the Public Strategies Group

Southeast Counties-Department of Human Services

Human Services Redesign Blueprint

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Jim Chrisinger
Babak Armajani

What is a blueprint?

A blueprint shows the form of the finished structure. But it is not itself the finished structure. Not all the details are filled in and it does not show all the steps that will be needed to build the new structure. It may include options for some components of the new structure and can make suggestions about construction pathways.

The blueprint is the result of designing, which is Phase I. Once there is agreement on the blueprint, we can move on to planning as Phase II. Planning fills in the detail and figures out how we get from the way we do things now to the way the blueprint shows we want to do things, including timing, implementation roles, choosing options, working out the dollars and details, and more.

Planning and implementation will take place over a multi-year period. Part of planning will be deciding stages, pilot efforts, and sequencing. Even though we do not now know how all this will unfold, we cannot wait to begin. Our situation and needs demand that we move forward now. We need to opportunistically pursue the blueprint, taking advantage of the urgency created by this financial crisis.

Embedded in the document below are lists of Planning and Implementation Issues. These issues are included here to both remind us of the difference between design and planning and to highlight the work to come.

Fundamentals of this Blueprint

Grounded in stakeholder input, the Steering Team's direction, and fiscal realities, this blueprint creates an outcome-focused, regionally-based human services system that produces the following outcomes for consumers, citizens, and the community:

- Best possible short-term and long-term outcomes for each available taxpayer dollar (Return on Taxpayer Investment).
- An engaged-consumer-centered system that is focused on meeting individual consumer needs, not system or institutional needs, including accessibility. It offers choices that meet personal and community outcomes. One size does not fit all. Consumers are also accountable and bear personal responsibility for achieving outcomes.
- A system commitment to measurement, learning, and continuous improvement.
- Transparency, equity in outcomes and access, and consistency of opportunity.
- A win-win-win deal for consumers, the counties, and Minnesota.

Service Delivery

The blueprint reflects a service delivery redesign based on these outcomes, which suggest new pillars for a new paradigm. The three pillars below signal everyone that they are no longer operating the same system. They help everyone change their thinking.

Engaged consumers in an engaged community: Engaged consumers participate in meeting their own needs with the help of their families and an engaged community. Consumers, including involuntarily consumers, are more proactive and responsible for their own needs by mobilizing their own assets and those in their communities. Accountability is shared between the engaged consumer and those providing assistance. For our purposes, "community" does not only refer to geographic locations. "Communities" may include ethnic groups, extended families, faith communities, work networks, and others, regardless of where they are physically.

Leveraged and enhanced technology: Technology such as online resource banks, websites, and smart phone apps that assist consumers to find their way to support. Current examples of such connecting technologies are 211 and MinnesotaHelp.info.

Navigators: Several different kinds of navigators help consumers. Some navigators connect consumers with the combination of community and government resources that will best meet their needs. The Chemical Dependency Pilot in the Southeast Region is already employing one form of the "navigator" concept. Other forms of navigators are discussed below.

Governance/Finance

The blueprint outlines a governance/finance redesign that distinguishes different kinds of functions performed in the human services system and creates for each a structure designed to maximize value and Return on Taxpayer Investment.

No- or Low-Touch Programs become more centralized, automated, and enabled by technology and higher degrees of specialization. Examples include child support enforcement, income maintenance and health care, and child-care licensing.

High-Touch Social Services gain added value through multiple, competitive options created in a new, Southeast Minnesota Results Cooperative. Counties, and in some cases consumers, are able to purchase different kinds and levels of services a la carte through the cooperative. Examples include child protection and welfare, chemical health, mental health, foster care licensing, and developmental disability services.

Low-Touch Administrative Services can be purchased as a package by counties from the cooperative. Economies of scale and specialization enable the cooperative to offer

counties an option for these services. Counties can decide whether they can get a better deal from the cooperative or continue to provide these services in-house. These services include administration, financial operations, technology, HR, training, and contract management.

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Following are highlights of the elements of the redesigned system. The sections following this overview elaborate these elements.

- **A wider range of resources.** The new system cultivates the advantage of more of the region's resources, not just those of government and those currently engaged. The distinctions among traditional human services provided by government, services offered by community-based organizations, private sector participation, and informal support from family, friends, and colleagues are further blurred. This wider array of options means fewer government resources are needed. More flexibility in matching resources with needs also means more efficient use of government resources.

- **Strength, needs, and responsibility.** When engaged consumers and their families need help, there are many access points. The first question consumers hear when they seek help is "what are your strengths?" Then a navigator can help them identify needs and resources to meet those needs. Connecting technologies will be an important tool in building on strengths and linking needs with resources. Engaged consumers are empowered by having easy access to their own records, focusing on their assets, and taking responsibility for choosing services that will best meet needs, and even having a role in planning the new system. An engaged-consumer-driven system is two-way: consumers are empowered and they also assume greater responsibility for their own choices and well-being.

- **A circle of support.** Many engaged consumers identify a small -- three-to-seven people -- network specifically identified to support that person, a circle of support. In most cases these will be family members, close friends, caregivers, and professionals already touching their lives. In other cases, the circle of support will need to consist mainly of professionals or more formal support systems. Engaged consumers take responsibility for improving their lives and making good use of the resources available to them. In many cases today, informal circles of support are already working well.

- **Navigators.** The circle of support may also include a person trained to be a "navigator." For many consumers, the navigator's job is to help the engaged consumer connect with resources and services that build on his/her strengths and meet her/his needs. Navigators are available as needed to help consumers and their families identify all the resources and support that are available to meet their needs,

beginning with the resources of the local community. If what is needed is a government program, the navigator can connect them with those programs. Many navigators are generalists empowered to be creative in meeting needs. Other navigators will play more specialized roles regarding more intense services or the safety of the consumer and those around the consumer.

- **Involuntary consumers.** While some roles will be different when consumers are not engaged voluntarily – for example in many child endangerment, substance abuse, legal incompetence, and domestic violence cases – the redesign features also apply. A circle of support, building on strengths, and community supports can also apply. Navigators here will need different talents and skills and will usually have to play a more directive role, especially early on. All involved will continue to need to be prepared to trigger intervention when required.

- **Eligibility.** Use technology, simplification, and focused expertise for complex cases to speed and reduce the level of overall staffing devoted to eligibility determinations for government programs. Intake information is taken once and eligibility for all programs is determined up-front. Human service professionals determine eligibility, which is usually separate from the role of a navigator. Navigators are typically not gatekeepers; they are connectors and advocates.

