# Issues Relating to the Administration of Family and Social Services Programs

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July 1995

Family and Social Services
Evaluation Committee

Indiana Legislative Services Agency

## Legislative Evaluation and Oversight

The Office of Fiscal and Management Analysis is a Division within the Legislative Services Agency that performs fiscal, budgetary and management analysis. Within this office teams of program analysts evaluate state agency programs and activities as set forth in IC 2-5-21.

The goal of Legislative Evaluation and Oversight is to improve the legislative decision-making process and, ultimately, state government operations by providing information about the performance of state agencies and programs through evaluation.

The evaluation teams prepare reports for the Legislative Council in accordance with IC 2-5-21-9. The published reports describe state programs, analyze management problems, evaluate outcomes, and include other items as directed by the Legislative Evaluation and Oversight Policy Subcommittee of the Legislative Council. The report is used by an evaluation committee to determine the need for legislative action.

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## Preface

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Each year, the Legislative Services Agency prepares reports for the Legislative Council in accordance with IC 2-5-21. This report concerns issues relating to the administration of family and social services programs. It has been prepared for use by the Family and Social Services Evaluation Committee.

This report gives special attention to:

(a) the continuation of the Office of the Secretary of Family and Social Services (IC 12-8-1);
(b) the continuation of the Division of Disability, Aging, and Rehabilitative Services Advisory Council, the Division of Family and Children Advisory Council, and the Division of Mental Health Advisory Council (IC 12-8-2);
(c) the continuation of the Family and Social Services Advisory Commission (IC 12-8-3);
(d) the continuation of the Office of Administration (IC 12-8-4);
(e) the continuation of the Office of Information Technology Services (IC 12-8-5);
(f) the continuation of the Office of Medicaid Policy and Planning (IC 12-8-6);
(g) the continuation of the Office of Planning, Innovation, and Federal Relations (IC 12-8-7);
(h) the continuation of authorities relating to divisions and directors (IC 12-8-8).

We gratefully acknowledge all those who assisted in the preparation of this report. The staff members of the Family and Social Services Administration were extremely professional in their response to our requests for information.

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## Chapter 1: Introduction

The Family and Social Services Administration (FSSA) was created in 1991 by P.L. 9-1991 as an outgrowth of two major studies that looked at the delivery of human services in Indiana. The Indiana General Assembly, in P.L. 13-1989, initiated a series of reports by the Legislative Services Agency (LSA), Senior Citizens, the Disabled, and Children in Indiana: Evaluation Audit (Legislative Services Agency, 1990 and 1991). The executive branch contracted with a consulting firm for the production of Vision for the Future, (Andersen, 1990). Both reports found that human service delivery in Indiana suffered from fragmentation of services; duplication of services; and lack of centralized policy planning, budgeting, evaluation, and research. The goal of reorganization was to bring together the programs from the Departments of Human Services, Public Welfare, and Mental Health under a coordinated system in order to eliminate the duplication of services and to provide human services more efficiently.

The objective of this report is to evaluate the performance of the administrative structure of the Office of the Secretary of Family and Social Services and the various entities referenced in IC 12-8-1 through IC 12-8-8. Performance is taken to mean the extent to which the creation of the FSSA administrative structure and the various entities established in IC 12-8-1 through IC 12-8-8 have (1) fulfilled their specific duties and responsibilities as defined by statute and (2) achieved the goals of the human services agencies as proposed in the Andersen and LSA reports. The specific entities to be evaluated are the following:

- Office of the Secretary of Family and Social Services (IC 12-8-1)
- Office of Administration (IC 12-8-4)
- Office of Information Technology Services (IC 12-8-5)
- Office of Medicaid Policy and Planning (IC 12-8-6)
- Office of Planning, Innovation, and Federal Relations (IC 12-8-7)
- Divisions and Directors (IC 12-8-8)
  - Division of Disability, Aging, and Rehabilitative Services (DDARS)
  - Division of Family and Children (DFC)
  - Division of Mental Health (DMH)
- Family and Social Services Bodies (IC 12-8-2)
  - DDARS Advisory Council
  - DFC Advisory Council
  - DMH Advisory Council
- Family and Social Services Advisory Commission (IC 12-8-3)

The reasons for conducting this study are as follows:

(1) IC 12-8-1 through IC 12-8-8 contain statutory termination dates of July 1, 1997 (SEA 89-1995);

(2) The Legislative Council, through its Legislative Evaluation and Oversight Policy Subcommittee, has requested information pertaining to the performance of the various entities established by IC 12-8-1 through IC 12-8-8. The Family and Social Services Evaluation Committee can use the evaluation results in deciding whether to recommend legislation to the General Assembly for continuing the Office of the Secretary of Family and Social Services and associated entities beyond the current termination date; and

(3) The evaluation results can be used as baseline data for future evaluations of the human services agencies in Indiana.

## Family and Social Services Administration

Two separate studies suggested a need to consider reorganization of human services agencies in Indiana. A series of interim reports published by the Indiana Legislative Services Agency (LSA) in 1990, followed by a final series of reports published in 1991, described and analyzed agencies and agency programs relating to five population groups: (1) children; (2) disabled adults; (3) families in poverty; (4) the mentally ill; and (5) senior citizens. According to the reports, the purpose of the two-year evaluation was "to examine services available to these populations with the goal being to provide a more effective and coordinated delivery system." Reports were issued for each population group describing each population, identifying issues affecting these population groups, reviewing the system for service delivery, and recommending changes in organizational structure.

Another study published in 1990 by Andersen Consulting for the executive branch arrived at similar conclusions regarding the general state of the health and human services delivery system and the need for a reorganization of the system. Both the LSA and the Andersen studies described a complex, fragmented delivery system that resulted in a duplication of efforts and a poor use of state resources.

Both studies generally concluded that any reorganization of the health and human services system should result in an accessible system with the ability to (1) focus resources to accomplish goals; (2) allocate resources appropriately across the system; (3) enhance coordination of planning and budgeting processes; (4) improve the quality of data necessary for program accountability, planning, and budgeting; (5) deliver the appropriate mix of services to individuals; and (6) establish a structure that promotes and supports coordination between programs and providers.

In order to accomplish these goals, the Office of the Secretary of Family and Social Services was established. This office included the Office of Administration; the Office of Information Technology Services; the Office of Medicaid Policy and Planning; and the Office of Planning, Innovation, and Federal Relations. In large part, the Department of Public Welfare became the Division of Family and Children; the Department of Mental Health became the Division of Mental Health; and the Department of Human Services became the Division of Disability, Aging, and Rehabilitative Services. Advisory bodies were created for each of the three divisions and for FSSA. In addition, individual programs were realigned within the divisions and funding streams were blended to the extent possible.

Office of the Secretary

The Office of the Secretary (See figure 1), as set out in IC 12-8-1-5, is responsible for coordinating the provision of technical assistance to each division for each of the following:

(1) compiling program budgets for each division;
(2) fiscal performance for each division;
(3) management and administrative performance for each division; and
(4) program performance for each division.

The Secretary is also accountable for the following:

(1) resolution of administrative, jurisdictional, or policy conflicts among the divisions;

(2) coordination of the activities of each of the divisions with the other FSSA entities, the General Assembly, and other state agencies;

(3) coordination of communication with the federal government and the governments of other states;
(4) development and ongoing monitoring of a centralized management information system and a centralized training system for orientation and cross-training;
(5) overall policy development and management of the State Medicaid Plan;
(6) liaison activities with other governmental entities and private sector agencies; and
(7) coordination of FSSA programs with related programs administered by the State Department of Health.

The Office of the Secretary consists of six authorized positions that include the Secretary, the General Counsel, the Director of External Affairs, two executive assistants, and an administrative assistant.

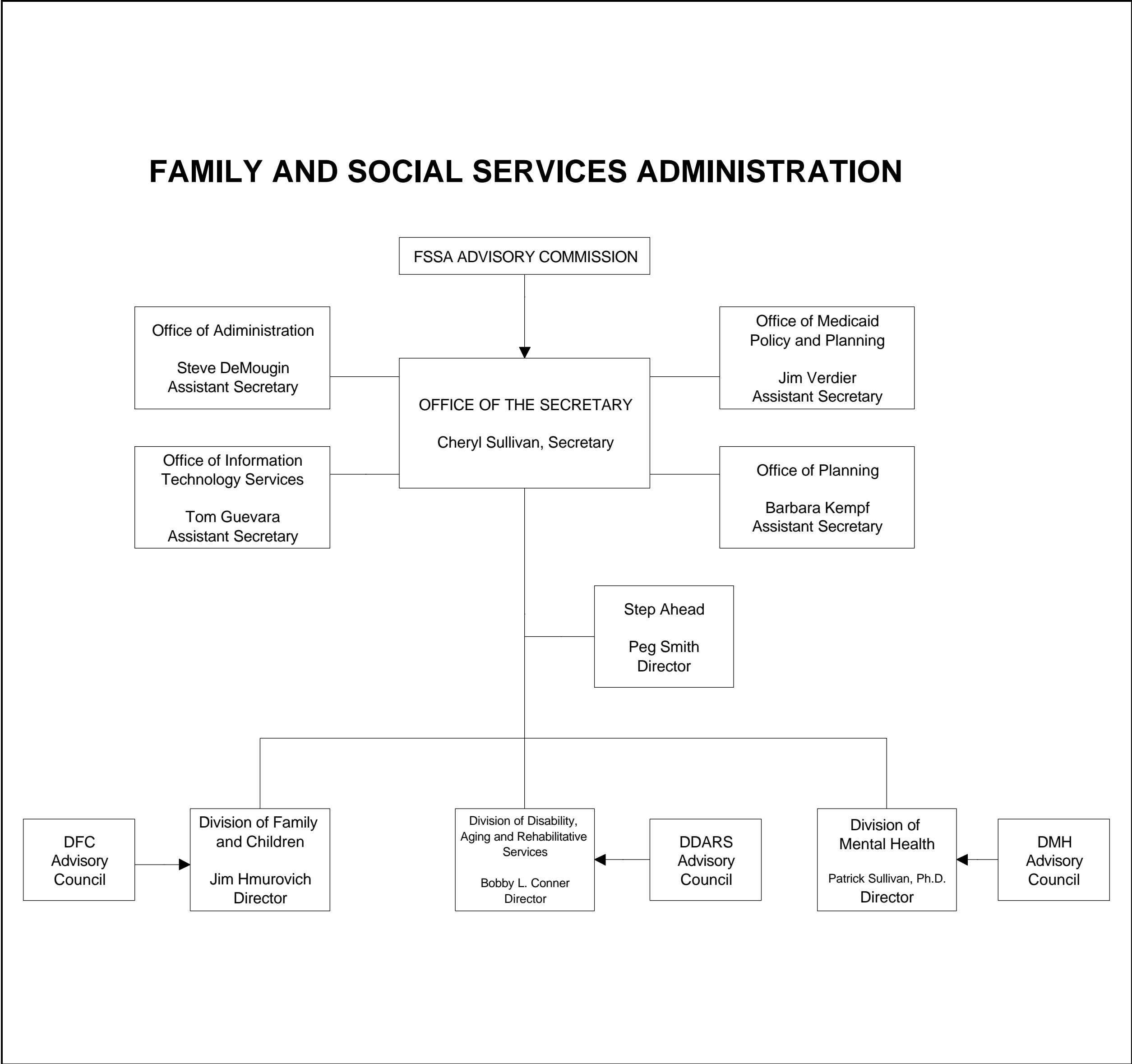


**Figure 1. FSSA Organizational Chart.**

In its efforts to provide management and coordination for all the programs, the Office of the Secretary has defined the vision, mission, and management values of FSSA. These can be found in Appendix A-6. The Office of the Secretary has also defined the four priorities of FSSA as the Step Ahead process, information development for policy decisions, provision of community-based services, and welfare reform. The Step Ahead process is designed to create teamwork among local, state, and federal administrators to help counties provide the best services as efficiently as possible to children and their families. The stated goal of the second priority, information development for policy decisions, is to develop sound data to guide policy decisions. Third, the goal of community-based services is to provide services for individuals as close to home as possible. Fourth, the goal of welfare reform is to help recipients become employed and self-sufficient through acceptance of personal responsibility for themselves and their families.

