UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, *et al.,*

Plaintiffs

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al.,*

Defendants

Civil No. 09-1775 (DWF/FLN)

Independent Consultant and Monitor

REPORT TO THE COURT:
Comprehensive Plan of Action Evaluation Criteria 93 and 98

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With regard to the *Ninth Compliance Report, Reporting Period May 1 - September 30, 2015* (Doc. No. 531), the "Gap Report,"[1] this verification review considers implementation of ECs 93 and 98 and tests the accuracy and completeness of DHS' compliance reporting to the Court and the solidity of the data underlying the reporting.[2] As the Court has stated over several years, DHS must ensure that its reporting is candid, complete, and not misleading. The Order of March 18, 2016 (Doc. No. 551) focuses on verification of DHS' reporting.

INTRODUCTION

Overall Conclusion. DHS does not yet demonstrate the existence of internal verification mechanisms to audit compliance with Evaluation Criteria 93 and 98.[3] This review raises the concern that this deficiency extends to other foundational aspects of DHS' reporting.

For EC 93, on Mobile Teams, the Court Monitor is to gather information from DHS "about the deployment of mobile teams in response to crisis situations at DHS facilities and in community settings." The review is to determine whether DHS reports of its efforts are "accurate and complete," and whether "the data relied upon . . . is reliable and valid."[4]

For EC 98, on the Successful Life Project, the Court Monitor is to "verify the accuracy and completeness of DHS's statements, and the reliability and validity of the data DHS relies on," and additionally to "evaluate the results of the project."

EC 93 and 98 are crucial elements of the Settlement Agreement and Comprehensive Plan of Action's "right time, right place" premises for the

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[1] The report covers the five-month gap between the Eighth and Ninth Compliance Reports (Doc. Nos. 440 and 531).

[2] In April and May 2016, the Court Monitor interviewed numerous DHS officials and staff regarding the matters discussed in this report. He also reviewed thousands of pages of documents, mainly source documents from CSS, MLB and SLP, and also summary spreadsheets, tables, emails, policy documents, and other documents.

[3] *See* Order of March 18, 2016 (Order) at 18-19. The Evaluation Criteria (ECs) were developed by the Court Monitor and the parties and approved by the Court as part of the Comprehensive Plan of Action ("CPA"). (Doc. Nos. 283, 284.) The CPA "serve[s] as both a roadmap to compliance and as a measuring stick for compliance." (Doc. No. 271 at 4).

[4] Order at 19-20.

"expansion" of community services supports. Such supports are to

> allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities receive the appropriate level of care at the *right time, in the right place, and in the most integrated setting* in accordance with the U.S. Supreme Court decision in *Olmstead v. L.C*, 527 U.S. 582 (1999).[5] (emphasis added)

"Wrong time, wrong place," absence of mobile teams or an underperforming Successful Life Project, undermine implementation of the Court's orders and fundamentally the lives of the intended beneficiaries.

Finding 1: The Gap Report for EC 93 and 98 is not based on DHS internal verification of the underlying source information.

This Court Monitor review makes some substantive findings which are different from those in the Gap Report, or which highlight incompleteness in the Gap Report. At least for EC 93 and 98, the JOQAC compiled the Gap Report not by verifying underlying source information, but by having the MLB/SLP staff fill in blanks in compliance report templates, provide summary tables, and engage in iterative email exchanges.[6] This review in contrast relies on the original underlying source data.

EVALUATION CRITERION 93

Evaluation Criterion 93

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.

Finding 2: DHS does not provide Mobile Teams as required by EC 93 and, during the Gap Report period, failed to implement planned Mobile Teams with allocated funds.

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[5] Settlement Agreement at 16.

[6] *Verification Documents for the Jensen Settlement Agreement Ninth Compliance Update Report (Reporting Period May 1 – September 30, 2015, EC 98*, Jensen EC 98 Cover Memo.docx. *See* April 25, 2016 email from Peg Booth to Court Monitor, re Request #1 (supplemental information).