- **Southeast Minnesota Results Cooperative.** A new regional entity, the Southeast Minnesota Results Cooperative, supports the new system. The heart of the new system is the network of people and resources that are the communities of southeast Minnesota. The co-op provides a vehicle for centralizing and specializing when that direction best serves consumers and saves money. The co-op also sets up a "marketplace" of social service providers that enables counties and consumers to seek the most effective, best tailored, and least costly services. The co-op serves as an organizational hub of a human services regional network; it orchestrates the network and the resources within it.

- **The Department of Human Services.** DHS plays a key role as a partner in the new system and will help plan, guide, and champion its successful implementation. Its role in technology solutions is particularly valuable. DHS's commitment and resources will be essential to system success.

- **Accountability and flexibility.** There will be an increased return on tax dollars when consumers, workers, programs, providers, and systems are most accountable for outcomes and have flexibility in how to produce those outcomes. Where appropriate, consumers and their circles of support make their own choices among options that best support them within available resources. Rigid rules and regulations based on accountability for public funds and audit requirements will be minimized.

- **Alignment.** Incentives and accountability for consumers, human service workers, programs, and governments are aligned to focus on outcomes and make the best use of each dollar. This approach is being tested in the CD pilot in southeast Minnesota. Outcomes are achieved with the least intrusive and least costly interventions needed. This alignment will ultimately coalesce around the outcomes and metrics being developed by the Steering Committee on Performance and Outcomes Reform.

- **Technology.** Up-to-date technology captures, stores, shares, and communicates relevant information for consumers and the people and systems that support them.

- **Communications.** Experts in marketing, communications, and branding introduce the new system to communities, help build capacity in communities, and inform consumers of the availability of help and how they can help themselves. This effort leads the charge to "change the conversation" from spending cuts vs tax increases to producing better results with available resources.

Make no mistake, what is outlined here is different from the way things are done now. When evaluating this blueprint, compare this "package" against the status quo. It will be easy to criticize particulars of the blueprint, just as it is easy to criticize aspects of the way things are done now. The better question is: Which system will better serve Minnesotans? And which system is more sustainable over time?

The redesigned system can achieve the same or better results with available resources by:

- Enabling more people to meet their own needs without having to be solely dependent on government programs;
- Streamlining and automating eligibility and application verification to make this activity less labor intensive to free up some staff resources for other activities;
- Leveraging more community and family resources to reduce the demands on government resources;
- Focusing more on early intervention and prevention;
- Better tailoring services to avoid using as many high cost, "deep end" resources, including reducing the length of time those resources are needed;
- Requiring more service providers to compete via consumer choice;
- Reducing time spent on paperwork and time wasted because of uncoordinated and fragmented demands from multiple entities and programs;
- Applying technology to free up more time for more value-added work and to reduce the need for face-to-face service, for example to track clients' involvement in programs;
- Reducing the costs of the system's internal support services by consolidating at the regional level; and
- Focusing more on outcomes than activities.

How will the redesigned system be different from what happens now?

Following are two scenarios that illustrate . . .

A 70-year-old man is in the hospital. He is ready for discharge to a nursing facility but the family needs funding for long-term care (LTC). His wife is living at home in the community . . .

In the current system:	**In the redesigned system:**
• The couple submits an Asset Assessment and Medical Assistance application for Long Term Care (LTC) to the county of residence for the person entering the nursing home. The nursing home he is entering is located in the neighboring county. • The county of financial responsibility receives these applications. The specialized financial worker (FW) who handles LTC cases is on vacation for two weeks, so the application waits for her return. • Upon return, the worker requests verification of income and assets from the family and learns that the family is working with an Estate Planning Attorney because there are assets including a trust and non-homestead property. The family's attorney calls the financial worker to get a better understanding of what's needed. • It takes several days and multiple phone	• The application may be submitted on-line. It will be directed to an FW who is a LTC specialist. • Vacations should not delay processing. • The necessary verification should be requested the first time. • The FW will need to consult with DHS less often. • Policy will be applied consistently. • Public Health and a social worker complete the LTC assessment regarding service needs.

calls before the attorney is able to produce the required documentation for verification. • Because of the complexity of the case and related policies the FW needs to contact DHS for policy clarification. The FW, in some counties, may be able to request help from the county attorney. • Long-term care eligibility determination takes months due to lack of clarity regarding policy, including what is needed for verification. • During this time, the nursing facility is wondering how and when they are going to get paid. The wife is unsure what to do because she needs to use their monthly income to maintain the home they have owned for 45 years. • After the Long Term Care eligibility determination is made, the county decides to transfer the case for "servicing" to the county where the client resides in the nursing facility. There is variation in the policy interpretation amongst counties, so this opens up some additional questions for the family. In other cases, the county of financial responsibility, once realizing the client is placed in another county, might send the application to the county of residence up front, adding additional lag time and confusion for the family and their attorney. • Long Term Care cases are getting more	

complicated due to factors including trusts, annuities, long term care insurance, and reverse mortgages. • Our population is aging and the system will enroll many more elderly people over the next several decades.	

MARTIN

County human services received a report of alleged child maltreatment regarding a 10-year-old Hispanic boy, Martin, who came to school with bruises on his face. When the school staff inquired, Martin said his dad pushed him and his face hit the corner of a kitchen cupboard. He didn't volunteer any further information and because he was having a difficult day already at school, they didn't ask any more questions.

The reporter states that Martin has been diagnosed by the family's physician with an autism spectrum disorder and has many challenging behaviors at home and school. His parents have tried hard, but Martin doesn't respond well to their directions. They have to tell him what to do over and over again; he often seems in his own world and this is making family life at home tough. They have shared with the teacher that they don't know what to do with Martin and are at their wits' end. At school, his attendance is poor and he is often tardy. School staff members view Martin as disconnected from other students and say he doesn't have any friends. He has a very hard time when the class changes rooms or if the classroom schedule changes. He has poor grades and frequently doesn't finish his work. He tends to get frustrated and becomes angry easily and without apparent reason. All this disrupts the classroom and interferes with other students' learning.

The parents and school have tried interventions to get him to follow their directions without much success. The parents seem to be open to help, given the way they share their concerns and frequently ask for ideas from his teacher. The school does not have any counseling or social worker in their district and they are experiencing greater frustration with the child also. They have made a referral for educational assessments through their special education department but are looking for additional help too.

