COMMISSION
ON REFORM
AND EFFICIENCY

CORE

REFORMING MINNESOTA'S HUMAN SERVICES DELIVERY SYSTEM

SUMMARY REPORT

MARCH 1993

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

THE CORE VISION OF STATE GOVERNMENT

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

Mission driven

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

Oriented toward quality outcomes

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

Efficient

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

Responsive to clients

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

Respectful of stakeholders

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

— Feb. 27, 1992

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EXECUTIVE SUMMARY

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

The Commission on Reform and Efficiency (CORE) reviewed the roles, responsibilities, and relationships of all the players in the state's human services system, from state and local government agencies to providers and service customers. Based on the input of more than 425 people involved in the system and other research, CORE identified six major barriers to an effective and efficient human services system:

- The system lacks a clear and comprehensive vision.
- Human service agencies do not have appropriate, coordinated missions.
- The system lacks unifying leadership.
- The system is fragmented, with responsibility for programs and services scattered among several distinct bureaucracies.
- The system is complex and prescriptive and focuses on process, rather than outcomes.
- Inappropriate incentives built into the system contribute to its fragmentation and prescriptiveness.

Based on the belief that Minnesota's health and human services system should be mission-driven, accountable, customer-focused, and outcome-driven, CORE makes 13 recommendations for overcoming these barriers.

Recommendation 1 would establish a secretary of health and human services who would report to the governor and oversee the programs, budgets, and administration of state human service agencies. Doing this would foster vision and leadership in the system and improve coordination and integration of services.

Recommendation 2 calls for the creation of local health and human services districts (HHSDs) for program planning and administration. Establishing these districts would improve linkages between resources and provide for more comprehensive planning.

Recommendation 3 directs the secretary of health and human services, along with the HHSDs, to identify target populations, determine service eligibility priorities, and develop a list of services eligible for state funding and constituting a "minimum and adequate level of services" to meet basic needs. These services could be enhanced by discretionary services provided through state and local funding.

Recommendation 4 urges creation of an HHSD grant to give local health and human services districts greater flexibility to meet local needs. This would increase the size of local social services block grant funds and eliminate many categorical grants, while maintaining a basic threshold of services.

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

Recommendations 6 through 8 address the prescriptive nature of rules, tightening the criteria

for what is included in rules, requiring an agency review and repeal process for existing rules, and recommending that state agencies permit and encourage regulated entities to apply for waivers from existing rules.

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

Recommendations 11 through 13 are designed to achieve a customer-focused system by encouraging state and county agencies to clearly define their customers and to empower staff to serve their customers. The legislature, state agencies, counties, and providers must work in partnership to empower customers to achieve their goals.

CORE projects a total of almost $50 million in savings over five years once Recommendations 1 through 4 are fully implemented.

Some of the recommendations can be implemented immediately by state and local governments, without additional statutory authority. Many others will require time to work out the details and to obtain necessary state and federal law changes.

Reform is not a one-time event but a process of continual change. CORE's recommendations point the way toward achieving a dramatically improved health and human services system in Minnesota.

INTRODUCTION

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

Project work plan

The CORE Human Services Project reviewed the roles, responsibilities, and relationships of state and county government in the delivery of health and human services programs within a coordinated system. For the purposes of this report, the departments of Human Services, Health, Corrections, Veterans Affairs, and Jobs and Training and the Minnesota Housing Finance Agency are the state human services agencies. County social services and public health agencies also are part of the statewide human services system.

Project staff received input from more than 425 people through individual interviews and focus groups. These people included service customers (end-users), state and county managers and professional staff, providers, and elected officials, among many others. Studies from Minnesota and other states were also reviewed to identify additional key barriers to achieving an improved human services system.

Ten experts in human services delivery acted as consultants to project staff throughout the design and recommendation development phases of the project. These individuals unofficially represented state agencies, legislative committees, counties, and a citizens group.

Over a nine-month period, the CORE Program Analysis Working Committee discussed briefing papers prepared by staff, deliberated issues and options, and developed the recommendations contained in this report, which were subsequently approved by the full commission.

Human services system principles

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

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

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

Current human services system

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

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

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

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

This report summarizes briefly the major components of the project. For a complete, detailed report of the project, contact the Department of Administration, Management Analysis Division, 203 Administration Building, 50 Sherburne Ave., St. Paul 55155, telephone (612) 296-7041.

FINDINGS

CORE has found six major barriers to an effective human services system in Minnesota. These challenges must be addressed to improve Minnesota's human services system.

