Olmstead Subcabinet Meeting

Monday, August 22, 2016 • 4:00 p.m. to 5:30 p.m.
Minnesota Housing Finance Agency – State Street Conference Room
400 Sibley Street, St. Paul, MN 55101

Agenda

1) **Call to Order**

2) **Roll Call**

3) **Agenda Review**

4) **Approval of Minutes** **3**
   a) Subcabinet meeting on July 25, 2016

5) **Reports**
   a) Chair
   b) Executive Director
   c) Legal Office
   d) Compliance Office

6) **Action Items**
   a) August 2016 Quarterly Report on Measurable Goals **19**
   b) Workplan Compliance Report **53**
   c) Proposed Adjustments to Workplan Activities **55**
      - Crisis Services 2A.2, 2A.3, 2A.4 (DHS)
      - Crisis Services 2J.3 (DHS)

7) **Information Items**
   a) Workplan items requiring report to Subcabinet:
      1. Community Engagement 4A.3, Present proposal on formation of a chartered workgroup (OIO) **57**

8) **Public Comments**

9) **Adjournment**

Next Subcabinet Meeting:

September 28, 2016 – 9:30 a.m. to 11:00 a.m.

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[AGENDA ITEM 4]

THESE ARE DRAFT MINUTES SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET

Olmstead Subcabinet Meeting
July 25, 2016 – 1:30 p.m. to 3:00 p.m.
Minnesota Housing, 400 Sibley Street, State Street Conference Room

1. **Call to Order**
   Action: N/A
   The meeting was called to order at 1:35 p.m. by Commissioner Mary Tingerthal (Minnesota Housing).

2. **Roll Call**
   Action: N/A
   Subcabinet members present: Mary Tingerthal, Chair, Olmstead Subcabinet (Minnesota Housing); Colleen Wieck (Governor's Council on Developmental Disabilities).

   Designees present: Chuck Johnson (Department of Human Services); Steve Dibb (Minnesota Department of Education); Deb Kerschner (Department of Corrections); Gil Acevedo (Department of Health); Jeremy Hanson Willis (Department of Employment and Economic Development) arrived at 1:42 p.m.

   Guests present: Kari Benson, Bill Burleson, Gretchen Ulbee, Alex Bartolic, Erin Sullivan Sutton, Adrienne Hannert (Department of Human Services); Mike Tessneer, Rosalie Vollmar, Tristy Auger, and Darlene Zangara (Olmstead Implementation Office); Anne Smetak, Tom O'Hern, and Ryan Baumtrog (Minnesota Housing); Kristie Billiar (Department of Transportation); Kim Peck, Claire Courtney, David Sherwood-Gabrielson, Carol Pankow (Department of Employment and Economic Development); Ellena Shoop (MN.IT); Stan Shanedling, Christina Nelson, Nicole Stockert, Mary Cahill (Department of Health); Anna McLafferty (Department of Corrections); Elizabeth Dressel (Governor's Office); Christina Schaffer (Minnesota Department of Human Rights); Daron Korte, Robyn Widley, Joan Breslin-Larson, Jennifer Alexander, Carolyn Cherry, and Marikay Litzau (Minnesota Department of Education); Melody Johnson (Governor's Council on Developmental Disabilities).

   Guests present via telephone: Sue Ewy (Minnesota Department of Health).

3. **Agenda Review**
   Chair Tingerthal stated the Health Care and Healthy Living topic report will be moved on the agenda to immediately follow the Action Items.

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4. **Approval of Minutes**
   a) **Subcabinet meeting on June 27, 2016**
   The June 27, 2016 Subcabinet meeting minutes were approved.

   Motion: Approve the June 27, 2016 Subcabinet meeting minutes.
   Action: Motion – Wieck. Second – Dibb.
   In Favor – All

5. **Reports**
   a) **Chair**
   Commissioner Tingerthal reported the following:
   - A public comment period is underway regarding the development of a comprehensive abuse and neglect prevention plan. Phase one began on July 19, 2016 through August 14, 2016 during which public comments will be accepted on what should be included in the plan. In the second phase, a draft plan will be posted to the website September 2, 2016 and public comments will be accepted on the draft plan through September 11, 2016. The Subcabinet will be asked to adopt the plan at the September 28, 2016 Subcabinet meeting. There may need to be an Executive Committee meeting regarding the plan in early September. Under the Olmstead plan measurable goals, the comprehensive plan on abuse and neglect should be approved by September 30, 2016.
   - Deputy Commissioner Steve Dibb (MDE) will retire at the end of July. The Subcabinet thanked him for his participation and contributions to the Olmstead Plan implementation and the Subcabinet.

   b) **Executive Director**
   There are no updates or reports.

   c) **Legal Office**
   There are no updates or reports.

   d) **Compliance Office**
   Mike Tessneer reported the following:
   - The process to annually review and adjust workplans will begin with meetings between OIO Compliance and agency sponsors and leads in August. At that

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time, OIO Compliance will walk through the process and timeline for completion. Revised workplans are due to the Court on September 30, 2016.

- Agencies will be reporting today on the workplans associated with Preventing Abuse and Neglect and Assistive Technologies.

6. Action Items

a) Proposed Workplans

PREVENTING ABUSE AND NEGLECT

GOAL 1

Kari Benson (DHS) reviewed the proposed workplan for Preventing Abuse and Neglect Goal 1. The goal is that by September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities.

Strategy 1 is to develop an educational campaign for mandated reporters and professional caregivers. The following workplan activities are being proposed:

A. Launch MN Adult Abuse Reporting Center (MAARC) public awareness campaign. Begin dissemination of postcard, first kiosk card and magnet (print material is targeted to the public, not mandated reporters).
B. Conduct statewide videoconference for health care and human services professionals, including mandated reporters, regarding the MAARC and the public awareness campaign. Disseminate information via professional licensing board listservs.
C. Review current and planned components of DHS public awareness campaign to promote reporting to the MN Adult Abuse Reporting Center.
D. Review DHS workplan activities in the Person Centered Planning Goal related to developing materials for people with disabilities, and a guide for case manager and assessors to use with people when they see them to help them understand their rights and ask questions to learn more if there are indicators of potential abuse/maltreatment.
E. Ongoing communication and dissemination with key stakeholders including MN Elder Justice Center stakeholder group and HDS PA and Licensing/MDH/Call Center stakeholder group.

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F. Release additional components of the MAARC public awareness campaign at the State Fair and statewide through other venues. Additional materials include: radio spots, social media posts and brochure.
G. Release final component of existing MAARC public awareness campaign: 2 minute video (online and DVDs)
H. Develop recommendations for the Subcabinet on the feasibility and estimated cost of additional public awareness and education activities to implement a major "Stop Abuse" campaign, including additional elements related to teaching people with disabilities their rights and how to identify if they are being abused.
I. Develop and submit proposed comprehensive abuse and neglect prevention plan to the Subcabinet for approval.

Ms. Benson (DHS) noted that OIO Compliance suggested changes to the language to ensure that people with disabilities, families and advocates are added to the groups receiving ongoing communication and dissemination. DHS agrees with the proposed changes.

Strategy 2 was included in the Subcabinet packet. There was no discussion or comments on the workplans under this strategy.

Strategy 2 is to develop a public awareness campaign. The following workplan activities are being proposed:
A. Agencies will solicit public input on the development of educational campaign on the prevention of abuse and neglect of people with disabilities. Input will be solicited from mandated reporters, professional caregivers, people with disabilities, families, and advocates.
B. Define key objectives of the educational campaign.
C. Identify the target audiences for the educational campaign.
D. Develop the key messages for the educational campaign.
E. Design the optimal channels of communication to be used.
F. Implement the campaign.

GOAL 2
Deputy Commissioner, Gil Acevedo (MDH) reviewed the proposed workplan for Preventing Abuse and Neglect Goal 2. The goal is that by January 31, 2020, the number of emergency room (ER) visits and hospitalizations of vulnerable individuals due to abuse and neglect will decrease by 50% compared to the baseline.

Strategy 1 is to use data to identify victims and target prevention. The following workplan activities are being proposed:

A. Analyze the date from the Minnesota Hospital Association (MHA) to determine the number of individuals who have been treated at a hospital due to abuse or neglect. Individuals who meet the definition of a vulnerable individual will then be identified based on if their source of admission was from either a licensed facility or a home health agency.
B. Once the baseline is established, the date will then be analyzed to determine any existing patterns and geographic areas which reflect higher incidences of abuse or neglect for vulnerable individuals.
C. Conduct a public education campaign targeted at providers who serve individuals with disabilities. Targeted prevention efforts will also be conducted in areas with higher rates of hospitalization and ER visits due to abuse and neglect of vulnerable individuals.

Strategy 2 is to monitor and improve accountability of providers. The following workplan activities are being proposed:

A. Report quarterly to the Olmstead Subcabinet the number of citations issued to Intermediate Care Facilities for Individuals with Intellectual Disabilities that document failure to report abuse, neglect and other maltreatment.
B. Submit quarterly to the Olmstead Subcabinet the number of citations issued to Supervised Living Facilities that document failure to comply with the development of an individualized abuse prevention plan, as required Minnesota Statue 626.557 subd.14 (b).
C. Analyze data from increased reporting to identify areas where targeted prevention strategies can be applied to reduce the occurrence of maltreatment to vulnerable individuals.

Strategy 3 is to refine the measurable goal. The following workplan activities are being proposed:

A. Reassessing MHA data annually to determine the efficacy of the educational efforts.
B. After reassessment of the MHA data and the effects of the educational campaign, the measurable goal will be reviewed on an annual basis.

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Colleen Wieck (Governor's Council on Developmental Disabilities) noted that the US Department of Health and Human Services, Office of the Inspector General, has completed a study in Connecticut and Massachusetts that is similar to what is being proposed in Strategy 1. She agreed to keep the Subcabinet updated on this issue.

GOAL 3

Alex Bartolic, (DHS) reviewed the proposed workplan for Preventing Abuse and Neglect Goal 3. The goal is that by December 31, 2021, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 20% compared to the baseline.

Strategy 1 is to develop remediation strategies for providers and professional caregivers. The following workplan activities are being proposed:

A. Collect data for initial maltreatment reports and complete validation testing of the MAARC data system.
B. Data reports developed and tested on initial and repeat maltreatment and demographic data of suspected victim and perpetrator. Data for repeat maltreatment reports by person will be collected for the 6-month timeframe (January 1 – June 30, 2017).
C. Data and reports will be validated. Baseline will be established.
D. Develop and test lead investigative agency remediation strategy reports.
E. Review and compile data on remediation strategies by lead investigative agency to identify strategies that may be effective at preventing repeat maltreatment of the same type.
F. Conduct training sessions with lead investigative agencies to share remediation strategies effective at preventing repeat maltreatment.
G. Complete an inventory of existing communication methods used to inform service providers. Develop communication plan to disseminate alerts.
H. Analyze repeat maltreatment data to identify patters/trends of abuse and neglect.
I. Disseminate communication alerts to providers and other key local stakeholders.

In response to a question from Commissioner Tingerthal (Minnesota Housing), Ms. Bartolic (DHS) reported that remediation, training, and support are a high priority in situations of repeat abuse.

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In response to a comment from Colleen Wieck (Governor's Council on Developmental Disabilities) about prevention messaging, DHS staff will work with the Ombudsman's Office to determine the best way to work together on communications and prevention messaging.

In response to questions from Deputy Commissioner Jeremy Hanson Willis (DEED), Ms. Bartolic stated that DHS has not yet established baseline data since the launch of the Minnesota Adult Abuse Reporting Center (MAARC). In aggregate numbers there has been a 60% increase in reporting volume since the launch of the MAARC. Ms. Bartolic stated that prior to the launch of the MAARC system, there were approximately 150 individuals who experienced maltreatment of the same type within a 6-month period. It is unknown how that will compare to the data now since the launch of the MAARC.

Strategy 2 is to engage quality councils by providing statewide and regional data on maltreatment reporting. Ms. Bartolic requested that these workplan activities be reworked for further modification and clarity. A new director of the State Quality Council was just hired and the regional councils are in the process of hiring new staff. Ms. Bartolic would like to have an opportunity for the new director of the State Quality Council to be involved in developing meaningful workplan items for this strategy.

Commissioner Tingerthal (Minnesota Housing) suggested that the workplan could contain a single item with a reasonable date by which a more detailed workplan could be presented.

Strategy 3 is to refine measurable goals. Kari Benson (DHS) reviewed the proposed workplan activity, which is to refine measurable goals on an annual basis to determine if the targets need to be revised.

GOAL 4

Jennifer Alexander (MDE) reviewed the proposed workplan for Preventing Abuse and Neglect, Goal 4. The goal is that by July 31, 2020, the number of identified schools that have had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years will decrease by 50% compared to baseline. The number of students with a disability who are identified as alleged

victims of maltreatment within those schools will also decrease by 50% by July 31, 2020.

Strategy 1 is to develop and utilize school tracking database. The following workplan activities are being proposed:

A. Collaborate with Mn.IT and computer programmer to create a report that calculates the number of maltreatment investigations involving a student with a disability within an individual school. Ensure program data is properly transitioned from current maltreatment program database system to new maltreatment web-focused database system.
B. Train program staff on database entry requirements to ensure all necessary information for specified goal is collected and stored in system.
C. Generate specific report and analyze necessary data from FY14-FY16 to establish baseline.

Strategy 2 is to continue to expand training for school personnel. The following workplan activities are being proposed:

A. Draft and send a letter to all identified schools to notify them of multiple investigations within their schools and to inform them of the current school years' PBIS training application process and deadlines.
B. Target schools identified from baseline data that have yet to submit applications for 2017-2019 PBIS cohort training and send a follow up letter encouraging participation in the trainings.
C. Provide ongoing targeted technical assistance and an annual training for school administrators on student maltreatment, mandated reporter requirements, PBIS, Restrictive Procedures, and discipline.
D. Report to the Subcabinet:
    - Number of schools identified as having 3 or more investigations of alleged maltreatment of students with a disability as established in the baseline data.
    - Number of identified schools participating/not participating in MDE approved PBIS cohort training; and corresponding number of maltreatment investigations.
    - Number of student's named as alleged victims in a maltreatment investigation within schools identified in baseline data.
    - Number of students named as alleged victims of maltreatment during and post PBIS training.

Strategy 3 is to improve school accountability for training. The following workplan activities are being proposed:

A. Develop web-based system that requires school district personnel to submit verification to MDE indicating that all school employees have been trained on child maltreatment mandated reporter requirements.
B. Test and implement web-based verification system.
C. Develop and update web-based mandated reporter requirement training and student maltreatment information materials on program website.
D. Notify school administrators of verification requirement and alternative training options via program website and superintendent mailings.
E. Annually report to the Olmstead Subcabinet:
    - Number of districts who fulfilled verification requirement procedures and confirmed mandated reporter training to all district employees.
    - Number of districts who did not fulfill verification requirements and did not confirm mandated reporter training to all district employees.

In response to questions from Deputy Commissioner Steve Dibb (MDE), Ms. Alexander (MDE) stated the definition of "mandated reporter" is from the Department of Human Services and can be clarified on communications within the school district. Essentially mandated reporters include all individuals that are in the education system.

In response to questions from Deputy Commissioner Jeremy Hanson Willis (DEED), Ms. Alexander (MDE) explained that specific data regarding the number of schools involved is not available at this time. She believes it is likely less than 100 schools, but MDE will know more once the baseline is established.

In response to a question from Deputy Commissioner Jeremy Hanson Willis (DEED), Assistant Commissioner Daron Korte (MDE) explained the 50% reduction goal was based on the estimate of 100 schools affected and knowing that PBIS training is valuable but voluntary. Once MDE obtains the baseline and begins to see where things are moving, it will reevaluate to see if that percentage can be moved upward.

Colleen Wieck (Governor's Council on Developmental Disabilities) asked if there was any legislation that requires a mandated report regarding the number of

investigations and number of students. Assistant Commissioner Korte responded that there was no such legislation.

PERSON-CENTERED PLANNING

Strategy 1 is to broaden the effective use of person-centered planning principles and techniques for people with disabilities. Alex Bartolic (DHS) reviewed the proposed workplan additions to the existing workplan for Person-Centered Planning.

The following workplan activities are being proposed:

A. Develop materials and training to guide professionals who inform people with disabilities about their rights and their individual abuse prevention plans to increase understanding of rights and the effectiveness of planning.
B. Develop inventory of existing requirements, materials, tools and training.
C. Create process map/prompts for recommended practices to identify opportunities for conversations about risk and choice.
D. Produce trainings for professionals on individual rights, abuse prevention planning, and skill building.

Motion: Approve the Preventing Abuse and Neglect Workplans with changes as noted.

Action: Motion – Johnson. Second – Hanson Willis.
In Favor – All

ASSISTIVE TECHNOLOGY

PERSON-CENTERED PLANNING

Alex Bartolic (DHS) reviewed the proposed workplan additions to the existing workplan for Person-Centered Planning.

Strategy 2 is to evaluate the effectiveness of person-centered planning principles and techniques for people with disabilities. The following workplan activities are being proposed:

A. Through the MnChoices assessment tool, assess whether assistive technology will be considered as part of an individual's support plan, and at reassessments, monitor access to an effective use of technology.
B. Incorporate assistive technology related questions into MnCHOICES assessment tool.

C. Analyze one full year of assistive technology data from MnCHOICES assessments.
D. Review analysis and make recommendations to DHS leadership.
E. DHS will work with System of Technology to Achieve Results (STAR) Program and the State Quality Council and its regional councils on strategies to increase awareness of, and monitor effective use of assistive technology as a means to increase quality of life and outcomes for people with disabilities.
F. DHS staff will coordinate with STAR program staff to arrange technical assistance/informational presentations to Person Centered Quality Review work groups or the State Quality Councils.
G. State Quality Council Work group will develop questions related to assistive Technology to utilize in their quality review process.

