Jensen Settlement Agreement Comprehensive Plan of Action (CPA)

August 2016 Semi-Annual Compliance Report

Reporting Period: October 1, 2015 – June 30, 2016

Minnesota Department of **Human Services**

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Introduction

This is the *Jensen* Settlement Agreement Comprehensive Plan of Action (CPA) – August 2016 Semi-Annual Compliance Report, created in response to the February 22, 2016 Order for Reporting on Settlement Agreement (Doc. No. 545). This report is based on data, documentation and information from October 1, 2015 through June 30, 2016, and addresses the following Evaluation Criteria (EC), as scheduled: EC 2, EC 3, EC 39, EC 41, EC 47, EC 48, EC 49, EC 50, EC 51, EC 52, EC 53, EC 64, EC 67, EC 68, EC 69, EC 70, EC 71, EC 72, EC 73, EC 74, EC 75, EC 76, EC 77, EC 78, EC 79, EC 93, EC 98 and EC 103. (*See* Doc. No. 545-1). This report also provides Exception Reports (beginning on page 65), for the following ECs: EC 56, EC 58, and EC 81.

Additionally, this report provides updates on topics that are not part of the Minnesota Department of Human Services' (the "Department") scheduled semi-annual reporting obligations. The Court, by Order dated June 21, 2016 (Doc. No. 578 at 5-7, 11), specifically requested some of these updates. Other updates are in follow-up to topics discussed in the Department's May 31, 2016 report to the Court (Doc. No. 572). These updates are in separate sections following the Department's regularly scheduled updates and exception reports. [See Responses to the Court's June 21, 2016 Order (Doc. No. 578) (beginning on page 72) and Updates to the Department's May 31, 2016 Report to the Court (Doc. No. 572) (beginning on page 77).]

The *Jensen/Olmstead* Quality Assurance and Compliance Office (JOQACO) developed this report from information submitted and verified by persons identified as being responsible for each EC. For each EC addressed in this report, the responsible party is identified by title.

JOQACO completed further verification and/or analysis of information submitted by the responsible party. This process is explained in more detail on pages 5-6 and throughout the report.

Background

The *Jensen* Settlement Agreement is the result of a lawsuit filed against the Department 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 ("JSA"; Doc. No. 104) allowed the Department and the plaintiffs to resolve the claims in a mutually agreeable manner. The Comprehensive Plan of Action ("CPA"; Doc. No. 283) outlines the actions the Department must take to comply with the terms of the JSA.

Jensen / Olmstead Quality Assurance and Compliance Office

As required by the CPA, the Department established the *Jensen* Implementation Office to manage and coordinate this plan.

On February 10, 2016, the *Jensen* Implementation Office moved from the Department's Community Supports Administration to the Department's Compliance Office and was renamed the *Jensen/Olmstead* Quality Assurance and Compliance Office (JOQACO).

JOQACO currently has four full-time professionals and one full-time support staff. The full-time professionals include a director, analyst, data analyst and the Internal Reviewer, who joined JOQACO on December 1, 2015. In January 2016, the JOQACO Office Manager retired from the Department. JOQACO submitted a request to fill this position with an attorney who would focus on compliance activities. In June 2016, the Department assigned an attorney, who is part of the Department's Compliance Office, to JOQACO.

The organizational and name changes for JOQACO have been accompanied by a shift in focus from implementation and coordination to quality assurance and compliance monitoring and measurement. Consistent with this new focus, JOQACO is developing enhanced verification protocols, expanding Internal Reviewer responsibilities, and managing the Master Contracts for the Independent Subject Matter Experts. For additional details on Independent Subject Matter Experts, see page 10.

On January 28, 2016, JOQACO initiated regular meetings with Department staff; JOQACO has extended invitations to these meetings to the Consultants for the *Jensen* Settlement Agreement, Roberta Opheim and Dr. Colleen Wieck. The purpose of these meetings is to review and discuss quality improvement activities and concerns relating to compliance with the *Jensen* Settlement Agreement Comprehensive Plan of Action Evaluation Criteria

JOQACO Compliance Verification Process

Consistent with JOQACO's shift in focus to quality assurance and compliance monitoring and measurement, JOQACO developed and is initiating testing of a multi-approach process for verifying information submitted to JOQACO and used in the Department's reports to the Court. This process will involve a variety of compliance verification activities, including on-site verification reviews by JOQACO to supplement and monitor the verification efforts of the program. The goal of these efforts is to ensure that the Department's quality assurance and compliance efforts, with respect to the JSA and CPA, are informed by information that is accurate, complete, and timely. This will ultimately help the Department further improve the services it provides to persons with developmental disabilities.

In developing this process, JOQACO sought to incorporate elements of the Olmstead Subcabinet's verification approach, as well as the suggestions of the Consultants. In late June 2016, JOQACO met with Dr. Wieck and Ms. Opheim to discuss desirable attributes of a verification process for CPA reporting. In July 2016, based on this discussion and elements of the Olmstead Subcabinet verification process, JOQACO developed a draft process document. JOQACO sought the feedback of Dr. Wieck and incorporated her comments into the process document. JOQACO will initiate a trial

demonstration of the process in August 2016 to assess the feasibility and effectiveness of the process and to test the clarity of the written document.

The verification process JOQACO developed and will be testing for reports to the Court uses three primary approaches: monthly or bi-monthly compliance updates to JOQACO for active ECs; program area verification of the information provided to JOQACO; and JOQACO on-site verification reviews. JOQACO will begin a trial demonstration of this process, which is described in more detail below, in August 2016.

JOQACO began to implement enhanced verification activities, including on-site verification reviews and document reviews for selected ECs, in preparation for this report. These activities are summarized in the status updates for the relevant ECs and will inform JOQACO's efforts to test and refine the compliance verification process over the coming months. As the Court directed in the June 21, 2016 Order (Doc. No. 578 at 7), the Department will be prepared to update the court on the status of the *Jensen* compliance verification process at the December 2016 Biannual Status Conference.

Compliance Updates:

Receiving monthly or bi-monthly compliance updates (frequency depending on the EC) will allow JOQACO to, at any given time, have an up-to-date understanding of the current status of each active EC and to more readily identify problematic trends or barriers to compliance. The following is an outline of the process by which the program areas will submit, and by which JOQACO will track and review, regular updates regarding the status of each active EC:

Submission of Compliance Updates by Program Areas:

1. A "responsible party" is assigned to each of the active CPA ECs.
2. JOQACO will establish a reporting schedule and a template for each compliance update.
3. Based on the monthly and bi-monthly reporting schedule and using the compliance update template, the responsible party will provide JOQACO with information and data from the previous one or two months regarding the current status of each assigned EC.
4. For each compliance update, the responsible party must also include an explanation of how the program area verified the information and data provided to JOQACO was accurate, complete and timely.
5. For ECs that require monthly compliance updates,[1] the responsible party will also be required to submit documentation that supports/corroborates the information and data reported in the compliance update. If an EC involves a large dataset or activities that program areas track in a

[1] As of July 2016, JOQACO requires monthly updates for the following ECs: EC 38, EC 47, EC 48, EC 50, EC 52, EC 54, EC 56, EC 58, EC 67, EC 68, EC 69, EC 71, EC 73, EC 93, and EC 98. Compliance updates for all other active ECs must be provided on a bi-monthly basis.

database, the responsible party will meet the supporting documentation requirement by submitting a data summary on a spreadsheet or similar document listing the relevant events, services provided, or people served, etc.[2] JOQACO may request additional documentation for a random sample of these events/services/persons.

6. Data and information reported in the regular compliance updates will, after verification by JOQACO (see below), be used to report on the relevant ECs in the semi-annual, annual, or exception reports to the Court.

Receipt and Review of Compliance Updates by JOQACO:

1. JOQACO will track receipt of scheduled compliance updates and contact the responsible party if JOQACO does not receive a scheduled update.
2. JOQACO will review each compliance update to determine whether the information submitted fully addresses the current status of that EC, whether reported verification efforts are consistent with the program area's protocol, whether required documentation was submitted, and whether required documentation confirms that the statements and information in the compliance update are accurate, complete, and timely.
3. JOQACO will document these review efforts, any concerns identified through these review efforts, and any follow-up undertaken to address identified concerns. (See the Verification Analysis section below.)

Program Area Internal Verification Reviews:

Program areas responsible for implementing the requirements of the CPA and providing updates on the current status of ECs will verify that information submitted to JOQACO is accurate, complete, and timely. Each program area must have a process, in writing and approved by JOQACO. The process must include the following components:

1. Parameters on what data/information will be gathered and when.
2. That the responsible party or their designee does program area reviews of the gathered data/information for accuracy and completeness.
3. That databases are, according to an established schedule, routinely reconciled with other sources of information (e.g., case notes).
4. That any errors or concerns identified for information maintained by the program area are documented and resolved. The compliance update submitted to JOQACO will include a description of these identified errors or concerns and how they were resolved.
5. That prior to submission to JOQACO, the responsible party or designee reviews and authorizes each compliance update. By submitting the update to JOQACO, the responsible

[2] ECs likely to fall into this category include the following: EC 38, EC 56, EC 58, EC 67-69, EC 71, EC 73, EC 83, EC 93, and EC 98.

party is attesting that the information and statements in the update have been verified as accurate, complete, and timely.

JOQACO On-Site Verification Reviews:
JOQACO will, on a semi-annual basis (corresponding to the reporting schedule), conduct on-site verification reviews for selected ECs. JOQACO will not inform program areas in advance which ECs JOQACO will review. This process will assess whether the information reported to JOQACO for the selected ECs is accurate, complete, and timely; whether the program area followed its own verification process in reporting; and, most importantly, whether there are opportunities for the program area to improve the quality of the services it provides and better ensure consistency with the requirements of the CPA.

The following describes the process for planning, implementing, and analyzing the results of JOQACO's on-site verification reviews:

Verification Plan:
Prior to conducting the verification reviews, JOQACO will prepare a Verification Plan. The Verification Plan will:

1. List the specific ECs to be reviewed and information that will be verified (scope).[3]
2. Identify any limits or constraints of the Verification Plan (cost, time, personnel).[4]
3. Identify how verification will be completed—on-site inspection of records or data, interviews, observation or other forms of testing, etc.
4. Define the sample size to be drawn. Sample size may be related to #2-- limits of time, cost, and personnel.
5. Identify the expected results. Depending on the nature of the EC and the data being reviewed, expected results might be based on benchmarks/requirements stated in the CPA, information reported by the program area, or previous reports.
6. Prepare a schedule or timeline.

Implementation of Verification Plan:
When performing verification reviews, JOQACO will complete the following tasks:

1. Conduct the verification according to the plan.

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[3] JOQACO's selection of the ECs to be included in each semi-annual review will be based on multiple considerations. These considerations include, but are not limited to, distribution of selected ECs across program areas and topics; the importance of the EC to the quality of life of people; discrepancies or concerns identified in the monthly/bi-monthly compliance updates or previous verification reviews; and significant staffing or policy changes in the relevant program area.

[4] If an EC selected for the semi-annual verification review involves a large dataset, JOQACO may conduct the verification review by random sampling.

2. During on-site visits, collect or view relevant documentation and speak with staff or clients, as appropriate and as consistent with Department policy. JOQACO may also follow up with lead agencies, case managers, or other external entities, as appropriate.
3. Document who was in attendance, how the verification was conducted, sample size, when the verification occurred (day, start time and end time), and where the verification occurred (physical location).
4. Capture and record the results.

Verification Analysis

JOQACO will analyze the results of the verification review to determine the status of the review and identify opportunities for improvement relating to the quality of services provided and consistency with the requirements of the JSA and CPA and relating to the accuracy, completeness, and timeliness of information submitted to JOQACO.

1. JOQACO will complete an analysis of the results of the verification spot-check reviews. JOQACO will compare obtained results to the expected results and to the requirements of the JSA and CPA.
2. JOQACO will document its compliance verification efforts, including the ECs JOQACO reviewed and any opportunities for improvement identified by JOQACO's verification reviews (or by the compliance update reviews). Opportunities for improvement may relate to the quality of services provided and consistency with the requirements of the JSA and CPA. Opportunities for improvement may also relate to the program area's submission of information to JOQACO regarding compliance with the JSA and CPA including, but not limited to, discrepancies in the information/data submitted, inadequacy of documentation, inadequacy of verification efforts, failure to fully report on the status of an EC or provide information requested by JOQACO, and untimeliness of submissions.
3. JOQACO will present opportunities for improvement identified in JOQACO's verification reviews to agency leadership as needed to address patterns of noncompliance, barriers to compliance, or a program area's failure/refusal to address identified opportunities for improvement. As appropriate, JOQACO will refer compliance concerns to the Internal Reviewer, the Department's Quality Assurance Leadership Team, Independent Subject Matter Experts, and/or the internal audits team
4. JOQACO will provide each program area with its verification review documentation and will specify a reasonable period of time for addressing any identified opportunity for improvement.

If JOQACO identifies opportunities for performance improvement through this verification process, JOQACO will charge the person responsible for the relevant EC with ensuring the program area develops a performance improvement plan. The responsible party will report to JOQACO on the steps taken under this performance improvement plan and JOQACO will verify the results.

Independent Subject Matter Experts

On February 1, 2016, the Department posted in SWIFT[5] the Request for Proposals (RFP) for qualified contractors to serve as Independent Subject Matter Experts (SMEs). These SMEs are to assist the Department in bringing significant improvements to the care and treatment of persons with developmental disabilities, as outlined in the JSA, through a master contract program. The RFP required that these vendors have a minimum of five years' experience in one or more specified Specialty Service Areas:

- Persons with Intellectual and Developmental Disabilities (IDD)[6], complex needs, or challenging behaviors
- Pharmacological reviews of medication regimens of persons with IDD with complex medical needs or challenging behaviors
- Positive behavior practices and
- Qualitative and quantitative research design.

In response to the RFP, the Department received proposals for one or more of the identified specialty service areas from 12 vendors. The RFP Evaluation team evaluated proposals according to the evaluation methodology identified in the RFP. The RFP Evaluation Team included Dr. Wieck and Ms. Opheim, JOQACO, and other Department professional staff selected based on areas of expertise. The evaluation team identified eight vendors to serve as SMEs in one or more specialty areas. The Department sent out contracts for these eight vendors on June 9, 2016, and the Department received back all signed contracts by the end of the reporting period (June 30, 2016).[7]

JOQACO will manage the master contracts with the SMEs. As the Department has noted in communication with the Court, identification of the need for SME review can generate from internal or external sources:

- A SME review can be triggered internally by request of the Commissioner, Compliance Office, Department-wide Quality Assurance Leadership Team (QALT), Internal Reviewer, and JOQACO. Internal requests for a SME review should be submitted to and approved by the Quality Assurance Leadership Team (QALT). Once the QALT has approved a request for a SME, JOQACO will identify and contact contracted vendors in the appropriate Specialty Service Area to determine availability.

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[5] SWIFT (Statewide Integrated Financial Tools) is the online financial, procurement, and reporting system used by the state of Minnesota.

[6] The term Intellectual and Developmental Disabilities (IDD) was used in the RFP because it is a term that is used by other states.

[7] On July 18, 2016, the Department fully executed all Independent Subject Matter Expert Master Contracts with the eight selected vendors.

- External parties, including Plaintiffs' Class Counsel, the Consultants, and the External Reviewer, can also initiate a SME review. External requests for a SME review should be submitted directly to JOQACO. JOQACO will identify and contact pre-approved vendors in the appropriate Specialty Service Area to determine availability.

The Department will follow the following process for SME reviews:

- The SME assigned to a request for review will be expected to provide JOQACO with a timely written report and documentation of recommendations. The Department will have ten days to respond to SME initial reports.
- The SME may also be asked to meet with *Jensen* Class Members and staff and/or provide oral reports.
- The SME will submit a final report to JOQACO within ten days after receipt of the Department's response, or within ten days of submission of the initial report, if the Department does not make a response.
- JOQACO will share final reports with Plaintiffs' Class Counsel, the Consultants, and the QALT for development of action plans and oversight of resolution of any negative findings.

Agency-wide Quality Assurance Leadership Team (QALT)

In 2015, the Department drafted a Performance Management and Quality Improvement Framework for People with Disabilities to establish a Department-wide structure to monitor the quality of programs and services provided to people with disabilities. On January 20, 2016, the Commissioner approved the Final Plan for the Performance Management and Quality Improvement Framework for People with Disabilities.

The Department held the first meeting of the agency-wide Quality Assurance Leadership Team (QALT), on January 27, 2016.[8] The Deputy Commissioner of the Central Office oversees the work of the QALT, which utilizes continuous improvement resources to identify opportunities for improvement, facilitate development of work plans, and track progress in the provision of services to people with disabilities. The following are examples of activities of the QALT that have touched on the JSA and CPA:

MSH Client Discharge: In February 2016, the QALT asked Department staff to review the situation that led to a person, who was committed solely as a person with a developmental disability, to remain at the Minnesota Security Hospital (MSH) for an extended period. In April 2016, the QALT reviewed an analysis of data relating to the timing of discharge and provisional discharge and a report of initial findings. At this meeting, the QALT discussed the role of the Department's Housing Supports

[8]The membership of the QALT was listed in the Ninth Compliance Update Report (Doc. No. 531 at 6-7).

Division in assisting the transition of this person and other current or future clients' transition out of MSH. The group also highlighted the importance of counties in successfully transitioning a person with developmental disabilities out of MSH. Direct Care and Treatment staff presented information on the importance of housing, and staff availability and flexibility, to help persons transition out of MSH. QALT has scheduled follow-up to discuss what the Department could do to help current and future clients transition out of MSH more quickly as well as prevent persons committed solely as a person with a developmental disability from admission to MSH.

Single Point of Entry: In June 2016, the QALT asked Department staff to review the Internal Reviewer's recommendations to improve the Single Point of Entry Project and to develop an implementation plan for these changes. The QALT established a work group that will follow up on this project in future meetings.

Standardization of Training: The Internal Reviewer submitted a proposal to the QALT at the July 20, 2016, meeting regarding the feasibility of standardizing training across Department divisions. The Internal Reviewer presented the recommendation from the Court regarding standardization of training (*see* Doc. No. 551 at 11), and the QALT agreed to consult in a review of training across the agency to consider opportunities for standardization. The QALT asked Department divisions to submit information on whether they provide training in any of the areas identified in the CPA. This information will be presented at the September QALT meeting. A subcommittee of the QALT involving relevant division representatives will then explore opportunities for standardization and report back to the QALT.