Lack of clear, comprehensive vision

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

Many individuals interviewed for the project identified lack of a clear vision as a serious detriment to the system. They expressed doubts that a unified sense exists of what is wanted and expected from the state's human services system.

Developing a clear vision is critical because the state's human services system operates in the turbulent environment of changing policies, funding, and leadership; is constantly expected to provide more services; and is facing public expectations that all government services should be made more efficient and accountable.

Lack of appropriate, coordinated missions

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

Interview and focus group participants observed that there is a lack of clear, coordinated missions in Minnesota's human services system. Agencies' missions do not always appropriately reflect their roles, and many missions overlap. Without a specific mission for each organization that has a role in the system, there is no consistency of purpose or clear point of reference for decisions.

An important element of any mission statement is clearly identifying the agency's customers. Many of the comments made by county social services agencies indicated that the Department of Human Services (DHS) does not view counties as its customers. Because the DHS provides limited direct services to citizens, it is not surprising that many interviewees felt that the mission of the DHS and its efforts should be refocused. The DHS mission statement's focus on the citizen, while undoubtedly well intended, has little to do with whether counties and providers are equipped with the necessary information and administrative tools to deliver services.

Lack of leadership

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

When people say Minnesota's human services system lacks leadership, they sometimes make the observation that there are many strong leaders, but each has a separate agenda that does not encompass all of human services; people may express the perception that human services issues often appear to be uninteresting to powerful people, compared with other public policy issues; or they may be talking about the fact that at the state level, agency top management changes frequently as a result of political change.

All these points of view were expressed in interviews and focus groups. Interviewees' comments demonstrate a persistent lack of confidence in the state health and human services system, particularly toward DHS. Respondents

did not think that anyone is taking responsibility for directing the system toward improvement. Nor did they feel that significant change was possible immediately, because of the system's complexity. Nonetheless, addressing the lack of vision, mission, and leadership was emphasized as a first and critical step toward reform of the health and human services system.

In Minnesota, no position exists from which one individual could exercise leadership for the entire human services system. Theoretically, the governor could do this. However, the scope of the governor's responsibilities prevents the kind of intense oversight that would be necessary for leading the large and complex health and human services system.

System fragmentation

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

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

Uncoordinated planning and service delivery

Public human services programs in Minnesota are provided through 84 county entities [2], each with its own services and delivery system. Despite the array of programs, people's needs still fall through the cracks. County service providers often are not aware of available nonprofit and private-sector services.

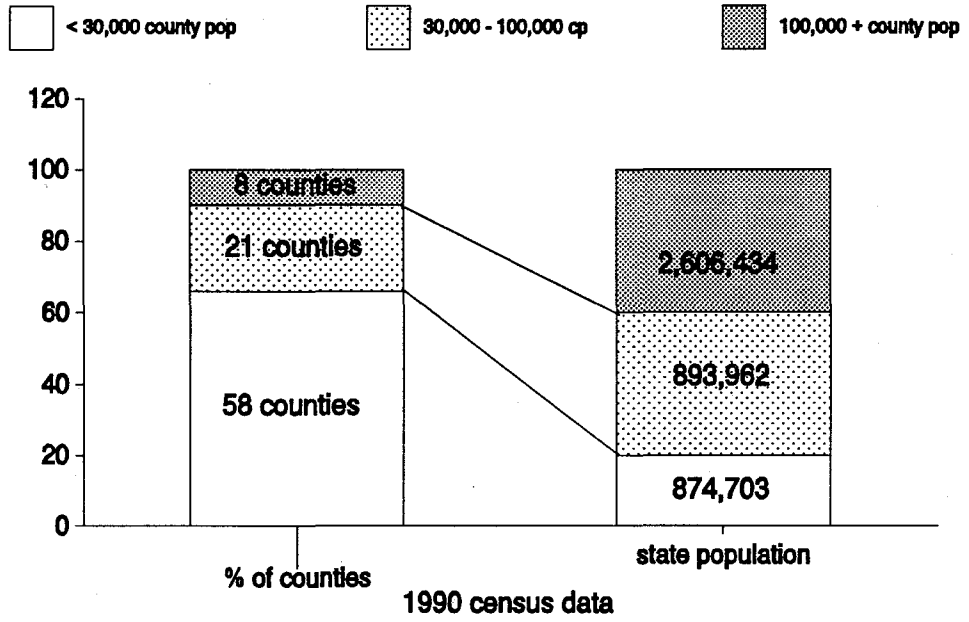
People directly involved in providing services believe that navigating the system is too difficult and confusing for citizens. It can be especially difficult and frustrating for people who are elderly or from another culture or who have a mental illness. People do not know what programs and services are available, much less how to obtain access to them. Clients of the welfare system say the best place to find out about programs is not from case workers but from people on the street. People attempting to identify options for their aging parents do not know where to go for comprehensive information and referrals.