The Office of General Counsel is part of the Office of the Secretary. It provides legal support and representation for all of the programs administered by FSSA in five major areas: (1) program advice; (2) review of administrative rules; (3) contract review; (4) representation at administrative hearings; and (5) liaison to the Attorney General. Prior to the creation of FSSA, each individual agency had its own legal staff to support its own programs. There were 73 authorized positions as of February 1995, with 67 of the positions filled. Immediately after reorganization (January 1992), 46 of the 51 authorized positions were filled. (For reasons unrelated to the reorganization, 17 legal positions in Marion (9), Lake (7), and Allen (1) counties were changed from independent contractor to employee status.)

The Office of External Affairs is also part of the Office of the Secretary. It provides support services to (1) fulfill statutory requirements for submission of reports to the General Assembly and federal government; (2) disseminate information to the public and the media; and (3) develop training materials for the staff of FSSA and organizations with whom the agency provides technical assistance. Prior to reorganization, the duties performed by the Office of External Affairs were carried out by the Office of Planning and Information of the Indiana Department of Human Services. In February 1995, there were nine authorized positions with no vacancies.

## Office of Administration

The Office of Administration's mission is to provide statewide financial management, administrative support, and human resource services to FSSA to enhance the efficiency and effectiveness of the program activities of the offices and divisions. It provides a number of services, including fiscal management, procurement, claims recovery, budget management, property management, revenue enhancement, capital management, human resource administration, payroll, and auditing. Prior to the 1991 reorganization, these activities were carried out by the respective Departments.

The Office of Administration consisted of 255 authorized positions with 40 vacancies in February 1995. Immediately after reorganization (January 1992), there were 303 authorized positions with 59 vacancies.

## Office of Information Technology Services

The mission of the Office of Information Technology Services (OITS) is to provide information systems development and technology support services to all employees of FSSA. OITS has 99 authorized positions, 88 of which were filled as of February 1995. This compares to 67 authorized positions immediately after reorganization (January 1992).

The duties and purposes of the Office are defined in IC 12-8-5-3 which are (1) development of systems for all divisions; (2) production support for all divisions; (3) strategic and analytical systems for all divisions; and (4) technical architecture for all divisions. OITS heads FSSA's effort to establish an information system that will result in more consistent collection of data, better sharing of information within and outside FSSA, and higher quality of program delivery through shared technical expertise. Prior to the creation of OITS, each of the individual departments acquired and maintained technology based on the department and program needs.

Office of Medicaid Policy and Planning

The mission of Office of Medicaid Policy and Planning (OMPP) is to finance basic cost-effective medical services for low-income residents of the state. Insurance coverage for health care is to be provided in accordance with the requirements of state and federal law and at a reasonable cost to Indiana's taxpayers while making timely and accurate payments to health care service providers. The Office develops and coordinates Medicaid policy for the state. The Secretary of FSSA, as the ultimate authority for the state Medicaid program, may adopt rules and implement the program. OMPP works with the DMH, DFC, and DDARS on Medicaid issues relating to the provision of services.

The Office has 67 authorized positions, 60 of which were filled as of February 1995. This compares to 47 authorized positions of which 41 were filled as of January 1992 (immediately after reorganization) . Prior to the reorganization, the Medicaid Office was part of the Department of Public Welfare.

Office of Planning, Innovation, and Federal Relations

The Office of Planning, Innovation, and Federal Relations focuses on the agency-wide strategic planning process, supporting the Indiana Collaboration Project, coordinating quality improvement processes across agency lines, facilitating dialogue and planning processes across agency lines, and maintaining federal relations. The Office of Planning, Innovation, and Federal Relations has two statutorily defined duties. IC 12-8-7-3 states the Office is responsible for (1) developing and monitoring strategic planning and innovation for all the FSSA divisions and (2) managing the relationships with the federal government and political subdivisions of the state.

Specific responsibilities include (1) supporting and facilitating the implementation and continuation of the FSSA strategic action planning process; (2) coordinating quality improvement efforts, including training across agency lines; (3) federal relations, including coordinating information exchange with the state's confessional delegation; (4) coordinating the planning for proposed federal reforms (e.g. block grants) across agency lines; (5) analyzing the impact of federal laws and policies on the state; and (6) disseminating information on funding opportunities to Step Ahead and other programs. As of February 1995, the Office had 14 authorized positions with 11 filled compared to 5 authorized positions with all 5 positions filled in 1992 (immediately after reorganization). Prior to reorganization these duties were performed by the respective departments.

Divisions of the Family and Social Services Administration

IC 12-8-8-2 through IC 12-8-8-6 defines the responsibilities of the three division directors within FSSA. The director:

(1) is the chief administrator of the director's division;
(2) is responsible to the Secretary for the operation and performance of the director's division;
(3) is the appointing authority for the division;
(4) may adopt rules relating to the operation of the division and to implement programs of the division;
(5) is the statutory authority that adopts rules;
(6) is the ultimate authority under IC 4-21.5 for purposes of the operation of the division and the programs of the division;
(7) shall consult with the Secretary on issues of family, social services, or health policy arising from administrative orders and procedures; and

(8) is responsible for development and presentation of the budget of the division.

Division of Disability, Aging, and Rehabilitative Services

The mission of Division of Disability, Aging, and Rehabilitative Services (DDARS) is to inform, protect, and serve all adults and individuals with disabilities, and their families, who are in need of human services, resources, or support toward the attainment of employment and self-sufficiency or to maintain independence. DDARS has 4,377 authorized positions which include four state developmental centers. The division had 4,374 authorized positions in 1992. The activities being conducted by DDARS were transferred from the Department of Mental Health and the Department of Public Welfare. DDARS is divided into four bureaus: (1) Aging and In-Home Services; (2) Developmental Disabilities Services; (3) Disability Determination; and (4) Rehabilitative Services which includes Blind and Visually Impaired Services, Deaf and Hard of Hearing Services, and Vocational Rehabilitative Services.

Division of Family and Children

The mission of the Division of Family and Children (DFC) is to help individuals and families take care of themselves. DFC performs a number of functions that include program evaluation, program integrity, policy development, child development, family protection, and family resources. DFC has programs that impact the early education, development, and care of children as well as programs that establish paternity, establish support orders, enforce existing support orders, and locate absent parents. The Division also includes child preservation services, Aid to Families with Dependent Children (AFDC), licensing of child-care homes and centers, and programs that serve low-income households and homeless individuals and families. The DFC had 4,606 authorized positions with 265 vacancies in February 1995. This compares to 4,411 authorized positions and 205 vacancies in January 1992. Many of the programs administered by the DFC were located in the Department of Public Welfare prior to reorganization.

Division of Mental Health

The mission of the Division of Mental Health (DMH) is to assure the availability of accessible, acceptable, and effective mental health and chemical dependency services for eligible Hoosiers. DMH is divided into four offices: (1) public policy; (2) transitional services; (3) contract management; and (4) client services. It has oversight of the six state hospitals for persons with mental illness. The Division had 3,289 authorized positions with 389 vacancies in February 1995 compared with 4,053 authorized positions and 307 vacancies in January 1992. Prior to reorganization, the Department of Mental Health was responsible for individuals with a mental illness or a development disability. As discussed previously, DDARS now has responsibility for individuals with developmental disabilities.

Family and Social Services Advisory Commission

The Family and Social Services Advisory Commission (IC 12-8-3-1) consists of 16 members. Most members are from state agencies with the duty of advising the Secretary on policy, comprehensive planning, and coordination of FSSA programs. This commission will be discussed in more detail later.

Division Advisory Councils

Under IC 12-8-2-2, an advisory council was established for each of the three divisions within FSSA (DDARS, DFC, and DMH). The membership of each advisory council was set at 11 members, including the division director (IC 12-9-4-3, IC 12-13-4-3, and IC 12-21-4-3). The members are appointed by the Secretary of FSSA and are to have a recognized knowledge of or interest in the programs administered by the division. State statute also requires these advisory councils to meet monthly. The councils will be discussed in more detail later.

Program Transfers

In addition to the FSSA offices and advisory bodies, several programs were transferred between the three divisions. These program realignments are listed in Appendix A-1.

FSSA Budget

The budget presentation process has also changed due to the creation of FSSA. The Office of the Secretary now has responsibility for compiling program budgets for the three new divisions. Generally, only one or two budget presentations for FSSA are now made to the State Budget Committee, House Ways and Means Committee, and the Senate Finance Committee. Prior to reorganization, each division prepared and presented their own budget. The budget for FY96 and FY97 is presented in Table 1.

**Table 1. FAMILY AND SOCIAL SERVICES - BIENNIUM BUDGET: FY96-FY97.**

| | | FY 96 | FY 97 |
|---|---|---|---|
| **FSSA - Administration** | General Fund | 14,649,280 | 14,649,280 |
| | Federal Funds | 5,301,573 | 5,301,573 |
| | **Total** | **19,950,853** | **19,950,853** |
| **Medicaid** | General Fund | 860,891,270 | 949,691,262 |
| | Dedicated Funds | 42,700,000 | 42,700,000 |
| | Federal Funds | 1,654,000,000 | 1,750,800,000 |
| | **Total** | **2,557,591,270** | **2,743,141,262** |
| **Division of Mental Health** | General Fund | 183,098,075 | 184,824,210 |
| | Dedicated Funds | 28,356,611 | 28,910,911 |
| | Federal Funds | 44,076,968 | 44,021,736 |
| | **Total** | **255,531,654** | **257,756,857** |
| **Division of Family and Children** | General Fund | 183,556,450 | 189,348,023 |
| | Dedicated Funds | 70,820,586 | 73,382,934 |
| | Federal Funds | 487,722,110 | 494,626,389 |
| | Local Funds | 33,306,575 | 31,672,305 |
| | **Total** | **775,405,721** | **789,029,651** |

| | | | |
|---|---|---|---|
| **Division of Disability, Aging, and Rehabilitative Services** | General Fund<br>Dedicated Funds<br>Federal Funds<br>Local Funds<br>**Total** | 142,773,089<br>63,828,688<br>100,060,445<br>1,171,500<br>**307,833,722** | 145311,787<br>64,254,488<br>100,163,290<br>1,171,500<br>**310,901,063** |
| **Total Family and Social Services** | General Fund<br>Dedicated Funds<br>Federal Funds<br>Local Funds<br>**Total** | 1,384,968,164<br>205,705,885<br>2,293,824,689<br>34,478,075<br>**3,918,976,813** | 1,483,824,562<br>209,248,333<br>2,397,575,733<br>32,843,803<br>**4,123,492,433** |

## Chapter 2: Evaluation Criteria

The design of this study is a goal-oriented approach to program evaluation where the administrative offices, divisions, and advisory bodies of FSSA are analyzed for their success in achieving goals. The administrative structure, represented by the Office of the Secretary of Family and Social Services, the four offices within FSSA, and the commission and three advisory councils, was created in the 1991 reorganization of Indiana human services agencies. Although each entity has a separate statutory termination date, each was established as a component of a reorganized service system. Consequently, the primary emphasis of this analysis is to evaluate the ability of the administrative structure, as a whole, to (1) achieve the goals intended for reorganization and (2) fulfill the legislative intent and statutory responsibilities of the entities.

The Indiana General Assembly concluded that a reorganization of the health and human services system was necessary. Both the LSA and Andersen Consulting studies generally concluded that any reorganization should result in an accessible system with the ability to (1) focus resources to accomplish goals; (2) allocate resources appropriately across the system; (3) enhance coordination of planning and budgeting processes; (4) improve the quality of data necessary for program accountability, planning, and budgeting; (5) deliver the appropriate mix of services to individuals; and (6) maintain a structure that promotes and supports coordination between programs and providers. The goals for a reorganized system, as described in the two studies, are depicted in Figure 2.

This report is not designed to measure the achievement of each of the individual goals listed above. For purposes of this evaluation, the goals intended for reorganization are grouped under two broader classifications (1) the goal of improving agency administration and management; and (2) the goal of improving the delivery of services. These goals are not mutually exclusive in that one of the ultimate reasons for improving agency administration and management is to improve the delivery of services. These two goals combined with the legislative intent and statutory requirements of the FSSA entities provide criteria against which program performance will be compared and presented.