Minnesota's Olmstead Work Plans

In sections of the Ninth Compliance Update Report (Doc. No. 531), the Department noted that some Olmstead work plan objectives address challenges related to community capacity in the context of transition planning, developing appropriate supports, assisting Facility residents towards more integrated community settings, and facilitating transfers out of MSH and Anoka Metro Regional Treatment Center. (Doc. No. 531 at 34-35, 38, 55, 57). Below is a list of examples of progress made during the reporting period in the areas of the Olmstead work plans that most closely touch on these themes—namely, Person-centered Planning, Transition Services, and Housing and Services.[9]

Person-Centered Planning and Transition Services

- Disability Services Division developed the Person-Centered, Informed Choice and Transition Protocol; all lead agency support planners are required to follow this protocol. This process is

[9] It should be noted that the relevant criteria in the CPA focus on a narrow aspect of these themes—outcomes for specific groups of persons with developmental disabilities—while the Olmstead work plans address each theme across a wider population.

designed to support people having and understanding real options in where and how they live so they can exercise informed choice.
- DHS has issued various communications and tools, provided training and mentorship in person-centered practices in a number of formats and venues.
- The Department and the Minnesota Department of Education have worked with the University of Minnesota's Institute for Community Integration to develop a plan for building a training and technical assistance infrastructure that will support person-centered practices.
- Disability Services Division established a new requirement for MnCHOICES[10] assessors to complete training in person-centered approaches.

Housing and Services
- The Department implemented the 2015 legislative changes to the Group Residential Housing (GRH) program to increase choice and access to individualized housing and supports, including communications and training.
- The Department increased access to information about integrated housing options for persons with disabilities using improved web-based approaches.
- The Department hosted "Housing Best Practices" forums for planners and other professionals to provide tools and build skills in developing individualized housing solutions.
- The Department utilized new Section 811 Project Rental Assistance funding.

More information is available on these activities in the reports to the Court on the Olmstead Plan.

[10] MnCHOICES is a person-centered assessment to help people with long-term or chronic care needs make care decisions, and select support and service options.

Evaluation Criteria State of Completion (Scheduled for Semi-Annual Reporting)

Settlement Agreement Section IV. METO Closure

Evaluation Criteria 2:

Facilities utilize person-centered planning principles and positive behavioral supports consistent with applicable best practices including, but not limited to the Association of Positive Behavior Supports, Standards of Practice for Positive Behavior Supports

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

The Facility incorporates use of person-centered planning principles and positive behavioral supports consistent with applicable best practices throughout their process, which begins with the Person-Centered Description. All eight persons served at MLB treatment homes[11] during the reporting period engaged with their team and/or the MLB Person Centered Planning Facilitator to contribute to the greatest extent possible to their Person-Centered Description. All persons participated in Picture of a Life, PATH, or MAPS[12] to develop their Person-Centered Plan, which directly informed their Positive Behavior Support Plan. Persons worked collaboratively with the Person Centered Planning Facilitator to create their vision for their future based on what is important to them and important for them. This information guides the development of action steps towards achieving the person's vision.

The Person-Centered Plans of MLB treatment home residents are updated on a monthly basis. MLB staff have developed a method of color-coding revisions and additions to the plan to make it easier to identify who made updates and when. The person and their team contribute to updates during monthly team meetings. Once MLB staff compile information from the team and person into the Person Centered Description-Picture of a Life document, MLB initiates the process of updating the Coordinated Services and Support Plan Addendum (CSSP-A), the Positive Behavior Support Plan, and support outcomes, consistent with Actions 2.3-2.6 and 2.8-2.9.

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[11] MLB treatment homes include Stratton Lake, Brobergs Lake and the two Eagle Pointe facilities. The term "treatment home" comes from the CPA. (*See* Doc. No. 283 at 2, 29.)

[12] Picture of a Life, PATH (Planning Alternative Tomorrows with Hope), and MAPS (Making Action Plans) are three processes that are commonly used for creating person-centered plans. These tools can be used to help the person think about what is important in their lives now and to think about what would make a good future.

During this reporting period, seven of the eight persons served in a MLB treatment home had a Positive Behavior Support Plan in place. As of the end of the reporting period, MLB had not yet developed a Positive Behavior Support Plan for C2, who was admitted on June 10, 2016, as C2 had not engaged in any challenging behaviors since admission. Upon the Internal Reviewer and JOQACO's review, it was recommended that a Positive Behavior Support Plan be developed for C2. MLB is to have the Positive Behavior Support Plan for C2 in place no later than September 15, 2016.

Two people served in a MLB Treatment Home during the reporting period (T1 and J2) met the criteria for a Positive Support Transition Plan (PSTP), outlined in Minn. Stat. § 245D.02, subd. 23b, and the Positive Supports Rule, Minn. R. 9544.0070, subp. 3, and have PTSPs.

As of this reporting period, seven of the eight persons served in a MLB treatment home has had, consistent with Action 2.6, a Functional Behavior Assessment completed that provides information regarding history and life experiences, the difficulties and problems the person has or currently is experiencing, past strategies, and results of support planning, and that has the content outlined in Action 2.7. The Functional Behavior Assessment informs the person's Positive Behavior Support Plan.

As an example, during this reporting period, J2 and J2's team[13] created a MAPS that included the following information: gifts, J2's dream for the future, where J2 would like to live, J2's preferences for family involvement, whether J2 would like a pet, and what J2 would like to explore for work. Target behaviors identified in J2's Functional Behavior Assessment and Positive Behavior Support Plan include physical and verbal aggression, property abuse, self-injurious behavior and elopement. Specific information from the Functional Behavior Assessment and Person-Centered Plan that was used in the development of J2's Positive Behavior Support Plan included the following: characteristics of people that work best with J2; the importance of having a daily plan in place and one that J2 can develop with staff; specific triggers, including issues with food and staff attention; shift transition; and the importance of talking with J2's parents.

To better prepare a person's team for MLB's utilization of person-centered planning and positive behavior supports, MLB management and clinical leads developed a Referral Response letter that MLB sends to the person making the referral, which provides additional details regarding roles and responsibilities, the transition planning process, person-centered planning, and positive behavior supports. If MLB admits a referred person, MLB staff also review the Referral Response letter at the admission meeting and again at the 10-day planning meeting.

[13] J2's team included J2, a representative from a provider, J2's father, and J2's case manager.

Verification

The responsible party verified information submitted to JOQACO for EC 2 through review of individual Person-Centered Descriptions and Transition Summaries and Plans. The responsible party also identified sections of the Transition Summary and Plan that were not complete for certain residents.

At the Cambridge Administrative Office for MLB, JOQACO staff reviewed the Transition Plans and Person-Centered Plans for S2 (Brobergs Lake), J1 (Brobergs Lake), G1 (Stratton Lake), and J2 (Stratton Lake) for the following elements: frequency of plan updates; ability to determine whether and when MLB made updates; actions taken and barriers to transition. JOQACO also conducted follow-up interviews with staff at Brobergs Lake and Stratton Lake. For the plans reviewed, JOQACO found that:

- Information regarding what is important to the person is well documented in the Transition Plans.
- With the exception of J2's Person-Centered Plan, MLB staff color-coded updates to the Person-Centered Plans, making it easier to identify what updates were made and when.
- MLB staff updated the four Transition Plans reviewed on a monthly basis.

JOQACO also identified opportunities for performance improvement including clearer documentation of the Transition Plan regarding options that have been pursued and the identification of outcomes and any barriers.

JOQACO followed up, in writing, with MLB on August 25, 2016, to request an Action Plan by September 15, 2016, that (1) details the steps MLB will take to complete the missing parts of residents Transition Summaries and Plans and to ensure, on an ongoing basis, that all Transition Summaries and Plans are complete; and (2) addresses the identified opportunities for performance review regarding documentation of options pursued as well identification of outcomes and barriers.

JOQACO also reviewed the Referral Response letter referenced above.

Evaluation Criteria 3:

Facilities serve only "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety."

Responsible Party: Minnesota Life Bridge Manager

Current Status

The admission criteria for MLB to serve only *"Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety,"* became MLB's policy and practice in late 2013. During this reporting period, there were 24 referrals to MLB. To determine if a person referred to

MLB meets the first criterion for admission—being a person with a developmental disability—the MLB Admissions Team[14] reviews the Central Pre-Admission Referral document, available diagnostic and other professional assessments[15], as well as service plans.[16] The specific information reviewed by MLB in determining whether the first criterion is met depends on what documentation the referral source submits with the MLB referral or what information is available to MLB.[17]

The person's history, legal documents, PSTP, and Individual Service Plan are typical documents the MLB Admissions Team reviews to verify whether a person meets the second criterion for admission - exhibiting severe behaviors that present a risk to public safety. MLB's admission criteria is not met if the person has behavior that is injurious to oneself but not to others. Behaviors that could put others at risk, such as physical aggression or assault, fire setting, significant property destruction causing high safety risk, use of weapons or objects as weapons, auto theft, sexual behavior which poses a safety risk to others, etc., are examples that may meet MLB's admission criteria.

MLB determined that all 24 people referred during this reporting period met the admission criteria for MLB services. Three (G1, T1, and J2) of the 24 referrals resulted in an admission to a MLB site. Two of these admissions (G1 and T1) are *Jensen* Class Members. During this reporting period, MLB also admitted one person (C2) subject to the "48-hour law."[18] C2 met the admission criteria for MLB because C2 has been diagnosed and committed as a person with a developmental disability and has exhibited behavior that poses a risk to public safety.

See Table 1 below for the status of the 24 referrals to MLB during this reporting period.

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[14] The MLB Admissions Team minimally includes the MLB Manager, Clinical Coordinator, and Transition Coordinator.

[15] Assessments reviewed might include psychiatric assessments, psychological or neuropsychological assessments, psychosocial or social history assessments, functional behavior assessments, etc.

[16] Service plans reviewed might include Coordinated Service and Support Plan or Individual Service Plan, Individual Abuse Prevention Plan, Individualized Education Program, and Person-Centered Description or Person-Centered Plan.

[17] MLB may need to ask for further supporting information or clarifying information if key documents are not included.

[18] Minn. Stat. § 253B.10, subd. 1(b).

Table 1: MLB Referral Outcomes

Month/Year	No of Referrals	Referral Outcomes
Oct 2015	3	1. Readmitted to MLB (G1) 2. Admitted to TBI Residential and Community Services in Duluth 3. Admitted to Northland Adult Foster Care
Nov 2015	0	No referrals
Dec 2015	4	1. Admitted to MLB (T1) 2. Admitted to a Divine Crisis Home 3. Admitted to Pine City Crisis (MSOCS); Bridges identified as the long-term provider. 4. Admitted to TBI Residential and Community Services in Duluth
Jan 2016	1	Person at Regions Hospital; Pinnacle is the identified provider[19]
Feb 2016	5	1. Admitted to a Divine Crisis Home 2. Admitted to Artesian Homes 3. Admitted to Mount Olivet Rolling Acres; Bridges program identified as the long-term provider 4. Admitted to Dungarvin 5. Released from jail and living with friends in the community; no longer receives Rule 185 services
March 2016	3	1. Admitted to MLB (J2) 2. Admitted to Anoka Metro Regional Treatment Center (pursuant to 48-hour law); Genesis has been identified as the long-term provider 3. Admitted to Genesis Group Homes
April 2016	0	No referrals
May 2016	4	1. In jail; REM identified as the long term provider[20] 2. Admitted to Mount Olivet Rolling Acres 3. Admitted to Hope Residence 4. In Mercy Hospital [21]
June 2016	4	1. Admitted to Pine City Crisis (MSOCS) 2. In Fairview Hospital; to be admitted to Opal Services 3. Admitted to Hillcrest (MSOCS) 4. County worked with provider (Community Living Options) and services not terminated

[19] Pinnacle has made an offer on a home in Golden Valley, which was accepted. Pinnacle is going through the inspection/appraisal process. It will be two to four months before the home is ready. Regions Hospital is advocating for discharge. Person was added to the crisis priority list for a crisis bed.

[20] Person admitted to CBS/CSS Crisis Home (Region 10) on July 27, 2016 from jail and will transition to REM after August 1, 2016.

[21] Person continues at hospital. The county case manager advised they cannot return to their apartment but the provider has not terminated services. Person added to crisis priority list on July 14, 2016.

MLB staff also provided diversion support for two people who were not formally referred to MLB:

- **October 2015:** Competency Restoration Training provided to the county case manager and the person was able to remain with provider
- **April 2016:** Competency Restoration Training provided to the county case manager and the person is residing at a halfway house.

To ensure that the Department continues to apply the admission criteria stated in EC 3, the MLB Admissions Coordinator will continue to review all referrals and applications to MLB to identify potential admissions as Minnesotans who have developmental disabilities and exhibit severe behaviors that present a risk to public safety. The MLB Admissions Coordinator and the MLB Information Coordinator maintain current data on MLB referrals, admissions, and transitions.

MLB staff work with the Disability Services Division Case Manager Policy Lead to help county case managers gain a better understanding of their responsibilities as part of transition planning, and of the resources available within the Disability Services Division to address funding barriers such as the process for requesting a rate exception, if needed.

Verification

The Department maintains and tracks data on MLB referrals, admissions, and transitions in the CareManager system and/or in the Weekly Diversion Meeting notes. JOQACO reviews Weekly Diversion Meeting notes prior to their dissemination to Plaintiffs' Class Counsel and the Consultants. JOQACO verified the data on referrals to MLB by crosschecking this information against the Weekly Diversion Meeting notes as well as through contacts with the MLB Transition Coordinator, MLB Information Coordinator, and Community-Based Services/Minnesota State Operated Community Services Admissions.

Settlement Agreement Section VII.B. Restraint Review – Internal Reviewer

Evaluation Criteria 39

In consultation with the Court Monitor during the duration of the Court's jurisdiction, DHS designates one employee as Internal Reviewer whose duties include a focus on monitoring the use of, and on elimination of restraints.

Responsible Party: *Jensen/Olmstead* Quality Assurance and Compliance Office Director

Current Status

On December 1, 2015, the Department hired the new Internal Reviewer, Dr. Daniel J. Baker. Consistent with EC 39, the Internal Reviewer's duties, described in more detail below, include a focus on monitoring the use and elimination of restraints at the Facility. The Internal Reviewer also monitors and follows up on the use of PRN medication at the request of the client, and 911 calls at the Facility.

Following each incident of emergency use of manual restraint (EUMR), a 911 call, or use of PRNs at the request of the client, MLB prepares a set of recommendations to provide improved positive supports to reduce the risk of recurrence of the challenging behavior that led to the incident. MLB sends the Internal Review form, which includes this set of recommendations, to the Internal Reviewer who verifies that the strategies identified by MLB are consistent with best practices and are likely to be effective. The Internal Reviewer provides feedback to MLB as appropriate and monitors MLB's progress toward completing these recommendations.

Upon arrival at the Department, the new Internal Reviewer established a weekly call with the MLB Clinical Coordinator, the MLB Information Coordinator, and MLB Community Residential Supervisors and Behavior Analysts. During each of these calls, MLB's efforts to complete the recommendations developed in response to incidents of EUMR, 911 calls, or use of PRNs at the request of the client are reviewed and progress toward reducing the risk of recurrence is discussed. The Internal Reviewer instituted this call to verify that MLB was making steady progress toward completing the recommendations and preventing future incidents. The Internal Reviewer also utilizes this call as an opportunity to provide ongoing guidance in the improvements of positive supports and to act as a source of information and referral. The Internal Reviewer reports progress and efforts to respond to the incidents monthly in the Internal Reviewer Monthly Report. The MLB Information Coordinator facilitates the weekly calls and maintains a spreadsheet, updated weekly, which the Internal Reviewer provides as an attachment to the Internal Reviewer Monthly Report.

During this reporting period, MLB reported 38 incidents that included PRNs at the request of the client, 911 calls, and/or EUMR. MLB uses DHS 3654 Form to report these incidents. Table 2 below presents a summary of these incidents.

Table 2: Monthly Summary of DHS 3654 Forms Completed

Month	Location	PRN	911 Call	PRN & 911 Call	EUMR	EUMR & 911 Call
October 2015	East Central	1				
	Stratton Lake	1				
	Brobergs Lake	1				
November 2015	East Central	1				
	Brobergs Lake		1	1		
December 2015	East Central		1			
	Stratton Lake	1				
	Brobergs Lake	1				
January 2016	East Central		1			
	Stratton Lake	1				
	Brobergs Lake	1	2	1		
February 2016	Stratton Lake	1				
	Brobergs Lake		1			
	Eagle Pointe				1	
March 2016	Stratton Lake	2	1			
	Eagle Pointe		1		1	1
April 2016	East Central		1			
	Stratton Lake					1
	Brobergs Lake					
	Eagle Pointe		1			1
May 2016	East Central		3			
	Stratton Lake	1				
	Brobergs Lake					
	Eagle Pointe		1			
June 2016	East Central		2			
	Brobergs Lake					
	Eagle Pointe	1			1	1
	TOTALS	**13**	**16**	**2**	**3**	**4**

Table 3 below provides additional information regarding 911 calls identified in DHS 3654 forms and Incident Reports, including the reason 911 was called.[22] See also page 72 for the Internal Reviewer's Update on the Prevalence and Justification for 911 Calls at the Facility and 911 Call Analysis.

[22] Table 3 includes three 911 calls initiated by the individual which are not reflected in Table 2 because calls initiated by the individual are not reported on DHS 3654 Forms.

Table 3: 911 Call Summary

Incident Date	Person	Location	Reason(s) 911 Called
11/20/15	**J1**	Brobergs Lake	Physical aggression between housemates
11/20/15	**S2**	Brobergs Lake	Physical aggression between housemates
12/6/15	**W2**	East Central	Elopement; W2 located by police
1/2/16	**S2**	Brobergs Lake	Physical and verbal aggression; suicide ideation (two 911 calls made)
1/4/16	**J1**	Brobergs Lake	Attempted elopement
1/17/16	**S2**	Brobergs Lake	Property damage; verbal threats
1/19/16	**W2**	East Central	W2 feeling unsafe and wanting to hurt self, taken to hospital and admitted
2/14/16	**J1**	Brobergs Lake	Verbal threats; elopement
3/1/16	**G1**	Stratton Lake	Property damage, G1 requested to go to hospital, taken to hospital and admitted
3/1/16	**T1**	Eagle Pointe	Physical aggression
3/26/16	**T1**	Eagle Pointe	Physical aggression; EUMR; taken to hospital
4/5/16	**W2**	East Central	Self-injury; feeling unsafe; admitted to hospital
4/5/16	**S2**	Brobergs Lake	**Individual initiated 911 call (Incident Report)**
4/5/16	**J2**	Stratton Lake	Physical aggression; multiple EUMRs; taken to hospital
4/22/16	**H2**	East Central	Verbal aggression; elopement
4/23/16	**T1**	Eagle Pointe	Threatening staff; police talked with T1
5/1/16	**H2**	East Central	Elopement to friend's house; police talked with H2, returned home
5/08/16	**W2**	East Central	Elopement; W2 requested staff to bring to hospital
5/14/16	**W2**	East Central	Elopement; W2 located by police; taken to hospital for possible ingestion of pills
5/30/16	**S2**	Brobergs Lake	**Individual initiated 911 call (Incident Report)**
5/30/16	**T1**	Eagle Pointe	Attempted to leave moving vehicle; taken to hospital
6/4/16	**Y2**	East Central	Elopement; Y2 located by police
6/15/16	**S2**	Brobergs Lake	**Individual initiated 911 call (Incident Report)**
6/21/16	**H2**	East Central	Verbal and physical aggression; property damage
6/21/16	**T1**	Eagle Pointe	Physical aggression; EUMR; taken to hospital

Verification

As part of the JOQACO internal quality assurance and verification processes, JOQACO developed a database to track all Incident Reports, Behavior Intervention Reporting Forms (BIRFs) and follow-up actions for persons served at MLB and members of the therapeutic follow-up group receiving services at a state-operated facility. This database has been in place since early 2016. JOQACO compares MLB incidents tracked in its database against the incident database maintained by MLB and the incident reports themselves.

