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Mission:

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential. Our values are:
• We focus on people, not programs.
• We provide ladders up and safety nets for the people we serve.
• We work in partnership with others; we cannot do it alone.
• We are accountable for results, first to the people we serve and, ultimately, to all Minnesotans.

DHS practices these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, diversity, justice, fairness and caring are of paramount importance.

Statewide Outcome(s):

Human Services supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

People in Minnesota are safe.

Context:

Minnesota's human services delivery system has a strong tradition of providing services for people in need and helping them live as independently as possible. The Minnesota Department of Human Services (DHS) plays a key role in that effort, along with Minnesota counties and tribes – which administer most direct services – and an array of community partners in the private sector. DHS provides oversight and direction for many health and human services programs, making sure providers meet service expectations. DHS employees also provide direct care and treatment to people with mental illness, chemical dependency and developmental disabilities as well as to individuals civilly committed for sex offender treatment.

Examples of the service administered by DHS include:

- An array of health care programs -- including Medical Assistance, MinnesotaCare, the Healthy Minnesota Contribution Program, and the Chemical Dependency Treatment Fund -- which purchase medical care and related home- and community-based services for children, the elderly and people with low incomes or disabilities.

- Economic support programs -- including the Minnesota Family Investment Program, the Diversionary Work Program, child support enforcement, child care assistance, Minnesota Supplemental Assistance, General Assistance, and the Supplemental Nutrition Assistance Program -- which provide assistance to Minnesotans in poverty or at risk of poverty as they work to re-establish their livelihoods.

- Child safety and well-being services designed to identify children subject to or at risk of abuse or neglect, and to intervene to improve the safety and quality of their home life or, if that isn't possible, to place them with safe and loving foster, relative or adoptive families.

- A number of grant programs to support local delivery of human services for a variety of populations in need, including recent refugee immigrant populations, adults and children with mental illness or substance abuse problems, people who are deaf or hard of hearing, vulnerable adults and the elderly.

- Direct care provided through a statewide array of community-based and residential services for people with mental illness, chemical dependency, developmental disabilities and/or an acquired brain injury, some of whom are civilly committed by the court because they may pose a risk to themselves or others.

- Inpatient services and treatment to people who are committed by the court as a sexual psychopathic personality or a sexually dangerous person.

Strategies:

DHS emphasizes several strategies across its budget activity and program areas to realize its mission and support the statewide outcomes listed above. The strategies currently emphasized within DHS are organized in four broad categories:

Provide smart care that keeps people healthy and in their homes and communities

- Keep more people fed and healthy by increasing nutrition assistance participation, especially for seniors.
- Better protect vulnerable adults, especially those directly in our care.
- Increase the number of Minnesotans served in their homes and communities rather than in institutions.
- Create pathways to employment.
- Increase access to affordable health care.
- Integrate primary care, behavioral health and long-term care.
- Launch a campaign to encourage people to plan for long-term care.
- Keep more children out of foster care and safely with their families.

Redesign our care delivery systems

- Institute payment reform in health care purchasing.
- Create a new partnership model for our work with counties and tribes.
- Use technology to increase our outreach through online applications, a new website and e-licensing initiatives.
- Develop secure alternatives for a select group of Minnesota Sex Offender Program clients.
- Develop integrated services through smarter use of technology.
- Implement MnCHOICES assessment model to better align services to individual needs.

Narrow disparities and improve outcomes

- Enhance capacity of our tribal partners to assume more direct service delivery
- Decrease the disproportionate number of children of color in out-of-home placements
- Narrow the health care quality gap between clients in publicly funded health care and private enrollees
- Increase enrollment outreach to communities of color
- Improve life expectancy for people with a serious mental illness
- Increase access to high quality child care

Reduce fraud, waste and abuse

- Establish Office of Inspector General to improve fraud prevention and lead to increased prosecutions and collections of overpayments.
- Expand field investigations through Medicaid Recovery Audit Contracts.
- Create new enforcement tools including background study expansion, data analytics and financial integrity standards in licensing.

Measuring Success:

The DHS Dashboard -- http://dashboard.dhs.state.mn.us/default.aspx -- provides Minnesotans with a simple way to track the department's progress toward key agency goals. Since June 2011, the DHS Dashboard has outlined and charted progress toward goals in four priority areas: people, innovation, equity and program integrity.

Human Services
Operations
http://www.dhs.state.mn.us/main/id_000261

Statewide Outcome(s):

Operations supports the following statewide outcome(s).

People in Minnesota are safe.

Efficient and accountable government services.

Context:

The Operations administration within the Minnesota Department of Human Services (DHS) provides the agencywide support and infrastructure needed for the effective and efficient delivery of human services. The work done in Operations ensures that federal and state compliance measures are in place and that proper fiscal accounting procedures are used in handling federal and state funds. The department's fraud prevention and detection efforts, which help ensure that public resources go to support those who need them by reducing fraud and abuse, are housed within Operations.

Operations works to ensure the necessary tools and capacity exist for the department's administrative work. Operations staff accomplish this by providing a wide variety of support services that include information and technology, human resource management, financial operations, facilities management and compliance services, as well as facilitating our work with our county and tribal partners. Primary customers for the Operations activities include human services staff, counties, tribes and community service providers.

Operations also provides direct program services that protect children and vulnerable adults as well as ensure fair and equal access to human services programs. Families, children and vulnerable adults need to be assured that the licensed facilities in which they receive care are safe and that people responsible for taking care of these family members, children and vulnerable adults meet service expectations. Operations staff license child and adult care programs, conduct fraud investigations related to human services program payments, and provide appeals processes for those who feel access to public services was wrongly reduced or ended. Primary customers include more than 289,000 individuals receiving care from a licensed service provider, individuals or providers receiving assistance or payments from human service programs and taxpayers.

Most Operations activities are funded through state general, health care access and special revenue funds and federal funds. Licensing activities are funded largely through special revenue fund proceeds from licenses and background study fees.

Strategies:

Operations functions fall generally into two categories: those efforts that support the effective and efficient delivery of human services and those efforts that contribute to keeping Minnesotans safe.

Effective and efficient delivery of human services - Operations provides the agencywide support and infrastructure required for the efficient and accountable delivery of human services. These activities include:

- Reducing fraud, waste and abuse. DHS created the Office of Inspector General (OIG) in August 2011. The OIG works to ensure government resources are going to those who need them by reducing fraud and abuse in the use and distribution of state and federal funds. The office is also using new tools to stop individuals and providers from receiving benefits and funds inappropriately.
- Providing an appeals process that helps ensure accountability and fairness for human services programs. Upon request, fair hearings are conducted for individuals or providers whose services, benefits or payments have been changed.
- Information and technology services, which includes day-to-day network maintenance and support and management of more than 300 system applications and several major statewide computer systems. The major systems, used by 87 counties and thousands of providers, are: (1) "Medicaid Management Information System" (MMIS), which processes Medical Assistance and MinnesotaCare claims; (2)

MAXIS, which is used by state and county workers to determine eligibility for public assistance and health care programs and to make public assistance payments; (3) "Providing Resources to Improve Support in Minnesota" (PRISM), which supports Minnesota's Child Support Enforcement program; and (4) "Social Service Information System" (SSIS), which is a county case management and data collection system for foster care, out-of-home placement, children's mental health, and adoption information.

- Financial operations. Staff develop agency budgets based on sound fiscal policy, provide accounting payment processes that ensure health care providers, child care providers or assistance recipients receive accurate and timely payments, and forecast program enrollment and expenditures to provide federal and state decision makers with sound fiscal estimates.
- Compliance services. Staff conduct operational and program evaluations, county audits, and reviews of grantees and contractors to ensure fiscal and compliance requirements are met.

Keeping people safe - Licensing activities help to ensure individuals receive services that meet accepted standards in safe, healthy environments. Staff conduct background studies to ensure that individuals providing direct care do not have disqualifying characteristics and conduct licensing reviews to ensure applicants and license holders comply with statutes and regulations. Operations licenses more than 23,000 service providers and conducts 252,000 background studies annually. Licensing activities also include conducting maltreatment investigations, removing individuals responsible for maltreatment from providing care services, and applying licensing sanctions when warranted to protect the health and safety of individuals. Licensing staff conduct approximately 950 maltreatment investigation each year.

A new Licensing Information Lookup website enables individuals to learn more about their care providers. In the first half of 2012, there was a 26 percent increase in the monthly number of visits to this website. This resource will continue to provide valuable information to Minnesotans as DHS strives to provide more relevant information about service providers on this website.

Operations supports several strategies in the agency's "Framework for the Future: 2012." https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG

- Establish Office of Inspector General to improve fraud prevention and lead to increased prosecutions and collections of overpayments
- Expand field investigations through Medicaid Recovery Audit Contracts
- Create new enforcement tools including background study expansion, data analytics and financial integrity standards in licensing
- Use technology to increase our outreach through online applications, a new website and e-licensing initiatives
- Create a new partnership model for our work with counties and tribes
- Enhance capacity of our tribal partners to assume more direct service delivery

Results:

Operations monitors and reports on key measures to tell us how well our strategies are working. DHS tracks the amount of funds recovered as a key measure of the effectiveness of OIG efforts. The Appeals Office tracks the timeliness with which appeals are heard and completed. This is important because there has been significant growth in the number of appeals that must be processed. (In FY 2008, the office closed out 6,482 appeals and in FY 2012, the office closed out 9,730 appeals.) Operations has added a performance measure to track usage of the Licensing Information Lookup website. We also track the number of licensing sanctions; these have remained relatively stable over the past four years. Our Minnesota IT Services (MN.IT) staff track the volume of information that is processed by one of the largest of the Department's major systems.

Performance Measures	Previous	Current	Trend
Funds received through recovery and investigation efforts from Medical Assistance (MA) providers[1]	$50 million	$68 million	Improving
Appeals cases closed out within statutory timelines[2]	91%	82%	Worsening
Use of Licensing Information Lookup website[3]	37,000 visits	50,000 visits	Improving

Performance Measures	Previous	Current	Trend
Number of Licensing sanctions[4]	859	888	Stable
Medicaid Management Information System (MMIS): Number of claims processed each month[5]	7.5 million	8.28 million	Improving

Performance Measures Notes:

1. Compares FY2008 (Previous) to FY2011 (Current). Source: DHS Dashboard data on Program Integrity – recovered funds: http://dashboard.dhs.state.mn.us/measure04.aspx
2. Compares the percentage closed within statutory timelines for FY 2008 (Previous) to FY 2012 (Current). Source: DHS monthly Appeals reports
3. Reports the number of unique visits that separate individuals made to the DHS Licensing Information Lookup website per month. Compares January 2012 (Previous) to July 2012 (Current). Source: DHS Licensing Information Lookup website: http://licensinglookup.dhs.state.mn.us
4. Compares 2008 (Previous) to 2011 (Current). Source: License Information System (LIS). The Licensing sanctions reported here include license revocations, suspensions, fines, conditional licenses and order of temporary immediate suspensions.
5. Compares July 2011 (Previous) to July 2012 (Current). Source: MN.ITS @ DHS MMIS reporting

Human Services
Children & Families

http://mn.gov/dhs/people-we-serve/children-and-families/

Statewide Outcome(s):

Children & Families supports the following statewide outcome(s).

Strong and stable families and communities.

People in Minnesota are safe.

Context:

Children & Families provides administrative support for programs serving low-income families, children, and low-income adults. This area includes administration of forecasted programs: the Minnesota Family Investment (MFIP) and Diversionary Work Programs, General Assistance, Group Residential Housing, Minnesota Supplemental Aid, and MFIP Child Care Assistance, as well as non-forecasted grant programs that provide funding for housing, food and child welfare services.

These services help to ensure that low-income people receive the support they need to be safe and help build stable families and communities. Programs administered in this area seek to keep more people fed and healthy by increasing nutrition assistance participation (especially for seniors), to keep more children out of foster care and safely with their families, to decrease the disproportionate number of children of color in out-of-home placements, and to increase access to high quality child care. Statewide administration of these programs ensures that federal funds are used in accordance with federal regulations, resources and services are distributed equitably across the state; and quality standards are maintained.

Funding includes a combination of state and federal dollars. Major federal block grants that support programs in this area include Temporary Assistance for Needy Families, the Child Care and Development Fund, the Social Services Block Grant and the Community Services Block Grants, totaling over $380 million a year. The Supplemental Nutrition Assistance Program (SNAP) is also administered in this area.

In 2011, an average of 469,904 people per month received help under the Supplemental Nutrition Assistance Program, and there were 17,716 reports of child abuse and neglect, involving 24,962 children.

Strategies:

Children & Families provides administrative direction and support to counties, tribes and community agencies. Support includes:

- Policy development and program implementation
- Grants management
- Training and technical assistance to counties, tribes and grantees
- Evaluation and auditing of service delivery and quality assurance reviews to ensure that effective services are delivered efficiently and consistently across the state.

This administration provides oversight of statewide child welfare services that focus on ensuring children's safety while supporting families, ensuring core safety services focus on preventing or remedying neglect, and providing basic food, housing and other supports to the most at-risk adults and children.

Children & Family Services supports the following strategies in the DHS Framework for the Future: 2012 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG):

- Keep people fed and healthy by increasing nutrition assistance participation by seniors through targeted outreach efforts
- Keep more children out of foster care and with their families
- Decrease the disproportionate number of children of color in out of home placements
- Increase access to high quality child care

- Create pathways to employment

Results:

Children & Families provides administrative support to a broad array of programs and services for low-income families and adults, and children. Included below are some key measures related to SNAP and child protection programs.

Performance Measures	Previous	Current	Trend
Percent of Children Not Experiencing Repeated Abuse or Neglect Within six Months of a Prior Report[1]	95.1%	95.6%	Improving
Percent of Children Either Reunified With Parents or Living With Relatives in Fewer than 12 Months from Last Removal from Home[1]	84.5%	85.7%	Improving
SNAP Participation Rate for All People in Poverty[2]	51%	56%	Improving

Performance Measures Notes:

1. Child Welfare Report, measurements compare 2010 data (previous) to 2011 data (current). http://www.dhs.state.mn.us/main/id_000152
2. Data on SNAP participation is for the years 2009 (previous) and 2010 (current) and come from the Food Support Access Index.

Human Services
Health Care
http://www.dhs.state.mn.us/id_006301

Statewide Outcome(s):

Health Care supports the following statewide outcome(s).

Minnesotans are healthy.

Context:

The Minnesota Department of Human Services (DHS) Health Care Administration is responsible for overseeing the development, operational components and federal and state compliance of Minnesota's public health care programs, including:

- *Medical Assistance* (MA, or Minnesota's Medicaid program), which provides coverage for an average of more than 660,000 low-income people each month, including children and families, people 65 or older, people who have disabilities and adults without children.
- *MinnesotaCare*, which is designed for Minnesotans who do not have access to affordable health care coverage. MinnesotaCare serves an average of 148,000 people each month, and can be critical to helping people leave welfare and go to work without losing health care coverage.
- *Healthy Minnesota Contribution Program*, which began July 1, 2012 and provides a subsidy for adults without children at the upper end of the MinnesotaCare income range to purchase private health care coverage in the individual insurance market.

Through these programs, the state pays all or part of enrollees' medical bills. In FY 2011, about 74 percent of DHS' all-funds (state and federal funds) budget was devoted to these programs. These programs provide a safety net for low-income families, the elderly, disabled and very low-income adults without children. When faced with no coverage, individuals often seek preventative care services in an emergency room setting or choose not to seek preventative care. Uninsured Minnesotans also receive care in an uncoordinated and uncompensated manner in disparate provider settings (as opposed to a primary care setting), and/or delay seeking health care for emerging conditions. All of these choices result in reduced health outcomes for Minnesotans and/or increased cost for taxpayers.

The goals of the DHS Health Care Administration (HCA) are to:

1. Reduce the number of uninsured Minnesotans, by helping eligible people get health care coverage and measuring the quality of this coverage to improve it;
2. Reform the payment and service delivery models for Minnesota's public health care programs, by designing our rates and systems to be transparent and of maximized value for the taxpayer dollar;
3. Utilize research, data and analysis to develop HCA initiatives, support DHS health care programs and evaluate results;
4. Employ technology solutions to reduce costs and improve services for applicants, members and providers; and
5. Encourage stakeholder communication across HCA, to promote understanding and support of Minnesota's public health care programs.

HCA is actively engaged in implementing federal and state health care reform initiatives, to maximize available opportunities and promote health reform.

Strategies:

HCA's operational components include eligibility policy, provider and member enrollment/relations, federal relations (with the Centers for Medicare & Medicaid Services, or CMS, which administers Medicaid federally), managed care enrollment and contracting, project management, purchasing and service delivery, claims processing, benefit recovery, system development and maintenance, performance measurement, and numerous other functions of a public health plan. (HCA shares some MA and MinnesotaCare coverage policy and rates

development functions with the DHS Continuing Care and Chemical and Mental Health Services administrations for those services.) HCA also develops improvements to the way we administer and deliver these programs.

DHS and HCA work with many stakeholders to help us determine how we can improve our health care programs:

Improve health outcomes of public health care recipients while lowering costs for taxpayers

- MA and MinnesotaCare provide coverage of care coordination services for people with chronic illnesses through physician clinics that are certified Health Care Homes.
- DHS, per legislative direction in 2011, is seeking federal approval to reform MA to achieve better outcomes for people with disabilities, seniors and other enrollees through the *Reform 2020* initiative. More information is available online at http://www.dhs.state.mn.us/main/dhs16_166654
- DHS is submitting a grant application for a CMS Innovation Challenge for the "Strong Start for Mothers and Babies" initiative, to decrease disparities in birth outcomes for infants from communities of color.
- DHS is working with many partners to launch the Money Follows the Person Rebalancing Demonstration Program, aimed at increasing the number of Minnesotans with disabilities served in their homes and communities rather than in institutions. (See http://www.dhs.state.mn.us/dhs16_162194
- DHS is partnering with the Minnesota Department of Health to help MA and MinnesotaCare enrollees prevent diabetes and other chronic disease by participating in the YMCA's Diabetes Prevention Program and receiving other incentives for healthy behavior. Funded through a five-year grant, this program will help clients improve their health while lowering state health care spending for chronic conditions.