An example of system fragmentation is the large number of older-citizen programs, which are managed by several different divisions within DHS and the Department of Health. Within each department, these divisions also are under the authority of different assistant commissioners. Aging programs become even more fragmented at the local level. Similar services are planned and provided through area agencies on aging, county public health agencies, and county social service agencies (as well as private agencies). A DHS survey [3] of county social services and public health agencies found that in most cases even the agencies themselves did not know which agency had lead responsibility for the state-required preadmission screening program.

Coordinated planning is almost nonexistent within the state executive branch. County administrators and program managers say that policy formulation is sometimes inconsistent among the various entities within state government that design services for the same populations.

Uncoordinated planning also occurs at the local level. For example, community social services

Figure 1. State population by county



land community health services planning is rarely coordinated, even though some of the programs and services provided are similar, because the plans are due at different times to different state agencies.

Almost everyone involved in the system admits that although coordinated planning should be a desired goal, and some examples of coordination do exist, it is time-consuming and labor-intensive, and there are not sufficient state or local resources available to do it. Turf issues also impinge on the ability to coordinate planning and services. Agencies have no real incentive to risk giving up some power to coordinate with other entities.

Resource capacity

According to various people who work in or receive services from the system, many counties are too small to provide effective local service delivery because they have neither an adequate staff to provide the highest quality services nor a big enough population base to achieve the scale necessary to provide many services. Because different counties have differing capacities, the level of quality may vary, even though standards are uniform across the state. For example, some counties are better at obtaining grants than others, resulting in different levels of service among counties. Larger counties also have the administrative capacity and the population to make good subjects for innovative pilot projects or similar experiments.

These larger counties are also more efficient in a comparison of the number of local political and administrative entities to population served. Sixty percent of the state's population is served by eight county boards of commissioners, while 20 percent is served by 58 county boards (see Figure 1). Similarly, 60 percent is served by 16 public health and social services administrations, while 20 percent is served by 91 public health and social services administrations.

Counties accuse the state of using a "cookie cut-

ter" approach in designing human services programs, such as when the state mandates that all counties use the same procedures. In this way, smaller localities are often forced to meet state standards that are very difficult for them. A social service director from a small county reported that his staff cannot keep up with the state bulletins that detail program regulations and procedures. CORE staff verified that in a typical 40-hour work week, a county social service agency could receive a bulletin from a state agency about every five and a half hours.

Resource capacity challenges also exist at the state level. State agency staff has been reduced over the past two years because of budget constraints. Many vacant positions have not been filled; state agencies are now trying to do more with fewer staff. The extensive county human services system strains the state's limited resources. While acknowledging the value of local control, state agency personnel also criticize the county-administered system, saying that it is terribly time-consuming for the state to deal with 87 counties, each of which, according to many people, "views itself as an equal partner with the state." It seems to state program managers that every question can have at least 87 variations. DHS staff have reported that the agency is unable to provide regular technical assistance or audits of all county social service agencies.

Professional specialization

Case management [4] has added to the problem of fragmentation because each program area has developed its own case managers who specialize in a rather narrow area and may not consider customers' broader interests. A customer explained, "If your worker is on vacation, you are out of luck. No one else can help you. The message is 'we don't care.'"

The problem is also manifested when a customer is receiving services from more than one agency. Providers reported that if one organization has initial responsibility for a customer, others sometimes back away, feeling it is "not their job" to address coordination issues. Additionally, the need to coordinate and reduce overlap is not always apparent to competing providers.

Turf protection

One of the aims of Minnesota's current system structure is to be able to meet local needs in a state with disparate economies, cultures, and demographics. However, this system also kindles ongoing and seemingly inevitable turf protection and competition among and within counties.

Turf protection within counties and among state agencies has been similar. Turf protection at the state and county levels sometimes prevents innovation from taking place, because change and cooperative service delivery are often perceived as a potential loss of power and control. Program managers may have trouble agreeing to a plan that may result in diminished funding or authority in their area of responsibility.

Complexity and prescriptiveness

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

The human services system operates through a set of very prescriptive rules and process standards for both philosophical and practical reasons. Many reasons, both philosophical and practical, exist for the fact that most of the human services system operates through a set of very prescriptive rules and process standards.

A philosophical explanation is the tension between local decision making and state account-

ability. The state-supervised, county-administered system was intended to enable local areas to plan services to fit their unique needs. The state was to set program parameters and provide oversight and professional assistance. Counties were responsible for providing services directly or through contracts with vendors.

