DEPARTMENT OF HUMAN SERVICES

October 15, 2019

The Honorable Donovan W. Frank
United States District Court
District of Minnesota
316 North Robert Street
St. Paul, Minnesota 55101

Re: ***Jensen, et al. v. Minnesota Department of Human Services, et al.***
Court File No.: 09-CV-01775 DWF/BRT

Dear Judge Frank:

Enclosed please find the Department's October 2019 Supplemental Report. This Report is filed pursuant to the Court's June 17, 2019 Order (Doc. No. 737).

Sincerely,

Charles E. Johnson
Deputy Commissioner

CC: Shamus O'Meara, Plaintiffs' Class Counsel
Colleen Wieck, Executive Director for the Governor's Council on Developmental Disabilities
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities

Jensen Settlement Agreement
October 2019 Supplemental Report
DHS Treatment Homes Report EC 88 and EC 93

DEPARTMENT OF HUMAN SERVICES

Table of Contents

Introduction

This Supplement is in response to the Court's June 17, 2019 Order to present the Department's "assessment and analysis on the need for and current availability of treatment homes" (Doc. 737 at 40). In its Order, the Court references both Evaluation Criteria (EC) 88 and EC 93. These ECs have different requirements and apply to different efforts. Therefore, the Department reports on these ECs separately below.

EC 88

EC 88 states:

> **EC 88** - MSHS-Cambridge will be closed. There will be community treatment homes dispersed geographically. Any need for additional community treatment homes beyond four will be determined based on a specific assessment of need based on client needs with regard to such criteria as those at risk for institutionalization or re-institutionalization, behavioral or other challenges, multiple hospitalizations or other transfers within the system, serious reported injuries, repeated failed placements, or other challenges identified in previous monitoring or interventions.

As reported in past reports, on August 29, 2014 the last person transitioned out of MSHS-Cambridge to a permanent community home, the Department closed the facility as part of the terms of the Jensen Settlement Agreement (JSA) (Docs. 342 and 531) and there are currently three "Minnesota Life Bridge" (MLB) homes dispersed geographically throughout the state. (See e.g., Doc. 710 at EC 88.) MLB homes are community treatment homes and are the "Facilities" referenced in the JSA and the Comprehensive Plan of Action (CPA). MLB homes provide crisis stabilization services to individuals with developmental disabilities who exhibit severe behavioral challenges.

The Court states that "additional verification and review is necessary regarding the number of treatment homes needed to satisfy the Agreement." (Doc. 737 at 33.) The JSA, however, plainly references a specific number of treatment homes after accounting for the closure of METO and its MSHS-Cambridge successor ("…two new adult foster care transitional homes…") in Recital 7 (Doc. 136-1 at 3) and the definition of "Facility" (Doc 136-1 at 5). As a consequence, the JSA requires that there be two treatment homes that are, in effect, successors to MSHS-Cambridge (now called MLB).

Although there are now three MLB homes instead of two, the Department does not read a mandate in EC 88 requiring additional MLB homes. Indeed, EC 88 does not specifically require MLB, and only MLB, to make needs assessments. If the Department were to assess a need for additional treatment homes beyond four, then any such assessments would be conducted by professionals in the field on a broad scale encompassing, at a minimum, state-operated services and private providers, and would include the criteria noted in EC 88, such as the efforts detailed below.

Minnesota Life Bridge Treatment Homes

In accordance with EC 3, the existing MLB homes serve Minnesotans who (1) experience developmental disabilities; and (2) exhibit severe behaviors, which present a risk to public safety. Currently, this population is also served by other residential providers, including other state-operated service residential providers and private 245D-licensed providers. State-operated service providers include the Department's Community Based Services (CBS) Minnesota State Operated Community Services (MSOCS) and short-term Crisis Homes.[1]

Since the Department started gathering data on the MLB waitlist on April 1, 2018, 22 individuals on the waitlist (54%) have gone on to be served by private providers.[2] Only three of these individuals were referred to MLB again following an unsuccessful placement with a private provider. This constitutes only 4% of total MLB referrals and indicates that other providers can successfully serve individuals eligible for MLB. Because individuals with developmental disabilities who exhibit severe behaviors are successfully being served in the community by private providers or other state-operated providers, the Department does not find a need to open more MLB treatment homes.

Additionally, the Department has engaged in the activities described below that constitute needs assessments of the service needs of individuals who are at risk of institutionalization and are experiencing complex behavioral challenges. These needs assessments inform whether clients in crisis should be served by state-operated services including MSOCS homes, Crisis Homes or MLB homes, and how the Department coordinates with private providers to prevent institutionalization of clients who can live in the community.

MSOCS Homes as Safety Net

Following recommendations from a 2013 Office of the Legislative Auditor report on state-operated services, the Department convened a community-based steering committee in the spring of 2015 to provide recommendations on CBS' MSOCS homes (the Recommendations). Steering Committee members included DHS staff from DSD and DCT, as well as stakeholders such as county organizations and the Ombudsman for Mental Health and Developmental Disabilities. Attachment B contains a copy of the Recommendations, which were finalized in December 2015.

The steering committee assessed the need for "safety net" service providers in Minnesota and made recommendations to the Department in December of 2015 on how to transition MSOCS into a safety net service provider. Safety net service providers are defined as providers who have the capacity to "support an individual with complex behavioral health needs…" (Attachment B at 24). A person who meets the safety net criteria must (1) have an intellectual disability, developmental disability, mental illness, severe and persistent mental illness, or brain injury; *and* (2) exhibit behaviors or symptoms

[1] Typically, MSOCS homes provide longer-term residential services and Crisis Homes provide shorter-term residential services for individuals at risk of losing their residential placement.

[2] See Attachment A.

that present a safety risk to self and/or others, including but not limited to physical aggression, property destruction, self-harming behavior (e.g., biting, scratching, cutting, head hitting, etc.), or frequent elopement; or have a history of legal offenses or involvement with law enforcement that has limited their opportunity for placement with a community provider. These safety net criteria are consistent with the criteria identified in EC 88.

The Recommendations, among other items, recommend that MSOCS transition its service delivery away from low-need individuals who private providers could serve, and focus its service delivery on provision of temporary, transitional services for individuals who meet the safety net criteria and who other providers are unable to serve. The Recommendations include and discuss a variety of programmatic and systemic approaches to transitioning MSOCS to focus on the safety net population. Following the issuance of the Recommendations, the legislature revised CBS' statutory purpose to prioritize serving individuals with complex behavioral needs that cannot be met by private providers. Minn. Stat. § 252.50, subd. 5(a)(1).

Within external constraints on how CBS can operate, the Recommendations have significantly informed CBS policy and decision-making. CBS must ensure compliance with Minn. Stat. § 245D.10 requirements for terminating services for a person[3] and legislative directives to balance funding concerns.[4] CBS must also navigate a competitive housing market when it attempts to lease properties and a statewide workforce shortage as it seeks staff to provide services.

Pursuant to the Recommendations, CBS is currently engaging in detailed planning on how to transition MSOCS homes to safety net homes,[5] and has steadily been transitioning MSOCS homes to safety net homes. CBS' initial focus has been transitioning homes in Dakota and Hennepin counties and CBS will incorporate best practices from this initial process as it expands the transition process to other counties. In the past five years, CBS has closed 23 MSOCS homes that served individuals who did not have complex behavioral needs,[6] and has opened 22 MSOCS homes that support individuals with complex behavioral needs, consistent with the safety net provider criteria. CBS currently operates a total of 108 MSOCS homes. CBS is currently engaging in a systematic transition to provision of safety net services, and among other strategies, does not accept any new residents who do not meet the safety net definition. This work is consistent with CBS' strategic planning goals.

CBS' long-term strategy to transition MSOCS homes to safety net homes is also consistent with the Department's data in the Crisis Waitlist Analysis in Attachment A showing that the length of individual

[3] Transitioning MSOCS homes to safety net homes requires current low-needs MSOCS residents to be replaced with safety net individuals. Under Minn. Stat. § 245D.10, MSOCS cannot involuntarily terminate services for a person in order to provide services to a different person.

[4] See, for example, Minn. Stat. § 245.03 subd. 2; Minn. Stat. § 252.50 subd. 2.

[5] See, for example, Attachment C, which is a process map for how MSOCS transitions a home to a safety net provider.

[6] CBS coordinated with these individuals, the county, the individuals' support teams and private providers to ensure person-centered transitions to a private provider.

stays in Crisis Homes has been increasing over time. As indicated in Attachment A, Crisis Homes are increasingly not temporary placements but are longer-term placements. This signals a greater need for longer-term residential providers, such as MSOCS homes, which have the capacity to support individuals with complex behavioral needs, rather than additional crisis or transitional capacity to support these individuals, such as treatment homes.

Waitlists

CBS also considers information on the need for crisis services in a residential setting for individuals with complex behavioral needs and risk of institutionalization from the waitlists for state-operated Crisis Homes, Minnesota Life Bridge homes and MSOCS homes.[7] These waitlists are not exclusive; individuals may be placed on multiple waitlists as long as they meet the eligibility criteria for that waitlist. Attachment A contains data and analysis on these CBS waitlists.

The MLB waitlist is a list of all individuals who have been referred to MLB. This includes individuals who have been determined to have a developmental disability according to Minnesota Rules, part 9525.0016, subpart 2, item B; and who exhibit severe behavior that presents a risk to public safety. This list also informs the Department as to how many individuals are at risk of institutionalization at any given time for behavioral reasons. As of July 31, 2019, there were 18 individuals on the MLB waitlist.

The Crisis Homes and MSOCS waitlist data on individuals with developmental disabilities also generally inform the Department as to how many individuals with developmental disabilities are at risk of institutionalization at any given time for behavioral reasons. As shown in Attachment A, as of July 31, 2019, there were 44 individuals on the Crisis Home waitlist and 65 individuals on the MSOCS waitlist.

Private Crisis Providers

In addition to CBS' work in response to the Recommendations and CBS' analysis of waitlists, the Department's Disability Services Division (DSD) develops policy for and recruits private providers to ensure that there is adequate access to services to support individuals with complex behavioral needs in the community. For example, in April 2016, DSD issued a Request for Proposals (RFP) for private crisis respite providers to provide services for individuals with developmental disabilities and complex behavioral needs.[8] DSD worked with responders to this RFP and, as a result, 44 new crisis respite beds were opened by December 2018 by private providers to provide crisis services[9] to clients who

[7] The Department does not maintain a separate waitlist for individuals in the Single Point of Entry.

[8] See Attachment D for a copy of the RFP.

[9] Crisis services are defined as services for "Short-term care and intervention strategies provided to a person due to: need for relief and support of the caregiver and protection of the person or others living with the person; or Person's need for behavioral or medical intervention." Furthermore, "[a] person is eligible to receive crisis respite services when caregivers and service providers are not able to provide necessary intervention and protection of the person or others living with that person. Crisis respite services allow the person to avoid institutional placement." See CBSM:

are at risk of institutionalization. Additionally, in 2016, DSD issued a Request for Information (RFI) for existing crisis service providers[10] to ensure that counties who were looking for crisis providers to serve clients with complex behavioral needs had the most up-to-date information.

As described below in the section on EC 93, the Department also undertakes comprehensive data analysis efforts on crisis services to inform policies on diversion supports. This data analysis further helps identify and assess needs for state and residential providers to support individuals with complex behavioral challenges.

EC 93

EC 93 states:

> DHS will provide augmentative service supports, consultation, mobile teams, and training to those supporting the person. DHS will create stronger diversion supports through appropriate staffing and comprehensive data analysis.

The Department has strengthened diversion supports by engaging in a variety of tasks, including those detailed below, that are informed by comprehensive data analysis.[11]

Single Point of Entry Process

One of the key Department efforts to strengthen diversion supports has been the creation of the Single Point of Entry process in February 2015 (Doc. 531 at 72) and the Universal Referral Form in April 2018 (Doc. 700 at 67). In combination, these processes have substantially improved the Department's ability to locate and streamline services for individuals at risk of institutionalization.[12] Throughout the continuous improvement of the Single Point of Entry process, the Department has used data analysis to improve the process and therefore strengthen diversion supports. For example, the first design of the Single Point of Entry process was piloted to gather information on strengths and potential weaknesses of the design, which informed subsequent full implementation of the

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002429.

[10] See Attachment E for a copy of the RFI.

[11] This Supplemental Report does not address "appropriate staffing" because the Court did not raise any concerns about appropriate staffing in the June 17, 2019 Order. Past CPA Compliance Reports detail the Department's compliance with EC 93's requirements for strengthening diversion supports through appropriate staffing, as well as the other requirements of the EC. (Docs. 710, 763 at EC 93.)

[12] As discussed in the past CPA Compliance Reports (Docs. 700, 710, 763 at EC 93), the Department also uses data on individuals in the Single Point of Entry system to strengthen diversion supports by improving service coordination. Specifically, the data points that the Single Point of Entry team gathers as it works with case managers to understand individual situations allow the team to determine what services and resources are needed for that specific person to prevent or reduce institutionalization.

process.[13] In 2016, the Department engaged an external consultant to conduct a review of the Single Point of Entry process and provide recommendations on improving the process.[14] Based on the information learned from that review, the Department implemented changes such as consolidation of regional resource specialists under one supervisor, which has improved the Department's ability to efficiently divert individuals in crisis away from institutions.

Resource Guides

The Department further strengthened diversion supports in 2017 and 2018 by developing nine resource guides for families and providers who support individuals with complex behavior.[15] These resources have been disseminated by QADC Services, DSD and the University of Minnesota to provide tools for support teams of individuals across the state who are at risk of institutionalization.

The resource guides are based on analysis of data gathered in the Successful Life Project and DHS's *Jensen*/Olmstead Quality Assurance and Compliance Office (JOQACO)'s 2017 risk assessment survey of the of *Jensen* Class Members and individuals previously served at MSHS-Cambridge. This survey was designed to gather information about the nature of behavioral and medical risk in this population. Subsequent analysis of the survey data informed the creation of the nine resource guides which are intended to help individuals avoid institutionalization, among other things.[16]

Positive Behavior Supports Training

The Department also strengthened diversion supports in 2019 by creating a standardized positive behavior supports training curriculum across the Department. This ensures that Department staff have the skills necessary to reduce the likelihood that behavioral incidents would result in an individual losing their residential placement.[17] The positive behavior supports standardization project arose out of the Internal Reviewer's analysis and the Department's Quality Assurance Leadership Team's (QALT) review of an inventory of agency trainings related to individuals with disabilities. This

[13] See Attachment F for a communication describing the Single Point of Entry pilot.

[14] See Attachment G for Alliant Consulting Report.

[15] Links to each resource guide are available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646A-ENG; https://mn.gov/dhs/assets/behavior-road-map_tcm1053-307672.pdf; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646B-ENG; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646C-ENG; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646-ENG; https://mn.gov/dhs/assets/mental-wellness_tcm1053-307677.pdf; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646D-ENG; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646E-ENG; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7648-ENG; https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7646F-ENG. These resource guides were previously reported on in Doc. 676 at EC 98 and Doc. 700 at EC 98.

[16] A full report on the risk assessment survey results is attached as Attachment H.

[17] The Department started to pilot the new positive supports training in August 2019 (Doc. 763 at 71) and the pilot will continue through December 2019.

resulted in QALT determining a need for a standardized positive behavior supports training, and directing its completion.

Gaps Analysis

The Department's Gaps Analysis, a comprehensive analysis of data gathered from across the state, has also strengthened Department policy on diversion supports. As discussed above in EC 88, the Department published an RFP in 2016 to recruit private providers for crisis respite services, which resulted in 44 new private crisis respite beds. These beds help divert individuals in crisis away from institutions. This RFP was informed in part by the Department's 2016 Gaps Analysis report that included data analysis on gaps related to crisis services[18] and identified crisis services as one of the four most common service gaps.[19]

Current Gaps Analysis and action planning efforts since 2017 build upon the 2016 Gaps Analysis by not just assessing current service gaps but also by developing policies and practices and supporting regional action planning to address service gaps. For example, the Department held a Gaps Analysis promising practices webinar in June 2019 for stakeholders to discuss best practices and solutions for regional stakeholders to ensure access to crisis services.[20] In September 2019, a Gaps Analysis regional workshop was held to develop and plan action steps and identify supports needed to address crisis service access issues locally. These types of activities strengthen diversion supports by fostering regional solutions to avoid or minimize the impact of crisis, which may help an individual avoid institutionalization. DSD uses the current Gaps Analysis and regional action planning process to gather data on access gaps in crisis service and uses that data to inform policies on and support capacity building of Home and Community-Based Services designed to prevent institutionalization. Gaps Analysis results are incorporated into and further analyzed in the Department's Status of Long-Term Services and Supports biannual reports to the legislature.[21]

[18] Crisis services are defined as services for "Short-term care and intervention strategies provided to a person due to: need for relief and support of the caregiver and protection of the person or others living with the person; or Person's need for behavioral or medical intervention." Furthermore, "[a] person is eligible to receive crisis respite services when caregivers and service providers are not able to provide necessary intervention and protection of the person or others living with that person. Crisis respite services allow the person to avoid institutional placement." See CBSM: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002429.

[19] Available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7302L-ENG.

[20] See Attachment I.

[21] The Department's August 2017 Legislative Report is available at https://www.leg.state.mn.us/docs/2017/mandated/170915.pdf.

HCBS Access Project

As of February 2019, DSD is also engaging in an HCBS Access Project, which is contracted work to develop measurements to monitor and evaluate access to HCBS.[22] It builds on prior work to evaluate HCBS and Long-Term Services and Supports (LTSS) access; users; utilization rates, patterns, and trends; and system capacity. This project is developing measures to allow DHS to better understand access to less acute care and crisis services from a data-driven longitudinal perspective and across multiple programs serving individuals with disabilities.

Unit-based Crisis Service Provider Recruitment

One current effort DSD is employing to strengthen diversion supports is to recruit more private providers capable of delivering unit-based crisis services.[23] Unlike daily crisis respite services, which are provided in-home by the person's residential provider, unit-based crisis services are provided by skilled positive support providers who travel to a person's home to deliver behavioral support to someone at risk of losing their residential placement because of behavioral challenges, or assisting providers in serving a person returning from a crisis setting. DHS has convened a workgroup to evaluate strategies for increasing unit-based crisis service provider capacity and to refine DSD's understanding of the need for this service. This work results in part from DSD's internal data analysis on crisis service use and provider capacity. [24]

In order to better understand how crisis services are used and what barriers to unit-based supports exist, DSD is developing a survey for lead agency supervisors. DSD is also engaged in dialogue with crisis respite service providers outside of the metro region to better understand limitations to providing unit-based crisis services. DSD expects that this outreach will result in greater provider capacity to provide unit-based crisis services and help to reduce institutionalization of individuals for behavioral reasons.

Workforce Shortage

In recognition of workforce shortages that have impacted the availability of trained and experienced staff to serve individuals with complex behavioral needs, DSD has partnered with the University of Minnesota to study the workforce. The Department produced a final report on this in May 2019 and presented that report to the Olmstead Subcabinet.[25] This comprehensive data analysis on the workforce shortage informs DSD policies related to establishing sufficient workforce in order to strengthen diversion supports and allow individuals with complex behavioral needs to remain living in

[22] A project overview is available at https://mn.gov/dhs/assets/HCBS-access-project-overview_tcm1053-373537.pdf.

[23] "Unit-based crisis service" refers to a 15-minute unit reimbursement of crisis services, as opposed to crisis services reimbursed on a daily basis.

[24] See the Crisis Respite Report in Attachment J.

[25] See Attachment K for a copy the Department's Report.

the community. Developing unit-based crisis service providers, as described above, is one effort to help support other provider staff.

BIRF Analysis

DSD also engages in regular analysis of Behavioral Incident Reporting Forms (BIRF) data from providers. DSD receives all BIRFs in an electronic format and can aggregate data drawn from these forms. In addition to reviewing BIRFs for concerning trends and patterns for particular individuals or providers, DSD is currently engaging in a project to analyze BIRF data related to 911 calls in order to better understand the relationship between behavioral crises and contact with law enforcement. DSD's review of BIRF data may help a person remain in their residential placement and divert the person from institutional placement for a behavioral reason.

Conclusion

The Court's Order requires the Department to "present [our] assessment and analysis on the need for and current availability of treatment homes." (Doc. 737 at 40.) As noted above, EC 88 and EC 93 have different requirements and apply to different efforts. The Department presents here its activities related to each of these ECs, in connection to the need for and availability of treatment homes.

The Department has met the requirements of EC 88, including through "a specific assessment of need." As described above, the Department assesses need for residential placements that serve individuals who would qualify for admission to MLB through review and analysis of data from relevant waitlists and implementation of the Recommendations.

Additionally, the Department has met the requirements of EC 93, including creating stronger diversion supports through comprehensive data analysis. The Department has relied on data analysis in its creation of a Single Point of Entry process, development of standardized positive behavior supports training, and recruitment of private providers to provide unit-based and crisis respite services. The Department also continually engages in data analysis to inform its policies that help individuals avoid institutionalization using the Gaps Analysis process, examining BIRF data, developing a way to measure crisis service access gaps, and analyzing the workforce shortage.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

October 2019 Supplemental Report

Attachments Index

Attachment	Description
A	DHS Crisis Waitlist Analysis
B	Community Based Steering Committee Recommendations
C	MSOCS Transition Process Map
D	Crisis Respite RFP
E	Crisis Respite RFI
F	Single Point of Entry Pilot Communication
G	Alliant Consulting Report
H	Risk Assessment Summary of Findings
I	Crisis Webinar Summary
J	Crisis Respite Report
K	Workforce Survey Report

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment A

to the October 2019 Supplemental Report

DEPARTMENT OF HUMAN SERVICES

DHS Crisis Waitlist Analysis

CSS Crisis Homes, Minnesota Life Bridge and MSOCS Residential Waitlists

October 15, 2019

Table of Contents

Listing of Tables

Listing of Figures

Background

In 2015, the Department piloted a process to improve the agency's ability to respond to requests for assistance in supporting people with disabilities in crisis. As a part of the pilot project, Direct Care and Treatment (DCT) and Disability Services Division (DSD) developed and implemented an interim process to ensure all requests received by internal Department staff, regarding the identified target population,[1] are entered in to one central location, reviewed and triaged daily.

On April 1, 2018, the Department launched full implementation of the Universal Referral form and related referral processes. With the full implementation of the standardized referral process, which utilizes an on-line form (Community Based Services Program Referral Form, DHS-3912) the Department began collecting data on all referrals for CSS Crisis Home Services, Minnesota Life Bridge (MLB), and Minnesota State-Operated Community Services (MSOCS) long-term residential services and Community Support Services (CSS) Mobile teams.

The Department developed this report through a collaborative effort between Direct Care and Treatment Community Based Services (CBS) and Quality Assurance and Disability (QADC) Services. The purpose of this report is to understand what data on crisis services Community Based Services is collecting and has made available.

What is the goal of crisis response?

The American Association on Mental Retardation's (currently known as the American Association on Intellectual and Developmental Disabilities) groundbreaking 2002 book, *Crisis Prevention and Response in the Community*, identifies the goal of crisis services as "the prevention and minimization of dangerous and destructive behaviors and the organized effective response when the crisis situation occurs."[2]

Consideration of people in crisis

The Department recognizes that consistent with person-centered thinking, the very concept of crisis using the person as the unit of analysis implies that the challenge presented by a person exceeds the capacity of the service provider. [3] Therefore, crisis is not defined by the person, but rather by the interaction between the person and their environment, which may be defined in terms of the

[1] The pilot project was limited to persons with developmental disabilities in crisis and at risk of losing their current placement.

[2] Hanson, Wieseler, Lakin and Braddock, 2002, p. xi

[3] Baker, Craven, Albin, & Wieseler, 2002

person's support network skill and resilience in handling the consequences of the person's behavior and choices.

Thus, equal behavior challenges across two people could have dramatically different responses from the person's support network, depending on the skill and resilience of the person's support network. In other words, while the behavior of one person supported by a skilled, resilient support network might not result in a crisis situation, a second person with similar behavior but supported by a less skilled, less resilient support network might end up being discharged from their residential services. Notably, a key component of support network resilience is risk tolerance, which varies considerably. Considering crisis as being entirely related to the person and not the provider misses the full array of factors leading to behavioral crises and the Department fully considers both.

Community Based Services Referral Process

Anyone in a person's support network, including lead agencies, providers, hospitals, jails, guardians or legal representatives, can submit a referral for CSS Home Crisis Services, Minnesota Life Bridge, MSOCS residential services and CSS Mobile teams. After the Community Based Services Program Referral Form is electronically completed and submitted to the Department, the referral form and required attached documentation are routed to the Community Based Services (CBS) referral intake staff for review and screening. Within one business day, Community Based Services referral intake staff contact the person who made the referral to acknowledge they received the referral.

For persons eligible for the DHS Single Point of Entry,[4] Community Based Services referral intake staff reviews the referral with the DHS Single Point of Entry team.[5] Single Point of Entry Team members have complementary expertise in resolving clinical and system barriers so people with disabilities can successfully live in the most integrated community setting possible. Together, team members develop a coordinated Department response to help the person and his/her support network resolve the behavioral crisis in the most integrated setting and manner possible.

[4] Person with developmental disabilities and/or brain injury who have lost or are at risk of losing their housing or supports.

[5] The DHS Single Point of Entry team includes representatives from the Disability Services Division; Chemical and Mental Health Division; Direct Care and Treatment Division and Successful Life Project.

Program Eligibility

All persons must meet program eligibility criteria before the Department will add the person to a program's waiting list.

CSS Crisis Homes

Crisis respite homes provide short-term care and intervention strategies to a person due to either:

- Need for relief and support of the caregiver and protection of the person or others living with the person; or
- Person's need for behavioral or medical intervention.

A person is eligible to receive crisis respite services when caregivers and service providers are not able to provide necessary intervention and protection of the person or others living with that person. Crisis respite services allow the person to avoid institutional placement. [6] CSS Crisis Homes serve people who have developmental disabilities or related conditions, and meet at least one of the following conditions:

- Are at risk of placement in a less integrated setting; or
- Have a current residential service provider willing to readmit them within 90 days; or
- Do not have a residential service provider available to support their immediate needs and preferences.

Minnesota Life Bridge

Minnesota Life Bridge[7] serves people whom:

- Have been determined to have a developmental disability, according to Minnesota Rules, part 9525.0016, subpart 2, item B[8]; and
- Exhibit severe behavior that presents a risk to public safety, in accordance with the *Jensen* Settlement Agreement Comprehensive Plan of Action Evaluation Criteria 3 (Doc. No. 283 at 5).

---

[6] Additional information on crisis respite can be found in the Community Based Services Manual (CBSM) at https://www.dhs.state.mn.us/main/id_002429

[7] Additional information of Minnesota Life Bridge can be found in the DHS Provides Information on the Minnesota Life Bridge Program DHS bulletin #18-76-02 at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-307196

[8] Minnesota Rules, part 9525.0016, subpart 2, item B states, "Person with developmental disability" means a person who has been diagnosed under this part as having substantial limitations in present functioning, manifested as significantly subaverage intellectual functioning, existing concurrently with demonstrated deficits in adaptive behavior and who manifests these conditions before the person's 22nd birthday.

MSOCS Residential Services

Minnesota State Operated Community Services (MSOCS) residential services provide support to people with complex behavioral health challenges who have been denied alternative support through private community providers. MSOCS residential services eligibility criteria[9] includes three parts. To be eligible for MSOCS residential services, a person must meet **all three** parts.

1. The person has at least one of the following diagnoses:
    a. Brain injury;
    b. Developmental disability;
    c. Intellectual disability;
    d. Mental illness; or
    e. Severe and persistent mental illness.

2. The person has at least one of the following:
    a. The person exhibits behaviors or symptoms that present a safety risk to self and/or others, including but not limited to the following:
        i. Physical aggression;
        ii. Property destruction;
        iii. Self-harming behavior (e.g., biting, scratching, cutting, head hitting, etc.);
        iv. Frequent elopement.
    b. The person has a history of legal offenses or involvement with law enforcement, which has limited their opportunity for placement with a community provider;
    c. The person does not require emergency hospital level of care for a medical condition or psychiatric illness.

3. The person has exhausted therapeutic progress in a hospital or inpatient treatment setting for his/her illness or behavior; AND the County of Financial Responsibility or referring agent and DHS Disability Regional Resource Specialist have determined there are no willing private providers to support the identified person for one of the following reasons:
    a. Providers who might be able to provide appropriate resources to support the person are not available in the identified or preferred geographical area; or
    b. Attempts at securing or developing a provider in the preferred geographical area have not succeeded.[10]

[9] Also referred to as "Safety Net" Criteria

[10] For a person who wants to live in a metro or urban area (e.g., Minneapolis-St. Paul, St. Cloud, Rochester, Duluth, Moorhead, etc.), documentation that the lead agency contacted at least eight different providers in the person's preferred geographic area who would have the skills to meet the person's needs. For a person who wants to live in a rural area of the state, documentation that the lead agency contacted at least four different providers in the person's preferred geographic area who would have the skills to meet the person's needs. If less than four providers are available in the person's preferred geographic area, the lead agency is expected to contact all available providers.

If a person meets the eligibly criteria for MSOCS Residential Services and there is no appropriate placement available within Minnesota State Operated Community Services residential services, the County of Financial Responsibility:

- Must have a licensed corporate bed available; or
- Apply for an exception, to the moratorium corporate foster care and community residential setting development, to allow for development of a new placement. [11]

CSS Mobile Teams

CSS mobile teams serve people where they live and minimize life disruptions. CSS mobile teams address behavioral crises in people's current settings whenever clinically appropriate and safely possible. CSS mobile teams promote positive supports and build collaborative support networks to strengthen people's ability to live in integrated community settings.[12]

Community Support Services (CSS) mobile teams serve people who have complex behavioral and health needs that are barriers to living successfully in integrated community settings.

This includes people with the following diagnoses:

- Brain injuries;
- Co-occurring substance use disorders;
- Developmental disabilities and related conditions; or
- Serious mental illnesses.

Successful Life Project

The Successful Life Project provides therapeutic follow-up of Jensen Class Members and people previously served at Minnesota Specialty Health System (MSHS)-Cambridge. The Department created the Successful Life Project to help prevent re-institutionalization and other transfers to settings that are more restrictive, and to maintain the most integrated setting for persons in the therapeutic follow-up group by providing consultation, services and supports to the person and their team. To provide people and their team with the appropriate amount of support, the Successful Life Project

[11]Additional information on the moratorium on corporate foster can be found in the Community Based Services Manual at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147271#

[12] Additional information on CSS mobile teams can be found in the Community Based Services Manual at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-294602#mobile

groups people based on the level of support needed. Persons identified in this report as receiving support from Successful Life Project staff are receiving priority or secondary levels of support.[13]

Data Sources

The Department used a number of data sources in the development of this report. Information on the various data sources is provided in Table 1. Data included in this report only includes persons with developmental disabilities.

Table 1: Data Dictionary

Data Element	Data Source(s)	Entered by
Date of Referral	Universal Referral Form and CBS Referral Initiation Tracking SharePoint	Case Manager/Social Worker Central Pre-admission staff
Date Added to Waitlist	Respective Referral Tracking SharePoint List (MLB, CSS Crisis Home, MSOCS Residential) and CareManager	Respective Referral Coordinator
Date Removed	Respective Referral Tracking SharePoint List (MLB, CSS Crisis Home, MSOCS Residential) and CareManager	Respective Referral Coordinator
Days on Waitlist	Respective Referral Tracking SharePoint List (MLB, CSS Crisis Home, MSOCS Residential)	Automatically Calculated
Placement Type at Time of Referral	Universal Referral Form	Case Manager/Social Worker
Reason Referral Closed	Respective Referral Tracking SharePoint List (MLB, CSS Crisis Home, MSOCS Residential)	Respective Referral Coordinator
Placement Type at Waitlist End	CareManager (Hallmark Events or Contact Notes and/or updates to Demographics) Some required confirmation of type through DHS Licensing Lookup	Respective Referral Coordinator Data Summary Preparer
Title	Respective Referral Tracking SharePoint List (MLB, CSS Crisis Home, MSOCS Residential)	Automatically generated by system on item creation from Referral Initiation Tracking item
IDD Status	Respective Referral Tracking SharePoint List (MLB, CSS Crisis Home, MSOCS Residential)	Automatically generated by system on item creation from Referral Initiation Tracking item

[13] Additional information on the Successful Life Project can be found in the DHS Community Based Services Manual at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_195871# or in the Successful Life Project DHS bulletin #19-48-01 at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-312658

Data Element	Data Source(s)	Entered by
CSS Mobile Active at Time of Referral	CareManager – Program Assignment	Respective Mobile Team Referral Coordinator or Team Lead
Referred to CSS Mobile	CareManager – Program Assignment for Referral Processing	Respective Referral Coordinator
Crisis Home Admission Date	Avatar	Respective Referral Coordinator
Crisis Home Length of Stay	Avatar	Automatically calculated from admission and discharge dates

Relevant Data Definitions

Avatar: An electronic health record used by Direct Care and Treatment

CareManager: DHS system used by QADC Services, Minnesota Life Bridge, Community Support Services and Disability Services Division to tract various data elements

County of Financial Responsibility (CFR): County responsible for payment of a person's social services

Corporate Foster Care: Licensed foster care setting where the license holder does not reside. This setting typically uses a shift-staff model (i.e., paid staff works shifts on a 24-hour basis). Unless otherwise specified, corporate foster care setting refers to either a MSOCS Corporate Foster Care setting or a corporate foster care operated by a private provider

Crisis Home: Unless otherwise specified, crisis home refers to either a Community Based Services CSS Crisis Home or a crisis home operated by a private provider

Crisis Respite: Short-term care and intervention strategies provided to a person due to the need for relief and support of the caregiver and protection of the person or others living with the person; and the person's need for behavioral or medical intervention

CSS Mobile Active at Time of Referral: At the time of the referral, person was receiving CSS Mobile Supports (yes/no)

Date added to waitlist: Date person determined to meet program eligibility

Date of referral: Date referral received by DHS Central Pre-Admission and entered into the Community Based Services Referral Initiation Tracking SharePoint site

Date Removed: Date person removed from the waitlist for any reason (i.e. admitted to CBS Program, case manager - lack of follow through, placement obtained with private provider, referral withdrawn etc.)

Days on Waitlist: Days on waitlist calculates the days between the date DHS adds a person to the waitlist and the date DHS removes the person from the waitlist. Days on waitlist does not include the time a person is on the 45-day hold. In situations where the placement was not successful within the 45-day period and the person added back onto the waitlist, the dates would be adjusted in the system to include the entire time (and not two separate periods)

IDD Status – Person has a documented diagnosis of intellectual or developmental disability (yes/no)

Lead agency: county, tribal nation or managed care organization

Placement Type at Time of Referral – Person's placement type at the time of the referral

Placement Type at Waitlist End – Person's placement type at the time DHS removes the person from the waitlist(s)

Private provider: Unless otherwise specified, can include a variety of program types operated by a non-state operated provider (person, organization or entity) enrolled with Minnesota Health Care Programs (MHCP) including foster care, crisis home, intermediate care facility for person with developmental disabilities, nursing home, etc.

Title: Name of the person being referred for services and their Medical Record (MREC) number

---

Waitlists

All persons must meet program eligibility criteria before the Department will add the person to the program's waiting list. (See pages 6 – 8.)

CSS Crisis Home Waitlist

Waitlist Inclusion [14]

1. Referral received. The county case manager typically submits the referral to DHS Central Preadmission. However, hospital social workers, relocation specialists from jails, and other entities supporting the person can also submit referrals.

2. DHS Central Pre-Admission processes the referral and enters referral into the **Community Based Services (CBS) Referral Initiation Tracking SharePoint site**.

[14] Waitlist inclusion is the process that must take place for the Department to add a person to a waitlist.

3. The Department contacts case manager by phone/email regarding any documentation that needs to be submitted.

4. Once the Department receives all required documentation and determines that the person meets CSS Crisis Home program eligibility criteria (see page 6), the Department adds the person to the waitlist (**CSS Crisis Home Referral Tracking SharePoint).**

Minnesota Life Bridge Waitlist

Waitlist Inclusion

1. Referral received. The county case manager typically submits the referral to DHS Central Preadmission. However, hospital social workers, relocation specialists from jails, and other entities supporting the person can also submit referrals.

2. DHS Central Pre-Admission processes the referral and enters referral into the **Community Based Services Referral Initiation Tracking SharePoint site**.

3. The Department contacts case manager by phone/email regarding any documentation that needs to be submitted.

4. Once the Department receives all required documentation and the Department determines that the person meets Minnesota Life Bridge program eligibility criteria (see page 6), the Department adds the person to the **Minnesota Life Bridge Services Referral Tracking SharePoint site**.

MSOCS Residential Services Waitlist

Waitlist Inclusion

1. Referral received. The county case manager typically submits the referral to DHS Central Preadmission. However, hospital social workers, relocation specialists from jails, and other entities supporting the person can also submit referrals.

2. DHS Central Pre-Admission processes the referral and enters referral into the **Community Based Services Referral Initiation Tracking SharePoint site**.

3. The Department contacts case manager by phone/email regarding any documentation that needs to be submitted.

4. Once the Department receives all required documentation and determines that the person meets MSOCS Residential Services program eligibility criteria (see pages 7-8), the Department adds the person to the waitlist (**MSOCS Residential Services Referral Tracking SharePoint).**

Removal from Waitlist (s)

Option 1

1. Person admitted to new placement,
2. Department places referral status on 45-day hold.
3. Within 45 days, it is the responsibility of the county case manager to make contact with the Department to let the Department know if the placement is not stable:
   a. If the placement is going well, the Department will close the referral and remove the person from the waitlist. The Department sends the county case manager an email letting them know the Department has closed the referral;
   b. If the county case manager does not contact the Department within 45 days, the Department assumes the person is stable and the referral is automatically closed. The Department sends the county case manager an email letting them know the Department has closed the referral;
   c. If placement not going well, the Department removes the 45-day hold and puts the person back on the waitlist.

Option 2 - For persons for whom historically placement transitions have been challenging

1. Person admitted to new placement.
2. The DHS admissions/transition coordinator contacts the county case manager weekly for two weeks to see how placement is going.
   a. If the placement is going well after two weeks, the referral is place on 45-day hold
3. Within 45 days, it is the responsibility of the county case manager to make contact with DHS to let the Department know if the placement is not stable:
   a. If the placement is going well, the Department will close the referral and remove the person from the waitlist. The Department sends the county case manager an email letting them know the Department has closed the referral;
   b. If the county case manager does not contact the Department within 45 days, the Department assumes the person is stable and the referral is automatically closed. The Department sends the county case manager an email letting them know DHS has closed the referral;
   c. If the placement not going well, the Department will remove the 45-day hold and put the person back on the waitlist.

Waitlist Overlap

If a person meets the eligibility criteria for multiple programs (CSS Crisis Home, Minnesota Life Bridge and MSOCS Residential Services) they may be included on multiple waitlists. Each program maintains its own waitlist.