### Methodology

Due to the large number of individuals affected by the Family and Social Services Administration, only a small percentage could be contacted and interviewed. Therefore, a sample of the consumers and providers of human services, state employees associated with FSSA, council members, and FSSA administrative personnel were selected. This sample represented individuals both at the administrative level and at the point of service delivery for each of the divisions. This evaluation was based on information obtained from the following sources:

(1) Interviews with and background information provided by FSSA personnel;
(2) Interviews with individuals representing major constituencies in the social services arena;
(3) Interviews with a director and caseworkers of a county office of the Division of Family and Children;
(4) Interview with a director of a Community Mental Health Center (CMHC);
(5) Interviews with a director and caseworkers of an Area Agency on Aging (AAA)/Community Action Agency (CAA);
(6) Survey questionnaires sent to DFC county directors of all 92 counties;
(7) Survey questionnaires sent to a random sample of 276 DFC caseworkers who had been employed since 1991 or before;
(8) Survey questionnaires sent to all 31 directors of AAA/CAA agencies;
(9) Survey questionnaires sent to all 30 directors of Community Mental Health Centers;

(10) Telephone survey of members of the FSSA Advisory Commission and advisory councils; and
(11) Review of advisory commission and advisory council agendas and minutes.

Area Agencies on Aging and Community Action Agencies are non-profit organizations that contract with the state to provide or arrange for the provision of human services to clients. Community mental health centers are private, non-profit organizations contracting with the state to provide mental health services to clients.

Response rates for the survey questionnaires (initial mailing with one follow-up) ranged from 70% to 84% over all groups. Respondents were assured of confidentiality with surveys encoded only to permit follow-up mailings. The survey questionnaires and response summaries are in Appendices A-2 through A-5.

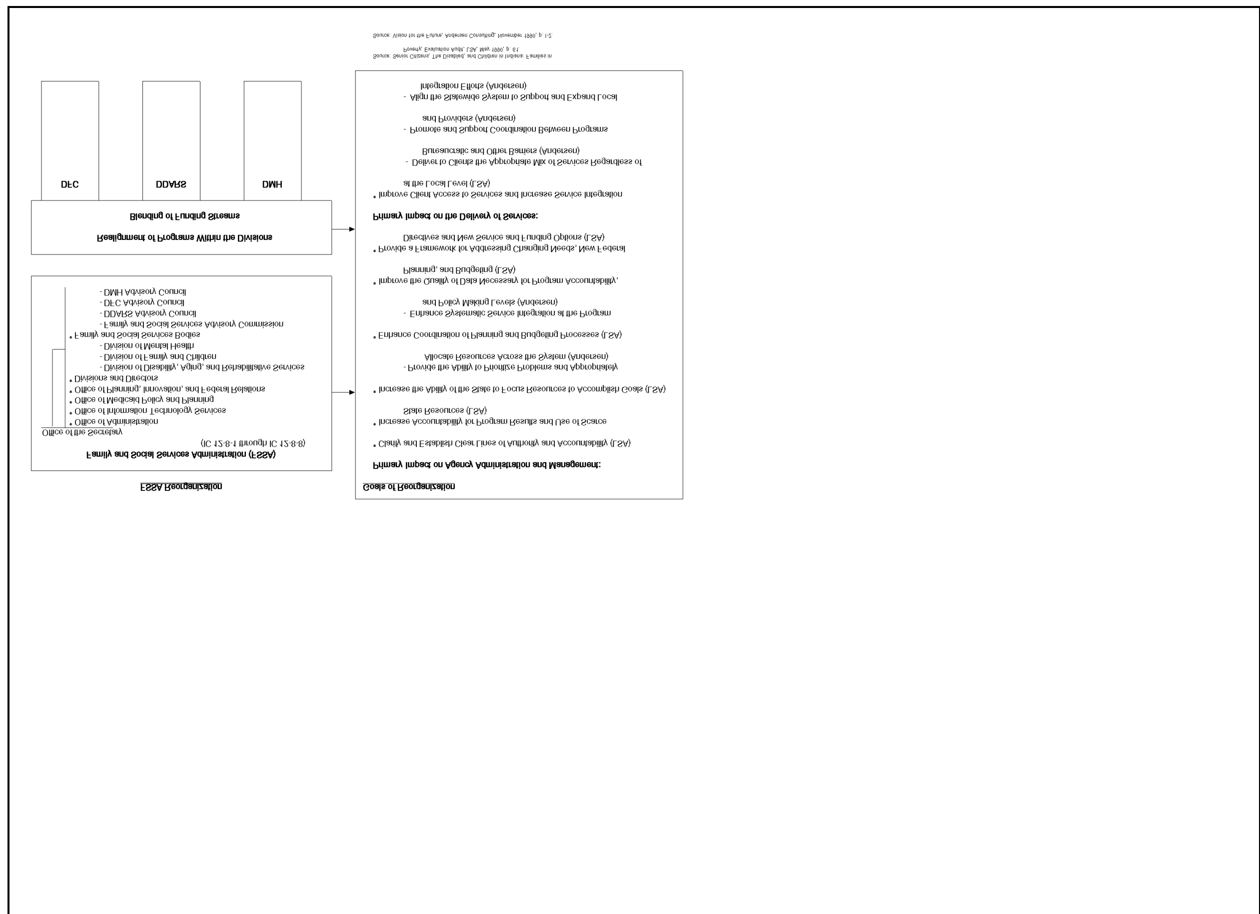


**Figure 2. Reorganization of Human Services Agencies in Indiana.**

Potentially Confounding Factors

The 1991 reorganization involved (1) the creation of the administrative structure of the Office of the Secretary of Family and Social Services and associated offices and (2) the realignment of programs and the blending of funding streams within the divisions (See Figure 2). The impact of the different components of the reorganization on achieving the goals cannot always be separated.

A second confounding factor is the difficulty of distinguishing between the specific management style of personnel within FSSA and the administrative structure established by statute. In fact, as described later, one influences the other.

Additional factors that can influence perceptions and survey responses are (1) the recent state funding crisis (lack of pay raises, hiring freeze, and/or fewer funds for services); and (2) any general morale problems that may exist within the state employee ranks. Morale problems can be caused by factors other than administrative structural components, such as lack of pay raises, workload, etc.

# Chapter 3: Analysis and Conclusions

FSSA accomplishments and concerns of advocates, providers, and state employees are described in this chapter. The following section discusses several accomplishments that were determined to have occurred as a result of or to have been facilitated by the reorganization of the human services agencies.

## A. FSSA Accomplishments

The success of the organizational structure can be measured by the extent to which the structure has affected (1) the agency administration and management and (2) the delivery of services. The following is a list and short description of FSSA accomplishments or activities that are related to the administration and management of the agency. Individual accomplishments included in this list were initially provided to the Legislative Services Agency by FSSA for the purposes of this evaluation. These accomplishments and activities were then further selected based on (1) the apparent extent to which consolidation of the agencies may have produced or contributed to the accomplishment or activity or (2) the extent to which the activity itself produces or contributes to the goals of reorganization. This list is followed by service-related accomplishments.

Administration-Related Accomplishments

*Medicaid-Related Accomplishments*

FSSA reports that the greater visibility and accountability arising from the creation of OMPP translates into several significant administrative efficiencies.

(1) **New federal Medicaid dollars** were obtained by recovering new federal Medicaid funding for state facilities for mental illness and developmental disabilities and by revising the Disproportionate Share Program for state psychiatric hospitals.

| | | |
|---|---|---|
| FFY90: | $20 M | Retroactive redetermination of rates for state developmental centers (Rec'd FY92) |
| FFY91: | $20 M | Retroactive redetermination of rates for state developmental centers (Rec'd FY92) |
| FFY92: | $15 M | Establishment of new rates for state developmental centers |
| FFY93: | $15 M | Establishment of new rates for state developmental centers |
| | $72 M | Claim disproportionate share payments to state mental illness hospitals |
| FFY94: | $15 M | Claim disproportionate share payments to state mental illness hospitals |
| | $ 3 M | Add new clients to Medicaid eligibility roles |
| | $83 M | Add new clients to Medicaid eligibility roles |
| FFY95: | $ 3 M | Institute Medicare B claims system for state developmental centers and state mental illness hospitals |

(2) **Intermediate Care Facilities/Mentally Retarded (ICF/MR) Reimbursement/Medicaid Certification:** New federal dollars were realized through reimbursement for ICF/MR case management services and for maintaining Medicaid certification for all state developmental centers

and developmental disability units of state hospitals.

(3) **Medicaid Management Information System (MMIS)/IndianaAIM:** IndianaAIM is the new Medicaid claims processing and information management system developed and implemented by FSSA and EDS. The system will at some point provide increased accuracy and timeliness of claims processing and enhanced ability for OMPP to analyze costs and outcomes of the Medicaid program. However, the initial implementation of the system has resulted in considerable payment delays and financial inconvenience to Medicaid providers.

The system was implemented on February 6, 1995, with no parallel system in place. Due to the transition to the system, claims were not processed from January 16 to February 6, 1995. As a result of this delay, an initial claims denial rate for the new system of 78% (compared to an average denial rate for FY94 of 19%) and additional claims suspensions due to new edits and audits, the amount of claims processed and paid dropped substantially in February. The weekly denial rate is currently at about 30%.

To compensate for the difficult implementation, cash advances were sent to all Medicaid providers who received a Medicaid payment of $1,000 or more in December 1994. In addition to the cash advances, EDS increased its claims resolution staff from 14 to 35 to help resolve claim denial problems. FSSA also added an additional 33 training workshops on the new system to help Medicaid providers learn the new process with an additional 36 training workshops scheduled for the month of July 1995. A number of provider bulletins highlighting common billing errors have been issued to the provider community. OMPP reports that the intention is to be caught up on claims processing by the end of June 1995 (the end of the fiscal year).

(4) **Medicaid Service Limitations/Reimbursement Reforms:** OMPP has reviewed services provided by the Medicaid program and has instituted a series of reforms in all provider categories to limit services to those that are medically necessary, appropriate, and consistent with the requirements of federal and state law. OMPP also instituted several reimbursement reforms in all provider categories, including transportation, home health agencies, hospitals, physicians and other practitioners, ICFs/MR, and nursing facilities.

OMPP has been very successful at reducing the state expenditures from the Medicaid program. OMPP estimates Medicaid expenditures will be reduced by $180 million in state dollars for FY95 as a direct result of formal rule changes. OMPP estimates that another $160 million will be saved as a result of other non-rule changes. However, it is also important to note that reduced expenditures from reimbursement changes and service limitations result in reduced payments to some providers with potential impacts on client access and reduced services to some Medicaid recipients. There is some concern in the provider community and among client advocates that reimbursement reform decisions have been made without adequate citizen input.

(5) **Medicaid Managed Care:** OMPP has established a mandatory managed care program for Medicaid recipients called Hoosier Healthwise. Two different networks were established: a Primary Care Case Management (PCCM) program was established that pays providers according to the traditional Medicaid fee schedule plus a monthly case management fee and a Risk-Based Managed Care program that reimburses providers with a predetermined payment per person. Program participants include Aid to Families with Dependent Children (AFDC) program recipients and non-AFDC pregnant women and children with incomes below the federal poverty level.

(6) **Medicaid Rehabilitation Option (MRO):** The MRO was implemented in FY92 to provide new services to the severely mentally ill in the community. According to FSSA, the MRO provided $20

million in additional services from new federal funds in FY92, $16 million in FY93, and $30 million in FY94.

(7) **Increased Policy Analysis and Development Capability:** According to FSSA, OMPP has strengthened its policy analysis, budgeting, and legal staff to assure that its reimbursement reforms, service limitations, and other program changes are fully analyzed before implementation and are monitored afterwards.

*Technology-Related Accomplishments*

The FSSA Office of Information Technology Services (OITS) participates in the development of information systems ranging from assistance in procurement of systems to actual programming. The following systems were mentioned as accomplishments by FSSA.

(1) **Aging Information Management Systems (AIMS):** The purpose of this system is to gather information concerning demographics, assessments, and services under the IN-Home Services Program. The system will track referrals, applications, care plans, and services regarding all in-home and community services including Pre-Admission Screening of nursing facility residents. The Bureau of Aging and IN-Home Services (BAIHS) and OITS cooperated on the development and field testing of this system.

(2) **Automation of the Disability Determination Bureau:** According to FSSA, the Disability Determination Bureau was one of the first disability determination bureaus in the country to become completely automated, resulting in increased productivity and reduced processing time. OITS has had a more limited role in the development of this system, but has been involved in support of the project procurement and contracting.