But because the legislature holds the executive branch accountable for how program funding is spent, state program managers feel responsible for the county expenditure of funds. As a result, through the years the executive branch has exerted more control over the choice of services and how they are delivered, and procedures have become more prescriptive.

A practical explanation of how and why program procedures are so complicated is that an evolution of sorts occurs in state management of human services programs. In their inception, most programs tend to be relatively straightforward and uncomplicated. As programs are implemented, problems and questions arise about various components that are resolved by formulating a policy. The number of individual policy components grows until there is a relatively large compendium of policies to guide the program and service delivery.

Furthermore, through the legislative and rules processes, special interest groups attain additional regulations designed to protect consumers from harm or otherwise advance their interests or to protect business interests. These groups' success, coupled with a strong negative public response when things go wrong because rules are not strong enough or not enforced, greatly increases the movement toward a prescriptive, rules-oriented system. As a result, efforts of program managers at the state, county, and vendor levels become focused on designing process standards to anticipate the worst-case scenario, rather than on achieving broad program goals.

Categorical funding and restrictive eligibility

Service equity means ensuring that all state citizens, regardless of where they live, have access to at least a minimum level of health and human services. Categorical funding is a result of attempts to attain service equity for various groups of people, such as people with developmental disabilities or mental illnesses. This has resulted in some statewide service mandates that most people concede go beyond a minimum level of services in some areas while overlooking needs in others. Many of these mandates impose requirements on counties, even though the legislature is not able to provide the full funding needed to deliver the level of services demanded.

Another problem with restrictive funding is that people's needs are rarely simple and often do not fit into just one category of services. Case managers say they are frustrated by rules that routinely block access to services. Sometimes the one thing that would help a client the most is unavailable because of restrictive program rules. Case managers must fit clients to the services available, as opposed to designing services to fit the client. Clients can feel as if they have opened the door to a closet full of clothes where nothing fits.

Inappropriate incentives

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

All systems contain incentives. Interviews with human services workers, customers, and providers revealed two important themes regarding incentives in the human services system: (1) incentives in the system are present, powerful, and affect behavior; and (2) incentives and

disincentives are often the unplanned and unanticipated consequences of decisions made for other reasons.

Inappropriate incentives for customers

Although the stated purpose of many human services programs is to move people out of difficult circumstances into a more stable, self-sufficient status, the reality can be very different. Many human services customers feel they could participate more in decision making and would be capable of being their own case manager if only they had access to better information. It appears to them that information is being withheld or doled out only when social workers decide the customer needs to know something. In focus groups, customers felt strongly that they wanted to be accountable for their part of the arrangement. But without accurate information, customers are dependent on the skill and willingness of social workers to put together the package of services they need.

Inappropriate incentives for human services workers

Human services workers also experience inappropriate incentives. Most programs in the system are heavily regulated, minimizing professional discretion. Most involve long chains of command to review and approve nearly every transaction. A social worker explained, "There is no incentive to act in good faith or use common sense." County social service directors noted that the areas where there is the least amount of law and regulation, such as child protection, seem to attract the best social workers, implying a correlation between a climate that encourages professional decision making and the ability to attract quality staff.

Inappropriate incentives for human services providers

The system offers few if any incentives for providers to satisfy human services customers. Customers are given little choice of provider, and providers are often granted near-monopolies on services. The main provider is often the county itself. The result of this system is that customer choice is constrained by where the customer lives and by the exclusive contracts that are most often used to purchase services. Often, the only way customers can exercise any "choice" of providers is by moving to another county.

Inappropriate incentives for elected officials

Elected officials receive little reward for considering the longer term and the larger community. The incentive for the politician who wants to remain in office is to support policies that have the short-term effect of earning votes in the district, regardless of whether these policies make sense in the longer term or for all state taxpayers as a whole. Similarly, fiscal solutions that solve a current crisis are usually seen as more valuable than long-term fixes, especially those with initial implementation costs.

The influence of powerful special interests on legislators can also make it difficult to make radical changes in the system, even if these changes would be in the best interests of the state's citizens as a whole. Despite the lack of incentives, however, some legislators and local officials have supported innovative experiments and provided leadership for significant changes.

RECOMMENDATIONS

To overcome the barriers to an effective and efficient human services system, CORE makes the following 13 recommendations.

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

Establishing a secretary of health and human services would address the lack of vision and leadership in Minnesota's human services system and provide for improved coordination and integration of planning and service delivery, along with guidance and authority for changing the system as necessary. The secretary should be primarily involved in policy direction and oversight, rather than in day-to-day operations of the agencies.

