COMMISSION ON REFORM AND EFFICIENCY

CORE

REFORMING MINNESOTA'S HUMAN SERVICES DELIVERY SYSTEM

DETAILED REPORT

MARCH 1993

Pursuant to 1991 Laws, Chapter 345, Article 1, Section 17, Subd 9

THE CORE VISION OF STATE GOVERNMENT

The Commission on Reform and Efficiency envisions a Minnesota state government that is mission driven, oriented toward quality outcomes, efficient, responsive to clients, and respectful of all stakeholders. These goals are defined below.

Mission driven

State government will have clearly defined purposes and internal organizational structures that support the achievement of those aims.

Oriented toward quality outcomes

State government will provide quality services. It will focus its human, technical, and financial resources on producing measurable results. Success will be measured by actual outcomes rather than processes performed or dollars spent.

Efficient

State government will be cost-conscious. It will be organized so that outcomes are achieved with the least amount of input. Structures will be flexible and responsive to changes in the social, economic, and technological environments. There will be minimal duplication of services and adequate communication between units. Competition will be fostered. Appropriate delivery mechanisms will be used.

Responsive to clients

State government services will be designed with the customer in mind. Services will be accessible, located conveniently, and provided in a timely manner, and customers will clearly understand legal requirements. Employees will be rewarded for being responsive and respectful. Bureaucratic approvals and forms will be minimized.

Respectful of stakeholders

State government will be sensitive to the needs of all stakeholders in providing services. It will recognize the importance of respecting and cultivating employees. It will foster cooperative relationships with local units of government, and nonprofit and business sectors. It will provide services in the spirit of assisting individual clients and serving the broader public interest.

— Feb. 27, 1992

CORE

STATE OF MINNESOTA
COMMISSION ON REFORM AND EFFICIENCY

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March 26, 1993

The Honorable Arne Carlson
Governor
130 State Capitol
St. Paul, Minnesota 55155

The Honorable Ember Reichgott
Minnesota Senate
Legislative Commission on Planning and Fiscal Policy
306 State Capitol
St. Paul, Minnesota 55155

Dear Governor Carlson and Senator Reichgott:

Pursuant to Laws of Minnesota 1991, Chapter 345, Article 1, Section 17, Subdivision 9, the Commission on Reform and Efficiency was directed to recommend long-term actions for improving government efficiency and effectiveness.

This is one of a series of reports being issued in response to our charge and provides detailed findings and recommendations regarding the state/county human services delivery system. We are pleased to report that the commission has identified numerous opportunities for significant reform. The problem analysis and recommendations contained in this and our subsequent reports represent the best thinking of our diverse and bipartisan group. You will see that we have taken our charge seriously and have not shied away from controversy. We respectfully request your continued support for the much-needed government reform detailed in the commission's reports and recommendations.

Sincerely,

Arend J. Sandbulte
Commission Chair

Jack Eugster
Chair
Working Committee

Dana B. Badgerow
Commissioner of
Administration

AJS/JE/DBB

c: Agency Heads
Legislators

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BY THE
MINNESOTA
COMMISSION ON
REFORM AND EFFICIENCY

MARCH 1993

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CONTENTS

EXECUTIVE SUMMARY

Minnesota is a leader in its commitment to health and human services. Many of its ideas and programs have been models for other states. Still, its health and human services system is far from perfect.

The Commission on Reform and Efficiency (CORE) reviewed the roles, responsibilities, and relationships of all the players in Minnesota's human services system, from state and local government agencies to providers and service customers. The commission also identified four key principles for the system, built upon the CORE reform imperatives: Minnesota's human services system should be mission-driven, accountable, customer-focused, and outcome-driven.

Based on the input of more than 425 people involved in the Minnesota's human services system and other research, CORE identified six major barriers to an effective and efficient human services system.

Major barriers

Minnesota's human services system lacks a clear and comprehensive vision. There is no unified sense of what is expected of the state's human services system.

Minnesota's human services agencies do not have coordinated missions. Agencies' missions do not always appropriately reflect their roles, and many missions overlap.

Minnesota's human services system lacks leadership. Interviewees' comments demonstrated a consistent lack of confidence that anyone is taking responsibility for directing the system toward improvement.

The state human services system is fragmented. Responsibility for the array of programs and services that make up the human services system is scattered among several distinct bureaucracies at the federal, state, and county levels. Fragmentation presents a challenge to program managers and customers alike. Major problems include uncoordinated planning and service delivery, limited resource capacity, professional specialization, and turf protection.

The state human services system is complex and prescriptive. The focus is on process, rather than on outcomes. Efforts of program managers at the state, county and vendor levels have become focused on designing process standards to avoid the worst-case scenario, rather than on achieving broad program goals.

Inappropriate incentives built into Minnesota's human services system contribute to its fragmented and prescriptive nature. Incentives and disincentives present in the system are often the unplanned and unanticipated consequences of decisions made for other reasons.

To develop a system that is mission-driven, accountable, customer-focused, and outcome-driven, CORE makes 13 recommendations for overcoming these barriers:

Recommendations

Recommendation 1 would establish a secretary for health and human services, who would report to the governor and oversee the programs, budgets and administration of state human services agencies.

A secretary for health and human services would address the lack of vision and leadership in Minnesota's human services system and improve the coordination and integration of planning and service delivery. The secretary would be primarily involved in policy direction and oversight, rather than day-to-day operations of the agencies.

The chief operating officer for each state health and human services agency would be a deputy secretary, who would report directly to the secretary. The state agencies that would be included in the health and human secretariat are Health, Human Services, Housing Finance, Veterans Affairs, Corrections, and parts of Jobs and Training.

Recommendation 2 calls for the creation of local health and human services districts (HHSDs). These districts would be created for local health and human services program planning and administration. Services would continue to be delivered within communities.

This new administrative structure would involve counties within a district in joint planning and administration to identify and address the health and human services needs of the entire district. Establishing these districts would improve linkages between resources and provide for more comprehensive planning. A single point of accountability for district-wide planning and administration would benefit people working within the system, as well as customers.

Recommendation 3 directs the secretary of health and human services, with the assistance of HHSDs and the concurrence of the legislature, to identify target populations, determine service eligibility priorities, and develop a list of health and social services eligible for state funding and constituting a "minimum and adequate level of services" to meet basic needs.

These services could be enhanced through the discretionary services provided through state and local funding. Discretionary options would vary depending on state and local resources.

Recommendation 4 urges creation of an "HHSD grant" to give local health and human services districts greater flexibility to meet local needs.

The HHSD grant would offer maximum flexibility to local districts. It would increase the size of local social services block grant funds and eliminate many categorical grants, while maintaining a basic threshold of services as the minimum. The HHSD grant would be formed by combining health and human services funding sources that are made up primarily of state dollars and are not entitlements.

Recommendation 5 proposes that state and local agencies and service providers fully adopt an outcomes orientation in budgeting, administration, regulation and enforcement, and direct service delivery.

Recommendations 6 through 8 address the prescriptive nature of rules. These recommendations tighten criteria for what is included in rules, require an agency review and repeal process for existing health and human services rules, and recommend that state agencies permit and encourage regulated entities to apply for waivers from existing rules.

Changes in rules and a less prescriptive system call for concurrent changes in the role of enforcement. ***Recommendations 9 and 10*** require state agencies to investigate and implement new methods of enforcement and sanctions for noncompliance with rules and regulations.

Recommendations 11 through 13 are designed to achieve a customer-focused system by encouraging state and county health and human services agencies to clearly define their customers and to empower staff to serve customers well. These recommendations also appeal to the legislature, state agencies, counties, and providers to work in partnership to empower customers to achieve their goals.

A secretary system can create an environment conducive to leadership and cooperation. Establishing health and human services districts, a set of basic services, and a new health and human services grant would reduce administrative and service fragmentation. Making pragmatic changes in the state's approach to human services rules and emphasizing performance could help to transform the system from a process to an outcomes orientation. Finally, adopting a customer focus at all levels of administration could make the system more responsive to the customers it is designed to serve.

CORE projects a total of almost $50 million savings over five years upon full implementation of a secretary structure, health and human services districts, and funding changes. The remaining recommendations would result in significant improvements in the way human services are delivered in Minnesota, improvements that would be clearly noticeable to human services customers.

CORE's recommendations are designed to mitigate the effects of pressures forcing the

system away from vision, away from a customer focus, and toward prescription and fragmentation. Some of the recommendations could be implemented immediately by state and local governments, without additional statutory authority. Many others would require time to work out the details and to obtain necessary state and federal law changes. Time is also needed to achieve the kinds of attitude and cultural changes necessary for a significantly reformed human services system.

Reform is not a one-time event but a process of continual change. Every attempt at change helps to pave the road for future reforms. CORE's recommendations build on past efforts and point the way toward achieving a dramatically improved health and human services system in Minnesota.

INTRODUCTION

The Commission on Reform and Efficiency examined Minnesota's human services delivery system as part of its efforts to recommend alternative strategies for delivering government services, streamlining service delivery, reducing costs, and improving accountability.

Project work plan

The CORE Human Services Project was charged with reviewing "the roles, responsibilities, and relationships between state and county government as they relate to the delivery of human services programs within a coordinated system."

The project undertook to examine Minnesota's system for providing human services to determine if changes could be made that would result in improved customer outcomes. The project did not focus on specific programs but instead examined the overall system of *delivery* for a wide variety of human services programs. The project reviewed the roles and responsibilities of the departments of Human Services, Health, Corrections, Veterans Affairs, Jobs and Training, and Education and the Minnesota Housing Finance Agency, as well as the roles of federal and local governments in service delivery.

The CORE Program Analysis Working Committee reviewed briefing papers prepared by staff, deliberated issues and options, and developed the recommendations contained in this report. The full commission approved these recommendations on Jan. 28, 1993.

Professional assistance

A group of 10 experts in human services delivery acted as consultants to CORE project staff. These individuals unofficially represented state agencies, legislative committees, counties, and a citizens group. They served as a sounding board for ideas and as counsel for keeping the project properly focused.

Human services system principles

To begin the project, the working committee defined four key principles for Minnesota's human services system, based on the CORE reform imperatives. This set of principles provided a guide for how the human services system can and should operate. These principles hold that Minnesota's human services system should be:

- *mission-driven*, having a clearly identified purpose for the system;

- *accountable* for carrying out specific responsibilities;
- *customer-focused*, concerned with meeting the needs of customers; and
- *outcome-driven*, making decisions based on measurable, specific results.

By stating clearly what the human services system should be, CORE provided a standard by which to evaluate the condition of the current system.

Persons interviewed

Once the system principles were articulated, the next step was to identify the most important barriers to achieving those principles. A cross-section of service customers (the end-users), state and county managers, providers, human services experts, and elected officials were asked to help identify barriers. CORE project staff conducted 55 interviews and focus groups with approximately 425 individuals (see Appendix A). Previous studies of human services systems in Minnesota and 16 other states were reviewed, along with the latest literature on human services delivery, to identify additional key barriers (see References).

With the barriers identified, CORE began the search for solutions with a focus primarily on improved customer outcomes.

BACKGROUND

Minnesota has a state-supervised, county-administered human services system. Services and eligibility for income maintenance (for example, Aid to Families with Dependent Children and food stamps) and health care programs are determined by state agencies, but counties are responsible for delivering these services to clients, either directly or through contracts with providers. Many social services are determined by counties. About half of the funding for social service programs is provided by counties from local property taxes. Community health services are supervised by the state but provided through county or city governments. Unemployment and jobs training programs are administered by state Job Service bureaus and local service providers. School districts provide some health and social services, and schools sometimes are the delivery sites for county- or city-provided services.

Service providers

Government providers

The government providers of services in Minnesota include cities, counties, and school districts.

Cities — For the most part, cities do not provide health and human services. The exceptions are some cities in larger metropolitan areas, which may have public health departments and social service programs. Many also provide what can be termed human services through parks and recreation programs; these services include day care, elderly activities, and youth programs. Block nurse programs are often run by neighborhood organizations.

Counties — Minnesota's 87 counties are bound by law to deliver services that the state has directed or permitted them to provide. Counties provide these services through staff and contracted providers.

The human services delivery system in most counties consists of a social services agency, a public health agency, and a community corrections component. In recent years, however, the judicial system, law enforcement agencies, and school districts have all assumed greater roles in identifying and delivering human services.

Each county is required by a variety of statutes and rules to provide state agencies with plans that specifically identify how the county will implement the programs of each agency. Funds provided by the state for implementing programs are disbursed to counties through formula allocations, competitive and noncompetitive grants, reimbursement for

services, or direct appropriations. Depending on the program, counties are required to or voluntarily provide funding to assist in implementation. For some programs, counties are required to submit to the funding agency periodic program and financial reports on how it is achieving the goals as outlined in the plan or specified in the mandates and how funds are being disbursed.

School districts — Minnesota's public schools are administered by 436 independent school districts with locally elected school boards. Funding for school programs comes from a combination of state appropriations and local property taxes. Districts are diverse in size, population density, resources, and the special needs of their students.

Other providers

Other providers of health and human services include area agencies on aging, Indian reservations, and many private businesses and nonprofit agencies. Businesses and foundations also contribute substantially to human services in the state.

Agencies on aging — The Minnesota Board on Aging, assisted by Department of Human Services (DHS) staff, plans or provides services and information to elderly persons in the state and educates the public about aging issues. The board, whose members are appointed by the governor, administers federal and state grants through 14 area agencies on aging (AAAs) throughout the state. AAA boundaries generally match those of economic development regions. Services provided through AAAs include federal Older Americans Act services such as senior companion services, foster grandparent programs, congregate and home-delivered meals, the Retired Senior Volunteer Program, and other local programs. An ombudsman program is staffed by DHS and assists with nursing home, acute care, and home care complaints.

Indian reservations — The 11 Indian reservations in Minnesota are involved with the delivery of human services to approximately 50,000 Native Americans. Both federal and state governments have classified the reservations as sovereign nations. As such, each reservation has a distinctly different relationship with state agencies in terms of the programs specifically designed for its populations and the amounts and types of funds allocated.

Nonprofit organizations — Many nonprofit organizations provide services in the state, ranging from medical care to education, support groups, and citizen advocacy.

Businesses and foundations — Minnesota's businesses rank the highest nationally in philanthropic contributions to the community. So many state businesses are leaders in this area that it would be difficult to list them. The Dayton-Hudson Foundation is one significant business contributor to human services in Minnesota.

Other foundations of special note include the Wilder Foundation and the McKnight

Foundation. As one of the few operating foundations in the nation, Wilder has piloted many programs that have later been expanded beyond the foundation. The McKnight Foundation is one of the largest in the nation and has a primary commitment to human services. Many programs can credit the McKnight Foundation for their success.

Influences on the system

Minnesota has many excellent health and human services programs. These programs have experienced a great deal of change over the last several decades as individuals and groups have sought to continually improve the system. A number of factors, both external and internal, significantly influence the delivery of human services in Minnesota, including the following:

- The human services system is complex, with many programs, needs, and administrative entities.
- The demographics of the state, and thus the customers of human services, are rapidly changing.
- The state is no longer operating in an era of abundant funding. Cost-cutting and efficiencies are now facts of life. The past three state budgets were designed to make up the deficit between projected state revenues and projected expenditures. Competition for scarce dollars has increased.
- The system is highly dependent on relatively inflexible federal funding to provide many programs.
- Minnesota ranks among the top five states in human services expenditures[1]; people receiving services from the system expect that services will continue to be provided at a high level of quality.
- The role of the courts in setting human services policy has become stronger in recent years; the growth in prescriptive rules and procedures is in part a response to the threat of litigation.

These broad factors point toward a need for reassessment of the delivery of human services in Minnesota. Following are CORE's findings that clearly define the challenges in the current system.

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[1]Minnesota ranked fourth in per capita state and local government expenditures for public welfare programs and eighth in the percentage of total state expenditures for human services. Source: Kathleen O'Leary Morgan, Scott Morgan, and Neal Quitno, eds. *State Rankings 1992: A Statistical View of the 50 United States* (Lawrence, Kans.: Morgan Quitno Corp., 1992).

FINDINGS

CORE has identified six major barriers to an effective human services system in Minnesota:

1. The system lacks a clear and comprehensive vision.
2. Human services agencies do not have appropriate, coordinated missions.
3. The system lacks leadership.
4. The system is fragmented. Responsibility for the array of programs and services that make up the human services system is scattered among several distinct bureaucracies at the federal, state, and county levels.
5. The system is complex and prescriptive. Its focus is on process, rather than on outcomes.
6. Inappropriate incentives built into the system contribute to its fragmented and prescriptive nature.

These challenges, which were identified through interviews and focus groups with about 425 participants, must be addressed to improve Minnesota's human services system.

Lack of clear, comprehensive vision

Finding No. 1. The human services system lacks a clear and comprehensive vision.

A vision is the essential reason for an organization or system's existence, its ideals, and its ultimately desired outcomes. A system's vision is developed by its policymakers. In government, policymakers include the governor, the legislature, department executives and, increasingly, the judiciary.

Many individuals interviewed by CORE identified a lack of a unifying vision as a serious detriment to the system. They said, for example:

> *Does the state know what it really wants?*
>
> *What is the state's long-range plan?*
>
> *Without a larger vision, something that spans boundaries, major reform cannot be accomplished.*
>
> *Sometimes we forget why we are doing what we are doing.*

Every organization needs to develop a vision that identifies the reasons for its existence and the outcomes it is designed to achieve. Without a vision, a system can work at cross-purposes with itself.

A variety of strategic planning models have been developed to assist organizations in developing a vision. A strategic planning process can also help an organization to determine organizational values, establish goals and objectives, and develop a list of priority issues.

For the human services system, developing a clear vision is critical because: (1) it operates in the turbulent environment of changing policies, funding, and leadership; (2) it is constantly being asked by advocates, the legislature, and the public to provide more services; and (3) it is confronting expectations that all government services should be reevaluated, be made more accountable, and rely on measurable outcomes.

For these reasons, policymakers should strive for consistency in the purposes for a human services system. In developing this consistent vision, it also is important to identify the problems that must be addressed and the outcomes desired.

Lack of appropriate, coordinated missions

Finding No. 2. Human services agencies do not have appropriate, coordinated missions.

A mission is a long-term view of what the organization's role is in attaining the vision. A mission answers the basic questions about what the organization's business should be and who its customers are. The mission is usually developed by the leadership of the organization. In government agencies, commissioners and their staff have primary responsibility for developing agency missions.

Comments from participants about the lack of clear or coordinated missions in Minnesota's human services system include:

> *DHS has been in a trend away from being a supervisory agency to being a regulatory/legalistic agency.*
>
> *If the role of the state is to make sure people's needs are met, there needs to be more of an emphasis on technical assistance than on the regulatory/sanction side.*
>
> *The state should get out of the business of being a provider, a licenser, and a payer of services.*
>
> *The result of [the process-oriented] approach is a shift of our mission of helping people to an obsession with making sure nothing goes wrong.*

There is no bottom-up, client-centered view of the whole program.

There is a concept of DHS as a cost-containment agency, not as a service-delivery agency. Many people perceive the mission as solely cost containment.

Once a vision is developed, each organization that has a role in attaining that vision needs a mission statement to ensure consistency and clarity of purpose, provide a point of reference for decisions, encourage commitment within the organization, and stimulate understanding. Each mission should support the vision.

Many examples of uncoordinated or overlapping missions exist throughout state government.[2] One is the overlap in planning for long-term care services in the missions for four DHS and Department of Health (MDH) divisions:

> MDH Health Resources Division: ". . . develops long-term care policy for the state and works with other state agencies to implement that policy."
>
> MDH Community Health Services Division: ". . . provides support and assistance to local community health boards in the planning of local public health programs and the delivery of services."
>
> DHS Long-Term Care Management Division: ". . . develops and coordinates long-term care policies, rules, procedures, and reimbursement systems . . . and the administration of home and community-based services."
>
> DHS Aging Program Division: ". . . works cooperatively and collaboratively with other divisions in the department to plan, develop, and implement services that are delivered to older persons . . . . It also works with other state agencies . . . [by] developing and analyzing policy impacting on older persons . . . ."

An important element of any mission statement is clearly identifying the customers of the organization. For example, the Department of Jobs and Training (DJT) mission statement indicates that it serves "the unemployed and underemployed." This statement is accurate, as DJT staff actually have direct contact with unemployed and underemployed individuals.

The Department of Human Services, on the other hand, states that its role is to "assist those citizens whose . . . resources are not adequate to meet their basic human needs." Although DHS programs are designed to assist these citizens, this statement does not clearly define the agency's role, since DHS employees rarely have contact with the end-users of human service programs. The day-to-day customers of DHS are county governments and service providers.

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[2]*See Minnesota Guidebook to State Agency Services,* 1992-1995. (St. Paul: State of Minnesota, 1992.)

County social services agencies indicate that DHS does not provide enough technical assistance, policy and program development, adequate information and feedback, or methods for quality improvement. This may be because the department does not view counties as its customers. One of the county representatives asserted that if DHS reassigned half the rule-making personnel to technical assistance, "we wouldn't need as many rules, and the clients would receive better service." Because DHS provides limited direct services to citizens, it is not surprising that many interviewees felt that DHS's mission and its efforts should be refocused.

For contrast, compare the mission statements of the Minnesota Department of Human Services and the New York State Department of Social Services:

Minnesota Department of Human Services, May 1992

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

New York State Department of Social Services, May 1992

The mission of the New York State Department of Social Services is to guide and support the provision of direct services by local districts and other agencies, through policy and program development, system support, technical assistance, information, monitoring and quality improvement.

The social services system in New York carries out our constitutional commitment to provide for the aid, care, and support of the needy by:

- Enhancing the well-being of our citizens through programs and services that promote self-sufficiency, health and family strength;
- Sustaining and protecting vulnerable citizens who are unable to care for themselves;
- Effectively managing cash and medical assistance to support people during the loss of employment and other adversity;
- Providing humane, long-term support to those with chronic needs; and
- Carrying out this mission in ways that strengthen the families of our state, respecting the dignity of individuals, and providing the maximum possible benefits to state citizens for the funds entrusted to us.

According to these two mission statements, New York's human services delivery system is state-administered and locally delivered; Minnesota's appears to be state-supervised *and* state-delivered. In fact, both departments provide limited direct service to clients and use a substate delivery system (Minnesota using counties and New York using local districts). The confusion is caused by the focus in Minnesota's DHS mission statement on the citizen who needs services, while New York's statement focuses on assisting the "districts and agencies" that provide services. DHS's focus on the citizen, while undoubtedly well-intended, has little to do with whether counties are equipped with the necessary information and administrative tools to deliver services.

The role of DHS in the Minnesota human services system is unclear. Although this may not be directly caused by a mission statement, the process of developing appropriate and coordinated missions for all human services agencies can help resolve and prevent this kind of confusion.

Lack of leadership

Finding No. 3. The human services system lacks leadership.

When people say Minnesota's human services system lacks leadership, they may be speaking of a desire for a strong, charismatic crusader leading the way; they may be making the observation that there are many strong leaders, but each has a separate agenda that does not encompass all of human services; they may be expressing the perception that human services issues often appear to be uninteresting to powerful people, compared with other public policy issues; or they may be talking about the fact that at the state level, commissioners and assistant commissioners change frequently as a result of political change.

All these points of view were expressed in interviews and focus groups. It is difficult to pinpoint just what is needed in the way of leadership to fill this void. But the perceived problems do indicate some possible solutions. Defining the essentials of leadership may be a start toward solving the problem.

One theorist puts it this way:

> Leadership is a part of management, but not all of it. A manager is required to plan and organize, but all we ask of the leader is that they get others to follow . . . . Leadership is the ability to persuade others to seek defined objectives enthusiastically. It is the human factor which binds a group together and motivates it toward goals. Management activities such as planning, organizing, and decision making are dormant cocoons until the leader triggers the power of motivation in people and guides them toward goals.[3]

[3]Fred E. Fiedler, *A Theory of Leadership Effectiveness* (New York: McGraw Hill, 1968).

Interview participants made these comments on this lack of leadership:

> *Nobody is in a position to see big issues or influence the system to the extent necessary even if they were seen.*
>
> *In the executive branch, there are many efforts to chart a vision and a course . . . . Why? How does this get unified?*
>
> *Threats, sanctions, and paper review substitute for leadership, people, and system development.*
>
> *There is not enough commitment at the top to carry out new ideas, such as being customer-focused.*
>
> *Agencies don't always work well together. There needs to be a higher authority than DHS. Otherwise, we are just rearranging the deck chairs on the* Titanic.
>
> *The single most influential action required for positive outcomes is stabilized leadership which provides vision for the system.*
>
> *Qualified leadership in office long enough to implement a plan is needed. It would provide connectedness between people and strategy.*

These comments demonstrate the persistent lack of confidence felt among participants in the health and human services system, particularly regarding DHS. Respondents did not think that anyone is taking responsibility for directing the system toward improvement. Neither did interviewees feel that significant change was possible immediately, because of the system's complexity. Nonetheless, addressing the lack of vision, mission, and leadership was emphasized as a first and critical step toward reform of the health and human services system.