Integrate primary care, behavioral health and long-term care

Minnesota will see large growth in cost and utilization of long-term care services as Minnesota's population ages. We can save money, reduce duplication of services and improve the health of our recipients if we better integrate our health care services. Some examples include:

- As part of *Reform 2020*, DHS is building on current state initiatives to improve performance of primary care and care coordination models for dual Medicare-Medicaid eligibles. Part of this focus is on primary care payment reform, and the consistent measurement and improvement in clinical outcomes. More information about this component of the overall reform is available at http://www.dhs.state.mn.us/main/dhs16_163573

- DHS is developing a grant project to integrate primary care and behavioral health care.
- DHS is partnering with Hennepin County on an innovative pilot project to test new strategies to better deliver human services to high-needs populations. This new demonstration, Hennepin Health, will provide a system that integrates medical, behavioral health and county human services for up to 10,000 low-income Minnesotans in a patient-centered model of care, improving patient outcomes while reducing overall costs.

Institute payment reform in health care purchasing

HCA is negotiating with potential Health Care Delivery System (HCDS) sites to begin full operation by January 2013. HCDS demonstration projects will contract directly with providers in a new way that allows them to share in savings for improving quality of care and patient experience and reducing the total cost of care for Medicaid enrollees. In this new model, MA enrollees will receive more coordinated care to improve their overall health, and health care providers will be paid based on the quality of care they provide to their patients and their ability to reduce the cost of care.

HCA's work also supports the following strategies in the DHS Framework for the Future: 2012 https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG

- Increase access to affordable health care
- Integrate primary care, behavioral health and long-term care
- Institute payment reform in health care purchasing
- Use technology to increase our outreach through online applications, a new website and e-licensing initiatives
- Narrow the health care quality gap between clients in publicly-funded health care and private enrollees
- Increase enrollment outreach to communities of color.

Results:

Minnesota is consistently a national leader in promoting and implementing policy and payment initiatives that improve access, quality, and cost-effectiveness of services provided through publicly funded health care programs. We monitor performance measures that help us get at key actions and strategies. If DHS can quickly reimburse providers who serve our recipients, these providers may be more apt to serve recipients of Minnesota's public health care programs. Timely disposition of applications greatly improves access to health care coverage for eligible customers. Treating people in emergency rooms is more expensive than keeping them healthy to begin with, so it makes sense to get people the primary care they need. This last performance measure needs improvement, since providing people with insurance offers access to the kind of preventive care that keeps costs down and helps people live better lives.

Performance Measures	Previous	Current	Trend
Percent of electronically submitted claims paid within two days[1]	98.4%	98.5%	Stable
Average number of days to process MinnesotaCare applications[2]	32 days	25 days	Improving
Percent of Minnesotans lacking health care insurance[3]	9%	9.1%	Stable

Performance Measures Notes:

1. Source: DHS Data Warehouse, measured quarterly. Compares Fiscal year 2012, 2nd Quarter (Previous) to Fiscal year 2012 3rd Quarter (Current). The goal is to continue to pay 98 percent of electronically submitted claims within two days.
2. Source: DHS HCEA Operations, measured quarterly. Compares Fiscal year 2012, 1st Quarter (Previous) to Fiscal year 2012 2nd Quarter (Current). The goal is to process applications for MinnesotaCare within thirty days.
3. Source: Minnesota Department of Health Access Survey (conducted semiannually). Compares 2009 (Previous) to 2011 (Current). Nearly three-fourths of the uninsured have some potential access to coverage but do not take advantage of it.

Human Services
Continuing Care
http://www.dhs.state.mn.us/main/dhs16_166609#

Statewide Outcome(s):

Continuing Care supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Continuing Care serves older Minnesotans and Minnesotans with disabilities who need long-term care services, including persons with physical or developmental disabilities, impairment due to chronic illness, deafness or hearing loss, mental illness and HIV/AIDS. These populations have a variety of needs including assistance with activities of daily living such as bathing and dressing, communication assistance, medical needs and behavioral supports, and advocacy and protective services. Continuing care services help support these populations to remain independent in their communities and so avoid costly institutionalization. Minnesota is required by federal law to provide services to eligible seniors and people with disabilities through Medicaid.

The Continuing Care Administration (CCA) is the administration within the Minnesota Department of Human Services (DHS) responsible for long-term care programs and services for people with disabilities and older Minnesotans with a variety of different needs and their families. The CCA mission is to improve the dignity, health and independence of the people we serve.

The Continuing Care Administration has four goals:

- Support and enhance the quality of life for older people and people with disabilities;
- Manage an equitable and sustainable long-term care system that maximizes value;
- Continuously improve how we administer services; and
- Promote professional excellence and engagement in our work.

The Continuing Care Administration is funded with state, federal and special revenue funds. The employees in Continuing Care administer more than $3.3 billion annually in state and federal funds serving over 400,000 Minnesotans annually.

Strategies:

Continuing Care functions are to:

1. Administer Medical Assistance (MA) long-term care programs (waivers and state plan services), which includes developing, seeking authority for and implementing policies, projects, and research. This includes administering state and federal grants and contracts, including the new Money Follows the Person Rebalancing Demonstration Program
2. Provide information, education, assistance, advocacy and direct service, including overseeing the state's adult protective services system.
3. Manage nursing home, Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD), and Day Training and Habilitation (DT&H) provider rates.
4. Assure service quality, conduct evaluations and measure results.
5. Staff the Governor-appointed MN Board on Aging (http://www.mnaging.org), the Ombudsman for Long-Term Care, numerous stakeholder work groups, and the Commission of Deaf, Deafblind and Hard of Hearing Minnesotans, a state agency housed within DHS (http://mn.gov/deaf-commission).
6. Provide administrative, financial, and operational management and support.
7. Provide technical assistance to stakeholders.

In addition to the normal administrative functions, which apply to all people served, Continuing Care staff perform unique specialized activities. Direct service functions include:

- Statewide regional service centers that help deaf, deafblind, and hard-of-hearing people access community resources and the human services system;
- The Telephone Equipment Distribution Program, which helps people with hearing loss or communication disabilities access the telephone with specialized equipment;
- HIV/AIDS programs that help people obtain and maintain needed health care coverage;
- Older Minnesotan ombudsman services, which assist consumers in resolving complaints and preserving access to services; and
- Online education in American Sign Language and advocacy in education, employment, health care, technology, public access, voter engagement and heritage.

Continuing Care supports the following strategies in the DHS Framework for the Future: 2012 https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG

- Keep people fed and healthy by increasing nutrition assistance participation by seniors through targeted outreach efforts
- Better protect vulnerable adults, especially those directly in our care
- Increase the number of Minnesotans served in their homes and communities rather than in institutions
- Implement MnCHOICES assessment model to better align services to individual needs

Results:

Continuing Care utilizes a variety of information sources and data to monitor and evaluate quality outcomes and provider performance to help us see how our strategies are working. Much of the information analyzed is from the DHS Data Warehouse or from various surveys of consumers, providers, and lead agencies.

Performance Measures	Previous	Current	Trend
1. Percent of waiver review follow-up cases corrected after issuance of corrective actions	84%	94%	Improving
2. Average statewide risk-adjusted nursing facility quality of care score out of a possible 100 points	69.6	70.8	Improving
3. Percent of working age consumers on disability waiver programs with earnings	43.9%	43.6%	Stable

Performance Measures Notes:

1. Measure one compares 2010 data (Previous) to 2011 data (Current). 2010 data is earliest available. Source: Waiver review database
2. Measure two compares CY 2008 data (Previous) to CY 2010 data (Current). Source: Minimum Data Set resident assessments.
3. Measure three compares CY 2008 data (Previous) to CY 2011 data (Current). Measure includes all disability waiver programs. Source: DHS Data Warehouse.

More information is available on the DHS Dashboard: http://dashboard.dhs.state.mn.us/ and the Continuing Care Performance Report: http://www.dhs.state.mn.us/main/dhs16_166609#

Human Services
Chemical & Mental Health

http://www.dhs.state.mn.us/main/id_000162; http://www.dhs.state.mn.us/main/id_000085; http://www.dhs.state.mn.us/main/id_000082

Statewide Outcome(s):

The Chemical & Mental Health Services Administration supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

In order to meet the shifting needs of adults with mental illness, children with an emotional disturbance or those struggling with substance abuse problems, the Department of Human Services (DHS) Chemical and Mental Health Services Administration (CMHS) works to ensure that the state has an accessible and comprehensive system for delivering treatment and supports for persons with mental illness and/or substance addiction.

The life expectancy of persons with serious mental illness is, on average, 25 years shorter than the general population. The causes of physical illness and death among people with serious mental illness are the same as those in other groups - smoking, obesity, diabetes - and are just as treatable.

About half of persons who have a serious mental illness also have a substance use problem. Research has found that integrating mental health and chemical dependency treatment is more effective than parallel services or completing treatment in one specific area (i.e. mental health) and then receiving treatment in the other area (i.e. chemical dependency).

Finally, the impact of traumatic experiences on the mental, physical and developmental health of children is coming to the forefront as an issue that must be dealt with. Trauma is common in the lives of children, and is ubiquitous across the child welfare population. Unmediated trauma creates toxic stress in the form of increased cortisol level, which interrupts the development of brain architecture in young children and produces chronic health and mental health problems in older children and youth through effects on the immune system. From there, negative life course consequences accrue, including school and employment problems, chronic health conditions, substance abuse, justice system involvement and early mortality and morbidity. The wide distribution of research studies on adverse childhood experiences (ACE) and early brain development has led to national attention on trauma-informed care, spearheaded by the Administration for Children and Families.

Strategies:

The three divisions within CMHS shape and implement state policy around mental health and chemical dependency treatment and prevention services. They work in close partnership with the continuing care, health care and state operated services arms of the department. Collaborative partners within state government include the departments of Health, Economic Development, Housing Finance and Corrections. External partners include tribes, counties, advocacy organizations a large array of treatment and supportive services providers health plans, professional training colleges, universities and research institutions. Among the key strategies now being pursued by CMHS staff are:

- Administering grants for mental health and substance abuse treatment, prevention, ancillary services and capacity development.
- Taking the lead role in coordinating and implementing mental and chemical health policy in the department's health care programs, county human services programs, licensing activities and continuing care programs.
- Working to better integrate chemical and mental health with primary health care and continuing care. One of the concrete goals within this effort is to increase the average lifespan of Minnesotans with Bipolar Disorder or Schizophrenia by ten years within the next ten years, known as the MN 10 by 10 Initiative. CMHS is also partnering with the Department of Health and the Institute for Clinical Systems to expand

training for primary care clinicians, emergency departments and mental health professionals on screening, brief intervention and referral to treatment (SBIRT) of persons with substance use disorders.

- Working to integrate health care for children and schools to improve access to prevention and early intervention services by reaching families in normal, non-stigmatizing environments and, ultimately, improving effectiveness of care by coordinating comprehensive assessment, evidence-based treatment, and outcomes measurement across several child-serving systems.
- Improving access to evidence-based care by providing training and incentives for the provision of treatment and supportive service models that have been proven effective through nationally recognized research, including Integrated Dual Disorders Treatment (IDDT), Assertive Community Treatment (ACT) and Illness Self-management and Recovery. CMHS continues to train clinicians serving children and youth in the use of the Minnesota Evidence-Based Practices Database and to collect individual treatment outcomes using standardized instruments.
- Launching statewide practice changes to implement trauma-informed care—based on the latest research from the University Minnesota, Kaiser Permanente, and the Centers for Disease Control and Prevention. Working with child welfare, public health, schools, and others, to prevent and remediate the lasting effects of adverse childhood experiences, CMHS will develop providers' capacity to reduce the long-term effects of traumatic events when they occur.
- Finally, Leading the State Substance Abuse Strategy group to implement the 2012 Minnesota State Substance Abuse Strategy Report recommendations related to prevention and treatment for abuse of opioids such as Oxycontin and heroin.

CMHS supports the following strategies in the DHS Framework for the Future: 2012
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG

- Increase the number of Minnesotans served in their homes and communities rather than in institutions.
- Integrate primary care, behavioral health and long-term care.
- Improve life expectancy for people with a serious mental illness.

Results:

Performance Measures	Previous	Current	Trend
Percent of Children in the child welfare system who received a metal health screening.[1]	55.3%	56.6%	Improving
The percent of adults in Assertive Community Treatment (ACT) who receive an annual comprehensive preventative physical exam.[2]	26.5%	27.8%	Improving
Percent of youth who report using alcohol in the past 30 days in funded communities.[3]	33.4%	23.5%	Improving
Number of mental health professionals trained annually in Trauma-Informed Care.[4]	new	23	Improving

Performance Measures Notes:

1. With parental consent, counties conduct mental health screenings for children in the child welfare and juvenile justice systems who have not had a recent assessment. The Previous measure is Calendar Year 2009; the Current measure is CY 2010. (DHS Public Dashboard)
2. Compares CY 2010 (Previous) and CY 2011 (Current). The measure is based on ACT recipients who are not Medicare eligible and who are enrolled 12 months in MA or MinnesotaCare. (DHS Public Dashboard)
3. Compares state Fiscal Year 2004 (Previous) and SFY 2010 (Current) as reported in the Minnesota Student Survey in communities receiving substance abuse prevention grant funds. The Department goal is to reduce this rate annually. (DHS internal performance tracking.)
4. Establish base measure for a new priority. Current year is CY 2012. Source: DHS Central Office Learning Center

Human Services
MFIP/DWP Grants
http://www.dhs.state.mn.us/main/id_004112

Statewide Outcome(s):

Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP) Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans have the education and skills needed to achieve their goals.

Context:

MFIP/DWP Grants provide temporary financial support to help meet the basic needs of low-income families with children and low-income pregnant women. Half the parents enrolled in MFIP or DWP were employed in the quarter before they turned to assistance. Common causes for job losses are layoff, reduced hours, birth of a baby by a parent with no leave time, need to care for an ill or disabled child or spouse, or transportation and child care costs that wages do not cover. MFIP benefits include both financial and nutrition assistance. For those leaving the program with employment, the Work Benefit (WB) provides a small monthly cash payment for a limited time. DWP provides up to four months of financial support designed to meet specific crisis situations and help families move immediately to employment. The goal of these programs is to stabilize families and improve economic outcomes through employment. Without these benefits, families would not have the resources to meet their basic needs.

In FY 2011, an average of 116,428 people per month received help through these programs, 70 percent of whom were children. The average monthly payment per person was $245, including the food portion of MFIP.

These programs are funded with a combination of state funds and federal Temporary Assistance for Needy Families (TANF) funds. MFIP/DWP Grants are administered by counties and tribes.

Strategies:

MFIP/DWP Grants provides financial assistance to help meet the basic needs of low-income families with children and to improve economic outcomes through employment.

- Parents are required to participate in employment services, to develop the skills necessary to move into the labor market as soon as possible.
- Under MFIP, families receive time-limited cash and food assistance benefits based on family size. The benefits are structured to reward families who work and are gradually reduced as income rises. Participants must engage in work-related activities to continue receiving assistance.
- DWP is focused on rapid entry into employment and provides up to four months of intensive job search assistance.
- WB provides a small cash payment ($25) for up to 24 months to help working families remain off assistance.

Success for families receiving assistance depends not only on the services delivered by counties, community agencies and tribes, but also on referrals and connections to the social services and health care system. This combination of financial assistance, employment services, and supports for children and adults helps to build on strengths to move families into the labor market and out of poverty. Helping parents become employed is directly related to the health of the economy. During the recession, more focus has been placed on training to develop the skills needed during the continuing recovery.

MFIP/DWP works together with related Department of Human Services (DHS) programs such as Support Services Grants and MFIP Child Care Assistance Grants. Those provide other supports such as employment and training services, transporation, and child care to ensure parents are able to participate in activities and accept employment.

Results:

Success in MFIP is measured in several ways. Two key measures are:

- The Self-Support Index is a Minnesota specific outcome measure that reflects the number of families who leave assistance or who are working at least 30 hours per week, and
- The federal measure for MFIP is the Work Participation Rate (WPR). The WPR is a process measure that reflects the number of hours parents are participating in a small number of approved actitivities.

Performance Measures	Previous	Current	Trend
Minnesota Self-Support Index	69%	67%	Worsening
Work Participation Rate	29.8%	40.2%	Improving

Performance Measures Notes:

1. The MFIP Self-Support Index compares 2010 (previous) and 2011(current).
2. TANF Work Participation Rate by Federal Fiscal Year, compares 2009 (previous) and 2010 (current).

For more information on these programs:
Minnesota Family Investment Program: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5830-ENG
Diversionary Work Program: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5848-ENG
Work Benefit: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5837-ENG

Human Services
MFIP Child Care Assistance Grants

http://www.dhs.state.mn.us/main/id_008688#

Statewide Outcome(s):

MFIP Child Care Assistance Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans have the education and skills needed to achieve their goals.

Context:

About three-quarters of Minnesota households with children ages 12 and younger use child care. These families are challenged to knit together child care that fits their preferences and needs, and is affordable, according to a 2009 study commissioned by the Minnesota Department of Human Services and conducted by Wilder Research. In households with low incomes, 20 percent of parents reported that child care problems interfered with their getting or keeping a job in the past year. Without this program, many low-income families would not be able to pay for child care and would be unable to work or pursue education leading to work.

