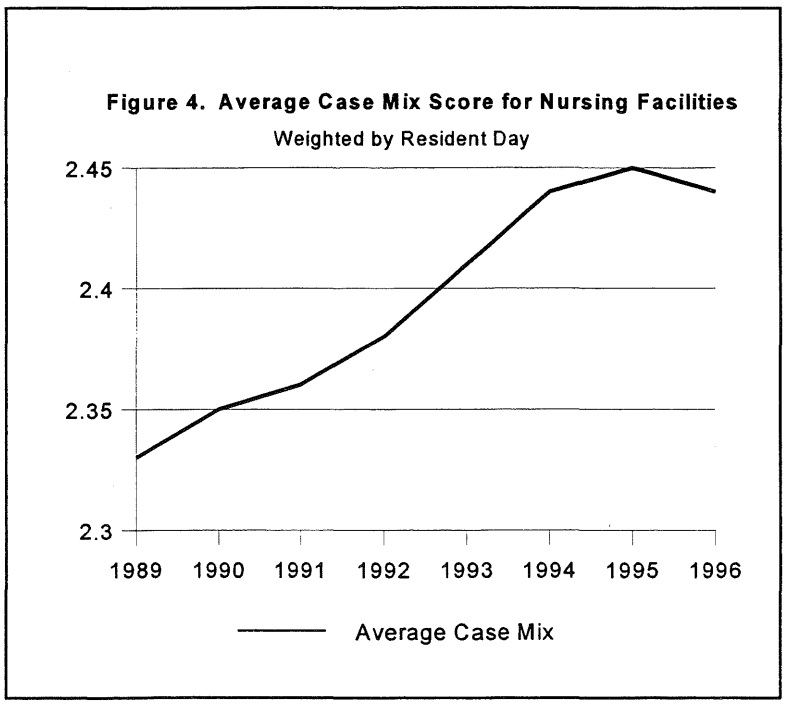


Figure 4. Average Case Mix Score for Nursing Facilities
Weighted by Resident Day
2.45
2.4
2.35
2.3
1989 1990 1991 1992 1993 1994 1995 1996
Average Case Mix

Children's Initiative

The Children's Initiative, established in 1994, is an intra-agency effort of the department. Its purpose is to pull together resources and expertise to ensure positive outcomes for children at risk. The Children's Initiative has direct control over child protection, adoption assistance, foster care, children's mental health, and other children's services. As a "safety net" for families and children, DHS recognizes the impact of social services, economic assistance and health care on families. The purpose of the Children's Initiative is to serve as a catalyst and improve services by "building on what works," like comprehensive and collaborative responses to family needs and early, preventive services.

Priorities:

- Support families in crisis to care for their children
- Help families find services quickly and conveniently
- Find permanent, stable homes for children who cannot live with their own families
- Oversee the foster care and child protection systems to ensure their focus on the best interests of the child
- Develop tools so that social workers, child protection professionals and others dealing with child welfare can effectively do their jobs.

Program responsibilities:

- Child Protection services
- Family Preservation services
- Out-of-home placement
- Adoption
- Children's Mental Health Collaborative
- Adolescent services

Program supports:

- Social Services Information System (SSIS)
- Child Welfare Training System

Goals:

The Children's Initiative has two major outcome goals. The two outcome goals are to assure child safety and permanency for children.

Performance Measurement:

During 1998, the Child Welfare Performance Indicators Task Force appointed a county/state work group to identify a small number of statewide measures of performance of child welfare services. The Task Force focused their development of performance indicators on two areas: child safety and

permanency for children. Other measures of child well-being may be added in the future, such as measures related to child health, quality of care and child functioning. There are seven indicators to measure statewide performance: three child safety outcome indicators and four child permanency outcome indicators.

Data from the Child Maltreatment Report and the Out-of-Home Placement Report will be used to provide information on those indicators for which we have available information for calendar year 1998. These data will be available in the spring of 1999. The Social Services Information System (SSIS) will be able to provide information on all indicators beginning in December 2000.

Child Safety Indicators:

- **Reduce the percent of child protection cases having a new maltreatment finding while case is open for child protection services.**
  - This is a new measure; data are now being collected.

- **Reduce the percent of child protection cases having a new maltreatment finding within 12 months of case closure.**
  - This is a new measure; data are now being collected.

