

## **Olmstead Subcabinet Meeting Agenda**

Monday, November 26, 2018 • 3:00 p.m. to 5:00 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

### **1) Call to Order**

### **2) Roll Call**

### **3) Agenda Review**

### **4) Approval of Minutes**

- |   |          |
|---|----------|
| a) Subcabinet meeting on October 29, 2018 | <b>3</b> |
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### **5) Reports**

- a) Chair
- b) Executive Director
- c) Legal Office
- d) Compliance Office

**[Agenda items 1-5d 3:00 – 3:10] 13**

### **6) Action Items**

- |  |                      |            |
|--|----------------------|------------|
| a) Direct Care and Support Services Workforce Workplans (DEED/DHS) | <b>[3:10 – 3:50]</b> | <b>19</b>  |
| b) November 2018 Quarterly Report                                  | <b>[3:50 – 4:30]</b> | <b>35</b>  |
| c) Plan amendment public input process /proposed workplans         | <b>[4:30 – 4:45]</b> | <b>95</b>  |
| d) Workplan Compliance Report for November                         | <b>[4:45 – 4:50]</b> | <b>101</b> |

### **7) Public Comments**

**[4:50 – 5:00]**

### **8) Adjournment**

**Next Subcabinet Meeting:** December 17, 2018 – 3:00 p.m. – 4:30 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

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## Olmstead Subcabinet Meeting Agenda Item

November 26, 2018

### Agenda Item:

- 4) *Approval of Minutes*
  - a) *Subcabinet meeting on October 29, 2018*

### Presenter:

*Commissioner Tingerthal (Minnesota Housing)*

### Action Needed:

- ☒ Approval Needed
- ☐ Informational Item (no action needed)

### Summary of Item:

*Approval is needed of the minutes for the October 29, 2018 Subcabinet meeting.*

### Attachment(s):

*4a) Olmstead Subcabinet meeting minutes – October 29, 2018*



**Olmstead Subcabinet Meeting Minutes**

Monday, October 29, 2018 • 3:00 p.m. to 4:30 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

**1) Call to Order****Action: NA**

Commissioner Hardy chaired the meeting in place of Commissioner Tingerthal. She called the meeting to order, welcomed everyone, and provided meeting logistics.

**2) Roll Call****Action: N/A**

**Subcabinet members present:** Shawntera Hardy, Department of Employment and Economic Development (DEED); Emily Piper, Department of Human Services (DHS); and Roberta Opheim, Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD)

**Subcabinet members on the phone:** Mary Tingerthal, Minnesota Housing

**Designees present:** Gil Acevedo, Minnesota Department of Health (MDH); Tim Henkel, Department of Transportation (DOT); Deb Kerschner, Department of Corrections (DOC); Daron Korte, Minnesota Department of Education (MDE); and Rowzat Shipchandler, Minnesota Department of Human Rights (MDHR)

**Guests Present:** Mike Tessneer, Darlene Zangara and Diane Doolittle, Olmstead Implementation Office (OIO); Ryan Baumtrog and Anne Smetak (Minnesota Housing); Erin Sullivan Sutton, Alex Bartolic, Adrienne Hannert, Crystal Fairchild and Samantha Holte (DHS); Emily Jahr, Tom Delaney and Holly Anderson (MDE); Maura McNellis-Kubat (OMHDD); Danielle Dannen (DEED); Larry Eisentadt and Oriane Casale (DEED) Stephanie Lenartz and Mark Kinde (MDH); Kristie Billiar (DOT); Christina Schaffer (MDHR); Gerri Sutton (Met Council); Christen Donley (DOC); Valerie DeFor (Minnesota State); Vickie Gerrits, Accra; Jesse Bethke Gomez, Metropolitan Center for Independent Living; Mary Kay Kennedy, Advocating Change Together; Tammie Campbell, Statewide Independent Living Council; Kody Olson, Minnesota Council on Disability; Bradford Teslow, David Sherwood Gabrielson, Diane Crist and Jeff Bangsberg (members of the public)

**Guests Present via telephone:** Kim Pettman and Rebecca St. Martin (members of the public)

**Sign Language and CART providers:** Mary Catherine (Minnesota Housing); ASL Interpreting Services, Inc.; Paradigm Captioning and Reporting Services, Inc.

**3) Agenda Review**

Commissioner Hardy asked if there were any changes needed to the agenda. None were noted. She reminded any attendees interested in providing public comment to sign up in the back of the room.

**4) Approval of Minutes****a) Subcabinet meeting on September 24, 2018**

Commissioner Hardy asked if there were any changes needed to the minutes for the September Subcabinet meeting. No edits were requested.

**Motion: Approve September 24<sup>th</sup> Subcabinet meeting minutes**

**Action: Motion – Henkel Second – Korte In Favor – All**

**5) Reports****a) Chair**

On behalf of the Subcabinet, Commissioner Hardy recognized Assistant Commissioner Gil Acevedo for his service to the Department of Health and the Minnesota Olmstead Plan. This will be his last Subcabinet meeting as he is ending his service at MDH.

**b) Executive Director**

Darlene Zangara (OIO) reported that the Community Engagement Workgroup has completed a series of working meetings. She will be reporting on the outcomes at the December Subcabinet meeting. The Workgroup focused on soliciting public input for the 2019 Olmstead Plan amendment process. Key elements include soliciting public comment in two phases. One will occur in January 2019 and another from mid-February through early March 2019. Public comments may be provided through email, phone, in-person and video listening sessions. Details will be presented at the November Subcabinet meeting.

**c) Legal Office**

There was no report from the Legal Office.

**d) Compliance Office**

Mike Tessneer reported that based upon input by the Subcabinet at the September meeting the Compliance Office has received additional information to be included in the 2018 Strategic Review. The final draft will be sent to the agencies for a final review. Upon completion of the final review it will be posted for reference during the 2019 Olmstead Plan Amendment process beginning in December.

**6) Action Items****a) Direct Care and Support Services workforce Workplans**

The review of this workplan was presented by Darielle Dannen (DEED) and Alex Bartolic (DHS). They provided a review of the key elements of the Direct Care and Support Services workforce Workplans.

Workplan activities were described related to these key strategies:

- Increase worker wages and/or benefits
- Expand the worker pool
- Improve the workforce by enhancing training for direct care and support professionals
- Increase job satisfaction (including quality of the job)

**[AGENDA ITEM 4a] DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET**

- Raise public awareness by promoting direct care and support careers
- Promote service innovation
- Enhance data collection

**Questions/Comments**

- Commissioner Piper (DHS) clarified that agencies are only accountable for workplan items consistent with their authorities. For example, DHS is not the workforce agency and although they may collaborate with DEED, they cannot be responsible for tasks for which DEED has authority. The role of DHS is to ensure that people who are eligible for Medicaid have access to the needed direct care staff.
- Commissioner Piper stated that the connection between investing resources in the direct care workforce and increasing actual staff/workforce to provide the service is missing in the workplans.
- Commissioner Piper questioned if there is a way to quantitatively measure the impact that better compensation would have on the quality of life for people with disabilities.
- Deb Kerschner (DOC) and Roberta Opheim (OMHDD) asked how the data analysis would measure the result of increased compensation.
- Commissioner Hardy observed that the workplan's connection to people with disabilities is missing and needs to be addressed in the workplan.
- Commissioner Hardy expressed that if more resources are needed to address the workforce shortage that needs to be clarified (such as a need for legislative action).

Based on this discussion, Commissioner Piper moved that the report be tabled until the November 26, 2018 Subcabinet meeting. This will allow sufficient time for DEED and DHS to address the identified issues.

**Motion: Table the Direct Care and Support Services workforce Workplans, ask the agency staff to rework the workplans based on the discussion, and present the workplan with changes at the November Subcabinet for approval.**

**Action: Motion – Piper Second – Tingerthal In Favor – All**

**b) Olmstead Plan 2018-2019 Workplans**

Mike Tessneer (OIO) introduced the proposed Olmstead Workplan document and described the process used. The annual review and refresh of the Olmstead Plan workplans has been taking place over the last month. The result of the review is included in the packet beginning on page 27. All 2017-2018 workplan activities are included in this document. The last column was added to indicate the status of each activity, and an explanation of each status is included in the document. Once the Subcabinet approves the proposed workplans, a clean version of the document will be posted on the website for reference.

Agency staff presented the draft workplans, highlighting new and revised activities.

### **Questions/Comments**

#### **Person-Centered Planning Workplans**

- Roberta Opheim (OMHDD) asked MDE if person-centered planning elements are applied to students of all ages. MDE responded that it applies to students in kindergarten through twelfth grade. (PC 1B.8c)
- Deb Kerschner (DOC) asked if the person-centered planning was integrated into the Individualized Education Program (IEP) process. MDE affirmed that it was. (PC 1B.8c)
- Deb Kerschner asked if the person-centered practices tool kit is available as she had searched the web site and was not able to locate it. DHS responded that the manual/tool kit is available and can be accessed through the Disability Hub. DHS is currently reviewing the website analytics to understand when people are not able to find what they are looking for and to make necessary changes. (PC 1B.6b)
- Deb Kerschner encouraged all agencies to work on using plain language that the public can understand. (PC 1B.6b)
- Roberta Opheim (OMHDD) asked where the bulletins were that announced information on person-centered planning. The agency noted that bulletins are posted for a specified time until they are incorporated into the manual. The manual is posted and includes the critical information originally put out in the bulletin.
- Roberta Opheim offered a general statement related to training of mental and behavioral health staff training in person-centered practices. She encouraged agencies to provide training with an evaluation component to determine if the recipients mastered the course work. (PC 1B.14)
- Commissioner Tingerthal (Minnesota Housing) offered a general comment pertaining to workplan items focused on staff training. It may be helpful to keep some of these efforts in the workplans over the coming year to keep the Subcabinet informed on training progress on critical elements in the Plan. DHS reported that much of their training on person-centered practices has been consolidated into system training and will be reported to the Subcabinet annually.
- Deb Kerschner (DOC) asked about the continuation of the auditing of individual service plans to ensure they meet person-centered protocols. DHS explained that the item to design and initiate the process has been completed, however the audits and agency feedback continues and is reported in the Quarterly Reports to the Subcabinet. (PC 2B.2)

#### **Transition Services Workplans**

- DHS proposed a change to what was in the packet. The intention was that activity TS 2A.7 was being replaced by the new activity TS 2A.7 to report on implementation of the federal home and community based rule implementation by June 30, 2019. The Subcabinet accepted this modification. (TS 2A.7)



**[AGENDA ITEM 4a] DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET****Community Engagement Workplans**

- Darlene Zangara (OIO) proposed a new edit to the deadline in the handout for activity CE 5D.1E. The current deadline is November 30, 2018 but she is proposing to move the deadline to December 31, 2018. (CE 5D.1E)

**Preventing Abuse and Neglect Workplans**

- Roberta Opheim (OMHDD) observed that in the Prevention of Abuse and Neglect topic area, agencies are addressing public awareness in two ways. MDH is working on the issue of developing a plain language version of the patient bill of rights. This will result in educating providers, individuals with disabilities and their families and supporters, and lead agencies. DHS will complete an analysis of the MAARC data on abuse and neglect and use this to disseminate alerts on critical areas to key stakeholders. DHS has agreed to do a presentation on this activity at a future Subcabinet meeting.

**Motion: The Subcabinet approves the agency workplans as presented.**

**Action: Motion – Tingerthal Second – Piper In Favor - All**

**c) Workplan Compliance Report for October**

Mike Tessneer (OIO) reported that seven workplan items were reviewed this month and there were no exceptions to report. The list of activities reviewed were included in the workplan compliance report in the meeting packet.

**Motion: Subcabinet accepts the October Workplan Compliance Report**

**Action: Motion – Piper Second – Rowzat In Favor - All**

**7) Informational Items and Reports****a) Quality of Life Survey 5C – Monthly report on implementation**

Darlene Zangara (OIO) provided a brief update on progress in completing the Quality of Life Survey. She reported that the contractor has reached the 75% completion level and expects to complete the final 25% by the end of November as projected.

The remainder of the reports on the agenda were not presented due to time constraints, but were included in the packet.

**8) Public Comments**

Roberta Opheim (OMHDD) asked about the process to follow up on the public comment from last month's meeting raising concern about people with disabilities need for improved access to the criminal justice system and recommending expanding the Olmstead Plan to include this as a topic area and adjusting Subcabinet membership. Mike Tessneer responded that the intention was to include these recommendations in the annual Plan amendment process. It was noted that, as part of the transition process, the Olmstead Executive Order has been submitted for consideration to be continued in the next administration. Commissioners Piper and Tingerthal

both voiced support for this important issue to be considered by the new Olmstead Subcabinet.

Commissioner Hardy asked those who signed up for public comment to address the Subcabinet.

**Bradford Teslow** (member of the public)

Public Comment Form was provided and will be filed appropriately with the official meeting records. Copies were not provided to Subcabinet members. Highlights included the following:

- Consider including public safety representatives in the Subcabinet to address people with disabilities access to the justice system
- Utilize the SAMHSA guidance on trauma informed care in application of services for people with disabilities
- Increase opportunities for people with disabilities to shape changes in policy from beginning of the process through the end
- The January 2018 bulletin on investigating sex trafficking should consider people with disabilities who fall victim.
- Housing should be included in chemical health treatment and supports
- Include a requirement for MN Housing initiatives to include training in trauma informed care

**Kim Pettman** (member of the public)

Written copy of testimony was not provided. Highlights included:

- Accessibility should be included across the Olmstead Plan
- Some schools in central MN have need for improved accessibility
- Accessibility is needed in housing and health care
- A 2016 state law requires state agencies to be in accessible buildings including public meeting space.
- The Direct care workforce summit in 2016 should have emphasized the need for greater public awareness
- There needs to be greater awareness beyond the MAARC data. It should include people with disabilities, health care, transit, and other marginalized groups with a disability.
- Consider adding Admin as a member of the Subcabinet to improve how state contracts are written to address accessibility
- Increase the number of agencies sending staff to the national ADA symposium

**Rebecca St. Martin** (member of the public)

Written copy of testimony was not provided. Highlights included:

- Consider a re-branding process for the direct support staff workforce. This could improve the public understanding of this profession
- People should understand that direct care workers jobs are very different based on who they are supporting. Direct care staff could be “certified” in different types of care.

**[AGENDA ITEM 4a] DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET**

- Change the way we reference the direct care staff from staff to caregiver or partner
- Compensation needs to match the value of their work.

**Jeff Bangsberg** (member of the public)

Public Comment Form was provided partially completed and will be filed appropriately with the official meeting records. Copies were not provided to Subcabinet members. Highlights included:

- Expressed a concern that the Subcabinet action to table the proposed Direct Care and Support Services Workforce workplan until November was a disappointing delay. The delay risks slowing down the needed progress on this important issue
- We are currently in a crisis due to lack of direct care staff across the state
- It is not clear what quantifiable data is needed and how this will be helpful
- If this data is necessary, the advisory work group will work with DEED to get this data to help define what a higher wage would do to bring more people into the workforce

Commissioner Piper restated that the workplan was tabled until the agencies could address the issues raised earlier in the meeting. The revised workplan is to be presented at the November Subcabinet.

**9) Adjournment**

Commissioner Tingerthal moved for adjournment. Assistant Commissioner Acevedo seconded. The meeting was adjourned at 4:35 p.m.