The Order directed review of the "mobile teams" required by the CPA. Separately from its judicial obligation, DHS beginning April 29, 2014 represented to the public, counties and providers that it was in fact providing "mobile teams."[7]

Mobile teams, as conceived by MLB, have a specific role as a first and rapid responder to crisis, and with capacity to provide staff and other resources, including inside community homes. The role is different from the other less intense and less rapid other types of mobile supports such as consultation or training.

DHS officials agree that the DHS does not provide mobile teams. The meaning of mobile teams is not ambiguous. In response to the court order, DHS defined mobile teams itself. "Early in 2015, mobile team positions were allocated in the FY 2016 Minnesota Life Bridge [MLB] budget."[8] The FY 2016 budget included $369,350 for mobile team staff and supervisor employee cost, 23% of the total employee cost for MLB, based on a written justification, and with specific staff structure.[9] MLB and Human Resources were engaged in 2015 setting up the mobile teams.[10] A detailed Project Plan was drafted.[11] Staffing was to include six behavior analysts and a behavior analyst supervisor (two staff were eliminated "to reduce budget").[12] Despite this go-ahead, MLB has not been permitted to establish mobile teams.

No documentation has been provided for dropping the mobile team project in the documents and emails provided by DHS (DHS represented that it was providing all mobile team information). There is only the former MLB

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[7] DHS Bulletin # 14-76-01, *Transition of Minnesota Specialty Health System (MSHS)-Cambridge to Minnesota Life Bridge: Admission and Transition Planning and Community Mobile Support Services* issued April 29, 2014.

[8] Affidavit of Mark Brostrom, 2015 MLB Director, April 29, 2016, submitted to Court Monitor, April 29, 2016 email from Maggie Friend, Request ##6-8.

[9] June 10, 2015 memorandum from Steve Jensen, MLP Executive Director, to Mark Brostrom, Director MLB, *Justification to hire for new Minnesota Life Bridge Mobile Teams – BA I – Four Positions;* April 28, 2016 email from Peg Booth, Request #8 (employee time spreadsheet).

[10] None of the documents on this topic provided to the Court Monitor for this review refer to funding concerns as a reason for failing to follow through on the budgeted mobile teams.

[11] "Mobile Support Teams Project Plan – Working Document," MSOCS Transition to Safety Net DRAFT Project Plan – Working Document.

[12] "Employee Time" budget spreadsheet for MLB/SLP.

Director's instruction June 13, 2015, to "Just delay until 2016."[13]

At the same time as the court-ordered mobile teams effort was unaccountably dropped by DHS, two things were happening which one would expect to have supported compliance with the mobile teams commitment:

a) During the Gap Report period, DHS commissioned a substantial analysis of the crisis it was facing. The *Report on DSD Crisis Improvement Project* recommended two options to address the crisis in developmental disabilities, *both* of which include creation of an "Intensive Crisis Team" approach to provide *mobile team support* to the "individual in his or her own home, family home, group home, work place and throughout the community."[14]

b) DHS has proceeded with $13.6 million in mobile mental health crisis grant awards, funding *mobile teams* in the mental health field and announced in a March 28, 2016 news release.[15]

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[13] June 13, 2015 email from Steve Jensen, MLP Executive Director, to Mark Brostrom, Director MLB, in April 28, 2016 email from Peg Booth, Request #8. An affidavit from the then MLB Director concludes his chronology with a June 4, 2015 meeting on mobile teams with Human Resources at which it was determined that more work needed to be done on position descriptions. Affidavit of Mark Brostrom, 2015 MLB Director, April 29, 2016, April 29, 2016 email from Maggie Friend, Request ##6-8. Mr. Brostrom's affidavit attachments show that by July 14, the "position information is ready to go," but on a July question to HR from him, "where are we on this?" there is only a response, "Still in holding. . . . Hopefully this week." *Id.* Nothing further is reported by DHS.