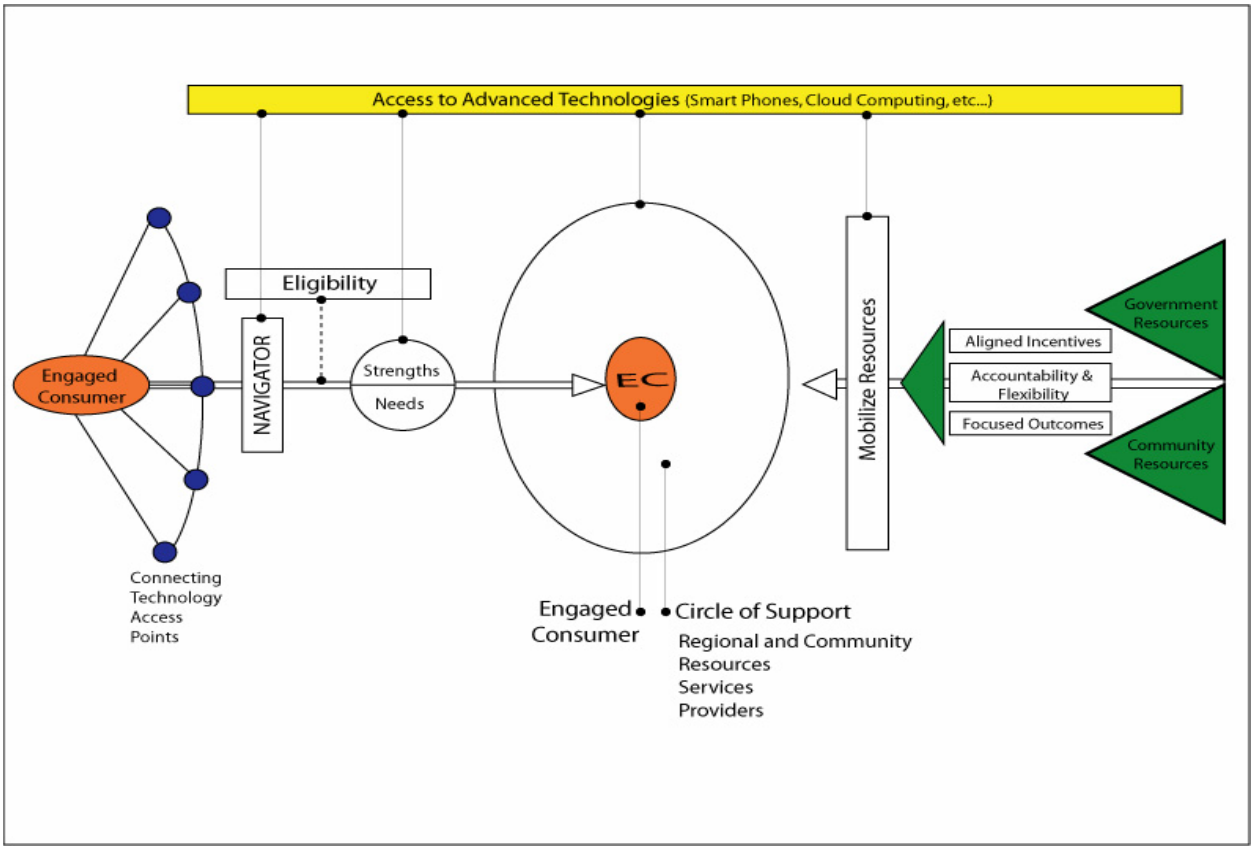
The social services agency screens the report and finds that it meets the criteria for a child protection assessment. A child protection assessment occurs and the social worker, Sara, learns through discussions with the parents that they are experiencing a high level of frustration with a child who doesn't seem to listen or act like other children. The parents don't know much about

autism, just that he has it. They don't know what to do and they think their two younger children are getting less attention because Martin takes so much time and effort. They are also worried the other children will begin to act like he does and they can't handle that. They don't know what to do but think maybe he needs to get help somewhere away from them. The parents are worried, exhausted, and share, reluctantly, that they are both starting to punish him physically. They don't want to keep doing this ……	
In the current system: • The family and the social worker, Sara, agree that the family needs ongoing support services and agree to write a case plan. • Sara has limited knowledge of autism spectrum disorders and limited access to specialized care. • Sara meets regularly with the parents, Martin, and the school and attempts to positively improve the situation. Sara researches autism spectrum disorders through Internet searches and seeks any knowledge available from the few other staff in her office. She attempts to improve things by "trial and error" to reduce Martin's challenging behaviors but these attempts achieve little success. • Martin's parents continue to experience frustration and anger when Martin's behaviors do not improve. An incident occurs and Martin's dad over-reacts and hits him, leaving bruises. • A new child protection report is made and meets criteria. A child protection family assessment is opened and the dad is unable to confidently say he won't hit Martin again if he gets angry.	**In the redesigned system:** • The family and the social worker, Sara, agree that the family needs support and agree to write a plan. As part of this plan, they identify Martin's and the family's "circle of support," which includes an aunt and uncle who live on the next block, one of Martin's teachers, and their parish priest. Sara will "navigate." • Sara has limited knowledge of autism spectrum disorders. • Through the co-op, Sara consults with experienced practitioners in the region with specialized knowledge. She seeks and receives guidance specific to immediate safety planning and she is able to link back to the regional practice group for feedback. • Sara helps the family and "circle" develop a safety plan that takes advantage of individual strengths and utilizes strategies designed specifically around Martin's autistic behaviors. The plan includes parental techniques that are most likely to prove helpful with autistic children and adapted for Martin. Members of the circle agree to support the family. • Sara coordinates, through the co-op, a comprehensive assessment of Martin with appropriate professionals who have