**Next Subcabinet Meeting:** November 26, 2018 – 3:00 p.m. – 5:00 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul



## Olmstead Subcabinet Meeting Agenda Item

November 26, 2018

### Agenda Items:

*5(d) Compliance Office Report*

### Presenter:

*Mike Tessneer (OIO)*

### Action Needed:

- ☐ Approval Needed
- ☒ Informational Item (no action needed)

### Summary of Item:

*This is the process and timeline regarding the Plan Amendment Process. It will be reviewed during the Compliance Office Report.*

### Attachment(s):

*5 d) Plan Amendment Process*



**[AGENDA ITEM 5d]****Process to Amend the Olmstead Plan and Timeline for 2019**

The Minnesota Olmstead Plan contains a provision for reviewing and updating the Plan annually. The 38 measurable goals in the March 2018 Plan are the product of extensive work between the state agencies, the consultants, the Court, and also incorporates input from the public. Once adopted by the Subcabinet, the measurable goals were submitted to the Court. The Olmstead Subcabinet is committed to ensuring that the ongoing work under the existing measurable goals continues in order to move towards a future where people with disabilities experience lives of inclusion and integration in the community.

Beginning with the 2018 Strategic Review in September, the Subcabinet agencies conducted reviews of the 38 measurable goals to determine the progress of implementation and identify areas in which there is justification to propose amendments. Proposed amendments must be for good cause, which means modifying the Plan to address obstacles that hinder progress or modifying the Plan with new ways to increase progress.

The Olmstead Plan lays out the parameters to be used in amending the measurable goals:

**Excerpt from “Updating and Extending the Olmstead Plan” (page 106)**

*“As the Subcabinet agencies continue to implement the processes and improvements described in the measurable goals, much will be learned regarding what practices are having a positive impact on the quality of life for people with disabilities. As improvements are made in the ability to gather and use better data, there will likely be opportunities to adjust the goals to accomplish improvements more quickly or in a better way.*

*In addition to its on-going oversight of workplans, the Subcabinet and State agencies will undertake an annual review process to evaluate whether the measurable goals should be amended for future years. The Subcabinet will seek public comment regarding the existing measurable goals. Based on that feedback and the experience of the agencies over the preceding year, State agencies will develop a set of proposed amendments to the measurable goals and present them to the Subcabinet for review and approval. Any amendments that are provisionally approved by the Subcabinet will be posted for review by the public and the Court, and will allow for a specific public comment period of at least 30 days. Following the comment period, the Subcabinet will consider whether any changes to the proposed amendments are warranted as a result of the public comments. Any subsequent changes to the proposed amendments will be posted for a brief public review period prior to adoption of the amendments to the Plan by the Subcabinet.”*

The process to accomplish updating and extending of the Olmstead Plan will use the following criteria:

- The amendment process will focus on quantifiable measures of the 38 goals and associated strategies in the March 2018 Olmstead Plan.
- People with disabilities, families, and the public will have multiple opportunities to comment throughout the amendment process.
- Any amendments will be for good cause and informed by public comments and lessons learned during the implementation of the Plan and identified in the 2018 Strategic Review. Proposed amendments to the goals and/or strategies are intended to improve progress toward achieving the goals.





**[AGENDA ITEM 5d]**

The following timeline has been developed for the 2019 revision of the Olmstead Plan

**Timeline for Amending the Olmstead Plan**

<b>DATE</b>	<b>TASK</b>
September 24	Subcabinet reviews the 2018 Strategic Review of Olmstead Plan implementation
October 29	Subcabinet approves the 2018 – 2019 Olmstead Plan Workplans
November 30	Agencies submit to OIO potential amendments to the Plan
December 3 - 10	OIO prepares: <ul style="list-style-type: none"> <li>• Annual Report (including a summary of potential amendments); and</li> <li>• First draft of proposed amendments to the Plan.</li> </ul>
December 10	OIO sends to the Subcabinet: <ul style="list-style-type: none"> <li>• Annual Report (including a summary of potential amendments);</li> <li>• First draft of proposed amendments to the Plan.</li> </ul>
December 17	Subcabinet approves the Annual Report and approves releasing proposed amendments to the Plan for public comment.
December 20 – January 31	Public comment period to solicit feedback on proposed amendments. OIO sends comments received to agencies weekly (beginning January 7).
December 27	DHS submits Annual Report to the Court on behalf of the Subcabinet
February 4	Agencies submit to OIO: <ul style="list-style-type: none"> <li>• Any revisions to the proposed amendments to the Plan; and</li> <li>• A summary of how public comments were taken into consideration.</li> </ul>
February 19	OIO sends to the Subcabinet: <ul style="list-style-type: none"> <li>• Any revised proposed amendments to the Plan;</li> <li>• Summary of public comments and how they were taken into consideration in the proposed amendments to the Plan.</li> </ul>
February 25	Subcabinet approves proposed amendments to the Plan.
February 26 – March 11	Public comment period to solicit final feedback on proposed amendments. OIO sends comments received to agencies weekly.
March 12	OIO sends final public comments to agencies for consideration.
March 13	Agencies send final draft of proposed amendments to OIO.
March 18	OIO sends Final draft of the amended Plan to the Subcabinet.
March 25	Subcabinet approves the amendments to the Plan.
March 29	DHS submits amended Plan to the Court.



## Olmstead Subcabinet Meeting Agenda Item

November 26, 2018

**Agenda Item:**

*6 (a) Direct Care and Support Services workforce workplans*

**Presenter:**

*Erin Sullivan Sutton (DHS) and Darielle Dannen (DEED)*

**Action Needed:**

- ☒ **Approval Needed**
- ☐ **Informational Item (no action needed)**

**Summary of Item:**

*Attached is a proposed workplan for the implementation of the Direct Care and Support Services Workforce Report recommendations that were presented to the Subcabinet in July 2018. The first draft of these workplans were reviewed by the Subcabinet in October. This revised draft of the workplan needs to be reviewed for approval by the Subcabinet. Track changes indicate changes from the workplans that were reviewed at the October Subcabinet meeting.*

**Attachment(s):**

*6(a) Olmstead Plan Workplan – Direct Care and Support Services workforce workplans*



## Olmstead Plan Workplan – Direct Care and Support Services Workforce

**Executive Sponsors:** Claire Wilson (DHS) and Jeremy Hanson Willis (DEED)  
**Leads:** Erin Sutton-Sullivan (DHS) and Danielle Dannen (DEED)

This workplan with recommended strategies and activities was developed in response to the Cross-Agency Direct Care and Support Workforce Shortage Working Group, which submitted a recommendations report to the Olmstead Subcabinet in March, 2018. This workplan is designed to improve access to needed services and increase quality of life for people with disabilities by increasing the number of qualified direct care workers and retention of experienced workers who are needed to support people to live, work and engage in their communities. Having well-trained direct care professionals in place, leads to better health outcomes, more consistent care as turnover rates drop, and supports people to be fully participating and contributing members of society. The stakeholder working group which brought forth recommendations drew on research and expertise within Minnesota and nationally to understand the issues, and prioritize strategies to meet the challenges Minnesota faces with demographic changes that are contributing to the current workforce shortage. This is not just a workforce shortage for direct support workers needed in long-term services and supports, but in all areas of commerce in our state. In evaluating what can be committed to at this time in a workplan, state agencies recognize their role, but cannot alone resolve the workforce challenges faced by people with disabilities. Others will pursue additional strategies and complement efforts state agencies are able to do at this time. The workplan is a living document that will be modified to reflect future legislation or other opportunities to collaborate on strategies.

### GOAL:

Expand, diversify and improve the pool of workers who provide direct care and support services in order to produce meaningful progress toward alleviating the direct care and support workforce shortage in Minnesota.

### STRATEGIES:

1. Increase worker wages and/or benefits
  - Provide a livable wage to enhance job satisfaction and retention, and address statutory limits on reimbursement rates that make it difficult for providers to pay direct care and support staff a livable wage.
  - Assess the potential of creating an employee pool group consisting of direct care and support professionals throughout the state to achieve the best possible health coverage at the most affordable price.
2. Expand the worker pool to ensure that people with disabilities have the workforce they need to live, learn, work and enjoy life in the most integrated setting.
  - Expand the worker pool to non-traditional candidates.

**[AGENDA ITEM 6a]**

- Explore options to address transportation barriers for direct care workers and the people who depend on their services.
  - Provide resources to help organizations utilize recruitment and retention strategies known to increase the quality of candidates hired.
  - Develop a service corps through partnerships with colleges, universities, and/or private partners.
  - Develop apprenticeship opportunities
3. Improve the workforce by enhancing training for direct care and support professionals
    - Assess the value of developing a training and scholarship program consistent with DEED's career pathway model.
    - Promote use of existing training and development options.
  4. Increase job satisfaction (including quality of the job)
    - Ensure access to effective supervision.
  5. Raise public awareness by promoting direct care and support careers
    - Leverage Minnesota's career, training, and business services to develop a statewide recruitment and promotional plan to attract jobseekers to direct care worker careers.
    - Create a recruitment and retention guide, promotional materials, and public service announcements on direct care and support careers targeted to potential workers.
    - Develop an educational awareness plan on direct care and support careers targeted to high school students.
  6. Promote service innovation
    - Identify and promote the use of technology solutions.
    - Examine possible policy or regulatory barriers to the employment of potential workers or the accessibility of services by the people who need them.
  7. Enhance data collection
    - Gather and report longitudinal direct care and support workforce data across long-term services and supports in Minnesota.
    - Identify ongoing data needs for monitoring workforce issues.
    - Gather and report annual direct care and support workforce data across service types and populations receiving long-term services and supports.
    - Monitor improvements or worsening of the workforce issues based on baseline data.
    - Provide funding to allow monitoring of the relationship between critical incidents, recidivism of institutionalization, and emergency room visits based on reductions or increases in vacancy and turnover rates.
    - Articulate an ideal monitoring system and data needs, determine existing data sources, determine gaps.

**Strategy 1:** Increase worker wages and/or benefits

1	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A.1	<p>Conduct analysis for a competitive workforce wage adjustment for Direct Care Workers (DCW) providing Home and Community Based Services (HCBS), with options for a one-time increase in compensation and indexed adjustments every two years. This will be based on the average of the Bureau of Labor Statistics Occupational Classifications (SOC) codes for similarly skilled/educated occupations and include total compensation.</p> <p>In addition, conduct analysis for bringing all DCW base wages up to the level of the highest DCW base wage, <u>as the highest priority for wage increases.</u></p> <p>Provide analysis of these changes on Waiver services, Personal Care Assistants (PCA) and Home Care Nursing. Provide analysis to <u>the Subcabinet. DHS leadership.</u></p>	<p><u>If acted upon through legislation, a competitive workforce wage and parity among DCWs will enable people with disabilities and providers of HCBS services to address current difficulties in attracting and retaining quality direct care workers to meet the health and safety, employment and community engagement needs of people receiving support across the state.</u></p> <p><u>More frequent adjustments will make HCBS rates keep pace with economic changes.</u></p> <p><u>HCBS rates will keep pace with economic changes.</u></p> <p><u>Rates will be adjusted to reflect price inflation and wage changes from every five years to every two years.</u></p> <p><u>These changes will enable the state to address challenges in attracting and retaining quality direct care staff to meet the demands of people needing support across the state.</u></p>	Provide analysis to <u>the Subcabinet. DHS leadership</u> by <b>January 31, 2019</b>	DHS
A.2	<p>Conduct analysis of Personal Care Assistant (PCA) reimbursement rates to allow for differentiation of rates based on the level of training and care required by the person receiving services. Provide analysis to <u>the Subcabinet. DHS leadership.</u></p>	<p><u>A report on what is required to adjust PCA rates to take into account higher levels of skills and training required to support people with greater and more complex support needs will be available to interested parties, including legislators, state agencies, providers, researchers, advocates and people who use services and their allies as they consider strategies to address workforce pressures.</u></p> <p>PCA rates will be responsive to meet the needs of people across the state.</p>	Provide analysis to <u>the Subcabinet. DHS leadership</u> by <b>January 31, 2019</b>	DHS

## [AGENDA ITEM 6a]

1	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A.3	Provide analysis and technical assistance to stakeholders who are interested in building support for legislation:  (Reimbursement rates and some DCW compensation rates are regulated in Minnesota through statute.)	Stakeholders will have sufficient understanding on reimbursement rates and DCW compensation rates in order to form recommendations for implementing a cost-based rate framework for Personal Care Assistance (PCA) services. This will help address the unprecedented challenges the state is experiencing in attracting and retaining quality staff needed to support people in their homes and community.	Complete technical assistance by <b>June 30, 2019</b>	DHS
A.4	Provide analysis to DHS leadership for an annual Direct Care Workforce study that will assess the health of the labor market for Medicaid-funded home and community-based services.	Policy makers, people with disabilities and service providers will be informed of HCBS direct care labor market trends and provider costs over time.	Provide analysis to DHS leadership by <b>January 31, 2019</b>	DHS
B.1	In partnership with the University of Minnesota's Institute on Community Integration (ICI) and <del>major</del> HCBS provider trade associations, conduct a sample-based provider survey on <u>the</u> direct care workforce in Minnesota.  Report to the Subcabinet the results of the survey. The report will include: <ul style="list-style-type: none"> <li>the number of direct care workers employed full-time and part-time;</li> <li>average wage for direct care staff and supervisors;</li> <li>access to and utilization of benefits for workers; and</li> <li>retention of staff.</li> </ul>	Report on <u>reimbursement rate wages and benefits</u> for <u>DCWs providing</u> HCBS for services will be available to interested parties, including legislators, state agencies, providers, researchers, advocates and people who use services and their allies as they consider strategies to address workforce pressures.	Report to the Subcabinet by <b>May 31, 2019</b>	DHS, ICI, <u>providers</u>
B.2	During the provider survey (in B.1), ICI will pilot a survey of direct care workers. Report to the Subcabinet on results of this survey.	Report on direct care worker survey will be available to <u>interested parties</u> to understand the workforce issues from the perspective of the worker, rather than the providers.	Report to the Subcabinet by <b>May 31, 2019</b>	DHS, ICI



## [AGENDA ITEM 6a]

1	Key Activity	Expected Outcome	Deadline	Agency/ Partners
C.1	Convene a group of experts to explore options to maximize the purchasing power of Direct Care Workers (DCWs) for benefits. Report to the Subcabinet on the outcomes of the discussion and <u>options identified. Make report available to other interested parties including legislators, advocates and providers.</u>	Identify options to maximize the purchasing power of DCWs for benefits. <u>This information will be shared with interested parties for their consideration.</u>	Report to the Subcabinet by <b>March 31, 2019</b>	DEED, <u>DHS</u>

**Strategy 2:** Expand the worker pool to ensure that people with disabilities have the workforce they need to live, learn, work and enjoy life in the most integrated setting.

