The Integrated Services Business Model Guide

Expanded documentation by the DHS Business Solutions Office
in partnership with MNIT Communications

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Contents

Executive summary

What is this document, and how is it used?

This guide is a tool to help people understand the information in the Integrated Services Business Model (ISBM or "the model"). The model is the agreed-upon framework for the delivery of human services in Minnesota in the future. Most of the information in the model is provided in the form of charts and a process map. While those visual tools were useful to develop the model and share it with internal partners, they don't provide enough information for someone unfamiliar with the field of human services or the background of the project to understand the model entirely. This guide describes what is in the model with more context so that it is easier to understand. This guide also walks through how the model was developed and how it will be used.

The model, and as a result, this guide, was created with an extensive amount of input from counties of varying sizes as well as representatives from some of Minnesota's tribal nations, the Minnesota Association of County Social Services Administrators (MACSSA), leadership from across the Minnesota Department of Human Services (DHS), DHS Agency Divisions, Information Technology (IT) governance teams, and Community Relations stakeholder groups, as well as county agencies in other states that are leading nationally in integrating human services.

What is the Integrated Services Business Model?

The Minnesota Department of Human Services (DHS) has complex technology solutions connecting services to more than one million people in the state. More than 30,000 county, tribal nation, and state staff and 200,000 providers use these systems to deliver services. These groups are working together to try to provide integrated service delivery. Integrated service delivery is a research-driven approach, focused on person-centered, multigenerational, root-cause-based ways of providing services to make peoples' lives better. DHS has also started modernizing IT systems to support integrated, person-centered human services delivery. These improvements will offer better, more tailored experiences to people applying for or participating in services, and also better experiences for the staff serving them.

Early in the spring of 2017, DHS began a partnership with the Minnesota Association of County Social Service Administrators (MACSSA) and White Earth Tribal Nation to set the vision for integrated, person-centered human services delivery in Minnesota. The result of this group's work is the Integrated Services Business Model, which will help to guide system modernization and transform many aspects of how people experience the human services system. The group purposefully decided to create the model to be specific enough to guide technology development and service delivery changes, yet flexible enough to work in every locality. They wanted to focus on the best way to deliver services, and not focus on the limitations of current policy or technology.

To develop the model, the group reviewed feedback from people receiving services about their experience, and visited counties and tribal nations that have taken steps to integrate their services, to learn about how they do

it. The group also talked with experts from other places in the country that are at the next steps of integrating services, and looked at research on service integration models. The project received technical assistance from the American Public Human Services Association (APHSA). The assistance from APHSA included guidance on best practices, coaching on how to develop the model, exchanging information with a cohort of other projects, help with a statewide assessment on the current state of integration, and a two-day retreat to help establish a plan to implement the model.

The group that created the model was a successful example of working together statewide, and the model is now at the heart of DHS' long-term strategic plan. The model is the foundation for changing the way services are delivered. DHS and its partners have started a multi-year planning effort to put these changes into place.

Current service delivery challenges

People seeking human services in Minnesota find that it can be difficult to understand how programs and services are structured. One reason it is challenging to understand is that some of largest and most important computer systems don't communicate with each other. This makes it difficult to see and share information. People have to share the same information over and over to different systems, even though they seem like they should be connected. It also means that staff must repeat processes. The computer systems use programming languages that are no longer taught in schools. This means that there's a small number of programmers who know how to maintain and make changes to the systems, which is a risk to the sustainability of the systems over time.

Human services programs have also grown larger and more complicated over the years. The programs don't always work together, and they receive funding in different ways. Laws and rules also change at the federal, state, and local level. This leads to many different ways of serving people, which means that they don't know what to expect. It also makes it hard for them to learn about all of the options, and make informed decisions.

Minnesota has a state-supervised, county-administered human services delivery system, meaning many programs and services are delivered locally. This gives counties and tribal nations some flexibility in how they serve their communities. This flexibility can be a positive, but it also lead to differences in how services are delivered in one community compared to another, which adds to the complexity and inconsistency that people can experience.

These challenges are why DHS is working with partners across the state to transform human services delivery and modernize technology systems. The model is the guiding framework for modernizing Minnesota's human services system to be more impactful and efficient for the people it serves. The following pages describe what the framework looks like for this future state.

Model overview

Vision set forth by the model

The goal of the model is to provide all Minnesotans with access to an integrated and accessible person-centered human services system, using technology that many people are familiar with in other parts of their lives. The model's goals include:

- Holistic, culturally appropriate human services to meet individual and family needs
- Empowerment for people to determine needs, choose services, and establish personal goals
- Information access and control by people and those working with them at all points
- Quality customer service provided throughout the person's experience

The model is built on the following themes.

Ease, empowerment, and person-centered approach

The model gives individuals and families the power to focus on personal goals, helps them prioritize and address immediate needs, and provides information about root causes for them to consider, as well as possible programs and services to help. The model envisions that programs and services will be coordinated across the community, county, tribal nation, and state. People will be able to choose supports and services that fit their daily lives and needs.

The current human services delivery system has many separate ways to enter. These are often based on a program or service's design, and when someone goes through a program's "door," services are often limited to what's available within that program area. The new model lets people enter through any door, and have the opportunity to explore the breadth of programs and services. This is the same whether the individual or family is talking to staff face to face or over the phone or internet, or using an electronic device, such as a computer, a kiosk or device that's not their personal computer, cell phone or other device. This also means using dynamic or "smart" forms, applications and processes across the system to save time and drive efficiency. Interactions between people and the human services system are described in the model as a spectrum, from low-touch to high-touch. The model allows for the entire spectrum to take place.

Data, measurement, and improved outcomes

The model also creates a vision for measurement and continuous improvement. This is done by using data in new ways, combining population and individual data. The goal that guides the vision for data in the model is to answer the question "are people better off?"

New tools for staff and people served

An integrated technology system will provide a shared workspace and online account for users (both people served and staff). Staff across the state will be able to spend less time doing data entry and workarounds for aged, flawed or unconnected systems. Instead they'll focus on more strategic, proactive work.

Everyone that receives services will have the option to use an online account, where information about them will be stored and organized. To revisit the concept of "doors," everyone will be given a "key" to access the online door to their services, even though they may choose other methods; people will also still have other options, such as telephone and in-person. Someone that they have authorized may also use their online account on their behalf. Any option will allow the same pathways to service.