In situations where a person is on both the CSS Crisis Home Waitlist and the Minnesota Life Bridge Waitlist, the Minnesota Life Bridge Transition Coordinator becomes the main contact. DHS minimizes

some of the overlap by including both the Minnesota Life Bridge Transition Coordinator and the assigned Community Based Services Admissions Coordinator on all emails with the case manager. For persons on CSS Crisis Home and Minnesota Life Bridge waitlist, the Department includes both contacts in all email communications. When the Department places a referral on a 45-day hold (or closes the referral) for one program, other program referrals will also be placed be on a 45-day hold (or closed the referral).

The Department also coordinates services through daily Single Point of Entry Triage meetings where the Single Point of Entry Team discusses all the Minnesota Life Bridge, CSS Crisis Homes and MSOCS crisis referrals and the 245D Termination of Services notices that the Department received. The Single Point of Entry Team also discuss referrals and situations that might be coming in and coordinate support of persons who fall under priority admissions. [15]

[15] Minn. Stat. § 253B.10 subd. 1(b 4) Procedures upon commitment requires persons committed under this chapter to the commissioner after dismissal of the patient's criminal charges must be admitted to a service operated by the commissioner within 48 hours.

Findings

The waitlists for CSS Crisis Homes, Minnesota Life Bridge and MSOCS Residential Services each include a historical placement waitlist and the current pending waitlist. The historical placement waitlist goes back to April 1, 2018, when the Department launched full implementation of the Universal Referral form and related referral processes. The historical placement waitlists only include persons that the Department has removed from the waitlist. The current pending waitlists reflect only those persons for whom a referral has been completed, and is waiting to be placed. The current pending waitlist represents all open referrals on July 31, 2019.

When persons on all three historical placement waitlists (CSS Crisis Homes, Minnesota Life Bridge and MSOCS Residential Services) were compared, of the 68 unduplicated people on the CSS Crisis Homes historical placement waitlist, 36 people were also on the Minnesota Life Bridge historical placement waitlist and 46 people were on the MSOCS Residential Services historical placement waitlist. Ten people appeared on all three historical waitlists. Two people were only on the Minnesota Life Bridge and MSOCS Residential Services Historical waitlist, and not CSS Crisis Homes.

CSS Crisis Home Waitlists

CSS Crisis Home Historical Placement Waitlist

Between April 1, 2018 and June 30, 2019, 137 referrals were made to CSS Crisis Homes and subsequently placed during this time period. The Crisis Home Historical Placement Waitlist only includes persons that the Department has removed from the waitlist. Persons remained on the CSS Crisis Home Historical Placement Waitlist from a minimum of 0 days (immediate placement) to a maximum of 237 days; the average time a person spent on the waitlist was 61.42 days and the median time was 48 days.

At the time of the CSS Crisis Home referral, 34% (47/137) were in a Corporate Foster Care Setting, 27% (37/137) were in a hospital, 11% (15/137) were in the family home and 7% (9/137) were in jail. See Table 2.

Table 2: Placement Type at Time of Historical CSS Crisis Home Referral

Placement Type	Number
Community Behavioral Health Hospital	1
Child Foster Care	1
Children's Mental Health Program	1
Children's Residential Facility	2
Corporate Foster Care	47

Placement Type	Number
Crisis Home[16]	6
Family Foster Care	4
Family Home	15
Guardian's Home	1
Homeless	3
Hospital	37
Hotel with Crisis Staff	1
Intermediate Care Facility for person with Developmental Disabilities	2
Independent Living	1
Jail	9
Own Home	2
Pre-adoption Home	1
Supported Living Services	2
Temporary Corporate Foster Care	1
Total Number	**137**

Of the 137 people on the CSS Crisis Home Historical Placement Waitlist, 16 people were receiving CSS Mobile team support at the time of the referral and one person was receiving support by Successful Life Project. Fifty-nine people on the CSS Crisis Home Historical Placement Waitlist were referred to a CSS Mobile Team.

At the time of CSS Crisis Home Historical Placement Waitlist end, of the 137 persons who were on the waitlist, 38% (52/137) were placed in a corporate foster care home, 26% (35/137) were placed in a crisis home and 9% (12/137) were in the family home. See also Table 3.

Table 3: Placement Type at CSS Crisis Home Historical Waitlist End

Placement Type	Number
Anoka Metro Regional Treatment Center	1
Assisted Living	2
Child Foster Care	1
Children's Residential Facility	1
Corporate Foster Care - Private Provider	47
Corporate Foster Care - CBS	5
Crisis Home - Private Provider	21
Crisis Home - CBS	14
Customized Living	3
Family Foster Care	4

[16] These include placements in crisis residences that were very short-term and the person was in need of other crisis residential support to replace that placement.

Placement Type	Number
Family Home	12
Home	1
Jail	1
Minnesota Life Bridge Treatment Home	5
Nursing Facility	1
Out of State - Behavioral Health Facility	1
Own Apartment	1
Own Home	2
Own Home with Services	1
Relatives Home	1
Residential Treatment Facility	1
Supported Living Services	1
Unlicensed Home	3
Not known	7
Total Number	**137**

For the 137 people whose CSS Crisis Home Waitlist referral was closed:

- 66% (90/137) obtained placement with a private provider
- 18% (24/137) were admitted to a Community Based Services program
- 10% (14/137) withdrew their referral

See also Table 4.

Table 4: Reasons CSS Crisis Home Waitlist Referral Closed

Reason Referral Closed	Number
Admitted to CBS Program	24
Case Manager - Lack of Follow Through	2
Other	7
Placement Obtained with Private Provider	90
Referral Withdrawn	14
Total Number	**137**

CSS Crisis Home Current Waitlist

As of July 31, 2019, there were 44 referrals on the CSS Crisis Home Current Waitlist. Persons on the Current CSS Crisis Home Waitlist were on there from a minimum of six days to a maximum of 355 days; the average time a person spent on the waitlist was 115.36 days and the median time was 85.50 days.

At the time of the CSS Crisis Home referral, 43% (19/44) were in a Corporate Foster Care setting, 32% (14/44) were in a hospital and 9% (4/44) were in the family home. See also Table 5.

Table 5: Placement Type at Time of Current CSS Crisis Home Referral

Placement Type	Number
Anoka-Metro Regional Treatment Center	1
Corporate Foster Care	19
Crisis Home	1
Detention Center	1
Family Home	4
Hospital	14
Intermediate Care Facility for person with Developmental Disabilities	2
Own Home	1
Residential Treatment Facility	1
Total Number	**44**

Of the 44 people on the CSS Crisis Home Current Waitlist, five people were receiving CSS Mobile team support at the time of the referral and two people were receiving support by Successful Life Project. Fourteen people on the CSS Crisis Home current waitlist were referred to a CSS Mobile Team.

2000 – 2019 CSS Crisis Homes Admissions and Average Length of Stay

The number of persons admitted to a CSS Crisis Home in 2000 through May 13, 2019, shows the highest yearly admissions were in 2004 (with 96 admissions) with a steady decrease of admissions through 2017 with only 17 admissions. See Figure 1. The average length of stay in a CSS Crisis Home in 2000 through August 19, 2019 shows that between 2004 and 2012, the average length of stay was 55.3 days. In 2014, the average length of stay began to increase. See Figure 2.

In 2004, CSS operated eight crisis homes with over 40 beds (one home had 10 beds). Up until 2014/2015, Disability Services Division policy on out-of-home crisis respite funding capped crisis homes stays at 45 days. Because of the funding cap, there was much greater pressure to get persons back to their home quickly; moreover, homes were much more willing to have people return, so there were fewer people stuck in functional homelessness.

One of the reasons for the both decrease in admissions and increase in the average length of stay was staffing issues for both Community Based Services and private providers having a difficult time with hiring and retaining staff due in part to general workforce labor shortages.

Figure 1: CSS Crisis Home Admissions 2000 through May 13, 2019

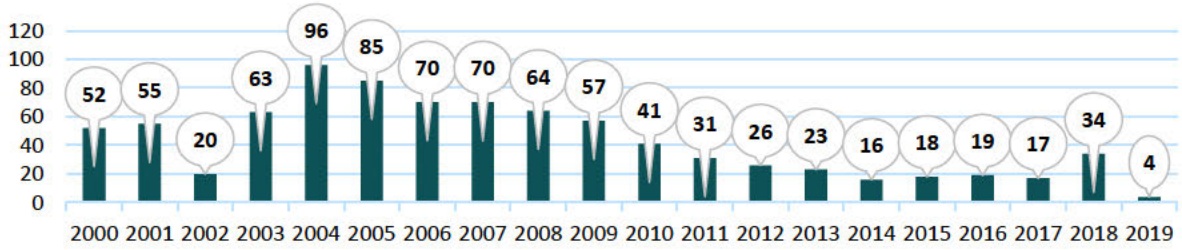
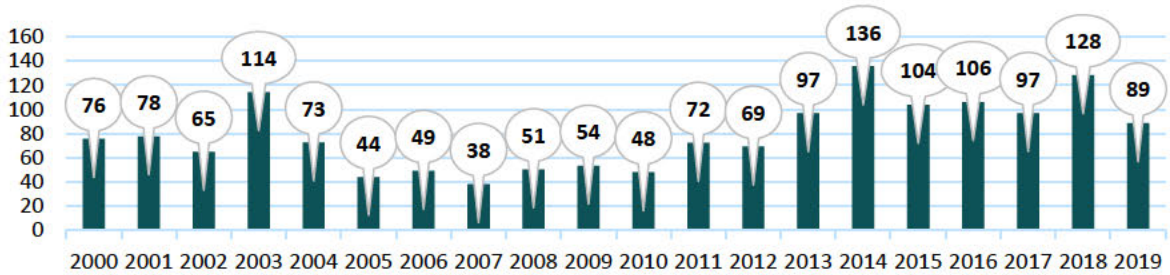


Figure 2: CSS Crisis Home Average Length of Stay Days in 2000 through August 19, 2019



Minnesota Life Bridge Waitlists

Minnesota Life Bridge Historical Placement Waitlist

Between April 1, 2018 and June 30, 2019, 41 referrals were made to Minnesota Life Bridge and subsequently placed during this time period. The Minnesota Life Bridge Historical Placement Waitlist only includes persons who have been removed from the waitlist. Persons remained on the Minnesota Life Bridge Historical Placement Waitlist from a minimum of 0 days (immediate placement) to a maximum of 184 days; the average time a person spent on the waitlist was 78.17 days and the median was 65.00 days.

At the time of the Minnesota Life Bridge referral, 34% (14/41) were in a Corporate Foster Care Setting, 24% (10/41) were in a hospital and 22% (9/41) were in jail or prison. See also Table 6.

Table 6: Placement Type at Time of Historical Minnesota Life Bridge Referral

Placement Type	Number
Corporate Foster Care	14
Crisis Home	3
Family Home	3
Hospital	10

Jail	8
Own Home	1
Prison	1
Supported Living Services	1
Total Number	**41**

Of the 41 people on the Minnesota Life Bridge Historical Placement Waitlist, five people were receiving CSS Mobile team supports at the time of the referral and five people were receiving support by the Successful Life Project. Seventeen people on the Minnesota Life Bridge Historical Waitlist were referred to a CSS Mobile Team.

At the time of Minnesota Life Bridge Historical Placement Waitlist end, 32% (13/41) were in corporate foster care, 24% (10/41) were in crisis homes and 17% (7/41) were at Minnesota Life Bridge. See also Table 7.

Table 7: Placement Type at Minnesota Life Bridge Historical Waitlist End

Placement Type	Number
Corporate Foster Care – Private Provider	12
Corporate Foster Care - CBS	1
Crisis Home – Private Provider	5
Crisis Home - CBS	5
Customized Living	1
Family Foster Care	1
Family Home	1
Jail	1
MLB Treatment Home	7
Nursing Home	1
Relatives Home	1
Residential Treatment Facility	1
Supported Living Services	1
Not known	3
Total Number	**41**

For the 41 people for whom the Minnesota Life Bridge Waitlist referral was closed:

- 54% (22/41) Obtained placement with private provider
- 32% (13/41) were admitted to CBS Program
- 12% (5/41) withdrew referral

See also Table 8.

Table 8: Reason Minnesota Life Bridge Referral Closed

Reason Referral Closed	Number
Admitted to CBS Program	13
Other	1[17]
Placement Obtained with Private Provider	22
Referral Withdrawn	5
Total Number	**41**

Minnesota Life Bridge Current Waitlist

As of July 31, 2019, there were 18 referrals on the Minnesota Life Bridge Waitlist. Persons were on the Minnesota Life Bridge Current Waitlist from a minimum of 50 days to a maximum of 378 days; the average time a person spent on the waitlist was 177.61 days and the median was 173.5 days.

At the time of the Minnesota Life Bridge referral, 50% (9/18) were in Corporate Foster Care and 32% 33% (6/18) were in a hospital. See Table 9.

Table 9: Placement Type at Time of Current Minnesota Life Bridge Referral

Placement Type	Number
Anoka Metro Regional Treatment Center	**1**
Corporate Foster Care	**9**
Family Home	**1**
Hospital	**6**
Minnesota Security Hospital	**1**
Total Number	**18**

Of the 18 people on the Minnesota Life Bridge Current Waitlist, six people were receiving CSS Mobile team support at the time of the referral and three people were receiving support by the Successful Life Project. Seven people on the Minnesota Life Bridge Current Waitlist were referred to a CSS Mobile Team.

Persons on Minnesota Life Bridge Waitlists Placed with Private Provider

Since April 1, 2018 (the start of the current data), three people (4%) out of a total of 68 referrals have been referred to Minnesota Life Bridge a second time. All three people had their first referral closed out after they obtained placement with a private provider. As of October 1, 2019, no person has been referred to Minnesota Life Bridge more than twice.

[17] Person was going to remain in jail for an extended period

MSOCS Residential Services Waitlists

MSOCS Residential Services Historical Placement Waitlist

Between April 1, 2018 and June 30, 2019, 69 referrals were made to MSOCS Residential Services and subsequently placed during this time period. The MSOCS Residential Services Historical Placement Waitlist only includes persons who have been removed from the waitlist. Persons remained on the MSOCS Residential Services Historical Placement Waitlist from a minimum of 0 days (immediate placement) to a maximum of 434 days; the average time a person spent on the waitlist was 109.7 days and the median was 86.0 days.

At the time of the MSOCS Residential Services referral 25% (17/69) were in a Corporate Foster Care Setting, 20% (14/69) were in a hospital, 12% (8/69) were in a crisis home and 9% (6/69) were in the family home. See Table 10.

Table 10: Placement Type at Time of Historical MSOCS Residential Services Referral

Placement Type	Number
Anoka Metro Regional Treatment Center	2
Community Behavioral Health Hospital	3
Childrens Mental Health Program	1
Childrens Residential Facility	1
Corporate Foster Care	17
Crisis Home	8
Family Foster Care	2
Family Home	6
Homeless	1
Hospital	14
Intermediate Care Facility for persons with Developmental Disabilities	2
Jail	4
Long Term Care Center	1
Minnesota Specialty Health System- Brainerd	1
Own Home	1
Pre-adoption Home	1
Prison	1
Skilled Nursing Facility	2
Supported Living Services	1
Total Number	**69**

Of the 69 people on the MSOCS Residential Services Historical Waitlist, four people were receiving CSS Mobile team supports and five were receiving supports by the Successful Life Project. Twenty-three people on the MSOCS Residential Services Historical Waitlist were referred to CSS Mobile Team.

At the time of MSOCS Residential Services Historical Waitlist end, 59% (41/69) were in corporate foster care, 7% (5/69) were in their family home, 4% (3/69) were in a Customized Living setting and 1% (1/69) were at a Crisis Home. See Table 11.

Table 11: Placement Type at Time of MSOCS Residential Services Historical Waitlist End

Placement Type	Number
Anoka Metro Regional Treatment Center	2
Assisted Living	1
Child Foster Care	1
Childrens Residential Facility	1
Corporate Foster Care – Private Provider	33
Corporate Foster Care- CBS	8
Crisis Home – Private Provider	1
Customized Living	3
Family Foster Care	1
Family Home	5
Intermediate Care Facility for persons with Developmental Disabilities	2
MLB Treatment Home	1
Moved Out of State	1
Nursing Home	1
Residential Treatment Facility-Out of State	1
Skilled Nursing Facility	1
Unable to Locate	1
Unlicensed Home	2
Not known	3
Total Number	**69**

For people for whom the MSOCS Residential Services referral was closed:

- 65% (45/69) obtained placement with private provider
- 13% (9/69) were admitted to CBS Program

See also Table 12.

Table 12: Reason MSOCS Residential Services Referral Closed

Reason Referral Closed	Number
Admitted to CBS Program	9
Case Manager - Lack of Follow Through	1
Commitment/DCT Inpatient Admission	1
Other	11[18]
Placement Obtained with Private Provider	45
No reason given	2
Total Number	**69**

[18] Examples of "other" include person was no longer interested, person moved out of state and unable to locate person

MSOCS Residential Services Current Waitlist

As of July 31, 2019, there were 65 referrals on the MSOCS Residential Services Current Waitlist. Persons were on the MSOCS Residential Services Current Waitlist from a minimum of 0 days (immediate placement) to a maximum of 992 days[19]; the average time a person spent on the waitlist was 202.06 days and the median was 139.00 days.

At the time of the MSOCS Residential Services referral 34% (22/65) were in a Corporate Foster Care Setting, 22% (14/65) were in a hospital, 12% (8/65) were in the family home and 8% (5/65) were in a crisis home. See also Table 13.

Table 13: Placement Type at Time of Current MSOCS Residential Services Referral

Placement Type	Number
Anoka Metro Regional Treatment Center	2
Community Behavioral Health Hospital	2
Child Foster Care	1
Corporate Foster Care	22
Crisis Home	5
Detention Center	1
Family Home	8
Hospital	14
Intermediate Care Facility for persons with Developmental Disabilities	1
Jail	3
MSH	2
Own Home	1
Residential Treatment Facility	3
Total Number	**65**

Of the 65 people on the MSOCS Residential Services Current Waitlist, nine people were receiving CSS Mobile team support and two were receiving supports from the Successful Life Project. Sixteen people on the MSOCS Residential Services Current Waitlist were referred to the CSS Mobile Team.

[19] The person who has been on the MSOCS Residential Services Current Waitlist for 992 days was at Minnesota Life Bridge from 4/21/2015-8/15/2016 and after a brief placement with private corporate foster care, the person was readmitted to Minnesota Life Bridge on 3/37/2017.

Analysis

Limitations of Data

The limitations in these data include two primary areas of note.

1. These data only reflect efforts once crisis is experienced. These data do not include data on the number of potential crises diverted without Departmental efforts. These data only concern persons who have already been identified as experiencing crisis. It can be postulated that a great number of potential crises could have occurred but were averted successfully by the provider.

2. Data do not include crisis diversion efforts from non-DHS supports. In addition to Community Support Services, there are private behavior consultants and behavior specialists who work for individual providers. The data do not include crisis diversion efforts from non-DHS supports.

Comparison of reasons referral closed for CSS Crisis Homes, Minnesota Life Bridge and MSOCS Residential Services Historical Placement Waitlists

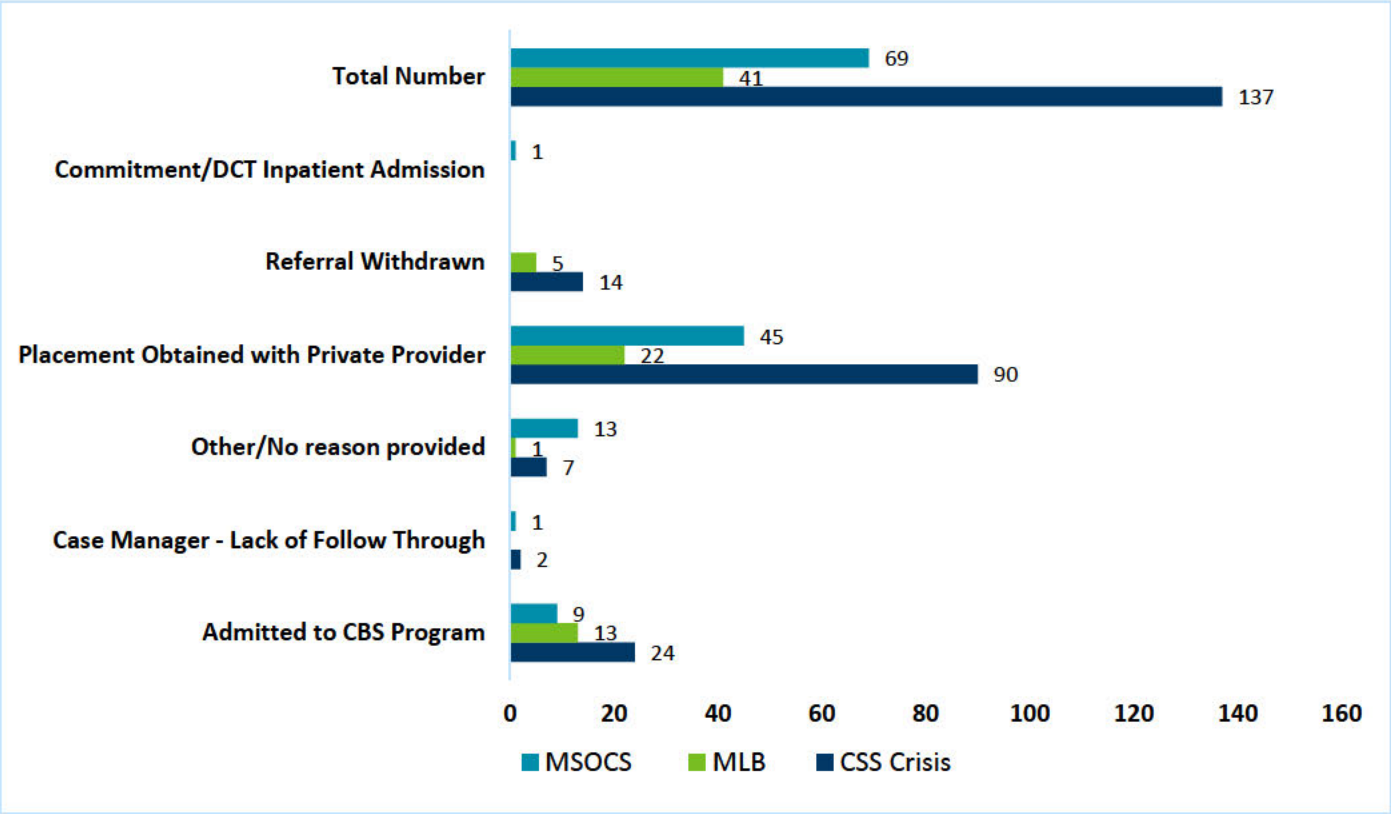
For the CSS Crisis Homes, Minnesota Life Bridge and MSOCS Residential Services Historical Placement waitlists the primary reason the Department closed the referral was due to a placement being found with a private provider.

See Table 14 and Figure 3.

Table 14: Comparison of Reasons Referral Closed – Historical

	CSS Crisis Home	MLB	MSOCS Residential
Admitted to CBS Program	24	13	9
Case Manager - Lack of Follow Through	2	0	1
Other/No Reason Identified	7	1	13
Placement Obtained with Private Provider	90	22	45
Referral Withdrawn	14	5	0
Commitment/DCT Inpatient Admission	0	0	1
Total Number	**137**	**41**	**69**

Figure 3: Comparison of Reasons Referral Closed – Historical



Waitlist Challenges for Persons on Minnesota Life Bridge or CSS Crisis Home Waitlist

A total of 15 people were on either the Current or Historical Placement Minnesota Life Bridge or CSS Crisis Home waitlists for more than 200 days. Of those 15 people who were on either the Minnesota Life Bridge or CSS Crisis Home waitlists, seven were on also on the other list for more than 100 days as well, indicating an overlap in referral practices and eligibility. The Internal Reviewer inspected available documentation on CareManager for each of the 15 people to determine the nature of their challenges. Each of these 15 people had multiple challenging factors that would make them difficult to place. These are listed in order of frequency below. See Table 15.

Table 15: Challenges for Persons on Minnesota Life Bridge or CSS Crisis Home Waitlist for over 200 days

Type of challenge	Number of people	Comments
Mental health disorder	13	The remaining person had Autism Spectrum Disorder
Dangerous levels of aggression, including weapon use	12	The two remaining people had problematic sexual behavior and self-injury
Suicidality and self-endangerment	6	
Multiple hospitalizations	5	
Autism Spectrum Disorder	5	
Criminal behavior	4	
Problematic sexual behavior	3	
Repeated elopement	3	
Difficulties within person's team relationships or decision-making	3	
Polydipsia (drinking fluids in an uncontrolled and potentially dangerous manner)	2	
Chemical dependency	1	Elopement for this person was related to seeking illegal drugs

Conclusion

The information presented in this report clearly identifies the array of different services and supports, as well as the degree of organization in Departmental activities. A key indicator of the effectiveness of the Department's activities is the small number of persons experiencing crisis (Tables 2, 5, 6, 9 10 and 11), as compared to the total number of persons with intellectual or developmental disabilities receiving supports from the Department. These data also highlight the role of private sector crisis resources in responding to behavioral crises.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment B

to the October 2019 Supplemental Report

Transitioning MSOCS Residential to a Safety Net Service:

Community Based Steering Committee Recommendations

REPORT TO DHS COMMISSIONER EMILY JOHNSON PIPER

DECEMBER 30, 2015

Transitioning MSOCS Residential to a Safety Net Service: Recommendations from the Community Based Steering Committee

Executive Summary

Minnesota State Operated Community Services (MSOCS) residential services provide housing and support to approximately 430 individuals in 120 state-operated group homes throughout Minnesota. To implement the Minnesota Olmstead Plan and recommendations from the Legislative Auditor, DHS is transitioning MSOCS to a safety net provider of services. "Safety net" has been defined by a set of diagnostic and behavioral criteria as well as a determination that private providers have declined to serve the individual. DHS estimates that about 275 MSOCS individuals might not meet this definition and thus could transition to service by private providers. This would enable MSOCS to serve individuals who do meet the safety net criteria who are currently in inappropriate settings including the Anoka Metro Regional Treatment Center, community hospitals, the Minnesota Security Hospital, or jails.

Former DHS Commissioner Lucinda Jesson formed a Community Based Steering Committee in the spring of 2015 to provide DHS with input regarding the transition of MSOCS to a safety net service. This report summarizes the recommendations of the Steering Committee to current Commissioner Piper as DHS plans and implements that transition. Recommendations can be summarized as follows:

1. DHS should adopt a new model of MSOCS as a safety net provider of temporary, transitional services for people with complex co-occurring conditions whom other providers are unable to serve for various reasons. These conditions could include developmental and intellectual disabilities, mental illnesses, chemical dependency, diseases, symptoms that include violent or sexually inappropriate behavior, sex offender status, and other involvement in the legal system (see page 7).
2. DHS should create a detailed project plan for the MSOCS Transition to Safety Net project, including a business plan for MSOCS, data analysis to inform decision-making, fiscal analysis to ensure adequate funding to support the safety net vision, a communications plan, and a training and technical assistance plan. This plan should be circulated for comment by relevant stakeholders and revised as needed (see page 9).
3. Throughout the planning and implementation of the MSOCS Transition to Safety Net project, participants should remember that the proposed changes will disrupt people's lives to varying degrees: the individuals themselves, their families and friends, the MSOCS staff, the staff of new providers who will serve individuals who decide to move, lead agency staff, and the communities in which the individuals live. It will be important to acknowledge this disruption at the outset and develop a compassionate, person-centered planning and transition process that allows adequate time and resources to work through the many challenges and disagreements that could emerge. At the same time, the process should maintain momentum in order to increase MSOCS' capacity to serve individuals who need a safety net level of service in less restrictive and more integrated settings (see page 11).
4. Communication and transparency will help ensure that the planning and transition process remains fair and that disagreements are identified early and worked out collaboratively. DHS should take the lead on informing all stakeholders about the project and the project plan, soliciting input and feedback to refine the process, facilitating ongoing problem-solving, and negotiating solutions in an open process that includes all relevant stakeholders (see page 29).

5. The transitioning of MSOCS homes should be a gradual process, with cohorts of individuals or homes being established in a way that takes multiple factors into account, including the circumstances and wishes of the MSOCS individuals; the capacity constraints faced by MSOCS, lead agencies, and providers; and the financial sustainability of MSOCS. Establishing priorities and timelines should be a collaborative effort of the individuals and their families, MSOCS, lead agencies, and private providers (see page 15).
6. Whenever possible, the MSOCS Transition to Safety Net project should adopt or align with existing or planned processes from related projects (for example, the Minnesota Olmstead Plan implementation and changes in Home and Community-Based Services). This will require setting realistic timelines that take into account the many ongoing changes in the social service system that are already taxing the capacity of state, lead agency, and private provider staff (see page 15).
7. Adequate training and technical assistance will be key to the success of this transition as many staff in MSOCS, private providers, and lead agencies will be taking on additional or new duties and/or serving populations with whom they have little experience. DHS should take a leadership role in providing or assuring that training and technical assistance are accessible, timely, and targeted to the specific needs of those being trained or assisted (see pages 15 and 32).
8. Several aspects of the MSOCS transition may require additional funding and/or proposals for legislative changes. The Community Based Steering Committee recommends the following (see page 18):
    a. Develop a means to fund a safety net vacancy factor, safety net staffing, and/or reduced home capacity to meet the needs of safety net individuals.
    b. Consider a subsidy to fund housing costs not covered by Group Residential Housing funds for individuals who choose not to, or cannot, live with others.
    c. Identify a means for ensuring flexibility in Adult Foster Care bed allocation.
    d. Allocate more funding for DHS's Community Support Services and for other technical assistance to families, lead agencies and providers to create and sustain community capacity.
    e. Ensure adequate funding to develop necessary services to support individuals needing safety net care (for example, housing modifications).
    f. Ensure funding to support adequate MSOCS staff development (e.g. complex care staff training).
    g. Allocate adequate funding to support business operations management and project management for MSOCS as it implements the MSOCS Transition to Safety Net project.
    h. Increase funding to support more crisis beds, including safety net crisis beds.

Transitioning MSOCS Residential to a Safety Net Service: Recommendations from the Community Based Steering Committee

Contents

Transitioning MSOCS Residential to a Safety Net Service: Recommendations from the Community Based Steering Committee

Minnesota State Operated Community Services (MSOCS) residential services provide housing and support to approximately 430 individuals in 120 state-operated group homes throughout Minnesota.[1] Almost all of the individuals have developmental or intellectual disabilities, and many have co-occurring mental and physical health challenges as well. MSOCS staff's review of individuals' records suggest that about two-thirds of these individuals could probably be served safely and effectively by community providers, thereby opening up capacity for MSOCS to serve individuals who meet certain diagnostic and behavioral criteria and whom other providers are unable to serve for various reasons.[2] People qualifying for safety net services could include people currently unable to leave the Anoka Metro Regional Treatment Center, community hospitals, or the Minnesota Security Hospital because of a lack of community provider capacity.

Because redesigning MSOCS to be a safety net provider will be a complex challenge, former Department of Human Services (DHS) Commissioner Lucinda Jesson established a Community Based Steering Committee to discuss and advise the Department on the range of policy options available.[3] The Community Based Steering Committee participants are listed in Appendix 1. This report summarizes the Steering Committee's recommendations regarding the MSOCS transition and outlines a strategy for supporting people with disabilities, especially those whose complex developmental, behavioral and physical health challenges have not been well-supported in their home communities.

I. Problem Statement

Transitioning MSOCS to serve only individuals whom other providers are unable to serve will help address the following problems:

- **Inadequate capacity** of Minnesota's service system to support individuals with complex co-occurring conditions including developmental or intellectual disabilities, mental illnesses, substance use disorders, symptoms that include violent behaviors or sexually inappropriate behavior, and/or physical health challenges.
- Historical insufficient person-centered planning for people living in MSOCS group homes that has led to many **individuals living in homes not of their choosing** when it is possible that they could be living more independently in the community with the appropriate supports.
- **The State's safety net role is being changed** to include services only for those individuals who meet diagnosis and behavioral criteria and whom other providers are unable to serve for various reasons.

[1] In addition to its residential services, MSOCS also provides vocational day training and habilitation services. For brevity, this report will use "MSOCS" to refer specifically to MSOCS Residential Services.

[2] The record review only considered whether individuals met the behavioral criteria for a safety net service, and did not involve the providers who will make the ultimate decision about whether or not they can serve a particular individual. The details of this record review are provided in Appendix 3.

[3] The definition of "safety net provider" is discussed in more detail in Appendix 2. For the purposes of this project, it means that MSOCS will only serve individuals who meet certain diagnostic and behavioral criteria and whom other providers are unable to serve for various reasons.

- **Mounting financial losses** in the MSOCS program (currently totaling about $800,000 per month).

A. Inadequate Community and Crisis Capacity

For 50 years Minnesota has been transitioning from centralized, state-operated institutional services for people with disabilities to a community-based model that provides local supports and services so that individuals can live how they want to in the communities of their choice. While Minnesota has made great progress in this transition, there are still gaps in the service system, especially in the funding and services needed to support people with complex co-occurring conditions including developmental or intellectual disabilities, mental illnesses, substance use disorders, symptoms that include violent or sexually inappropriate behavior, physical health challenges, sex offender status, and other involvement in the legal system. As described in the media and in past DHS legislative reports, these gaps can result in people either not receiving the services they need or receiving those services in inappropriate and overly-restrictive settings.[4]

Minnesota's health and social services providers—both community-based and state-operated—have collaborated with counties and tribes to develop the capacity to support individuals with such complex needs. However, there are barriers that can be difficult to overcome, including the lack of qualified staff to serve a particular set of needs, the difficulty of hiring qualified staff (especially in rural areas), fear of liability, physical plant challenges, need for upfront investment in site development, and rates that may not cover the cost of the initial investments or ongoing services. In addition, county or tribal case managers who are responsible for assisting individuals may not have the training, time, or funding to provide the specialized help that is needed.

As a result of these challenges, there is currently inadequate community capacity to serve people with complex co-occurring conditions. One particularly important service that is in short supply in Minnesota is crisis and treatment services for individuals with disabilities. When an individual is struggling, often a crisis team can assist the individual, family, and provider as the problem is resolved, enabling the individual to remain stable at home. If that solution is impossible, crisis services can also provide out-of-home care for a short period of time until the individual regains stability and can move back home or to a more appropriate setting. Both of these solutions prevent the individual from having to move to a hospital setting or in some cases, being taken to jail. This supports the individual's wellbeing, helps the family and other care-givers, is cost-effective, and ensures the system's ability to provide safe and effective care not only to the individual in crisis but to the people he or she lives with. Crisis services are a key to an efficient and effective service system for people with complex needs.

The impacts of inadequate community services are severe. People may be forced into hospitals or other institutional settings when they could have been better served in less restrictive settings. Moreover, people can't leave hospitals or treatment centers when they no longer need that level of care because there is no community provider or setting that is set up to meet their needs. This not only impedes the individuals' recovery and ability to live integrated lives in the communities of their choice, it also wastes resources and prevents people who *do* require that level of care from receiving services. These

[4] *Plan for the Anoka Metro Regional Treatment Center*, DHS Legislative Report, February 18, 2014, pp. 62-80; *Independence to Inclusion*, video produced by Twin Cities Public Television, first broadcast on 4/15/2014, available at http://www.mnvideovault.org/mvvPlayer/customPlaylist2.php?id=26487#0; *Failing the Disabled: How Minnesota Isolates and Marginalizes Thousands of Adults with Disabilities*, 5-part series from Star Tribune, 11/8/15-11/12/15, available at http://www.startribune.com/a-matter-of-dignity-a-five-day-special-report/339820912/.

shortages reverberate through the service system. For example, a person who can't find services in their home community gets stuck at the Anoka Metro Regional Treatment Center, thereby holding a bed that is sorely needed by another person who is stuck in a community hospital without the specialized psychiatric services to treat their mental illness. The community hospital might be forced to hire security guards or close adjacent beds in the unit in order to maintain safety of the patient, other patients, and staff, which reduces the hospital's capacity to serve its community's needs. A person-centered community-based system requires that individuals be able to move freely and quickly to the levels of service they need and that the service system respond flexibly when those needs change.

B. Individuals Living in Unnecessarily Segregated Settings

As Minnesota closed its state-operated institutions for people with developmental disabilities, many of the individuals were moved into four-person group homes that have been operated by MSOCS. While these have become homes for many of those individuals, people were not always given options or allowed to choose the type of living arrangement that would help them lead the life they want. This historical lack of person-centered planning led to many individuals living in MSOCS when they might prefer to live more independently in the community with appropriate supports. In compliance with the principles of Minnesota's Olmstead Plan, the state is helping to organize person-centered planning for the individuals living in MSOCS homes to determine how and where each wants to live.

C. State-Operated Services as Safety Net Providers

State law mandates that "Enterprise activities within state-operated services shall specialize in caring for vulnerable people for whom no other providers are available or for whom state-operated services may be the provider selected by the payer."[5] The 2013 Legislative Auditor's report on state-operated services expands this idea to all of the services provided under the DHS Direct Care and Treatment Administration, recommending that DHS only operate "safety net" services that other providers are unable to offer for various reasons.[6]

As part of its planning, the Community Based Steering Committee refined a definition of "safety net" for the purposes of the MSOCS transition project (see Appendix 2). The definition has two parts: diagnostic and behavioral criteria, and a determination of whether a private provider is willing to serve the individual. The Steering Committee directed MSOCS to review the records of the individuals currently living in its residential group homes to estimate how many individuals might meet the diagnostic and behavioral criteria. The review suggested that about 275 individuals probably do not meet the diagnostic and behavioral criteria in the safety net definition; it is not yet known how many will meet the other major criterion—that no private provide elects to serve them. Appendix 3 provides background on this estimate. The exact number of individuals who meet both of the safety net criteria will not be known until person-centered planning is completed.[7]

D. Financial Losses in the MSOCS Program

MSOCS is currently losing about $800,000 each month. One reason for the losses is that many individuals living in MSOCS homes do not require the safety net level of services they are receiving. Another reason is that the current payment rates for some clients are far below the cost of providing

[5] Minnesota Statutes 2015, 246.0136, subd. 1. MSOCS is an "enterprise provider" in that it is designed to be an operation that sustains itself through reimbursements for the services it provides.

[6] *State-Operated Human Services*, Minnesota Office of the Legislative Auditor, February 2013, pp. 118-119.