JOQACO also maintains copies of the Internal Reviewer's Monthly Reports, which document the Internal Reviewer's activities regarding follow-up to incidents. JOQACO reconciled the data reported in this section with the Incident Reports/BIRFs, information in JOQACO's database, and the Internal Reviewer's Monthly Reports.

Evaluation Criteria 41

The Internal Reviewer will consult with staff present and directly involved with each restraint to address: 1) Why/how de-escalation strategies and less restrictive interventions failed to abate the threat of harm; 2) What additional behavioral support strategies may assist the individual; 3) Systemic and individual issues raised by the use of restraint; and 4) the Internal Reviewer will also review Olmstead or other issues arising from or related to, admissions, discharges and other separations from the facility

Responsible Party: *Jensen/Olmstead* Quality Assurance and Compliance Office Director

Current Status

EC 41 directs the Internal Reviewer to consult with staff involved with incidents of restraint at the Facilities to address why less restrictive interventions or de-escalation strategies failed, what additional behavioral support strategies may assist the person, and systemic or individual issues raised by the use of restraints. This consultation and review occurs through the process described above in the status update for EC 39, page 20.

EC 41 also directs the Internal Reviewer to review Olmstead or other concerns arising from or related to admissions, discharges, and other separations from the Facility. The Internal Reviewer reviews each MLB admission or discharge and includes this review in the Internal Reviewer Monthly Report. The Internal Reviewer reviews each admission or discharge with a summary of the implications of that admission or discharge for Minnesota's Olmstead vision. The two most significant concerns noted are: (a) long tenures of MLB residents due to difficulties in placement, and (b) incomplete information about the person upon admission. The former is addressed in the sections below related to transition planning (ECs 47-53), and the latter has been addressed in the Internal Reviewer's Monthly Reports, with a summary in the April 2016 report.

The Internal Reviewer re-instituted the "Rhythm of the Day" assessments initiated by the prior Internal Reviewer. As done previously, the Internal Reviewer is using the section of the Monthly

Report entitled "Rhythm of the Day" to assess the degree to which the lives of people supported at MLB include culturally typical rhythms and activities. These assessments are conducted on a quarterly basis. Each assessment highlights, on a rotating basis, an individual residing at MLB. Content includes efforts to improve daytime activities, meaningful work, and preferred recreation for the highlighted individual. The focus is on the degree to which people supported at MLB have the daily rhythms and activities they prefer as documented in their Person-Centered Descriptions (PCD). For example, the Rhythm of the Day section in the Internal Reviewer's June 2016 Monthly Report explained that the current supports for J1 are in significant concordance with J1's preferred lifestyle, but noted that the acquisition of competitive employment remained an area for development and that J1 expressed dissatisfaction with his living quarters being on a lower level of the home. In his July Monthly Report, the Internal Reviewer followed up with J1's situation, noting that, in August, J1 would be moving to an upstairs apartment that would be more consistent with J1's preferences. The Internal Reviewer also noted that J1 is awaiting final approval for admission to a local employment program of J1's choosing.

With respect to discharges from MLB, clinical expertise is a limiting factor in effectively supporting *Jensen* class members and former MLB residents in more integrated settings, consistent with the requirements of the CPA. As the Internal Reviewer has noted in his Monthly Reports, timely transition for MLB residents remains a challenge. During this reporting period, the Internal Reviewer provided training to internal Department staff and external audiences, including providers and lead agency staff (counties and health plans) on a variety of topics relevant to support of class members and MLB residents. These trainings aim to increase clinical expertise in the community, which in turn will help to address the challenge of timely transition for MLB residents, and are summarized in Table 4, below.

Table 4: Internal Reviewer Training

Date	Topic	Audience
12/22/2015	Mental Health Support for People with Intellectual or Developmental Disability[23]	Internal: Successful Life Project
2/24/2016	Person-centered Thinking	Internal, External, and Providers: Person-centered Planning Community of Practice
3/7/2016	Mental Health Support for People with IDD	Internal: Crisis Home staff
3/15/2016	Mental Health Support for People with IDD	Internal: CSS staff
4/1/2016	Intellectual or Developmental Disability supports	Internal and External: Special Needs Health Plan representatives and Mobile Crisis workers[24]
4/15/2016	Mental Health Support for People with IDD	Internal: PBS Leadership Group
4/20/2016	Intellectual or Developmental Disability supports	Internal and External: Dakota County Case Managers Group
4/26/2016	Including a Mental Health Disorder into an FBA	Internal, External, and Providers: Positive Supports Community of Practice
6/1/2016	Positive Supports	Internal, External, and Providers: Special Needs Health Plan representatives
6/14/2016	Mental Health Support for People with Intellectual or Developmental Disability	Internal, External, and Providers: Special Needs Health Plan representatives
6/16/2016	Positive Supports	Internal, External, and Providers: Mobile Crisis workers

The Internal Reviewer is also an active participant in the following Department work groups/committees with activities that implicate or touch on the JSA, either directly or indirectly:

- DSD-DCT Project Core/Steering Team
- Interim (PSTP) Review Panel
- Lead Agency Review Subcommittee

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[23] Because mental health diagnoses are prevalent within the *Jensen* Class and MLB residents, the Internal Reviewer's training activities related to mental health support for persons with a developmental disability are particularly relevant to the effort to build clinical capacity to support these individuals. For a person with a mental health disorder, knowledge of strategies for including a mental health diagnosis within a Functional Behavior Assessment (FBA) is needed to competently complete an FBA; similarly, knowledge of the nature of the disorder and potential treatments is necessary to establish an effective positive support plan.

[24] Mobile crisis workers included mental health outreach workers (mostly private providers) who respond to mental health crises. These persons do not work with people with developmental disabilities (DD) as a focus population, but occasionally respond to a call involving a person with DD who lives with their family.

- MN Association of Positive Behavior Support
- Person-Centered Planning and Equity
- Person-Centered Work Group and Person-Centered Examples Subcommittee
- Positive Behavior Support Leadership Group
- Quality Assurance Leadership Team (QALT)

Through these training and committee activities, the Internal Reviewer has sought to increase relevant clinical expertise and gain familiarity with the services and providers, both internal and external to the Department that provide support to Minnesotans with developmental disabilities—including *Jensen* Class Members and current or former MLB residents.

Verification

As part of the JOQACO internal quality assurance and verification processes, JOQACO developed a database to track all Incident Reports, BIRFs, and follow-up actions for persons served at MLB and members of the therapeutic follow-up group receiving services at a state-operated facility. This database has been in place since early 2016. JOQACO compares MLB incidents tracked in its database against the Incident Reports and the incident database maintained by MLB.

JOQACO also maintains copies of the Internal Reviewer's Monthly Reports, which document the Internal Reviewer's activities regarding monitoring and follow-up to incidents, his reviews of admissions and discharges, and his quarterly Rhythm of the Day assessments. The data reported in this section were reconciled with the Incident Reports/BIRFs, information in JOQACO's database, and the Internal Reviewer's Monthly Reports.

Settlement Agreement Section VIII. Transition Planning

Evaluation Criteria 47

The State undertakes best efforts to ensure that each resident is served in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings. Each individual currently living at the Facility, and all individuals admitted, will be assisted to move towards more integrated community settings. These settings are highly individualized and maximize the opportunity for social and physical integration, given each person's legal standing. In every situation, opportunities to move to a living situation with more freedom, and which is more typical, will be pursued.

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

During this reporting period, MLB served eight people in the four MLB treatment homes. MLB admitted four people during this reporting period and discharged two people to community-based homes.

MLB makes best efforts to provide each resident with the most integrated or best alternative setting while they plan for further transition to a more integrated setting in the community. MLB starts transition planning upon admission to the Brobergs Lake, Stratton Lake, and Eagle Pointe treatment homes and transition planning continues throughout the person's stay at these sites. More detailed information about the transition planning process at MLB, as well as MLB's efforts to ensure that each resident is served in the most integrated setting appropriate to their needs and that opportunities to move to a more integrated community setting are being pursued, are provided in the status updates to ECs 48-53, see pages 28-36.

In the Ninth Compliance Update Report (Doc. No. 531), the Department reported that it was difficult for some treatment teams to accept the direction or expectations of MLB during the person's stay, such as the importance of seeking permanent options or the importance of positive behavior supports/person-centered approaches. (*Id.* at 34.) In effort to better clarify MLB's mission, expectations, and reliance on person-centered approaches and positive behavior supports, and to correct any misconceptions up front, MLB management and clinical leads have developed a Referral Response letter that MLB sends to the person making the referral. The Referral Response letter provides additional detail regarding roles and responsibilities and detailed information regarding the transition planning process, person-centered planning, and positive behavior supports. After MLB admits a referred person, MLB staff review the Referral Response letter with the team at the admission meeting and again at the 10-day planning meeting. This new effort has been in place since early 2016.

In the Ninth Compliance Update Report (Doc. No. 531), the Department also reported that one of the challenges to continued compliance with this EC is a lack of community capacity for transitioning persons out of MLB. The Department noted that sections of Minnesota's Olmstead work plans might address some of the challenges regarding community capacity. For a brief list of examples of progress made during the reporting period in the areas of the Olmstead work plans that most closely touch on community capacity and transitioning to the most integrated setting possible, see earlier section on Minnesota's Olmstead Work Plan (beginning on page 12).

Verification

See the verification sections for ECs 48-53, pages 28-36.

JOQACO reviewed, and has on file, a copy of the Referral Response letter discussed in this status update.

Evaluation Criteria 48

The State actively pursues the appropriate discharge of residents and provided them with adequate and appropriate transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting and to which the individual does not object.

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

During this reporting period, two people (L1 and J3) transitioned from MLB to community-based homes. MLB provided both people with adequate and appropriate Transition Plans, protections and services consist with their individualized needs. Both people also received supports from Community Support Services (CSS) to facilitate their transitions.

The Department's pursuit of the appropriate discharge of MLB residents begins with the transition planning process. MLB starts transition planning upon admission to the Brobergs Lake, Stratton Lake and Eagle Pointe treatment homes and continues throughout the person's stay at these sites. The primary guide to the transition planning process is the creation of a PATH, MAPS, or Picture of a Life that the person develops, with the support of the Person Centered Planning Facilitator. The plan covers where the person would like to live, what kind of home they would like, with whom they would like to live, what they will do for fun, what they will do for work, and desired family involvement. This picture-guided description of the person's desired life is translated into written documentation in the Person-Centered Plan and Transition Plan.[25]

A draft Transition Plan is to be completed within 30 days of admission, consistent with Action 48.1, and is to include requirements identified in the CPA and JSA (see, e.g., Action 52.5). The transition planning process continues throughout the person's stay at MLB. The person and their team contribute to transition planning and plan updates through monthly team meetings. During these monthly meetings, an agenda is created, the items discussed, action items set for the next meeting, and the Person-Centered Plan and Transition Plan updated with newly learned information.

During an on-site visit in July 2016, JOQACO conducted a spot check verification review of transition plans for four persons served at Brobergs Lake and Stratton Lake (more detail below under "Verification"). JOQACO confirmed that all four of the persons had transition plans and that MLB updated these plans on a monthly basis. However, it took longer than 30 days to develop a transition

[25] Near the beginning of the reporting period, MLB began using an improved Transition Plan format that enhanced the team's ability to create effective Transition Plans. Feedback received from providers has been positive. The Department provided the Court Monitor, Plaintiffs' Class Counsel, and Consultants with a draft copy of the revised Transition Plan in March 2015 for feedback, as well as the final version of the Transition Plan in May 2015.

plan for two of the persons (J2 and T1) admitted during the reporting period. MLB reported that the delay in initiating the two transition plans was due in part to a delay in receiving documentation from the referral source.[26] JOQACO followed up in writing with MLB in August 25, 2016, requesting an Action Plan by September 15, 2016 detailing the steps MLB will take to ensure that Transition Plans are developed within 30 days of admission, notwithstanding delays in receiving referral documentation.

As part of the transition planning process and its efforts to pursue the appropriate discharge of residents, MLB ensures that residents have the opportunity to explore potential homes and communities. For example, in October and December 2015, S2 visited and toured four different homes to find out if they would be a good match for S2's preferences. In January 2016, representatives from Hermantown came to Brobergs Lake to meet with J3 to discuss J3 visiting and potentially relocating to the Hermantown Midway House. In February 2016, two providers attended G1's team meeting to see if G1 was interested in learning more about their services. MLB reports that the providers are looking to develop a new site for G1 and are searching for property in the communities of G1's choice.

In the Ninth Compliance Update Report (Doc. No. 531), the Department reported that one of the challenges to continued compliance with this EC is a lack of community capacity for transitioning persons out of MLB. The Department noted that sections of Minnesota's Olmstead Work Plan might address some of the challenges regarding community capacity. For a brief list of examples of progress made during the reporting period in the areas of the Olmstead Work Plan that most closely touch on community capacity and transitioning to the most integrated setting possible, see earlier section on Minnesota's Olmstead Work Plan (beginning on page 12).

Verification

JOQACO reviewed the Transition Plans for the two people (L1 and J3) who transitioned from MLB to community-based homes during this reporting period. Both L1 and J3's Transition Plans were consistent with requirements for transition planning identified in EC 49 – EC 53, including the following:

- The person and their family or other people chosen by the person are involved to the greatest extent possible given each situation (EC 49).
- Person-centered principles and processes are used to obtain the greatest degree of self-determination and independence possible for that person throughout the process (EC 50).

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[26] The Internal Reviewer has also documented the delay in receiving referral information in his Monthly Reports.

- Persons are given opportunities express choices regarding preferred activities contributing to their quality of life (EC 51).

JOQACO compared L1's "Person-Centered Description – Picture of a Life and Action Planning" document with their "Transition Summary and Plan" document. L1's Transition Summary and Person-Centered Description contain consistent documentation of L1's choices regarding where they want to live. The new provider staff were involved in L1's transition planning process prior to L1's move. L1 is very close to and active with their family and wanted to move close to them. L1's family lives in the same town, as L1's new home.

JOQACO also compared J3's "Person-Centered Description – Picture of a Life and Action Planning" document with their "Transition Summary and Plan" document. J3's Transition Summary and the Person-Centered Description contain consistent documentation of J3's choices regarding where they want to live. J3 would like to live in a big city to meet new people and have fun activities – J3 moved to an area that meets these criteria. At the time of J3's transition, J3 was still exploring possibilities for jobs. J3's staff, case manager, and Ombudsman have all been actively involved with J3.

JOQACO targeted on-site verification for EC 48. JOQACO wanted to obtain a better understanding of options being pursued and barriers to transition. At the Cambridge Administrative Office for MLB, JOQACO staff reviewed the Transition Plans and Person-Centered Plans for S2 (Brobergs Lake), J1 (Brobergs Lake), G1 (Stratton Lake) and J2 (Stratton Lake) for the following elements: frequency of plan updates, ability to determine whether and when MLB made updates, actions taken, and barriers to transition. JOQACO also conducted follow-up interviews with staff at Brobergs Lake and Stratton Lake. For the plans reviewed, JOQACO found that:

- Information regarding what is "important to" the person is well documented in the Transition Plans. This information is important to identify and target options preferred by the person.
- With the exception of J2's Person-Centered Plan, MLB staff color-coded updates to the Person-Centered Plans, making it easier to identify what updates were made and when.
- MLB updated the four Transition Plans reviewed on a monthly basis.

JOQACO also identified opportunities for performance improvement, including the following:

- JOQACO determined that MLB staff initiated only two of the four draft Transition Plans reviewed within the 30-day period stated in Action 48.1. This delay in initiating the Transition Plan is a barrier to transition that MLB needs to address.
- MLB needs to provide clearer documentation in the Transition Plan regarding options that have been pursued, identification of outcomes and any barriers to transition.
- After identification of a provider, MLB should have a standardized process for transition planning to clarify who is responsible for each task and the necessary timeline (for areas such as operations, clinical, and logistics).

- MLB and Community-Based Services need to develop strategies regarding the transition of persons who no longer require MLB level of services but are reluctant to leave MLB.

JOQACO has verbally communicated with the Community-Based Services Director the above identified opportunities for performance improvement. JOQACO followed up in writing with MLB and Community-Based Services on August 25, 2016 requesting an Action Plan by September 15, 2016, to address the identified opportunities for performance improvement.

Evaluation Criteria 49

Each resident, the resident's legal representative and/or family to the extent permitted by law, has been permitted to be involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication method he or she (or they) prefer.

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

MLB takes steps to encourage each person, the person's legal representative and/or family, to the extent permitted by law, to be involved in the processes detailed in the status updates for ECs 48 and 50-53. MLB documents family, friends, and other non-paid supports involved in the planning processes within the Person-Centered Description-Picture of a Life Plan (name, time known, and role) and within the Transition Plan. The person, however, has the final say on what is included in the plans and therefore what is in the plans ultimately comes from the person.

Team meetings can and have been scheduled on weekends to accommodate family and guardian work schedules. MLB house staff have set up their own conference call account and have purchased a wireless Bluetooth speaker device to ensure guardians can hear and be heard during telephone meetings, which encourages their continued participation. The following are some specific examples of choices made by MLB residents and facilitated by MLB regarding participation in planning:

- G1 has set the dates and times that work best as to when and where to have G1's team meeting. They have invited their guardian and case manager to attend. Their guardian is the person they consider closest to them and therefore their most desired attendee. MLB staff ensure that the guardian is contacted via their preferred method for dates, times, and if changes happen regarding G1's meeting. MLB staff transport G1 to their meetings when they occur outside of the home.
- Due to the inability of S2's guardian to secure transportation to Cambridge, MLB staff have been transporting S2 to the guardian's town for team meetings, thereby ensuring S2's guardian has continued participation in the planning process.
- Due to the long drive for J3's guardian, MLB staff have transported J3 to the guardian's area for team meetings, both to visit people J3 knows and misses and to ensure J3's guardian is able to attend the meeting and participate in the planning process.