Efficiency and simplification

In addition to developing better systems and improving service delivery, the alignment and simplification of programs and policies is an important part of the model vision. These steps will contribute to a more efficient and effective human services environment.

Guiding principles of the model

Nine principles guide the model. These principles, along with the vision, are why the model was designed. The principles are:

- Racially and culturally appropriate efforts support an equitable human services delivery system
- The human services framework is person-centered
- Social determinants of health help identify root causes and track progress for individuals, families and communities
- A multigenerational approach to providing human services takes into account the needs of the whole family, rather than one individual
- Data analytics are embedded across the model to measure effectiveness and provide information for continuous service quality improvement
- People can interact with human services either through self-service or with staff
- There is a balance between centralized accountability and regional flexibility
- Systems, actions, and values are aligned toward a common vision in partnership across the state
- State, county, tribal nation, community, and provider staff have the tools and support they need to best serve individuals and families

The model's vision and principles add to work done in 2014 on the Minnesota Model for Integrated Service Delivery. One aspect of the model's development was to validate that document, and then expand from that foundational document.

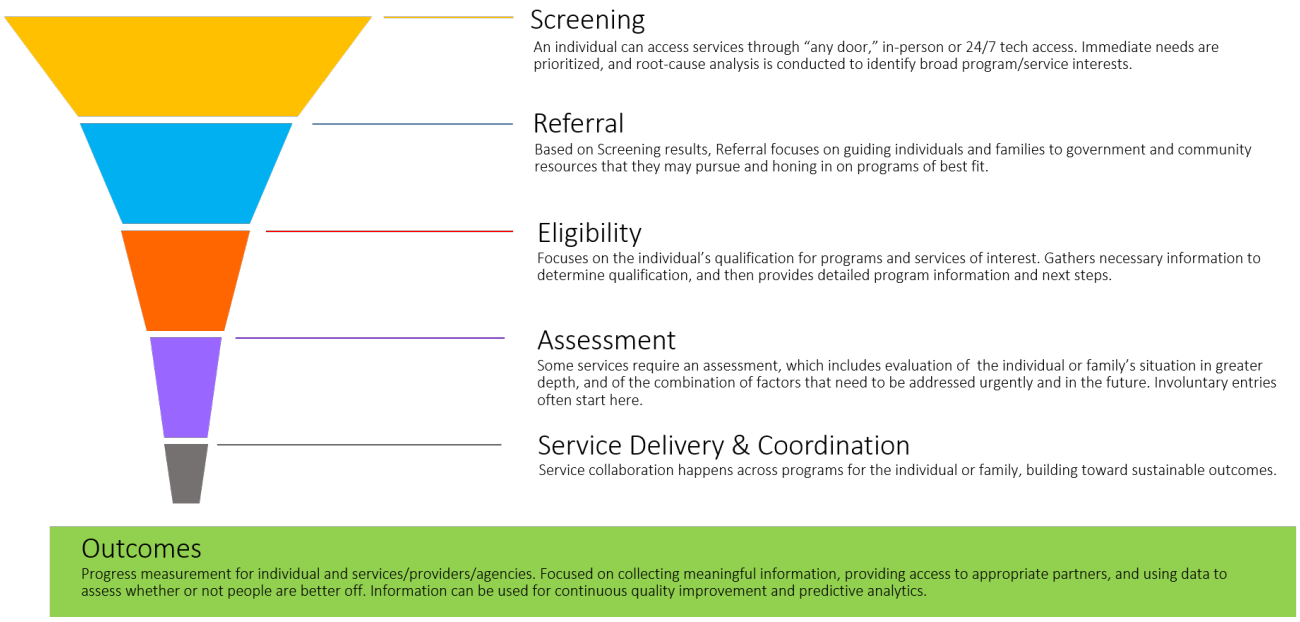
Composition of the model

The model is centered on the experience of people as they seek and receive services. It follows how an individual or family might move through the human services system. The model identifies different components that will enable this process, for almost any program or need and in any location. This broad, inclusive approach demonstrates how it's possible to bring programs together to offer holistic service, though there's a lot of detail that will need to be worked out to make this happen in reality. Clearly defining these components and what they involve creates a basic standard for what people will be able to expect across all human services.

- **Screening** identifies and prioritizes needs, and begins root cause analysis in order to identify program and service interests
- **Referral** focuses on guiding individuals and families to government and community resources that they may pursue, and honing in on programs of best fit
- **Eligibility** focuses on if an individual qualifies for programs and services of interest by gathering information needed to determine qualification for programs and determine next steps
- **Assessment** includes evaluating an individual or family's situation in greater depth, along with the combination of factors that need to be addressed urgently and in the future
- **Service Delivery and Coordination** is where collaboration happens across programs and services for the individual or family, building toward sustainable outcomes
- **Outcomes** are how progress for individuals and service providers is measured; it is focused on collecting meaningful information to determine if and how individual circumstances have changed for the better