[7] Some individuals have already participated in person-centered planning, but others have not.

supports. These rates were established prior to 2014 based on negotiations between MSOCS and counties. Current statute related to the statewide Disability Waiver Rates System (DWRS) prohibits re-negotiation of these rates. The rates will be gradually adjusted (through banding) until full adaptation of DWRS rates in either 2019 or 2020. The DWRS rate is expected to cover the cost of providing supports, but MSOCS will incur losses throughout the "banding" period for these clients.[8]

For those individuals whose person-centered planning identifies a change in service needs or leads to a decision to move, MSOCS' financial situation will improve as each transition occurs. In addition, as new individuals are admitted into MSOCS, their rates will be determined based on current costs, thus further improving MSOCS' financial situation. While the Community Based Steering Committee does not believe that life-changing decisions should be based on funding concerns, the Steering Committee does recognize the gravity of MSOCS' financial situation and its impact on operational viability. It is important to proceed with person-centered planning that will both assist individuals to get the lives they want *and* help address MSOCS' financial challenges.

II. Solution: The MSOCS Transition to Safety Net Project

To address the problems outlined above, the Community Based Steering Committee has worked with DHS to outline a complex project to transition MSOCS to a safety net service. The project is based on a new vision for MSOCS' role in the service system.

A. Safety Net Vision for MSOCS

Minnesota's vision for people with disabilities is that they will live integrated lives in the residences and communities of their choice. This requires a community-based model of care in which the services and resources needed to support people are available locally and community providers provide the bulk of that support. State-operated services would only be needed in situations where adequate community capacity has not yet been developed. The Community Based Steering Committee believes that safety net services should be flexible and temporary; they should provide transitional support (both to the individual and to a willing private provider) until the individual can be served by a private provider in his or her chosen community.

In this model, MSOCS' role would be to provide technical assistance and temporary, transitional crisis and medium-term (3-5 years) residential services. Community Support Services (a sister division to MSOCS residential services) would work with lead agencies and private providers to support individuals in crisis in their homes if possible. For individuals who have had to move to crisis residential or institutional care, MSOCS would assist in the transition to private providers instead of being a long term provider of residential services itself. This can be accomplished by:

- MSOCS operating a limited set of crisis homes for rapid capacity and short term stabilization and transition; and
- MSOCS partnering with private providers to bring up homes and jointly supporting individuals, with MOSCS services transitioning out of the home over time and the provider gradually assuming the lead role in providing services. The homes would reflect a variety of

[8] Minnesota statute allows adjustment of banded rates when there is a change in the client's support needs. MSOCS and the Disability Services Division are collaborating to ensure these adjustments occur where applicable but most of the historic rates being paid for MSOCS clients probably cannot be addressed through these adjustments.

configurations—not just the traditional four-person group home. One example of such a partnership could involve a home being owned or leased by a private provider but the individual's transition out of crisis being led by MSOCS staff (at the request of the lead agency and the private provider). The private provider's staff would shadow and gradually assume daily operations as that became operationally and clinically advisable. A scenario like this would allow for an individual or group of individuals to have housing stability independent of who is providing the services.

These arrangements would be driven by the lead agency (county or tribe) based on individual circumstances, with MSOCS brought in as a short-term service provider when needed. When requested by the lead agency because community providers are not able to support specific individuals, MSOCS would collaborate with lead agencies and community providers to develop, implement and transition new or existing services to increase community capacity. MSOCS would also collaborate with other divisions within DHS on technical assistance and system oversight (for example, on quality tracking, workforce development, or needs forecasting).

The MSOCS Transition to Safety Net project will be designed to honor the choices and needs of the 430 people currently living in MSOCS group homes while moving with appropriate speed to open MSOCS capacity that could be used to serve individuals who meet the criteria for safety net services. The project will work to balance the choices and needs of both groups while avoiding over-extending all of the collaborators: individuals and families, DHS staff, counties and tribes, providers, insurers, advocates, and others whose work will make these transitions possible. In addition to planning, the major activities of the project include the following:

- **Transition of people living in MSOCS who do not meet the safety net criteria**: Work with lead agencies to identify and develop a base of collaborative providers willing to serve individuals who do not meet the safety net criteria in a variety of residential settings.
  - Based on the results of person-centered planning and transition planning, individuals currently living in MSOCS-owned homes who do not meet safety net criteria would transition out of the physical homes to new homes with support from private service providers; or[9]
  - Some homes leased by MSOCS and housing individuals who do not meet safety net criteria could shift to private providers by transferring the leases if the individuals want to continue living together. The private provider would supply the staff while MSOCS staff would move to other new or existing programs, increasing capacity at those locations.
- **Additional capacity for individuals who do meet safety net criteria**: Existing and new MSOCS homes would be designed with a medium-term (3-5 years or less) transition timeframe. Some existing MSOCS homes would be repurposed and some new residential configurations would be developed, and existing staff would be trained and equipped to provide support to a more challenging population. For new homes, residential homes could be leased from a private provider, modified to meet the needs of the individuals choosing to live there, and staffed to support highly complex arrays of community-integrated services for the identified individuals.

[9] It may also be possible that state-owned homes could be transferred to private providers. DHS staff are looking into this possibility, which may be constrained by state laws that limit how state bond-financed properties can be used and transferred.

Once the home was stable and fully supporting the individual or individuals living there, the home would be transitioned to the private provider.

- **New crisis capacity**: The DHS Disability Services Division is planning to put out an RFP to private providers to establish crisis homes. In addition, MSOCS could repurpose existing owned property to add up to four regional intensive crisis homes with 4 beds each (16 total) next to existing MSOCS homes. This would increase capacity in the crisis system. As more private providers establish crisis services, the system's need for MSOCS intensive crisis capacity will be reviewed.
- **Increased consultation capacity**: Increase the capacity of technical assistants or crisis consulting teams such as Community Support Services to assist individuals, lead agencies and providers through transitions and to help individuals avoid or manage crises so they can remain stable in the community.
- **Increased service development support**: Increase DHS's capacity-building teams and resources to assist lead agencies and providers in the work of conducting person centered planning and developing local service capacity.
- **System support and oversight**: In addition to the MSOCS services described above, several system support and oversight functions would need to be strengthened within DHS or other agencies to ensure the system is meeting the safety net needs of Minnesota's most vulnerable populations. These include education, employment, and transportation supports and oversight functions like quality assurance, performance data tracking, and prediction of future needs of the system.

B. Development of a Project Plan

The Community Based Steering Committee strongly supports the MSOCS Transition to Safety Net project proposal. The project as currently envisioned by the Community Based Steering Committee has 5 phases, as outlined in the following table.

MSOCS Transition to Safety Net Project Plan		
Phase	**Activities**	**Preliminary Timeframe**
Phase I: Set-up	Form Steering Committee and create charter, assign DHS staff, prepare background documents to describe project, prepare recommendations to the Commissioner.	2nd and 3rd quarters CY2015 (completed)
Phase II: Preparation for person-centered planning	Develop diagnostic and behavioral criteria for individuals requiring safety net services for the purposes of this project. Undertake a preliminary review of the records of each individual served by MSOCS. Draft a process for the collaborative person-centered planning based on guidance from Olmstead implementation projects. Establish a process for identifying private providers who are interested in serving individuals currently served by MSOCS who do not meet safety net criteria. Evaluate existing budget and rate-setting tools and processes for individuals who will be transitioning. Develop a business plan for the safety net MSOCS program.	3rd quarter 2015 - 1st quarter CY2016
The following three phases will be a repetitive cycle of person-centered planning, transition planning, and implementation for each individual. MSOCS will collaboratively identify cohorts of individuals to go through these cycles (based on the individuals' needs, lead agency and provider capacity, system resources, and the business needs of MSOCS).		
Phase III: Person-centered planning for all MSOCS individuals	Lead agencies review or lead collaborative person-centered planning with each MSOCS individual and their support teams to determine what is important to and for the person, focusing on how and where they would like to live. For individuals who choose to transition to a different provider or home, complete transition planning.	4th quarter CY2015 – 4th quarter CY2017
Phase IV: Transition planning for MSOCS programs and individuals	Given the person-centered plans of each individual currently living in MSOCS and the ongoing needs of incoming individuals, DHS will collaborate with individuals, families, DHS staff and labor partners, lead agencies, providers, and other stakeholders to create transition plans and design the organizational changes within MSOCS necessary to make those plans possible.	1st quarter CY2016 – 4th quarter CY2017
Phase V: Implementation of the transition	Implement individuals' transition plans and the programmatic changes that will be necessary to shift MSOCS to a safety net provider.	Target: 1st quarter CY2016 – 4th quarter CY2018

The Community Based Steering Committee recommends that DHS create a detailed project plan that includes at least the following:

- A business plan for MSOCS that outlines the expected size of the population to be served, the staffing, funding, and other resources needed to serve that population, and the necessary organizational changes.
- Additional data analysis to inform the prioritization of cohorts of individuals or homes to begin person-centered planning and possible transitions.
- A fiscal analysis to ensure that adequate funding is available to support the safety net vision of MSOCS (which includes funds for individuals supported by MSOCS and by private providers).
- A communications plan to ensure that stakeholders are engaged in the planning process and have ample opportunity to provide input as plans are developed (see Appendix 4 for preliminary plan).
- A training plan to ensure that MSOCS staff receive the training they need to support new populations (see Appendix 5 for preliminary plan).

III. What Will It Take?

Throughout the Community Based Steering Committee's discussions, participants identified scores of activities, resources, and arrangements necessary for the success of the new vision of MSOCS. This section describes those items, some of which are outside the scope of the MSOCS Transition to Safety Net project itself. The Steering Committee emphasized the importance of project staff working with other divisions and other DHS project staff to help ensure that these success factors are all in place as needed. Some of the items may require new or additional efforts (for example, the need for workforce development), and the Steering Committee will make specific recommendations for additional work to address those.

A. Supporting Individuals and Families

1. Current Challenge

The MSOCS Transition to Safety Net project will help achieve the Minnesota Olmstead Plan vision that people with disabilities are living, learning, working, and enjoying life in the most integrated settings of their choice. It is important to recognize at the outset, however, that this project may bring uncertainty, fear and disruption for many individuals who currently live in MSOCS homes, their family members and guardians, and their communities. Even for those who don't meet the criteria for safety net services and who are excited about the possibility of transitioning with their housemates to a private provider, setting up their own apartment or house with appropriate supports, or moving to a home with new housemates, this project could be temporarily frightening. For those who are not yet sure what their options are or how those options might improve their lives, the project will almost certainly raise fears and potential mistrust.

For some people these fears will go far beyond the fact that change is difficult. Some individuals living in MSOCS homes have never been given a choice about where to live, and the prospect (for both individuals and families) of figuring out new living arrangements may be difficult to even think about at first. For others who have painful memories of being moved in the past and losing valued relationships, this project may bring up that pain. In situations where an individual and guardian do not agree on a

person-centered plan, or where some of the individual's wishes will not be possible to honor given the constraints on MSOCS' new role, anger and frustration are likely to arise and require attention.

At the same time, the MSOCS Transition to Safety Net project will provide new options and welcome changes for individuals who meet the criteria for safety net care and are currently stuck in inappropriate settings (including the Anoka Metro Regional Treatment Center, the Minnesota Security Hospital, community hospitals, and jails). The project must maintain momentum or these individuals and their families will continue to suffer due to the lack of safety net services.

In addition to concerns about the opportunities and difficulties of moving to new living situations, the Steering Committee received comments highlighting the importance of integrated and coordinated service delivery for individuals being served in the community. Providers of residential services currently ensure most of this integration but as individuals live more independently, the responsibility for integration will be shared across the individual and family and providers of case management, housing, social, medical, educational, and employment services. Some individuals and families will be comfortable and skilled enough to handle the integration of their services. Others will require significant assistance with integration. The transition of more individuals to community-based services may put more pressure on individuals, family members, social workers, case managers, and care coordinators to ensure integrated, coordinated service delivery.

2. Current Efforts and Solutions

The person-centered planning process that is the basis of the Olmstead Plan implementation is designed to ensure that individuals' preferences are considered and that individuals have informed choice when deciding where and how to live. However, the Community Based Steering Committee heard many concerns that individuals might not get the level of support needed to make truly informed choice and that it would be difficult to monitor the quality of person-centered planning processes. Moreover, the guidelines and processes are not set up to address the complicated emotions and disruptions that may occur as a result of this planning. Much of that work will be left to families and guardians, social workers, support staff, and caregivers.

The Minnesota Olmstead Plan includes new mechanisms to assure that person-centered principles are followed. In addition to the many training and technical assistance tools that are being developed for lead agencies and providers, person-centered and self-advocacy training is also being prepared for individuals and their families, and evaluation and oversight functions are also being strengthened:

- Individuals receiving community based services and supports will be surveyed to find out whether they feel they have exercised informed choice and whether they are in charge of their services and supports.
- Lead agencies will conduct self-audits on their person-centered planning processes, and DHS will audit lead agencies' person-centered plans and transition plans.
- DHS is evaluating the potential of a monitoring role for the State Quality Council in overseeing the effectiveness of person-centered planning. DHS will also contract with regional quality councils to monitor person-centered processes in their regions.

All of these activities will be tracked and reviewed by the Olmstead Subcabinet and the courts. Advocacy organizations can also help ensure that decisions are based on true understanding of the options available and that disagreements are processed in a way that is person-centered and respectful of the rights of people with disabilities.

3. Community Based Steering Committee Recommendations

- Throughout the planning and implementation of the MSOCS Transition to Safety Net project, participants should remember that the proposed changes could fundamentally disrupt people's lives, the lives of their families and friends, and other people residing in their communities. It is the Community Based Steering Committee's hope that consistently acknowledging this fact will help us all maintain our humility and our willingness to stretch toward people or feelings or perspectives that we don't understand or don't agree with, even when they slow things down or cause "messes" that are uncomfortable to work through. At the same time, we need to do our best to maintain project momentum in order to increase MSOCS' capacity to serve individuals who need a safety net level of service in more integrated settings.
- The MSOCS Transition to Safety Net project should follow the person-centered planning processes being developed as part of the Olmstead planning and described in the Transition Protocols (see Appendix 6). These will help ensure that individuals have the opportunity to learn about options, articulate where and how they want to live, and exercise informed choice.
- During person-centered planning, it will be important to consider ways to separate housing and support services in order to give individuals maximum control over their lives. The process should also explore the possibility of home ownership and individual leasing options where desired; the four-person group home should be just one option among many.
- The person-centered plans of individuals transitioning out of MSOCS should include careful consideration of the need for integration among community-based services and how that integration will be accomplished for each individual and his or her family.
- DHS should prepare plain-language summaries of the person-centered planning process, informed choice, and transition protocols that are targeted to non-professionals. Individuals, families, guardians and friends will use these materials to better understand the processes and ask questions if they have any.
- DHS should require that person-centered plans include consideration of technologies that could support individuals' safety and independence. Person-centered planners and support staff should communicate in plain language with individuals, families, and guardians about the possibility of using technology as part of the individual's support plan. Privacy and safety concerns should be addressed.
- Throughout the process, project staff should provide clear, timely communication of changes ahead and make themselves available to answer questions and hear concerns.

B. Supporting DHS, Lead Agency, and Provider Staff

1. Current Challenge

The MSOCS Transition to Safety Net project is taking place during a time of incredible change in the policies, operation, and services that support people with disabilities. The changes include the development and implementation of MnCHOICES assessment and related planning processes, the new disability rates management system, the implementation of 245D requirements for providers of home and community based services, a change in the level of care for nursing facilities, a new Positive Supports Rule, shifts in the role of state-operated services, and implementation of the Jensen Settlement Agreement which includes the development and implementation of the Minnesota Olmstead Plan. All of these changes require an incredible amount of work on the part of DHS, lead

agency, and provider staff. People are stretched thin and some feel overwhelmed by the prospect of even more change.

The DHS staff who currently support MSOCS individuals are going to be particularly affected by this project. For many of them, the individuals in MSOCS homes have become "family" and changing those relationships will be emotionally draining and disorienting. All MSOCS staff face uncertainty about how their jobs will change, who their coworkers will be, what new skills they will have to learn and what current skills might become less valued, and what it might be like to support a new client population. For some, this uncertainty may lead to fear or questioning about whether they want to continue in the career they have practiced for so many years.

2. Current Efforts and Solutions

All of the policy and operational changes listed above were developed with collaborative processes among key stakeholders that required frequent meetings, preparation of background documents, complex negotiations, pilot tests, data analyses, and development of communication and training plans to support the change. This level of collaboration will help make the changes successful, and the MSOCS Transition to Safety Net project will require similar levels of collaboration. Designing the transition process in a way that gives staff the time, knowledge, and resources they need to fulfill their roles will be necessary for success. Section D below looks in more detail at the transition planning and process.

Addressing the particular needs of MSOCS staff will primarily be the responsibility of DHS management and its labor partners. There are already mechanisms in place to work through decisions that affect staff, including regular local and statewide labor-management meetings and labor contracts that spell out the rules and processes that govern job classes, position descriptions, promotions, re-assignments, layoffs, and other job changes. The MSOCS Transition to Safety Net project will rely on these agreements and processes to work through the changes that will be needed.

3. Community Based Steering Committee Recommendations

- The Steering Committee recognizes that reliable and consistent staffing contributes to good client outcomes, so DHS should ensure the adequacy and stability of staffing to meet the complex needs of the MSOCS safety net population. This should include a focus on predictable schedules and FTE allocations, which should also assist with recruitment and retention.
- Include staff in transition planning and care planning.
- Support clear communication of transition plans and timelines.
- Provide adequate training, on-site observation opportunities, on-the-job experience, and mentoring so that staff feel prepared and competent to do their jobs. This is especially important for direct-care staff, but also applies to other roles.
- Provide easy-to-use tools and guides to support the person-centered planning process and transition planning.
- Provide adequate technical assistance (see the following section for more detail).
- Use existing collaboration and decision-making forums to work through any changes that are needed in DHS bargaining agreements in order to implement the MSOCS Transition to Safety Net project.

C. Providing Adequate Training and Technical Assistance

1. Current Challenge

With many reforms underway, DHS has developed several technical assistance resources to support implementation of the changes. The Community Based Steering Committee expressed concern about whether these resources will have enough capacity to assist all of the participants in the MSOCS Transition to Safety Net project.

2. Current Efforts and Solutions

DHS's Community Support Services (CSS) employs 50 professionals and 8 augmentative staff to provide consultation, training, and technical assistance to strengthen the community living of Minnesotans with complex behavioral health challenges. CSS achieves positive outcomes through initiating and guiding positive behavioral supports, building collaborative support networks, and advocating for person-centered approaches. CSS currently serves approximately 350 individuals and their support networks. The Community Based Steering Committee heard stories about the high-quality technical assistance that CSS has played in preventing institutionalization and supporting transition planning for people with complex needs, but they also heard that CSS has a waiting list that is months long.

The Community Supports and Consumer Safeguards staff in the Disability Services Division (DSD) are preparing tools and trainings to assist lead agencies and providers with person-centered planning and transition planning. DSD has also initiated a "Community of Practice" to assist service planners as they support individuals in transition. Given that DHS is still building capacity to provide such technical assistance, it is not clear whether there is enough capacity in these providers to meet the demand.

3. Community Based Steering Committee Recommendations

- The MSOCS Transition to Safety Net project should coordinate with the existing and planned efforts to assist lead agency and provider staff with implementing the new home and community-based service requirements, rate-setting changes, and the Minnesota Olmstead Plan.
- DHS should increase Community Support Services capacity to ensure that there are enough staff available to assist providers in preventing problems and in planning and supporting transitions. CSS staff need to be knowledgeable, experienced professionals who are trained on available resources and who can propose realistic solutions. The staff complement should include expertise and specialization to assist with a variety of diagnoses and disabilities, and CSS staff should be immediately available by phone when needed.
- Training and technical assistance should include information about the potential applications of new technologies to support individuals' autonomy and privacy and leverage staff resources where appropriate.

D. Refining the Transition Planning Process

1. Current Challenge

As described in the preceding section, the MSOCS Transition to Safety Net project is a complex and ambitious undertaking that will require a high level of collaboration among stakeholders. The Community Based Steering Committee heard many suggestions from participants about how this process should be managed or about specific elements of the process. Participants were particularly concerned about the magnitude of the project and the possibility that it could move too fast and

overwhelm the limited resources and staff that are available to work on it (in DHS, lead agencies, and provider organizations).

2. Current Efforts and Solutions

Because MSOCS is always in the process of assisting individuals in transition in and out of MSOCS homes, there are already significant processes and relationships in place that the MSOCS Transition to Safety Net project will rely upon. Ongoing collaborative meetings include the Disability Services Division's State/County Workgroup, the Community Based Services stakeholder group, the Home and Community-Based Partners Panel, the Transition Protocols Implementation Committee, the HCBS Settings Rule Advisory Committee, and the State Quality Council. The Community Based Steering Committee itself has become a useful group for sharing ideas and developing initial consensus that can then be reviewed among a wider variety of stakeholders.

3. Community Based Steering Committee Recommendations

- The MSOCS Transition to Safety net project plan should adopt realistic timelines that recognize the significant tasks and changes that staff are already dealing with. For example, lead agencies should be given a reasonable timeframe to complete person-centered reviews: at least 60 days. Where possible, the person-centered planning process should align with the individual's next scheduled annual or semi-annual visit.
- DHS and its partners should continue to invest in collaborative planning. This should include allotting adequate staff for project management, meeting facilitation, and documentation to help ensure that the project continues to move forward.
- The Community Based Steering Committee should continue to meet periodically to provide input on the MSOCS Transition to Safety Net project.
- The MSOCS Transition to Safety Net project should be set up in "cohorts" of individuals or homes, so that early transitions can be learning opportunities that will help inform subsequent transitions and so that the project will roll out gradually. Funding for transitioning of these cohorts should be included in legislative requests for 2016-2018.
- It is DHS's responsibility to ensure that safety net services are available for the people who need them, so current capacity and operations need to be maintained as Minnesota moves toward the new model. Capacity should not be reduced unless and until private providers are fulfilling the needs for care. It even may be possible that MSOCS capacity will need to be expanded to prevent the creation of new gaps in the service system during and after the transition.
- The ongoing transitions from MSOCS to the community that are already in the works should continue; the MSOCS Transition to Safety Net project process should not hold them back.
- The prioritization of individuals or homes will be a key determiner of project success. Reality dictates that a variety of factors will determine prioritization, beginning with the needs and desires of individuals and including consideration of capacity within DHS, lead agencies, and providers, and the financial sustainability of the individual program as well as MSOCS as a whole. DHS should propose an initial prioritized list and work with all participants to refine it. The Steering Committee recommends that DHS consider beginning with individuals who scored a "0" or "1" on the client record review (indicating that they do not meet any of the behavioral criteria for a safety net service) so that the transition process can be modified or enhanced before proceeding to individuals with more complex needs. For more information on the client record review, see Appendix 3.

- Where ever possible, the project should use existing or already-planned processes and tools (for example, those being developed as part of the Olmstead Plan implementation) rather than developing solutions unique to this project. This will be a key to completing such an ambitious project and to assuring its sustainability.
- Even if the project relies on already-established tools and processes, there may be times that there will be inadequate staff or resources to complete the work required. DHS, for example, should not just assume that lead agency case managers will be able to take on additional work and/or that lead agencies can contract for additional case management. The project should seek collaborative solutions to address situations in which a lead agency just doesn't have the resources to complete the work in a timely way.
- DHS should ensure proper administrative staffing for implementation of these recommendations, including business operations, data analysis, and project management.
- When MSOCS begins to identify providers who might be interested in serving current MSOCS individuals (through a Request for Information or some other process), the requests should include enough specific information and opportunities for providers to meet the individual so that providers can make a reasoned judgement regarding their interest in possibly serving that individual or taking over the program.
- DHS should include consideration of the new safety net model of MSOCS in its legislative planning, including asking for additional resources to support the project.

E. Ensuring Adequate Staffing (Workforce)

1. Current Challenge

Providers of services for people with disabilities are facing a staffing crisis. Demographics make it continually more difficult to fill caregiving positions, especially in rural communities. At the same time, the training and experience required to do these jobs is increasing as DHS implements new standards and requirements for home and community-based services. Staffing shortages are partly an issue of low wages, which provide a disincentive to choose careers in caregiving. The new vision for MSOCS as a transitional service provider will require ample, skilled, and flexible staffing at private providers and MSOCS-operated homes as well as in lead agencies.

2. Current Efforts and Solutions

A statewide summit on mental health workforce planning was held in the summer of 2015. A collaborative workgroup is now planning next steps.[10] Many of the recommendations being considered by this group would apply to careers in caregiving for people with intellectual or developmental disabilities as well, although there may need to be more focus on entry level positions like personal care assistants and human services technicians.

Technology offers proven opportunities to buttress providers' staffing and increase individuals' independence and privacy. Providers will need strong support and technical assistance to learn to utilize

[10] For information, see the Mental Health Workforce webpage at http://www.healthforceminnesota.org/mental-health/. This includes a link to the Mental Health Workforce Plan for Minnesota.

new technologies. While providers already self-organize workshops and conferences to communicate about technological opportunities, more efforts are needed in this area.

Providers and state labor partners have expressed support for the idea of shared staffing models as homes are transferred from MSOCS operation to private provider operation, but the details of how this would work have not been figured out. Questions include how staff would be managed and how such arrangements might complicate relationships between staff who are working together but who are employed by different employers.

3. Community Based Steering Committee Recommendations

- DHS should be actively involved in workforce development to support community based services. This should include efforts to educate students and adults about these positions and support for training people to fill them. DHS should assign responsibility for workforce development to a particular division or department in order to ensure accountability.
- DHS should work with its labor partners and other stakeholders to explore shared staffing models for transitions of individuals or homes from MSOCS to private providers.
- DHS should also work with partners to consider the possibility of a "float pool" to augment staffing when regularly-scheduled staffing is not enough to fulfill individuals' needs safely. Questions to be answered include: What response time is expected? How many staff are needed? Where are those staff located, and whose policies do they follow? How would float pool staff establish rapport with such a large group of potential clients? When would the float pool be called in instead of calling other assistance (e.g., CSS, crisis teams, law enforcement)? How would the privacy of health information of other residents be protected?
- Technology can help support individuals in ways that increase individuals' independence and privacy while extending providers' staff capacity. DHS should act as a leader and innovator in the use of technology, and DHS policy staff should refrain from adopting rules that unnecessarily constrain technology applications.

F. Ensuring Adequate Funding for Services to People with Disabilities

1. Current Challenge

Most individuals currently receiving services in MSOCS homes are funded through the Developmental Disabilities Waiver, the Community Access for Disability Inclusion Waiver, the Brain Injury Waiver, or private insurance.

The Disability Waiver Rate System payment frameworks are based on direct care staff wages as determined by the Bureau of Labor Statistics. The wage for residential frameworks is $12.41, and $13.33 for day frameworks. In addition to direct staff wages, the framework then applies other costs such as employee benefits, vacation and sick time, training, taxes, workers' compensation, supervisor wages, and cost of living increases. According to providers, these relatively low wages lead to difficulties in finding and hiring staff, high training costs, and rapid turnover as employees leave for better-paying jobs. Skeleton staffing and high churn rates can have a significant negative effect on individual care quality and stability of individuals and homes.

Providers also experience financial pressures when they are forced to incur costs that are not covered by reimbursement rates or that must be invested before any reimbursement revenue can be collected to offset them. For example, current Group Residential Housing rates are insufficient when individuals choose to live on their own or with only one housemate, leaving providers with shortfalls because lease

rates exceed funding. Providers can also face significant startup costs, including property location and leasing arrangements, physical plant changes, technology investments, vehicle purchases, and the costs of locating, hiring, and training new staff. While there are possible sources of funds for some of these expenses and waiver reimbursements would ultimately cover some others, there is a significant outlay of cash required before a provider actually begins receiving reimbursement. Some providers are not willing, or cannot afford, to make this upfront financial commitment.

Providers may also risk losses as individuals move to other homes as part of their person-centered plans. If an MSOCS home is licensed for four beds, for example, and the occupancy is reduced as individuals move to private providers, there will be periods of lost revenue. It is impossible to perfectly align the entering and leaving of individuals who each have their own unique timetable. The Disability Waiver Rate System assumes a vacancy factor of 3.9%. In the new model of MSOCS as a transitional provider, it will be necessary to financially support excess capacity that exceeds with the DWRS allows in order to ensure that MSOCS services are available when people need them.

MSOCS' current financial losses also pose challenges for the successful implementation of the MSOCS Transition to Safety Net project. With MSOCS currently losing about $800,000 per month, there is no existing source of funds to cover staff transition costs (including re-training, moves, resignations, and retirements) that are expected to arise as the project is implemented. The losses will also make it very difficult to invest up-front in new development and to support the business operations, data analysis, and project management staff that will be needed to drive the MSOCS Transition to Safety Net project.

2. Current Efforts and Solutions

The Disability Waiver Rate System includes an exception process whereby lead agencies can request additional funding needed to support people with extraordinary needs. MSOCS, lead agencies and the Disability Services Division (DSD) are working together to develop exceptions for people coming into the MSOCS system to ensure that services costs are covered, acknowledging that waiver funds cannot be used for room and board with the exception of crisis respite services. However, the exception process cannot be used for people who were receiving services in the same MSOCS location prior to 2014, as those rates are banded. Statute only allows adjustment of banded rates when there is a change to the client's support needs that has occurred since the implementation of the Disability Waiver Rate System. MSOCS and DHS's Disability Services Division are collaborating to ensure these adjustments occur where applicable, but most of the inadequate rates cannot be addressed through exceptions adjustments.

Crisis Respite, both in-home and out-of-home, is a service in the Developmental Disabilities Waiver and approval has been requested from the Center for Medicaid Services approval to add this to the other waivers. Crisis Respite is paid for at market rates in the Disability Waiver Rate System and therefore is not subject to banding or to a framework. For out-of-home crisis respite, waiver funds can also be used to cover room and board. To the extent that MSOCS and Community Support Services activities can qualify as crisis respite services, a market rate can be set to cover their costs.

3. Community Based Steering Committee Recommendations

- DHS should use the existing processes for making exceptions to the banded rate when possible.
- DHS should ensure that funding is flexible and adequate to cover the initially-higher costs of an individual's transition to a community provider, including training, start-up costs, and temporarily increased staffing.

- DHS should look into the possibility of including a "vacancy factor" in funding mechanisms so that crisis and transitional homes can remain solvent as they maintain adequate capacity and allow for the transitions of clients in and out. This is analogous to the funding of fire departments, where timely availability of services is paramount.
- DHS should seek funding mechanisms to expand the capacity of Community Support Services to assist lead agency and private providers to better support individuals in the community, thus helping to ensure both clinical and financial stability.

G. Ensuring Adequate Housing Opportunities

1. Current Challenge

The shortage of affordable housing, especially in rural communities, is a key barrier to community integration. While increasing funding to support housing for people with disabilities (e.g., Group Residential Housing funds) can help address this problem, there is also the fundamental reality that there are not enough homes available for rent at any reasonable price. Specific concerns include:

- New property development will be necessary in addition to helping ensure that funds are available to help people with disabilities rent or purchase permanent homes.
- Providers of community housing expressed concern that state-operated services have historically paid higher lease rates than private providers for comparable properties, and that landlords might not have realistic expectations about the rates that private providers can afford to pay for leased properties. However, more recently state-operated services have been paying rates closer to market averages.
- There is resistance in some communities to opening new homes for people with disabilities, especially those whose symptoms include aggression or sexually inappropriate behavior or who have sex offender status. This resistance disregards federal fair housing laws and could make it even more difficult to implement the new vision for MSOCS, especially as MSOCS begins to serve more individuals coming out of the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital.

2. Current Efforts and Solutions

Housing for people with disabilities is a central focus of the Minnesota Olmstead Plan, which lays out a multi-faceted approach to increasing housing options and availability. The Olmstead Plan and work plans provide an extensive summary of Minnesota's efforts to improve housing availability and affordability, so those will not be summarized here.[11]

3. Community Based Steering Committee Recommendations

- The MSOCS Transition to Safety Net project staff should continue to work with the many agencies and projects that are increasing housing capacity for people with disabilities. A specific focus should be on assuring that the financial planning includes consideration of flexible housing arrangements so that, for example, an individual can decide to use his or her funding to live alone or purchase a home, or so that a crisis home can remain staffed and sustainable even when all of its beds are not full.

[11] Putting the Promise of *Olmstead* into Practice: Minnesota Olmstead Plan, State of Minnesota, August 10, 2015, p. 36+.

- DHS should increase its collaboration with lead agencies, providers, and advocates to address the stigma that underlies resistance to community integration and to help the public understand federal fair housing laws, the Olmstead Plan, and the rights of people with disabilities.

IV. Summary and Conclusion

This report has presented the thinking of the Community Based Steering Committee as it has outlined a plan for transitioning MSOCS to a safety net provider of transitional residential services for individuals with complex needs. The Steering Committees recommendations can be summarized as follows:

1. DHS should adopt a new model of MSOCS as a safety net provider of temporary, transitional services for people with complex co-occurring conditions whom other providers are unable to serve for various reasons. These conditions could include developmental and intellectual disabilities, mental illnesses, chemical dependency, diseases, symptoms that include violent or sexually inappropriate behavior, sex offender status, and other involvement in the legal system.
2. DHS should create a detailed project plan for the MSOCS Transition to Safety Net project, including a business plan for MSOCS, data analysis to inform decision-making, fiscal analysis to ensure adequate funding to support the safety net vision, a communications plan, and a training and technical assistance plan. This plan should be circulated for comment by relevant stakeholders and revised as needed.
3. Throughout the planning and implementation of the MSOCS Transition to Safety Net project, participants should remember that the proposed changes will disrupt people's lives to varying degrees: the individuals themselves, their families and friends, the MSOCS staff, the staff of new providers who will serve individuals who decide to move, lead agency staff, and the communities in which the individuals live. It will be important to acknowledge this disruption at the outset and develop a compassionate, person-centered planning and transition process that allows adequate time and resources to work through the many challenges and disagreements that could emerge. At the same time, the process should maintain momentum in order to increase MSOCS' capacity to serve individuals who need a safety net level of service in less restrictive and more integrated settings.
4. Communication and transparency will help ensure that the planning and transition process remains fair and that disagreements are identified early and worked out collaboratively. DHS should take the lead on informing all stakeholders about the project and the project plan, soliciting input and feedback to refine the process, facilitating ongoing problem-solving, and negotiating solutions in an open process that includes all relevant stakeholders (see page 29).
5. The transitioning of MSOCS homes should be a gradual process, with cohorts of individuals or homes being established in a way that takes multiple factors into account, including the circumstances and wishes of the MSOCS individuals; the capacity constraints faced by MSOCS, lead agencies, and providers; and the financial sustainability of MSOCS. Establishing priorities and timelines should be a collaborative effort of the individuals and their families, MSOCS, lead agencies, and private providers.
6. Whenever possible, the MSOCS Transition to Safety Net project should adopt or align with existing or planned processes from related projects (for example, the Minnesota Olmstead Plan implementation and changes in Home and Community-Based Services). This will require setting realistic timelines that take into account the many ongoing changes in the social service system that are already taxing the capacity of state, lead agency, and private provider staff.

7. Adequate training and technical assistance will be key to the success of this transition as many staff in MSOCS, private providers, and lead agencies will be taking on additional or new duties and/or serving populations with whom they have little experience. DHS should take a leadership role in providing or assuring that training and technical assistance are accessible, timely, and targeted to the specific needs of those being trained or assisted.
8. Several aspects of the MSOCS transition may require additional funding and/or proposals for legislative changes. The Community Based Steering Committee recommends the following:
    a. Develop a means to fund a safety net vacancy factor, safety net staffing, and/or reduced home capacity to meet the needs of safety net individuals.
    b. Consider a subsidy to fund housing costs not covered by Group Residential Housing funds for individuals who choose not to, or cannot, live with others.
    c. Identify a means for ensuring flexibility in Adult Foster Care bed allocation.
    d. Allocate more funding for DHS's Community Support Services and for other technical assistance to families, lead agencies and providers to create and sustain community capacity.
    e. Ensure adequate funding to develop necessary services to support individuals needing safety net care (for example, housing modifications).
    f. Ensure funding to support adequate MSOCS staff development (e.g. complex care staff training).
    g. Allocate adequate funding to support business operations management and project management for MSOCS as it implements the MSOCS Transition to Safety Net project.
    h. Increase funding to support more crisis beds, including safety net crisis beds.

The Community Based Steering Committee makes these recommendations with full awareness of the complexity of the MSOCS Transition to Safety Net project. The Steering Committee urges DHS Commissioner Piper to consider its recommendations and move forward with deliberate planning and resource allocation. The Steering Committee offers its support during this process and looks forward to continuing to collaborate with DHS on this important project.

Appendix 1: List of Community Based Steering Committee Participants

DHS Partner Members

Michael Herzing, Counties/MACSSA

Roberta Opheim, Office of the Ombudsman for Mental Health and Developmental Disabilities

Deb Sjostrom, Counties/MACSSA

Delphine Steiner, AFSCME

Jo Pels, AFSCME

Joann Holton, AMSCME

Kathy Fodness, MAPE

My Lee, MMA

Barb Turner, ARRM

DHS Staff

Lucinda Jesson, former DHS Commissioner[12]

Jennifer DeCubellis, Community Supports Administration Assistant Commissioner

Alex Bartolic, Disability Services Director

Connie Jones, Human Resources Director

Sarah Berg, Communications

Daniel Hohmann, MSOCS

Dan Newman, Disability Supports Division

Don Chandler, MSOCS

Shirley Nelson-Williams, MSOCS

Sue Koch, Community Supports Administration

Alex Kotze, Chief Financial Officer, DHS

Maura McNellis-Kubat, Community Supports Administration

[12] Commissioner Jesson left DHS just as the Community Based Steering Committee's report was being finalized, so the report is being delivered to the new DHS Commissioner, Emily Johnson Piper.

Appendix 2: Safety Net Definition

The Community Based Steering Committee has accepted the following criteria for defining "safety net" for the purposes of the MSOCS Transition to Safety Net project. Prior to referring an individual to MSOCS, it is expected that all individuals being considered for admission have reviewed and been turned down for alternative support and/or placement options through private community providers.

Definitions

A "Safety Net Service Provider" is defined as a provider who has the capacity—in the geographic location where the provider system operates—to support an individual with complex behavioral health needs in a way that is focused on the needs, abilities and preferences of the individual.

Safety Net Criteria

To meet the criteria for safety net services, an individual must meet all three of the following criteria and at least one of the "system conditions" listed below.

Criterion 1: The individual has at least one of these diagnoses:

- Intellectual Disability
- Developmental Disability
- Mental Illness
- Severe and Persistent Mental Illness
- Brain Injury

Criterion 2: The individual has at least one of these circumstances:

- The individual exhibits behaviors or symptoms that present a safety risk to self and/or others, including but not limited to physical aggression, property destruction, self-harming behavior (e.g., biting, scratching, cutting, head hitting, etc.), or frequent elopement.
- The individual has a history of legal offenses or involvement with law enforcement that has limited their opportunity for placement with a community provider.

Criterion 3: The individual does not require emergency hospital level of care for a medical condition or psychiatric illness.