2	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A	<p>Promote Direct Support Connect through mailings, social media and personal contacts to increase awareness of the PCA workforce shortage and recruit potential workers. The focus will be on new immigrants, students and non-traditional candidates.</p> <p>Outreach will be coordinated with</p> <ul style="list-style-type: none"> <li>• New refugee programs</li> <li>• Minnesota State colleges/universities</li> <li>• University of Minnesota</li> <li>• Private college consortiums</li> <li>• Advocacy groups</li> </ul> <p>Annually report to the Subcabinet on recruitment efforts.</p>	There will be an increase of <del>new immigrants, students and non-traditional</del> workers entering the Direct care workforce.	Report to Subcabinet on recruitment efforts beginning <b>September 30, 2019 and annually thereafter</b>	DHS, <u>stakeholders</u>

## [AGENDA ITEM 6a]

2	Key Activity	Expected Outcome	Deadline	Agency/ Partners
B	DHS will provide marketing materials promoting Direct Support Connect to DEED to make available at CareerForce (Workforce) <u>locations</u> . <u>Centers</u> throughout the State of Minnesota. <u>The goal is to expand the worker pool.</u> <u>The purpose is to increase awareness of the PCA workforce shortage and recruit potential workers</u>	More workers will register on Direct Support Connect through information received at CareerForce <u>locations</u> . <u>The goal is to expand the worker pool.</u> <u>Centers. There will be an increase of people entering the direct care workforce.</u>	Provide materials to DEED by <b>June 30, 2019</b>	DHS, DEED
C	Complete a legislative report on a transportation study related to the Waiver Transportation service. <ul style="list-style-type: none"> <li>Examine conclusions reached by MnCOTA (Minnesota Council on Transportation Access) concerning employment related transportation barriers faced by youth and low-income adults.</li> <li><del>Work with MnDOT and the Met Council to propose strategies to overcome barriers including ideas such as van pools, car sharing, and greater access to public transportation.</del></li> </ul> Report to the Subcabinet on the summary of the legislative report and recommendations for improving transportation access for people.	The study will include recommendations for service rates. The legislative report will <u>also</u> include recommendations about other strategies that could provide greater access to transportation for direct care workers <del>as well</del> .	Report to the Subcabinet by <b>May 31, 2019</b>	DHS, DOT
D	HealthForce Minnesota/Minnesota State will identify potential members of service corps: <ul style="list-style-type: none"> <li>High school juniors/seniors interested in health careers (high school credit).</li> <li>Post-secondary students interested in health careers (credits/credentials) and in other academic areas e.g.</li> </ul> This group would be provided with the potential of tuition forgiveness or scholarships for part time work commitment. Annually report to the OIO on the status of this activity.	Development of a direct <del>S</del> support service will increase the number of direct care workers available to support people with disabilities.	Report on status by <b>July 31, 2019</b> and annually thereafter	<del>DHS,</del> Health Force Minnesota

**Strategy 3:** Improve the workforce by enhancing training for direct care and support professionals

<b>3</b>	<b>Key Activity</b>	<b>Expected Outcome</b>	<b>Deadline</b>	<b>Agency/ Partners</b>
A.1	<p>Health Force Minnesota/Minnesota State Pathway Development Team will identify competencies required, available training, gaps in training, barriers/challenges to expanding training, and plan to develop an identified pathway.</p> <p>DEED's Employment and Training Program staff will <u>work with organizations on Career pathway development to ensure alignment, provide technical assistance when necessary.</u></p> <p>Report to the Subcabinet on identified gaps and barriers and recommendations to address them.</p>	Recommendations can be used to develop additional trainings for DCWs.	Report to the Subcabinet by <b>June 30, 2019</b>	DEED, <del>DHS</del> , Healthforce MN/ MN State ( <u>lead</u> )
A.2	<p>Work with Minnesota State to develop and offer courses/trainings throughout Minnesota, based on recommendations above. Annually report to the Subcabinet on status of training development.</p>	Direct care workers will have access to quality training statewide resulting in better services for people with disabilities.	Report to Subcabinet by <b>August 31, 2019</b> and annually thereafter	<del>DHS</del> , MN State
B	<p>Compile list of existing training and development options such as: PCA Choice, Service Employees International Union (SEIU), DHS Individual PCA training, agency Qualified Professionals, <u>and non-profit Career Pathways</u>, etc.</p> <p>Publicize the list of training resources to employers (agencies and individuals) and direct care and support professionals.</p>	Direct care workers will have access to quality training statewide resulting in better services for people with disabilities.	Publicize list of trainings by <b>January 31, 2019</b>	DHS

**Strategy 4:** Increase job satisfaction (including quality of the job)

4	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A	Provide information to <u>PCA</u> agencies on strategies to expedite hiring and onboarding processes for PCAs to reduce time lag, from initial recruitment of first time workers to deployment.  Annually report to OIO on status of this activity.	People with disabilities will experience a decrease in wait time for hiring and onboarding <del>of</del> new staff. This will also impact the availability of emergency staff for both traditional agencies and PCA Choice.	Report status by <b>August 31, 2019</b> and annually thereafter	DHS

**Strategy 5:** Raise public awareness by promoting direct care and support careers

5	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A	Create materials to promote <u>Direct Care Worker (DCW)</u> , <u>PCA</u> -careers including a recruitment and retention guide, marketing materials and potential public service announcements. <ul style="list-style-type: none"> <li>Analyze existing materials;</li> <li>Modify existing materials if necessary;</li> <li>Create new materials if needed</li> </ul>	A package of materials will be available to market <u>DCW</u> <del>PCA</del> careers. There will be an increase of direct care workers available to support people with disabilities.	Materials will be available by <b>June 30, 2019</b>	DHS, <del>key</del> stake-holders
B	Conduct a social media campaign to promote awareness of <u>DCW</u> , <u>PCA</u> careers and Direct Support Connect.	There will be an increase of direct care workers available to support people with disabilities.	Complete campaign by <b>June 30, 2019</b>	DHS, <del>stake-</del> holders
C.1	DHS will provide <del>a list of PCA and DCW employers</del> contact information <u>for Direct Care Worker employers</u> to DEED.	DEED will have <u>DCW employers</u> contact information to add to the CareerForce platform.	Provide list of employers by <b>March 31, 2019</b>	DHS

5	Key Activity	Expected Outcome	Deadline	Agency/ Partners
C.2	<u>DEED will reach out to Conduct outreach to PCA and DCW employers as the CareerForce platform is developed to add them to the platform. support online healthcare networking collaborations.</u> <u>DEED will encourage the involvement of DCW employers to join in CareerForce job and career fairs to expand recruitment efforts to additional job seekers.</u>	<u>Direct Care Worker employers will be aware of resources to support them in recruiting employees into their field or for open positions.</u> <u>Job seekers will have a greater awareness of direct support and career pathways. There will be an increase of direct care workers available to support people with disabilities.</u>	Outreach will begin by <b>June 30, 2019</b>	DEED
<del>C.3</del>	<del>Encourage the involvement of PCA and DCW employers to join job and career fairs to expand recruitment efforts to additional job seekers.</del>	<del>Job seekers will have a greater awareness of direct support and career pathways. There will be an increase of direct care workers available to support people with disabilities.</del>	<del>Outreach will begin by June 30, 2019</del>	<del>DEED</del>
D	Report to the Subcabinet on the efforts to promote awareness of PCA and DCW careers and the Direct Support Connect website completed in activities 5A – 5C. <del>23</del>	More people will be aware of Direct Support Connect with the goal of expanding the worker pool. <del>There will be an increase of direct care workers available to better</del> support people with disabilities.	Report to Subcabinet by <b>December 31, 2019</b>	DHS, DEED

**Strategy 6:** Promote service innovation

6	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A	<p>Promote the use of assistive technology (AT), through regional meetings with case managers and conference presentations.</p> <p>Continue participation in a workgroup to develop improvements in the service planning process; <del>and</del> <u>I</u>the use of technology will be an essential component of that planning.</p> <p>Continue to work with industry representatives on a major initiative directed toward increasing the use of technology as a response to the workforce shortage.</p> <p>Promote the Minnesota Guide to Assistive Technology website (<a href="https://mn.gov/admin/at/">https://mn.gov/admin/at/</a>), which supports people through the process of identifying how AT can help meet their support needs.</p> <p>Report to the Subcabinet on the status of these activities.</p>	Including discussion of how technology might be used to meet a person's desired outcomes during service planning will increase awareness, and use of AT. DHS provides care planners with resources to support the technology discussion. The expected outcome is an increase in the use of assistive technology and targeting use of human assistance (staff) where most needed.	Report to the Subcabinet by <b>July 31, 2019 and annually thereafter</b>	DHS, STAR, MDE,
B	<p>Expand the use of <del>monitoring</del>-technology <u>as an option to be discussed during support</u>-service planning with the goal of increasing community living, employment, and participation in meaningful activities or reducing staffing as appropriate.</p> <p>Report the status of this activity.</p>	Properly deployed <del>monitoring</del> -technology can support people to live more independently and to appropriately reduce the need for staff in some situations.	Report status by <b>June 30, 2019</b>	DHS,

## [AGENDA ITEM 6a]

6	Key Activity	Expected Outcome	Deadline	Agency/ Partners
C	Design and market Life Sharing supports as a relationship-based service models, for interested people with disabilities and people/families who want to provide support. (Life Sharing will make it possible for a person with a disability to live with a person who is willing to support them, and share experiences. It communicates mutuality: a real community life, not a service life, is the expectation.) Pursue CMS proposal if needed.  Annually report to Subcabinet on the status of the service model.	Expanded community based residential options will be available for people with disabilities.	Report on status by <b>July 31, 2019</b> and annually thereafter	DHS

## Strategy 7: Enhance data collection.

7	Key Activity	Expected Outcome	Deadline	Agency/ Partners
A	Inventory existing data sources to determine gaps in data on the direct care workforce in Minnesota.  Report to the Subcabinet.	This report focuses on publicly available data or data that DEED has the ability to compile for public release to inventory gaps in data on the direct care workforce in Minnesota. It only inventories <i>population level data</i> from surveys and administrative data sources such as Unemployment Insurance (UI) wage records.	Report to Subcabinet by <b>January 31, 2019</b>	DEED, DHS
B	Analyze incident report data (submitted to DHS) for the MA population to determine whether if admissions of people to hospitals or long-term care facilities may be due to lack of direct care workers.  If so, compile and track the number and type of incidents, associated costs if incident resulted in visit to provider/specialty/hospital. Report findings to the Subcabinet.	There will be a better understanding of the impact on direct care worker staffing shortages on unnecessary hospitalizations/nursing home admissions.	Report findings to the Subcabinet by <b>July 31, 2019</b>	DHS

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## Appendices

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ©AAIDD

2018, Vol. 56, No. 4, 234–250 DOI: 10.1352/1934-9556-56.5.234

Direct Support Professionals and Quality of Life of People with Intellectual and Developmental Disabilities

*Carli Friedman*

### Abstract

Direct Support Professionals (DSPs) are the 'backbone' of long term services and supports (LTSS) in the United States (Bogenschutz, Hewitt, Nord, & Hepperlen, 2014, p. 317). This study examined the relationship between DSPs and people with intellectual and developmental disabilities' (IDD) quality of life. To do so, we utilized Personal Outcome Measure interviews from over 1,300 people with IDD to examine the impact DSP change has at individual and organizational levels. We found DSP continuity is central to quality of life of people, including human security, community, relationships, choice, and goals. States cannot continue to provide near-poverty level reimbursement rates for DSPs and still ensure quality of life.

<https://www.nytimes.com/2000/07/16/nyregion/home-health-care-aides-are-in-demand-but-in-short-supply.html>

<https://www.apmresearchlab.org/stories/2018/11/02/a-caring-crisis-caregiving-occupations-in-minnesota-see-high-vacancies-low-unemployment>

### DEFINITIONS IN IMPLEMENTATION PLAN

- **Direct Support Connect** – is a free job board created to match people who are looking for direct care jobs with people who need personal care assistants. Each would enter a profile of what they are looking for, some characteristics about themselves, location, etc. This free statewide website will allow people to search using various criterion to find a job or a worker. It is currently supported by the Disability Services Division of DHS. The web address is [www.directsupportconnect.org](http://www.directsupportconnect.org)
- **CareerForce:** The state's unified public workforce system; combining state and federal funding to support the work of the 16 local Workforce Development Boards, the Governor's Workforce Development Board and various non-profit partners into one system. CareerForce seeks to unify an inclusive service delivery system for workforce development in the state of Minnesota that includes services in-person at our almost 50 CareerForce locations (formerly Workforce Centers) and online. The timeline for the system rebranding is November – spring 2019.

**[AGENDA ITEM 6a]**

- **HealthForce Minnesota (HFM)** is a collaborative partnership of education, industry and community that was created to increase the number and expand the diversity of healthcare workers; to integrate health science education practice and research; and to build capacity for education and industry to collaborate to enhance patient care. It is one of 8 Centers of Excellence within the Minnesota State system.
- **Minnesota State Pathways Development Team** – this is a team that will be developed of various community partners with expertise in different areas. They plan to look at current direct care jobs, their training/education requirements, and how in a career pathway someone can start out from a lower end job (like a PCA) to advance to other health related careers. They also intend to explore whether different levels could exist within a job category such as a PCA.
- **Employment and Training (ETP)** – is a division within DEED which supports Minnesotans seeking new employment through policy guidance, program administration and direct services. ETP supports local and statewide partnerships designed to develop and improve career skills and obtain employment at family sustaining wages. Division activities also support the needs of businesses in recruiting and training their current and future workforces to ensure that no Minnesotan is left on the economic sidelines.
- **CareerForce Platform** – is CareerForceMN.com which is currently in the development stages and will be an on-line platform to connect career seekers with employers. It is part of our CareerForce workforce system redevelopment. We expect the platform to be completed and launched in the spring of 2019.
- **Direct care worker (DCW)** – the general term used to describe anyone that is providing support in any type of setting, whether it be at a group home, residential facility or in a person's home., employment, etc. it is meant to be encompassing of all individuals that perform this type of work.
- **Personal care assistant (PCA)** – this term is specifically used when referring to a specific type of direct care worker who provides support under a particular Medicaid reimbursed service currently established at \$17.41 an hour and administered through a PCA agency. So a PCA would be considered to be a direct care worker but not all direct care workers are PCAs.

## Olmstead Subcabinet Meeting Agenda Item

November 26, 2018

### Agenda Items:

*6(b) November 2018 Quarterly Report*

### Presenter:

*Agency Sponsors and Leads*

### Action Needed:

- ☒ Approval Needed
- ☐ Informational Item (no action needed)

### Summary of Item:

*This is a draft of the November 2018 Quarterly Report on progress of Olmstead Plan measurable goals.*

### Attachment(s):

*6b) November 2018 Quarterly Report on Olmstead Plan Measurable Goals*



## **Minnesota Olmstead Subcabinet**

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



#### **REPORTING PERIOD**

**Data acquired through October 31, 2018**

#### **DATE REVIEWED BY SUBCABINET**

**November 26, 2018**

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**[AGENDA ITEM 6b]****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 approved for waiver funding at a reasonable pace; 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. Timeliness of waiver funding
3. Quality of life measurement results
4. Increasing system capacity and options for integration

This quarterly report includes data acquired through October 31, 2018. Progress on each measurable goal will be reported quarterly, semi-annually, or annually. Information reported for each goal includes: the overall goal, annual goal, baseline, results for the reporting period, analysis of data, comment on performance and the universe number when available. The universe number is the total number of individuals potentially impacted by the goal. This number provides context as it relates to the measure.

This quarterly report also includes Olmstead Implementation Office (OIO) compliance summary reports on the status of workplans. 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](http://Mn.gov/Olmstead).<sup>i</sup>

**EXECUTIVE SUMMARY**

This quarterly report covers twenty-seven measurable goals.<sup>ii</sup> As shown in the chart below, thirteen 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. Five goals are in process.