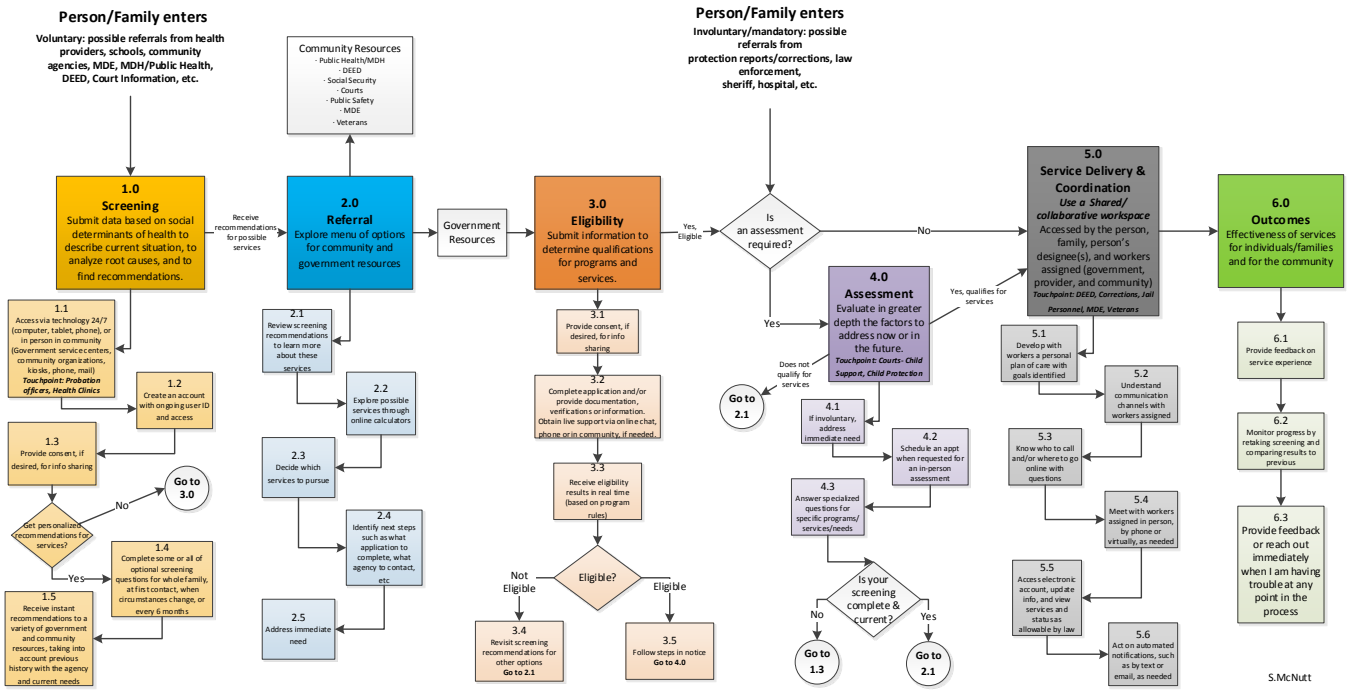
Graphics, process maps, and charts from the model

The graphic below demonstrates how an individual or family seeking help might flow through the human services system. It's the basic, most universal view of what a person's experience would be. The flow starts when there's a first contact between a person and an agency or organization, and the person responds to a screening questionnaire. The screening begins high-level analysis of their needs as well as potential root causes. Then, the person can explore relevant recommendations and narrow in on the options that interest them most. They provide further information to figure out their eligibility for specific programs, and then they may complete any necessary assessments, which add further context to their situation. After that, service coordination and delivery can begin, which includes working together with staff to develop a personal plan. Progress measurement and continuous improvement are important functions happening throughout the experience to make it better over time, including formal and informal feedback from the person.



The flow won't necessarily describe the experience of every single individual or family, but it provides a standard by which, for the most part, people should be served.

More details about what takes place during each component of the model are expanded in a process map, which was created from the perspective of the individual or family seeking services, rather than from the perspective of the staff, agency, or provider. This process map is where many of the model's specifics are shared. It may not look like a large amount of information, but each box has a number of underlying implications for what must take place and how it will be supported by the human services system as a whole.

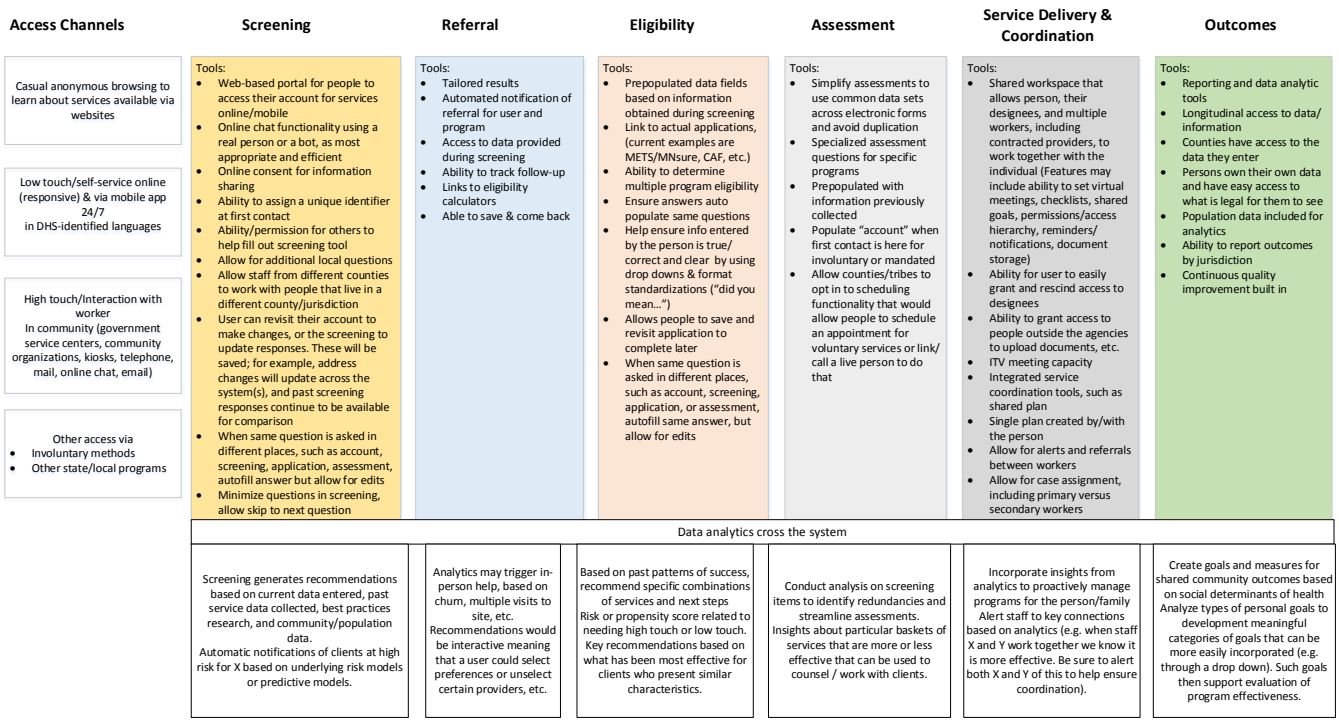


Human services are by nature often not experienced in such a linear, tidy way; people's lives are complex. The process map is a useful tool for understanding the ideal flow of how services are decided, arranged, and delivered, but the project team acknowledged that the practical application will need to be somewhat more flexible and fluid.