System Conditions

In addition to meeting all three of the preceding criteria, an individual must meet one of the following three sets of system conditions in order to be considered appropriate for "safety net" services.

System Condition Set 1: For crisis respite support (anticipated to last fewer than 90 days):

- The individual must be at risk of receiving treatment or care at a more restrictive facility or an inpatient DCT facility, and
- The individual's current provider must be willing and able to readmit the individual within 90 days, and
- There are no private residential providers available to support the individual's immediate needs and preferences.

System Condition Set 2: For residential support (anticipated to last more than 90 days):

- The individual must have exhausted therapeutic progress in a hospital or inpatient treatment setting for his/her illness or behavior, and
- The lead agency and DHS Disability Services Division must have determined that there are no willing and able private providers to support the individual. This determination could be made either because providers who might be able to provide appropriate resources to support the individual are not available in the identified or preferred geographical area or because attempts at securing or developing a provider in the preferred geographical area have not succeeded.

If there is no appropriate residential placement available within MSOCS, the lead agency must have a corporate Adult Foster Care bed slot available or apply for the exception to the moratorium process in order to allow for MSOCS development of a placement.

System Condition Set 3: For vocational/day services:

The lead agency and DHS Disability Services Division must have determined that there are no willing and able private providers to support the identified individual for one of the following reasons:

- Private provider programs with the necessary resources to provide the identified supports required for the individual are not available in the identified or preferred geographical area; or
- Past attempts at providing the needed program supports within the private provider system have been unsuccessful.

Appendix 3: MSOCS Individual Record Review

In the fall of 2015, MSOCS supervisors reviewed the records of current MSOCS individuals to get a sense of which individuals might meet the diagnostic and behavioral criteria for safety net services. Considering all three diagnostic and behavioral criteria for safety net services (i.e., not the criteria that consider whether a private provider is available to serve the individual):

- **About 140 individuals** (about one-third) appear to meet the diagnostic and behavioral criteria for safety net services; **275** (about two-thirds) do not.
- The analysis included data from 113 homes; MSOCS owns 52 of those homes. There are **152** individuals in those owned homes who did not appear to meet the diagnostic and behavioral criteria.
- There are **46** MSOCS homes in which all the current individuals do not appear to meet the diagnostic and behavioral criteria for safety net services. Twenty of these homes are leased and 26 are owned.

A. Data Overview

Between August 30 and September 16, MSOCS supervisors reviewed 415 individual records to help managers determine who might meet the diagnostic and behavioral criteria for a safety-net level of care. For each individual, supervisors filled out a form that was based on the Safety Net Definition that has been reviewed by the Community Based Steering Committee (see Appendix 2). The data from the forms was gathered into a Sharepoint database and a database administrator created a spreadsheet of the data with the individual identifying information removed. A summary of the data was presented to the Community Based Steering Committee on September 22, 2015.

B. Diagnostic and Behavioral Criteria for Safety Net Services

There are three criteria that an individual must meet to satisfy the diagnostic and behavioral criteria for safety net services. The first requires a diagnosis of intellectual or developmental disability, mental illness, or brain injury. The second requires either behaviors that pose a potential threat to self or others *or* a history of involvement with the legal system. The third requires that the person *not* need a hospital level of care.

Criterion 1: Diagnosis

Only one individual (out of 415) did not have a diagnosis of an intellectual or developmental disability, mental illness, or brain injury. That individual has a degenerative condition with behavioral side effects.

Criterion 2: Risk Behaviors or History of Legal Offenses

The final determination of whether an individual's behaviors require safety net services will not be made until the person-centered planning phase of this project. To get a *preliminary* sense of the numbers of individuals who might need safety net services, reviewers answered the following question about diagnoses and types of behaviors, their frequency, and their intensity:

In the last 12 months, has the individual exhibited behaviors or symptoms that present a safety risk to self and/or others including but not limited to the following? (select all that apply)

For those selected, indicate the frequency and intensity.

Behavior	Frequency	Intensity *(see description below)*
☐ Physical Aggression		
☐ Property Destruction		
☐ Self-Harm (biting, scratching, cutting, head hitting, swallowing inedible objects, etc.)		
☐ Elopement		
☐		

•Minor impact: the behavior or symptoms have a MINOR impact on activities of daily living but they DO NOT present the potential for physical harm that seriously threatens a person's or others health and safety.

•Moderate impact: the behavior or symptoms have a MODERATE impact on activities of daily living AND present the potential for physical harm that MODERATELY threatens a person's or others health and safety.

•Major impact: the behavior or symptoms SIGNIFICANTLY limits activities of daily living AND/OR presents the potential for physical harm that seriously threatens a person's or others health and safety.

Figure 1: Survey question regarding frequency and intensity of types of behavior

To analyze these responses and determine a threshold for what could be considered "safety net," we devised a point system and assigned points to each response, as shown below. For example, if a person had weekly property destruction behaviors at a moderate level of intensity, that was assigned 4 points. If the person also had daily self-harm behaviors at a minor level of intensity, that was assigned 2 additional points, for a total of 6 points.

Category of Behavior	Minor	Moderate	Major
Less than once a month	1 point	2 points	9 points
Monthly	1 point	2 points	10 points
Weekly	1 point	4 points	12 points
Daily	2 points	6 points	16 points
Hourly	2 points	8 points	20 points

Five Categories of Behavior
Physical Aggression
Property Destruction
Self-Harm
Elopement
Other

Table 1: Point system used to translate frequency and intensity of behaviors into a "safety net" threshold

We assigned the points based on our understanding of the challenges that the frequency or intensity of each type of behavior pose for service providers. Any individual whose behaviors in the past year were scored for a total of 10 or more points was considered to be at a "safety net" level. We recognize that any point system and threshold is somewhat arbitrary, but we feel that this system is at least easily-

understood and it provides a good starting point for discussions about how such decisions could be made later.

The point totals of the 415 individuals whose records were reviewed are shown below.

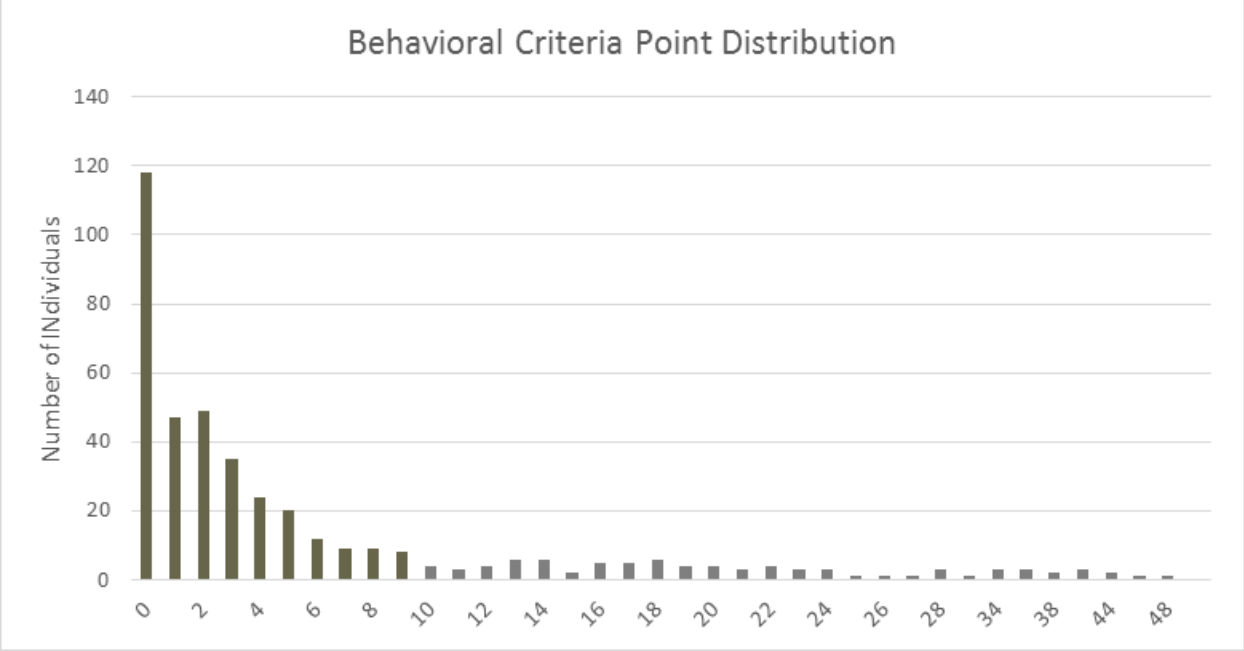


Figure 2: Graph of Point Totals and the Number of Individuals Assigned that Number of Points. Individuals with 10+ points were included in the "safety net" category.

Based on the point system and the "safety net" threshold of 10 points, the review found that:

- 90 individuals were determined to have behaviors that presented a potential threat to the safety of self or others
- 83 individuals had a history of legal offenses or involvement with law enforcement that had limited their opportunity for placement with a community provider.
- 32 individuals met both of these criteria.

Criterion 3: Individual Does Not Require a Hospital Level of Care

For this review, we assumed that all individuals in MSOCS homes did not require a hospital level of care. However, the survey included a question asking supervisors whether an individual would be at risk for hospitalization if not receiving their current level of supports. Supervisors identified 143 individuals, or 34% of the sample, as requiring their existing level of services in order to avoid a risk of hospitalization. This information could be considered during person-centered planning, but is not strictly a part of the safety net definition.

C. Conclusion: All Three Behavioral Criteria for Safety Net Services

Taking all three criteria into account, 141 individuals appear to meet the diagnostic and behavioral criteria for safety net services and 275 did not.

Appendix 4: Preliminary Project Communications Plan

A. Background

Communication and transparency will help ensure that the MSOCS Transition to Safety Net project is well-understood and that stakeholders are committed to its success. They will also contribute to a process that is efficient and fair, so that problems or disagreements are identified early and worked out collaboratively. DHS should take the lead on informing all stakeholders about the project and the project plan, soliciting input and feedback to refine the process, facilitating ongoing problem-solving, and negotiating solutions in an open process that includes all relevant stakeholders. This document outlines the overall approach to communication during the project. Specific communication plans for specific events will be developed collaboratively as those events emerge.

B. Communication goals

- Build understanding of the MSOCS Transition to Safety Net project's vision, priorities, strategies and goals among staff and stakeholders
- Provide accurate, timely and useful information to key audiences
- Promote and support collaborative problem-solving among the many partners in the project

C. Communications strategies

The DHS Communications division will support these goals by working closely with project staff and partners to:

- Formulate key messages about the project or specific activities within the project
- Identify or create opportunities to communicate the key messages
- Use multiple tools to share information and messages

D. Audiences

- Individuals served by MSOCS, families and guardians
- DHS staff
- Labor partners
- Lead agencies (counties, tribes, managed care organizations)
- Private providers
- Advocacy groups
- Legislators

E. Initial key messages (to be developed with project partners)

- We are committed to ensuring that the MSOCS Transition to Safety Net project is person-centered and that it contributes to the Olmstead goal of people with disabilities living, learning, working, and enjoying life in the most integrated settings of their choice.
- Changes will take time and require careful and collaborative planning
- The success of the project requires that individuals and their families—as well as staff at MSOCS, lead agencies, and private providers—are prepared for the changes accompanying MSOCS' transition to a safety net service.

F. Communications tools

1. Publications & written communications

- Brochures
- Fact sheets/FAQs
- Letters
- DHS Bulletins
- Listserves – e.g., *News from DHS*
- Web content (see Web section)
- Project plans and reports

2. Web

- MSOCS-specific web pages
  - Links to posted reports/documents
  - Listserve sign up
- CountyLink

3. Employee communications

- Employee emails
- Forums
- DHS Today

4. Media relations

- News releases/op-eds
- Pitch calls
- Respond to reporter requests

G. Key dates

There will be key times when specific communications plans are needed to ensure we are communicating with collaborating stakeholders and other audiences:

- Completion of the Steering Committee's report (December 2015)
- Prioritization and scheduling of individuals and homes to begin the planning process
- Implementation of changes for each cohort of individuals or homes

H. Outcomes

Communications work will:

- Raise awareness of plans to transition MSOCS residential services to a transitional safety net provider

- Provide all of the stakeholders involved in this project with the information and tools they need to understand the changes that are taking place, the reasons for those changes, and the roles they can play in the planning and implementation of the project.
- Support the progress of the MSOCS Transition to Safety Net project
- Celebrate the successes of the individuals that MSOCS serves and the staff of all of the providers who support them

Appendix 5: Preliminary MSOCS Transition Training Plan

A. Transitioning Individuals out of MSOCS

At the request of the lead agency, MSOCS staff will provide individual-specific training.

1. Training areas: Individual specific training

- Preferences of the person based on current staff knowledge and experiences in supporting the individual
- Support Plans overview:
    - Coordinated Services and Support Plan addendum (CSSPa) which will likely touch on each of the following:
        - Person Centered Plans/Person Centered Description (PCP/PCD)
        - Positive Support Transition Plans (PSTP)
        - Behavior Management Plans
        - Self-Management Assessment (SMA)
        - Medication Management
        - Dietary, personal care, transportation needs and preferences
        - Individual schedules and activities

2. Who can provide the training?

- Support teams (i.e., guardian/LARs, case managers/social workers, family, friends, etc.)
- Current MSOCS site staff and RNs at the direction of the supervisor.
- Subject Matter Experts with knowledge of the individual:
    - Behavior Professionals
    - RN's
    - Psychologist/psychiatrists
    - Crisis consultants
    - Etc.
- Community Support Services staff

3. How will the training be delivered?

- Observation and side-by-side mentoring with the individuals both before and after transition to the other provider
- Reimbursement has historically been through contracting with the provider for the post-transition training at the request of the receiving provider

*Frequency/duration of the training will be dependent on the needs of the individual and the request of the receiving provider or at the direction of the lead agency.

B. Transitioning Individuals into MSOCS

As needed to support the individual(s) being referred to MSOCS, training will be provided in the following manner.

1. Training areas

- General (not individual-specific) training
    - All current and incoming staff will continue to receive CBS/MSOCS required training
        - Licensing and policy required training include
            - Effective and Safe Engagement (EASE) 2.0 (Basic, Intermediate, or Enhanced depending on the home and individuals). This training will include:
                - Verbal and preventative techniques
                - Self-protection interventions
                - Protection of others
                - Other classes upon request as required to fulfill the needs of the individual(s) being supported
            - CPR/First Aid
            - Medication Administration
            - Person Centered Thinking
            - Positive Behavior Supports
    - For staff working in the transitioning or repurposed sites:
        - EASE 2.0 training needed to meet with specific requirements of the individuals moving into the site
        - Mentoring and cross-training at MSOCS sites supporting individuals with challenging behavior
        - General training on working with individuals with mental illnesses and/or intellectual disabilities
- Individual specific training-
    - Visiting with the individual at their current setting and learning about their preferences first hand through conversation and observation
    - Mentoring and cross-training with staff at the individuals' current setting
    - Training on the diagnostic-specific information related to the individual and how the individual symptoms present
    - Support Plans overview and development (in many cases the individuals that will be supported at MSOCS may not have the required support plans so they will need to be developed as MSOCS staff learn more about the individual):
        - Coordinated Services and Support Plan addendum (CSSPa) which will likely touch on each of the following:
            - Person Centered Plans/Person Centered Description (PCP/PCD)
            - Positive Support Transition Plans (PSTP)
            - Behavior Management Plans

- Self-Management Assessment (SMA)
- Medication Management
- Dietary, personal care, transportation needs and preferences
- Individual schedules and activities

2. Who will provide the training?

- Support teams (i.e., guardians/LARs, case managers/social workers, family, friends, etc.)
- Subject Matter Experts with knowledge of the individual:
  - Behavior Professionals
  - RNs
  - Psychologist/psychiatrists
  - Crisis consultants
  - Etc.
- Community Support Services staff
- Staff from the receiving facility

3. How will the training be delivered?

- Observation and side-by-side mentoring with the individuals both before and after transition
- Class room
- Reading materials
- Videos when available
- Video conferences
- Consultation

Throughout all transitions MSOCS will make the best attempt to provide training specific to the needs of the individuals and the learning needs and preferences of the staff supporting them. As these are different for each individual and staff, and because they sometimes change over time, MSOCS will continually work toward developing training and training systems responsive to each individual's needs and the staff supporting them at a specific period of time.

Appendix 6: Transition Protocols Summary

The Minnesota Department of Human Services (DHS) has developed a set of four transition protocols to support people receiving long-term services and supports and mental health services to move from more segregated settings to more integrated homes of their choice.

Counties, tribes, managed care organizations, advocates, and staff from state-operated facilities are currently participating in implementation workgroups to develop the best practices and tools that will guide transition teams as they work together to develop meaningful plans for people who are making a transition. The protocols were tested in late summer 2015 and are currently being used on a limited basis as a pilot phase. Adjustments will be made based on this experience and the protocols will be finalized in February 2016. DHS is providing training and technical assistance to lead agencies and is developing tools and materials for people and their families and the professionals who support them.

A. Foundation Principles

The protocols are designed to work in various circumstances while also remaining true to five principles:

- **Involvement of the individual and family:** Each person, the person's family and/or legal representative, and any others chosen by the person shall be involved in any evaluation, decision-making, and planning processes to the greatest extent practicable, using whatever communication method the person prefers.
- **Use of person-centered principles and processes**: To foster each person's self-determination and independence, state agencies shall ensure the use of person-centered planning principles at each stage of the process to facilitate the identification of the person's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.
- **Expression of choice and quality of life**: Each person shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality of life.
- **Life options and alternatives:** State agencies shall undertake best efforts to provide each person with reasonable alternatives for living, working, and education.
- **Provision of adequate services in community settings:** It is the goal of state agencies that all people be served in integrated community settings with adequate supports, protections, and other necessary resources which are identified as available by service coordination.

B. Four Protocols

1. Outreach Protocol

Typically, transition planning has not have been triggered until someone expressed a desire to move. The expectations of the Outreach protocol reflect the value in Minnesota's Olmstead Plan that people who are not opposed to moving should be given that opportunity. Clearly, this is a different way of thinking than has been normative in the past.

In order to make an informed choice, people need to realize what their options are and what those options mean. Some people may need the opportunity to learn how different options could be viable for them. Similarly, sometimes other people who are significant to the individual need to learn what is possible.

2. Transition Planning Protocol

The transition protocol identifies qualities of a good transition plan. Like in the outreach process, good transition plans are ones in which the person has choices among multiple options. The person needs to understand that they have choices and what it means to have choices. Because some people have spent considerable time in situations where they have not experienced real choices nor control over their lives, it may take time for the person to understand what this means and how to exercise choice. It may be that the person needs to try options to learn what they like and what they are capable of doing for themselves. It should not be assumed that the first move to a more integrated setting will be the ultimate transition.

Another quality of good planning is that the person who is transitioning is kept informed about the process, including any changes to the plan and changes in personnel.

A third essential element of good planning lies in the process of transitioning between professionals. A good plan has limited value if it is not adhered to in the new setting. Professionals need to take care to ensure that there is sufficient coordination during the transition from one set of supports to another.

Each person's transition plan is a living document and should be changed as the person's needs and wants change. The transition planning protocol must be followed for transitions from any segregated setting to a more integrated to ensure that a minimum set of standards is adhered to across settings and populations.

3. Follow-up Protocol

The Follow-up Protocol is designed to ensure that the person's transition planning led to the person living in the place of his or her choice, with appropriate supports and services in place to support his or her person-centered plan. Following up with the person is also a way to identify obstacles in the way of fully implementing the individual's plan and ensuring that there are steps in place to overcome those obstacles.

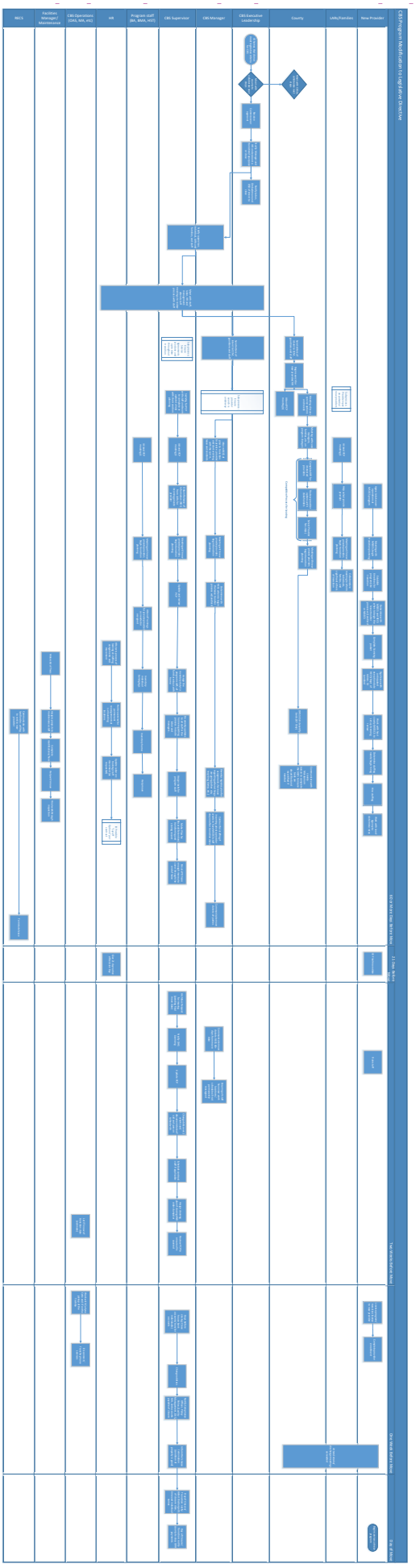
4. System Measurement Protocol

By following this protocol, state agencies will be able to measure the strengths and weaknesses of the system over time. This analysis will be used to address weaknesses and build upon strengths in order to continually improve the system.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment C

to the October 2019 Supplemental Report



Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment D

to the October 2019 Supplemental Report

Minnesota Department of Human Services Disability Services Division

Request for Proposals for Qualified Facilities to Provide Out-of-Home Crisis Respite Services for Adults and Children with Intellectual or Developmental Disabilities (I/DD)

Date of Publication: April 18, 2016

Americans with Disabilities Act (ADA) Statement: This information is available in accessible formats for people with disabilities by calling 651-431-2400 or by using your preferred relay service. For other information on disability rights and protections, contact your agency's Americans with Disabilities Act (ADA) coordinator.

Table of Contents

I. Introduction

A. Purpose of Request

The Minnesota Department of Human Services, through its Disability Services Division (State), is seeking Proposals from qualified Responders to increase the network of providers who can successfully serve adults and children with intellectual or developmental disabilities (I/DD) in need of short-term, out-of-home crisis respite services. Crisis respite is defined under the Developmental Disability Waiver plan as "short-term care and intervention strategies to an individual for both medical and behavioral needs that support the caregiver and/or protect the person or others living with that person." Responders must be a provider organization with experience serving adults and children with challenging behavioral support needs. Successful responders will be granted an exception to the moratorium on community residential setting licenses by the Commissioner, as described in Minnesota Statutes section 245A.03 Subd.7.

B. Objective of this RFP

The objective of this RFP is to identify and select a qualified Responder(s) to perform the tasks and services set forth in this RFP. As a result of this RFP, the State anticipates awarding new community residential setting license capacity for up to 40 people in out-of-home crisis respite services: licensed capacity for up to 20 people (12 for children, 8 for adults) to be awarded within the seven county Twin Cities metro area (defined as Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties); and licensed capacity for up to 20 people in greater (non-Twin Cities metro) Minnesota.

Previous experience serving people with complex needs, and rates will be a factor in the evaluation of the Proposals. This RFP does not obligate the State to award any new community residential setting license capacity or complete the project, and the State reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by the Responder.

C. Background

When people with disabilities experience a crisis, it is important that they experience as little disruption in their living situation as possible and avoid unnecessary stays in institutional settings. To the extent possible, disruption to daily life must be brief, minimal, and targeted to meet the person's choices and needs. Crisis services are intended to do three things: (1) stabilize a person in their current setting; (2) triage to determine if more intensive services are necessary; and (3) divert people from unnecessarily accessing segregated settings. This can be influenced by timely and appropriate crisis services and increased capacity of community providers delivering positive support strategies.

Over the past several years, the inability to access timely crisis services has resulted in people being unnecessarily hospitalized or placed in other segregated settings. In Minnesota's Olmstead Plan, (http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_196300.pdf), the State has pledged to address this by expanding home and community-based crisis services throughout the state to have timely access to crisis services that are clinically appropriate. By expanding short-term residential crisis services, people will avoid unnecessary hospitalizations or other restrictive services.

The State is in need of qualified providers to provide out-of-home crisis respite services, as defined under the Developmental Disability Waiver, for adults and/or children with I/DD who are (a) on the Developmental Disabilities (DD) Waiver, or (b) eligible for the DD Waiver and need to access this service to mitigate a crisis (crisis-only respite). These services will include stabilization, positive support and transition planning, and participation in the development of permanent housing and service options to more quickly move people out of crisis placement when that level of service is no longer needed.

Out-of-home crisis respite services are currently paid for through the DD waiver program by Minnesota local lead agencies (counties and tribes). In order to provide these services, successful responders will execute Service Agreements with the lead agencies which detail terms for specific services provided and rates.

Currently, there is a moratorium on licenses for new community residential setting facilities, pursuant to Minn. Stat. 245A.03 subd. 7. In order to increase the number of providers who are available to provide out-of-home crisis respite serves under the waiver programs, State anticipates granting exceptions to the moratorium under Minn. Stat. 245A.03 subd. 7. Successful responders to this RFP will be eligible for a community residential setting license under Minn. Stat. 245A.

For clarity, this RFP will serve only to select providers who are eligible for a license as an exception to the moratorium under Minn. Stat. 245A.03 subd. 7. Eligible providers must also successfully complete the licensing requirements for a community residential setting license pursuant to 245A.04 *et. seq.*

II. Scope of Work

A. Overview

The intent of this RFP is to increase the network of out-of-home crisis respite providers to successfully serve adults and/or children with I/DD who are (a) on the DD Waiver, or (b) eligible for the DD Waiver and need to access this service to mitigate a crisis (crisis-only respite) by increasing the number of licensed facilities to provide these services.

Out-of-home crisis respite provides an appropriate level of service for persons experiencing elevated or specific behavioral support needs beyond what their current support system can provide. The goal is to stabilize the person, reduce the level of intensive behavioral support needed, and return the person back to more integrated services and supports.

The State is seeking to award new community residential setting licensed capacity for providers experienced and skilled in serving people in need of out-of-home crisis respite. Respondents must be entities or people that currently hold or intend to obtain licensure under Minn. Stat. chapter 245D, and also meet the requirements under 245D as an intensive support service provider.

B. Service Population

The adults and children who need out-of-home crisis respite may exhibit a variety of extremely challenging behaviors, often accompanied by complex, multiple co-occurring conditions. The severity and frequency of these occurrences can vary, but often the challenging behaviors are severe and occur multiple times in a day. A provider can expect to experience the following, in any combination (this list is not exhaustive):

Challenging Behaviors

- Severe physical and/or verbal aggression;
- Harm to self/suicide risks;
- Illegal activity;
- Substance abuse;
- Elopement;
- Severe property destruction;

- Sexual acting out;
- School/Work problems, including behavioral and other difficulties in peer relationships;

Secondary Diagnosis
People served in crisis respite may also carry with them a range of secondary diagnoses, including mental health issues as well as physical and medical conditions such as:

- Autism Spectrum Disorder
- Fetal Alcohol Syndrome;
- Brain Injury;
- Antisocial Personality Disorder;
- Attention-Deficit/Hyperactivity Disorder;
- Depression;
- Post-Traumatic Stress Disorder;
- Psychosis;
- Obsessive or compulsive behavior or paranoia;
- Unusual preoccupations with food, diet, and/or body image;
- Sleep disorders;
- Diabetes;

Other Characteristics

- Communication disorders;
- Need for medication monitoring/assessment;
- Standard nursing supports

Family Related Issues
Family issues can play a large role in both the crisis that eventually results in a crisis system involvement and the successful treatment and disposition of the placement. The vendor will encounter the complete spectrum of family issues, such as:

- Recent changes in parental relationships;
- History of physical, sexual, or emotional abuse, and exposure to violence;
- Poverty;
- History of drug or alcohol abuse;
- Grief issues

C. Qualifications

The intent of the RFP is to increase the network of providers and award new community residential setting license capacity for out of home crisis respite so people in crisis have access to timely, appropriate, high-quality out-of-home crisis respite options. Core components of crisis respite services include:

1. Assessment of the person and situation to determine the crisis precipitating factors.
2. Development and implementation of a support plan based on positive support strategies, in coordination with the person's expanded support team.
3. In coordination with the person's expanded support team, development and implementation of a person-centered transition plan, based on the State's published transition planning protocol (http://mn.gov/dhs/images/PCP_protocol.pdf), to aid the person's transition out of crisis respite to a more integrated setting.
4. Recommendations for support plan revisions to prevent or minimize future crisis situations and increase the likelihood of maintaining stability of the person in his/her home.
5. Coaching and training the person's service providers and other natural supports to manage challenging behavior and successfully implement the person-centered transition plan and support plans.

The following are required components of providing crisis respite services; respondents should include information describing these components in their proposals in order to demonstrate their qualifications:

1. Experience with serving individuals in crisis. The successful respondent can demonstrate having the skills and ability to provide sustained, uninterrupted service to people with highly complex and challenging behavior support needs. A capacity to initiate services within as little as one day after referral is critical. In addition, direct and on-going access to expertise in the following areas is highly desirable:
    a. Person-centered thinking and planning
    b. Positive behavior supports
    c. Functional behavior assessment

2. Person-centered services. The successful respondent can demonstrate both understanding and experience with providing services based on person-centered principles and practices. Services should be individualized to balance the unique needs and desires of the person in the context of crisis stabilization, transition planning, and helping the person return to a more integrated long-term living environment.

3. Flexible service environments. The successful respondent is able to assure:
    a. Service environments are appropriate, safe, and flexible to accommodate the various needs of persons experiencing behavioral crises.
    b. Housing options are wheelchair accessible strongly encouraged and preferred.
    c. Housing options are appropriate for serving people with challenging behaviors and are designed with elopement and aggressive behavior in mind.

4. Commitment to providing comprehensive stabilization and transition services. The successful respondent will specify its plans to provide the following:
    a. Ability to provide/ access staff, 24 hours a day, to respond to a person's needs.
    b. Knowledge, access, and ability to connect with relevant community resources to ensure integration of the person with her/his community during the course of out-of-home crisis respite services.
    c. Transition planning, based upon the transition protocols developed by the State (http://mn.gov/dhs/images/PCP_protocol.pdf), to provide assistance with locating long-term, integrated living options within the person's preferred community.
    d. Capacity to provide coaching and training to the person's service provider(s) and natural supports to effectively support the person post-crisis.

5. Emergency Backup Plan. The successful respondent will specify its plans to provide emergency backup to persons served and staff 24 hours-a-day to sustain services in-place and prevent hospitalization and/or involvement of law enforcement to the extent possible. Include a description of any intended on-call system and plans to provide backup staffing whenever necessary.

6. Access to a network of multidisciplinary providers who understand the unique needs of persons with challenging behaviors and/or complex medical needs.
    a. Demonstrated relationships and collaboration with practitioners of diverse expertise to guarantee comprehensive care and services are available to the individuals served. Examples include:
        i. Medical Practitioners
        ii. Psychologists
        iii. Pharmacologists
        iv. Behavioral Therapists
        v. Behavior Analysts
        vi. Person-Centered Planners
        vii. Occupational Therapists
        viii. Speech Therapists
        ix. Educators/other school personnel

b. A collaborative working relationship with local law enforcement.
c. Culturally competent providers

D. Additional Documentation

The following documentation is requested to be included in all submitted proposals.

1. Documentation of Staff Qualifications

   Vendors are required to submit documentation detailing relevant staff and/or consultant qualifications. Such qualifications may include, but are not limited to:

   a. Training and demonstrated competence in person-centered planning.
   b. Training and demonstrated competence in functional behavior assessment.
   c. Training and demonstrated competence in positive supports.
   d. Training and demonstrated competence in supports for person with autism, including sensory diet.
   e. Certified behavior analysts.
   f. Licensed mental health professionals.
   g. Licensed health professionals.

III. Proposal Format

Proposals must conform to all instructions, conditions, and requirements included in the RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the proposal are at the responder's risk and may, at the discretion of the State, result in disqualification of the proposal for nonresponsiveness. Acceptable proposals must offer all services identified in Section II - Scope of Work and agree to the conditions specified throughout the RFP.

A. Required Proposal Contents

Responses to this RFP must consist of all of the following components (See following sections for more detail on each component).

1. Table of Contents

2. Proposal Requirements

   a. Statement of Understanding
   b. Description of Proposed Service
   c. Implementation Plan
   d. Relevant Responder Experience/Resumes of Lead Responder Staff
   e. Financial Stability and Professional Responsibility of Responder

3. Innovative Concepts (If Applicable)

4. Required Statements

   a. Responder Information and Declarations
   b. Exceptions to RFP Terms
   c. Affidavit of Noncollusion

d. Trade Secret/Confidential Data Notification
e. Submission of Certified Financial Audit, IRS Form 990, or Most Recent Board-Reviewed Financial Statements
f. Disclosure of Funding Form
g. Certification and Restriction on Lobbying

5. Cost Proposal

6. Appendix (If Applicable)

Any additional information thought to be relevant, but not applicable to the prescribed format, may be included in the Appendix of your Proposal.

B. Proposal Requirements

The following will be considered minimum requirements of the proposal emphasis should be on completeness and clarity of content.

1. Statement of Understanding
This component of the proposal should demonstrate the responder's understanding of the services requested in this RFP, the nature of the agreement specific to the awarding of new community residential setting license capacity to provide out-of-home crisis respite services, and any problems anticipated in accomplishing the work. Specifically, the Proposal should demonstrate the Responder's familiarity with the project elements, a summary of its solution(s) to the problems presented and knowledge of the requested services and/or deliverables.

2. Description of the Proposed Service
According to the 2015 DHS Gaps Analysis Study (http://mn.gov/dhs/partners-and-providers/continuing-care/data-measures/gaps-analysis/current-study/index.jsp), 23 percent of Minnesota's lead agencies rated Crisis respite as one of their "top three" most significant service gaps for people with disabilities. Lead agencies reported an estimated 111 people on waiting lists for crisis respite services. In your proposal, please describe the level of need for services in the proposed geographic area the services will be provided, as well as what groups of individuals will be targeted for services by the program. Please discuss whether your Application will have a local, regional or statewide impact on service to individuals with complex behavioral needs who are in crisis. Additionally, if there are specific properties that will be assigned to serve as crisis respite homes should the Proposal be awarded, please include the details of the properties as well as where they are located. Additionally, please specify if the Respondent plans and/or is willing to support dedicated group homes to serve as respite homes should this Proposal be awarded, the number of people the Proposal could serve if awarded and if the Respondent would be willing to serve fewer people than the number submitted in the proposal. Responder should include proposed staffing for the project. Responder should include its risk assessment/management plan.

3. Implementation Plan:
All Applications submitted under this RFP must address, in sufficient detail, how the Responder will fulfill the expected outcomes and features set forth above. Repeating the outcomes and features and asserting that they will be performed is not an acceptable response. This section should detail how the project will be carried out in an effective and efficient manner, including who will be involved, what resources are required, the resources and staff already in existence, target dates for project activities and a timeframe for completion. Provide a description of the project plan you propose to implement.

4. Relevant Responder Experience, Resumes of Lead Responder Staff:
This section must include information on the programs and activities of the agency, the number of people served, the geographic area where services can be provided and the number of additional people that could be served by the Responder if awarded this Proposal.

The Responder should demonstrate the length, depth, and applicability of prior experience in providing the requested services. This component of the Proposal must include previous experiences that will demonstrate the Responder's ability to deliver the services requested in this RFP. Responder may identify entities for which it has supplied similar services to those requested in the RFP, if any. If such organizations are identified, Responder should include each identified organization's name and address, and the name, title and telephone number of a contact of each organization. Responder should also provide a narrative description of the actual services provided to the organization(s). Describe what role, if any, staff proposed for this project had in the referenced service. Letters of reference may be included.

The Responder should also demonstrate the skill and experience of proposed lead staff. At a minimum, resumes must be provided for employees who would be assigned lead responsibilities on this Project. Resumes should describe the education, professional affiliations, and other relevant background of the lead staff to be assigned to this project. No change in the Successful Responder's personnel assigned to this project will be permitted without the prior approval of the State Program Manager.

5. Financial Stability and Professional Responsibility of the Responder:
It is crucial that the State locate reliable providers to serve people with disabilities in need of these services. The Successful Responder must be both fiscally and professionally responsible. Therefore, Responders must include in their Proposals both sufficient financial documentation to establish their financial stability and satisfactory information regarding their professional responsibility.

Financial information may include a current Financial Statement, a copy of an independent audit conducted within the last year, documentations of cash reserves to carry you through shortages or delays in receipt of revenue, and/or other documents sufficient to substantiate responsible fiscal management. In the event a Responder is either substantially or wholly owned by another corporate entity, the Proposal must also include the most recent detailed financial report of the parent organization. Please also include information about any pending major accusations that could affect your financial stability.

Professional responsibility information includes providing information concerning any complaints filed with or by professional and/or state or federal licensing/regulatory organizations within the past two years against your organization or its employees relating to the provision of services. If such complaints exist, please include the date of the complaint(s), the nature of the complaint(s), and the resolution/status of the complaint(s), including any disciplinary actions taken.

All Proposals must also include information about pending litigation and/or litigation resolved within the past two years that relates to the provision of services by your organization and/or its employees. If such litigation exists, please include the date of the lawsuit, nature of the lawsuit, and the dollar amount being requested as damages, and if resolved, what the resolution was (e.g. settled, dismissed, withdrawn by plaintiff, verdict for plaintiff with $x damages awarded, verdict for Responder, etc.).

Responder should also submit information which demonstrates recognition of their professional responsibility. This may include awards, certifications, and/or professional memberships.

The information collected from these inquiries will be used in the State's determination of the award of new community residential setting license capacity. It may be shared with other persons within DHS who may be involved in the decision-making process, and/or with other persons as authorized by law. You are not required to provide any of the above information. However, if you choose not to provide the requested information, your organization's Proposal may be found nonresponsive and given no further consideration. The State reserves the right to request any additional information to assure itself of a Responder's financial and professional status.

6. Responder Qualifications:
In response to the items listed in Section II, C, above, please describe Responder's relevant qualifications for the licensure available through this RFP.

7. Cost Proposal
Responders must use the "Cost Proposal Sheet" form to submit their Cost Proposal (available in Appendix A).

The rate(s) identified in the Cost Proposal must reflect all costs, including but not limited to: mass mailings, fees, commissions, compensation, equipment and other charges by the Responder for the service and/or deliverable.