<b>Status of Goals – November 2018 Quarterly Report</b>	<b>Number of Goals</b>
Met annual goal	10
On track to meet annual goal	3
Not on track to meet annual goal	2
Did not meet annual goal	7
In Process	5
<b>Goals Reported</b>	<b>27</b>

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

- During this quarter, 36 individuals left ICF/DD programs to more integrated settings. After three quarters, the number is 140 which exceeds the annual goal of 72. (Transition Services Goal One A)
- During this quarter, 195 individuals with disabilities under age 65 in a nursing facility longer than 90 days moved to more integrated settings. After three quarters, 79% of the annual goal has been achieved. (Transition Services Goal One B)
- During this quarter, 272 individuals moved from other segregated settings to more integrated settings. After three quarters, the total number is 867 which exceeds the annual goal of 500. (Transition Services Goal One C)

**[AGENDA ITEM 6b]**

- Planning for individuals experiencing a transition has improved through adherence to Transition Protocols. Current performance is at 88.5% compliance. (Transition Services Goal Four)
- The utilization of the Person Centered Protocols has improved over the last four quarters. Of the eight person centered elements measured in the protocols, performance on all elements improved over the 2017 baseline. Four of the eight elements show progress over the previous quarter, and three of the eight are at 90% or greater in this quarter. (Person-Centered Planning Goal One)

**Timeliness of Waiver Funding Goal One**

- There are fewer individuals waiting for access to a DD waiver. At the end of the current quarter 73% of individuals were approved for funding within 45 days. Another 20% had funding approved after 45 days.

**Increasing system capacity and options for integration**

- The number of individuals experiencing a restrictive procedure is lower, at 644 individuals this year compared to 692 in the previous year. (Positive Supports Goal One)
- The number of reports of use of emergency use of manual restraints is lower, at 843 reports this quarter compared to 904 in the previous quarter. (Positive Supports Goal Two)
- The number of individuals approved for the emergency use of mechanical restraints at the end of the quarter is 13, which met the annual goal of 13. (Positive Supports Goal Three B)
- The number of individuals in competitive integrated employment increased by 814 in the past year. (Employment Goal Two)
- The number of women with disabilities and/or serious mental illness who had a cervical cancer screening was 27,270, which is an increase of 5,877 over baseline. (Health Care and Health Living Goal One)
- The number of children and adults with disabilities who had an annual dental visit was 33,746 over baseline. (Health Care and Healthy Living Goal Two)
- The percentage of people receiving community services within 30 days after discharge from the hospital was 94.1% and met the annual goal of 91%. (Crisis Service Four B)
- The percentage of people receiving crisis services within ten days of referral was 88.9%. This met the annual goal of 87%. (Crisis services Goal Five)

**Listed below are measurable goals targeted for improvement. Proposed steps for improvement are included in this report.**

- Transition Services Goal Two to decrease the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting.
- Transition Services Goal Three to increase the number of individuals leaving the MSH to a more integrated setting.
- Positive Supports Goal Three A to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Housing and Services Goal One to increase the number of people living in the most integrated housing of their choice.
- Lifelong Learning and Education Goal Two to increase the number of students with disabilities enrolling in integrated postsecondary education settings.
- Crisis Services Goal Four A to increase the percent of people who are housed five months after discharge from the hospital (due to a crisis).



## 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)	January – March 2018	36
• Nursing Facilities	January – March 2018	195
• Other segregated settings	January – March 2018	272
• Anoka Metro Regional Treatment Center (AMRTC)	July – September 2018	20
• Minnesota Security Hospital (MSH)	July – September 2018	15
Net number who moved from segregated to integrated settings		538

More detailed information for each specific goal is included below. The information includes the overall goal, annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance and the universe number when available. The universe number is the total number of individuals potentially impacted by the goal. This number provides context as it relates to the measure.

**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.

**Annual Goals** for the number of people moving from (A) ICFs/DD; (B) nursing facilities; and (C) 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	June 30, 2018
<b>A)</b> Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84	84	72
<b>B)</b> Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740	740	750
<b>C)</b> Segregated housing other than listed above	1,121	50	250	400	500
<b>Total</b>		<b>874</b>	<b>1,074</b>	<b>1,224</b>	<b>1,322</b>

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

**2018 goal**

- For the year ending June 30, 2018 the number of people who have moved from ICFs/DD to a more integrated setting will be **72**

**Baseline:** January - December 2014 = 72

**RESULTS:**

The goal is **on track** to meet the 2018 goal of 72.

Time period	Total number of individuals leaving	Transfers <sup>iv</sup> (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	138	18	62	<b>58</b>
2016 Annual (July 2015 – June 2016)	180	27	72	<b>81</b>
2017 Annual (July 2016 – June 2017)	263	25	56	<b>182</b>
2018 Quarter 1 (July – September 2017)	48	1	5	<b>42</b>
2018 Quarter 2 (October – December 2017)	81	2	17	<b>62</b>
2018 Quarter 3 (January – March 2018)	62	6	20	<b>36</b>
<b>Totals (Q1 + Q2 + Q3)</b>	<b>191</b>	<b>9</b>	<b>42</b>	<b>140</b>

**ANALYSIS OF DATA:**

From January – March 2018, the number of people who moved from an ICF/DD to a more integrated setting was 36. This is 26 fewer people than in the previous quarter. During the first three quarters, the total number is 140 which exceeds the annual goal of 72.

**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

**[AGENDA ITEM 6b]**

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.

DHS continues to work with private providers and Minnesota State Operated Community Services (MSOCS) that have expressed interest in voluntary closure of ICFs/DD. Providers are working to develop service delivery models that better reflect a community-integrated approach requested by people seeking services. A total of 12 out of 15 MSOCS ICFs/DD converted since January 2017 for a reduction of 72 state-operated ICF/DD beds. DHS is working with one county to determine the best way to serve the 12 adults currently being served in the remaining three settings. No timeline for conversion of these homes has been confirmed.

For the period January through June 2018, a total of 51 ICF/DD beds were decertified in six locations. One facility decertified 8 beds that were vacant. The remaining five facilities (43 beds) were closed.

**UNIVERSE NUMBER:**

In June 2017, there were 1,383 individuals receiving services in an ICF/DD.

**TIMELINESS OF DATA:**

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

**B) NURSING FACILITIES****2018 goal**

- For the year ending June 30, 2018, 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 **750**.

**Baseline:** January - December 2014 = 707

**RESULTS:**

The goal is **on track** to meet the 2018 goal of 750.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	1,043	70	224	<b>749</b>
2016 Annual (July 2015 – June 2016)	1,018	91	198	<b>729</b>
2017 Annual (July 2016 – June 2017)	1,097	77	196	<b>824</b>
2018 Quarter 1 (July – September 2017)	264	14	48	<b>202</b>
2018 Quarter 2 (October – December 2017)	276	21	54	<b>201</b>
2018 Quarter 3 (January – March 2018)	259	20	44	<b>195</b>
<b>Totals (Q1 + Q2 + Q3)</b>	<b>799</b>	<b>55</b>	<b>146</b>	<b>598</b>

**[AGENDA ITEM 6b]****ANALYSIS OF DATA:**

From January – March 2018, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 195. This is 6 fewer people than in the previous quarter. After three quarters, the number is 79% of the annual goal of 750. The goal is on track.

**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.

**UNIVERSE NUMBER:**

In June 2017, there were 1,502 individuals with disabilities under age 65 who received services in a nursing facility for longer than 90 days.

**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.

**[AGENDA ITEM 6b]****C) SEGREGATED HOUSING****2018 goal**

- For the year ending June 30, 2018, the number of people who have moved from other segregated housing to a more integrated setting will be **500**.

**BASELINE:** During July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to a more integrated setting.

**RESULTS:**

The goal is **on track** to meet the 2018 annual goal of 500.

Time period	Total moves	Receiving Medical Assistance (MA)			No longer on MA
		Moved to more integrated setting	Moved to congregate setting	Not receiving residential services	
2015 Annual (July 2014 – June 2015)	5,703	<b>1,137 (19.9%)</b>	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
2016 Annual (July 2015 – June 2016)	5,603	<b>1,051 (18.8%)</b>	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
2017 Annual July 2016 – June 2017	5,504	<b>1,054 (19.2%)</b>	492 (8.9%)	3,466 (63.0%)	492 (8.9%)
2018 Quarter 1 (July – September 2017)	1,461	<b>298 (20.4%)</b>	110 (7.5%)	922 (63.1%)	131 (9.0%)
2018 Quarter 2 (October – December 2017)	1,381	<b>297 (21.5%)</b>	116 (8.4%)	854 (61.8%)	114 (8.3%)
2018 Quarter 3 (January – March 2018)	1,522	<b>272 (17.9%)</b>	143 (9.4%)	972 (63.8%)	135 (8.9%)
<b>Total (Q1 + Q2 + Q3)</b>	<b>4,364</b>	<b>867 (19.9%)</b>	<b>369 (8.5%)</b>	<b>2,748 (62.9%)</b>	<b>380 (8.7%)</b>

**ANALYSIS OF DATA:**

From January – March 2018, of the 1,522 individuals moving from segregated housing, 272 individuals (17.9%) moved to a more integrated setting. During the first three quarters, the total number is 867 which exceeds the annual goal of 500.

**COMMENT ON PERFORMANCE:**

There were significantly more individuals who moved to more integrated settings (17.9%) than those who moved to congregate settings (9.4%). This analysis also shows the number of individuals who are not receiving residential services and those no longer on MA. These categories are defined below.

The data indicates that a large percentage (63.8%) 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.

**[AGENDA ITEM 6b]**

**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)

**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.

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

**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.

**[AGENDA ITEM 6b]**

**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>v</sup> will be reduced to 30% (based on daily average).

**2019 goal**

- By June 30, 2019, the percent of people at AMRTC awaiting discharge will be reduced to  $\leq 30\%$

**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 2019 goal of  $\leq 30\%$ .

Time period	Percent awaiting discharge (daily average)	
2016 Baseline (July 2015 – June 2016)	Daily Average = 42.5% <sup>2</sup>	
	Mental health commitment	Committed after finding of incompetency
2017 Annual (July 2016 – June 2017)	44.9%	29.3%
2018 Annual (July 2017 – June 2018)	36.9%	23.8%
2019 Quarter 1 (July – September 2018)	50.9%	27.7%

**ANALYSIS OF DATA:**

From July – September 2018, 50.9% 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. This percentage is higher than 7 of the last 8 quarters. The goal is not on track to meet the 2019 goal to reduce the percentage awaiting discharge to 30%.

From July – September 2018, 17 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 those who were civilly committed after being found incompetent on a felony or gross misdemeanor charge who moved to integrated settings.

<sup>1</sup> The baseline included individuals at AMRTC under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency).

<sup>2</sup> This data for July 2015 - June 2016 was reported as a combined percentage for individuals under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency). After July 2016, the data is reported for the two categories.

Time period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moves to integrated setting by	
					Mental health commitment	Committed after finding of incompetency <sup>vi</sup>
July 2016 – June 2017	267	155	2	110	54	56
July 2017 – June 2018	274	197	0	77	46	31
Quarter 1 (July – Sept 2018)	71	51	0	20	17	54

**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.

The percentage of patients hospitalized at AMRTC who are civilly committed after being found incompetent continues to increase and is currently around 75%.

The percentage of patients hospitalized at AMRTC who are under mental health commitment only is around 25%. With the continued decrease in the number of patients hospitalized at AMRTC under only mental health commitments, every patient not needing hospital level of care has greater impact on the overall percentage.

During the last year there was a higher percentage of individuals awaiting discharge for those under mental health commitment (50.9%) than for those who were civilly committed to AMRTC after being found incompetent (27.7%). However, the percentage of patients hospitalized at AMRTC who are civilly committed after being found incompetent continues to increase and is currently around 75%.

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 and discharge 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.
- Improvements in AMRTC's notification process to courts and parties in criminal cases for individuals who were civilly committed after a finding of incompetency who no longer meet hospital criteria of care.



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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 has convened 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 the community. Counties and community providers will be consulted and engaged in this effort as well. Annual reporting to the Olmstead Subcabinet on the status of these efforts will begin by December 31, 2018.

**UNIVERSE NUMBER:**

In Calendar Year 2017, 383 patients received services at AMRTC. This may include individuals who were admitted more than once during the year. The average daily census was 91.9.

**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.

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**2018 goal**

- By December 31, 2018 the average monthly number of individuals leaving to a more integrated setting will increase to  $\geq 9$

**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 2018 goal of 9.

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
January – December 2017	199	114	9	76 Average = 6.3
Quarter 1 (Jan – March 2018)	64	47	2	15 Average = 5.0
Quarter 2 (April – June 2018)	53	32	0	21 Average = 7.0
Quarter 3 (July – Sept 2018)	44	28	1	15 Average = 5.0

**ANALYSIS OF DATA:**

From July – September 2018, the average monthly number of individuals leaving Forensic Services<sup>3</sup> to a more integrated setting was 5. The average number moving to an integrated setting decreased from 7 in the previous quarter. The goal is not on track to meet the annual goal of 9.

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 (those civilly committed after being found incompetent on a felony or gross misdemeanor charge, those who are committed as Mentally Ill and Dangerous (MI&D), 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 called Forensic Services.

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<b>Time period</b>	<b>Type <sup>vi</sup></b>	<b>Total moves</b>	<b>Transfers</b>	<b>Deaths</b>	<b>Moves to integrated</b>
January – December 2015	Committed after finding of incompetency	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	Committed after finding of incompetency	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>
January – December 2017	Committed after finding of incompetency	133	94	2	27
	MI&D committed	55	17	6	32
	Other committed	11	3	1	7
	<b>Total</b>	<b>199</b>	<b>114</b>	<b>9</b>	<b>(Avg. 6.3) 76</b>
Quarter 1 (Jan – March 2018)	Committed after finding of incompetency	45	36	0	9
	MI&D committed	19	11	2	6
	Other committed	0	0	0	0
	<b>Total</b>	<b>64</b>	<b>47</b>	<b>2</b>	<b>(Avg. 5.0) 15</b>
Quarter 2 (April – June 2018)	Committed after finding of incompetency	31	24	0	7
	MI&D committed	21	8	0	13
	Other committed	1	0	0	1
	<b>Total</b>	<b>53</b>	<b>32</b>	<b>0</b>	<b>(Avg. 7.0) 21</b>
Quarter 3 (July – Sept 2018)	Committed after finding of incompetency	31	20	0	11
	MI&D committed	12	7	1	4
	Other committed	1	1	0	0
	<b>Total</b>	<b>44</b>	<b>8</b>	<b>1</b>	<b>(Avg. 5.0) 15</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 in 2017 increased the base funding for state operated facilities 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. These positions are primarily in direct care positions such as registered nurses, forensic support specialists and human services support specialists. As of September 2018, 97% of professional positions are filled and 96.2% of direct care positions were filled.

**[AGENDA ITEM 6b]****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.
- Individuals whose county case management staff has refused or failed to adequately participate in developing an appropriate provisional discharge plan for the individual

Some barriers to discharge identified by the Special Review Board (SRB), in their 2017 MI&D Treatment Barriers Report as required by Minnesota Statutes 253B.18 subdivision 4c(b) included:

- The patient lacks an appropriate provisional discharge plan
- A placement that would meet the patient's needs is being developed
- Funding has not been secured

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. As a result of these efforts, through November 2018, Forensic Services recommended reductions-in-custody to the Special Review Board for 73 individuals, 55 of which were granted thus far, with 11 results pending.
- Collaboration within DHS to expand community capacity and individualized services for a person's transitioning.

**Committed after finding of incompetency**

Forensics also admits and treats individuals who are civilly committed after being found incompetent on felony or gross misdemeanor charges. These individuals are provided mental health treatment and competency education.

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DHS has convened 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. Annual reporting to the Olmstead Subcabinet on the status of these efforts will begin by December 31, 2018.