- **Reduce the number of deaths and near deaths resulting from child abuse or neglect and child's living arrangement at time of death.**
  - In 1997, there were 8 deaths and 72 life-threatening injuries.

Child Permanency Indicators:

- **Increase the percent of children who are residing in a permanent arrangement within 12 months of initial placement.**
  - This is a new measure; data are now being collected.

- **Decrease the percent of children who have been in placement more than 12 months during the last 60 months.**
  - This is a new measure; data are now being collected.

- **Increase the percent of children under guardianship who are adopted within 12 months of coming under state guardianship.**
  - In 1996, 14.6% of children under guardianship were adopted within 12 months.
  - In 1997, 10.6% of children under guardianship were adopted within 12 months.

- **Decrease the percent of children under guardianship of state who have not declined adoption, aged out of the system and are not adopted.**
  - In 1996, 5.2% of the children under guardianship aged out of the system and were not adopted.
  - In 1997, this percentage decreased to 4.5%.

Continuing Care

Continuing Care furthers the department's mission by helping individuals with disabilities access health care, residential care, social services, employment supports and housing assistance. Continuing Care enables Minnesotans with support needs to live as independently as possible, to participate fully in community life and to make contributions to the broader society.

While Continuing Care policy development is guided by multiple department core values, two are especially worth noting--first, our efforts are about safety nets and ladders up and second, we work in partnership with communities to help people function and succeed. People can live independently with their disabilities, recover from mental illness and resolve a chemical dependency problem. Department policies are based on the concept that effective services focus on people's needs while supporting their existing strengths. Informal supports are strengthened, not supplanted.

The **Chemical Dependency Division** is the State Authority on Alcohol and Drug Abuse. The division establishes statewide policy and responses to alcohol and drug abuse. Its guiding principle is to promote a reduction of alcohol and other drug problems and their effects on individuals, families and society. This activity provides basic information about chemical abuse and dependency, plans an effective service system, evaluates prevention and treatment programs, administers federal block grant dollars, operates a reimbursement system to collect first and third party payments and financially supports needed services. The CD Division oversees the state's Consolidated Chemical Dependency Treatment Fund which funds treatment costs for Minnesotans who lack the resources to pay for needed treatment. Citizen input is through the Drug and Alcohol Abuse Advisory Council and the American Indian Advisory Council.

Community Support for Minnesotans with Disabilities is a division of the department which provides progressive and innovative policy and funding direction on an array of community-based services and supports to people with physical disabilities, chronic health conditions, traumatic brain injury and developmental disabilities. This area promotes the development of flexible, creative and person-centered support options which are less costly than institutional care and advances practices which build self-determined lives. Individuals can access a wide array of services, according to their specific needs, including case management, skilled nursing care, home health aids, personal care attendant services, day training and habilitation or home and community-based waivered services.

The **HIV/AIDS Programs** increase the longevity, quality of life and productivity of Minnesotans living with HIV or AIDS. The HIV/AIDS Programs offer options which help Minnesotans living with HIV obtain access to needed medical or health care and reduce reliance on publicly funded programs. These four programs offer assistance to obtain health insurance, drug reimbursement, nutritional supplements and dental care. The programs are funded by federal Ryan White CARE Act funds or state funds for insurance continuation and drug reimbursement.

The **Mental Health Division** is the designated State Mental Health Authority. The division assures that a broad array of community-based mental health services is available throughout Minnesota for

persons with serious and persistent mental illness. This division establishes statewide policy and standards for care and provides funding for new and innovative mental health services and ongoing support of such services. The division works closely with other state agencies to develop housing and employment options for the target population.

Efforts are focused on developing assistance which allows people to live independently when possible and, if independence is not possible, to live in treatment settings that are clean, safe, caring and effective. Regional initiatives across the state are expanding community-based service options and developing alternative service delivery models which reduce reliance on facility-based care. These initiatives are also integrating staff and other resources from the regional treatment centers into the local community mental health delivery system.

State Operated Services (SOS) provide the safety net for people who are unable to receive services any other way. Historically this has occurred primarily in facility-based settings across the state. Regional treatment centers (RTCs) in Anoka, Brainerd, Cambridge, Fergus Falls, Moose Lake, St. Peter and Willmar and the state nursing home (Aw-Gwah-Ching) provide services to people with mental illness, developmental disabilities, chemical dependency and traumatic brain injuries and to elderly people with challenging behaviors.