Leadership is central to the development of a human services vision and the coordination of human services missions. The difficulty with leadership lies in its relationship to power. One person might have the ability to be an effective leader but not the full authority to act. Another person might be in a position of power but fail to exercise leadership. In both cases, there is a leadership void.

In Minnesota, no position currently exists wherein an individual *could* exercise leadership for the entire human services system. Theoretically, the governor could do this. The scope of the governor's responsibilities, however, prevents the kind of constant attention that would be necessary to lead the large and complex health and human services system.

System fragmentation

Finding No. 4. The human services system is fragmented. Responsibility for the array of programs and services that make up the system is scattered among several distinct bureaucracies at the federal, state, and county levels.

Minnesota's human services system is made up of several state agencies[4] and a local delivery system administered by counties. This state-supervised, county-delivered system was designed to permit local flexibility in services delivery, essential in a state as geographically large and variously populated as Minnesota. Because of the interactive effect of programs directed by several federal and state agencies, however, system fragmentation is a challenge to program managers and customers.

Services to persons with developmental disabilities (DD) illustrate this point. Three federal agencies set standards and funding for these programs, and four state agencies are responsible for administering various DD programs. Within DHS, 12 divisions are responsible for planning and administering state DD programs. There are 436 school districts and 84 county human services agencies responsible for delivering DD services. Of these 84 local agencies, most do not deliver DD services directly but contract with one or several vendors who provide the services to customers.

Fragmentation in communication

According to state and county personnel, there is a lot of time-consuming communication, but "it is not effective communication" that helps people serve the customer. Instead, they say, "there is a lot of process communication." Sometimes the state doesn't communicate with itself: the Department of Health (MDH) may cite a facility for failure to comply with health and safety regulations but not inform the DHS Licensing Division until several days later. Similarly, DHS may seek to place a residential facility under receivership and fail to communicate this action to MDH.

Administrative systems that do not work together are a barrier to coordinated planning. For example, units in the departments of Health and Education attempted to set up a joint spending account for a small grant they shared, but administrative complexities prevented it.

People who are providing services believe that navigating the system is too difficult and confusing for citizens. It can be especially difficult and frustrating for people who are elderly or from another culture or who have a mental illness. People don't know what programs and services are available, much less how to obtain access to them. Clients of the welfare system say the best place to find out about programs is not from case workers

[4]See Appendix B for charts of state agencies' human services programs.

but from people on the street. People attempting to identify options for their aging parents don't know where to go for full information and referrals. Even a perusal of the telephone directory doesn't make it easier. Public human services programs in Minnesota are provided through 84 county entities,[5] each with its own services and delivery system. Different counties offer different public services, so that the services available to people often depend on where they live.

Although many different programs are available, people needing services still fall through the cracks. County service providers often aren't aware of available nonprofit and private-sector services. For example, a receptionist at a county office reported that although the office does have a resource manual, it is out of date. There is no incentive for service providers to work together to plan services. Customers must fill out applications for services again and again. They must repeatedly explain their problems before they finally get to the right person or the right program.

Customers and even case managers say that when they do find a program that can help, they often have to check and recheck the program policies with different state personnel because there is a fear of doing things wrong, and it seems everyone has a different answer.

Uncoordinated planning and service delivery

A lack of coordinated planning exists at the local, state, and federal levels. County administrators and program managers say that policy formulation is sometimes inconsistent among various state government entities that design services for the same populations.

Programs typically do not coordinate planning. For example, child care programs have become complicated because the DHS Family Support Programs Division is responsible for financing, while the Children's Services Division is responsible for the program rules. These divisions are under the authority of two different assistant commissioners at the agency.

Another example is federally funded aging programs, which are in a different DHS division from the nursing home and senior alternative care programs. These divisions also are under the authority of two different assistant commissioners. Aging programs become even more fragmented at the local level. Similar services are planned and provided through area agencies on aging, county public health agencies, and county social service agencies (as well as private agencies). A DHS survey of county social services and public health agencies found that in most cases, it was unclear which agency had lead

[5]One set of three counties and a pair of counties have combined human services administrations, making a total of 84 county human services administrative entities among the 87 counties.

responsibility for the state-required preadmission screening program.[6] An interagency group called Intercom is planning to review and restructure preadmission screening.

Another factor complicating planning is the existence of three different fiscal years (local, state, and federal). This makes the Community Social Services Act (CSSA) and community health services (CHS) planning and budgeting processes difficult to carry out. CSSA plans are due months ahead of the local budget, so these plans always require complicated amendments and revisions with the state. Additionally, CSSA and CHS plans are rarely coordinated because they are due at different times to different state agencies.

Almost everyone involved in the system admits that although coordinated planning should be a desired goal, and some examples of coordination do exist, it is time-consuming and labor-intensive, and resources for it are insufficient at the state and local levels. Turf issues also impinge on planning and service coordination. Agencies have no real incentive to risk giving up some power to coordinate with other entities.

A human services case study illustrates the effects of fragmented bureaucratic structures. In France, a holistic, integrated mental health services plan was proposed but never implemented because of coordination problems and turf issues. Program administrators had no incentive to coordinate services and make the new plan work. By contrast, in a similar undertaking in Sweden, major structural changes at a national level eliminated similar turf protection issues, and enabled the development of supportive relationships and local coordinating mechanisms, which led to successful implementation. In this study, a fragmented bureaucratic structure resulted in failure to implement a new program (France), while a cohesive, integrated structure (in Sweden) resulted in success.[7]

Minnesota's human services system is more complicated than those in some other states because of the state's diverse geography and population and the fact that the system is designed to be administered by 87 disparate entities (the counties), as well as more than 400 school districts. Researchers have noted that "intergovernmental strife multiplies if a state has many regions with sharp disparities in cultural identity, economic vitality, and natural resources" and that "often the reason behind state-local tension is the state's role as referee for inter-local disputes."[8] This struggle among local entities with the state in the role of referee encourages local entities to protect their turf, rather than cooperate.

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[6]Minnesota Department of Human Services, *A Review of the Preadmission Screening and Alternative Care Grant Programs* (St. Paul: DHS, March 21, 1991).

[7]Organization for Economic Cooperation and Development, *Policies for Innovation in the Service Sector: Identification and Structure of Relevant Factors* (Washington, D.C.: OECD Publications Center, 1977).

[8]Deborah D. Roberts, "Carving out Their Niche: State Advisory Commissions on Intergovernmental Relations," *Public Administration Review*, November/December 1989.

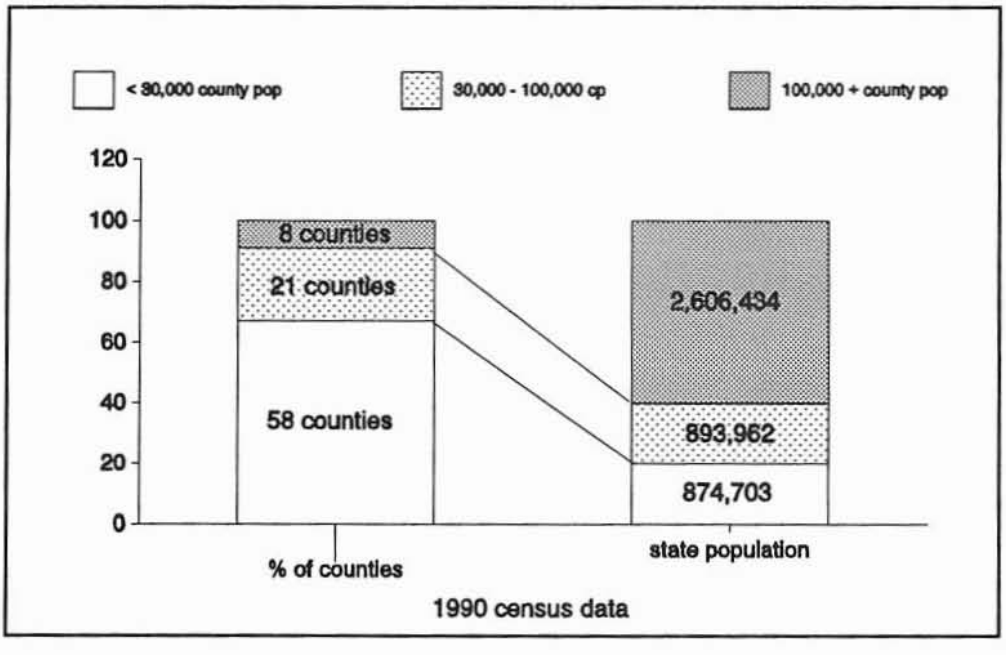
Resource capacity

According to various people who work in or receive services from the system, many counties, because of their size, do not have enough staff to adequately plan and administer services or a large enough population base to achieve the scale necessary to offer some services. Thus, the level and quality of service delivery vary among counties, even though standards are uniform across the state. For example, some counties are better at obtaining grants than are others, resulting in different levels of service among counties. Larger counties also have the capacity and the population base to be good subjects for innovative pilot projects or similar experiments.

The larger county health and human services administrations are recognized by state agency staff as being more capable and professional, because they are able to employ planners and financial experts as well as an adequate number of professionals who provide direct services. Still, small counties with few staff are expected to provide the same level of program planning and analysis. Small counties have complained that they do not have the staff resources to keep informed of state policies and that applying for grants and producing other documents and applications can be difficult.

Sixty percent of Minnesota's population resides in the eight counties with more than 100,000 population. Twenty percent resides in 21 counties of 30,000 to 100,000 population, and another 20 percent resides in the 58 counties with less than 30,000 population. This means that more than half the state's population is served by eight county administrations, while another fifth is served by 58 (Figure 1).

Figure 1. State population by county



The 44 Community Health Services (CHS) districts, which were established in 1987, set a precedent for consolidated local services administration in the state.[9] People who work within the system generally agree that CHS districts work well and are small enough to keep decisions on an understandable local level. Counties have demonstrated their comfort with this configuration. Only one county has withdrawn from its CHS district; counties that applied together for SAIL (Seniors Agenda for Independent Living) funds in 1992 frequently did so along CHS lines.[10]

Although they are based on a minimum population base of 30,000, the actual average CHS district size is 97,150. Of the 44 districts, 21 are single county regions with populations ranging from 11,682 in Watonwan County to 1.03 million in Hennepin County. In the remaining 23 multicounty districts, the population ranges from 24,731 in District 35 to 241,755 in District 4.

Resource capacity challenges also exist at the state level. State agency staff has been reduced over the past two years because of budget constraints. Many vacant positions have not been filled, meaning that the state is now trying to do more with fewer staff. The fragmented county-administered human services system strains the state's limited resources. State agency professionals sometimes find themselves doing important clerical tasks (answering phones, preparing informational packets), rather than attending to policy matters. DHS staff say that it is difficult and time-consuming to reply to dozens of inquiries from various county administrations regarding program policies and that they are unable to provide technical assistance or audits of all social service agencies on a regular basis.

While acknowledging the benefits of local control, state agency personnel also criticize the county-administered system, saying that it is terribly time-consuming for the state to deal with 84 county human services entities, each of which views itself as an equal partner with the state. It seems to state program administrators that every question can have at least 84 variations. For example, two state employees are assigned to work on the state preadmission screening (PAS) program. Eighty-four county social services agencies and at least 66 public health agencies provide PAS services, and staff from each of these agencies contact these two state employees for policy clarification or assistance.

A common complaint from counties is that the state agencies do not do a good job of investigating and replicating methods that have worked in other programs and could be transferrable. Resource problems at the state and county levels prevent counties from creating and testing innovations and prevent the state from researching and transmitting what works.

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[9]M.S. 145A.09. Appendix D is a map of CHS districts and E lists CHS district populations.

[10]SAIL pilot projects required that project areas have a minimum population of 2,500 people 85 or older or include at least four contiguous counties (M.S. 256B.0917).

Professional specialization

Case management has added to the problem of fragmentation because each program area has developed its own specialized case managers who may not consider customers' broader interests.

This problem becomes manifest when a customer is receiving services from more than one agency. Different agencies and programs have different cultures and are protective of their roles in providing services. Because of this turf protection, it takes time to build trust among agencies, even within a county (such as between county health and social service agencies). Focus group participants reported that if one agency has initial responsibility for a customer, others sometimes back away, feeling it is "not their job" to address coordination issues. In addition, the need to coordinate and reduce overlap is not always apparent to competing agencies.

Customers wonder whether they can get the help they need, because it can be difficult to find the right specialist. One customer recounted, "I had a problem and called [the person I talked to the first time]. In a situation that is an emergency, [financial workers] don't know what to do. I thought my financial worker *was* my social worker. All of a sudden, I found out I have a separate child care worker for child care problems."

Another customer said, "If your worker is on vacation, you are out of luck. No one else can help you. The message is 'we don't care.'"

Conclusions

The complexity and tendency toward specialization in human services program areas make it a challenging task to implement innovative changes. Conflict may exist over goals, priorities, and means to achieving goals. In Minnesota, this problem is compounded by the fact that several agencies are responsible for health and human services programs.

One of the aims of Minnesota's system is to meet local needs in a state with disparate economies, cultures, and demographics. This system, however, also kindles ongoing and seemingly inevitable turf protection and competition within and among counties. Rural-urban splits are most common; farm-nonfarm rural is another. The fact that more than one fourth of the state's residents live in Hennepin County often results in a Hennepin-everyone else split.

Turf protection issues within counties and among state agencies have been similar. At the state and county levels, these issues sometimes prevent innovation from taking place, because counties and state agencies tend to perceive change and cooperative service delivery as a potential loss of power and control. Program administrators may have trouble agreeing to a plan that may result in diminished funding or authority in their area of responsibility.

Some researchers have pointed out the rather unsurprising finding that what makes innovation difficult is that the framework set up by a central authority often does not meet local needs. These studies show that the key to successful innovation is that changes are "contained within the [existing] framework . . . or else it must be possible to alter the framework."[11] Minnesota's state-supervised, county-administered human services framework was based upon principles of local decision making and was designed to enable services delivery to be tailored to meet local needs. The current framework of this system should be changed, however, because it is inefficient and does not foster cooperation.

Complexity and prescriptiveness

Finding No. 5. The human services system is complex and prescriptive. Its focus is on process, rather than on outcomes.

One of the ironies of the present complex human services system is that its problems are often ascribed to "the bureaucracy," while the classic theoretical bureaucracy, as invented in this country in the 1930s, was intended to be a rational, simple system. Here, as in most cases, theory is neater than practice. Over time, a system intended to be simple and easily controlled becomes specialized in its functions, which requires increased coordination. This results in some type of prescribed process (written rules, established guidelines and procedures) to ensure coordination, and different priorities emerge in these newly specialized areas. Political scientists have noted that public institutions "try to make their task environment as predictable, and devoid of irrationality, as possible," but this results in a bureaucracy "trying to maintain a faltering hold on rationality and predictability, in a world that is often irrational and unpredictable."[12]

An approximate history of the evolution of complexity in public bureaucracies would be:

1. Services are created and expanded in response to problems.
2. Problems become increasingly challenging.
3. Services become more dependent on large, complex supporting infrastructures.
4. Interactions and interdependencies among services increase difficulties.
5. Evaluation becomes increasingly important.
6. Services can be compromised by politics and interactions with other programs.
7. Specialists emerge to deal with each part of the now complex system.[13]

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[11]OECD, *Policies for Innovation.*

[12]Louis G. Tornatzky, *Innovation and Social Process: A National Experiment in Implementing Social Technology* (New York: Pergamon Press, 1980).

[13]OECD, *Policies for Innovation.*

Thus evolves a complex, apparently irrational system that has lost sight of its original purpose and goals.

The effect of interdependencies cannot be underestimated. Every program is so complicated and so many interactive effects exist that solutions designed to solve a problem in one area often create another problem or unintended effect somewhere else. This complicates not only the administrative process but also planning and policy analysis. Implementing meaningful change in the system is difficult in this type of environment.

A human services customer explained the effects of prescriptive programs: "I want people to listen to me, to listen to what I need, rather than tell me what I'm going to get. One time they say they are giving me the max, but the next time, I might get more, even though I didn't ask for it. Sometimes people get more than they need, while other times, they don't get what they need."

"It doesn't appear that service is the goal," mused a county worker. "The goal seems to be meeting program procedures." This focus on procedures makes flexibility difficult and doesn't acknowledge the differences among individuals.

Customers see the same thing. "How are social workers held accountable?" asked a former customer who now works in the system. "A good job is how many people they see in a day, not if they helped them, or sent them away crying. When a walk-in person is seen, the workers rush to the appointment book to make sure they get 'credit' for seeing that person. It looks like this is their real goal."

Focus Is on Process, Rather Than Outcomes

There are many reasons, both philosophical and practical, for the fact that most of the human services system is operated through a set of very prescriptive rules and process standards.

A basic philosophical explanation is the tension between local decision making and state accountability. Designers of the Minnesota human services system planned a state-supervised, county-administered system. The state was to set program parameters and provide oversight and professional assistance. Counties were responsible for providing services directly or through contracts with vendors. But because the legislature holds the state executive branch accountable for how program funding is spent, state program managers became anxious about county expenditure of funds. This brought about a focus on procedures. Through the years, the executive branch has gained more control over the choice of services and how they are delivered, and procedures have become more prescriptive.

A state agency program manager commented on this problem: "Counties want us to just leave the money on the stump and trust them. The state has made some attempts to be

flexible. But because we are accountable for how the money is spent, the counties are not given great flexibility."

State agency and county personnel pointed out that there are no incentives for counties to save money in a program budget; if they do not use all of a program allocation, their funding base is usually cut the next year. The result is that it often seems, said a county worker, that "no one cares what the program outcomes are as long as the funding keeps coming. This is what drives the system, not concern for the customer."

A simple, practical explanation also exists for how and why program procedures became so complicated. State management of these programs evolves: In their inception, most programs tend to be relatively straightforward and uncomplicated. As programs are implemented, problems and questions arise about various components that are resolved by formulating a policy to address them. The number of individual policy components grows until there is a relatively large compendium of policies to guide program and service delivery.

At the same time, through the legislative and rules processes, additional regulations are promulgated at the urging of special interest groups. These groups' success, coupled with a strong negative public response when things go wrong because rules are not strong enough or not enforced, greatly increases the movement toward a prescriptive, rules-oriented system. As a result, efforts of program managers at the state, county, and vendor levels become focused on designing process standards to anticipate the worst-case scenario, rather than focusing on achievement of broad program goals.

Legal liability is a major disincentive for professionals to use their own judgment in determining what would be in a client's best interest (rather than to depend on rules and procedures). Because of this, the system requires a high level of paperwork to cover any contingency. "The system should allow us to act in good faith" said a social worker. "But because of legal issues, there is a regulatory mindset that is more concerned about process than outcome."

This situation is creating professionals (social workers, for example) who depend solely on rules rather than on their professional judgment. "It's gotten to the point that we are afraid to move for fear that we may be breaking some regulation" explained another social worker.

More than 851 rules (exceeding 1,200 pages) govern county administration or delivery of human services. In addition, county social service administrators receive nearly 400 bulletins a year from state agencies. These bulletins, which often are several pages long, detail requirements for complying with state laws and rules.

A social service director from a small county reported that his staff cannot keep up with the state bulletins. CORE staff verified that based on a 40-hour work week, a county

social service agency could receive a bulletin from a state agency about every five and a half hours. Smaller local agencies are overwhelmed, and even larger counties do not always have the capacity to comply with all the requirements.

State agency personnel are aware of a certain irony in this focus on process. They consider the federal government rules for state health and human services programs to be too prescriptive but admit that the state micromanages the counties and providers in the same way. Complaints are also made about legislative micromanagement of state executive branch programs through line-item budget and position control and through mandated program requirements designed to meet real or perceived needs of customers and providers.

But counties accuse the state of using a "cookie cutter" approach in formulating human services programs. They say the state assumes that characteristics (problems, demographics, resources) that exist in one county must exist in all, so that one way of doing things is prescribed for all areas of the state. This is also evidenced when one county suggests or invents a program or way of doing things that seems to address all of the state agency's concerns, so the agency mandates that all counties use the same procedures. Thus, smaller counties with few resources face the taxing challenge of trying to meet state standards that have been set by large counties.

State agencies do not have the capacity to determine or to enforce full compliance with these regulations. A shift to a focus on outcomes by the state could eliminate much of the detail that creates ineffectiveness and weak accountability in the system.

An example of a shift of focus to outcomes is the revision of the Community Social Services Act requirements. Statutory changes in 1991 focused CSSA plans more on outcomes and limited reporting of details in the plans. DHS is currently reviewing the CSSA plan format and eliminating unnecessarily prescriptive portions.

Categorical funding and restrictive eligibility

The restrictive nature of human services funding also contributes to a fragmented system. Restrictive program eligibility is used because money is appropriated to serve specific groups of people. People's needs are rarely simple, however, and often do not fit into just one category of services. For example, a person receiving therapy and medication for a mental illness could also need other medical care, housing assistance, or job training. One need often indicates another; meeting just one need and not an interrelated one is like providing a person a recipe and ingredients for banana bread but no oven to bake it.

County social workers say that restrictive eligibility is too prescriptive. "Our clients are not really whoever walks in the door needing help but who fits into the state eligibility restrictions," said one. An unintended result is that clients often feel that the social workers do not care about their customers. The feeling of one customer was echoed by

many: "If you don't fit their idea of what a 'welfare case' should look like, they don't want to help you."

Categorical funding is partly a result of attempts to attain service equity for various targeted groups, such as people with developmental disabilities or mental illnesses. Service equity means ensuring that all state citizens, regardless of where they live, have access to at least a minimum level of health and human services. In categorical funding, the legislature appropriates money in specific amounts to provide specific kinds of services only. Due to the influence of special interest groups, statewide service mandates have been developed that most people concede go beyond a minimum level of services in some areas and overlook needs in others. Many of these mandates impose requirements on counties without providing the funding needed to deliver the level of services demanded.

County workers explained that categorical funding "ties the hands of the counties" that are trying to deliver services to meet people's needs. State mandates have been a major source of controversy in recent years. The state mandates specific services and funding amounts for those services without regard to local needs or capacity. This is important to counties because they use local property taxes to pay for a significant portion of these services. Counties provide about 50 percent of the total local social services funding, with 95 percent of this money coming from local property taxes. Local officials thus are confronted with having to spend limited local resources with no choice about the services provided with these funds.

While categorical funding and restrictive eligibility often make it difficult for counties to match available services to a customer's need, they also limit the provision of early intervention services and prevent a holistic approach to customer needs. Case managers must fit clients to the services available, as opposed to designing services to fit the client. Clients can feel as if they have opened the door to a closet full of clothes where nothing fits.

"In some cases, we have to tell clients to come back when it gets worse," said a county social worker, because they do not fit the program eligibility guidelines. Early intervention is virtually impossible in such cases. One client recounted her story:

> I have three kids and no family in this state. I had a good job, but I lost it in a layoff. I was desperate but I couldn't get help. Finally, because I couldn't afford a place to live I moved in with friends and let the kids go live with their dad out of state. I wanted to get my kids back, but because they weren't with me, I didn't qualify for help. But I couldn't afford a place for them without the help. I can't tell you the amount of 'Gee, you're really in a pickle, but we can't help you' I heard from social workers. They did finally find a way to help, but I was angry for a long time. Do you have to be something that needs to be scraped off the ground before you can get help?

Multiple eligibility standards also add to program complexity and inflexibility, making it difficult to design an integrated program for a client and consuming administrative capacity that could more effectively be used to deliver programs. Social workers say it is also difficult to design local prevention programs if the proposed preventive services do not fit an existing funding category. A county social worker explained, "We try to match the needs of families to the services and funding available. It should be the other way around."

The problem is that programs are not designed to meet the needs of the customer but to put the customer into a preexisting program. County workers are frustrated by rules that routinely block access to services. Sometimes the one thing that would most help a customer is unavailable because of restrictive program rules. An example would be the case of a woman who is 62 years old and needs in-home personal care assistance and meals in order to continue living at home with her 65-year-old spouse, who is also frail. They are both eligible for home-delivered meals, provided by the area agency on aging. However, only the husband is old enough to qualify for the state Alternative Care Program that will provide personal care services. If no other funding source can be found to pay for the woman's personal care services, her only option may be to move to a nursing home.

Program evaluation and technical assistance

Two other factors that play a part in whether the system is focused on outcomes or process are the relative lack of program evaluation and shortcomings in technical assistance provided by the state to counties and other providers.