**UNIVERSE NUMBER:**

In Calendar Year 2017, 581 patients received services at MSH. This may include individuals who were admitted more than once during the year. The average daily census was 358.4.

**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, 2020, 100% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of the ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.] [Revised March 2018]

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**Baseline:** For the period from October 2017 – December 2017, of the 26 transition case files reviewed, 3 people opted out of using the My Move Plan Summary document and 1 person did not inform their case manager that they moved. Of the remaining 22 case files, 15 files (68.2%) adhered to the transition protocol.

**RESULTS:**

This goal is **in process**.

Time period	Number of transition case files reviewed	Number opted out	Number not informing case manager	Number of remaining files reviewed	Number not adhering to protocol	Number adhering to protocol
Quarter 1 July – Sept 2017	29	6	0	23	11 of 23 (47.8%)	12 of 23 (52.2%)
Quarter 2 Oct – Dec 2017	26	3	1	22	7 of 22 (31.8%)	15 of 22 (68.2%)
Quarter 3 Jan – March 2018	25	5	3	17	2 of 17 (11.8%)	15 of 17 (88.2%)
Quarter 4 April – June 2018	34	6	2	26	3 of 26 (11.5%)	23 of 26 (88.5%)

**ANALYSIS OF DATA:**

For the period from April – June 2018, of the 34 transition case files reviewed, 6 people opted out of using the My Move Plan document and 2 people did not inform their case manager that they were

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moving. Of the remaining 26 case files, 23 files (88.5%) adhered to the transition protocol. Adherence to the transition protocols has improved over the last three quarters.

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 will the person 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.

In addition to reviewing for adherence to the transition protocols (use of the My Move Plan document), case files are reviewed for the presence of person-centered elements. This is reported in Person-Centered Planning Goal One.

**COMMENT ON PERFORMANCE:**

In January 2018, Lead Agency Review began requiring lead agencies to remediate missing or non-compliant 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. Corrective action plans will be required when patterns of non-compliance are evident. Because the move occurred prior to the Lead Agency site review, transition measures related to the contents of the My Move Plan Summary cannot be remediated. However, Lead Agencies are provided information about which components of the My Move Plan were compliant/non-compliant for each of the transition cases that were reviewed.

**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. TIMELINESS OF WAIVER FUNDING

This section reports progress of individuals being approved for home and community-based services waiver funding. An urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The 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. The goal reports the number of individuals that have funding approved at a reasonable pace and those pending funding approval.

**TIMELINESS OF WAIVER FUNDING GOAL ONE:** Lead agencies will approve funding at a reasonable pace for persons: (A) exiting institutional settings; (B) with an immediate need; and (C) with a defined need for the Developmental Disabilities (DD) waiver. [Revised March 2018]

**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	Reasonable Pace 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 in process.

#### Time period: July – September 2017

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	29	21 (72%)	6 (21%)	2 (7%)
Immediate Need	122	83 (68%)	32 (26%)	7 (6%)
Defined Need	297	189 (64%)	80 (27%)	28 (9%)
<b>Totals</b>	<b>448</b>	<b>293 (66%)</b>	<b>118 (26%)</b>	<b>37 (8%)</b>

#### Time Period: October – December 2017

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	28	14 (50%)	12 (43%)	2 (7%)
Immediate Need	110	74 (67%)	34 (31%)	2 (2%)
Defined Need	229	141 (62%)	71 (31%)	17 (7%)
<b>Totals</b>	<b>367</b>	<b>229 (62%)</b>	<b>117 (32%)</b>	<b>21 (6%)</b>

**Time Period: January - March 2018**

<b>Urgency of Need Category</b>	<b>Total number of people assessed</b>	<b><u>Reasonable Pace</u> Funding approved within 45 days</b>	<b>Funding approved after 45 days</b>	<b>Pending funding approval</b>
Institutional Exit	19	16 (84%)	2 (11%)	1 (5%)
Immediate Need	114	79 (69%)	26 (23%)	9 (8%)
Defined Need	256	177 (69%)	63 (25%)	16 (6%)
<b>Totals</b>	<b>389</b>	<b>272 (70%)</b>	<b>91 (24%)</b>	<b>26 (7%)</b>

**Time Period: April - June 2018**

<b>Urgency of Need Category</b>	<b>Total number of people assessed</b>	<b><u>Reasonable Pace</u> Funding approved within 45 days</b>	<b>Funding approved after 45 days</b>	<b>Pending funding approval</b>
Institutional Exit	20	12 (60%)	6 (30%)	2 (10%)
Immediate Need	121	89 (74%)	26 (21%)	6 (5%)
Defined Need	311	227 (73%)	61 (20%)	23 (7%)
<b>Totals</b>	<b>452</b>	<b>328 (73%)</b>	<b>93 (20%)</b>	<b>31 (7%)</b>

**ANALYSIS OF DATA:**

From April – June 2018, of the 452 individuals assessed for the Developmental Disabilities (DD) waiver, 328 individuals (73%) had funding approved within 45 days of the assessment date. In the previous quarter, of the 389 individuals assessed, 272 individuals (70%) had funding approved within 45 days of assessment. This quarter achieved the highest proportion of people being approved for funding within 45 days since the measure has been in place, even with a greater number of people receiving assessments.

**COMMENT ON PERFORMANCE:**

Lead agencies receive monthly updates regarding the people who are still waiting for DD funding approval through a web-based system. Using this information, lead agencies can view the number of days a person has been waiting for DD funding approval 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 individuals pending funding approval on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When these issues arise, 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 pending funding approval issues occur and has added staff resources to monitor compliance with reasonable pace goals.

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.



**[AGENDA ITEM 6b]**

Below is a summary table with the number of people still waiting for funding approval at specific points of time. Also included is the average and median days waiting of those individuals who are still waiting for funding approval. The average days and median days information has been 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 waiting for funding approval as of July 1, 2018 (94) has decreased since October 1, 2017 (152).

**People Pending Funding Approval as of April 1, 2017**

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

**People Pending Funding Approval as of July 1, 2017**

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

**People Pending Funding Approval as of October 1, 2017**

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

**People Pending Funding Approval as of January 1, 2018**

<b>Category</b>	<b>Number of people pending funding approval</b>	<b>Average days pending</b>	<b>Median days pending</b>
Institutional Exit	1	144	144
Immediate Need	22	108	74
Defined Need	66	184	140
<b>Total</b>	<b>89</b>		

**People Pending Funding Approval as of April 1, 2018**

<b>Category</b>	<b>Number of people pending funding approval</b>	<b>Average days pending</b>	<b>Median days pending</b>
Institutional Exit	5	65	61
Immediate Need	20	109	73
Defined Need	35	154	103
<b>Total</b>	<b>60</b>		

**People Pending Funding Approval as of July 1, 2018 <sup>4</sup>**

<b>Category</b>	<b>Number of people pending funding approval</b>	<b>Average days pending</b>	<b>Median days pending</b>
Institutional Exit	6	360	118
Immediate Need	26	115	85
Defined Need	62	120	70
<b>Total</b>	<b>94</b>		

**People Pending Funding Approval as of October 1, 2018**

<b>Category</b>	<b>Number of people pending funding approval</b>	<b>Average days pending</b>	<b>Median days pending</b>
Institutional Exit	12	112	74
Immediate Need	26	110	78
Defined Need	76	132	106
<b>Total</b>	<b>114</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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<sup>4</sup> During the verification process for the August 2018 Quarterly Report, DHS identified a data discrepancy for the Institutional Exit category. It was determined that there were coding errors for two individuals that inflated the numbers in the average days pending and median days pending columns. DHS worked with the counties to update the data and correct the error. Although the error has been resolved, because this is a point in time measure the data cannot be recreated to show the updated data in the table.

## IV. QUALITY OF LIFE MEASUREMENT RESULTS

The results for the 2017 National Core Indicator (NCI) survey for individuals with intellectual and developmental disabilities were published in September 2018. The national results of the NCI survey are available on their website at [www.nationalcoreindicators.org](http://www.nationalcoreindicators.org). The Minnesota state reports are also available on the NCI website at [www.nationalcoreindicators.org/states/MN](http://www.nationalcoreindicators.org/states/MN). In Minnesota, the overall sample size for the 2017 survey was 2,199.

### Summary of National Core Indicator Survey Results from Minnesota in 2016 - 2017

Each year, NCI asks people with intellectual and developmental disabilities and their families about the services they get and how they feel about them. NCI uses surveys so that the same questions can be asked to a large group. Each year people in many states take part in an NCI meeting. Every year a new group of people are asked to meet. During the meeting people are asked the NCI survey questions. The questions are asked of the person who gets services from the state. For some questions, a family member, friend, or staff member who knows the person well can answer. The summary below shows the answers that people gave to some of the NCI survey questions.

Question	2015 - 2016		2016-2017	
	Yes	No	Yes	No
1. Do you have a paid job in your community?	41%	59%	35%	65%
2. Would you like a job in the community	52%	48%	47%	53%
3. Do you like where you work?	92%	8%	89%	11%
4. Do you want to work somewhere else?	34%	66%	28%	72%
5. Did you go out shopping in the past month?*	92%	8%	92%	8%
6. Did you go out on errands in the past month?*	91%	9%	89%	11%
7. Did you go out for entertainment in the past month?*	83%	17%	82%	18%
8. Did you go out to eat in the past month?*	86%	14%	89%	11%
9. Did you go out for a religious or spiritual service in the past month?*	46%	54%	47%	53%
10. Did you participate in community groups or other activities in community in past month?	37%	63%	43%	57%
11. Did you go on vacation in the past year?	58%	42%	48%	52%
12. Did you have input in choosing your home?	56%	44%	45%	55%
13. Did you have input in choosing your roommates?	34%	66%	22%	78%
14. Do you have friends other than staff and family?	83%	17%	82%	18%
15. Can you see your friends when you want to?	77%	23%	81%	19%
16. Can you see and/or communicate with family whenever you want?	94%	6%	87%	13%
17. Do you often feel lonely?	11%	89%	10%	90%
18. Do you like your home?	89%	11%	88%	12%
19. Do you want to live somewhere else?	29%	71%	26%	74%
20. Does your case manager ask what you want?	89%	11%	84%	16%
21. Are you able to contact case manager when you want?	87%	13%	89%	11%
22. Is there at least one place you feel afraid or scared?	30%	70%	18%	82%
23. Can you lock your bedroom?	42%	58%	45%	55%
24. Do you have a place to be alone at home?	99%	1%	98%	2%
25. Have you gone to a self-advocacy meeting?	30%	70%	29%	71%

\*Asked the number of times an activity occurred in the past month. The "No" percentage indicates an answer of 0 times.

**QUALITY OF LIFE SURVEY**

The Quality of Life Survey is designed to be a longitudinal survey, which means participants will be re-surveyed in the future. The Quality of Life Baseline Survey was conducted between February and November 2017. At completion, 2,005 people, selected by random sample, participated in the survey. This survey was designed specifically for people with disabilities of all ages in all settings. In Minnesota, the survey was targeted to people who are authorized to receive state-paid services in potentially segregated settings. This survey sought to talk directly with individuals to get their own perceptions and opinions about what affects their quality of life.

The [Olmstead Plan Quality of Life Survey Baseline Report](#) was accepted by the Olmstead Subcabinet on March 26, 2018. Key baseline results were included in the May 2018 Quarterly Report and the full report was attached as an exhibit.

It is expected that subsequent Quality of Life Surveys will be conducted two or three times during the following three years to measure changes from the baseline. The next survey is expected to be completed in December of 2018. Future surveys are subject to adequate funding.

The difference between the baseline survey and follow-up surveys will be used to better understand whether increased community integration and self-determination are occurring for people with disabilities receiving services in selected settings.

The first follow-up survey is currently underway. The 2018 Quality of Life Survey began in June 2018 and will continue throughout November 2018. The goal is to capture 500 completed surveys. The surveys will be analyzed and compared to the results from the baseline survey.

As of November 14, 2018, of the 500 individuals, 453 individuals (91%) have been interviewed. Of the 47 interviews remaining to reach 500, 44 individuals are scheduled for an interview.

**Summary of activities:**

- 3,482 calls made
- 496 consents received
- 453 interviews completed
- 44 interviews scheduled

**Other key activities that have occurred to date include:**

- Outreach to providers, guardians and individuals with disabilities to establish interviews;
- Interviews are being conducted;
- Regular meetings with Olmstead Implementation Office, DHS, DEED, Quality of Life Advisory Group and the Improve Group to monitor progress; and
- Development of research questions and analysis plan for the final report.

The 2018 Quality of Life Survey Results report is expected to be presented to the Olmstead Subcabinet by December 31, 2018.

## 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. The information for each goal includes the overall goal, annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance and the universe number, when available. The universe number is the total number of individuals potentially impacted by the goal. This number provides context as it relates to the measure.

**PERSON-CENTERED PLANNING GOAL ONE:** By June 30, 2020, plans for people using disability home and community-based waiver services will meet protocols. Protocols are based on the principles of person-centered planning and informed choice. [Revised March 2018]

**Baseline:** In state fiscal year 2014, 38,550 people were served on the disability home and community-based services. From July 1, 2016 – June 30, 2017 there were 1,201 disability files reviewed during the Lead Agency Reviews. For the period from April – June 2017, in the 215 case files reviewed, the eight required criteria were present in the percentage of files shown below.

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%)

### RESULTS:

This goal is **in process**.

Time Period	(1) Preferences	(2) Dreams Aspirations	(3) Choice	(4) Rituals Routines	(5) Social Activities	(6) Goals	(7) Living	(8) Work
Baseline April – June 2017	74%	17%	79%	62%	83%	70%	80%	71%
Quarter 1 July – Sept 2017	75.9%	6.9%	93.1%	37.9%	93.1%	79.3%	96.6%	93.1%
Quarter 2 Oct – Dec 2017	84.6%	30.8%	92.3%	65.4%	88.5%	76.9%	92.3%	92.3%
Quarter 3 Jan – March 2018	84.6%	47.3%	91.6%	68.9%	93.5%	79.6%	97.5%	94.1%
Quarter 4 April – June 2018	80.2%	40.1%	92.8%	67.1%	94.5%	89.5%	98.7%	78.9%

**[AGENDA ITEM 6b]****ANALYSIS OF DATA:**

For the period from April – June 2018, in the 237 case files reviewed, the eight required criteria were present in the percentage of files shown above. Performance on all eight elements has improved over the 2017 baseline. Four of the eight elements showed progress from the previous quarter. Three of the eight are at 90% or greater this quarter.

**Total number of cases and sample of cases reviewed**

<b>Time Period</b>	<b>Total number of cases (disability waivers)</b>	<b>Sample of cases reviewed (disability waivers)</b>
Quarter 1 (July – September 2017)	934	192
Quarter 2 (October –December 2017)	1,419	186
Quarter 3 (January – March 2018)	8,613	628
Quarter 4 (April – June 2018)	1,226	237

**Counties Participating in Audits<sup>5</sup>**

<b>July – September 2015</b>	<b>October – December 2015</b>	<b>January – March 2016</b>	<b>April – June 2016</b>
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

<b>July – September 2016</b>	<b>October – December 2016</b>	<b>January – March 2017</b>	<b>April – June 2017</b>
30. Hubbard	38. Cook	44. Chisago	47. MN Prairie Alliance <sup>6</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>7</sup>		51. Beltrami
35. Polk	43. Washington		
36. Clay			
37. Aitkin			

<sup>5</sup> Agency visits are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS).

