

# **Minnesota Olmstead Subcabinet**

## **Quarterly Report on Olmstead Plan Measurable Goals**



### **REPORTING PERIOD**

**Data acquired through October 31, 2017**

### **DATE APPROVED BY SUBCABINET**

**November 27, 2017**

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## I. PURPOSE OF REPORT

This quarterly report provides the status of work being completed by State agencies to implement the Olmstead Plan. 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 includes data acquired through October 31, 2017. Progress on each measurable goal will be reported quarterly, semi-annually, or annually. Reports are reviewed and approved by the Olmstead Subcabinet. After reports are approved they are made available to the public on the Olmstead Plan website at Mn.gov/Olmstead.<sup>i</sup>

This quarterly report also includes Olmstead Implementation Office (OIO) compliance summary reports on the status of workplans.

### EXECUTIVE SUMMARY

This quarterly report covers twenty-six measurable goals.<sup>ii</sup> As shown in the chart below, fourteen of those goals were either met or on track to be met. Nine goals were categorized as not on track, or not met. For those nine goals, the report documents how the agencies will work to improve performance on each goal. Three goals are in process.

Status of Goals - November 2017 Quarterly Report	Number of Goals
Met annual goal	9
On track to meet annual goal	5
Not on track to meet annual goal	2
Did not meet annual goal	7
In Process	3
<b>Goals Reported</b>	<b>26</b>

**Listed below are areas critical to the Plan where measurable progress is being made.**

Progress on movement of people with disabilities from segregated to integrated setting

- More individuals are leaving ICF/DD programs to more integrated settings. After three quarters, 143 individuals left ICF/DD programs to more integrated settings. This exceeds the annual goal of 84.
- More individuals are leaving nursing facilities for more integrated settings. After three quarters, 590 individuals moved from nursing facilities. This is 80% of the annual projected goal.
- More individuals are leaving other segregated settings to more integrated settings. After three quarters, 780 individuals moved from other segregated settings to more integrated settings. This exceeds the annual goal of 400.

- There is an increase in the number of individuals exiting the AMRTC timely. The percent of individuals at the AMRTC who do not need a hospital level of care has trended down over the past three quarters.
- There is an increase in the number of individuals leaving the MSH to a more integrated setting. Over the past two quarters, the average number of individuals leaving to a more integrated setting has increased.

#### Movement of individuals from waiting lists

- There continues to be no need for a waiting list for the CADI waiver. Successful efforts to provide individuals access to the CADI waiver have prevented the need for a waiting list.
- There are fewer individuals waiting for access to a DD waiver. At the end of the current quarter there were 152 individuals on the waiting list compared to 237 the previous quarter.

#### Increasing system capacity and options for integration

- More people gained access to integrated housing. There was an increase of 998 individuals accessing housing or 98% of the annual goal.
- There was an increase in the number of individuals obtaining competitive integrated employment. Over 2,066 individuals found employment exceeding the annual goal of 1,500.
- Fewer people are experiencing the use of emergency use of manual restraint. There was a reduction of 69 individuals or 9% from the previous year.

#### **The following measurable goals have been targeted for improvement:**

- Transition Services Four to increase the percent of individual's transition plans that meet the required protocols.
- Waiting List Three to eliminate the waiting list for persons in the Institutional Exit and Defined Need categories.
- Person Centered Planning One to increase the percent of individual's plans that meet the required protocols.
- Positive Supports Three A to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Housing and Services One to increase the number of individuals living in integrated housing.
- Lifelong Learning and Education Two to increase the number of students with disabilities enrolling in an integrated postsecondary education setting.
- Crisis Services Four A to increase the percent of people housed five months after being discharged from the hospital.

Two goals (Crisis Services One and Two) are included in the Addendum to update data previously reported. The newly reported data provides more complete information. The status of these goals did not change.

## 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)	Jan – March 2017	74
• Nursing Facilities	Jan – March 2017	210
• Other segregated settings	Jan – March 2017	267
• Anoka Metro Regional Treatment Center (AMRTC)	July - August 2017	21
• Minnesota Security Hospital (MSH)	July - August 2017	23
Net number who moved from segregated to integrated settings		495

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<sup>iii</sup> will be 7,138.

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**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:

	2014 Baseline	June 30, 2015	June 30, 2016	June 30, 2017
<b>A)</b> Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84	84
<b>B)</b> Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740	740
<b>C)</b> Segregated housing other than listed above	1,121	50	250	400
<b>Total</b>		<b>874</b>	<b>1,074</b>	<b>1,224</b>

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

**2017 goal**

- For the year ending June 30, 2017 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 2017 goal of 84.

Time period	Total number of individuals leaving	Transfers <sup>iv</sup> (-)	Deaths (-)	Net moved to integrated setting
July 2014 – June 2015	138	18	62	<b>58</b>
July 2015 – June 2016	180	27	72	<b>81</b>
Quarter 1 (July – September 2016)	51	8	9	<b>34</b>
Quarter 2 (October – December 2016)	57	7	15	<b>35</b>
Quarter 3 (January – March 2017)	100	5	21	<b>74</b>

**ANALYSIS OF DATA:**

From January – March 2017, the number of people who moved from an ICF/DD to a more integrated setting was 74. During the first three quarters, 143 individuals moved to a more integrated setting which exceeds the annual goal of 84.

**COMMENT ON PERFORMANCE:**

DHS provides reports to counties about persons in ICFs/DD who are not opposed to moving with community services, as based on their last assessment. As part of the current reassessment process,

individuals are being asked whether they would like to explore alternative community services in the next 12 months. Some individuals who expressed an interest in moving changed their minds, or they would like a longer planning period before they move.

For those leaving an institutional setting, such as an ICF/DD, the Olmstead Plan reasonable pace goal 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.

A Person-Centered Planning, Informed Choice and Transition Protocol was approved by the Olmstead Executive Committee in February 2016. A revision including minor edits was approved by the Olmstead Subcabinet in March 2017. Trainings and presentations are being provided to increase education and technical assistance on housing subsidies, methods of working with landlords, and services available to do so, as well as different services that are available to support people as they move from an ICF/DD to an integrated setting.

DHS continues to work with private providers and Minnesota State Operated Community Services (MSOCS) that have expressed an interest in voluntary closures of ICFs/DD. A total of 11 out of 15 MSOCS ICFs/DD converted since January 2017, for a reduction of 66 state-operated ICF/DD beds. One additional ICF/DD facility, serving two people is scheduled to convert in November 2017. DHS is working with one county to determine whether the state or another provider will serve individuals in three more state-operated ICFs. No timeline for conversion of these homes has been confirmed.

**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.

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## B) NURSING FACILITIES

### 2017 goal

- For the year ending June 30, 2017, 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:

The goal is **on track** to meet the 2017 goal of 740.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
July 2014 – June 2015	1,043	70	224	<b>749</b>
July 2015 – June 2016	1,018	91	198	<b>729</b>
Quarter 1 (July – September 2016)	283	29	53	<b>201</b>
Quarter 2 (October – December 2016)	260	24	57	<b>179</b>
Quarter 3 (January – March 2017)	259	8	41	<b>210</b>

### ANALYSIS OF DATA:

From January – March 2017, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 210. This is 31 more people than in the previous quarter. During the first three quarters, 590 individuals moved to a more integrated setting, which is 80% of the annual goal of 740.

### COMMENT ON PERFORMANCE:

DHS reviews data and notifies lead agencies of people who accepted or did not oppose a move to 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.

In July 2016, Medicaid payment for Housing Access Services was expanded across waivers. Additional providers are now able to enroll to provide this service. Housing Access Services assists people with finding housing and 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.



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## C) SEGREGATED HOUSING

### 2017 goal

- For the year ending June 30, 2017, the number of people who have moved from other segregated housing to a more integrated setting will be **400**.

**INTERIM BASELINE:** During July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to a more integrated setting. A standardized informed choice process is being implemented. When data from this process is deemed reliable and valid, baseline and goals will be re-evaluated and revised as appropriate.

### RESULTS:

The goal is **on track** to meet the 2017 goal of 400.

Time period	Total moves	Receiving Medical Assistance (MA)			
		Moved to more integrated setting	Moved to congregate setting	Not receiving residential services	No longer on MA
July 2014 – June 2015	5,703	<b>1,137 (19.9%)</b>	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
July 2015 – June 2016	5,603	<b>1,051 (18.8%)</b>	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
Quarter 1 (July – September 2016)	1,254	<b>245 (19.5%)</b>	99 (7.9%)	790 (63%)	120 (9.6%)
Quarter 2 (October – December 2016)	1,313	<b>268 (20.4%)</b>	128 (9.8%)	817 (62.2%)	100 (7.6%)
Quarter 3 (January – March 2017)	1,463	<b>267 (18.2%)</b>	131 (9%)	936 (64%)	129 (8.8%)

### ANALYSIS OF DATA:

From January – March 2017, of the 1,463 individuals moving from segregated housing, 267 individuals (18.2%) moved to a more integrated setting. During the first three quarters, 780 individuals moved to a more integrated setting which exceeds the annual goal of 400.

### COMMENT ON PERFORMANCE:

There were significantly more individuals who moved to more integrated settings in this quarter (18.2%) than who moved to congregate settings (9%). This analysis also illustrates the number of individuals who are no longer on MA and who are not receiving residential services as defined below.

The data indicates that a large percentage (64%) of individuals who moved from segregated housing are not receiving publicly funded residential services. Based on trends identified in data development for Crisis Services Goal Four, it is assumed the majority of those people are housed in their own or their family's home and are not in a congregate setting.

### COMMENT ON TABLE HEADINGS:

The language below provides context and data definitions for the headings in the table above.