Strategy 3 is to incorporate assistive technology assessment into person centered planning processes. The following workplan activities are being proposed:

A. Person centered planning processes will be enhanced though a common process across Department of Human Services, Education, Employment and Economic Development and Administration. This process will increase awareness of Assistive Technology, related services, resources and funding sources.
B. Department of Admin's STAR Program will convene an Assistive Technology workgroup of representatives from DHS, MDE, DEED and Department of Admin.
C. Develop common process for planning for use of technology.
D. Evaluate process and make recommendations for revisions to processes.

Commissioner Tingerthal (Minnesota Housing) requested that language be added to the workplan incorporating the STAR process and the ability to consult with people who have disabilities.

TRANSITION SERVICES

Alex Bartolic (DHS) reviewed the proposed workplan additions to the existing workplan for Transition Services.

Strategy 3 is to increase service options for individuals making transitions. The following workplan activities are being proposed:

A. Provide technical assistance and education about assistive technology to lead agencies and providers and provide examples of innovative uses of assistive technology to support people in make successful transitions to the most integrated settings.

B. Develop an assistive technology track at the DHS Statewide Age and Disability Odyssey conference.
C. Measure use of Technology For Home (Tech4Home) assessment and education services including type of activity, number people of impacted and client satisfaction.
D. Assess the effectiveness of the services and make recommendations for improvements as needed.

EMPLOYMENT

Carol Pankow (DEED) reviewed the proposed workplan additions to the existing Employment workplan.

Strategy 4 is to develop additional strategies for increasing competitive, integrated employment among people with disabilities. The following workplan activities are being proposed:

A. Cross Agency AT Workgroup will develop methods for collecting, sharing, and education on current assistive technology (AT) trends and outline in a communication plan.
B. Develop and provide a presentation to the Diversity and Inclusion Council about how AT allows access to state resources and can support employment for current and prospective state workers with disabilities.

In response to comments from Colleen Wieck (Governor's Council on Developmental Disabilities) and Deputy Commissioner Jeremy Hanson Willis (DEED), regarding the All Hands on Deck Report and the audit of accessibility in State workforce centers, Ms. Pankow agreed to add an additional activity to the workplan regarding accessibility.

LIFELONG LEARNING AND EDUCATION

Joan Breslin Larson (MDE) reviewed the proposed workplan additions to the existing Lifelong Learning and Education workplan.

Strategy 6 is to expand effectiveness of Assistive Technology Teams Project. The following workplan activities are being proposed:

A. MDE will recruit Assistive Technology (AT) Teams from districts.
B. MDE will provide professional development to each participating AT team, with a specific curriculum delivered to Years 1, 2, and 3 AT teams. There will be a minimum of quarterly activities each school year.

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C. MDE will develop documentation protocols for teams to use in documenting outcomes of consideration in the IEP team process.
D. AT teams will complete Quality Indicators in Assistive Technology (QIAT) matrices (self-assessment) to determine current status of consideration of AT in their setting.
E. Each participating AT team will report to MDE the number of Individualized Education Programs (IEPs) on which team members served, during which active consideration of AT resulted in improved access to AT for the student.
F. MDE will evaluate, monitor and adjust professional development and technical assistance to support teams in outcomes related to active consideration of assistive technology.

Motion: Approve the Assistive Technology Workplans with changes as noted.
Action: Motion – Wieck. Second – Hanson Willis.
In Favor – All

b) July 2016 Workplan Compliance Report

A written report from Mike Tessneer, OIO Compliance, contained in the Subcabinet packet, reported on the Workplan Compliance Report. There were 53 items reviewed in July. Of the 53 total items:

- 47 items (89%) were completed
- 4 items (7%) were on track
- 2 items (4%) was reported as an exception

c) Adjustments to Workplan Activities

- Housing and Services 4A.4 (DHS)
- Quality of Life 3E.2 (OIO)

Commissioner Tingerthal stated that the Compliance Report and Adjustments to Workplan Activities in the report are straightforward. In the interest of time she requested a motion to approve the reports as written.

Motion: Approve the proposed adjustments to Workplan activities as written.
Action: Motion – Wieck. Second – Dibb.
In Favor – All

7. **Monthly Topic Report – Health Care and Healthy Living**
   Deputy Commissioner Gil Acevedo (MDH) and Gretchen Ulbee (DHS) gave a presentation on Health Care and Healthy Living. The PowerPoint presentation handout is available in the Subcabinet packet on the Minnesota's Olmstead Plan website.

   In response to a question from Commissioner Tingerthal (Minnesota Housing), Gretchen Ulbee (DHS) stated that goals are considered for the number of people on Medicaid who would be eligible for services in a Behavioral Health Home.

   In response to a question from Commissioner Tingerthal (Minnesota Housing), Deputy Commissioner Gil Acevedo (MDH) explained that approximately half of persons with disabilities are on managed care plans where there are contractual requirements with the health plans to coordinate with Behavioral Health Homes to provide necessary data. It is more difficult to obtain data when there is no managed care plan and county providers work closely with the client to obtain necessary data.

   In response to a question from Commissioner Tingerthal (Minnesota Housing), Deputy Commissioner Gil Acevedo (MDH) explained the information does not identify or pull out individuals specifically with disabilities. But MDH believes that if it increases education and awareness of cardiovascular disease and/or cervical cancer, it will improve health outcomes for those individuals.

   In response to a comment from Colleen Wieck (Governor's Council on Developmental Disabilities), Mary Manning (MDH) stated work is being done to address accessibility standards in Behavioral Health Homes for people with disabilities and disparities.

   Commissioner Tingerthal (Minnesota Housing) requested that content be included in the next revised workplan to highlight whether there are specific actions necessary to ensure physical accessibility for health care facilities.

8. **Informational Items**

   a) **Workplan items requiring report to Subcabinet**
      1. **Community Engagement 1D,** Report activities promoting Olmstead Plan (OIO)
      2. **Crisis Services 2J.2,** report status of crisis respite being added to waiver (DHS)
      3. **Education 1A and Positive Supports 1B,** Report number of schools using Positive Behavioral Interventions and Supports (PBIS) (MDE)

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4. **Education 2A,** Report number of students with Developmental Cognitive Disorders (DCD) and Autism Spectrum Disorders (ASD) in the most integrated setting (MDE)
5. **Education 3A.2,** Report graduation rates for American Indian and Black students with disabilities (MDE)
6. **Employment 5A.4 and 5A.5,** Report impact of Workforce Innovation and Opportunity Act (WIOA) and Order of Selection Process (DEED)
7. **Health Care 4A,** Report National Core Indicator (NCI) survey results related to health status and access to services (DHS)

b) Follow-Up from Previous Meetings

1. ICFs/DD and Nursing Facilities – number breakdown of metro vs greater Minnesota (DHS)
2. Transition to Community grants and movement from Minnesota Security Hospital and Anoka Metro Regional Treatment Center (DHS)

Commissioner Tingerthal (Minnesota Housing) noted that the Subcabinet was provided with written materials on the above informational items and asked if any member of the Subcabinet had questions or concerns on those items.

Colleen Wieck (Governor's Council on Developmental Disabilities) asked if MDE, in item 2A, could report separately on Developmental Cognitive Disabilities and Autism Spectrum Disorder in future reports. MDE agreed that could be done.

9. Public Comments

There were no public comments.

10. Adjournment

The meeting was adjourned at 3:11 p.m.

Motion:	**Adjournment.**	
Action:	**Motion – Dibb.**	**Second: Acevedo.**
	In Favor – All	

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Minnesota Olmstead Subcabinet

Quarterly Report on Olmstead Plan Measurable Goals

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REPORTING PERIOD

Data acquired through July 31, 2016

DATE REPORT PRESENTED TO SUBCABINET

August 22, 2016

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I. PURPOSE OF REPORT

This quarterly report to the Court and the public provides the status of work being done by state agencies to implement the Olmstead Plan. As directed by the Court, the goals related to the number of people moving from segregated settings into more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures will be reported in every quarterly report.

Reports are compiled on a quarterly basis. For the purpose of reporting, the measurable goals are grouped in four categories:

1. Movement of people with disabilities from segregated to integrated settings
2. Movement of individuals from waiting lists
3. Quality of life measurement results
4. Increasing system capacity and options for integration

This quarterly report of August 22, 2016 includes data acquired through July 31, 2016. Progress on each measurable goal will be reported either quarterly, semi-annually, or annually in accordance with the Court Orders issued on February 12, 2016 (Doc. 540-2) and June 21, 2016 (Doc. 578).

As required by the Court's June 21, 2016 Order, the annual goals included in this report are those goals for which data is reliable and valid in order to ensure the overall report is complete, accurate, timely, and verifiable. In light of that Order, the following measurable goals will be reported in future quarterly reports, which will ensure the data is determined to be reliable and valid before it is reported to the Court: Housing & Services Goal One will be reported in the November 2016 quarterly report, and Positive Supports Goals 4 and 5, and Transition Services Goal 4 will be reported in the February 2017 quarterly report.

This quarterly report also includes Olmstead Implementation Office (OIO) compliance summary reports on mid-year reviews of measurable goals, status of workplans, and any adjustments made to workplans.

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II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

This section reports on the progress of five separate Olmstead Plan goals that assess movement of individuals from segregated to integrated settings.

QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

The table below indicates the cumulative net number of individuals who moved from various segregated settings to integrated settings for each of the five goals included in this report. The reporting period for each goal is based on when the data collected can be considered reliable and valid.

Net number of individuals who moved from segregated to integrated settings during the reporting period:		
Setting	**Reporting period**	**Number moved**
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	Oct – Dec 2015	23
• Nursing Facilities	Oct – Dec 2015	231
• Other segregated settings	Next report Feb 2017	Next report Feb 2017
• Anoka Metro Regional Treatment Center (AMRTC)	April – June 2016	27
• Minnesota Security Hospital (MSH)	April – June 2016	20
Net number who moved from segregated to integrated settings		**291**

More detailed information for each specific goal is included below. The information includes the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance.

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TRANSITION SERVICES GOAL ONE: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[i] will be 7,138.

Annual Goals for the number of people moving from ICFs/DD, nursing facilities and other segregated housing to more integrated settings are set forth in the following table:

	Baseline Calendar year 2014	June 30, 2015 Goal	June 30, 2016 Goal
A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84
B) Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740
C) Segregated housing other than listed above	Not Available[ii]	50	250
Total		**874**	**1,074**

A) INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (ICF/DD)

2016 goal

- For the year ending June 30, 2016 the number of people who have moved from ICFs/DD to a more integrated setting will be **84**

Baseline: January - December 2014 = 72

RESULTS:
The goal is on track to meet the 2016 goal of 84.

Time Period	Total number of individuals leaving	(-)Transfers[iii]	(-)Deaths	Net moved to integrated setting
July 2014 - June 2015	158	24	63	**71**
Quarter 1 (July – September 2015)	37	7	14	**16**
Quarter 2 (October – December 2015)	57	11	23	**23**
Totals Q1 + Q2	94	18	37	**39**

ANALYSIS OF DATA:
From October – December 2015, the number of people moving from an ICF/DD to a more integrated setting was 23, which is seven more than the previous quarter. In the first 6 months of state fiscal year 2016, a total of 39 people moved from an ICF/DD to a more integrated setting. This is approximately 46% of the annual goal of 84.

COMMENT ON PERFORMANCE:
The state provides reports to counties about persons in ICFs/DD who are not opposed to moving with community services. As part of the current process, individuals are being whether they would like to

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move in the next 12 months. The agency is finding that some individuals who expressed an interest in moving are declining to move in that 12-month timeframe. For those leaving an institutional setting such as an ICF/DD the new reasonable pace standard is to ensure access to waiver services funding within 45 days of requesting community services. DHS monitors and provides technical assistance to counties in providing timely access to the funding and planning necessary to facilitate a transition to community services.

DHS is on track to complete reassessments by December 2016. At that time, we will have up-to-date information to evaluate the goals about who would like to move (not opposed to moving), what people want and will have worked with counties to identify barriers to be addressed.

A person-centered planning, informed choice and transition protocol was introduced in February 2016. Technical assistance through different venues is focused on those who are helping people leaving ICFs/DD. Work is being done to increase education and technical assistance on housing subsidies, methods of working with landlords, and services available to do so.

Several providers have expressed an interest in voluntary closures of ICFs/DD. DHS is working to support the planning process for integrated community service development. These closures would permanently reduce bed capacity.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

B) NURSING FACILITIES

2016 goal

- For the year ending June 30, 2016 the number of people who have moved from Nursing Facilities (for persons with a disability under 65 in facility longer than 90 days) to a more integrated setting will be **740**

Baseline: January - December 2014 = 707

RESULTS:
This goal is on track to meet the 2016 goal of 740.

Time Period	Total number of individuals leaving	(-)Transfers [iii]	(-)Deaths	Net moved to integrated setting
July 2014 – June 2015	1,509	203	527	**779**
Quarter 1 (July – September 2015)	374	23	171	**180**
Quarter 2 (October – December 2015)	511	59	221	**231**
Totals Q1 + Q2	885	82	392	**411**

ANALYSIS OF DATA:
From October – December 2015, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 231, compared to 180 people in the previous quarter. 411 people under the age of 65 have moved to more integrated settings in the first half of state fiscal year 2016. This is more than half of the annual target. If moves continue at approximately the same rate, the 2016 goal of 740 is expected to be met.

COMMENT ON PERFORMANCE:
DHS reviews data and notifies lead agencies of people who have not refused or opposed more integrated options. Lead agencies are expected to work with these individuals to begin to plan their moves. DHS continues to work with partners in other agencies to improve the supply of affordable housing and knowledge of housing subsidies.

Beginning in December 2015, Section 811 rental subsidies became available to some individuals moving from institutional settings.

In July 2016, Medicaid payment for Housing Access Services will be expanded across waivers. Additional providers will be able to enroll to provide this service. Housing Access Services assists people with finding housing, setting up their new place, including a certain amount of basic furniture, household goods and/or supplies and payment of certain deposits.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

C) SEGREGATED HOUSING

2016 goal

- For the year ending June 30, 2016 the number of people who have moved from other segregated housing to a more integrated setting will be **250.**

RESULTS:
The data development for this goal area was not available for the August 2016 Quarterly Report due to limited information technology resources and competing data priorities for other goal areas. OIO Compliance staff are working with DHS to ensure the agency puts the necessary processes and timelines in place so that the data will be collected and verified. It is expected that baseline data and reliable, verified measurements will be available in the February 2017 Quarterly Report.

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TRANSITION SERVICES GOAL TWO: By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[iv] will be reduced to 30% (based on daily average).

2016 goal

- By June 30, 2016 the percent of people at AMRTC awaiting discharge will be **≤ 35%**

Baseline: During the period from July 2014 – June 2015, a change in utilization of AMRTC caused an increase in the percent of the target population to 36%

RESULTS:
The 2016 goal of ≤ 35% was not met.

Time Period	Total number of individuals leaving	(-) Transfers [iii]	(-) Deaths	Net moved to integrated setting	% awaiting discharge
Quarter 1 (July – Sept 2015)	65	41	0	24	40.4%
Quarter 2 (October – Dec 2015)	75	41	0	34	44.9%
Quarter 3 (January – March 2016)	67	38	0	29	46.6%
Quarter 4 (April – June 2016)	74	47	0	27	38.3%
Annual Totals	281	167	0	**114**	**Avg = 42.5%**

ANALYSIS OF DATA:
From April – June 2016, the average percent of people at AMRTC awaiting discharge was 38.3% compared to 46.6% in the previous quarter. Despite the downward trend in the last quarter, the 2016 goal of 35% was not met.

COMMENT ON PERFORMANCE:
When an individual is accused of committing a crime, but is deemed mentally unfit to stand trial, the State of Minnesota sends that person to a mental health facility to receive treatment before eventually standing trial. Today, many of these individuals are cared for in secure treatment centers or at a hospital level of care at Anoka Metro Regional Treatment Center (AMRTC), though they could be served in a less-intensive setting. Having these individuals at AMRTC distracts from the target population of the work toward the goal of getting more people out of AMRTC.

In order to make progress on this goal, structural and systemic changes in the mental health system and housing access need to be made. These changes will ensure that individuals exiting AMRTC have integrated living options, and receive timely care.

As part of his Supplemental Budget Proposal to the 2016 Legislature, the Governor proposed the creation of a new, stand-alone Competency Restoration Program (CRP) to treat Minnesotans accused of a crime, but deemed incompetent to stand trial (this would free up hospital space for Minnesotans who need treatment in a secure setting).

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To accomplish this, a third level of state-operated CRP care would be created for individuals needing to be restored to competency. The three levels include:

1) Hospital level of care when clinically indicated (located at AMRTC);
2) A secure setting for restoration located at Minnesota Security Hospital (MSH); and
3) A proposed locked community residential setting.

This third level of care is where the greatest need exists and would greatly reduce the reliance on AMRTC, freeing up much needed hospital beds for individuals needing hospital level of care (approximately 20 hospital beds at Anoka and 10 secure beds at MSH.)

To achieve this third level, an existing program would be closed and the site repurposed. Efforts on a restructuring plan are underway.

To help reduce the number of people awaiting discharge, AMRTC staff use management tools to be proactive about length of stay and prevent unnecessary delays. Staff track individual cases: anticipated discharge date and barriers to discharge at AMRTC in the seven county metro area, Southeast Minnesota 10 County Region and Southwest Minnesota 18 County Region. AMRTC regularly shares information with and meets with stakeholders to ensure that appropriate and timely discharge planning are in place for individuals served.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

TRANSITION SERVICES GOAL THREE: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month.