<sup>6</sup> The MN Prairie Alliance includes Dodge, Steele, and Waseca counties.

<sup>7</sup> The SW Alliance includes Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock counties.

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July – September 2017	October – December 2017	January – March 2018	April – June 2018
52. Pennington	58. Stearns	61. Dakota	64. Big Stone
53. Winona	59. McLeod	62. Scott	65. Des Moines Valley Alliance <sup>8</sup>
54. Roseau	60. Kandiyohi	63. Ramsey	66. Kanabec
55. Marshall			67. Nicollet
56. Kittson			68. Rice
57. Lake of the Woods			69. Sibley
			70. Wilkin

**COMMENT ON PERFORMANCE:**

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, DHS selected eight items as being cornerstones of a person-centered plan.

In January 2018, Lead Agency Review began requiring lead agencies to remediate missing or non-compliant 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. Corrective action plans will be required when patterns of non-compliance are evident. For the purposes of corrective action person-centered measures are grouped into two categories: development of a person-centered plan and support plan record keeping.

For the lead agencies reviewed during this time period, most counties reviewed were required to develop corrective action plans in at least one category for at least one disability waiver program. Big Stone County was not required to develop corrective action plans in the area of person-centered practices.

**UNIVERSE NUMBER:**

In Fiscal year 2017 (July 2016 – June 2017), 47,272 individuals received disability home and community-based services.

**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.

<sup>8</sup> The Des Moines Valley Health and Human Services Alliance includes Cottonwood and Jackson counties.

**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.

**2018 Goal**

- By June 30, 2018, the number of people experiencing a restrictive procedure will be **reduced by 5% from the previous year or 46 individuals**

**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 2018 goal to reduce by 5% from the previous year or 46 individuals 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
2017 Annual (July 2016 - June 2017)	692 (unduplicated)	69
<b>2018 Annual (July 2017 - June 2018)</b>	<b>644 (unduplicated)</b>	<b>48</b>
Quarter 1 (July - September 2017)	260 (duplicated)	N/A – quarterly status of annual goal
Quarter 2 (October - December 2017)	265 (duplicated)	N/A – quarterly status of annual goal
Quarter 3 (January - March 2018)	267 (duplicated)	N/A – quarterly status of annual goal
Quarter 4 (April – June 2018)	284 (duplicated)	N/A – quarterly status of annual goal

**ANALYSIS OF DATA:**

The 2018 goal to reduce the number of people experiencing a restrictive procedure by 5% from the previous year or 46 individuals was met. From July 2017 – June 2018, the number of individuals who experienced a restrictive procedure decreased from 692 to 644. This was a 7% reduction of 48 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 was met in the first year of implementation.

**COMMENT ON PERFORMANCE:**

There were 284 individuals who experienced a restrictive procedure this quarter:

- 255 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.
- 29 individuals experienced restrictive procedures other than EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). DHS staff and the External Program Review Committee (EPRC) 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



**[AGENDA ITEM 6b]**

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 EPRC 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 EPRC conducted outreach to providers in response to EUMR reports. It is anticipated the EPRC'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 purpose of EPRC engagement in these cases is to provide guidance to help reduce the frequency and/or duration of future emergency uses of manual restraint.

During Quarter 4, the EPRC conducted case reviews and offered technical assistance for 25 people identified as having high-frequency use of EUMR as reported through BIRF reports.

**UNIVERSE NUMBER:**

In Fiscal Year 2017 (July 2016 – June 2017), 42,272 individuals received services in licensed disability services, e.g., home and community-based services.

**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, 2018, the number of reports of restrictive procedures will be reduced by **369**.

**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 2018 goal to reduce by 369 to 7,006 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
2017 Annual (July 2016 – June 2017)	3,583	425
<b>2018 Annual (July 2017 – June 2018)</b>	<b>*3,739</b>	<b>+ 156</b>
Quarter 1 (July – September 2017)	991	N/A – quarterly status of annual goal
Quarter 2 (October – December 2017)	955	N/A – quarterly status of annual goal
Quarter 3 (January – March 2018)	904	N/A – quarterly status of annual goal
Quarter 4 (April – June 2018)	843	N/A – quarterly status of annual goal

\* The annual total of 3,739 is greater than the sum of the four quarters or 3,693. This is due to late submissions of 46 BIRF reports of restrictive procedures throughout the four quarters.

#### ANALYSIS OF DATA:

From July 2017 - June 30, 2018 the number of restrictive procedures reports was 3,739. The 2018 goal to reduce to 7,006 was met. During Quarter 4, there was a decrease of 61 from 904 during the previous quarter. It is important to note that the 2018 overall goal was met in the first year of implementation.

#### COMMENT ON PERFORMANCE:

There were 843 reports of restrictive procedures this quarter. Although the overall number of reports of restrictive procedures continues to decrease, there are more instances of increased use with specific people. The biggest driver is the increase in the emergency use of manual restraint; this is where engagement/intervention by the External Program Review Committee is increasing.

Of the 843 reports:

- 665 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 (EPRC) 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.

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- Beginning in May 2017, the EPRC 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 41 reports of EUMR from the previous quarter.
- 178 reports involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). The EPRC provides ongoing monitoring over restrictive procedures being used by providers with persons under the committee's purview. 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 close monitoring and engagement by the EPRC with the approved cases of emergency use of procedures enables DHS to help providers work through some of the most difficult cases of ongoing use of mechanical restraints. 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.
  - There was a decrease of 20 non-EUMR restrictive procedure reports from the previous quarter.
- 25 uses of seclusion involving 7 people were reported this quarter:
  - 15 uses involving 4 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).
  - 8 uses involving 1 person occurred as part of an approved Positive Support Transition Plan during the 11-month phase out period.
  - 1 use involved an individual at the Minnesota Sex Offender Program 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).
  - 1 report involving the unapproved use of seclusion with an individual was also reported. DHS provided technical assistance to the provider and the report was referred to Licensing intake for investigation

**UNIVERSE NUMBER:**

In Fiscal Year 2017 (July 2016 – June 2017), 42,272 individuals received services in licensed disability services, e.g., home and community-based services.

**TIMELINESS OF DATA:**

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

**POSITIVE SUPPORTS GOAL THREE:** Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544<sup>vii</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.

**2018 Goal**

- By June 30, 2018, reduce mechanical restraints to no more than  
(A) **185** reports of mechanical restraint  
(B) **13** 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 2018 goal to reduce to 185 reports was **not met**.

(B) The 2018 goal to reduce to no more than 13 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
2017 Annual (July 2016 – June 2017)	664	16
<b>2018 Annual ( July 2017 – June 2018)</b>	<b>*671</b>	<b>13</b>
Quarter 1 (July – September 2017)	192	15
Quarter 2 (October – December 2017)	167	13
Quarter 3 (January – March 2018)	158	13
Quarter 4 (April – June 2018)	153	13

\* The annual total of 671 is greater than the sum of the four quarters or 670. This is due to late submission of 1 BIRF report of mechanical restraints throughout the four quarters.

**ANALYSIS OF DATA:**

This goal has two measures.

- From July 2017 – June 2018, the number of reports of mechanical restraints was 671. This is an increase of 7 from the previous year. The 2018 goal to reduce to 185 was not met.
- At the end of the reporting period (June 2018), the number of individuals for whom the emergency use of mechanical restraint was approved was 13. This remains unchanged from the previous year. The 2018 goal to reduce to no more than 13 individuals 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

**[AGENDA ITEM 6b]**

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 EPRC were conducted by the Interim Review Panel.

Of the 153 BIRFs reporting use of mechanical restraint in Quarter 4:

- 125 reports involved 11 of the 13 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 2 reports from Quarter 3.
  - For 2 people approved for emergency use reported, there were no uses of mechanical restraint during this quarter.
- 22 reports, involving 7 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.
- 4 reports involving 1 person was submitted by a provider whose use was within the 11-month phase out period.
- 2 reports indicating mechanical restraint for 2 individuals were, upon investigation, coding errors by the provider.

**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.)

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**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 2017 overall goal was reported in the February 2018 Quarterly Report. The status of the goal will continue to be reported.

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)
2017 Annual (July 2016 – June 2017)	62 (unduplicated)
Quarter 1 (July – September 2017)	17 (duplicated)
Quarter 2 (October – December 2017)	17 (duplicated)
Quarter 3 (January – March 2018)	15 (duplicated)

**ANALYSIS OF DATA:**

From January to March 2018, the number of people who discontinued disability waiver services after a crisis was 15. 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.

**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 15 people who discontinued waiver services because of a behavior crisis in Quarter 3:

- 9 people have since reopened to waiver services
- 6 people did not reopen to waiver services
  - 2 people and/or their guardians chose to return to the community without waiver services
  - 1 person was placed out of state in children's residential treatment
  - 2 people were civilly committed as Mentally Ill and Dangerous (MI&D) and admitted to or are awaiting admission to MSH – St Peter
  - 1 person was civilly committed as Chemically Dependent and admitted to chemical dependency treatment

**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.

**[AGENDA ITEM 6b]****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.

**PERSON CENTERED PLANNING GOAL TWO:** By 2017, increase the percent of individuals with disabilities who report that they exercised informed choice, using each individual's experience regarding their ability: to make or have input into (A) major life decisions and (B) everyday decisions, and to be (C) always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey.

	2014 Baseline	2015 Goal	2016 Goal	2017 Goal
(A) Major life decisions	40%	45% or greater	50% or greater	55% or greater
(B) Everyday decisions	79%	84% or greater	85% or greater	85% or greater
(C) Always in charge of their service and supports	65%	70% or greater	75% or greater	80% or greater

**(A) INPUT INTO MAJOR LIFE DECISIONS****2017 Goal**

- By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions will increase to 55% or higher

**Baseline:** In the 2014 NCI Survey, 40% reported they had input into major life decisions

**RESULTS:**

The 2017 goal was **not met**.

Time Period	Number Surveyed	Percent reporting they have input into major life decisions
2014 survey (Baseline)	--	40%
2015 survey	400	44.3%
2016 survey	427	64%
2017 survey	1,987	51%

**ANALYSIS OF DATA:**

The 2017 NCI survey results indicated that 51% of people reported they have input into major life decisions. The 2017 goal of 55% or higher was not met. The 2017 results of 51% are a decrease from the previous year results of 64%. However, when looking at the four data points (including the baseline) the 2016 results for this measure of 64% appears to be an outlier in the trend line.

The data for this measure is taken from the NCI-DD survey. The population surveyed included adults with Intellectual or Developmental Disabilities (I/DD) who get case management services and at least one other service. In odd numbered years, starting in 2017, the NCI-DD survey is used to look for trends at the regional level. This requires a larger sample. Therefore the sample size in odd numbered years will

**[AGENDA ITEM 6b]**

be substantially larger than the sample size in even numbered years. While there are some differences on individual questions among the regions there does not appear to be systematic regional variation.

**COMMENT ON PERFORMANCE:**

The percent of individuals reporting they have input into major life decisions decreased in 2017 as compared to 2016. One possible reason is that people are more aware of their rights and/or they may have changing expectations as they become more aware of different options. The table below shows the percentage by the setting that people live in (ICF/DD, community group residential setting, own home or parent/family home). There is substantial variation in the results of the measure based on setting.

**Percent of individuals reporting they have input into major life decisions by setting**

<b>Residential setting</b>	<b>2016</b>	<b>2017</b>
Own home	80%	74%
Live with family	77%	64%
ICF/DD	61%	48%
Group Residence	50%	41%
Foster/host	--	42%

**TIMELINESS OF DATA:**

The NCI survey is completed annually. Survey results are available once the results are determined to be accurate and verifiable.

**(B) INPUT INTO EVERYDAY DECISIONS****2017 Goal**

- By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input in everyday decisions to 85% or higher

**Baseline:** In the 2014 NCI Survey, 79% reported they had input into everyday decisions

**RESULTS:**

The 2017 goal was **met**.

<b>Time Period</b>	<b>Number Surveyed</b>	<b>Percent reporting they have input in everyday decisions</b>
2014 survey (Baseline)	--	79%
2015 survey	400	84.9%
2016 survey	427	87%
2017 survey	2,043	92%

**ANALYSIS OF DATA:**

The 2017 NCI survey results indicated that 92% of people reported they have input in everyday decisions. The 2017 goal of 85% or greater was met.



**[AGENDA ITEM 6b]**

The data for this measure was taken from the NCI-DD survey. The population surveyed included adults with Intellectual or Developmental Disabilities (I/DD) who get case management services and at least one other service. In odd numbered years, starting in 2017, the NCI-DD survey is used to look for trends at the regional level. This requires a larger sample. Therefore the sample size in odd numbered years will be substantially larger than the sample size in even numbered years.

**COMMENT ON PERFORMANCE:**

While there are some differences on individual questions among the regions there does not appear to be systematic regional variation.

**TIMELINESS OF DATA:**

The NCI survey is completed annually. Survey results are available from the national vendor once the results are determined to be reliable and valid.

**(C) ALWAYS IN CHARGE OF THEIR SERVICES AND SUPPORTS****2017 Goal**

- By 2017, increase the percent of people with disabilities other than I/DD who are always in charge of their services and supports to 80% or higher

**Baseline:** In the 2014 NCI Survey, 65% reported they were always in charge of their services and supports.

**RESULTS:**

The 2017 goal was **not met**.

Time Period	Number Surveyed	Percent reporting they are always in charge of their services and supports
2015 survey (Baseline)	--	65%
2016 survey	1,962	72%
2017 survey	377	63%

**ANALYSIS OF DATA:**

The 2017 NCI survey results indicated that 63% of people reported they are always in charge of their services and supports. The 2017 goal of 80% or greater was not met.

The data for this measure was taken from the NCI-AD survey. The population surveyed included adults with a physical disability as identified on a long-term services and supports assessment for Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), Brain Injury (BI) waivers, Home Care services or Developmental Disability screening document and who receive case management and at least one other service. In even numbered years the NCI-AD is used to look for trends at the regional level. This requires a larger sample. Therefore the sample size in even numbered years will be substantially larger than the sample size in odd numbered years.

**COMMENT ON PERFORMANCE:**

The percent of individuals reporting they are always in charge of their services and supports decreased in 2017 as compared to 2016. Further investigation was conducted on this measure. There is substantial variation based on where a person resides. The overall change from 2016 to 2017 is statistically significant. However, when testing the changes by the different residential setting, the only change that is statistically significant is the change in 'Group Home'. Therefore, the primary driver of the decrease in the percent of people who feel that they are always in control of their services and supports appears to be the change in the people who reside in Group Homes.

**Percent reporting they are always in charge of their services and supports by setting**

Residential setting	2016	2017
Own home	74%	68%
Group home	71%	49%
Foster home	77%	65%

**TIMELINESS OF DATA:**

The NCI survey is completed annually. Survey results are available from the national vendor once the results are determined to be reliable and valid.

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**HOUSING AND 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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**2018 Goal**

- By June 30, 2018, 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 4,009 over baseline to 10,026 (about 67% 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 2018 annual goal to increase by 4,009 over baseline was **not met**.

Time period	People in integrated housing	Change from previous year	Increase over baseline
2014 Baseline (July 2013 – June 2014)	5,995*	--	--
2015 Annual (July 2014 – June 2015 )	6,910*	+915	915 (15.3%)
2016 Annual (July 2015 – June 2016)	7,605*	+695	1,610 (26.8%)
2017 Annual (July 2016 – June 2017)	8,745*	+1,140	2,750 (45.8%)
2018 Annual (July 2017 – June 2018)	9,869	+1,263	3,852 (64.2%)

\*See the Addendum for information about discrepancies in these reporting periods from previously reported data.