While the model's primary focus is on the experience of people seeking and participating in services, there are additional important aspects of service delivery that cannot be demonstrated that way. For this reason, the model contains two additional charts. The first represents the agency or provider perspective of each component:

Screening	Referral	Eligibility	Assessment	Service Delivery & Coordination	Outcomes
• Universal entity identification number will identify history with agency and services, and link family members together, across the state • Information automatically populates across tools and services • Standard screening state-wide, focused on assessing the social determinants of health; always offered but not mandatory • Screening will identify immediate needs and generate referrals based on analytics to allow for person centered decision making • Screening data available to workers as appropriate that subsequently work with the individual or family • If working with someone directly, use screening results to help them understand next steps • Ability to see previous interactions across program and counties as appropriate	• Provide information and assistance about services, virtually, over the phone or in person, at government offices and community partners based on individual needs and preferences in conjunction with insights from analytics • Provide navigation of services (high touch) when desired or needed based on initial root cause analysis	• Determine eligibility even if screening or referral have not occurred • Trigger multiple services at the same time (program alignment and simplification allow for this) • Use shared platform • Incorporate insights from analytics to proactively manage programs for which an individual is eligible	• Compare screening data to service data to determine which programs integrate successfully • Identify assessments, such as MnCHOICES, CPAC, Housing Coordination, corrections, CASI, WIC, MDS, for specific program participation • Assessments have been simplified to use common data sets across electronic forms and avoid duplication	• Access by the person, family, person's designee(s), and workers assigned (government, provider, and community) • Notify services providers when family has multiple workers • Respect cultures of individuals served • Access to information of the individual and ability to make connections • Provide a platform for a person centered integrated individual or family plan (does not replace other plans, but may draw from them) • Use clear communication channels for individual and between workers	• Identify indicators to measure integrated service outcomes • Use social determinants of health screening to strategize with client on goal completion • Measure individuals' satisfaction on service experience using common tool state-wide • Identify and track disparities and whether progress is being made on equity • Access to data by counties/tribes for analytics

The second chart is focused on technology that supports each component. These technology-based tools should be considered necessary to carrying out the vision of the model, but are not sufficient by themselves. They were included because the project team felt there were certain IT functions that they wanted to be sure were known, and may not have been understood otherwise based on other model content. This includes data analytics capabilities, as well.



Taken all together, these pages that make up the model offer a comprehensive view for the future of integrated, person-centered human services delivery in Minnesota. The following sections of this document walk through the components of the model one by one, summarizing the related content from each map and chart of the model into a single chapter.

The model is a starting point for IT systems modernization and providing integrated, person-centered human services. A lot of careful statewide planning and partnership will needs to take place to move Minnesota forward on this journey.

Screening

Vision

An individual can access services through "any door," online through self-service at any time, through personal contact face-to-face, by online chat or meeting, by email, or over the phone. Screening will help to prioritize immediate needs, and begin a root cause analysis to identify broad program and service interests.

Description

When a person or family is seeking help with an issue, no matter by what method, a brief questionnaire will be offered. The questionnaire, called the "screening," will ask questions that begin to assemble a picture of the current situation of the person or family. The social determinants of health are the foundation of these questions as they help to identify a person or family's unmet needs. Answers given through the screening will help the system to offer relevant, personalized, and prioritized recommendations that can help the person or family understand their options and make informed decisions.

During the screening, the person will be able to create or log into their online account. If they are new to the system, they will be assigned a unique identifier to be associated with their history across all programs and services. If they already have a unique identifier and online account, the screening step will add to and update information already shared, and their service history in the state will be available for their reference and convenience. Having an online account will allow a person to view, save, and share results as well as their historical information. If a person prefers to complete the screening in person or over the phone with staff assistance, staff will be available to act on their behalf. However, the screening is an online tool.

The screening will be the preferred first step for a person seeking help, as described above, but will also be available throughout the different components of the model, to record someone's changing situation over time and help to continually measure their progress and define their needs. It will be offered at all entry points where DHS, county, tribal nation, or community organization staff interact with people being served, or online, through self-service.

Essential attributes

The screening tool is:

- A standardized, statewide questionnaire, with the ability to add limited locally-specific questions
- A research-based questionnaire, focused on the social determinants of health
- A quick questionnaire with a limited number of questions (approximately 10-12 questions)
- A dynamic or "smart" tool that won't ask questions that aren't applicable
- Always offered; optional for both voluntary and involuntary entrants

The unique identifier will:

- Be assigned to a single person, ideally during screening, although it can be created at other points too
- Identify, or link to, the person's history with the agency (or agencies) and usage of services, and core demographic information
- Be able to be linked relationally to other unique identifiers (for example, linking family members to each other)
- Be used statewide throughout the human services delivery realm by DHS, counties, and tribal nations

During Screening, the online account means:

- A person or family will not have to tell their story over and over; the information gathered during the screening and shared during online account setup can serve as the basis for their story and contacts with the human services system going forward
- People will have the ability to provide consent for information sharing; what they're consenting to will be easy to understand

How Screening contributes to person-centered service

Screening means:

- People will feel heard, and the response will make sense for their needs, strengths, and preferences
- There will be options for people even if they do not provide consent for information-sharing
- Increased consistency, no matter where a person or family enters the system or who they talk to about services
- A quick diagnostic tool to help identify needs holistically in addition to addressing immediate issue

Referral

Vision

After someone completes the screening, they can view their recommendations. The Referral component guides individuals and families to government and community resources that make the most sense for their situation. Referral also helps them select which programs and services to pursue.

Description

Information shared during the screening works together with other data in the system to offer an individual or family a list of options matching their wants and needs. Referral recommendations will be comprehensive and include government and community resources. Recommendations will be put together in a way that shows several options in a way that is not overwhelming. Both the Screening and Referral components are optional, but encouraged steps in the model.

Through Referral, people will be able to understand what the next steps are for pursuing the programs and services. For example, if they need food today, a recommendation they receive may be the address, location, and hours for a nearby food shelf. The recommendation could also take them directly to an application for a food assistance program. If a person chooses, they could also be instantly referred to a program by the system.

The Screening and Referral steps shouldn't take a long time to complete, no matter which way a person gets in touch with DHS, a county, tribal nation, or other provider. People will also be able to save their information and come back. If they are trying to address an urgent need and don't want to consider additional options, they can pursue only what they want to and wait to explore others when they are ready.

Essential attributes

Referral is:

- An easy-to-navigate guide to government and community program and service options
- A real-time tool with accurate, current information
- Influenced by the social determinants of health
- Structured and designed simply, with help always available
- Accessible online or in person

Referral resources offered will:

- Be tailored to a person or family's individual circumstances
- Include community and government resources
- Be saved to a person's online account

- Pull from a database of available services from DHS, counties, tribal nations, and community organizations
- Not be limited to county and tribal nation resources; options should be based on convenience and meeting needs
- Include current location information and contact information (phone numbers, emails, website, and open hours, etc.)