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

The six major responsibilities of the secretary should be:

1. *Create a vision for health and human services.* The secretary should be accountable for developing a comprehensive vision for the human services delivery system. It is essential that the secretary involve the executive branch, the legislature, and citizens in the creation of this vision.

2. *Establish state health and human services agency missions.* The secretary should work with the health and human services deputy secretaries to determine an appropriate mission for each agency that specifies that agency's role in the health and human services system, including definition of their customers and outcome goals.

3. *Ensure coordination and integration of health and human services programs.* The secretary should have the authority to coordinate and integrate health and human services programs among all state health and human services agencies.

4. *Exercise comprehensive policy and budget responsibility.* Although priorities would be developed with input from the agencies, the secretary should, in consultation with the governor and the Department of Finance, weigh agency policy and budget interests against the larger goals and interests of the state as a whole. The secretary should exert control over agency budgets at the program level only; agency managers should retain control over administrative budgets.

5. *Coordinate legislation and oversee rule development.* In addition to budgetary control of policy, the secretary should have substantial control over policy through the coordination of legislation and oversight of rule development for all human services agencies.

6. *Develop guidelines for human services data collection and information.* The secretary should develop guidelines for data collection and information management, including standardization parameters, for health and human services agencies.

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

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

This new administrative structure would involve counties within a district in comprehensive joint planning and administration to identify and address the health and human services needs of the entire district. Duplication and gaps in services should be apparent, and resources could be pooled to the best use. Better linkages between resources and a single point of accountability for districtwide planning should benefit people working within the system as well as customers.

Establishing the districts

To make the change to districts as flexible as possible, CORE recommends that counties initially be given the option of arranging HHSD configurations that may be different from current CHS district configurations [5], as long as they have a minimum population of 30,000 and number no more than 44 districts. The number of local administrative units would decrease significantly, from more than 150 to a maximum of 44. After the initial HHSD configurations are settled, changes could be made only by the legislature on a case-by-case basis.

The HHSD structure would replace current CHS and county social service and public health administrations with a stronger, comprehensive administration. Every county would be affected by this organizational change: counties that are in a single-county CHS district could remain a single-county HHSD but would combine their social services and health administrations; counties with less than the minimum required population would combine social services and health administrations with the other counties in a multicounty district so that there is one health and human services administrative entity within the district.

Administration and accountability for HHSDs would require joint powers or similar agreements among counties within a district but would not require the establishment of an entirely new governmental unit. County board governance would function much as it does now, except that health and human services decisions would be made either by a combined district board made up of all county commissioners in the district or a delegated subgroup of commissioners.

Using current CHS district configurations as a basis for comparison, the ratio of county commissioners to population in a district can be projected, as illustrated in Table 1.

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

It is important to note that the creation of HHSDs does not require a district to centralize

Table 1. Ratio of County Commissioners to Population

Size of county	Total population	No. of county commissioners	Avg. population per county commissioner
8 largest counties	2,606,434	50	52,129
21 mid-size counties	893,962	105	8,514
58 smallest counties	874,703	290	3,016
Size of CHS district	**Total population**	**No. of county commissioners**	**Avg. population per county commissioner**
Single-county districts	3,051,891	113	27,008
" (except Hennepin)	2,091,460	106	19,052
2-county districts	541,050	130	4,162
3-county districts	177,729	45	3,950
4- to 5-county districts	604,429	157	3,850

the delivery of services. Whether a district has one county or more than one, services would continue to be provided at the most efficient and effective decentralized level, as close to customers as possible, as determined by individual districts.

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

To achieve this concept, a distinction must be made between those services that are essential and meet system goals ("minimum and adequate") and those that are discretionary. The process for establishing a minimum and adequate level of services would include determining *target population groups* to be served and then, within each group, *service eligibility priority*. It is significant that this process would begin with identification of people to be served and a prioritization of need, rather than with a listing of services. Once the determination of priority populations was made, a *list of services* that would be paid for with state funds could be developed.

Only those persons who meet the eligibility priority criteria for the target populations would receive state-financed services. This minimum and adequate level of services would be enhanced by discretionary services provided by individual HHSD plans. These discretionary options would vary depending on state and local resources.

Because this is a new and complex approach, a few examples of how this system could work are useful:

- *Target population:* poor families

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

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

- Target population: people with a mental illness

  Priority: statutory definition of "severe and persistent mental illness" and income below a defined amount

  Services: psychiatric care, medication management, mental health therapy, housing assistance, independent living skills training, vocational training or assistance, crisis care, etc.