**Total Moves:** Total number of people in one of the following settings for 90 days or more and had a change in status during the reporting period:

- Adult corporate foster care
- Supervised living facilities
- Supported living services (DD waiver foster care or in own home)
- Board and Care or Board and Lodge facilities

Moves are counted when someone moves to one of the following:

- More Integrated Setting (DHS paid)
- Congregate Setting (DHS paid)
- No longer on Medical Assistance (MA)
- Not receiving residential services (DHS paid)
- Deaths are not counted in the total moved column

**Moved to More Integrated Setting:** Total number of people that moved from a congregate setting to one of the following DHS paid settings for at least 90 days:

- Adult family foster care
- Adult corporate foster care (when moving from Board and Care or Board and Lodge facilities)
- Child foster care waiver
- Housing with services
- Supportive housing
- Waiver non-residential
- Supervised living facilities (when moving from Board and Care or Board and Lodge facilities)

**Moved to Congregate Setting:** Total number of people that moved from one DHS paid congregate setting to another for at least 90 days. DHS paid congregate settings include:

- Board and Care or Board and Lodge facilities
- Intermediate Care Facilities (ICFs/DD)
- Nursing facilities (NF)

**No Longer on MA:** People who currently do not have an open file on public programs in MAXIS or MMIS data systems.

**Not Receiving Residential Services:** People in this group are on Medical Assistance to pay for basic care, drugs, mental health treatment, etc. This group does not use other DHS paid services such as waivers, home care or institutional services. The data used to identify moves comes from two different data systems: Medicaid Management Information System (MMIS) and MAXIS. People may have addresses or living situations identified in either or both systems. DHS is unable to use the address data to determine if the person moved to a more integrated setting or a congregate setting; or if a person's new setting was obtained less than 90 days after leaving a congregate setting.

Based on trends identified in data development for Crisis Services Goal Four, it is assumed the majority of these people are housed in their own or their family's home and are not in a congregate setting.

#### **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.

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**TRANSITION SERVICES GOAL TWO:** By June 30, 2019, the percent of people under mental health commitment 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<sup>y</sup> will be reduced to 30% (based on daily average). [Revised in February 2017]

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**2018 goal**

- By June 30, 2018, the percent of people at AMRTC awaiting discharge will be ≤ 32%

**Baseline:** From July 2014 - June 2015, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 36% on a daily average.<sup>1</sup>

**RESULTS:**

This goal is **not on track** to meet the 2018 goal of ≤ 32%.

Time period	Percent awaiting discharge (daily average)	
July 2015 – June 2016	Daily Average = 42.5% <sup>2</sup>	
	Mental health commitment	Restore to competency
Quarter 1 (July – September 2016)*	40.5%	33.0%
Quarter 2 (October – December 2016)*	44.0%	35.1%
Quarter 3 (January – March 2017)	50.9%	28.8%
Quarter 4 (April – June 2017)	44.3%	20.3%
<b>Annual Total (July 2016 – June 2017)</b>	<b>44.9%</b>	<b>29.3%</b>
Quarter 1 (July – September 2017)	34.8%	28.2%

\*Data for July – December 2016 was previously reported as a combined percentage for individuals under mental health commitment and under restore to competency. The goal was revised in February 2017 to include only those under mental health commitment. The data is now being reported separately for each group.

**ANALYSIS OF DATA:**

From July – September 2017, 34.8% of those under mental health commitment at AMRTC no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting.

The percentage of individuals awaiting discharge under mental health commitment decreased from 44.3% in the previous quarter to 34.8% this quarter. The percentage of individuals awaiting discharge under restore to competency increased from 20.3% in the previous quarter 4 to 28.2% this quarter.

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<sup>1</sup> The baseline included individuals at AMRTC under mental health commitment and restore to competency.

<sup>2</sup> The data for July 2015 - June 2016 included individuals at AMRTC under mental health commitment and restore to competency.

From July – September 2017, 21 individuals at AMRTC under mental health commitment left and moved to an integrated setting. The table below provides information about those individuals who left AMRTC. It includes the number of individuals under mental health commitment and under restore to competency who moved to integrated settings.

Time period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moves to integrated setting by	
					Mental health commitment	Restore to competency
Quarter 1 (July - Sept 2016)	61	27	0	34	5	29
Quarter 2 (Oct - Dec 2016)	57	38	1	18	7	11
Quarter 3 (Jan - Mar 2017)	81	53	1	27	18	9
Quarter 4 (April – June 2017)	68	37	0	31	24	7
<b>Annual Totals July 2016 – June 2017</b>	<b>267</b>	<b>155</b>	<b>2</b>	<b>110</b>	<b>54</b>	<b>56</b>
Quarter 1 (July – Sept 2017)	65	35	0	30	21	9

#### COMMENT ON PERFORMANCE:

AMRTC continues to serve a large number of individuals who no longer need hospital level of care, including those who need competency restoration services prior to discharge. There is a higher percentage of individuals awaiting discharge under mental health commitment (34.8%) than those who are at AMRTC under restore to competency (28.2%). Multiple efforts may be contributing to the improvement in percentage of individuals awaiting discharge under mental health commitment from the previous quarter, including an increase in the frequency of collaborative meetings with county partners and improvements in AMRTC's treatment and discharge planning procedures. While the percentage of individuals awaiting discharge has declined, it is difficult to determine whether this is a trend.

It remains unclear why the percentage remains significantly higher for those under mental health commitment. One contributing factor for the growing difference in percentage for those awaiting discharge under restore to competency is the expansion of the Community Competency Restoration Program in St. Peter, allowing for the transfer of individuals at AMRTC who no longer meet hospital level of care criteria resulting in a reduction in the length of stay.

Individuals under mental health commitment have more complex mental health and behavioral support needs. When they move to the community, they may require 24 hour per day staffing or 1:1 or 2:1 staffing. Common barriers that can result in delayed discharges for those at AMRTC include a lack of housing vacancies and housing providers no longer accepting applications for waiting lists.

Community providers often lack capacity to serve individuals who exhibit these behaviors:

- Violent or aggressive behavior (i.e. hitting others, property destruction, past criminal acts);
- Predatory or sexually inappropriate behavior;

- High risk for self-injury (i.e. swallowing objects, suicide attempts); and
- Unwillingness to take medication in the community.

Ongoing efforts are facilitated to improve the discharge planning process for those served at AMRTC:

- Improvements in the treatment planning process to better facilitate collaboration with county partners. AMRTC has increased collaboration efforts to foster participation with county partners to aid in identifying more applicable community placements and resources for individuals awaiting discharge.
- Improvements in AMRTC's notification process for individuals who no longer meet hospital criteria of care to county partners and other key stakeholders to ensure that all parties involved are informed of changes in the individual's status and resources are allocated towards discharge planning.

In order to meet timely discharge, individual treatment planning is necessary for individuals under mental health commitment who no longer need hospital level of care. This can involve the development of living situations tailored to meet their individualized needs which can be a very lengthy process. AMRTC continues to collaborate with county partners to identify, expand, and develop integrated community settings.

DHS is convening a cross-division, cross-administration working group to improve the timely discharge of individuals at MSH and AMRTC to identify: barriers, current and future strategies, and any needed efficiencies that could be developed between AMRTC and MSH to support movement to community. Counties and community providers will be consulted and engaged in this effort as well. DHS will report back to the Olmstead Subcabinet on these efforts annually starting December 31, 2018.

**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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**TRANSITION SERVICES GOAL THREE:** By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital to a more integrated setting will increase to 10 individuals per month. [Revised in February 2017]

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**2017 goal**

- By December 31, 2017 the average monthly number of individuals leaving to a more integrated setting will increase to  $\geq 8$

**Baseline:** From January – December 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) to a more integrated setting was 4.6 individuals per month.

**RESULTS:**

The goal is **not on track** to meet the 2017 goal of 8.

Time period	Total number of individuals leaving	Transfers <sup>iv</sup> (-)	Deaths (-)	Net moved to integrated setting
January – December 2015	188	107	8	73 Average = 6.1
January – December 2016	184	97	3	84 Average = 7.0
Quarter 1 (January – March 2017)	45	22	3	20 Average = 6.7
Quarter 2 (April – June 2017)	51	27	3	21 Average = 7.0
Quarter 3 (July – September 2017)	52	28	1	<b>23 Average = 7.7</b>

**ANALYSIS OF DATA:**

From July – September 2017, the average monthly number of individuals leaving Forensic Services<sup>3</sup> to a more integrated setting was 7.7. The average number moving to an integrated setting increased from 7.0 in Quarter 2 to 7.7 in Quarter 3. Despite the increases in the last two quarters, this goal is not on track to meet the 2017 goal of 8 or more.

Beginning January 2017, Forensic Services began categorizing discharge data into three areas. These categories allow analysis surrounding continued barriers to discharge. The table below provides detailed information regarding individuals leaving Forensic Services, including the number of individuals who moved to integrated settings (under restore to competency, Mentally Ill and Dangerous (MI&D) committed, and Other committed).

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<sup>3</sup> MSH includes individuals leaving MSH, Transition Services, Forensic Nursing Home, and the Competency Restoration Program at St Peter. These four programs are collectively referred to as Forensic Services.

Time period	Type	Total moves	Transfers	Deaths	Moves to integrated
January – December 2015	Restore to competency	99	67	1	31
	MI&D committed	66	24	7	35
	Other committed	23	16	0	7
	<b>Total</b>	<b>188</b>	<b>107</b>	<b>8</b>	<b>(Avg. 6.1) 73</b>
January – December 2016	Restore to competency	93	62	0	31
	MI&D committed	69	23	3	43
	Other committed	25	15	0	10
	<b>Total</b>	<b>187</b>	<b>100</b>	<b>3</b>	<b>(Avg. 7.0) 84</b>
Quarter 1 (Jan – March 2017)	Restore to competency	23	15	1	7
	MI&D committed	19	7	1	11
	Other committed	3	0	1	2
	<b>Total</b>	<b>45</b>	<b>22</b>	<b>3</b>	<b>(Avg. 6.7) 20</b>
Quarter 2 (April – June 2017)	Restore to competency	31	24	1	6
	MI&D committed	16	2	2	12
	Other committed	4	1	0	3
	<b>Total</b>	<b>51</b>	<b>27</b>	<b>3</b>	<b>(Avg. 7.0) 21</b>
Quarter 3 (July – Sept 2017)	Restore to competency	39	24	0	15
	MI&D committed	12	3	1	8
	Other committed	0	0	0	0
	<b>Total</b>	<b>52</b>	<b>27</b>	<b>1</b>	<b>(Avg. 7.7) 23</b>

#### COMMENT ON PERFORMANCE:

MSH, Transition Services, Forensic Nursing Home, and the Competency Restoration Program (CRP) at St. Peter serve different populations for different purposes. Together the four programs are known as Forensic Services. DHS efforts continue to expand community capacity. In addition, Forensic Services continues to work towards the mission of Olmstead through identifying individuals who could be served in more integrated settings.