In the past decade, a key goal of the SOS system has been to reduce reliance on inpatient and facility-based care by providing a variety of treatment options in homelike settings. Some of the SOS programs are provided in partnership with other community health care providers, some at the request of county agencies in the competitive marketplace, and others through direct appropriation to assure provision of the safety net needs of the most vulnerable Minnesotans.

In response to community concern and legislative direction, DHS operates three treatment programs targeted to disabled persons who pose a risk to society:

- The Minnesota Sexual Psychopathic Personality Treatment Center in Moose Lake treats individuals who are committed by the court system as sexually dangerous persons.

- The Minnesota Security Hospital in St. Peter provides forensic mental health services including court-ordered evaluations.

- Minnesota Extended Treatment Options (METO), in Cambridge, provides both residential and community support services to people with developmental disabilities whose behaviors present a public safety risk. Clients receive intensive treatment so they can live safely in the community.

The **Demonstration Project for People with Disabilities** is a pilot project which beings together advocates, consumers, counties, health plans, state agencies and others to create more flexible health and related services for people with disabilities to enhance models of community service systems using models which apply managed care concepts. This project seeks to improve care and contain

costs by combining funding from a variety of sources and centralizing decision making around client services planning, so that needed health and related services are delivered to disabled persons in a timely manner and in ways that best meet individuals' needs.

Services Provided: Continuing Care services include:

- Home care, skilled nursing and other services which allow persons at risk of institutionalization to live at home
- Individualized community-based services and supports for persons with disabilities which allow them to live self-determined and independent lives
- Community support and residential treatment for adults with serious and persistent mental illness
- Chemical dependency treatment and after-care
- Group home payments for individuals with mental retardation or a related condition;
- Group residential housing payments
- Adaptive technology and translation services for the deaf and hard of hearing
- HIV-related medications, dental services, insurance premiums and nutritional products
- Adult and child foster services
- Guardianship services for persons who are wards of the Commissioner of Human Services.

Continuing Care for persons with disabilities meets individual needs through a variety of funding mechanisms:

- Funding is made available to counties to purchase services or to create services to meet specific local needs
- Payment is made directly by the state to service providers for services rendered
- Grants are provided directly to individuals to buy the services they need
- Premiums are paid which provide needed health care coverage
- Services are provided directly by the state.

Goal:

The primary goal of Continuing Care is to promote independent living for persons with disabilities by funding or providing a broad range of residential care and social services close to home communities, instead of in institutional settings. Encouraging and funding alternatives to institutional care that are accountable and cost-effective are significant for achieving this goal.

DHS places a strong emphasis on developing services and supports that accomplish the following goals:

- Build informal supports from family, friends and community
- Have decisions made at a level which is closest to the person
- Encourage local innovation, efficiency and accountability
- Allow flexible purchasing to meet individual needs
- Promote self-determination, self-reliance and self-sufficiency
- Decrease reliance on publicly-funded supports when possible

- Purchase supports on a performance rather than a cost basis
- Coordinate long-term and acute care services
- Assure a statewide safety net.

Performance Measurement:

- **Decrease the use of institutional services to support persons with disabilities.**
  - The average daily census in regional treatment centers for persons with developmental disabilities declined from 419 in F.Y. 1996 to 194 in F.Y. 1998.
  - The average daily census in regional treatment centers for persons with serious and persistent mental illness declined from 842 in F.Y. 1996 to 619 in F.Y. 1998.
  - The number of people with developmental disabilities residing in nursing facilities was reduced from 1,074 persons in F.Y. 1996 to 574 persons in F.Y. 1998.
  - The average length of stay in a regional treatment center for persons with serious and persistent mental illness declined from 122 days in F.Y. 1996 to 98 days in F.Y. 1998.
  - The number of individuals with developmental disabilities proactively receiving community support services to prevent institutionalizationincreased from 79 in F.Y. 1996 to 608 in F.Y. 1998. These supports are now available in all 87 counties.