- *Target population:* people older than 60

  Priority: functional ability equivalent to nursing home case mix B through K and income below a defined amount

  Services: home-delivered meals, home health care, chore services, homemaker services, public health nursing, assisted living services, transportation, etc.

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

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

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

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

The HHSD grant would be formed by combining health and human services funding sources that are made up primarily of state dollars and are not entitlements. These sources include funds from Community Social Services, community health services, Semi-Independent Living Services, Title III aging program and non-Medicaid mental health grants, and state-operated residential care funding.

A significant portion of the HHSD grant would be composed of funds from state regional treatment centers (RTCs). The grant would clearly have an effect on RTCs, because many districts may choose community rather than RTC placement for people for whom community settings are appropriate.

CORE recognizes that many discussions have taken place with regard to the future of RTCs, and that a memorandum of understanding (MOU) exists between the state and RTC employee bargaining units. The secretary of health and human services should be fully cognizant of this memorandum when planning any action for system change that may affect RTCs. The calculations of the fiscal impact of this recommendation do take this MOU into account.

This recommendation would eliminate many state mandates for social services but would require clear reporting from HHSDs on how block grant funding is spent. Each HHSD board would be responsible for approving the health and human services budget for a district. After determining the district's health and social services needs, the board would approve a specific health and social service levy that would apply to all taxpayers within the district.

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

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

Effectively changing from an emphasis on process to an emphasis on results throughout the delivery system could have the most pivotal effect on the system. This recommendation includes suggestions for four specific areas in which to develop an emphasis on outcomes:

1. *Focus on outcomes in state and local agency budgets.* Using outcome measures in agency budgets can provide information to determine whether programs actually are working. Health and human services outcomes can be difficult to quantify and do not easily provide opportunities for controlled experimentation. But by emphasizing an outcomes focus, the right questions (that is, results- vs. process-oriented) are more likely to be asked and information valuable to policy decisions become available.

2. *Focus on outcomes in state relationships with local health and human services districts.* An outcomes focus in state-local relationships can be achieved in many ways: state agencies could focus on outcomes when designing and approving local human services plans; allocation formulas could be based on achieving stated results; and technical assistance could be provided to local entities based on where help is most needed to achieve results, rather than on how to comply with state-specified processes.

3. *Focus on outcomes in state relationships with direct service providers.* A number of possibilities for implementing this approach have the potential for cost efficiency. Providers could be paid based on customer outcomes, rather than on a fee-for-service or cost basis. Rules could be less detailed. Providers who continually meet quality and safety requirements could be inspected less frequently.

4. *Focus on outcomes for people who receive human services.* State agencies provide few direct services. Because of this, the state should encourage (but not prescribe) a focus on end-user outcomes at the local service delivery level. Providers, though, would find it difficult to implement this recommendation fully without implementation of other recommended policy changes (see Recommendations 2 through 4) that would establish more flexible means of meeting customers' needs.

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

Detailed, restrictive rules are the single largest factor contributing to the prescriptive nature of Minnesota's human services system. If agencies begin writing less prescriptive rules that allow for more professional decision making at the direct service level, the costs of providing services should decrease, and the quality of service to customers should improve because the focus will be on the customers' real needs.

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

By instituting a formal procedure for reviewing and repealing rules and by establishing an expectation that agencies will undertake this process, the present burden of rules could be substantially reduced. Using the process in the state's Administrative Procedure Act to review and repeal rules will ensure that important rules are not summarily eliminated.

CORE does not expect agencies to have the resources to undertake all these actions at once. Therefore, this recommendation suggests two priorities: (1) review all rules for service delivery that are built on but go beyond federal standards; and (2) review and, if justified, repeal all rules that are not *direct* health and safety rules, professional licensing rules, or rules that protect consumer rights.

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

Although some rules do have *variance* provisions, these are most often used to apply for an exception from a specific part of a rule, such as a variation in physical plant requirements. These variances are not a new way to achieve positive customer outcomes. Instead, the state should encourage agencies to consider and grant larger-scale *waivers* to rules to meet this goal.

Employing this recommendation would require those requesting a waiver to develop and propose a plan that demonstrates how they would achieve statutory outcomes. Rather than making a rule change that affects all providers, only those who have the desire and capacity to undertake the effort would be affected by rule waivers. This recommendation provides abundant opportunity for innovation.