2016 goal

- For year ending December 31, 2016 the average monthly number of discharges will increase to **≥ 11**

Baseline: From January – December 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) was 9 individuals per month.

RESULTS:
The goal is not on track to meet the 2016 goal.

Time period	Total number of individuals leaving	Transfers [iii]	Deaths	Net moved to integrated setting
January – December 2015	188	107	8	73 Average = 6.1
Quarter 1 (January – March 2016)	40	23	1	16 Average = 5.3
Quarter 2 (April – June 2016)	47	26	1	20 Average = 6.7
Totals (Q1 + Q2)	87	49	2	**36** **Average = 6**

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ANALYSIS OF DATA:
From April – June 2016, the monthly average number of discharges from MSH to a more integrated setting was 6.7 compared to 5.3 in the previous quarter. During the same period, the monthly average total number of discharges from MSH was 15.66.

COMMENT ON PERFORMANCE:
To help increase the number of individuals leaving MSH staff conducted the following activities:

- **County Collaboration**
  Current efforts to increase the number of transitions include working with the counties, in particular, Hennepin and Ramsey Counties, to increase the number of providers that are willing and able to serve individuals transitioning into the community from MSH. Hennepin County completed a Request for Interest, hired a transitions coordinator to assist with new developments, and expanded their forensic case management division by 2 licensed social workers.

  MSH continues to participate in quarterly collaboration meetings with Hennepin, Dakota and Ramsey counties. The focus is on identifying individuals who are able to be served in more integrated settings, while working to expand community capacity.

- **MSH/DHS Collaboration**
  MSH continues to partner with Whatever It Takes grant recipients to create more opportunities to successfully transition individuals from MSH to the community. The grantees include selected counties and providers.

  MSH has consulted with a variety of DHS divisions to navigate newer practices, in an effort to expand re-integration options for individuals served. Examples include:
  - Triage with DHS Licensing for newly created, and customized homes, developed by private community-based providers.
  - Triage related to developing customized living arrangement for individual, who would receive state-provided staffing (due to unique needs).
  - Triage to identify options to increase options for individuals over the age of 65, who only qualify for Elderly Waiver.

  To make a significant impact on the timely re-integration of individuals at MSH to integrated settings requires structural and larger systemic changes, including the following:

- **Competency Restoration Program Recommendations**
  Competency Restoration Program Recommendations are outlined above in report on Transition Services Goal 2.

- **Proposed Legislative Recommendations**
  The proposed legislative recommendations below were presented by the Bureau of Mediation Services (BMS) workgroup, and passed along to DHS leadership for Legislative considerations for 2016. It is felt that each proposal would contribute to enhanced and more robust service delivery, which would in turn, impact length of stay, and timelier transitioning for individuals to return to a more integrated setting.

- **MSH Staffing Proposal**
  In January 2016, the Bureau of Mediation Services (BMS) aided in the facilitation of a variety of committees, to focus on collaborative problem-solving. DHS has an obligation to serve the people of Minnesota, specifically the most vulnerable individuals. Forensic Services, a division of DHS, is required to provide current, state of the art, evidenced-based treatment for individuals with complicated diagnoses who have been, most often, also involved in the criminal justice system. Many of the individuals served have experienced multiple treatment failures and/or can no longer be accepted for treatment in less restrictive settings. Forensic Services provides secure treatment which assists them in recovery so that they can move back into the community and live meaningful lives.

  The complexity of their mental health, and associated illness such as chemical dependency, cognitive disabilities, personality disorders, and often multiple medical health issues, requires a professionally trained staff from a variety of clinical backgrounds. Provision of therapeutic treatment has to be driven from clinical staff who understand complicated co-morbid conditions. Best clinical practice to serve patients with illnesses of this acuity strongly suggests that in order for treatment to be effective, it must be individualized but comprehensive. Staff who provide the 24/7 direct care need to continually enhance their skills in working with complex individuals. There is a high need for training that helps build proficiency in de-escalation, and engagement that leads to treatment recovery, and transitions to more integrated settings.

  A "St. Peter Security Hospital Safe Staffing" proposal was submitted to the Legislature. The Legislature did not provide funding to bring staffing levels at MSH up to national standards.

- **Bonding Proposal**
  MSH requires a facility upgrade and renovations, which can provide a safe and therapeutic environment to those served, and contributes to treatment recovery, and transitions to integrated settings. In 2014, lawmakers passed a bonding bill that secured more than $56 million for MSH renovations and a new transition program building, which will add 48 beds to the transition unit and 56 beds to the MSH once construction is finished this fall.

  A bonding proposal of $70.3 million to finish renovations and update MSH was proposed this past session, but was not funded during the regular session.

- **Resident Appropriateness**
  A Bureau of Mediation Services (BMS) sub-committee made legislative recommendations related to Resident Appropriateness. The recommendations reflect the need for additional resources and statutory changes in order to better support the mission of MSH, and specialty services necessary for patients with developmental disabilities and Autism Spectrum Disorder, so they may be diverted (as necessary from a secure treatment setting) and reintegrated to the community in a timely fashion.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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III. MOVEMENT OF INDIVIDUALS FROM WAITING LISTS

This section reports progress on the movement of individuals from the home and community based services waiting lists. A new urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The new system categorizes urgency into three categories including: institutional exit; immediate need; defined need. Reasonable pace standards have been established for each of these categories.

Data was available from the new urgency categorization system beginning in June 2016 to be included in this August 2016 quarterly report. The baseline will be established at the end of the first full year of collecting urgency data in December 2016, and will be included in the February 2017 quarterly report.

WAITING LIST GOAL ONE: By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.

Baseline: As of May 30, 2015, the CADI waiver waiting list was 1,420 individuals.

RESULTS:
The goal appears to be on track to meet the October 1, 2016 goal of eliminating this waiting list.

Time period	Number on CADI waiver waiting list at end of quarter	Change from previous quarter
April – June 2015	1,254	<174>
July – September 2015	932	<322>
October – December 2015	477	<455>
January – March 2016	193	<284>
April – June 2016	7	<186>

ANALYSIS OF DATA:
From April 1 – June 30, 2016, the statewide CADI waiver waiting list decreased to 7 people, compared to 193 people from the previous quarter. Since June 2015 there has been a reduction of 1,247 individuals on the waiting list.

COMMENT ON PERFORMANCE:
During this quarter, DHS contacted lead agencies that had people on a CADI waiver waiting list. DHS provided technical assistance when it was needed in order for lead agencies to eliminate their waiting lists by offering systems guidance and/or making additional funding available.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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WAITING LIST GOAL TWO: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.

Baseline: In April 2015, there were 3,586 individuals on the DD waiver waiting list.
(This baseline from the June 2016 Plan, was based on the previous reporting system and cannot be used for direct comparison with current waiting list data. A new baseline will be established at the end of the first full year of collecting urgency data in December 2016, and will be included in the February 2017 quarterly report.)

RESULTS:
Reporting Period: January – March 2016

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Still on waiting list
Leaving an Institution	14	6 (43%)	7 (50%)	1 (7%)
Immediate Need	93	53 (57%)	30 (32%)	10 (11%)
Defined Need	217	72 (33%)	71 (33%)	74 (34%)
Totals	**324**	**131 (41%)**	**108 (33%)**	**85 (26%)**

ANALYSIS OF DATA:
From January 1 – March 31, 2016, out of 324 individuals on the Developmental Disabilities (DD) waiver waiting list, 131 individuals (41%) had funding approved within 45 days of the assessment date. An additional 108 individuals (33%) had funding approved after 45 days. The total number of individuals assessed between January - March 2016 with an institutional exit, immediate need or defined need that did not have funding in place that are on the DD Waiver waiting list is 85 (26%).

COMMENT ON PERFORMANCE:
DHS is in the midst of implementing a new DD Waiver waiting list categorization system, which bases a person's waiting list status on their urgency of need for waiver services. The previous method of reporting DD waiting list figures is no longer valid and cannot be used for direct comparison with current waiting list data. As a result, DHS is currently in a transition period between the historic DD waiting list and the new urgency definitions.

Currently, lead agencies receive monthly updates of persons on the waiting list, the number of days since the assessment where the waiting list category was determined, and whether reasonable pace standards are met. If reasonable pace standards are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency seeking remediation.

Not all persons who are assessed are included in the above tables. Only individuals who meet the criteria of one of the three urgency categories are included in the table. If an individual's need for services changes, they may request a reassessment or information will be collected during a future assessment.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

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WAITING LIST GOAL THREE: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a (b) and 256B.092, subdivision 12(b).

RESULTS:

PERSONS LEAVING AN INSTITUTION

Time Period	Number of people assessed	Still on waiting list
January – March 2016	14	1 (7%)

PERSONS WITH IMMEDIATE NEED

Time Period	Number of people assessed	Still on waiting list
January – March 2016	93	10 (11%)

ANALYSIS OF DATA:
From January – March 2016, 1 person out of 14 remained on the DD waiver waiting list after leaving an institution, and 10 people out of 93 remained the DD waiver waiting list with an immediate need.

COMMENT ON PERFORMANCE:
DHS focuses a large amount of waiting list technical assistance on approving waiver funding for persons in the institutional exit and immediate need categories. DHS directly contacts lead agencies if people in these categories have been waiting longer than 45 days. If this goal is not met, DHS explains options available to the lead agency to approve funding for persons in these categories.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

WAITING LIST GOAL FOUR: By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.

RESULTS:
DHS began collecting new DD waiting list data beginning December 1, 2015. As of the date of this report, three years have not passed since this implementation date. This data will be available in December 2018.

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WAITING LIST GOAL FIVE: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.

RESULTS:

DEFINED NEED

Time Period	Number of people assessed	Still on waiting list
January – March 2016	217	74 (34%)

ANALYSIS OF DATA:
As of March 31, 2016, the number of people assessed between January 1 – March 31, 2016 with a Defined Need who remained on the Developmental Disabilities waiver waiting list was 74 people.

COMMENT ON PERFORMANCE:
DHS encourages lead agencies to approve funding for persons in the Defined Need category following approval of persons in the institutional exit and immediate need categories and as waiver budget capacity allows. If a lead agency makes a determination that it does not have sufficient capacity to approve funding for persons in the defined need category, DHS expects the lead agency to maintain a budget reserve of 3% or less pursuant to Minnesota Statute. DHS monitors lead agency waiver budgets and provides projections to lead agencies in order to make this determination.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

IV. QUALITY OF LIFE MEASUREMENT RESULTS

The 2015 National Core Indicators (NCI) survey results were reported in the May 2016 Quarterly Report. The 2016 NCI survey results will be reported as they become available.

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V. INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

This section reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported in each quarterly report.

PERSON CENTERED PLANNING GOAL ONE: By June 30, 2020, plans for people using disability home and community-based waiver services will meet required protocols. Protocols will be based on the principles of person centered planning and informed choice.

Baseline: During the period July 2014 – June 2015, 38,550 people were served by disability home and community based services. However, a baseline for the current percentage of plans that meet the principles of person centered planning and informed choice needs to be established.

RESULTS:
The Person Centered Planning, Informed Choice and Transition Protocol was approved by the Subcabinet Executive Committee on February 10, 2016. The audit process to measure progress is in place. The first year's data will be used to set a baseline. This baseline will be presented to the Subcabinet at the February 2017 meeting.

Interim quarterly reporting began in May 2016 and includes the total number of cases, the number of cases reviewed, and identification of the counties participating in the audit.

Audit Sample

Time Period	Total Number of Cases (Disability Waivers)	Sample of Cases Reviewed (Disability Waivers)
Quarter 1 (July – September 2015)	617	155
Quarter 2 (October – December 2015)	3,005	432
Quarter 3 (January – March 2016)	9,375	556
Quarter 4 (April – June 2016)	1,762	323
Totals	**14,759**	**1,466**

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Counties Participating in the Audit*

Quarter 1	Quarter 2	Quarter 3	Quarter 4
1. Koochiching	7. Mille Lacs	13. Hennepin	19. Renville
2. Itasca	8. Faribault	14. Carver	20. Traverse
3. Wadena	9. Martin	15. Wright	21. Douglas
4. Red Lake	10. St. Louis	16. Goodhue	22. Pope
5. Mahnomen	11. Isanti	17. Wabasha	23. Stevens
6. Norman	12. Olmsted	18. Crow Wing	24. Grant
			25. Freeborn
			26. Mower
			27. Lac Qui Parle
			28. Chippewa
			29. Ottertail

*Agencies visited are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS)

ANALYSIS OF DATA:
From July 2015 through June 2016, a total of 1,466 case files have been reviewed throughout the disability waiver programs (Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disability Inclusion (CADI) and Developmental Disabilities (DD)) across 29 lead agencies. Lead agencies include counties and tribes.

COMMENT ON PERFORMANCE:
The review process uses multiple methods to gather and review data, such as Medicaid Management Information Systems (MMIS) downloads, review of case files, interviews with agency leadership, and focus groups with agency staff. Part of the onsite activities is case file review, where a sample of case files from each program is reviewed using a sampling strategy prescribed and approved by the Center for Medicare and Medicaid Service (CMS). This sampling methodology allows us to determine the presence or absence of compliance within and across all programs. The purpose of the case file review is to identify areas of non-compliance with technical requirements and to identify tools and practices used by the lead agency that contribute to both strong technical compliance and improved outcomes for individuals, including person-centered practices. The results of case file review are then reported to CMS.

As a result of new regulations such as CMS Home and Community-Based Services (HCBS) Settings Rule, an increased focus has been placed on person-centered practices during this round of Lead Agency Reviews including those required in the Person-Centered, Informed Choice and Transition Protocol. There have been changes and updates to Lead Agency Review protocols to respond to person-centered requirements in order to assure consistent practices across all lead agencies. This includes the evaluation of items in individuals' care plans such as strengths, dreams and aspirations, a person's preference for working, living, and learning and documentation of their satisfaction with services and supports. Once the final analysis is complete, a report is prepared for each lead agency and recommendations are given.

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Of the 11 agencies reviewed in this quarter, all have received recommendations relating to person-centered planning and thinking. Recommendations include:

- Encourage lead agencies to set expectations for the quality and content of support plans.
- Train staff on providing person-centered services.
- Encourage changes in agency practices.
- Encourage changes to how agencies work with community partners.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

POSITIVE SUPPORTS GOAL ONE: By June 30, 2018 the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will decrease by 5% or 200.

2016 Goal

- By June 30, 2016 the number of people experiencing a restrictive procedure will be **reduced by 5% from the previous year or 51 individuals**

Annual Baseline: In 2014 the number of individuals who experienced a restrictive procedure was 1,076.
In 2015 the number of individuals who experienced a restrictive procedure was 867.

RESULTS:
The results on the annual goal will be reported in November 2016.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
Quarter 1 (July - September 2015)	299 (duplicated)	N/A– quarterly status of annual goal
Quarter 2 (October - December 2015)	297 (duplicated)	N/A– quarterly status of annual goal
Quarter 3 (January – March 2016)	348 (duplicated)	N/A– quarterly status of annual goal

ANALYSIS OF DATA:
During January – March 2016, the number of individuals who experienced a restrictive procedure increased by 51 from 297 to 348 compared to the previous quarter.

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COMMENT ON PERFORMANCE:
There were 348 individuals who experienced a restrictive procedure this quarter.

- 314 individuals were only subject to emergency use of manual restraint (EUMR). EUMRs are not prohibited and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.

- 34 individuals experienced restrictive procedures *other than* EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). DHS staff and the Interim Review Panel provide follow up and technical assistance for all reports involving restrictive procedures *other than* EUMR. It is anticipated that focusing technical assistance with this subgroup will reduce the number of individuals experiencing restrictive procedures and the number of reports (see goal 3).

Under the Positive Supports Rule, the upcoming External Program Review Committee (expected to convene by March 2017) has the duty to review and respond to Behavior Intervention Reporting Form (BIRF) reports involving EUMR. It is anticipated the Committee's work will help reduce the larger number of people who experience EUMR through the guidance they will provide to license holders regarding specific uses of EUMR.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL TWO: By June 30, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596.

Annual Goals

- By June 30, 2015 the number of reports of restrictive procedures will be reduced by **430**.
- By June 30, 2016 the number of reports of restrictive procedures will be reduced by **409.**

Annual Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:
The goal is on track to meet the 2016 goal.

Time period	Number of BIRF Reports	Reduction from previous year
2015 Annual (July 2014 – June 2015)	5,124	3,478
Quarter 1 (July – September 2015)	907	N/A – quarterly status of annual goal
Quarter 2 (October – December 2015)	1,019	N/A – quarterly status of annual goal
Quarter 3 (January – March 2016)	1,039	N/A – quarterly status of annual goal
Total (Q1 + Q2 + Q3)	**2,965**	N/A – quarterly status of annual goal

ANALYSIS OF DATA:
From January to March 2016 the number of BIRF reports slightly increased to 1,039 from 1,019 in the previous quarter.

COMMENT ON PERFORMANCE:
On August 31, 2015, the Positive Supports Rule went into effect for 245A licensed services when the services are provided to an individual with a developmental disability. This increased the number of Department of Human Services licensed programs required to report restrictive procedures via the Behavior Intervention Report Form by more than 16,000. This quarter, at least 84 behavior intervention reports were received from this additional cohort of providers.

If the trend for the first three quarters continues, DHS expects to meet the 2016 annual goal of reducing reports by 409.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL THREE: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[v], with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport).

- **By December 31, 2019 the emergency use of mechanical restraints will be reduced to ≤ 93 reports and ≤ 7 individuals.**

2016 Goal

- By June 30, 2016, reduce mechanical restraints to no more than
  - **369** reports of mechanical restraint
  - **25** individuals approved for emergency use of mechanical restraint

Baseline: From July 2013 - June 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals.