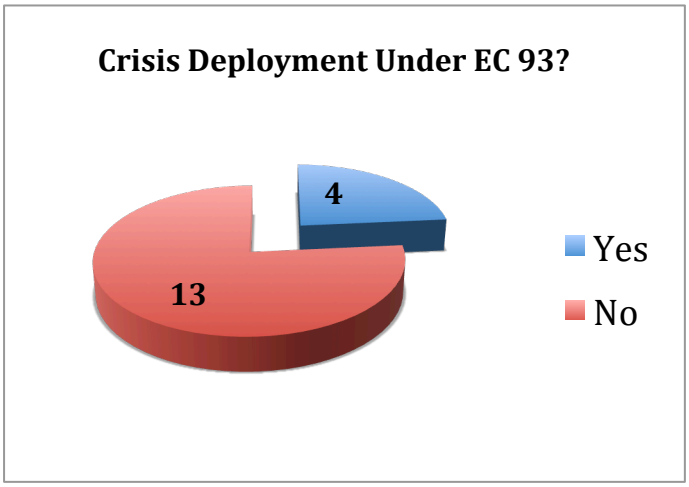
[14] Manfred Tatzman, *Report on DSD Crisis Improvement Project*, June 14 - August 20, 2015 at 28. The first option would have the mobile team within Minnesota Life Bridges and CSS, and the second option would have the mobile team be created through an RFP to providers, funded by DHS.

[15] The DHS News Release dated March 28, 2016 states,

> "When people are in crisis, they need the right help right away," said Human Services Commissioner Emily Johnson Piper. "Mobile mental health crisis services provide that help to people wherever they are." * * *
>
> Research has shown that not only are mobile crisis services effective at keeping people in crisis from needing psychiatric hospitalization, they are also better than hospitalization at linking people in crisis to outpatient services and are effective in finding hard-to-reach individuals. *As a result, four out of five people who receive mobile mental health services do not go to the*

The Gap Report adroitly skirts the question of whether there is compliance with the mobile team requirement. The Report contradictorily states *both* that DHS "does provide mobile teams" *and also*, "There are not separate distinct mobile teams; instead, Minnesota Life Bridge deploys current staff as needed."[16] JOQAC administration believes that any vehicular staff response is the equivalent of a mobile team. (for example, "Tim Moore, he's very mobile.").

Finding 3: DHS' Gap Report information on EC 93 is not accurate; very few mobile supports were provided.



DHS provided few mobile supports for individuals with developmental disabilities in crisis situations referred during the Gap Report period. The Gap Report points to MLB and CSS providing "mobile supports to persons and providers."

DHS excuses itself for not providing mobile teams by claiming that instead it provides "mobile supports." The evidence is that mobile supports are essentially not present. *See also* Findings 4 and 5.

DHS identified 17 crisis deployments for verification by the Court Monitor. These were 100% of all such deployments initiated in the Gap Report period, according to DHS. It was agreed that the "sample" on EC 93 would be this 100% group.

All but 4 of the 17 were not "mobile supports" but were interactions such as routine consultation and state court psychological evaluations. DHS declined the Court Monitor's invitation to revise its designation of these as mobile crisis deployments.

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hospital. (emphasis added)

http://mn.gov/dhs/media/news/index.jsp?id=1053-212398#/list/appId//filterType//filterValue//page/1/sort/Date/order/descending. April 19, 2016 email from Peg Booth (attaching news release).

[16] Gap Report at 61.

WERE THE EC 93 DEPLOYMENTS IN CRISIS SITUATIONS?

Initials	Nature of CSS/SLP/MLB Involvement	Crisis Deployment?
CK	"Second opinion" psychological evaluation for court on appropriate diagnosis.	No
BC	Non-crisis assistance regarding behavioral issue..	No
EG	Consultation and review of restraint incidents.	No
WO	Consultation regarding transition plan.	No
LE	Consultation. This was "not crisis."	No
CT	Individual under commitment was moving to a crisis home. Psychologist did "brief consultation" in non-emergency to help with thinking re conditional discharge.	No
CL	Psychologist "snapshot" involvement in remote discharge from hospital.	No
CJ	Psychologist consultation for court required evaluation reports.	No
JS	Psychologist court evaluation re recommitment to hospital	No
MP	Psychologist met individual at hospital to conduct evaluation for completion of provisional discharge re court commitment.	No
JK	Referral to SLP for continued development of person-centered plan.	No
TC	Referral to SLP for development of a Functional Behavioral Analysis	No
JB	Referral to CSS for behavior consultation; provider was using its own behavior consultation services. "Not emergency. No need for CSS to act."	No
JB	Case Manager concern that client might be demitted from provider home.	Yes
TB	Individual moved from home where he was demitted to first bed provider found (an inappropriate bed).	Yes
LA	Individual was demitted from home in "hot" situation.	Yes
TS	Provider staff walked off from individual's home and quit.	Yes

Finding 4: Mobile supports were not utilized to prevent residential admission of any individuals during the report period.