- Due to J1's guardian living out-of-state, MLB home staff use their conference call account and the wireless Bluetooth speaker device (to ensure the guardians can hear and be heard during meetings) in order to ensure continued participation of J1's guardian.
- J2's guardians are usually not available to attend J2's meetings in person, so MLB home staff use their conference call account and the wireless Bluetooth speaker device (to ensure the guardian can hear and be heard during meetings) in order to ensure continued participation of both guardians.
- T1's family supports live out-of-state, so the MLB home staff use the conference call account and wireless Bluetooth speaker device (to ensure the guardian can hear and be heard during meetings) in order to ensure T1's family's continued participation. In addition, MLB has held team meetings on weekends, to accommodate T1's family's work schedules.

As noted above in the status update for EC 47, in early 2016, the MLB management and clinical leads developed a Referral Response letter that MLB sends out at the time a referral is made to the program. This letter provides additional details regarding roles and responsibilities, the transition planning process, person-centered planning, and positive behavior supports at MLB. If MLB admits a referred person to one of the MLB homes, MLB reviews this letter at the admission meeting and again at the 10-day planning meeting. This letter includes information on the involvement of the person and their team in evaluation, decision-making and planning processes.

Verification

The responsible party verified information submitted to JOQACO for EC 49 through review of individual Transition Summaries, Transition Plans, and Progress Review Meeting minutes for persons at MLB treatment Homes.

JOQACO reviewed a copy of the Referral Response letter.

Evaluation Criteria 50

To foster each resident's self-determination and independence, the State uses person-centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

MLB uses person-centered planning principles at each stage of the transition planning process, beginning with the Person-Centered Description. As explained in the status update to EC 2, during this reporting period, all eight persons served at MLB treatment homes engaged with their team and/or the MLB Person Centered Planning Facilitator to contribute to the greatest extent possible to their Person-Centered Description. All persons served at MLB treatment homes during the reporting

period participated in Picture of a Life, PATH, or MAPS to develop their Person-Centered Plan. The information in the Person-Centered Plan informs the person's Transition Plan, Positive Behavior Support Plan, and other key documents such as the Individual Service Plan and Coordinated Services and Support Plan Addendum, consistent with Action 50.3.

The Person-Centered Plans and Transition Plans of MLB treatment home residents are updated on a monthly basis, consistent with Action 50.2. MLB staff have developed a method of color-coding revisions and additions to the plan to make it easier to identify who made updates and when. The person and their team contribute to updates through monthly team meetings.

As explained in greater detail in EC 49, MLB takes steps to ensure that the person and their legal representatives and/or family members are involved in the planning process to the greatest extent practicable. See pages 31 and 32, for examples of choices made by MLB residents and facilitated by MLB regarding participation in planning.

Verification

The responsible party verified information submitted to JOQACO for EC 50 through review of individual Person-Centered Descriptions, Transition Summaries, and Transition Plans of persons at MLB treatment homes.

JOQACO conducted on-site verification activities with respect to Transition Plans of MLB residents at the Brobergs Lake and Stratton Lake homes. See the "Verification" section for EC 48, pages 29-31, for more detail about these verification activities and JOQACO's findings.

Evaluation Criteria 51

Each resident has been given the opportunity to express a choice regarding preferred activities that contribute to a quality life.

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

Consistent with Actions 51.1 and 51.2, each person residing at an MLB treatment home has the ability to plan their day and to fill their day with activities that are important to them and important for them. Planning is done through general conversation, weekly house meetings, Positive Behavior Support Review meetings, or use of a daily planning or trip planning tool.

Prior to any community trip, staff discuss with the person when, where and how long the outing will be; who will be with the person during the outing; whether the person would like to attempt conversation with peers or others; and whether the person would like to meet a new person on the outing. MLB details this process in the person's individual support plan.

The following is an example of how MLB has facilitated the ability of persons to have daily opportunities to engage in meaningful activities that are personalized, individualized, and selected by the person:

It is very important to S2 that people who support them make plans with them. When staff make plans for S2, or others change S2's plans, it can be very frustrating or confusing for S2 and is a primary source of problem behavior occurrence. When discussing plans with S2, staff offer or remind S2 of activities that are important to S2, program objectives, and related activities in which it is important for S2 to participate.

Verification

The responsible party verified information submitted to JOQACO for EC 51, through review of individual Transition Summaries and Transition Plans, Progress Review Meeting minutes, and Community Services and Support Plan Addendum - Progress Report and Recommendations for persons served at an MLB treatment home.

Evaluation Criteria 52

It is the State's goal that all residents be served in integrated community settings and services with adequate protections, supports and other necessary resources which are identified as available by service coordination. If an existing setting or service is not identified or available, best efforts will be utilized to create the appropriate setting or service using an individualized service design process.

Responsible Party: Minnesota Life Bridge Clinical Coordinator

Current Status

During this reporting period, two persons (L1 and J3) transitioned from MLB to community-based homes. Both individuals had Transition Plans, which JOQACO reviewed for consistency with their needs and preferences (see "Verification" section below for more details). Both people also received supports from Community Support Services (CSS) to facilitate their transitions.

As part of MLB's efforts to assist people in moving forward to living in a more integrated setting that is consistent with person's needs and preferences, with adequate protections, supports and other necessary resources, MLB provides each person with opportunities to explore potential future home communities and potential future service providers. Some examples from this reporting period include:

- In October and December 2015, S2 visited and toured four different homes to find out if they would be a good match for S2's preferences.
- In January 2016, representatives from a home in Hermantown came to Brobergs Lake to meet with J3 to discuss J3 visiting and potentially relocating to the Hermantown.

- In February 2016, two providers attended G1's team meeting to see if G1 was interested in learning more about their services. MLB reports that the providers are looking to develop a new site for G1 and are searching for property in the communities of G1's choice.

Verification:

JOQACO reviewed the Transition Plans for the two people (L1 and J3) who transitioned from MLB to community-based homes for compliance with EC 52. More specifically, JOQACO compared L1's "Person-Centered Description – Picture of a Life and Action Planning" document with their "Transition Summary and Plan" document. L1's Transition Summary and Person-Centered Description contain consistent documentation of L1's choices regarding where they want to live. The new provider staff were involved in L1's transition planning process prior to L1's move.

JOQACO also compared J3's "Person-Centered Description – Picture of a Life and Action Planning" document with their "Transition Summary and Plan" document. J3's Transition Summary and the Person-Centered Description contain consistent documentation of J3's choices regarding where they want to live. J3's staff, case manager, and Ombudsman have all been actively involved with J3. (*See also* the Internal Reviewer's May and June Monthly Reports for a review of J3's discharge).

Evaluation Criteria 53

The provisions under this Transition Planning Section have been implemented in accord with the Olmstead decision.

Responsible Party: Minnesota Life Bridge Clinical Coordinator; Minnesota Life Bridge Director

Current Status

MLB continues to implement person-centered transition planning and provide people with opportunities to receive services in integrated settings, in accord with the *Olmstead* decision, to the extent possible and according to the preferences of the person. MLB, by its overall design, is a temporary treatment program meant to help people move forward into more integrated settings. Persons served are highly involved in developing their Person-Centered Descriptions and Transition Plans. If, after being provided with information to make an informed choice, they choose a "segregated" service, MLB documents this choice in their individual record. Persons and their support teams are encouraged to make an informed choice for future providers and MLB encourages transition to more independent settings whenever possible. During this reporting period, no person at MLB was transitioned to services in a more segregated setting.

MLB continues to work with providers willing to serve persons with complex behaviors and needs and to stress the necessity of identification of customized supports, driven by the Person-Centered Plan developed by the person and consistent with the requirements for transition planning outlined in EC 49 – EC 53.

Verification

See Verification for EC 48, pages 29-31.

Settlement Agreement Section IX.D. Other Practices at the Facility – No Inconsistent Publicity

Evaluation Criteria 64

The Facility has a mission consistent with the Settlement Agreement and this Comprehensive Plan of Action.

Responsible Party: Minnesota Life Bridge Manager

Current Status

The mission of MLB can be described by the phrase, "Successful Transition to a Successful Life." Consistent with EC 3, MLB serves adults who have been determined to have a developmental disability and who exhibit severe behavior that poses a risk to public safety. MLB's residential treatment services are intended to be short-term, lasting no longer than is necessary to stabilize the person's behavioral crises and facilitate successful transition to living in homes of their choosing. MLB requires the use of positive behavioral supports and person-centered planning approaches consistent with best practices and prohibits the use of mechanical restraints of any kind, prone restraint, chemical restraint, seclusion and time out, and all other aversive or deprivation practices.

The Department described these principles in the Bulletin on MLB (# 14-76-01), issued on April 29, 2014. This Bulletin has been revised and updated and is now in the process of being finalized and approved. The Department expects the updated Bulletin to be available on its public web site in September 2016. The Department is also updating the Community-Based Services Manual[27] page about MLB for consistency with the updated Bulletin. These updates seek to explain more clearly and concisely the mission and services of MLB, which are consistent with the JSA and CPA.

Verification

JOQACO has reviewed and provided input on the updated Bulletin and associated documents.

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[27] The Community Based Services Manual is an on-line reference tool for lead agencies who administer home and community-based services that support older Minnesotans and people with disabilities located on the department's County Link web site at http://www.dhs.state.mn.us/main/id_000402.

Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services

Evaluation Criteria 67

The expansion of community services under this provision allows 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).

Responsible Party: Community Supports Services Director

Current Status

During this reporting period, Community Support Services (CSS) mobile teams provided assessment, triage, and care coordination to 298 persons with developmental disabilities. This number includes 61 individuals who received long-term monitoring; the supports provided to individuals receiving long-term monitoring will be addressed in more detail in ECs 68 and 69.

JOQACO requested additional information for a random sample of the 237 persons that received CSS supports, excluding the persons who received long-term monitoring during the reporting period. The following are examples of supports received by persons in this random sample:

- E1 lost their residential placement after involvement with the criminal justice system. CSS assisted the person's team to secure placement in a group home and provided direct support, care coordination, and technical assistance during E1's transition from jail to the new home. After the move, CSS continued to provide care coordination and consultation to ensure a successful transition and development of programming to support E1's efforts toward a desired community lifestyle. Supports are ongoing.
- F1 was referred to CSS because F1's interfering behaviors, such as elopement and inappropriate touching, were leading the provider to have difficulty keeping staff and had led F1's employer to cut down F1's work hours. CSS completed a FBA and collaborated with F1's team to develop recommendations and supports based on the FBA. CSS monitored and assisted with the team's implementation of these recommendations. At the end of the reporting period, CSS was in the process of assisting F1's team with updating F1's Person-Centered Plan and with adjusting F1's Work Plan to address F1's dissatisfaction with current tasks/assignments. Supports are ongoing.
- I1 was referred to CSS based on concerns regarding I1's unsafe behavior on social media and difficulty with boundaries. CSS worked directly with I1 and provided technical assistance to I1's staff to help improve I1's social skills and understanding of safety and boundaries. Supports are ongoing.
- During the reporting period, CSS provided regular consultation and technical assistance to S1's team regarding behavioral concerns at home and work. By the end of the reporting

period, S1 was exhibiting fewer target behaviors, displaying less intense aggression, and was exploring the possibility of an additional vocational placement. Supports are ongoing.

These are just some examples of how CSS services support persons with developmental disabilities to assure that they receive the appropriate level of care at the right time, in the right place, and in the most integrated setting possible.

Verification

The responsible party reported to JOQACO that he verified the number of persons who received supports from CSS and verified that persons were receiving the appropriate level of care, at the right time, in the right place, in the most integrated setting possible, through the following process:

1. The responsible party reviewed information obtained from the CSS Project Tracking System[28] listing all people with developmental disabilities served by CSS for the period October 1, 2015 through June 30, 2016. CSS provided the spreadsheet listing these people to JOQACO, after the responsible party confirmed with staff that this spreadsheet accurately reported the data pulled from the CSS Project Tracking System.
2. To distinguish between people receiving standard CSS supports versus people receiving long-term monitoring (see ECs 68 and 69), the responsible party eliminated all people listed on the spreadsheet detailing persons who received long-term monitoring during the reporting period. This eliminated 61 people from the spreadsheet. The resulting list of 237 people served by CSS during the reporting period is documented on a separate spreadsheet, also provided to JOQACO.
3. The responsible party selected a random sample[29] for verification of clinical activities. The sample size was 5% of the number of people with developmental disabilities served by CSS during the reporting period, excluding persons receiving long-term monitoring.
4. For persons in the random sample, the responsible party then reviewed key elements of the case notes, quarterly reports, and other documentation to verify that supports were provided during the reporting period and that the supports provided were appropriate.

JOQACO also conducted its own verification activities with respect to EC 67, obtaining case notes for a random sample of 15 people, or about 6%, who were included in the CSS case notes database during the reporting period, excluding persons receiving long-term monitoring. JOQACO reviewed the case notes to verify that people included in the random sample received supports from CSS during the reporting period and that these supports were appropriate. JOQACO contacted a CSS worker to

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[28] Database housing CSS case notes and billing information.

[29] The responsible party used a random number generator (www.random.org) to generate numbers corresponding to the spreadsheet row number of individuals in the population.

clarify information about the supports provided to two people. The CSS worker responded by email to provide additional details and verify the case notes.

JOQACO's review confirmed that during the reporting period, 12 out of 15 people in the sample received supports from CSS, each spanning periods of four or more months. The case note entries document that CSS provides frequent interactions with people receiving supports and their team. Services provided are person-centered and address the person's specific situation, needs, and preferences.

JOQACO identified opportunities for performance improvement with respect to CSS' data. Of the 15 people in the random sample, two did not actually receive supports during the reporting period. The case notes for these two people indicate that CSS made contact with the case manager or team to inquire about the need for CSS services, but that CSS was informed that its involvement was unnecessary. Another person in the random sample did in fact receive services from CSS, but nearly all of these supports were provided before the reporting period; CSS kept the person's case open from October-December 2015 in case the Interim Review Panel required any follow-up from CSS regarding the person's Positive Support Transition Plan. JOQACO is meeting with the CSS Director and staff in September 2016 to determine whether there is a way of flagging persons in these types of situations so that CSS and JOQACO can more easily obtain a complete and accurate picture of who is receiving what services from CSS at any given time.

Evaluation Criteria 68

The Department identifies, and provides long term monitoring of, individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and to prevent multiple transfers within the system.

Responsible Party: Community Supports Services Director

Current Status

During the reporting period, CSS provided long-term monitoring ("Extended Supports") to 61 persons with clinical and situational complexities. JOQACO requested additional information for a random sample of the 61 persons who received long-term monitoring during the reporting period. The following are examples of supports received by persons in this random sample:

A3: CSS had been providing long-term monitoring to A3 before this reporting period, and continued services up until the last month of this reporting period, when CSS transitioned A3's follow-up to the Successful Life Project (SLP). The outcome goals for CSS involvement were actually met in April 2016, but CSS remained involved with A3 for an additional time period for continuity of supports.

While A3 received long-term monitoring, there were meetings with A3 and A3's support team at least every two months. A3 wanted to start a business; CSS facilitated team meetings to discuss issues relevant to this goal, including any effects on SSI payments, what would happen if A3 could not do

the work for a day or two, staff concerns about safety, and what would need to be done for A3 to set up a corporation. CSS also fielded questions from A3. A3 was asked to present on the business at a regional human services meeting in June 2016, and reportedly did an excellent job talking about the business. SLP is now the contact for ongoing follow-up for A3.

M3: In October 2015, CSS received a request for technical assistance from M3's residential provider. The CSS worker provided technical assistance and reviewed M3's current behavioral functioning and incidents at the home. CSS also provided consultation on crisis planning. Due at least in part to this assistance, M3 did not have to leave the residence.

When there was an incident later in the reporting period that resulted in a hospital stay and 72-hour hold, CSS provided care coordination and discussed support resource strategies with the residential provider. At the last team meeting during the reporting period, M3 and M3's team reviewed and discussed M3's Positive Support Transition Plan data, progress at work, and implementation of M3's Positive Support Transition Plan in the home and across environments. CSS support continues.

As these examples illustrate, CSS' long-term monitoring efforts have provided strategies to address changing needs and to prevent transfers within the system.

Verification

As part of their verification process, the responsible party verified the total number and names of people by crosschecking each entry on the spreadsheet provided to JOQACO with project entries in the CSS Project Tracking System. The responsible party eliminated cases that were closed prior to October 1, 2015. The responsible party selected a random sample for verification of clinical activities; the sample size was 5% of the number of people receiving long-term monitoring during the reporting period. The responsible party then reviewed the CSS Quarterly Reports for each person in the sample.

JOQACO also conducted verification activities with respect to EC 68, obtaining case notes for a random sample of 10 out of the 61 people who received long-term monitoring during the reporting period. JOQACO's review confirmed that, during the reporting period, all of the people in the random sample received monitoring and supports from CSS. As of the end of the reporting period:

- CSS monitoring and supports were ongoing for eight people;
- CSS had transferred one case to SLP; and
- CSS had closed one case because the person had made progress such that they no longer required long-term monitoring by CSS.

Evaluation Criteria 69

Approximately seventy five (75) individuals are targeted for long term monitoring.

Responsible Party: Community Supports Services Director

Current Status

As discussed in the status update for EC 68, during the reporting period, CSS provided long-term monitoring to 61 people with clinical and situational complexities.

Verification

As part of their verification process, the responsible party verified the total number and names of people by crosschecking each entry on the spreadsheet provided to JOQACO with project entries in the CSS Project Tracking System. The responsible party eliminated cases that were closed prior to October 1, 2015.

JOQACO also conducted verification activities with respect to EC 68, obtaining case notes for a random sample of 10 out of the 61 people who received long-term monitoring during the reporting period. JOQACO's review confirmed that, during the reporting period, all of the people in the sample received monitoring and supports from CSS.

Evaluation Criteria 70

CSS mobile wrap-around response teams are located across the state for proactive response to maintain living arrangements.

Responsible Party: Community Supports Services Director

Current Status

CSS maintains 9 mobile wrap-around response teams and 23 office locations across the state[30]. CSS mobile teams promote positive supports and build collaborative support networks to strengthen the integrated community living of persons with complex behavioral health challenges.

To prevent and resolve behavioral crises, CSS mobile teams provide outreach services including:

- Augmentative staffing supports

[30] The CSS Brochure with information on the location of the statewide teams can be found on the Department's web site at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6506-ENG.

- Assessment
- Consultation
- Engagement and coordination with community resources and
- Training

CSS staffs each mobile team with at least two people with experience and training in behavior analysis, social work, psychology, nursing, and/or organization development and training. When CSS mobile supports are engaged, at least one member of the mobile team provides outreach services, in consultation with other mobile team members. To build collaborative support networks around persons supported, CSS mobile teams work in coordination with the person's team and community resources to prevent or resolve behavioral crises.

CSS' mobile teams receive administrative and managerial support from CSS Director, Southern and Northern Regional Managers, two Office Coordinators, and Direct Care and Treatment Information Technology Specialists. The administrative and managerial support provided by these people facilitates data collection and central data management related to CSS mobile team activities.