- **Increase the utilization of flexible, cost-effective support models that allow individual needs to be met in a variety of community-based settings.**
  - The number of persons receiving chemical dependency treatment in outpatient settings increased from 7,318 in F.Y. 1996 to 8,552 in F.Y. 1998.
  - The post treatment abstinence rate of adults admitted for primary chemical dependency treatment is 62.9% for inpatient treatment and 69.2% for outpatient treatment.
  - The number of persons with disabilities persons served by the various home and community-based waiver programs at the end of F.Y. 1998 is as follows:

Community Alternatives for Disabled Individuals (CADI) Waiver	2,906
Community Alternatives for Children (CAC) Waiver	135
Home and Community-based Waiver for Persons with Mental Retardation or a Related Conditions (MR/RC) Waiver	6,884
Traumatic Brain Injury (TBI) Waiver	306
TOTAL	10,321

- **Increase the number of adults utilizing continuing care supports which enable them to function independently outside of institutions, remain healthy or make contributions to their community.**
  - The number of adults receiving personal care assistance was 7,157 in F.Y. 1996 and

decreased to 6,595 in F.Y. 1998.

- The number of adults with serious and persistent mental illness who were provided support services to obtain employment increased from 27 in F.Y. 1992 to 1064 in F.Y. 1998.
- The number of persons with HIV/AIDS who were provided access to critical health care services rose from 904 in F.Y. 1996 to 1,115 in F.Y. 1998.
- The number of adults with mental retardation or related conditions receiving home and community-based services increased from 4,712 in F.Y. 1996 to 6,074 in F.Y. 1998.

- **Maintain or increase the availability of family support and self-determination options.**
  - The number of families receiving family support options was 726 in F.Y. 1996 to 719 in F.Y. 1998.
  - The number of people participating in self-determination initiatives has increased from 0 in F.Y. 1996 to 75 in F.Y. 1998. These participants engage in person-centered planning activities, control allocated resources through individualized budgets, and take greater responsibility to manage the supports they receive..

- **Provide ancillary services which enable special populations, such as low-income women and people of color, to access and benefit from continuing care services.**
  - Low income women who received ancillary services (such as psychological services, family counseling, and financial counseling) achieved a 62.4% rate of treatment completion. This compared to a completion rate of 64.1% for non low-income women.

Economic and Community Support

Economic and Community Support Strategies (ECSS) works closely with Minnesota counties to help Minnesotans whose financial resources are inadequate to meet their basic needs. It assists low-income families with children to move out of poverty by emphasizing work and providing supports for working families. Child support enforcement services are provided by the state and counties to maximize families' receipt of child support. ECSS maintains a safety net for adults without children who are unable to support themselves. It provides services to assist deaf and hard of hearing Minnesotans.

Services Provided:

- The Minnesota Family Investment Program (MFIP) is the foundation for assisting families to move from welfare to work. MFIP participants are expected to support themselves and their families to the best of their abilities. In return, the MFIP program provides supports to help families make the transition from welfare to work. The MFIP grant replaces Aid to Families with Dependent Children (AFDC), Food Stamps, Family General Assistance (FGA) and Project STRIDE grants, restructuring the welfare system around 4 goals:
  - Expecting work
  - Supporting work
  - Rewarding work
  - Reducing long-term dependence on welfare as the primary source of family income

- Work Grants provide employment and training services to help low-income families and individuals avoid or end public assistance dependency. Employment and training services are provided to MFIP participants and to food stamp recipients as required under federal law through the Food Stamp Employment and Training (FSET) requirements.

- Child Support Enforcement is an activity that recognizes that many children fall into poverty and depend on public assistance when child support is not paid. Child Support Enforcement services are provided by the state and counties to maximize families' receipt of child support and, when necessary, track down parents who are not supporting their children.

- General Assistance (GA) is a state-funded "safety net" program for individuals and couples without children who cannot fully support themselves.

- Minnesota Supplemental Aid (MSA) provides cash assistance to aged, blind and disabled individuals who are in financial need. MSA is a state-funded program that is required by the federal government to supplement Supplemental Security Income (SSI).

- Refugee Services are a collection of strategies designed to meet the special self-sufficiency and resettlement needs of refugees. These services include:
  - Refugee Cash Assistance/Refugee Medical Assistance

- Social Services for Refugees
- Services for Asian Youth

- The Telephone Assistance Plan (TAP) provides telephone cost subsidies to certain low-income Minnesotans.