Responders should assume a 90% occupancy rate in determining the proposed daily rate. Proposed daily rates for out-of-home crisis respite under the DD Waiver should include room and board costs. Payments can only be made only to those entities or people that are 245D license holders and meet the current licensure requirements of Minn. Stat. chapter 245D as an intensive support service provider.

Any payment for the work described in this RFP will be made by Minnesota local lead agencies to the successful responders through service agreements with the lead agencies. The State will not be responsible for any compensation to responders for the services described in this RFP.

In a separate narrative, describe and explain what the estimated rates pay for. Your explanation should provide sufficient detail to justify the total rate. The rate must be complete and reasonable, and the narrative should specify how it was determined.

The rate and narrative will be judged on efficient use of funds (that is, funds are being spent on direct services versus administrative costs, as detailed in their budget proposal) and overall cost-effectiveness.

C. Innovative Concepts (If Applicable)

The detailed needs and requirements for Responders in this RFP are not intended to limit the Responder's creativity in preparing a Proposal. Responders may submit innovative ideas, new concepts, partnership arrangements, and optional features in response to this RFP. However, Responder must still address the needs and requirements stated in this RFP. Submitting only a different idea instead of addressing the needs and requirements stated in the RFP will result in the Responder's Proposal being found nonresponsive and receiving no further consideration.

Any additional innovative concept submitted by a Responder will only be reviewed after the required needs stated in the RFP have been addressed. The State will review such additional features to determine whether or not, in the State's sole discretion, the features enhance the rest of the Responder's Proposal. If, at the State's sole discretion, it is determined that the additional innovative concepts would enhance the rest of the Responder's Proposal, the State *may* award bonus points to the Responder's Proposal in accordance with the evaluation process of this RFP.

D. Required Statements

Complete the correlating forms found in **eDocs**[1] by searching for the form numbers referenced below, or pasting the form file path name found in the footnotes below to your browser, and submit them as the "Required Statements" section of your proposal. You must use the current forms found in eDocs. Failure to use the most current forms found in eDocs in completion of the proposal are at the responder's risk and may, at the discretion of the State, result in disqualification of the proposal for nonresponsiveness."

[1] http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp

1. Responder Information and Declarations (Responder Information/Declarations Form DHS-7020-ENG)[2]: Complete and submit the attached "Responder Information and Declarations" form. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form.

2. Exceptions to RFP Terms (Exceptions to Terms and Conditions Form DHS-7019-ENG)[3]: The contents of this RFP and the proposal(s) of the successful responder(s) may become part of the final agreement if a community residential setting license(s) is awarded. Each responder's proposal must include a statement of acceptance of all terms and conditions stated within this RFP or provide a detailed statement of exception for each item excepted by the responder. **Responders who object to any condition of this RFP must note the objection on the attached "Exceptions to RFP Terms" form. If a responder has no objections to any terms or conditions, the responder should write "None" on the form.**

Responders are cautioned that any exceptions to the terms of the standard State request which give the responder a material advantage over other responders may result in the responder's proposal being declared nonresponsive. Proposals being declared nonresponsive will receive no further consideration for award.

3. Affidavit of Noncollusion (Affidavit of Noncollusion Form- DHS-7021)[4] : Each responder must complete and submit the attached "Affidavit of Noncollusion" form.

4. Trade Secret/Confidential Data Notification (Trade Secret/Confidential Data Notice Form- DHS-7015-ENG)[5]: All materials submitted in response to this RFP will become property of the State and will become public record in accordance with Minnesota Statutes, section 13.591, after the evaluation process is completed.

If the responder submits information in response to this RFP that it believes to be trade secret/confidential materials, as defined by the Minnesota Government Data Practices Act, Minnesota Statutes, section 13.37, and the responder does not want such data used or disclosed for any purpose other than the evaluation of this proposal, the responder must:

a. clearly mark every page of trade secret materials in its proposal at the time the proposal is submitted with the words "TRADE SECRET" or "CONFIDENTIAL" in capitalized, underlined and bolded type that is at least 20 pt.; the State does not assume liability for the use or disclosure of unmarked or unclearly marked trade secret/confidential data;

b. fill out and submit the attached "Trade Secret/Confidential Information Notification Form," specifying the pages of the proposal which are to be restricted and justifying the trade secret designation for each item. If no material is being designated as protected, a statement of "None" should be listed on the form;

c. satisfy the burden to justify any claim of trade secret/confidential information. In order for a trade secret claim to be considered by the State, detailed justification that satisfies the statutory elements of Minnesota Statutes, section and the factors discussed in Prairie Island Indian Community v. Minnesota Dept. of Public Safety, 658 N.W.2d 876, 884-89 (Minn.App.2003) must be provided. Use of generic trade secret language encompassing substantial portions of the proposal or simple assertions of trade secret interest without substantive explanation of the basis therefore will be regarded as nonresponsive requests for trade secret exception and will not be considered by the State in the event of a data request is received for proposal information; and

d. defend any action seeking release of the materials it believes to be trade secret and/or confidential, and indemnify and hold harmless the State, its agents and employees, from any judgments awarded against the State in favor of the party requesting the materials, and any and all costs connected with that defense. In submitting a

[2] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7020-ENG
[3] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7019-ENG
[4] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7021-ENG
[5] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7015-ENG

response to this RFP, the responder agrees that this indemnification survives as long as the trade secret materials are in the possession of the State. The State is required to keep all the basic documents related to its contracts, including selected responses to RFPs, for a minimum of six years after the end of the contract. Non-selected RFP proposals will be kept by the State for a minimum of one year after the award of a contract, and could potentially be kept for much longer.

The State reserves the right to reject a claim if it determines responder has not met the burden of establishing that the information constitutes a trade secret or is confidential. The State will not consider prices or costs submitted by the responder to be trade secret materials. Any decision by the State to disclose information designated by the responder as trade secret/confidential will be made consistent with the Minnesota Government Data Practices Act and other relevant laws and regulations. If certain information is found to constitute a trade secret/confidential, the remainder of the Proposal will become public; only the trade secret/confidential information will be removed and remain nonpublic.

The State also retains the right to use any or all system ideas presented in any proposal received in response to this RFP unless the responder presents a positive statement of objection in the proposal. Exceptions to such responder objections include: (1) public data, (2) ideas which were known to the State before submission of such proposal, or (3) ideas which properly became known to the State thereafter through other sources or through acceptance of the responder's proposal.

5. Documentation to Establish Fiscal Responsibility: The successful responder must be fiscally responsible. Therefore, responders must include in their proposals sufficient financial documentation to establish their financial stability.

IRS Form 990s. If a responder is a not-for-profit organization that completed an IRS Form 990 in 2014, responder is required to submit its 2014 990.

If responder is concerned that its 2014 IRS Form 990 does not demonstrate its fiscal responsibility, it may supplement its application with any of the additional material described below. An IRS Form 990 is a federal tax return for nonprofit organizations. Nonprofit organizations that are recognized as exempt from federal income tax must file a Form 990 or Form 990 EZ if it has averaged more than $25,000 in annual gross receipts over the past three tax years. Please do submit any information about any pending major accusations that could affect your financial stability.

Organizations without 2014 IRS Form 990s.

(1) Organizations that have not completed an IRS Form 990 should submit a certified financial audit if they have one. A certified financial audit is a review of an organization's financial statements, fiscal policies and control procedures by an independent third party to determine if the statements fairly represent the organization's financial position and if organizational procedures are in accordance with Generally Accepted Accounting Principles (GAAP). Any organization with an annual revenue greater than $750,000 is required to have a certified financial audit completed for any fiscal year in which they have total revenue of more than $750,000.

(2) If the organization does not have a certified financial audit, the organization must submit its most recent board-reviewed financial statements if it has a board.

(3) If the organization does not have a certified financial audit or board-reviewed financial statements because it does not have a board, the organization should submit a certified statement of assets and debts (balance sheet) and evidence of cash flow including amounts in a checking account.

Responders may also include documentations of cash reserves to carry you through shortages or delays in receipt of revenue, and/or any other documents sufficient to substantiate responsible fiscal management.

State may request additional information from these responders as necessary to determine financial stability.

All responders must submit any information about any pending major accusations that could affect your financial stability.

In the event a responder is either substantially or wholly owned by another corporate entity, the proposal must also include the most recent detailed financial report of the parent organization, and a written guarantee by the parent organization that it will unconditionally guarantee performance by the responder in each and every term, covenant, and condition of such contract as may be executed by the parties.

If the responder is a county government or a multi-county human services agency that has 1.) had an audit in the last year by the State Auditor or an outside auditing firm or 2) meets the requirements of the Single Audit Act, the responder is not required to submit financial statements. However, the State reserves the right to request any financial information to assure itself of a county's financial status.

The information collected from these inquiries will be used in the State's determination of eligibility for a license. It may be shared with other persons within the Minnesota Department of Human Services who may be involved in the decision-making process, and/or with other persons as authorized by law. If you choose not to provide the requested information, your organization's proposal will found nonresponsive and given no further consideration. The State reserves the right to request any additional information to assure itself of a responder's financial reliability. If a responder's submission in response to this component does not demonstrate its financial stability, the responder may fail this requirement and be disqualified from further consideration.

IV. RFP Process

A. Responders' Conference

A virtual Responders' Conference will be held on Wednesday, May 11th at 10 am Central Time. The Responders conference will serve as an opportunity for responders to ask specific questions of State staff concerning the project. Attendance at the virtual Responders' Conference is not mandatory but is recommended. Oral answers given at the conference will be non-binding. Written responses to questions asked at the conference will be sent to all identified prospective responders after the conference.

People interested in attending the Responders' Conference can access the conference by the following link:
https://dhs-dsd.webex.com/dhs-dsd/onstage/g.php?MTID=edde7ac071dabb5801b17a0e364dee87a.
Dial-in information for the Responders Conference is as follows:
Dial-in: 1-866-427-2706
Conference ID: 90664567

B. Responders' Questions

Responders' questions regarding this RFP must be submitted in writing prior to 4:00 p.m. Central Time on April 29th. All questions must be addressed to:

Request for Proposal Response
Attention: Carol Anthony
Disability Services Division
Department of Human Services
P.O. Box 64967
St. Paul, MN _55164-0967
Phone (651) 431 - 2015
FAX #: (651) 431-7411

Questions may also be e-mailed to: carol.anthony@state.mn.us

Other personnel are NOT authorized to discuss this RFP with responders before the proposal submission deadline. **Contact regarding this RFP with any State personnel not listed above could result in disqualification.** The State will not be held responsible for oral responses to responders.

Questions will be addressed in writing and distributed to all identified prospective responders. Every attempt will be made to provide answers timely, with the intent that they are sent no later than April 29th.

C. Proposal Submission

One (1) original and two (2) copies of the proposal must be submitted. Proposals must be physically received (not postmarked) by 4:00 p.m. Central Time on Thursday, May 26th to be considered. Late proposals will not be considered and will be returned unopened to the submitting party. Faxed or e-mailed proposals will not be accepted.

Clearly label the original "Proposal – Original" and each copy "Proposal – Copy". All proposals, including required copies, must be submitted in a single sealed package or container. The main body of the proposal pages must be numbered and submitted in 12-point font on 8 ½ X 11 inch paper, single spaced. The size and/or style of graphics, tabs, attachments, margin notes/highlights, etc. are not restricted by this RFP and their use and style are at the responder's discretion.

The above-referenced packages and all correspondence related to this RFP must be delivered to:

Attention: Carol Anthony
Disability Services Division
Department of Human Services
P.O. Box 64967
St. Paul, MN 55164-0967
Phone (651) 431 - 2015
FAX #: (651) 431-7411

It is solely the responsibility of each responder to assure that their proposal is delivered at the specific place, in the specific format, and prior to the deadline for submission. **Failure to abide by these instructions for submitting proposals may result in the disqualification of any non-complying proposal.**

V. Proposal Evaluation and Selection

A. Overview of Evaluation Methodology

1. All responsive proposals received by the deadline will be evaluated by the State. Proposals will be evaluated on "best value" as specified below, using a 100 point scale. The evaluation will be conducted in four phases:

a. Phase I Required Statements Review
b. Phase II Evaluation of Proposal Requirements
d. Phase III Selection of the Successful Responder(s)

2. During the evaluation process, all information concerning the proposals submitted, except identity, address, and the amount requested by responder, will remain non-public and will not be disclosed to anyone whose official duties do not require such knowledge.

3. Nonselection of any proposals will mean that either another proposal(s) was determined to be more advantageous to the State or that the State exercised the right to reject any or all Proposals. At its discretion, the State may perform an appropriate cost and pricing analysis of a responder's proposal, including an audit of the reasonableness of any proposal.

B. Evaluation Team

1. A evaluation team will be selected to evaluate responder proposals.

2. State and professional staff, other than the evaluation team, may also assist in the evaluation process. This assistance could include, but is not limited to, the initial mandatory requirements review, contacting of references, or answering technical questions from evaluators.

3. The State reserves the right to alter the composition of the evaluation team and their specific responsibilities.

C. Evaluation Phases

At any time during the evaluation phases, the State may, at the State's discretion, contact a responder to (1) provide further or missing information or clarification of their proposal, (2) provide an oral presentation of their proposal, or (3) obtain the opportunity to interview the proposed key personnel. Reference checks may also be made at this time. However, there is no guarantee that the State will look for information or clarification outside of the submitted written proposal. Therefore, it is important that the responder ensure that all sections of the proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

1. Phase I: Required Statements Review

The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified in these sections to move to Phase II. The Responder may fail the Required Statements Review in the event that the Responder does not affirmatively warrant to any of the warranties in the Responder

Information and Declarations. Additionally, the State reserves the right to fail a Responder in the event the Responder does not make a necessary disclosure in the Responder Information and Declarations or makes a disclosure which evidences a conflict of interest.

2. Phase II: Evaluation of Technical Requirements of Proposals (75 Points)

a. Points have been assigned to these component areas. The total possible points for these component areas are as follows:

Component Total	Possible Points
i. Statement of Understanding	20
ii. Description of the Proposed Service	20
iii. Implementation Plan	15
iv. Relevant Responder Experience/Resumes of Lead Responder Staff	15
v. Financial Stability and Professional Responsibility of Responder	5
vi. Responder Qualifications	
vii. Rate	25
Total:	75

b. The evaluation team will review the components of each responsive Proposal submitted. Each component will be evaluated on the team's evaluation of the Responder's understanding and the quality and completeness of the Responder's approach and solution to the problems or issues presented.

c. After reviewing the Proposals, the members of the evaluation team will rate each Proposal component using the following formula:

Component Rating	**Point Factor**
Excellent	1.00
Very Good	0.85
Good	0.70
Fair	0.55
Poor	0.40
Unacceptable	0.00

Each component will be given a rating between Excellent and Unacceptable. The corresponding point factor will be multiplied by the total possible points for that component.

For example:

Component 2. Description of Proposed Service – can earn a maximum of 20 points.
It is given a "very good" rating, which has a point factor of (0.85).

20 possible points x (0.85) point factor = 17 earned points for the Description of Proposed Service component.

The scores for all five components of each Proposal will then be totaled. The highest possible score for the Technical Proposal is 75 points.

d. Innovative Concepts (Optional). Only after the Proposal have been ranked, and it has been determined that the Responder's Proposal has passed Phase II, will any innovative concepts submitted by Responder be reviewed. If a Proposal is found not to have passed Phase II, any innovative concepts submitted will not receive consideration. The amount of bonus points to be given a Proposal for innovative concepts is at the sole discretion of the State, depending on how much the State determines the ideas enhance the rest of the Proposal. The amount given, if any, will be by consensus of the evaluation team. The State is under no obligation to give a Proposal any bonus points in any situation. The maximum possible bonus points are 10.

3. Phase III - Evaluation of Cost Proposals (25 Points)

4. Phase IV - Selection of the Successful Responder(s)

a. Only the Proposals found to be responsive under Phases I, II, and III will be considered in Phase IV.

b. The evaluation team will review the Proposal scores in making its recommendations of the Successful Responder(s). A Responder's total score will be the sum of the scores received for its proposal.

c. The State may submit a list of detailed comments, questions, and concerns to one or more responders after the initial evaluation. The State may require said response to be written, oral, or both. The State will only use written responses for evaluation purposes. The total scores for those responders selected to submit additional information may be revised as a result of the new information.

d. The evaluation team will make its recommendation based on the above-described evaluation process. The Successful Responder(s), if any, will be selected approximately **two weeks** after the Proposal submission due date.

e. The final award decision will be made by the Commissioner of the Minnesota Department of Human Services or his or her authorized designee ("Commissioner"). The Commissioner has the discretion to accept or reject the recommendation of the evaluation team.

D. Eligibility for Licensure and Unsuccessful Responder Notice

If a responder(s) is selected to be granted an exception to the licensure moratorium, the State will notify the successful responder(s) in writing of their selection and the State's desire to award community residential service setting licenses, contingent on meeting the current licensure requirements of Minn. Stat. chapter 245D as an intensive support service provider. Until the State awards the licenses described above with the selected responder(s) and the responders meet all necessary licensing requirements, all submitted proposals remain eligible for selection by the State.

In the event that the licensing requirements are not met with the selected responder(s), the evaluation team may recommend another responder(s).

After the State and chosen responder(s) have awarded the licenses, the State will notify the unsuccessful responders in writing that their proposals have not been accepted. All public information within proposals will then be available for responders to review, upon request.

VI. Required Terms and Conditions

A. Requirements. All responders must be willing to comply with all state and federal legal requirements regarding the performance of the services described in this RFP.

B. Governing Law/Venue. This RFP must be governed by the laws of the State of Minnesota. Any and all legal proceedings arising from this RFP in which the State is made a party must be brought in the State of Minnesota, District Court of Ramsey County. The venue of any federal action or proceeding arising here from in which the State is a party must be the United States District Court for the State of Minnesota.

C. Preparation Costs. The State is not liable for any cost incurred by Responders in the preparation and production of a proposal. Any work performed prior to the issuance of a fully executed community residential services licensing agreement will be done only to the extent the responder voluntarily assumes risk of non-payment.

D. Contingency Fees Prohibited. Pursuant to Minnesota Statutes, section 10A.06, no person may act as or employ a lobbyist for compensation that is dependent upon the result or outcome of any legislation or administrative action.

VII. State's Authority

Notwithstanding anything to the contrary, the State reserves the right to:

A. Reject any and all proposals received in response to this RFP;

B. Disqualify any responder whose conduct or proposal fails to conform to the requirements of this RFP;

C. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation, and duplicate all public information in response to data requests regarding the proposal;

D. Select for licensure a proposal other than that with the lowest cost or the highest evaluation score;

E. Consider a late modification of a proposal if the proposal itself was submitted on time and if the modifications were requested by the State and the modifications make the terms of the proposal more favorable to the State, and accept such proposal as modified;

F. At its sole discretion, reserve the right to waive any non-material deviations from the requirements and procedures of this RFP;

G. Cancel the RFP at any time and for any reason with no cost or penalty to the State.

H. Correct or amend the RFP at any time with no cost or penalty to the State. The State will not be liable for any errors in the RFP or other responses related to the RFP.

Remainder of the page intentionally left blank. (Appendices follows)

Appendix A: Cost Proposal Sheet- Proposed Rate

The Successful Responder will not receive any other compensation as a result of this RFP. Therefore, the Responder must consider **all** costs it will incur (including mass mailing costs, services, equipment, travel costs, fees, commissions, etc.) in determining the proposed rate(s). Any assumptions made regarding the impact of inflationary factors during the term of the agreement are the sole responsibility of the Responder. Payment for the covered services will contain no cost-of-living adjustment provision.

This form must be signed by an individual authorized to legally bind the Responder. The title of the person signing and the date this form was signed must be entered.

RFP responding to: _____

Company Name and Address:

_____

Daily Rate(s): $_____

Responders should assume a 90% occupancy rate in determining the proposed daily rate. Proposed daily rates for out-of-home crisis respite under the DD Waiver should include room and board costs. Payments can only be made only to those entities or people that are 245D license holders and meet the requirements of Minn. Stat. chapter 245D as an intensive support service provider.

Attach a breakdown of costs that resulted in this rate.

By signing this Cost Proposal, I do hereby certify the Responder named above wishes to enter a price for the services requested by the Minnesota Department of Human Services in the correlating RFP. This cost or price data submitted with this Proposal is accurate, complete and current as of the following date.

Signature: _____
Title: _____
Date: _____

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment E

to the October 2019 Supplemental Report

Minnesota Department of Human Services
Disability Services Division

Request for Information to Provide In-Home Crisis Respite Services

Date of March 21, 2016 Publication:

Americans with Disabilities Act (ADA) Statement: This information is available in accessible formats for people with disabilities by calling 651-431-4300 or by using your preferred relay service. For other information on disability rights and protections, contact your agency's Americans with Disabilities Act (ADA) coordinator.

Table of Contents

I. Introduction

A. Purpose of Request

The Minnesota Department of Human Services, through its Disability Services Division (State), is seeking information ("Provider Information") from qualified Responders to increase the network of providers who can successfully serve adults and children with intellectual or developmental disabilities (I/DD) in need of short-term, in-home crisis respite services. Responders must be a provider organization with experience serving adults and children with challenging behavioral support needs.

B. Objective of this RFI

The objective of this RFI is to gain information on willing providers available and qualified to provide in-home crisis respite services. In-home crisis respite is currently an available service funded by the Developmental Disability (DD) Waiver as a negotiated, market-rate service**.** The State is seeking to strengthen the capacity for providing timely crisis services by having more information about the number and availability of qualified providers offering crisis respite services in-the-home of people receiving respite services.

All information provided by responders to this RFI will be reviewed on a monthly basis by State. Any information on qualified responders will made available to State staff and State partners, particularly Minnesota lead agencies, in order to direct lead agencies to available providers for services covered by the waiver programs described in this RFI.

This RFI will be open for one year, and the Provider Information described below may be submitted and will be reviewed on a rolling basis. This RFI does not obligate the State to award services, and the State reserves the right to cancel this RFI if it is considered to be in its best interest. All costs incurred in responding to this RFI will be borne by the Responder.

C. Background

When people with disabilities experience a crisis, it is important that they experience as little disruption in their living situation as possible and avoid unnecessary stays in institutional settings. To the extent possible, disruption to daily life must be brief, minimal, and targeted to meet the person's choices and needs. Crisis services are intended to do three things: (1) stabilize a person in their current setting; (2) triage to determine if more intensive services are necessary; and (3) divert people from unnecessarily accessing segregated settings. This can be influenced by timely and appropriate crisis services and increased capacity of community providers delivering positive support strategies.

Over the past several years, the inability to access timely crisis services has resulted in people being unnecessarily hospitalized or placed in other segregated settings. In Minnesota's Olmstead Plan, the State has pledged to address this by expanding home and community-based crisis services throughout the state to have timely access to crisis services that are clinically appropriate. By expanding short term in-home crisis services, people will avoid unnecessary hospitalizations or other restrictive services.

The State is in need of qualified providers to provide in-home crisis respite services for adults and/or children with I/DD who are (a) on the Developmental Disabilities (DD) Waiver, or (b) eligible for the DD Waiver and need to access this service to mitigate a crisis (crisis-only respite). These services will include stabilization, positive support planning, person-centered transition planning if determined necessary by the person and

his/her team, and participation in the development of service options to more successfully support the person once a crisis respite level of service is no longer needed.

The State seeks further information on responders who are enrolled providers in Minnesota Health Care Programs and licensed to provide in-home crisis respite services in order to provide Minnesota lead agencies searching for this service with an up-to-date list of active providers. Currently, the State and local lead agencies do not have a streamlined approach for determining which enrolled MHCP providers are available and licensed to provide these services; and which licensed providers are also enrolled MHCP providers who are available to provide these services. Any Provider Information submitted in response to this RFI from enrolled MHCP and licensed providers who are available to provide in-home crisis respite services will be reviewed and provided to the lead agencies on a monthly basis so that State and counties are aware of which providers are currently available to perform these services.

Providers who are not currently enrolled MHCP providers or licensed to provide in-home crisis respite services but anticipate becoming qualified to do so are also encouraged respond to this RFI. However, these providers will only be included in the list of current providers once they have completed the licensing and enrollment requirements. It is the obligations of the provider to inform the State once they have successfully completed the licensing and enrollment processes. At that point, the State will include the provider on the list of current providers of in-home crisis respite services.

II. Scope of Work

A. Overview

The intent of this RFI is to increase the network of in-home crisis respite providers to successfully serve adults and/or children with I/DD who are (a) on the DD Waiver, or (b) eligible for the DD Waiver and need to access this service to mitigate a crisis (crisis-only respite).

In-home crisis respite provides an appropriate level of service for persons experiencing elevated or specific behavioral support needs beyond what their current support system can provide. The goal is to stabilize the person in his/her current living environment and reduce the level of intensive behavioral support needed.

In-home crisis respite is a flexible service designed to support the individual's needs at the time of the emergency. In-home crisis respite services provide intervention strategies specifically designed to keep the person in their home and in their community. In-home crisis respite also provides support to caregivers to maintain the primary caregiving relationship, preventing out of home placement. In-home crisis respite is a market-rate service, with the rate negotiated between the qualified provider and the State**.**

Respondents must be entities or people that currently hold or intend to obtain licensure under Minnesota Statutes, chapter 245D, and also meet the requirements under 245D as an intensive support service provider. Responders must also be enrolled providers in Minnesota Health Care Programs.

B. Service Population

The adults and children who need in-home crisis respite may exhibit a variety of extremely challenging behaviors, often accompanied by complex, multiple co-occurring conditions. The severity and frequency of these occurrences can vary, but often the challenging behaviors are severe and occur multiple times in a day. A provider can expect to experience the following, in any combination (this list is not exhaustive):

Challenging Behaviors

- Severe physical and/or verbal aggression;
- Harm to self/suicide risks;
- Illegal activity;

- Substance abuse;
- Elopement;
- Severe property destruction;
- Sexual acting out;
- School/Work problems, including behavioral and other difficulties in peer relationships;

Secondary Diagnosis
People served in crisis respite may also carry with them a range of secondary diagnoses, including mental health issues as well as physical and medical conditions such as:

- Autism Spectrum Disorder
- Fetal Alcohol Syndrome;
- Brain Injury;
- Antisocial Personality Disorder;
- Attention-Deficit/Hyperactivity Disorder;
- Depression;
- Post-Traumatic Stress Disorder;
- Psychosis;
- Obsessive or compulsive behavior or paranoia;
- Unusual preoccupations with food, diet, and/or body image;
- Sleep disorders;
- Diabetes;

Other Characteristics

- Communication disorders;
- Need for medication monitoring/assessment;
- Standard nursing supports

Family Related Issues
Family issues can play a large role in both the crisis that results in a crisis system involvement and the successful treatment and disposition of the episode. The vendor will encounter the complete spectrum of family issues, such as:

- Recent changes in parental relationships;
- History of physical, sexual, or emotional abuse, and exposure to violence;
- Poverty;
- History of drug or alcohol abuse;
- Grief issues

C. Outcomes of Service/Qualifications

The intent of the RFI is to increase the network of providers for in-home crisis respite so people in crisis have access to timely, appropriate, high-quality in-home crisis respite options. Core components of crisis respite services include:

1. Assessment of the person and situation to determine the crisis precipitating factors.
2. Development and implementation of a support plan based on positive support strategies, in coordination with the person's expanded support team.
3. Recommendations for support plan revisions to prevent or minimize future crisis situations and increase the likelihood of maintaining stability of the person in his/her home.
4. Coaching and training the person's service providers and other natural supports to manage challenging behavior and successfully implement the person-centered support plan.
5. In coordination with the person's expanded support team, development and implementation of a person-centered transition plan, based on the State's published transition planning protocol (http://mn.gov/dhs/images/PCP_protocol.pdf), to aid the person's transition should alternate, out-of-home living arrangements be determined the best long-term course of action.

The following are important components of providing high-quality crisis respite services; successful respondents should strive to include information describing these components in their proposals:

1. Experience with serving individuals in crisis. The successful respondent can demonstrate having the skills and ability to provide sustained, uninterrupted service to people with highly complex and challenging behavior support needs. A capacity to initiate services within as little as one day after referral is critical. In addition, direct and on-going access to expertise in the following areas is highly desirable:
    a. Person-centered thinking and planning
    b. Positive behavior supports
    c. Functional behavior assessment

2. Person-centered services. The successful respondent can demonstrate both understanding and experience with providing services based on person-centered principles and practices. Services should be individualized to balance the unique needs and desires of the person in the context of crisis stabilization, transition planning, and helping the person remain in his/her home.

3. Commitment to providing comprehensive stabilization and services. The successful respondent will specify its plans to provide the following:
    a. Capacity to provide coaching and training to the person's service provider(s) and natural supports to effectively support the person post-crisis.
    b. Knowledge, access, and ability to connect with relevant community resources to ensure integration of the person with her/his community during the course of crisis respite services.
    c. Ability to provide/access staff, up to 24 hours a day, to respond to a person's needs.
    d. When necessary, transition planning, based upon the transition protocols developed by the State (http://mn.gov/dhs/images/PCP_protocol.pdf), to provide assistance with locating long-term, integrated living options within the person's preferred community.

4. Emergency Backup Plan. The successful respondent will specify its plans to provide emergency backup to persons served and staff to sustain services in-place and prevent hospitalization and/or involvement of law enforcement to the extent possible. Include a description of any intended on-call system and plans to provide backup staffing whenever necessary.

5. Access to a network of multidisciplinary providers who understand the unique needs of persons with challenging behaviors and/or complex medical needs.
    a. Demonstrated relationships and collaboration with practitioners of diverse expertise to guarantee comprehensive care and services are available to the individuals served. Examples include:
        i. Medical Practitioners
        ii. Psychologists
        iii. Pharmacologists
        iv. Behavioral Therapists
        v. Behavior Analysts
        vi. Person-Centered Planners
        vii. Occupational Therapists
        viii. Speech Therapists
        ix. Educators/other school personnel
    b. A collaborative working relationship with local law enforcement.
    c. Culturally competent providers

D. Additional Documentation

The following documentation is requested to be included in all submitted Provider Information responses.

1. Documentation of Staff Qualifications

   Vendors are encouraged to submit documentation detailing relevant staff and/or consultant qualifications. Such qualifications may include, but are not limited to:

   a. Training and demonstrated competence in person-centered planning.
   b. Training and demonstrated competence in functional behavior assessment.
   c. Training and demonstrated competence in positive supports.
   d. Training and demonstrated competence in supports for person with autism, including sensory diet.
   e. Certified behavior analysts.
   f. Licensed mental health professionals.
   g. Licensed health professionals.

III. Requested Provider Information

The State requests that interested providers submit the following information. The State will use this information to compile a list of enrolled MHCP and licensed providers who are available and interested in performing in-home crisis respite services.

A. Outline of Provider Information Contents

Responses to this RFI should contain the following components (See following sections for more detail on each component).

1. Table of Contents

2. Provider Information

   a. Statement of Understanding
   b. Description of Proposed Service
   c. Implementation Plan
   d. Relevant Responder Experience/Resumes of Lead Responder Staff
   e. Financial Stability and Professional Responsibility of Responder

3. Innovative Concepts (If Applicable)

4. Required Statements

   a. Responder Information and Declarations
   b. Trade Secret/Confidential Data Notification
   c. Evidence of current licensure and MHCP enrolled provider status

5. Rates

6. Appendix (If Applicable)

B. Provider Information Requested

1. Statement of Understanding

This component of the response should demonstrate the responder's understanding of the services requested in this RFI, the nature of the agreement specific to providing in-home crisis respite services, and any problems anticipated in accomplishing the work. Specifically, the response should demonstrate the Responder's familiarity with the project elements, a summary of its solution(s) to the problems presented and knowledge of the requested services and/or deliverables.

2. Description of the Proposed Service
According to the 2015 DHS Gaps Analysis Study (http://mn.gov/dhs/partners-and-providers/continuing-care/data-measures/gaps-analysis/current-study/index.jsp), 23 percent of Minnesota's lead agencies rated Crisis respite as one of their "top three" most significant service gaps for people with disabilities. Lead agencies reported an estimated 111 people on waiting lists for crisis respite services. In your response, please describe the level of need for services in the proposed geographic area the services will be provided, as well as what groups of individuals will be targeted for services by the program. Please discuss how you will have a local, regional or statewide impact on service to individuals with complex behavioral needs who are in crisis. Responder should include its risk assessment/management plan.

3. Implementation Plan:
All responses submitted under this RFI should address, in sufficient detail, how the Responder will fulfill the expected outcomes and features set forth above. This section should detail how the project will be carried out in an effective and efficient manner, including who will be involved, what resources are required, and the resources and staff already in existence. Provide a description of the project plan you propose to implement.

4. Relevant Responder Experience, Resumes of Lead Responder Staff:
This section should include information on the programs and activities of the agency, the number of people served, the geographic area where services can be provided and the number of additional people that could be served by the Responder.

The Responder should demonstrate the length, depth, and applicability of prior experience in providing the requested services. This component of the Proposal must include previous experiences that will demonstrate the Responder's ability to deliver the services requested in this RFI. The Responder may identify entities for which it has supplied similar services to those requested in the RFI, if any. If such organizations are identified, Responder should include each identified organization's name and address, and the name, title and telephone number of a contact of each organization. Responder should also provide a narrative description of the actual services provided to the organization(s). Describe what role, if any, staff proposed for this project had in the referenced service. Letters of reference may be included.

The Responder should also demonstrate the skill and experience of proposed lead staff. Resumes should describe the education, professional affiliations, and other relevant background of the lead staff to be assigned to this project. This section should contain information responsive to the requests in Section II, D, above.

C. Innovative Concepts (If Applicable)

The detailed needs and requirements for Responders in this RFI are not intended to limit the Responder's creativity in delivering in-home crisis respite services. Responders may submit innovative ideas, new concepts, partnership arrangements, and optional features in response to this RFI.

D. Required Statements

The following are required statements that must be included with your Response. Complete the correlating forms found in the RFI Appendix and submit them as the "Required Statements" section of your response.

1. Responder Information and Declarations

Complete and submit the attached "Responder Information and Declarations" form. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form.

2. Trade Secret/Confidential Data Notification

All materials submitted in response to this RFI will become the property of the State and will become public record in accordance with Minnesota Statutes, section 13.591. If the Responder submits information that it believes to be trade secret/confidential materials, as defined by the Minnesota Government Data Practices Act, Minn. Stat. § 13.37, and the Responder does not want data used or disclosed for any purpose other than the evaluation of this Response, the Responder must:

a. Clearly mark every page of trade secret materials in its response with the words "TRADE SECRET" or "CONFIDENTIAL" in capitalized, underlined and bolded type that is at least 20 pt.; the State does not assume liability for the use of disclosure of unmarked or unclearly marked trade secret/confidential data;
b. Fill out and submit the attached "Trade Secret/Confidential Information Notification Form", specifying the pages of the response which are to be restricted and justifying the trade secret designation for each item. If no material is being designated as protected, a statement of "None" should be listed on the form;
c. Satisfy the burden to justify and claim of trade secret/confidential information. Use of generic trade secret/confidential language encompassing substantial portions of the response or simple assertions of trade secret interest without substantive explanation of the basis therefore will be regarding as nonresponsive requests for trade secret/confidential exception and will not be considered by the State in the event of a data request is received for information; and
d. Defend any action seeking release of the materials it believes to be trade secret and/or confidential and indemnify and hold harmless the State, its agents and employees, from any judgments awarded against the State in favor of the party requesting the materials, and any and all costs connected with that defense. In submitting a response to this RFI, the Responder agrees that this indemnification survives as long as the trade secret materials are in the possession of the State.

The State reserves the right to reject a claim if it determines Responder has not met the burden of establishing that the information constitutes a trade secret or is confidential. **The State will not consider prices or costs submitted by the Responder to be trade secret materials.** Any decision by the State to disclose information designated by the Responder as trade secret/confidential will be made consistent with the Minnesota Government Data Practices Act and other relevant laws and regulations. If certain information is found to constitute a trade secret/confidential, the remainder of the Application will become public; only the trade secret/confidential information will be removed and remain nonpublic. The State also retains the right to use any or all system ideas presented in any material received in response to this RFI unless the Responder presents a positive statement of objection in the Application. Exceptions to such Responder objections include: (1) public data, (2) ideas which were known to the State before submission of such Application, or (3) ideas which properly became known to the State thereafter through other sources or through acceptance of the Responder's Application.

E. Rates

Please submit a description of Responder's current rate and how that rate is calculated. The rate(s) identified should reflect all costs, including but not limited to: mass mailings, fees, commissions, compensation, equipment and other charges by the Responder for the service and/or deliverable.

Payments can only be made only to those entities or people that are 245D license holders and meet the current licensure requirements of Minn. Stat. chapter 245D as an intensive support service provider.

State recognizes that quoted rates are subject to change and State cannot require Responders to apply their quoted rates for future services.

IV. RFI Process

A. Responders' Questions

Responders' questions regarding this RFI may be submitted on a rolling basis. All questions must be addressed to:

Request for Information Response
Attention: Carol Anthony
Disability Services Division
Department of Human Services
P.O. Box 64967
St. Paul, MN _55164-0967
Phone (651) 431 - 2015
FAX #: (651) 431-7411

Questions may also be e-mailed to: carol.anthony@state.mn.us

Other personnel are NOT authorized to discuss this RFI with responders before the proposal submission deadline. **Contact regarding this RFI with any State personnel not listed above could result in disqualification.** The State will not be held responsible for oral responses to responders.

Questions will be addressed in writing and distributed to all identified prospective responders. Every attempt will be made to provide answers timely, with the intent that they are sent no later than one month from receipt.

B. Provider Information Submission

One (1) original and two (2) copies of the response must be submitted. Responses may be submitted on an on-going, rolling basis until March 1, 2017. Responses may be either emailed as a PDF or sent as a paper file to the contact information below.

Clearly label the original "Provider Information – Original" and each copy "Provider Information – Copy".

The above-referenced packages and all correspondence related to this RFI must be delivered to:

Attention: Carol Anthony
Disability Services Division
Department of Human Services
P.O. Box 64967
St. Paul, MN 55164-0967
Phone (651) 431 - 2015
FAX #: (651) 431-7411
Email: carol.anthony@state.mn.us

It is solely the responsibility of each responder to assure that their response is delivered at the specific place, and in the specific format.

C. Compilation of In-home Crisis Respite Services Provider List

State will review all Provider Information submitted on a monthly basis. Any submissions that contain the described-information above will be compiled to create a list of active In-home Crisis Respire service providers list. This list and providers' information will be used by the State and shared with its lead agency partners in order to determine which providers are currently able to deliver these services.

Responses received from Providers who are not currently enrolled MHCP providers or licensed to provide in-home crisis respite services will only be included in the list of current providers once they have completed the licensing and enrollment requirements. It is the obligations of the provider to inform the State once they have successfully completed the licensing and enrollment processes. At that point, the State will include the provider on the list of current providers of in-home crisis respite services.