During the reporting period, Minnesota Life Bridge did not have capacity to admit to its residential homes all of those it determined to be eligible. 11 people were referred to MLB, 7 of whom were deemed eligible for admission to MLB. Of the 7, 4 persons were placed on the wait list.[17] One was admitted to MLB, one was diverted to an MSOCS crisis home, and one was diverted to a private provider crisis bed. MLB does not report that its mobile supports were utilized for prevention of admission of any of the individuals.[18]

Finding 5: Slow movement of individuals through the "temporary" MLB successor facilities is impeding timely provision of services to those eligible for MLB.

As stated above, during the reporting period, Minnesota Life Bridge did not have capacity to admit all of those it determined to be eligible. JOQAC on January 13, 2016 initiated an internal discussion on the issue. "One of the concerns that has been raised for the past year (or more) is the length of time to transition people from MLB back to the community."[19] The MLB bottleneck exacerbates the need for crisis services, including mobile teams.[20] The absence of mobile teams (and of mobile supports) is therefore likely to lead to the unnecessary institutionalization of people in the community who are in crisis.

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[17] Persons are kept on the wait list until admitted to MLB or until MLB is informed by the County Case Manager that an alternate placement is found.

[18] *December XX, 2015 [sic]*, Tables 9 (MLB Referrals) and 10 (MLB Diversions and Referrals Outcomes).

[19] January 13, 2016 email from Peg Booth to SLP and DCT staff and officials, in April 25, 2016 email from Peg Booth re Request #1 (supplemental information).

[20] *See* Tatzman report, at note 14 *supra*.

EVALUATION CRITERION 98

Evaluation Criterion 98

DHS will maintain therapeutic follow-up of Class Members, and clients discharged from METO/MSHS-Cambridge since May 1, 2011, by professional staff to provide a safety network, as needed, to help prevent re-institutionalization and other transfers to more restrictive settings, and to maintain the most integrated setting for those individuals.

EC 98 is perhaps the most crucial safeguard in the Court's orders for the plaintiff class and those in the successor facilities. It obligates the state to follow up on these individuals – with no end date – with the goals of a) protection from re-institutionalization and other transfers to more restrictive settings, and b) maintenance of the most integrated setting for those individuals. This group includes "members at risk of losing their homes, at risk of transfer to settings that are more restrictive, and those transitioning to new homes."[21] . The CPA calls the work "therapeutic follow up" and DHS named it the "Successful Life Project."

There are 343 SLP members. The SLP identifies those most in need of attention as the "Priority List." The number of individuals on the Priority List is in flux, as one would expect. The Priority List provided to the Court Monitor for this review comprised 43 individuals as of the end of the Gap Report period. A random sample of 18 was drawn by the Court Monitor and JOQAC. The Court Monitor with the Court's approval focuses his attention on SLP's functioning and on the Priority List. *See* Findings 6 to 8 below.

Finding 6: SLP-wide data raises concerns regarding SLP's success in achieving its goals.

From the SLP sample, there are six SLP members currently at MSH with admission dates from 2006 to 2015.[22] One sample member was discharged from MSH in 2016.[23] During the SLP's existence, two members were admitted to AMRTC and discharged, one in 2014 and one in 2015.[24] For

[21] Gap Report at 63; Order at 15, n. 7.

[22] The admission dates were 12/23/15 (D.D.), 8/7/15 (K.C.), 1/25/10 (R.N.), 3/20/09 (R.F.), 6/6/08 (T.K.) and 12/27/06 (M.H.).

[23] B.O. was at MSH from 6/16/03 to 1/21/16.