Online calculators will:

- Be offered for estimating eligibility, but not for determining it
- Help people understand qualifications, and guide people to programs and services that may be options for them based on their situation
- Be linked or embedded as resources; many helpful, well-established calculator tools are already online

From Referral, a person may choose to:

- Send instant referral notifications to organizations and programs of interest, or choose not to
- Compare available options, like they would when shopping online
- Go directly to an eligibility application

How Referral contributes to person-centered service

Asking for permission and consent means:

- Giving people the power to make decisions about if and how they share their information
- It is clear when a person moves from browsing through options that might work for them to sharing information to follow up on their recommendations
- People will be able to prioritize the steps they want to take; functionality will exist for people to indicate which programs or services they want to pursue and the order in which they would like to pursue them

Recommendations will:

- Give people a better understanding of the programs and services available to them
- Include pertinent information that may be helpful to consider when making decisions
- Allow for easy contact through email, websites, phone numbers, location-mapping, and hours
- Give people the ability to select or unselect preferences or providers
- Be able to be organized and prioritized by the person
- Include options that match the person's needs; for example, if a person elects that they need food today, their recommendations need to include options that clearly provide a solution to that
- Give people the opportunity to meet needs discovered through the screening
- Offer clear next steps when a person makes a decision about the services they want

Eligibility

Vision

Eligibility focuses on a person or family's qualification for programs and services. It gathers information to determine qualification, provides program information, and guides next steps.

Description

Based on programs people choose in Referral, they move on to Eligibility and share information that helps decide if they qualify for programs and services. But, Eligibility also doesn't necessarily depend on Screening or Referral taking place first. It can take place independently at any time the person or family chooses to do it. If a person does go through Screening and Referral first, information they shared in those steps will fill in automatically on their eligibility application. This will work because the person will be tied to the unique identifier from their online account. The person will then go through the online application process to fill in gaps and confirm their information is correct. The eligibility application will be dynamic or "smart," so that the person will only be asked to provide relevant information. Online chat and other help options will be available.

To find out if they're eligible, people often need to provide documents and other required information that they may need to search for. Because of this, the system will be able to save what they've filled in on their application and they can come back at a later time. Live help will be available throughout process. Also, applications will be simplified and many programs will share the same eligibility application.

People will receive eligibility results in real-time whenever possible. They'll be able to move forward with programs if they're eligible. If they're not eligible, they can easily go back to their Referral recommendations to find other options.

Eligibility includes the qualification for programs and services when a person receiving benefits reports a change in circumstances, or when eligibility is re-evaluated when it's time to renew. People will be able to submit information through their online account, including providing documentation. People will receive eligibility results in real time and can obtain live support via online chat, phone or in-person help.

Essential attributes

The eligibility application is:

- Focused on a person's qualification for programs and services of interest
- Able to determine eligibility for multiple programs at the same time
- Prepopulated with information already available about the person, for them to verify as they fill it out

Real-time determination and results-sharing means:

- Establishing eligibility for multiple programs in a comprehensive and simple way immediately
- That people receive immediate results, allowing them to immediately move on to post-eligibility activities and receive benefits as soon as possible
- If a person isn't eligible, the reason why is given, and they can revisit their recommendations to explore other options

How Eligibility contributes to person-centered service

Eligibility tools will:

- Be built with the foundational premise of striving to let people share their information only once
- Allow a person to apply online and get real-time eligibility determinations for programs
- Highlight missing information so that the person will know what's needed to move forward
- Make it easier for staff to do their jobs through increased mobility and minimized data entry
- Make it easier for people to provide information and get the help they need via the method that works best for them
- Help ensure that information entered by the person is correct by using drop-down lists and format standardizations
- Gather the minimum information needed to determine eligibility for the programs a person has chosen to pursue
- Present eligibility notices in a clear, understandable way

Assessment

Vision

Some programs and services may require an Assessment, which means evaluating an individual or family's situation in greater depth. This often involves looking at a combination of factors that need to be addressed urgently and in the future. Involuntary entries to the system are often referred to a specific assessment in order to arrange required services.

Description

An assessment may be a necessary step for a person to access certain programs or services. If an assessment is not needed for a program or service, it's possible to skip to the Service Delivery and Coordination component. If an assessment determines that a program isn't the right fit, a person can return to their Referral recommendations.

Assessments can be a required entry point for individuals and families in situations where they are mandated to participate in a program, for example, by court order, rather than by personal choice. These are called mandatory or involuntary situations. In these cases, people will complete the assessments that are required of them, and then they will have the option to take the screening and explore their recommended programs and services. That way, they can see if they qualify for more services than the mandatory program they need to pursue. Taking a look at more options is encouraged as part of the person-centered approach; they may have additional needs and desires, and a screening can help identify root causes, too, that might not be addressed by their mandatory program participation. Doing an assessment in these cases often starts the online account and sets up the unique identifier if one doesn't already exist for the person.

Assessments may be an important step for some programs, as well, regardless of whether the person is a voluntary or mandatory participant. They can also be important for people whose situations are complicated. Assessments can help build a personal plan encompassing a person's specific needs, strengths, opportunities, and goals.

Similar to what takes place during the eligibility application, relevant information already shared automatically fills and is used for online and in-person contacts related to assessments. The model also calls for simplifying assessments, making them less burdensome for people and staff. This will also help with on-going service and care coordination.

Progress and outcomes are tracked in the model and may prompt re-assessments for a person or family over time as circumstances change. A re-assessment may also be necessary if the previous assessment is not current.