(3) **Indiana Client Eligibility System (ICES):** ICES is a statewide, integrated, on-line computer system that performs eligibility determinations simultaneously for three different programs: AFDC, Medicaid, and Food Stamps. The purpose of ICES is to eliminate paper budgeting that can reduce mathematical errors and processing as well as to enable the FSSA to make changes in mass from the central office. According to FSSA, the time required to complete an application has been reduced. This has allowed the transfer of 59 public assistance caseworkers to child welfare services and the elimination of 6 clerical positions. ICES has also allowed the reduction in the use of paper forms for a reduced baseline expenditure of $175,000.

The implementation of ICES has not been without problems. As seen by the results of the survey of DFC directors and caseworkers in Table 2, there are a number of problems in the system. Although 81% of the DFC county directors and 61% of the caseworkers reported that ICES did increase efficiency, 19% of county directors and 39% of caseworkers felt there was no difference or a decrease in efficiency. While the results show a substantial positive response to ICES improving efficiency, many of the written comments qualified their response by saying "the system is great when it works." Other typical comments discussed the significant amount of down time with ICES and the large error rate with ICES. DFC reported that the problem appears to be a computer capacity problem which will be remedied with some reprogramming and a management of usage.

**Table 2.**

| **How has the Indiana Client Eligibility System (ICES) affected the operation of your office?** | | |
|---|---|---|
| | | |

| | DFC Co. Directors | DFC Caseworkers |
|---|---|---|
| Much more or somewhat more efficient | 81% | 61% |
| I see no difference | 4% | 14% |
| Much less or somewhat less efficient | 15% | 25% |

Implementation of ICES also resulted in the installation of a statewide fiber-optic telecommunications network. FSSA will use the network to operate ICES, the Indiana Support Enforcement Tracking System (ISETS), the Indiana Child Welfare Information System (ICWIS), and Vocational Rehabilitation computer systems. The Bureau of Motor Vehicles will also be able to use the network to connect local branch offices.

(4) **Vocational Rehabilitation Automation Project:** FSSA has completed the first phase of this project. The purpose of the project is, ultimately, to provide an automated statewide case management system resulting in productivity gains, improved client services, and enhanced efficiency. Although FSSA involvement in this project has been limited to date, anticipated federal approval, is expected to increase activity on this project.

(5) **Indiana Child Support Enforcement Tracking system (ISETS):** Sixteen counties are currently using ISETS. The main goal of the system is to combine all child support data, now kept separately in each county, into a single data network. FSSA projects additional child support collections of $10 million annually through use of this system.

As with the implementation of ICES, the ISETS system has not been without problems. The state is faced with a federal deadline of October 1, 1995, to implement the system in all 92 counties. However, according to FSSA, no additional counties are planned for implementation until certain financial processing and data conversion problems are resolved. If the system is not on-line by this deadline, the state could lose federal funding.

(6) **Indiana Child Welfare Information System (ICWIS):** This system will establish a link between all child welfare services, including ICES, ISETS, courts, and law enforcement agencies. The system will include a Sexual Offender Registry, administered by the Indiana Criminal Justice Institute, and the Child Abuse Tracking System mandated by P.L. 142-1993.

(7) **Computer linkage with E-Mail:** FSSA has linked FSSA policy staff by computer across all divisions and offices. In addition, all Step Ahead Coordinators and County/State Facilitators will have access to computer equipment and e-mail capability.

(8) **Comprehensive Information Directory:** This directory lists sources of FSSA information, including program name, account number, contact person, phone number, frequency of data collection, and a general description of the data. The purpose of the directory is to promote greater sharing of information throughout and across agencies.

(9) **Data Warehouse and the Data Providers' Group:** These represent efforts to establish information systems for policy development, everyday management of FSSA programs, and welfare reform. The Data Providers' Group is to coordinate data providers within the agency and across all offices and divisions within FSSA.

*Other Administration-Related Accomplishments*

(1) **Strategic Action Plan:** FSSA developed a Strategic Action Plan designed to accomplish four major goals: accountability, organizational development, program planning, and self-sufficiency. According to FSSA, development of the strategic plan provided the opportunity for FSSA staff, advocates, and members of the public to put existing ideas and methods on the table and to examine FSSA strengths and identify challenges. FSSA will use the Strategic Plan to determine which initiatives should be expanded; which should be re-examined; how the agency staff prioritize their time; and how FSSA's work is to be evaluated.

There is quite a difference in perception in how useful the Strategic Action Plan will be among those individuals surveyed. One-third of county DFC directors believe it will be useful (Table 3), while only 10% of CMHC directors and 13% of AAA directors believe it will. It is difficult for many of the respondents to see the connection between the plan and daily operations.

**Table 3.**

| **Will the FSSA Strategic Action Plan be useful to your office in the provision of services to your clients?** | | | |
|---|---|---|---|
| | County Directors | CMHCs | AAAs CAAs |
| Very useful or somewhat useful | 34% | 10% | 13% |
| I have no opinion | 27% | 43% | 35% |
| Not very useful or not at all useful | 39% | 48% | 52% |

(2) **Consolidated Legal Resources:** Consolidation of the legal staff appears to have significant administrative benefits. The creation of the Office of General Counsel (OGC) has allowed the program attorneys to be in close proximity and the legal resources to be consolidated. This, along with bi-weekly meetings, has allowed attorneys to consult with each other about issues common to all FSSA divisions and offices and about program areas other than their own. This can reduce the number of conflicting rules, regulations, and policies. Attorneys are now able to be more aware of the impact that decisions in one program may have on other programs.

The attorneys are also able to represent all segments of FSSA, including state institutions and county offices, in personnel litigation providing for a more consistent legal representation across the agency. Also, FSSA maintains that OGC works to identify and eliminate legal barriers to the delivery of services to children and families. OGC attorneys also provide assistance in the processing of contracts and advice regarding the treatment of trusts and transfers of property for Medicaid eligibility determinations in the counties.

(3) **Fee-For-Service Reimbursement System for Community Rehabilitation Programs:** FSSA/ Vocational Rehabilitation Services (VRS) and the Bureau of Developmental Disabilities Services (BDDS) cooperated to develop a fee-for-service reimbursement system for Community Rehabilitation Programs. The locating of VRS, BDDS, and the Bureau of Child Development within the same agency

permitted the joint examination of services and the development of consistent standards and quality services.

(4) **Aging and IN-Home Services Coordinated Contracting:** According to FSSA, the contracting system for the Bureau of Aging and IN-Home Services was streamlined. Multiple contract periods were eliminated, improving the audit trail between budgets, contracts, and expenditures. The Bureau of Aging and IN-Home Services worked with the FSSA Office of Administration and the Office of General Counsel to coordinate the contracting process. A total of 130 contracts spanning two years were condensed into 16 contracts.

(5) **Quality Assurance System:** This system is a consolidation of 16 distinct quality assurance systems into one statewide system for the IN-Home Services Program. The purpose is to enable the state, Area Agencies on Aging, and providers to better administer, deliver, and monitor in-home services in Indiana in a more consistent and similar manner. This system was a result of a consolidated effort by the FSSA Office of Administration, the Bureau of Aging and IN-Home Services, and the Indiana University School of Law.

(6) **Reduced Overtime Utilization:** FSSA decreased the total amount spent on overtime at the four state developmental centers by over 15% from FY91 to FY94. This was accomplished, at least in part, by downsizing the population at the centers. Downsizing the population was assisted through the collaborative efforts of the Bureau of Aging and IN-Home Services, the Vocational Rehabilitation Services, and the Bureau of Developmental Disabilities Services (formerly not a bureau within DDARS).

(7) **Request for Proposal (RFP) Process:** FSSA developed an RFP process to competitively bid job placement services. This performance-based process will, according to FSSA, enable 63 providers to develop services based upon a community's needs in a more efficient manner and will also allow supportive services to be made available to families as welfare reform is implemented. According to FSSA, the development of this process was a result of collaboration between division directors.

Service-Related Accomplishments

Some of the major goals of reorganization were to improve client access to services, increase service integration at the local level, and deliver to clients the appropriate mix of services. The criterion by which the organizational structure is to be measured is, thus, the extent to which the structure has affected the agency's ability to deliver services to clients. The following is a list and short description of service-related accomplishments attributable to reorganization. The individual accomplishments included in this list were selected based on the apparent extent to which consolidation of the agencies would have had an impact on the accomplishment.

(1) **Step Ahead Process:** The Step Ahead Comprehensive Early Childhood Grant Program, developed in 1991, seeks to coordinate and collaborate services at the county level in order to meet the needs of children ages 0-13 and their families. By October 1995, FSSA plans to extend the program to include the elderly and disabled. All 92 counties have formed Step Ahead Councils and completed needs assessments of what services are being provided, gaps in service delivery, and how county demographics are affecting service delivery to children and families. Local Step Ahead Council members vary from county to county, but generally include representatives from the county DFC office, the local AAA, the local CMHC, a local school corporation, local service agencies, the county extension agent, the Community Action Agency, the local United Way, parent advocacy

groups, city government, and local consumers. According to survey responses and interviews, the perception of the effectiveness of the Step Ahead Process varies by county.

(2) **Medicaid Waiver Task Force:** This Task Force reviewed waiver utilizations and cost efficiencies. Issues addressed resulted in an increase in the number of individuals and families that receive home and community-based services under the ICF/MR Medicaid Waiver program from 44 to 585. It also increased program flexibility and improved timeliness. It consisted of representatives from FSSA's Office of Administration, DMH, DFC, DDARS, and OMPP, advocates for individuals served through various FSSA programs, consumers, and providers of services.

(3) **Combination of requirements and definitions:** The Bureau of Aging and IN-Home Services brought together funding from the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program, Title III of the Older Americans Act, Social Services Block Grant (SSBG), Older Hoosiers Account, U.S. Department of Agriculture, five Medicaid Waivers and local funding to provide a comprehensive, coordinated alternative to institutional placement. The combination of 11 programs brought together over $98 million of federal and state funds. This increased the number of individuals and families served from approximately 80,000 to over 90,000 within the same budget constraints. Fiscal, accounting, auditing, legal, and program staff collaborated in combining program requirements and definitions of programs.

(4) **Statewide Expansion of Quality Child Care:** The reorganization provided the Bureau of Child Development the ability to collaborate on child care projects. This effort was aided because all participants were under the same organizational structure and common documents were able to be produced through collaboration. Specific projects and accomplishments include the Early Childhood Education Accreditation and Public Broadcasting Partners.

(5) **Case Management System for IN-Home Services:** This provides a single point of entry through AAAs. It allows case managers to better serve individuals and families by providing a comprehensive, coordinated approach to seeking and accessing client services. The number of clients receiving enhanced case management services increased by approximately 10,000 to over 90,000. Prior to reorganization, many of the in-home services were administered by multiple state agencies and clients had to apply for services through multiple state agencies.

(6) **Consolidated State Plan for Aging and IN-Home Services:** This plan offers a comprehensive approach to Aging and IN-Home Services and programs through AAAs. This approach was not possible prior to consolidation because many of the programs and funding mechanisms were in multiple state agencies.

(7) **Home- and Community-Based Care Working Group:** OMPP, DDARS, DMH, and DFC formed a staff working group for the purpose of developing more home- and community-based care options for the elderly and persons with disabilities.

(8) **Central State Hospital:** The collaboration of DFC, DDARS, and DMH resulted in a more coordinated effort in the development of services to support placement of persons in the community upon the closing of Central State Hospital. Examples of the collaborative effort include Vocational Rehabilitation Services in DDARS providing a grant of $1.4 million for supported employment through the CMHC's in the Central State District. A second example is the Bureau of Developmental Disabilities Services (under DDARS) using money transferred from DMH to develop community-based services  for 86 Central State Hospital patients who had developmental disabilities.

(9) **Planning Initiative:** The DFC and DMH collaborated in a planning initiative to increase the number of public, community-based child and adolescent mental health and addictions services available. They also collaborated on the leveraging of county and state dollars for juvenile services to maximize reimbursement through Title IV-E Foster Care and the Medicaid Rehabilitation Option.

(10) **Healthy Families Indiana Project:** Established in 23 counties, this project helps to identify families at risk of child abuse and neglect and offers a home visitor program. This program blends money from FSSA's DFC and DMH, the Indiana State Department of Health, and the Criminal Justice Institute. It also blends federal funds from a number of sources, including the Substance Abuse Treatment Fund, Sexual Offense Prevention, and Maternal and Child Health Prevention.