[24] K.C. was admitted to AMTRC 6/30/15 and discharged 8/7/15. D.F. was

the same group, there was no change in the individual's residence from the first SLP assessments to this review (October 2014 to April 2016) for 55 individuals;[25] for those who did move, others,

- Move to home 1
- Move to hospital 1
- Move to Minnesota Security Hospital 2
- Moves to "less restrictive alternative" 5

The extent to which SLP was or was not involved in addressing the situation of the individuals in institutions is beyond the scope of this review, but these data raise concerns regarding SLP's success in achieving its goals.[26]

Finding 7: SLP is not sufficiently mature or ready for review of its outcomes or of success in meeting the court-ordered goals.

Dr. Tim Moore is now the Clinical Director of SLP.[27] He rates compliance with EC 98 as "Incomplete" and projects a deadline of November 30, 2016, extended from the earlier August 31, 2014.[28] The Gap Report did not assert compliance or use its ambiguous phrase "meets criteria" for EC 98. Even in the midst of the Court Monitor review, SLP had not yet begun to consider how to assess its own outcome results.[29] As of this report, SLP's processes and staff responsibilities are not yet fully defined or operationalized.[30] As DHS reports, SLP continues to not be fully staffed.[31]

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admitted 7/11/14 and discharged 12/30/14.

[25] Additionally, there are 7 with unknown locations, and 5 deaths reported by DHS. April 27, 2016 email from Peg Booth re Requests #18 and 19.

[26] For example, the initial Phase 1 SLP assessments show: D.F. (AMRTC. Elderly father brought him to a hospital for help after D.F. missed medications; transferred to AMRTC); T.K. (MSH. "no plans for discharge; "Been here for 10 years;. Doesn't know what he needs to do to get discharged."); M.H. (MSH. "6 or 7 restraints since 2012"); R.F. (restraint and seclusion).

[27] Dr. Moore's title is now MN Life Bridge/CSS/SLP/Diversion Clinical Director. Dr Tim Moore Multiple Evaluations.xlsx.

[28] Dr Tim Moore Multiple Evaluations.xlsx.

[29] SLP Operational Meeting minutes 4/11/16 ("Requirements of Court Monitor's Review," "How do we capture outcome data? Are we getting closer to what the EC stated? Identify gaps. What are some improvements?")

[30] SLP Operational Meeting minutes: 9/14/15 (SLP Procedure; "final tweaks," "Final version to be forwarded" for number assignment and signature"); 8/31/15 (person centered planning; "still early in the process with the teams");

Finding 8: It is impossible to determine at this point whether or when the gaps and deficiencies will be addressed and overcome, or whether the late 2016 self-identified compliance deadline for the critical EC 98 will be met.

A high DHS official involved now and in 2015 in MLB/CSS/SLP management describes the 2015 period including the Gap Report as administrative "chaos." What another official called a "void" was created when top leadership left the organization (Anne Barry, Direct Care and Treatment, and Steve Jensen, MLB). During the chaos, DHS obtained at least two outside management consultation evaluations on what it considered to be a crisis.[32] The new Commissioner made changes. Then, an organizational restructuring occurred since the Court's Order of March 18, 2016. Under the April, 2016 re-organization, the Jensen/Olmstead Quality Assurance & Compliance Office (JOQAC), directed by Dr. Margaret Fletcher-Booth, was moved under the Chief Compliance Officer in the DHS General Counsel's Office.[33] The JOQAC for the first time now directly supervises the SLP. The move of SLP has created what an administrator calls "confusion."

Finding 9: SLP has insufficient authority to secure cooperation from others to further its court-ordered goals.

In a minority though significant number of cases, SLP has had longstanding difficulties obtaining cooperation from SLP members' teams, providers and county case managers.[34] This limits the SLP's effectiveness in

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9/28/15 (new position for board-certified behavior analyst, with old tasks deleted and new guidelines added)

[31] Gap Report at 65.

[32] *See* Tatzman report, at note 14 *supra*; and a separate crisis review by Management Analysis & Development, the state's fee-for-service consultation entity.

[33] April 2016 Organization Charts, Chief Compliance Officer and JOQAC.