During the reporting period, CSS received 17 satisfaction surveys from persons who received services from CSS mobile teams, eight satisfaction surveys from legal representatives of persons unable to complete the survey, and 50 surveys from county case managers.

The surveys CSS received from the persons who received services or their legal representatives contained the following responses:

- 100 % (17/17) of persons who received CSS mobile team services responded positively to the statement "I learned things that helped me."
- 75% (6/8) of legal representatives responded positively to the statement, "CSS helped the person receiving services with their challenges."

A review of the responses CSS received from the person's lead agency case manager revealed the following:

- 94% (47/50) responded positively to the statement, "CSS responded in a timely manner."
- 96% (48/50) responded positively to the statement, "Requests for services and/or expected outcomes were achieved."
- 87% (39/45) responded positively to the statement, "CSS intervention helped prevent a loss of placement, prevented hospitalization, or prevented placement in a more restrictive setting."

Five survey respondents, including three county case managers, one contracted case manager and one service recipient, identified specific concerns in their survey responses including:

- Expected outcomes (1)

- Waiting period (3) and
- Wanted CSS to assist in finding them a job (1).

CSS followed up directly with the four case managers and the CSS lead consultant for the service recipient to ensure a full understanding of the concern, provide clarifying information, and address any system issue within CSS. CSS did not make a direct follow-up with the service recipient as other support network members were addressing the concern expressed (wanting CSS to assist them in getting a job).

Verification

As part of their verification process, CSS reviewed the CSS Staff Directory report, which was last updated April 14, 2016. CSS also crosschecked staff against the CSS Contacts on the CSS SharePoint site, which CSS updates routinely as staff changes occur.

The responsible party assigned to this EC responded personally to three of the survey responders and the CSS lead consultant for the service recipient. The CSS Southern Regional Manager followed up with the fifth survey respondent.

The concerns indicated in surveys and CSS' responses to these concerns are documented in CSS' Client and Customer Concern Response Log, which CSS provided to JOQACO.

JOQACO reviewed the following documents submitted by CSS to confirm that these documents supported the information provided by CSS: the CSS spreadsheet with survey responses from persons receiving services, legal representatives and county case managers; the survey response log; and the CSS staff directory.

Evaluation Criteria 71

CSS arranges a crisis intervention within three (3) hours from the time the parent or legal guardian authorizes CSS' involvement.

Responsible Party: Community Supports Services Director

Current Status

As explained in the status update for EC 70, CSS maintains 9 mobile teams and 23 office locations throughout the state.

During this reporting period, CSS arranged for a crisis intervention in 12 persons' situations. CSS arranged a crisis intervention within three hours from the time the parent or guardian authorized CSS' involvement in nine out of the 12 cases. See Table 5 below.

Table 5: CSS Crisis Intervention

Date &Time Consent Received	Date & Time of First Official Contact	Time Between Consent and Initial Contact (Hours)
01/07/2016 08:40 AM	01/07/2016 12:30 PM	**3.83**
04/20/2016 03:12 PM	04/20/2016 04:51 PM	**1.65**
02/11/2016 11:07 AM	02/11/2016 11:43 AM	**0.60**
10/26/2015 12:32 PM	10/26/2015 01:23 PM	**0.85**
11/16/2015 09:00 AM	11/16/2015 09:00 AM	**0.00**
11/13/2015 11:45 AM	11/13/2015 11:45 AM	**0.00**
06/01/2016 04:00 PM	06/01/2016 04:00 PM	**0.00**
01/20/2016 11:46 AM	01/20/2016 12:15 PM	**0.48**
10/15/2015 08:00 AM	10/15/2015 08:30 AM	**0.50**
10/09/2015 09:00 AM	10/09/2015 09:00 AM	**0.00**
03/30/2016 01:38 PM	03/31/2016 09:30 AM	**19.87**[31]
05/03/2016 01:40 PM	05/03/2016 06:00 PM	**4.33**

Verification

The responsible party reviewed a spreadsheet created by CSS staff with data regarding response times from the CSS Service Inquiry Tracking database. Initially, the responsible party reported that there were two outlier response times with respect to the time between receipt of consents to initial contact. When the responsible party crosschecked the information reported against case note entries, however, the responsible party determined that, in one of these instances, CSS staff entered the initial contact time incorrectly into the Service Inquiry Tracking database. The CSS staff documented the initial contact time as 4 pm when in fact, CSS' initial contact occurred at 8:30 am—30 minutes after

[31] Refer to the "Verification" section for EC 71 for more information about the circumstances surrounding this outlier response time.

CSS received the signed consent. The information reported in the status update above reflects this correction.

JOQACO requested more information about the reasons that contributed to the delay in initial contact after receiving consent for the outlier response time. According to the responsible party, the delay occurred when the intake coordinator went home ill and receipt of the consent was missed in the hand-off of responsibility for monitoring consents. As part of CSS' revamping of their referral process through Central Pre-Admissions, CSS is developing a failsafe plan to prevent this type of situation from repeating itself. JOQACO will be discussing this issue during a meeting with the CSS Director and staff in September 2016 and will continue to follow up with CSS to ensure that the revamped referral process addresses this concern.

Evaluation Criteria 72

CSS partners with Community Crisis Intervention Services to maximize support, complement strengths, and avoid duplication.

Responsible Party: Community Supports Services Director

Current Status

CSS continues to collaborate with other crisis intervention services, including the Metro Crisis Coordination Program (MCCP)[32], to maximize support and avoid duplication. CSS met at least quarterly with MCCP during this reporting period.

CSS also continues to provide services to persons when lead agencies do not have funding available to pay for CSS services (Action 72.1); however, during this reporting period, CSS did not receive any requests to provide unfunded services.

On October 15, 2015, the CSS Director travelled to Bemidji to meet with stakeholders from lead agencies in Region 2. On January 14, 2016, the CSS Director travelled to Brainerd to meet with stakeholders from lead agencies in Region 5. These meetings included presentations on CSS services and the Department's ongoing work to improve crisis supports. These meetings also provided a forum for questions and discussion of opportunities to strengthen collaborations between the Department and lead agencies.

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[32] The Metro Crisis Coordination Program (MCCP) is a collaborative effort among the seven metro counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington. MCCP works interdependently with individuals, private providers and public agencies to prevent crises that affect the residential and/or work (educational) placements of persons with developmental disabilities.

Verification

The responsible party reviewed source documents, including minutes from the CSS/MCCP Collaboration meetings held during the reporting period (on October 8, 2015, October 29, 2015, January 21, 2016, and April 28, 2016) and the agendas for the Regional Meetings (held October 15, 2015 and January 14, 2016). The responsible party directly participated in the January 2016 CSS/MCCP Collaboration meeting. The responsible party also reviewed the electronic folder where requests for unfunded services are stored to confirm that no such requests were made during the reporting period.

JOQACO reviewed the source documents submitted by CSS that confirm the collaboration between CSS and MCCP, including minutes and sign-in sheets from the meetings between MCCP and CSS from October 8, 2015 through April 28, 2016, and the agenda for the two regional meetings referenced in this status update.

Evaluation Criteria 73

CSS provides augmentative training, mentoring and coaching.

Responsible Party: Community Supports Services Director

Current Status

During this reporting period, CSS provided 45 augmentative training sessions to 526 members of community support networks. These trainings covered a variety of topics relevant to support of persons with developmental disabilities, including Client Negotiations, De-escalation Techniques, Support Strategies for Clients, and Diagnoses and Recommended Intervention Strategies. CSS also mentors and coaches support networks for people with developmental disabilities by providing the services described in the status updates for ECs 67-69.

CSS continues to review and update its training curricula as necessary to ensure consistency with best practices. For example, on October 2, 2015, the CSS Training Committee[33] approved a Version 2.0 of the Introduction to Positive Behavior Support training curriculum, to address elements of the Positive Supports Rule. On the same date, CSS also approved a Version 2.0 of the Functional Behavior Assessment and Intervention training curriculum.

[33] The CSS Training Committee that approved the revised curricula included the following CSS staff: a Registered Nurse Senior; two Behavior Analyst III Supervisors; two Behavior Analysts IIIs; a Social Worker; a Behavior Modification Assistant and the Direct Care & Treatment Training Coordinator.

CSS continues to have sufficient administrative and managerial staff to track and analyze data related to training. CSS recently expanded its capacity for data management through creation of a Data Coordinator position for CSS. Additionally, CSS will be adding a Management Analyst position to develop and support sustainable, timely, and complete data collection and analysis.

A review of the training survey responses CSS received from the 453 external providers who participated in a CSS training revealed:

- 99.1 % (449/453) responded positively to the statement, "The class was valuable/useful."
- 100% (453/453) responded positively to the statement, "I would recommend the training to others."

Verification

The responsible party generated the information reported in this status update for augmentative training sessions by reviewing the CSS Program Evaluation database, which contains data on all training sessions provided by CSS staff; filtered the data to identify only training sessions that occurred during the reporting period; and eliminated all internal training sessions that were captured by this data pull.

The responsible party and JOQACO reviewed the manuals containing the CSS curricula for training sessions on Positive Behavior Support and Functional Behavior Assessment and Intervention; the version history for each manual lists the dates of review, update, and approval.

JOQACO also reviewed CSS' spreadsheets of internal and external training completed during this reporting period, which identifies lead trainer, date, location and audience for each training. JOQACO also reviewed the training evaluation summary spreadsheet submitted by CSS to support the reported survey results.

Evaluation Criteria 74

CSS provides staff at community based facilities and homes with state of the art training encompassing person-centered thinking, multi- modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking.

Responsible Party: Community Supports Services Director

Current Status

During this reporting period, CSS provided 45 augmentative training sessions to 526 members of community support networks, as explained in the status update for EC 73.

As explained in the status update for EC 73, CSS reviews training curricula to ensure consistency with best practices. As noted in the Ninth Compliance Update Report (Doc. No. 531 at 49-50), during the

previous reporting period, the CSS Support/Supervisor led a workgroup to update the CSS Positive Behavior Support curriculum, to address new elements of the Positive Supports Rule, and to update the Functional Behavior Assessment and Intervention training curriculum. The workgroup included a Behavior Analyst 3 Supervisor (CSS Northern Region) and a Behavior Analyst 3 (CSS Northeast). As noted in the status update for EC 73, the CSS Training Committee approved both updated curricula during this reporting period.

Verification

For an explanation of verification activities regarding the services provided under this EC and EC 73, refer to the "Verification" section for EC 73.

Evaluation Criteria 75

CSS' mentoring and coaching as methodologies are targeted to prepare for increased community capacity to support individuals in their community.

Responsible Party: Community Supports Services Director

Current Status

Through its augmentative training sessions, CSS mentors and coaches persons who support persons with developmental disabilities in the community. During this reporting period, CSS provided 45 augmentative training sessions to 526 members of community support networks. CSS also mentors and coaches support networks for people with developmental disabilities by providing the services described in the status updates for ECs 67-69. CSS targets its mentoring and coaching methodologies to increase community capacity by training people to provide support in the community.

Consistent with Action 75.2, CSS currently tracks the following issues for persons receiving long-term monitoring: (1) frequency of behaviors dangerous to self or others; (2) frequency of interactions with the criminal justice system; (3) sudden increases in usage of psychotropic medications; (4) multiple hospitalizations or transfers within the system; (5) serious reported incidents, (6) repeated failed placements or (7) other challenges identified in previous monitoring or interventions and cost of placement. By March 1, 2017, CSS will begin tracking these issues for all people with developmental disabilities receiving CSS services. CSS's recently expanded capacity for data management through the creation of a data coordinator position will facilitate this expanded tracking. Additionally, CSS anticipates adding a management analyst position to develop and support sustainable, timely, and complete data collection and analysis.

Verification

For an explanation of verification activities regarding services provided pursuant to ECs 67-69, refer to the "Verification" sections under those ECs. For an explanation of verification activities regarding

augmentative training sessions provided pursuant to ECs 73-74, refer to the "Verification" sections under those ECs.

Evaluation Criteria 76

An additional fourteen (14) full time equivalent positions were added between February 2011 and June 30, 2011, configured as follows: Two (2) Behavior Analyst 3 positions; One (1) Community Senior Specialist 3; (2) Behavior Analyst 1; Five (5) Social Worker Specialist positions; and Five (5) Behavior Management Assistants

Responsible Party: Community Supports Services Director

Current Status

During this reporting period, CSS worked with Human Resources to advertise vacancies during the reporting period and fill vacancies with individuals with the required qualifications. More specifically, CSS hired four Behavior Analyst 3 Supervisors during this reporting period. The staff hired in those positions have the following qualifications:

- Master's degree in social work; Licensed Independent Clinical Social Worker; several years' experience providing military and civilian supports to people with behavioral health challenges and training support networks.
- Master's degree in applied behavior analysis and therapy; Board Certified Behavior Analyst; and several years' experience supporting people with complex behavioral health challenges and training support networks.
- Bachelor's degree in applied behavior analysis ; intensive training in person-centered positive behavior support through the University of Minnesota Institute on Community Integration; several years' experience supporting people with complex behavioral health challenges and training support networks.
- Master's degree in education; taught special education at college level; 20+ years' experience supporting people with complex behavioral health challenges as a direct support professional, residential supervisor and manager, crisis home supervisor, and behavioral consultant.

CSS also hired two Behavior Analyst 3s during this reporting period; the staff hired have the following qualifications:

- Master's degree in counseling psychology and took several courses in applied behavior analysis.
- Intensive training and mentoring in person-centered thinking and planning as well as positive behavior support received through the Director of Positive Behavior Support for Direct Care & Treatment and the MLB Clinical Coordinator; and several years' experience supporting people with complex behavioral health challenges and training support networks.

Additionally, CSS hired an Occupational Therapist Senior during this reporting period. The person hired is a Registered and Licensed Occupational Therapist (OTR/L) in Minnesota, with several years' experience developing and implementing OT strategies with people with complex behavioral health challenges and training support networks.

Verification

The responsible party reviewed documents related to the hiring process, such as communications with Human Resources, and has personal knowledge of CSS staff hired during the reporting period. The responsible party verified the qualifications of newly hired staff through participation in the hiring process and through communication with hiring supervisors and managers.

JOQACO reviewed the documents submitted by the responsible party for EC 76 to confirm that they supported the information reported.

Evaluation Criteria 77

None of the identified positions are vacant.

Responsible Party: Community Supports Services Director

Current Status

During this reporting period, staff in one of the identified positions (Social Worker Specialist) received a promotion. However, that staff person is maintaining their caseload until the position is backfilled. The Department has posted for this position and interviews begin on August 16, 2016.

Verification

The responsible party verified this information by reviewing the CSS Mobile Teams Organization Chart and communicating with the CSS Southern Regional Manager, who is supporting the hiring process for the Social Worker Specialist vacancy.

Evaluation Criteria 78

Staff conducting the Functional Behavioral Assessment or writing or reviewing Behavior Plans shall do so under the supervision of a Behavior Analyst who has the requisite educational background, experience, and credentials recognized by national associations such as the Association of Professional Behavior Analysts. Any supervisor will co-sign the plan and will be responsible for the plan and its implementation.

Responsible Party: Community Supports Services Director

Current Status

All CSS staff providing clinical oversight of FBAs and Behavior Plans hired after December 10, 2014, possess nationally recognized certifications.

One of the CSS supervisors responsible for co-signing FBAs was hired before December 10, 2014, and lacked credentials recognized by a national association. To meet the requirements of EC 78, this supervisor submitted an application for the NADD Certified Clinician (NADD-CC) credential in February 2015.

On May 31, 2016, the supervisor attained the NADD-CC credential. The NADD-CC credential identifies clinicians who demonstrate mastery of five core competencies[34] in supporting persons with IDD who also experience mental illnesses. With this certification, the supervisor has joined the ranks of only twenty-six[35] other such accomplished clinicians internationally.

Verification

JOQACO has reviewed the NADD Certification and has a copy available on file. The supervisor is also listed on the NADD Certified Clinicians web page.

Settlement Agreement Section X.B. System Wide Improvements – Olmstead Plan

Evaluation Criteria 79

The State and the Department developed a proposed Olmstead Plan, and will implement the Plan in accordance with the Court's orders. The Plan will be comprehensive and will use measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the "Most Integrated Setting," and which is consistent and in accord with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). The Olmstead Plan is addressed in Part 3 of this Comprehensive Plan of Action.

Responsible Party: Director of Compliance, Olmstead Implementation Office

Current Status

On May 31, 2016, the Department filed with the Court a proposed updated Olmstead Plan, which incorporated new goals on Assistive Technology and Prevention of Abuse and Neglect. The Court held a status conference on June 6, 2016, which included discussion of issues related to the Olmstead Plan. The Court approved the updated Olmstead Plan, including the new goals, by Court Order on June 21, 2016.

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[34] The NADD five core competencies include, Positive Behavior Supports and Effective Environments, Psychotherapy, Psychopharmacology, Assessment of Medical Issues, and Assessment.
[35] NADD Certified Clinicians web page, retrieved 7/12/2016 (http://thenadd.org/products/accreditation-and-certification-programs/nadd-certified-clinicians/.

The Olmstead Subcabinet and the Olmstead Implementation Office are monitoring the implementation of the Plan, and the Department is submitting separate reports to the Court on the Olmstead Plan. (*See, e.g.*, Doc. Nos. 547-1, 569-1.)

Verification

JOQACO reviewed and has on file Doc. No. 578, filed June 21, 2016. The Director of JOQACO was present at the June 6, 2016, status conference.

Closure of MSHS-Cambridge and Replacement with Community Homes and Services

Evaluation Criteria 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.

Responsible Party: Community Supports Services Director

Current Status

In its June 21, 2016 Order, the Court specifically sought clarification of the following with respect to EC 93: "(1) What is the definition of mobile teams under EC 93? (2) When and how have mobile teams been deployed under this definition in the reporting period? (3) What were the outcomes of these deployments? (4) Were the mobile teams' efforts timely and effective? (Doc. No. 578 at 5.) These questions are addressed in order below.

1. ***What is the definition of mobile teams under EC 93?***

During this reporting period, CSS mobile teams took responsibility for mobile support services under EC 93. CSS mobile teams promote positive supports and build collaborative support networks to strengthen the integrated community living of persons with complex behavioral health challenges. To prevent and resolve behavioral crises, CSS mobile teams provide outreach services including:

- Augmentative staffing supports
- Assessment
- Consultation
- Engagement and coordination with community resources and
- Training.

CSS mobile teams are located across the state to promote regional responsiveness. Each mobile team includes at least two staff with experience and training in behavior analysis, social work, psychology,

nursing, and/or organization development and training. When CSS mobile supports are engaged, at least one member of the mobile team provides outreach services, in consultation with other mobile team members.

To build collaborative support networks around persons supported, CSS mobile teams work in coordination with the person's team and community resources to prevent or resolve behavioral crises.