• The family has relatives living nearby but they do not believe they could manage Martin's behaviors and their support systems are limited. Martin is placed on a health and welfare hold and placed into foster care. Martin does not react well to being separated from his family and the foster parents struggle to manage him. • A placement screening team meets and determines that Martin needs specialized treatment (includes a determination of IV-E eligibility). • Martin is placed in a home located a distance from his community. Visits with Martin's family are limited and there are few interventions to assist them in understanding his diagnosis and to build parenting techniques with them while Martin is gone. • Martin does well in his foster home, which is very structured and an Individual Education Plan (IEP) is created when he is determined to be eligible due to his autism diagnosis at school. Martin returns to his parents' home and Sara continues to support the family during this transition. The potential for further disruption is high due to a lack of parental involvement during Martin's placement and their lack of knowledge of how best to parent him.	expertise specific to autism spectrum disorder. As a result of the assessment, the family gains factual information about the specifics of his disorder and learn there are ways to "manage" autistic behaviors. This learning builds their confidence; they are not bad parents. Additionally, a specific but limited sum of money is available to the family for support. • Via the virtual human services web portal, which includes all the local and co-op resources, Sara helps the family access no-cost services and spend an initial portion of their allocated funds for appropriate referrals and/or targeted interventions, including more in-depth information and education specific to Martin's condition. The co-op provides "consumer reports" information and performance records for service providers so the family can make more informed choices, and in this case more culturally appropriate support, including Spanish-language providers. • Mom and dad each get an app for their smart phones that give them 24-7 access to the community crisis hotline where they can get help, including Spanish language counseling, if they feel that they may be losing control with Martin. • "Circle" members check in with the family from time to time to offer support. The uncle takes Martin fishing occasionally, one of his favorite things to do. With the parents' permission, the local priest asks other parishioners to include Martin, his siblings, and parents in activities that give

	family members a break and provide emotional support. • Martin's needs are met within the community and co-op. Out-of-home placement is avoided. • Throughout, the family benefits from frequent guidance by practitioners with specialized knowledge of autism. Circle members strengthen their competence and help ensure that Martin's and his family's needs are adequately met. • Sara's knowledge and skill base are strengthened and she demonstrates increased competence. Her willingness to access and utilize the regional practice group in other cases grows. Opportunities to strengthen the social work practice across counties increase and ensure more consistent service to families.

The redesigned system looks like this . . .



Blueprint Elements

Outcomes – Return on Taxpayer Investment (ROTI)

Work will continue to develop a set of outcome measures, including metrics that link outcomes with dollars. As noted above, this ROTI will need to align with the expected work product of the Steering Committee on Performance and Outcomes Reform.

We will also follow the ROTI work of the Washington State Institute for Public Policy. The State of Washington's 2009 Legislature directed the Institute "to calculate the return on investment to taxpayers from evidence-based prevention and intervention programs and policies." The Institute's report in response is due in June 2011.

Governance, Funding, and Operations

We developed six governance options, including discussions of funding, from which we distilled the recommendation below. The six options are available in a separate document if desired.

Given the complexities and the politics of our situation, it appears likely that governance for the redesign may start in one place, corresponding to current preferences and constraints, and evolve over time as trust and experience develop.

Consider, as you review the recommendation below, the framework in the chart below, distinguishing two types of activities. The lists in each of the two columns are illustrative only. Please note also that some activities could appear in more than one column because they can come in more and less intensive forms, depending on the consumer and situation. In fact, it would probably be more helpful to see services and activities as a continuum, starting with "no touch" on the left and "high touch" on the right, with many somewhere between. Our point is that each category of activities could be enhanced or hindered by various governance and funding approaches.

Infrastructure and Administrative Activities ("no or low touch")	**More Intensive, Longer-Term Activities ("high touch")**
Examples: • Eligibility (e.g. LTC) • Child care & support • POS contracting • Talent pooling • Specialized skills • Client records • Training • Risk Pooling • IT • HR (activities in this column are most ripe for efficiencies that can be generated by technology and process improvement)	Examples: • Clients reaching lifetime limit under TANF • Teen Parents • Disabled • Care Management • MH/CD • CPS • APS (activities in this column are most ripe for community collaboration)

This framework suggests that lower touch activities are better candidates for centralization or options that allow counties to purchase them from others instead of doing them themselves. As you work to the right on the continuum, there is a stronger case for keeping the activity in the local county or community to foster the stronger, more frequent relationships needed for success. Governance choices can facilitate the use of this framework. This framework is used in the recommendation that follows:

Administration of No- or Low-Touch Programs, Region-wide
(principal advantage: consistent and efficient administration of very complex programs, with critical mass enabling specialization in complex areas.)

Implemented initially as a regional entity or phased in by program area and potentially evolving over time to state administration:

- Child Support Enforcement
- Income Maintenance & Health Care (MFIP, DWP, GA, MSA, GRH, RCA, Food Support, CCAP, EA, EGA, EMSA, MA, MinnesotaCare)
- Child Care Licensing
- Question: include health care access transportation and eligibility for home & community-based waivers here, or eligibility AND service management? Or put service management below in "Social Services?"

(begin with selected functions rather than transition them all at once)

Local provider networks, formal & informal

Financial Swap

Memorandum of Understanding

SE Minnesota Results Cooperative
(formed through an SDA, JPA, or other means)

Social Services (high-touch) (principal advantage: added value for clients and leverage local community relationships/resources)	**Infrastructure/Administrative Operations (low-touch)** (principal advantage: cost savings)
Delivered by individual counties or through the Cooperative. Decision up to each county, for each service area. May purchase a la carte, at various levels ranging from minimum standards with no prevention to evidence-based practices.	Delivered through the multi-county cooperative as a package.

• Child Protection & Welfare
  o Adolescent Services
  o Teen Parents
  o Early Intervention
• Adoption
• Adult Protection
• Guardianship
• Chemical Health, adult and children
• Mental Health, adult and children
• Foster Care Licensing
• Developmental Disability & Other Adult Services
	• Administration
	• Financial Operations
	• Reporting (fiscal, management & performance measurement)
	• Technology
	• Human Resources
	• Training
	• Compliance and Quality Assurance
	• Contract Management (including RFPs, writing, and performance management)

Overall Governance/Finance Planning and Implementation Notes:

- **Change**. We recognize that this governance/finance proposal represents significant change. We propose it because change is not our choice to make. Lack of funding and other circumstances mean change, substantial change. Our choice is whether we direct the change or let others direct it for us.

- **Multi-year transition**. Think of all this in terms of a three-to-five-year transition plan. We will want to chart a phased, three-to-five-year path. Multi-year agreements will be needed for planning purposes.

- **Legal framework**. Start with the assumption that we will use the existing Service Delivery Authority (SDA) framework as a legal vehicle. We could propose the idea to the SDA Council, per their direction/application and explore that option, which is currently in place. Look for a different legal vehicle, like a JPA, if the SDA route does not appear satisfactory.

- **Technology**. There will be a great need for technological interfaces between the "no or low touch" operations and the rest. This technology will be the foundation for and enable "virtual service delivery" for the region.

- **Bargaining units.** In any public employment entities that may emerge from this redesign, the employees will decide who will represent them.