[34] SLP Priority List Minutes 1/25/16 (B.C.: "Case Manager has not returned any of Katy's calls"); 10/5/15 ("LJ "Difficulty getting in to the door with this team. Team is concerned about HIPPA and about Jodi going to the home."); SLP Operational Meeting minutes 1/4/16 (case managers sometimes not responding re BIRF [behavior intervention] inquiries). When the SLP nurse followed up in January 2016 on her prior medical review recommendations, there were issues in 8 of the 25 cases in which response lack of response was found (6 "no response from the team;" 1 no response from psychiatrist, 1 "slow response from the team"). 4/19/16 email from Peg Booth, SLP Nurse

promoting improvements for its members. Additionally, although the CPA empowers DHS to act effectively with regard to obtain cooperation from counties and providers, the SLP sees itself as able merely to offer recommendations and assistance which counties and providers may freely reject.

Finding 10: The SLP "full assessment," which is key to a EC 98 goal, is many months behind schedule.

Phase 1 of SLP was an initial assessment and screening. Phase 2, now in progress, is required for "full assessment and recommendations" to "determine whether the Successful Life Project member is receiving services in the most integrated setting appropriate to meet that person's needs, and that the Successful Life Project member chooses."[35] DHS intended that, "The first full assessment period will begin in early 2015 and is expected to be completed by December 31, 2015."[36] The work is seriously behind schedule. The first full assessment was not completed until June 18, 2015. (The Gap Report inaccurately states that the second phase began March 16, 2015). Only 24 of these assessments have been completed, 15 of them in 2015 and the other 9 in 2016; only 10 had been completed by the end of the Gap Report period.[37]

Finding 11: The SLP nurse is an outstanding positive resource for SLP and does excellent thorough work; however, the medical needs of all SLP members are not being fully served by her alone (without additional nursing or similar medical staff).

SLP's medical resource is one nurse for 343 members. She performs thorough medical reviews (though often without seeing the person), makes typically detailed recommendations, and tracks team responses to the recommendations. She has identified needs which were not noted or addressed by the individuals' teams.[38] Her work is very organized,

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records, "Jan 2016 Follow-Up.

[35] DHS Bulletin #15-76-01, Successful Life Project at 4.

[36] DHS Bulletin #15-76-01, Successful Life Project at 5.

[37] Table, "Date PBS-SET Completed." April 27, 2016 response to Court Monitor Request #14.

[38] For example, C.Mc. (raising questions about nature and need for ECT C.Mc. was receiving 2 to 4 times per month); SF (recommendations regarding lab test results, need for assessment of a mouth lesion, vision screening, dental care, GI specialist consultation, and diabetes management); J.B.

comprehensive and well-documented for those she has reviewed.[39] Most SLP members, however, have not had a medical review done. The nurse's time is mostly spent keeping up with specific requests for reviews, rather than completing reviews for all the other SLP members. Her follow-up on the reviews sometimes does not take place until months afterward.[40] Some provider/case manager teams resist medical reviews; if the team says no, the SLP nurse stops her efforts.

Finding 12: SLP Behavior Analyst staff are the mainstays in the field for maintaining contact with SLP members, their case managers and provider teams. They do much able work, though they are stretched.

The files the analysts maintain demonstrate much activity and concern for the individuals they serve. It is also evident that these staff are stretched in their work. For example, SLP decided in August 2015 to require these staff to provide weekly email updates to the teams (contacts/updates were not as regular earlier). It was a challenge for SLP staff to meet this requirement; for many SLP members, they did not.[41] SLP continues to be understaffed, as DHS reports.

(among other issues, justification for more than two psychotropic medications from different therapeutic classes, follow up on increased heart rate, and medication side effect monitoring).

[39] *See Successful Life Project: Medical Review Guidelines* (Updated 4/17/15).

[40] For example, JK. (4 months later); E.G. (4 months). On P.M., on April 19, 2016, ten months after her medical review, the SLP Nurse Consultant informed the Court Monitor that SLP had not received any response to it from P.M.'s interdisciplinary team.

[41] For example, A.F. (8/10/15 promised weekly updates; no updates after 9/14/15 SLP email); BD (emails approximately every other week on average); C.McR. (emails one to four weeks apart from one another starting 7/27); M.D. (8/10 states "no update;" 8/18 states "no update;" then 3 updates in September); J.B. (weekly updates starting 8/17; 9/14: "not seen L in last couple of weeks" and 9/28 (same, and "no contact within this last week"); R.T. (first weekly update 8/3); J.Mc. (first weekly update 8/14); SS (first weekly update 9/14); P.M. (first weekly update 8/17); K.G. (first weekly update 7/28).