The Minnesota Family Investment Program (MFIP) Child Care Assistance Grants provide financial subsidies to help low-income families pay for child care so that parents may pursue employment or education leading to employment, and so children are well-cared for and prepared to enter school ready to learn. MFIP child care serves families who currently participate in the MFIP or Diversionary Work Program (DWP), or who have recently done so. In FY 2011, an average of 9,798 families with 17,498 children per month were served with a monthly average payment of $961 per family. State law determines the maximum rates this program will pay to providers and providers are paid at the rate charged up to this limit. All families who meet eligibility requirements may receive this help. This program is funded with state and federal funds that include the federal Child Care and Development Fund and the Temporary Assistance for Needy Families (TANF) fund. Counties administer the Child Care Assistance Program.

Strategies:

MFIP Child Care Assistance Grants provide supports to help improve outcomes for the most at-risk children and their families by increasing access to high quality child care.

- Receipt of child care assistance helps families with low incomes access quality child care. Families choose their providers in the private child care market. Maximum rates paid through the program are set for each type of care: center-based, family child care and legal non-licensed child care.
- A higher reimbursement rate is paid to child care providers who provide high quality child care. Participation in high quality care increases the likelihood of improved school readiness.

Results:

Maximum rates paid to providers under the child care assistance program may not cover the full cost of care because they are not based on the current market rates. This may be a barrier to parents' access to many of the child care providers in their communities. The percent of child care provider rates that are fully covered by the Child Care Assistance Program is worsening. If maximum rates are held constant or reduced, this trend will continue as rates in the private child care market increase.

High quality early child care and education experiences are associated with better child outcomes, particularly for children from low-income families. Up to a 15 percent higher maximum rate is paid to providers who meet certain accreditation or education standards established in statute. In 2011 and 2012, one-fifth of the children served by the Child Care Assistance Program received care from a provider who met these quality standards.

Performance Measures	Previous	Current	Trend
Percent of Child Care Providers Covered by Maximum Rates –	38.4%	27.6%	Worsening

Performance Measures	Previous	Current	Trend
Family Child Care[1]			
Percent of Child Care Providers Covered by Maximum Rates – Center Child Care[1]	32.5%	20.6%	Worsening
Percent of Children Receiving Child Care Assistance who are in Accredited Programs[2]	19.3%	20.0%	Stable

Performance Measures Notes:

1. Child Care Assistance Program Family Profile, 2010 (Previous), 2011 (Current). http://www.dhs.state.mn.us/main/groups/economic_support/documents/pub/dhs_id_057781.pdf
2. Quality Child Care Assistance Children and Family Services Dashboard, 2011 (Previous), 2012 (Current).

For additional information on the Child Care Assistance Programs see:https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4745-ENG

Human Services
General Assistance Grants
http://www.dhs.state.mn.us/main/id_002558#

Statewide Outcome(s):

General Assistance Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

General Assistance (GA) Grants provide state-funded, monthly cash grants for people without children who have very limited income and are unable to fully support themselves. Without additional income supports these individual would likely fall further into poverty and become homeless. The most common eligibility reason for people at enrollment is illness or incapacity (67 percent). 32 percent of those eligible have applied for other income benefits such as Supplemental Security Income (SSI) or Retirement, Survivors and Disability Income. The GA grant helps meet some of their basic and emergency needs. In SFY 2011, an average of 20,963 people per month received an average monthly payment of $165. People who become eligible for SSI are no longer eligible for GA and become eligible for Minnesota Supplemental Aid (MSA) to supplement their SSI income.

GA helps to address homelessness and poverty in Minnesota and is funded through the state general fund.

Strategies:

General Assistance is the primary safety net for people without children who are unable to work and do not have enough money to meet their basic needs. Many people receive these benefits while they wait for more stable assistance such as Supplemental Security Income, a federal income supplement program that helps aged, blind and disabled people who have little or no income.

- GA contributes to stabilizing crisis situations, avoiding homelessness, and making connections to other resources, resulting in better outcomes.
- The department works with the Social Security Administration and the state's Disability Linkage Line® to identify possible ways to streamline the disability determination process, and connects recipients with resources to assist in the SSI application process.
- The Department of Human Services works with counties, tribes, homeless service providers and other non-profit advocacy agencies to advise on and administer the GA program.

Results:

Recipients of GA who appear to meet SSI eligibility criteria are required to apply for SSI or Social Security Disability Insurance (SSDI). SSI eligibles must sign an Interim Assistance Agreement which allows the state to recoup some of the GA dollars when the person receives other benefits such as SSI. Approval for SSI results in higher and more stable income for aged, blind and disabled adults. When SSI is approved, the state is reimbursed for GA payments made for the retroactive time period that matches the SSI approval.

Performance Measures	Previous	Current	Trend
Percent of GA Recipients Required to Apply for SSI	33%	31%	Stable

Performance Measures Notes:

“Percent of GA Recipients Required to Apply for SSI” is the number of people receiving GA who signed an Interim Assistance Agreement. Data compares 2010 (Previous) to 2011 (Current).

Human Services
Minnesota Supplemental Aid Grants

Website: http://www.dhs.state.mn.us/main/id_004114#

Statewide Outcome(s):

Minnesota Supplemental Aid (MSA) Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Minnesota Supplemental Aid (MSA) grants help to address homelessness and poverty in Minnesota. MSA Grants provide a state-funded monthly cash supplement to help people who are aged, blind or disabled, and who receive federal Supplemental Security Income (SSI) benefits to meet their basic needs that are not met by SSI alone. Nearly half of MSA recipients are age 60 or older and 79 percent are disabled. MSA grants are intended to cover basic need items and other daily or special necessities. Some recipients who do not receive SSI because their income is too high may still be eligible for MSA if they meet other eligibility criteria.

In SFY 2011, an average of 30,000 people per month received an average monthly MSA supplement of $91. This supplements a typical monthly SSI benefit is $698 for an individual living alone.

Minnesota established the MSA program in 1974. Federal maintenance of effort regulations require that states maintain payment levels that were in effect in March 1983 or the state risks losing Medicaid federal financial participation. The program serves as the supplement to Minnesota recipients of the SSI program. People who become eligible for SSI are no longer eligible for GA and become eligible for MSA to supplement their SSI income.

Strategies:

The Department of Human Services works with counties, tribes, the Social Security Administration, service providers, and other non-profit advocacy agencies to identify persons eligible for the program and to advise and administer MSA program policy.

Results:

People who receive SSI are categorically eligible for MSA, but must apply for benefits. While the MSA program has had stable enrollment of around 30,000 individuals over time, the number of adults who receive SSI but do not receive MSA is increasing. This is an indicator that people are not fully accessing the benefits they are eligible to receive. While further analysis is needed, some of the increase may be due to small differences in policies which could be addressed through a change in MSA policy.

Performance Measure	Previous	Current	Trend
Number of Adults on SSI with no MSA	38,870	45,518	Worsening

Performance Measures Notes:

*Social Security Research, Statistics, & Policy Analysis – “SSI Recipients by State and County” data compares 2010 (previous) and 2011 (current), www.ssa.gov/policy/docs/statcomps/ssi_sc/

Human Services
Group Residential Housing Grants

Website: http://www.dhs.state.mn.us/main/id_002549#

Statewide Outcome(s):

Group Residential Housing Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Group Residential Housing (GRH) is a state-funded income supplement program that pays for room and board costs for low-income adults who have been placed in a licensed or registered setting. GRH Grants assist individuals who have illnesses or disabilities, including developmental disabilities, mental illnesses, chemical dependency, physical disabilities, advanced age, or brain injuries, to prevent or reduce institutionalization or homelessness. Approximately 16 percent of GRH recipients are seniors, and those who are younger than 65 years of age all have a combination of factors that limit their self-sufficiency. Without GRH, program recipients likely would be in institutional placements or homeless.

In FY 2011, an average of 18,200 people received GRH payments each month. The average monthly GRH payment per person was $530. The GRH program is funded with state general fund dollars and receives some federal funding for food and nutrition costs.

Strategies:

GRH provides an income supplement used to cover room and board and other necessary housing-related services for aged, blind, ill or disabled individuals to prevent or reduce homelessness and institutional residence. Without this aid, program recipients would likely be in institutional placements or homeless.

- Participants are encouraged to seek earned income opportunities.
- Individuals who also receive General Assistance are required to apply for federal Supplemental Security Income.

The Department of Human Services works with counties, tribes, residential housing service providers, community agencies, and other state agencies, including the Department of Health and the Minnesota Housing Finance Agency to deliver these services. Counties contract with GRH facilities to establish the monthly room & board rate.

Results:

An increase in the number of GRH recipients who are no longer homeless indicates an improvement in the prevention and reduction of homelessness. Performance trends are impacted by the availability of affordable housing in the community, general community economic health, and the availability of employment opportunities.

Performance Measures	Previous	Current	Trend
Number of GRH Recipients Who Are No Longer Homeless	867	1224	Improving

Performance Measures Notes:

Information regarding GRH recipients who are no longer homeless is based on department data on individuals receiving Housing First housing with services. Housing First is a national model that provides housing and support services to maintain an individual's housing. Comparison years are December 2010 (Previous) and December 2011 (Current).

Human Services
Minnesota Care
http://www.dhs.state.mn.us/main/id_006255

Statewide Outcome(s):

Minnesota Care supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Many working Minnesotans cannot afford – or do not have – health insurance coverage options available through their employer(s). The MinnesotaCare program provides health care coverage for low-income, working families and adults in Minnesota with higher income levels than the Medical Assistance program, who do not have access to affordable health insurance individually or through their employer. Populations covered under MinnesotaCare include pregnant women, children, parents/caretakers, and adults without children. In FY 2011, MinnesotaCare covered approximately 148,000 people in an average month.

MinnesotaCare covers preventive services and well-child visits, physician services, ambulance and emergency room services, laboratory and x-ray services, prescription drugs, chiropractic services, rehabilitative therapy, vision care, chemical dependency treatment and mental health services, inpatient and outpatient hospital care, immunizations, medical transportation, dental care, and services through rural health clinics, federally qualified health centers, and Indian health. All adults without children and parents at the upper income levels receive some lesser benefits than other populations on MinnesotaCare, most significant of which is a $10,000 limit to hospital services.

Families and individuals seeking coverage under MinnesotaCare can apply directly to the state (MinnesotaCare state operations) or through their county. DHS contracts with non-profit health plans to provide health care services through their provider networks to MinnesotaCare enrollees. Except for certain low-income children, applicants are not eligible if they have other health insurance (including Medicare), have access to coverage through their employer and the employer's share of the premium is 50 percent or more, have had access to such coverage in the past 18 months, or have had other insurance within the past four months. There are no health condition barriers, but MinnesotaCare applicants must pay a premium, meet income guidelines and other requirements to qualify. Enrollees pay a premium based on income. The average enrollee premium for FY 2011 was $22 per person per month. The premium for some low-income children was $4 per month until July 1, 2012, when the premium for those children went down to zero. The full list of MinnesotaCare populations, income and asset limits is online at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4346-ENG.

MinnesotaCare is funded with appropriations from the health care access fund, from federal Medicaid funds, and from enrollee premiums.

Approximately 50,000 adults without children on MinnesotaCare moved to the Medical Assistance (MA) program under the MA early expansion that became effective March 1, 2011. As of July 1, 2012, some MinnesotaCare adults without children at the upper end of the income range (above 200 percent of the Federal Poverty Guidelines) moved to the new Healthy Minnesota Contribution Program, which provides a subsidy for adults without children to purchase private health care coverage in the individual market.

Strategies:

DHS works with many stakeholders to determine how we can improve our health care programs. Here are some examples of how DHS is working toward program improvements:

Improving health outcomes of public health care program recipients while lowering costs for taxpayers

- MinnesotaCare provides coverage of care coordination services for people with chronic illnesses through physician clinics that are certified Health Care Homes.

- DHS, per legislative direction in 2011, is seeking federal approval to reform Minnesota's public health care programs to achieve better outcomes for people with disabilities, seniors and other enrollees through the Reform 2020 initiative. More information is available online at http://www.dhs.state.mn.us/main/dhs16_166654
- DHS is submitting a grant application for a CMS Innovation Challenge for the "Strong Start for Mothers and Babies" initiative, to decrease disparities in birth outcomes for infants from communities of color.
- DHS is partnering with the Minnesota Department of Health to help public health care program enrollees prevent diabetes and other chronic disease by participating in the YMCA's Diabetes Prevention Program and receiving other incentives for healthy behavior.

Integrate primary care, behavioral health and long-term care
DHS is developing a grant project to integrate primary care and behavioral health care. This grant project includes the development of a methodology to identify children who are considered "socially complex" and would benefit from medical care coordination.

Institute payment reform in health care purchasing
DHS is negotiating with potential Health Care Delivery System (HCDS) sites to begin full operation by January 2013. HCDS demonstration projects will contract directly with providers in a new way that allows them to share in savings for improving quality of care and patient experience and reducing the total cost of care for public health care program enrollees. In this new model, MinnesotaCare enrollees will receive more coordinated care to improve their overall health, and health care providers will be paid based on the quality of care they provide to their patients and their ability to reduce the cost of care.

Results:

Performance Measures	Previous	Current	Trend
Percent of Minnesotans lacking health insurance[1]	9%	9.1%	Stable
Percent of children receiving well-child visits[2]	40.3%	42.1%	Improving
Number of clinics certified as health care homes[3]	0	155	Improving

Performance Measures Notes:

1. Measure is the percent of Minnesotans that do not have health insurance. Nearly three-fourths of the uninsured have some potential access to coverage but do not take advantage of it. Source: Minnesota Department of Health, Health Access Survey (measured semi-annually). Compares 2009 (Previous) to 2011 (Current).
2. Measure is the percentage of children who receive six well child visits (e.g. age-specific preventive visits and screenings) by 15 months of age through their health care provider. Source DHS Data Warehouse (measured annually). Compares calendar year 2009 (Previous) and CY 2010 (Current).
3. Measure is the number of physician clinics certified by the Minnesota Department of Health as health care homes that provide care coordination services for people with chronic illnesses. Source: Minnesota Department of Health (measured quarterly). Compares the beginning of CY 2011 (Previous) and CY 2011 fourth quarter (Current).

Human Services
GAMC

Statewide Outcome(s):

GAMC supports the following statewide outcome(s).

Minnesotans are healthy.

Context:

GAMC (General Assistance Medical Care) ended on June 1, 2010. GAMC was a state entitlement program that paid for health care services for very low income single adults ineligible for Medical Assistance or other state or federal health care programs. Health care coverage provided through GAMC was 100 percent paid for with state General Fund dollars.

Strategies:

To bring an orderly close to the GAMC program, department staff must properly manage the tails of remaining GAMC financial obligations. In the FY 2012-13 biennium, this work included: making the last managed care withhold payments; making negative accounting adjustments when disability determinations made GAMC recipients retroactively eligible for Medical Assistance; and managing a settle up payment process for hospitals that provided care to GAMC recipients before June 1, 2010.

Moving forward, department staff will continue to appropriately manage any remaining hospital settlement payments relating to the old GAMC program. (Laws 2011, First Special Session Chapter 9, Article 10, Section 2, Subd. 2, https://www.revisor.mn.gov/data/revisor/law/2011/1/2011-SP1-009.pdf#page=210 rider "Payments for Cost Settlements")

Results:

N/A

Performance Measures	Previous	Current	Trend
N/A			

Performance Measures Notes:

Human Services
Medical Assistance
http://www.dhs.state.mn.us/MA

Statewide Outcome(s):

Medical Assistance supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Medical Assistance (MA) is Minnesota's Medicaid program that provides comprehensive coverage to the lowest-income families and individuals not able to afford coverage. Medical services covered by MA include preventive care, primary and specialty medical care, dental, mental health and chemical dependency services and long-term care coverage. The goal of this joint federal-state program is to avoid impoverishing low income elderly and disabled people due to high health care costs, and to provide basic health care coverage for very low income families and children. These services also help support older people and people with disabilities to function more independently in their homes and communities or in institutional settings. MA has lower income guidelines than MinnesotaCare, does not have premiums or insurance barriers, and pays for previously incurred medical bills. MA is funded with general fund appropriations and federal Medicaid funds. In fiscal year 2011, MA served a monthly average of 665,483 people and had total spending (federal, state and local) of $7.5 billion, of which $3 billion was the Minnesota state budget share.

Share of MA Total Enrollment and Payments by Population in FY2011

MA Population	Share of Total Enrollment[1]	Share of Total Payments[2]
Families with children[3]	70%	30%
Elderly	8%	22%
Disabled	18%	47%
Adults without children[4]	4%	1%

Notes: [1] Enrollment figures are based on a 12-month average.
[2] Payments include withhold payments to health plans in the year paid. Payments do not include an offset for pharmacy rebates.
[3] Families with children payments include payments relating to Emergency MA, Family Planning Waiver, and Breast and Cervical Cancer coverage.
[4] Adults with no children coverage began in March 2011.

The Minnesota Depertment of Human Services (DHS) partners with all 87 Minnesota counties to administer the MA program, and enrolls or contracts with most health care providers and health plans across the state to deliver care to MA enrollees. MA enrollees fall under one of five general categories:

1. MA Coverage of Basic Health Care for Elderly and Disabled

In FY2011, this segment of MA funds supported an average of 174,491 people per month (many of whom are also enrolled in Medicare as "dual eligibles"). The state budget share of this spending was $944.28 million. Recipients of these services are low-income elderly (65 years or older) and people who are blind or have a disability, who receive health care coverage or financial assistance to help them pay for their Medicare premiums and cost sharing/copayments (this approach is often cheaper than if the state provided their health coverage).

This segment of the MA program also includes employed persons with disabilities (a monthly average of over 7900 working people), who receive full MA coverage under the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program. This program encourages people with disabilities to work and enjoy the benefits

of being employed by allowing working people with disabilities to qualify for MA under higher income and asset limits than standard MA. More information on MA-EPD is available online at http://www.dhs.state.mn.us/id_004088

2. MA Coverage of Care through Long-Term Care Waivers & Home Care
In FY2011, this segment of MA funds supported an average of 54,780 people per month. The state budget share of spending was $888.78 million. Recipients of MA LTC waivers and home care services are low-income Minnesotans who are elderly or have disabilities. These long-term care services and health care-related supports enable them to live as independently as possible in their communities.