To support these services, Economic and Community Support Strategies provides the following supports for public assistance programs:

- Operating and maintaining the eligibility and delivery systems critical to grant recipients for their monthly subsistence and medical needs.
- Determining eligibility for economic support grants.
- Maintaining the automated data interfaces among systems, including MAXIS, PRISM, MMIS, the federal Social Security Administration and Internal Revenue Service systems.
- Collecting and distributing child support payments, locating absent parents, establishing paternity and enforcing court orders.
- Conducting federally mandated quality control reviews, payment accuracy assessments and administration evaluations for MFIP, Food Stamps, MA, Child Support and MinnesotaCare.
- Administering the Electronic Benefit Distribution System
- Managing Program Integrity prevention and control functions to minimize fraud.
- Supporting county agency delivery of services through training, instructional manuals, policy assistance and system support through help desks.
- Implementing policy changes and development and analysis of legislation.
- Participating with other state agencies and community organizations to identify and address welfare reform issues.

Goal:

The goal of Economic and Community Support Strategies is to reduce welfare dependency by assuring that economic support programs reward work and responsibility; creating reforms that help families move out of poverty and are responsive to economic realities; and ensuring that noncustodial parents support their children.

Progress toward this goal can be measured by evaluating the effectiveness of the MFIP program in moving participants into the workforce. Measurement of child support enforcement activities will show the extent to which improvements in child support collections are achieved.

Performance Measurement:

- **Increase in the percent of MFIP families with reported earnings.**
  - In 1990-1996, the baseline average monthly employment rate for AFDC recipients was 9.9%.
  - In July-September, 1998, the average monthly employment rate for MFIP recipients was 29.7%

- **Increase in the percent of MFIP families who receive food assistance only**
  - In July-September, 1998, the percent of MFIP families receiving food assistance only was 4.4%. There is no AFDC baseline for this measure.

- **Increase in the average collection per open child support case.**
  - The average collection amount per open child support case was $1,617 in S.F.Y. 1996.
  - The average collection amount per open child support case rose to $1,747 in S.F.Y. 1997.

Health Care

Health Care administers the state's medical assistance and health care programs. Specific Health Care responsibilities are four-fold.

First, the **State Medicaid Director** administers policy for the federal Medicaid program in Minnesota, including serving as liaison to the Health Care Financing Administration (HCFA). The State Medicaid Director also oversees tribal and waiver relations.

Second, the **Health Care for Families and Children Division** administers MinnesotaCare, Medical Assistance (Medicaid) and General Assistance Medical Care programs. This division develops eligibility policy for the three health care programs. The division supervises administration of the eligibility programs, performed by counties and MinnesotaCare operations, by providing training and other assistance.

Third, the **Purchasing and Service Delivery Division** administers negotiations, contracting, purchasing and benefits and payment policies for the health care programs. DHS purchases health care services through both fee-for-service and managed care. To improve access and quality while containing costs, DHS increasingly relies on managed-care services. This division provides these services:

- Establishes rates for health services
- Monitors contracted agencies
- Oversees customer service and provider help lines
- Operates a prior authorization unit
- Operates a managed care ombudsman unit
- Provides training and publications

Fourth, **Performance Measurement and Quality Improvement (PMQI)** assesses the quality and level of health care provided to public clients and monitors the services purchased for quality improvement and progress on achieving health care goals. PMQI provides these services:

- Research and develop performance measures to evaluate health care programs
- Develop and maintain health-care data and information systems
- Conduct clinical-focused studies
- Evaluate population health
- Administer customer satisfaction surveys
- Establish quality assurance and improvement standards for health care purchasing
- Monitor Medicaid fraud and abuse
- Oversee managed care quality assurance and improvement
- Administer Minnesota's federal Early Periodic Screening, Diagnosis and Treatment program, benefit policy for Maternal and Child Health Care and school-based health care services.

Goal:

Health Care has four main goals: 1) reduce the number of people who are uninsured: 2) ensure the quality of care provided to clients while enrolled in DHS' health care programs; 3) purchase quality health care for DHS clients at the lowest possible price; and 4) eventually reduce the ongoing reliance on publicly funded health care systems.

Performance Measurement:

Reducing the number of uninsured:

- **Increase the monthly average number of individuals enrolled in MinnesotaCare.**
  - The average number of individuals enrolled in MinnesotaCare increased from 88,274 in 1996 to 97,854 in 1998 (see Table 1).

Ensuring the quality of care:

- **Increase the percentage of low birth weight babies delivered at facilities for high-risk deliveries and neonates.**
  - In 1996 83% of low birth weight babies were delivered at facilities for high-risk deliveries and neonates, as were 81% of very low birth weight babies (see Figure 5).
  - The Year 2004 target is 100% for both measures.