Measuring the outcome of programs is an integral part of program evaluation. System participants at the state and county levels assert that the state's program evaluation activity is inadequate or nonexistent. Generally, the state does not have staff dedicated to this task because the legislature has been reluctant to fund this type of position, preferring to channel limited resources to direct services. In addition, a thinned-out state staff must focus its resources on day-to-day program management.

As a state employee said: "The legislature wants to micromanage programs and state agency operations. At the same time, they have inadequate quantitative information with which to make those decisions and to control and develop policy." Another acknowledged the problems involved in explaining the need for these resources: "It is politically difficult to sell the need for effective information systems when people don't see how that helps the programs."

Although the legislature generally does not fund positions to do outcomes evaluation or data development, "it continues to be one of their expectations that we do this, even while they cut program staff," a state manager explained. "Even though we would like to, we have no time to focus on outcomes evaluation."

Interviewees noted that outcomes in human services programs can be difficult to quantify or may require years of longitudinal studies to assess. At the same time, others said there is not enough evaluation of the quality of services.

Technical assistance is limited for the same reasons evaluation is. County representatives say that state agencies do not provide them with technical assistance and feedback that is truly valuable for managing programs. "We get rules," said a county employee, "but we don't get feedback on how we're doing."

Although state agencies do provide a great deal of technical assistance, many program managers at the county and vendor level assert that it is the wrong kind: it is focused on rules and regulations, rather than on management. This is caused to a significant extent by frequent program policy changes that must be communicated and explained. Consultation and technical assistance on computer systems, reporting, accounting, and problem solving is apparently quite limited. The kind of assistance the counties would like includes help with planning, budgeting, designing experiments, and handling customer relations, as well as sharing successful innovations.

In addition to technical assistance, counties and providers also seek better data for evaluation. DHS recently developed new computerized systems for income maintenance and social service programs that, despite some initial difficulties, should provide counties and state managers with more useful data than has been available in the past.

Conclusions

The state human services system is complex for many reasons: changing populations in need of health and social services, the way bureaucracies inexorably move from simple to complicated, the influence of special interests, and a litigious society. While human services programs are originally designed to meet the needs of people, programs become complicated because other factors influence the process. This effect is clear in everyday procedures, rules and regulations, and funding.

It is difficult to unstick a complex mass of regulations so that the system can operate more flexibly. What is needed is a willingness to change, a realization that change takes time, and a spirit of innovation at the local, state, and federal levels.

Inappropriate incentives

Finding No. 6. Inappropriate incentives built into the human services system contribute to its fragmented and prescriptive nature.

All systems contain incentives, some designed and others unplanned. CORE's interviews

with Minnesota human services workers, customers, and providers revealed two important themes regarding incentives in the human services system:

- The incentives are present, powerful, and affect behavior.
- The incentives are, for the most part, not linked to the purpose of the program. They are often the unplanned and unanticipated consequences of decisions made for other reasons.

Many people, from customers to decision makers to taxpayers, do not trust the human services system. They feel the system talks one way and acts another. Despite professing certain principles, such as equity, fairness, responsiveness, and openness, the system often functions in quite different ways. Several groups indicated that this kind of experience with the system is widespread. Such comments as "There is no reason to serve people with complex cases," "Honesty doesn't pay," and "There is no incentive to act in good faith or use common sense" illustrate the effect of powerful, unplanned incentives in the human services system.

Inappropriate incentives for customers

Two inappropriate incentives built into the human services system for customers are (1) the encouragement of dependency and (2) the lack of a role as equal partners with the system in achieving desired outcomes.

Although the stated purpose of many human services programs is to move people out of difficult circumstances into a more stable, self-sufficient status, the reality is much different. Becoming self-sufficient as quickly as possible is very difficult because of the minimal levels of support in most programs and a lack of personal encouragement and assistance due to heavy caseloads. As one customer said:

> Most people want to get off [of assistance], but it's so hard. As soon as you just begin to break even, the system punishes you for your effort by taking away everything and exposing you and your kids to catastrophe again. What if your kids get sick? What if the car breaks down? It is better to stay on the system and be able to see your kids than to work 80 hours a week in a dead-end job.

Those who are most successful at achieving independence generally have sources of outside support: family, friends, a new partner. But the system does not always reward this support: the part-time income of a 17-year-old child of a parent on Aid to Families with Dependent Children (AFDC) is counted as family income, resulting in a reduction in assistance for the whole family. One woman recounted her difficulty in meeting program requirements because, although she could not support her family, she owned the small house that she and her children lived in. Her case manager told her that she would be able to qualify for better assistance if she were renting instead.

Many human service customers feel they could participate more in decision making and would be capable of being their own case manager if only they had access to better information. It appears to them that information is being withheld or doled out only when social workers decide the customer needs to know something. Without accurate information, customers are dependent on the skill and willingness of social workers to put together the package of services they need. One customer explained the difficulties:

> Getting into the human services system is not easy. People don't know what is available. People don't get information on how to qualify, who's eligible, or what agency to see. In order to find things out, you need a mediator. The system doesn't educate you — you find out from the community, word of mouth.

Responsible human services customers are caught in a dilemma. They are not able to advocate for themselves, because the information they need is held by the system. And the system is unable to adequately serve customers due to program complexity, lack of a comprehensive information and referral system, and uncoordinated case management.

The human services system needs to share responsibility with customers for achieving good outcomes. The customer must be an active partner, or the change will not happen. Customers in focus groups felt strongly that they wanted to be accountable for their part of the "deal."

Models exist that indicate that customer accountability and shared responsibility for outcomes are possible. Dakota County, for example, has a pilot project funded by the McKnight Foundation that provides comprehensive case management and support services to 100 families either on AFDC or at risk of needing public support. Project Fast Forward, as it is called, advocates for customers, automates and shares information with a network of service providers, and is clearly focused on the outcome: helping customers to become economically self-sufficient. Although this program works within the existing system, it has the advantage of extra funds than can be used flexibly to meet immediate needs and small caseloads of 25 to 35 individuals. It builds on the capabilities of the customer and demands accountability from both the customer and the system. As a condition of participation, customers agree to a contract for action and must maintain progress toward their goals. In addition, providers meet as a board of directors to eliminate system disincentives to customers achieving self-sufficiency.

Dakota County also has been the site of a Parents as Case Manager pilot project that uses vouchers to allow more flexibility in purchasing services, such as respite care, by parents of children with developmental disabilities. This program rewards parents for their active involvement with flexible funds and has resulted in providing more services at the same cost. Another new state-level pilot program, the Minnesota Family Investment Program, is designed to demonstrate that the system can be changed in ways that will foster independence from welfare.

Inappropriate incentives for human services workers

Human services workers also experience inappropriate incentives. Role conflicts often impede accountability, and focusing on outcomes can be difficult because the system generally exhibits a lack of trust in everyone involved in it.

Role conflicts abound in human services. They exist between the cost-containment and customer service roles of financial workers and between the incentive to keep waiting lists short and the desire to provide complete case management. Role conflicts also emerge from the desire to protect the confidentiality of personal data and the need to collaborate with other professionals to achieve the best outcomes for the customer. Professional standards and training are also sometimes in conflict with the employer's requirements. Workers find themselves pulled back and forth between roles, unable to do any job very well. Clear separation of incompatible roles would help resolve these issues.

State agency staff who deliver services directly are asked to wear many hats. The participants in the focus groups said that many of these roles are in direct conflict with each other. For example, licensing field staff are often approached by facility owners with questions. Some of these questions may indicate that the facility is out of compliance with licensing requirements. Strictly speaking, the licenser should immediately sanction for the violation. However, the facility owners do not have any other resource to ask since technical assistance is not readily available. The choice facing the licensor is, what is more important: immediate accountability for the licensing standard or helping the owner come into compliance, thereby keeping the facility open? It is a difficult dilemma for a direct service worker, with disincentives for any possible course of action.

This issue is directly related to the lack of clear missions for human service agencies. When the mission of an agency is clear, staff are less likely to be confused about their roles in working toward that mission.

Another barrier to achieving an outcomes orientation is that direct service staff do not feel trusted or supported. Most programs in the human services system are heavily regulated, minimizing professional discretion. County social service directors noted that the areas where there is the least amount of law and regulation, such as child protection, seem to attract the best social workers, implying a correlation between a climate that encourages professional decision making and being able to attract quality staff. Most programs have long chains of command to review and approve nearly every transaction. A social worker explained, "There is no incentive to act in good faith or use common sense."

Being held accountable for outcomes also means being accountable for the performance of a whole person and not just the delivery of a narrow service. Any performance standards will have to be designed to acknowledge the difficulty of helping people change. Standards should be created to document progress, as well as ultimate success. One state uses a system that rates performance as "on track" or "off track."

Inappropriate incentives for human services providers

The human services system has a staggering array of providers. Minnesota has a very active nonprofit and for-profit human services economy. At a recent conference sponsored by the Minneapolis Foundation, it was estimated that there are 1,200 human service provider agencies in Hennepin County alone. This loosely organized network of providers is a potent economic and political force.

The system offers few if any incentives for providers to satisfy human services customers. Customers are given little choice of provider, and providers are often granted near-monopolies on services. The main provider is often the county itself. The result is that a customer's choice is tightly constrained by which county the customer lives in and by the exclusive contracts through which services most often are purchased. Often, the only way customers can exercise their "choice" of providers is by moving to another county. According to experts, large contracts are too often awarded to single providers. Designing contracts so that multiple providers compete for customers would offer incentives for providing excellent customer service.[14]

Once a provider is established in a community, tremendous pressure arises to keep that provider operating. With larger organizations, this is primarily because they provide jobs and spin-off employment for a community. The most obvious example of this is the state regional treatment centers, but the same phenomenon affects other providers. This pressure is a strong incentive for public officials not to allow an enterprise to die, even if it no longer meets the market preferences of customers.

Providers also have few incentives to compete on outcomes. The human services system is oriented to providing and purchasing services, not obtaining outcomes. Providers compete for contracts on the basis of being able to meet the requirements at the lowest cost, not on providing the best outcomes. Making a profit involves negotiating the requirements and the price, not negotiating the outcomes within the price. A huge amount of activity, therefore, is devoted to program requirements in the legislative and rules process by agencies, advocates, and providers.

The current rule-driven system also keeps out some new, small providers that find the detailed rules and requirements economic barriers to entry. Even existing providers that provide high-quality services and strive to be customer-focused and outcome-oriented have a hard time doing so within the constraints of the system. They are sometimes required by law to divert resources into areas that are a lower priority for them and their customers.

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[14]Ted Kolderie, "The Two Different Concepts of Privatization," *Public Administration Review*, July/August 1986; "Contracting as an Approach to Management" (Public Services Redesign Project, Center for Policy Studies, Minneapolis: no date.)

Inappropriate incentives for human services agencies

State agencies are not able to view customers comprehensively. Determining with any accuracy the total public financial investment in an individual or a family receiving public assistance is impossible. Though there may be detailed data within each program area, no composite is available. Without comprehensive data, state agencies cannot determine if a better outcome could have been obtained by allocating the same amount of funding differently.

Until the system begins to view people comprehensively and builds the information systems to support that perspective, the effectiveness of human services spending will be limited. Existing program-based systems have been sufficient to detect fraud and ensure standardization. A comprehensive, outcome-based approach, however, would require different tools, such as statewide information and referral information, a case management communication system, expert systems technology, and easy access to eligibility and program requirements.

Inappropriate incentives for elected officials

Elected officials receive little reward for considering the longer term and the larger community. Terms of office are relatively short, and voters, even well informed ones, are prone to the what-have-you-done-for-me-lately syndrome. The incentive for the politician who wants to remain in office is to support policies that have the short-term effect of earning votes in the district, regardless of whether these policies make sense in the longer term or for all state taxpayers as a whole. Similarly, cost-saving solutions that solve a current crisis are more valuable than long-term fixes, especially those that take money to initiate. Linkages between powerful special interests and legislators can also make it difficult to make radical changes in the system, even if these changes would be for a greater good. Despite the lack of incentives, however, some legislators and local officials have supported innovative experiments and provided leadership for significant changes.

Conclusion

These findings are the challenges, or barriers, that must be addressed to improve Minnesota's human services system. The recommendations that follow are designed to address the issues raised by the findings.

RECOMMENDATIONS

As CORE's findings reveal, Minnesota's political and professional commitment to human services is strong, but somewhere in the process of translating ideas into action, barriers get in the way of the effective, efficient delivery of these services.

To overcome these barriers, CORE recommends 13 changes to the system. Each of these recommendations is described in full below.

State health and human services organization

1. Establish a secretary of health and human services who reports to the governor and oversees the programs, budgets, and administration of state human services agencies.

The chief operating officer for each health and human services agency would be a deputy secretary reporting directly to the secretary. State agencies that should be included under the secretary for health and human services are: Health, Human Services, Housing Finance, Veterans Affairs, Corrections, and parts of Jobs and Training.

Need for reform

Minnesota's human services system lacks overall, unifying leadership. In the current system, the most likely person to provide this leadership is the governor. The sheer scope of the governor's responsibilities, however, and the size and complexity of the human services system mean that the governor cannot possibly devote the time to human services that it needs.

The next level of executive administration within current state government — agency commissioners — is also an unlikely source of this unifying leadership. The responsibilities of operating an agency, plus the need to compete with other agencies for scarce funding to provide human services, make it difficult for a commissioner to take a leadership role for the entire state health and human services system.

Such a leader would help the system develop a single, unifying vision, so it would act in a more holistic manner. Separate visions developed by separate agencies or by affected populations are insufficient to improve the system. Having a unifying vision is particularly important for focusing on outcomes (discussed in more detail under Recommendation 5).

At the same time, the state's human services agencies need nonduplicative, coordinated missions. Each agency's mission should be designed to fulfill a specific aspect of human services. With coordination, no mission — and therefore few programs — would be duplicated.

Minnesota's system needs an individual who can become familiar with all human services issues throughout the system and has the authority to make state agencies work together in spite of competition for turf or power. Other issues described in CORE's findings, such as overly prescriptive rules and inadequate program evaluation and technical assistance, are also addressed in this recommendation.

Purpose of a secretary

The purpose of establishing a secretary for health and human services is to address the lack of vision and leadership in Minnesota's human services system, to improve the coordination and integration of planning and service delivery, and to provide guidance for changing the system as necessary.

The secretary should be involved primarily in policy direction and oversight, rather than day-to-day operations of the agencies. The secretary should be accountable for the coordination of policy implementation and service delivery, regardless of department jurisdictional boundaries and other traditional obstacles to cooperation.

The six major responsibilities of the secretary should be:

1. Create a vision for state health and human services.

A single entity must be *accountable* for the development of a comprehensive vision for the human services delivery system. The secretary would be in a better position than deputy secretaries or the governor to focus the vision on the overall goals of the entire system. The secretary should guide the vision process to focus on the specific role of government in citizens' lives, avoiding overly general goals ("everyone will be happy"), as well as on outcomes expected as a result of government intervention.

The governor would be involved in creation of the vision to the extent that the secretary would be appointed to carry out a particular political agenda. The secretary must also involve the legislature in the creation of this vision. Laws and policies must be in harmony with the vision. The process of developing this vision would also encourage the legislature to focus on long-term goals for health and human services, rather than just short-term budget and political priorities.

Citizen input is another important component of this vision creation. The secretary should seek multiple avenues of citizen participation, such as encouraging citizen involvement in local planning processes or conducting major citizen input projects such as Minnesota Milestones.

2. Establish state health and human services agency missions.

The secretary should convene all state health and human services deputy secretaries to determine appropriate missions for each agency. The mission of each agency should spell out the agency's role in the system as well as define its customers and outcome goals.

Agency staff should be fully involved in the development of human services missions. Staff are the most familiar with health and human services programs, whom they serve, and how they have evolved. This information is essential to the creation of appropriate missions for each agency. Staff also are the ones who will actually carry out the missions. Involving them in the development of the missions is crucial to the success of the effort. This process has the potential to build consensus and understanding of the agencies' missions from deep within the organizations; it would also help create staff acceptance of the missions and ensure that agencies' actions are consistent with their missions.

The secretary, having authority over all state health and human services agencies, should have no vested interest in any single agency and therefore no boundaries to guard. Mission development should involve the clarification and redefinition of current state agency missions. As missions are clarified and the roles of each agency made more distinct, some programs may need to be combined or moved from one agency to another. The secretary would be far more likely to accomplish this than individual agency commissioners with programs and budgets to protect.

3. Ensure the coordination and integration of health and human services programs.

The secretary should have the authority to ensure the coordination and integration of programs among state health and human services agencies. This authority meshes with the responsibilities for creating vision and overseeing agency missions. An effective leader in this position could improve program integration and coordination while enhancing the unique roles and responsibilities of the agencies involved.

One important function of the secretary would be to address the current duplication of requirements and multiple review of various local human services plans. The secretary could ensure that the need to receive and review plans and information from local administrations is coordinated at the state level (for example, by mandating the use of a single health and human services district plan; see Recommendation 2).

Having a single person accountable for coordinating the state's health and human services programs could also provide a point of access for citizens who feel they are getting the run-around from state agencies. This pinpointing of accountability should generate a greater impetus to ensure that the system is coordinated and responsive to its customers.

The purpose of a secretary would be to enhance rather than to remove accountability from deputy secretaries. The addition of a secretary would allow agency heads to have

a closer working relationship with their manager by reducing the ratio from the present one governor to 26 commissioners to one governor to eight secretaries and one secretary to about six health and human services deputy secretaries.

The secretary of health and human services should make specific efforts to coordinate services with the secretary of education (the creation of this position is part of CORE's executive reorganization recommendations). Schools more and more have become the providers of social services for children. This expanding responsibility makes coordination between these two major areas of state government even more crucial. CORE does not recommend that these areas fall under a single secretary, because the scope of issues and budgets would be too large.

4. Exercise comprehensive policy and budget responsibility.

The secretary and deputy secretaries of health and human services, along with the governor and the Department of Finance, should be responsible for establishing state health and human services program and funding priorities.

Health and human services deputy secretaries and their staff would have crucial knowledge of the programs within their departments, interactions with other programs, and a sense of how well their programs work. While taking advantage of this expertise, the secretary should have the authority to compel and manage the budget prioritization process and to arbitrate disagreements among the deputy secretaries. Through a collaborative process with the deputy secretaries and agency staff, the secretary should have greater potential to build consensus on priorities among health and human services agencies than is currently the case.

The secretary could also fulfill an important moderating function. The secretary should act in accord with directives from the governor and Finance and independently of any special interest group or the individual state human services agencies, weighing specific interests against the larger goals and interests of the state as a whole. As a part of this process, the health and human services vision and priorities should be balanced with those of the environment, education, transportation, and others.

The secretary should exert control over agency budgets at the program level only; agency managers should retain control over administrative budgets.

5. Coordinate legislation and oversee rule development.

The secretary should have substantial control over policy through the coordination of legislation and oversight of rule development and implementation, as well as through budgetary controls. While the deputy secretaries would propose legislative initiatives, the secretary could initiate others, review and approve all legislative proposals with the governor, and coordinate efforts to secure passage of the proposals.

To reduce the regulatory burden of rules, the secretary should hold deputy secretaries responsible for: (1) preparing for each legislative session a list of rules that should be repealed because they are obsolete, unnecessary, or superseded, so that they may be included in the revisor of statutes' bill; and (2) monitoring the overall progress of rule making and reporting on delays. Additionally, before requesting rule-making authority as part of legislation, the deputy secretaries should report to the secretary on other options that could achieve the policy objectives proposed in a bill.

To see that agency rules effectively implement specific legislative directives, the secretary should review all proposed rules that exceed federal standards, and the deputy secretaries should be required to justify exceeding the standards. The secretary should develop a standardized process and establish the criteria for agency review of waivers and variances from rules and should periodically review whether these criteria are applied consistently by agencies.

6. Develop guidelines for human services data collection and information.

The secretary should be accountable for developing and maintaining health and human services data and information systems. The secretary should develop guidelines for data collection and information management, including standardization parameters. Models of data coordination and cooperation should be developed within state government. In addition, technical assistance and support for data sharing and development should be provided by the state to other governing entities whose data bases would be of value to state policy analysts and decision makers.

The current health and human services data system is fragmented among the different agencies and levels of government. Most of the individual data systems are incompatible: data from one cannot easily be correlated with data from another. Before dollars are invested in some level of standardization of the system, it is important that the rationale for change and the overall goals for the state's data system (or systems) be established. The secretary should clearly identify the need for change and initiate the process.

The Department of Administration's Information Policy Office stresses a cooperative approach to data management, rather than the imposition of a new data systems structure. The secretary should facilitate the development of data communities wherever possible. Data communities are groups of data gatherers and users who join forces to make their data more compatible and, ultimately, more useful. Data communities are often self-defined. They may be large, such as all county social service agencies, or small, such as departments within a single county. The importance of data communities is that need drives the scope of the undertaking and limits the tendency to expend resources unnecessarily. In some cases, the secretary may need to mandate cooperation between groups that need to share information.

Information needed for policy analysis is often different from that needed to operate

human services programs. As the person accountable for ensuring that state health and human services agency missions are consistent with their roles, the secretary would be in the best position to ensure that the data practices of the agencies are consistent with their missions. At the same time, the secretary should require agencies to put systems in place that emphasize local planning and input in information used for setting state policies.

The collected data should enable the state to evaluate the outcomes of its programs. The secretary would be in the best position to require accountability from state agencies for outcomes and to demand appropriate use of data collection.

The authority of the secretary in all these responsibilities is not intended as restrictive but rather as enabling innovation to occur. The role of the secretary is to involve all agencies in the planning steps prior to the implementation of systemwide changes. However, when implementation is imminent — a point at which good intentions sometimes fail — the secretary can require all human services agencies to participate fully.

Local health and human services organization

2. Designate local health and human services districts (HHSDs) using current community health service (CHS) district boundaries as a starting point. These districts would be created for local health and human services program planning and administration. Services would continue to be delivered within communities. Decisions about district health and human services should be made by county commissioners within a district, with votes proportional to the population represented.

Need for reform

CORE's findings on health and human services system fragmentation indicate that the statewide administrative complexity of the system needs to be reduced. An important step in that direction would be to reduce the number of local health and human services administrative entities from the approximate 150 (84 human services administrations and at least 66 public health administrations) that now exist to a more manageable number.

The findings on resource capacity indicated that smaller counties often do not have sufficient staff to meet state requirements or sufficient population to provide adequate services. State agency staff are also burdened by the numerous local administrative entities.

Purpose of HHSDs

By consolidating all planning, budgeting, and administrative functions within each of 44 HHSDs, the number of local administrative units would decrease significantly. This new administrative structure would involve counties within a district in comprehensive joint planning and administrative oversight to identify and address the health and human services needs of the entire district. Duplication and gaps in services should be apparent, and resources could be pooled for the best use. Better linkages between various resources and a single point of accountability for districtwide planning should also benefit people working within the system, as well as customers.

While some problems should be mitigated by other recommendations to reduce the prescriptive nature of state policies, a more comprehensive solution is needed to realize real efficiencies in the state's locally delivered human services system.

CHS districts

A significant advantage of using CHS district boundaries for consolidation of health and human services planning and administration is that they already exist: some structure is in place, although it would need to be strengthened. A system of 44 HHSDs recognizes the current configuration that is familiar to the public health community.

To make the change to districts as flexible as possible, CORE recommends that counties initially be given the option of arranging HHSD configurations that may be different from current CHS district configurations, as long as they have a minimum population of 30,000. After HHSD configurations are initially settled, reconfigurations would be made only by the legislature, on a case-by-case basis.

While creation of HHSDs would establish a new administrative structure for health and human services, the HHSD structure would *replace* current CHS districts, as well as current county social service and public health administrations, with a stronger, comprehensive entity. Every county would be affected by this organizational change: counties that are now in a single-county CHS district could remain a single-county health and human services district but would combine their social services and health administrations; counties with less than the minimum required population would combine social services and health administrations with other counties in a multicounty district so that each district would have one health and human services administration.

Several large cities also have public health departments. The issue of whether these should be merged with the county HHSDs was not specifically addressed. Before a recommendation is made to consolidate city and county CHS districts, this issue should be studied by the affected localities.

It is unclear at this time whether health and human services districts should actually be

larger geographically and fewer in number than the current CHS districts. Good information on optimum geographic or population size is not available. While there are advocates for fewer, larger districts, the relative success of the 44 CHS districts seemed to be a reasonable basis for settling on this number.

It is important to note that the creation of HHSDs does *not* require a district to centralize the delivery of services. In multiple- or single-county districts, services would continue to be provided at the most efficient and effective decentralized level, as close to customers as possible, as determined by individual district administrations.