"LTC waivers" refer to home and community-based services (HCBS) available under a federal Medicaid waiver. These programs are called waivers because they allow states to "waive" the Medicaid rules that require individuals to be served in institutional settings. Waivers are available to people who qualify for MA and who have certain levels of need, within available funding. More information on the HCBS waiver programs is online at http://www.dhs.state.mn.us/id_003726#.

3. MA Coverage of Care in Long-Term Care Facilities
In FY2011, this segment of MA funds supported an average of 19,308 people per month. The state budget share of spending was $377.44 million. Recipients of these services are elderly or have disabilities, reside in a nursing facility, and receive 24-hour care and supervision in an institutional-based setting, including nursing care, help with activities of daily living and other care needs, including housing, meals, and medication administration. More information on nursing facilities is online at
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5961-ENG

This segment of the MA program also includes services to persons with developmental disabilities who receive 24-hour care, active treatment in intermediate care facilities (ICFs/DD). ICF/DD residents may also receive day training and habilitation (DT&H) services. DT&H services help people with disabilities develop and maintain life skills, participate in the community, and engage in productive and satisfying activities.

4. MA Coverage of Basic Health Care for Families with Children
In FY 2011, this segment of MA funds supported an average of 463,151 people per month. The state budget share of spending was $791.21 million. Recipients of this health care coverage are often the poorest Minnesotans, and include low income pregnant women, children, and parents/caretakers.

This segment of the MA program also includes funding for the Minnesota Family Planning Program (MFPP), which provides coverage of family planning and related health care services for people not currently enrolled in MA or MinnesotaCare.

5. MA Coverage for Adults without Children
In the four-month period from March–June 2011, this segment of the MA program served an average of 82,800 people per month. The state budget share of spending was $50.78 million. Recipients of this health care coverage are single adults with income at or below 75 percent of the federal poverty guidelines ($8,388 per year). Federal law allows all states to expand MA eligibility to cover adults with no children effective January 2014, and allowed some states to expand coverage to low income adults without children earlier. Minnesota expanded its MA program to this population beginning March 1, 2011.

The full list of Medical Assistance populations, income and asset limits is online at http://edocs.dhs.state.mn.us/lfserver/Public/DHS-4346-ENG. For more information on expenditures and enrollment, go to http://www.dhs.state.mn.us/main/id_016358, scroll down to "Background Data Tables for the Expenditure Forecast," and click on "Background data tables for February 2012."

Strategies:

DHS works with many stakeholders to determine how we can improve our health care programs. Here are some examples of how DHS is working toward improvements in MA:

Improve health outcomes of Medicaid recipients while lowering costs for taxpayers

- MA provides coverage of care coordination services for people with chronic illnesses through physician clinics that are certified Health Care Homes.

- DHS, per legislative direction in 2011, is seeking federal approval to reform MA to achieve better outcomes for people with disabilities, seniors and other enrollees through the *Reform 2020* initiative. More information is available online at http://www.dhs.state.mn.us/main/dhs16_166654.
- DHS is submitting a grant application for a CMS Innovation Challenge for the "Strong Start for Mothers and Babies" initiative, to decrease disparities in birth outcomes for infants from communities of color.
- DHS is working with many partners to launch the Money Follows the Person Rebalancing Demonstration Program, aimed at increasing the number of Minnesotans with disabilities served in their homes and communities rather than in institutions. (See http://www.dhs.state.mn.us/main/dhs16_162194).
- DHS is partnering with the MN Department of Health to help MA enrollees prevent diabetes and other chronic disease by participating in the YMCA's Diabetes Prevention Program and receiving other incentives for healthy behavior.

Integrate primary care, behavioral health and long-term care

Minnesota will see large growth in cost and utilization of long-term care services as Minnesota's population ages. We can control cost growth, reduce duplication of services and improve the health of our recipients if we better integrate our health care services. Some examples include:

- As part of *Reform 2020*, DHS is building on current state initiatives to improve performance of primary care and care coordination models for dual Medicare-Medicaid eligibles. Part of this focus is on primary care payment reform. More information about this component of the overall reform is available online at http://www.dhs.state.mn.us/dhs16_163573
- DHS launched the "*Own Your Future*" public awareness campaign to encourage Minnesotans to plan for aging care needs and increase the number of Minnesotans who take action to address and provide for their future long-term care.
- DHS is developing a grant project to integrate primary care and behavioral health care.
- DHS submitted the Long-Term Care Realignment waiver proposal to CMS in February of 2012 to request federal authority to implement the new nursing facility level of care criteria.
- DHS is partnering with Hennepin County on an innovative pilot project to test new strategies to better deliver human services to high-needs populations by integrating medical, behavioral health and county human services for up to 10,000 low-income Minnesotans.

Institute payment reform in health care purchasing

DHS is negotiating with potential Health Care Delivery System (HCDS) sites to begin full operation by January 2013. HCDS demonstration projects will contract directly with providers in a new way that allows them to share in savings for improving quality of care and patient experience and reducing the total cost of care for Medicaid enrollees. In this new model, MA enrollees will receive more coordinated care to improve their overall health, and health care providers will be paid based on the quality of care they provide to their patients and their ability to reduce the cost of care.

Results:

Performance Measures	Previous	Current	Trend
1. Percent of Minnesotans lacking health insurance	9%	9.1%	Stable
2. Percent of children receiving well-child visits	40.3%	42.1%	Improving
3. Number of clinics certified as health care homes	0	155	Improving
4. Percent of seniors served by home and community-based services	54%	62.4%	Improving
5. Percent of people with disabilities served by home and community-based services	92%	94.5%	Improving

Performance Measures Notes:

1. Measure is the percent of Minnesotans that do not have health insurance. Nearly three-fourths of the uninsured have some potential access to coverage but do not take advantage of it. Source: Minnesota Department of Health, *Health Access Survey,* measured semi-annually. Compares 2009 (Previous) to 2011 (Current).

2. Measure is the percent of children who receive six well child visits (e.g. age-specific preventive visits and screenings) by 15 months of age through their health care provider. Source: DHS Data Warehouse, measured annually. Compares calendar year 2009 (Previous) and CY 2010 (Current) data
3. Measure is the number of physician clinics certified by the Minnesota Department of Health as health care homes that provide care coordination services for people with chronic illnesses. Source: Minnesota Department of Health, measured quarterly. Previous measure represents the beginning of CY 2011; current measure is CY 2011 forth quarter.
4. Measure is the percent of older adults receiving publicly funded long-term care services who receive home and community-based services (HCBS) through the Elderly Waiver or Alternative Care program instead of services in nursing homes. Source: DHS Data Warehouse. Compares FY 2007 (Previous) and FY 2011 (Current) data.
5. Measure is the percent of people with disabilities receiving publicly funded long-term care services who receive HCBS services through disability waiver or home care programs instead of services in nursing homes or Intermediate Care Facilities. Source: DHS Data Warehouse. Compares FY 2007 (Previous) and FY 2011 (Current) data.

More information is available on the DHS Dashboard: http://dashboard.dhs.state.mn.us.

Human Services
Alternative Care
http://www.dhs.state.mn.us/main/dhs16_137084

Statewide Outcome(s):

Alternative Care supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans are healthy.

Context:

Between now and 2030, Minnesota will experience the most profound age shift in its history. Along with the rest of the nation and the world, we will become older not just as individuals but as a society. The baby boomers—1.5 million strong in Minnesota—are leading us into this uncharted territory as they begin to age. By 2030, we will have 1.3 million persons over 65, or one out of every four Minnesotans. Later, in 2050, we will have the largest number ever of people over 85. Over two-thirds of persons age 85 and older have at least one disability. Older persons are more likely to have multiple disabilities, and each of these chronic conditions poses a challenge to the individual's ability to live independently. Therefore, Minnesotans' need for community-based long-term care services, which are usually not covered by Medicare, will continue to increase. Alternative Care services support seniors, their families, caregivers and communities to enable seniors to stay in their homes and communities and avoid costly institutionalization.

The Alternative Care (AC) Program is a state-funded, cost-sharing program that supports certain home- and community-based services for eligible Minnesotans age 65 and over. The program provides services to prevent and delay transitions to Medical Assistance-funded services, such as Elderly Waiver and nursing home care. The program helps prevent the impoverishment of eligible seniors and shares the cost of care with individuals on the program by maximizing use of their own resources. It is available to individuals who need the level of care provided in a nursing home but choose to receive services in the community, and whose income and assets would be inadequate to fund a nursing home stay for more than 135 days.

The AC program served a monthly average of 3,086 older Minnesotans in FY 2011, at an average monthly cost of $769. The program is funded with state funds along with monthly program participation fees paid by the client. Payments made by the state for AC services are subject to estate recovery.

Strategies:

Alternative Care services are delivered in a person's own home. AC covers the following services: adult day services, caregiver assessment, case management, chore services, companion services, consumer-directed community supports, home health aides, home-delivered meals, homemaker services, environmental accessibility adaptations, nutrition services, personal emergency response system, personal care, respite care, skilled nursing, specialized equipment and supplies, training and support for family caregivers and transportation.

DHS partners with community providers, counties, tribal health entities and the Department of Health in administering and monitoring AC services.

More information is available on the Alternative Care fact sheet:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4720-ENG.

Results:

Improvement in the percentage of seniors supported in their own homes rather than institutions contributes to the Statewide Outcome of strong and stable families and communities. We monitor performance measures that help us see how our strategies in this program are working. Measures we track include the percentage of elderly receiving publicly funded long-term care services who receive home and community-based long-term care services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services; and the percentage of public long-term care funding for seniors that is spent on Elderly Waiver, Alternative Care or home care services instead of nursing home services. We also measure the proportion of AC spending that is

used for Consumer-Directed Community Supports, which is a newer approach that gives participants more flexibility and responsibility for directing their own services and supports - compared to services provided through the traditional program – including hiring and managing direct care staff.

Performance Measures	Previous	Current	Trend
Percent of elderly served by home and community-based services[1]	54%	62.4%	Improving
Percent of long-term care spending for home and community-based services for elderly[2]	34.1%	42.7%	Improving
Percent of AC spending on Consumer-Directed Community Supports (CDCS)[3]	1.6%	4.2%	Improving

Performance Measures Notes:

1. Compares FY 2007 (Previous) to FY2011 (Current) data. Source: DHS Data Warehouse
2. Compares 2007 (Previous) to 2011 (Current) data. Source: DHS Data Warehouse
3. Compares FY 2007 (Previous) to FY2011 (Current) data. This is a 197 percent increase over five years. Source: DHS Data Warehouse.

More information is available on the Continuing Care Performance Reports webpage at http://www.dhs.state.mn.us/main/dhs16_166609# and the DHS Dashboard: http://dashboard.dhs.state.mn.us.

Human Services
CD Treatment Fund

http://www.dhs.state.mn.us/adad

Statewide Outcome(s):

The CD Treatment Fund supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Chemical addiction can affect persons of any age, race, religion, or income. According to the 2006 Substance Abuse and Mental Health Service (SAMHSA) National Survey on Drug Use, 22.6 million people, or 9.2 percent, of people in the U.S aged 12 and older were chemically dependent. Chemical dependence broke down as follows: 3.2 million people were dependent on both drugs and alcohol, 3.8 million were dependent on drugs alone, and 15.6 million were dependent on alcohol alone. Of this 22.6 million people, only 1.6 percent received treatment. Without treatment, the consequences of substance use for the individual and society are staggering. It includes unnecessary disability, unemployment, mental illness, homelessness, incarceration, and suicide.

The Consolidated Chemical Dependency Treatment Fund (CCDTF) provides funding for residential and non-residential addiction treatment services for eligible low-income Minnesotans who have been assessed as needing treatment for chemical abuse or dependency. Approximately 50 percent of all CD treatment admissions for Minnesota residents are paid for through the CCDTF. Almost all treatment providers in the state are enrolled as CCDTF providers.

The CCDTF combines otherwise separate funding sources – MA, Minnesota Care, other state appropriations and the federal Substance Abuse, Prevention and Treatment block grant – into a single fund with a common set of eligibility criteria, and a single process for evaluating and placing persons with substance abuse problems in appropriate treatment. Counties also contribute a share toward the cost of treatment, paying 15 percent of treatment costs for Medicaid recipients and 22.95 percent for non-Medicaid recipients. Federal Medical Assistance Percentage (FMAP) is collected on the treatment program services provided to Medicaid recipients.

Minnesota Statutes, section 254B.01 Subd.3 defines chemical dependency services payable by the CCDTF. This definition applies to a wide variety of services applicable within a service continuum of care.

Strategies:

A uniform, statewide process for determining eligibility and evaluating treatment needs is the primary strategy by which the CCDTF allocates is resources. For those eligible for Medicaid, DHS has permission from the Centers for Medicare and Medicaid Services to predicate access to treatment based in the results of a standardized clinical evaluation. Minnesota Indian tribes, counties, and state contracted managed care organizations are defined as *placing authorities.* Counties and Indian tribes assess and place persons who meet both clinical (Rule 25 - Minnesota Rules 9530.6600 through 9530.6655) and financial eligibility (Rule 24 - Minnesota Rules 9530.6800 through 9530.7030). State contracted MCO's are required to use the same assessment tools to provided assessment and placement for their enrollees.

The CCDTF also provides the CD treatment services for all Medical Assistance and Minnesota Care clients enrolled on a fee-for-service basis. Because of this, it is imperative that the CCDTF adapt and align with the ongoing changes in the state's health care programs. Recently, coordination between fee-for-service and state contracted managed health care plans presents a number of challenges.

- Managed Care Organization billing systems do not accommodate the specificity of the current CCDTF rate structure, requiring manual processing by the MCOs.
- CD treatment providers bear the burden of coordinating funding streams when recipients move between managed care and fee-for-service coverage.

- While the fee-for-service and managed care plans have identical benefit sets for CD treatment services, the federal rules for financial participation in MCO capitation payments results in an awkward system where MCO's initially pay residential-non-hospital CD providers for both treatment program services and room and board services, and then must obtain reimbursement for the room and board from the CCDTF.

Results:

Treatment completion has been found to be a strong indicator of continued sobriety after treatment. While there has been a small decrease in the percentage of clients completing treatment, there is also concern as to how trends of reduced authorizations for treatment might reflect emerging barriers to both access to and completion of treatment.

The CCDTF was designed to allow funding to follow clients to clinically appropriate services. Persons who obtain treatment through the CCDTF must obtain placement authorization through their local county or tribal placing authority. For fiscal years (FY) 2010, 2011, and 2012, the number of clients authorized varies by placing authority. Placements tabulated for FY 2012 indicate that 13 counties/tribes authorized an increase in placements over FY 2011. However, across all counties and tribes, there is a 19 percent average reduction in the number of placements. For those same placements, the average dollar amount authorized was also reduced from an average of $9,245.67 to $6,258.67. The department plans further analysis to identify and then ameliorate any negative impact of non-clinical considerations on access and provision of treatment.

Performance Measures	Previous	Current	Trend
Percent of persons completing chemical dependency treatment[1]	61.2%	60.3%	Worsening
Reduction from admission to discharge of the percent of clients who report use of alcohol in the past 30 days past use of alcohol[2]	33.0%	32.5%	Stable
Number of persons accessing chemical dependency treatment[3]	49,610	47,742	Worsening

Performance Measures Notes:

NOTE: Measures in this section are based on reports from all CD treatment admissions, not just those funded through public funds.

(1) Previous year represents Fiscal Year 2009 and current year represents FY 2010.
(2) Change in percent of clients who reported alcohol use within the last 30 days at time of admission and then on discharge. Previous figures from calendar year (CY) 2009 (Admit 48.2 percent, Discharge 15.2 percent) Current figures from CY 2010 (Admit 46.7 percent, Discharge 14.2 percent).
(3) Previous year represents FY 2010 and current year represents FY 2011.

Human Services
Support Services Grants
http://www.dhs.state.mn.us/main/id_004112

Statewide Outcome(s):

Support Services Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans have the education and skills needed to achieve their goals.

Context:

Half the parents who apply for the Minnesota Family Investment Program (MFIP) were employed in the quarter they turned to assistance. Common causes for the recent job losses are layoff, reduced hours, illness, birth of a baby to a parent with no leave time, need to care for an ill or disabled child or spouse, or transportation and child care costs that wages do not cover.

Support Services Grants provide funding for job counselors to help parents participate in work activities, including searching for jobs and addressing barriers to employment. Without these funds, families would not receive supports in moving to work and help in meeting emergency needs. Support Services Grants include funding for an array of employment services including job search, job placement, training, education, and other supports such as emergency needs for low-income families with children. These grants fund a portion of county administration of the Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP). Also included are funds for employment supports for adults who receive benefits through the Supplemental Nutrition Assistance Program, or SNAP. (For more information on the SNAP Employment and Training Program, http://www.dhs.state.mn.us/main/id_002556)

Support Services grants are allocated to counties and tribes to provide these services and are funded with a combination of state and federal funds, including Temporary Assistance for Needy Families (TANF). In 2011, on average more than 35,000 people were enrolled in employment services each month.

Strategies:

Support Services Grants covers costs of services to create pathways to employment by addressing barriers, helping stabilize families and adults, and by building skills that ensure participants are prepared to find and retain employment. Services are delivered by Workforce Centers, counties, tribes, and community agencies. Service providers evaluate the needs of each participant and develop an individualized employment plan that builds on strengths and addresses areas of need. Services include:

- Help to stabilize housing and to access child care, medical benefits, chemical and mental health services;
- Basic education, English proficiency training, skill building and education programs to prepare participants for the labor market;
- Job search assistance and job placement services to help participants locate employment that matches skills and abilities; and
- Innovative programs to address special populations or needs such as a single point of contact for teen parents that includes public health home visits, subsidized work experiences, integrated services for families with serious disabilities, and support for the FastTRAC program, which links education and credentials to high demand careers.