Legislation this past session increases the base funding to improve clinical direction and support to direct care staff treating and managing clients with complex conditions, some of whom engage in aggressive behaviors. The funding will enhance the current staffing model to achieve a safe, secure and therapeutic treatment environment.

#### MI&D committed and Other committed

MSH and Transition Services primarily serve persons committed as Mentally Ill and Dangerous (MI&D), providing acute psychiatric care and stabilization, as well as psychosocial rehabilitation and treatment services. The MI&D commitment is for an indeterminate period of time, and requires a Special Review Board recommendation to the Commissioner of Human Services, prior to approval for community-based placement (Minnesota Stat. 253B.18). MSH also serves persons under other commitments. Other commitments include Mentally Ill (MI), Mentally Ill and Chemically Dependent (MI/CD), Mentally Ill and Developmentally Disabled (MI/DD).

One identified barrier is the limited number of providers with the capacity to serve:

- Individuals with Level 3 predatory offender designation;
- Individuals over the age of 65 who require either adult foster care, skilled nursing, or nursing home level care;
- Individuals with DD/ID with high behavioral acuity; and
- Individuals who are undocumented.

Ongoing efforts are facilitated to enhance discharges for those served at Forensic Services, including:

- Collaboration with county partners to identify those individuals who have reached maximum benefit from treatment.
- Collaboration with county partners to identify community providers and expand community capacity (with specialized providers/utilization of Minnesota State Operated Community Services).
- Utilization of the Forensic Review Panel, an internal administrative group, whose role is to review individuals served for reductions in custody (under MI&D Commitment), and who may be served in a more integrated setting.
  - The Forensic Review Panel also serves to offer treatment recommendations that could assist the individual's growth/skill development, when necessary, to aid in preparing for community reintegration.
- Collaboration with DHS/Direct Care and Treatment entities to expand community capacity and individualized services for a person's transitioning (Whatever It Takes, Licensing Division, and Disability Services Division).

### **Restore to Competency**

Individuals under competency restoration treatment, Minn. R. Crim. R. 20.01, may be served in any program at Forensic Services. Primarily CRP serves this population, and the majority of individuals are placed under a concurrent civil commitment to the Commissioner, as Mentally Ill. The limited purpose of CRP services is to restore a person's capacity to meaningfully participate in criminal proceedings, and his/her discharge is governed by the criminal court.

Competency restoration treatment may also be paired with a civil commitment of MI&D. These individuals would be served at MSH, and in rare circumstances Transition Services or the Forensic Nursing Home. For this report, the "Restore to Competency" category represents any individual who had been under court ordered competency restoration treatment, though not under commitment as MI&D (as transitions to more integrated settings for those under MI&D requires Special Review Board review and Commissioner's Order).

- All individuals at CRP competency entered the program under "treat to competency" orders.
- Forensic Services has expanded programming to individuals under "treat to competency", by opening a Community Competency Restoration Program in the St. Peter community.
- While AMRTC continues to provide care to those who may be under this legal status, individuals referred to CRP in St Peter are determined to no longer require hospital-level care.

DHS is convening a cross-division, cross-administration working group to improve the timely discharge of individuals at MSH and AMRTC to identify barriers, current and future strategies, and any needed efficiencies that could be developed between AMRTC and MSH to support movement to community.



Counties and community providers will be consulted and engaged in this effort as well. DHS will report back to the Olmstead Subcabinet on these efforts annually starting December 31, 2018.

**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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**TRANSITION SERVICES GOAL FOUR:** By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person-centered planning process that adheres to transition protocols that meet the principles of person-centered planning and informed choice.

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**2017 Goal**

- By June 30, 2017, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person-centered planning and informed choice will increase to 30%.

**Baseline:** From July – September 2016, of the 31 transition cases reviewed, four cases (12.9%) adhered to transition protocols that meet the principles of person-centered planning and informed choice.

**RESULTS:**

The 2017 goal of 30% was **not met**.

Time period	Total number of cases reviewed (disability waivers)	Number of transition cases reviewed (disability waivers)	Number of cases meeting protocols	% of cases meeting protocols
Quarter 1 July – Sept 2016	289	31	4	12.9%
Quarter 2 Oct – Dec 2016	311	23	6	26%
Quarter 3 Jan – March 2017	386	27	2	7%
Quarter 4 April – July 2017	213	34	2	6%
Annual July 2016 – June 2017	1,199	115	14	<b>12.2%</b>

**ANALYSIS OF DATA:**

The DHS Lead Agency Review implemented case file review protocols beginning July 2016 to monitor lead agencies implementation of the Person-Centered, Informed Choice and Transition Protocol. A sample of people who have been identified as having a transition in their living setting were added to the case file review.

During Quarter 4, DHS reviewed 213 case files through the lead agency review process to determine the percent of people choosing to move to a more integrated setting who have a plan that “adheres to transition protocols that meet the principles of person-centered planning and informed choice”. Of these case files, 34 indicated a transition had occurred. Two cases (6%) of the 34 case files met the

criteria of person-centered planning and informed choice. The 2017 annual goal to increase to 30 percent of plans that adhere to transition protocol standards was not met.

#### **COMMENT ON PERFORMANCE:**

The Person-Centered, Informed Choice and Transition Protocols were initiated with lead agencies in July of 2016. Since the lead agency review looks at documentation completed up to 364 days prior to the site visit, reviews through the first three quarters of 2017 included plans that were written before the protocol was issued.

Since July 2016, the Lead Agency Review Team has made recommendations to each county visited on how to improve their person-centered practices. Counties are in varying stages on their person-centered journey. The recommendations encourage lead agencies to set expectations for the quality and content of support plans as well as to seek out and provide training for their staff on providing person-centered practices. This may involve changes in agency practices as well as changes to how agencies work with their community partners.

Beginning in January 2018, DHS will require individual remediation when lead agencies do not comply with the person-centered protocols. When findings from a case file review indicate that files do not contain all required documentation, the agency will be required to bring all cases into full compliance by obtaining or correcting the documentation. All corrections must be made within 60 days of the Lead Agency Review site visits. Corrective action plans will be required when patterns of non-compliance are evident.

Of the seven counties reviewed during this reported time period, 23 of the 34 transition cases used the “My Move Plan” document which includes many of the key elements required. The three counties in the MN Prairie Alliance had 100% compliance with the My Move Plan, while the remaining counties used the document about 50% of the time.

DHS conducted regional day-long training and technical assistance sessions with counties and tribes during May through September 2017. Due to high demand, DHS has scheduled an additional five training sessions through December 2017. A supervisor tool kit is being developed to support counties, tribes and contracted case management providers in the oversight of plan development according to the protocol. The expectation is that the number of plans that adhere to the protocols will increase over time and during 2018.

#### **Criteria used in case file reviews**

The plan is considered to meet the person-centered protocols if all eight items below are present:

1. The support plan describes goals or skills that are related to the person’s preferences.
2. The support plan includes a global statement about the person’s dreams and aspirations.
3. Opportunities for choice in the person’s current environment are described.
4. The person’s current rituals and routines are described.
5. Social, leisure, or religious activities the person wants to participate in are described.
6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.
7. The person’s preferred living setting is identified.
8. The person’s preferred work activities are identified.

The plan is considered to meet the transition protocols if all ten items below (from “My Move Plan” document) are present:

1. Where is the person moving?
2. Date and time the move will occur.
3. Who will help the person prepare for the move?
4. Who will help with adjustment during and after the move?
5. Who will take the person to new residence?
6. How the person will get his or her belongings.
7. Medications and medication schedule.
8. Upcoming appointments.
9. Who will provide support after the move; what they will provide and how to contact those people (include informal and paid support), including supporting the person to adjust to the changes.
10. Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

**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.

### 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, and Defined Need. Reasonable pace goals have been established for each of these categories.

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

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

**RESULTS:**

The CADI waiting list remains at zero and is **on track** to stay at zero. CADI waiver services continues to show that no one is on the 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>
July – September 2016	0	<7>
October – December 2016	0	0
January – March 2017	0	0
April – June 2017	0	0
July – September 2017	0	0

**ANALYSIS OF DATA:**

As of October 1, 2016 the Community Access for Disability Inclusion (CADI) waiver waiting list was eliminated. As of September 30, 2017 the CADI waiver waiting list remains at zero.

**COMMENT ON PERFORMANCE:**

DHS will continue to monitor and report quarterly on any occurrence of individuals being placed on the CADI waiver waiting list.

DHS will continue to monitor data and work with lead agencies to ensure that eligible individuals are allocated the CADI waiver and do not end up on the waiting list.

**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.

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

**Baseline:** From January – December 2016, of the 1,500 individuals assessed, 707 individuals or 47% moved off the DD waiver waiting list at a reasonable pace. The percent by urgency of need category was: Institutional Exit (42%); Immediate Need (62%); and Defined Need (42%).