Appendix A: Responder Information/Declarations Form

Responder Information

Responder Name:_____
Website:_____
Address:_____
Telephone Number:

Contract Information
Contact Name:_____
Title: _____
Telephone Number: _____
Fax Number: _____
E-mail: _____

Name(s) of individuals involved with the preparation of this response:_____.

The above-named responder submits the attached Provider Information in response to the following Minnesota Department of Human Services Request for Information (state which RFI you are responding to):
_____

By submission of this response, responder warrants that:

1. The information provided is true, correct and reliable. Responder understands that the submission of inaccurate or misleading information may subject the Responder to suspension or debarment proceedings and any other remedies available by law.

2. No attempt has been made or will be made by Responder to induce any other person or firm to submit or not to submit a response to this RFI.

By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of, and legally bind, the Responder.

Authorized Signature: _____
Printed Name: _____
Title: _____
Date:_____ Telephone Number:_____

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment F

to the October 2019 Supplemental Report

Success of the Interim Single Point of Entry

On February 19, 2015, DHS piloted the Interim Single Point of Entry (SPE) in an effort to improve DHS' ability to respond to requests for assistance in supporting people with intellectual or developmental disabilities who have lost or are at risk of losing their community-based housing.

As a part of this pilot, Direct Care and Treatment and Disability Services Division developed an interim process for requests received regarding individuals in the target population. This interim process ensured these requests were entered into one centralized location, and reviewed and triaged daily to better coordinate care for these individuals.

Over the course of the six month pilot, 73 referrals were entered, representing 66 unique individuals for whom a coordinated effort from DHS was required. Of the requests received, 23% (17 referrals) resulted in permanent placement; 54% (39 referrals) were in the stages of care coordination, including finding placement; 15% (11 referrals) were in active triage; and 8% (6 referrals) were redirected to other DHS programs as they did not meet the target population definition.

One of the expected outcomes of the pilot was the testing of the newly developed business processes and technologies in order to inform the longer-term project for a single point of entry for a larger population of person with disabilities supported by DHS. On August 17, 2015, Phase 1 of the Sustainable Single Point of Entry was launched as a part of the next steps towards a fully sustainable single point of entry.

Purpose of Phase 1: Sustainable Single Point of Entry

Phase 1 of the Sustainable Single Point of Entry will continue to focus efforts on serving the target population as defined in the Interim SPE. Phase 1 will also include members in the Jensen Settlement class and Jensen Therapeutic Groups and others from groups monitored by DSD and Minnesota Life Bridge (MNLB) who fit the target population definition.

A subset of CareManager, the Netsmart care coordination technology, was launched on August 17, 2015. This new technology solution allows for continued collaboration across the DCT and DSD administrations for this expanded target population as well as more robust data gathering and reporting.

During the three days of go live (August 17-19), 412 individuals already known to DHS were entered into CareManager for the purposes of continued care coordination. As of September 17, 2015, fourteen new referrals were entered and are now in the crisis triage process.

Ultimately, through improved collaboration, communication and earlier intervention strategies, DHS will be able to better support people in their communities and reduce the need for services in more restrictive settings.

Phase 1: Sustainable Single Point of Entry Project

What has changed?

For DHS partners and providers, there is still a 'no wrong door' approach for contacting DHS regarding persons in or out of the target population.

DHS staff who receive contacts regarding persons within the target population are asked to continue to use the Single Point of Entry phone number (651-431-4056). A Quick Reference Tool is included for your convenience.

Starting October 1, 2015 the Single Point of Entry phone number (651-431-4056) will be shared with community service professionals, such as case managers and hospital discharge workers, who will be instructed to use this phone number when they are working with a person with disabilities who needs assistance from DHS to locate appropriate HCBS residential services. Also starting October 1st, the target population of the Single Point of Entry process will expand to include persons with disabilities at risk of losing or who have already lost their community-based housing and are in need of new housing or additional supports to maintain or return to the most integrated setting of their choice.

Questions

If you have any questions concerning the project or Phase 1: Sustainable SPE, please contact Peg Booth at peg.booth@state.mn.us or (651) 431-5776.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment G

to the October 2019 Supplemental Report

Alliant
CONSULTING
I N C

State of Minnesota
Department of Human Services
Disability Services Division

Disability Services and
Direct Care and Treatment Divisions
Crisis Response Process Improvement Initiative

Navigator Pilot Evaluation Summary

May 24, 2016

555 7th Street West

Suite #101

St. Paul, MN 55102

Toll Free **888-291-1955**

Local 651-291-0607

Fax 651-291-1498

www.alliantconsulting.com

State of Minnesota - Department of Human Services
Disability Services Division - Disability Services and
Direct Care and Treatment Divisions
Crisis Response Process Improvement Initiative

Navigator Pilot Evaluation Summary

May 24, 2016

Table of Contents

State of Minnesota - Department of Human Services
Disability Services Division - Disability Services and
Direct Care and Treatment Divisions
Crisis Response Process Improvement Initiative

Navigator Pilot Evaluation Summary

May 24, 2016

INTRODUCTION

In order to develop and maintain services for individuals with disabilities who have complex needs, lead agencies and providers may require technical expertise, assistance and resources beyond what is readily available in their communities. The Department of Human Services (DHS) is often called upon in these situations. Because of a lack of clarity about the roles of various divisions within DHS, it is difficult for lead agencies and providers to access the right support and technical assistance in a timely fashion. In addition, there is lack of clarity as to the role of DHS as a safety net provider.

The Direct Care and Treatment Division (DCT) and the Disability Services Division (DSD) began an initiative to address this problem in fall 2014. Their goal was to design and operationalize a plan to build community capacity and improve the ability to provide timely, appropriate response to crisis situations and clarify roles within and between the two Divisions.

A project charter was developed, a team assembled and the project was launched in January 2015. The discovery phase was completed between February and March 2015. This resulted in a “to be” process design, which in turn lead to several supportive design and implementation work streams. A Navigator pilot was conducted between March and December as one of the phase two work streams.

In January 2016 the project Leadership Team along with the Office of Continuous Improvmeent (OCI) decided to provide dedicated project management to support a Navigator Proof of Concept work stream. The work team was charged with evaluating the current “Navigator Pilot” and based on that evaluation to design a proposed navigator role and process, clarifying criteria, roles and responsibility, organization, work flow, volume and work load detail, and improved process and communication links. Lastly the work team was charged with outlining what it would take to implement such a role and process including key changes, expected outcomes, and benefits.

APPROACH / KEY FINDINGS

The approach for the evaluation and design work was accomplished by a work team that included members from DSD and DCT who were currently working with the Single Point of Entry (SPE) crisis process and Navigator pilots, three County project team members (Hennepin, Olmsted and Pope) as well as a regional resource specialist (RRS) team member. Subject matter experts were also tagged as needed to influence and vet the evaluation findings and inform the proposal. The Project Steering and Leadership teams provided input and guidance throughout the process to assure alignment with other work efforts and programs.

State of Minnesota - Department of Human Services
Disability Services Division - Disability Services and
Direct Care and Treatment Divisions
Crisis Response Process Improvement Initiative

Navigator Pilot Evaluation Summary

May 24, 2016

In order to evaluate the navigator pilot and determine ideal navigator role and responsibiities it was necessary to look at the entire Single Point of Entry (SPE) process. It was important to separate the “normal” work taking place thoughout the process from the “Navigator Pilot” work. The overall evaluation goal was to build on what was working and identify opportunities to leverage. Findings are listed by theme relative to the SPE process and functions.

SPE Process Strengths and Opportunties

CareManager – Central sytem currently used by DSD, CSS, CPA, MSOCs and MLB

- At every point along the process the accessibility and efficiency of having a central system that can be accessed as needed by multiple programs to share information in real time was noted as a strength and time saver.
- The drawbacks at this juncture in time are the double entry that every program experiences and the limited reporting and data collection currently in place.
- Another opportunity was the fact that basic data entry into CareManager of SPE eligible clients was happening in several functional areas.

Elevated Collaboration – CPA, Program Coordination, Navigator, Daily Triage

- The current SPE process facilitates unprecedented collaboration between DCT and DSD programs. This collaboration has reduced an enormous amount of duplicate work efforts previously spent when no single point of entry existed for the target population.
- There are, however, opportunties through assignment and role clarity to further reduce duplicate effort and leverage collaboration more effectively at many points in the process.

Training, Guidance and Support

- At every process point a certain level of training and guidance is provided to Case Management in the form of helping with the most effective referral placement, data collection, funding and services guidance and contacts to appropriate resources.
- There is an opportunity to channel much of this training and guidance to the optimal point in or before the process with technical assistance for lead agencies to proactively support and connect to the optimal resources and services when dealing with placement crisis or potentially avert crisis.
- An opportunity exists to market one key resource (RRS) to lead agencies as the proactive link to guidance and support and Just-in-Time training.

Clear Published Roles and Responsibilities

- Improvements can be achieved by the right work being performed at the optimal point in the process – for example: all data entry should be performed at the Single Point of Entry – Central Pre-admissions (CPA).

- There are also opportunities for the right work to be performed by the right staff based on the highest value to the Customer and Client – example: baseline referral training provided by RRS rather than Program Coodinator or Capacity Builder.

Reduction of Duplicate Work Effort through Transparency and Team Approach

- Program Coordination would be more efficient leveraging a collaborative team approach. Improvements can also be realized for an accurate, valid crisis waitlist.
- A united approach to assignments, prioritization and escalation will improve process clarity and efficiency. Once criteria is established for navigation assignments, this team would be in the ideal place to identify clients who should have navigators and escalate the assignment.
- Assigned Leads could reduce “shot gun” approach to Case Management for data collection – saving time and reducing work load through their efforts to collaborate internally and consolidate information requests from Case Managers wherever possible.

Clarify and Align Escalation

- Clear criteria needed that triggers a Navigator assignment
- Clear criteria needed for exceptional escalation that triggers action/ path to decision maker

Baseline Data Collection and Metrics

- Accurate data and reporting is needed to understand workload and volume impacts for planning, understanding backlog trends and to be able to audit for system improvements.

Navigator Pilot Assessment

Key Attributes

- Regional connectivity – understands the landscape and unique needs of their area.
- Internal DHS expertise - knows how the DHS system works – who to contact and how to work through the system
- Creative problem solver with action orientation
- Supportive, accountable mentor

Estimated Work Effort and Volume

Key work effort was determined by the pilot experience and includes two basic work efforts.

- **Entry** – initial reach out and partnering with Case Manager to develop a solution and plan. This work is estimated at 5 hours per week for up to 13 weeks (one quarter)
- **Active Monitoring / Check-in**: Once the plan is developed and underway the navigator will proactively reach out to check progress and offer solutions if barriers are encountered. Estimated work effort is 1 hour/week for the duration of the working

plan – ending at placement with a 45 day check-in followed by discharge if client is stable.

- **Volume:** As of this report, the average daily census of the SPE population is 81 (includes all SPE clients assigned to MLB, SLP, DSD, DCT. The number of navigation eligible clients is estimated to be 5-10% of the active census (between 4-8 clients).

Pilot Outcomes and Benefits

- Mentoring and support provided by Navigator pilots enhanced DHS image with Case Management and Lead Agencies, DHS was perceived as partnering to find solutions to difficult challenges.
- Leveraging DHS clout resulted in greater accountability and timeliness with providers when partnering with Lead Agencies.
- Working DHS magic within the system – Navigator pilot was helpful in guiding the Case Managers through the system that has changed so much over time by leveraging optimal internal resources to achieve creative solutions.
- Better matched placements were accomplished through the Navigator partnership by leveraging Person Centered guidance and training resulting in higher success potential, more stability and reduced future crisis situations.
- Individual client success story: The most complex client pilot (duration one year)- a client with a history of hospitalization every other month is in a stable community-based placement (as of March 2016) and has had no hospitalization since September 2015, leads her own status meetings, has joined a health club and is volunteering.

SPE NAVIGATION RECOMMENDATIONS AND KEY CHANGES

Single Point of Entry

- CPA will be the single point of entry for all SPE data entry. Data entry for 245 D/BIRF notifications resulting in lost placement will be entered into CareManager by CPA rather than Theresa Mustonen CCB.

Program Coodination and Assignment

- The Program Coordination Team will take ownership of the Daily Triage Meeting and New SPE referral assignments. By the beginning of September, SLP and Adult and Children's Mental Health will join the Daily Triage team with the objective to collaborate on solutions, improve service coordination and align work effort in preparation for expanded navigation functions and Olmstead crisis expansion.
- Working as a team they will share client updates, prioritize and escalate SPE clients who meet navigation criteria to the RRS supervisor who will either take on or make navigation assignments to a mentored RRS navigator

- Assigned program leads monitor and check-in with assigned active client Case Managers every three weeks to support referral placement and proactive communication with the Lead Agencies.
- Standard notification will be sent at placement to the Case Manager stating that the client will be discharged from CareManager in 45 days if client remains stable in new placement. Placement information is documented in CareManager by assigned lead.
- Standard discharge notification is emailed to the CaseManager at 45 days from placement when the client is discharged in CareManager

CBS Crisis Pool (waitlist)

- Only clients in crisis (have lost or imminent loss of community based housing) will be allowed on the Crisis Pool (waitlist).
- Standard notification procedures in place for placement and discharge.
- Proactive communication and alignment with MCCP as needed by Program Lead.

RRS and Navigation

- Due to the ad hoc nature and low volume of the SPE target population, the low number (less than 10%) of the clients that would meet navigator criteria, and the alignment of attributes and core functions, the SPE navigation function will to be incorporated into the RRS role.
- The RRS team will be reorganized under one Supervisor and RRS core functions will evolve to include proactive crisis referral guidance, support, resource connectivity and Just-in-Time training for Case Managers and Lead Agencies.
- The RRS team will also include a navigation function for SPE clients who meet the navigation criteria. The RRS supervisor will determine navigation training, mentoring and assignments.
- The RRS Supervisor will initiate a monthly Navigation meeting, which will include cross division navigators. The objective will be to leverage and align work effort and to elevate cross division service coordination for individual clients as well as identify trends, solutions and barriers to improve system results.

Cross Agency Resource Team

- Cross division resources will be leverage on an ad hoc basis by navigators for individual client solutions.
- Cross division resources will also be leveraged as a team to help influence system solutions based on navigation and crisis referral trends and reporting.
- Membership and initial meeting invitations will be confirmed by the end of August. The initial meeting will be scheduled in September.
- This cross division team will look at data coming from the SPE program coordination and navigation experience on a quarterly basis to leverage and align larger work efforts and to look at potential system solutions and address gaps and barriers.

Ad Hoc Escalation Team

- Formerly involved in the Daily Triage, members of this group will be leveraged individually by the Program Coordinators based on the assigned lead needs.

Data Key Indicator Reporting

- Baseline and expanded key indicators are outlined in the Implementation plan. Accurate data reporting is imperative to effective planning and staffing going forward, especially given the ad hoc nature of the volume.
- Initially the monthly data reports (New, Discharged and Active Census) will be handled by Theresa Mustonen.
- Cassie Birkeland has been identified as our data resource for generating reports. Program coordinators and navigators will be involved in the data analysis and trending responsibilities – looking to identify barriers and solutions to improve system results as well as individual placements.

NAVIGATION

Function Purpose: Navigator develops, strengthens and leverages regional and DHS system expertise and partnerships to guide, mentor and collaborate with Lead Agency / Case Manager offering creative problem solving options and resource connectivity. This position exists to advance high priority and complex SPE clients to a quality solution through their Lead Agency's work as well as to forge effective DHS cross boundary program resource and service collaboration in identifying individual solutions as well as trends, gaps and recommendations for aligned system improvements. This position will collaborate on an as needed basis with navigator functions in other cross division areas

SPE Criteria

- Person with DD at risk of losing or who has lost community based housing and is in need of new housing or additional supports to maintain or return to the most integrated setting of their choice.

High Priority /Complex Clients

- Imminent loss, highly complex clients with no clear solutions or options; Criminal Justice releases, clients with frequent crisis history, children without potential placement options, commitments,….

Navigator Engagement Criteria

- Complex SPE (Single Point of Entry) and high priority clients who <u>have lost</u> community based housing and the client's Lead Agency / Case Manager have exhausted all known solutions or encountered obstacles beyond their sphere of control.

Important Indicators

- Navigation is a back end process based on escalation criteria - a navigator cannot be requested by a Lead Agency or Case Manager.

- Navigators do not perform Case Management work – but guide, mentor and connect Case Managers to the right resources and solutions.
- The RRS team is not the only group where a navigation function exists - CSS, CCB, SLP and Mental Health will also support a navigation function.

TRANSITION AND IMPLEMENTATION CONSIDERATIONS

The implementation plan is divided into two phases; transtion (June- August) and implementation (September to January). Key activities, timelines and responsibility have been determined. An implementation, oversight and project management system is designed. All documentation and background information is located on the DSD-DCT Improvement project SharePoint site.

In an effort to ensure the best project managment transition from Alliant to the Olmstead Project Manager – transition meetings have occurred during the past several weeks. The implementation plan has been reviewed and all the necessary background information has been posted on the SharePoint Implementation and Transition document library.

The following bullets represent parting advice and counsel for implementation success:

- Program Coordination Team – this team is the heart of the SPE Navigator process. The elevated communication and collaboration of this group will ensure the success of the process. Their ownership and collaboration in the newly designed Daily Triage meeting objectives will ensure continued success.
- Program Coordinators and navigators should continue to work toward a standardized approach to their work – aligning each other along the way.
- Ensure that the Communication Matrix, which outlines all key meetings and communication points, is leveraged appropriately. Objectives and agendas should be confirmed and adhered to whenever possible to ensure effective meetings.
- Team leads need to be confirmed for several of the new meetings as indicated on the Implmentation plan and in the Communication matrix. Formal facilitation will be important at all key meetings to ensure objectives are met and agendas are effective.
- Suggested project management agendas are also included in the matrix for the key Implementation and Oversight meetings as requested by the Olmstead Project Manager.
- The Implementation plan has been designed with key activities and dates. It will be the responsibility of the Activity Leads to add more detailed activities, responsibilities and actual timelines during the course of implementation work. These should all be updated on the Implementation plan posted on SharePoint. Version controls are in place.
- Implementation Team meetings should be leveraged not only for project updates but also as work sessions as appropriate.

- Staffing and workload will continue to be a challenge. It may be necessary to audit key positions to determine opportuntities to ensure the right work is being performed by the appropriate role in advance of adding in the navigation function. This may apply not only to RRS but to CBS and CSS as well.
- Once the RRS supevisor is in place, a navigation mentoring plan should be established and confirmed and a formal navigation team established.
- The true navigation function should be completely criteria driven. Every effort should be made to ensure that proactive training, guidance and support delivered by the RRS core function includes crisis referral system training. Formal navigation should be reserved for those clients who have no obvious placement solution and need the elevated partership with a DHS navigator to create a solution.
- The expansion of a navigation function into other areas such as SLP, CSS and Adult and Children's Mental Health will certainly mean that proposed data and meeting objectives may need to shift and adapt appropriately as this evolution takes place.
- Data reporting and analysis is a key function that demands resources and time. The key indicators suggested may need to change or evolve to support the kind of effective planning and preparation, understand staffing implications and to identify system trends going forward. As of this report, data volume and workload information has been difficult to confirm. Continued focus and effort toward data accuracy and proactive reporting and analysis is imperative.

ACCOLADES

We would like to recognize the contribution of time and participation by the work team members over and above their job responsibilities; Katy Mattson (DSD), Theresa Mustonen (DSD), Shannon Smith (DSD), Barb Trytten (CBS), Jerry Rondeau (CSS), Louella Kaufer (Hennepin), Robin Sommer (Olmsted) and Phyllis Reller (Pope).

We would like to make a special note of thanks to:

- Sponsors; Alex Bartolic and Don Chandler
- Team Lead; Erwin Concepcion
- OCI Team members, especially Rebecca Budimlija
- The Project Leadership and Steering Team Members

It has been a great pleasure to work with such a group of dedicated professionals.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment H

to the October 2019 Supplemental Report

DEPARTMENT OF HUMAN SERVICES

Summary of Findings and Implications for Support from a Risk Assessment of *Jensen* Class members and People Previously Served at MSHS-Cambridge

Jensen/Olmstead Quality Assurance and Compliance Office

July 2017

Risk Assessment Survey

July 2017

Contents

Executive Summary

Background of the Risk Assessment Survey

The Jensen Settlement Agreement is the result of a lawsuit filed against the DHS in 2009 alleging that residents of the former Minnesota Extended Treatment Options (METO) program were unlawfully and unconstitutionally secluded and restrained. The Jensen Settlement Agreement allowed the department and the plaintiffs to resolve the claims in a mutually agreeable manner. The DHS's Successful Life Project provides therapeutic follow-up to members of the *Jensen* Plaintiffs' Class ("*Jensen* Class Members") and people who had been served at MSHS-Cambridge, which is the program that succeeded METO.[1] The purpose of therapeutic follow-up is to provide consultation, services and supports to the person and their team to help prevent re-institutionalization and transfers to settings that are more restrictive, maintain the most integrated setting, and achieve a quality life, as defined by the person. As required by the Comprehensive Plan of Action, the Department established the *Jensen* Implementation Office to manage and coordinate this plan. The *Jensen* Implementation Office moved to the Department's Compliance Office in early 2016 and was renamed the *Jensen*/*Olmstead* Quality Assurance and Compliance Office (JOQACO), and assumed supervision of the Successful Life Project.

In January-February 2017, the Successful Life Project and DHS's *Jensen*/Olmstead Quality Assurance and Compliance Office (JOQACO) asked the Case Managers of *Jensen* Class Members and people previously served at MSHS-Cambridge to complete a risk assessment for these people. The risk assessment was based on previously published research, and was completed through an online survey that Case Managers accessed through a link in an e-mail invitation. The survey was sent to the Case Managers for a total of 281 *Jensen* Class Members and people served at MSHS-Cambridge, with a 92% survey completion rate. The purpose of the survey was to gather information about the nature of behavioral and medical risk in this population with the goal of providing better-informed therapeutic follow-up. JOQACO and the Successful Life Project would like to thank all of the Case Managers who completed this survey. The survey will be revised and will be sent out semi-annually so that JOQACO and the Successful Life Project can continue to track risk factors over time in this population.

Results of the Risk Assessment Survey

The most relevant five findings are listed below.

1. People in this population experience a high amount of risk. The average person had seven risk factors reported. Three people had 21 risk factors reported.
2. The following four risk factors were reported for over 50% of the people:

[1] MSHS-Cambridge closed in 2014 and replaced with the Minnesota Life Bridge program, which provides treatment services in homes integrated within Minnesota communities.

- Difficulty with handling stress
- Difficulty with socialization
- Taking more than 5 prescription medications more than 3 days a week
- Difficulty with motivation.

3. There is an association between each psychiatric diagnosis and particular risk factors. In particular, the co-occurrence between Anxiety Disorder, Depressive Disorder and Post-traumatic Stress Disorder (PTSD) is very common. In contrast, members with Autism Spectrum Disorder (ASD) or Fetal Alcohol Spectrum Disorder (FASD) do not tend to have co-occurring diagnoses of Anxiety Disorder, Depressive Disorder or PTSD. In addition, there is no co-occurrence between Autism Spectrum Disorder and Fetal Alcohol Spectrum Disorder in this population.
4. Gender disparities were noted, with females having a higher number of risk factors than males.
5. There was a clear breakout of 26 people having the highest reported levels of risk.

Utilization of the Risk Assessment Survey Findings

These findings will be used to improve therapeutic follow-up for these people. There will be efforts to provide better supports through both population-wide and individual supports. Population-wide strategies will use a population health approach, which has been defined as considering "the health outcomes of a group of people, including the distribution of such outcomes within the group." Population health strategies have been embraced by many elements of the health care system in the United States, but have been slower to be utilized by services for people with intellectual disabilities. SLP population-wide efforts will include the creation of informational support to care providers regarding the types of risk experienced by this population and efforts to identify the types of risk that are most associated with behavioral crisis. This will enhance the ability of SLP to offer support proactively, prior to the onset of a behavioral crisis. Individual follow-up will include contacting Case Managers for people with the highest reported amount of risk and building additional expertise into the Successful Life Project to address areas of the highest reported level of risk.

There are three important areas of caution that must be noted in interpretation of this report. First, these findings are based on Case Manager reporting, and are not otherwise substantiated. Second, diagnoses (in particular psychiatric diagnoses) are often reported to vary as many people have multiple diagnoses, and efforts to verify reported psychiatric diagnoses using other data sources did not result in confirmation of the diagnoses reported in the survey. Third, these findings are only relevant to *Jensen* Class members and people previously served at MSHS-Cambridge. While broader implications can be inferred, they are not directly supported.

Jensen Class Member Risk Assessment

Background of the Risk Assessment Survey

The Jensen Settlement Agreement is the result of a lawsuit filed against the DHS in 2009 alleging that residents of the former Minnesota Extended Treatment Options (METO) program were unlawfully and unconstitutionally secluded and restrained. The Jensen Settlement Agreement allowed the department and the plaintiffs to resolve the claims in a mutually agreeable manner. The DHS's Successful Life Project provides therapeutic follow-up to members of the *Jensen* Plaintiffs' Class ("*Jensen* Class Members") and people who had been served at MSHS-Cambridge, which is the program that succeeded METO.[2] The purpose of therapeutic follow-up is to provide consultation, services and supports to the person and their team to help prevent re-institutionalization and transfers to settings that are more restrictive, maintain the most integrated setting, and achieve a quality life, as defined by the person. As required by the Comprehensive Plan of Action, the Department established the *Jensen* Implementation Office to manage and coordinate this plan. The *Jensen* Implementation Office moved to the Department's Compliance Office in early 2016 and was renamed the *Jensen*/*Olmstead* Quality Assurance and Compliance Office (JOQACO), and assumed supervision of the Successful Life Project.

In January-February 2017, the *Jensen*/Olmstead Quality Assurance and Compliance Office (JOQACO) asked the Case Managers of all *Jensen* Class Members and people previously served at MSHS-Cambridge to complete a risk assessment on these people. The risk assessment was based on previously published research by Dr. Daniel Baker and efforts in other states to assess risk presented by people who present behavioral challenges. JOQACO and the Successful Life Project (SLP) reviewed prior efforts of this type and added additional questions based on current experiences of risk in the therapeutic follow-up group. The questions on the survey are presented in the following section.

The survey was completed through an online format that Case Managers accessed through a link in an email invitation. The purpose of the survey was to gather information about the nature of behavioral and medical risk in this population, with the goal of providing better-informed therapeutic follow-up to these people. JOQACO would like to thank all of the Case Managers who completed this survey. The survey will be revised and will be sent out semi-annually so that JOQACO can continue to track risk factors over time in this population.

The survey was sent to the Case Managers for a total of 281 people, with a 92% survey completion rate, as shown in the table below. 321 people are in that group, but 40 were not

[2] MSHS-Cambridge closed in 2014 and replaced with the Minnesota Life Bridge program, which provides treatment services in homes integrated within Minnesota communities.

included in the survey sample due to being un-available for a variety of reasons (e.g., person is deceased, moved out of state, or location unknown).

Table 1.

Status	Number
Completed	259
Incomplete	22
Removed	40
Total	**321**

The Risk Assessment

On the survey, the Case Manager assigned to each individual indicated whether the individual had a range of risk factors or other difficulties. There were a total of 28 risk factors listed that could be noted as present for the individual. The risk factors were grouped into the areas of: (a) General Risk Factors, (b) Medical Risk Factors, (c) Psychiatric Diagnoses, and (d) Other Areas of Difficulty. The items listed below are the questions that appeared on the survey; no further explanations or definitions were given on the survey. Please note that "Depression" was listed on the survey; the more correct term is "Depressive Disorder," and that is used in the subsequent sections of this report.

General Risk Factor Items

- Frequent emergency use of physical restraint in a 90-day period (Please exclude use of physical restraints that are in alignment with ongoing support plan)
- Rapid changes in frequency or intensity of behavior across weeks or days
- Communication difficulties between person and care providers that have led to problematic behavior
- Actively searching for opportunities to harm others
- Has engaged in or discussed a plan of deliberate self-harm or suicide
- Use of inpatient psychiatric care more than once in the past year
- Change in psychotropic medications more than three times in the past year (Please consider only changes in type of medication)
- Difficulty implementing the behavior plan or health care plan
- Difficulty in obtaining support due to factors such as lack of available support, family or agency instability, or care
- Decision-makers (family or agency staff) do not support person living in present environment

Medical Risk Factor Items

- Unwillingness/refusal/decline to address chronic health conditions, OR, does not follow direction/recommendations from health care professional
- Two or more medically related, overnight hospital stays in the past year
- Presence of 2 or more chronic medical conditions
- Taking more than 5 prescription medications more than 3 days a week
- Use of intoxicating substances (e.g. recreational drugs or alcohol), tobacco, vaping, caffeine, or energy drinks
- Unsafe sexual activity due to lack of health precautions or dangerous situations (e.g., unknown or multiple partners)
- Noncompliance with medication

Psychiatric Diagnoses

- Anxiety Disorder
- Post-Traumatic Stress Disorder
- Depression [sic Depressive Disorder]
- Autism Spectrum Disorder
- Fetal Alcohol Spectrum Disorder

Areas of Difficulty

- Difficulty with communication
- Difficulty with handling stress
- Difficulty with socialization
- Difficulty with daily routines
- Difficulty with motivation

Risk Assessment Results

The Risk Assessments were completed by Case Managers on a total of 259 *Jensen* Class Members and people previously served at MSHS-Cambridge. Please refer back to Table 1 for the background on the survey population.

Number of Risk Factors

Overall, of the 28 possible risk factors, people ranged between having 0 and 21 risk factors present. On average, an individual had 7 total risk factors present, with a standard deviation of 4.26. The following table shows the number and percent of people by the total number of risk factors present (out of a possible 28).

Table 2.

Total Number of Risk Factors Present	Number of People	Percent of People
0	8	3.1%

Total Number of Risk Factors Present	Number of People	Percent of People
1	7	2.7%
2	19	7.3%
3	28	10.8%
4	22	8.5%
5	28	10.8%
6	19	7.3%
7	16	6.2%
8	18	6.9%
9	18	6.9%
10	25	9.7%
11	15	5.8%
12	12	4.6%
13	7	2.7%
14	7	2.7%
15	2	0.8%
17	3	1.2%
19	1	0.4%
20	1	0.4%
21	3	1.2%

Top Risk Factors

The following table summarizes the top ten areas that were present for the people included in this survey. Five out of ten of the top items were from the *Areas of Difficulty* section of the Risk Assessment.

Table 3.

Risk or Difficulty Area	Number of People	Percent of People
1. Difficulty with handling stress	210	81.1%
2. Difficulty with socialization	160	61.8%

3. Taking more than 5 prescription medications more than 3 days a week	152	58.7%
4. Difficulty with motivation	131	50.6%
5. Difficulty with communication	122	47.1%
6. Difficulty with daily routines	109	42.1%
7. Depressive Disorder (Psychiatric Diagnosis)	83	32.0%
8. Rapid changes in frequency or intensity of behavior across weeks or days	73	28.2%
9. Presence of 2 or more chronic medical conditions	70	27.0%
10. Communication difficulties between person and care providers that have led to problematic behavior	69	26.6%

General Risk Factors

People ranged between having 0 to 9 of the 10 general risk factors present. On average, people had 1.4 general risk factors present, with a standard deviation of 1.8. Approximately 43% of people had none of the risk factors present.

Table 4.

General Risk Factor Items	Number of People	Percent of People
Rapid changes in frequency or intensity of behavior across weeks or days	73	28.2%
Communication difficulties between person and care providers that have led to problematic behavior	69	26.6%
Difficulty implementing the behavior plan or health care plan	50	19.3%
Has engaged in or discussed a plan of deliberate self-harm or suicide	44	17.0%
Difficulty in obtaining support due to factors such as lack of available support, family or agency instability, or care	40	15.4%
Use of inpatient psychiatric care more than once in the past year	28	10.8%
Change in psychotropic medications more than three times in the past year (Please consider only changes in type of medication and not dosage adjustments)	21	8.1%
Actively searching for opportunities to harm others	16	6.2%

General Risk Factor Items	Number of People	Percent of People
Decision-makers (family or agency staff) do not support person living in present environment	14	5.4%
Frequent emergency use of physical restraint in a 90-day period (Please exclude use of physical restraints that are in alignment with ongoing support plan.	13	5.0%
None of the above	111	42.9%

Medical Risk Factors

People ranged from having 0 to 6 of the 7 medical risk factors present. On average, people had 1.5 medical risk factors present, with a standard deviation of 1.3. Approximately 23% of people had none of the risk factors present.

Table 5.

Medical Risk Factor Items	Number of People	Percent of People
Taking more than 5 prescription medications more than 3 days a week	152	58.7%
Presence of 2 or more chronic medical conditions	70	27.0%
Unwillingness/refusal/decline to address chronic health conditions, OR, does not follow direction/recommendations from health care providers	59	22.8%
Use of intoxicating substances (e.g. recreational drugs or alcohol), tobacco, vaping, caffeine, or energy drinks	46	17.8%
Noncompliance with medication	29	11.2%
Two or more medically related, overnight hospital stays in the past year	23	8.9%
Unsafe sexual activity due to lack of health precautions or dangerous situations (e.g., unknown or multiple partners)	11	4.2%
None of the above	60	23.2%

Psychiatric Diagnoses

People ranged between having 0 and 3 of the 5 psychiatric diagnoses present. On average, people had 0.9 psychiatric diagnoses present, with a standard deviation of 0.9. Approximately 41% of people had none of the psychiatric diagnoses present.

Table 6.

Psychiatric Diagnoses	Number of People	Percent of People
Depressive Disorder	83	32.0%
Anxiety Disorder	65	25.1%
Autism Spectrum Disorder	33	12.7%
Fetal Alcohol Spectrum Disorder	26	10.0%
Post-Traumatic Stress Disorder	25	9.7%
None of the above	107	41.3%

Areas of Difficulty

Case Managers were asked to indicate whether the individual had any difficulties that are common for people with Intellectual or Developmental Disabilities. People ranged between having 0 and 6 of the 6 areas of difficulty present. On average, people had 3.2 areas of difficulty present, with a standard deviation of 1.8. Approximately 7% of people had none of the areas of difficulty present.

Table 7.

Areas of Difficulty	Number of People	Percent of People
Difficulty with handling stress	210	81.1%
Difficulty with socialization	160	61.8%
Difficulty with motivation	131	50.6%
Difficulty with communication	122	47.1%
Difficulty with daily routines	109	42.1%
None of the above	17	6.6%

Results by Program Demographics

Additional analyses compared risk scores by other participant characteristics. The below table provides a summary of the average number of risk factors by SLP program status, level of intellectual disability, age and gender.[3] Overall, people who were in SLP Priority status had the highest average level of risk (14 average risks) compared to those in Secondary (10 average risks) and Proactive (6 average risks) status. However, members in Secondary status tended to have a higher average number of psychiatric diagnoses (as reported through Risk Assessment) than those in Priority status.

People who have a diagnosis of "profound intellectual disability" or "other intellectual disability" (also referred to in MN as "Related Conditions" in MN, and includes Cerebral Palsy and Epilepsy) had the overall highest risk scores (11 average score for each), compared to those who have "severe" (8 average score), "moderate" (6 average score) and "mild" (7 average score) intellectual disabilities.

People age 22 to 35 had the highest overall average risk scores (8 average score) when compared to people age 36 to 50 (7 average score) and age 51-74 (6 average score). However, people aged 51-74 had the highest average medical risk score. With regard to gender, females had higher risk factor scores, on average, than males, across all categories of risk factors. In total, females had an average score of 9 risk factors, compared to males, who had an average score of 6 risk factors.

How to interpret the table:

N= number of people within each category. Shading indicates a statistically significant correlation.

Average is the average number of risk factor scores for each group. *Standard (Std.) deviation* is a measurement of how spread out the scores are. For example, Priority status people had an average total risk score of 14.08, with a standard deviation of 4.68. This means that approximately 68% of people with Priority status had a score between 9.4 (14.08 minus 4.68) and 18.76 (14.08 plus 4.68).

Table 8.

	N	General Risk Factors Score		Medical Risk Factor Score		Psychiatric Diagnosis Score		Areas of Difficulty Total		Grand Total Score	
		Average	Std. Deviation	Average	Std. Deviation	Average	Std. Deviation	Average	Std. Deviation	Average	Std. Deviation

[3] System data was pulled for these variables and matched with the risk assessment results. Results only reflect individuals on which a risk assessment was completed, not the entire population.

SLP Status											
Priority	13	5.46	2.33	3.07	1.66	1.07	0.95	4.46	1.56	14.08	4.68
Secondary	25	2.64	1.84	2.24	1.59	1.32	0.95	3.8	1.22	10	4.1
Proactive	219	1.04	1.4	1.32	1.2	0.84	0.91	3.07	1.82	6.27	3.71
Level of Intellectual Disability											
Other Intellectual Disability	10	3.4	1.96	1.8	1.47	1.8	0.92	4.2	1.55	11.2	4.42
Profound	2	1	0	3	1.41	1.5	0.71	5.5	0.71	11	2.83
Severe	9	1.11	1.05	1.67	1.41	0.67	0.71	4.89	1.76	8.33	3.54
Moderate	55	1.11	1.55	1.4	1.21	0.65	0.73	3.13	1.7	6.29	3.63
Mild	173	1.44	1.88	1.52	1.39	0.92	0.97	3.12	1.77	6.99	4.37
Age											
22 to 35	106	1.84	2.08	1.52	1.4	1.05	1.01	3.39	1.73	7.79	4.61
36 to 50	103	1.26	1.6	1.42	1.27	0.83	0.89	3.23	1.82	6.74	3.94
51 to 74	48	0.83	1.51	1.65	1.38	0.71	0.77	2.77	1.86	5.96	3.94
Gender											
Female	75	2.17	2.21	1.89	1.51	1.32	1.07	3.41	1.73	8.8	4.95
Male	180	1.12	1.56	1.34	1.23	0.72	0.81	3.16	1.81	6.34	3.72
All Total	**257**	**1.42**	**1.83**	**1.5**	**1.34**	**0.89**	**0.93**	**3.21**	**1.79**	**7.03**	**4.27**

Association between Risk Factors

Additional analyses were conducted using Chi Square Test of Independence to determine which risk factors had a statistically significant association to one another. In order to highlight these statistically significant findings, only percentages where the difference was statistically significant with a p value of ≤ 0.05 are reported.

How to interpret the table:

This table shows the percentages of people with each risk factor based on whether they had each psychiatric disorder present. For example, 60% of people with an Anxiety Disorder (Anxiety Disorder Present) also had Depressive Disorder, compared to 23% of people who do not have an Anxiety Disorder (Anxiety Disorder Not Present). This difference is statistically significant with a p value of ≤ 0.05.