2. ***When and how have mobile teams been deployed under this definition in the reporting period?***

As reported in the status updates for ECs 67-69, CSS mobile teams provided supports to 298 people during the reporting period, including supports to persons receiving long-term monitoring (ECs 68-69). In effort to avoid redundancy, and in recognition that EC 93 comes under a section of the CPA about closing the Cambridge facility and replacing it with community homes and services, the discussion in this section is focused on mobile team supports provided to persons who have a connection to the Facilities, such as persons referred to MLB during the reporting period and persons at or transitioning out of MLB during the reporting period.

During the reporting period, CSS deployed mobile team supports to six people referred to MLB.[36] The mobile team interventions in these six cases included consultation and training to existing supports to stabilize the person's situation in the most integrated setting safely possible. In every case, at least one member of the CSS team provided outreach services, in consultation with other mobile team members.

For three of the six people, deployment of CSS mobile team supports was initiated during the reporting period:

- S3 was referred to CSS for mobile team supports in December 2015 because of aggressive behaviors that caused S3 to lose their job, that were posing a barrier to participation in community activities, and that had led to legal proceedings.[37] One or two CSS mobile team members provided weekly supports to S3 and assisted S3's team to develop a support plan that would help reduce S3's aggressive behavior. Part of the goal was to develop a support plan that could address the court's concerns regarding S3's behavior without jail time or restriction.
- L2 was referred to CSS for mobile team supports in October 2015 because of increased aggression and medical concerns. Shortly after CSS became involved in L2's case, L2's

[36] Most of these persons' situations triggered CSS mobile team involvement before referral was made to MLB.
[37] In this case, the MLB referral was submitted because of legal proceedings; Commitment and Rule 20 proceedings are in progress.

provider gave notice that L2's home was being closed. CSS mobile team members, through a combination of in-person and phone contact, provided consultation to L2's team to stabilize L2's behavior and medical concerns and to help locate another provider or home.

- S4 was referred to CSS for mobile team supports in January 2016.[38] S4's case manager referred S4 for CSS mobile team supports because S4 was likely going to be discharged from their current group home. A CSS mobile team psychologist met with S4 and S4's team through both in-person and phone contacts to identify S4's needs and wants in a provider and coordinated with S4's team to identify a provider who could develop a home for S4.

For the other three of the six people, the CSS mobile team supports were initiated before the reporting period. Two of these people (G1 and R1) were receiving long-term monitoring; the other person (B3) started receiving mobile team supports from CSS in the latter half of 2014. In all cases, however, the MLB referral and the mobile team supports addressing the situation or incidents connected to the MLB referral occurred during the reporting period.

During the reporting period, CSS also deployed mobile team supports to two persons discharged from MLB to the community (L1 and J3). For one of these people (J3), CSS initiated mobile team supports in April 2016, shortly before the person's discharge from MLB. For the other person (L1), CSS initiated mobile team supports prior to the reporting period, in March 2015, and continued the deployment into the reporting period—including the person's transition from MLB. In these cases, as for the six cases discussed above involving MLB referrals, at least one member of the CSS team provided outreach services, in consultation with other mobile team members.

3. ***What were the outcomes of these deployments?***

By the end of the reporting period, the six people referred to MLB who received CSS mobile team supports had either remained in the community (pending the outcome of legal proceedings), returned to the community, or had made concrete steps toward returning to the community—such as discharge from a hospital and/or identification of a permanent provider. The following provides greater detail regarding the progress or outcomes as of the end of the reporting period for these six people:

- **S3**: Legal proceedings are ongoing. With CSS' support, however, S3's current provider is willing to continue to serve S3. Both S3's county case manager and CSS believe that S3 can continue to be served by the current provider. S3 remains on the MLB waitlist because of the ongoing legal proceedings.

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[38] CSS classified the mobile team supports received by S4 as a crisis response.

- **L2:** L2 was discharged from the hospital and admitted to a crisis home pending their readiness for transition to back to a residential provider. CSS plans to assist with L2's transition to the community.
- **S4**: As of the end of the reporting period, S4 is still in the hospital, but a provider has been identified and is developing a home for S4.[39] CSS is offering the provider services and training to help support S4 in the community.
- **R1**: R1 was admitted to the hospital in February 2016, and did not wish to return to the previous provider. The CSS mobile team, in collaboration with SLP, assisted R1's team with finding a crisis placement to get R1 out of the hospital and facilitated the transition planning process for R1. As of the end of the reporting period, a permanent provider has been identified and is moving forward with developing a home for R1.
- **G1**: CSS assisted G1's team with securing a placement for G1 at MLB and assisted with G1's transition from the hospital to MLB in October 2015. During the reporting period, CSS continued to monitor G1's progress while G1 is at MLB and continued to be available as a community resource to G1's team as they work to locate a permanent provider for G1.
- **B3**: B3 was admitted to the hospital in late December 2015 after an incident of elopement that resulted in law enforcement involvement. Because of B3's behaviors, B3's former provider no longer was willing to provide services. Prior to B3's hospitalization, CSS was preparing to close B3's case; however, after this incident, CSS stayed on the case for an additional few months and provided consultation to B3's team in the search for a new provider. CSS closed the case in March 2016, with the understanding that CSS could provide support to a new provider, once the new provider was identified. In May 2016, B3 was discharged from the hospital and admitted to a residential foster care provider.

CSS also played a role in supporting the transition to the community for two persons discharged from MLB during the reporting period:

- **J3**: In his May and June Monthly reports, the Internal Reviewer provided updates regarding J3's transition to the community noting, among other things, that CSS has been active in the transition process and remains involved post-move to assure continuity of behavioral supports. The Internal Reviewer reported that, as of the 45-day meeting, J3 "was doing quite well" although J3 had not yet secured paid, competitive employment, which is a goal of the team. The Internal Reviewer noted that there had been one instance of property destruction, but the team made changes in the support strategies and there had not been a recurrence.
- **L1**: As with J3, CSS was active in the transition process for L1 and remained involved post-move. Near the end of the reporting period, CSS provided consultation to L1's team as the

[39] The provider made an offer on a home, which was accepted. The provider is going through the inspection/appraisal process. It will be two to four months before the home is ready. The hospital is advocating for discharge. The person was added to the crisis priority list.

team worked to support L1 through and mitigate the consequences of criminal charges resulting from L1's damage of a nearby home.

4. ***Were the mobile team efforts timely and effective?***

Timeliness

One way to assess the timeliness of CSS mobile team efforts is to look at the time it took CSS to initiate supports after receiving a request for service. As noted above, a number of the mobile team supports received during the reporting period were initiated prior to the reporting period. For the three people referred to MLB whose mobile team supports were initiated during the reporting period, the following is a summary of the time it took CSS to initiate services after receiving an inquiry for service:

- One person whose mobile team supports were initiated during the reporting period (S4) was classified as being in a crisis situation. In S4's case, CSS initiated the referral process the same day CSS received the service inquiry. Although the first official contact did not occur until one week later, this delay was due to not receiving consent until one week after initiating the referral process. Within 30 minutes of receiving the consent, CSS made the first official contact.
- In the case of S3, CSS sent the legal rights packet and release of information forms to S3's guardian the same day that CSS received the request for services from S3's case manager. CSS received the consent the following day and one day after that met in person with S3 and S3's staff.
- In the case of L2, CSS sent out the intake paperwork the same day CSS received a referral phone call from L2's case manager. This paperwork and the consents were returned the following day. The lead CSS mobile team member received the case information four days later and called L2's case manager the same day to set up the first meeting with L2's team. The first meeting with L2's team occurred two days later.

Another way to assess the timeliness of CSS mobile team efforts is to look at how customers of CSS mobile team services viewed the timeliness of CSS' response. A review of the responses CSS received from county case manager revealed that 94% (47/50) of the respondents responded positively to the statement, "CSS responded in a timely manner."

Effectiveness

One way to evaluate the effectiveness of CSS mobile team efforts is to look at the progress achieved by persons served. See pages 53 through 56 above for summaries of services provided and progress achieved for the subset of mobile team supports that are the focus of this section. For additional information about the 298 CSS mobile team supports provided during the reporting period, see ECs 67-69 (pages 37 to 41).

Another way in which to assess the effectiveness of CSS mobile team supports is to look at how members of the person's team viewed the effectiveness of the mobile team's supports. A review of the survey responses CSS received from county case managers revealed the following:

- 96% (48/50) responded positively to the statement, "Requests for services and/or expected outcomes were achieved."
- 87% (39/45) responded positively to the statement, "CSS intervention helped prevent a loss of placement, prevented hospitalization, or prevented placement in a more restrictive setting."

Verification

The responsible party determined that seven people received mobile team supports by comparing the list of persons who were referred to MLB during the reporting period against the list of persons who received supports from CSS mobile teams during the reporting period. After reviewing the CSS documentation for services provided to these people, JOQACO determined that only six of these people received supports from CSS for a sufficient length of time during the reporting period to be counted here.

JOQACO reviewed case notes and other documents relating to the provision of mobile team supports by CSS to the six persons referred to MLB and to the two persons discharged from MLB during the reporting period. JOQACO compared the information in these documents against information reported by CSS and MLB and used these documents to obtain information about the outcome and effectiveness of these deployments.

JOQACO reviewed the CSS spreadsheet with survey responses from persons receiving services, legal representatives and county case managers, survey response log and the staff directory provided by CSS to confirm that these documents supported the information provided by CSS.

Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge

Evaluation Criteria 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.

Responsible Party: *Jensen/Olmstead* Quality Assurance and Compliance Office Director

Current Status

The following will first summarize the organizational and process changes that have occurred with the Successful Life Project (SLP) during this reporting period and then will address the four questions asked by the Court in its June 21, 2016 Order with respect to EC 98: "(1) How many individuals have been followed up with in the reporting period? (2) In what settings were these individuals residing? (3) Have these individuals' lives been improved? (4) Were these individuals prevented from re-institutionalization or transfers to more restrictive settings?" (Doc. No. 578 at 6 & n.3.)

Organizational Changes

On April 6, 2016, JOQACO assumed supervision of SLP. Currently, SLP includes four Board Certified Behavior Analysts and one Registered Nurse. There are currently two vacancies, one for the SLP Coordinator position and one for a Board Certified Behavior Analyst. JOQACO initiated the 1768 process[40] to fill the SLP Coordinator position in June 2016, and the hiring process is ongoing. Before filling the Behavior Analyst position, the JOQACO Director is looking to identify gaps in the current skills of team members and is working with SLP staff to identify the competencies needed and qualities that should be sought in a new Behavior Analyst. SLP will be seeking people who have knowledge of intervention strategies including but not limited to mental health intervention strategies, mental wellness, and positive behavior supports.

SLP staff report to the JOQACO Director and receive clinical supervision from the Internal Reviewer. JOQACO has reviewed and updated the Board Certified Behavior Analyst and Registered Nurse Position Descriptions to provide better clarity regarding roles and responsibilities. The JOQACO Director also reviewed and revised the SLP Coordinator Position Description. New responsibilities for this position include working with lead agency case managers to address the issues and concerns of guardians or legal representatives providing consent. This position will also work with the Internal Reviewer on strategies for therapeutic follow-up of all SLP members, including identification

[40] 1768 is the on-line process used by the Department to fill staff vacancies.

and monitoring of persons who are at potential risk to provide early intervention as well as contact with correctional facilities housing people in the therapeutic follow-up group.

To improve coordination with CSS, Direct Care and Treatment, and the Disability Services Division regarding services to members of the therapeutic follow-up group, JOQACO has identified a SLP Behavior Analyst to participate in the daily Single Point of Entry Triage Meetings beginning August 1, 2016.

Changes to SLP Approach and Processes

To communicate more easily the services that SLP is providing to members of the therapeutic follow-up group, SLP has identified three different levels of support:

- **Priority:** The person has lost or is facing the potential loss of placement/home. Classification at this level of support takes into account both the challenge presented by the person's behaviors and the capacity of the placement.
- **Secondary**: Person is presenting challenging behavior, but placement is not threatened.
- **Proactive:** All therapeutic follow-up group members NOT receiving Priority or Secondary levels of support.

SLP is in the process of refining these definitions and the specific services and support provided at each level. SLP is also adding these categories to CareManager for reporting purposes.

Question 1: How many individuals have been followed up with during the reporting period?

During this reporting period, SLP staff provided supports to 87 members of the Therapeutic Follow-up group. This support resulted in the completion of:

- 25 PBS - SETs[41]
- 17 Person-Centered Plans
- 12 Positive Behavior Support Plans

[41]The PBS-SET is the Positive Behavior Support-System Evaluation Tool. This tool focuses on evaluating the following areas: physical environment, social setting, schedule/predictability of routine, communication, general agency expectations, community access & involvement, support of staff, development and implementation of PBS plans, monitoring and decision making, person centered planning, additional supports, and management.

- 11 Health assessments
- 10 Functional Behavior Assessments
- 1 Medication reviews
- 3 Nursing consultations

Supports to the 87 members of the therapeutic follow-up group also included 24 instances of proactive supports, which included technical assistance/consultation, Behavior Intervention Reporting Form/Incident follow-up, demission notification follow-up, and other follow-up and training. While some of the proactive supports resulted in opening an active case, most did not.

During this reporting period, SLP closed 20 priority or secondary cases. The SLP team determined that these people no longer needed the higher level of support.

Question 2: In what settings were these individuals residing?

The 87 persons supported by SLP during this reporting period lived in a variety of settings including:

- 57 Corporate foster care
- 3 Crisis home
- 4 Home of family/friend
- 9 Own home
- 4 ICF/DD
- 1 Jail/Detention center
- 1 Hospital
- 7 State Operated Facility (MSH, MSOP, MLB)
- 1 Unknown

Question 3: Have these individuals' lives been improved?
and
Question 4: Were these individuals prevented from re-institutionalization or transfers to more restrictive settings?

As explained in the section on Evaluation Tools (page 82), efforts are in progress to determine whether the Olmstead Quality of Life Survey could help provide a quantitative answer to the question of the impact of SLP and the Department's other activities under the JSA on the lives of *Jensen* class members and members of the therapeutic follow-up group.

During this reporting period, SLP developed a consumer satisfaction survey that will address the quality of clinical supports provided by SLP and the ease of utilizing SLP services—questions that will at least indirectly address the impact of SLP services on people's lives. During August or September 2016, JOQACO will send a written and electronic survey to all therapeutic follow-up

group members who received any support from SLP in the prior 12 months. There will be one version for persons with disabilities receiving services and legal representatives, and one for care providers. The exact number of persons who will receive the survey is still being determined.

Even without these quantitative tools, it is evident from updates regarding therapeutic follow-up group members to whom SLP provided support during this reporting period that SLP supports have improved the lives of these people. With the assistance of SLP support, situations have been stabilized and some persons have been able to move, or are in the planning stages to move, to a more integrated residential or work setting. The following are examples of how the lives of people receiving SLP follow-up improved during the reporting period:

- Since October 2015, after a private provider discharged A2 from their corporate foster care, A2 moved into an independent apartment with support staff (April 2016). SLP assisted in developing a person-centered plan and provided training and technical assistance. On April 22, A2 (a big sports fan) was hired for a job at Target Field. Prior to this opportunity, A2 worked at a day program.
- B1 was residing in a crisis home when SLP became involved. SLP worked with B1 and the team to complete a Person-Centered Plan, which guided development of a new home.
- SLP has worked with B2 and B2's provider on the development of a Positive Behavior Support Plan. B2 has demonstrated a decrease in interfering behaviors. B2 has started work at a vocational placement and is currently earning alone time in the community and developing goals/plans to move to B2's own apartment.
- SLP worked with B3's provider to develop a Functional Behavior Assessment and Person-Centered Plan and to provide training and technical support. B3 identified that B3 did not like the work at his/her day program and that he/she is more interested in working outside on a lawn crew. The team is currently working to help B3 get a job that is consistent with B3's preferences.
- C3's provider contacted SLP for consultation and technical assistance. At C3's vocational placement, C3's 1:1 staffing is slowly and successfully being faded out, which allows C3 to work more in the community.
- C4 moved into a new apartment on May 31, 2016. C4 also started to work for a company contracted to work the Twins' games. C4 loves working as a team leader at the stadium.
- SLP is working with a residential provider to further refine F3's Positive Behavior Support Plan and build capacity for data collection/analysis. The residential provider is developing a single site for F3.
- M1's BIRF rates have decreased from 25 in 2015 to only four in the first half of 2016. SLP has completed a PBS-SET, FBA, training, technical assistance/consultation, and a Person-Centered Plan. M1's staff is committed to helping M1 live a fuller life and creatively working to develop opportunities to access the community and family including use of an iPad as a communication tool. When M1's mother died this past spring, M1 participated with family by using M1's iPad to "talk" at the funeral.

- S2 was struggling at S2's residential and vocational placements. Last fall, S2 was at risk of losing placement due to aggression. SLP worked with S2's team to address the recommendations resulting from the PBS-SET. S2 transferred from corporate foster care into a new placement in January 2016. S2 currently lives in a home developed through individualized housing services for persons who are hard of hearing. S2 has three roommates who are also deaf and attends a special program for hearing impaired adults at Rise[42].
- W1 has continued to reduce challenging behaviors and increase access to community activities. W1's family is involved and regularly includes W1 in their gatherings. The team has risen to the challenge to get W1 out into the community for activities ranging from Special Olympics to going to movies and crafting events with peers. Currently, SLP has been working with a behavior analyst to develop a communication program to increase W1's talking from a one-word utterance to three-to-five-word sentences. SLP recently changed W1's level of service from priority to secondary.

With regard to re-institutionalization or transfers to a more restrictive setting, the vast majority of the therapeutic follow-up group members who received follow up during this reporting period were not residing in restrictive settings and did not transfer to settings that are more restrictive during the reporting period, suggesting positive stability. In total, during this reporting period, six members of the therapeutic follow-up group have been able to move or are in the planning stages to move to a more integrated residential or work setting (see Table 6 below):

Table 6: Movement to More Integrated Settings

TFU Member	Movement
A2	A2 has moved to an independent apartment and has a new job at Target Field
B1	B1 will be moving into their own home through a private provider
C4	C4 has moved into his new apartment
F3	Residential provider working to develop a single site for F3
M2	M2 is living in an independent setting
R1	R1 has moved from the hospital to a crisis home. R1's team is working to develop a corporate foster care setting where R1 can live independently with staff support.

[42] RISE is a private provider serving people with a wide range of disabilities.

Three out of the 87 persons receiving SLP supports were transferred to settings that are more restrictive during the reporting period:

1. G1 was admitted to MLB on October 20, 2015. CSS remains the lead consultant.
2. J1 was admitted to MLB on August 18, 2015. SLP will assist with transition planning when MLB identifies a home for J1.
3. G2 was admitted to a community hospital, following a demission from the provider. G2 was admitted to MLB on July 15, 2016. SLP was involved in transition planning and training MLB staff.