- **Local partnerships and relationships**. A key will be to focus on preserving existing local partnerships, relationships, and financing, while leveraging the "regionalness." Counties would maintain control over financing by deciding individually how much to raise and how much to spend and deciding which services would be delivered and purchased from the co-op and which services would continue to be provided directly by the county. This autonomy will allow counties to preserve existing local partnerships and relationships by taking advantage of cost savings and increased service options that can be gained through regional collaboration, as well as attract new resources and funding. These relationships should foster more virtual service connections, like telemedicine in the current mental health initiative.

- **Financial Swap.** The counties and the state will explore the potential in a cost-neutral swap of current payments and financial responsibilities to reduce overhead and complexity. For example, the counties might take over more of the cost of social service programs and the State might take over more of the non-federal share of mental health.

- **The Memorandum of Understanding (MOU)**. Determine whether the MOU is bilateral (between DHS and either the counties or the co-op) or trilateral (between DHS, the counties, and the co-op). In either case the MOU will reflect the basic accountability principles articulated in the design: strong accountability for outcomes in return for flexibility in how those outcomes are achieved. **Attributes** we want in the "MOU" include:
    - An alignment of accountability around outcomes. All parties commit to do their part to maximize outcomes and ROTI. When outcomes and ROTI improve, all the parties "win."
    - Flexibilities and authority are extended in return for commitments to achieve outcomes and improve ROTI. Child protection and IV-E outcomes might provide a good area in which to pilot this concept.
    - Responsibilities and commitments that make the deal more a partnership of equals than a master-servant relationship.
    - Agreements on the services that are housed in the Co-op and in which DHS plays a role.
    - Simplicity.
    - Strong appeal for Counties and DHS. A great MOU would be one that both sides see as strongly in their interest and therefore want to join.

- **Different county budget timelines**. Planning also needs to address timing issues created by varying budget planning and decision cycles among the counties.

Planning notes related to the box at the top of the first page, "No or Low-Touch Operations Region-wide:"

- These could ultimately be handled by DHS statewide.

Planning notes related to the "SE Minnesota Results Cooperative:"

- **Social Services "side" of the co-op**. For the social services side of the co-op, there are many potential providers who compete for the work. Counties and their "centers of excellence" will be among providers. The co-op helps put a broad range of provider connections and contracts in place for County use. The "social services" side of the co-op also enables Counties to choose levels of service. This choice could be exercised service-by-service or the co-op could structure services in tiered packages. For example, those wanting the highest level could purchase services based in research-proven models. At the other end, Counties could opt for a minimum standards level. They could also choose an intermediate level between "research-based" and "minimum standards."

- **Reporting to DHS**. A decision will be needed regarding reporting to DHS. Will the co-op report together or will individual counties continue to report separately?

- **Infrastructure "side" of the coop**. For the infrastructure side of the co-op, counties can opt into the co-op or not. Once in, with reasonable notice to other members, they may also opt out of the co-op. But, to fully realize the synergies of infrastructure collaboration, counties choose to be in for all services, or not to be in at all. It is a package. This side of the co-op will not be launched until a critical mass of counties have made a commitment, a number sufficient to make it effective and efficient.

- **Financial participation in the co-op.** There are two aspects of financial participation in the co-op: a) capitalizing and *owning* the co-op; and b) purchasing services from the co-op. The co-op will require some seed capital to get started. This seed capital could come from a third party source, or it could come from members purchasing shares in approximate proportion to the size of their human service system. The need for seed capital can be minimized, however, by having members pay for at least a portion of services at the beginning of the fiscal year. Members may purchase the infrastructure package and/or individual social services from the co-op for fees developed by the co-op board. These co-op revenues go into a revolving fund managed by the co-op staff.

- **"Shares"** could work in one of several ways:
    1. Counties invest to establish "ownership" based on a formula grounded in historical human services "burden," which could adjust over time.
    2. Counties can themselves determine how much ownership they want and invest accordingly. All Counties' contributions would necessarily total to 100% of the shares.
    3. Seek foundation or other third-party investment for some or all of the shares, which could later be "sold" to Counties.
    4. Or some blend of the three options above.

- **Co-op governance**. The co-op is governed by a board consisting of Commissioners from participating counties, a County Administrator, and one human services director from each of the current three "hubs," with voting weighted on the basis of shares owned and/or volume of purchases. The Co-op Board sets the co-op budget, rates for services, staffing levels, performance metrics, and makes investments, all based on estimates of usage. During the year, the Board oversees performance and reports to the Counties and DHS via performance metrics and fiscal reporting.

- **Co-op staff.** Co-op staff are hired by and accountable to the Co-op Board. Financial accountability to the Board, and ultimately, to the membership, is maintained through monthly profit & loss statements and a monthly balance sheet. An executive director, appointed by the Board, hires and manages all co-op staff, and is accountable to members for service quality and to the Board for keeping spending within revenues.

- **Gainsharing**. "Gainsharing" is a way to incent more value through less spending by giving those who influence the spending a direct financial stake in spending less. In addition to lower costs for infrastructure services and better deals for social services, the "customer counties" can reap additional gainsharing money through rebates based in lowered overall costs and year-end savings.

Connections: tailored and timely services

Open doors . . .

When someone in southeast Minnesota needs assistance, they and their families can easily access help through multiple "doors," not just at government human services offices. Access is also available by phone, online, through local service organizations, churches, counselors, workplaces, shelters, food banks, local libraries, and more. Prospective consumers are encouraged to take the initiative and responsibility to find solutions, beginning with connections in their own community.

In many cases, leveraged and enhanced technologies enable engaged consumers and their families to get the help they need with limited or even no involvement from traditional government. When consumers do need more, or don't have access to enhanced technology, they can interact directly with a strengths-based network that empowers them and the people who work and volunteer in the network. The network is a mix of virtual government and human beings and a mix of local and regional resources.

Where needed, engaged consumers can identify a personal network, their circle of support. For most consumers, this network of from three-to-seven people would likely include family, friends, colleagues, neighbors, caregivers, professionals already engaged with the consumer, or others who are best positioned to help and who have the confidence of the consumer. For youth, teachers and other school professionals may be members of the circle of support.

One member of the circle can take on the role of navigator. Or intake and assessment may connect consumers with appropriate navigators, i.e. a navigator matched up well with the consumer's capacities and with the level of knowledge and

experience needed to connect them with resources and help them find solutions. We will need "navigators at different levels" to accurately connect consumers with the resources they need. But note that the navigators are usually not the resource people; they are most often the connectors for resources. Examples of "navigators at different levels" appear in the section on navigators below.