Essential attributes

Assessments are:

- Completed within a mobile, responsive, and reliable information technology system because assessments can take place away from an office and in unpredictable circumstances
- Generally completed in an efficient way
- Structured in a way to find out the root causes of a person or family's situation in order build a personal plan to address them
- Easily accessed online or in-person in real time by staff who assist individuals and families

Assessment simplification means that:

- Policies and practices will be changed to combine assessments whenever possible
- Common terms and information will be used across multiple forms
- Less time between completing the assessment and providing services
- More staff time is freed up for more face-to-face time with individuals and families

Leveraging technology where possible includes:

- Self-service online options with ways to directly contact staff, whether via chat, voice or video conference
- Using an online account, automatically filling in information and making results and outputs visible whenever possible
- Scheduling functionality to give people the ability to set up appointments or get in touch with someone who can help them to do that
- A thorough online help function that is available for people and staff
- Real-time access to data in the system
- Connections across agencies where programs and services are provided
- The ability to replace routing, filing and storing paper with electronic documents
- Giving providers the ability to work with and share information in real-time with staff and the individual or family being served

How Assessment contributes to person-centered service

A person-centered approach to assessments means that:

- Getting help with the assessment is easy
- Assessments can be accessed in real-time, online when possible
- New services may be identified and offered to the individual or family during the assessment process
- The experience reflects a whole-family, person-centered practice, looking at strengths and goals, as well as the social determinants of health

Service Delivery and Coordination

Vision

Service collaboration happens across programs for the individual or family, building outcomes that can be sustained over time.

Description

A shared workspace is the foundation for Service Delivery and Coordination in the model. This shared workspace ties together with a person's online account. People and individuals they choose to share their information with can access the workspace. Some examples of those individuals might include special education teachers, therapists, family members, guardians, attorneys, and so forth. State, county and tribal government staff, providers, and community organizations would also have access to this information as allowed.

The shared workspace gives a person, family, or authorized individual control over these permissions. This gives the right people access to the right amount of information. People need to understand the information they're sharing and with whom. Checkpoints for consent need to be very clear, and it should not work against someone if they decide not to volunteer additional information beyond what's required. Also, this will ensure that a person understands how information is shared, in what ways it's shared, and who they can contact if they have questions.

Service Delivery and Coordination is where a person develops a personal plan with their assigned staff that outlines the goals they want to achieve**.** The personal plan and goals will be guided by the person and in alignment with the social determinants of health as well as other program or service assessments and guidelines.

Within the shared workspace, a person or their representative can update information and view services and statuses as allowed by law. They can also get and act on automated notifications. A person will be able to meet with staff in person, by phone, or virtually, however they choose. Getting in touch with the staff that help them should be easy. There should always be help available in person, by phone, online, and in other ways that may develop over time.

Essential attributes

The shared workspace is:

- How an individual or family can choose to manage their services
- A single place where everyone involved in the care of a person or family can plan and deliver services
- A central place to work together, meet, share checklists, set and track goals, set and adjust permissions, check history, set reminders, receive notifications, store documents, and arrange meetings

- A way to work together, when relevant, with other state agencies, such as the Department of Employment and Economic Development (DEED), Department of Corrections (DOC), Department of Education (MDE), Department of Veteran Affairs (MDVA), as well as counties, tribal nations, and community organizations
- Where information about people and their services is stored and shared
- A personal electronic health and human services record

Service delivery and coordination has tools that:

- Standardize the information collected and how it's collected and stored
- Include the ability for staff to view people who are active or inactive in a program
- Notify service providers when a person or family is being helped by multiple staff and make connections when needed
- Encourage service coordination with shared alerts and referrals between staff
- Give staff that help the same people and families the ability to share information when it's appropriate
- Include contracted providers in the shared workspace
- Integrate program-related and required plans
- Help manage the activities that different staff might complete for a person, allowing DHS, county, and tribal nation staff to work together online and understand what else is taking place

Easy contact points mean:

- Clear communication between individuals and staff
- Simple ways to find out who to contact and where to go with questions
- Automated text or email notifications and the ability to act on them
- Several ways a person or family may contact the staff that are helping them
- The ability to update account information and view services and statuses

How Service Delivery and Coordination contributes to person-centered service

A collaborative approach means that:

- People are at the center of service delivery and coordination; they can explore and pursue the services that best fit their needs by creating personalized goals and plans, and focusing on their strengths
- People have low-touch and high-touch options based on their preferences; some people will feel empowered by this new level of control, and others may have more assistance to use it
- People will have the ability to control access to their information and documents
- People can authorize the representatives they want to access their information with opt-in and opt-out permission options that are easy to request and put in place
- People can advocate for themselves and understand their risk factors related to human services the same way they would for certain diseases

- Success is more likely because using data and predictive analytics will match a person's goals and help them choose the programs that fit
- Services are provided across a continuum, not just as safety net services
- Cultures of people served are respected throughout

Outcomes

Vision

Outcomes measure progress for individuals, families, communities, programs and services, providers, and agencies. Outcomes can be sustained, and help to inform improvements across the human services system.

Description

Outcomes combines individual, community, population and agency data to help build healthier communities and a better system. An integrated, person-centered human services delivery system is intended to help individuals and families achieve positive outcomes. Also, DHS and its partners should see efficiency and positive impacts across the system. Measurements will be put in place to find out if people are better off because of the services they've received. These measurements will also help improve services and encourage innovation at all levels.

People will be able to provide feedback on their service experiences. Consistent questions will be used across the state to gather feedback. Counties and tribal nations will also use these questions and have the ability to add some that are specific to their communities.

People can monitor their progress by going through the screening again and comparing new with previous results. That's one way that they'll be able to track progress on their goals and set new ones. A standard set of information will become part of an individual's electronic record to measure progress. Gathering and storing this information will follow a standard process. DHS will be able to aggregate and use this information to identify trends, opportunities and patterns because it is tied to a person's unique identifier. This information can be used for continuous quality improvement and predictive analytics.

Essential attributes

Outcomes are:

- Measured for individuals, programs and services, providers, agencies, communities and statewide
- Indicators that define the impact made, whether that's positive, negative or somewhere in between
- Defined and measured based on the social determinants of health
- The basis for continuous quality improvement functions
- Predictive analytics that show the probability of success for programs and people
- Key to successful, innovative partnerships with organizations across the state
- Key to providing good service to those who are unwilling to share their information, too

Measurements and capabilities include:

- Identifying standards to determine the impact of service plans over time
- Cultural considerations
- The system's ability to collect and store data and outcome measures
- Flexibility to be modified when new leaders are in place
- The ability to report outcomes by jurisdiction or other category
- Access to information for counties and tribal nations
- Data entered at county and tribal nation offices
- The ability to partner with other agencies, for example, the Department of Employment and Economic Development (DEED), to share data and analyze information
- Online help functions built for users
- The ability to identify points in the system where users have experienced problems and test improvements

The data analytics function will:

- Do outcome-based analysis and evaluation
- Be built around goals
- Allow counties to perform local analytics
- Integrate community, state, tribal nation, and national data
- Identify patterns and multigenerational impacts
- Predict risk factors
- Show achievements made by integrating services
- Measure service experience satisfaction
- Identify and track service equity gaps and progress
- Connect to outcomes required by state and federal rules
- Compare screening data to service data to help evaluate program success

How Outcomes contributes to person-centered service

On the individual level, Outcomes can provide:

- An individual or family the ability to measure and understand their progress
- Measures of independence, quality of life, and wellness to see if they are better off
- Ways for a person to use and control their own information
- Insights for continuous goal-setting and planning around known risks and trends
- More proactive coordination and programming across all offerings

Data used for measuring outcomes will:

- Allow counties and tribal nations to find out which persons or communities need the most and least resources and use that information to improve the way they provide services
- Be gathered in a standard way; for example, things like address information needed across programs and systems and categories for drop-down options
- Be collected and used in a timely way to lead to better decision-making

Next steps

What's next?