Another four people who received SLP follow-up during the reporting period resided in restrictive settings, such as MSH or prison, but had transferred to these settings prior to the reporting period. The following are updates for these people for this reporting period:

- C1 is at MSH and moved from Unit 200 to Unit 600; C1 engaged in very few challenging behaviors during the reporting period.
- F2 is at MSH and working with their team to find a more integrated location. The team has been unsuccessful in finding a provider that will take F2 due to F2's offender history.
- H1 is at MSH and is ready to transition to a more integrated setting. The team has identified a foster care provider in a more independent apartment setting. The team is waiting for the county to finish the licensing process.
- Y1 was moved from a maximum-security facility to a super maximum-security facility. SLP has maintained contact with the prison facility.

Verification

On July 20, 2016, JOQACO identified three random samples of people who received supports from the SLP during this reporting period: Random Sample #1 - Persons identified as receiving Primary or Secondary supports (20); Random Sample #2 - Persons identified as receiving Proactive supports (10); and Random Sample #3 - Persons identified as receiving SLP Nursing supports (6).

Between August 3 and August 9, 2016, JOQACO reviewed case notes for each of the three samples and compared with information SLP staff reported in their summary updates to JOQACO. As needed, the JOQACO contacted SLP staff for additional clarification.

JOQACO was able to verify information reported by SLP staff with the information in the case notes from CareManager for 30 of 36 people. Through interviews with SLP staff, JOQACO was able to verify SLP involvement for the six people whose case notes were not in CareManager. JOQACO also determined through these interviews where SLP staff documented the information, if not in CareManager.

JOQACO reminded SLP staff to be sure to utilize CareManager for all documentation and will follow up with SLP staff during the next reporting period to ensure this happens.

The JOQACO Director also interviewed three case managers regarding the outcomes reported by SLP for four people (A2, B1, R1 and M4). All case managers interviewed confirmed that what SLP reported was accurate.

Modernization of Rule 40 (EC 103)

Evaluation Criteria 103

Within thirty (30) days of the promulgation of the Adopted Rule, Plaintiffs' Class Counsel, the Court Monitor, the Ombudsman for Mental Health and Developmental Disabilities, or the Executive Director of the Governor's Council on Developmental Disabilities may suggest to the Department of Human Services and/or to the Olmstead Implementation Office that there are elements in the Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013) which have not been addressed, or have not adequately or properly been addressed in the Adopted Rule. In that event, those elements shall be considered within the process for modifications of the Olmstead Plan. The State shall address these suggestions through Olmstead Plan sub-cabinet and the Olmstead Implementation Office. Unresolved issues may be presented to the Court for resolution by any of the above, and will be resolved by the Court.

Responsible Party: DHS Deputy Senior Counsel

Current Status

The Department began meeting with the Office of Ombudsman for Mental Health and Developmental Disabilities and the Governor's Council on Developmental Disabilities in the fall of 2015 to discuss elements of the Rule 40 Advisory Committee recommendations that may not be adequately or properly addressed by the Positive Supports Rule or other Department efforts. These discussions were put on hold during the 2016 legislative session and will be picked up again in July 2016. As elements are identified as not adequately or properly addressed, the Department, in conjunction with the Office of Ombudsman for Mental Health and Developmental Disabilities and the Governor's Council on Developmental Disabilities, will determine how to proceed to address them.

Verification

The responsible party was personally involved in the events reported in the status update for this EC.

Exception Reporting

Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training

Evaluation Criteria 56

Facility staff receive the specified number of hours of training: Therapeutic interventions (8 hours); Personal safety techniques (8 hours); Medically monitoring restraint (1 hour).

Responsible Party: Minnesota Life Bridge Manager

Current Status

Facility direct care staff fulfill the training requirements specified by this EC through the following annual trainings:

- Effective and Safe Engagement (EASE) 2.0 Assess & Plan and Skills Demonstration (16 hours)
- Minnesota Life Bridge Therapeutic Interventions and Emergency Use of Personal Safety Techniques (TI/PST)/EASE Procedure (1 hour)
- Medically Monitoring Restraint (1 hour).

Because the MLB training year runs from March 12 to the following March 11, the 2015/2016 training year was still in progress as of the end of the reporting period covered by the 2015 Compliance Annual Report (Doc. No. 553). In the 2015 Annual Report, the Department reported the following percentages of MLB and East Central staff who, as of December 31, 2015, had completed all of the required hours of EASE, TI/PST/EASE Procedure, and Medically Monitored Restraint training:

- 43% of MLB direct care staff and 0% of East Central direct care staff had completed the required hours of EASE training
- 27% of MLB direct care staff and 31% of East Central direct care staff had completed the required hour of TI/PST/EASE Procedure training and
- 82% of MLB direct care staff and 62% of East Central direct care staff had completed the required hour of Medically Monitored Restraint training.

(*Id.* at 16.) The Department noted that MLB and East Central held a number of staff training sessions after the end of the reporting period and before the end of the training year. (*Id.*) The final assessment of training completion was not available as of the date the Annual Report was filed, but the Department reported that a preliminary analysis showed a significant increase in completion of required 2015/2016 annual training. (*Id.*)

JOQACO subsequently confirmed that, while there was a significant increase in completion of required 2015/2016 training hours by the end of the training year, some training hours remained outstanding. Based on the information available to JOQACO, the following percentages of staff

completed all of the required hours of EASE, TI/PST/EASE Procedure, and Medically Monitored Restraint training by the end of the 2015/2016 training year: [43]

- 97.7% of MLB direct care staff and 84.6% of East Central direct care staff completed the required hours of EASE training
- 97.7% of MLB direct care staff and 100% of East Central direct care staff completed the required hour of TI/PST/EASE Procedure training and
- 95.3% of MLB direct care staff and 100% of East Central direct care staff completed the Medically Monitored Restraint training.

JOQACO directed MLB and East Central to ensure that all staff with outstanding hours from the 2015/2016 training year completed those outstanding hours in the 2016/2017 training year. These make-up training hours are to be *in addition to* the annual requirements for the 2016/2017 training period. JOQACO has been monitoring the progress of training to confirm that the training hours needed to satisfy outstanding 2015/2016 annual requirements are being completed and are being tracked separately from the training hours needed to complete the 2016/2017 annual requirements.

As of the date of this report, all active staff at MLB and East Central have completed outstanding training hours for EC 56 from the 2015/2016 training year.

Settlement Agreement Section IX.B. Other Practices at the Facility – Hours of Training

Evaluation Criteria 58

Facility staff receive the specified number of hours of training: Person-centered planning and positive behavior supports (with at least sixteen (16) hours on person-centered thinking / planning): a total 40 hours; Post Crisis Evaluation and Assessment (4 hours).

Responsible Party: Minnesota Life Bridge Manager

Current Status

Facility direct care staff fulfill the training requirements specified by this EC through the following annual trainings:

- Effective and Safe Engagement (EASE) 2.0 Assess & Plan and Skills Demonstration (16 hours)
- Minnesota Life Bridge Therapeutic Interventions and Emergency Use of Person Safety Techniques Procedure (TPI/PST)/EASE Procedure (1 hour)

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[43] These percentages do not include one staff who was hired by/transferred to MLB on March 9, 2016, and did not have an opportunity to complete all of the trainings prior to the end of the training year on March 11, 2016.

- Person-Centered Training (12 hours for existing employees, 16 hours for new employees)
- Positive Behavior Supports (12 hours for existing employees, 24 hours for new employees) and
- Crisis Intervention/Post Crisis Intervention and Assessment (4 hours).

Because the MLB training year runs from March 12 to the following March 11, the 2015/2016 training year was still in progress as of the end of the reporting period covered by the 2015 Compliance Annual Report (Doc. No. 553). In the 2015 Annual Report, the Department reported the following percentages of MLB and East Central staff who, as of December 31, 2015, had completed all of the required number of hours of the trainings listed above:

- 43% of MLB direct care staff and 0% of East Central direct care staff had completed the required hours of EASE training
- 27% of MLB direct care staff and 31% of East Central direct care staff had completed the required hour of TI/PST/EASE Procedure training
- 82% of MLB direct care staff and 62% of East Central direct care staff had completed the required hour of Medically Monitored Restraint training
- 18% of existing MLB direct care staff and 8% of existing East Central staff had completed the required hours of Person-Centered Training
- 45% of MLB direct care staff and 38% of East Central staff had completed the required hours of Crisis Intervention/Post Crisis Intervention training
- 70% of MLB direct care staff had completed the required hours of Positive Behavior Supports training; 23% of East Central direct care staff had completed the required hours of Positive Behavior Supports training.

(*Id.* at 18.) The Department noted that MLB and East Central held a number of staff training sessions after the end of the reporting period and before the end of the training year. (*Id.* at 18-19.) The final assessment of training completion was not available as of the date the Annual Report was filed, but the Department reported that a preliminary analysis of the training completed as of March 11, 2016, showed a significant increase in completion of required 2015/2016 annual training. (*Id.* at 19.)

JOQACO subsequently confirmed that, while there was a significant increase in completion of required 2015/2016 training hours by the end of the training year, some training hours remained outstanding. Based on the information available to JOQACO, the following percentages of staff completed all of the required hours of the specified trainings by the end of the 2015/2016 training year:[44]

[44] These percentages do not include one staff who was hired by/transferred to MLB on March 9, 2016, and did not have had an opportunity to complete all of the trainings prior to the end of the training year on March 11, 2016.

- 97.7% of MLB direct care staff and 84.6% of East Central direct care staff had completed the required hours of EASE training;
- 97.7% of MLB direct care staff and 100% of East Central direct care staff had completed the required hour of TI/PST/EASE Procedure training;
- 95.3% of MLB direct care staff and 100% of East Central direct care staff had completed the required hour of Medically Monitored Restraint training;
- 72.1% of MLB direct care staff and 100% of East Central direct care staff had completed the required hours of Person-centered Training;
- 86.0% of MLB direct care staff and 100% of East Central direct care staff had completed the required hours of Crisis Intervention/Post Crisis Intervention Training; and
- 72.1% of MLB direct care staff and 100% of East Central direct care staff had completed the required hours of Positive Behavioral Supports Training.

JOQACO directed MLB and East Central to ensure that all staff with outstanding hours from the 2015/2016 training year completed those outstanding hours in the 2016/2017 training year. These make-up training hours were to be *in addition to* the annual requirements for the 2016/2017 training period. JOQACO has been monitoring the progress of training to confirm that the training hours needed to satisfy outstanding 2015/2016 annual requirements were being completed and were being tracked separately from the training hours needed to complete the 2016/2017 annual requirements.

As of the date of this report, all active staff[45] at MLB and East Central have completed outstanding training hours for EC 58 from the 2015/2016 training year.

Verification and Monitoring (ECs 56 and 58)

As explained in the Ninth Compliance Update Report (Doc. No. 531 at 40-41) and the 2015 Compliance Annual Report (Doc. No. 553-1 at 17), MLB enters information about staff training completion, including staff competency results, into the Department's web-based Pathlore Learning Management System. Since early 2016, JOQACO's data analyst has requested, on a monthly basis, reports from Pathlore to review for missing or inaccurate data. This has involved, among other efforts, reviewing the Pathlore reports for errors or discrepancies and spot-checking information reported in Pathlore for consistency with training sign-in sheets or other documentation related to training. Through this process, JOQACO identified some Pathlore data entry errors, course code identification problems, and problems with timely entry of training hours into Pathlore—all of which JOQACO brought to the attention of MLB. JOQACO's data analyst has also provided MLB with

[45] One staff who was hired to work at MLB in an on-call/intermittent capacity has not, as of the date of this report, completed 6.0 hours of Person-Centered Training that is outstanding from the 2015/2016 training year. However, this staff has not been active in working shifts at MLB in recent months. MLB informed the staff that they must contact MLB by August 8 and complete all needed training updates or they will be deemed to have voluntarily resigned.

tracking sheets on a regular basis to help MLB chart progress toward meeting staff training requirements. JOQACO directed MLB to submit updated and verified tracking sheets to JOQACO on a monthly basis and will be meeting with MLB in September 2016 to formulate a more detailed plan of action regarding completion and reporting of training hours.

In addition, JOQACO interviewed MLB staff about certain aspects of training while completing on-site verification reviews at Stratton Lake and Brobergs Lake in July 2016. JOQACO's review of the MLB training reports from Pathlore identified a number of hours of self-study labeled "PBS On-going Learning and Practice" (Course Code-SOS0001966). It was unclear from the description in Pathlore what staff studied during these training hours and how/by whom competency was evaluated. Both of the Brobergs Lake staff interviewed stated that, on a weekly basis, they receive and review information about updates to Positive Support Transition Plans, Positive Behavior Supports, client progress notes or meeting minutes. The Stratton Lake staff members interviewed by JOQACO also stated that a similar review of updated client information packets is also the practice at Stratton Lake. The designated coordinator for each site is responsible for assessing staff competency through interviews and documenting the results of the staff competency assessment. As there are ongoing changes to persons' plans and not all MLB staff participate in the meetings where such changes are developed, it is important that MLB has a way to ensure that staff are made aware of changes and demonstrate competency in these changes, as evaluated by the designated coordinator.

JOQACO did identify opportunities for performance improvement in staff training. Both staff interviewed at Brobergs Lake expressed a need for more training support at the home from higher level BAs. Both staff interviewed at Stratton Lake expressed a need for better documentation of training processes. JOQACO is following up with MLB regarding these staff concerns; among other things, JOQACO is asking that MLB create a document that sets out the processes and expectations for training—particularly the content, competency, and documentation requirements associated with self-study training hours—to better ensure the consistency and quality of training. On August 25, 2016, JOQACO requested in writing that MLB provide, by September 15, 2016, an Action Plan to develop such a document.

Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital

Evaluation Criteria 81

The State takes best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability.

Responsible Party: Executive Director – Forensic Services, JOQACO Director, and DHS Deputy Senior Counsel

Current Status

On May 19, 2015, MSH admitted a person (O1) committed solely as a person with a developmental disability. Since admission, the Department actively pursued transition planning. The Department also provided the Court Monitor, Plaintiffs' Class Counsel, and Consultants with weekly updates on the status of the transition for this person, and collaborated with the Consultants and involved county officials. Exploration of community-based options began in June 2015. During Calendar Year 2015, the Department and the County of Financial Responsibility (CFR) explored many in state and out-of-state options.[46]

On November 11, 2015, the Department identified an investor to work with the Department to purchase a home for O1. In December 2015, the Department identified a house in the northern suburbs. The Department viewed the home on December 17, 2015. The investor toured the home on December 28, 2015, and made a contingent offer. MSH and Community Based Services made arrangements for O1 to tour the home on January 29, 2016. Closing on the home occurred on February 19, 2016. Following the closing, modifications to the home and licensing of the home began.

O1's transition team reconvened on January 20, 2016. Scheduled transition meetings occurred at least every other week until O1's move to the new home in June 2016. The Director of Positive Behavior Support | Direct Care & Treatment Minnesota Department of Human Services, led the collaborative development of O1's Transition Plan and continues to be actively involved in the program.

On June 22, 2016, MSH discharged O1 to O1's community home. With O1 now living in the community, there are no persons at MSH who were transferred to or placed at MSH based solely on a commitment as a person with a developmental disability.

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[46] In the Ninth Compliance Update Report, the Department reported that the CFR had published a Request for Information specifically for this person. The Department has since learned that the CFR did not complete a RFI process, but rather reached out directly to specific providers via personal conversations. Only one provider responded and, after an initial meeting with the CFR, they declined to be involved.

In February 2016, the Quality Assurance Leadership Team (QALT) asked Department staff to review the situation that led O1 to remain at the Minnesota Security Hospital (MSH) for an extended period. In April 2016, the QALT reviewed an analysis of data relating to the timing of discharge and provisional discharge and a report of initial findings. At this meeting, the QALT discussed the role of the Department's Housing Supports Division in assisting O1 and other current or future clients' transition out of MSH. The group also highlighted the importance of counties in successfully transitioning a person with developmental disabilities out of MSH. Direct Care and Treatment staff presented information on the importance of housing, and staff availability and flexibility, to help persons transition out of MSH. QALT has scheduled follow-up to discuss what the Department could do to help current and future clients transition out of MSH more quickly as well as prevent persons committed solely as a person with a developmental disability from admission to MSH.

Verification

The JOQACO Director and DHS Deputy Senior Counsel attended discharge-planning meetings for O1.

MSH verified there were no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability through review of admissions during the period of January 1, 2016 – June 30, 2016 from the AVATAR[47] PM Report-Admission Report[48]. MSH cross-referenced this report with weekly AVATAR Report-DD in Forensics.[49]

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[47] AVATAR is the electronic health record used by MSH.

[48] This report provides the following information by program and unit: person's name, date and time of admission, age at admission, date of birth, type of admission (i.e. transfer, commitment, and evaluation), legal status, and county of financial responsibility. Legal status is reviewed to ensure MSH has not admitted a person committed solely as DD.

[49] This report provides the following information by program and unit: person's name, date of admission, county of financial responsibility, predatory offender designation, diagnosis and legal status. This report identifies anyone at MSH who has a diagnostic code of Mild, Moderate, or Unspecified intellectual disability.

Responses to the Court's June 21, 2016 Order (Doc. No. 578)[50]

Update on Community Support Services and Crisis Intervention Outcomes

In the June 21 Order, the Court requested an update "on the outcomes for individuals with disabilities resulting from Defendants' efforts with respect to Community Support Services and crisis interventions throughout the state (*see* ECs 67-72; Doc No. 551 at 12-14)." (Doc. No. 578 at 6.)

As explained on page 82, efforts are in progress to determine whether the Olmstead Quality of Life Survey could help provide a quantitative answer to the question of the impact of CSS' and the Department's other activities under the JSA and CPA on the lives of *Jensen* Class Members and members of the therapeutic follow-up group.

In the meantime, the Department has provided in this report information about services provided to specific people served by CSS during the reporting period and the impact of those services on these people's lives. (See the status updates for ECs 67-68 and 93.) Also instructive are the responses to CSS consumer satisfaction surveys for services provided during the reporting period (see pages 42-43).

Update on the Prevalence and Justification for 911 Calls at the Facility

In the June 21 Order, the Court requested an update on "the prevalence and justification for 911 calls at the facilities, including a statement of whether the calls resulted in the use of handcuffs or chemical restraint (*see* ECs 28-30; Doc. No. 551 at 8-10)." (Doc. No. 578 at 6). In the June 21 Order, the Court also requested "information on whether any training is provided at the facilities to educate staff on the impropriety of using 911 calls in lieu of positive behavioral supports for the purpose of implementing prohibited restraints." (*Id.* at 6 n.4). The following addresses both of these requests.