HHSDs should also make it easier for school districts to coordinate provision of health and social services through schools because there would be significantly fewer health and human services administrations with which to communicate.

Local accountability and funding

Two major issues are implicit in the creation of health and human services districts: local governance and local funding decisions.

Because the rationale behind Minnesota's state-administered, locally delivered health and human services system is to place decision making at the local level, any new health and human services district structure would continue to require oversight by local elected officials and accountability to citizens. Establishing HHSDs would reduce the number of current health and human services administrative entities by about two-thirds. However, because the district configurations are based on population, they are still small enough for existing local elected officials to govern.

The largest eight counties in the state have a combined population of 2,606,434 and are governed by 50 county commissioners, a ratio of one commissioner to every 52,129 citizens. In the 21 midsize counties (those with populations between 30,000 and 100,000), the ratio is one county commissioner to every 8,514 citizens. In the 58 smallest counties (where the population is less than a million total), the ratio is one commissioner to every 3,016 citizens.[15]

Using current CHS district configurations as a basis for comparison, the ratio of county commissioners to population in a district can be calculated. In the 23 single-county districts, the ratio is one commissioner to every 27,008 citizens. (Excluding Hennepin County from this group brings the ratio down to 1:19,052.) In two-county districts, the ratio is 1:4,509; in three-county districts, it is 1:3,950; and in four- and five-county districts, it is 1:3,850.

[15] See Appendix E.

These comparisons make it clear that smaller counties do not lose a significant level of representation when they combine with other counties in a district configuration. The smallest counties are most likely to belong to three-, four-, or five-county district configurations.

Administration and accountability for HHSDs would require joint powers or similar agreements among counties within a district but would not require the establishment of an entirely new governmental unit. Local decision making would occur much as it does now, except that health and human services decisions would be made by combined HHSD boards rather than by individual county boards.

Either all of the elected county commissioners from each participating county or a delegated subset of those commissioners would constitute the HHSD board. For example, if three counties were in a district and each county had five commissioners, the counties involved would determine whether the HHSD board would consist of all 15 commissioners or a delegated subgroup of commissioners. The board would be responsible for establishing the district administrative office, hiring a district administrator, delegating administrative powers to the director, and determining provision of discretionary services. Thus, accountability would still reside with the county commissioners. CORE recommends that county commissioner votes within a district be proportional to the population represented.

The HHSD board would be responsible for approving the budget for the district. Programs and funding would be based on priorities, set by the HHSD board, for all counties in the district. After determining the district's health and social services financial needs, the board would approve a specific health and social service levy that would apply to all taxpayers within the HHSD. Allocation of funds would be based on needs as identified in the approved HHSD plan for local health and human services expenditures.

This approach would require all counties within a district to think of themselves as one entity. Districtwide levies would *not* guarantee each county the return of a dollar in expenditures for each dollar of property tax levied for social services. Pooling resources within an HHSD would target common health and social services needs and desired outcomes for the entire district and address those needs through a comprehensive plan.

Health and human services funding

3. The secretary of health and human services, with the assistance of the health and human services districts and the concurrence of the legislature, should identify target populations, determine services eligibility priorities, and develop a list of health and social services that are eligible for state funding and that constitute a *minimum and adequate level of services* that meet the basic needs of Minnesota citizens most requiring assistance.

Need for reform

In the current human services system, categorical funding often results in a relatively small number of persons receiving a great deal of public assistance to meet their needs, while others whose needs do not fit into a narrow category receive few or no services. In addition, the restrictive nature of categorical funding prevents health and human services workers from fitting services to the specific needs of customers.

Purpose of basic services

The purpose of defining a list of minimum and adequate services that constitute a set of basic services is to ensure a level of service equity throughout the state that meets the basic needs of people most requiring assistance. The intent is to limit the number of services that are considered basic.

While maximum flexibility is desired, there must be some equity in the types of services that should be available to clients, regardless of the county of residence. Thus, CORE's funding recommendations employ the concept of minimum and adequate services to ensure that some threshold of services is available, while still allowing for maximum flexibility at the service level.

Funding target populations

To achieve service equity, a distinction must be made between those services that are essential and meet system goals ("minimum and adequate") and those that are discretionary. The process for establishing a list of minimum and adequate levels of services would include (1) identification of target population groups to be served, and (2) a determination of service eligibility priorities within each group.

It is significant that this process begins with the identification of people to be served and a prioritization of need (eligibility), rather than with a listing of services. Once the target

populations are identified, a list of services that could meet their needs should be developed.

Not all services on the list would be guaranteed to all persons who are members of the target population. Only those persons who meet the priority eligibility criteria for the given services would receive them. This minimum and adequate level of services could be enhanced through the discretionary services provided by the individual HHSD plans. These discretionary options would vary depending on state and local resources.

The impact of this approach is significant. The natural result is that some areas of the state may choose to offer more services to certain target groups than others, depending on their resources and needs. A minimum and adequate approach to service equity implies acceptance or tolerance of some variation in the provision of health and human services statewide, above a basic services level.

Service variation is already a reality in Minnesota. The secretary, through the state's vision for health and human services, should work with the legislature in defining the list of minimum and adequate services and priorities.

Some examples will illustrate how this concept could be implemented:

- *Target population:* poor families

  Priority: income at or below 175 percent of the federally defined official poverty level

  Services: housing assistance, non-Medicaid health care services, child day care, vocational training, family planning assistance, school readiness programs, and other services

- *Target population:* unemployed people

  Priority: unemployed over a designated number of weeks or unemployed single head of household

  Services: vocational training programs, housing assistance, support groups, and other services

- *Target population:* people with a mental illness

  Priority: statutory definition of "severe and persistent mental illness"

  Services: psychiatric care, medication management, mental health therapy, housing assistance, independent living skills training, vocational training or assistance, crisis care, and other services; also, community education and outreach programs

- *Target population:* people who are HIV-positive

  Priority: people who have a diagnosis of an AIDS-related disease

  Services: counseling services, nutrition services, public health nursing services, emergency medical care, home health care services, home-delivered meals, and other programs; also, community education and AIDS prevention programs

This approach depends on the development of flexible funding, described in Recommendation 4, as well as on the elimination of many state health and human services mandates.

4. Create a new HHSD grant to give local health and human services districts greater flexibility to meet local needs. A basic set of services would be agreed on as the *minimum and adequate level of services* (see Recommendation 3). All health and human services districts would be required to provide these basic services. This basic level would be funded with no less than 60 percent and no more than 70 percent of available state resources. The remaining 30 to 40 percent of state funds would be allocated in the form of discretionary block grants.

The grant would combine funds from the following current programs: Community Social Services, community health services, Semi-Independent Living Services, Title III and other non-Medicaid aging programs, non-Medicaid mental health programs, and state-operated residential care funding.

The grant would pool funding sources that are made up primarily of state dollars and/or are not entitlements. These funds include Community Social Services (CSSA), community health services (CHS), Semi-Independent Living Services (SILS), Title III and other aging programs, non-Medicaid mental health programs, and most of the state-operated residential care (RTC) funds. Between 60 and 70 percent of the total available state funds would be targeted to fund basic services, while the remaining 30 to 40 percent of the monies would be used to fund the block grant. Assigning the majority of funds to basic services is based on the desire to provide an adequate level of service equity throughout the state but still allows more local flexibility than is currently the case. Table 1 compares current block grant and categorical funding with CORE's recommended HHSD grant. Table 2 details the proposed targeted and block grant funds in comparison with the total budgets of the Departments of Human Services and Health.

Table 1. Comparison of current funding and HHSD grant

FY 1993 funding:	(thousands)	
CSSA	$99,067	Community Social Services block grant
Community Health Services	$18,933	Community health block grant
SILS	$5,278	categorical funding
Title XX Aging Programs	$43,482	categorical funding
Mental Health grants	$29,189	categorical funding
State Operated Residential Care	$203,042	categorical funding
	$398,991	
		Source: Minnesota 1992-93 Proposed Biennial Budget
Proposed HHSD funding:	(thousands)	
	$159,596	block grant funding
	$239,395	targeted funding (minimum & adequate)
	0	categorical funding
	$398,991	

The division of funds is designed to leave a significant portion of the funds in the block grant, so that HHSDs are able to tailor services to meet local needs. Between 30 and 40 percent of funds is specifically designated for the block grant to encourage the legislature to resist expanding the set of basic services until no money is left for the block grants to address local needs.

This recommendation would eliminate most state mandates for community services but would require clear reporting from HHSDs on how block grant monies are spent.

A significant portion of the HHSD grant is comprised of funds from state-operated residential care, primarily from regional treatment centers (RTCs). Combining these funds into an HHSD grant and giving counties the flexibility to decide how they are spent would likely have an effect upon RTCs, because many counties may choose community rather than RTC placement for people for whom alternative settings are appropriate.

The major goal of this proposal is improved customer outcomes. Counties must be able to demonstrate, through whichever plan of action they select, that the services they make available to each individual client are ones that help to achieve desired outcomes for that client. Flexible funding is accompanied by the responsibility of each county to establish outcome goals and measures and then to make progress toward them.

CORE recognizes that many discussions have taken place with regard to the future of the regional treatment centers and that a memorandum of understanding (MOU) exists

Table 2. DHS and MDH Budgets

Department of Human Services FY 1993 State Budget
Program Funding & Percentages

	(thousands)	
Health Care programs	$2,332,628	62.7%
Social Services grants*	$87,445	2.4%
CSSA	$99,067	2.7%
SILS	$5,278	0.1%
Aging Programs**	$43,482	1.2%
Mental Health	$29,189	0.8%
State Residential Care***	$203,042	5.5%
State Operated Residential Care	$26,624	0.7%
Economic Support & Transition*	$95,116	2.6%
MN Supplemental Aid	$64,453	1.7%
General Assistance Grants	$62,609	1.7%
Work Readiness Grants	$36,558	1.0%
AFDC	$388,622	10.5%
Child Care Fund	$45,118	1.2%
Economic Support/ Elderly	$45,438	1.2%
Administration	$149,053	4.0%
Other	$4,967	0.1%
TOTAL	$3,718,689	100.0%

* Balance of program funding after subtracting funds below this category.

** AAA services; Foster Grandparents, Retired Seniors, Senior Companion, & Alternate Care programs.

*** Does not include state nursing homes or Security Hospital. (These are included in the next item.)

Department of Health FY 1993 Budget
Program Funding & Percentages

	(thousands)	
Disease Prevention & Control	$7,866	6.2%
Public Health Labs	$4,951	3.9%
Environmental Health	$11,469	9.0%
Health Promotion & Education	$3,106	2.4%
Maternal & Child Health	$53,570	41.9%
Community Health Services	$18,933	14.8%
Health Resources	$13,977	10.9%
Health Systems Development	$1,831	1.4%
Health Support Services	$12,121	9.5%
TOTAL	$127,824	100.0%

Shaded funds proposed for inclusion in HHSD grant
Total = $399 million

between the state and RTC employee bargaining units. The secretary of health and human services should be fully cognizant of this memorandum when planning any action for system change that may affect the RTCs. The calculations of the fiscal impact of this recommendation do take this MOU into account (see Appendix F).

This recommendation is intended to offer maximum flexibility to local districts to tailor services to meet local needs. The creation of a new HHSD grant encompasses the concepts of service equity and flexibility by increasing the size of local block grant funds and decreasing the size of categorical grants, while still maintaining a basic threshold of services as the minimum. HHSDs would have discretion in establishing eligibility criteria and the service package related to the block grant and local share of funding.

Human services delivery

The redesign of health and human services administration and funding is a key step in addressing the barriers to effective health and human services delivery in Minnesota. These restructured systems, however, may fail to reach total system goals if implemented alone. Recommendations 5 through 13 must be adopted and implemented before or at the same time as new health and human services structures are set in place.

5. State and local agencies and service providers should fully adopt an outcomes orientation in budgeting, administration, regulation and enforcement, and in direct service delivery.

Effectively changing from an emphasis on process to an emphasis on results throughout the delivery system could have a pivotal effect on the system. Adopting an outcomes orientation has been widely advocated and generally acknowledged as a good approach. Implementing this orientation, however, requires persistence, creativity, and openness to significantly new ways of thinking and doing things.

Because of the difficulty of changing the health and human services culture from process to outcomes, priorities must be determined for applying this approach. Focusing on one area at a time is the best way to begin, and one approach will necessarily entail adopting parts of others.[16] This recommendation includes suggestions for four specific areas in which to develop an emphasis on outcomes.

[16]Gordon Culp and Anne Smith, "Applying Total Quality Management," in *Water Environment and Technology* (Alexandria, Va.: Water Environment Federation, July 1992.)

1. Focus on outcomes in state and local agency budgets.

While budgets are a tool to implement policy, they also, more than any other single factor, direct policy. Policy decisions are based on available funding and assumptions of what will be the best expenditure of these funds. Strengthening the present efforts to adopt an outcomes orientation in state agency budgets should provide better information to support better policy decisions within agencies and by the legislature. An incentive for state agencies to fully adopt this process is that the legislature should eventually become more focused on outcomes and relinquish some micromanagement of state agencies, such as staff numbers and line item specificity. (See CORE's budgeting and financial management recommendations for performance-based budgeting; some of these could also be used by local administrative entities.[17])

Using outcome measures in agency budgets can provide information for determining whether programs actually are working. Program design is enhanced by clarifying policy assumptions, and information gained can be used for program management and evaluation. While an outcomes focus is easily implemented in some fields, health and human services outcomes can be difficult to quantify and do not easily provide opportunities for controlled experimentation. It is imperative, therefore, to clarify what is expected from a program. For example, a larger income maintenance caseload can be the result of greater economic problems, rather than the failure of income maintenance self-sufficiency programs. Because extraneous factors can be hard to control, state agencies have often erred on the side of prescribing a process, with the expectation that this will ensure certain outcomes. By using an outcomes focus, the right questions (that is, results-oriented vs. process questions) are more likely to be asked and information valuable to policy decisions is more likely to become available.

An example of the application of these principles would be the design and implementation of a program to foster better health in young children and thereby reduce medical costs to the state. Suppose that the assumptions that went into designing a solution included the following sequence:

- Only 57 percent of children are immunized properly,[18] which leads to higher health care costs;
- Parents want their children to be immunized;
- A public information campaign and requirements for day care and schools will ensure that most parents know of the need for immunizations;

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[17]Commission on Reform and Efficiency, *Budgeting and Financial Management in Minnesota State Government* (St. Paul: CORE, February 1993).

[18]Office of Strategic and Long-Range Planning (Minnesota Planning), *Minnesota Milestones* (St. Paul: Minnesota Planning, December 1992), 1990 statistic.

- Parents who can afford to have their children immunized will do so, but a lack of health insurance prevents some children from being immunized;
- The state will be able to pay for an adequate amount of free immunizations;
- The state will be able to adequately inform parents about free immunizations; and
- Poor parents will get the free immunizations for their children.
- Therefore, all children will be immunized properly, and
- There will be higher levels of health and lower medical costs for children in the state.

By providing exact and continuous feedback, a well-designed budget performance accountability system allows such assumptions to be tested at each step. If any of the assumptions are incorrect, the outcomes measurements will show it. Changes can then be made early in program implementation.

2. ***Focus on outcomes in state relationships with local health and human services districts.***

There are many ways to achieve an outcomes focus in state-local relationships: state agencies could shift their focus from process to results when designing and approving local human services plans; allocation formulas could be based on achieving stated outcomes; and technical assistance could be provided to local entities based on where help is most needed to achieve outcomes, rather than on how to comply with state-specified processes. Training for state and local staff would be necessary to implement this approach.

3. ***Focus on outcomes in state relationships with direct service providers.***

Many possibilities exist for implementing this approach, a number of which have great potential for cost efficiency. Providers could be paid based on customer outcomes, rather than on a fee-for-service or cost basis. Rules could be written less prescriptively. Providers who continually meet quality and safety requirements could be inspected less frequently.

An outcomes orientation in state-provider relationships can work in both directions, from providers to state agencies and from state agencies to providers. Examples of applying this concept are:

- While the state may use the outcomes of appeals as a measure of success, a different measure should be used to determine the success of state service to providers. Because the outcome, or final decision, of an appeal often is not resolved in favor of a provider, state service to customers in this area could be measured by whether appeals are resolved in a timely and professionally courteous manner. The state could cooperate with provider associations to devise a survey instrument that would measure

the state's performance in these areas. The associations could then conduct annual surveys that are officially reported to the executive or legislative branch.

- Agencies should study opportunities to use outcome-based rules for reimbursement of services. Research at the University of Minnesota on the establishment of client outcome measures should be studied for its applicability to health and human services rules.

4. Focus on outcomes for people who receive human services.

State agencies provide few direct services. Because of this, the state should encourage (but not prescribe) a focus on end-user outcomes at the local service delivery level. Local providers, though, would find it difficult to implement this recommendation fully without concurrent state implementation of other recommended policy changes (see Recommendations 2 through 4) that would allow flexibility in meeting customers' needs.

Local health and human services providers should be encouraged to begin or expand efforts to achieve positive outcomes for customers. Writing an agreement (or "contract") between the case manager and the customer is a way of defining customer goals, developing a plan, and measuring achievement.

Clearly defining the achievement of customers' self-sufficiency goals as the desired outcome may be especially beneficial in income maintenance programs. The ultimate goals of any transitional assistance program should be to help customers achieve self-sufficiency as quickly as possible. Such a definition would improve our ability to gauge the success and cost-effectiveness of these programs and would assist customers in reaching their goal of exiting the system.

Improve accountability in rules, enforcement, and sanctions

Some of the findings in this report regarding the need to improve accountability and reduce dependence on rules go beyond the scope of this project and are addressed in CORE's report on the administrative rules system.[19] The CORE Human Services Project addresses accountability issues directly related to health and human services with Recommendations 6 through 10.

[19]Commission on Reform and Efficiency, *Minnesota's Administrative Rules System* (St. Paul: CORE, March 1993).

6. Health and human services rules should not be written for every possible scenario but rather to target potentially critical situations. These critical situations are those in which customers have no choice about the degree of risk to which they are exposed and those involving the financial solvency of providers or provider organizations. Rules should outline minimal acceptable standards, rather than the highest possible standards.

Need for reform

Unnecessarily restrictive rules are the single largest factor contributing to the prescriptive nature of Minnesota's human services system. Largely because of the fear of litigation, some rules are written to avoid any areas where professional discretion could lead to a lawsuit. The problem with this approach is that gradually the goal becomes a lack of lawsuits, rather than positive outcomes for customers.

Purpose of writing rules differently — If agencies can bring about a change in the way rules are written so that they are less prescriptive and allow for more professional decision making at the direct-service level, the costs of providing services should decrease, and the quality of service to customers should improve because the focus will be on the customers' real needs.

Adoption of this recommendation would result in types of rules different from those that presently exist. Examples of rule provisions that would probably *continue* under this recommendation are:

- Minn. Rules 4655.7700-7860, regarding administration of medication in nursing homes.
- Minn. Rules 9505.1550, listing tests that must be performed as part of a child health screening program.
- Minn. Rules 4685.1930, requiring health maintenance organizations to file an annual statement of revenue and expenses in accordance with a national standard.
- Minn. Rules 9505.1820, requiring nursing homes to keep financial records and designating the required contents of those records.

Specific rule provisions such as the following would likely *not appear* in rules written under this recommendation:

- Minn. Rules 9520.0600, listing required contents of personnel files for private mental health residential program providers, including an annual employee training and development plan.

- Minn. Rules 9525.0310, requiring all meals in residential facilities for individuals with developmental disabilities to be served in a dining room at small (six to eight people) tables including both sexes.

- Minn. Rules 9550.004, permitting local social service agencies to contract with third parties to provide social services but also specifying the contents of the county-provider contract.

- Minn. Rules 4655.9020, requiring nursing home housekeeping supplies to be stored at least eight inches above the floor, to facilitate cleaning.

7. The secretary of health and human services should be responsible for initiating an agency review and repeal process for existing health and human services rules. Priorities for review should be established and this activity undertaken as agency resources permit.

Need for reform

Rules are used as a tool to ensure quality services, but, as indicated above, they can also be a problem. Because of their prescriptive nature, rules can unnecessarily stifle innovation and good service delivery. Over time, such as during the past decade, the simple accumulation of rules can create an enormous burden and needless expenditure of staff resources. This is especially true when outmoded rules remain on the books. Therefore, not only should new rules be written differently, but agencies also should undertake to review and repeal existing rules whenever possible.

Purpose of a repeal process — Through the institution of a formal procedure for review and repeal of rules and the expectation that agencies would undertake this process, the burden of rules potentially can be reduced. Using the process in the state's Administrative Procedure Act to review and repeal rules would ensure that important rules are not summarily eliminated.

CORE does not expect agencies to have the resources to undertake all these actions at once. Therefore, it suggests two priorities for action:

- *Review all rules for service delivery that are built on but exceed federal standards.*

  State health and safety regulations that exceed federal standards should be reviewed and unnecessary parts repealed. For example, federal rules for lighting requirements inside nursing homes consist of one sentence stating the requirement of "adequate and comfortable lighting in all areas," while state rules include 21 different, specific footcandle requirements for various areas within a nursing home.

  Depending on administrative law judge and attorney general opinions, it may or may not be possible to reduce state rules to this level of simplicity. Whenever possible, however, only the core of the federal standards should remain to ensure client health and safety.

  At least one agency (MDH) has already undertaken this type of review, demonstrating that it can be done. The MDH effort is intended to simplify some nursing home rules while retaining essential protections.

- *Review and, if justified, repeal all rules that are not* direct *health and safety rules, professional licensing rules, or rules that protect consumer rights.*

  This option would provide the possibility of simplifying all existing health and human services rules. Obsolete rules would not have to go through the APA review procedures but could be repealed as part of agencies' submissions to the revisor's annual bill.

Other review and repeal priorities should be determined by agencies as they become feasible based on the availability of staff resources.

8. State agencies should permit and encourage regulated entities (such as HHSDs and providers) to apply for waivers from existing rules.

Need for reform

This recommendation is intended to address the need expressed by counties and providers for more flexibility in operating state-funded programs and provides an opportunity to propose alternatives to current rules.

Purpose of allowing waivers — While some rules now have *variance* provisions, these are most often used to apply for an exception from a specific part of a rule, such as a variation in physical plant requirements. These variances are not a new way to achieve positive customer outcomes. To meet this goal, the state should encourage providers and HHSDs to apply for larger-scale waivers to rules. Employing this recommendation would

require those requesting a waiver to develop and propose a plan that demonstrates how they would achieve statutory outcomes.

Instead of rule changes that affect all providers, rule waivers would affect only those who have the desire and capacity to seek the change. Under this reform, providers and counties could design alternative ways to meet statutory outcomes and apply for a rule waiver from the state in order to try their experiment. In contrast to Recommendation 7, this recommendation would relieve the executive branch of the burden of reviewing all or a large subset of existing rules, avoids possible problems associated with lifting a large set of rules for all regulated entities, and provides the most opportunity for innovation. Contracts between the state and providers, such as an arrangement now being negotiated between DHS and Anoka County, would be a way of implementing this recommendation.

By using rule waivers, solutions may be found to pervasive problems. A point could be reached where a large number of regulated entities had attained waivers from a set of existing rules. The state then would have the option of eliminating those rules for all similar providers and substituting previously approved waiver options.

9. Agencies should investigate and implement new methods of enforcement. These new ways would include more use of conflict resolution techniques; provision of technical assistance and oversight in proportion to noncompliance occurrences; peer or citizen review panels; and rewards and incentives, such as public recognition of exemplary providers and educational opportunities that impart "best practices" principles. The secretary of health and human services should be responsible for ensuring that such methods are sought and used.

Need for reform

The state has limited ability to enforce standards. Enforcement mechanisms are limited to sanctions when things have obviously gone wrong. Changes in rules and a less prescriptive system call for concurrent changes in the role of enforcement. This could include changing the definition and role of technical assistance so that the job of some facility inspectors is to assist facility management in understanding and planning how to meet program rules, rather than to cite violations. Agencies should work with providers and HHSDs to determine what kinds of technical assistance providers need and what kinds of rewards and incentives they would find motivating.

Purpose of better enforcement — Rules need to be enforced; otherwise, they simply add to the bureaucratic burden without improving customer outcomes. Developing new

enforcement methods and strategies would improve the state's ability to ensure that desired outcomes are achieved.

Some questions that the secretary and state agencies would need to ask to find these new mechanisms include: What is the intent of the agency's regulations? What is the desired outcome? Do the regulations ensure that outcome? How are regulations enforced? Do current enforcement methods achieve desired results? Are they cost-effective? What standard should be used to make enforcement decisions? Who or what entity would have the authority and responsibility to make enforcement decisions?