Consumers can create their own individual plan in dialog with their navigator and circle of support. The first question is "What do you have?" not "What are you eligible for?" Engaged consumers can access a variety of resources and services starting with the least intrusive and least costly. Consumers and their circles of support assume mutual responsibility for building on strengths and meeting needs. Consumers are not passive clients; they have a reciprocal responsibility to help create a constructive path forward.

Families and friends are an integral part of this approach but if family members and friends are not willing or able to support a consumer, others can help as volunteers or a paid navigator can take on this role. Families are broadly interpreted and include anyone a consumer defines as their family.

Engaged consumers are often able to exercise their own choices in the services that are most likely to best meet their needs e.g. those that are culturally competent, easily accessible, are accessed through vouchers, etc. Navigators have the flexibility to tailor solutions around consumer strengths and to meet consumer needs.

Access is a continuum. For example, enhanced technologies might lead a person to what they need without any other assistance, like finding a food bank. If they have more complex needs, a service access point -- virtual or physical -- connects them with a navigator who will help them identify their circle of support. The circle of support may then be able to resolve the problem, like offering a place to stay. If the problems cannot be resolved by the circle, then government and community resources can be brought to bear, like alcohol treatment, juvenile delinquency placement, child support services, food support, and drug-free housing.

Planning and Implementation Issues:

- *Include consumers, employees, advocates, unions, and providers in the planning of all aspects of the new system.*
- *Explore the various ways to empower consumers and use navigators to connect with resources without creating more "structure" than needed.*
- *Build in training for navigators and other human service workers so they are better able to help design creative solutions with consumers. Who will need a navigator?*

- *Build on existing strength-based assessments already in use, explore other strengths evaluation programs, and consider asking Gallup to create a version of their Strengths Finder assessment for this purpose.*
- *Explore Systems of Care used for mental health and other services which is a nationally known promising practice that is based on strengths, coordinated networks, community based services and supports, and builds on people's cultural and linguistic preferences.*
- *Explore how the CD Pilot might provide a good model for the new system's service delivery model, including intensive navigators for deep-end folks and capped dollars. Mental health is a strong, initial candidate for this model.*

Eligibility

Streamline eligibility while maintaining integrity and access. Use technology to increase consistency and uniformity and reduce the demands eligibility determinations make on staff.

Reduce the number of eligibility determinations needed and make better use of resources by first screening, assessing strengths and needs, and then deciding whether an eligibility determination is appropriate. The "new normal" means consumers need to first take advantage of informal supports. Eligibility is a means, not the primary purpose of a consumer's interaction with us.

Legal, financial, and data privacy barriers, particularly federal laws, may prevent huge, immediate strides here, but we should make as much progress as quickly as we can. Currently, many resources go to this activity, resources that can better be used elsewhere.

Begin with the following strategies:

- Use technology, online application and processing, and process improvement to streamline and simplify eligibility determination. Capture this data in the system so that these questions do not have to be asked and answers recorded again.
- Collapse requirements so there are fewer separate eligibility processes, e.g. use the same standards and proof requirements across multiple programs.
- Human services professionals determine eligibility. Separate this "gatekeeper" role from the navigator roles of connecting, advocacy, and support.
- Automate the routine determinations and focus the complex determinations in a small center of excellence.

Ultimately, in as many cases as possible, make eligibility presumed.

Use a range of methods for protecting against fraud and abuse, including education, incentives, sampling, and audits.

Planning and Implementation Issues:

- *In 2014, all Medicaid eligibility will be 133% of poverty so this might be able to serve as a more or less universal standard for eligibility or alignment around policy rules.*
- *Work regionally with DHS to determine how to best standardize eligibility.*
- *Check out learning from how Florida completely automated Medicaid eligibility determinations.*
- *Explore the potential for "intelligent-based application" IT solutions here.*
- *Do we need to distinguish here between those services one applies for and those that are involuntary but where there may be flexibility for FFP for those eligible?*

Leveraged and Enhanced Technologies

Technologies can make connections. Use technology to empower consumers and navigators, improve results, and save money. Leveraged and enhanced technologies consist of an array of online resources and methods of connecting people with resources. They include community, non-profit, for-profit, faith community, government, and other resources. This array of connections expands and evolves as resources change in response to demand and availability. It takes advantage of middleware and web 2.0 cloud computing to link and substitute for existing systems.

Leveraged and enhanced technologies:

- Can handle aspects of intake and assessment.
- Give consumers portable access to their human service case information, medical records, and other important data. This information could also be available on a smart card. Smart cards could also include children's school information.
- Provide alternatives to face-to-face meetings or classroom services, including telepresence. These alternatives can be used for online training for consumers, navigators, human service workers, and volunteers.
- Provide a conduit for consumer satisfaction, provider performance, and quality control information.
- Incorporate creative uses of social media.
- Help attract to human services the next generation of public servants that are more tech savvy, both in government positions and as part of the network of resources.

- Reduce the need for as much on-site supervision. This technology can create a visual record during "virtual" home visits for new baby visits and the elderly in their homes.

We can also take advantage of the increasing availability of smartphones and the potential for applications, "apps," to enhance consumer success. University of Wisconsin researchers have developed an app for people dealing with addiction. This app, "Addiction-CHESS," gives consumers access to an online support group and counselors. A "panic button" connects the consumer with help on the phone when the consumer experiences cravings or is triggered by people or places associated with drug or alcohol use. A GPS feature can also send an alert if the consumer gets close to an area of previous drug or alcohol activity. Consumers can also use the app for real-time video counseling. It also includes tools and graphs that celebrate milestones in recovery. This app is now being tested in Massachusetts.

Hosting these technologies will be a function of the Southeast Minnesota Results Cooperative, the organizational hub of the regional network.

Planning and Implementation Issues:

- *Use current experience with MinnesotaHelp.info, United Way 211, and Bridge to Benefit to inform the creation and construction of these technologies. Strive to leverage existing systems rather than creating new ones.*
- *Leverage other current automation initiatives, such as the on-line application and electronic verification. Explore partnerships to develop apps and other technology applications.*
- *Build in education for consumers and navigators about how to use the tools.*
- *Develop integrated voice response (IVR) solutions for those who do not have ready access to computers.*

Navigator

Navigators will come in more than one form. Some navigators can first help engaged consumers recognize and pull together family, friends, and others who can become the immediate resource network, the consumer's circle of support. If a consumer does not have family or friends capable or willing to be a resource, the navigator can recruit others in the network to help. Someone in each circle of support is the designated navigator.