#### Assessments between January – December 2016

Urgency of Need Category	Total number of people assessed	<u>Reasonable Pace</u> Funding approved within 45 days	Funding approved after 45 days
Institutional Exit	89	37 (42%)	30 (37%)
Immediate Need	393	243 (62%)	113 (29%)
Defined Need	1,018	427 (42%)	290 (30%)
<b>Totals</b>	<b>1,500</b>	<b>707 (47%)</b>	<b>433 (30%)</b>

**RESULTS:** This goal is on track.

#### Time period: January – March 2017

Urgency of Need Category	Total number of people assessed	<u>Reasonable Pace</u> Funding approved within 45 days	Funding approved after 45 days	Still on waiting list
Leaving an Institution	31	22 (71%)	5 (16%)	4 (13%)
Immediate Need	90	60 (67%)	18 (20%)	12 (13%)
Defined Need	288	155 (54%)	52 (18%)	81 (28%)
<b>Totals</b>	<b>409</b>	<b>237 (58%)</b>	<b>75 (18%)</b>	<b>97 (24%)</b>

#### Time period: April – June 2017

Urgency of Need Category	Total number of people assessed	<u>Reasonable Pace</u> Funding approved within 45 days	Funding approved after 45 days	Still on waiting list
Leaving an Institution	36	15 (42%)	16 (44%)	5 (14%)
Immediate Need	117	63 (54%)	37 (32%)	17 (14%)
Defined Need	353	163 (46%)	127 (36%)	63 (18%)
<b>Totals</b>	<b>506</b>	<b>241 (48%)</b>	<b>180 (35%)</b>	<b>85 (17%)</b>

#### ANALYSIS OF DATA:

From April – June 2017, of the 506 individuals assessed for the Developmental Disabilities (DD) waiver, 241 individuals (48%) had funding approved within 45 days of the assessment date. In the previous quarter, of the 409 individuals assessed, 237 individuals (58%) had funding approved within 45 days of assessment. This quarter there was a lower percentage of individuals with funding approved within 45 days, however there was a smaller percentage who remained on the waiting list.

**COMMENT ON PERFORMANCE:**

Lead agencies receive monthly updates regarding the people who are on the DD waiver waiting list through a web-based system. Using this information, lead agencies can view the number of days a person has been on a waiting list and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS continues to allocate funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.

Lead agencies may encounter waiting list situations on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When a waiting list issue arises, a lead agency may be unfamiliar with the reasonable pace funding requirement due to the infrequency of this issue at their particular agency. DHS continues to provide training and technical assistance to lead agencies as waiting list issues occur and has added staff resources to monitor compliance with reasonable pace goals.

While a smaller proportion of people moved off the waiting list at a reasonable pace, compared to the previous quarter, a higher percentage had funding approved overall. This quarter, 83 percent of people had funding approved, an increase from 76 percent during the previous quarter.

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.

Below is a summary table with the number of people still on the waiting list as of the first day of April, July and October, 2017. Also included is the average and median days waiting of those individuals who are still on the waiting list. The average days and median days information was collected since December 1, 2015. This data does not include those individuals who had funding approved within the 45 days reasonable pace goal. The total number of people still on the waiting list as of October 1, 2017 (152) has decreased since July 1, 2017 (237).

**Waiting List Status as of April 1, 2017**

<b>Category</b>	<b>Number of people on waiting list</b>	<b>Average days on waiting list</b>	<b>Median days on waiting list</b>
Institutional Exit	13	91	82
Immediate Need	16	130	93
Defined Need	172	193	173
<b>Total</b>	<b>201</b>		

**Waiting List Status as of July 1, 2017**

<b>Category</b>	<b>Number of people on waiting list</b>	<b>Average days on waiting list</b>	<b>Median days on waiting list</b>
Institutional Exit	13	109	103
Immediate Need	26	122	95
Defined Need	198	182	135
<b>Total</b>	<b>237</b>		

**Waiting List Status as of October 1, 2017**

Category	Number of people on waiting list	Average days on waiting list	Median days on waiting list
Institutional Exit	12	136	102
Immediate Need	36	120	82
Defined Need	104	183	137
<b>Total</b>	<b>152</b>		

**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).

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**RESULTS:** This goal to eliminate the waiting list was **not met**.

**INSTITUTIONAL EXIT CATEGORY**

Time period	Number of people assessed	Still on waiting list at end of period
January – March 2016	14	1 (7%)
April – June 2016	31	9 (29%)
July – September 2016	20	7 (35%)
October – December 2016	29	5 (17%)
January – March 2017	31	4 (13%)
April – June 2017	36	5 (14%)

**IMMEDIATE NEED CATEGORY**

Time period	Number of people assessed	Still on waiting list at end of period
January – March 2016	93	10 (11%)
April – June 2016	126	10 (8%)
July – September 2016	100	14 (14%)
October – December 2016	89	7 (8%)
January – March 2017	90	12 (13%)
April – June 2017	117	17 (14%)

**ANALYSIS OF DATA:**

From April - June 2017, for persons in the Institutional Exit category, five individuals (14%) remained on the DD waiver waiting list at the end of the reporting period. For persons in the Immediate Need category, seventeen individuals (14%) remained on the DD waiver waiting list at the end of the reporting period. The goal to eliminate the waiting list for these two categories was not met.

**COMMENT ON PERFORMANCE:**

DHS focuses its 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 continues to provide technical assistance to the lead agency to approve funding for persons in these categories.

Lead agencies may encounter waiting list situations on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When a waiting list issue arises, a lead agency may be unfamiliar with the reasonable pace funding requirement due to the infrequency of this issue at their particular agency. DHS continues to provide training and technical assistance to lead agencies as waiting list issues occur and has added staff resources to monitor compliance with reasonable pace goals.

The proportion of people in the Institutional Exit category who were still on the waiting list in this quarter remained relatively constant from previous quarters. The overall goal to eliminate the Institutional Exit and Immediate Need categories was not met. Demonstrating complete elimination of these categories is challenging as, because of the process used to screen new DD waiver recipients, most new recipients will appear on the waiting list prior to accessing the waiver. DHS plans to recommend updates to this goal during the Olmstead Plan amendment process to better define success as people in these two categories accessing waiver funding at a reasonable pace. Going forward, DHS will work with lead agencies to continue to approve funding according to the reasonable pace goals.

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

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**RESULTS:** This goal is in process.

**DEFINED NEED CATEGORY**

Time period	Number of people assessed	Still on waiting list
January – March 2016	217	74 (34%)
April – June 2016	323	102 (32%)
July – September 2016	285	88 (31%)
October – December 2016	257	65 (25%)
January – March 2017	288	81 (28%)
April – June 2017	353	63 (18 %)

**ANALYSIS OF DATA:**

From April – June 2017, for persons in the Defined Need category, 63 people (18%) out of 353 people remained on the DD waiver waiting list.



**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.

In this quarter, the proportion of people who were still on the waiting list in the Defined Need category decreased from the previous quarter.

**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**

### **NATIONAL CORE INDICATORS (NCI) SURVEY**

The results for the 2016 NCI survey for individuals with intellectual and developmental disabilities were reported in the August 2017 Quarterly Report.

### **QUALITY OF LIFE SURVEY**

The Quality of Life Survey Administration Plan is currently being implemented by The Improve Group. The survey is expected to include 2,000 surveys.

The Improve Group:

- Continues to obtain consent releases and schedule appointments
- Maintains communications with lead agencies and service providers and coordinated communications with OIO and the agencies
- Continues to interview individuals for the Quality of Life Survey
- Continues to strategically navigate through various barriers to obtain access and consents from guardianship services, guardians and providers
- Continues strategic outreach efforts in partnership with DHS and DEED to secure consents

Data as of October 25, 2017:

- More than 1,600 interviews have been completed
- 161 interviews have been scheduled

The OIO and the Improve Group are meeting weekly to provide support, troubleshoot problems, and monitor survey implementation.

## 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.

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**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.

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### 2017 goal

- By June 30, 2017, the percent of plans that meet the required protocols will increase to 50%.

**Baseline:** From July – September 2016, 289 cases were reviewed. Of those cases, 47 (16.3%) were identified as having plans that met the person-centered protocols. During the period July 2014 – June 2015, there were 38,550 people served by disability home and community based services.

### RESULTS:

The 2017 goal of 50% was **not met**.

Time Period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)	Number of cases meeting protocols	Percent of cases meeting protocols
Quarter 1 July – Sept 2016	1,682	289	47	16.3%
Quarter 2 Oct – Dec 2016	2,030	311	57	18.3%
Quarter 3 Jan – March 2017	3,311	386	48	12.4%
Quarter 4 April – June 2017	1,357	213	15	7%
<b>Annual July 2016 – June 2017</b>	<b>8,380</b>	<b>1,199</b>	<b>167</b>	<b>13.9%</b>

### ANALYSIS OF DATA:

From June 2016 - July 2017, 1,199 files were reviewed. Of those files, 167 (13.9%) were identified as having plans that were person-centered. The 2017 goal of 50% was not met. Because different counties are reviewed each quarter, the change in percent from one quarter to the next does not mean the counties from the previous quarter are doing better or worse.

In July 2016, the DHS Lead Agency Review began monitoring lead agency implementation of the Person-Centered, Informed Choice and Transition Protocol<sup>4</sup>. Though lead agencies are responsible to ensure each person has a support plan that includes all required person-centered elements, the Lead Agency Review is focusing on key areas of the protocol.

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<sup>4</sup> A Person-Centered Planning, Informed Choice and Transition Protocol was approved by the Olmstead Executive Committee in February 2016. A revision including minor edits was approved by the Olmstead Subcabinet in March 2017.

The Lead Agency Review team looks at twenty-five person-centered items for the disability waiver programs (Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disability Inclusion (CADI) and Developmental Disabilities (DD)). Of those twenty-five items, eight were identified as being cornerstones of a person-centered plan. If all eight items are present, the plan is considered to meet the person-centered protocols.

The eight key areas are listed below. Also included are the results of the Quarter 4 review to indicate the percentage of plans that met the criteria for that item.

1. The support plan describes goals or skills that are related to the person's preferences. (74%)
2. The support plan includes a global statement about the person's dreams and aspirations. (17%)
3. Opportunities for choice in the person's current environment are described. (79%)
4. The person's current rituals and routines are described. (62%)
5. Social, leisure, or religious activities the person wants to participate in are described. (83%)
6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described. (70%)
7. The person's preferred living setting is identified. (80%)
8. The person's preferred work activities are identified. (71%)

Current DHS standard requires that **all eight** items are present in the support plan (or in supporting documents, i.e. assessment or case notes) held by the lead agency. If **one** of the eight items is missing, the support plan is considered as not meeting the protocols of a person-centered plan. The item most commonly missing is item two, "The support plan includes a global statement about the person's dreams and aspirations."