Some examples of how new methods of enforcement could work are:

- HHSDs could develop their own procedural standards. They would be required to demonstrate that they are achieving agreed-to outcomes, in accordance with their approved state plan.

- An HHSD that is meeting plan outcomes would not receive "process" directives or advice from the state unless it requests them.

- Providers that continually meet rule standards could be inspected less frequently.

- Peer or citizen review panels could work with providers and the state to monitor compliance and determine solutions to compliance problems.

- Customer advocacy groups could be encouraged to play a significant enforcement watchdog role or to publish provider ratings.

- Exemplary providers could be listed (and rated) in a guidebook to services that would be distributed to consumers.

- HHSDs and providers with demonstrated excellence in management could be a part of technical assistance consultations to provide "best practices" information to other HHSDs and providers.

- State technical assistance could include more examples of successful approaches and innovation and facilitate design of individually appropriate strategies to attain statewide goals.

10. Agencies should identify and implement meaningful sanctions for noncompliance with rules and regulations. Agencies might develop a conflict resolution procedure; increase the use of escalating warnings and probationary status with greater oversight; require customer or peer review input to agencies for determination of sanctions; publicly announce the sanction status of providers; and reduce funding and shift it to another provider, among other options. The secretary of health and human services should be responsible for ensuring that this process occurs.

Need for reform

Current sanctions are limited to fining or revoking the licenses of providers who do not comply with state rules and regulations and limiting funding to counties that do not comply with state requirements. The state, however, may not wish to invoke these sanctions because they could have a negative effect on customers. For example, revoking the license of a noncompliant residential facility would force the residents to move.

Purpose of meaningful sanctions — In addition to current options, different kinds of sanctions are needed to increase the state's options for action when faced with noncompliance. Some examples of how this recommendation could work are:

- A specific conflict resolution process could be implemented within each agency to deal with first-time or lesser incidents of noncompliance.
- Noncomplying providers and HHSDs could be placed on probation, with escalated oversight and tighter administrative controls.
- The state could publicly report the nature and results of unresolved substantiated complaints against providers. Provider ratings could be published in guidebooks to services.
- Consumer or peer review panels could provide input to agency determinations of appropriate sanctions for violations of state regulations.
- If outcomes are not being met or if rules are disregarded, the state could reduce the portion of reimbursement or funding intended to cover administrative costs. In the worst cases, program funding could be reduced and shifted to another HHSD or provider that has a good record and is willing and able to take over provision of those services.

Become customer-focused

The state health and human services system exists for its end-users. Once a bureaucracy is set in place, however, the process begins to take precedence over the people the system is intended to serve. A redesigned health and human services system must take deliberate steps to counteract this effect. Recommendations 11 through 13 address this area.

11. State and county health and human services agencies should clearly define who their customers are.

Need for reform

One of the circumstances confusing the issue of customer focus is the fact that different health and human services agencies serve different types of customers. Even single agencies may serve multiple sets of customers. For example, county social services workers work directly with the end-user, but county program directors may have most of their contact with vendors of services. Both end-users and vendors are customers of the county.

DHS has far more contact with county personnel and providers than with end-users. The legislature's customers are citizens, who expect legislators to create policies and laws that serve the public interest. Confusion over who is the customer of any particular service makes it difficult to evaluate outcomes.

Purpose of identifying customers — CORE has identified the end-user as the primary customer of the health and human services system. It is this person for whom the system exists. While agencies must meet the needs of their identified customers, the purpose of the system must not be forgotten. Although appropriately identified as customers, those other than the end-user are actually stakeholders in the system. These stakeholders include state agencies, counties, providers, interest groups, elected officials, and taxpayers.

As part of the mission-building process, state agencies must clarify who their customers are within each program. Once customers are clearly identified, agencies would be better able to focus on serving them. At the local level, health and human services districts should define customers as they develop their district plans.

12. State and local staff should be empowered to serve their customers.

Need for reform

Most health and human services staff want to do a good job and serve their customers well. But the current system structure discourages or prevents staff from operating with a customer focus (see the Findings section). The previous recommendations on flexible funding and system restructuring are designed to remove some of the system's disincentives to focusing on customers, but additional changes are needed.

Purpose of empowering staff — By empowering staff to serve customers, the state is sending a powerful and consistent message about what is important — about what its vision for human services is. If the vision states one goal but all structures mitigate against that goal, staff will be caught in the middle.

Changing the structures — such as funding or rule changes that allow more flexibility in eligibility for some services — would strongly affect the ability of staff to serve their customers. Besides structural changes, however, additional methods could be used to empower staff to be responsive to customer needs, including: reducing layers of supervision to allow more professional discretion and reduce response time; rewarding and recognizing staff for desired outcomes, rather than for size of caseload or other nonoutcome measures; and providing timely and constructive performance feedback to employees. In addition, managers should model the behaviors they wish staff to adopt, such as respect for customers and prompt responses to inquiries.

Another approach to this goal is to adopt a statewide "can-do" attitude with regard to human services. Minnesota's inclination to capture as much federal funding as possible has created a reluctance to try anything with even a remote possibility of jeopardizing that funding, often leading to a general "can't be done" attitude. Experts on quality improvement in government, however, recommend taking another look at the state's interpretations of federal regulations. Experience shows that often there is more room than one might think to change the way things are done, even without federal waivers.[20] This is not to imply that the difficulty of obtaining federal permission for innovation is not valid. In fact, some state ideas require federal law changes, because these innovations go far beyond what can be authorized through a federal waiver.

[20]John Kirkpatrick, senior vice-present for government operations, Process Management International. Speech to Minnesota Quality Conference, Minneapolis, Oct. 8, 1992.

13. The legislature, state agencies, counties, and providers should work in partnership to empower customers to achieve their goals.

Need for reform

As noted before, the end-user of health and human services is the real customer of the system. Professionals have traditionally thought of these individuals and families as "clients." Thinking of them as customers, however, and adopting a customer-service mentality and nomenclature could have a far-reaching effect on the interactions between these customers and the health and human services system.

To use the system effectively, end-users and their families need several key pieces of knowledge, such as where to get comprehensive and coordinated information and where to register complaints. These kinds of contact points should be developed so that customers have resources, as well as recourse for poor or disrespectful service.

Purpose of empowering customers — Increasing the customer's ability to achieve goals has great potential for making real change in the system. The goals of different customers would be very different, depending upon their individual situations. In general, however, empowerment means that enough information and flexibility are provided in the system to get the right services to the right people at the right time — and in the most cost-effective manner. If customers are empowered to reach their goals, the entire system is able to reach its goals.

When systems are built on process, not results, it is easy for the customer to become just another piece of the process, rather than the reason for the process in the first place. Particularly in health and human services, where many end-users come to the system at a time of personal crisis, it is critical to give these customers as much power as possible to change their circumstances. Rather than treat them as helpless, the system should empower end-users to use the system in the way that makes the most sense for them.

End-users should be given choices wherever they exist. For example, they should be able to choose the types of services they want and the providers of those services as long as the services are cost-effective. Organizational and end-user customers should be regularly surveyed for feedback on system responsiveness to their needs, such as technical assistance or timely hearing of appeals, and should be given assurance that the system will change and improve, based on that feedback.

When the customer is an agency or a direct service provider, the system should empower these entities to serve *their* customers well. This should be done not only through flexible funding and administrative requirements but also by providing management training and resources for improving service quality.

Conclusion

Minnesota has many excellent health and human services programs, but within its system are several significant barriers to delivering these services effectively and efficiently. Adoption of these 13 recommendations should help Minnesota meet these challenges and develop an improved health and human services system.

IMPLICATIONS FOR SERVICES TO OLDER MINNESOTANS

As a way of determining their practical effect, CORE's human service recommendations are applied in this section to a specific area of human services.[21] Services to older persons were selected primarily because of the anticipated growth in both demand and state dollars needed to meet that demand.

The complexity of elderly services makes it difficult to simply apply the recommendations to the "elderly services system." This system is really a collection of numerous unique programs that serve different types of customers with different needs. Some human service programs use functional status to determine need and serve primarily, though not exclusively, older customers. Other programs use age as the criteria for eligibility, but that age may be 60, 65, or some other number. Still other programs are highly intertwined with one another, so that a change in one service area greatly affects another. A significant change in Medicaid eligibility for nursing home care, for example, could affect the demand for services funded by the state's alternative care grant program, the Community Social Services Act, community health services, and area agencies on aging.

Another complicating factor in the elderly services system is that some programs are means-tested and some are not. This section, therefore, provides a general idea of what *types* of impact the application of the human services recommendations could have on services to the elderly. It is not an in-depth analysis of how the entire system would be affected.

Two points are important to keep in mind: First, CORE's recommendations for the human services system were not developed within the constraints of existing law; that is, commission members understood that some state and federal laws would have to be changed to allow the recommendations to be implemented. Second, many of the examples refer to efforts that are already under way by human service agencies to improve the elderly services system.

[21]The input of representatives from a variety of senior organizations and state agencies, including the Interagency Long-Term Care Policy Committee, was very helpful in drafting this section. The section, however, does not necessarily reflect their views in all areas.

Potential impacts

Recommendation 1. Establish a secretary of health and human services

Vision and mission — The secretary of health and human services would be responsible for integrating into a more coordinated whole the activities of various state agencies that now provide elderly services. The secretary could accomplish this in large part by creating a vision and mission for the state's elderly services system and by merging certain agency divisions so that they work toward common goals.

A vision and mission for elderly services could be incorporated into an overall vision and mission for human services. One place to begin this discussion could be the vision and mission statements developed by the Senior's Agenda for Independent Living (SAIL) project in late 1990:

> The Vision: SAIL envisions a system in Minnesota in which: political, social, legal, regulatory, and service system environments promote choice and alternatives; seniors are supported in their efforts to remain in the community if that is their choice; a management infrastructure supports the effective and efficient delivery of services; there is coordination in the planning, administration, and delivery of services to seniors; there is a national health insurance and long-term care insurance program that works with the state system to ensure seniors' access to a wide range of health and long-term care services; and service systems are community-based to meet the needs and preferences of local seniors.
>
> The Mission: The state of Minnesota should continue its commitment to preserving the personal choice and maximizing the autonomy of its citizens by developing policies and plans of actions which promote the independent living of its older citizens while considering the needs of the citizenry as a whole.[22]

The secretary might intensify current efforts to integrate various elderly services programs to ensure that services and policies are working toward the vision and mission that have been established. In the present system, various divisions and agencies are separately responsible for administering and evaluating a range of aging services.

Policy development — The secretary could also integrate activities and streamline decision making by establishing one policymaking and one advisory council that would make recommendations on aging issues directly to the secretary.

The policymaking council might be an expansion or modification of the Interagency Long-Term Care Planning Committee (INTERCOM). INTERCOM was established by the legislature in 1983 to identify long-term care issues requiring coordinated interagency polices, conduct analyses, coordinate policy development, and make recommendations

[22]Minnesota Board on Aging and the Interagency Board for Quality Assurance, *Seniors Agenda for Independent Living* (St. Paul: MBA and IBQA, 1990), pp. 3-4.

to the commissioners of Health and Human Services for the effective implementation of these policies. An expanded council could consist of deputy secretaries representing all relevant departments under the secretary's purview.

INTERCOM is charged by the governor with developing "strategies to reduce escalating expenditures in the state's long-term care budget." A secretary could rely on INTERCOM for expertise on many issues, such as further developing and implementing vision and mission statements; evaluating the advantages and disadvantages of creating a Senior Services Division; creating and funding an elderly services data base; and appropriately funding long-term care.

The advisory council could be modeled after the Minnesota Board on Aging and designed to represent the interests of consumers.

Establishing priorities — In developing and implementing vision and mission statements, the secretary could take a proactive role in prioritizing strategies for improving Minnesota's long-term care system.

For example, the secretary could direct state departments to assist health and human service districts (see Recommendation 2) in developing more aggressive strategies for controlling costs and serving seniors in noninstitutional settings. The secretary could make it a priority to integrate and improve data administration, so that the state can better identify who is using long-term care services, how these services are funded, and how service use may change in the future.

Leadership — While establishing a secretary of health and human services has the potential for improving the state's elderly services system, such improvements would depend to a great extent on the person chosen to be the secretary. Ideally for elderly services, the secretary would be knowledgeable, experienced, and interested in aging issues. The secretary would also be prudent in directing resources to persons who most need them and able to effectively balance the needs of the elderly with the needs of other Minnesotans, including taxpayers.

At the same time, the secretary would be just one person who would have to work with many agencies, commissioners, consumers, other interested parties, and policies. Even the ideal secretary will not find it easy to integrate the diverse parts of Minnesota's complex system.

Recommendation 2. Designate local health and human services districts

The implementation of this recommendation would consolidate the local administration and planning of various aging programs. At present, numerous programs separately provide services to older persons at the regional and local levels. For example, county public health and social services agencies use alternative care grant monies to provide

such services as adult foster care and home health aides; county social service agencies use Community Social Services Act (CSSA) funds to provide chore and other services; area agencies on aging (AAAs) use primarily federal funds to provide such services as meals and adult day care; and community health services (CHS) agencies use their funds to provide such items as home health aide and homemaker services.

Under this recommendation, the health and human services districts (HHSDs) would be responsible for planning and administering services formerly administered by AAAs and county health and human services departments. Administration of programs now funded by the Alternative Care Grant Program, CHS, CSSA, and area agencies on aging, for instance, could be consolidated to achieve common goals, use common forms, and collect common data. This would eliminate unnecessary duplication and confusion over which agency is accountable for the total service package provided to a given client.

HHSDs would be designated as area agencies on aging. This would reduce the complexity of having county boundaries for some services, CHS boundaries for others, and AAA regional districts for still others. As required by federal law, Title III-funded services would continue to be directed to older persons. (An alternative to this could be to designate the state unit on aging as the state's only AAA and then distribute funds from there.) Other federal laws related to AAAs would need to be examined.

Combining traditional AAA activities with the administration of other elderly services could be a difficult transition for some individuals and agencies. In Oregon, where AAAs assumed the responsibility for administering the entire range of senior services, it was found that:

> Oregon did not develop this state-local financial management system for long term care services without difficulty. In particular, local AAAs had been used to grant funding and considerable autonomy vis-a-vis that state government. The AAAs' undertaking of Medicaid-program-related tasks required sharply different operating procedures, standardization and reporting, cultural changes and much less autonomy than previously. As a result of the difficulties involved in working out these relations, Oregon adopted for a time a highly structured, formal negotiation process between SSD [the Senior Services Division] and the local AAAs to implement its program management system.[23]

However, county public health and social services agencies in Minnesota are familiar with state and federal procedures and requirements regarding Medicaid and other funding sources.

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[23]Diane Justice (with Lynn Etheredge, John Luerrs, and Brian Burell), *State Long Term Care Reform: Development of Community Care Systems in Six States* (Washington, D.C.: Center for Policy Research, National Governors Association, April 1988), p. 128; Estelle Brouwer, *No Easy Cure: Possible Options for Controlling Minnesota's Medical Assistance Spending* (Minneapolis: University of Minnesota, December 1992), p. 36.

Recommendations 3 and 4. Establish HHSD grants

In implementing these recommendations in the elderly services system, one of the first steps would be to establish a list of services that could be funded through the basic services package and through the block grant. Another step would be to specify eligibility criteria for persons receiving any of the basic services. In addition, eligibility criteria would need to be established for persons receiving services funded by the block grant. Below is an example of how the service lists and eligibility categories might be developed.

1. Establish a list of services available in the basic services package.

This list would be generated by the secretary of health and human services with the assistance of HHSDs and the concurrence of the legislature. In developing the list, the secretary would examine state needs in relation to the types and amounts of services currently provided by the sources of funding going into the basic services equity fund. *The list of services would be inclusive of all ages and current categories (that is, not categorical).* In developing the list of services, the secretary would consult with senior services experts and organizations in the public and private sectors, such as geriatricians, case managers, INTERCOM, and seniors' organizations.

Not all services on the list would be guaranteed to all persons who are eligible for the basic services equity package, just as all Medicare-, Medicaid-, or insurance-funded services are not automatically available to all persons who quality for Medicare, Medicaid, or private insurance. Only persons who meet the eligibility criteria for specific services would be provided with those services. The list would include the types of services that can be provided with the basic services funding. For example, items on the list relevant to the elderly could include home health care and adult day care.

The decision regarding what services are included in the basic services package would in part determine what types of services are included in the block grant-funded package. For instance, if a service were not included in the basic services package, an HHSD might decide that it needed to include the service in the list of block grant-funded services.

2. Establish a list of services available through the block grant services package.

Each HHSD would have discretion to determine what services it wishes to fund through the block grant. In developing the list, the HHSD would likely examine the specific needs of the district and the types and amounts of services provided by all sources in the area.

As with the basic services equity package, not all services on the list would be guaranteed to all persons eligible for the block grant services. Only persons who meet the eligibility criteria for specific services would be given those services. The list would include the

types of services that can be provided with block grant funding. For example, items on the list relevant to the elderly could include homemakers, chore services, home-delivered meals, and transportation.

Allowing for greater flexibility in the type of services available for seniors (and other targeted groups) can improve both customer satisfaction and efficiency. Seniors seeking services would be evaluated individually to determine what type of services they wanted and needed, rather than steered toward specific services for which funding is available.

3. Establish eligibility criteria for the basic services package.

Criteria for the basic services package would be established by the secretary of health and human services with the assistance of the HHSD and with the concurrence of the legislature. Categories of eligibility could be prioritized among different target populations. For example, older persons seeking services might be required to go through a version of the state's preadmission screening process to have their needs assessed and a priority category assigned. More analysis would be needed to determine the exact categories that would be appropriate, but the system could work as follows:

Persons who are given a level 1 (high) priority for services might be those with few or no informal sources of support and low incomes, and determined to be at case mix G to K if they were admitted to a nursing home. Persons who are given a level 2 priority for services might include those with few informal sources of support and low incomes, and determined to be at case mix B to F. Persons given a level 3 priority for services might be those with few informal sources of support and low incomes, and determined to be at case mix A.

Depending on an analysis of the state's budget, needs, current services, and other factors, the secretary and the legislature could determine which priority level is eligible for the basic service package. The decision of who is eligible for the basic services package would in large part determine how eligibility is set for the block grant-funded services. For instance, if the decision were made that the basic services package would fund services for seniors at priority levels 1 and 2, the block grant monies could be used to fund services for persons at level 3.

4. Establish eligibility criteria for services funded by the block grant and fund those services.

The HHSDs would have discretion to set priorities on the types of services they wanted to fund through the block grant and the eligibility criteria for block grant-funded services.

Districts with a large elderly population, high rates of institutionalization, and few community-based services could emphasize the development of alternatives to institutionalization. Districts with many community alternatives for seniors might want to devote

a portion of their funds to wellness clinics or education. Through the consolidation of many sources of funding, funds previously spent on one type of service could be directed to another type or target group.

As an example of how this could work, assume that the state-funded services for seniors are at priority levels 1 and 2. An HHSD with a large and growing senior population might decide to fund services for seniors at level 3 and for seniors who meet some less stringent criteria. An HHSD could decide to help make alternatives to nursing homes available to persons at all income and functional levels, for instance, by providing seed money for small businesses developing alternatives. Other HHSDs with a relatively small elderly population and many alternative services could decide to provide discretionary services only to seniors at level 3 or not at all, focusing instead on other target populations.

For this type of system to work, the state would need to develop a fair and reasonable means of setting eligibility criteria. Also, the state and the districts must be prepared for powerful lobbying by advocacy groups and others who want to ensure that no monies are directed away from their constituencies. Advocacy groups, consumers, and administrators must to be willing to trade small pots of money designated for very specific services for greater local flexibility in meeting local and individual needs.

Moving to this type of system would directly affect the senior services system by changing who is eligible for many services funded in whole or part by the state and what types of services are provided. Depending on the decisions of the secretary, the legislature, and the HHSD on service packages and eligibility criteria, senior access to services could change. On the positive side, this system likely would make it easier for seniors to understand what services are available and how to apply for them. For seniors who are eligible for services, this system would increase the likelihood that care is coordinated and tailored to meet their individual needs.

Recommendation 5. Adopt an outcomes orientation

Below are several examples of how an outcomes orientation could be emphasized in the elderly services system:

1. Efforts at implementing performance-based budgeting are already under way in state agencies. The continued and expanded use of outcomes measures in state budgets can be used to provide necessary information about whether programs are actually working to achieve expected goals. An example of the application of these principles would be the design and implementation of a program to prevent high-cost nursing home placements. Suppose that the assumptions underlying the development of the prevention program included the following sequence:

   - Older persons do not want to live in nursing homes;

- Older persons prefer to stay in their own homes where they have always lived;
- Preventive care at home will be less expensive than nursing home care;
- Older persons will pay for preventive care in their own homes before they are frail enough to enter a nursing home;
- The present system will be able to inform older persons about preventive care and will be able to provide those services; and
- This will cause a decline in the nursing home placement rate.
- Therefore, not as many older persons will quality for medical assistance (MA); and,
- The state will save money in the MA program.

By providing exact and continuous feedback, a well designed budget performance accountability system allows these assumptions to be tested at each step. If any of the assumptions are incorrect, the outcomes measurements should show it. Changes can then be made early in program implementation.

2. State agencies could adopt a greater outcomes focus in their relationships with HHSDs. For instance, the state could require HHSD budgets to specify how the package of services available to seniors will further the state's mission for elderly services (How are services expected to affect the rate of institutionalization in that district? How will quality and cost-effectiveness be ensured?). This type of outcomes orientation is already evident in some projects funded under the state's SAIL strategy.

3. State agencies could encourage providers to apply for rule waivers if they can show they have an innovative way of attaining desired outcomes.

4. The state could continue to encourage a customer-focused outcomes orientation at the local service delivery level (such as through outcomes-based reimbursement). An example of shifting the focus to outcomes for services to elderly persons would involve implementing recent changes in the Alternative Care Grant Program that allow counties to use up to 10 percent of these funds on unspecified services, such as transportation, chore services, or training for informal caregivers.[24] This permits a client services coordinator to determine specifically what an older person may need to remain at home, rather than limiting the options to services that may not help to achieve the desired client outcome.

In implementing outcome approaches for senior services, it is important not to underestimate the complexity of developing appropriate outcome measures. As Donna

[24]M.S. 256B.0913, Subd. 5. A report on this provision and recommendations were due to the legislature Feb. 15, 1993.

Ambler Peter notes, "It is obvious that although there is a need for outcomes for various categories of clients in long-term care, their development is slow and complicated."[25] Moreover, state administrative staff and providers who are initially enthusiastic about replacing the regulation of process with outcomes monitoring may find implementation of outcomes-based reimbursement difficult:

> Although states have been intrigued by the idea of linking outcomes to payment, they have shied away for fear that predicted outcomes are not powerful enough indicators on which to base a payment system, and that sanctions may not stick in an outcome based system given our litigious society and the difficulty of affixing personal responsibility for negative outcomes.[26]

Recommendations 6 through 10. Improve accountability in rules, enforcement, and sanctions

One implication of these recommendations for elderly services is that the state would continue to review rules pertaining to nursing homes and other providers to ensure that the rules are not overly prescriptive. MDH, for example, is comparing state regulations for nursing home operation with federal nursing home rules, with the intent of repealing nonessential parts of the state rules.

In the area of waivers, implementation of Recommendations 6 through 10 would permit HHSDs and providers to propose alternative methods for achieving statutory program outcomes. One example of how this might be applied in elderly services would be a large network of assisted-living facilities that obtains state and federal waivers related to quality assurance and fee-for-service financing and instead serves clients on a capitated (per person) basis, with outcome measures serving as the basis for the capitated rate.

As part of developing new methods of enforcement and sanctions, the state could work with senior advocacy groups to survey seniors and publish a consumer guidebook that would rate service providers in each HHSD according to a combination of survey responses and state records of providers' regulation compliance scores. The guidebook could provide data relating to the cost and availability of services (such as health agencies, adult foster care providers, nursing homes, and other services in the area). This could be an incentive for better provider performance and provision of senior-preferred, quality services.

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[25]Donna Ambler Peter, "An Overview of Current Research Relating to Long-term Outcomes," *Nursing and Health Care*, March 1989, p. 135.

[26]Rosalie Kane and Robert Kane, "Long-term Care: Variations on a Quality Assurance Theme," *Inquiry 25*, Spring 1988, p. 141.

Recommendation 11. Clearly define customers

If this recommendation were applied to the elderly services system, the HHSDs and providers would be defined as the major customers of state agencies. Agency staff could assist districts in effective planning, coordination, and provision of services to seniors. Agency staff could provide more consultation in the areas of rules interpretation, for instance, and continue efforts to improve existing rules.