Some files also reflect great diligence in maintaining contact with SLP members and providers. *E.g.*, D.A. (during the covered time period, the provider was in "crisis mode (or near crisis mode) almost weekly;" 27 emails or on-site visits between 6/2 and 9/28); J.A. (emails almost weekly).

Finding 13: The Gap Report's statement regarding discovery of two previously unlocated people is not accurate.

The following statements in the Gap Report are not true. The Report states, '[d]uring this reporting period," two people "who were previously unable to be located, J.D. and T.W were found and that SLP "has contacted both those people and have completed their [Phase 1 initial] assessments."[42] After the Court Monitor requested documentation of this assertion, DHS disclosed that the Gap Report statements were not accurate.[43]

J.D. and T.W., though considered off the map by SLP, were never "unlocated." It is not true that during the Gap Report period these individuals were found and contacted, and their assessments completed . Both their Phase 1 assessments were completed in *2014*, J.D.'s on November 14, 2014 and T.W.'s on December 9, 2014.

- T.W. was living in Minneapolis, at an address known to SLP, with his grandfather and others, and was recovering from a gunshot wound; he had no case manager and no services. He was looking for program or support, for transportation, and wanted help finding his own place to live.

- J.D. had been living in and our of New Mexico for a number of years, homeless without a fixed address. He called SLP to do the assessment and informed SLP that he "Needs to find a Dr. in New Mexico" for his epilepsy. He reported he had "broke[n] out of Cambridge with a screwdriver made of paper clips" "unscrewing a window."

Finding 14: The Gap Report's other factual representations are generally accurate with several major exceptions.

DHS STATEMENTS IN GAP REPORT	Conclusion	Findings
"In May 2015, project staff made follow-up phone calls to the 15 people (or their legal representative) who declined to participate in	ACCURATE IN PART DATA RELIED	There is documentation that as of May 13, 2015, "The plan is to reach out to the list of individuals who we could not reach to schedule the

[42] Gap Report at 64.

[43] April 27, 2016 email from Peg Booth, re Request #12.

the initial assessment to encourage their participation. None of the people (or legal representatives) who declined to participate in the initial assessment during Phase I had changed their mind and consented to participate."	UPON NOT PROVIDED	assessments" and that the calls were to start that day. There is no documentation that the calls were made or of the results of the calls. (The Court Monitor had specifically requested the information on the calls).[44]
"The second phase of evaluations began March 16, 2015, with Successful Life Project continuing to focus on the priority list for scheduling contacts and assessments."	NOT ACCURATE INCOMPLETE & MISLEADING	The first full assessment was not completed until June 18, 2015 (not March 16, 2015). Only 10 were completed as of the end of the Gap Report period. *See also* Finding 10 at 12 *supra*.
[Summarizing lengthy topic in Gap Report: Discussion of report of 2014 rape, prosecution, follow up with prosecutor and providing "brief training on the Jensen Settlement Agreement," and on "who the Court Monitor is."]	VERIFIED AS ACCURATE INCOMPLETE & MISLEADING OCCURRED BEFORE GAP REPORT PERIOD	The compliance activities and follow-up occurred with regard to class member E.G., regarding whom DHS was reporting regularly under the April 8, 2015 *Court Monitor Recommendation to the Court Regarding Class Member E.G.,* Doc. No. 407. The DHS activities stated here were to prepare a report to the Court Monitor in response to his Report to the Court. In any event, all the activities took place in April 2015 before the Gap Report period.[45]

[44] April 29, 2016 email from Maggie Friend, re Request #15, attaching May 13, 2015 email from Cassandra Birkland to Elizabeth Bonnell and others.

[45] April 20 and 21, 2015 emails from Christina Baltes to Peg Booth and Anne Barry; DHS April 22, 2015 *Jensen Class Member Court Monitor Update*, April 22, 2015. in April 26, 2016 email from Peg Booth re Request #16.

Respectfully submitted,

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