The model will lead to major changes for how technology systems are built and how service is delivered in Minnesota. It's an exciting step in the direction of ensuring person-centered, integrated human services delivery. There are many considerations to be taken into account as DHS and partners plan for implementation.

The model is new, and many interested individuals and groups need to be consulted, both on the considerations that need to be made and on the approach that will be taken to make it come to life. Technology modernization efforts will take a number of years, and developing those requirements is a large task. DHS and other groups will need to look at how their organizations are structured currently and how they will need to change over time to achieve the model's vision. Partnerships across the state and with the federal government are important to designing our approach to the work ahead. Policy and program alignment and simplification efforts are at the root of the work. All of these efforts require a great deal of study in order to be successful.

This doesn't mean that person-centered human services delivery is only possible in the distant future. In fact, there have been achievements toward that goal all over the state for years. Sharing those achievements is critical for identifying changes that can take place quickly without technology solutions or rule changes. These achievements are an important part of developing a culture of continuous learning and improvement.

MACSSA and DHS agree on the model's goals and initial implementation plans. This agreement will be crucial in making strategic resource investments over the next several years. The shared vision will help to prioritize work that will drive change responsibly and quickly. Most important of all, putting the experiences of the people served at the center of decision-making will drive implementation forward.

Appendix A—Key terms and definitions

Some terms used in the model and in this guide have varied meanings and different implications to different people or sectors. Within the model and this guide, these definitions are what those terms mean.

Term	Definition
Accessible (accessibility)	Can be reached, used, seen or understood by everyone. DHS is responsible for ensuring compliance with local, state and federal nondiscrimination laws and regulations in employment and human services delivery. DHS must ensure public access to information about programs to related public and private entities that monitor or are involved with the department's operations. Federal and state statutes, regulations, and rules require that state and county entities notify the public that their written materials are available in accessible formats to individuals with disabilities.
APHSA (American Public Human Services Association)	The American Public Human Services Association (APHSA) is a bipartisan, nonprofit membership organization representing state and local health and human service agencies through their top-level leadership. APHSA seeks to influence modern policies and practices that support the health and well-being of all children and families and that lead to stronger communities.
Continuous improvement	An ongoing effort to improve products, services, or processes.
Data analytics	Qualitative and quantitative techniques used to examine data sets in order to draw conclusions about the information they contain, often with the aid of specialized software. Generally, data is extracted and categorized to identify and analyze behavioral data and patterns. Data analytics technologies and techniques can enable organizations to make more informed decisions, improve operational efficiency, optimize customer service efforts, and respond to emerging trends.

Term	Definition
DHS (The Minnesota Department of Human Services)	The Minnesota Department of Human Services (DHS) helps to provide essential services to Minnesota's most vulnerable residents. Working with many others, including counties, tribal nations, and nonprofits, DHS helps ensure that Minnesota seniors, people with disabilities, children and others meet their basic needs and have the opportunity to reach their full potential. While the vast majority of human services in Minnesota are provided by partners, DHS (at the direction of the governor and Legislature) sets policies and directs the payments for many of the services delivered. As the largest Minnesota state agency, DHS administers about one-third of the state budget. The largest financial responsibility of DHS is to provide health care coverage for low-income Minnesotans. DHS is also responsible for securing economic assistance for struggling families, providing food support, overseeing child protection and child welfare services, enforcing child support, and providing services for people with mental illness, chemical dependency, or physical or developmental disabilities. Through licensing services, DHS ensures that certain minimum standards of care are met in private and public settings for children and vulnerable adults. DHS also provides direct service through regional offices for people who are deaf or hard of hearing; through DHS Direct Care and Treatment, which provides direct care to people with disabilities; and through the Minnesota Sex Offender Program.
Door (or program door, any door)	Any entry point in which people enter the human services delivery system. This could be through existing program participation, seeking information online, over the phone, or in person in any number of ways, involuntary or court-ordered interactions and programs, and so forth.

Term	Definition
High-touch	Interactions between people and the human services system are described in the model as a spectrum, from low-touch to high-touch. The model allows for the entire spectrum to take place. Many people prefer or require assistance with any or all aspects of arranging or participating in services. Staff that can provide clear, consistent, and courteous personal interactions through a variety of channels are the key to high-touch services. In-person and telephone channels account for the majority of interactions today, and are anticipated to remain significant in the foreseeable future. For many programs, in-person assistance is a critical part of service arrangement and delivery, whether in someone's home or in a state, local, or provider facility, government center, or community organization location. There will also be options to communicate over email, by live chat online, by arranging digital meetings with audio and or video capability. This range of options offers flexibility for people served to choose what works best for them, and to be able to continuously adjust and evolve those interactions over time, by situation, desire, or need. Removing barriers to a broader array of options for interaction is key to creating this more flexible, adaptive environment. It's unlikely every option will be available for every scenario, but that should be the goal. *See "Low-touch" definition for more information.*
Human services	An interdisciplinary field with the objective of meeting human needs through an applied knowledge base, focusing on prevention as well as remediation of problems, and maintaining a commitment to improving the overall quality of life of service populations. This involves the study of social technologies (practice methods, models, and theories), service technologies (programs, organizations, and systems), and scientific innovations that are designed to ameliorate problems and enhance the quality of life of individuals, families, and communities to improve the delivery of service with better coordination, accessibility, and accountability. *See "DHS" definition for more information.*