As another example, the state could assume responsibility for facilitating the exchange of information across districts. If a district were particularly successful at reducing the rate of institutionalization or implementing outcome-oriented policies for providers, for instance, the state could make sure that these best practices were shared with other districts to help them develop similarly successful programs.

Seniors and providers would both be customers of the HHSDs. HHSDs would especially be responsible for monitoring senior satisfaction with services.

Evaluations could be done, for example, to determine how satisfied seniors are with the delivery of various services and to elicit suggestions for change. Customer input could also be gathered when developing outcome measures for districts and providers.

Recommendations 12 and 13. Empower staff and customers

Combining a customer focus with the integration of administrative and funding functions within HHSDs could raise customer satisfaction by reducing red tape and streamlining decision making.

HHSDs also could improve customer satisfaction and empower customers through their flexibility in meeting particular customer needs (see also Recommendation 4). HHSDs should be able to create a package of services designed to meet individual needs using both basic and discretionary services. This benefit may vary considerably among districts, depending on the number and types of discretionary services funded by each one. HHSDs could also serve as a point of access for seniors seeking to determine the range of services available to them.

Finally, the state could specifically fund and ensure the development of a data base that clearly shows the costs, services, and sources of funding for senior services. At present, it is difficult for customers of all sorts to evaluate whether they are getting their money's worth from the services provided.

FISCAL IMPACT

Funding health and human services is not likely to get any easier. Minnesota is already among the top spenders in the nation for health and human services. There probably will never be enough money for all essential health and human services. Increasingly, the state will need to focus on new ways to make the best use of available resources. This section outlines the costs and potential savings associated with each recommendation.

These CORE recommendations are designed to make the delivery of health and human services more efficient and more effective. Some of the recommendations have clear implementation costs, some have a cost-neutral net effect, and others have implications for significant long-term savings.

Table 3 shows the estimated costs and savings of those recommendations for which reasonable assumptions about potential fiscal effects could be made; detailed calculations are presented in Appendix F.

Table 3. Recommendations with Significant Fiscal Impact

Activity	Annual Savings	Annual Increase	Transition Costs	5-year Projection
Establish Office of Secretary of Health and Human Services				
Add 8 positions	—	$472,300	—	$2,361,500
Eliminate 22 agency positions replaced by Office of the Secretary	($1,273,300)	—	$303,300	($6,063,200)
Establish Health and Human Services Districts (HHSDs)				
Eliminate duplicative director positions (county savings)	($2,404,000)	—	(see Appendix F)	($12,020,000)
Establish Health and Social Services Block Grant				
Increase community placements of mentally ill persons	($33,235,440)	$25,354,360	$5,202,000	($34,203,400)
TOTAL	($36,912,740)	$25,826,660	$5,505,300	**($49,925,100)**

Costs and savings

Recommendation 1: Establish a secretary of health and human services

Establishing a health and human services secretary is expected to result in net savings of $497,700 the first year and $801,000 in subsequent years. Although the cost of a secretary will depend on the number of staff assigned to that office, the cost of the health and human services secretary's salary, an administrative assistant, and several professional staff is more than offset by eliminating a number of current deputy commissioner and other positions.

The benefit of establishing a secretary for health and human services goes beyond dollar savings. Creating this position presents an opportunity for authoritative leadership and accountability in the human services system. Fragmentation and turf protection among agencies have been significant barriers to effective provision of services. The secretary has the potential to overcome these barriers and make the human services system more responsive, efficient, and effective. The secretary will also have the authority to consolidate or eliminate duplicative functions in health and human services agencies, increasing the potential for additional cost savings.

Recommendation 2: Designate health and human services districts

A number of counties could potentially reduce costs by consolidating public health and social services administrations within the proposed health and human services districts. Projected savings are based on the assumption that current community health service (CHS) configurations will also be the HHSD configurations. Using the current average single-county public health and social services director salaries as a basis, some counties in the new districts could realize total savings of $2.4 million per year, or $4.8 million per biennium. This savings in county funds would be realized by the 21 counties that would combine with other counties into larger health and human services districts.

The population base of the HHSD administrations would be smaller than the average populations of most of the larger single-county districts, so consolidation should not pose undue management problems for new administrations. Efficiencies would also be created by merging administrative and support functions, consolidating staff expertise, and/or reallocating staff from administrative functions to direct customer service.

Recommendations 3 and 4: Establish HHSD grants

Freeing counties from many services mandates and consolidating funding sources raise the possibility of savings in overall health and human services expenditures. Savings from efficiencies realized through flexibility cannot be absolutely predicted, though it is reasonable to anticipate that some savings would be realized through the placement of a

higher percentage of mentally ill people in appropriate community settings than in regional treatment centers (RTCs). Actual savings will depend upon the rate of this movement and the cost of community care.

Based on DHS data, CORE projects that annually, about 1,080 mentally ill (MI) clients would receive treatment in community settings rather than in an RTC. This means that 400 RTC MI beds would no longer be needed, for a net savings of almost $2.7 million the first year and $7.9 million in subsequent years. This projection accounts for severance costs for employees dislocated from RTCs as a result of this change to more community placements.

Recommendation 5: Adopt an outcomes orientation

Agency budgets

Focusing on outcomes will enable agencies to better evaluate whether programs are working effectively and will help the state avoid expensive mistakes. This focus will require additional staff time to develop valid outcome measures and evaluate programs. As an example of the costs of setting outcome measures, the CORE Budget Project estimated that it cost $24,000 for the Office of Waste Management and $6,000 for the Department of Transportation to contract for consultant services to determine outcome measures for one program for each agency. An unmeasured amount of agency staff time also went into these efforts. Health and human services programs tend to be large, encompassing many complex issues and therefore many variables. This makes it difficult to determine appropriate outcome measures and to evaluate these programs. Thus, it can be assumed that the cost of determining outcome measures for all health and human services agencies programs would be substantial — as would the savings from discontinuing programs with poor outcomes.

State-local relationships

The most tangible benefit of an emphasis on outcomes between the state and local entities would be for local administrators, who would be able to focus their efforts and staff time on achieving results, rather than on complying with overly detailed and prescriptive administrative requirements. However, the state would also realize a benefit. Although quantitative data on the cost of writing rules, bulletins, and procedures manuals is not available, state agency experts say it is significant. An outcomes approach could cut these costs noticeably.

The overall effect of an outcomes approach would be cost-neutral for state agencies. Staff time now spent on rules and procedures could be shifted to technical assistance (to help local agencies achieve their desired outcomes), program evaluation (to determine actual outcomes), and enforcement of a smaller set of rules.

Providers

Focusing on outcomes achieved by providers is expected to be cost-neutral. If outcomes are eventually used to determine payment, however, this approach could generate savings for the state by encouraging efficiencies in service delivery.

End-users

Long-term cost savings should be realized throughout the system when providers are better able to respond to customer needs for assistance in the most cost-effective way. The real benefits of focusing on outcomes for end-users, however, are the long-term effects of achieving health and self-sufficiency for as many citizens of the state as possible.

Recommendations 6 through 8: Improve accountability in rules

Designing and implementing a rule review and repeal process would initially be costly, primarily in terms of staff time. Agencies are unlikely to undertake this effort without incentives or mandates to do so. It is difficult and time-consuming to design objective standards for repeal, especially in the category of customer rights and protection.

An example of the time-consuming nature of this process is the current MDH review and repeal of some nursing home rules that exceed federal regulations. Now nearing completion, this project has required two years and two full-time employees. In the long term, as the number of unnecessary and obsolete rules diminishes through implementation of this recommendation and as rules are written differently, the costs of maintaining rule review and repeal activities should diminish.

To allow rule waivers, state agencies would have to develop a waiver review process and determine standards for granting waivers. The staff time required to implement these is unknown. Costs could escalate temporarily if additional staff or contractors are needed to get this process underway. Some innovative approaches may require changes in federal law. Pursuing federal law changes would be time-consuming for state staff but likely worthwhile over the long term.

Rule waivers offer a good potential for savings in the cost of doing business and providing services. Providers and HHSDs could devise plans that match their own resource capacities while still accomplishing desired results for customers. Finally, the state's commitment to allowing waivers and emphasizing outcomes makes it more likely that potential cost-saving innovations will be proposed.

Recommendations 9 through 10: Establish effective enforcement and sanctions

The costs of developing and implementing new methods of rule enforcement and meaningful sanctions would be primarily in state staff resources. These costs could be mitigated if staff is relieved of other duties (such as extensive rule and bulletin writing) as other CORE recommendations are also implemented.

Recommendations 11 through 13: Become customer-focused

Empowering health and human services staff to meet customer needs requires more flexibility in the structures that define what staff can or cannot do for people. Some of this flexibility must be sought at the federal level. Development and implementation of ideas that require federal waivers or law changes necessitate a great investment in staff time and resources. Staff training would likely be needed to attain the kind of attitude shift necessary to have a true customer focus. Further costs would be incurred in developing avenues for customer feedback and communication.

However, the potential payoffs from staff empowerment are multiple. By allowing staff to serve customers effectively, agencies become more efficient. Staff find more job satisfaction through knowing they can make a real difference in customers' lives, which should increase productivity (by attracting the best workers) and reduce turnover.

Some human services customers may always rely upon the system, such as persons who have severe, permanent disabilities and no source of income. Many others who use the system, however, do so reluctantly, and hope for self-sufficiency. Empowering customers to reach their goals also implies some initial costs in program evaluation and design of new alternatives. To the extent that encouraging customers to reach their goals means eliminating their need for human services, this recommendation could create significant savings or cost avoidance.

One source of savings would come from reducing the number of long-term human services customers. Another possibility is that future growth in the human services budget would be forestalled by serving more customers for the same amount of money. These possibilities can only be quantified based on programs and policies yet to be developed or refined.

IMPLEMENTATION

To create a framework for understanding both the scope and level of difficulty in implementing each of CORE's recommendations for the human services delivery system, an implementation plan and time line were developed for each of the recommendations.

Major changes would be necessary in order to implement the recommendations. The process of change can be divided into three areas: (1) changes that could be made administratively; (2) changes that would require new state statutory authority; and (3) changes that would require federal involvement, such as new federal law or new or amended waivers.

Table 4 on the next page illustrates the changes necessary for each recommendation. In each case, a check mark (✓) indicates that a new administrative policy or state law is needed for implementation of the recommendation. Specific state statutory changes are indicated with bullets (•). Federal waivers or law changes are indicated in the "federal change" column.

Administrative changes include some of the responsibilities of the secretary, such as improving data collection and uniformity standards or developing outcome measures for planning and evaluating all programs. Administrative changes also include shifts in managerial style to encourage a customer focus.

Recommendations that need state statutory authority include establishing the executive office and responsibilities of the secretary, creating health and human services districts, and developing new funding formulas.

Federal law changes would be needed to implement an outcomes focus in some areas, such as reimbursing providers on the basis of customer outcomes. Federal waivers would be needed to make some of the changes to accountability, such as waiving some rules.

Table 4. Implementation Plan

RECOMMENDATION	Administrative change	Statutory change ✓ = new statutory authority needed	Federal change
1. Secretary for health and human services			
Create a secretary for health and human services.		✓ (see CORE executive reorganization recommendations)	
• Create a vision for health and human services.		✓	
• Establish state health and human services agency missions.		✓	
• Ensure coordination and integration of health and human services programs.		✓	
• Exercise comprehensive policy and budget responsibility.		✓	
• Develop and maintain human services data collection and information.	✓		
• Coordinate legislation and oversee rule development.	✓	• APA	Some waivers or law changes may be required.
2. Health and human services districts			
Designate local health and human services districts using current CHS district boundaries.		• CHS, CSSA, county levy authority ✓	
3-4. Funding health and human services			
Establish a minimum and adequate level of services designed to meet basic needs.		• Categorical grants • CSSA ✓ (see funding below)	Some approvals or waivers may be required.
Create a new HHSD grant.		• Categorical grants • CSSA ✓ (new formula)	Some waivers or approvals needed. Change OAA designation.

RECOMMENDATION	Administrative change	Statutory change ✓ = new statutory authority needed	Federal change
5. Outcomes orientation			
• Use outcome measures in agency budgets.	✓	✓ (See CORE budget recommendations)	
• Focus on outcomes in state relationships with HHSDs.	✓ (some)	• CSSA ✓	
• Focus on outcomes in state-provider relationships.		• Many statutes regulating providers	Some changes to laws and rules or waivers needed.
• Focus on outcomes when planning or delivering services to citizens.	✓	• Many statutes regulating providers	Some changes to laws and rules or waivers needed.
6-10. Improved accountability			
Write rules to target potentially critical situations and to outline minimal acceptable standards.	✓	✓	Some changes to laws, rules, and agency procedures needed.
Review and repeal some rules.		• APA ✓	Some changes to laws and rules or waivers needed.
Permit regulated entities to apply for waivers from existing rules.	✓ (some)	• APA ✓	Some changes to laws and rules or waivers needed.
Agencies investigate and implement new and effective enforcement strategies.	✓	✓ (may need)	Some changes to laws and rules or waivers needed.
Agencies investigate and implement meaningful sanctions for noncompliance with rules.	✓	✓ (may need)	
11-13. Customer focus			
Clearly define health and human services customers.	✓		
Empower staff (state and local) to serve customers.		(Linked to funding and rules)	
Empower customers to achieve their goals.		(Linked to funding and rules)	Some changes in federal rules or waivers needed.

Implementation time line

Changing systems takes time. While structures of bureaucracies are unwieldy and change slowly, altering any organizational culture is a long-term, transformational process.

As the implementation plan indicates, many of the changes that would be needed can be accomplished by state and local governments. This means that some of the recommendations could be implemented immediately. Many others would require time to work out the details.

To illustrate the planning necessary to realize CORE's recommendations for the human services delivery system, Table 5 on Pages 83 and 84 provides projected dates for the start and full implementation of each of the recommendations. Although it suggests a rather ambitious starting point (the 1993 legislative session), full implementation dates could remain the same even if initial legislation were not passed until the 1994 session.

Some important points should be noted:

- Recommendation 1, establishing a secretary for health and human services, is scheduled to begin in 1995, after the end of current agency commissioners' terms.

- Recommendations 2, 3, and 4 are linked and have the same date for full implementation. CORE recommends that legislation be passed by 1994 to develop a plan for the creation of health and human services districts and that work begin immediately on development of a set of "minimum and adequate" services.

- Some work could begin immediately on implementing Recommendations 5 through 13, although state statutory changes and some federal waivers may be required to implement the recommendations affecting rules.

The recommendations that require federal waivers or law changes have the longest time lines, because of the difficulty of effecting change at the federal level. Many recommended shifts in focus, however, could be started while the structural changes are being planned and developed. In particular, state and local agencies could begin immediately to change to management styles that focus on customer service.

Beginning implementation immediately does not necessarily mean that change would occur rapidly. For example, enabling state agencies and local entities to fully adopt an outcomes orientation and a customer focus would require some structural changes that must be realized through the implementation of other recommendations. Additionally, because changing from a process orientation to a customer focus requires a culture change within state and local agencies, it is expected that an eight-year process would be necessary to reach these goals.

Table 5. Implementation Timeline

RECOMMENDATION	1993	1994-1995	1996-1997	1998-2000
1. State health and human services administration				
HHS Secretary	CORE introduce, legislature pass bill specifying authority of secretary and agency commissioners.	Appoint secretary 1/1/95. Establish comprehensive budget and policy responsibility.	Vision, agency missions, program integration and coordination, rule and data standards established.	Uniform data standards and new rule standards fully implemented.
2. Local health and human services administration				
HHS Districts	CORE introduce, legislature pass bill requiring a plan for HHS districts by 2/15/94.	Agency bill specifying district configuration and authority. Executive branch works on implementation plan.	Implementation 7/1/97.	
3-4. Funding health and human services				
"Minimum and adequate" services package	CORE introduce, legislature pass bill requiring a new list of services and priorities.	Agencies, legislative staff, others develop services and priorities list. Pass bill 1995 session.	Full implementation by 7/1/97.	
New social services funding formula	CORE introduce, legislature pass bill requiring HHS agencies to design a new funding formula, eliminating state categorical grants.	Agencies develop a new funding formula. Pass bill requiring implementation to coincide with implementation of HHSDs.	Implementation 7/1/97.	
5. Adopt an outcomes orientation.				
Use outcome measures in HHS agency budgets	Continue present implementation.	Continue to increase outcome measures in HHS budgets.	Full use of maximum possible number of outcome measures by FY 1997 budget.	
Focus on outcomes in agency relationships with HHSDs	Make administrative changes where possible.	Agencies continue current review of rules and include unnecessary parts in Revisor's bill for repeal.	Pass any bills necessary to fully implement this recommendation.	
Focus on outcomes in state relationships with providers	CORE introduce, legislature pass bill requiring agencies to review state statutes and rules regulating providers.	Agencies include unnecessary rules parts in Revisor's bill for repeal.	Agencies work with federal HHS to change federal rules or laws necessary to implement an outcomes focus or pilot projects.	Full implementation of outcomes-focused pilot projects by 7/1/2000.
Focus on outcomes in services delivery to citizens	Agencies provide technical assistance to encourage direct service providers to focus on outcomes. MFIP implementation.	Agencies introduce, legislature pass bill to change statutes that unnecessarily hamper an outcomes focus. MFIP implementation.	Agencies work with federal HHS to change federal rules or laws necessary to implement an outcomes focus. MFIP evaluation.	Full implementation of outcomes-focused pilot projects by 7/1/2000. MFIP evaluation

RECOMMENDATION	1993	1994-1995	1996-1997	1998-2000
6-10. Improve accountability				
Write rules to target critical situations, and to outline minimal acceptable standards	CORE introduce, legislature pass bill requiring agencies to review internal rulemaking standards. Clarify in APA, if necessary.	Agencies identify necessary state statutory changes, and write necessary legislation.	Full implementation by 7/1/96.	
Review and repeal existing rules	CORE introduce, legislature pass bill making changes in APA and rulewriting process (CORE Rules project). Agencies begin or continue rule review.	Agencies continue current review of rules and include unnecessary parts in Revisor's bill for repeal.	Agencies write any state bills, & work with federal HHS to change federal rules or laws necessary to fully implement this recommendation.	Full implementation by 7/1/2000.
Permit regulated entities to apply for waivers from existing rules	CORE introduce, legislature pass bill requiring agencies to determine a process and standards for waivers.	Secretary's office write rule for waiver review process and standards. Based on requests, agencies identify state and federal rules that need revision.	Agencies write any state bills, & work with federal HHS to change federal rules or laws necessary to fully implement this recommendation.	Full implementation by 7/1/2000.
Implement effective enforcement strategies	CORE introduce, legislature pass bill requiring agencies to determine new, effective enforcement strategies.	Agencies identify state statutory changes needed, and write necessary legislation.	Full implementation by 7/1/96.	
Implement meaningful sanctions for noncompliance with state regulations	CORE introduce, legislature pass bill requiring agencies to determine new, meaningful sanctions for noncompliance with state regulations.	Agencies identify state statutory changes needed, and write necessary legislation.	Full implementation by 7/1/96.	
11-13: Become customer-focused				
Clearly define health and human services customers	(This will be part of the bill outlining duties of the HHS Secretary.)	Link to definition of mission for agencies.		Full implementation by 7/1/2000.
Empower staff to serve customers	(Statutory provisions and time lines to implement this recommendation are linked to funding and rules recommendations.)			Full implementation by 7/1/2000.
Empower customers to achieve their goals	(Statutory provisions and time lines to implement this recommendation are linked to funding and rules recommendations.)			Full implementation by 7/1/2000.

CONCLUSION

Minnesota is a leader in its commitment to health and human services. Many of its ideas and programs have served as models for the rest of the country. Still, the system is far from perfect. Good intentions get waylaid by the barriers described in this report. These prevent success in the human services system and contribute to a persistently negative public perception of human services in general. Reform is not a one-time event, but a process of continual change. Time and many positive experiences with a reformed system will be necessary to dispel these negative images.

Implementation of these recommendations would make significant progress toward improving Minnesota's human services delivery system:

- The system needs leadership to guide development of a clear vision and coordinated missions. Instituting a secretary of health and human services could create an environment conducive to leadership and cooperation.

- The administration and delivery of human services have both become fragmented. Implementing health and human services districts and establishing a set of basic services along with a new health and human services block grant would reduce this fragmentation.

- Multiple pressures have driven the system toward process and away from results. Making pragmatic changes in the state's approach to rules for human services and emphasizing outcomes in areas where the state provides funding could help to reverse this trend.

- The health and human services system exists to serve the citizens of Minnesota. The recommendations in this report emphasize the importance of adopting a customer focus at all levels of administration to make the system more responsive to its customers.

Health and human services constitute the government's attempt to bridge the gap between need and self-sufficiency — temporarily for some people, permanently for others. Government, however, does not and should not play this role alone. Many nonprofit organizations, private-sector firms, and volunteers are significantly involved in helping to meet people's needs. It is appropriate for government to expect families, churches, community groups, and individuals to be the first to respond to human needs. Ultimately, the success of society depends on how well these elements work together to give assistance when and where it is needed.

SOURCES

Books

American Enterprise Institute for Public Policy Research. *Government Regulations: Proposals for Procedural Reform.* Washington, D.C.: American Enterprise Institute for Public Policy Research, 1979.

Clive Ardier, ed. *The Nordic Model: Studies in Public Policy Innovation.* Farnborough, England: Gower, 1980.

Michael M. Atkinsen and Marsha A. Chandler. *The Politics of Canadian Public Policy.* Toronto: University of Toronto Press, 1983.

Alan S. Blinder, ed. *Paying for Productivity: A Look at the Evidence.* Washington, D.C.: Brookings Institution, 1990.

Jack A. Brizius and Michael D. Campbell. *Getting Results.* Washington, D.C.: Council of Governors' Policy Advisors, 1991.

Reginald K. Carter; foreword by Leon H. Ginsberg. *The Accountable Agency.* Beverly Hills, Calif.: Sage, 1983.

Michael Clayue et al. *Reforming Human Services: The Experience of the Community Resource Boards in British Columbia.* Vancouver: University of British Columbia Press, 1984.

Robert W. Crandall and Lester B. Lave, eds. *The Scientific Basis of Health and Safety Regulation.* Washington, D.C.: Brookings Institution, 1981.

George Feaver and Frederick Rosen. *Lives, Liberty and the Public Good: New Essays in Political Theory for Maurice Cranston.* New York: St. Martin's Press, 1987.

Fred E. Fiedler. *A Theory of Leadership Effectiveness.* New York: McGraw Hill, 1968.

Thomas North Gilmore. *Making a Leadership Change: How Organizations and Leaders Can Handle Leadership Transitions Successfully.* San Francisco: Jossey-Bass, 1988.

Laura Irwin Langbein. *Discovering Whether Programs Work: A Guide to Statistical Methods for Program Evaluation.* Santa Monica, Calif.: Goodyear, 1980.

Lester B. Lave. *The Strategy of Social Regulation: Decision Frameworks for Policy.* Washington, D.C.: Brookings Institution, 1981.

Giandomenico Majone. *Deregulation or Re-regulation?: Regulatory Reform in Europe and the United States*. New York: St. Martin's Press, 1990.

James L. Mercer. *Strategic Planning for Public Managers*. New York: Quorum Books, 1991.

Jack A. Meyer. *Incentives vs. Control in Health Policy: Broadening the Debate*. Washington, D.C.: American Enterprise Institute for Public Policy Research, 1987.

Minnesota Department of Administration. *Minnesota Guidebook to State Agency Services 1992 - 1995*. St. Paul: State of Minnesota, 1992.

Kathleen O'Leary Morgan, Scott Morgan, and Neal Quitno, eds. *State Rankings 1992: A Statistical View of the 50 United States*. Lawrence, Kans.: Morgan Quitno Corp., 1992.

National Research Council (United States), Panel to Evaluate Microsimulation Models for Social Welfare Programs. *Improving Information for Social Policy Decisions*. Washington, D.C.: National Academy Press, 1991.

Organization for Economic Cooperation and Development. *Policies for Innovation in the Service Sector: Identification and Structure of Relevant Factors*. Washington, D.C.: OECD Publications Center, 1977.

David Osborne and Ted Gaebler. *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*. Reading, Mass.: Addison-Wesley, 1992.

Dennis J. Palumbo, ed. *The Politics of Program Evaluation*. Newbury Park, Calif.: Sage, 1987.

Martin Rein. *From Policy to Practice*. Armonk, N.Y.: M.E. Sharpe, 1983.

Morris Schafer. *Implementing Change in Service Programs: Project Planning and Management*. Newbury Park, Calif.: Sage, 1987.

Alan Stone. *Regulations and Human Services Alternatives*. Washington, D.C.: Congressional Quarterly Press, 1982.