## B. Centralized Authority

Additional issues were raised through interviews and survey responses. There is substantial opinion that decision-making may be centralized beyond that which produces the most efficient management and vertical flow of information. Secondly, there is a belief held by advocates, employees, and providers that the creation of the FSSA administrative structure has not improved the support provided to local offices and providers of services. Finally, there have been concerns, consistently expressed in interviews, as to the ability of the public to provide significant input into major decisions and program rules under the authority of FSSA. These issues are described below.

A large number of survey responses and statements in interviews indicated that the administration of FSSA and the decision-making authority within the agency were considerably more centralized than before reorganization. There are some advantages to the centralization of authority. The achievements and activities described in the preceding several pages document some of the results of collaboration and cooperation between divisions within FSSA and the ability of the divisions of FSSA to speak with one voice with other agencies and entities external to FSSA.

However, the consolidation of authority has also affected other relationships and functions of the agency. Those include access by advocates and the public, timeliness in decision-making and action, and the potential benefits achievable through decision-making closer to the point of service delivery. The centralization of authority is relevant to the evaluation because of questions that it raises: Does the reorganized administrative structure promote or facilitate the occurrence of more centralized decision-making? Does the more centralized decision-making process which exists impede or improve the operational effectiveness of the agency?

The more centralized structure takes the form, principally, of less authority for the division directors and field staff and more authority for the Office of the Secretary of FSSA, both in the Secretary's position as well as the offices of the assistant secretaries. More centralized decision-making, to some extent, can be a result of a specific management style. On the other hand, the statute establishing the administrative structure and the coordinating function, itself, can contribute to the shift in authority. The statute that establishes the responsibilities for the divisions of FSSA establishes the relationship between the divisions and the Office of the Secretary. IC 12-8-8-2(b) provides that division directors are responsible to the Secretary for the operation and performance of their division. Before the establishment of FSSA, the Commissioners of the Departments of Public Welfare, Mental Health, and Human Services each answered directly to the Governor. However, under the existing administrative structure and current statute, the Secretary has line authority for the three divisions.

Secondly, the establishment of the Office of the Secretary and the Offices of the Assistant Secretaries for the purpose of coordinating implies some shift in authority from the division directors to the Office of the Secretary. The very act of coordination requires some shift in authority to the Office of the Secretary. Thus, to some extent the reorganization, by statute and because of the coordinating function, would tend to promote a more centralized authority. The question becomes one of degree.

Potential effects of reduced authority of the division directors are reflected by some of the comments of consumer and provider advocates. Some comments include (a) "Having to go through the Secretary reduces the ability of division directors to serve as a route for public input"; (b) "It has created a sense of distance and a lack of ownership"; (c) "I see no evidence that the centralized decision-making has stopped bad decision-making from being made, but it has slowed things down"; and (d) It represents a "diminishment in the role of the consumer in the policy-making process due to the reduction in authority of the division directors."

The view that there has been a loss in division authority with consequent disadvantages is held also by some providers. As depicted in Table 5, in responding to the question of whether the ability of the division's central office to help the local operation was improved after the creation of FSSA, 75% of the CMHC directors responding indicated either somewhat worse or much worse than before. Of those with written responses, most (8 out of 10) were positive with regard to the division, but indicated that one of the reasons the division's central office was not as helpful under FSSA was because the division director and division personnel had less authority than before.

District Directors vs. Regional Managers

Before 1994, the 92 county offices of the DFC were organized, for management purposes, into nine regions. The county director of the largest county in each region was named the district director who acted as liaison between the state Department of Public Welfare and the county offices. After April 1994, the nine districts were replaced by six regions, each to have a regional manager whose responsibility it is to relate information and concerns to the DFC Director, coordinate between counties, and ensure quality in the field. The change to regional managers represented a change in function. According to the Division, the responsibility of the regional managers is organizational control rather than involvement in the daily operating decisions of the counties. The annual budget for the regional managers is about $500,000 including salaries and fringes.

According to survey results (Table 4), the regional manager concept is not well received by the county directors with 73% of the county directors responding preferring the district directors while only 17% approve of the regional manager concept. Reasons mentioned by the county directors for preferring district directors include the following: (1) regional managers are less accessible and harder to reach; (2) regional managers are not as knowledgeable or understanding since they, for the most part, do not come from the director ranks; (3) the regions represent too large an area compared to the old districts; and (4) the regional managers are influenced more from above than they are advocates for local needs. Survey responses may reflect dissatisfaction with the role of the regional managers and the need for support of program and operational problems versus organizational and policy concerns.

On the other hand, it was mentioned that regional managers do have more time since they are not also a county director and that the regional managers are able to consider all counties on a more equal basis because they don't have responsibility for a home county of their own. The Division also maintains that the fact that the regional managers tend not to come from within the system provides an advantage in that they can look at the system from a different perspective.

**Table 4.**

| **How has the change from having district directors to regional managers affected the operation of your office?** | |
|---|---|
| | County Directors |
| Much better or somewhat better having district directors | 73% |
| I see no difference | 10% |
| Much better or somewhat better having regional managers | 17% |

## C. Perception of Insufficient Support from Central Office and/or FSSA

*Support*

There is a perception on the part of providers and state employees at the local level that reorganization has not improved the support provided by either the separate divisions or FSSA. Support from both FSSA and the three divisions is essential to delivering services in an efficient and effective manner.

The general perception among the directors of the DFC county offices, CMHCs, AAAs and CAAs, is that the creation of FSSA has not resulted in a greater ability of the division central offices to provide support to the local operations. This perception varies by group surveyed and the variation may be due in part to the differences in the nature of the programs offered through each division. Responses may also differ due to the relationship of the surveyed group to FSSA. DFC county offices are state offices directly providing services while CMHCs and AAAs/CAAs have a contractual relationship with the state. This may to some extent imply different requirements and needs for support or different definitions of support (e.g., timeliness of support vs. level of support). However, the responses to the survey questions do reflect the perceptions and beliefs of those surveyed regarding the ability of FSSA or the divisions to provide whatever support is felt to be needed by these groups.

The perception that there has been no improvement in the ability of the division central office to help the local office appears to be greatest among the CMHC directors. Ninety-five percent of the CMHC directors responding felt that there was either no difference in the ability of the division central office to help or a lesser ability to help after the creation of FSSA (Table 5). Several written comments accompanying the survey indicated that, although the respondents felt positive toward the division, the perceived inability of the division to help the locals was due to the loss of authority of the division director and division personnel and also to the subordination of the division within FSSA. Of the other groups surveyed, 74% to 90% of those responding felt that the ability of the division central office to help the local operation had not been improved.

**Table 5.**

| **Overall, how do you think the ability of the _____ central office to help your operation has been changed by the creation of the Family and Social Services Administration?** | | | | |
|---|---|---|---|---|
| | **DFC** | **DFC** | **DMH** | **DDARS** |
| | County Directors | County Casewkrs | CMHCs | AAAs CAAs |
| Much improved or somewhat improved | 11% | 18% | 5% | 24% |
| I see no difference | 27% | 54% | 20% | 24% |
| Much worse or somewhat worse than before | 63% | 27% | 75% | 53% |

A similar question posed to the survey groups examined whether the ability to provide services to clients was changed by the creation of FSSA. Based on the results of the surveys, the creation of FSSA has not had much of an impact on the perceived ability of local offices and service providers to provide services (Table 6). This perception is similar among the county DFC directors, CMHC

directors, and AAA/CAA directors. Only 0% to 21% of the directors in each category believed that the creation of FSSA improved their ability to provide services.

**Table 6.**

| **Overall, how do you think the ability to provide services to your clients has been changed by the creation of the Family and Social Services Administration?** | | | |
|---|---|---|---|
| | County Directors | CMHCs | AAAs CAAs |
| Much improved or somewhat improved | 17% | 0% | 21% |
| I see no difference | 48% | 45% | 50% |
| Much worse or somewhat worse than before | 34% | 55% | 29% |

Again, this perception can differ by group surveyed. The variation may be due in part to the differences in the nature of the programs offered through each division or the relationship of the surveyed group to FSSA. However, the responses to the survey questions do reflect the perceptions and beliefs of those surveyed regarding the ability of FSSA to affect the ability to provide services. Reasons mentioned for all groups for the responses above (those indicating no difference or worse) included increased bureaucracy, lack of timeliness of decision-making and contract approvals, the loss of key people in the divisions, lack of training, and increased difficulty in getting answers to questions.

An often heard complaint from advocates and CMHC directors was the length of time it takes to finalize contracts. CMHC directors were asked to characterize the length of time with which contracts are approved by FSSA now as compared to before reorganization. All respondents believed that it took the same amount of time or longer to get contracts approved after, compared to before, the creation of FSSA. The delay in contracts has even resulted in some CMHCs having to borrow money to cover their expenses. Some of the reasons stated for the lengthy process were the lengthy signature process, the legal process, micromanagement, multiple amendments, and increased bureaucracy.

Other concerns expressed were that FSSA is not field-driven; FSSA is insensitive or out of touch with the daily operations in the field; it takes a long time to get questions answered; local employees and service providers do not know whom to contact at the central office; the state has become even less responsive to the needs of the county offices; and local offices spend much time responding to questions from multiple layers of management which leaves less time for providing services.

*Training*

Training is an important component of support. Inadequate training can lead to high error rates, waste, and duplication of effort which can, in turn, affect the delivery of services. In its Strategic Action Plan, FSSA has emphasized its commitment "to the ongoing training of staff and consumers to develop a stronger, more cohesive system of service delivery with the end result being the empowerment of both staff and consumers". Training was also listed in the Andersen and LSA reports as a major problem prior to reorganization.

Several comments were received expressing concerns about the amount of training received on ICES. Most training at the county level is on-the-job training and, in the opinions of some, not sufficient to overcome the complexities of a new computer system that merges three separate programs: AFDC, Medicaid, and Food Stamps. Prior to ICES, caseworkers tended to specialize in one program. Since the implementation of ICES, however, caseworkers have had to administer all three programs. Although the computer system is designed to enable caseworkers to work through questions required by all three programs, the system has had problems. These system problems have resulted in frustration on the part of caseworkers and have also contributed to an error rate for the Food Stamp program that is one of the highest in the nation. There is a perception by some caseworkers that increased training on ICES and the different programs would allow them to perform eligibility determinations more accurately.

The Secretary of FSSA acknowledges the priority of training. One of the goals of FSSA, as stated in the Strategic Action Plan, is to provide staff training and development. Recently the DFC instituted training sessions for caseworkers. Training will take place at 11 sites throughout the state and include an orientation to ICES, AFDC, food stamps, and Medicaid policy. Training will begin with new employees and will gradually grow to include existing employees.

## D. Public Access

Finally, there have been concerns, consistently expressed in interviews, as to the ability of the public to provide significant input into major decisions and program rules under the authority of FSSA. These concerns ranged from the public's involvement and ability to participate in the agency decision-making process to the appropriate functioning of the advisory bodies.

### Rule-Making

Avenues for formal citizen participation in the rule-making process for the human services agencies were significantly changed by the reorganization. Prior to reorganization, two of the three departments that were merged into FSSA had citizen boards providing some form of oversight of the executive departments.

The State Board of Public Welfare was responsible for the adoption of all policies, rules, and regulations for the State Department of Public Welfare, and all administrative and executive duties and responsibilities of the department were to be discharged by the administrator, subject to the approval of the State Board. Other duties of the Board included fixing the administrator's salary and the salaries of the officers and employees of the department, as well as approval of the employees appointed by the administrator and the division directors. In addition, the state administrator was to prepare and submit to the State Board for its approval a biennial budget for the department.

Also prior to reorganization, the 12-member State Mental Health Board, although possessing less authority than the Board of Public Welfare, existed in an advisory capacity to the Commissioner of Mental Health. The Mental Health Board advised on matters pertaining to personnel, institutional and program administration, the development of new goals and broad program objectives for the department, the coordination of the various services of the department, and the operation of mental health programs conducted by the department, as well as other matters. The Commissioner was required to obtain the approval or disapproval of the Board before submitting any proposed major policy or program change to the Governor for approval. Disapproval by the Board did not prohibit submission of the proposed major policy or program change to the Governor. However, if the Board disapproved and the Commissioner submitted the policy to the Governor anyway, the Chairman of the Mental Health Board was to communicate in writing to the Governor the fact that the Board disapproved, the reasons for the disapproval, and any alternative recommendations of the Board. The Mental Health Board, with the consent of the Governor, also had the authority to establish any advisory boards the Board deemed necessary to fulfill its functions.