Results:

Success for families and adults receiving assistance depends on the services delivered by counties, community agencies and tribes and on referrals and connections to the social service and health care system. Helping parents become employed is directly related to the health of the economy. During the recession more focus has been placed on training to develop the skills that will be needed during the continuing recovery.

Success in MFIP is measured in several ways. Two key measures are:

- The Self-Support Index, which is a Minnesota outcome measure that reflects the number of families who leave assistance or who are working at least 30 hours per week.
- The federal measure for MFIP, which is the Work Participation Rate (WPR). The WPR is a process measure that reflects the number of hours parents are participating in a small number of work activities.

Performance Measures	Previous	Current	Trend
Minnesota Self-Support Index	69%	67%	Worsening
Federal Work Participation Rate	29.8%	40.2%	Improving

Performance Measures Notes:

1. MFIP Self-Support Index, 2010 (Previous), 2011 (Current).
2. TANF Work Participation Rate 2009 (Previous), 2010 (Current).

Human Services
BSF Child Care Assistance Grants
http://www.dhs.state.mn.us/main/id_008688#

Statewide Outcome(s):

Basic Sliding Fee Child Care Assistance Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans have the education and skills needed to achieve their goals.

Context:

About three-quarters of Minnesota households with children ages 12 and younger use child care. These families are challenged to knit together child care that fits their preferences and needs, and is affordable, according to a 2009 study commissioned by the Minnesota Department of Human Services and conducted by Wilder Research. In households with low incomes, 20 percent of parents reported that child care problems interfered with their getting or keeping a job in the past year. Without this program, many low-income families would not be able to pay for child care and would be unable to work or pursue education leading to work.

Basic Sliding Fee (BSF) Child Care Assistance Grants provide financial subsidies to help low-income families who are not participating in the Minnesota Family Investment Program or the Diversionary Work Program pay for child care so that parents may pursue employment or education leading to employment, and so children are well-cared for and prepared to enter school ready to learn. In FY 2011, an average of 10,090 families with 17,978 children per month was served, with a monthly average payment of $814 per family. State law determines the maximum rates the program will pay to providers. This program is funded with county, state and federal funds that include the federal Child Care and Development Fund and the Temporary Assistance for Needy Families (TANF) fund. Not all families who meet eligibility requirements under this program receive benefits because funding is capped at a specific amount each year. Counties administer the Child Care Assistance Program.

Strategies:

The BSF program provides supports to help improve outcomes for the most at-risk children and their families by increasing access to high quality child care.

- Receipt of child care assistance helps families with low incomes access quality child care. Families choose their providers in the private child care market. Maximum rates paid through the program are set for each type of care: center-based, family child care, and legal non-licensed care.
- A higher reimbursement rate is paid to child care providers who provide high quality child care. Participation in high quality care increases the likelihood of improved school readiness.

Results:

Maximum rates paid to providers under the child care assistance program may not cover the full cost of care because they are not based on the current market rates. This may be a barrier to parents' access to many of the child care providers in their communities. The percent of child care provider rates that are fully covered by the Child Care Assistance Program is worsening. If maximum rates are held constant or reduced, this trend will continue as rates in the private child care market increase.

High quality early child care and education experiences are associated with better child outcomes, particularly for children from low-income families. Up to a 15 percent higher maximum rate is paid to providers who meet certain accreditation or education standards established in statute. In 2011 and 2012, one-fifth of the children served by the Child Care Assistance Program received care from a provider who met these quality standards.

Basic Sliding Fee funds are allocated to counties. Counties sometimes do not have adequate funds to serve all families who apply, in which case they are placed on a waiting list. Other counties do not spend all available funds. This results in unspent funds in some counties while families are being added to a waiting list in other counties.

Performance Measures	Previous	Current	Trend
Percent of Child Care Providers Covered by Maximum Rates – Family Child Care[1]	38.4%	27.6%	Worsening
Percent of Child Care Providers Covered by Maximum Rates – Center Child Care[1]	32.5%	20.6%	Worsening
Percent of Children Receiving Child Care Assistance who are in Accredited Programs[2]	19.3%	20.0%	Stable
Basic Sliding Fee Waiting List[3]	4,661	7,551	Worsening

Performance Measures Notes:

1. Child Care Assistance Program Family Profile, 2010 (Previous), 2011 (Current). http://www.dhs.state.mn.us/main/groups/economic_support/documents/pub/dhs_id_057781.pdf
2. Quality Child Care Assistance, Children and Family Services Dashboard, 2011 (Previous), 2012 (Current).
3. Child Care Assistance Program Waiting List; May 2011 (Previous), 2012 (Current). May 2012 link: http://www.dhs.state.mn.us/main/groups/economic_support/documents/pub/dhs_id_057782.pdf

For additional information on the Child Care Assistance Programs, see:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4745-ENG

Human Services
Child Care Development Grants
http://www.dhs.state.mn.us/main/id_008689#

Statewide Outcome(s):

Child Care Development Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans have the education and skills needed to achieve their goals.

Context:

The first few years of children's lives are key to their intellectual, emotional and social development. Everyone wants to know that children are being well cared for while family members are at work or school. High quality child care that is available and affordable is important to children's safety, healthy development, and families' self-sufficiency.

Child Care Development Grants promote services to improve school readiness, and the quality and availability of child care in Minnesota. These services include consumer education to parents and the public, and activities that help parents choose care for more than 230,000 Minnesota children cared for in licensed child care settings. Services include development and implementation of a an early childhood quality rating and improvement system called Parent Aware, and grants, consultation and financial supports to Minnesota's 13,000 licensed child care providers to improve quality. These grants are funded primarily with federal Child Care and Development Funds with additional federal support from Minnesota's Race to the Top-Early Learning Challenge grant and some state funds.

It is important that all children and their families have access to high-quality child care and education programs. These grants provide leadership and support to programs working to increase the availability of quality care and education in Minnesota.

Strategies:

The Department of Human Services works with public and private agencies and individuals to promote school readiness through education and training. Grants are used to improve the quality of early childhood and school-age care, and increase access to high quality care, especially for high-need children. Grants help parents support their children's success through information about child care by providing:

- Information to families and communities through Minnesota's Child Care Resource & Referral parent referral services and Parent Aware;
- Grants and financial supports to providers for quality improvement;
- Training, coaching, consultation and other workforce supports for early childhood and school-age care providers to increase their knowledge and skills in child development, instructional practices and ways to meet the needs of individual children; and
- Reimbursements to child care programs and providers to cover some of the fees associated with completing accreditation with a nationally recognized child care accreditation program.

Results:

Performance Measures	Previous	Current	Trend
Referrals to Parents Made by Child Care Resource & Referral Agencies[1]	22,181	22,427	Stable
Number of Child Care Centers Receiving Reimbursement for Accreditation Fees[2]	28	49	Improving
Number of Family Child Care Programs Receiving Reimbursement for Accreditation Fees[2]	2	16	Improving

Performance Measures Notes:

1. Data is from a report produced by Wilder Research, “Results of Referral Outcomes Follow-up Surveys, July 2009 through June 2010” (Previous) and “Results of Referral Outcomes Follow-up Surveys, July 2010 through June 2011” (Current).
2. Family child care and center-based programs are reimbursed for one-half of the direct cost of accreditation fees, upon successful completion of accreditation with a nationally recognized child care accreditation program. Compares 2011 (Previous) and 2012 (Current), as tracked by the Department of Human Services.

Human Services
Child Support Enforcement Grants
http://www.dhs.state.mn.us/main/id_000160#

Statewide Outcome(s):

Child Support Enforcement Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Context:

Every child needs financial and emotional support, and every child has the right to support from both parents. Minnesota's child support program benefits children by enforcing parental responsibility for their support. According to *Custodial Mothers and Fathers and Their Child Support: 2009*, a report released by the U.S. Census Bureau in December 2011, Americans who pay child support provide an average of $430 per month to custodial parents of those children. Child support represents a high proportion of income for lower income custodial parents. Among custodial parents below the poverty level who received the full amount of ordered payments in 2009, child support represented an average of 62.6 percent of their annual individual income. Conversly, among custodial parents of all income levels, child support payments received represented 16.1 percent of their average annual individual income in 2009. In 2010, 26.8 percent of all custodial parents sought government assistance in collecting child support.

Child Support Enforcement Grants help strengthen families by providing concrete financial supports. Child Support is an important component to help families be self-sufficient. Child support enforcement is administered by counties acting under state direction and supervision. These grants assure that assistance in obtaining basic support, medical support and child care support is available to children through locating parents, establishing paternity and support obligations. Without these supports, many custodial families would not have the financial resources to become self-sufficient. Additional grants provide federal funding to improve non-custodial parents' access to their children. Funding is a mix of federal grants, state general fund and fees.

County and state child support offices provide services to more than 395,000 custodial and non-custodial parents and their 268,000 children. In 2011, the child support program collected and disbursed $602 million in child support. Access and visitation funds served 347 families in FY 2011.

Strategies:

Working with counties and tribes, the following activities help to support and stabilize families:

- Establish paternity: Establish legal parentage through genetic testing, Recognition of Parentage or other means;
- Establish and modify court orders: Establish court orders for child support, medical support and child care support, based on statutory guidelines;
- Enforce court orders: Assure payment of court-ordered support through remedies established in federal regulation and state law, such as income withholding, driver's license suspension, and passport denial; and
- Collect and disburse child support payments: Collect and process payments from employers, parents, counties and other states, credit support obligations and issue support funds to families.

Results:

The federal government funds the child support program at the state level in part through performance incentives. Incentives are calculated by measuring the state program's performance in core program activities: paternity establishment, order establishment, collection of current support and collection of arrears (past due support). States are ranked by their scores on the performance measures. Minnesota ranks among the top five states on the collections measures, and among the top 20 on paternity and order establishment measures.

Performance Measures	Previous	Current	Trend
Child Support Current Collection Rate[1]	69%	70%	Improving
Paternity Establishment Rate - percent of children who were born outside of marriage for whom paternity was established in open child support cases for the year [1,2]	91%	92%	Improving
Order Establishment Rate – percent of open cases within the year that have orders established by year's end[1,2]	85%	86%	Improving
Arrears Collection Rate – percent of cases with arrears due within the year that had a collection on that arrears[1,2]	70%	70%	Stable

Performance Measures Notes:

1 Measurements compare 2010 data (Previous) to 2011 data (Current). Each measurement has a threshold of 80 percent. This represents the point at which states begin earning and maximizing federal incentives.

2 Federal measures may be found in the 2011 Minnesota Child Support Performance Report, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4252L-ENG.

Human Services
Children's Services Grants
http://www.dhs.state.mn.us/main/id_000152

Statewide Outcome(s):

Children's Services Grants supports the following statewide outcome(s).

People in Minnesota are safe.

Strong and stable families and communities.

Context:

Having strong families and communities is an effective first line of defense for keeping children safe, especially in times of stress. Children who have been abused and neglected are more likely to perform poorly in school, get involved in criminal activities and abuse or neglect their own children. Programs and services that cultivate the factors shared by strong families and communities actually minimize long-term costs, such as intervention for crime, corrections, truancy, hospitalization, special education and mental health care.

Research provdes compelling evidence that strength-based child welfare interventions such as those funded with Children's Services Grants, result in safer children and more stable families. Without these services, children and families remain at risk.

Children's Services Grants seek to ensure the safety, permanency and well-being of children involved in the child protection system. In 2011, 17,716 reports of child abuse and neglect were assessed involving 24,962 children. Of these, 4,589 children were determined to be victims of child maltreatment. In the same year, 11,368 children experienced an out-of-home placement and 1,133 were either adopted or had a permanent transfer of legal custody to a relative.

Grants in this activity are funded through a combination of state and federal dollars, including federal foster care, state and federal Adoption Assistance, and federal Family Preservation and Family Support Grants.

Strategies:

Children's Services grants fund a continuum of statewide child welfare services including adoption assistance, Indian Child Welfare services, child protection, homeless youth services, and child abuse and neglect services through counties, tribes, and community based providers. Grants provide supports to help keep more children out of foster care and safely with their families, and to decrease the disproportionate number of children of color in out-of-home placements. Most recently these grants have been used to:

- Reform the child welfare system to focus on ensuring children's safety while supporting families;
- Improve the Minnesota Child Welfare Training System;
- Work with tribes to design and develop tribal approaches that ensure child safety and permanency; and
- Transfer responsibilities from counties to tribes to deliver a full continuum of child welfare services to American Indian children and families on two reservations.

These services are essential in keeping children safe and families stable.

Results:

The Department of Human Services monitors the performance of counties and tribes in delivering child welfare services. Minnesota outcomes match or exceed most federal standards. Efforts to engage families early and collaboratively, and provide evidenced-based services with a focus on safety and timely permanency, have resulted in improving or maintaining outcomes.

Performance Measures	Previous	Current	Trend
Percent of Children Not Experiencing Repeated Abuse or Neglect Within 6 Months of a Prior Report	95.1%	95.6%	Improving
Percent of Children Reunified With Parents or Living With Relatives in Less than 12 Months from Latest Removal from Home	84.5%	85.7%	Improving
Percent of Children Adopted in Less than 24 Months from Latest Removal from Home	48.2%	48.1%	Stable

Performance Measures Notes:

All measures are from Minnesota's Child Welfare Report. Measurements compare 2010 data (Previous) to 2011 data (Current). Child protection statistical reports are posted on the DHS Child protection Publications page: http://www.dhs.state.mn.us/main/id_003712.

See also Child Welfare Dashboard:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137

Human Services
Child & Community Service Grants
http://www.dhs.state.mn.us/main/id_000152

Statewide Outcome(s):
Child & Community Service Grants supports the following statewide outcome(s).

People in Minnesota are safe.

Strong and stable families and communities.

Context:
Children & Community Service grants provide funding to support core safety services for vulnerable children and adults, including response to reports of maltreatment, assessments of safety and risk, case management and other supportive services that help keep children and adults safely in their own homes; and support safe alternative living arrangements such as foster care. Grants provide funding to counties and tribes to purchase or provide these services for children, families and vulnerable adults.

In 2011, 17,716 reports of child abuse and neglect were assessed involving 24,962 children. Of these, 4,589 children were determined to be victims of child maltreatment. In the same year, 11,368 children experienced an out-of-home placement and 1,133 were either adopted or had a permanent transfer of legal custody to a relative.

These grants include state funds and the federal Social Services Block Grant, and serve over 300,000 people annually.

Strategies:
Funding through these grants provides core safety services that focus on preventing or remedying neglect, preserving and rehabilitating families, and providing for community-based care. Services include:

- Response to reports of child and adult maltreatment, and assessment of safety and risk of harm;
- Adoption and foster care supports; and
- Case management and counseling.

Grants provide child protection services to help keep more children out of foster care and safely with their families and to decrease the disproportionate number of children of color in out-of-home placements. They help ensure that vulnerable children and adults are better protected and receive support services in their communities.

Results:
The Department of Human Services monitors the performance of counties and tribes in delivering social services. Minnesota outcomes match or exceed most Federal standards. Efforts to engage families early and collaboratively, and provide evidence-based services with a focus on safety and timely permanency has resulted in improving or maintaining outcomes.

Performance Measures	Previous	Current	Trend
Percent of Children Not Experiencing Repeated Abuse or Neglect Within 6 Months of a Prior Report	95.1%	95.6%	Improving
Percent of Children Reunified to parents or living with relatives in Less than 12 Months from Latest Removal From Home	84.5%	85.7%	Improving
Percent of Children Adopted in Less than 24 Months from Latest Removal From Home	48.2%	48.1%	Stable

Performance Measures Notes:

All measures are from Minnesota's Child Welfare Report. Measurements compare 2010 data (Previous) to 2011 data (Current). Child protection statistical reports are posted on the DHS Child protection Publications page: http://www.dhs.state.mn.us/main/id_003712

See also the DHS Child Welfare Dashboard:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137

Human Services
Children & Economic Support Grants
http://www.dhs.state.mn.us/main/id_002550

Statewide Outcome(s):

Children & Economic Support Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans have the education and skills needed to achieve their goals.

Context:

Poverty imposes substantial barriers on the health and development of individuals and families. The Minnesota Department of Human Services administers nearly 200 grants annually to more than 100 grantee organizations to help people in poverty meet their basic needs for food, clothing and shelter, and attain the skills, knowledge and motivation to become more self-reliant. Without these funds, more people would be hungry and homeless.

Children & Economic Support Grants provide funding for housing, food, poverty reduction, and financial education services for low-income families and individuals. Examples of strategies are listed below.

- Supportive and transitional housing services to address the needs of homeless individuals and families by helping them find safe and stable housing. More than 12,000 people received temporary shelter and services in 2011, and more than 3,500 people who experienced long-term homelessness received services.
- Emergency services funding for organizations that provide emergency shelter and essential services to homeless adults, children and youth; served over 200,000 individuals and families in 2011.
- Funding for food banks, food shelves and on-site meal programs.
- Supplemental Nutrition Assistance Program (SNAP) outreach and nutrition education.
- Programs administered by Community Action Agencies that help low-income people become more economically secure. These agencies served over 280,000 Minnesotans with help to gain employment and supports in 2011.

The largest portion of this budget area is federal funding for the Supplemental Nutrition Assistance Program. In FY 2011, the SNAP program provided help with food for an average of 469,904 persons per month receiving an average monthly payment of $119. Outreach and nutrition education are conducted under this activity.

Funding sources include state grants and federal grants from the U.S. Departments of Agriculture (USDA), Health and Human Services (HHS), Housing and Urban Development (HUD), as well as private foundations.

Strategies:

People living in poverty frequently face numerous barriers and have complex needs. Children and Economic Support Grants employs strategies targeting both short-term crisis stabilization efforts and long-term strategies to help people leave poverty and sustain economic security for themselves and their families into the future, including:

- Providing basic food, housing and other supports to the most at-risk adults and children;
- Providing funding, training, and technical assistance to counties and tribes for services to reduce barriers for long-term homeless adults, youth and families; and
- Helping the most at-risk adults and children attain the skills, knowledge, and motivations that will result in their becoming more economically secure.