TABLE 1

MinnesotaCare Enrollment

Fiscal Years 1991-1998

Fiscal Year	Average Monthly Enrollees	Fiscal Year	Average Monthly Enrollees
1991	12,133	1996	88,276
1992	22,896	1997	93,136
1993	35,217	1998	97,854
1994	62,232	1999 (projected)	108,871
1995	77,417		

- **Increase the use of preventive dental services by managed care recipients.**
  - The number of visits of preventive dental care increased from 37 per 1000 eligibility months in 1996 to 39 per 1000 eligibility months in 1997
  - The rate of visits for preventive dental services has increased each of the last four years for managed care recipients (see Figure 6), surpassing the rate provided under the fee-for-service system.

- **In managed care programs, increase the percent of two-year-olds who have received all scheduled vaccinations.**
  - 46% of two-year-olds enrolled in Prepaid Medical Assistance Programs (PMAP) in 1996 received complete vaccinations (see Figure 7).
  - 67% of two-year-olds enrolled in PMAP in 1997 received complete vaccinations.
  - The Minnesota Public Health Goal is 90% with complete vaccinations in 2004.

Figure 5
Low Birth Weight Babies Delivered at Facilities for High-Risk Deliveries and Neonates (PMAP 1996 Data)

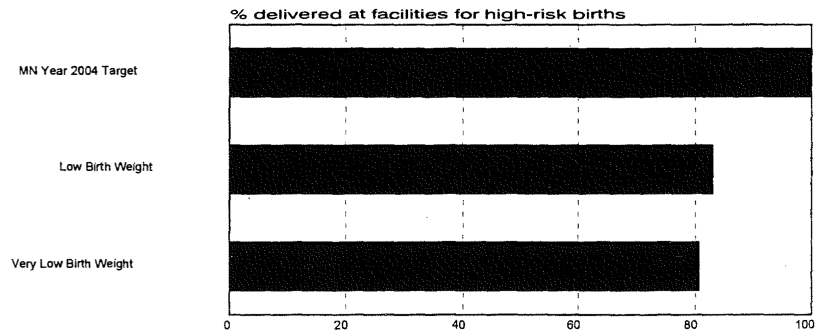
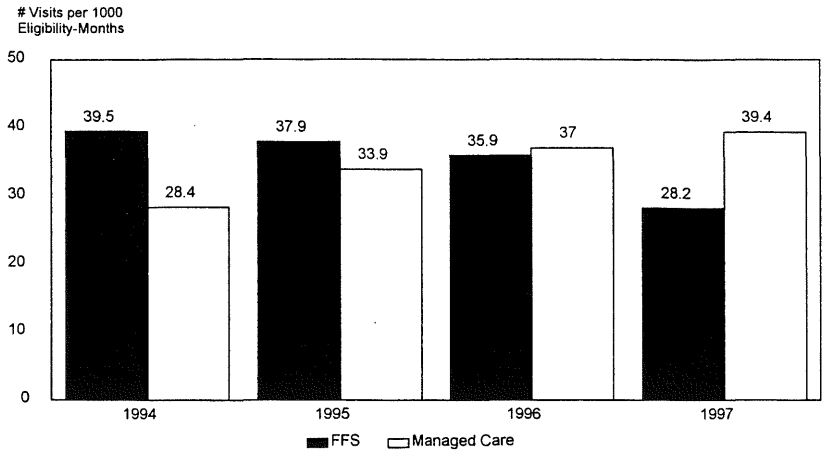


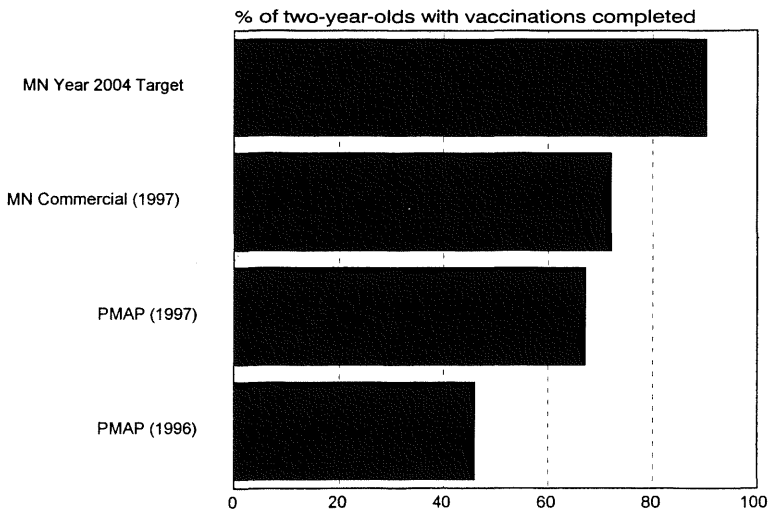
Figure 6
Preventive Dental Services



Notes:

1. 1994 figures are based on only the third and fourth quarters. 1997 figures are based only on the first and second quarters.
2. Fee-for-service figures are based on a sample of fee-for-service eligibles that excludes those groups of persons categorically excluded from managed care.
3. Managed care figures are based only on those plans that reported services for the year.

Figure 7
Childhood Immunizations



Purchasing quality health care:

- **Increase the cost-effectiveness of purchased health care services while ensuring adequate access to services.**
  - Measures are being developed.

Reducing reliance on publicly funded health care:

- **Increase the proportion of former MFIP recipients who no longer need publicly-funded health care.**
  - 14,165 former MFIP recipients transitioned with MinnesotaCare and were no longer enrolled in any public program in 1996 (see Table 2).
  - This number increased to 15,016 in 1997.

Table 2
Number of Former MFIP Recipients Off All Public Programs After Transitioning with MinnesotaCare

State Fiscal Year 1994	6,507
State Fiscal Year 1995	10,757
State Fiscal Year 1996	14,165
State Fiscal Year 1997	15,016

GLOSSARY OF ACRONYMS

AFDC Aid to Families with Dependent Children--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. This program was replaced by Temporary Assistance to needy Families through welfare reform in 1996.

CAC Community Alternatives for Children 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.

CADI Community Alternatives for Disabled Individuals 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.

DHS Minnesota Department of Human Services

ECSS Economic and Community Support Strategies, the DHS business which administers many of the welfare programs for the state.

F.Y. Fiscal Year. The state fiscal year is from July 1 to June 30; the federal fiscal year is from October 1 to September 30.

FSET Food Stamp Employment and Training Program, which provides employment and training services to Food Stamp recipients, emphasizing quick employment and focusing on job seeking and job placement activities.

GA General Assistance, a 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.

GAMC General Assistance Medical Care, a 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.

HCFA Health Care Financing Administration, the federal umbrella agency for the Medicaid program, an agency of the U. S. Department of Health and Human Services.

MA Medical Assistance, 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.

MAPS Minnesota Accounting and Procurement System is a statewide accounting and procurement system designed to meet the financial management needs of large government organizations.

MAXIS A master computer system which tracks, records and monitors all public assistance benefits activity (AFDC/TANF, MA, GA, GAMC), eligibility and payments.

METO Minnesota Extended Treatment Options is a program in Cambridge which provides both residential and community support services to people with developmental disabilities whose behaviors present a public safety risk.

MFIP Minnesota Family Investment Program, 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.

MMIS Medicaid Management Information System, a mainframe computer system that processes provider invoices, edits for recipient and service eligibility, pays allowed charges and provides recipient payment history.

MR/RC Mental retardation or a related condition

MSA Minnesota Supplemental Aid, a state program which provides cash assistance to aged, blind and disabled recipients of Supplemental Security Income (SSI).

PMAP Prepaid Medical Assistance Program

PRISM Providing Resources to Improve support in Minnesota (PRISM) is a statewide computer system in child support enforcement. It automates state child support case management and accounting and includes features to improve customer services.

RTC Regional Treatment Center, 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 DHS.

S.F.Y.	State Fiscal Year, July 1 to the following June 30.
SOS	State Operated Services provides the safety net for people who are unable to receive services in any other way. SOS includes both RTCs and community-based programs.
SSI	Supplemental Security Income, a federal program which provides cash assistance under Title XVI of the Social Security Act at aged, blind and disabled persons to help pay their living expenses.
SSIS	Social Services Information System, an information system designed to provide uniform access to data on social services cases.
STRIDE	Success Through Reaching Individual Development and Employment (STRIDE) Project was Minnesota's primary welfare to work program which provides employment and training services to AFDC recipients to help them become employed. STRIDE's goals have been incorporated into MFIP.
TAP	Telephone Assistance Plan, a plan related to providing assistance in the use of telephones to deaf and hard of hearing, speech impaired or mobility-impaired persons.
TBI	Traumatic Brain Injured, 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.