<u>Family and Social Services Advisory Commission</u>

This level of citizen oversight of executive agencies was modified significantly by the replacement of the Board of Public Welfare and the Mental Health Board by the FSSA advisory bodies. The Family and Social Services Advisory Commission was comprised of 16 members including the following representatives of state agencies:

(1) Director of the Budget Agency;
(2) Superintendent of Public Instruction;
(3) Commissioner of the Department of Correction;
(4) An individual from the Executive Staff of the Lieutenant Governor's Office;
(5) An individual from the Executive Staff of the Governor's Office;

(6) A member of the Executive Board for the State Department of Health;
(7) Two members from the Disability, Aging, and Rehabilitative Services Advisory Council;
(8) One member from the Division of Family and Children Advisory Council;
(9) One member from the Division of Mental Health Advisory Council;
(10) Two individuals from the public appointed by the Governor;
(11) Two members of the Senate; and
(12) Two members of the House of Representatives.

Indiana Code 12-8-3-5 defined the duties of the Commission as advising the Secretary of FSSA on policy, comprehensive planning and coordination of family and social services programs, and coordination of family and social services program with related programs administered by the State Department of Health. The Commission is staffed by employees of FSSA. No rule-approval authority or budgetary oversight function was specifically provided for the FSSA Advisory Commission or the division advisory councils.

Change in Commission Membership and Responsibility

Concerns regarding the effectiveness of the FSSA Advisory Commission as well as frustrations with the FSSA rule-making process, resulted in the introduction of House Bill 1758 in the 1995 legislative session. In essence, HEA 1758, effective July 1, 1995, creates a new 15-member Family and Social Services Committee to replace the FSSA Advisory Commission. The membership of the Committee will consist of members from the public. The legislation prohibits voting members being from the executive or legislative branch of the state. The Committee has been given rule-approval authority over any rule adopted by the Office of the Secretary of FSSA, the three divisions, and the Office of Medicaid Policy and Planning. The Committee will also have authority to advise the Secretary on policy, comprehensive planning, the coordination of family and social service programs, and the coordination of family and social services programs with related programs by the State Department of Health.

The redefinition of the responsibilities of the Family and Social Services Committee to include rule-approval authority may allay some of the concerns over the rule-making process that were identified in surveys and interviews. Additional concerns, consistently expressed, were that the ability of the public to provide input into the decision-making process of the agency on an informal basis has also decreased or, at best, not been improved by the reorganization. This is due, in part, to the change in the organizational structure and the authority of division directors that consequently changed the level of access to the policy decision-makers. Where before, advocates could meet with the specific department commissioner on a rules issue or funding concern, now the greater authority resides in the Secretary's Office. Although the consolidation of the decision-making process into a single office in order to achieve blended funding and coordinated programs was the intent of the reorganization, this is also perceived by some provider and consumer advocates as reduced access to the decision-making process, both in terms of rule promulgation and budget and funding matters.

**FSSA Advisory Bodies**

Public/citizen input has been recognized as having an important role in the delivery of human services. Thirty-seven health and human service boards and commissions exist for the purpose of facilitating public access. FSSA staff can use the expertise of advisory groups in developing and operating programs. Both the 1990 Legislative Services Agency Evaluation Audit and the 1990 Andersen Consulting report recognized that the individual advisory groups existing prior to

reorganization were not effective in carrying out their respective roles due to the fragmented policy structure that existed prior to reorganization. The Andersen report recommended that citizen input be obtained through a single advisory body for each division. The legislation establishing the FSSA mirrored the Andersen recommendation by creating an overall Family and Social Services Advisory Commission as well as advisory councils for the DFC, DDARS, and DMH. The Commission and the advisory councils are discussed separately below.

### Family and Social Services Advisory Commission

The FSSA Advisory Commission has met three times since its creation in July 1991. The last meeting occurred on May 19, 1995. The meeting prior to May 1995 was June 1, 1994. When the Commission has convened, its role has been to listen to updates of various programs by FSSA employees. In surveying members of the Commission as well as reviewing meeting minutes, the Commission appears to have provided little input into the formation of policy or programs. The Commission did not formally meet to provide input into the development of the FSSA Strategic Action Plan which is to be the guide by which FSSA will provide human services in the future.

### Division Advisory Councils

Three division advisory councils were established with the reorganization. Membership is to consist of the division director and 10 members appointed by the Secretary who have a recognized knowledge of or interest in the programs administered by the division. Current membership of the Councils tends to be advocates for the populations served by the respective divisions. By statute, the councils are to meet monthly. The statute is silent as to the specific duties and responsibilities of the councils.

In surveying members of the advisory councils and reviewing meeting minutes, three potential problems were observed: (1) a lack of appointments to the councils; (2) a lack of statutory guidance; and (3) a lack of public input.

### Lack of Appointments

None of the three advisory councils currently have all of the members required by statute. The Division of Mental Health Advisory Council has two recent vacancies (out of ten members). The DDARS Advisory Council has only one current vacancy. However, the DFC Advisory Council has lacked six members for at least a year, leaving only four members on the council to conduct business. The lack of membership, as one Advisory Council member stated, limits what can be accomplished.

### Lack of Statutory Guidance

One of the problems faced by the Advisory Councils may be the lack of statutory guidance as to their duties and responsibilities. While statute defines membership and frequency of meetings, no duties or responsibilities are specified, other than in the selection of the term "advisory" in the name of the Council. Review of the minutes indicates the Councils have tried numerous times to determine their roles and responsibilities. Advisory Council members have expressed their frustration about the amount of time devoted in meetings to determining their purpose.

Lack of Public Input

After surveying the membership of the Councils and reviewing the meeting minutes, it appears that the DDARS and DFC Advisory Councils have not been effective. These Advisory Councils have served more as one-way communication from their respective Divisions to the councils rather than as a means of obtaining public input or receiving recommendations on policy matters.

In addition, the DDARS and DFC Advisory Councils have not been meeting as frequently as required by statute to allow the members who are on the councils the opportunity to participate in the process. The councils are to meet at least monthly according to statute. Over the last 18 months, the DFC Advisory Council has met only nine times while the DDARS Advisory Council has met only eight times.

Members feel their expertise would be useful to the Division to help them avoid problems in policy and program implementation. The role of the DDARS and DFC Advisory Councils has been to listen to presentations by FSSA staff. Any response to policy decisions by council members has been after the decisions have been made.

Successful Council

The Division of Mental Health Advisory Council appears to be the only effective advisory council. Membership on the Council has been stable with 8 of the 10 initial members having served on the Advisory Council since its creation. A review of the minutes shows the Council having involvement in the early policy formulation on the major issues facing the DMH. The Division of Mental Health has organized each of the five major populations under their responsibility into subcommittees of the Council. While these subcommittees meet separately, joint meetings of the Advisory Council and the subcommittees are also sometimes held.

Another example of the successful functioning of this Advisory Council is the input the Council has provided in the development of the federal Mental Health Block Grant application. The survey of the Advisory Council members shows that members believe that they do play a role in policy recommendation. Advisory Council members believe there is good communication both ways and that the DMH has done a good job of asking for and receiving as much input as possible.

The relative effectiveness of the three advisory councils and the FSSA Advisory Commission is probably due, in large part, to the priority placed on them. However, the effectiveness of the councils could potentially be influenced by the number of advisory committees associated with the divisions. The Division of Mental Health has only five advisory committees (while DFC has nine and DDARS has 16). This may have had an effect on the success of the Mental Health Advisory Council. In effect, the Division of Mental Health may have more time to spend with the advisory council on policy issues since it has fewer advisory bodies to deal with. It should be noted that there is no evidence to relate the amount of time each division spends on the various advisory councils/committees/boards and the effect this plays on the effectiveness of the councils.

## References

Bringing the Pieces Together...Strategic Action Plan, Indiana Family and Social Services Administration, November 1, 1994.

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Indiana Family and Social Services Administration: 1995-97 Biennial Budget Presentation, FSSA, January 19, 1995.

Senior Citizens, The Disabled, and Children in Indiana: Families in Poverty, Evaluation Audit, Legislative Services Agency, May 1990.

Step Ahead: Indiana Collaboration Project, FSSA, May 1995.

Vision for the Future, Andersen Consulting, November 1990.

# Appendix

## Appendix A-1. FSSA Program Realignments.

**FROM:** **Department of Mental Health**

TO: Division of Disability, Aging, and Rehabilitative Services

- Diagnosis and Evaluation
- Day Services for People with DD
- Epilepsy
- Epilepsy Clinic
- Institute for Autism
- Supported Employment
- Follow-Along
- Alternative Family Program
- Independent Living Support Services
- Semi Independent Living Program
- Supervised Group Living Program
- Integrated Field Services
- Ft. Wayne State Hospital
- Muscatatuck State Hospital
- New Castle State Hospital
- Northern Indiana State Hospital
- PASSARR
- Autism Waiver

TO: Division of Family and Children

- Prevention Services to High Risk Groups
- Handicapped Infants and Toddlers - First Steps Program

**FROM: Department of Public Welfare**

TO: Division of Disability, Aging, and Rehabilitative Services

- Room and Board Assistance
- Assistance to Residents in County Home

TO: Office of Medicaid Policy and Planning

- Medicaid

TO: The Department of Health

- Indiana AID's Drug Assistance Program

**FROM: The Department of Human Services**

TO: Division of Family and Children

- Services to Families and Children Programs
- Child Abuse Prevention
- Domestic Violence Youth Services Bureau
- Project Safe Place
- Crisis Nursery
- Child Day Care Services Program
- Child Development Associate Scholarship Grant
- School Age Child Care
- Dependent Age Program
- Grants to Preschool Program
- Commodities Program
- Migrant Nutrition Program
- Emergency Shelter Grant
- Department of Energy Weatherization
- Low Income Heat and Energy Assistance Program
- Section 8 Housing, Moderate Rehabilitation
- Migrant Outreach Programs

TO: Division of Mental Health

- Completion of Referral of Information and Monitoring of Addiction Services
- Drug Addicts Section

TO: Department of Health

- Blind Registry

## Appendix A-2. Survey Questionnaire Sent to DFC County Directors (Responses and Percentages)

Please circle the response that you feel is most accurate. Most of the questions have space for written comments. Your written comments and explanations are most important. If you need additional room to provide your response, please feel free to attach another sheet of paper. Your survey responses will be confidential. (Please note that the survey is double-sided.)

(1) What is the population of the county in which your office is located?

| | | |
|---|---|---|
| a. Greater than 70,000 | **15** | **20.0%** |
| b. Greater than 25,000, but less than 70,000 | **32** | **42.7%** |
| c. Less than 25,000 | **28** | **37.3%** |
| | **75** | |

(2) Do you receive more or less cross-divisional support from DMH or DDARS now than before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **3** | **4.2%** |
| b. Somewhat more. | **8** | **11.1%** |
| c. No change. | **52** | **72.2%** |
| d. Somewhat less. | **9** | **12.5%** |
| e. Much less. | **0** | **0.0%** |
| | **72** | |

In what way? Please comment:

(3) Do you feel there is more or less **communication** between the DFC central office and your office now than before reorganization?

| | | |
|---|---|---|
| a. Much more. | **13** | **17.6%** |
| b. Somewhat more. | **26** | **35.1%** |
| c. I don't see any difference. | **15** | **20.3%** |
| d. Somewhat less. | **13** | **17.6%** |
| e. Much less. | **7** | **9.5%** |
| | **74** | |

Please elaborate:

(4) Do you believe that the differences described above regarding **communication** are due more to the change in the FSSA administrative structure or to the specific management style involved? (Choose one)

| | | |
|---|---|---|
| a. FSSA administrative structure. | **32** | **54.2%** |
| b. Specific management style. | **26** | **44.1%** |
| | **58** | |

Please comment:

(5) Have you and your staff received more or less cross-divisional **training** from DMH and DDARS since reorganization?

| Response | Count | Percent |
|---|---|---|
| a. Much more. | **0** | **0.0%** |
| b. Somewhat more. | **4** | **5.5%** |
| c. I see no difference. | **64** | **87.7%** |
| d. Somewhat less. | **2** | **2.7%** |
| e. Much less. | **3** | **4.1%** |
| | **73** | |

Please comment:

(6) How has the change from having district directors to regional managers affected the operation of your office?

| Response | Count | Percent |
|---|---|---|
| a. It was much better having the district directors. | **39** | **52.7%** |
| b. It was somewhat better having the district directors. | **15** | **20.3%** |
| c. I see no difference. | **7** | **9.5%** |
| d. It is somewhat better having the regional managers. | **6** | **8.1%** |
| e. It is much better having the regional managers. | **7** | **9.5%** |
| | **74** | |

In what way? Please comment:

(7) How has the Indiana Client Eligibility System (ICES) affected the operation of your office? It is:

| Response | Count | Percent |
|---|---|---|
| a. Much more efficient. | **15** | **20.5%** |
| b. Somewhat more efficient. | **44** | **60.3%** |
| c. I see no difference. | **3** | **4.1%** |
| d. Somewhat less efficient. | **10** | **13.7%** |
| e. Much less efficient. | **1** | **1.4%** |
| | **73** | |

Please explain:

(8) What is the average time spent on eligibility determination per client now compared to before reorganization?

| Response | Count | Percent |
|---|---|---|
| a. It takes much less time now. | **5** | **6.6%** |
| b. It takes somewhat less time now. | **38** | **50.0%** |
| c. I see no difference. | **17** | **22.4%** |
| d. It takes somewhat more time now. | **14** | **18.4%** |
| e. It takes much more time now. | **2** | **2.6%** |
| | **76** | |

What is your best estimate as to the time difference?