Outreach and nutrition education efforts under SNAP help keep more people fed and healthy, and increases nutrition assistance participation.

Results:

There are many programs to help people with their food needs, such as emergency food help, SNAP and Minnesota Food Assistance. Measures below show increased participation in the SNAP program to help keep people fed and healthy.

Grants for long-term homeless youth, adults, and families assist people in finding and maintaining housing and increasing their self-sufficiency. (For more information on housing programs, see: http://www.dhs.state.mn.us/main/id_002548)

Performance Measures	Previous	Current	Trend
SNAP Participation Rate for All People in Poverty[1]	51%	56%	Improving
SNAP Participation Rate for Seniors in Poverty[1]	32%	37%	Improving
Percent of Long-Term Homeless Enrolled in Services and Permanent Housing[2]	70%	71%	Stable
Percent of Long-Term Homeless Enrolled in Services with No Income[2]	20%	10%	Improving

Performance Measures Notes:

1. Data on SNAP participation is for the years 2009 (Previous) and 2010 (Current).
   The participation rate for all people in poverty comes from the Food Support Access Index (FSAI). SNAP participation rate for seniors in poverty is available at: http://dashboard.dhs.state.mn.us/measure01-6.aspx. Note: At the end of calendar year 2011, 44.7 percent of seniors in poverty were accessing SNAP.
2. Data on long-term homeless services is for the years 2010 (Previous) and 2011 (Current), from the "Summary Long-Term Homeless Supportive Service Grants Annual Homeless Management Information System (HMIS) Report." Income information is collected periodically while receiving services and when exiting from services.

Human Services
Refugee Services Grants
http://www.dhs.state.mn.us/main/id_004115#

Statewide Outcome(s):

Refugee Services Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Minnesotans have the education and skills needed to achieve their goals.

Context:

Refugees have had to flee their country of origin and are unable to return because of a well-founded fear of persecution. When no other options exist, the United States, as well as most Western nations, provides refugees an opportunity for permanent resettlement. Most refugees resettled in the United States over the last two decades have been Southeast Asians, but more recently the population has become more diverse with people from countries in strife, such as Bosnia, Somalia, Sudan, Liberia, Iraq and the former Soviet Union.

Refugee Services Grants provide assistance to refugees, asylees and victims of human trafficking to resettle in Minnesota. Grants are provided to state and local agencies, including county and voluntary resettlement agencies, school districts and community agencies in order to enhance human, health, educational, employment and training services. In 2011, an average of 1,210 persons per month received employment and social services through these grants, at an average monthly cost of about $300 per recipient.

The activity is funded with federal grants appropriated through the United States Department of Health and Human Services.

Absent these services, fewer refugees will find work and more will lack the medical, social and financial supports necessary to resettle successfully.

Strategies:

Refugee Services Grants provide an array of services, including:

- Medical health screening
- Refugee cash assistance
- Information and referral
- Translation and interpreter services
- Case management services
- Citizenship and naturalization preparation services
- Supported employment services and transportation

Grants are used in partnerships with local voluntary resettlement agencies, the Minnesota Departments of Health and Education, providers and refugee communities. They support services that improve health, safety and stability during resettlement.

Results:

The department's Refugee Services uses several client outcome indicators to determine the effectiveness of its grant management activity.

Performance Measures	Previous	Current	Trend
Percent of Refugees Receiving Health Screening within 90 Days of Arrival	96%	96%	Stable
Percent of Refugees Who are Employed	49%	54%	Improving

Performance Measures Notes:

Measurements come from the Office of Refugee Resettlement Performance Report. Measures compare 2010 (Previous) to 2011 data (Current).

Human Services
Health Care Grants

Statewide Outcome(s):

Health Care Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Context:

Health Care Grants are used to provide support, infrastructure, investment or outreach that benefits enrollees in public health care programs, Medical Assistance (MA) and MinnesotaCare, and some uninsured or underinsured individuals. DHS seeks grants to augment our own operational efforts. In doing so, we engage experts outside of DHS to help ensure that eligible Minnesotans are enrolled in the appropriate health care program, and that those enrolled (especially our youngest and/or most vulnerable or hard to reach) get all the care that we are paying for. Grantees can be providers, counties, or community organizations. These grants have historically targeted projects or work that is not funded under the MA or MinnesotaCare program and that provide support to those program and enrollees. The grants are not typically for direct care.

Health Care Grants are funded from appropriations from the state General Fund and Health Care Access Fund, and some federal funds.

Strategies:

The Health Care Grants administered by DHS can change over time depending on the length of the funding or project. These grants can often be for one year or ongoing for several years and are for a specific project, demonstration or function that are usually the result of state legislation. Grantees can range from providers, counties, or community organizations. For example, one of the long-standing grants funded out of this budget activity provides payments to providers, counties, community organizations for assisting individuals with the application process for MA and MinnesotaCare.

The grants currently funded under this budget activity include:

- *Neighborhood Care Network*. Provides funding to operate a consumer health care information line.
- *Outreach Grants or Minnesota Community Application Agent (MNCAA) Program*. Provides funding for an external organization to effectively provide culturally appropriate outreach and renewal assistance services to Minnesotans enrolled in MA or MinnesotaCare.
- *Child and Teen Checkups and Immunization Registry Grants*. Provide administrative funds for activities that support the work of local Child and Teen Checkups and Immunization Registry activities.

Results:

The DHS Health Care Administration is committed to measuring our work. One measure the Health Care Grants contribute to reducing is the percent of lower-income Minnesotans that do not have health insurance even if they are eligible for public programs. DHS has also begun to collect information on the number of successful applications completed by application agents under the MNCAA program. Although data is not yet available, in the future we will be able to report on this targeted performance measure.

Performance Measures	Previous	Current	Trend
Percent of Minnesotans lacking health insurance	9%	9.1%	Stable

Performance Measures Notes:

Compares 2009 (Previous) to 2011 (Current). Nearly three-fourths of the uninsured have some potential access to coverage but don't take advantage of it. Source: Minnesota Department of Health, *Health Access Survey* (conducted semiannually).

Human Services
Aging & Adult Services Grants
http://www.dhs.state.mn.us/main/id_005734

Statewide Outcome(s):

Aging and Adult Services Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans are healthy.

Context:

Between now and 2030, Minnesota will experience the most profound age shift in its history. Along with the rest of the nation and the world, we will become older not just as individuals but as a society. The baby boomers—1.5 million strong in Minnesota—are leading us into this uncharted territory as they begin to age. By 2030, we will have 1.3 million persons over 65, or one out of every four Minnesotans. Later, in 2050, we will have the largest number ever of people over 85. Over two-thirds of persons age 85 and older have at least one disability. Older persons are more likely to have multiple disabilities, and each of these chronic conditions poses a challenge to the individual's ability to live independently. Therefore, Minnesotans' need for community-based long-term care services will continue to increase. Aging and Adult Services Grants support seniors, their families, caregivers and communities to enable seniors to stay in their homes and communities and avoid costly institutionalization.

The purpose of Aging and Adult Services Grants is to provide non-medical social services and supports for older Minnesotans and their families to enable older adults to stay in their own homes and avoid institutionalization. These funds increase service availability and service choice for older Minnesotans in both urban and rural communities, and so provide greater opportunity for Minnesotans to age at home. Several of the state grant programs are aligned and coordinated with the services provided under the federal Older Americans Act (OAA). Federal OAA funds in Minnesota are administered through the Minnesota Board on Aging to provide core social services to at-risk older adults and their family caregivers who are not yet eligible for public programs. Services are targeted to people with the greatest social and economic need.

Strategies:

Aging and Adult Services Grants promote evidence-based models that leverage local private funds and in-kind contributions to promote affordable services that are both dependable and sustainable. Aging and Adult Services grants provide the following services.

- Nutritional services including congregate meals to 56,000 people, home-delivered meals to 13,000 people, and grocery delivery to 660 people annually.
- Increased service availability and service choice for older Minnesotans through service development opportunities provided by the Community Service/Community Services Development (CS/SD), Family Caregiver Support, and ElderCare Development Partnership (EDP) grant programs. Services include: transportation, chore, assistance with activities of daily living, and other services that help people stay in their own homes; evidence-based health promotion, chronic disease management, and falls prevention services; and respite and other supportive services to family caregivers. In the FY 2010-2011 biennium, over 14,000 people were served and capacity was increased by more than 6,000 volunteers.
- Support to more than 16,000 older volunteers per year who provide services through the RSVP, Foster Grandparent, and Senior Companion programs.
- Through the Senior LinkAge Line®, comprehensive assistance and individualized help to more than 67,000 people through 125,000 calls in 2011. Senior LinkAge Line® has trained long-term care options counselors that assist individuals to find community resources, including supports for family caregivers, counseling about Medicare, supplemental insurance, and other health and long-term care insurance options; and comprehensive prescription medication expense assistance, including assistance with Medicare Part D benefits and Medicare plan selection to beneficiaries of all ages.
- Information about community-based resources and customized long-term care planning tools to 353,000 visitors in 2011, through www.minnesotahelp.info, a web-based database of over 29,000 services.

- An intensive long-term care options counseling service provided by the Senior LinkAge Line®, known as Return to Community, that helps people successfully remain in their homes after discharge from a nursing home. Since the launch of this service in 2010, over 2,800 consumers have been contacted for discharge support; of those, direct assistance was provided to 500 older adults at their request to return home and 700 are receiving five years of telephonic follow-up at home.
- A benefit through the Essential Community Supports program for people who will not be eligible for Medical Assistance.

Services are administered in partnership with Area Agencies on Aging, local counties and tribes, and community providers.

Results:

Minnesota has seen continuous improvement in the number of seniors served by community-based rather than institution-based services. Measures we track include the percent of elderly receiving publicly funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. The percent of seniors served in the community has consistently remained steady or improved over the past five years. DHS, through its partners, surveys users of the Senior LinkAge Line® and found an increasing number of people who would recommend Senior LinkAge Line® services to others.

Performance Measures	Previous	Current	Trend
1. Percent of elderly served by home and community-based services	54%	62.4%	Improving
2. Percent of consumers who would recommend the Senior LinkAge Line® to others	93%	96%	Improving
3. Number of people who have moved from nursing homes back to the community through the Return to Community Initiative	82	204	Improving
4. Percent of family caregivers who report that the intervention helped them provide care for a longer period of time	93%	95%	Improving

Performance Measures Notes:

1. Compares FY 2007 (Previous) to FY 2011 (Current). Source: DHS Data Warehouse
2. Compares 2007 (Previous) to 2011 (Current). Source: Consumer Surveys, WebReferral database
3. Compares data for the last three quarters of calendar year (CY) 2010 (Previous) to CY 2011 data (Current). Source: Return to Community Database
4. Compares CY 2005 (Previous) to CY 2011 (Current), as measured by an annual survey of family caregivers receiving Older Americans Act-funded caregiver support services. Source: Annual Caregiver Program Participant Survey

More information is available on the DHS dashboard: http://dashboard.dhs.state.mn.us and the Continuing Care Performance Report: http://www.dhs.state.mn.us/main/dhs16_166609.

Human Services
Deaf & Hard Of Hearing Grants

http://www.dhs.state.mn.us/main/dhs16_139339

Statewide Outcome(s):

Deaf and Hard of Hearing Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Context:

Hearing loss occurs at all stages of life. Three out of every 1,000 newborns have hearing loss. Two-thirds of seniors over age 75 have hearing loss. In Minnesota, between 530,000 and 742,000 people are estimated to have some degree of hearing loss. Of those, about 15% are deaf and as many as 1,600 individuals are deafblind. The impact of hearing loss on each individual is unique, depending on the degree and type of hearing loss. Isolation, loss of meaningful communication, diminished independence and misdiagnosis of mental health issues are common effects of hearing loss. Deaf and Hard of Hearing Services grants assist Minnesotans of all ages who are deaf, deafblind and hard of hearing with communication access and other supports they need to be involved in their families and communities.

The purpose of Deaf and Hard of Hearing Grants is to provide statewide services that enable at-risk Minnesotans who are deaf, deafblind, or hard of hearing to gain and maintain the ability to live independently and participate in their families and communities. Deaf and Hard of Hearing Grants supported 18,800 people in state fiscal year 2011.

Deaf and Hard of Hearing grants are primarily funded by the state's general fund. Additional funding for real-time television captioning grants is provided through a fee assessed on phone bills and collected by the Department of Commerce. (DHS is not able to count the number of television viewers who use captioning.)

More information about other programs and services provided in the Deaf and Hard of Hearing Services Division is available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6573-ENG.

Strategies:

Deaf and Hard of Hearing Grants provide services that enable deaf, deafblind, or hard of hearing Minnesotans to live in their communities. Services provided include:

- Sign language interpreter referral and interpreter-related services that allow Minnesotans who are deaf, hard of hearing, and deafblind to access emergency core services such as courts, medical care, mental health services, and law enforcement.
- Deafblind grants to support adults who are both deaf and blind so they can live independently and stay in their own homes.
- Specialized mental health services that provide linguistically and culturally appropriate services including home-based outreach supports, a drop-in center, inpatient therapy, outpatient therapy, family counseling, and educational opportunities for families, schools, and mental health providers. A peer support program is being developed for individuals who are deaf and have a serious mental illness.
- Mentors who work with families that have children with hearing loss to develop the family's communication competence, including use of American Sign Language.
- Real-time television captioning grants to allow consumers in greater Minnesota who are deaf, deafblind and hard of hearing to have access to live local news programming from some television stations.

DHS partners with statewide community providers, mental health professionals, local television stations and the Department of Commerce to provide services.

Results:

Consumers of deaf and hard of hearing grant-funded services are surveyed to measure satisfaction with the quality and timeliness of services. Consumers have reported increasing satisfaction with services received.

Performance Measures	Previous	Current	Trend
1. Percent of consumers in DHHS grant-funded programs who are satisfied with quality of services they received	86%	95%	Improving
2. Percent of consumers in DHHS grant-funded programs who are satisfied with timeliness of the services they received	87%	89%	Improving

Performance Measures Notes:

Both measures compare 2008 data (Previous) to 2011 data (Current). Data source: Consumer satisfaction surveys. More information on these measures is available online on the Continuing Care Performance Report: http://www.dhs.state.mn.us/main/dhs16_166609#

Human Services
Disabilities Grants

http://www.dhs.state.mn.us/main/id_010527

Statewide Outcome(s):

Disabilities Grants supports the following statewide outcome(s).

Strong and stable families and communities.

Minnesotans are healthy.

Context:

Disability is a naturally occurring part of human life. Disability can occur at birth or be acquired later in life and can include physical disabilities, developmental disabilities, chronic medical conditions, and acquired or traumatic brain injuries. The US Census Bureau estimates that nearly 400,000 or 14 percent of Minnesotans have a disability or disabling condition. Individuals with disabilities are unique and have a variety of needs that may range from assistance with bathing and dressing to needing 24 hour care and supervision. Disability grants provide services and supports to enable Minnesotans with disabilities to remain in their communities and avoid institutionalization. These grants also provide funding to local counties, tribes, families and providers to support individuals with disabilities.

The purpose of Disabilities Grants is to provide community service options for individuals with disabilities, support to lead agencies, and to develop and maintain a system-wide infrastructure. These funds increase service availability and service choice for people with disabilities and their families; help people with HIV/AIDS with medical expenses; provide information and assistance on disability programs and services; and support county and tribal infrastructure.

Disabilities grants are funded by the state general fund, federal funds, and special revenue funds. The HIV/AIDS programs receive federal funds from the Ryan White Care Act and receive rebate funding from pharmaceutical companies for drugs and insurance.

More information about Disabilities Grants and the number of people served is available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6575-ENG.

Strategies:

Disabilities Grant programs include the following.

- The Family Support Grant (FSG) provides cash to families to offset the higher-than-average cost of raising a child with a disability.
- The Consumer Support Grant (CSG) helps individuals purchase home care, adaptive aids, home modifications, respite care, and other assistance with the tasks of daily living.
- Semi-Independent Living Services (SILS) are used by adults with developmental disabilities to live in the community. The funding is used to purchase instruction or assistance with nutrition education, meal planning and preparation, shopping, first aid, money management, personal care and hygiene, self-administration of medications, use of emergency resources, social skill development, home maintenance and upkeep, and transportation skills.
- HIV/AIDS programs assist enrollees with premiums to maintain private insurance, co-payments for HIV-related medications, mental health services, dental services, nutritional supplements, and case management.
- Housing Access Services provides a grant to a non-profit organization to help individuals move out of licensed settings or family homes into their own homes.
- The Disability Linkage Line (DLL) provides one-to-one assistance to help people learn about their options and connect with the supports and services they choose.
- Local planning grants provide assistance to counties and tribes for the development of community alternatives to corporate foster care placements. During FY 2013, this funding will be used to support

counties and tribes in gathering information to inform the statewide gaps analysis and needs determination processes.

- The Advocating Change Together grant provides funding to the non-profit Advocating Change Together, which is a statewide self-advocacy organization for people with disabilities.
- Technology Grants for Corporate Foster Care Alternatives provides funding for case consultation, evaluation and consumer information grants to assist in developing alternatives to shift-staff foster care residential services models.
- People, Inc. receives a grant to support a living skills training program for people with intractable epilepsy who need assistance in the transition to independent living.

Results:

The Minnesota Department of Human Services (DHS) monitors data, reviews counties, and administers surveys to consumers to evaluate services. Minnesota has seen continuous improvement in the number of people with disabilities served by community-based rather than institution-based services. Measures we track include the percent of people with disabilities who are receiving publicly funded long-term care services through a disability waiver or home care program instead of services in a nursing facility or intermediate care facility. The percent of people with disabilities served in the community has consistently remained steady or improved over the past five years.