RESULTS:
The goal for number of reports is not on track to meet the 2016 goal. The number of individuals is on track to meet the 2016 goal.

Time period	Number of Reports during the time period	Number of individuals at end of time period
2015 Annual - July 2014 – June 2015	912	21
Quarter 1 (July – September 2015)	144	19
Quarter 2 (October – December 2015)	178	16
Quarter 3 (January – March 2016)	168	16
Total (Q1 + Q2 + Q3)	**490**	---

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ANALYSIS OF DATA:
From January 1, 2016 to March 31, 2016 the number of reports decreased to 168, compared to 178 in the previous quarter. During that same time period, the number of individuals approved for use of mechanical restraint stayed the same at 16.

COMMENT ON PERFORMANCE:
On August 31, 2015, the Positive Supports Rule went into effect for 245A licensed services when the services are provided to an individual with a developmental disability. This increased the number of DHS licensed programs required to report restrictive procedures via the Behavior Intervention Report Form (BIRF) by more than 16,000. In situations where mechanical restraints have been in use, these providers are required to develop a Positive Support Transition Plan within 30 days of the implementation of the Positive Supports Rule, and to phase out the use of mechanical restraints by August 31, 2016.

To continue the use of mechanical restraints beyond the phase out period, a provider must submit a request for the emergency use of these procedures. These requests are reviewed by the Interim Review Panel (IRP) to determine whether or not they meet the stringent criteria for continued use of mechanical restraints. The IRP consists of members with knowledge and expertise in the use of positive supports strategies. The IRP sends its recommendations to the DHS Commissioner's delegate for final review and either time-limited approval or rejection of the request. With all approvals by the Commissioner, the IRP includes a written list of person-specific recommendations to assist the provider reduce the need for use of mechanical restraints. In situations where the IRP feels a license holder needs more intensive technical assistance, phone and/or in-person consultation is provided by panel members.

Of the 168 BIRFs reporting use of mechanical restraint:

- 121 reports involved the 16 people with review by the IRP and approval by the Commissioner for the emergency use of mechanical restraints.
- 26 reports*, involving 6 people, were submitted by providers whose use falls within the phase out period.
- 13 reports* were submitted for one person who was determined by the IRP to apply and use a restraint device on him/herself voluntarily and independently. The IRP continues to monitor this case although the device is not used against the person as a restraint.
- 5 reports*, involving 2 people, came from 2 different providers that were inappropriately using mechanical restraint contrary to Chapter 245D and the Positive Supports Rule. In one case, the provider self-identified the inappropriate use and retrained staff prior to submitting the BIRF. The other provider misunderstood the requirements and immediately stopped use of the device after technical assistance from DHS.
- 3 reports*, involving 3 people, were inaccurately coded and did not involve the use of mechanical restraint by a DHS license holder.

*DHS staff follows up on these reports with a phone call to the license holder to review the reported intervention and provide technical assistance.

With the phase out period coming to an end for providers required to submit BIRFs beginning August 31, 2015, we expect there may be new requests for the emergency use of mechanical restraints by or shortly after September 1, 2016. This may cause the number of people with approval to increase over the next few reporting periods.

At the end of the third quarter, we have already received 490 reports of mechanical restraint, which surpasses the annual goal of ≤ 369 reports. DHS will not meet the 2016 annual goal. DHS is currently on pace to see 652 reports of mechanical restraint use in Fiscal Year 2016. If this trend holds, it will represent about a 28% reduction in reports of mechanical restraint use compared to Fiscal Year 2015 (912 reports), although a 40% reduction was required to meet this year's annual goal.

The number of people for whom the emergency use of mechanical restraint is approved during the quarter continues to hold at 16, which is on pace to meet the 2016 goal of no more than 25 people approved for these interventions.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

CRISIS SERVICES GOAL THREE: By June 30, 2017, the number and percent of people who discontinue waiver services after a crisis will decrease to 45% or less. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.)

2016 Goal

- By June 30, 2016, the number will decrease to **no more than 55 people** (percent will adjust in relation to total number served in FY 16).

Baseline: State Fiscal Year 2014 baseline of 62 people who discontinued waiver services (3% of the people who received crisis services through a waiver).

RESULTS:
The results on the annual goal will be reported in May 2017.

Time period	Number of People Who Discontinued Disability Waiver Services After a Crisis
2015 Annual (July 2014 – June 2015)	54 (unduplicated)
Quarter 1 (July 2015 – September 2015)	26 (duplicated)

ANALYSIS OF DATA:
From July to September 2015, the number of people who discontinued disability waiver services after a crisis was 26. The annual number reported represent an unduplicated count of people who discontinue disability waiver services after a crisis in the fiscal year. The quarterly numbers are duplicated. People may discontinue disability waiver services after a crisis in multiple quarters in a year. The quarterly numbers can be used as indicators of direction, but cannot be used to measure annual progress.

COMMENT ON PERFORMANCE:
DHS will continue to monitor and may recommend changing the measure to accurately reflect progress toward the reduction of people who leave community based services after a crisis and remain in segregated settings as a result.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period.

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SEMI-ANNUAL AND ANNUAL GOALS

This section includes reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported on semi-annually or annually as the goal becomes due. Each specific goal includes: the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance.

EMPLOYMENT GOAL THREE: By June 30, 2020, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive, integrated employment will be 763.

2016 Goal

- By June 30, 2016, the number of students with Developmental Cognitive Disabilities (DCD) in competitive, integrated employment will be 125.

Baseline: 2014 group total in competitive, integrated employment = 313 (35%) (N=894)

RESULTS: The 2016 goal was met.

Time period	Number of students with DCD, ages 19-21 that enter into competitive, integrated employment
October 2015 to June 2016	137

ANALYSIS OF DATA:
During the 2015 - 2016 school year, 137 students (73 males and 54 females) ranging in ages from 19-21 with developmental cognitive disabilities, participated in competitive, integrated employment. All students worked part-time vs. full-time as their primary job is that of being a secondary student. Students were employed in a variety of businesses with wages ranging from $9.00 to $12.50 an hour. Students received a variety of supports including: employment skills training, job coaching, interviewing skill development, job placement and the provision of bus cards.

COMMENT ON PERFORMANCE:
In the fall of 2015, sixteen local education agencies were identified to be a part of the Employment Capacity Building Cohort (ECBC). Districts reached out to their local vocational rehabilitation supervisors/counselors and county level supervisors/case-managers from disability services to become a part of their local team.

The ECBC teams have experienced an increase in coordination of employment activities between DEED, DHS and MDE. Evidence-based practices such as benefits education and planning, student-centered planning including informed choice, and engaging youth in paid work before exiting from school have proven successful in assisting 137 youth with developmental cognitive disabilities reach competitive, integrated employment. Three additional district teams have been invited to the ECBC for the 2016-2017 school years.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported two months after the end of the reporting period.

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COMMUNITY ENGAGEMENT GOAL ONE: By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992.

A) By June 30, 2019 the number of self-advocates will increase to 1,575.

B) By June 30, 2019, the number of people with disabilities involved in planning publicly funded projects at the subcabinet agency level will increase to 417.

A) SELF ADVOCATES

2016 Goal

- By June 30, 2016, the number of self-advocates will increase by 50 for a total of 1,250.

Baseline: There are 1,200 active self-advocates involved in the Self Advocates Minnesota (SAM) network statewide and participating in Tuesdays at the Capitol.

RESULTS: The 2016 goal was met.

Time period	Number of new self-advocates
July 2015 – June 2016	**62**

ANALYSIS OF DATA:

OIO has engaged with various self-advocate groups and organizations around the state and provided Olmstead 101 workshops to self-advocates, families and providers. OIO is working with Advocating for Change Together (ACT), Centers of Independent Living (CILS) and Certified Peer Support Specialists (CPSS) to explore the issues of self-advocacy – recruitment, development and training.

- **12** participated in Leading Transportation Access training.
- **28** participated in ACT's Olmstead Academy program.
- **6** joined the Self-Advocates Minnesota (SAM) Leadership Circle.
- **10** committed to an 18 month process to host the 2017 State Self-Advocacy conference.
- **3** assisted with the exploration of creating a Medicaid billable peer-to-peer support program.
- **3** were certified by ACT to co-facilitate peer to peer trainings to help people working in segregated settings understand their options for alternative employment.

COMMENT ON PERFORMANCE:

It was extremely beneficial and effective to collaborate with various groups, i.e., ACT, SAM, CIL, and CPSS to support recruitment, development and training opportunities for self-advocates. The last six months was focused on fact finding and analyzing needs assessments. The data shares that there is a great need for:

- Funding opportunities to support in-depth trainings and promote engagement of Self-Advocates in program/product development and committees.
- Additional support and recognition for self-advocate organizations, including SAM.
- More opportunities for development of structured self-advocacy groups and activities.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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B) PUBLICLY FUNDED PROJECTS

2016 Goal

- By June 30, 2016, the number people with disabilities involved in a publicly funded project will increase by 50 for a total of 92.

Baseline: There were 42 individuals with disabilities involved in planning 6 publicly funded projects.

RESULTS: The 2016 goal was met.

Time period	Number of self-advocates involved in publicly funded projects
July 2015 – June 2016	**56**

ANALYSIS OF DATA:

- Leading in Transportation Access Project included the training of 12 individuals with disabilities.
    - **12** participants filed a complaint with the local sidewalk supervisor and obtained results.
    - **1** is a member of the committee for the new Soccer Stadium.
    - **1** worked with the transportation office in Duluth.

- Advocating Change Together (ACT) Olmstead Academy. After completing the Olmstead Academy, participants are required to carry out their advocacy plan.
    - **28** implemented Disability Integration Projects in their home communities.
    - **10** committed to an 18 month process to host the 2017 State Self-Advocacy conference.
    - **3** assisted with the exploration of creating a Medicaid billable peer-to-peer support program.
    - **3** were certified by ACT to co-facilitate peer to peer trainings to help people working in segregated settings understand their options for alternative employment.

COMMENT ON PERFORMANCE:

OIO has learned that a clearer definition of "publicly funded projects" is necessary. Individuals with disabilities participate in publicly funded projects in different ways. In some projects they lead and some they follow. It is important to recognize that there is an array of publicly funded projects. Some examples of participation may include: community gardening; fishing in a Catfish Derby; competing in a community artwork competition; participating in the development of a new soccer stadium; becoming a co-trainer for peer-to peer training.

OIO is committed to work with the organizations to lead the efforts of increasing participation in publicly funded projects.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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PROPOSED BASELINES AND MEASURABLE GOALS

The August 10, 2015 Olmstead Plan was approved by the Court September 29, 2015. The Plan included four goals that lacked sufficient data to establish baselines and goals. The Plan required these goals to be set at points in the future. Two of these goals were included in the May 2016 Quarterly Report. This section includes the remaining two proposed baselines and measurable goals for Crisis Services 4 and 5.

These proposed baselines and measurable goals were presented to the Subcabinet for review on June 27, 2016 and were provisionally approved. These provisionally approved goals and baselines will be considered as part of the Plan amendment process as described on page 113 of the Olmstead Plan dated June 1, 2016.

CRISIS SERVICES GOAL FOUR: By June 30, 2018, people in community hospital settings due to a crisis, will have appropriate community services within 30 days of no longer requiring hospital level of care and, within 5 months after leaving the hospital, and they will have a stable, permanent home.

Annual Goal

- By February, 2016 a baseline and annual goals will be established

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This measure represents the percent of people on Medical Assistance (MA) who received community services within 30-days after discharge from a hospital due to a crisis. In addition, five months after the discharge date, what percent of people were housed, not housed or in a treatment facility. Because these are two distinct data points, it makes sense to establish separate goals for each.

PROPOSED GOAL A

Proposed Baseline A: In Fiscal Year 2015, 89.21% people received follow-up services within 30-days after discharge from the hospital compared to 88.56% in Fiscal Year 2014.

Proposed Goal A: Increase the percent of people who receive appropriate community services within 30-days after discharge from the hospital. (**Note:** the percent adjusts in relation to the total number of people served in the fiscal year)

- By June 30, 2017, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 90%.
- By June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91%.

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PROPOSED GOAL B

Proposed Baseline B: In Fiscal Year 2015, 81.89% of people discharged from the hospital due to a crisis were housed 5 months after the date of discharge compared to 80.94% in Fiscal Year 2014.

Proposed Goal B: Increase the percent of people who are housed 5 months after discharge from the hospital. (**Note:** the percent adjusts in relation to the total number of people served in the fiscal year)

- By June 30, 2017, the percent of people who are housed 5 months after discharge from the hospital will increase to 83%.
- By June 30, 2018, the percent of people who are housed 5 months after discharge from the hospital will increase to 84%.

Additional Background Information:

Fiscal Year	# of people who went to a hospital due to crisis and were discharged	#/percent who received community services within 30-days after discharge		Number/percent housed within 5 months after hospital discharge						
				Housed	Not housed	Treat-ment facility	Not using public programs	De-ceased	Unable to determine type of housing	Total
2014	14,891	**13,187**	**88.56%**	**12,052**	1,036	832	546	116	309	14,891
				80.94%	6.96%	5.59%	3.67%	0.78%	2.07%	
2015	13,786	**12,298**	**89.21%**	**11,290**	893	672	517	99	315	13,786
				81.89%	6.48%	4.87%	3.75%	0.72%	2.29%	

Rationale:

- This measure represents the percent of people who received community services within 30-days after discharge from a hospital due to a crisis. In addition, five months after the discharge date, the percent of people housed, not housed or in a treatment facility.
- Once the analysis of the data for this goal area was underway it was determined that this goal requires measuring two distinct data points: (A) people who received services in the community after a discharge from the hospital and, (B) those who are housed after a discharge from the hospital.
- DHS looked at the trend data for the past four fiscal years (2012 – 2015) in order to establish the first goal for this measure (number/percent who received community services within 30-days). Trend data from fiscal years 2014 and 2015 was used to establish the goal for the second part of the measure (number/percent housed within 5 months after hospital discharge).
- DHS is not able to obtain person level detail information from hospitals about individuals who no longer meet the hospital level of care, but are not able to discharged because there is no place to discharge to. Without having person level detail data, DHS is unable to track all the components of this measure over time. Additionally, there is no current definition of what permanent, stable housing means and no way to systematically track that within any existing systems.

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Data Limitations

Overall Limitations

- This is a diverse population who are served by a variety of DHS's programs. Some of the people included in this measure receive several services through DHS over long periods of time through programs like the waivers or group residential housing. In these cases, there is quite a lot of data available about them. Others receive more limited services or only use services for a short time. As a result, there is less data available on the types of supports and housing they use.
- The data used to identify where people live come from two different data systems: MMIS and MAXIS. People may have addresses or living situations identified in either or both. Since the systems are used for different purposes and updated at different times, some of the information is conflicting and difficult to interpret.
- Additional data from fiscal years 2012 and 2013 is needed to look at data trends in these areas in order to establish future goals.

Housing Data Limitations

- DHS is most confident in the housing data when it is provided through a DHS program in either MAXIS or MMIS. Information is more limited when DHS is not the payor.
- A housing type field does not exist in either system, so it is often not possible to distinguish details of living situations, such as whether they are permanent or temporary, based on an address.
- Facility information may be different than the resident address in MAXIS or MMIS
- DHS does not have a comprehensive list of facilities where people receive services or reside. In cases where DHS is not paying for services, it may not be possible to determine if someone is housed or not from an individual's home address. Therefore, this group falls into the "unable to determine" category.
- Addresses are not standardized when they are entered into the data systems. This is currently a manual process for standardizing addresses across systems and many are not yet defined.
- In some cases, a variety of different types of services are provided under one address (e.g. supportive housing and emergency shelter). For example, one person may be receiving treatment while another person may be only using temporary shelter at the same location. Some people are no longer using services through DHS five months after their hospital discharge, so it is not possible to identify where they are living.

Explanation of Data for Community services:

- Follow-up services include mental health services, home and community-based waiver services, home care, physician services, pharmacy, and chemical dependency treatment.

- Trend data from the past four fiscal years to support the 1% increase:

Fiscal Year	Number of people who went to a hospital due to crisis and were discharged	Number/percent who received community services within 30-days		Percent change
2012	13,533	11,930	88.15%	
2013	13,638	11,990	87.92%	-0.23%
2014	14,891	13,187	88.56%	0.64%
2015	13,786	12,298	89.21%	0.65%

Settings considered as "housed":

- Housed is defined as a setting in the community where DHS pays for services including ICF/DDs, Single Family homes, town homes, apartments, or mobile homes.

  NOTE: For this measure, settings were not considered as integrated or segregated.

Settings considered as "not housed":

- Not Housed is defined as homeless, correction facilities, halfway house or shelter.

Settings Considered as "treatment facility":

- Treatment facility is defined as institutions, hospitals, mental and chemical health treatment facilities, except for ICF/DDs.

CRISIS SERVICES GOAL FIVE: **By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.**

Annual Goal

- By January 31, 2016, establish a baseline of the length of time it takes from referral for crisis intervention to the initiation of crisis services and develop strategies and annual goals to increase access to crisis services, including specific measures of timeliness.

Proposed Baseline: Between September 1, 2015 and January 31, 2016, the average length of a crisis episode was 81.3 days

Proposed Interim Goal:

- By June 30, 2017, decrease the average length of a crisis episode to **79** days.
- By June 30, 2018, decrease the average length of a crisis episode to **77** days.
- By June 30, 2019, develop and propose a measure that reflects the broader community crisis services and establish a baseline.

Rationale:

Most of the data needed to accurately capture the initiation of crisis services and crisis interventions is collected by other community partners and providers. At this time, the data is not collected systematically or consistently by external partners and providers, so it is not available as a baseline.