We expect that existing caseworkers will become many of the first navigators. We also expect that as the system evolves, others outside government can also serve as navigators, particularly as navigators mainly working with engaged community resources.

Navigators recognize that consumers come to the new system with strengths and their own resources that are essential components of the new system. Navigators help consumers identify and build on their strengths and choose what is needed, not all that is conceivably available nor all that could be offered.

Note that some navigators mostly serve as connectors, not the resources themselves. These navigators are generalists who know the network and have the talent to engage the consumer and the circle of support to achieve outcomes with the least cost and intrusion. These navigators focus on facilitating, empowering, and orchestrating. They advocate for the consumer in the network. For those who have previously played "gatekeeper" roles, training and support will be particularly important to help shift to a different mindset.

Other navigators, however, will play a different role. They may have to trigger interventions to ensure safety or the integrity of the system. Following are some initial suggestions about different roles or "levels" for navigators:

Level 1

- Family/Friend/Neighbor Navigator – a volunteer in the consumer's individual or family network willing to help the consumer define and utilize their support network and connect them to any needed informal or formal supports. This approach should work well for individuals with strong family or community relationships that are still in place. These navigators can connect consumers in areas of service such as basic public assistance, disability services, elderly services, early intervention in child welfare or children's mental health, youth services, and early intervention for adults with behavioral health needs.

Level 2

- Capacity Building Navigator – a paid private or county social worker who helps establish a volunteer navigator over time that is part of the consumer's natural supports. While building the capacity of the volunteer navigator, the social worker helps access informal and formal supports based on a consumer-oriented plan. This level of navigator is needed when no one within the consumer's natural support network is taking on the role or when a volunteer navigator needs some capacity building because the needs of the consumer are not being met. This paid navigator would work with consumers and families with more challenges who need more than information and referral or simple application materials. These consumers would be more multi-system users for things like housing, public assistance, employment, childcare, and any specialty services in CD, MH, DD, disabled or elderly services. (Voluntary consumers)

Level 3

- Safety Navigator – a county or private social worker paid to assess a consumer or family in terms of a personal, family, or community safety issue. Any situation that could lead to non-voluntary services would fit in this category. This would include services like adult protection, child protection, adult or children's mental health, youth services, or adult and youth chemical health services. In this area there are high standards for assessment, case planning, and documentation that counties need for court processes and/or reimbursement.

Planning and Implementation Issues:

- *Look at the experience of non-profits that have used the navigator model.*
- *Hire for talent and attitude; train for knowledge and skill.*
- *Value and build on the strengths, commitment, knowledge, and experience of current human service workers in government and non-profits.*
- *Navigators should receive training in appreciative inquiry and other methods of focusing on strengths.*
- *Explore others' experience with Systems of Care.*
- *Explore ways the navigator role could be supplemented with a "help desk" function.*
- *Be careful that we are not formalizing informal systems that are already working well for many.*

Resources

Engaged consumers and navigators have available to them a robust region-wide resource network of support in and for the whole community, with multiple ways to find help. Resources reach beyond the current portfolio of community and state/county government supports and services to include more from municipal governments, non-profits, faith communities, service organizations, foundations, volunteer networks, interested individuals, and others.

Enhanced technologies spread knowledge of engaged community resources and provide access. Once connected with resources, at whatever level, an engaged consumer's circle of support can evolve to meet changing needs, with the assistance of the navigator if needed. Similarly, volunteers and others can raise awareness, educate, and reach out in communities to continually expand the network of services and support available. The blueprint's assumption is that everyone needs support and resources but some need more help than others. "The community is the system."

For the new system to succeed, the following are needed:

- Resources available to engaged consumers are designed to augment not replace existing consumer supporters. They range from informal support and prevention to high-end services requiring eligibility.
- Many people and diverse organizations are connected via technology to help all ages and ethnic and cultural backgrounds find appropriate help.
- Everyone in the community should be encouraged to identify their resource network for emergencies and identify what they can provide to others.
- Make resources available in multiple forms that work for consumers. For example, make it easy for consumers to comply with required classes by making them available 24/7 on-line. Explore incentive options.

The Southeast Minnesota Results Cooperative orchestrates resources, expands the network, troubleshoots, and monitors and reports on provider performance.

A different approach to resources animates this blueprint. Instead of a group of eligibles each getting the full basket corresponding to that eligibility, the new system more carefully matches consumer strengths and an array of resources to meet needs. We are shifting from thinking primarily about "entitlements to inputs" toward more emphasis on "opportunities to achieve outcomes." This new dynamic directly challenges what many see as the essence of "fairness" and "equity" regarding resources. In the new system, what's "fair" is each consumer having an equal opportunity to have their needs met. That's not how the system works now.

Planning and Implementation Issues:

- *Consider a campaign for "everyone has a network" and community or family support is "the first place you go and last place you land."*
- *Consider creating a community Asset Bank.*
- *Plan for services that are culturally competent and respect ethnic and other differences. Increase participation by relating to the history, culture, and ceremony of consumers, including allowing the navigator to include cultural rituals.*
- *Allocate resources, perhaps from the communities themselves, to build capacity in the community. Check with community resources to see where they are maxed out to determine where capacity needs to be built.*
- *Create pathways for provider certifications.*
- *For the long run, consider how we can encourage people to enter and remain in the human service professions.*

What's different when the Consumer is not here voluntarily?

This blueprint resonates most strongly when we think of consumers who are able and willing to engage with connecting technologies, a navigator, and the network to

build on their strengths and find solutions to their problems. But what about those who will be engaged with the new system involuntarily? Examples include many situations involving child endangerment or neglect, substance abuse, mental health, those who are legally incompetent, domestic violence, and perhaps eventually juvenile justice and corrections. Many of these consumers may be unwilling or unable, at least initially, to identify a circle of support and guide their own plans with a navigator.

Even in these situations -- sometimes especially in these situations -- we can achieve better outcomes with fewer resources if we can assemble a circle of support, engage the "involuntary consumer," identify strengths and assets, and tailor community and government services to best solve today's problems and prevent more in the future.

For people who do not have the capacity to participate in a process with friends and family, the navigator will have to play a larger role in interpreting the needs of the client, being their advocate, and identifying and securing appropriate support and services.

For those "forced" to interact with the human services system today because they may be a danger to themselves or others or who have to comply with certain activities in order to receive benefits, the current system mostly presents services and then enforces compliance. In the new system, "the enforcer" becomes more of a "facilitator."