Louis G. Tornatzky. *Innovation and Social Process: A National Experiment in Implementing Social Technology*. New York: Pergamon Press, 1980.

Tony Tripodi, Phillip Fellen, and Irwin Epstein. *Differential Social Programs Evaluation*. Itasca, Ill.: F.E. Peacock, 1979.

U.S. Data on Demand Inc. and State Policy Research Inc. *States in Profile*. 2d ed. McConnellesberg, Pa.: U.S. Data on Demand and State Policy Research, 1992.

U.S. Department of Commerce. *1990 Census of Population, General Population Characteristics, Minnesota*. Washington, D.C.: U.S. Department of Commerce, 1992.

U.S. Department of Housing and Urban Development. *Building Better Communities through Regulating Reform: A Guide to Regulatory Change*. Washington, D.C.: HUD, 1987.

Joseph S. Wholly, Kathryn E. Newcomer, et al. *Improving Government Performance: Evaluation Strategies for Strengthening Public Agencies and Programs*. San Francisco: Jossey-Bass, 1989.

Articles

Thomas W. Church and Milton Heumann, "The Underexamined Assumptions of the Invisible Hand: Monetary Incentives as Policy Instruments," *Journal of Policy Analysis and Management*, 1989.

Gordon Culp and Anne Smith, "Applying Total Quality Management," *Water Environment and Technology* July 1992.

Dulworth, Lande and Usliner, "Employee Involvement Systems in United States Corporations: Right Objectives, Wrong Strategies," *National Productivity Review* (Spring 1990).

Saul W. Gellerman and William G. Hodgson, "Cyanamid's New Take on Performance Appraisal." *Harvard Business Review* (May/June 1988).

Charles Heckscher, "Can Business Beat Bureaucracy?," *American Prospect* (Spring 1991).

Rosalie Kane and Robert Kane, "Long-term Care: Variations on a Quality Assurance Theme," *Inquiry* (Spring 1988).

Rosabeth Moss Kantor, "The Attack on Pay," *Harvard Business Review* (March/April 1987).

Steven Kerr, "On the Folly of Rewarding A, While Hoping for B," *Academy of Management Journal* (1975).

Ted Kolderie, "The Two Different Concepts of Privatization," *Public Administration Review* (July/August 1986).

Kristin Kurtenbach, "Just One Mandate Too Many," *Governing* (May 1991).

Donna Ambler Peter, "An Overview of Current Research to Long-term Outcomes," *Nursing and Health Care* (March 1989).

F. Stevens Redburn. "On Human Services Integration." *Public Administration Review* (May/June 1977.)

M.J. Richter, "Managing Information: The County Study," *Governing* (August 1992).

Deborah D. Roberts, "Carving out Their Niche: State Advisory Commissions on Intergovernmental Relations," *Public Administration Review* (November/December 1989).

Otis White, "The Mysteries of Innovative Government," *Governing* (October 1991).

Charles R. Wise, "Public Service Configurations and Public Organizations: Public Organization Design in the Post-Privatization Era," *Public Administration Review* (March/April 1990).

Other sources

Action for Children Commission. *Kids Can't Wait: Action for Minnesota's Children.* St. Paul: Minnesota Planning, February 1992.

Association of Minnesota Counties. *Salary Survey*. St. Paul: AMC, 1992.

Estelle Brouwer. *No Easy Cure: Possible Options for Controlling Minnesota's Medical Assistance Spending*. Minneapolis: University of Minnesota, December 1992.

Financial Management Division, *Minnesota County Human Service Cost Report for Calendar Year 1991*. St. Paul: Minnesota Department of Human Services, 1991.

Governor's Planning Council on Developmental Disabilities. *Minnesotans Speak Out*. St. Paul: Minnesota Department of Administration, November 1992.

Diane Justice (with Lynn Etheredge, John Luerrs, and Brian Burell). *State Long -Term Care Reform: Development of Community Care Systems in Six States*. Washington, D.C.: Center for Policy Research, National Governor's Association, 1988.

John Kirkpatrick, senior vice-president for government operations, Process Management International. Speech to Minnesota Quality Conference, Minneapolis, October 8, 1992.

Ted Kolderie. *Contracting as an Approach to Management*. Minneapolis, Minn.: Public Services Redesign Project, n.d.

Legislative Audit Commission. *Financing County Human Services*. St. Paul: Minnesota Office of Legislative Auditor, February 1987.

George Mikovich et al., "Pay for Performance: Perspectives and Research." In *Pay for Performance: Evaluating Performance Appraisal and Merit* (Washington, D.C.: National Research Council, 1989).

James C. Miller, III. *Regulatory Reform: Some Problems and Approaches*. New York: American Management Association, reprint no. 72, August 1977.

Minnesota Board on Aging and Interagency Board for Quality Assurance. *Seniors Agenda for Independent Living*. St. Paul: MBA and IBQA, 1990.

Minnesota Department of Human Services. *The Children's Mental Health Integrated Fund*. St. Paul: Department of Human Services, May 13, 1992.

——. *Primer on Minnesota Programs and Services for Persons with Developmental Disabilities and Related Conditions*. St.Paul: Department of Human Services, June 1991.

——. *A Review of the PreAdmission Screening and Alternative Care Grant Programs*. St. Paul: Department of Human Services, March 21, 1991.

——. *Social Service Mandates*. St. Paul: Department of Human Services, December 1990.

Minnesota Planning. *Minnesota Milestones*. St. Paul: Minnesota Planning, December 1992.

Office of the Inspector General. *Services Integration: A Twenty-Year Retrospective*. Washington, D.C.: U.S. Department of Health and Human Services, January 1991.

Susan D. Robison. *Putting the Pieces Together: Survey of State Systems for Children in Crisis*. Denver: National Conference of State Legislatures, July 1990

Nelson A. Rockefeller College of Public Affairs and Policy. *Assessment of the Structure and Functioning of the New York State Department of Social Service: Findings, Conclusions, and Recommendations*. Albany, N.Y.: University at Albany, State University of New York, May 1992.

U.S. General Accounting Office. *Integrating Human Services: Linking At-Risk Families with Services More Successful Than System Reform Efforts*. Washington, D.C.: GAO, September 1992.

——. *Welfare Simplification: Projects to Coordinate Services for Low-income Families*. Washington, D.C.: GAO, August 1986.

APPENDICES

APPENDIX A

INTERVIEW INVENTORY

ORGANIZATION/AGENCY	INDIVIDUALS INTERVIEWED
Anoka County Department of Social Services	Julie Brunner, Director Bob York, Program Director
Anoka County Jobs and Training Center	Jerry Vitzhum
Anoka County Schools	Sue Butler, Director of Special Education
National Human Services Organizations	Contacts made by telephone. Number of organizations contacted: 15. Number of people interviewed: 20.
California, Indiana, Kansas, Kentucky, Maryland, Nebraska, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Washington, and Wisconsin Departments of Human Services	Contacts made by telephone. Number of people interviewed: 17.
Office of Ombudsman for Mental Health	Bruce Johnson, Director
Office of Attorney General	Gail Olson and Human Services staff
Department of Jobs & Training	Executive Team
Department of Jobs & Training	Paul Wasko, John Brenneman
Department of Human Services	Executive Team
Department of Human Services	Barb Anderson, Bob Baird, Jim Campbell, Jon Darling, Neil Doughty, Dennis Erickson, John Gostovich, Joel Kvamme, Ron Lang, James Loving, Steve Nelson, Dan Newman, Al Rasmussen, Phil Sorenson, Dr. Cindy Turnure, Gwen Wildermuth, Helen Yates, John Zakelj
Department of Finance	Anne Barry, Dave Johnson, Lois McCarron, Pam Wheelock
Department of Health	Ryan Church, Andrea Walsh

ORGANIZATION/AGENCY	INDIVIDUALS INTERVIEWED
Departments of Human Services, Health, Education, Corrections, Jobs & Training, and Housing Finance	Two focus groups of middle management and professional staff
Association of Minnesota Counties	Pat Conley; six county administrators
Itasca County Social Services	Tom Papin, Director
Joining Forces, Itasca County	Anne Huntley, Director and members
Washington County Social Services	Jim Schug, Director
DHS Mandates Advisory Committee	Committee members
Senate Counsel & Research	Michael Scandrett, counsel
House Appropriations Committee	Marcie Jefferys, fiscal analyst
Human Services of Faribault & Martin Counties	Duane Shimpach, Director
Dakota County Social Services	Dave Rooney, Director; Helen Dahlberg, Beth Fossen, Susan Askelin
Minnesota Association of County Social Service Directors	Focus Group: Board of Directors
Association of Minnesota Counties	Meetings in Twin Cities, Mankato, and Fergus Falls
DHS County Commissioners Advisory Committee	Advisory Committee members
Minnesota Planning	Marilyn Larson, Susan Roth
Humphrey Institite	Paul Light, Ted Kolderie
Citizens League	Lyle Wray
Minnesota Chamber of Commerce	Bill Blazar
Minnesota Business Partnership	Estelle Brouwer
Metropolitan Council	Hal Freshley
Developmental Disability Council	Dr. Colleen Wieck
State Commission on Developmental Disabilities	Lynette Knapp, Co-Chair

ORGANIZATION/AGENCY	INDIVIDUALS INTERVIEWED
Minnesota Social Services Association	Focus Group: Mabel Brewer (Pilot City), Gary Weiers (Mower Co.), Norbert Bruegmann (Jackson Co.), Judy Burens (Childrens Home Society), Cindy Regouski (Morrison Co.), Maureen Wilkers (Sherburne Co.), Fay Bawek (Anoka Co.)
Itasca County Clients	Focus group
Dakota County Clients	Focus group
Project Empowerment, Minneapolis	Two focus groups: clients and providers
Interagency Committee on Long-Term Care (INTERCOM)	Committee members and representatives from senior organizations

Recommendations Response Summary

Based on the decisions made at the Nov. 17, 1992, working committee meeting, CORE staff prepared a 20-page document summarizing CORE draft recommendations on the human services delivery system. This document was mailed to about 90 affected state agencies, associations, and other interested groups and individuals to seek their written comments.

CORE received 27 responses: six from state agencies, 13 from counties, and eight from associations and special interest groups.

This summary outlines these responses on the four broad recommendation areas: state health and human services organization; local health and human services organization; health and human services funding; and health and human services delivery.

State health and human services organization

Department of Human Services: A secretary must have the ability to appoint both commissioners and assistant commissioners, in order to initiate change in the "short 4-year window of opportunity." The department is concerned that the secretary will be so far removed from agencies that "depth of understanding of concerns and impacts becomes questionable." The agency supports the recommendation to coordinate data collection.

Department of Health: The recommendation for a secretary will "diminish the public health perspective" as public health represents a small portion of the state health and human services budget. The agency recommends "less disruptive, more acceptable, less costly, probably more effective alternatives," such as "interagency discussions/forums." If the secretary recommendation is implemented, "changes to the secretary's responsibilities . . . should allow more autonomy to agencies while improving coordination." These changes include maintaining the responsibilities for agency vision, mission, and budget within each agency.

Department of Finance: A comprehensive vision for health and human services may not be helpful. The response seems to indicate that present management incompetence is the real issue and that a secretariat system does not address this issue. Secretary authority to balance funding priorities among programs and agencies "will not work" because secretaries will not be above turf issues and will not be able to respond to the interests of the state as a whole. The secretarial model "is more hierarchy, another layer of control and is based on the notion that a high-level individual holds the key to making things work." Recommends "networked solutions" championed by Osborne and Gabler.

Minnesota Planning: Recommends restructuring services instead of agencies. "Departments should be organized around the needs of customers . . . consolidating services for children and their families into one or two departments that span the whole range of

health, human services and education may be a better way to go."

Governor's Planning Council on Developmental Disabilities: The creation of a vision for the human service delivery system is "crucial."

*Pat Conley, Association of Minnesota Counties (*unofficial response): Questions whether, "a Governor would be well served by having only 6 secretaries instead of the 26 department heads in which to communicate." Strongly supports the concept of having state goals and plans and "if it takes a secretary to make department heads do statewide planning, so be it." Urges the secretary to include local staff and officials in the planning process.

Paul McCarron, Anoka County commissioner: "While county government is not in a position to direct state organization, any effort at coordination and integration of programs at the state level would be welcome . . . ."

David L. Sayler, director of Wilkins County Family Service Agency: "The Secretary of Health and Human Services would be an excellent way to coordinate fragmented services and create an overall vision for heath and human services, if the position is nonpolitical."

Nita Aasen, director of Nicollet County Public Health Nursing Service: The secretary "would increase the cost to taxpayers by adding another layer to government . . . . [I]t is important that this appointee have an orientation to prevention."

Minnesota Public Health Association: Concerned that under a secretary of health and human services, public health will get "lost" in the human services bureaucracy.

Minnesota Alliance for Health Care Consumers: The secretary should avoid intergenerational contests for services. This group endorses the strategies for improving accountability.

American Federation of State, County and Municipal Employees (AFSCME): The secretary adds another layer of bureaucracy to government. The development of a vision "can take ten years, as in the RTC downsizing, and requires input from many interest groups."

Care Providers of Minnesota: It is unclear how the secretary will improve coordination, because there are already coordinating committees, such as INTERCOM. What is needed is consolidation, not coordination.

Local health and human services organization

Department of Human Services: There is "general agreement with the concept of a different kind of structure with fewer administrative entities." There is also general agreement that "if you are going to take on the massive political battle to change from 84 to a lesser number of entities, you might as well go all the way to 9 or 10 entities."

Suggests that CORE propose the concept of a reduced number of administrative entities and have counties group together voluntarily.

Department of Health: The agency "has found the CHS district boundaries well suited for program planning and administration. It is expected that implementation of this recommendation will improve service coordination and delivery to communities."

Minnesota 2000: There should be combined planning with school districts for delivering of health and human services primarily to students.

Governor's Planning Council on Developmental Disabilities: HHSDs "must assure equitable access to community supports and services for people with developmental disabilities and their families."

Pat Conley: "Any reforms suggested must respect the authority of the elected county commissioners, because they are accountable to the taxpayers."

David L. Sayler: Designating local health and human services districts using current CHS region boundaries is not consistent with providing the best human services system because the districts would be controlled by large counties and would be less responsive to low-income individuals.

Joel Churness: Forwarded a board resolution from Lac Qui Parle County indicating that the commissioners "strongly oppose the concept of designating local health and human services districts based on community health services (CHS) district boundaries, and reducing the current county agencies from 84 to 44 community health districts."

Nita Aasen: Observed that while the CHS regions are seen as ideal structures, problems with the stability of boundaries and minimal uniformity among regions would continue to exist for health and human services districts.

Minnesota Association of Community Health Administrators: The recommendation should identify the Koochiching-Itasca-Aiken joint health and human services planning as an example.

Minnesota Public Health Association: Supports the recommendation to create health and human services districts using current CHS regional boundaries.

AFSCME: Noted that merging health and human service districts has been proposed in the past and has been met with opposition from local government and other groups.

Health and human services funding

Department of Human Services: The proposal for minimum and adequate services is "admirable in concept," but it is difficult to determine a set of minimum services. The legislature's past efforts "have brought us where we are today." There is "agreement on including RTC monies into a block grant." The department expects the RTC lobby to "actively resist."

Department of Health: "Some mechanism needs to be included that will ensure an appropriate level of expenditure for general and public health services."

Department of Finance: The idea of minimum and adequate services to meet basic needs "makes a lot of sense." Implementation will not be easy. This approach "doesn't help the county with decisions about service rationing." While the recommendations are "a good section," they rely on the philosophy that service needs can be determined at the local government level. "A totally different approach" is needed, such as capitation funding.

Minnesota 2000: "The thrust of this recommendation is superb. There must be a definition of basic needs and a clear statement on whether the local districts and or counties will have taxing authority of their own."

Governor's Planning Council on Developmental Disabilities: "We have not had good experience with CSSA, and so we reserve judgment about another block grant . . . . Any new funding mechanism should remove the geographical differences between counties and between rural and urban areas."

Pat Conley: Notes that "the politics would be difficult and probably doom the recommendation from the start."

Paul McCarron: County government has long supported the principles of block grant funding. Such problems as prescriptive requirements, the increased development of categorical grants, the lack of additional funding for current block grants, and the categorical requirements for county maintenance of effort funding have eroded the discretion and flexibility associated with block grant funding.

David L. Sayler: Supports the recommendation to provide a minimum, adequate level of service to meet the basic needs of citizens. Added that counties must be allowed the flexibility to design service plans to address their own unique characteristics.

Nita Aasen: "Prevention has been the primary mission of public health and if . . . merged with other types funding, prevention would be jeopardized . . . ."

Minnesota Association of Community Health Administrators: Fears that prevention and health promotion would be funded secondarily to treatment services.

AFSCME: Concerned that the alternative funding structure will be eroded over time, as has occurred with other block grants. Also concerned that the proposed funding structure would destroy the negotiated downsizing of RTCs.

Health and human services delivery

Department of Human Services: These recommendations are "strongly supported" by DHS. The agency has recently undertaken similar efforts. Its experience shows that "implementation of outcomes is neither easy nor inexpensive." Success requires "close coordination and buy off from the legislature . . . for potential to be realized."

Department of Health: "An emphasis on outcomes is appropriate, but the focus should include both long-term and short-term results. The outcomes of many preventive health interventions are not measurable for years."

Department of Finance: This is a "well-designed series of recommendations." Investigation of actual programs and more detail are needed.

Pat Conley: Strongly supports the recommendations in this section. Outcome measurements and greater coordination of services can be achieved through incentives rather than mandates.

Paul McCarron: Counties would welcome a move away from process and prescriptive state requirements to a more outcome-oriented focus.

David L. Sayler: Supports the recommendations. He added however that "implementing this drastic change of policy from process to outcomes could be very difficult" and recommends "a gradual implementation of this goal."

Minnesota Alliance for Health Care Consumers: Endorses the concept of streamlining the rule-making process.

AFSCME: Since quality is hard to define, the concept of using outcomes should be considered over an adequate amount of time to guarantee that existing processes are not sacrificed.

Summary of Robin PanLener's response

In a Feb., 1993, letter to CORE Chairman Arend Sandbulte, Robin PanLener, CORE member and president of the Minnesota Association of Professional Employees, raised several issues regarding the CORE Human Services Project. Following is a summary of those comments:

Generally, he objects strongly to the CORE recommendations on human services. He agrees with the project goal of improving client outcomes but feels that the report has another goal of expediting the closure of regional treatment centers, requiring RTC clients to enter privately operated facilities, and that the commission has not paid sufficient attention to the "10-year plan" for downsizing the RTCs that was negotiated between affected parties.

He also feels that private services are not likely to meet the needs of RTC clients. He does not agree with what he sees as the implication of the report to use outside contractors instead of state employees to provide services. In addition, he cites the Chemical Dependency Treatment Fund as an example of a "bad outcome" after program funds were consolidated.

APPENDIX C

STATE HEALTH AND HUMAN SERVICES AGENCIES AND PROGRAMS

Primary State Agencies	Department of Health	Department of Jobs & Training	Housing Finance Agency
Department of Human Services	Department of Education	Department of Veterans Affairs	Department of Corrections
Other State Entities	Department of Finance	Minnesota Planning	Attorney General
	Office of the Governor	State Legislature	Boards, councils, & commissions
Delivery System	Minnesota counties	School districts	Area agencies on aging
	Indian reservations	Nonprofit providers	Private providers
Other Stakeholders	Judicial system	Law enforcement	Advocacy groups

Human services in Minnesota are planned, delivered, regulated, or otherwise affected by many entities. The Department of Human Services is the primary state human services agency. The departments of Health and Jobs and Training also plan or regulate many human services, as do the departments of Education, Veterans Affairs, and the Housing Finance Agency. Other entities affect these agencies' administration of human services programs. These include executive branch offices, the legislature, various boards and commissions, service providers, and other stakeholders.

The following tables[1] depict three important elements that help in understanding human services delivery in Minnesota state agencies. The first is the identification of programs within an agency. The second is a classification of how the program's services are delivered, as indicated by a ★. The third indicates which agencies provide similar or complementary services to those of the primary agency, as indicated by a √.

Note: Agency listings are provided as background material to aid in an understanding of how the human services system in Minnesota is organized. Because complementary listings do not necessarily indicate duplication, these lists alone should not be used to make specific determinations about program delivery.

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[1]The *Minnesota Guidebook to State Agency Services 1992-1995* was the primary reference source for agency program information. (Published by the Minnesota Department of Administration, 1992.) On all organizational charts and tables, only those divisions including human services programs are listed.

DEPARTMENT OF HUMAN SERVICES

The **Department of Human Services** administers the largest budget of any state agency — a total of more than $3 billion annually. About three-quarters of the DHS budget is spent on health care programs; the Medical Assistance program makes up most of that percentage. The remainder of the department's programs are social services and what are traditionally thought of as "welfare" programs. About half the DHS budget comes from federal funds. Services are provided through various combinations of federal state, local and client funding.

	State-delivered	County-delivered	Other providers	Health	Jobs & Training	Veterans Affairs	Corrections	Education	Housing Finance
HEALTH CARE & MENTAL HEALTH									
Medical Assistance & GAMC Eligibility	★	★		√					
Medical Assistance Prior Authorization	★								
State Health Insurance (MNCare, HIV...etc.)	★	★	★	√		√			
Medical Care		★	★	√		√			
EPSDT (Early & Periodic Screening-children)		★	★	√				√	
Home Health Care		★	★	√					
Nursing Homes & Preadmission Screening	★	★	★	√		√			√
Medicaid Waiver Programs		★	★	√				√	√
Traumatic Brain Injury Services	★	★	★	√	√	√			
Community Mental Health		★	★	√					√
Regional Treatment Centers	★			√					
ASSISTANCE PAYMENTS									
Assistance Payments Eligibility	★	★							
G.A. & M.S.A. Eligibility		★		√	√				
Emergency Assistance		★							
Work Readiness		★			√				
Food Stamps		★		√	√			√	
Refugee & Immigrant Assistance		★		√	√			√	
Aid to Families with Dependent Children		★		√	√				
Telephone Assistance Plan		★							

	State-delivered	County-delivered	Other providers	Health	Jobs & Training	Veterans Affairs	Corrections	Education	Housing Finance
SOCIAL SERVICES									
Chemical Dependency	★	★	★	√		√			
Elderly Ombudsman & OAA programs	★		★						
Family Preservation		★	★						
Child Support Enforcement	★	★						√	
Child Protection		★					√		
Children's Funds (Trust Fund & Child Care)	★	★	★		√				
Adoption & Guardianship	★	★	★						
Children's Services	★	★	★	√	√			√	
Child & Adult Foster Care		★	★	√					
Child Day Care		★	★	√				√	
Adolescent Services		★	★	√	√			√	
Deaf Services	★	★	★						
DD Residential Programs	★	★	★	√					
DD Day Training & Habilitation		★	★						
OTHER									
Program Licensing	★	★		√					

MINNESOTA DEPARTMENT OF HEALTH

The **Minnesota Department of Health** (MDH) links with local health programs through the Community Health Services (CHS) system. Services include health promotion, disease prevention and control, family health, environmental health, home health and emergency medical services. The newly established health insurance program (MinnesotaCare) for uninsured Minnesotans and the licensing and regulation of residential facilities are also provided through MDH.

	State-delivered	County-delivered	Other providers	Human Services	Education	Jobs & Training	Housing Finance	Corrections
HEALTH PROTECTION								
Refugee Health Screening Coordination	★							
COMMUNITY HEALTH SERVICES								
Public Health Nursing	★	★		√	√			
MATERNAL & CHILD HEALTH								
Services to Children with Handicaps	★	★	★	√	√			
Women, Infants & Children (WIC)	★	★	★	√	√			
Supplemental Food (MAC)			★	√	√			
Child Health Screening & Promotion	★	★	★	√	√			
MN HEALTH CARE COMMISSION (MinnesotaCare)		★	★	√				
HEALTH CARE DELIVERY SYSTEMS								
Managed Care Regulation/Access	★			√				
HEALTH RESOURCES								
Survey & Compliance	★			√				
Quality Assurance & Review	★			√			√	
Health Facility Complaints	★	★	★	√				

DEPARTMENT OF JOBS AND TRAINING

The **Department of Jobs and Training** facilitates economic security by providing programs and services that promote economic independence and self-sufficiency for the unemployed and underemployed. The human services system is directly affected by programs in the following divisions: The division of **Community Based Services**, the **Rehabilitation Services Division, and State Services for the Blind.**

	State-delivered	County-delivered	Other providers	Human Services	Education	Training & Econ. Dev.	Corrections	Housing Finance	Health
COMMUNITY-BASED SERVICES									
Self-sufficiency									
Community & Economic Assistance			★						
Head Start			★	√	√				√
Emergency/Transition Housing			★	√				√	
Emergency Food Assistance			★	√	√				√
Work & Training									
Work Readiness		★		√	√				
Food Stamp Employment		★		√					
Stride		★		√					
Youth Employment & Training			★	√	√		√	√	
Dislocated Workers			★						
Energy Programs			★					√	
Job Training Partnership Act		★	★	√	√				
Rehabilitation Services	★		★	√	√		√		
Services for the Blind	★		★	√	√	√			

MINNESOTA HOUSING FINANCE AGENCY

The **Minnesota Housing Finance Agency** (MHFA) was created by the state legislature in 1971 for the purpose of providing ". . . sanitary, decent and safe residential dwellings at prices or rentals which persons and families of low and moderate income can afford."