A 2009 moratorium in state law on corporate foster care helps to curb the growth of residential settings. We are tracking the percent of people with disabilities who receive home and community-based services in their own home instead of in a residential setting, such as foster care. Current data shows improvement on this measure for people with developmental disabilities but has yet to show an impact for people with other disabilities.

More information is also available on the DHS dashboard: http://dashboard.dhs.state.mn.us and the Continuing Care Performance Report: http://www.dhs.state.mn.us/main/dhs16_166609.

Performance Measures	Previous	Current	Trend
1. Percent of people with disabilities served by home and community-based services	92%	94.5%	Improving
2. Percent of people with disabilities (excluding developmental disabilities) who receive home and community-based services in their own home	65%	63%	Worsening
3. Percent of people with developmental disabilities who receive home and community-based services in their own home	34.6%	35.7%	Improving
4. Number of people that Housing Access Services has helped move to a home of their own	48	71	Improving
5. Percent of consumers who would recommend the Disability Linkage Line (DLL) to others	99%	100%	Stable

Performance Measures Notes:

1. Compares FY 2007 (Previous) to FY2011 data (Current). Source: DHS Data Warehouse.
2. Compares 2007 (Previous) to 2011 data (Current). Source: DHS Data Warehouse.
3. Compares 2007 (Previous) to 2011 data (Current). Source: DHS Data Warehouse.
4. Compares calendar year 2010, quarter two data (Previous) to CY 2012, quarter two data (Current). Since the program began, Housing Access Services has moved 459 people with disabilities into homes of their own. Source: DHS Grant reports.
5. Compares CY 2008 data (Previous) to CY 2011 data (Current). Source: DLL Customer Satisfaction Surveys.

More information is also available on the DHS dashboard: http://dashboard.dhs.state.mn.us and the Continuing Care Performance Report: http://www.dhs.state.mn.us/main/dhs16_166609.

Human Services
Adult Mental Health Grants
http://www.dhs.state.mn.us/main/id_000085

Statewide Outcome(s):
Adult Mental Health Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:
Mental illness strikes all ages, all economic levels, and all races. For people with mental illness, it disrupts learning and educational plans for the future, job security and income. One out of every four persons live with a mental health problem. Mental illness also affects families – spouses, parents, siblings, grandparents and children. People living with a mental illness are at significant risk for being homeless. According to a 2009 Wilder Research Homeless study, 55 percent of homeless adults surveyed had a serious mental illness. Having a mental illness can sometimes be fatal. Suicide is one of the leading causes of death. In Minnesota, eleven out of every 100,000 adults take their own lives each year.

National and state statistics demonstrate that individuals with mental illness have higher mortality rates than others due to untreated or undertreated physical health issues. Seeking a primary care physician for annual physical health screenings can result in earlier and less-costly treatment of common chronic illnesses.

Adult mental health services provide the supports people need at crucial times in their lives. Grant funding is used to increase the number of Minnesotans served in their homes and communities rather than in institutions and to improve life expectancy for people with a serious mental illness.

Strategies:
Provide a statewide network of crisis response services. Mobile crisis teams can provide outreach to persons and intervene quickly in community neighborhoods when people experience a mental health crisis. Crisis beds can also help people stay closer to home and avoid costly hospital stays. Crisis response services save lives by provided support and intervention that allows people to remain in the community and avoid the additional life disruption that a hospital stay entails. They also allow law enforcement professionals to carry on with their other duties of protecting the citizenry and they frequently team with law enforcement officers to lessen the time that law enforcement officers must spend intervening in mental health crisis, transporting individuals or waiting for the individual at a hospital. Crisis response services also can allow emergency room doctors to focus on treating physical ailments rather than focusing on persons with mental health issues.

Co-locate medical and mental health services wherever possible. Since persons with mental illness are at significant risk of diabetes, heart disease, and other chronic health conditions, it is important to link physical health services with mental health services. Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, locally based treatment to people with mental illnesses. ACT provides highly individualized services directly to consumers through multidisciplinary teams. Staff are available around-the-clock to deliver the majority of treatment, rehabilitation, and support services required by each client to live in the community. Most recently, ACT teams have focused on improving the physical health of individuals with mental illness through better linkages with primary care clinics. In Minnesota, efforts to reduce the number of persons with mental illness who die 25 years earlier than the general population focus on the following two strategies.

- Improved integration of physical and mental health care.
- Providing every ACT client with an annual physical focusing on health and wellness indicators, including body mass index, tobacco and alcohol use, blood pressure, LDL cholesterol, and blood sugar. Any indicator failing outside the “normal/desirable” range will be followed up by the team.

Provide access to crisis housing funds to ensure people don't lose their housing during their hospital stay. A short term crisis housing retention fund helps people with to 90 days of financial assistance for mortgage, rent, and utilizes for adults with very chronic, severe mental illness. This assistance is used to help the person to retain their home while they are getting needed mental health treatment and using their income to pay for treatment. This is the only program in the state that provides this service.

Results:

Crisis Response Services Results - Adult residents in every county in the state can access some form of Crisis Response Services.

Assertive Community Treatment Results - An important performance measure is the degree to which the services succeed in keeping the client well and living in the community rather than requiring hospitalization or institutional care.

Crisis Housing Fund Results - Crisis Housing Funds served persons with severe, chronic long-term mental illness. It allows individuals to retain their housing while they received needed mental health treatment.

Performance Measures	Previous	Current	Trend
The percentage of adults in Assertive Community Treatment (ACT) who are not Medicare eligible and enrolled 12 months in Minnesota Health Care Programs who have received an annual comprehensive preventative exam.[1]	26.5%	27.8%	Improving
Percent of Adults with serious mental illness who remain in the community six months after discharge from an inpatient psychiatric setting.[2]	65%	65%	Stable
Changes in inpatient days for persons served in Intensive Community Recovery Service (ICRS)[3]	9.23	3.93	Improving
Changes in inpatient days for persons served in Assertive Community Treatment (ACT)[3]	22.63	10.01	Improving
The percentage of adults receiving Rehabilitative Mental Health Services who are screened for substance abuse[4]	69.2%	77.8%	Improving

Performance Measures Notes:

1. Previous measures Calendar Year 2010 and Current measures CY 2011.
2. Previous measures Calendar Year 2009 and Current measures CY 2010. The measure looks at a readmission to any psychiatric inpatient care unit (either State Operated or Community) within six months of discharge from a psychiatric inpatient care unit.
3. Previous measures Inpatient days per client for the year before starting program and current measures inpatient days per client the year after starting the program. The department goal is to reduce the need for hospitalization and keep persons served in the community.
4. Previous measures State Fiscal Year 2008 and Current measures State Fiscal Year 2011 of the percentage of individuals receiving adult rehabilitative mental health services (Assertive Community Treatment, Adult Rehabilitative Mental Health Services, or Intensive Community Recovery Services) who are screened for the possibility of substance use. Recovery from mental illness can be more difficult when an individual has undiagnosed and/or untreated substance abuse issues.

Human Services
Child Mental Health Grants
http://www.dhs.state.mn.us/main/id_000162

Statewide Outcome(s):
Child Mental Health Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:
Emotional or mental illness strikes all ages, all economic levels, and all races. Many children have mental health issues that can seriously affect aspects of their lives and the stability of their family.

- Studies estimate that mental health problems affect one in five young people at any given time.
- Many children and adolescents experience emotional disorders, such as depression, anxiety and attention-deficit, conduct and eating disorders.
- An estimated 91,000 children in Minnesota need treatment for emotional disturbances.
- In Minnesota, nine percent of school-age children and five percent of preschool children have a serious emotional disturbance, which is a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and in school.
- Children and youth with a serious emotional disturbance experience risks related to reduced graduation rates, increased involvement with juvenile corrections and more substance abuse problems.

Children's Mental Health Grants fund children's mental health services provided by non-profit agencies, schools, Medicaid-enrolled mental health clinics, tribes, counties, and culturally specific agencies. While the public mental health system is responsible for the full continuum of children's mental health treatment interventions and ancillary services, grants cover treatment services for children who are uninsured or whose family insurance does not cover necessary mental health services. In addition, grants fund coordination of physical healthcare and developmental disabilities services and build community alternatives to inpatient hospitalization and residential treatment.

The evidence base behind mental health prevention, treatment, and recovery/resiliency services continues to grow and promises better outcomes for people with, and at risk for, mental disorders. We can now say with certainty that:

- Mental health is essential to overall health;
- Prevention works;
- Treatment is effective; and
- Children can increase their resilience to mental illness.

Strategies:
Children's Mental Health Grants support children with mental illness by:

- Integrating mental health into the overall health care delivery system;
- Filling gaps in a full array of services/supports;
- Expanding the capacity of mental health care delivery;
- Reducing disparities among communities;
- Measuring effectiveness of services; and
- Providing for the efficient use of limited resources.

To help children and youth become healthy Minnesotans, the Children's Mental Health Grants train providers on evidence-based practices; build statewide provider capacity; cover treatment and supports for under/uninsured children; and provide for easy access to the earliest possible, effective interventions when a mental health

problem emerges. When a child suffers trauma or other adverse childhood experiences (ACEs), the children's mental health system-as a core component of Minnesota's child and family-serving systems-has the responsibility to remediate life-long detrimental effects on physical and mental health.

Partners are essential for a dynamic and learning mental health service delivery system. For children, coordination of care encompasses many other child-serving sectors of the public and private health and human service systems of Minnesota - including primary care, day care, substance abuse treatment, schools, public health, child welfare, juvenile justice, adult transition services, and services to parents designed to prevent traumatic events in a child's life and to build or repair the crucial parent-child attachment bond.

Results:

Strategies of the Children's Mental Health Grants are measured at both the system performance level and the individual client outcomes level.

- Individual treatment effectiveness is measured through the Children's Mental Health Outcome Reporting System, using standardized measurement instruments, the results of which are submitted by treating mental health professionals to DHS through a Web-based reporting system.
- Grantee and system performance is evaluated in the annual Children's Mental Health Grants Outcomes and Division Progress Report. The report separately evaluates each children's mental health grant funded by state appropriation or the federal Mental Health Block Grant. It reports service utilization; age, gender, and cultural/ethnic demographics; location of services; insurance status; improved access; provider trainings; and client outcomes summaries.

Performance Measures	Previous	Current	Trend
Service Utilization Rate (per 10,000 children)[1]	342	437	Improving
Percent of Children in the child welfare system who received a mental health screening[2]	55.3%	56.6%	Improving

Performance Measures Notes:

1. Service Utilization Rate: An indicator of service access, this indicator counts the number of children (under age 18) receiving any mental health service from the publicly financed healthcare system per 10,000 children in the general child population. Compares Calendar Year (CY) 2008 (Previous) and CY 2010 (Current). Note: Utilization rate is not an indicator of need for services as the incidence of emotional disturbance is far higher than the rate at which the children access treatment.
2. With parental consent, counties conduct mental health screenings for children in the child welfare and juvenile justice systems who have not had a recent assessment. The previous measure is CY 2009; the current measure is CY 2010.

Human Services
CD Treatment Support Grants
http://www.dhs.state.mn.us/adad

Statewide Outcome(s):

CD Treatment Support Grants supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

Chemical addiction can affect persons of any age, race, religion, or income. According to the 2006 Substance Abuse and Mental Health Service (SAMHSA) National Survey on Drug Use, 22.6 million people (9.2 percent) of people in the U.S aged 12 and older were chemically dependent. Chemical dependence broke down as follows: 3.2 million people were dependent on both drugs and alcohol, 3.8 million were dependent on drugs alone, and 15.6 million were dependent on alcohol alone.

Of this 22.6 million people, only 1.6 percent received treatment. Without treatment, the consequences of substance use for the individual and society are staggering: unnecessary disability, unemployment, mental illness, homelessness, incarceration, suicide and wasted lives. Chemical Dependency (CD) Treatment Support grants pays for statewide prevention, intervention, treatment support, recovery maintenance, and case management services, including culturally appropriate services and support. A combination of state and federal dollars supports this activity.

Research studies indicate that the prevalence of substance abuse is higher for certain communities/populations or that some groups do not succeed in chemical dependency treatment at the same rate as the general population. Specific improvement efforts to address these disparities include prevention strategies and treatment support services that focus on the unique strengths and needs of these various communities/populations. The value of these specialized services is especially highlighted as counties and tribes recognize the role treatment support services play in successfully serving families with substance abuse problems in the Temporary Assistance to Needy Families and Child Welfare programs.

Strategies:

The majority of this program's is from the federal Substance Abuse Prevention and Treatment block grant. Federal rules specify that some of these federal funds be targeted toward treatment supports of Native Americans, women, women with children, the elderly, and other diverse populations. Specifically, roughly $4 million on women's services and $5 million from each annual award is spent on prevention targeted to culturally specific communities of highest need on a regional basis. Minnesota expends the remaining $5 million on treatment support and recovery maintenance for specific target populations.

Roughly $1 million of state general fund are appropriated each fiscal year for grants to American Indian Tribes to conduct prevention and treatment support services for American Indians.

The state works with prevention and recovery support providers in the community, along with regional coordinators in all seven areas of the state. DHS collaborates with the Minnesota Departments of Health, Public Safety, Education and Corrections in program planning, data collection and analysis.

Results:

The performance measures demonstrate this activity's contribution to strong and stable families and communities as reflected by reductions in past 30 day use of alcohol by young people. The state-wide outcomes are also supported by reducing to zero the number of drug-positive babies born to mothers in programs serving them.

Performance Measures	Previous	Current	Trend
Past 30 day use of alcohol by youth in funded communities (1)	33.4%	23.5%	Improving
Babies born with positive drug screens (2)	20%	11%	Improving

Performance Measures Notes:

(1) Percent of children in communities receiving substance abuse prevention funding as reported in the Minnesota Student Survey. Previous represents calendar year (CY) 2004 and Current represents CY 2010.
(2) Number of at risk babies reported with positive toxicology screens in communities receiving prevention funding. Previous represents FY 2005 and Current represents FY 2011.

Human Services
SOS Mental Health

http://www.dhs.state.mn.us/sos

Statewide Outcome(s):

SOS Mental Health supports the following statewide outcome(s).

Minnesotans are healthy.

People in Minnesota are safe.

Context:

Mental illnesses can affect persons of any age, race, religion, or income. According to the National Alliance on Mental Illness – Minnesota (NAMI-MN), it is estimated that mental illnesses affect one in five families. Without treatment, the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives. The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States. By ensuring access to services and supports that have been proven to be effective, recovery is possible.

Minnesota's policy for serving people with disabilities has emphasized a broad array of community-based treatment and support options enabling people to access the most appropriate care as close to their home community and natural support systems as possible. This policy has worked well for many individuals but continues to have gaps for individuals with co-occurring and complex conditions. As a result, these individuals do not move through the system and become "stuck' in inappropriate levels of care. A bottleneck in the care system results. This occurs in all levels of the mental health treatment continuum including community hospitals, community corrections and State Operated Services (SOS) treatment sites. A shortage of mental health providers has also resulted in a restriction of available capacity in the SOS treatment system.

Strategies:

As part of a broader continuum of care, SOS's Mental Health services provide specialized treatment and related supports for youth and adults with serious mental illness (SMI), emotional disturbances, and co-occurring neurocognitive disabilities. These services are provided in an array of facilities including psychiatric hospitals, intensive residential treatment services (IRTS), and a variety of other service settings. State Operated Services' Mental Health Services are funded with state general fund appropriations. In fiscal year 2012, 2,457 individuals received mental health services from SOS Mental Health programs. An additional 5,030 received dental services within the five dental clinics.

SOS provides quality treatment using a person-centered approach to care. To be successful, care must be provided in a safe and appropriate level of care environment. SOS has developed services at different levels of the continuum to allow clients to move through the mental health treatment system and back to the community.

The ability to safely move individuals from one level of care to another is a challenge due to the limited resources available to clients. Individuals that no longer require inpatient hospital care but who can't be discharged due to lack of community resources reduce the ability to appropriately serve individual who do need inpatient care as beds are full. Though gaps still exist for some clients, many are able to return to their homes and community. SOS continues to reach out to the service system to partner with other community providers in order to assure individuals with mental illness receive the services they need to successfully live in the community. Key current strategies to help clients successfully manage their return to the community are:

- Ensuring prompt psychiatric follow-up upon their return to a community setting.
- Working to reduce the number of medications necessary to control each client's symptoms.

Both these serve to support the client's continued effective treatment following their transition to community living.

DHS is also seeking a new Medicaid waiver to redesign the relationship of the Anoka Metro Regional Treatment Center (AMRTC) to the rest of the Medicaid program. Virtually all people receiving treatment services at AMRTC

are Medicaid-eligible at admission or would be Medicaid-eligible if the services were available in the community, and a majority are also Medicare recipients. A waiver of the federal law prohibiting Medicaid coverage for persons "residing in institutions for mental diseases" for people receiving services at AMRTC would allow MA coverage and reimbursement while receiving treatment at AMRTC. It also would allow Minnesota to make additional strides in reducing lengths of stay, reserving the AMRTC setting only for the most acute needs, and assisting timely and smooth transitions back to community-based supportive services.

In addition, State Operated Services is undertaking a comprehensive planning process to better define its role in delivering services to person with complex needs. This planning effort is coordinated with state health care reform initiatives, Olmstead planning, courts/law enforcement/corrections planning, and broader healthcare organizations. Agreeing on a shared vision for the role of SOS in the state's safety net between DHS, community providers and stakeholders would put SOS in a better position to collaborate effectively in these other policy-making settings and could result in improved care for people, improved relationships with other providers, a more seamless safety net, and financial savings.

Results:

SOS measures success in the strategies outlined above in the reduction in the length of stay for clients and in the reduction in the number of non-acute bed days. When a client can move through the system and return quickly to the community there is a greater chance they will retain their support system and living arrangement. A key measure of success is the reduction of non-acute bed days which result when a client longer needs inpatient hospital level of care but cannot be discharged for lack of funding or availability of an appropriate placement. Inability to discharge from a hospital setting is costly and restricts the systems flow resulting in individuals who need hospital level of care being held in inappropriate settings including community corrections and emergency rooms.