As a result, DHS proposes to use an interim measure. The interim measure represents a specific group of people who are referred to DHS because they are in crisis. Generally, this group includes people who have not been able to find other community resources because of their challenging needs, so they are a key target population for the Olmstead Plan. Also, since DHS is helping to serve or coordinate care for them, it is possible to provide consistent, reliable data on the crisis response.

This interim measure focuses on people who are referred to crisis services using the Single Point of Entry (SPE). DHS has established the SPE as part of a continuous improvement project to improve DHS's ability to better respond to requests for assistance in supporting people with disabilities in crisis and to track the coordination of care. Initially, this project is focusing on people with developmental or intellectual disabilities who are in crisis and at risk of losing their current placement.

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Additional Background information

- **Who is included in the measure?**
  This measure represents people who have been referred because they are in crisis. All of the people included have an intellectual or developmental disability and are at risk of losing their current placement.
- **How many people are impacted by this measure?**
  Between September 1, 2015 and January 31, 2016, 26 people were discharged because their crisis was resolved.
- **What does it mean?**
  This measure represents the average length of time it takes to help people who are in crisis to get into a stable situation. Some people may be admitted to a state program while others may be served in the community.
- **How is the data collected?**
  This data is collected in CareManager, a system that is being used by DHS programs to improve collaboration and coordination of assistance for people with disabilities in crisis. DHS programs Minnesota Life Bridge, Community Support Services, Successful Life Project, and the Disability Services Division Community Capacity Building Team use Care Manager to share information about care coordination, services, and responses for people in crisis.

Interim Measure Description

People discharged through CareManager who meet the single point of entry criteria September 2015 – January 2016			
Reason for discharge	**Number of episodes**	**Average length of episode (days)**	**Number of people**
Crisis Resolved	29	81.3	26

Data Limitations:

- CareManager is a new system that was implemented in August 2015. As a result, the data may still be in flux as staff continue to learn the system and new protocols and procedures for information entry continue to evolve.
- Data for this interim measure is not available prior to August 18, 2015.
- Data on service initiation is limited to individuals served by Direct Care and Treatment crisis programs.
- Currently, it is not possible to directly measure access to services and placement within 10 days within CareManager. People who are referred to the Single Point of Entry receive a range of services; from direct services provided by a DHS program to care coordination with county case managers. Much of this information, especially about services people receive from other providers, is captured in manually entered case notes. At this time, it is not possible to capture it in a consistent format. DHS continues to work with the software vendor to improve the system to capture more refined data for reporting.

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VI. COMPLIANCE REPORT ON WORKPLANS AND MID-YEAR REVIEWS

This section summarizes the monthly review of workplan activities and the mid-year reviews completed by OIO Compliance staff.

WORKPLAN ACTIVITIES

OIO Compliance staff reviews workplan activities on a monthly basis to determine if items are completed, on track or delayed. Any delayed items are reported to the Subcabinet as exceptions. The Olmstead Subcabinet reviews and approves workplan implementation, including workplan adjustments on an ongoing basis.[vi]

The first review of workplan activities occurred in December 2015 and included activities with deadlines through November 30, 2015. Ongoing monthly reviews began in January 2016 and include activities with deadlines through the month prior and any activities previously reported as an exception.

The summary of those reviews are below.

	December 2015	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016	July 2016
Number of workplan activities reviewed during time period	67	49	42	34	30	28	25	53
• Number of activities completed	41	18	24	19	13	15	19	47
• Number of activities on track	19	*25	*10	*10	15	13	5	4
• Number of activities reporting exceptions	7	*6	*8	*5	2	0	1	2
• Number of exceptions requiring Subcabinet action	0	0	0	0	0	0	0	0

*These numbers correctly indicate the number of activities on track and the number of activities reporting exceptions for the months of January, February and March. Those rows were inadvertently transposed in the May 2016 Quarterly Report.

MID-YEAR REVIEW OF MEASURABLE GOALS REPORTED ON ANNUALLY

OIO Compliance staff will complete a mid-year review of all measurable goals that are reported on an annual basis to monitor progress, verify accuracy, completeness and timeliness, and identify risk areas. The OIO Compliance staff will report any concerns identified through these reviews to the Subcabinet. Commentary or corrective actions as directed by the Subcabinet will be included in the quarterly report following the action.

Mid-year reviews conducted in June and July found no exceptions.

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VII. ADDENDUM

There is no addendum to this quarterly report.

ENDNOTES

[i] This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options also reported under Housing Goal One.
[ii] A baseline is not available because there is no standardized informed choice process currently in place to determine how many individuals in segregated settings would choose or not oppose moving to an integrated setting. Once this baseline is established, the goals will be re-evaluated and revised as appropriate.
[iii] Transfers refer to individuals exiting segregated settings who are not going to an integrated setting. Examples include transfers to chemical dependency programs, mental health treatment programs such as Intensive Residential Treatment Settings, nursing homes, ICFs/DD, hospitals, jails, or other similar settings. These settings are not the person's home, but a temporary setting usually for the purpose of treatment.

[iv] As measured by monthly percentage of total bed days that are non-acute. Information about the percent of patients not needing hospital level of care is available upon request.
[v] Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.
[vi] All approved adjustments to workplans are reflected in the Subcabinet meeting minutes, posted on the website, and will be utilized in the annual workplan review and adjustment process.

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[AGENDA ITEM 6b]

Workplan Compliance Report for August 2016

Total number of workplan activities reviewed	30	
• Number of activities completed	23	77%
• Number of activities on track	6	20%
• Number of activities reporting exceptions	1	3%

Exception Reporting

Workplan Activity, Deadline and Description	Status Reported	Description of Exception	Sponsor/Lead Exception Report (Reason, Plan, Action needed)
Crisis Services 3B.2 Deadline: July 31, 2016 Begin enrollment of individuals with disabilities on release from Department of Corrections in Forensic Assertive Community Treatment (FACT) team services	Delayed. Screening has occurred for two potential FACT clients. It is anticipated there will be some officially enrolled clients in August, but as of August 4, 2016 no clients were enrolled in FACT. Some of the delay is attributed to the difficulty getting a psychiatrist with experience in the criminal justice system on board due to workforce shortages.	Missed Deadline	DHS – Erin Sullivan Sutton **Reason for Exception:** This delay is attributed to workforce shortages in the direct care industry and timing of release dates of eligible consumers**.** **Plan to Remedy:** • Employees of the FACT team will start full-time the week of August 29, 2016. • There are 4 current referrals. 3 of the 4 referrals have anticipated releases in late August/early September. • The plan would be to admit during the transition to the community by **September 30, 2016.** **Subcabinet action needed:** No subcabinet action is recommended at this time.

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[AGENDA ITEM 6c]

ADJUSTMENTS NEEDED TO WORKPLAN ACTIVITIES – AUGUST 2016
(Adjustments indicated below in **Bold Red text**)

Workplan activity, deadline and description	Sponsor, Reason for Adjustment, Adjustment Needed
Crisis Services 2A.2 – 2A.4 • 2A.2: Use collected data to design pilot project plan for school year (2016-2017) by **September 30, 2016**. • 2A.3: Conduct pilot project in school year 2016-17 by **June 30, 2017** • 2A.4: Statewide scale-up using lessons learned in the pilot. This will include recruitment of racially and ethnically diverse service providers by **September 1, 2017**.	DHS - Erin Sullivan Sutton **Adjustments Needed:** • 2A.2: Move deadline from 9/30/2016 to **12/31/16**. • 2A.3: Conduct pilot project ~~in school year 2016-17~~ **from 1/2017 to 12/2017** by ~~6/30/2017~~ 12/31/17. • 2A.4 – Move deadline from 9/1/17 to **9/1/18**. **Reason for Adjustments:** Data collected in the last school year, from metropolitan area crisis response teams and the intermediate school districts they serve, demonstrated the need for increased coordination across local crisis response providers and systems (e.g. law enforcement, schools, crisis providers) to address the needs of students with complex disabilities in crisis. It is important to note that intermediate school districts do not exist in Greater Minnesota, where students with complex disabilities are served in small school districts and cooperative districts. The unique needs of students with complex disabilities residing in Greater Minnesota and attending these school districts should be considered for purposes of initially designing a model system of local crisis services for statewide scale up. The pilot for serving students with complex disabilities attending *independent school districts* in the metro area and Greater Minnesota is projected to start in January 2017. In order to obtain a sufficient amount of valid data the collection period would span from January 2017- December 2017. The statewide scale-up would begin in September 2018 at the beginning of the school year to allow adequate time for data review and local level planning between various crisis response services partners.

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Workplan activity, deadline and description	Sponsor, Reason for Adjustment, Adjustment Needed
Crisis Services 2J.3 • 2J.3: Develop 20 additional crisis respite beds by **August 31, 2016**	DHS - Erin Sullivan Sutton **Adjustment Needed** to Activity and Deadline: • 2J.3: ~~Develop~~ **Award license capacity for** 20 additional crisis respite beds by ~~8/31/2016~~ **12/31/2016.** **Reason for Adjustment:** An RFP to develop up to 40 new crisis respite beds was issued on April 18, 2016, with proposals due by May 27, 2016. Based on the responses received, 7 new crisis respite beds have been awarded. DHS is revising and will issue another RFP to develop additional crisis respite capacity, expanding eligibility to providers of CADI and BI waiver participants, and incorporating feedback received from providers as to what they viewed as barriers to responding to the first RFP.

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[AGENDA ITEM 7a1]

Community Engagement Advisory Group Proposal

What is the Community Engagement Advisory Group?

The Community Engagement Advisory Group partners individuals with disabilities with the staff of the Olmstead Implementation Office and the Olmstead Subcabinet to provide guidance for the Olmstead Plan. As part of this Community Engagement Advisory Group process, individuals with disabilities and their families are invited to serve on various committees, work groups and focus groups related to the Olmstead Plan to ensure that the individuals with disabilities' point of view, perspective, and experience are not only heard, but also integrated into the planning, development and quality assurance that are embedded in the philosophy of Olmstead to ensure high-quality, highly-engaged, person-centered Plan. Through their unique perspectives, they give input and voice on issues that impact their quality of lives as well as the next individual's life.

What Is the Mission of the Advisory Group?

The Community Engagement Advisory Group will provide guidance to the Olmstead Subcabinet regarding the Olmstead Plan utilizing the values of person-centered philosophy and community engagement.

The definition of guidance will be refined after year one. Year one's strategic focus includes:

1. Define and strengthen community engagement with State Agencies/OIO impacting the Olmstead Plan.
2. Promote the Quality of Life Survey
3. Communication plan for diverse communities with disabilities
4. Guide public input processes for Amending and Expanding the Olmstead Plan

Who is the Advisory Group advising?

The Olmstead Advisory Group advises the Olmstead Implementation Office and the Olmstead Subcabinet.

Benefits of a Community Engagement Advisory Group:

For the Olmstead Implementation Office and the Subcabinet

- Provide an effective strategy for receiving and responding public input.
- Result in more efficient, engaged planning to ensure that goals and work plan strategies really meet the needs and priorities of individuals with disabilities`.
- Lead to increased understanding, communications and engagement between individuals with disabilities, families and state leaders
- Transform the culture toward person-centered planning
- Develop opportunities to embed Olmstead philosophy
- Strengthen community relations
- Recognize and embrace that community engagement is hallmark for Olmstead Plan's success.

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For Individuals with Disabilities

- Gain a better understanding of the Olmstead Plan.
- Appreciate being listened to and having their opinions valued.
- Become advocates for individuals with disabilities in their community.
- Understand how to become an active participant in the planning, development and evaluation of the Olmstead Plan.
- Develop relationships with members of advisory group and Olmstead leaders.
- Provide an opportunity to build leadership and other new skills.

It is about Embracing Change

- Involves a cultural shift.
- Hearing about requirements and expectations of individuals with disabilities.
- Listening to stories of individuals with disabilities and their families.
- Altering expectations of Olmstead leaders and our government.
- Becoming comfortable with uncertainty.
- Honoring each other's expertise.
- Understanding . . . Then bridging the gap.

Community Engagement Advisory Group Makes Sense

- Need is for real time, ongoing feedback into Olmstead Plan's development and implementation.
- More than just a snapshot!
- Olmstead Plan needs to be driven by individuals with disabilities.

The Voice of Individuals with Disabilities Can Make a Difference

- Increase community engagement.
- Improve equity and person-centeredness.
- Improve the experience for individuals with disabilities.
- Increase support and alliances for state leadership.

Tapping into Olmstead Vision Statements and Principles – Person Centered Philosophy and Community Engagement

OLMSTEAD SUBCABINET

> **Vision Statement:** *People with disabilities are living, learning, working, and enjoying life in the most integrated setting.*

In January of 2015, Governor Dayton issued a new Executive Order (15-03) that articulated the role of the subcabinet in more detail. Among other things, the order directed the subcabinet to

oversee and monitor Plan implementation and modification; to appoint an Executive Director of the OIO; and to develop a quality improvement plan.
The Executive Order further directed the subcabinet to adopt procedures that would include clarifying and defining the role of the OIO. Accordingly, in March 2015, the subcabinet adopted procedures that established a dual role for the OIO: (1) quality assurance and accountability, including compliance evaluation, verification and oversight; and (2) engagement with the community, especially people with disabilities, including on-going management of communications and the Quality of Life survey.

PERSON-CENTERED

> **Vision Statement:** *People with disabilities will decide for themselves where they will live, learn, work, and conduct their lives. The individual will choose the services to support these decisions through a planning process directed by the individual or the individual's representative, that discovers and implements what is important to the person and for the person and is meant to improve the person's quality of life. People with disabilities will receive information about the benefits of integrated settings through visits or other experiences in such settings and will have opportunities to meet with other people with disabilities who are living, working, learning and receiving services in integrated settings.*

Person-Centered is a fundamental principle that government and service providers begin by listening to individuals about what is important to them in creating or maintaining a personally-valued, community life. Planning of supports and services is not driven or limited by professional opinion or available service options but focused on the person's preferences and whole life context.

The Minnesota Olmstead Plan sees person-centered planning as foundational to overcoming system biases and supporting peoples' ability to engage fully in their communities. The following definition is meant to help providers, families, communities and individuals in understanding what qualifies as a person-centered plan in the Olmstead Plan. It is recognized that people may choose different levels of responsibility in the planning process, from taking complete charge of their own planning, service arrangements and budgets to relying on a designated representative or family member to assist them.

COMMUNITY ENGAGEMENT

> **Vision Statement:** *People with disabilities will have the opportunity to fully engage in their community and connect with others in ways that are meaningful and aligned with their personal choices and desires.*

In the Olmstead decision, the U.S. Supreme Court ruled that states must eliminate unnecessary segregation of persons with disabilities and ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

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Community engagement is one way to measure the level of integration. All Americans have a right to engage in activities of their choosing that help them connect with other people and give them greater control over their lives, such as building friendships and relationships with people they choose, joining a faith community, volunteering or taking on a leadership role with a neighborhood organization, attending cultural events, or participating in community decision-making (for example, voting).

The principles of the Community Engagement Advisory Group can be defined as it applies to all individuals with any disabilities, all ages and all of Minnesota. Some basic principles included as well:

- **Dignity and Respect**. Olmstead leaders will listen and honor people with disabilities' perspectives and choices. Their knowledge, values, beliefs, and cultural backgrounds will be included into the planning, development and implementation of the Olmstead Plan.
- **Information Sharing.** Olmstead Implementation Office and the Subcabinet will communicate and engage with people with disabilities to ensure informed decisions and participation is happening effectively.
- **Engagement.** Individuals with disabilities are encouraged and supported in participating in planning, developing and implementing the Olmstead plan at the level they choose.
- **Person-Centered.** The Olmstead leaders will listen to individuals about what is important to them in creating or maintaining a personally-valued, community life.
- **Collaboration.** Individuals with disabilities, families and Olmstead leaders will collaborate in policy and program development, implementation and evaluation of the Olmstead Plan.

How Do We Make Sure People Don't Get Confused with the Olmstead Subcabinet?

The Olmstead Implementation Office will be the Community Engagement Advisory Group's sponsor and will develop a charter (work plan) with a clear communication plan that describes the purpose and scope of work for the Community Engagement Advisory Group. The charter will also include the roles of the members, goals, tasks and timelines. The Communications/Community Engagement Specialist will serve as the Liaison/Coordinator for the Advisory Group.

The following definition of Workgroups is extracted from the Olmstead Subcabinet procedures.

> **C. WORKGROUPS**
>
> The Subcabinet may convene workgroups consisting of consumers, their families, advocacy organization, service providers, and/or other governmental entities. Workgroups may include members of the Subcabinet. Each workgroup shall develop a charter that describes the scope of its work, and shall report regularly to the Subcabinet if directed.

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[AGENDA ITEM 7a1]

Advisory Group Structure Considerations

- Composition should reflect various constituencies
- Size: 7 – 11 members
- Other state agency leaders/staff encouraged periodically to attend as guests
- Establish terms of membership
- Quarterly meetings
- OIO Staff liaisons
- Chair or co-chairs
- Establish agenda in conjunction with staff liaison
- Application process for selection of members by the Subcabinet

What Will the Community Engagement Advisory Group Do? How Will Those Tasks Intersect with the Olmstead Subcabinet?

The Olmstead Implementation Office will propose a charter, initial work plan and an application process for the Advisory Group to the Subcabinet for approval. The Community Engagement Advisory Group work plan will define the tasks. Additional tasks may also be assigned to the Advisory Group by the Olmstead Subcabinet or the Implementation Office. The work plan will be evaluated or revised on yearly basis. The work plan will be treated similar to the Olmstead Plan's work plans. Regular reports will be made to the leadership at the subcabinet meetings.