If the requirement for item 2 were not included in the calculation and only seven items were counted, the compliance for Quarter 4 would increase from 7% to 33%. DHS is evaluating the method for reporting data collected via the lead agency review process and whether the current way of requiring all eight items is an accurate reflection of what is happening in lead agencies. DHS will make recommendations during the Olmstead Plan amendment process of any changes necessary.

#### Counties Participating in Audits\*

July – September 2015	October – December 2015	January – March 2016	April – June 2016
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

July – September 2016	October – December 2016	January – March 2017	April – June 2017
30. Hubbard	38. Cook	44. Chisago	47. MN Prairie Alliance <sup>5</sup>
31. Cass	39. Fillmore	45. Anoka	48. Morrison
32. Nobles	40. Houston	46. Sherburne	49. Yellow Medicine
33. Becker	41. Lake		50. Todd
34. Clearwater	42. SW Alliance <sup>6</sup>		51. Beltrami

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

#### **COMMENT ON PERFORMANCE:**

The Person-Centered, Informed Choice and Transition Protocols were initiated with lead agencies in July of 2016. Since the lead agency review looks at documentation completed up to 364 days prior to the site visit, reviews through the first three quarters of 2017 included plans that were written before the protocol was issued.

Since July 2016, the Lead Agency Review Team has made recommendations to each county visited on how to improve their person-centered practices. Counties are in varying stages on their person-centered journey. The recommendations encourage lead agencies to set expectations for the quality and content of support plans as well as to seek out and provide training for their staff on providing person-centered practices. This may involve changes in agency practices as well as changes to how agencies work with their community partners.

Beginning in January 2018, DHS will require individual remediation when lead agencies do not comply with the person-centered review protocols. When findings from case file review indicate files did not contain all required documentation, the agency is required to bring all cases into full compliance by obtaining or correcting the documentation. All corrections must be made within 60 days of the Lead Agency Review site visits. Corrective action plans will be required when patterns of non-compliance are evident.

DHS conducted regional day-long training and technical assistance sessions with counties and tribes during May through September 2017. Due to high demand, DHS has scheduled an additional five training sessions through December 2017. A supervisor tool kit is being developed to support counties, tribes and contracted case management providers in the oversight of plan development according to the protocol. The expectation is that the number of plans that adhere to the protocols will increase over time and during 2018.

#### **TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it will be reported three months after the end of the reporting period.

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<sup>5</sup> The MN Prairie Alliance includes Dodge, Steele, and Waseca counties.

<sup>6</sup> The SW Alliance includes Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock counties.

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**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.

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**2017 Goal**

- By June 30, 2017, the number of people experiencing a restrictive procedure will be **reduced by 5% from the previous year or 49 individuals**

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

**RESULTS:**

This 2017 goal was **met**.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
2016 Annual (July 2015 – June 2016)	761 (unduplicated)	106
<b>2017 Annual (July 2016 - June 2017)</b>	<b>692 (unduplicated)</b>	<b>69</b>
Quarter 1 (July - September 2016)	297 (duplicated)	N/A – quarterly status of annual goal
Quarter 2 (October – December 2016)	280 (duplicated)	NA – quarterly status of annual goal
Quarter 3 (January – March 2017)	283 (duplicated)	NA – quarterly status of annual goal
Quarter 4 (April – June 2017)	263 (duplicated)	NA – quarterly status of annual goal

**ANALYSIS OF DATA:**

The 2017 goal to reduce the number of people experiencing a restrictive procedure by 5% from the previous year or 49 individuals was met. From July 2016 to June 2017, the number of individuals who experienced a restrictive procedure decreased from 761 to 692. This was a 9% reduction of 69 from the previous year. It's important to note that the June 30, 2018 overall goal to reduce the number of people experiencing restrictive procedures by 200 has already been reached.

**COMMENT ON PERFORMANCE:**

There were 263 individuals who experienced a restrictive procedure this quarter:

- 239 individuals were subjected to Emergency Use of Manual Restraint (EUMR) only. Such EUMRs are permitted and not subject to phase out requirements like all other “restrictive” procedures. These reports are monitored and technical assistance is available when necessary.
- 24 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 Positive Supports Goal Three).

Under the Positive Supports Rule, the External Program Review Committee convened in February 2017 has the duty to review and respond to Behavior Intervention Reporting Form (BIRF) reports involving EUMRs. Beginning in May 2017, the External Program Review Committee conducted outreach to providers in response to EUMR reports. It is anticipated the Committee's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR. The impact of this work toward reducing the number of EUMR reports will be tracked and monitored over the next several quarterly reports.

#### **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.

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**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.

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#### **Annual Goals**

- By June 30, 2017, the number of reports of restrictive procedures will be reduced by **388**.

**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 2017 goal was **met**.

Time period	Number of BIRF reports	Reduction from previous year
2015 Annual (July 2014 – June 2015)	5,124	3,478
2016 Annual (July 2015 – June 2016)	4,008	1,116
<b>2017 Annual (July 2016 - June 2017)</b>	<b>3,583*</b>	<b>425</b>
Quarter 1 (July – September 2016)	960	N/A – quarterly status of annual goal
Quarter 2 (October – December 2016)	802	N/A – quarterly status of annual goal
Quarter 3 (January – March 2017)	954	N/A – quarterly status of annual goal
Quarter 4 (April – June 2017)	805	N/A – quarterly status of annual goal
<b>Total (Q1 + Q2 + Q3 + Q4)</b>	<b>3,521</b>	

\*The annual total of 3,583 is greater than the sum of the four quarters or 3,521. This is due to late submissions of 62 BIRF reports of restrictive procedures throughout the four quarters.

**ANALYSIS OF DATA:**

The 2017 goal to reduce the number of reports of restrictive procedures by 388 was met. From July 2016 to June 2017, the number of restrictive procedure reports decreased from 4,008 to 3,583 or 425. It's important to note that the June 30, 2018 overall goal to reduce the number of reports people by 1,596 has already been reached.

**COMMENT ON PERFORMANCE:**

There were 805 reports of restrictive procedures this quarter.

- 636 reports were for emergency use of manual restraint (EUMR). Such EUMRs are permitted and not subject to phase out requirements like all other “restrictive” procedures. These reports are monitored and technical assistance is available when necessary.
  - Under the Positive Supports Rule, the External Program Review Committee has the duty to review and respond to BIRF reports involving EUMRs. Convened in February 2017, the Committee’s work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR.
  - Beginning in May 2017, the External Program Review Committee conducted outreach to providers in response to EUMR reports. The impact of this work toward reducing the number of EUMR reports will be tracked and monitored over the next several quarterly reports.
  - This quarter shows a decrease of 102 reports of EUMR from the previous quarter. Follow up by the External Program Review Committee has begun in Quarter 4, and will be monitored for its impact on the number of reports received.
- 169 reports involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). DHS staff provide follow up and technical assistance for all reports involving restrictive procedures that are not implemented according to requirements under 245D or the Positive Supports Rule. The External Program Review Committee provides ongoing monitoring over restrictive procedures being used by providers with persons under the committee’s purview. Focusing existing capacity for technical assistance primarily on reports involving these restrictive procedures is expected to reduce the number of people experiencing these procedures, as well as reduce the number of reports seen here and under Positive Supports Goal Three.
  - The number of non-EUMR restrictive procedure reports decreased by 47 over the previous quarter.
- 10 uses of seclusion involving 6 people were reported this quarter:
  - 8 uses involving 5 people occurred at Minnesota Security Hospital, in accordance with the Positive Supports Rule (i.e., not implemented as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience).
  - 2 uses involving one person occurred as part of an approved Positive Support Transition Plan during the 11-month phase out period.
  - One use of penalty consequences was unapproved, with technical assistance provided by DHS staff to prevent further occurrence.
  - One reported use of time out was found upon technical assistance follow-up to be miscoded and did not include the use of time out as defined under 245D.

**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.



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**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<sup>vi</sup>, 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 (A)  $\leq 93$  reports and (B)  $\leq 7$  individuals.
- 

#### 2017 Goal

- By June 30, 2017, reduce mechanical restraints to no more than  
(A) **277** reports of mechanical restraint  
(B) **19** 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:

- (A) The 2017 goal for number of reports was **not met**.  
(B) The 2017 goal for number of individuals was **met**.

Time period	(A) Number of reports during the time period	(B) Number of individuals at end of time period
2015 Annual (July 2014 – June 2015)	912	21
2016 Annual (July 2015 – June 2016)	691	13
<b>2017 Annual (July 2016 – June 2017)</b>	<b>664*</b>	<b>16</b>
Quarter 1 (July – September 2016)	161	13
Quarter 2 (October – December 2016)	133	16
Quarter 3 (January – March 2017)	197	16
Quarter 4 (April – June 2017)	157	16
<b>Total (Q1 + Q2 + Q3 + Q4)</b>	<b>648</b>	<b>---</b>

\*The annual total of 664 is greater than the sum of the four quarters or 648. This is due to late submissions of 16 BIRF reports of mechanical restraints throughout the four quarters.

#### ANALYSIS OF DATA:

This goal has two measures. One of the measures met the 2017 goal, and the second did not.

From July 2016 to June 2017, the number of reports of mechanical restraints was 664. Although the number of reports decreased by 40 in Quarter 4 and by 27 from 2016, the 2017 goal to reduce the number of reports to 277 was not met.

At the end of the reporting period (July 2016 – June 2017), the number of individuals for whom the EUMR was approved was 16. The 2017 goal to reduce the number of individuals approved to 19 was met.

#### COMMENT ON PERFORMANCE:

Under the requirements of the Positive Supports Rule, in situations where mechanical restraints have been part of an approved Positive Support Transition Plan to protect a person from imminent risk of

serious injury due to self-injurious behavior and the use of mechanical restraints has not been successfully phased out within 11 months, a provider must submit a request for the emergency use of these procedures to continue their use.