Performance Measures	Previous	Current	Trend
Average Number of Non-Acute bed days per adult patient[1]	9.4	8	Improving
Mental Health [post discharge] Follow Up Rate[2]	73%	75.7%	Improving
The average number of psychotropic medications prescribed at discharge[3]	2.4	2.3	Improving

Performance Measures Notes:

1. Previous measures Calendar Year (CY) 2010, fourth quarter and Current measures CY2011, fourth quarter (Source: DHS Public Dashboard)
2. The percent of clients hospitalized for mental illness who have a follow-up appointment set up within 30 days in place at time of discharge. Prompt follow-up in the community is an important factor in avoiding re-hospitalization. Previous measures CY 2011 and Current year measures CY 2012, 2nd Quarter. (Source: DHS Internal Performance Tracking)
3. The average number of psychotropic medications prescribed at discharge. Previous measure is third quarter state fiscal year 2011 and Current measure is third quarter state fiscal year 2012. Decreasing prescribed medications increases compliance which in turn results in increased stability following discharge. (Source: DHS Internal Performance Tracking)

Human Services
SOS Enterprise Services

http://www.dhs.state.mn.us/sos

Statewide Outcome(s):

SOS Enterprise Services supports the following statewide outcome(s).

Minnesotans are healthy.

People in Minnesota are safe.

Context:

According to the Coalition for Whole Health, Recommendations on Coverage of Mental Health and Substance Use Disorder Services, published in August 2011, nearly one-third of adults and one-fifth of children had a diagnosable substance use or mental health problem in the last year. Individuals with severe mental health and severe substance use disorders are known to have greater mortality rates, dying 25 to 37 years earlier than the general population. In 2009, 23.5 million Americans needed treatment for an illicit drug or alcohol problem, but only 4.3 million people received treatment. Several states have found that providing adequate mental health/addiction treatment benefits slows the escalation in health care costs and reduces Medicaid spending.

In 2006–2008, the Centers for Disease Control (CDC) reported that in the United States, about one in six children had a developmental disability ranging in severity levels. As these children become adults, some are unable to self-manage their own disabilities or continue their existing living arrangement or find employment.

State Operated Services' (SOS) Enterprise Services is for those individuals that other community providers cannot or will not serve due to the individuals complex service needs. SOS Enterprise services served 2,043 clients in the Community Addiction Recovery Enterprise programs, 35 children in foster care services, 896 clients in vocational programs, and 524 clients in community-based residential services in fiscal year 2012.

Strategies:

State Operated Services specializes in providing services to vulnerable people for whom no other providers are available or for whom State Operated Services may be the provider selected by the payer. As such, these services fill a need in the continuum of services for vulnerable people with disabilities by providing services not otherwise available. SOS Enterprise Services focus on providing treatment and residential care for adults and children with chemical dependency, behavioral health issues, and developmental disabilities. SOS Enterprise Services operates in the marketplace with other providers, funded solely through revenues collected from third-party payment sources. As such, these services do not rely on a state appropriation for funding. Enterprise services are fully funded by public or private third-party health insurance or other revenue sources.

Current services SOS provides on an enterprise basis include:

- **Chemical Addiction Recovery Enterprise (C.A.R.E.)** programs provide inpatient and outpatient treatment to persons with chemical dependency and substance abuse problems. Programs are operated in Anoka, Brainerd, Carlton, Fergus Falls, St. Peter, and Willmar.
- **Child and Adolescent Behavioral Health Services (CABHS)** provide an array of foster care services to children or adolescents who have severe emotional disturbances and serious acting out behaviors. Child and Adolescent Behavioral Health Services provides these services at sites statewide and the treatment structure of the foster care home is based on a combination of evidence-based models, including the multidimensional treatment foster care model, wrap-around services model, and, where appropriate, dialectical behavioral therapy.
- **State Operated Services community-based residential services** for people with disabilities typically are provided in four-bed group homes. Individual service agreements are negotiated with the counties for each client based on his/her needs. Clients take advantage of and are integrated into the daily flow of their community.

- **Day Training and Habilitation (DT&H)** programs provide vocational support services to people with disabilities and include evaluation, training, and supported employment. Individual service agreements are negotiated for each client.

Results:

Performance Measures	Previous	Current	Trend
Percent of persons admitted to Community Addiction Recovery Enterprise (C.A.R.E.) who completed treatment[1]	65.3%	66.1%	Improving
The amount of income earned by clients participating in day treatment and habilitation (DT&H) programs[2]	$1,000	$1,550	Improving
The number of patients discharged that return to C.A.R.E. within 60 days.[3]	9.1%	7.4%	Improving

Performance Measures Notes:

1. Previous represents the average between all C.A.R.E. programs for CY 2009 and Current represents CY 2010. The department goal is to increase treatment rates by five percent. This measure is important because completion of a chemical dependency treatment program is an indication of client engagement and increases likelihood of sobriety after discharge. (Source: DHS internal performance tracking)
2. Previous represents CY 2011 and Current represents CY 2012. This measure is important because it demonstrates the department's commitment to recognizing that people with disabilities can do useful work and be productive citizens. (Source: DHS internal performance tracking)
3. Previous represents FY 2011 and Current represents FY 2012. This measure is important because it demonstrates that the patient's treatment is working and they are able to remain in recovery and live in their community. (Source: SOS medical records system)

Human Services
SOS MN Security Hospital

http://www.dhs.state.mn.us/sos

Statewide Outcome(s):

SOS MN Security Hospital supports the following statewide outcome(s).

People in Minnesota are safe.

Minnesotans are healthy.

Context:

Mental illnesses can affect persons of any age, race, religion, or income. According to the National Alliance on Mental Illness – Minnesota (NAMI-MN), it is estimated that mental illnesses affect one in five families. Mental illness falls along a continuum of severity. Without treatment, the consequences of mental illness for the individual and society are staggering and can lead to an individual with high severity to commit acts that seriously endanger themselves or others.

The Minnesota Security Hospital (MSH) in St. Peter provides multidisciplinary treatment services to adults and adolescents who have the most severe illnesses and who have endangered others and now present a serious risk to public safety. Persons are admitted into the MSH from throughout the states pursuant to judicial or other lawful orders, for assessment and/or treatment of acute and chronic major mental disorders, including persons committed by the courts as mentally ill and dangerous. The population served in the secure perimeter of the Minnesota Security Hospital is growing at a forecasted rate of five to seven per year. With an average length of stay of 6.2 years, in fiscal year 2012, 233 persons were served by this program. An additional 167 persons received services in the MSH Transition Program, 213 persons received services in the treat to competency program (Criminal Court Procedure Rule 20.01 and 20.02), and 39 persons received services in the Forensic Nursing Home.

The population admitted to the Minnesota Security Hospital present many challenges and serving this population successfully requires that the state meet all those challenges well. In recent years, the Minnesota Security Hospital has had numerous client safety issues and employee injuries, indications that we need to do more to meet the needs of the people we're serving and the employees who serve them.

Strategies:

The Minnesota Security Hospital provides treatment, comprehensive, court-ordered forensic evaluations; including competency to stand trial and pre-sentence mental health evaluations. The Minnesota Security Hospital operates a transition program that provides a supervised residential setting offering social rehabilitation treatment to increase self-sufficiency and build the skills necessary for a safe return to the community.

In response to physical plant shortcomings contributing to client and staff safety problems, the 2012 Legislature appropriated $3.7 million in bonding for the predesign and design of the first phase of a two-phase project to remodel existing facilities and develop new residential, program, activity and ancillary facilities on the upper campus of the St. Peter Regional Treatment Center. This action launched the necessary planning activities for renovation and construction needs to improve patient safety and reduce employee injuries associated with the environment. The department will remain in regular communication regarding the results of that planning and next steps in meeting the physical plant needs related to treating our clients.

MSH shares the St. Peter campus with the Minnesota Sex Offender Program (MSOP). Designs are intended to address issues the department faces as it operates MSH and MSOP on the same campus. This project will result in the eventual relocation of all MSH residential and program activities from the lower campus to the upper campus. The lower campus will be reused and redeveloped for MSOP as a separate project. New facilities on the upper campus will allow the long-term needs of different populations served by MSH to be met.

Besides the secure and transition programs operated at the Minnesota Security Hospital, the program also operates a forensic nursing home which provides services to those individuals who are in need of nursing home

level of care and are committed as mentally ill and dangerous, sexual psychopathic personality (SPP), a sexually dangerous person (SDP), or those on medical release from the Department of Corrections (DOC).

Results:

Important performance measures for this program include:

- monitoring the percent of eligible patients are participating in therapeutic work activities which build skills and work habits in preparation for transition to a job placement in the community. Eligible patients include those in the Forensics Transitions Service (FTS) and Minnesota Security Hospital (MSH) Young Adult and Adolescent Program and Special Needs Services.
- increasing the percent of persons who are successfully and safely provisionally discharged from forensic transition services into the community. This measure is important because it ensures that persons committed to the Minnesota Security Hospital are completing their treatment and being successfully placed into the community.
- reducing the number of worker's compensation claims. This measure is important because it monitors the safety of our work environment for our employees and the rate of worker's compensation claims.

Performance Measures	Previous	Current	Trend
The percent of eligible patients who are engaged in therapeutic work activities[1]	69%	71%	Improving
The percent of persons who have been provisionally discharged from forensic transition services into the community[2]	14%	18%	Improving
Number of worker compensation claims filed[3]	20	28	Worsening

Performance Measures Notes:

1. Previous represents Calendar Year (CY) 2012, first quarter and the current represents CY 2012, second quarter. (Source: DHS internal performance tracking)
2. Previous represents CY 2011 and the current represents CY 2012, first two quarters. (Source: SOS medical records system)
3. Previous represents CY 2012 first quarter and the current represents CY 2012 second quarter. (Source: DHS internal performance tracking)

Human Services
Minnesota Sex Offender Program

http://www.dhs.state.mn.us/main/dhs16_149914

Statewide Outcome(s):

The Minnesota Sex Offender Program (MSOP) supports the following statewide outcome(s).

People in Minnesota are safe.

Minnesotans are healthy.

Context:

The Minnesota Sex Offender Program (MSOP) provides services to individuals who have been court-ordered to receive sex offender treatment. Minnesota is one of 20 states that has civil commitment laws to indeterminately detain individuals for treatment to address their sexual dangerousness and as part of a broader strategy to manage the risks to public safety presented by sexual offenders. The statutory mission of MSOP is to promote public safety by providing sex offender treatment to individuals determined by the court as high-risk for reoffending and civilly committed to the Minnesota Department of Human Services (DHS) for treatment.

Most of MSOP clients, but not all, come from the state Department of Corrections (DOC). Toward the end of their sentences, all individuals convicted of sexual offenses are reviewed by the Risk Assessment Community Notification Unit within DOC. Through this process, the DOC determines which cases to refer for consideration of civil commitment as a sexually dangerous person (SDP) or sexual psychopathic personality (SPP). It is then up to respective counties to determine if they wish to pursue civil commitment for these individuals after their period of incarceration is complete.

If a civil court determines an individual meets the statutory criteria for civil commitment, the person is committed to MSOP for court-ordered sex offender treatment for an indeterminate period of time. Transfer, provisional discharge or discharge from MSOP must also be ordered by the court. In 2012, the courts ordered the first provisional discharge from the program in many years.

MSOP is funded through general fund appropriations and county payments. Committing counties are responsible for 25% of the cost of care.

Strategies:

Civil commitment is only one tool on the statewide continuum of comprehensive sex offender management and supervision. MSOP accomplishes its mission through the following strategies:

- Creating a therapeutic environment that is safe for clients and staff. The treatment model is client-centered and has a clear progression across the continuum of care.
- Maximizing public safety by using state-of-the art technology to monitor client movement both inside the facility perimeter and for those with community privileges.
- Prioritizing our responsibility to Minnesotans through efficient use of state resources to effectively enhance, develop, and manage a comprehensive and individualized treatment program.
- Working together with community stakeholders, policy makers, and other state agencies to prevent sexual violence.
- Developing resources for MSOP clients court-ordered for provisional discharge while maintaining public safety via community-based clinical services, integrated supervision and risk management, stable housing, and meaningful employment.

Results:

The number of clients served in MSOP has grown from 483 at the end of state fiscal year 2008 to 653 at the end of state fiscal year 2012. Despite its continued growth trend, MSOP has demonstrated numerous clinical advances, operational efficiencies, and security enhancements over the last few years.

Because individuals committed to MSOP can chose whether to participate in treatment, MSOP tracks the rate of participation in sex-offender specific treatment. MSOP also measures and reports the program's operational per diem on an annual basis. The operational per diem measures the average program-wide daily costs for treating and housing MSOP clients. A downward trend indicates efficiency improvements in operating the program.

We have begun collecting information on a new performance measure that tracks the average of weekly clinical service hours per participant. We have also begun collecting information on the number of reportable injuries and claims for worker's compensation. In the future, we will also be able to report on these new performance measures.

Performance Measures	Previous	Current	Trend
Rate of participation in sex-offender specific treatment (quarterly measure)[1]	85%	86%	Stable
Operational Per Diem[2]	$302	$290	Improving

Performance Measures Notes:

1 Compares March 31, 2012 (Previous) to June 30, 2012 (Current). Source: DHS Dashboard.
2 Compares FY 2011 (Previous) to FY 2013 (Current). Source: DHS Dashboard. The Operational Per Diem measures DHS' average program-wide daily costs for treating and housing MSOP clients.

Human Services
Fiduciary Activities

Statewide Outcome(s):

Fiduciary Activities supports the following statewide outcome(s).

Strong and stable families and communities.

Context:

The Fiduciary Activities budget program includes expenditures accounted for in the state's fiduciary fund group. By definition, the fiduciary fund group is used to account for assets held in trust by the government for the benefit of individuals or other organizations. Accordingly, the fiduciary fund group is excluded from the state's budgetary fund balance presentation. By isolating these expenditures in this budget program, spending in the other DHS budget activities is not distorted.

For DHS, the bulk of these expenditures are attributable to the payment of child support collections to custodial parents. Listed below are the specific types of expenditures included in this program.

- Child support payments: Payments made to custodial parents from funds collected by the state from noncustodial parents.
- MAXIS off-line recoveries: Funds recovered by the state and money received from counties that cannot be receipted MAXIS (the state computer system that determines eligibility for and issues public assistance payments). The funds are held here until DHS can determine what program is to be credited and to whom payment should be made. Payments are made to the U.S. Treasury for federal shares of recoveries, to counties for incentives, to clients for returned money or their balance of interim assistance recoveries, to providers for Supplemental Security Income (SSI) services, or to the state for any state share of recoveries.
- Long-term care civil penalties: Monies collected by the federal Centers for Medicare & Medicaid Services (CMS) from nursing homes that are assessed penalties for noncompliance. The portion given to states must be used solely for approved projects that specifically address nursing home deficiencies.

The expenditures and associated accounting processes in this activity are supported administratively by the budgets within the Central Office program.

Strategies:

Maintain necessary staff and information technology resources to adequately support payment collections and disbursement activity.

Results:

Minnesota citizens and DHS clients expect accurate, efficient, and timely payment processing. This performance measure tracks the efficiency and timeliness of child support collections disbursed to families. DHS consistently ranks in the top five states for processing child support payments.

Performance Measures	Previous	Current	Trend
Percent of Unresolved Undistributed Child Support Collections	2.1%	2.2%	Stable

Performance Measures Notes:

Compares Federal fiscal year 2009 (Previous) and federal fiscal year 2010 (Current). Source: Preliminary 2010 federal child support report.

Human Services
Technical Activities

Statewide Outcome(s):

Technical Activities supports the following statewide outcome(s).

Efficient and accountable government services.

Context:

The Technical Activities budget program includes transfers and expenditures between federal grants, programs and state agencies that Department of Human Services (DHS) staff account for in different funds in the state's accounts, and that must be properly processed in the state's SWIFT accounting system. This budget program also includes administrative reimbursements earned by other human services entities or other state funds that DHS must ensure is passed through to the proper entities and accurately recorded in the state's accounting system. By isolating these expenditures in this budget program, spending reported in other DHS budget activities is not distorted and federal grant accounting requirements are followed.

Listed below are specific types of inter-fund and pass-through expenditures included in the Technical Activities budget program.

- Federal administrative reimbursement earned by and paid to counties, tribes and other local agencies.
- Federal administrative reimbursement earned by and paid to other state agencies.
- Administrative reimbursement (primarily federal funds) earned on statewide indirect costs and paid to the General Fund.
- Administrative reimbursement (primarily federal funds) earned on DHS Central Office administrative costs and paid to the general fund, health care access fund and special revenue fund as prescribed by state law and policy.
- Transfers between federal grants, programs and state agencies that are accounted for as expenditures in the state's SWIFT accounting system.
- Other technical accounting transactions.

Expenditures and associated accounting processes reflected by this program are supported administratively by the Operations budget activity within the Central Office budget program.

Strategies:

DHS maintains necessary staff and information technology resources to adequately support accurate, efficient, and timely federal fund cash management.

Results:

DHS measures the extent to which federal funds are deposited within two working days.

Performance Measures	Previous	Current	Trend
Percent of federal fund deposit transactions completed (deposited in State treasury) within two working days of the amount being identified by the SWIFT accounting system.[1]	not available[2]	89%	Stable

Performance Measures Notes:

1. SWIFT identifies and creates an invoice when federal funds are due to the State Treasury. This efficiency measure monitors the percent of deposit transactions that staff complete within two working days of the SWIFT invoice process. The current measure is for the latter three quarters of SFY 2012. Source: DHS Receipt Center records
2. The federal draw process changed with the new SWIFT accounting system and a previous percent measure is not available.