(9) Do you think the Step Ahead Program is an effective means of coordinating services in your county?

| Response | Count | Percent |
|---|---|---|
| a. Very effective. | **6** | **8.0%** |
| b. Somewhat effective. | **28** | **37.3%** |
| c. I see no difference. | **14** | **18.7%** |
| d. Somewhat ineffective. | **9** | **12.0%** |
| e. Very ineffective. | **18** | **24.0%** |
| | **75** | |

Please elaborate:

(10) The goals of FSSA and the Strategic Action Plan are clearly specified and understandable.

| | | |
|---|---|---|
| a. Strongly agree. | **5** | **6.5%** |
| b. Agree | **40** | **51.9%** |
| c. I have no opinion. | **19** | **24.7%** |
| d. Disagree. | **11** | **14.3%** |
| e. Strongly disagree. | **2** | **2.6%** |
| | **77** | |

Please elaborate:

(11) Will the FSSA Strategic Action Plan be useful to your office in the provision of services to your clients?

| | | |
|---|---|---|
| a. Very useful. | **3** | **4.1%** |
| b. Somewhat useful. | **22** | **29.7%** |
| c. I have no opinion. | **20** | **27.0%** |
| d. Not very useful. | **22** | **29.7%** |
| e. Not at all useful. | **7** | **9.5%** |
| | **74** | |

Please elaborate:

(12) Overall, how do you think the ability of the DFC central office to help your operation has been changed by the creation of the Family and Social Services Administration?

| | | |
|---|---|---|
| a. Much improved. | **2** | **2.7%** |
| b. Somewhat improved. | **6** | **8.0%** |
| c. I see no difference. | **20** | **26.7%** |
| d. Somewhat worse than before. | **32** | **42.7%** |
| e. Much worse than before. | **15** | **20.0%** |
| | **75** | |

Please summarize your reasons why:

(13) Overall, how do you think the ability to provide services to your clients has been changed by the creation of the Family and Social Services Administration?

| | | |
|---|---|---|
| a. Much improved. | **1** | **1.3%** |
| b. Somewhat improved. | **12** | **15.8%** |
| c. I see no difference. | **37** | **48.7%** |
| d. Somewhat worse than before. | **19** | **25.0%** |
| e. Much worse than before. | **7** | **9.2%** |
| | **76** | |

Please summarize your reasons why:

(14) Do you as a county director have enough authority to efficiently and effectively carry out the responsibilities of the county office?

| | | |
|---|---|---|
| a. The county director needs more authority. | **30** | **44.1%** |
| b. No change is necessary. | **32** | **47.1%** |
| c. There is not enough direction from the DFC central office. | **6** | **8.8%** |
| | **68** | |

Please summarize your reasons why:

(15) Are there any other effects, improvements, or problems resulting from reorganization on the operation of your office (e.g. eligibility determination, child welfare/child protection responsibilities, etc.)?

## Appendix A-3. Survey Questionnaire Sent to DFC Caseworkers (Responses and Percentages)

Please circle the response that you feel is most accurate. Most of the questions have space for written comments. Your written comments and explanations are most important. If you need additional room to provide your response, please feel free to attach another sheet of paper. Your survey responses will be confidential. (Please note that the survey is double-sided.)

1. What is the population of the county in which your office is located?

| Response | Number | Percent |
|---|---|---|
| a. Greater than 70,000 | **99** | **48.3%** |
| b. Greater than 25,000, but less than 70,000 | **66** | **32.2%** |
| c. Less than 25,000 | **40** | **19.5%** |
| | **205** | |

2. What is your main job responsibility?

| Response | Number | Percent |
|---|---|---|
| a. Public assistance | **141** | **68.8%** |
| b. IMPACT | **3** | **1.5%** |
| c. Child welfare/child protection | **53** | **25.9%** |
| d. Other ____________ | **8** | **3.9%** |
| | **205** | |

3. How has the amount of services available to clients changed since the 1992 reorganization?

| Response | Number | Percent |
|---|---|---|
| a. Large increase | **35** | **17.3%** |
| b. Increase | **100** | **49.5%** |
| c. No change | **51** | **25.2%** |
| d. Decrease | **12** | **5.9%** |
| e. Large decrease | **4** | **2.0%** |
| | **202** | |

Please comment:

4. Do you feel that you have enough authority to effectively and efficiently do your job?

| Response | Number | Percent |
|---|---|---|
| a. Need more authority | **90** | **45.5%** |
| b. No change is necessary | **108** | **54.5%** |
| | **198** | |

Please comment:

5. How has **communication** among the administration, caseworkers, clients, and providers changed since reorganization?

| Response | Number | Percent |
|---|---|---|
| a. Much improved | **8** | **4.1%** |
| b. Somewhat improved | **38** | **19.3%** |
| c. I see no difference | **78** | **39.6%** |
| d. Somewhat worse | **43** | **21.8%** |
| e. Much worse | **30** | **15.2%** |
| | **197** | |

Please comment:

6. How much **cross-training and education** (in areas other than the program in which you work) have you received since reorganization?

| Response | Number | Percent |
|---|---|---|
| a. Much more | **23** | **12.2%** |
| b. Somewhat more | **58** | **30.7%** |
| c. I see no difference | **76** | **40.2%** |
| d. Somewhat less | **8** | **4.2%** |
| e. Much less | **24** | **12.7%** |
| | **189** | |

Please comment:

7. How has public confidence in the services that your office provides changed since reorganization?

| Response | Number | Percent |
|---|---|---|
| a. Greatly increased | **1** | **0.5%** |
| b. Increased | **30** | **14.9%** |
| c. I see no difference | **121** | **60.2%** |
| d. Decreased | **42** | **20.9%** |
| e. Greatly decreased | **7** | **3.5%** |
| | **201** | |

Please comment:

8. How has the Indiana Client Eligibility System (ICES) affected your job? It results in me being:

| Response | Number | Percent |
|---|---|---|
| a. Much more efficient | **20** | **10.4%** |
| b. Somewhat more efficient | **98** | **50.8%** |
| c. I see no difference | **27** | **14.0%** |
| d. Somewhat less efficient | **38** | **19.7%** |
| e. Much less efficient | **10** | **5.2%** |
| | **193** | |

Please explain:

9. What is the average time spent on eligibility determination per client now compared to before reorganization? (If eligibility determination is not part of your job responsibility, skip this question)

| Response | Number | Percent |
|---|---|---|
| a. Much less time now | **14** | **9.5%** |
| b. Somewhat less time now | **44** | **29.9%** |
| c. No difference | **41** | **27.9%** |
| d. Somewhat more time now | **39** | **26.5%** |
| e. Much more time now | **9** | **6.1%** |
| | **147** | |

What is your best estimate as to the time difference?

10. Overall, how do you think the ability of the DFC central office to help your operation has been changed by the creation of the Family and Social Services Administration?

| Response | Number | Percent |
|---|---|---|
| a. Much improved | **4** | **2.0%** |
| b. Somewhat improved | **32** | **16.2%** |
| c. I see no difference | **107** | **54.3%** |
| d. Somewhat worse | **37** | **18.8%** |
| e. Much worse | **17** | **8.6%** |
| | **197** | |

Please summarize your reasons why.

11. How effective do you think the Step Ahead Program is as a means of coordinating services in your county?

| | | |
|---|---|---|
| a. Very effective | **9** | **5.8%** |
| b. Somewhat effective | **36** | **23.2%** |
| c. I see no difference | **81** | **52.3%** |
| d. Somewhat ineffective | **10** | **6.5%** |
| e. Very ineffective | **19** | **12.3%** |
| | **155** | |

Please elaborate:

12. Are there any other effects, improvements, or problems resulting from reorganization on the operation of your office or your ability to do your job (e.g. eligibility determination, child welfare/child protection responsibilities, etc.)?

## Appendix A-4. Survey Questionnaire Sent to AAAs/CAAs (Responses and Percentages)

The Family and Social Services Administration was created in the 1992 reorganization of human services. Some of the goals intended for reorganization were to realize administrative efficiencies, reduce fragmentation and duplication of programs, and provide greater accessibility for consumers of state services.

Please circle the response that you feel is most accurate. Most of the questions have space for written comments. Your written comments and explanations are most important. If you need additional room to provide your response, please feel free to attach another sheet of paper. Your survey responses will be confidential. (Please note that the survey is double-sided.)

(1) Is your agency a:

| | | |
|---|---|---|
| a. Community Action Agency | **14** | **58.3%** |
| b. Area Agency on Aging | **7** | **29.2%** |
| c. Dually designated agency | **3** | **12.5%** |
| | **24** | |

(2) Do you feel there is more or less **communication** between the DDARS central office and your office now than before reorganization?

| | | |
|---|---|---|
| a. Much more. | **1** | **4.5%** |
| b. Somewhat more. | **4** | **18.2%** |
| c. I don't see any difference. | **6** | **27.3%** |
| d. Somewhat less. | **6** | **27.3%** |
| e. Much less. | **5** | **22.7%** |
| | **22** | |

Please elaborate:

(3) Do you believe that the differences described above regarding **communication** are due more to the change in the FSSA administrative structure or to the specific management style involved? (Choose one)

| | | |
|---|---|---|
| a. FSSA administrative structure. | **7** | **41.2%** |
| b. Specific management style. | **10** | **58.8%** |
| | **17** | |

Please comment:

(4) Do you receive more or less **support** from the Division of Mental Health (DMH) now than before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **0** | **0.0%** |
| b. Somewhat more. | **0** | **0.0%** |
| c. No change. | **12** | **75.0%** |
| d. Somewhat less. | **2** | **12.5%** |
| e. Much less. | **2** | **12.5%** |
| | **16** | |

In what way? Please comment:

(5) Do you receive more or less **support** from the Division of Family and Children (DFC) now than before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **1** | **4.5%** |
| b. Somewhat more. | **3** | **13.6%** |
| c. No change. | **8** | **36.4%** |
| d. Somewhat less. | **7** | **31.8%** |
| e. Much less. | **3** | **13.6%** |
| | **22** | |

In what way? Please comment:

(6) Do you receive more or less **support** from the Office of Medicaid Policy and Planning now than you received from the Medicaid Division prior to the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **0** | **0.0%** |
| b. Somewhat more. | **4** | **22.2%** |
| c. No change. | **10** | **55.6%** |
| d. Somewhat less. | **1** | **5.6%** |
| e. Much less. | **3** | **16.7%** |
| | **18** | |

In what way? Please comment:

(7) How would you characterize the coordination between the Office of Medicaid Policy and Planning (OMPP) and the Division of Disabilities, Aging, and Rehabilitative Services (DDARS)?

| | | |
|---|---|---|
| a. Very effective | **0** | **0.0%** |
| b. Somewhat effective | **1** | **8.3%** |
| c. Adequate | **6** | **50.0%** |
| d. Somewhat ineffective | **4** | **33.3%** |
| e. Very ineffective | **1** | **8.3%** |
| | **12** | |

Please explain:

(8) Have you and your staff received more or less **training** from DMH and DFC since reorganization?

| | | |
|---|---|---|
| a. Much more. | **1** | **4.5%** |
| b. Somewhat more. | **0** | **0.0%** |
| c. I see no difference. | **10** | **45.5%** |
| d. Somewhat less. | **4** | **18.2%** |
| e. Much less. | **7** | **31.8%** |
| | **22** | |

Please comment:

(9) Do you think the Step Ahead Program is an effective means of coordinating services in your county or district?

| | | |
|---|---|---|
| a. Very effective. | **0** | **0.0%** |
| b. Somewhat effective. | **0** | **0.0%** |
| c. I see no difference. | **4** | **17.4%** |
| d. Somewhat ineffective. | **6** | **26.1%** |
| e. Very ineffective. | **13** | **56.5%** |
| | **23** | |

Please explain:

If you are involved in more than one Step Ahead Program with varying degrees of effectiveness, please elaborate.