**[AGENDA ITEM 6b]****ANALYSIS OF DATA:**

From July 2017 through June 2018 the number of people living in integrated housing increased by 3,852 (64%) over baseline to 9,869. Although the 2018 goal was not met, the increase of 3,852 was 96% of the annual goal of 4,009. The increase in the number of people living in integrated housing from July 2017 to June 2018 was 1,263 compared to an increase of 998 in the previous year.

As reported in the addendum, a new methodology is being used to report the data in this measure. All previously reported numbers dating back to 2014 were recalculated using the new method. Data was corrected back to the beginning of reporting of this measure and is included above. A change to the baseline will be proposed through the Olmstead Plan amendment process beginning in December 2018.

**COMMENT ON PERFORMANCE:**

Although the 2018 annual goal was not met, the growth 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 public assistance, 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 5,000 over baseline to 11,137 in competitive integrated employment.

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**2018 Goal**

- By June 30, 2018, the number of individuals in competitive integrated employment will increase to 8,737.

**Baseline:** In 2014, of the 50,157 people age 18-64 in Medicaid funded programs, 6,137 were in competitive integrated employment. Medicaid funded programs include: 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).

**RESULTS:**

The 2018 annual goal to increase the number of individuals in competitive integrated employment to 8,737 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
Baseline (July 2013 – June 2014)	50,157	6,137	12.2%	--	--
July 2014 – June 2015	49,922	6,596	13.2%	459	459
2017 Annual Goal (July 2015 – June 2016)	52,383	8,203	15.7%	1,607	2,066
2018 Annual Goal (July 2016 – June 2017)	54,923	<b>9,017</b>	16.4%	<b>814</b>	2,880

**ANALYSIS OF DATA:**

During July 2016 – June 2017, there were 9,017 people in competitive integrated employment earning at least \$600 a month. The 2018 goal to increase the number of individuals in competitive integrated employment to 8,737 was met.

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.

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.

**[AGENDA ITEM 6b]****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 3.5% in June of 2017.
- **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.
- **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 received federal approval for HCBS waiver amendments that allow the state to offer three new employment services: Exploration, Development, and Support. These services are now available to waiver recipients and current recipients are transitioning their services at annual reevaluations. The Minnesota Department of Human Services is providing training and technical assistance to implement these services.
- **Implementing employment innovation grants:** DHS is has executed innovation grants and is currently selecting recipients for the latest round of innovation to promote innovative ideas to improve outcomes for people with disabilities in the areas of work, living, and connecting with others in their communities.

**EDUCATION GOAL TWO:** By June 30, 2020, the number of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase by 492 (from 2,107 to 2,599). [Revised in March 2018]

### 2018 Goal

- By June 30, 2018, the number of students with disabilities who have enrolled in an integrated postsecondary setting in the fall after graduating will increase by 230 over baseline to 2,337.

**Baseline:** Based on 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 2,107 enrolled in the fall of 2014 into an integrated postsecondary institution.

### RESULTS:

The 2018 goal of 2,337 was **not met**.

Time Period	Students with disabilities graduating	Students enrolling in accredited institution of higher education	Change from baseline
2016 Baseline – 2014 SLEDs (August 2014 – July 2015 data)	6,749	2,107 (31.2%)	--
2017 Annual Goal – 2015 SLEDs (August 2015 – July 2016 data)	6,722	2,241 (33.3%)	134 (2.1%)
2018 Annual Goal – 2016 SLEDs (August 2016 – July 2017 Data)	6,648	<b>2,282 (34.3%)</b>	175 (3.1%)

### ANALYSIS OF DATA:

Of the 6,648 student with disabilities who graduated in 2016, there were 2,282 students (34.3%) who enrolled in an accredited institution of higher education in fall 2016. This was an increase of 175 over the baseline. The 2018 goal to increase to 2,337 was not met.

Beginning with the 2015 SLEDs data, additional data was provided by student race and ethnicity. This supplemental information includes the percentage of high school students with disabilities within each of five racial or ethnic groups that graduated from high school and subsequently enrolled in an accredited institution of higher education in the fall of that year. For example, in 2015, 22% of the American Indian or Alaskan Native students with disabilities who graduated from high school that year subsequently enrolled in accredited institutions of higher education.

### Percentage of graduates with disabilities in each racial/ethnic group enrolling in accredited institutions of higher education

Racial or Ethnic Group	2015 SLEDs	2016 SLEDs
American Indian or Alaskan Native	22%	23%
Asian or Pacific Islander	35%	35%
Hispanic	27%	28%
Black, not of Hispanic Origin	28%	28%
White, not of Hispanic Origin	35%	36%

**[AGENDA ITEM 6b]****COMMENT ON PERFORMANCE:**

While Minnesota saw a decrease in the number of students enrolled in institutes of higher education in the fall 2016, students may be choosing to enter into short term certificate programs, within a technical college for specific skills training. To be considered enrolled in an accredited institution of higher education for the purposes of SLEDs reporting, a student must be on a credit earning track towards a certificate, diploma, two or four year degree, or other formal award.

In addition, Minnesota continues to have a strong employment outlook and many students with disabilities are choosing to enter the job market in entry-level positions, gaining experience, independence or saving money for college, as higher education expenses continue to be on the rise. SLEDs 2016 data reported that 2,901 (44%) of students with disabilities were employed in competitive integrated employment. The SLEDs website is located at <http://sleds.mn.gov/>.

Based on a review of disaggregated data, a targeted activity was designed to increase successful postsecondary enrollment results for Black and American Indian students with disabilities. This aligns with MDE's current federal State Systemic Improvement Plan (SSIP). For school year 2017-18, MDE staff collaborated with TRIO Student Support Services currently serving students at institutions of higher education. Using a scale-up approach, for school year 2018-19, MDE will disseminate additional Minnesota Postsecondary Resource Guides at Minneapolis Technical and Community College, Hennepin Technical College and Fond Du Lac Technical College. In addition, MDE staff will share on-line training resources that are currently located on Normandale Community College website at <http://www.normandale.edu/osdresources>.

**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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**TRANSPORTATION GOAL THREE:** By 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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Greater Minnesota 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>9</sup>

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**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.

**RESULTS:**

This goal is **in process**.

**Percentage of public transportation meeting minimum service guidelines for access**

Time period	Weekday	Saturday	Sunday
December 2016 (Baseline)	47%	12%	3%
December 2017	47%	16%	5%

**ANALYSIS OF DATA:**

In Greater Minnesota the larger communities providing fixed route and complimentary para-transit 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. The increase in Sunday service is attributed to the addition of service in Rochester.

**COMMENT ON PERFORMANCE:**

Each year in January the transit systems will be analyzed for the level of service they have implemented. Transit systems do include unmet needs in their applications, but the actual service implemented can vary based on a host of factors including; lack of drivers and limited local funding share and local service priorities. Transit systems are in the process of developing their Five Year Plans which will provide greater detail on future service design.

**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>9</sup> Greater Minnesota Transit Investment Plan is available at [www.dot.state.mn.us/transitinvestment](http://www.dot.state.mn.us/transitinvestment).



**[AGENDA ITEM 6b]****Minimum Service Guidelines for Greater Minnesota<sup>10</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

**TIMELINESS OF DATA:**

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

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**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>11</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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**2017 Goal**

- By December 31, 2017 the number accessing appropriate care will increase by 518 over baseline

**Baseline:** In 2013 the number of women receiving cervical cancer screenings was 21,393.

**RESULTS:**

The 2017 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
January – December 2017	27,270	<632>	5,877

**ANALYSIS OF DATA:**

During calendar year 2017 the number of women with disabilities and/or serious mental illness who had a cervical cancer screening was 27,270. The 2017 annual goal to increase by 518 over baseline was met. The number accessing cervical cancer screenings increased steadily from the 2013 baseline through the 2015 reporting period. Although, the number decreased in 2016 and 2017 from the 2015 reporting period, the December 31, 2018 overall goal to increase by 833 has already been reached.

<sup>10</sup> Source: MnDOT Greater Minnesota Transit Investment Plan, 2017

<sup>11</sup> Appropriate care will be measured by current clinical standards.

**[AGENDA ITEM 6b]****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.

The March 2018 Olmstead Plan included a new strategy to develop and implement measures for health outcomes. The health outcome includes monitoring and reporting the number and percentage of adult public program enrollees (with disabilities) who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days. The first reporting of that measure is included below. The information is broken down in three groupings.

**Adults with disabilities with serious mental illness (SMI)**

Time Period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	14,796	3,107	21.00%
January – December 2015	16,511	3,438	20.82%
January – December 2016	12,701	2,673	21.05%
January – December 2017	12,659	2,504	19.78%

**Adults with disabilities without serious mental illness (SMI)**

Time Period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	13,977	2,780	19.89%
January – December 2015	15,117	2,931	19.39%
January – December 2016	12,593	2,469	19.61%
January – December 2017	13,467	2,549	18.93%

**Adults without disabilities**

Time Period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	3,735	295	7.90%
January – December 2015	5,351	386	7.21%
January – December 2016	2,522	159	6.30%
January – December 2017	3,109	239	7.69%

The number and rate of all-cause readmissions among people with disabilities, with and without Serious Mental Illness (SMI), dropped slightly from 2016 to 2017. A dropping rate of hospital readmissions is a positive trend. This means that people with disabilities are not experiencing a “bounce-back” to the hospital as frequently as they were in previous years. No single cause has been pinpointed for the improvement between 2016 and 2017. Health plans and hospitals have many reasons to strive toward improving these numbers, including the Integrated Care Systems Partnership initiative in Special Needs Basic Care.

**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.

**[AGENDA ITEM 6b]**

**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.

**A) CHILDREN ACCESSING DENTAL CARE****2017 Goal**

- By December 31, 2017 the number of children accessing dental care will increase by 820 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 2017 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
January – December 2017	21,439	<4,551>	5,079

**ANALYSIS OF DATA:**

During calendar year 2017 the number of children with disabilities who had an annual dental visit was 21,439. This was an increase of 5,079 over baseline. The 2017 annual goal to increase by 820 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 increased slightly in 2015 and then has decreased by 4,884 since 2015. 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. During 2017, the reduction in the number of children with an annual dental visit is likely due to how they are counted. The annual dental visit measure only counts children who were continuously enrolled with a Managed Care Organization (MCO) or as a Fee-for-Service recipient for 11 of a 12 month period. During this time frame a large MCO ended its contract with DHS in many counties. This resulted in families switching health plans and not being counted in the measure. The measure counted only people with continuous coverage in a single health plan.

**[AGENDA ITEM 6b]**

The March 2018 Olmstead Plan includes a new strategy to develop and implement measures for health outcomes. This measure includes monitoring and reporting the number of enrollees (adults and children with disabilities) who used an emergency department for non-traumatic dental services. The intention is to get a more complete picture of level of access of people with disabilities to dental care.

Time period	Number of children with emergency department visit for non-traumatic dental care	Change from previous year
January – December 2014	314	
January – December 2015	330	16
January – December 2016	324	<6>
January – December 2017	185	<139>

During 2016 and 2017, there has been a reduction in the number of children using emergency departments for non- traumatic dental care. This may be as a result of a dental collaborative that incentivizes managed care plans to closely monitor and assist in helping people find preventative dental care.

**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.

**B) ADULTS ACCESSING DENTAL CARE****2017 Goal**

- By December 31, 2017 the number of adults accessing dental care will increase by 670 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 2017 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
January – December 2017	50,060	<1,350>	28,667

**ANALYSIS OF DATA:**

During calendar year 2017 the number of adults with disabilities who had an annual dental visit was 50,060. This was an increase of 28,667 over baseline. The 2017 annual goal to increase by 670 over baseline was met. There were significant gains between the 2013 baseline year and the 2014 reporting period. The number of children with adults accessing dental care increased slightly in 2015 and then has decreased by 5,411 since 2015. It's important to note that the December 31, 2018 overall goal to increase by 1,055 has already been reached.

**[AGENDA ITEM 6b]****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. During 2017, the reduction in the number of adults with an annual dental visit is likely due to how they are counted. The annual dental visit measure only counts adults who were continuously enrolled with a Managed Care Organization (MCO) or as a Fee-for-Service recipient for 11 of a 12 month period. During this time frame a large MCO ended its contract with DHS in many counties. This resulted in families switching health plans and not being counted in the measure. The measure counted only people with continuous coverage in a single health plan.

The March 2018 Olmstead Plan added a new strategy to develop and implement measures for health outcomes. This measure includes monitoring and reporting the number of enrollees (adults and children with disabilities) who used an emergency department for non-traumatic dental services. The intention is to get a more complete picture of level of access of people with disabilities to dental care.

<b>Time period</b>	<b>Number of adults with emergency department visit for non-traumatic dental care</b>	<b>Change from previous year</b>
January – December 2014	3,884	--
January – December 2015	4,233	349
January – December 2016	4,110	<123>
January – December 2017	2,685	<1,425>

During 2016 and 2017, there has been a reduction in the number of adults using emergency departments for non- traumatic dental care. This may be as a result of a dental collaborative that incentivizes managed care plans to closely monitor and assist in helping people find preventative dental care.

**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

##### 2018 Goal

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

**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 2018 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
2016 Baseline July 2014 – June 2015	13,786	11,290 81.9%	893 6.5%	672 4.9%	517 3.7%	99 0.7%	315 2.3%
2017 Annual Goal July 2015 – June 2016	15,027	11,809 78.6%	1,155 7.7%	1,177 7.8%	468 3.1%	110 0.7%	308 2.1%
2018 Annual Goal July 2016 – June 2017	15,237	12,017 78.8%	1,015 6.9%	1,158 7.6%	559 3.7%	115 0.8%	338 2.2%

- “**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 2016 – June 2017, of the 15,237 individuals hospitalized due to a crisis, 12,017 (78.8%) were housed within five months of discharge. This was a 0.2% increase from the previous year. In the same time period there was a 0.2% decrease of individuals in a treatment facility within five months of discharge. The 2018 goal to increase to 84% was not met.

##### COMMENT ON PERFORMANCE:

There has been an overall increase in the number of individuals receiving services. In June 2017, 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

**[AGENDA ITEM 6b]**

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 working to sustain and expand the number of grantees utilizing 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 grants began in June of 2016, with a fourth round of grants planned for 2019.

**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.

**B) COMMUNITY SERVICES****2018 Goal**

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

**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 2018 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	
2016 Baseline July 2014 – June 2015	13,786	<b>12,298</b>	<b>89.2%</b>
2017 Annual Goal July 2015 – June 2016	15,027	<b>14,153</b>	<b>94.2%</b>
2018 Annual Goal July 2016 – June 2017	15,237	<b>14,343</b>	<b>94.1%</b>

**ANALYSIS OF DATA:**

From July 2016 – June 2017, of the 15,237 individuals hospitalized due to a crisis, 14,343 (94.1%) received community services within 30 days after discharge. This was a 0.1% decrease from the previous year. The 2018 goal to increase to 91% 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.

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**CRISIS SERVICES GOAL FIVE:** By June 30, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

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**2018 Goal**

- By June 30, 2018, the percent of people who receive crisis services within 10 days will increase to 87%.

**Baseline:** From July 2015 – June 2016, of the people on Medical Assistance who were referred for clinically appropriate crisis services, 85.4% received those services within 10 days. The average number of days was 2.3.

**RESULTS:**

This 2018 goal was **met**.