Term	Definition
Integrated, or integration	Services are coordinated and work together efficiently and effectively to help reach agreed-upon goals. From a technology standpoint, systems are able to successfully communicate and share information seamlessly. The Center for Medicaid Services refers to integration as harmonization of plans, processes, information, resource decisions, actions, results, and analyses to support key organization-wide goals. Effective integration goes beyond alignment and is achieved when the individual components of a performance management system operate as a fully interconnected unit.
Involuntary, or mandatory	This term covers anyone mandated or ordered to participate in the human services system, rather than by their personal elective choice. Examples include individuals and families referred by protection reports or corrections, law enforcement or sheriff, courts, hospitals, etc. *See "Voluntary" definition for more information.*
Low-touch	Interactions between people and the human services system are described in the model as a spectrum, from low-touch to high-touch. The model allows for the entire spectrum to take place. In-person and telephone channels account for the majority of interactions today, and are anticipated to remain significant in the foreseeable future. But, there will also be increased options to communicate over email, by live chat online, by arranging digital meetings with audio and or video capability. There will also be self-service options, online or at a kiosk, with real-time results, enabling those that are able and desire the ability to complete many tasks themselves, without staff help. These are considered "low-touch" users. This range of options offers flexibility for people served to choose what works best for them, and to be able to continuously adjust and evolve those interactions over time, by situation, desire or need. Removing barriers to a broader array of options for interaction is key to creating this more flexible, adaptive environment. It's unlikely that every option will be available for every scenario, but that should be the goal. *See "High-touch" definition for more information.*

Term	Definition
MACSSA (Minnesota Association of County Social Service Administrators)	The Minnesota Association of County Social Service Administrators (MACSSA) is a statewide association made up of county public social service directors or other administrative designees. The Association has been in existence since 1946 and is representative of all 87 Minnesota counties. Their mission is "building a unified network of partnerships to advocate for meaningful system improvement, influence policy and legislation and promote quality human services that positively impact our citizens, communities and counties throughout Minnesota."
Minnesota Model for Integrated Service Delivery	Minnesota's Department of Human Services was charged by the legislature to simplify policy and to modernize human services delivery systems to better meet the needs of people served, servicing agencies and to increase accountability to all Minnesotans. In 2014, a guiding document was assembled, and endorsed by MACSSA, the Integrated Service Delivery System Steering Team, and the DHS Enterprise Architecture Board.
MNIT (Minnesota IT Services)	Minnesota IT Services (MNIT) is the information technology agency for Minnesota's executive branch.
Multigenerational	A model in which the family is viewed as an emotional system in which patterns of interacting and coping, as well as unresolved issues, can be passed down from one generation to the next and can cause stress to the family members onto whom they are projected. A multigenerational approach focuses on addressing the needs of the whole family. The multigenerational model integrates child-focused services, parent and caregiver services, and adult-focused services. This model is also commonly referred to as the two-generation approach or whole family approach.

Term	Definition
Person-centered	Person-centeredness is an important concept to modern health and human services approaches. It involves listening to people about what is important to them in order to help them live, learn, work, and fully participate in their communities on their terms. The goal is for people to lead lives that are meaningful to them. There are a number of closely related concepts around person-centeredness that play into this; the Center for Medicaid Services outlines the following, among others: • Person-centered practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals • Person-centered thinking helps to establish the means for a person to live a life that they and the people that care about them have good reasons to value • Person-centered planning is a way to assist people who need services and supports to construct and describe what they want to bring purpose and meaning to their life.
Recommendation engine	A system that identifies and provides recommended content or digital items for users. As mobile apps and other advances in technology continue to change the way users choose and utilize information, the recommendation engine is becoming an integral part of applications and software products. Recommendation engines are also known as recommendation systems.
Root cause	The underlying, originating reason that drives a chain of resulting effects. Here is an example of this from the human services realm: a person may be seeking cash assistance. However, the underlying reason they might need cash assistance could be that they were let go from a job for missing work, and the underlying reason for that might be that their childcare is unreliable. Identifying a root cause can help to actually resolve the issue more effectively and more permanently, rather than attempting to provide services that only resolve the presenting or most pressing issue. *See "Root cause analysis" definition for more information.*

Term	Definition
Root cause analysis	Root cause analysis helps identify what, how, and why something happened, thus preventing recurrence. There is an entire methodology around root cause analysis in certain settings; here, the meaning is more general -- the principle that rather than looking only at the presenting or surface issues, there may be an underlying, causal issue that should also be addressed. *See "Root cause" definition for more information.*
Social determinants of health	Conditions in the environment in which people are born, live, learn, work, play, worship, and age affect a wide range of health, functioning, and quality-of-life outcomes and risks. Therefore, research-based frameworks have emerged to help assess and improve those conditions, often centered on food, housing, utilities, health care, child care, education, employment, and transportation, among others.
State-supervised, county-administered	An administrative structure in which counties and local jurisdictions employ the staff and provide the services while the state monitors compliance. The state is responsible for legislative and policy development as well as compliance with federal requirements. Minnesota is one of nine states in the U.S. that has this administrative structure.
System modernization (information technology (IT) system modernization)	DHS — in close cooperation with counties, tribal nations and other key partners — will create a streamlined, person-centered delivery system by integrating several existing systems and re-thinking and improving social service delivery in Minnesota. IT system modernization touches all DHS human services programs. This is a comprehensive effort to streamline and modernize service delivery for all Minnesotans, focused on the following outcomes: modernize health care and human services delivery by creating a single eligibility portal for individuals in need of access to services; replace aging technology and establishing an integrated, people-centered service delivery system, including steps for eligibility, assessment, enrollment, and case management in partnership with local agencies; modernize payment and provider management for all health care and long-term care services; support a modern, people-centered care environment that includes integrated electronic health records.
Unique identifier	A numeric or alphanumeric string associated with a single entity within information technology systems.

Term	Definition
Voluntary	This term refers to individuals or families seeking or participating in services or programs within the human services system by their own elective choice. Examples include people referred by health providers, schools, community agencies, the Department of Health or Public Health, the Department of Education, the Department of Employment and Economic Development, and so forth. *See "Involuntary or mandatory" definition for more information.*
White Earth Nation	The White Earth Band of Ojibwe, or *Gaa-waabaabiganikaag Anishinaabeg*, is a Native American band located in northwestern Minnesota. The band's land base is the White Earth Indian Reservation. With more than 19,000 members in 2007, the White Earth Band is the largest of the six component bands of the federally recognized Minnesota Chippewa Tribe. It is also the largest band in the state of Minnesota.