(10) The goals of FSSA and the Strategic Action Plan are clearly specified and understandable.

| | | |
|---|---|---|
| a. Strongly agree. | **0** | **0.0%** |
| b. Agree | **3** | **13.6%** |
| c. I have no opinion. | **9** | **40.9%** |
| d. Disagree. | **8** | **36.4%** |
| e. Strongly disagree. | **2** | **9.1%** |
| | **22** | |

Please elaborate:

(11) Will the FSSA Strategic Action Plan be useful to your office in the provision of services to your clients?

| | | |
|---|---|---|
| a. Very useful. | **1** | **4.3%** |
| b. Somewhat useful. | **2** | **8.7%** |
| c. I have no opinion. | **8** | **34.8%** |
| d. Not very useful. | **9** | **39.1%** |
| e. Not at all useful. | **3** | **13.0%** |
| | **23** | |

Please elaborate:

(12) Overall, how do you think the ability of the DDARS central office to help your operation has been changed by the creation of the Family and Social Services Administration?

| | | |
|---|---|---|
| a. Much improved. | **0** | **0.0%** |
| b. Somewhat improved. | **5** | **26.3%** |
| c. I see no difference. | **5** | **26.3%** |
| d. Somewhat worse than before. | **7** | **36.8%** |
| e. Much worse than before. | **2** | **10.5%** |
| | **19** | |

Please summarize your reasons why:

(13) Overall, how do you think the ability to provide services to your clients has been changed by the creation of the Family and Social Services Administration?

| | | |
|---|---|---|
| a. Much improved. | **0** | **0.0%** |
| b. Somewhat improved. | **5** | **20.8%** |
| c. I see no difference. | **12** | **50.0%** |
| d. Somewhat worse than before. | **4** | **16.7%** |
| e. Much worse than before. | **3** | **12.5** |
| | **24** | |

Please summarize your reasons why:

(14) Are there any other effects, improvements, or problems resulting from reorganization on the operation of your office (e.g. eligibility determination, provision of services, etc.)? Please explain.

## Appendix A-5. Survey Questionnaire Sent to Community Mental Health Centers (Responses and Percentages)

The Family and Social Services Administration was created in the 1992 reorganization of human services. Some of the goals intended for reorganization were to realize administrative efficiencies, reduce fragmentation and duplication of programs, and provide greater accessibility for consumers of state services.

Please circle the response that you feel is most accurate. Most of the questions have space for written comments. Your written comments and explanations are most important. If you need additional room to provide your response, please feel free to attach another sheet of paper. Your survey responses will be confidential. (Please note that the survey is double-sided.)

(1) Do you feel there is more or less **communication** between the Division of Mental Health (DMH) central office and your office now than before reorganization?

| Response | Count | Percent |
|---|---|---|
| a. Much more. | **5** | **23.8%** |
| b. Somewhat more. | **5** | **23.8%** |
| c. I don't see any difference. | **7** | **33.3%** |
| d. Somewhat less. | **4** | **19.0%** |
| e. Much less. | **0** | **0.0%** |
| | **21** | |

Please elaborate:

(2) Do you believe that the differences described above regarding **communication** are due more to the change in the FSSA administrative structure or to the specific management style involved? (Choose one)

| Response | Count | Percent |
|---|---|---|
| a. FSSA administrative structure. | **3** | **15.8%** |
| b. Specific management style. | **16** | **84.2%** |
| | **19** | |

Please comment:

(3) How would you characterize the **length of time** with which contracts are approved by FSSA now as compared to before the 1992 reorganization?

| Response | Count | Percent |
|---|---|---|
| a. Takes much longer now. | **7** | **35.0%** |
| b. Takes somewhat longer now. | **6** | **30.0%** |
| c. I see no difference. | **5** | **25.0%** |
| d. Takes somewhat less time now. | **2** | **10.0%** |
| e. Takes much less time now. | **0** | **0.0%** |
| | **20** | |

Please elaborate:

(4) How would you characterize your relationship with the Division of Disabilities, Aging, and Rehabilitative Services (DDARS) in terms of the amount of services provided now compared to before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more services provided. | **1** | **5.6%** |
| b. Somewhat more services provided. | **1** | **5.6%** |
| c. No difference. | **11** | **61.1%** |
| d. Somewhat fewer services provided. | **1** | **5.6%** |
| e. Much fewer services provided. | **4** | **22.2%** |
| | **18** | |

Please elaborate:

(5) Do you receive more or less **support** from the DDARS now than before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **1** | **5.6%** |
| b. Somewhat more. | **1** | **5.6%** |
| c. No change. | **11** | **61.1%** |
| d. Somewhat less. | **2** | **11.1%** |
| e. Much less. | **3** | **16.7%** |
| | **18** | |

In what way? Please comment:

(6) How would you characterize your relationship with the Division of Family and Children (DFC) in terms of the amount of services provided now compared to before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more services provided. | **1** | **5.3%** |
| b. Somewhat more services provided. | **8** | **42.1%** |
| c. No difference. | **10** | **52.6%** |
| d. Somewhat fewer services provided. | **0** | **0.0%** |
| e. Much fewer services provided. | **0** | **0.0%** |
| | **19** | |

Please elaborate:

(7) Do you receive more or less **support** from the Division of Family and Children (DFC) now than before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **2** | **10.5%** |
| b. Somewhat more. | **7** | **36.8%** |
| c. No change. | **10** | **52.6%** |
| d. Somewhat less. | **0** | **0.0%** |
| e. Much less. | **0** | **0.0%** |
| | **19** | |

In what way? Please comment:

(8) How would you characterize the timeliness of Medicaid reimbursements now compared to before the 1992 reorganization?

| | | |
|---|---|---|
| a. Much faster now. | **0** | **0.0%** |
| b. Somewhat faster now. | **2** | **10.0%** |
| c. I see no difference. | **1** | **5.0%** |
| d. Somewhat slower now. | **1** | **5.0%** |
| e. Much slower now. | **16** | **80.0%** |
| | **20** | |

Please elaborate:

(9) Other than the timing of Medicaid reimbursement, do you receive more or less **support** from the Office of Medicaid Policy and Planning now than you received from the Medicaid Division prior to the 1992 reorganization?

| | | |
|---|---|---|
| a. Much more. | **3** | **15.0%** |
| b. Somewhat more. | **2** | **10.0%** |
| c. No change. | **7** | **35.0%** |
| d. Somewhat less. | **3** | **15.0%** |
| e. Much less. | **5** | **25.0%** |
| | **20** | |

In what way? Please comment:

(10) How would you characterize the coordination between the Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health (DMH)?

| | | |
|---|---|---|
| a. Very effective | **1** | **4.8%** |
| b. Somewhat effective | **9** | **42.9%** |
| c. Adequate | **2** | **9.5%** |
| d. Somewhat ineffective | **7** | **33.3%** |
| e. Very ineffective | **2** | **9.5%** |
| | **21** | |

Please explain:

(11) Have you and your staff received more or less **training** from DDARS since reorganization?

| | | |
|---|---|---|
| a. Much more. | **0** | **0.0%** |
| b. Somewhat more. | **1** | **6.3%** |
| c. I see no difference. | **13** | **81.3%** |
| d. Somewhat less. | **2** | **12.5%** |
| e. Much less. | **0** | **0.0%** |
| | **16** | |

Please comment:

(12) Have you and your staff received more or less **training** from DFC since reorganization?

| | | |
|---|---|---|
| a. Much more. | **0** | **0.0%** |
| b. Somewhat more. | **3** | **17.6%** |
| c. I see no difference. | **14** | **82.4%** |
| d. Somewhat less. | **0** | **0.0%** |
| e. Much less. | **0** | **0.0%** |
| | **17** | |

Please comment:

(13) Do you think the Step Ahead Program is an effective means of coordinating services in your county or district?

| | | |
|---|---|---|
| a. Very effective. | **0** | **0.0%** |
| b. Somewhat effective. | **7** | **35.0%** |
| c. I see no difference. | **0** | **0.0%** |
| d. Somewhat ineffective. | **3** | **15.0%** |
| e. Very ineffective. | **10** | **50.0%** |
| | **20** | |

Please explain:

If you are involved in more than one Step Ahead Program with varying degrees of effectiveness, please elaborate.

(14) The goals of FSSA and the Strategic Action Plan are clearly specified and understandable.

| | | |
|---|---|---|
| a. Strongly agree. | **0** | **0.0%** |
| b. Agree | **5** | **23.8%** |
| c. I have no opinion. | **11** | **52.4%** |
| d. Disagree. | **4** | **19.0%** |
| e. Strongly disagree. | **1** | **21.0%** |
| | **21** | |

Please elaborate:

(15) Will the FSSA Strategic Action Plan be useful to your office in the provision of services to your clients?

| | | |
|---|---|---|
| a. Very useful. | **0** | **0.0%** |
| b. Somewhat useful. | **2** | **9.5%** |
| c. I have no opinion. | **9** | **42.9%** |
| d. Not very useful. | **6** | **28.6%** |
| e. Not at all useful. | **4** | **19.0%** |
| | **21** | |

Please elaborate:

(16) Overall, how do you think the ability of the DMH central office to help your operation has been changed by the creation of the Family and Social Services Administration?

| | | |
|---|---|---|
| a. Much improved. | **0** | **0.0%** |
| b. Somewhat improved. | **1** | **5.0%** |
| c. I see no difference. | **4** | **20.0%** |
| d. Somewhat worse than before. | **10** | **50.0%** |
| e. Much worse than before. | **5** | **25.0%** |
| | **20** | |

Please summarize your reasons why:

(17) Overall, how do you think the ability to provide services to your clients has been changed by the creation of the Family and Social Services Administration?

| | | |
|---|---|---|
| a. Much improved. | **0** | **0.0%** |
| b. Somewhat improved. | **0** | **0.0%** |
| c. I see no difference. | **9** | **45.0%** |
| d. Somewhat worse than before. | **9** | **45.0%** |
| e. Much worse than before. | **2** | **10.0%** |
| | **20** | |

Please summarize your reasons why:

(18) Are there any other effects, improvements, or problems resulting from reorganization on the operation of your center? Please explain.

## Appendix A-6. Family and Social Services Administration Mission Statement.

### Vision

We all come from families. The family is the foundation of Indiana culture and must be valued for its rich diversity. The integrity and dignity of the family must be protected, nurtured and mutually respected. Our families will achieve their vision to be as emotionally and economically self-sufficient, safe and healthy as possible. Families will be involved in constructive activities, have a good quality of life, be adaptable to the joys and tragedies of life and contribute to the betterment of Hoosier communities.

### Mission

The Office of the Secretary of Family and Social Services Administration helps people to help themselves. Focusing on self-sufficiency and dignity, the office is developing a system addressing individual and family needs through prevention and early intervention, preservation. Recognizing that government is not the only answer, the Office of the Secretary fosters collaboration among people, communities and other units of government to move families and individuals toward self-sufficiency.

### Purpose

Formulating overall policy for families, children and persons with disabilities in the state.

Coordinating the service delivery system and processes that cut across program, division and state agency lines to meet the needs of families, children and persons with disabilities.

Developing and implementing a statewide strategic action plan including goals, objectives and priorities to integrate the work of government, citizens and the private sector in addressing the needs of families.

Meeting the needs of families all at one time rather than one at a time.

Strengthening abilities of families to succeed.

### Management Values:

Customer service is our top priority.

Success will be achieved through partnerships with our stakeholders.

Every employee is a contributor who is valued and trusted to develop a productive, innovative and dynamic organization.

We are committed to direct, two-way external and internal communication.

We will adhere to the highest standards of personal integrity.

Teamwork will create an effective, caring and rewarding environment.

Our stewardship responsibilities require us to make the best possible use of taxpayers' dollars.

Source: Family and Social Services Administration, 1994.