These results indicate that there was an association between each psychiatric diagnosis and particular risk factors. In particular, the co-occurrence between Anxiety Disorder, Depressive Disorder and Posttraumatic Stress Disorder (PTSD) was very common. In contrast, members with ASD or FASD did not tend to have co-occurring diagnoses of Anxiety Disorder, Depressive Disorder or PTSD. In addition, there was no co-occurrence between ASD and FASD in this population. This could be a result of "diagnostic overshadowing" in which once a person gets a diagnosis of one disability, clinicians may not see other disorders, because the primary diagnosis overshadows other potentially diagnosable conditions.

Table 9.

	Anxiety Disorder Present	Anxiety Disorder Not Present	Depressive Disorder Present	Depressive Disorder Not Present	PTSD Present	PTSD Not Present	ASD Present	ASD Not Present	FASD Present	FASD Not Present
Psychiatric Disorders										
Anxiety Disorder			47%*	15%	44%*	23%	ns	ns	ns	ns
Depressive Disorder	60%*	23%			60%*	29%	ns	ns	ns	ns
PTSD	17%*	7%	18%*	6%			ns	ns	ns	ns

	Anxiety Disorder Present	Anxiety Disorder Not Present	Depressive Disorder Present	Depressive Disorder Not Present	PTSD Present	PTSD Not Present	ASD Present	ASD Not Present	FASD Present	FASD Not Present
ASD	ns	ns	ns	ns	ns	ns			0%	14%*
FASD	ns	ns	ns	ns	ns	ns	0%	12%*		
General Risk Factors										
Frequent emergency use of physical restraint in a 90-day period	ns	ns	ns	ns	ns	ns	12%*	4%	ns	ns
Rapid changes in frequency or intensity of behavior across weeks or days	39%*	25%	ns	ns	ns	ns	ns	ns	50%*	26%
Communication difficulties between person and care providers that have led to problematic behavior	ns	ns	36%*	22%	ns	ns	42%*	24%	50%*	24%
Actively searching for opportunities to harm others	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Has engaged in or discussed a plan of deliberate self-harm or suicide	26%*	14%	27%*	13%	ns	ns	ns	ns	35%*	15%
Use of inpatient psychiatric care more than once in the past year	ns	ns	ns	ns	24%*	9%	ns	ns	27%*	9%

Risk Assessment Survey

	Anxiety Disorder Present	Anxiety Disorder Not Present	Depressive Disorder Present	Depressive Disorder Not Present	PTSD Present	PTSD Not Present	ASD Present	ASD Not Present	FASD Present	FASD Not Present
Change in psychotropic medications more than three times in the past year	17%*	5%	ns	ns	ns	ns	ns	ns	19%*	7%
Difficulty implementing the behavior plan or health care plan	29%*	16%	29%*	15%	ns	ns	ns	ns	ns	ns
Difficulty in obtaining support due to factors such as lack of available support, family or agency instability, or care provider burnout	ns	ns	ns	ns	32%*	14%	ns	ns	ns	ns
Decision-makers (family or agency staff) do not support person living in present environment	11%*	4%	10%*	3%	ns	ns	ns	ns	ns	ns
Medical Risk Factors										
Unwillingness/refusal/decline to address chronic health conditions, OR, does not follow direction/recommendations from health care professional	ns	ns	33%*	18%	ns	ns	ns	ns	39%*	21%

	Anxiety Disorder Present	Anxiety Disorder Not Present	Depressive Disorder Present	Depressive Disorder Not Present	PTSD Present	PTSD Not Present	ASD Present	ASD Not Present	FASD Present	FASD Not Present
Two or more medically related, overnight hospital stays in the past year	15%*	7%	ns	ns	ns	ns	ns	ns	ns	ns
Presence of 2 or more chronic medical conditions	ns	ns	36%*	23%	8%	29%*	ns	ns	ns	ns
Taking more than 5 prescription medications more than 3 days a week	71%*	55%	ns	ns	ns	ns	ns	ns	ns	ns
Use of intoxicating substances (e.g. recreational drugs or alcohol), tobacco, vaping, caffeine, or energy drinks	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Unsafe sexual activity due to lack of health precautions or dangerous situations (e.g., unknown or multiple partners)	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Noncompliance with medication	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Areas of Difficulty										
Difficulty with communication	ns	ns	ns	ns	ns	ns	67%*	44%	ns	ns
Difficulty with handling stress	97%*	76%	ns	ns	ns	ns	ns	ns	96%*	79%

Risk Assessment Survey

	Anxiety Disorder Present	Anxiety Disorder Not Present	Depressive Disorder Present	Depressive Disorder Not Present	PTSD Present	PTSD Not Present	ASD Present	ASD Not Present	FASD Present	FASD Not Present
Difficulty with socialization	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Difficulty with daily routines	ns	ns	ns	ns	ns	ns	ns	ns	69%*	39%
Difficulty with motivation	ns	ns	64%*	44%	ns	ns	ns	ns	89%*	46%

ns indicates that the difference is not statistically significant. Shading indicates a statistically significant correlation. Blue shading indicates an inverse correlation.

* p value ≤ 0.05

Association between Participant Characteristics and Risk Factors

Additional analyses were also conducted using Chi Square Test of Independence to determine how association to risk factors may vary by SLP status, gender and age. In order to highlight these statistically significant findings, only percentages where the difference was statistically significant are reported. Because the number of people with *Priority* or *Secondary* status were too low to carry out these statistical tests, these two categories were combined.

Program Status

Overall, people with *Priority* or *Secondary* program status were more likely to have some of the risk factors present at much higher rates than those in *Proactive* status. No association was found between program status and the presence of the psychiatric disorders listed in the below table. However, there was a greater association for people who have a *Priority* or *Secondary* program status and a number of the other risk factors. For example, people who have *Priority* or *Secondary* status were more than four times as likely as those with *Proactive* status to have ***difficulty implementing the behavior plan or health care plan*** (55% vs. 13%). They were also two to three times as likely to have:

- Rapid changes in frequency or intensity of behavior across weeks or days (66% vs. 22%)
- Communication difficulties between person and care providers that have led to problematic behavior (55% vs. 22%)

- Engaged in or discussed a plan of deliberate self-harm or suicide (42% vs. 13%)
- Difficulty in obtaining support due to factors such as lack of available support, family or agency instability, or care provider burnout (37% vs 12%)
- Use of intoxicating substances (e.g. recreational drugs or alcohol), tobacco, vaping, caffeine, or energy drinks (34% vs. 15%)

Gender

Overall, females had ten of the risk factors present at much higher rates than males. For example, females were almost five times as likely to have ***engaged in or discussed a plan of deliberate self-harm or suicide*** (39% vs. 8%). They also were two to three times as likely to have:

- Anxiety Disorder (40% vs. 19%)
- Depressive Disorder (19% vs. 6%)
- FASD (19% vs. 7%)
- Use of inpatient psychiatric care more than once in the past year (21% vs. 7%)
- Difficulty implementing the behavior plan or health care plan (31% vs. 15%)
- Non-compliance with medication (20% vs. 8%)

Age

Overall, people aged 22 to 35 had eight risk factors present at much higher rates than older groups, especially those aged 51 and older. They were more than twice as likely to have times as likely to have FASD (17%) than people aged 36 to 50 (8%) and 51 to 74 (0%). People aged 22 to 35 were also more likely to have:

- Engaged in or discussed a plan of deliberate self-harm or suicide (22%) than people age 36 to 50 (18%) and 51 to 74 (4%)
- Difficulty implementing the behavior plan or health care plan (26%) than people age 36 to 50 (18%) and 51 to 74 (8%)
- Difficulty in obtaining support due to factors such as lack of available support, family or agency instability, or care provider burnout (24%) than people age 36 to 50 (11%) and 51 to 74 (8%)

In addition, people aged 36 to 50 were less likely to have ***frequent emergency use of physical restraints in a 90 day period*** (1%) than people age 22 to 35 (9%) and age 51 to 74 (6%).

Risk Assessment Survey

How to interpret the table:

This table shows the percentages of people by SLP status, gender and age who have each risk factor. Only differences where there was a statistically significant value are shown. For example, 40% of females were reported to have an Anxiety Disorder, whereas only 19% of males had an Anxiety Disorder. This difference is statistically significant with a p value of ≤ 0.05.

Table 10.

	SLP Status		Gender		Age		
	Priority/ Secondary	**Proactive**	**Female**	**Male**	**22 to 35**	**36 to 50**	**51 to 74**
Psychiatric Disorders							
Anxiety Disorder	ns	ns	40%*	19%	ns	ns	ns
Depressive Disorder	ns	ns	47%	26%	ns	ns	ns
PTSD	ns	ns	19%	6%	ns	ns	ns
ASD	ns	ns	ns	ns	ns	ns	ns
FASD	ns	ns	19%*	7%	17%*	8%	0%
General Risk Factors							
Frequent emergency use of physical restraint in a 90-day period	ns	ns	ns	ns	9%*	1%	6%
Rapid changes in frequency or intensity of behavior across weeks or days	66%*	22%	40%*	23%	ns	Ns	Ns
Communication difficulties between person and care providers that have led to problematic behavior	55%*	22%	ns	ns	ns	ns	ns
Actively searching for opportunities to harm others	ns	ns	ns	ns	ns	ns	ns

Risk Assessment Survey

	SLP Status		Gender		Age		
	Priority/ Secondary	Proactive	Female	Male	22 to 35	36 to 50	51 to 74
Has engaged in or discussed a plan of deliberate self-harm or suicide	42%*	13%	39%*	8%	22%	18%	4%*
Use of inpatient psychiatric care more than once in the past year	ns	ns	21%*	7%	ns	ns	ns
Change in psychotropic medications more than three times in the past year	ns	ns	ns	ns	ns	ns	ns
Difficulty implementing the behavior plan or health care plan	55%*	13%	31%*	15%	26%*	18%	8%
Difficulty in obtaining support due to factors such as lack of available support, family or agency instability, or care provider burnout	37%*	12%	ns	ns	24%*	11%	8%
Decision-makers (family or agency staff) do not support person living in present environment	ns	ns	ns	ns	ns	ns	ns
Medical Risk Factors							
Unwillingness/refusal/decline to address chronic health conditions, OR, does not follow direction/recommendations from health care professional	37%*	20%	ns	ns	ns	ns	ns
Two or more medically related, overnight hospital stays in the past year	ns	ns	ns	ns	ns	ns	ns
Presence of 2 or more chronic medical conditions	45%*	24%	ns	ns	ns	ns	ns

	SLP Status		Gender		Age		
	Priority/ Secondary	Proactive	Female	Male	22 to 35	36 to 50	51 to 74
Taking more than 5 prescription medications more than 3 days a week	79%*	55%	ns	ns	ns	ns	ns
Use of intoxicating substances (e.g. recreational drugs or alcohol), tobacco, vaping, caffeine, or energy drinks	34%*	15%	ns	ns	ns	ns	ns
Unsafe sexual activity due to lack of health precautions or dangerous situations (e.g., unknown or multiple partners)	ns	ns	ns	ns	ns	ns	ns
Noncompliance with medication	ns	ns	20%*	8%	ns	ns	ns
Areas of Difficulty							
Difficulty with communication	ns	ns	ns	ns	ns	ns	ns
Difficulty with handling stress	ns	ns	ns	ns	84%	85%	69%*
Difficulty with socialization	ns	ns	ns	ns	ns	ns	ns
Difficulty with daily routines	61%*	39%	ns	ns	50%	40%	29%
Difficulty with motivation	66%*	48%	63%*	47%	59%	51%	35%*

ns indicates that the difference is not statistically significant. Shading indicates a statistically significant correlation.

* p value ≤ 0.05

DEPARTMENT OF HUMAN SERVICES

Utilization of These Findings

The Successful Life Project and JOQACO will utilize these findings to improve therapeutic follow-up for *Jensen* Class members and people previously served at MSHS-Cambridge. There are two broad categories in which the findings will be utilized: Population-wide Supports and Individual Supports. Population-wide strategies will use a population health approach, which has been defined as considering "the health outcomes of a group of people, including the distribution of such outcomes within the group." Both fit within a Population Health Management framework. Some of these interventions will be used to address the entire population of *Jensen* Class members and people previously served at MSHS-Cambridge. Other interventions will be used by SLP to improve supports for specific people or sub-populations with specific risk factors. Please note that many of the actions described below include the phrase "will explore," as some actions would prove infeasible, and others will be prioritized based on likely outcome. Not all action items will be completed.

Population-wide Supports

1. JOQACO and SLP will explore the use of these findings to do a retrospective study of people supported by SLP who went into some form of acute behavioral crisis and determine if any specific risk factors are associated with onset of behavioral crises.
2. JOQACO and SLP will explore the use of those findings to determine if additional types of support are needed, especially in terms of SLP staffing or outside resources. For example, this could include recommending the use of Speech Language Pathology services more often to addresses risk presented by difficulties in communication, particularly communication which alerts care providers to physical pain or discomfort. Please refer to Tables 3-7.
3. A number of people were on multiple medications. The SLP RN will explore additional means for gathering information about medications and side effects. The information will be gathered either on a proactive basis or once SLP support has been initiated for a person. Somnolence, insomnia, agitation, and weight gain are all side effects for commonly prescribed medications, and all can contribute to

problematic or challenging behavior. These side effects in particular will be explored. Please refer to Table 5.

4. JOQACO and SLP will further investigate the gender disparities noted. Please refer to Table 10. There are multiple possible explanations for this phenomenon. Further investigation of these considering additional multivariate analyses will be explored.
5. JOQACO and SLP will create informational resource materials for people receiving therapeutic follow-up based on reported areas of need in Tables 3-7. Two of these resource materials have already been created and are in final preparation for dissemination:
    A. Behavior Road Map
    B. Mental Wellness Fact Sheet

    A third resource material is in preparation, with a completed draft: Stress Management Fact Sheet.

    Additional resources may be completed in the following areas:
    A. FASD
    B. Addressing unwillingness to follow medical orders
    C. Social skill development

6. Table 9 presents information suggesting that, in terms of risk, people with FASD, ASD, and Mental Health disorders are different populations. SLP will explore gathering additional expertise in providing supports for these behaviorally disparate groups and explore developing treatment packages for these groups. While every person is different and interventions need to be tailored to each situation, establishing a common “playbook” or starting point in designing services will create greater efficiencies in treatment design.

7. JOQACO and SLP will explore finding resources within Minnesota to provide additional therapeutic services for areas of risk identified in the findings of the Risk Assessment. These include treatment providers for specific psychiatric diagnoses, advanced knowledge about FASD, and sexual health.

Individual Supports

1. JOQACO and SLP identified the top 26 people based on level of risk factors and has already provided direct follow up to Case Managers regarding the nature of that person’s risk. The SLP Coordinator contacted these Case Managers in July 2017 to inquire about the adequacy of supports for these people and is in the process of gathering responses. People with higher risk also will be targeted to receive additional SLP follow up when SLP supports are not actively being provided. These data are presented in aggregate in Table 2.
2. JOQACO and SLP will use the risk factors identified as the starting point for any future consultation. SLP will focus on using person-centered planning tools to address some of the risk factors, (e.g., communication difficulties, which are a specific focus on Person-centered Plans.).
3. The Risk Assessment will be built into the SLP intake process when initiating support for a person, with completion by support providers rather than Case Managers.

4. SLP will explore development of Unique Treatment Plans for people who have frequent psychiatric hospitalizations. SLP will develop a common template. This is currently being piloted with one person supported by SLP currently in a hospital in Willmar, MN. This hospital is interested in creating Unique Treatment Plans for all people with IDD who are admitted from a residential provider, and ultimately for all people who have an IDD they serve.
5. JOQACO and SLP will use the Risk Assessment in a longitudinal manner to determine if there is a reduction in reported risk factors for people receiving SLP supports.

Future Use of the Risk Assessment

1. The Risk Assessment will be completed semi-annually, with revisions and clarifications to the survey, including adding changes in residence, additional psychiatric diagnoses options, and adding questions based on additional types of risk noted in the open ended questions.
2. JOQACO and SLP will track individual responses over time. If there are increases in risk factors, JOQACO will provide a follow up to determine if additional supports are needed.
3. Additional analysis will be carried out on future risk assessment information in order to determine whether particular risk factors are predictive of negative preventable outcomes for *Jensen* Class members and people previously served at MSHS-Cambridge.

Limitations of the Risk Assessment Survey

There are three important areas of caution that must be noted in interpretation of this report. First, these findings are based on Case Manager reporting and are not otherwise substantiated. Second, this group often has many diagnoses, in particular psychiatric diagnoses, which vary over time. Efforts to verify reported psychiatric diagnoses using other data sources did not result in full confirmation of the diagnoses reported in the survey. Third, these findings are specific to *Jensen* Class members and people previously served at MSHS-Cambridge. While broader implications can be inferred, they are not directly supported.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment I

to the October 2019 Supplemental Report

DEPARTMENT OF HUMAN SERVICES

Promising Practices for Addressing the Crisis Services Shortage

A Summary of the Gaps Analysis Process Webinar (June 2019)

The Gaps Analysis is an ongoing process to understand and improve access to services systems for older adults, persons with disabilities, and children, youth and adults living with mental health conditions in Minnesota. A key step in this process is to identify promising strategies to improve service access. To facilitate this, the Minnesota Department of Human Services (DHS) and Wilder Research hosted four webinars highlighting current strategies to address prioritized service access issues. During the June 25 webinar, five panelists shared their experiences implementing strategies to address Minnesota's crisis services shortage.

The webinar discussion highlighted key considerations for local stakeholders considering similar strategies, such as critical partnerships, resources needed, and barriers encountered. Below are some of the key themes and resources that arose during the discussion

Crisis services shortage in the context of this discussion

For the purposes of the webinar conversation, the crisis services shortage included crisis stabilization and related crisis services and supports. Crisis stabilization services are mental health services that are provided after crisis intervention to help an individual return to their level of functioning from before the crisis ensued. Crisis services and supports also include prevention and support for caregivers.

Panelists and featured initiatives

Renee Bymark, ElderCircle (https://www.facebook.com/ElderCircle-256049927751768), renee@eldercircle.org

Featured initiative: Based in Grand Rapids, ElderCircle provides services, resources, and referrals to empower older adults to maintain active living and healthy independence. They offer a range of respite supports, including: the Respite Education and Support Tools (REST) program supporting informal caregivers; group support and workshops for caregivers; one-on-one caregiver consulting; Powerful Tools for Caregivers workshops; supportive in-home technology, like activity monitoring, medication dispensers, and life alert buttons; Navigating MCI and Dementia, a 10-week early stage program for individuals with dementia and their care partners; Virtual Dementia Tours, an evidence-based experience to help better understand the physical and mental challenges of living with dementia; support groups; and more.

Colleen Fodness, Dakota County Community Living Services (https://www.co.dakota.mn.us/HealthFamily/Disabilities/Pages/default.aspx), colleen.fodness@co.dakota.mn.us

Featured initiative: Dakota County participates in the Metro Crisis Coordination Program (MCCP), which has worked to expand crisis bed capacity and planned respite for caregivers across the Twin Cities metro area. Dakota County recently launched a pilot program to address gaps in mental and behavioral health supports for children with intellectual or developmental disabilities. The program aims to improve family stability and prevent out-of-home placement for children, better address the complex mental health and behavioral needs of children, and engage caregivers with skills-based learning. The program provides children and their guardians with longer-term services and supports than typical children's mental health services allow, and a coordinated service model offering behavioral supports, caregiver coaching, teaching, and modeling under the home- and community-based waiver services, particularly crisis respite.

"...[H]aving this coordinated service... primarily scheduled to be delivered in the home, is quite promising at this point."
– Colleen Fodness, Dakota County Community Living Services

Tanya Leskey and Mike Willie, Wadena County Human Services (http://www.co.wadena.mn.us/197/Human-Services), tanya.leskey@co.wadena.mn.us; mikew@co.wadena.mn.us

Featured initiative: The Wadena County Mental Health Task Force was formed in response to a grassroots concern that people in mental health crisis were being stranded in the emergency room (ER) or jail. The Task Force includes local stakeholders from 14 different entities, including health care, law enforcement, community health departments, and health providers. Together, they identify needs and address issues and solutions via sub-groups, or bring them to the Region V+ Adult Mental Health Initiative (AMHI). Examples of efforts include:

- A collaboration initiated by the Lakewood Health System with local ERs, which aims to ensure appropriate level of care for people with inpatient psychiatric needs.
- A collaboration between local law enforcement and jails, the Comprehensive Re-entry Project, which provides screening to identify people with mental illness and chemical dependency issues.
- A Regional Transition Specialist, hosted by Source Well, who provides a regional perspective and assists counties with transitioning individuals out of community behavioral health hospitals and the Anoka-Metro Regional Treatment Center.
- A Supportive Housing initiative, led by the Central Minnesota Housing Partnership, which includes a new 40-unit building (construction to begin in 2019), with 20 units with supportive services.

"That's what we have found to be hugely successful in our Region V, and here locally, … is finding things don't have to be huge and complicated. The simpler and the more clean you can make things, the more progress we seem to make. Reaching that consensus and finding those common goals, and keeping it simple, is where we've reached our success."
– Tanya Leskey, Wadena County Human Services

Jim Temple, Metro Crisis Coordination Program (http://metrocrisis.org/), jtemple@mtolivet-mora.org

Featured initiative: The Metro Crisis Coordination Program (MCCP) coordinates crisis services for people with intellectual or developmental disabilities in the 7-county Twin Cities metro area. MCCP coordinates with nine different providers, DHS, and the seven counties they serve to provide crisis support planning, technical assistance and training for families and programs, augmentation services, and coordination of 40 crisis beds. Representatives from each county meet monthly to discuss operations and new initiatives and work closely with the DHS Disability Services Division.

"Part of the reason the coordination was needed was to really have a better idea what the need, the demand, and the availability were. As being kind of the front door to the system, we track all of those things."
– Jim Temple, Metro Crisis Coordination Program

Key themes and highlights

Partnerships and coordination are important for all of the featured initiatives.

- ElderCircle described several partnerships that help them reach families in the community, including Essentia Health Deer River highlighting ElderCircle's services with doctors, connecting with Fairview Grand Itasca and Fairview in St. Louis County to share supports that are available following discharge, and working with Itasca County Public Health, Itasca County Health and Human Services, Itasca County YMCA, and the city of Grand Rapids to bring educational tools to the community.
- Dakota County's pilot program relies on an integrated team that includes DHS, health services, disability services, and the Dakota County Children's Mental Health Division.

"I think what we're all learning is that to do this well, and to address the gaps and have some positive impact on outcomes, we need good communication and coordination."
– Colleen Fondness, Dakota County Community Living Services

- Wadena County Human Services highlighted the wide base of expertise as a key component of their Task Force. Task Force members have identified additional partners willing to engage on specific strategies through their subcommittee.

"[W]ith our local task force, it really was about saying, what is our common need? What is our common goal? And what resources do we have available to try to address that? ... So instead of all of us trying to work separately, what can we do collaboratively to address those? Both locally, regionally and then through any means legislatively."
– Tanya Leskey, Wadena County Human Services

"And we understand that nobody has a silver bullet and this is a really big state issue and we are a small, rural county. But we can do what we can. Trying to take the chunks of it that we can manage has really been our strategy."
– Mike Willie, Wadena County Human Services

- The Metro Crisis Coordination Program said their initial discussions with the partners were important to finding common ground. Over the years, they have continued to work toward consensus across the seven counties, despite varying needs and levels of demand.

"But taking that time to make sure everybody really understands and does have consensus is critical."
– Jim Temple, Metro Crisis Coordination Programs

Panelists identified financial and organizational resources for their work.

- Wadena County Human Services identified the needs in their area and mapped out the resources different entities had available, then identified roles and responsibilities for each agency to prevent overlap.

"At one of [the Region V+ AMHI] meetings recently, we completed a mapping to get everybody on board with what crisis services exist in our community. And I really feel like that was a beneficial tack to make sure that everybody's on the same page and having the same information about what crisis services are really available in our region and where the gaps are, and how we can continue to make progress and evolve."
– Mike Willie, Wadena County Human Services

- Wadena County Human Services also identified a DHS Innovations grant to support the regional transition specialist position and a Source Well innovations grant to support the comprehensive re-entry regional project. They are considering additional grants, AMHI funding, and county funding as possibilities for sustaining the work.
- Metro Crisis Coordination Services is primarily waiver funded, and worked with the Disability Service Division to get the codes that work best, primarily for the CADI waiver, to differentiate between technical assistance and behavioral analysis.
- ElderCircle is waiver funded, receives regional and state funding, and offers many services on a cost-share basis, through private pay, and using a sliding fee based on income to meet needs of residents.
- Dakota County looked first at how to engage with waiver services in a coordinated way, but is also looking for ways to broaden and identify additional funding streams to offset costs.

Panelists highlighted some of the ways they navigate challenges.

- In response to changing demographics and a growing older adult population, ElderCircle is thinking ahead about how best to serve baby boomers and connect them with supports before they are in a crisis situation.
- The Metro Crisis Coordination Program highlighted the need to clearly define what your organization does and stick with it. While it can be tempting to go beyond, focusing on what they set out to do is helpful.
- Wadena County Human Services discussed having structure and regular meetings, with the goal of maintaining relationships, even at times when there may not be an imminent crisis to address.

"...[W]e have to keep that level of motivation up throughout the whole process, because that's when we really have seen some gains and really seen some positive outcomes, is when you have that level of motivation."
– Mike Willie, Wadena County Human Services

One panelist highlighted their approach to legislative action from a local perspective.

- Wadena County Human Services worked with their groups of stakeholders and identified core issues to bring to their state senator, who held a listening session with them.

"We have found that in having those direct conversations is what has worked for us. Having those stories heard, having those real-life situations. So it was, again, at a very grass-roots level."
– Tanya Leskey, Wadena County Human Services

Demand for crisis beds came up repeatedly throughout the webinar.

- Dakota County and the Metro Crisis Coordination Program both acknowledged that adding more beds wouldn't solve the problem. Both highlighted the need to continue to focus on prevention and to eliminate some of the service gaps pre-crisis and post-crisis.

Next steps

Complete recordings of the webinars will be available on the DHS Gaps Analysis website (https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/gaps-analysis/).

If you have questions about the DHS Gaps Analysis process, contact dhs.gapsanalysis@state.mn.us.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment J

to the October 2019 Supplemental Report

CRISIS RESPITE REPORT

Overview

Within the last year, at various stake holder engagement activities, Disability Services Division (DSD) staff have learned from counties across the state that crisis respite remains a need in their counties and for the people they support. The Regional Resource Specialist (RRS) and Community Capacity Building (CCB) teams began to analyze available data related to the need for crisis services in the state. This included looking at the need for crisis respite bed capacity and crisis respite unit based services. Therefore, this report was initiated by DSD staff to create a comprehensive data based report on the crisis respite systems current operational state and intended to be used as an internal document/resource. Information was pulled from various data sources maintained by different departments within DHS. The accuracy and timeframes of the information in this report is limited by the division that maintains it.

Data on Crisis Use, Need, and Capacity

1. Timely access to preventative positive support services[1]
   The need remains high for proactive and timely intervention in cases where people being supported are engaging in serious and dangerous challenging behavior and highly trained competent professional staff are either not available in the person's area, or have long waiting lists for service initiation. According to the known 245D licensed providers in DHS Licensing Lookup[2] a lack of services in the person's area or lack of availability to provide services at the time a person needs it, create situations that can lead to service termination notices.

   Direct Care and Treatment[3] within the Department of Human Services provides a unit based crisis respite service referred to as CSS Mobile crisis teams. According to the Community Services and Support (CSS)[4] referral list (provided to DSD from CBS staff) the average wait time (how long it takes from date of referral to first date of service) for CSS mobile crisis services is 35 days statewide.

   Data is from 4/4/18 through 4/26/19

CSS Region	Average Wait Time for Service Initiation
Brainerd Team	28 Days
Metro Mobile Team	36 Days
Northeast Team	67 Days
Northwest Team	34 Days
Region 7E Team	11 Days
Southeast Team	55 Days
Southwest Team	61.5 Days
Overall Average	**35 Days**

[1] The Community Based Services Manual (CBSM) defines **Positive support services (formerly behavioral support):** Services that consist of developing, implementing and monitoring a person-centered, individually designed, proactive plan to address challenging behaviors. A waiver positive support professional develops this plan to enhance a person's quality of life through the process of teaching or increasing positive behavior. When possible, the person leads the process to develop a positive behavior support plan and/or positive support transition plan.

[2] Data DSD has on 245D License providers is as accurate as the system maintained and updated by DHS Licensing.

[3] According to the CBSM: Direct Care and Treatment: DHS-operated Community-Based Services (CBS) provide services for people with a variety of complex behavioral and health needs throughout Minnesota

[4] Data DSD has from CBS is as accurate as the system maintained by CBS. Anyone who meets program eligibility is included on this list.

The Community Capacity Team maintains a database of all of the service termination notices sent to the commissioner from 245D service providers for anyone receiving 245D services[5]. This includes children and adults and people with mental health diagnoses, developmental disabilities, and brain injury.

Since 12/21/18 through 6/17/19:

DSD has received **310 service termination and suspension notices**.

Of these: 48% have a primary diagnosis of DD/IDD

37% have a primary diagnosis of MI

6% have a primary diagnosis of BI

According to the providing submitting the notice, the reasons for the notice are as follows:

Reasons for the Notice	
1. Necessary for person's welfare; needs cannot be met	**28%**
2. Safety of person or others; positive supports ineffective	**38%**
3. Health of person or others endangered	**12%**
4. Program not paid/not paid for person's services	**5%**
5. Program ceases operation	**15%**
6. The person has been terminated by their county social service agency from waiver eligibility.	**1%**

Below is a table of the number of service termination notices received by region from **12/21/2018 through 7/17/2019** along with regional crisis respite capacity:

State Regions	Number of Service Termination Notices through 7/17/19	Number of Crisis Respite Homes and Beds
Region 1	12	0 Homes/0 Beds
Region 2	8	0 Homes/0 Beds
Region 3	21	5 Homes/20 Beds (3 17 and under beds and 17 17+ beds)

[5] DSD directly receives faxes from 245D providers when services are terminated or suspended. This data is as accurate as 245D providers are as consistent with meeting requirements.

Region 4	34	0 Homes/0 Beds
Region 5	10	0 Homes/0 Beds
Region 6	8	2 Homes/8 Beds (all 17+)
Region 7W	17	4 Homes/14 Beds (all 17+)
Region 7E	17	2 Home/8 Beds (all 17+)
Region 8	7	0 Homes/0 Beds
Region 9	11	0 Homes/0 Beds
Region 10	40	1 Homes/4 Beds (all 17+)
Region 11	189	11 Homes/44 Beds (16 17 and under beds and 28 17+ beds)
Total	374	24 Homes/92 Beds

2. Timely access to crisis respite.

According to the Department of Human Services August 2017 Legislative Report on the Status of Long-Term Services and Supports completed by the Aging and Adult Services, Disability Services, Mental Health, Nursing Facility Rates and Policy the following service gaps are described:

> *"Although not identified as frequently as workforce, housing, and transportation, several other service gaps were prioritized by multiple regions. At least four regions identified the following service gaps as a priority for a given population group:*
> - *Crisis stabilization (children with mental health conditions)*
> - *Residential treatment (children with mental health conditions)*
> - *Respite care (persons with disabilities)".*

According to the 2016-2017 Minnesota Adult Family Survey Final Report and the 2016-2017 Minnesota Child Family Survey Final Report for the National Core Indicators survey, timely access to crisis respite is an issue faced by many people with developmental disabilities in Minnesota. Note that these surveys are administered to random samples of adults ages 18-64 with a developmental disability and families of children with a developmental disability, and thus do not reflect the entire Minnesota disability waiver population.

Survey Question: If you asked for crisis or emergency services during the past year, were services provided when needed?

	Yes	No	Number of Respondents
Adults MN	**41%**	**59%**	**76**
Adults NCI	50%	50%	2489
Children MN	**44%**	**56%**	**97**
Children NCI	51%	49%	660

According to the Community Based Services Universal Referral data[6] the programs in the table below are the primary program/services requested for the dates indicated. The referrals made include people with IDD/DD, Brain Injury, and Mental Health diagnoses

Data is from 1/1/18 through 4/26/19

Which Program Requested	Total Requests	Program Capacity
CSS Crisis Homes[7]	103	4 Homes/16 Beds
CSS Mobile Support[8]	41	400 Technical Assistance Cases
MLB - Minnesota Life Bridge[9]	10	3 Homes/10 Beds
MSOCS Long-Term Residential[10]	47	100 Homes/375 Beds
Total Requests	203	-

As of 7/15/19 **207 people are on a waiting list** for at least one of the DHS programs in the table below. Again, these include people with IDD/DD, Brain Injury and Mental Health Diagnoses:

Program Waiting List	Total Number of People Placed on Waiting List	Program Capacity
CSS Crisis Homes	50	4 Homes/16 Beds
CSS Mobile Support	62	400 Technical Assistance Cases
MLB-Minnesota Life Bridge	21	3 Homes/10 Beds
MSOCS Long-Term Residential	74	100 Homes/375 Beds

Since 2016 until 4/26/19 the total number of people on the Crisis Services –Short-Term Residential wait list has totaled 518 people with 98 people having been placed on the wait list more than once (leaving 420 single users).

3. Length of stay.
Once a person has been admitted to a crisis respite home, most often after having their previous services terminated, the length of stay can be up to a year or even exceed a year. Some of the people whose behaviors are complex and challenging and require additional staff ratios, a single person site, or highly trained

[6] The Universal Referral form allows case managers to make one referral for CBS crisis and residential programs from which the person referred might benefit. The Universal Referral data from CBS is maintained by CBS and was shared with DSD
[7] As defined in the CBSM: The CSS crisis homes provide short-term services to people who need residential crisis stabilization
[8] As defined in the CBSM: To serve people where they live and minimize life disruptions, CSS mobile teams address behavioral crises in people's current settings whenever clinically appropriate and safely possible.
[9] As defined in the CBSM: MLB is a residential treatment program for people with developmental disabilities or related conditions who exhibit severe behaviors that pose a risk to public safety.
[10] As defined in the CBSM: MSOCS residential services provide support to people who have been denied alternative support through private community providers

professional staff can spend a great deal of time waiting in a crisis respite home after stabilization due to the lack of resources and system capacity to provide services. This is an issue the Metro Crisis Coordination Program (MCCP) has experienced as well as the MSOCS crisis homes. MCCP represents a collaboration between 7 Twin Cities Metro counties and provides a coordinated response to individuals experiencing crises that may disrupt their home or work stability. MCCP coordinates both private crisis respite homes and crisis respite 15 minute unit based services.

According to data provided by MCCP for 19 people receiving crisis respite services the shortest length of time spent in crisis respite totaled 37 days with the longest time spent in crisis of 521 days. The total number of days for all 19 people equaled 2,714 days with an average number of days of 142.8 days.

For 19 people receiving crisis respite services through MCCP as of 4/26/19

Shortest Time Spent in Crisis Respite	**37 Days**
Longest Time Spent in Crisis Respite	**521 Days**
Total number of days for all people in crisis respite	**2,714 Days**
Average number of days spent in crisis respite	**142.8 Days**

4. Transitions

Once a person has transitioned from a crisis respite home, possibly after several months or after a year, some will encounter issues within the first 6 months in their new setting that puts them at risk for hospitalization, crisis respite placement, and service termination. Therefore, well planned, funded, and high fidelity transition planning is a need for some highly complex people.

The data provided below is from Care Manager[11] for people who have received service termination notices more than once and have needed to access crisis respite support more than 1 time. The data includes people with IDD, BI, and MI diagnosis.

Person	Programs Opened in Care Manager[12]	Number of Care Manager Episodes	Challenging Behaviors Identified in Service Termination Notices	Total Number of BIRF Reports[13] for Person	PSTP[14] Yes/No

[11] Data accuracy is limited to the skill of those using Care Manager and the accuracy in which they enter information.

[12] People that are referred to, and eligible for MSOCS, CSS Crisis Respite, CSS and Minnesota Life Bridge have case files, "referred to as episodes" opened in Care Manager to keep track of contacts with the person and their team and other person specific details.

[13] BIRF stands for Behavior Intervention Reporting Form. Minnesota Administrative Rule 9544.0020 Subpart 3 defines Behavior Intervention Reporting Forms to mean the form prescribed by the commissioner to collect data in accordance with the requirements in Minnesota Statutes, section 245.8251, subdivision 2.

[14] PSTP stands for Positive Support Transition Plan. Minnesota Statues 245D.02 subdivision 23b defines Positive Support Transition Plan to mean the plan required in section 245D.06, subdivision 8, to be developed by the expanded support team to implement positive support strategies to:

(1) eliminate the use of prohibited procedures as identified in section 245D.06, subdivision 5;

(2) avoid the emergency use of manual restraint as identified in section 245D.061; and

1	DSD SPE[15]	2	Physical aggression towards staff	23	Yes
2	DSD CSS Synergy	3	Frequent elopement.	1	No
3	DSD SPE CBS Crisis/Residential/Follow-along	2	Physical aggression towards staff	42	Yes
4	DSD MLB	2	Physical aggression towards staff	2	No
5	DSD SPE CSS	2	Physical aggression towards staff and housemates.	3	No
6	CSS	2	Physical aggression towards housemates.	36	No
7	DSD SPE	2	Physical aggression towards staff	3	No
8	SPE DSD Crisis/Residential/Follow-along	3	Physical aggression towards staff and housemates.	1	No
9	DSD SPE	2	Frequent elopement.	3	No
10	MLB DSD SPE Crisis/Residential/Follow-along	3	Physical aggression towards staff and housemates.	24	Yes
11	MLB DSD SPE Crisis/Residential/Follow-along	2	Physical aggression towards staff	0	No
12	DSD CSS	2	Physical aggression towards staff	49	No
13	DSD SPE MLB	2	Physical aggression towards staff	17	Yes
14	DSD SPE	2	Physical aggression towards staff	6	No
15	DSD SPE	2	SIB-General	4	No

(3) prevent the person from physically harming self or others.

[15] SPE stands for Single Point of Entry. DHS has standardized the referral process for DHS-operated crisis and residential services so there is a single point of entry. The new process coordinates crisis resolution responses for people with developmental disabilities and related conditions. The DHS Single Point of Entry team includes representatives from the:

- Disability Services Division
- Chemical and Mental Health Division
- Direct Care and Treatment Division
- Successful Life Project.

Team members have complementary expertise in resolving clinical and system barriers so people with disabilities can successfully live in the most integrated community setting possible.