9. Agencies should investigate and implement new methods of enforcement. These new ways would include more use of conflict resolution techniques; provision of technical assistance and oversight in proportion to noncompliance occurrences; peer or citizen review panels; and

rewards and incentives, such as public recognition of exemplary providers and educational opportunities that impart "best practices" principles. The secretary of health and human services should be responsible for ensuring that such methods are sought and used.

The state has a limited ability to enforce standards. Enforcement mechanisms are limited to sanctions when things have obviously gone wrong. Changes in rules and a less prescriptive system call for concurrent changes in the role of enforcement. Agencies should work with providers and HHSDs to determine what kinds of technical assistance they need and what kinds of rewards and incentives they would find motivating.

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

Current sanctions are limited to fining or revoking licenses of providers who do not comply with state rules and regulations and limiting funding to counties that do not comply with state requirements. In addition to these, different kinds of sanctions are needed to increase the state's options for action when faced with noncompliance. Agencies accountable to the secretary of health and human services should develop a plan for determining appropriate options and implementing them.

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

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

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

The previous recommendations on flexible funding, system restructuring, and rules are designed to remove some of the disincentives to a customer focus built into the health and human services system. Additional methods to empower staff to be responsive to customer needs include reducing layers of supervision to allow more professional discretion and faster response time and rewarding and recognizing staff for desired outcomes, rather than caseload size or other nonoutcome measures. In addition, managers should model the behaviors they wish staff to adopt, such as respect for customers and prompt responses to inquiries.

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

In general, the end-user of health and human services is the real customer of the system. Professionals have traditionally thought of these individuals and families as clients. Although these customers often do not have a choice about being in the system and are therefore not customers in the traditional sense, adopting a customer-service mentality and nomenclature could have a far-reaching effect on the nature of the interactions between these people and the system.

In order to use the system effectively, end-user customers and their families need several key

pieces of knowledge, such as where to get comprehensive and coordinated information and where to register complaints. These kinds of contact points should be fully developed so that customers have resources, as well as recourse for poor or disrespectful service. They should be given choices wherever possible. For example, as long as the services are cost-effective, the customers should be able to choose the types of services they receive and the providers of those services.

Organizational and end-user customers should be regularly surveyed for feedback on system responsiveness to their needs and should be assured that, based on that feedback, the system will change to improve how things are done.

FISCAL IMPACT

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

Recommendations 1 through 4 have significant, quantifiable fiscal effects. CORE projects a total of almost $50 million in savings over five years upon full implementation of these four recommendations.

Costs and savings

Recommendation 1: Establish a secretary of health and human services

This recommendation is expected to result in net savings of $497,700 the first year and $801,000 in subsequent years.

The benefit of establishing a secretary for health and human services goes beyond dollar savings. Creating this position would present an opportunity for authoritative leadership and accountability in the human services system. The secretary would also have the authority to consolidate or eliminate duplicative functions in agencies within the health and human services secretariat, increasing the potential for additional cost savings.

Recommendation 2: Establish health and human services districts

A number of counties have the potential to reduce costs by consolidating public health and social services administrations within the proposed HHSDs. Savings would be realized by the counties that combine with other counties into larger districts. Projected savings are based on the assumption that current CHS configurations would also be the HHSD configurations. Using the current average single-county public health and social services director salaries as a basis, 21 counties in the new districts could realize savings totaling $2.4 million per year, or $4.8 million per biennium. Efficiencies could also be created by merging support functions, consolidating staff expertise, and/or reallocating staff from administrative functions to direct customer service.

Recommendations 3 and 4: Establish an HHSD grant

Savings to be realized through more flexible funding cannot be absolutely predicted, though it is likely that a percentage of regional treatment center patients with mental illnesses would be served instead by less expensive community care options. Actual savings would depend on the rate and cost of placement in the community.

Based on data supplied by DHS, CORE projects that annually, about 1,080 clients who are mentally ill would receive treatment in community settings, rather than in an RTC. This means that 400 current RTC beds for persons with mental illness would no longer be needed, for a net savings of almost $2.7 million the first year and $7.9 million in subsequent years. The first-year projection includes severance costs for employees dislocated from RTCs as a result of this change.

Recommendation 5: Adopt an outcomes orientation

Focusing on outcomes in agency budgets will enable agencies to better evaluate whether pro-

Table 2. Recommendations with Significant Fiscal Impact

Activity	Annual Savings	Annual Increase	Transition Costs	Five-year Projection
Establish office of secretary of health and human services				
Add eight positions	—	$ 472,300	—	$ 2,361,500
Eliminate 22 agency positions replaced by office of the secretary	($ 1,273,300)	—	$ 303,300	($ 6,063,200)
Establish health and human services districts (HHSDs)				
Eliminate duplicative director positions (county savings)	($ 2,404,000)	—	—	($ 12,020,000)
Establish health and social services block grant				
Increase community placements of mentally ill persons	($ 33,235,440)	$ 25,354,360	$ 5,202,000	($ 34,203,400)
TOTAL	($ 36,912,740)	$ 25,826,660	$ 5,505,300	**($ 49,925,100)**

grams are working effectively and will help the state avoid expensive mistakes. The cost of determining outcome measures for all health and human services agency programs can be assumed to be substantial, though the savings from avoiding programs with poor outcomes should also be significant.