Timeline

- October 24, 2016: Present Proposed Charter, Work Plan and Application process for new Advisory Group
- November 15, 2016 – December 26, 2016: Post/release application for Advisory Group membership
- January 2017: Select Advisory Group members
- March 2017: Host 1st Advisory Group Meeting (Quarterly Meetings)

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BLACKLINE VERSION indicating updates to

Subcabinet packet of August 15th

Minnesota Olmstead Subcabinet

Quarterly Report on Olmstead Plan Measurable Goals

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REPORTING PERIOD

Data acquired through July 31, 2016

DATE REPORT PRESENTED TO SUBCABINET

August 22, 2016

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I. PURPOSE OF REPORT

This quarterly report to the Court and the public provides the status of work being done by state agencies to implement the Olmstead Plan. As directed by the Court, the goals related to the number of people moving from segregated settings into more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures will be reported in every quarterly report.

Reports are compiled on a quarterly basis. For the purpose of reporting, the measurable goals are grouped in four categories:

1. Movement of people with disabilities from segregated to integrated settings
2. Movement of individuals from waiting lists
3. Quality of life measurement results
4. Increasing system capacity and options for integration

This quarterly report of August 22, 2016 includes data acquired through July 31, 2016. Progress on each measurable goal will be reported either quarterly, semi-annually, or annually in accordance with the Court Orders issued on February 12, 2016 (Doc. 540-2) and June 21, 2016 (Doc. 578).

As required by the Court's June 21, 2016 Order, the annual goals included in this report are those goals for which data is reliable and valid in order to ensure the overall report is complete, accurate, timely, and verifiable. In light of that Order, the following measurable goals will be reported in future quarterly reports, which will ensure the data is determined to be reliable and valid before it is reported to the Court: Housing & Services Goal One will be reported in the November 2016 quarterly report, and Positive Supports Goals 4 and 5, and Transition Services Goal 4 will be reported in the February 2017 quarterly report.

This quarterly report also includes Olmstead Implementation Office (OIO) compliance summary reports on mid-year reviews of measurable goals, status of workplans, and any adjustments made to workplans.

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II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

This section reports on the progress of five separate Olmstead Plan goals that assess movement of individuals from segregated to integrated settings.

QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

The table below indicates the cumulative net number of individuals who moved from various segregated settings to integrated settings for each of the five goals included in this report. The reporting period for each goal is based on when the data collected can be considered reliable and valid.

Net number of individuals who moved from segregated to integrated settings during the reporting period:		
Setting	**Reporting period**	**Number moved**
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	Oct – Dec 2015	23
• Nursing Facilities	Oct – Dec 2015	231
• Other segregated settings	Next report Feb 2017	Next report Feb 2017
• Anoka Metro Regional Treatment Center (AMRTC)	April – June 2016	27
• Minnesota Security Hospital (MSH)	April – June 2016	20
Net number who moved from segregated to integrated settings		**301~~291~~**

More detailed information for each specific goal is included below. The information includes the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance.

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TRANSITION SERVICES GOAL ONE: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[i] will be 7,138.

Annual Goals for the number of people moving from ICFs/DD, nursing facilities and other segregated housing to more integrated settings are set forth in the following table:

	Baseline Calendar year 2014	June 30, 2015 Goal	June 30, 2016 Goal
A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84
B) Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740
C) Segregated housing other than listed above	Not Available[ii]	50	250
Total		**874**	**1,074**

A) INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (ICFs/DD)

2016 goal

- For the year ending June 30, 2016 the number of people who have moved from ICFs/DD to a more integrated setting will be **84**

Baseline: January - December 2014 = 72

RESULTS:
The goal is on track to meet the 2016 goal of 84.

Time Period	Total number of individuals leaving	(-)Transfers[iii]	(-)Deaths	Net moved to integrated setting
July 2014 - June 2015	158	24	63	**71**
Quarter 1 (July – September 2015)	37	7	14	**16**
Quarter 2 (October – December 2015)	57	11	23	**23**
Totals Q1 + Q2	94	18	37	**39**

ANALYSIS OF DATA:
From October – December 2015, the number of people moving from an ICF/DD to a more integrated setting was 23, which is seven more than the previous quarter. In the first 6 months of state fiscal year 2016, a total of 39 people moved from an ICF/DD to a more integrated setting. This is approximately 46% of the annual goal of 84.

COMMENT ON PERFORMANCE:
The state provides reports to counties about persons in ICFs/DD who are not opposed to moving with community services. As part of the current process, individuals are being asked whether they would like

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to move in the next 12 months. The agency is finding that some individuals who expressed an interest in moving are declining to move in that 12-month timeframe. For those leaving an institutional setting such as an ICF/DD the new reasonable pace standard is to ensure access to waiver services funding within 45 days of requesting community services. DHS monitors and provides technical assistance to counties in providing timely access to the funding and planning necessary to facilitate a transition to community services.

DHS is on track to complete reassessments by December 2016. At that time, we will have up-to-date information to evaluate the goals about who would like to move (not opposed to moving), what people want and will have worked with counties to identify barriers to be addressed.

A person-centered planning, informed choice and transition protocol was introduced in February 2016. Technical assistance through different venues is focused on those who are helping people leaving ICFs/DD. Work is being done to increase education and technical assistance on housing subsidies, methods of working with landlords, and services available to do so.

Several providers have expressed an interest in voluntary closures of ICFs/DD. DHS is working to support the planning process for integrated community service development. These closures would permanently reduce bed capacity.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

B) NURSING FACILITIES

2016 goal

- For the year ending June 30, 2016 the number of people who have moved from Nursing Facilities (for persons with a disability under 65 in facility longer than 90 days) to a more integrated setting will be **740**

Baseline: January - December 2014 = 707

RESULTS:
This goal is on track to meet the 2016 goal of 740.

Time Period	Total number of individuals leaving	(-)Transfers [iii]	(-)Deaths	Net moved to integrated setting
July 2014 – June 2015	1,509	203	527	**779**
Quarter 1 (July – September 2015)	374	23	171	**180**
Quarter 2 (October – December 2015)	511	59	221	**231**
Totals Q1 + Q2	885	82	392	**411**

ANALYSIS OF DATA:
From October – December 2015, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 231, compared to 180 people in the previous quarter. 411 people under the age of 65 have moved to more integrated settings in the first half of state fiscal year 2016. This is more than half of the annual target. If moves continue at approximately the same rate, the 2016 goal of 740 is expected to be met.

COMMENT ON PERFORMANCE:
DHS reviews data and notifies lead agencies of people who have not refused or opposed more integrated options. Lead agencies are expected to work with these individuals to begin to plan their moves. DHS continues to work with partners in other agencies to improve the supply of affordable housing and knowledge of housing subsidies.

Beginning in December 2015, Section 811 rental subsidies became available to some individuals moving from institutional settings.

In July 2016, Medicaid payment for Housing Access Services was~~ill be~~ expanded across waivers. Additional providers will be able to enroll to provide this service. Housing Access Services assists people with finding housing, setting up their new place, including a certain amount of basic furniture, household goods and/or supplies and payment of certain deposits.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported six months after the end of the reporting period.

C) SEGREGATED HOUSING

2016 goal

- For the year ending June 30, 2016 the number of people who have moved from other segregated housing to a more integrated setting will be **250.**

RESULTS:
Reporting for this goal is delayed. The data development for this goal area was not available for the August 2016 Quarterly Report due to limited information technology resources and competing data priorities for other goal areas. OIO Compliance staff are working with DHS to ensure the agency puts the necessary processes and timelines in place so that the data will be collected and verified. It is expected that baseline data and reliable, verified measurements will be available in the February 2017 Quarterly Report.

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TRANSITION SERVICES GOAL TWO: By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[iv] will be reduced to 30% (based on daily average).

2016 goal

- By June 30, 2016 the percent of people at AMRTC awaiting discharge will be **≤ 35%**

Baseline: During the period from July 2014 – June 2015, a change in utilization of AMRTC caused an increase in the percent of the target population to 36%

RESULTS:
The 2016 goal of ≤ 35% was not met.

Time Period	Total number of individuals leaving	(-) Transfers [iii]	(-) Deaths	Net moved to integrated setting	% awaiting discharge
Quarter 1 (July – Sept 2015)	65	41	0	24	40.4%
Quarter 2 (October – Dec 2015)	75	41	0	34	44.9%
Quarter 3 (January – March 2016)	67	38	0	29	46.6%
Quarter 4 (April – June 2016)	74	47	0	27	38.3%
Annual Totals	281	167	0	**114**	**Avg = 42.5%**

ANALYSIS OF DATA:
From April – June 2016, the average percent of people at AMRTC awaiting discharge was 38.3% compared to 46.6% in the previous quarter. Despite the downward trend in the last quarter, the 2016 goal of 35% was not met.

COMMENT ON PERFORMANCE:
When an individual is accused of committing a crime, but is deemed mentally unfit to stand trial, the State of Minnesota sends that person to a mental health facility to receive treatment before eventually standing trial. Today, many of these individuals are cared for in secure treatment centers or at a hospital level of care at Anoka Metro Regional Treatment Center (AMRTC), though they could be served in a less-intensive setting. Having these individuals at AMRTC detracts~~istracts~~ from the target population and~~of~~ the work ~~toward the goal~~ of getting more people out of AMRTC.

In order to make progress on this goal, structural and systemic changes in the mental health system and housing access need to be made. These changes will ensure that individuals exiting AMRTC have integrated living options, and receive timely care.

As part of his Supplemental Budget Proposal to the 2016 Legislature, the Governor proposed the creation of a new, stand-alone Competency Restoration Program (CRP) to treat Minnesotans accused of a crime, and in need of competency restoration. ~~but deemed incompetent to stand trial (this would free up hospital space for Minnesotans who need treatment in a secure setting).~~

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To accomplish this, a third level of state-operated CRP care would be created for individuals needing to be restored to competency. The three levels include:

1) Hospital level of care when clinically indicated (located at AMRTC);
2) A secure setting for restoration located at Minnesota Security Hospital (MSH); and
3) A proposed locked community residential setting.

This third level of care is where the greatest need exists and would greatly reduce the reliance on AMRTC, freeing up much needed hospital beds for individuals needing hospital level of care (approximately 20 hospital beds at Anoka and 10 secure beds at MSH.)

To achieve this third level, an existing program would be closed and the site repurposed. ~~Efforts on~~ A~~a~~ restructuring plan is~~are~~ underway.

To help reduce the number of people awaiting discharge, AMRTC staff use management tools to be proactive about length of stay and prevent unnecessary delays. Staff track individual cases: anticipated discharge date and barriers to discharge at AMRTC in the seven county metro area, Southeast Minnesota 10 County Region and Southwest Minnesota 18 County Region. AMRTC regularly shares information with and meets with stakeholders to ensure that appropriate and timely discharge planning are in place for individuals served.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

TRANSITION SERVICES GOAL THREE: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month.

2016 goal

- For year ending December 31, 2016 the average monthly number of discharges will increase to **≥ 11**

Baseline: From January – December 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) was 9 individuals per month.

RESULTS:
The goal is not on track to meet the 2016 goal.

Time period	Total number of individuals leaving	Transfers [iii]	Deaths	Net moved to integrated setting
January – December 2015	188	107	8	73 Average = 6.1
Quarter 1 (January – March 2016)	40	23	1	16 Average = 5.3
Quarter 2 (April – June 2016)	47	26	1	20 Average = 6.7
Totals (Q1 + Q2)	87	49	2	**36** **Average = 6**

ANALYSIS OF DATA:
From April – June 2016, the monthly average number of discharges from MSH to a more integrated setting was 6.7 compared to 5.3 in the previous quarter. During the same period, the monthly average total number of discharges from MSH was 15.66.

COMMENT ON PERFORMANCE:
To help increase the number of individuals leaving MSH staff conducted the following activities:

- **County Collaboration**
  Current efforts to increase the number of transitions include working with the counties, in particular, Hennepin and Ramsey Counties, to increase the number of providers that are willing and able to serve individuals transitioning into the community from MSH. Hennepin County completed a Request for Interest, hired a transitions coordinator to assist with new developments, and expanded their forensic case management division by 2 licensed social workers.

  MSH continues to participate in quarterly collaboration meetings with Hennepin, Dakota and Ramsey counties. The focus is on identifying individuals who are able to be served in more integrated settings, while working to expand community capacity.

- **MSH/DHS Collaboration**
  MSH continues to partner with Whatever It Takes grant recipients to create more opportunities to successfully transition individuals from MSH to the community. The grantees include selected counties and providers.

  MSH has consulted with a variety of DHS divisions to implement~~navigate~~ newer practices, in an effort to expand re-integration options for individuals served. Examples include:
  - Consulted~~Triage~~ with DHS Licensing for newly created, and customized homes, developed by private community-based providers.
  - Considered~~Triage related to~~ developing customized living arrangement for individual, who would receive state-provided staffing (due to unique needs).
  - ~~Triage to identify options to increase~~Considered options for individuals over the age of 65, who only qualify for Elderly Waiver.

  To make a significant impact on the timely re-integration of individuals at MSH to integrated settings requires structural and larger systemic changes, including the following:

- **Competency Restoration Program Recommendations**
  Competency Restoration Program Recommendations are outlined above in report on Transition Services Goal 2.

- **Proposed 2016 Legislative Recommendations**
  The proposed legislative recommendations below were presented by the Bureau of Mediation Services (BMS) workgroup, and passed along to DHS leadership for l~~L~~egislative considerations for 2016. It is believed~~felt~~ that each proposal would contribute to enhanced and more robust service delivery, which would in turn, impact length of stay, and timelier transitioning for individuals to return to a more integrated setting.

- **MSH Staffing Proposal**
  In January 2016, the Bureau of Mediation Services (BMS) aided in the facilitation of a variety of committees, to focus on collaborative problem-solving. DHS has an obligation to serve the people of Minnesota, specifically the most vulnerable individuals. Forensic Services, a division of DHS, is required to provide current, state of the art, evidenced-based treatment for individuals with complicated diagnoses who have been, most often, also involved in the criminal justice system. Many of the individuals served have experienced multiple treatment failures and/or can no longer be accepted for treatment in less restrictive settings. Forensic Services provides secure treatment which assists them in recovery so that they can move back into the community and live meaningful lives.

  MSH staff are highly specialized. Individuals~~People~~ admitted to MSH often have~~The complexity of their~~ mental health~~,~~ and co-occurring disorders ~~associated illness~~ such as chemical dependency, cognitive disabilities, and personality disorders. They may also have~~, and often multiple~~complex medical conditions. ~~health issues,~~Provision of treatment for these individuals requires a professionally trained staff from a variety of clinical backgrounds. ~~Provision of therapeutic treatment has to be driven from clinical staff who understand complicated co-morbid conditions. Best clinical practice to serve patients with illnesses of this acuity strongly suggests that in order for treatment to be effective, it~~Treatment must be individualized and~~but~~ comprehensive. Direct care s~~Staff~~ ~~who provide the 24/7 direct care~~ need ongoing training to ~~continually enhance their skills in working with complex individuals. There is a high need for training that helps~~ build proficiency in de-escalation, and engagement that leads to treatment recovery, and transitions to more integrated settings.

  A "St. Peter Security Hospital Safe Staffing" proposal was submitted to the Legislature. The Legislature did not provide funding to bring staffing levels at MSH up to national standards.

- **Bonding Proposal**
  MSH requires a facility upgrade and renovations, which can provide a safe and therapeutic environment to those served, and contributes to treatment recovery, and transitions to integrated settings. In 2014, lawmakers passed a bonding bill that secured more than $56 million for MSH renovations and a new transition program building, which will add 48 beds to the transition unit and 56 beds to the MSH once construction is finished this fall.

  A bonding proposal of $70.3 million to finish renovations and update MSH was proposed this past session, but was not funded during the regular session.

- **Resident Appropriateness**
  A Bureau of Mediation Services (BMS) sub-committee made legislative recommendations related to Resident Appropriateness. The recommendations reflect the need for additional resources and statutory changes in order to better support the mission of MSH, and specialty services necessary for patients with developmental disabilities and Autism Spectrum Disorder, so they may be diverted (as necessary from a secure treatment setting) and reintegrated to the community in a timely fashion.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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III. MOVEMENT OF INDIVIDUALS FROM WAITING LISTS

This section reports progress on the movement of individuals from the home and community based services waiting lists. A new urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The new system categorizes urgency into three categories including: institutional exit; immediate need; defined need. Reasonable pace standards have been established for each of these categories.

Data was available from the new urgency categorization system beginning in June 2016 to be included in this August 2016 quarterly report. The baseline will be established at the end of the first full year of collecting urgency data in December 2016, and will be included in the February 2017 quarterly report.

WAITING LIST GOAL ONE: By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.

Baseline: As of May 30, 2015, the CADI waiver waiting list was 1,420 individuals.

RESULTS:
The goal appears to be on track to meet the October 1, 2016 goal of eliminating this waiting list.

Time period	Number on CADI waiver waiting list at end of quarter	Change from previous quarter
April – June 2015	1,254	<174>
July – September 2015	932	<322>
October – December 2015	477	<455>
January – March 2016	193	<284>
April – June 2016	7	<186>

ANALYSIS OF DATA:
From April 1 – June 30, 2016, the statewide CADI waiver waiting list decreased to 7 people, compared to 193 people from the previous quarter. Since June 2015 there has been a reduction of 1,247 individuals on the waiting list.

COMMENT ON PERFORMANCE:
During this quarter, DHS contacted lead agencies that had people on a CADI waiver waiting list. DHS provided technical assistance when it was needed in order for lead agencies to eliminate their waiting lists by offering systems guidance and/or making additional funding available.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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WAITING LIST GOAL TWO: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.