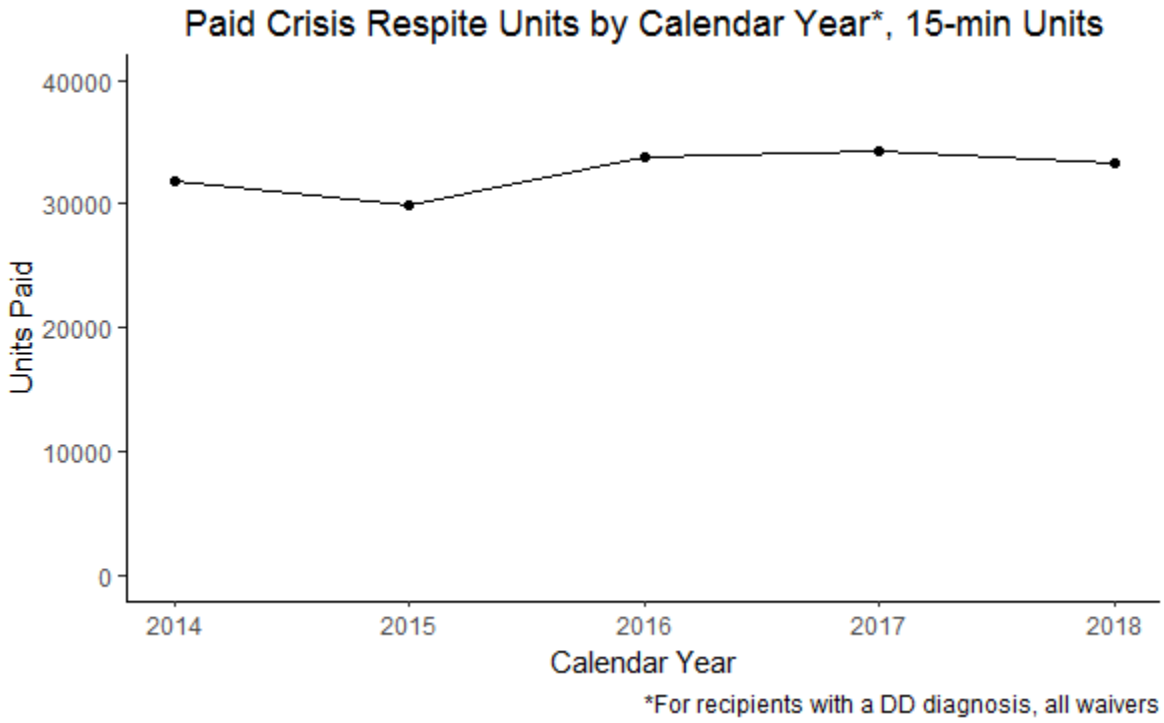
16	MLB DSD SPE Crisis/Residential/Follow Along	2	Physical aggression towards staff and frequent elopement.	11	No
17	DSD SPE Crisis/Residential/Follow-along	2	Physical aggression towards staff and frequent elopement.	26	Yes
18	MLB DSD Crisis/Residential/Follow-along	2	SIB-General	17	Yes
19	DSD SPE	2	Physical aggression towards staff	33	No
20	MLB DSD SPE Crisis/Residential/Follow-along	2	Physical aggression towards staff	3	No
21	DSD SPE	2	Physical aggression towards staff	6	Yes
22	MLB DSD SPE Crisis/Residential/Follow-along	2	No details provided.	16	No
23	DSD SPE	2	No Details provided.	0	No

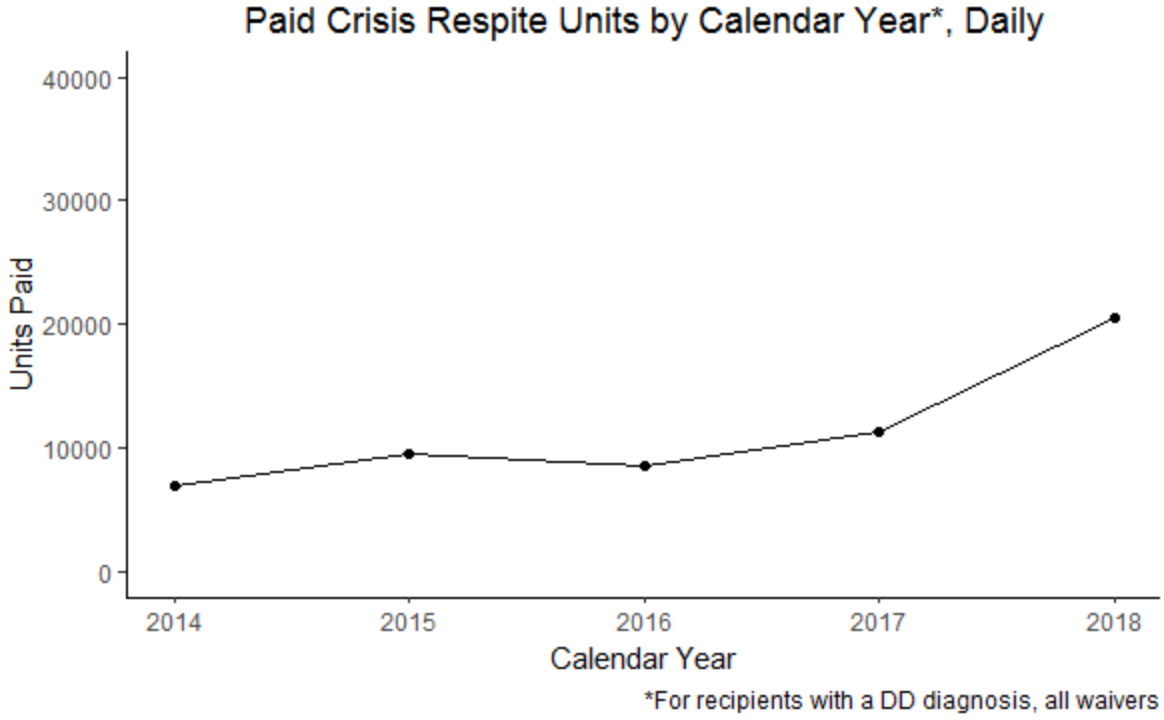
Other population and aggregate data for the 23 people in the above table include:

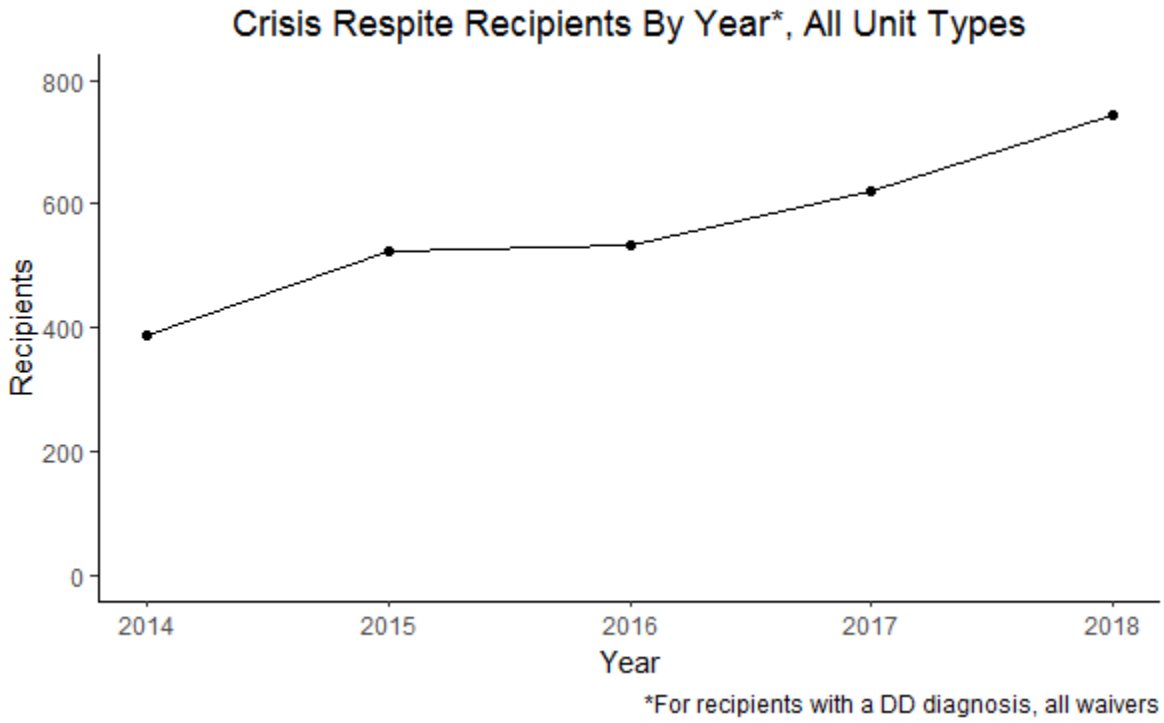
Gender	Diagnosis	Age
70% Male	39% DD only	Oldest 54 years old
30% Female	13% MI only	Youngest 10 years old
	48% MI and DD	

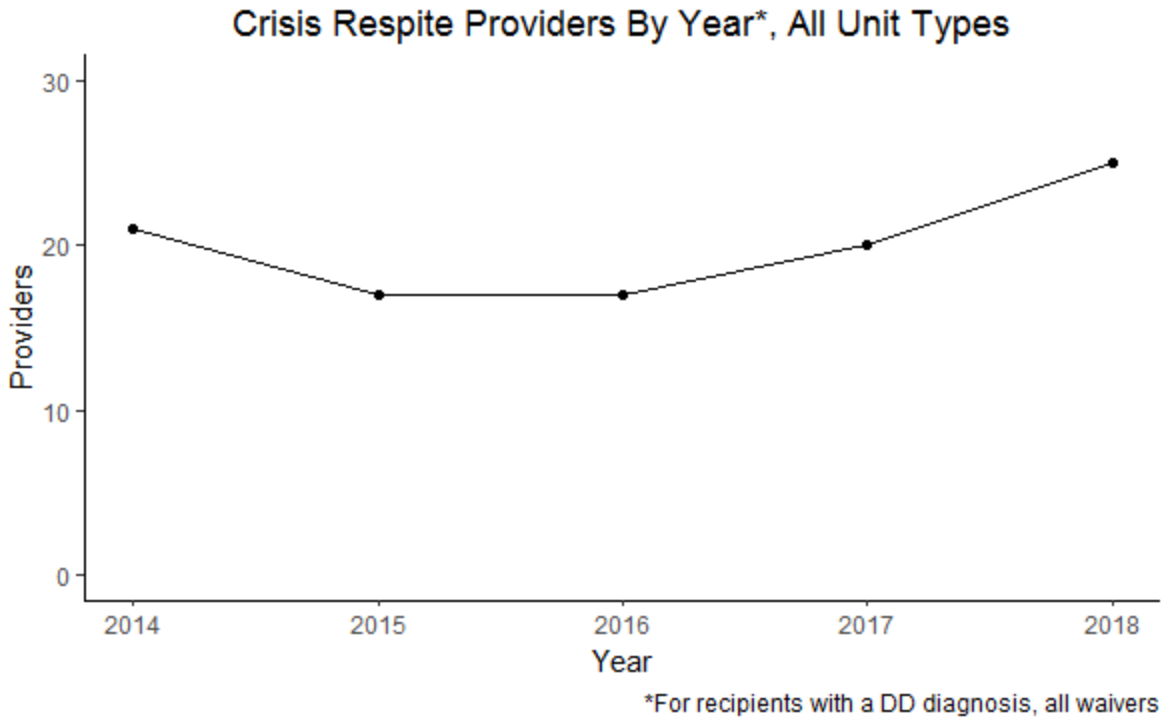
5. Utilization of crisis respite services.

To examine utilization of crisis respite services over time, we identified the number of paid crisis respite units, recipients, and providers for calendar years 2014-2018. These analyses show the number of units, recipients, and providers with corresponding service agreements and payment records for crisis respite procedure codes T1005, T1005 TG, and S9215. Data are not available for 2019 due to a delay between service delivery and billing. The graphs below show the results of the crisis utilization analysis.


Paid Crisis Respite Units by Calendar Year*, 15-min Units
40000
30000
20000
10000
0
Units Paid
2014
2015
2016
2017
2018
Calendar Year
*For recipients with a DD diagnosis, all waivers


Paid Crisis Respite Units by Calendar Year*, Daily
40000
30000
20000
10000
0
Units Paid
2014
2015
2016
2017
2018
Calendar Year
*For recipients with a DD diagnosis, all waivers





This analysis shows that 15 minute unit utilization has remained fairly stable over time, but daily unit utilization has increased since 2014. Additionally, the number of recipients and providers has increased. This analysis only indicates utilization and should not be used to infer causation or the level of need for crisis services. For example, it cannot be determined whether the increase in recipients indicates an increase in the number of people needing crisis services or whether need remained consistent over time but more recipients used services due to the increase in providers. Because of these limitations, the results of this analysis should not be used to predict future crisis respite utilization.

Analysis and Next Steps

The Community Capacity Building team initiated this analysis to understand the state of crisis respite services in Minnesota and to begin to consider next steps. This report indicates a need for more crisis services and additional provider capacity to train direct support professionals in delivering effective intensive behavior support services to successfully support people in community settings and avoid hospitalizations. In addition, the length of stay in crisis respite homes indicates the need to identify other solutions which will require continued and possibly expanded system analysis.

Of importance to describe here is that DHS has standardized the referral process for DHS-operated crisis and residential services so there is a single point of entry. Single Point of Entry (SPE) is intended to coordinate crisis resolution responses for people with developmental disabilities and related conditions. The DHS Single Point of Entry team includes representatives from the:

- Disability Services Division
- Behavioral Health Division
- Direct Care and Treatment Division
- Successful Life Project.

SPE has been operating since 2015. Data analysis on this effort including what is working well and what needs to change is currently underway.

Consistent with the data in this analysis, the Community Capacity Building Team and partners within Disability Services Division are engaging in the following activities:

- Met with members from Behavioral Health to look at crisis services across divisions.
- Started a provider community of practice with outstate crisis respite providers. This group meets on a monthly basis and is intended to be a place for support, learning, discovery and resource development.
- Began to host cross divisional meetings to determine potential options for determining crisis respite needs by county.
- Began to attend cross agency meetings to determine critical aspects of crisis respite services and understand why so few providers provide crisis respite unit based services.
- RRS and the CCB team staff have met with Jim Temple and Beth Nord with MCCP to learn more about how the program operates financially, programmatically, and what resources MCCP offers to crisis respite providers and counties.
- Engaged the Direct Care and Treatment DHS division in discussing:
  - CSS capacity and possible expansion.
  - MSOCS safety net services – what this means and how to maximize the 100+ community based homes with DHS direct support professionals.
- Started meeting with the QADC Services, Direct Care and Treatment leadership and DSD staff around the SPE process to analyze effective current practices and adjust to meet changing needs.

The Community Capacity Building team has also identified the following next steps for continued work:

- Compare service termination data to BIRF data to assess for correlation between behavioral incidents and service termination.
- Compare service termination data to information about 911 calls.

- Consider if there are any correlations in behavioral incidents, 911 calls or demographic information to service terminations to see if there are predictors in order to intervene earlier.
- Consider how utilization of crisis respite services have changed over time.
- Engage with counties and professionals to learn more about the need for crisis respite services within specific counties and regions.
- Continue to engage with Direct Care and Treatment leadership around the possible maximization and efficient use of DHS safety net resources to better meet the needs of people experiencing crisis.
- Continue to engage with the QADC Services and Direct Care and Treatment leadership about the SPE process.
- Continue to evaluate crisis respite utilizations.

Jensen, et al. v. Minnesota Department of Human Services, et al.
U.S. District Court, District of Minnesota, Case No. 09-cv-1775 (DWF/BRT)

Attachment K

to the October 2019 Supplemental Report

DEPARTMENT OF HUMAN SERVICES

2018 - 2019 Direct Support Workforce Survey

Prepared for the Minnesota Olmstead Subcabinet

May 2019

Background

In March 2018, the Cross-Agency Direct Care and Support Workforce Shortage Working Group presented their "Recommendations to Expand, Diversity and Improve Minnesota's Direct Care and Support Workforce" report to the Olmstead Subcabinet. Their report laid out a strategic vision for tackling the crisis in the direct care and support workforce. The cross-agency working group identified seven prioritized recommendations, one of which was to enhance data collection about the direct care and support workforce across long-term services and supports in Minnesota. This report responds to that recommendation, and includes information on wages and benefits for full-time and part-time direct support workers, retention, supervisor staff, and is a first step toward collection of this data. This report fulfills key activities B.1 of the Olmstead Plan Workplan.

To fulfill the data collection recommendation, DHS partnered with the University of Minnesota's Institute on Community Integration (ICI) to conduct the Minnesota Direct Support Workforce Survey in mid-2018. The effort was cooperatively developed with provider trade associations including, Association of Residential Resources of Minnesota (ARRM), Care Providers of Minnesota, Leading Age Minnesota, Minnesota Homecare Association, and Minnesota Organization for Habilitation and Rehabilitation (MOHR).

The survey was conducted between November 2018 and February 2019 and asked respondents to respond based on calendar year 2017 values. The survey was executed on a random stratified sample basis and provider participation was voluntary. 185[1] organizations representing all regions and provider types completed the survey, as shown in the tables below. The 185 responding organizations is a response rate of 42% of the sample, and a representation of about 15% of the providers included in the sampling. Though 185 organizations completed the survey, some organizations did not respond to all questions.

Table 1: Survey respondents by region

Region	Number of respondents	Percentage of respondents
7-county metro area	81	43.8%
Regional center counties[2]	30	16.2%
Greater Minnesota	74	40.0%
Total	**185**	**100%**

[1] Analysis based on paid claims submitted in calendar year 2017 identified 1,272 provider organizations that met identified parameters to be considered to have direct support workers employed in their organization. The random stratified sample that received the survey was 444 provider organizations.

[2] Regional Center counties were identified by the location of a regional center city within them. The identified regional center cities are Mankato (Blue Earth County), Moorehead (Clay County), Duluth (St. Louis County), and St. Cloud (Stearns County).

Table 2: Survey respondents by provider type

Service type[3]	Number of respondents	Percentage of respondents
State plan home health aide	11	5.9%
Personal care assistance	61	33.0%
Waiver day services	34	18.4%
Waiver residential services	51	27.6%
Waiver unit-based services	28	15.1%
Total	**185**	**100%**

Survey findings

Direct support workers

Direct support workers provide critical services for people with disabilities and older adults who require support to live, work, and enjoy living in their communities. Because the work performed by direct support workers is varied, people may use different names for this occupation. For the purposes of this data collection effort, a direct support worker was defined as an employee whose primary responsibility was to provide support, training, supervision, and personal assistance to people with disabilities or an older adult. This definition does not include professional or licensed staff. The provider organizations that responded to the survey employ 28,673 direct support workers that fit this definition who serve 37,773 people with disabilities and older adults.

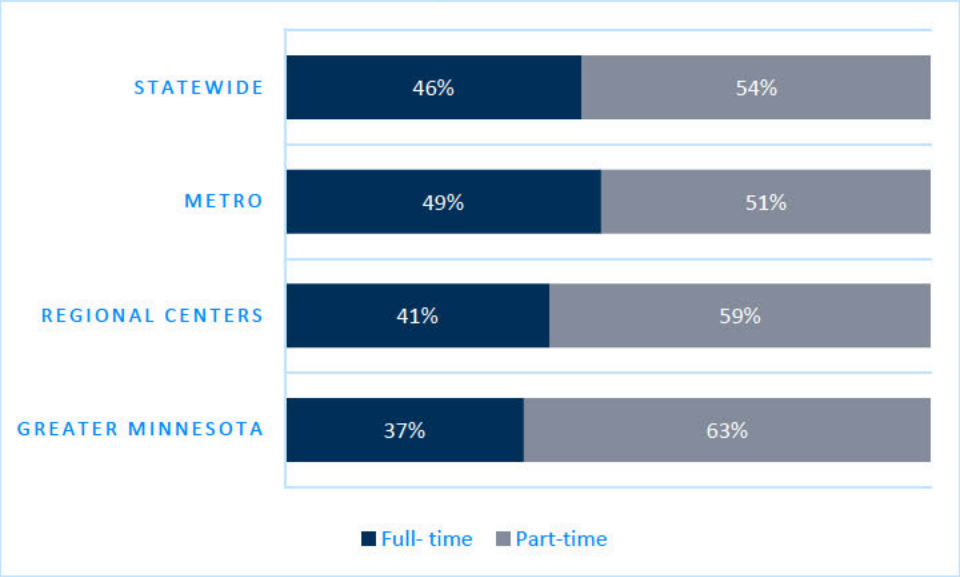
Employment Type

Of the providers surveyed statewide, 46% of direct support workers were employed full-time and 54% were employed part-time[4]. This relationship varies across the different regions, with over half of direct support workers working part-time in Greater Minnesota (63%) to a nearly even split in the Metro. Statewide, however, there are more part-time direct support workers than full-time. Please see figure 1 for further details.

[3] The different service types are based on billing codes for the service identified in the grouping, and include all fee for service and managed care claims for calendar year 2017. Programs using these billing codes are all HCBS waivers and state plan services. Provider organizations are only represented once in the sample based on their identified service group. Some providers may provide other services, though they were included only in one service group for sampling and response rate purposes.

[4] Providers were asked to denote full-time and part-time workers as they do in their organization, if they could, and therefore there is no direct definition in the survey data of who is considered a part-time and full-time worker. This was done to make it easier for provider organizations to report on their organization than fitting to survey parameters.

Figure 1: Full-time and Part-time by Region



Traditionally, in many occupations, full-time workers have higher wages and greater access to benefits than part-time workers. Because the direct support workforce in Minnesota is majority part-time, the result could be lower wages and less access to benefits, as well as a more unstable workforce.

Wages

Wages are often the driving force behind the health of a workforce, and direct support workforce is no different. Without competitive wages, employers are likely to lose employees to other industries that offer more career advancement and less demanding work for equitable, or better, pay. This issue is further magnified for policymakers because many of the organizations that provide services under these programs receive payment from rates set by the state, however appropriate those may be to address direct support worker wages. In recent years there have been legislative attempts to increase direct support worker wages to a competitive level, with varying success.

Statewide median wage

At a statewide level, the median wage[5] of a direct support workers is $12.04 an hour. This value aggregates the median wages for all employment types, regional locations of service, and types of service. This survey aimed to collect a more detailed view of wages for direct support workers in Minnesota. The following sections provide information about the specific findings.

[5] For purposes of this document, all wages reported are for awake direct support workers. The survey also asked about asleep wages, but they are not reported on in this summary.

Wages by employment type

As mentioned in previous sections of this report, typically part-time workers have lower wages than full-time. This is the case in the Minnesota direct support workforce. The statewide median full-time direct support worker wage is $12.45 an hour, while the median part-time direct support workers wage is $12.00. This means that a part-time worker would have to work about 41.5 hours a week to make the same has a full-time direct support workers working 40.

Wages by Region

Regional differences also influence wages, as cost of living and workforce availability varies between locations. This survey found that there were regional difference in wages, including variation between the difference of wages of full-time and part-time workers. Please see figure 2 for further details.

Figure 2: Median wages for full-time and part-time workers, by region

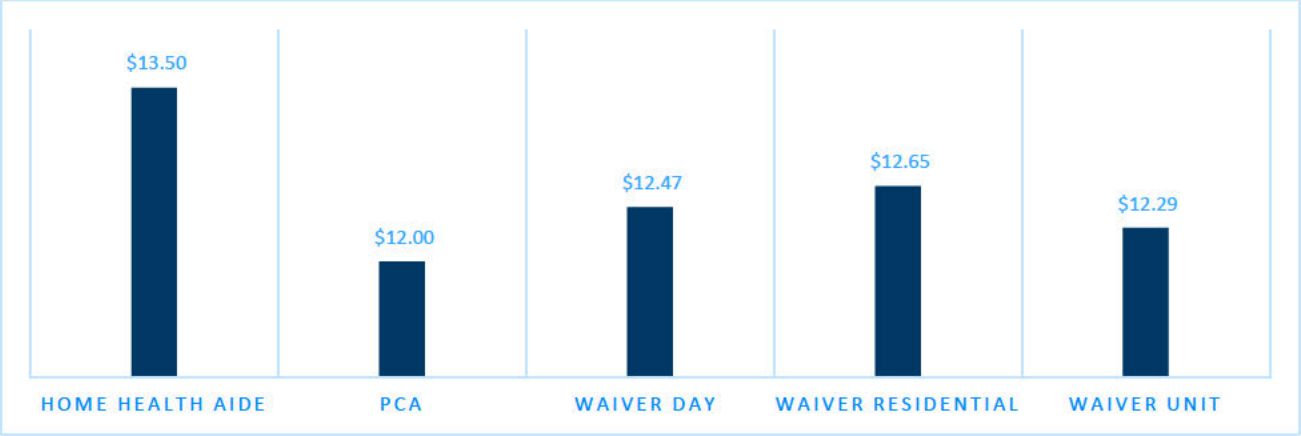
The greatest wage disparity is found in the regional centers. In that region, where part-time workers make up the large majority of the workforce, the difference between full-time and part-time workers wages is 10%. This means that a part-time worker would have to work 44 hours a week to make about the same as a full-time direct support workers working 40.

Wages by Service type

The survey respondents provide services to people with disabilities and older adults across many DHS programs, as well as other government programs and private pay clients. Even within an individual provider organization, they may serve people through multiple service types and programs. Only 39% of provider organizations reported that they provided services in one category, while the majority provide service in 2-5 of the service type categories.

Each of the service categories have at least one payment rate for services. The waiver categories may have more than one due to different rate methodologies between the disability waivers and elderly waiver, in addition to the rate differences within the disability waivers due to the transition to the Disability Waiver Rate System, also known as banding. These different pay rates have resulted in wage variation for direct support workers across the service types, sometimes resulting in different wages for different direct support workers work within the same organization. Figure 3 breaks out the median wage by service category.

Figure 3: Median wage, by service category



Benefits

Available and sufficient benefits have a direct effect on retaining staff in the direct care and support workforce. The benefits available to direct support workers vary across organizations, or may not be offered at all. The survey asked whether organizations offered paid time off, paid sick leave, paid vacation, health insurance, and other benefits[6]. Some organizations that responded to the survey did not complete the benefits questions; therefore, data in this section are expressed as percentages of the organizations that answered the specific question.

The following table summarizes the percentage of responding organizations that offered different types of benefits to full-time and part-time employees.

Table 3: Benefits offered to full-time and part-time employees

Benefit offered	Percentage of organizations offering to full-time employees	Percentage of organizations offering to part-time employees
Paid time off	56.9%	34.5%
Paid sick leave	37.3%	17.3%
Paid vacation	43.4%	21.1%
Health insurance	56.0%	10.6%

[6] In order to incorporate the current practices of all provider organizations, the survey included both paid time off, and paid sick/vacation time in the understanding that few to no organizations would be providing both.

Paid time off and health insurance were the most frequent benefits offered to full-time direct support workers. Paid time off and paid vacation were the most frequent benefits offered to part-time direct support workers. With the exception of health insurance, benefit offerings were similar between full-time and part-time employees of responding organizations. Organizations that offer health insurance require direct support workers to work a median value of 33 hours per week to be eligible for health insurance. This could explain the significant gap between health insurance offerings for full-time and part-time employees.

The survey found that only 56% of full-time and 11% of part-time direct support workers are offered health insurance. Additionally it found, only 38% of direct support workers enrolled in the health insurance plan offered by their organizations. This means that even as just about half of the full-time direct support workers are offered access to health insurance, less than half of those are enrolled through their employer.

The employee cost of health insurance and type of insurance strongly affect the perception of whether this is an attractive offered benefit. Table 4 summarizes average monthly health insurance premium costs for direct support workers and corresponding employer contributions for different coverage types. The type of insurance offered was about 43% high deductible, 26% full-coverage, and 31% of unidentified types. With the exception of coverage, the survey found that the median premiums paid by direct support workers were higher than employer contributions.

Table 4: Median Premiums and employer contributions, by type of coverage

Type of coverage	Direct support worker premium	Employer contribution
Individual coverage	$117	$430
Two-person coverage	$474	$505
Family coverage	$760	$578

The survey also asked organizations whether several other benefits were offered. The following table summarizes the proportion of responding organizations that offered other benefits that were not differentiated by full-time and part-time employees.

Table 5: Other benefits offered to employees

Benefit offered	Percentage of organizations offering to employees
Health savings account (with employer contribution)	20.4%
Dental insurance	75.0%
Vision insurance	40.5%
Life insurance	68.1%
Short-term disability	48.3%
Long-term disability	40.5%
Retirement benefits	75.0%
Tuition reimbursement	16.4%
Wellness programs	31.9%

Turnover and job vacancies

Workforce stability is critical to adequately support people with disabilities and older adults. Measures that are helpful to understand the stability of the workforce are the proportion of people that leave positions in any given year, or turnover, and how many positions are not filled, or job vacancies.

Turnover

Turnover is a measure used to understand the stability of the workforce because it may indicate that people are not staying in positions long enough to gain experience to perform their work adequately. High turnover in the first year of employment may indicate a more inexperienced workforce. An unstable, inexperienced workforce that supports people with disabilities and older adults can result in further problems because there may not be opportunities to build personal relationships and trust.

During the survey period, the national average turnover rate for the healthcare and social assistance industry, of which direct support worker-like occupations are included, was 33%[7]. This survey looked at the turnover for full-time and part-time direct support workers, and found that the median turnover rate for direct support workers statewide was over 33%, with 46.2% of that turnover occurring in the first 6 months of employment. For part time workers the median turnover rate is 33.3%, of which 49% was within 6 months of hire. If turnover continued for the entire part-time workforce at this rate, the workforce would be completely replaced within 26 months. For full-time workers the median turnover was slightly lower at 28%, with 40% of that turnover in the first 6 months of hire.

Vacancy Rates

High percentages of job vacancies would indicate that there are not enough workers to fulfill the demand in the field, meaning those that are employed are doing too much work or that work is not being completed. During the same period covered in this survey, the Minnesota job vacancy rate was 4.4%[8] for all positions. The full-time median statewide vacancy rate for direct support workers is over nine percentage points higher, at 13.5%.

The combination of high turnover and high job vacancies together indicate an unstable workforce that does not have the experience to learn their jobs fully while also taking on more work to make-up for the unfilled positions. This level of work can lead to burnout and the further loss of direct support workers from an already strained workforce.

---

[7] Health care and social assistance category; https://www.bls.gov/news.release/jolts.t16.htm

[8] https://mn.gov/deed/data/data-tools/job-vacancy/

Supervisors

In addition to direct support workers, supervisors play an integral role in the success of the service systems for people with disabilities and older adults. They provide oversight to the work of direct support workers and often step in to fill gaps in availability of staff. The model of supervision varies by provider organization, though broader measures of workforce stability can be applied. The median salary for supervisors was $40,729. The statewide turnover and vacancy rate for supervisors were both lower than direct support workers and the national average turnover, which could point to more stability in this group, even if some instability still exists.

In order to better understand how unfilled direct support shifts are being filled with high turnover and vacancy rates for direct support workers, provider organizations were also asked if supervisors were compensated above and beyond their salaries when required to work any unfilled direct support shift. Of the provider organizations that responded, only 34% offered some type of additional compensation for these shifts, meaning that 66% of organizations do not. The compensation offered to supervisors in these cases included a one-time bonus, differential pay, and the direct support worker wage for the hours worked.

Conclusion

The Minnesota Direct Support Workforce survey provided a level of detail about the direct support workforce that previously was not available. This information will expand the conversations about wages and benefit access for direct support workers, and lend itself to the broader conversation about the direct support workforce crisis the nation is experiencing.

The data gathered from this survey, however, represents only the providers in the random stratified sample who were able to complete the survey voluntarily. While rigorous sampling methods were used to create the potential pool of provider respondents, smaller providers reported that they did not have the time or staff resources to complete the survey. Required reporting for all providers could yield different values, or outcomes from the same questions.

Further investment and work on this type of data collection in an ongoing manner is necessary to expand the understanding of the direct support workforce in Minnesota. The Governor‘s 2019 budget mandates this type of reporting. Continuing to study and report on the health of the direct support labor market is critical to informing and monitoring future investments in this workforce.

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/BRT

AFFIDAVIT OF MARGARET FLETCHER BOOTH, PH.D., CONCERNING VERIFICATION OF MINNESOTA DEPARTMENT OF HUMAN SERVICES' OCTOBER 2019 SUPPLEMENTAL REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

MARGARET FLETCHER BOOTH, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as the Manager, Quality Assurance and Disability Compliance Services ("QADC Services"). I have personal knowledge of the facts in this affidavit.

2. I am familiar with the above-captioned case and settlement.

3. In order to verify that all data in DHS' October 2019 Supplemental Report ("Report") is reliable and valid, and that the statements in the Report are accurate, complete, timely, and verified, QADC Services: (1) had various individuals provide specific information for the Report; and (2) had those individuals attest in an affidavit that

they have personal knowledge of any data or information they provided for the Report and verify that any such data they provided is reliable and valid and that any such information they provided is accurate, complete, timely and verified.

4. Based upon this process and my own personal knowledge, I verify that all data in the Report is reliable and valid, and that all statements in the Report are accurate, complete, timely, and verified.

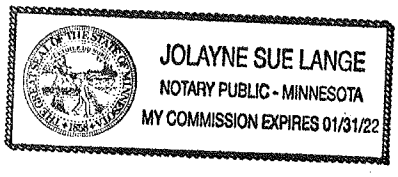
FURTHER YOUR AFFIANT SAYETH NOT.

Margaret Fletcher-Booth

MARGARET FLETCHER BOOTH, Ph.D.

Subscribed and sworn to before me on

October 14, 2019



Jolayne Lange

NOTARY PUBLIC

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/BRT

AFFIDAVIT OF MARGARET FLETCHER BOOTH, PH.D., CONCERNING VERIFICATION OF MINNESOTA DEPARTMENT OF HUMAN SERVICES' OCTOBER 2019 SUPPLEMENTAL REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

MARGARET FLETCHER BOOTH, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Manager, Quality Assurance and Disability Compliance Services ("QADC Services"). I have personal knowledge of the facts in this affidavit.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information relating to DHS' October 2019 Supplemental Report ("Report").

3. I have personal knowledge of any data or information I provided for the Report concerning EC 88 and EC 93 and verify that any such data I provided is reliable and valid and that any such information I provided is accurate, complete, timely and verified.

4. I further verify that any data I provided for the Report is either (1) public data under applicable laws, or (2) if it is not-public data, the data subject(s) of any such not-public data have consented to such data being used publicly, or (3) I have alerted QADC Services at DHS so that the data can be filed under seal.

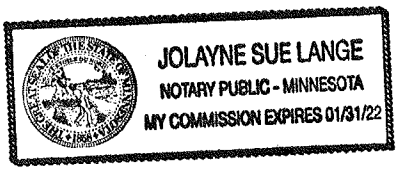
FURTHER YOUR AFFIANT SAYETH NOT.

Margaret Fletcher Booth

MARGARET FLETCHER BOOTH, Ph.D.

Subscribed and sworn to before me on

October 9, 2019



Jolayne Lange

NOTARY PUBLIC

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/BRT

AFFIDAVIT OF DANIEL J. BAKER, PH.D., CONCERNING VERIFICATION OF MINNESOTA DEPARTMENT OF HUMAN SERVICES' OCTOBER 2019 SUPPLEMENTAL REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

DANIEL J. BAKER, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Internal Reviewer, Quality Assurance and Disability Compliance Services ("QADC Services"). I have personal knowledge of the facts in this affidavit.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information relating to DHS' October 2019 Supplemental Report ("Report").

3. . I have personal knowledge of any data or information I provided for the Report concerning EC 88 and EC 93 and verify that any such data I provided is reliable

and valid and that any such information I provided is accurate, complete, timely and verified.

4. I further verify that any data I provided for the Report 3 is either (1) public data under applicable laws, or (2) if it is not-public data, the data subject(s) of any such not-public data have consented to such data being used publicly, or (3) I have alerted QADC Services at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

DANIEL J. BAKER, Ph.D.

Subscribed and sworn to before me on

October 8, 2019

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/22

Jolayne Lange
NOTARY PUBLIC

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/BRT

AFFIDAVIT OF ALEXANDRA BARTOLIC, CONCERNING VERIFICATION OF MINNESOTA DEPARTMENT OF HUMAN SERVICES' OCTOBER 2019 SUPPLEMENTAL REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

ALEXANDRA BARTOLIC, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Director of the Disability Services Division. I have personal knowledge of the facts in this affidavit.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information relating to DHS' October 2019 Supplemental Report ("Report").

3. I have personal knowledge of any data or information I provided for the Report concerning EC 88 and EC 93 and verify that any such data I provided is reliable

and valid and that any such information I provided is accurate, complete, timely and verified.

4. I further verify that any data I provided for the Report is either (1) public data under applicable laws, or (2) if it is not-public data, the data subject(s) of any such not-public data have consented to such data being used publicly, or (3) I have alerted Quality Assurance and Disability Compliance Services at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

Alexandra Bartolic
ALEXANDRA BARTOLIC

Subscribed and sworn to before me on

October 11, 2019

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/22

Jolayne Lange
NOTARY PUBLIC

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/BRT

AFFIDAVIT OF CURTIS BUHMAN, CONCERNING VERIFICATION OF MINNESOTA DEPARTMENT OF HUMAN SERVICES' OCTOBER 2019 SUPPLEMENTAL REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

CURTIS BUHMAN, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS")as a Manager in the Disability Services Division. I have personal knowledge of the facts in this affidavit.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information relating to DHS' October 2019 Supplemental Report ("Report").

3. I have personal knowledge of any data or information I provided for the Report concerning EC 88 and EC 93 and verify that any such data I provided is reliable

and valid and that any such information I provided is accurate, complete, timely and verified.

4. I further verify that any data I provided for the Report is either (1) public data under applicable laws, or (2) if it is not-public data, the data subject(s) of any such not-public data have consented to such data being used publicly, or (3) I have alerted Quality Assurance and Disability Compliance Services at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

CURTIS BUHMAN

Subscribed and sworn to before me on

October 3, 2019

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/22

NOTARY PUBLIC

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/BRT

AFFIDAVIT OF DONOVAN CHANDLER, CONCERNING VERIFICATION OF MINNESOTA DEPARTMENT OF HUMAN SERVICES' OCTOBER 2019 SUPPLEMENTAL REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

DONOVAN CHANDLER, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Executive Director of Community Based Services in the Direct Care and Treatment Division. I have personal knowledge of the facts in this affidavit.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information relating to DHS' October 2019 Supplemental Report ("Report").

3. I have personal knowledge of any data or information I provided for the Report concerning EC 88 and EC 93 and verify that any such data I provided is reliable

and valid and that any such information I provided is accurate, complete, timely and verified.

4. I further verify that any data I provided for the Report is either (1) public data under applicable laws, or (2) if it is not-public data, the data subject(s) of any such not-public data have consented to such data being used publicly, or (3) I have alerted Quality Assurance and Disability Compliance Services at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

DONOVAN CHANDLER

Subscribed and sworn to before me on

October 10, 2019

LORI ANN AYON
COMM. #31073241
Notary Public
State of Minnesota
My Commission Expires 1/31/2021

NOTARY PUBLIC