Time period	Number referred for crisis services	Number receiving services within 10 days	Percentage receiving services within 10 days	Average days for service
July 2015 – June 2016 (Baseline)	808	690	85.4%	2.3
July 2016 – June 2017	938	843	89.9%	2.0
July 2017 – June 2018	2,258	2,008	88.9%	2.1

**ANALYSIS OF DATA:**

From July 2017 – June 2018, of the 2,258 people referred for crisis services, 2,008 of them (88.9%) received services within 10 days. This was an increase of 3.5% over baseline and a decrease of 1.0%



**[AGENDA ITEM 6b]**

from the previous year. The average number of days waiting for services was 2.1. The 2018 goal to increase to 87% was met.

**COMMENT ON PERFORMANCE:**

After a crisis intervention, individuals are referred to crisis stabilization services. Crisis stabilization services are mental health services to help the recipient to return to/maintain their pre-crisis functioning level. These services are provided in the community and are based on the crisis assessment and intervention treatment plan.

These services:

- consider the need for further assessment and referrals;
- update the crisis stabilization treatment plan;
- provide supportive counseling;
- conduct skills training;
- collaborate with other service providers in the community; and/or
- provide education to the recipient's family and significant others regarding mental illness and how to support the recipient.

An infusion of funding during the 2016-2017 biennium supported the expansion of crisis services to 24/7 availability across the state. These crisis services include referral to stabilization services that help ensure that clients are able to return to and maintain their pre-crisis levels of functioning. Referrals to stabilization services are often made with a "warm hand-off" that is expected to ensure that clients access the new service to which they have been referred. For example, a crisis staff may sit with the client while they make the phone call to schedule the crisis stabilization service within 10 days following the crisis event. In addition, workforce development activities are underway to help ensure that an adequate number of providers are available to meet the needs of clients experiencing crisis and needing crisis stabilization services following an initial assessment and/or intervention.

**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.

**PREVENTING ABUSE AND NEGLECT GOAL FOUR:** By July 31, 2020, the number of identified schools that have had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years will decrease by 50% compared to baseline. The number of students with a disability who are identified as alleged victims of maltreatment within those schools will also decrease by 50% by July 31, 2020.

#### **2018 Goal**

- By July 31, 2018, the number of identified schools and students will decrease by 10% from baseline

**Baseline:** From July 2013 to June 2016, there were 13 identified schools that had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years. There were 66 students with a disability who were identified as alleged victims of maltreatment within those schools.

#### **RESULTS:**

This 2018 goal was **met**.

<b>Time Period</b>	<b>Number of schools with three or more investigations</b>	<b>Number of students with disabilities identified as alleged victims</b>
July 2013 - June 2016	13	66
July 2016 - June 2017	1	14
July 2017 - June 2018	1	8

#### **ANALYSIS OF DATA:**

Thirteen baseline schools were identified as having three or more investigations of maltreatment involving allegations of physical abuse of students with a disability during a three year period (July 2013-June of 2016). The identified schools were encouraged to participate in an approved Positive Behavioral Interventions and Supports (PBIS) training to help with de-escalation and behavior management skills of staff. It was expected that with participation in PBIS training the number of students with a disability who were identified as alleged victims of maltreatment (physical abuse) within the 13 identified schools would decrease.

The results in subsequent years show a reduction in the number of reports of physical abuse in those schools and number of involved students, however, a correlation between PBIS training and reduction of investigations, as well as involved number of students with disabilities as alleged victims, could not be substantiated. The observed reductions may be attributable to other involved factors, such as enhanced training opportunities on abuse and neglect, and increased online resources regarding mandated reporting and increased school accountability.

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

There has been a reduction in reports of physical abuse in the majority of the identified schools. Upon further review of the data and subsequent meetings with OIO Compliance Office, MDE will propose a revision to this goal during the 2019 Plan Amendment process. Goal revision will focus more closely on reducing actual incidence of student maltreatment with preventative strategies that are aligned with other Prevention of Abuse and Neglect activities in the Olmstead Plan.

## 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>viii</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 – December 2016	428	269	125	34	0
January – December 2017	284	251	32	8	1
January 2018	46	45	0	1	0
February 2018	20	16	2	2	0
March 2018	18	16	2	0	0
April 2018	21	19	1	1	0
May 2018	9	9	0	0	0
June 2018	15	15	0	0	0
July 2018	49	49	0	0	0
August 2018	8	8	0	0	0
September 2018	9	9	0	0	0
October 2018	7	7	0	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

### Data Discrepancy: Housing and Services Goal One

The measure used to report progress on Housing and Services Goal One includes data provided by Minnesota Housing on housing achieved through the Bridges rental assistance program. While preparing the numbers for the November 2018 Quarterly Report, Minnesota Housing detected an issue in how the outcomes were being reported. The reporting going forward will to use the new method to accurately report performance.

As a result of this work, all previously reported numbers dating back to 2014 were recalculated using the new method. Data was corrected back to the beginning of reporting of this measure and is updated in the November 2018 Report. With the updated data, the 2017 annual goal for Housing and Services was met.

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**HOUSING AND 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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### Previously Reported

Time period	People in integrated housing	Change from previous year	Increase over baseline	Annual Goal
2014 Baseline (July 2013 – June 2014)	6,017	--	--	--
2015 Annual (July 2014 – June 2015 )	6,920	+903	903 (15%)	Increase by 617 Goal Met
2016 Annual (July 2015 – June 2016)	7,608	+688	1,591 (26.4%)	Increase by 1,580 Goal Met
2017 Annual (July 2016 – June 2017)	8,606	+998	2,589 (43%)	Increase by 2,638 Goal Not met

### Updated Reporting (including updated baseline)

Time period	People in integrated housing	Change from previous year	Increase over baseline	Status of Goal
2014 Baseline (July 2013 – June 2014)	5,995	--	--	--
2015 Annual (July 2014 – June 2015 )	6,910	+915	915 (15.3%)	Increase by 617 Goal Met
2016 Annual (July 2015 – June 2016)	7,605	+695	1,610 (26.8%)	Increase by 1,580 Goal Met
2017 Annual (July 2016 – June 2017)	8,745	+1,140	2,750 (45.8%)	Increase by 2,638 Goal Met

## 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> As of the May 2018 Quarterly Report The terminology changed from "Restore to Competency" to "Committed after Finding of Incompetency." The change clarifies the status of the individual when they enter the program that works on competency (Rule 20). The population being measured in this goal did not change.

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

<sup>viii</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.

## Olmstead Subcabinet Meeting Agenda Item

November 26, 2018

**Agenda Item:**

*6 (c) Public input process proposed workplans*

**Presenter:**

*Darlene Zangara (OIO)*

**Action Needed:**

☒ **Approval Needed**

☐ **Informational Item (no action needed)**

**Summary of Item:**

*Attached is an overview of the Olmstead Plan Amendment Public Input Plan. Also attached is the proposed workplan for soliciting and utilizing public comment on Olmstead Plan implementation.*

*The workplan needs to be reviewed for approval by the Subcabinet.*

**Attachment(s):**

*6c) Public input process proposed workplans*

## **Olmstead Subcabinet Meeting Agenda Item**



## **Olmstead Plan Amendment Public Input Plan**

### **Overview**

In preparation for the annual amendment process of the Olmstead Plan, the Olmstead Implementation Office (OIO) has created the Public Input Plan for gathering and receiving input from people with disabilities, their families and the general public to ensure that feedback is utilized in the amendment process. Additionally, the Public Input Plan includes ways to report back to the public as a way to cultivate reciprocal, accessible, and inclusive communication between the Subcabinet, OIO, state agencies, people with disabilities, and the general public.

### **Summary of the Plan**

Based on the recommendations of the Olmstead Community Engagement Workgroup, OIO has created a Public Input Plan for the Olmstead Plan Amendment Process. The Public Input Plan will include the following activities:

- Four in-person and one video/phone conference listening sessions throughout the state during Round One
- Two video/phone conference listening session to gather statewide input during Round Two
- Two online platform input opportunities to gather input
- Public input opportunities through social media, email, phone, etc.

This public input process will include a statewide communications strategy, culturally competent outreach practices, and an accessible and inclusive meeting planning checklist, to reach the widest and most diverse audience possible to provide feedback on Olmstead Plan amendments.

The two periods for public input will be from December 20, 2018 -January 31, 2019 and February 26-March 11, 2019. The first period will encompass both general comments and amendment-specific comments. This first period will include five listening sessions both in-person and video/phone conference session, online input form, phone and email input. The second period will pertain to amendment-specific comments only during the video/phone conference listening session; online input form, phone and email input.

OIO will communicate with all Subcabinet agencies and their respective leads to compile and address public comments on Plan amendments, implement analysis plan and report back to the public about main themes of public comments and how the comments influenced plan amendments.

### **Next Steps**

OIO will roll out a series of communications, including tool kits and information for Subcabinet agencies and the general public. OIO will work collaboratively with Subcabinet agencies to receive public comments and close the feedback loop.



## Communications Workplan

**Strategy 2:** Strengthen two-way, reciprocal, and responsive communication among the Subcabinet, OIO, state agencies, people with disabilities, and the general public.

2	Key Activity	Expected Outcome	Deadline	Agency/ Partners
E.1	Identify key messages to be used throughout the public input process. The messages will include: an overview of the Olmstead Plan; the Plan amendment process; and opportunities for input.	Communications will have a clear, consistent message regarding the purpose of the public input and the ways the input will be gathered and considered.	Identify message by <b>December 3, 2018</b>	OIO
E.2	OIO will identify targeted groups and use strategic communications tools (social media, E-news, website, etc.) to invite written public input from people with disabilities and the general public.	Statewide awareness of the public input process and how to participate will grow through online tools and platforms.	Identify targeted groups and begin outreach by <b>December 3, 2018</b>	OIO
E.3	OIO will identify and implement specific strategies to reach people with disabilities and family members in under-represented communities.	People with disabilities and family members from under-represented communities (such as communities of color, LGBTQ communities, religious minorities, immigrants and refugees, etc.) will have opportunities to provide input into the Olmstead Plan amendment process	Identify strategies by <b>December 3, 2018</b>	OIO
E.4	OIO will submit weekly summaries of public input to Subcabinet agencies.	Comments will be sent to the Subcabinet agencies and OIO Compliance.	Weekly beginning <b>January 7, 2019</b>	OIO
E.5	OIO will post an online form to gather feedback for Round 1.	People with disabilities will have multiple opportunities to participate in the public input process for amending and extending the Olmstead Plan.	Online form posted by <b>December 20, 2018</b> thru <b>January 31, 2019</b>	OIO
E.6	OIO will post an online form to gather feedback for Round 2.	People with disabilities will have multiple opportunities to participate in the public input process for amending and extending the Olmstead Plan.	Online form posted by <b>February 26, 2019</b> thru <b>March 11, 2019</b>	OIO
E.7	OIO will facilitate as many as five listening sessions in various regions of the state to gather public input for the 1st Round. The listening sessions will be either in person or video.	Communities throughout the state will have the opportunity to provide input into the Olmstead Plan amendments.	Complete listening sessions by <b>January 31, 2019</b>	OIO

2	Key Activity	Expected Outcome	Deadline	Agency/ Partners
E.8	OIO will conduct two videoconferences or conference calls to engage people with disabilities and stakeholders from various regions of the state for the second round of public input.	People with disabilities will have multiple opportunities to participate in the public input process for amending and extending the Olmstead Plan.	Complete videoconference/ conference call by <b>March 11, 2019</b>	OIO
E.9	OIO will <b>report to the Subcabinet</b> on the engagement opportunities held throughout the state for people with disabilities and the general public to provide input into Olmstead Plan amendments. The report will include: <ul style="list-style-type: none"> <li>• Summary of activities</li> <li>• Number of individuals participating</li> <li>• Analysis of responses including themes</li> <li>• Demographic data collected for participants in public input process</li> <li>• Appendix including public comments</li> <li>• Recommendations for improvement</li> </ul>	The Subcabinet will understand the types of engagement activities held and the number participating to gather public input on the Plan amendment process.	Report to Subcabinet by <b>April 30, 2019</b>	OIO

## Olmstead Subcabinet Meeting Agenda Item

November 26, 2018

**Agenda Item:**

*6 (d) Workplan Compliance Report for November*

**Presenter:**

*Mike Tessneer (OIO Compliance)*

**Action Needed:**

- ☒ **Approval Needed**
- ☐ **Informational Item (no action needed)**

**Summary of Item:**

*This is a report from OIO Compliance on the monthly review of workplan activities. There are no exceptions to report.*

*The Workplan Compliance Report includes the list of activities with deadlines in October that were reviewed by OIO Compliance in November and verified as completed.*

**Attachment(s):**

*6c - Workplan Compliance Report for November 2018*



**[AGENDA ITEM 6d]****Workplan Compliance Report for November 2018**

Total number of workplan activities reviewed (see attached)	6	
• Number of activities completed	6	100%
• Number of activities on track	0	0%
• Number of activities reporting exception	0	0%

**Exception Reporting**

No activities are being reported as an exception.





**Workplan Reporting for November 2018 (listed alphabetically)**

<b>Activity</b>	<b>Key Activity</b>	<b>Expected Outcome</b>	<b>Deadline</b>	<b>Agency</b>	<b>Agency Response</b>
CM 2D.2	Maintain a monthly calendar to monitor and implement communication activities.	Audiences will be engaged in the Olmstead Plan implementation through communications.	8/31/2017* (monthly)	OIO	Verified as complete for November 2018 occurrence.
CR 2G	Conduct semi-annual reviews of crisis providers to identify problems in response times. Provide technical assistance to children and adult mental health crisis providers in the areas of intake screening, triage and dispatch system in order to improve response time.	Improve response times for children and adult mental health crisis providers. Quick response time increases the likelihood the crisis response can reach the following goals: (1) promote the safety and emotional stability; (2) minimize further deterioration of people in crises; (3) help people obtain ongoing care and treatment; and (4) prevent placement in settings that are more intensive, costly, or restrictive.	10/1/2018 (semi-annually)	DHS	Verified as complete for October 2018 occurrence.
ED 6B	MDE will provide professional development to each AT Project school district, with a specific curriculum delivered to Years 1, 2 and 3 participants. There will be a minimum of quarterly activities each school year.	Participating school districts will increase skills and knowledge in the provision of assistive technology services to students with IEP, with a specific focus on consideration of AT during the IEP team meeting.	10/31/2018 (annually)	MDE	Verified as complete for October 2018 occurrence.
ED 6C.1	MDE will develop and use an AT consideration framework for schools to use during the 2017-2018 school year. Annually report on the use of the framework.	Participating school districts will have an AT consideration framework to monitor efforts. The AT consideration framework for Year 1 school districts will include specifications for: (1) identification of student needs; (2) discussion of the student's environment; (3) identification of relevant student tasks; and (4) discussion of appropriate tools.	10/31/2018 (annually)	MDE	Verified as complete for October 2018 occurrence.
PR4 1B	Train program staff on database entry requirements to ensure all necessary information for specified goal is collected and stored in system.	Increase integrity and accuracy of data.	Begin by 10/1/2018 (annually)	MDE	Verified as beginning in October 2018

## [AGENDA ITEM 6d]

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency Response
QL 5C	OIO will monitor Quality of Life Survey implementation. Provide a <b>monthly report to the Subcabinet</b> on the progress of survey implementation. The report will address progress on the activities 5D – 5J below.	The Subcabinet will be apprised of action steps, benchmarks and deliverables of the Quality of Life Survey.	6/30/2018 (monthly)	OIO	Included in November 2018 Quarterly Report