Baseline: In April 2015, there were 3,586 individuals on the DD waiver waiting list. (The~~is~~2015 baseline ~~from the June 2016 Plan~~, was based on the previous reporting system and cannot be used for direct comparison with current waiting list data. A new baseline will be established at the end of the first full year of collecting urgency data in December 2016, and will be included in the February 2017 quarterly report.)

RESULTS:
Reporting Period: January – March 2016

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Still on waiting list
Leaving an Institution	14	6 (43%)	7 (50%)	1 (7%)
Immediate Need	93	53 (57%)	30 (32%)	10 (11%)
Defined Need	217	72 (33%)	71 (33%)	74 (34%)
Totals	**324**	**131 (41%)**	**108 (33%)**	**85 (26%)**

ANALYSIS OF DATA:
From January 1 – March 31, 2016, out of 324 individuals on the Developmental Disabilities (DD) waiver waiting list, 131 individuals (41%) had funding approved within 45 days of the assessment date. An additional 108 individuals (33%) had funding approved after 45 days. The total number of individuals assessed between January - March 2016 with an institutional exit, immediate need or defined need that did not have funding in place that are on the DD Waiver waiting list is 85 (26%).

COMMENT ON PERFORMANCE:
DHS is in the midst of implementing a new DD Waiver waiting list categorization system, which bases a person's waiting list status on their urgency of need for waiver services. The previous method of reporting DD waiting list figures is no longer valid and cannot be used for direct comparison with current waiting list data. As a result, DHS is currently in a transition period between the historic DD waiting list and the new urgency definitions.

Currently, lead agencies receive monthly updates of persons on the waiting list, the number of days since the assessment where the waiting list category was determined, and whether reasonable pace standards are met. If reasonable pace standards are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency seeking remediation.

Not all persons who are assessed are included in the above tables. Only individuals who meet the criteria of one of the three urgency categories are included in the table. If an individual's need for services changes, they may request a reassessment or information will be collected during a future assessment.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

DRAFT

WAITING LIST GOAL THREE: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a (b) and 256B.092, subdivision 12(b).

RESULTS:

PERSONS LEAVING AN INSTITUTION

Time Period	Number of people assessed	Still on waiting list
January – March 2016	14	1 (7%)

PERSONS WITH IMMEDIATE NEED

Time Period	Number of people assessed	Still on waiting list
January – March 2016	93	10 (11%)

ANALYSIS OF DATA:
From January – March 2016, 1 person out of 14 remained on the DD waiver waiting list after leaving an institution, and 10 people out of 93 remained the DD waiver waiting list with an immediate need.

COMMENT ON PERFORMANCE:
DHS focused~~s~~ a large amount of ~~waiting list~~ technical assistance on approving waiver funding for persons in the institutional exit and immediate need categories. DHS directly contacted~~s~~ lead agencies if people in these categories had~~ve~~ been waiting longer than 45 days. If the 45-day timeline ~~is goal~~ is not met, DHS explains options available to the lead agency to approve funding for persons in these categories.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

WAITING LIST GOAL FOUR: By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.

RESULTS:
DHS began collecting new DD waiting list data beginning December 1, 2015. As of the date of this report, three years have not passed since this implementation date. This data will be available in December 2018.

DRAFT

WAITING LIST GOAL FIVE: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.

RESULTS:

DEFINED NEED

Time Period	Number of people assessed	Still on waiting list
January – March 2016	217	74 (34%)

ANALYSIS OF DATA:
As of March 31, 2016, the number of people assessed between January 1 – March 31, 2016 with a Defined Need who remained on the Developmental Disabilities waiver waiting list was 74 people.

COMMENT ON PERFORMANCE:
DHS encourages lead agencies to approve funding for persons in the Defined Need category following approval of persons in the institutional exit and immediate need categories and as waiver budget levels ~~capacity~~ allow~~s~~. ~~If a lead agency makes a determination that it does not have sufficient capacity to approve funding for persons in the defined need category,~~ DHS expects the lead agency to maintain a budget reserve of 3% or less pursuant to Minnesota Statute. DHS monitors lead agency waiver budgets and provides projections to lead agencies in order to make this determination.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported four months after the end of the reporting period.

IV. QUALITY OF LIFE MEASUREMENT RESULTS

The 2015 National Core Indicators (NCI) survey results were reported in the May 2016 Quarterly Report. The 2016 NCI survey results will be reported as they become available.

The Quality of Life survey process has been reviewed and approved by the Institutional Review Board (IRB). The Olmstead Implementation Office issued an RFP for the next phase of the survey process. It is anticipated that a provider will be selected during the fall of 2016.

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V. INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

This section reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported in each quarterly report.

PERSON CENTERED PLANNING GOAL ONE: By June 30, 2020, plans for people using disability home and community-based waiver services will meet required protocols. Protocols will be based on the principles of person centered planning and informed choice.

Baseline: During the period July 2014 – June 2015, 38,550 people were served by disability home and community based services. However, a baseline for the current percentage of plans that meet the principles of person centered planning and informed choice needs to be established.

RESULTS:
The Person Centered Planning, Informed Choice and Transition Protocol was approved by the Subcabinet Executive Committee on February 10, 2016. The audit process to measure progress is in place. The first year's data will be used to set a baseline. This baseline will be presented to the Subcabinet at the February 2017 meeting.

Interim quarterly reporting began in May 2016 and includes the total number of cases, the number of cases reviewed, and identification of the counties participating in the audit.

Audit Sample

Time Period	Total Number of Cases (Disability Waivers)	Sample of Cases Reviewed (Disability Waivers)
Quarter 1 (July – September 2015)	617	155
Quarter 2 (October – December 2015)	3,005	432
Quarter 3 (January – March 2016)	9,375	556
Quarter 4 (April – June 2016)	1,762	323
Totals	**14,759**	**1,466**

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Counties Participating in the Audit*

Quarter 1	Quarter 2	Quarter 3	Quarter 4
1. Koochiching	7. Mille Lacs	13. Hennepin	19. Renville
2. Itasca	8. Faribault	14. Carver	20. Traverse
3. Wadena	9. Martin	15. Wright	21. Douglas
4. Red Lake	10. St. Louis	16. Goodhue	22. Pope
5. Mahnomen	11. Isanti	17. Wabasha	23. Stevens
6. Norman	12. Olmsted	18. Crow Wing	24. Grant
			25. Freeborn
			26. Mower
			27. Lac Qui Parle
			28. Chippewa
			29. Ottertail

*Agencies visited are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS)

ANALYSIS OF DATA:
From July 2015 through June 2016, a total of 1,466 case files have been reviewed throughout the disability waiver programs (Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disability Inclusion (CADI) and Developmental Disabilities (DD)) across 29 lead agencies. Lead agencies include counties and tribes.

COMMENT ON PERFORMANCE:
The review process uses multiple methods to gather and review data, such as Medicaid Management Information Systems (MMIS) downloads, review of case files, interviews with agency leadership, and focus groups with agency staff. Part of the onsite activities is case file review, where a sample of case files from each program is reviewed using a sampling strategy prescribed and approved by the Center for Medicare and Medicaid Service (CMS). This sampling methodology allows us to determine the presence or absence of compliance within and across all programs. The purpose of the case file review is to identify areas of non-compliance with technical requirements and to identify tools and practices used by the lead agency that contribute to both strong technical compliance and improved outcomes for individuals, including person-centered practices. The results of case file review are then reported to CMS.

As a result of new regulations such as CMS Home and Community-Based Services (HCBS) Settings Rule, an increased focus has been placed on person-centered practices during this round of Lead Agency Reviews including those required in the Person-Centered, Informed Choice and Transition Protocol. There have been changes and updates to Lead Agency Review protocols to respond to person-centered requirements in order to assure consistent practices across all lead agencies. This includes the evaluation of items in individuals' care plans such as strengths, dreams and aspirations, a person's preference for working, living, and learning and documentation of their satisfaction with services and supports. Once the final analysis is complete, a report is prepared for each lead agency and recommendations are given.

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Of the 11 agencies reviewed in this quarter, all have received recommendations relating to person-centered planning and thinking. Recommendations include:

- Encourage lead agencies to set expectations for the quality and content of support plans.
- Train staff on providing person-centered services.
- Encourage changes in agency practices.
- Encourage changes to how agencies work with community partners.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

POSITIVE SUPPORTS GOAL ONE: By June 30, 2018 the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will decrease by 5% or 200.

2016 Goal

- By June 30, 2016 the number of people experiencing a restrictive procedure will be **reduced by 5% from the previous year or 51 individuals**

Annual Baseline: In 2014 the number of individuals who experienced a restrictive procedure was 1,076.
In 2015 the number of individuals who experienced a restrictive procedure was 867.

RESULTS:
The results on the annual goal will be reported in November 2016.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
Quarter 1 (July - September 2015)	299 (duplicated)	N/A– quarterly status of annual goal
Quarter 2 (October - December 2015)	297 (duplicated)	N/A– quarterly status of annual goal
Quarter 3 (January – March 2016)	348 (duplicated)	N/A– quarterly status of annual goal

ANALYSIS OF DATA:
During January – March 2016, the number of individuals who experienced a restrictive procedure increased by 51 from 297 to 348 compared to the previous quarter.

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COMMENT ON PERFORMANCE:
There were 348 individuals who experienced a restrictive procedure this quarter.

- 314 individuals were only subject to emergency use of manual restraint (EUMR). EUMRs are not prohibited and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.

- 34 individuals experienced restrictive procedures *other than* EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). DHS staff and the Interim Review Panel provide follow up and technical assistance for all reports involving restrictive procedures *other than* EUMR. It is anticipated that focusing technical assistance with this subgroup will reduce the number of individuals experiencing restrictive procedures and the number of reports (see goal 3).

Under the Positive Supports Rule, the upcoming External Program Review Committee (expected to convene by March 2017) has the duty to review and respond to Behavior Intervention Reporting Form (BIRF) reports involving EUMR. It is anticipated the Committee's work will help reduce the larger number of people who experience EUMR through the guidance they will provide to license holders regarding specific uses of EUMR.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL TWO: By June 30, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596.

Annual Goals

- By June 30, 2015 the number of reports of restrictive procedures will be reduced by **430**.
- By June 30, 2016 the number of reports of restrictive procedures will be reduced by **409.**

Annual Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:
The goal is on track to meet the 2016 goal.

Time period	Number of BIRF Reports	Reduction from previous year
2015 Annual (July 2014 – June 2015)	5,124	3,478
Quarter 1 (July – September 2015)	907	N/A – quarterly status of annual goal
Quarter 2 (October – December 2015)	1,019	N/A – quarterly status of annual goal
Quarter 3 (January – March 2016)	1,039	N/A – quarterly status of annual goal
Total (Q1 + Q2 + Q3)	**2,965**	N/A – quarterly status of annual goal

ANALYSIS OF DATA:
From January to March 2016 the number of BIRF reports slightly increased to 1,039 from 1,019 in the previous quarter.

COMMENT ON PERFORMANCE:
On August 31, 2015, the Positive Supports Rule went into effect for 245A licensed services when the services are provided to an individual with a developmental disability. This increased the number of Department of Human Services licensed programs required to report restrictive procedures via the Behavior Intervention Report Form by more than 16,000. This quarter, ~~at least~~ 84 behavior intervention reports were received from this additional cohort of providers.

If the trend for the first three quarters continues, DHS expects to meet the 2016 annual goal of reducing reports by 409.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

POSITIVE SUPPORTS GOAL THREE: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[v], with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport).

- **By December 31, 2019 the emergency use of mechanical restraints will be reduced to ≤ 93 reports and ≤ 7 individuals.**

2016 Goal

- By June 30, 2016, reduce mechanical restraints to no more than
  - **369** reports of mechanical restraint
  - **25** individuals approved for emergency use of mechanical restraint

Baseline: From July 2013 - June 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals.

RESULTS:
The goal for number of reports is not on track to meet the 2016 goal. The number of individuals is on track to meet the 2016 goal.

Time period	Number of Reports during the time period	Number of individuals at end of time period
2015 Annual - July 2014 – June 2015	912	21
Quarter 1 (July – September 2015)	144	19
Quarter 2 (October – December 2015)	178	16
Quarter 3 (January – March 2016)	168	16
Total (Q1 + Q2 + Q3)	**490**	---

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ANALYSIS OF DATA:
From January 1, 2016 to March 31, 2016 the number of reports decreased to 168, compared to 178 in the previous quarter. During that same time period, the number of individuals approved for use of mechanical restraint stayed the same at 16.

COMMENT ON PERFORMANCE:
On August 31, 2015, the Positive Supports Rule went into effect for 245A licensed services when the services are provided to an individual with a developmental disability. This increased the number of DHS licensed programs required to report restrictive procedures via the Behavior Intervention Report Form (BIRF) by more than 16,000. In situations where mechanical restraints have been in use, these providers are required to develop a Positive Support Transition Plan within 30 days of the implementation of the Positive Supports Rule, and to phase out the use of mechanical restraints by August 31, 2016.

To continue the use of mechanical restraints beyond the phase out period, a provider must submit a request for the emergency use of these procedures. These requests are reviewed by the Interim Review Panel (IRP) to determine whether or not they meet the stringent criteria for continued use of mechanical restraints. The IRP consists of members with knowledge and expertise in the use of positive supports strategies. The IRP sends its recommendations to the DHS Commissioner's delegate for final review and either time-limited approval or rejection of the request. With all approvals by the Commissioner, the IRP includes a written list of person-specific recommendations to assist the provider reduce the need for use of mechanical restraints. In situations where the IRP feels a license holder needs more intensive technical assistance, phone and/or in-person consultation is provided by panel members.

Of the 168 BIRFs reporting use of mechanical restraint:

- 121 reports involved the 16 people with review by the IRP and approval by the Commissioner for the emergency use of mechanical restraints.
- 26 reports*, involving 6 people, were submitted by providers whose use falls within the phase out period.
- 13 reports* were submitted for one person who was determined by the IRP to apply and use a restraint device on him/herself voluntarily and independently. The IRP continues to monitor this case although the device is not used against the person as a restraint.
- 5 reports*, involving 2 people, came from 2 different providers that were inappropriately using mechanical restraint contrary to Chapter 245D and the Positive Supports Rule. In one case, the provider self-identified the inappropriate use and retrained staff prior to submitting the BIRF. The other provider misunderstood the requirements and immediately stopped use of the device after technical assistance from DHS.
- 3 reports*, involving 3 people, were inaccurately coded and did not involve the use of mechanical restraint by a DHS license holder.

*DHS staff follows up on these reports with a phone call to the license holder to review the reported intervention and provide technical assistance.

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With the phase out period coming to an end for providers required to submit BIRFs beginning August 31, 2015, we expect there may be new requests for the emergency use of mechanical restraints by or shortly after September 1, 2016. This may cause the number of people with approvals to increase over the next few reporting periods.

At the end of the third quarter, we have already received 490 reports of mechanical restraint, which surpasses the annual goal of ≤ 369 reports. DHS will not meet the 2016 annual goal. DHS is currently on pace to see 652 reports of mechanical restraint use in Fiscal Year 2016. If this trend holds, it will represent about a 28% reduction in reports of mechanical restraint use compared to Fiscal Year 2015 (912 reports), although a 40% reduction was required to meet this year's annual goal.

The number of people for whom the emergency use of mechanical restraint is approved during the quarter continues to hold at 16, which is on pace to meet the 2016 goal of no more than 25 people approved for these interventions.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after the end of the reporting period.

CRISIS SERVICES GOAL THREE: By June 30, 2017, the number and percent of people who discontinue waiver services after a crisis will decrease to 45% or less. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.)

2016 Goal

- By June 30, 2016, the number will decrease to **no more than 55 people** (percent will adjust in relation to total number served in FY 16).

Baseline: State Fiscal Year 2014 baseline of 62 people who discontinued waiver services (3% of the people who received crisis services through a waiver).

RESULTS:
The results on the annual goal will be reported in May 2017.

Time period	Number of People Who Discontinued Disability Waiver Services After a Crisis
2015 Annual (July 2014 – June 2015)	54 (unduplicated)
Quarter 1 (July 2015 – September 2015)	26 (duplicated)

ANALYSIS OF DATA:
From July to September 2015, the number of people who discontinued disability waiver services after a crisis was 26. The annual number reported represent an unduplicated count of people who discontinue disability waiver services after a crisis in the fiscal year. The quarterly numbers are duplicated counts. People may discontinue disability waiver services after a crisis in multiple quarters in a year. The

quarterly numbers can be used as indicators of direction, but cannot be used to measure annual progress.

COMMENT ON PERFORMANCE:
DHS will continue to monitor and may recommend changing the measure to accurately reflect progress toward the reduction of people who leave community based services after a crisis. ~~and remain in segregated settings as a result.~~

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported seven months after the end of the reporting period.

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SEMI-ANNUAL AND ANNUAL GOALS

This section includes reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported on semi-annually or annually as the goal becomes due. Each specific goal includes: the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance.

EMPLOYMENT GOAL THREE: By June 30, 2020, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive, integrated employment will be 763.

2016 Goal

- By June 30, 2016, the number of students with Developmental Cognitive Disabilities (DCD) in competitive, integrated employment will be 125.

Baseline: 2014 group total in competitive, integrated employment = 313 (35%) (N=894)

RESULTS: The 2016 goal was met.

Time period	Number of students with DCD, ages 19-21 that enter into competitive, integrated employment
October 2015 to June 2016	137

ANALYSIS OF DATA:
During the 2015 - 2016 school year, 137 students (73 males and 54 females) ranging in ages from 19-21 with developmental cognitive disabilities, participated in competitive, integrated employment. All students worked part-time because~~vs. full-time as~~ their primary job is that of being a secondary student. Students were employed in a variety of businesses with wages ranging from $9.00 to $12.50 an hour. Students received a variety of supports including: employment skills training, job coaching, interviewing skill development, job placement and the provision of bus cards.