	State-delivered	County-delivered	Other providers	Human Services	Education	Jobs & Training	Health	Corrections
HOME IMPROVEMENT PROGRAMS								
Home Improvement Loans			★	√				
Property Rehabilitation and Preservation			★					
Home Energy Loans			★			√		
HOME OWNERSHIP OPPORTUNITY								
Community Reinvestment			★					
Mortgage Assistance			★					
Indian Housing			★					
Affordable Housing Partnership			★					
MULTIFAMILY PROGRAMS								
Homesharing Program			★					
Family Rentals			★					
Homeless Assistance			★	√	√	√		
M.I. Rental Assistance Demonstration			★	√				
Residences for Persons with DD			★	√				
Subsidized Housing Preservation			★					
New Construction Tax Credits			★					
SPECIAL NEEDS HOUSING			★					

MINNESOTA DEPARTMENT OF EDUCATION

The **Minnesota Department of Education** provides human services through its planning and programs for students with disabilities, community education, prevention and risk reduction, and child nutrition. A number of the programs listed on the table are in areas where significant coordination with other state agencies occurs. The agency serves 436 local school districts and other educational agencies through a program of planning, research, consultation, coordination, communication and in-service education.

	State-delivered	School districts	Other providers	Human Services	Health	Jobs & Training	Housing Finance	Corrections
COMMUNITY EDUCATION								
Adult Basic Education		★	★	√		√		√
Adult Refugee and LEP Education		★		√				
Adults with Disabilities		★	★	√		√		
Early Childhood Programs		★		√	√	√		
Family Literacy			★					
GED		★	★					
School Age Child Care		★	★	√	√	√		
Migrant Education		★	★	√	√			
SPECIAL EDUCATION								
Early Childhood Special Education		★	★	√	√			
Transitional Special Education				√				
OTHER PROGRAM AREAS								
Educational Choice Programs		★	★	√*	√*	√*		
Food and Nutrition Programs		★	★		√			
Homeless Programs			★	√		√	√	
Youth Service and Development		★	★			√		
Drug Abuse Issues		★	★	√	√			√
Violence Programs		★	★	√	√			√

* Agencies primarily refer clients

DEPARTMENT OF VETERANS AFFAIRS

The **Department of Veterans Affairs** assists Minnesota veterans in obtaining benefits and services provided by the federal Department of Veterans Affairs. The department also operates four veterans homes that provide boarding care or nursing care to veterans and their spouses.

	State-delivered	County-delivered	Other providers	Human Services	Health	Education
War Orphans Education Program	★					√
Veterans Educational Assistance Program	★					√
Veterans Preference	★					
Claims Assistance	★	★		√		
Guardianship	★			√		
Veterans Homes	★				√	

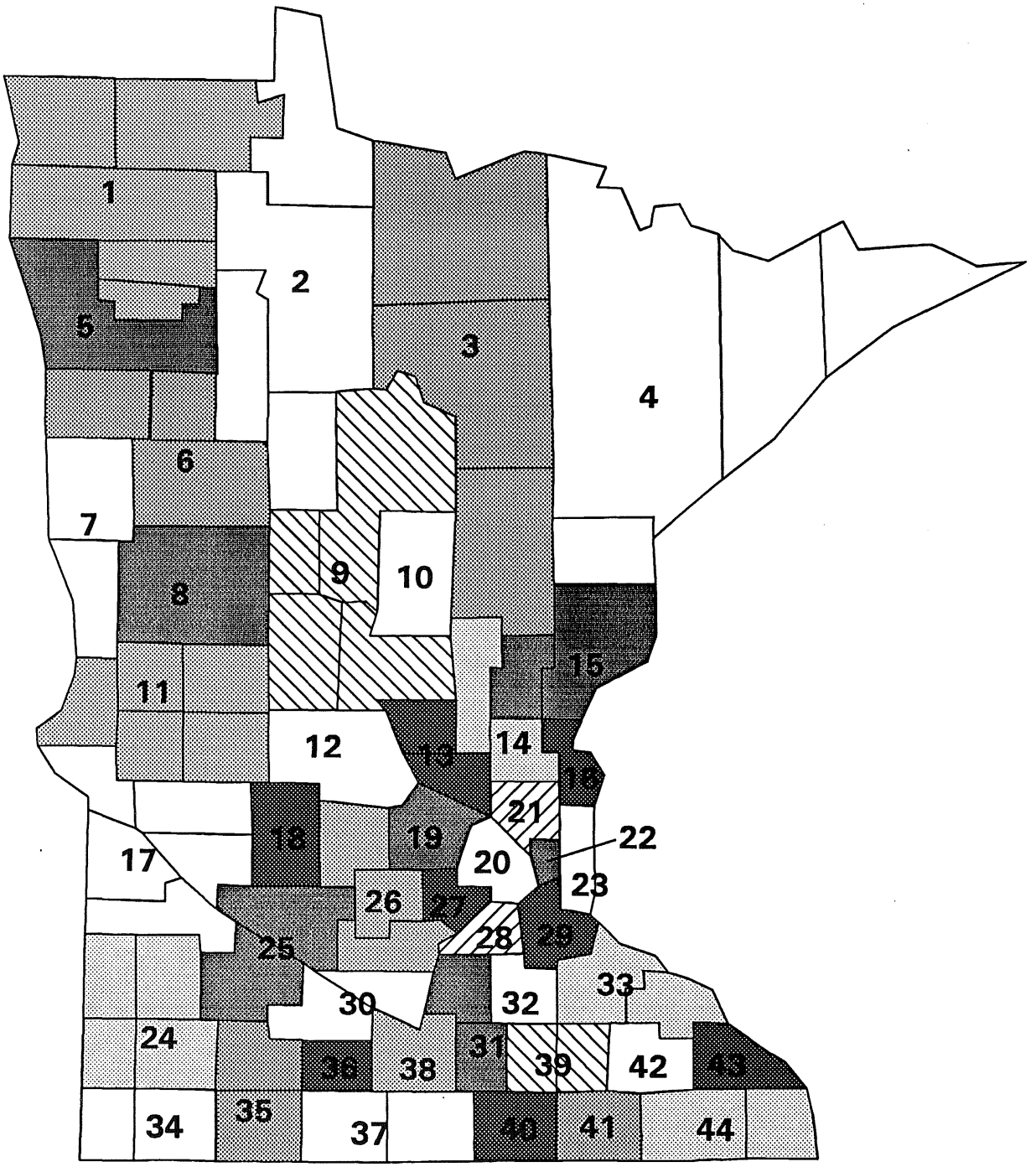
DEPARTMENT OF CORRECTIONS

The **Department of Corrections,** through the Community Corrections Act (CCA) and a variety of victim services programs, provides technical assistance and funding to local human services providers. The CCA is designed to encourage development of local correction systems that include sanctions for offenders and a variety of community service programs.

	State-delivered	County-delivered	Other providers	Human Services	Education	Jobs & Training
COMMUNITY SERVICES						
Field Services		★				
Community Corrections Act		★		√		
Contracted Services		★		√	√	√
MANAGEMENT DIVISION						
Program for Battered Women			★	√		
Victims of Sexual Assault			★	√		
Victims of Crime/Abused Children			★	√		

APPENDIX D

Community Health Services Districts



APPENDIX E. COUNTIES & CHS DISTRICTS BY SIZE AND DIRECTOR SALARIES

	Population	# of county commissioners	Pop. served per commissioner	SS Dir. Salary (000s)	Health Dir Salary (000s)	SS & PH Salaries (000s)
District 1						
Kittson	5,767	5	1,153	41	26	67
Marshall	10,993	5	2,199	43	N/R*	43
Pennington	13,306	5	2,661	40	N/R	40
Red Lake	4,525	5	905	34	N/R	34
Roseau	15,026	5	3,005	39	N/R	39
Total	49,617	25	1,985	197	26	223
District 2						
Clearwater	8,309	5	1,662	55	38	93
Beltrami	34,384	5	6,877	55	40	95
Hubbard	14,939	5	2,988	46	N/R	46
Lake of the Woods	4,076	5	815	44	N/R	44
Total	61,708	20	3,085	200	78	278
District 3						
Aitkin	12,425	5	2,485	40	38	78
Itasca	40,863	5	8,173	66	53	119
Koochiching	16,299	5	3,260	50	45	95
Total	69,587	15	4,639	156	136	292
District 4						
Carlton	29,259	5	5,852	54	43	97
Cook	3,868	5	774	41	38	79
Lake	10,415	5	2,083	41	N/R	41
St. Louis	198,213	7	28,316	73	47	120
Total	241,755	22	10,989	209	128	337
District 5						
Polk	32,498	5	6,500	49	37	86
District 6						
Becker	27,881	5	5,576	45	36	81
Mahnomen	5,044	5	1,009	41	N/R	41
Norman	7,975	5	1,595	38	N/R	38
Total	40,900	15	2,727	124	36	160
District 7						
Clay	50,422	5	10,084	N/R	40	40
Wilkin	7,516	5	1,503	40	34	74
Total	57,938	10	5,794	40	74	114
District 8						
Otter Tail	50,714	5	10,143	58	43	101
District 9						
Cass	21,791	5	4,358	57	48	105
Morrison	29,604	5	5,921	45	41	86
Todd	23,363	5	4,673	46	34	80
Wadena	13,154	5	2,631	51	31	82
Total	87,912	20	4,396	199	154	353
District 10						
Crow Wing	44,249	5	8,850	55	38	93

	Population	# of county commissioners	Pop. served per commissioner	SS Dir. Salary (000s)	Health Dir Salary (000s)	SS & PH Salaries (000s)
District 11						
Douglas	28,674	5	5,735	48	35	83
Grant	6,246	5	1,249	32	36	68
Pope	10,745	5	2,149	43	31	74
Stevens	10,634	5	2,127	40	37	77
Traverse	4,463	5	893	35	N/R	35
Total	60,762	25	2,430	198	139	337
District 12						
Stearns	118,791	5	23,758	66	62	128
District 13						
Benton	30,185	5	6,037	49	37	86
Sherburne	41,945	5	8,389	58	41	99
Total	72,130	10	7,213	107	78	185
District 14						
Isanti	25,921	5	5,184	51	40	91
Mille Lacs	18,670	5	3,734	42	30	72
Total	44,591	10	4,459	93	70	163
District 15						
Kanabec	12,802	5	2,560	48	28	76
Pine	21,264	5	4,253	47	38	85
Total	34,066	10	3,407	95	66	161
District 16						
Chisago	30,521	5	6,104	50	N/R	50
District 17						
Big Stone	6,285	5	1,257	36	N/R	36
Chippewa	13,228	5	2,646	49	N/R	49
Lac Qui Parle	8,924	5	1,785	36	N/R	36
Swift	10,724	5	2,145	36	30	66
Yellow Medicine	11,684	5	2,337	44	N/R	44
Total	50,845	25	2,034	201	30	231
District 18						
Kandiyohi	38,761	5	7,752	42	40	82
District 19						
Wright	68,710	5	13,742	60	43	103
District 20						
Hennepin	1,032,431	7	147,490	97	N/R	97
District 21						
Anoka	243,641	7	34,806	58	58	116
District 22						
Ramsey	485,765	7	69,395	69	57	126
District 23						
Washington	145,896	5	29,179	71	78	149

	Population	# of county commissioners	Pop. served per commissioner	SS Dir. Salary (000s)	Health Dir Salary (000s)	SS & PH Total salaries (000s)
District 24						
Lincoln	6,890	5	1,378	N/R	N/R	0
Lyon	24,789	5	4,958	53	30	83
Murray	9,660	5	1,932	N/R	N/R	0
Pipestone	10,491	5	2,098	31	N/R	31
Total	51,830	20	2,592	84	30	114
District 25						
Redwood	17,254	5	3,451	43	35	78
Renville	17,673	5	3,535	44	36	80
Total	34,927	10	3,493	87	71	158
District 26						
McLeod	32,030	5	6,406	49	39	88
Meeker	20,846	5	4,169	47	35	82
Sibley	14,366	5	2,873	49	38	87
Total	240,756	15	16,050	487	314	801
District 27						
Carver	47,915	5	9,583	57	52	109
District 28						
Scott	57,846	5	11,569	54	47	101
District 29						
Dakota	275,227	7	39,318	70	63	133
District 30						
Brown	26,984	5	5,397	43	40	83
Nicollet	28,076	5	5,615	45	37	82
Total	55,060	10	5,506	88	77	165
District 31						
LeSueur	23,239	5	4,648	39	31	70
Waseca	18,079	5	3,616	43	41	84
Total	41,318	10	4,132	82	72	154
District 32						
Rice	49,183	5	9,837	50	50	100
District 33						
Goodhue	40,690	5	8,138	59	39	98
Wabasha	19,744	5	3,949	39	39	78
Total	60,434	10	6,043	98	78	176
District 34						
Nobles	20,098	5	4,020	48	38	86
Rock	9,806	5	1,961	45	N/R	45
Total	29,904	10	2,990	93	38	131
District 35						
Cottonwood	12,694	5	2,539	39	N/R	39
Jackson	11,677	5	2,335	47	32	79
Total	24,371	10	2,437	86	32	48
District 36						
Watonwan	11,682	5	2,336	41	16	57
District 37						
Faribault	16,937	5	3,387	N/R	N/R	N/R
Martin	22,914	5	4,583	60	34	94
Total	39,851	10	3,985	60	34	94
District 38						
Blue Earth	54,044	5	10,809	57	40	97
District 39						
Dodge	15,731	5	3,146	38	38	76
Steele	30,729	5	6,146	43	41	84
Total	46,460	10	4,646	81	79	160
District 40						
Freeborn	33,060	5	6,612	53	34	87
District 41						
Mower	37,385	5	7,477	44	35	79
District 42						
Olmsted	106,470	5	21,294	61	43	104
District 43						
Winona	47,828	5	9,566	54	45	99
District 44						
Fillmore	20,777	5	4,155	39	33	72
Houston	18,497	5	3,699	39	32	71
Total	39,274	10	3,927	78	65	143
GRAND TOTAL	**4,375,099**	**445**	**9,832**	**$4,359**	**$2,786**	**$7,145**

Totals by county and district size

8 largest counties	2,606,434	50	52,129	$565	$408	$973
21 midsize counties	893,962	105	8,514	$1,062	$834	$1,896
58 smallest counties	874,703	290	3,016	$2,390	$1,342	$3,732
4–5 county districts	604,429	157	3,850	$1,288	$585	$1,873
3–county districts	351,243	45	7,805	$767	$486	$1,253
2–county districts	541,050	120	4,509	$1,010	$769	$1,709
1–county districts	3,051,891	113	27,008	$1,216	$881	$2,097
(excl. Hennepin)	2,019,460	106	19,052	$1,119	$881	$2,000

SS & PHN Director salaries per 10,000 population

$3.73	Largest 8 counties (100,000+ population)
$21.21	21 midsize counties (30,000–99,999 population)
$42.67	Smallest 58 counties (< 30,000 population)
$6.87	1–county districts (22 districts)
$9.90	(excluding Hennepin)
$32.88	2–county districts (12 districts)
$35.67	3–county districts (3 districts)
$30.99	4–5 county districts (7 districts)

* N/R means not reported. In most cases, this is because counties share one person for this position.

Sources: 1990 U.S. Census; Association of Minnesota Counties 1992 salary survey.

APPENDIX F

FISCAL ASSUMPTIONS

Recommendation 1: Establish Office of the Secretary of Health and Human Services: Savings of $497,700 the first year and $801,000 in subsequent years.

1. All personnel costs combined average or midpoint salaries with fringe benefits.
2. Numbers rounded to nearest 100.
3. Office and supply costs are not calculated. With a reduction of total positions, the costs could be expected to decrease.
4. Positions included in the Executive Office of the Secretary include:

One executive secretary @ $108,000	$ 108,000
One administrative clerical @ $ 39,000	39,000
Two chief officers @ $ 62,400	124,800
Three planning and policy professionals @ $ 56,000	168,000
One clerical support @ $ 32,500	32,500
SUBTOTAL	**$472,300**

5. Current agency positions replaced by executive office include:

5.5 deputy commissioners @ $ 80,600	$ 443,300
5.5 administrative coordinators @ $ 62,400	343,200
5.5 clerical support @ $ 32,500	178,800
5.5 planning and policy professionals @ $ 56,000	308,000
SUBTOTAL	**($ 1,273,300)**

6. One-time transition costs, including severance: 20 percent of executive salaries; 30 percent of other positions.

Deputy commissioners and administrative coordinators	$ 157,300
Professional and clerical support staff	146,000
SUBTOTAL	**$ 303,300**

Recommendation 2: Establish Health and Human Services Districts (HHSDs): Annual savings of $2,404,000 in county funds.

1. New districts would follow current CHS district boundaries.

2. Health and human services administrative and planning offices would be centralized for each district, allowing 104 health and social services director positions to be eliminated.

3. Savings are based on social services and public health director salary costs only. Potential savings in fringe benefits would be offset by the costs of layoffs, severance, or early retirement incentives.

4. Other staff reorganization for new HHSDs would be cost neutral.

5. Savings would be less if counties chose to hire additional staff with the salary savings.

6. Savings would be realized by the counties that currently are in a multi-county district but that do not share a Social Services or Public Health Nursing Director with other counties.

HHSD POTENTIAL SAVINGS	Social Service Directors Total	Public Health Directors Total	COMBINED TOTAL
Current expenditures for 21 small counties in a multi-county CHS district	$2,801,000	$1,703,000	$4,504,000
Proposed expenditures for 21 small counties joined into districts*	($1,218,000)	($882,000)	$(2,100,000)
Savings potential per year:	$1,583,000	$821,000	**$2,404,000**

* Based on average single-county district expenditure.
Source: Association of Minnesota Counties 1992 Salary Survey

Recommendations 3 and 4: Establish Service Equity and Create New HHSD Block Grant: Savings of $2,679,080 the first year and $7,881,080 in subsequent years.

The HHSD block grant allows counties to choose the most appropriate treatment setting for human services customers in need of residential care. Savings of approximately $2,679,080 in the first year and $7,881,080 in subsequent years are expected to result from new efficiencies in placements for some current residents of regional treatment centers (RTCs). This is based on the following assumptions:†

1. Based on the most recent (April 1991) RTC staff standardized client assessment, 42 percent of current mentally ill RTC residents could be appropriately served outside the RTC.

2. Ongoing state support for community alternatives would be necessary to support community care for these individuals. The level of community alternatives needed can be calculated based on:

   a. RTCs would stop serving the 400 "easiest" residents, most of whom have RTC stays of 2 to 12 months. For this group of residents, each RTC bed serves an

†Information provided by the Department of Human Services.

average of three people per year. Ten percent of the long-term MI residents would be more appropriately served in nursing facilities (see assumption c, below). Therefore, 90 percent of the 400 individuals would be suitable for community alternatives. This would require 1,080 community "slots" (400 x 90% x 3).

b. Occasional rehospitalization would be needed for people receiving community support services. DHS experience with community support programs indicates a hospitalization reduction of 60 to 70 percent. If current RTC beds represent 146,000 bed-days (400 beds x 365 days), about 30 percent of those bed-days will still be needed (43,800 bed-days). The table below reflects those 43,800 days of hospitalization at $460 per day in inpatient units of community hospitals. It is also assumed that federal reimbursement will be available through modification of the DRG payment system, or through a special MA contract that would allow payment over current DRG rates.

c. Needs assessment data indicated that the best setting for about 40 of the 1,080 people would be in community nursing facilities. The table below estimates their cost at the current average maximum metro "K" rate of $122 per day for FY 1992, plus 5 percent inflation per year through FY 1995.

d. The table below assumes flexible funding to provide individualized services to the individuals. It is assumed that the state will fully utilize federally reimbursable options such as personal care attendants and home health services. It is assumed that the average cost for MA-reimbursable services (including drugs and other ancillary services) will be $50 per day. MA funds will be supplemented by state and county funds to cover needs that are not MA reimbursable, estimated at an average of an additional $30 per day. Both the MA and non-MA figures represent total cost, and are reduced further by $10 each to reflect services currently being paid for through existing programs for those times of the year when these individuals are not in an RTC.

3. Assuming no cuts in current community capacity, annual costs to serve 400 current RTC residents (about 40 percent of the current total of mentally ill individuals in RTCs, excluding the Security Hospital) would be:

Estimated annual cost to provide community alternatives to 400 RTC MI beds	Total Cost	State Share
MA Grants: Periodic rehospitalization in community hospitals	$ 20,148,000	$ 9,268,080
MA Grants: Nursing facilities	2,061,962	948,503
MA Grants: Personal care, home health, day treatment, other ancillary services	15,768,000	7,253,280
State MH Grants: Community support, housing, crisis services	7,884,000	7,884,000
TOTAL	$ 45,861,962	$ 25,353,863
Average cost per day per bed eliminated	$ 314.12	$ 173.66

4. Based on RTC FY 1992 per diems and MI census, the average systemwide per diem for mentally ill individuals is $227.64, in state dollars. The state share cost for community care is $174 per day. The difference is a savings of $7.8 million a year:

RTC cost: $227.64 x 400 x 365 = ($ 33,235,440)
Community cost: $173.66 x 400 x 365 = $ 25,354,360
($ 7,881,080)

5. With closing of 400 RTC beds, a staff reduction at affected RTCs can be assumed. Based on the state RTC employee bargaining unit Memorandum of Understanding, employees can choose either another state job or enhanced severance pay. The enhanced severance packages include: cash payoff up to $7,500; normal severance (40 percent of sick leave); vacation payoff; uncontested unemployment claims; and six months of state-paid portion of individual health insurance. The following assumptions also apply:

   a. For 400 MI beds, there are:

Type of staff	FTEs	# of actual employees	% full-time	% part-time	Full-time employees	Part-time employees
Direct Care	475	589	63%	37%	371	218
General Support	60	66	80%	20%	53	13
				TOTAL	424	231

   b. Based on past experience, about 50 percent of employees can be expected to take another state job; about 50 percent can be expected to take the enhanced severance package.

   c. Full-time employee severance package totals $18,000; part-time employee severance package totals $12,000.

   d. Calculation:

424 employees · 50% · $18,000 = $3,816,000
231 employees · 50% · $12,000 = $1,386,000
$5,202,000 severance cost
(first year transition cost)

Adding the severance cost to the first-year net savings of $7,881,080 reduces total savings in the first year to $2,679,080.

ADDENDUM TO ANALYSIS OF RECOMMENDATIONS 3 and 4:

CORE staff prepared the last analysis based on data supplied by DHS. CORE staff then provided a draft of this appendix to DHS staff prior to publication. As a result, DHS

informed CORE that some of the original assumptions supplied by DHS were not entirely correct. DHS also expressed concern about the CORE comparison of RTC cost with community cost. Subsequent to a meeting that included CORE, DHS and Department of Finance staff, DHS determined that they would not be able to supply CORE with updated information.

The issues discussed were:

- Length of stay is probably longer than originally projected. The effect is that fewer community slots would be needed, reducing the total cost of community care.

- Although DHS originally stated that MA reimbursement for mentally ill individuals in RTCs was negligible, the agency later stated that there was a measurable amount of MA reimbursement. This has the effect of reducing RTC cost.

- The estimated present cost of community care seems to be very low in original DHS estimates. A revised estimate would have the effect of reducing the projected cost of community care.

- The cost of community service needed seems very high in the original DHS estimate. The effect of a revised estimate would be a lower community care cost.

As a result of this discussion, CORE speculates that the net effect of these potential changes could be a measurable increase in the projected savings.

ACKNOWLEDGMENTS

The CORE Program Analysis Working Committee members were: Jack Eugster, chair; John Brandl; Sen. Arlene Lesewski; Lee Luebbe; Kati Sasseville; Erma Vizenor; and Steve Watson.

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The project team included: Dorothy Bliss, Jan Buelow, Anne Kelly, and Dwight Lindstedt. Dorothy Bliss and Jan Buelow wrote the final report; Laura Iversen researched and wrote the section on the impact of the recommendations on services to the elderly. Nancy Feldman supervised the work of the team.

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