These requests are reviewed by the External Program Review Committee (EPRC) to determine whether or not they meet the stringent criteria for continued use of mechanical restraints. The EPRC consists of members with knowledge and expertise in the use of positive supports strategies. The EPRC 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 EPRC includes a written list of person-specific recommendations to assist the provider to reduce the need for use of mechanical restraints. In situations where the EPRC believes a license holder needs more intensive technical assistance, phone and/or in-person consultation is provided by panel members.

Prior to February 2017, the duties of the ERPC were conducted by the Interim Review Panel.

Of the 157 BIRFs reporting use of mechanical restraint in Quarter 4:

- 144 reports involved 11 of the 16 people with review by the EPRC and approval by the Commissioner for the emergency use of mechanical restraints during the reporting quarter.
  - This is a decrease of 31 from Quarter 3.
  - 5 people approved for emergency use reported no uses of mechanical restraint during this quarter.
- 1 report was inaccurately coded as mechanical restraint. The reported intervention consisted of temporary withholding or removal of objects being used to hurt self or others, which is a specific procedure permitted under MN Rule 9544.0050 Subp. 1.
- 12 reports, involving 6 people, were submitted by Minnesota Security Hospital for uses of mechanical restraint that were not implemented as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

#### **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.

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

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**2017 Goal**

- By June 30, 2017, the number will decrease to **no more than 45 people**.

**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 goal is **in process**.

Time period	Number of people who discontinued disability waiver services after a crisis
2015 Annual (July 2014 – June 2015)	54 (unduplicated)
2016 Annual (July 2015 – June 2016)	71 (unduplicated)
Quarter 1 (July – September 2016)	16 (duplicated)
Quarter 2 (October – December 2016)	10 (duplicated)
Quarter 3 (January –March 2017)	16 (duplicated)

**ANALYSIS OF DATA:**

From January – March 2017, the number of people who discontinued disability waiver services after a crisis was 16. The quarterly numbers are duplicated counts. People may discontinue and resume 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. The annual number reported represents an unduplicated count of people who discontinue disability waiver services after a crisis during the four quarters.

**COMMENT ON PERFORMANCE:**

Given the small number of people identified in any given quarter as part of this measure, as of March 2017, DHS staff is conducting person-specific research to determine the circumstances and outcome of each identified waiver exit. This will enable DHS to better understand the reasons why people are exiting the waiver within 60 days of receiving a service related to a behavioral crisis and target efforts where needed most to achieve this goal.

Of the 16 people who discontinued waiver services because of a behavior crisis in this reporting period:

- 12 people have since reopened to waiver services
- 2 people are no longer in institutional settings but have chosen not to reopen to the waiver
- 2 people have chosen to receive services in institutional settings (1 in an ICF/DD, the other in a nursing facility)

**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.

## 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 semi-annually or annually. 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.

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**HOUSING & SERVICES GOAL ONE:** By June 30, 2019, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 5,547 (from 6,017 to 11,564 or about a 92% increase).

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### 2017 Goal

- By June 30, 2017, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 2,638 over baseline to 8,655 (about 44% increase).

**Baseline:** From July 2013 – June 2014, there were an estimated 38,079 people living in segregated settings. Over the 10 year period ending June 30, 2014, 6,017 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing. Therefore, 6,017 is the baseline for this goal.

### RESULTS:

The 2017 annual goal to increase by 2,638 over baseline was **not met**.

Time period	People in integrated housing	Change from previous year	Increase over baseline
2015 Annual (July 2014 – June 2015 )	6,920	+903	903 (15%)
2016 Annual (July 2015 – June 2016)	7,608	+688	1,591 (26.4%)
2017 Annual (July 2016 – June 2017)	8,606	+998	<b>2,589 (43%)</b>

### ANALYSIS OF DATA:

From July 2016 through June 2017 the number of people living in integrated housing increased by 2,589 (43%) over baseline to 8,606. Although the 2017 goal was not met, the increase of 2,589 was 98% of the annual goal. The increase in the number of people living in integrated housing from July 2016 to June 2017 was 998 compared to an increase of 688 in the previous year.

### COMMENT ON PERFORMANCE:

Although the 2017 annual goal was not met, the result was larger than the previous year. A contributing factor to missing the goal may be the tight housing market. When there is a tight housing market, access to housing is reduced and landlords may be unwilling to rent to individuals with limited rental history or other similar factors.

### 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.

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**EMPLOYMENT GOAL TWO:** By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,015 or 10% in competitive integrated employment.

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A new baseline was established and approved by the Subcabinet on November 27, 2017 and is included below. This is the first quarterly report using the baseline.

**2017 Goal**

- By June 30, 2017, a data system will be developed to measure the following: the number of individuals who are working in competitive integrated employment; the number of individuals not working in competitive integrated employment; and the number of individuals not working in competitive integrated employment who would choose or not oppose competitive integrated employment.
- By June 30, 2017, the number of individuals in competitive integrated employment will increase by 1,500 individuals

**Baseline:** In 2014, there were 50,157 people age 18-64 who received services from one of the following programs: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD). Of the 50,157 total MA recipients, there were 6,137 in competitive integrated employment.

**RESULTS:**

- The 2017 goal to develop a data system is **in process**.
- The 2017 annual goal to increase by 1,500 over baseline was **met**.

**MA Recipients (18 -64) in Competitive Integrated Employment (CIE)**

Time period	Total MA recipients	Number in CIE (\$600+/month)	Percent of MA recipients in CIE	Change from previous year	Increase over baseline
July 2013 – June 2014 (Baseline)	50,157	6,137	12.2%	--	--
July 2014 – June 2015	49,922	6,596	13.2%	459	459
July 2015 – June 2016	52,383	8,203	15.7%	1,607	2,066

**ANALYSIS OF DATA:**

The 2014 baseline has now been established to be 6,137. As of June 2016 an additional 2,066 people in certain Medicaid programs are earning at least \$600 a month as compared to baseline data. Most notably, the increase between June 2015 and June 2016 is more than three times greater than the increase between June 2014 and June 2015. The results from the first three reporting periods show strong progress towards an increase of 5,015 (10%) in the number people in competitive integrated employment by June 30, 2020.

The data reported is a proxy measure to track the number of individuals in competitive integrated employment from certain Medicaid programs and includes the number of people who have monthly

earnings of over \$600 a month. This is calculated by dividing the annual earnings of an individual (as reported by financial eligibility workers during re-qualification for Medicaid) by the number of months they have worked in a given fiscal year. The Olmstead Plan amendment process will incorporate that number into the baseline for this goal.

During development of the employment data dashboard in 2015, DHS tested the use of \$600 a month as a proxy measure for competitive integrated employment. This was done by reviewing a random sample of files across the state. DHS staff verified that information from the data system matched county files and determined that when people were working and making \$600 or more, the likelihood was they were in competitive integrated employment.

#### **COMMENT ON PERFORMANCE:**

Possible contributing factors to explain the increase in the number of people in certain Medicaid programs in competitive integrated employment include:

- **Improving economy:** During the same time period of this data, the overall unemployment rate in Minnesota fell from 4.2% in June of 2014 to 3.4% in June of 2016.<sup>7</sup>
- **Increased awareness and interest:** Providers and lead agencies are paying attention to the goals of people to work in competitive integrated employment.
- **Implementation of the Workforce Innovation and Opportunities Act (WIOA):** Signed into law in July 2014, this act amended Section 511 of the Rehabilitation Act and placed additional requirements on employers who hold special wage certificates to pay people with disabilities subminimum wages. In response to WIOA requirements, some employers may have increased wages to above minimum wage or some service providers may have put greater emphasis on services leading to competitive integrated employment. During this time period, however, there was not a similar growth in employment among people with disabilities at the national level.<sup>8</sup>
- **Interagency efforts to increase competitive integrated employment:** During the time period of this data, DHS, DEED, and MDE have all made efforts to meet Minnesota's Employment First Policy and Olmstead Plan goals. This included interagency coordination and projects contained as part of the employment section of Minnesota's Olmstead Plan.

#### **Moving Forward**

Moving forward, DHS continues to work to ensure that all Minnesotans with disabilities have the option of competitive integrated employment. DHS seeks to meet its Olmstead Plan measurable goal and continuously improve efforts around employment. Part of these efforts include:

- **Providing three new employment services in the Medicaid Home and Community Based Services (HCBS) waivers:** Minnesota has submitted HCBS waiver amendments to CMS that would allow the state to offer three new employment services: Exploration, Development, and Support. These services will provide new options and resources behind competitive integrated employment.
- **Improving communication to people with disabilities and training for service professionals:** DHS will be undertaking several efforts in the coming year to improve its communication, training, and

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<sup>7</sup> Minnesota Unemployment Statistics. Labor Market Information - Minnesota Department of Employment and Economic Development. Accessed September 27, 2017 <https://mn.gov/deed/data/>

<sup>8</sup> nTide Jobs Report: Steady Job Numbers May Signal Start of Turnaround for People with Disabilities. Accessed September 27, 2017 <http://researchondisability.org/home/ntide/ntide-news-item/2016/04/01/ntide-jobs-report-steady-job-numbers-may-signal-start-of-turnaround-for-people-with-disabilities>

guidance around employment. These efforts include mailings to people receiving HCBS services, improvements in employment data dashboards, trainings for service professionals, and website updates.

- **Releasing and Implementing employment innovation grants:** DHS is currently implementing innovation grants totaling \$1.8 million to promote innovative ideas to improve outcomes for people with disabilities in the areas of work, living, and connecting with others in their communities. Additionally, over the next year, DHS will be selecting grant recipients for \$2 million of grant money to provide innovation solutions for youth with disabilities to achieve competitive integrated employment.