Again, the method is to identify strengths, engage a circle of support, formulate plans, and match support and services, all to achieve the desired outcomes. The navigator here will need to have talent and be skilled in "winning compliance" more often than "enforcing compliance," especially with someone who will likely be resistant. This approach is similar to proven practice models such as those used in Family Group Decision Making, Family Assessment, and Motivational Interviewing. Experience has shown that this approach engenders less resistance and gains more buy-in and is therefore more often successful. For it to work well, however, it requires that all the major players in the system buy in, e.g. service providers and judges.

This approach can also yield many of the same benefits it does with "regular" consumers:

- Earlier problem identification and more preventive intervention;
- More, better work accomplished outside the documentation-heavy formal system;
- More appropriate, more successful, and less costly services and other support; and
- More holistic and sustainable progress.

While navigators focus on support and facilitation, they must also be prepared to trigger intervention when safety or the law requires it.

Planning and Implementation Issues:

- *Provide training to help "enforcers" become "facilitators," while maintaining safety.*
- *Navigators need to have at their disposal adequate and quality services.*
- *Engage and raise awareness among other system players.*
- *Engage and raise awareness among legislators so that "incidents" have less chance to upend the system.*

Accountability & Incentives

Combine more accountability for outcomes with more flexibility at every level. Create new "deals" across a system that makes outcomes the most important thing, not the rules. Regularly measure key results and hold performance conversations to learn and improve. Be transparent. Publish performance data at multiple levels and be sure that the data are available to engaged consumers, navigators, counties, DHS, elected officials, and taxpayers via the web as supports are chosen.

We can get a better return on taxpayer investment by:

- Aligning incentives for consumers, navigators, providers, and other stakeholders to achieve outcomes, encourage earlier intervention, prevention, and the use of the least intrusive and lower-government-dollar-cost solutions.
- Negotiating contracts between the state and the Southeast Minnesota Results Cooperative and between the co-op and providers based on accountability for outcomes and combining accountability for outcomes with more flexibility to make it easier to achieve the outcomes. Pay for results and behavior change, not units of service.
- As much as possible, allowing engaged consumers and their navigators or supporters to use vouchers to choose what providers and services will best and most cost-efficiently meet their needs based on something like a "consumer reports" about providers and services. Explore the use of incentives.
- Creating opportunities to learn what works and to improve.
- Making robust data available in real time to engaged consumers, navigators, providers, managers, elected officials, and communities across the region.
- Encouraging flexible service design and delivery to promote cultural competency and tailored solutions.

The Southeast Minnesota Results Cooperative and those working centrally in the co-op can be resources for creating accountability frameworks, incentives, and then providing

technical assistance for using them to foster learning and improvement and more effective and efficient services.

Planning and Implementation Issues:

- *Evaluate disincentives in the current system and convert them to incentives.*
- *Explore the myriad ways we could use non-monetary rewards and recognition to incent performance in the system. Monetary incentives can also productively be used in provider contracts to incent the achievement of outcomes and more value.*
- *Learn from other jurisdictions' use of performance contracting and use of performance information to improve outcomes and efficiency.*

Role of DHS

DHS also sees the new system as better from its point of view; DHS helps resolve problems and advocates for the new system.

DHS:

- Endorses the new system, advocates for it with the media, executive branch, and with citizens, and actively helps implement it.
- Negotiates contracts with the Southeast Minnesota Results Cooperative to assure accountability to taxpayers and flexibility to produce the best return on taxpayer dollars.
- Assists in securing federal waivers and federal rule and law changes and waiving state rules and supporting state law changes to enable and support the new system.
- Helps source technology and other supports and resources for the new system.
- Maintains a dashboard to show indicators and provide timely information to counties and the Southeast Minnesota Results Cooperative. The contents of the dashboard will need to be determined. Again, note the link with the work of the Steering Committee on Performance and Outcomes Reform.
- Helps identify and support solutions to address fraud and abuse, while minimizing rules based on mistrust.

Links with Other Related County Services

This blueprint is built for human services. But it is intended to help create a system that has the potential to integrate public health, corrections, health-care-related transportation, and veterans, as counties choose.

Planning and Implementation Issues:

- *Follow Minnesota's implementation of federal health reform and adapt this blueprint and implementation to align with opportunities.*
- *Keep the region's public health, corrections, and other pertinent operations in the loop and invite a dialogue to develop ideas for integration.*
- *Explore solutions to the question of the lack of alignment between Child Welfare and Child Support on one hand and judicial districts on the other. It would be better if people had the flexibility to go where they wanted to go to transact business.*

Communications and "Marketing"

Success will be enhanced by a sophisticated communications/marketing/branding plan that includes:

- Partnership with experts in branding and communications.
- Telling the story about the new system and its successes, including measureable outcomes achieved.
- Communicating to the current workforce that their skills and commitment to serve are valued and they are critical to implementing the new system.
- A call-to-action message that the whole community can contribute and benefit in the short and long term.
- Leveraging new social media.

Make it Transparent. Create Evangelists. Make it Big!

A core element here is "changing the conversation." This human services redesign initiative is part of a larger movement to lift the public and policy debates out of the false dichotomy of "cut spending" or "raise taxes." While there may indeed be less money in the system, that does not necessarily mean we have to settle for less of the current system as a solution.

Our effort and others are raising awareness and generating momentum for systemic change that can generate better results with the available resources. Our communications should point out "What's in it for me?" From the redesign,

- What's in it for consumers and their families?
- What's in it for counties?
- What's in it for communities?
- What's in it for DHS?
- What's in it for taxpayers?
- What's in it for policymakers?
- What's in it for human services employees?
- What's in it for service providers?

Planning and Implementation Issues:

- ***Building the strategy — make it transparent***
  - *Gather information through interviews and conversations with key stakeholders to discuss the blueprint and what follows and gather feedback*
  - *Conduct research.*
  - *Build the plans and report back to the stakeholders, incorporating what was heard in the meetings.*
  - *Announce Phase II planning results and kick-off the campaign.*
- ***Stakeholders — create evangelists***
  - *Tailor the message for stakeholders including: advocates, state, county, feds, DHS, taxpayers/general public, county employees, faith communities, and others in social services & non-profit networks.*
- ***Media Strategy — make it big***
  - *The campaign should be led with PR including: media relations (newspapers, etc.) and government relations.*
  - *During the kick-off, consider public service advertising.*
- ***Creative Strategy — make it folksy, optimistic, and simple***
  - *Keep the message very simple, e.g. "Sharing resources, just like neighbors do."*