COMMENT ON PERFORMANCE:
In the fall of 2015, sixteen local education agencies were identified to be a part of the Employment Capacity Building Cohort (ECBC). Districts reached out to their local vocational rehabilitation supervisors/counselors and county level supervisors/case-managers from disability services to become a part of their local team.

The ECBC teams have experienced an increase in coordination of employment activities among~~between~~ DEED, DHS and MDE. Evidence-based practices such as benefits education and planning, student-centered planning including informed choice, and engaging youth in paid work before exiting from school have proven successful in assisting 137 youth with developmental cognitive disabilities reach competitive, integrated employment. Three additional district teams have been invited to the ECBC for the 2016-2017 school years.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported two months after the end of the reporting period.

DRAFT

COMMUNITY ENGAGEMENT GOAL ONE: By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992.

A) By June 30, 2019 the number of self-advocates will increase to 1,575.

B) By June 30, 2019, the number of people with disabilities involved in planning publicly funded projects at the subcabinet agency level will increase to 417.

A) SELF ADVOCATES

2016 Goal

- By June 30, 2016, the number of self-advocates will increase by 50 for a total of 1,250.

Baseline: There are 1,200 active self-advocates involved in the Self Advocates Minnesota (SAM) network statewide and participating in Tuesdays at the Capitol.

RESULTS: The 2016 goal was met.

Time period	Number of new self-advocates
July 2015 – June 2016	**62**

ANALYSIS OF DATA:

OIO has engaged with various self-advocate groups and organizations around the state and provided Olmstead 101 workshops to self-advocates, families and providers. OIO is working with Advocating for Change Together (ACT), Centers of Independent Living (CILs~~S~~) and Certified Peer Support Specialists (CPSS) to explore the issues of self-advocacy – recruitment, development and training.

- **12** participated in Leading Transportation Access training.
- **28** participated in ACT's Olmstead Academy program.
- **6** joined the Self-Advocates Minnesota (SAM) Leadership Circle.
- **10** committed to an 18 month process to host the 2017 State Self-Advocacy conference.
- **3** assisted with the exploration of creating a Medicaid billable peer-to-peer support program.
- **3** were certified by ACT to co-facilitate peer to peer trainings to help people working in segregated settings understand their options for alternative employment.

COMMENT ON PERFORMANCE:

It was extremely beneficial and effective to collaborate with various groups, i.e., ACT, SAM, CIL, and CPSS to support recruitment, development and training opportunities for self-advocates. The last six months was focused on fact finding and analyzing needs assessments. The data shares that there is a great need for:

- Funding opportunities to support in-depth trainings and promote engagement of Self-Advocates in program/product development and committees.
- Additional support and recognition for self-advocate organizations, including SAM.
- More opportunities for development of structured self-advocacy groups and activities.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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B) PUBLICLY FUNDED PROJECTS

2016 Goal

- By June 30, 2016, the number people with disabilities involved in a publicly funded project will increase by 50 for a total of 92.

Baseline: There were 42 individuals with disabilities involved in planning 6 publicly funded projects.

RESULTS: The 2016 goal was met.

Time period	Number of self-advocates involved in publicly funded projects
July 2015 – June 2016	**56**

ANALYSIS OF DATA:

- Leading in Transportation Access Project included the training of 12 individuals with disabilities.
    - **12** participants filed a complaint with the local sidewalk supervisor and obtained results.
    - **1** is a member of the committee for the new Soccer Stadium.
    - **1** worked with the transportation office in Duluth.

- Advocating Change Together (ACT) Olmstead Academy. After completing the Olmstead Academy, participants are required to carry out their advocacy plan.
    - **28** implemented Disability Integration Projects in their home communities.
    - **10** committed to an 18 month process to host the 2017 State Self-Advocacy conference.
    - **3** assisted with the exploration of creating a Medicaid billable peer-to-peer support program.
    - **3** were certified by ACT to co-facilitate peer to peer trainings to help people working in segregated settings understand their options for alternative employment.

COMMENT ON PERFORMANCE:

OIO has learned that a clearer definition of "publicly funded projects" is necessary. Individuals with disabilities participate in publicly funded projects in different ways. In some projects they lead and some they follow. It is important to recognize that there is an array of publicly funded projects. Some examples of participation may include: community gardening; fishing in a Catfish Derby; competing in a community artwork competition; participating in the development of a new soccer stadium; becoming a co-trainer for peer-to peer training.

OIO is committed to work with the organizations to lead the efforts of increasing participation in publicly funded projects.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

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PROPOSED BASELINES AND MEASURABLE GOALS

The August 10, 2015 Olmstead Plan was approved by the Court September 29, 2015. The Plan included four goals that lacked sufficient data to establish baselines and goals. The Plan required these goals to be established~~set at points~~ in the future. Two of these goals were included in the May 2016 Quarterly Report. This section includes the remaining two proposed baselines and measurable goals for Crisis Services 4 and 5.

These proposed baselines and measurable goals were presented to the Subcabinet for review on June 27, 2016 and were provisionally approved. These provisionally approved goals and baselines will be considered as part of the Plan amendment process as described on page 113 of the Olmstead Plan dated June 1, 2016.

CRISIS SERVICES GOAL FOUR: By June 30, 2018, people in community hospital settings due to a crisis, will have appropriate community services within 30 days of no longer requiring hospital level of care and, within 5 months after leaving the hospital, and they will have a stable, permanent home.

Annual Goal

- By February, 2016 a baseline and annual goals will be established

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This goal measures two things and will be measured using two separate measures. The first measure (Proposed Goal A) represents the percent of people on Medical Assistance (MA) who received community services within 30-days after discharge from a hospital due to a crisis.

The second measure (Proposed Goal B) ~~In addition, five months after the discharge date,~~includes the~~what~~ percent of people that were housed, not housed or in a treatment facility, five months after their discharge date. See Proposed Goal B below for more information on this measure.~~Because these are two distinct data points, it makes sense to establish separate goals for each.~~

PROPOSED GOAL A

Proposed Baseline A: In Fiscal Year 2015, 89.21% people received follow-up services within 30-days after discharge from the hospital compared to 88.56% in Fiscal Year 2014.

Proposed Goal A: Increase the percent of people who receive appropriate community services within 30-days after discharge from the hospital. (**Note:** the percent adjusts in relation to the total number of people served in the fiscal year)

- By June 30, 2017, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 90%.

- By June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91%.

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PROPOSED GOAL B

Proposed Baseline B: In Fiscal Year 2015, 81.89% of people discharged from the hospital due to a crisis were housed 5 months after the date of discharge compared to 80.94% in Fiscal Year 2014.

Proposed Goal B: Increase the percent of people who are housed 5 months after discharge from the hospital. (**Note:** the percent adjusts in relation to the total number of people served in the fiscal year)

- By June 30, 2017, the percent of people who are housed 5 months after discharge from the hospital will increase to 83%.
- By June 30, 2018, the percent of people who are housed 5 months after discharge from the hospital will increase to 84%.

Additional Background Information:

Fiscal Year	# of people who went to a hospital due to crisis and were discharged	#/percent who received community services within 30-days after discharge (Goal A)		Number/percent housed within 5 months after hospital discharge (Goal B)						
				Housed	Not housed	Treat-ment facility	Not using public programs	De-ceased	Unable to determine type of housing	Total
2014	14,891	**13,187**	**88.56%**	**12,052**	1,036	832	546	116	309	14,891
				80.94%	6.96%	5.59%	3.67%	0.78%	2.07%	
2015	13,786	**12,298**	**89.21%**	**11,290**	893	672	517	99	315	13,786
				81.89%	6.48%	4.87%	3.75%	0.72%	2.29%	

- **"Housed"** is defined as a setting in the community where DHS pays for services including ICFs/DD, Single Family homes, town homes, apartments, or mobile homes. **NOTE:** For this measure, settings were not considered as integrated or segregated.
- **"Not housed"** is defined as homeless, correction facilities, halfway house or shelter.
- **"Treatment facility"** is defined as institutions, hospitals, mental and chemical health treatment facilities, except for ICFs/DD.

Rationale:

- ~~This measure represents the percent of people who received community services within 30-days after discharge from a hospital due to a crisis. In addition, five months after the discharge date, the percent of people housed, not housed or in a treatment facility.~~
- Once the analysis of the data for this goal area was underway it was determined that this goal requires measuring two distinct data points: (A) people who received services in the community after a discharge from the hospital and, (B) those ~~who are~~ housed after a discharge from the hospital.
- DHS looked at the trend data for the past four fiscal years (2012 – 2015) in order to establish the first goal for this measure (number/percent who received community services within 30-days). Trend data from fiscal years 2014 and 2015 was used to establish the goal for the second part of the measure (number/percent housed within 5 months after hospital discharge).

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- DHS is not able to obtain person level detail information from hospitals about individuals who no longer meet the hospital level of care, but are not able to discharged because there is no place available~~to discharge to~~. Without having person level detail data, DHS is unable to track all the components of this measure over time. Additionally, there is no current definition of what permanent, stable housing means and no way to systematically track that number~~within any existing systems~~.

Data Limitations

Overall Limitations

- This is a diverse population ~~who are~~ served by a variety of DHS's programs. Some of the people included in this measure receive several services through DHS over long periods of time through programs like the waivers or group residential housing. In these cases, there is ~~quite~~ a lot of data available about them. Others receive more limited services or only use services for a short time. As a result, there is less data available on the types of supports and housing they use.
- The data used to identify where people live come from two different data systems: MMIS and MAXIS. People may have addresses or living situations identified in either or both. Since the systems are used for different purposes and updated at different times, some of the information is conflicting~~ and difficult to interpret~~.
- Additional data from fiscal years 2012 and 2013 is needed to look at data trends in these areas in order to establish future goals.

Housing Data Limitations

- DHS is most confident in the housing data when it is provided through a DHS program in either MAXIS or MMIS. Information is more limited when DHS is not the payor.
- A housing type field does not exist in either system, so it is often not possible to distinguish details of living situations, such as whether they are permanent or temporary, based on an address.
- Facility information may be different than the resident address in MAXIS or MMIS
- DHS does not have a comprehensive list of facilities where people receive services or reside. In cases where DHS is not paying for services, it may not be possible to determine if someone is housed or not from an individual's home address. Therefore, this group falls into the "unable to determine" category.
- Addresses are not standardized when they are entered into the data systems. This is currently a manual process for standardizing addresses across systems and many are not yet defined.
- In some cases, a variety of different types of services are provided under one address (e.g. supportive housing and emergency shelter). For example, one person may be receiving treatment while another person may be only using temporary shelter at the same location. Some people are no longer using services through DHS five months after their hospital discharge, so it is not possible to identify where they are living.

Explanation of Data for Community services:

- Follow-up services include mental health services, home and community-based waiver services, home care, physician services, pharmacy, and chemical dependency treatment.

- Trend data from the past four fiscal years to support the 1% increase:

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Fiscal Year	Number of people who went to a hospital due to crisis and were discharged	Number/percent who received community services within 30-days		Percent change
2012	13,533	11,930	88.15%	
2013	13,638	11,990	87.92%	-0.23%
2014	14,891	13,187	88.56%	0.64%
2015	13,786	12,298	89.21%	0.65%

~~**Settings considered as "housed":**~~

- ~~Housed is defined as a setting in the community where DHS pays for services including ICF/DDs, Single Family homes, town homes, apartments, or mobile homes.~~

~~**NOTE:** For this measure, settings were not considered as integrated or segregated.~~

~~**Settings considered as "not housed":**~~

- ~~Not Housed is defined as homeless, correction facilities, halfway house or shelter.~~

~~**Settings Considered as "treatment facility":**~~

- ~~Treatment facility is defined as institutions, hospitals, mental and chemical health treatment facilities, except for ICF/DDs.~~

CRISIS SERVICES GOAL FIVE: By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

Annual Goal

- By January 31, 2016, establish a baseline of the length of time it takes from referral for crisis intervention to the initiation of crisis services and develop strategies and annual goals to increase access to crisis services, including specific measures of timeliness.

Proposed Baseline: Between September 1, 2015 and January 31, 2016, the average length of a crisis episode was 81.3 days

Proposed Interim Goal:

- By June 30, 2017, decrease the average length of a crisis episode to **79** days.
- By June 30, 2018, decrease the average length of a crisis episode to **77** days.
- By June 30, 2019, develop and propose a measure that reflects the broader community crisis services and establish a baseline.

Rationale:

Most of the data needed to accurately capture the initiation of crisis services and crisis interventions is collected by other community partners and providers. At this time, the data is not collected systematically or consistently by external partners and providers, so it is not available as a baseline.

As a result, DHS proposes to use an interim measure. The interim measure represents a specific group of people who are referred to DHS because they are in crisis. Generally, this group includes people who have not been able to find other community resources because of their challenging needs, so they are a key target population for the Olmstead Plan. Also, since DHS is helping to serve or coordinate care for them, it is possible to provide consistent, reliable data on the crisis response.

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This interim measure focuses on people who are referred to crisis services using the Single Point of Entry (SPE). DHS has established the SPE as part of a continuous improvement project to improve DHS's ability to better respond to requests for assistance in supporting people with disabilities in crisis and to track the coordination of care. Initially, this project is focusing on people with developmental or intellectual disabilities who are in crisis and at risk of losing their current placement.

Additional Background information

- **Who is included in the measure?**
  This measure represents people who have been referred because they are in crisis. All of the people included have an intellectual or developmental disability and are at risk of losing their current placement.
- **How many people are impacted by this measure?**
  Between September 1, 2015 and January 31, 2016, 26 people were discharged because their crisis was resolved.
- **What does it mean?**
  This measure represents the average length of time it takes to help people who are in crisis to get into a stable situation. Some people may be admitted to a state program while others may be served in the community.
- **How is the data collected?**
  This data is collected in CareManager, a system that is being used by DHS programs to improve collaboration and coordination of assistance for people with disabilities in crisis. DHS programs Minnesota Life Bridge, Community Support Services, Successful Life Project, and the Disability Services Division Community Capacity Building Team use Care Manager to share information about care coordination, services, and responses for people in crisis.

Interim Measure Description

People discharged through CareManager who meet the single point of entry criteria September 2015 – January 2016			
Reason for discharge	**Number of episodes**	**Average length of episode (days)**	**Number of people**
Crisis Resolved	29	81.3	26

Data Limitations:

- CareManager is a new system that was implemented in August 2015. As a result, the data may still be in flux as staff continue to learn the system and new protocols and procedures for information entry continue to evolve.
- Data for this interim measure is not available prior to August 18, 2015.
- Data on service initiation is limited to individuals served by Direct Care and Treatment crisis programs.
- Currently, it is not possible to directly measure access to services and placement within 10 days within CareManager. People who are referred to the Single Point of Entry receive a range of services; from direct services provided by a DHS program to care coordination with county case managers. Much of this information, especially about services people receive from other providers, is captured in manually entered case notes. At this time, it is not possible to capture it in a consistent format. DHS continues to work with the software vendor to improve the system to capture more refined data for reporting.

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VI. COMPLIANCE REPORT ON WORKPLANS AND MID-YEAR REVIEWS

This section summarizes the monthly review of workplan activities and the mid-year reviews completed by OIO Compliance staff.

WORKPLAN ACTIVITIES

OIO Compliance staff reviews workplan activities on a monthly basis to determine if items are completed, on track or delayed. Any delayed items are reported to the Subcabinet as exceptions. The Olmstead Subcabinet reviews and approves workplan implementation, including workplan adjustments on an ongoing basis.[vi]

The first review of workplan activities occurred in December 2015 and included activities with deadlines through November 30, 2015. Ongoing monthly reviews began in January 2016 and include activities with deadlines through the month prior and any activities previously reported as an exception.

The summary of those reviews are below.

	December 2015	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016	July 2016
Number of workplan activities reviewed during time period	67	49	42	34	30	28	25	53
• Number of activities completed	41	18	24	19	13	15	19	47
• Number of activities on track	19	*25	*10	*10	15	13	5	4
• Number of activities reporting exceptions	7	*6	*8	*5	2	0	1	2
• Number of exceptions requiring Subcabinet action	0	0	0	0	0	0	0	0

*These numbers correctly indicate the number of activities on track and the number of activities reporting exceptions for the months of January, February and March. Those rows were inadvertently transposed in the May 2016 Quarterly Report.

MID-YEAR REVIEW OF MEASURABLE GOALS REPORTED ON ANNUALLY

OIO Compliance staff will complete a mid-year review of all measurable goals that are reported on an annual basis to monitor progress, verify accuracy, completeness and timeliness, and identify risk areas. The OIO Compliance staff will report any concerns identified through these reviews to the Subcabinet. Commentary or corrective actions as directed by the Subcabinet will be included in the quarterly report following the action.

Mid-year reviews conducted in June and July found no exceptions.

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VII. ADDENDUM

There is no addendum to this quarterly report.

ENDNOTES

[i] This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options also reported under Housing Goal One.
[ii] A baseline is not available because there is no standardized informed choice process currently in place to determine how many individuals in segregated settings would choose or not oppose moving to an integrated setting. Once this baseline is established, the goals will be re-evaluated and revised as appropriate.
[iii] Transfers refer to individuals exiting segregated settings who are not going to an integrated setting. Examples include transfers to chemical dependency programs, mental health treatment programs such as Intensive Residential Treatment Settings, nursing homes, ICFs/DD, hospitals, jails, or other similar settings. These settings are not the person's home, but a temporary setting usually for the purpose of treatment.

[iv] As measured by monthly percentage of total bed days that are non-acute. Information about the percent of patients not needing hospital level of care is available upon request.
[v] Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.
[vi] All approved adjustments to workplans are reflected in the Subcabinet meeting minutes, posted on the website, and will be utilized in the annual workplan review and adjustment process.

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