### **Data Improvement**

DHS seeks to continuously improve its data and measures around competitive integrated employment. These efforts will allow DHS to refine its proxy measure for competitive integrated employment to more completely capture the definition of competitive, integrated employment found in Minnesota's Employment First Policy.<sup>9</sup> Some of these efforts include:

- **Informed Choice Data:** DHS added Informed Choice Employment questions to both the MnCHOICES and Mental Health Information Systems (MHIS) to determine those working in competitive integrated employment, those not working, and those interested in Competitive Integrated Employment (CIE). DHS is in the process of analyzing and validating the data from both sources in order to integrate the information to get an unduplicated count of the number of individuals in CIE or wanting CIE. This new data is important because it will allow DHS to look at the provision of services and employment outcomes according to a person's informed choice decision about employment.
- **Employment Data Dashboards:** DHS is refining dashboards to display employment outcome information for people in certain Medicaid programs. As part of these efforts, DHS is looking at the "employer of record" for people earning wages to help greater clarify who is employed through competitive employers and who is employed through special, subminimum wage certificate holders. Currently this is a manual process for validating the "employer of record".
- **Interagency Data Sharing and Coordination:** DHS is working with MDE and DEED to share and create consistency across the employment data in each agency. These efforts are included in the Olmstead Plan workplans.

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<sup>9</sup> Minnesota's Employment First Policy is available at:

[http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16\\_190416.pdf](http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_190416.pdf)

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**EDUCATION GOAL TWO:** By June 30, 2020, the number of students who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase by 425 (39%) (from 2,174 to 2,599). [Revised in February 2017]

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**2017 Goal**

- By June 30, 2017 there will be an increase of 100 (34%) over baseline to 2,274.

**Baseline:** Using the 2014 Minnesota's Statewide Longitudinal Education Data System (SLEDs), of the 6,749 students with disabilities who graduated statewide in 2014, a total of 2,174 (32.2%) attended an integrated postsecondary institution from August 2014 to July 2015.

**RESULTS:**

The 2017 goal was **not met**.

Time Period	Students graduating	Students entering an accredited institution of higher education	Change from baseline
2014 SLEDs [Baseline] (August 2014 – July 2015)	6,749	2,174 (32.2%)	--
2015 SLEDs Data (August 2015 – July 2016)	6,747	2,154 (31.9%)	<20>

**ANALYSIS OF DATA:**

Of the 6,747 student with disabilities who graduated in 2015, there were 2,154 students (31.9%) who enrolled in an accredited institution of higher education in fall 2015, spring 2016, or both. This was a decrease of 20 students from the 2014 baseline.

**COMMENT ON PERFORMANCE:**

The SLEDs data that was available and used for this report did not include data provided by the Minnesota Office of Higher Education, and is not publicly accessible at the SLEDs website. In addition, MDE defines ideal performance as immediate enrollment in an accredited institution of higher education in the fall after graduation in the spring (as opposed to delayed enrollment) and the data used for this report includes spring enrollment data by students who delayed enrollment. MDE will propose changes to this goal through the Olmstead Plan amendment process to use SLEDs data to be consistent in publicly reporting results.

**TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it will be reported 16 months after the end of the reporting period.



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**HEALTHCARE AND HEALTHY LIVING GOAL ONE:** By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care<sup>10</sup> focusing specifically on cervical cancer screening and follow up care for cardiovascular conditions will increase by 833 people compared to the baseline.

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**2016 Goal**

- By December 31, 2016 the number accessing appropriate care will increase by 205 over baseline

**Baseline:** In 2013 the number of women receiving cervical cancer screenings was 21,393 and the number of individuals accessing follow up care for cardiovascular conditions was 1,589.

**RESULTS:**

The 2016 goal was **met**.

Time Period	Number receiving cervical cancer screenings	Change from previous year	Change from baseline
January – December 2013	21,393	Baseline Year	Baseline Year
January – December 2014	28,213	6,820	6,820
January – December 2015	29,284	1,071	7,891
January – December 2016	27,902	<1,382>	6,509

The beta blocker measure for follow up care for cardiovascular conditions is no longer reflective of current clinical practice and has been discontinued.

**ANALYSIS OF DATA:**

During calendar year 2016 the number of women with disabilities and/or serious mental illness who had a cervical cancer screening was 27,902. The 2016 annual goal to increase by 205 over baseline was met. The number accessing cervical cancer screenings increased steadily from the 2013 baseline through the 2015 reporting period. The number decreased from 29,284 in 2015 to 27,902 in 2016, a difference of 1,382. It's important to note that the December 31, 2018 overall goal to increase by 833 has already been reached.

**COMMENT ON PERFORMANCE:**

2014 changes in state law regarding Medicaid eligibility resulted in a large increase in overall Medicaid enrollment as compared to the 2013 baseline.

DHS will continue to work on improving access and quality of preventive care for people with disabilities. DHS plans to recommend an additional health care measure during the Olmstead Plan amendment process.

**TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

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<sup>10</sup> Appropriate care will be measured by current clinical standards.

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**HEALTHCARE AND HEALTHY LIVING GOAL TWO:** By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by (A) 1,229 children and (B) 1,055 adults over baseline.

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**A) CHILDREN ACCESSING DENTAL CARE**

**2016 Goal**

- By December 31, 2016 the number of children accessing dental care will increase by 410 over baseline

**Baseline:** In 2013, the number of children with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 16,360.

**RESULTS:**

The 2016 goal was **met**.

Time period	Number of children with disabilities who had annual dental visit	Change from previous year	Change from baseline
January – December 2013	16,360	Baseline Year	Baseline Year
January – December 2014	25,395	9,035	9,035
January – December 2015	26,323	928	9,963
January – December 2016	25,990	<333>	9,630

**ANALYSIS OF DATA:**

During calendar year 2016 the number of children with disabilities who had an annual dental visit was 25,990. This was an increase of 9,630 over baseline. The 2016 annual goal to increase by 410 over baseline was met. There were significant gains between the 2013 baseline year and 2014 reporting period. The number of children with disabilities accessing dental care has leveled off and has not seen appreciable increases since 2014. It's important to note that the December 31, 2018 overall goal to increase by 1,229 has already been reached.

**COMMENT ON PERFORMANCE:**

2014 changes in state law regarding Medicaid eligibility resulted in a large increase in overall Medicaid enrollment as compared to the 2013 baseline. DHS plans to recommend an additional health care measure during the Olmstead Plan amendment process.

**TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

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**B) ADULTS ACCESSING DENTAL CARE****2016 Goal**

- By December 31, 2016 the number of adults accessing dental care will increase by 335 over baseline

**Baseline:** In 2013, the number of adults with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 21,393.

**RESULTS:**

The 2016 goal was **met**.

Time period	Number of adults with disabilities who had annual dental visit	Change from previous year	Change from baseline
January – December 2013	21,393	Baseline Year	Baseline Year
January – December 2014	52,139	30,746	30,746
January – December 2015	55,471	3,332	34,078
January – December 2016	51,410	<4,061>	30,017

**ANALYSIS OF DATA:**

During calendar year 2016 the number of adults with disabilities who had an annual dental visit was 51,410. This was an increase of 30,017 over baseline. The 2016 annual goal to increase by 355 over baseline was met. The number of adults accessing dental care increased steadily between the 2013 baseline period and the 2015 reporting period. The number decreased from 55,481 in 2015 to 51,410 in 2016, a difference of 4,071. It's important to note that the December 31, 2018 overall goal to increase by 1,055 has already been reached.

**COMMENT ON PERFORMANCE:**

2014 changes in state law regarding Medicaid eligibility resulted in a large increase in overall Medicaid enrollment as compared to the 2013 baseline.

DHS plans to recommend an additional health care measure during the Olmstead Plan amendment process.

**TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

**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.

## A) STABLE HOUSING

### 2017 Goal

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

**Baseline:** From July 2014 – June 2015, 81.9% of people discharged from the hospital due to a crisis were housed five months after the date of discharge compared to 80.9% in the previous year.

### RESULTS:

This 2017 goal was **not met**.

Time period	Discharged from hospital	Status five months after discharge from hospital					
		Housed	Not housed	Treatment facility	Not using public programs	Deceased	Unable to determine type of housing
July 2014 – June 2015	13,786	11,290	893	672	517	99	315
		81.9%	6.5%	4.9%	3.7%	0.7%	2.3%
July 2015 – June 2016	15,027	11,809	1,155	1,177	468	110	308
		78.6%	7.7%	7.8%	3.1%	0.7%	2.1%

- “**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.

### ANALYSIS OF DATA:

From July 2015 – 2016, of the 15,027 individuals hospitalized due to a crisis, 11,809 (78.6%) were housed within five months of discharge. This was a 3.3% decrease from the previous year. In the same time period there was a 2.9% increase of individuals in a treatment facility within five months of discharge. The 2017 goal to increase to 83% was not met.

### COMMENT ON PERFORMANCE:

There has been an overall increase in the number of individuals receiving services. In June 2016, the number of people receiving services in a treatment facility was nearly double the amount of people receiving treatment in a treatment facility at baseline. This indicates more people are receiving a higher level of care after discharge. This includes Intensive Residential Treatment Services (IRTS) and chemical dependency treatment programs that focus on rehabilitation and the maintenance of skills needed to live in a more independent setting.

Additionally, a contributing factor to missing the goal may be the tight housing market. When there is a tight housing market, access to housing is reduced and landlords may be unwilling to rent to individuals with limited rental history or other similar factors. DHS is expanding the number of grantees for the Housing with Supports for Adults with Serious Mental Illness grants. These grants support people living with a serious mental illness and residing in a segregated setting, experiencing homelessness or at risk of homelessness, to find and maintain permanent supportive housing. The first round of grants began in June of 2016, with additional rounds occurring every six months. DHS expects to see the impact of this work in later data.

**TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it is reported 16 months after the end of the reporting period.

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**B) COMMUNITY SERVICES**

**2017 Goal**

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

**Baseline:** From July 2014 – June 2015, 89.2% people received follow-up services within 30-days after discharge from the hospital compared to 88.6% in the previous year.

**RESULTS:**

This 2017 goal was **met**.

Time period	# of people who went to a hospital due to crisis and were discharged	# and percentage of individuals who received community services within 30-days after discharge	
July 2014 – June 2015	13,786	12,298	89.2%
July 2015 – June 2016	15,027	14,153	94.2%

**ANALYSIS OF DATA:**

From July 2015 – 2016, of the 15,027 individuals hospitalized due to a crisis, 14,153 (94.2%) received community services within 30 days after discharge. This was a 5% increase over the previous year. The 2017 goal to increase to 90% was met.