The overall effect of an outcomes approach in state-local relationships would be cost-neutral for state agencies. Some staff time now spent on rules and procedures could be shifted to providing technical assistance (to help local agencies achieve their desired outcomes) and program evaluation (to determine actual outcomes).

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

The benefits of focusing on outcomes for the end-user customer are the long-term effects of achieving health and self-sufficiency for as many citizens of the state as possible.

Recommendations 6, 7 and 8: Improve accountability in rules

Designing and implementing a rule review and repeal process would be initially costly, primarily in terms of staff time. Implementation costs could escalate temporarily if additional staff or contractors were needed to get this process under way. Some innovative approaches may require

changes in federal law. Pursuing these changes would be time-consuming and therefore expensive, but likely would be cost-effective over the longer term.

Rule waivers have good potential for savings in the cost of doing business and providing services. Providers and HHSDs could devise plans that match their own resource capacities while still accomplishing desired results for customers. State agency commitment to permitting waivers and emphasizing outcomes makes it more likely that potential cost-saving innovations would be proposed.

Recommendations 9 and 10: Establish effective enforcement and sanctions

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

Recommendations 11, 12 and 13: Adopt a customer focus

Empowering human services staff to meet customer needs requires a change to more flexibility in the structures that define what staff can or cannot do for people. Some of this flexibility must be sought at the federal level. Developing and implementing ideas that require federal waivers or law changes require a great investment in staff time and resources. Some staff training would likely be needed. Further costs might be incurred in developing avenues for customer feedback and communication.

Some human services customers may always rely on the state's system, such as persons who have severe, permanent disabilities and no source of income. Many others who use the system, however, do so reluctantly and hope for self-sufficiency. To the extent that encouraging customers to reach their goals means eliminating their need for human services, this recommendation could create significant savings or cost-avoidance.

In conclusion, funding health and human services is not likely to get any easier. Minnesota is already among the top spenders in the nation for health and human services. There will probably never be enough money for all essential health and human services. Increasingly, Minnesota's system will need to focus on new ways to make the best use of available resources.

IMPLEMENTATION

Many of the recommended changes could be accomplished by state and local governments without additional statutory authority; thus, they can be implemented immediately. Others would require time to work out the details and to obtain necessary state and federal law changes.

Some important points should be noted:

- Recommendation 1, establishing a secretary for health and human services, is proposed to begin in 1995, after the end of the current agency commissioners' terms.
- Recommendations 2, 3, and 4 are linked and have the same proposed date for full implementation. CORE recommends that legislation be passed by 1994 to develop a plan for the creation of health and human services districts and that work begin immediately on development of a set of "minimum and adequate" services.
- Some work can begin immediately on implementing Recommendations 5 through 13, although state statutory changes and some federal waivers may be required to implement the recommendations affecting rules.

CONCLUSION

Implementation of the recommendations in this report would make significant progress toward improving Minnesota's human services delivery system.

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

Minnesota is a leader in its commitment to health and human services. Many of its ideas and programs have served as models for the rest of the country. Its system is filled with talented and dedicated professionals doing their best to serve citizens. Still, the system is far from perfect. Good intentions often evaporate when confronted by the barriers described in this report.

CORE's recommendations are designed to mitigate the effects of those pressures that are forcing the system away from vision, away from a customer focus, and toward prescriptiveness and fragmentation. They point the way toward achieving a dramatically improved health and human services system in Minnesota.

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

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The project staff team included Dorothy Bliss, Jan Buelow, Anne Kelly, and Dwight Lindstedt. Dorothy Bliss and Jan Buelow wrote the final report. Nancy Feldman supervised the work of the team.

ENDNOTES

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

2. One set of three counties and a pair of others have combined human services administrations, for a total of 84 county human services administrative entities among the 87 counties.

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

4. Case management involves determination of eligibility for services and arrangement of service provision to clients.

5. CHS districts were established in 1987 (M.S. 145A.09). These districts consolidate local public health services planning into 44 districts; with one exception, they have a minimum population of 30,000.

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