**COMMENT ON PERFORMANCE:**

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

Mental health services that are accessible in local communities allow people to pursue recovery while remaining integrated in their community. People receiving timely access to services at the right time, throughout the state, help people remain in the community. Strengthening resources and services across the continuum of care, from early intervention to inpatient and residential treatment, are key for people getting the right supports when they need them. Community

rehabilitation supports like Adult Rehabilitative Mental Health Services (ARMHS), Assertive Community Treatment (ACT), and Adult Day Treatment provide varying intensity of supports within the community. Intensive Residential Rehabilitative Treatment Services (IRTS) and Residential Crisis services can be used as a stepdown or diversion from in-patient, hospital services. DHS continues to fund grants and initiatives aimed at providing community-based mental health services throughout the state and across the care continuum.

**TIMELINESS OF DATA:**

In order for this data to be reliable and valid, it is reported 16 months after the end of the reporting period.

## PROPOSED BASELINE

Transportation Goal Three provides that by April 30, 2017, a baseline be established that relates to access to expanded transit coverage in 90% of the public transportation service areas in Minnesota. Data was sought from MnDOT and the Met Council to attempt to set a baseline that would cover both Greater Minnesota and the metropolitan area.

MnDOT data was available for inclusion in the August 2017 Quarterly Report, however the Met Council data was not. After consulting with the Olmstead Implementation Office (OIO) Met Council staff determined that the existing measurable goal does not adequately apply to transportation issues in the metropolitan area. The Met Council will be proposing a new goal related to transportation in the metropolitan area in the Olmstead Plan amendment process.

A new baseline was established using MnDOT data for access to transportation in Greater Minnesota. The baseline was approved by the Subcabinet at the November 27, 2017 meeting. This is the first Quarterly Report using the baseline.

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**TRANSPORTATION GOAL THREE:** By December 31, 2025, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access.

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Transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT "Greater Minnesota Transit Investment Plan."<sup>11</sup>

Baseline: A baseline for access will be established by April 30, 2017.

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### RESULTS:

The 2017 goal to establish a baseline was **met**.

### PROPOSED BASELINE:

In December 2016, the percentage of public transportation in Greater Minnesota meeting minimum service guidelines for access was 47% on weekdays, 12% on Saturdays and 3% on Sundays.

Percentage of public transportation meeting minimum service guidelines for access	
Weekday	47%
Saturday	12%
Sunday	3%

### ADDITIONAL INFORMATION

Minimum service guidelines for Greater Minnesota are established based on service population (see table below). In Greater Minnesota the larger communities are attaining the weekday span of service. Smaller communities (less than 7,500) are not yet meeting the weekday level of access in all instances. Very few transit systems in Greater Minnesota operate Saturday or Sunday Service. This is mainly due to limited demand for service.

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<sup>11</sup> Greater Minnesota Transit Investment Plan is available at [www.dot.state.mn.us/transitinvestment](http://www.dot.state.mn.us/transitinvestment).

## Minimum Service Guidelines for Greater Minnesota<sup>12</sup>

Service Population	Number of Hours in Day that Service is Available		
	Weekday	Saturday	Sunday
Cities over 50,000	20	12	9
Cities 49,999 – 7,000	12	9	9
Cities 6,999 – 2,500	9	9	N/A
County Seat Town	8 (3 days per week)*	N/A	N/A

\*As systems performance standards warrant

### COMMENT ON PERFORMANCE:

Each year in January the transit systems will be analyzed for the level of service they have implemented. Transit systems apply for funding on an annual basis. The applications take unmet needs into account. However, the actual service implemented can vary based on various factors including; lack of drivers and limited local funding share. The performance should increase as the span of service is established and the priority service expansion for transit systems is considered.

### 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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<sup>12</sup> Source: MnDOT Greater Minnesota Transit Investment Plan, 2017



## VI. COMPLIANCE REPORT ON WORKPLANS AND MID-YEAR REVIEWS

This section summarizes the monthly review of workplan activities and review of measurable goals 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.<sup>vii</sup>

The first review of workplan activities occurred in December 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.

Reporting period	Number of Workplan Activities				
	Reviewed during time period	Completed	On Track	Reporting Exceptions	Exceptions requiring Subcabinet action
December 2015	67	41	19	7	0
January 2016	49	18	25	6	0
February 2016	42	24	10	8	0
March 2016	34	19	10	5	0
April 2016	30	13	15	2	0
May 2016	28	15	13	0	0
June 2016	25	19	5	1	0
July 2016	53	47	4	2	0
August 2016	30	23	6	1	0
September 2016	15	8	6	1	0
October 2016	16	10	5	1	0
November 2016	25	21	4	0	0
December 2016	14	11	3	0	0
January 2017	40	35	2	3	0
February 2017	24	18	6	0	0
March 2017	15	10	4	1	1
April 2017	15	12	3	0	0
May 2017	11	9	2	0	0
June 2017	20	19	1	0	0
July 2017	57	54	3	0	0
August 2017	26	22	1	3	0
September 2017	18	16	2	0	0
October 2017	29	28	8	0	0

### **MID-YEAR REVIEW OF MEASURABLE GOALS REPORTED ON ANNUALLY**

OIO Compliance staff engages in regular and ongoing monitoring of measurable goals to track progress, verify accuracy, completeness and timeliness of data, and identify risk areas. These reviews were previously contained within a prescribed mid-year review process. OIO Compliance staff found it to be more accurate and timely to combine the review of the measurable goals with the monthly monitoring process related to action items contained in the workplans. Workplan items are the action steps that the agencies agree to take to support the Olmstead Plan strategies and measurable goals.

OIO Compliance staff regularly monitors agency progress under the workplans and uses that review as an opportunity to identify any concerns related to progress on the measurable goals. OIO Compliance staff report on any concerns identified through the reviews to the Subcabinet. The Subcabinet approves any corrective action as needed. If a measurable goal is reflecting insufficient progress, the quarterly report identifies the concerns and how the agency intends to rectify the issues. This process has evolved and mid-year reviews are utilized when necessary, but the current review process is a more efficient mechanism for OIO Compliance staff to monitor ongoing progress under the measurable goals.

## VII. ADDENDUM

### CRISIS SERVICES GOALS ONE AND TWO

#### Data Discrepancies

In a recent data maturity and validation review for Crisis Services Goals One and Two, DHS learned that several crisis providers were not reporting data in a timely fashion to meet the 3 month data validation window. Approximately 10% of the data was being received after the due date.

After conferring with the Olmstead Implementation Office, DHS reran the data for January - December 2016 to get a more accurate count of episodes and provided the updated numbers below. Included below is the data reported in the May 2017 Quarterly Report (three months after the reporting period) and the updated data (six months after the reporting period).

The data for January –June 2017 will be reported in the February 2018 Quarterly Report. DHS is working with providers so that reports are submitted on time in the future.

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#### Crisis Services One – Percent of children who receive children’s mental health crisis services and remain in their community

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##### Previously reported in May 2017 (Data as of 3 months after reporting period)

- The 2016 annual goal of increase to 81% was met based on 6 months data.
- The goal is **on track** to meet the 2017 goal of 83%.

Time period	Total Episodes	Community	Treatment	Other
January – June 2016	1,302	1,085 (83.3%)	172 (13.2%)	45 (3.5%)
July – December 2016	998	825 (82.7%)	119 (11.9%)	54 (5.4%)

##### Updated Reporting (Data as of 6 months after the reporting period)

- The 2016 annual goal of increase to 81% was met based on 6 months data.
- The goal is **on track** to meet the 2017 goal of 83%.

Time period	Total Episodes	Community	Treatment	Other
January – June 2016	1,318	1,100 (83.5%)	172 (13.0%)	46 (3.5%)
July - December 2016	1,128	922 (81.7%)	142 (12.6%)	64 (5.7%)

- Community = emergency foster care, remained in current residence (foster care, self or family), remained in school, temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, residential treatment (Children’s Residential Treatment).
- Other = children’s shelter placement, domestic abuse shelter, homeless shelter, jail or corrections, other.

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**Crisis Services Two – Percent of adults who receive adult mental health crisis services and remain in their community**

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**Previously reported in May 2017 (Data as of 3 months after reporting period)**

- The 2016 annual goal of increase to 84% was not met based on 6 months data.
- The goal is **on track** to meet the 2017 goal of 60%.

Time period	Total Episodes	Community	Treatment	Other
January – June 2016	5,206	3,008 (57.8%)	1,463 (28.1%)	735 (14.1%)
July – December 2016	4,859	2,661 (55%)	1,497 (31%)	701 (14%)

**Updated Reporting (Data as of 6 months after the reporting period)**

- The 2016 annual goal of increase to 84% was not met based on 6 months data.
- The goal is **on track** to meet the 2017 goal of 60%.

Time period	Total Episodes	Community	Treatment	Other
January – June 2016	5,436	3,136 (57.7%)	1,492 (27.4%)	808 (14.9%)
July - December 2016	5,554	3,006 (55.2%)	1,657 (29.8%)	831 (15.0%)

- Community = emergency foster care, remained in current residence (foster care, self or family), remained in school, temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, residential treatment (Children's Residential Treatment).
- Other = children's shelter placement, domestic abuse shelter, homeless shelter, jail or corrections, other.

## ENDNOTES

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<sup>i</sup> Reports are also filed with the Court in accordance with Court Orders. Timelines to file reports with the Court are set out in the Court's Orders dated February 12, 2016 (Doc. 540-2) and June 21, 2016 (Doc. 578). 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. See Doc. 578.

<sup>ii</sup> Some Olmstead Plan goals have multiple subparts or components that are measured and evaluated separately. Each subpart or component is treated as a measurable goal in this report.

<sup>iii</sup> 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.

<sup>iv</sup> 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.

<sup>v</sup> 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.

<sup>vi</sup> Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.

<sup>vii</sup> All approved adjustments to workplans are reflected in the Subcabinet meeting minutes, posted on the website, and will be utilized in the workplan review and adjustment process.