911 Call Analysis

Table 7, below, summarizes the twenty-five (25) 911 calls made from the facilities during the reporting period. This count includes three calls initiated by the person receiving supports, with 22 calls made by staff. In two cases, the person became physically assaultive of the responding officers. In both of those cases, police manually restrained the person; in one of these two instances, police also handcuffed the person. These two cases were the only instances in which responding officers performed any form of restraint.

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[50] In the Court's June 21, 2016 Order (Doc. No. 578), the Court also requested clarification with respect to EC 93 (*id.* at 5 n.2) and EC 98 (*id.* at 6 n.3). The Court's requests for clarification on these topics are addressed in the sections of this report providing status updates on EC 93 (pages 52-57) and EC 98 (pages 58-64).

There were no cases of the responding officers:

- Arresting persons,
- Initiating physical restraint, or
- Performing chemical restraint.

There were, however, seven cases in which either the responding officer or ambulance transported persons to medical facilities. (See Table 3, page 22.)

Table 7: 911 Call Analysis

Incident Date	Person	Location	Was person manually restrained by police?	Were handcuffs used?
11/20/15	**J1**	Brobergs Lake	No	No
11/20/15	**S2**	Brobergs Lake	No	No
12/6/15	**W2**	East Central	No	No
1/2/16	**S2**	Brobergs Lake	No	No
1/2/16	**S2**	Brobergs Lake	No	No
1/4/16	**J1**	Brobergs Lake	No	No
1/17/16	**S2**	Brobergs Lake	No	No
1/19/16	**W2**	East Central	No	No
2/14/16	**J1**	Brobergs Lake	No	No
3/1/16	**G1**	Stratton Lake	No	No
3/1/16	**T1**[51]	Eagle Pointe	**Yes**	No
3/26/16	**T1**	Eagle Pointe	No	No
4/5/16	**S2**[52]	Brobergs Lake	No	No
4/5/16	**J2**[53]	Stratton Lake	**Yes**	**Yes**
4/22/16	**H2**	East Central	No	No
4/23/16	**T1**	Eagle Pointe	No	No
5/1/16	**H2**	East Central	No	No
5/08/16	**W2**	East Central	No	No
5/14/16	**W2**	East Central	No	No
5/30/16	**S2**[54]	Brobergs Lake	No	No
5/30/16	**T1**	Eagle Pointe	No	No
6/4/16	**Y2**	East Central	No	No
6/15/16	**S2**[55]	Brobergs Lake	No	No
6/21/16	**H2**	East Central	No	No
6/21/15	**T1**	Eagle Pointe	No	No

[51] T1 was assaultive of police and attempted to get T1's phone back from the police officer's pocket after hitting the officer's chest with an open hand.
[52] Call initiated by S2
[53] J2 was assaultive of police, spit at police, and was self-injurious.
[54] Call initiated by S2
[55] Call initiated by S2

Training Regarding 911 Calls

To investigate the training provided to MLB staff regarding calls to 911, the Internal Reviewer used three sources of information:

1. A review of MLB Procedure #15868, Therapeutic Interventions and Emergency Use of Personal Safety Techniques;
2. Training given to staff annually on Procedure #15868; and
3. A recent Positive Supports Transition Plan for a person supported by MLB whose behavior has resulted in 911 calls.

Review of MLB Procedure #15868

MLB Procedure #15868 guides use of physical intervention. MLB staff are given training on this Procedure as part of the Crisis/Post-crisis training. The policy states that staff "shall use the least amount of intervention necessary to safely physically manage an individual, only when less restrictive behavioral support strategies have been ineffective in sustaining safety, and only concurrent with the uncontrolled behavior." The policy calls for use of positive behavior supports as a means for making positive changes in behavior, but does not give specific guidance on when to call 911, and does not make explicit the connection between positive behavior supports and 911 utilization. There is, however, extensive guidance in this procedure about documentation of 911 calls.

Training on Minnesota Life Bridge Procedure #15868

The Internal Reviewer reviewed the training given to MLB staff on Procedure #15868 as part of the Crisis/Post-crisis training. This training did not give guidance on when to call 911, though reporting for 911 calls was mentioned.

Examination of a Positive Supports Transition Plan

The Internal Reviewer's examination of a Positive Supports Transition Plan for a person supported by MLB whose behavior has resulted in 911 calls noted inclusion of the following content: "If [the person] engages in any activity that poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety, do the following:

1. Use EASE techniques as trained to de-escalate the situation.
2. Follow procedure #15868 Therapeutic Interventions and Emergency Use of Personal Safety.
3. Call 911 for law enforcement support as needed.

It is the recommendation of the Internal Reviewer that MLB develop policies specific to the appropriate utilization of 911 and that training on these specific policies be added to the training for

MLB staff. It is also recommended by the Internal Reviewer that guidance specific to the appropriate utilization of 911 be added to each Positive Supports Transition Plan. The Internal Reviewer will follow up with MLB on these recommendations during the MLB conference call on August 19, 2016.

In an effort to improve the capacity of the Department and providers to support persons with challenging behavior, the Internal Reviewer provided 11 training sessions during this reporting period targeting crucial areas of clinical need, including Positive Supports. See **Table 4:** Internal Reviewer Training, page 25.

Compliance Verification Process

In the June 21 Order, the Court recommended, (1) "that DHS establish a protocol to govern DHS' compliance evaluation and verification efforts, including efforts involving Independent Subject Matter Experts or the *Internal Reviewer*"; (2) "that DHS implement this protocol as soon as possible so that it may be used between now and the August 31, 2016 Compliance Update Report deadline"; and (3) that DHS "consult with the Consultants to facilitate this process." (Doc. No. 578 at 6-7.)

See earlier sections on the JOQACO Compliance Verification Process (beginning on page 5) and Independent Subject Matter Experts (beginning on page 10).

Updates to the Department's May 31, 2016 Report to the Court (Doc. No. 572)

Staff Training (ECs 54-57)

In response to the Court's March 18, 2016 Order (Doc. No. 551) regarding staff training at the Facility (ECs 54-57), the Internal Reviewer evaluated and provided feedback on MLB staff training curricula. The Internal Reviewer's evaluation and recommendations are documented in the Department's May 31, 2016 Report to the Court (*see* Doc. No. 572 at 5-13). In the May 31 Report, the Department stated,

"JOQACO will follow up with MLB on the recommendations of the Internal Reviewer regarding training. JOQACO will obtain a plan of action to incorporate the recommendations no later than June 10, 2016, with anticipated implementation no later than July 15, 2016. The Executive Director of JOQACO is also currently participating in a business improvement project focused on increasing MLB training compliance with an expected completion date in July 2016. (*Id.* at 13.)"

The Internal Reviewer recommendations related to training included:

- **Effective and Safe Engagement (EASE):** Revise videos to present cautions in the videos as well as in the actual training sessions.
- **Positive Behavior Supports:** Identification of areas in which additional material should be added to be consistent with best practices (i.e. setting events and content on mental health).
- **Crisis Intervention/Post Crisis Intervention and Assessment:** Mental wellness support strategies should be added; the term "wellness" should be defined; and a competency exam should be added, as required by the CPA.
- **Medically Monitored Restraint:** Additional materials are needed to assure greater consistency with best practice standards and more thorough sharing of best practices with trainees.

The Internal Reviewer had no recommendations with respect to Person-Centered Training.

On June 6, 2016, JOQACO shared the Internal Reviewer's recommendations related to staff training with MLB. Of the five staff training areas, MLB has direct control over the curriculum of three areas, namely Positive Behavioral Supports (PBS), Crisis Intervention/Post Crisis Intervention and Assessment, and Medically Monitored Restraint (MMR).

On June 9, JOQACO met with MLB to discuss the report recommendations concerning the curriculum changes within their control. MLB addressed these recommended changes by July 15, 2016. The Internal Reviewer verified that Minnesota Life Bridge made all of the recommended changes in

Positive Behavioral Supports, Crisis Intervention/Post Crisis Intervention and Assessment, and Medically Monitored Restraint training curriculums.

As stated in the May 31 report to the court, the Internal Reviewer used "Product Evidence" not "Observation Evidence" in his review. In August 2016, the Internal Reviewer observed a session of the Crisis Intervention/Post Crisis Intervention and Assessment to verify that the training was conducted with fidelity to the revised training curriculum that had been approved by the Internal Reviewer. The Internal Reviewer made the following observations:

- During the observed training session, there was full fidelity to the training materials in all material aspects.
- The trainer supplemented the materials with real life examples drawn from the residents of MLB homes and presented situations relevant to the job responsibilities.
- One notable addition was that the trainer also discussed the fact that crisis moments are not the moments for teaching to occur.
- There was a strong effort to use only plain language.

In August 2016, the Internal Reviewer also observed sections of the Positive Behavior Supports training to verify that the training was conducted with fidelity to the revised training curriculum that had been approved by the Internal Reviewer. The Internal Reviewer made the following observations:

- During the observation, there was full fidelity to the training materials in all material aspects.
- The trainer supplemented the materials with real life examples that were drawn from the residents of MLB homes and presented situations relevant to the job responsibilities.
- One notable addition was that the trainer focused heavily on instructional strategies; this content was added to the training after the Internal Reviewer's review of the training materials. The Internal Reviewer recommends that this new content be modified to include examples of how instruction can be can be used to support behavior intervention.

The Internal Reviewer is sharing with the trainers and MLB administrators his observations and recommendations regarding the training sessions he attended. The Internal Reviewer will also observe a future session of Medically Monitored Restraint trainings, which will provide the Internal Reviewer with an additional opportunity to verify that MLB has addressed his recommendations with respect to this training.

The other staff training area for which the Internal Reviewer recommended changes, EASE, is not within MLB's control to make changes to the curriculum or delivery method because the Department's Learning and Development Division developed the training. The Internal Reviewer has discussed with the developers of EASE his recommended changes. The EASE curriculum developers have addressed all recommendations. The Internal Reviewer will observe the finished product when it is available.

Six Sigma Green Belt Project Update

In April 2016, as part of their Six Sigma[56] Green Belt training and certification, the JOQACO Director and CSS Director identified MLB staff training as their continuous improvement project area. The project objective is *"The percentage of Minnesota Life Bridge (MLB) employees who complete all Jensen-required training within the required timelines will increase from 89% to 97% by January 12, 2017."* As part of the Six Sigma DMAIC [57] process, key players examined a number of challenges related to completion of training and identified a number of solutions that MLB is in the process of implementing, including:

- Standardizing Training Participant Forms with pre-populated fields for course code and delivery method (in progress).
- Developing protocols defining roles and responsibilities related to training completion (will be completed by October 1, 2016).
- Publishing clear timelines for training completions (will be completed by December 1, 2016).

Standardization of Training

The Internal Reviewer submitted a proposal to the QALT at the July 20, 2016, meeting regarding the feasibility of standardizing training across divisions. The Internal Reviewer presented the recommendation from the Court regarding standardization of training, (*see* Doc. No. 551 at 11), and the QALT agreed to consult in a review of training across the agency to consider opportunities for standardization. The QALT asked Department divisions to submit information on whether they provide training in any of the areas identified in the CPA. This information will be presented at the September QALT meeting. A subcommittee of the QALT involving relevant division representatives will then explore opportunities for standardization and report back to the QALT. See also previous sections on the QALT and Standardization of Training on page 12.

Community Support Services (ECs 67-72)

In the Department's May 31, 2016 Report to the Court (Doc. No. 572), the Internal Reviewer reported on his efforts to "verify the results reported in the Gap Report," regarding ECs 67-72 and to "develop a substantive performance report to elaborate on [Community Support Services] and crisis interventions," as directed by the Court's March 18, 2016 Order (Doc. No. 551). In response to the

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[56] Six Sigma is a set of techniques and tools that seeks to focus on customer requirements through minimizing variability and improving process quality.

[57] DMAIC is an acronym for Define, Measure, Analyze, Improve and Control and refers to a data-driven improvement cycle used for improving, optimizing and stabilizing business processes and designs. The DMAIC improvement cycle is the core tool used to drive Six Sigma projects.

Internal Reviewer's report regarding ECs 67-72, the Department stated that it would take the following actions:

1. "JOQACO will follow up with CSS on the recommendations of the Internal Reviewer regarding **database maintenance**. JOQACO will obtain a plan of action to incorporate these recommendations no later than June 10, 2016, with anticipated implementation no later than July 15, 2016." (Doc. No. 572 at 25.)
2. "JOQACO will play a greater role in **reviewing and verifying information** contained in future reports. JOQACO will use a standard, documented process to pull data so that it can be recreated at a later date." (*Id.*)
3. "JOQACO will also explore with the Internal Reviewer the feasibility of the introduction of a **precision business intelligence presence**." (*Id.* at 26.)
4. "With respect to the recommendations of the Internal Reviewer regarding **overlap of crisis intervention services,** JOQACO will follow up with CSS. JOQACO will obtain a plan of action to incorporate the recommendations no later than June 10, 2016, with anticipated implementation no later than July 15, 2016." (*Id.* at 26.)
5. "With respect to the Internal Reviewer's comments regarding **CSS's ability to work in a more proactive manner,** the Department agrees that time is always better spent on prevention rather than crisis management. . . . JOQACO will explore with the Internal Reviewer the primary and secondary intervention approaches mentioned in his report as potential improvements to CSS and SPE services." (*Id.*)

CSS Database Maintenance Action Plan

On June 6, 2016, JOQACO shared with CSS the Internal Reviewer's recommendations related to information management systems and data. On June 10, CSS provided JOQACO with the following action plan:

Monthly, prior to submitting information to JOQACO, CSS will:

- Visually inspect databases regarding persons served (including those receiving Long-Term monitoring and persons with developmental disabilities receiving standard CSS services);
- Compare information to secondary sources of information; and
- Reconcile any calculation discrepancies noted.

In CSS submissions to JOQACO during the reporting period, the responsible party attested that the information provided to JOQACO from CSS databases had been visually inspected and, for a random sample of persons served, compared against other sources of information (such as case notes). (See, for example, the "Verification" sections for ECs 67-69.) During the next reporting period, JOQACO will engage in verification activities to confirm that CSS is continuing to follow its action plan with respect to database maintenance.

JOQACO Role in Reviewing and Verifying Information

See earlier section on JOQACO Compliance Verification Process beginning on page 5.

Precision Business Intelligence

Precision Business Intelligence is a technology-driven process for analyzing data and presenting actionable information to help make more informed decisions and gather analytical insights about business practices. In the context of SLP, precision business intelligence practices would mean gathering data with respect to specific clinical needs and supports through an iterative process to improve the effectiveness and efficiency of SLP therapeutic follow-up activities.

On June 9, 2016, JOQACO met with the Internal Reviewer to discuss recommendations in the May 31, 2016 Report concerning Precision Business Intelligence. On June 21, 2016, JOQACO and the Internal Reviewer met with SLP to gather input on defining primary, secondary and proactive levels of service for therapeutic follow-up group members. As part of a pilot project, JOQACO is targeting precision business intelligence practices and principles to the monitoring and provision of services to therapeutic follow-up group members who are in the proactive services group.

SLP is also looking at how to better use technical resources to identify and serve targeted information needs.

Overlap with the Successful Life Project and Community Support Services (Doc. No. 572 at 26)

On June 7 and June 27, 2016, JOQACO met with CSS to discuss the Internal Reviewer recommendations concerning overlap of SLP and CSS. To avoid confusion as to who will take the lead for therapeutic follow-up group members entered into the Single Point of Entry; SLP will now have a representative at the morning triage meetings for the Single Point of Entry[58]. To ensure that both CSS and SLP staff have access to all case notes on therapeutic follow-up group members, the CSS Director is following up with CSS System Support to discuss moving CSS data on persons with developmental disabilities to the CareManager system, which is the system used by SLP. CSS will also participate in an upcoming SLP meeting to discuss CSS/CareManager documentation processes.

CSS Ability to work in a More Proactive Manner

On June 27, 2016, JOQACO and the Internal Reviewer met with CSS to discuss the recommendations concerning the ability of CSS to work in a more proactive manner. Based on that meeting, it was determined that JOQACO will use the SLP precision business intelligence pilot to assess how SLP's efforts to work more proactively could be translated to the CSS model. To ensure that there is

[58] SLP has identified the staff who will participate in the daily Single Point of Entry triage calls on a regular basis beginning August 1, 2016.

continued follow-up on this Internal Reviewer recommendation, JOQACO will keep CSS informed about the progress of the SLP precision business intelligence pilot.

Evaluation Tools

In the Department's May 31, 2016 Report to the Court, the Internal Reviewer, as directed by the Court (See Doc. No. 551 at 16), examined evaluation tools used to review the quality of plans developed in the provision of services to persons with disabilities. (Doc. No. 572 at 27-31.) The Department noted, however, that "the Court's March 18, 2016 Order seems to seek information regarding a more direct measure—are peoples' lives being improved by the Department's efforts." To this end, the Internal Reviewer examined the Olmstead Quality of Life Survey to determine whether the inclusion of a sample of *Jensen* class members in the administration of this survey could help provide a quantitative answer to the question of whether the Department's efforts under the JSA have had a positive impact on the lives of class members or persons in the therapeutic follow-up group. The Internal Reviewer discussed his review of the Quality of Life Survey at the August 2016 Quality Assurance Leadership Team meeting, and work is in progress to address a number of logistical issues and determine the feasibility of pursuing this project.

Evaluation Criteria

EC#	Evaluation Criteria	CPA Section	Reporting
1.	The Facilities will comply with Olmstead v. L.C. The Facilities are and will remain licensed to serve people with developmental disabilities. The Facility will eliminate unnecessary segregation of individuals with developmental disabilities. People will be served in the most integrated [sic] setting to which they do not object. Each individual's program will include multiple opportunities on an ongoing basis to engage with: (1) citizens in the community, (2) regular community settings, (3) participating in valued activities (4) as members of the community. These community activities will be highly individualized, drawn from the person-centered planning processes, and developed alongside the individual.	Settlement Agreement Section IV. METO Closure	**Annual**
1.1	Each individual's planning processes will specifically address integration within the following life areas: (1) home; (2) work; (3) transportation; (4) lifelong learning and education; (5) healthcare and healthy living; and (6) community and civic engagement.	Settlement Agreement Section IV. METO Closure	
1.2	Cambridge and successor facilities apply strong efforts to individualize and personalize the interior setting of the home. This includes exerting maximal feasible efforts to assist individuals to personalize and individualize their bedrooms and common areas, to make each common area aesthetically pleasing, and to actively support individuals to bring, care for, acquire, and display personal possessions, photographs and important personal items. Consistent with person-centered plans, this may include the program purchasing such items, which will build towards transition to a new place to live.	Settlement Agreement Section IV. METO Closure	
2.	Facilities utilize person-centered planning principles and positive behavioral supports consistent with applicable best practices including, but not limited to the Association of Positive Behavior Supports, Standards of Practice for Positive Behavior Supports.	Settlement Agreement Section IV. METO Closure	**Semi-Annual**
2.1	Each individual will be involved to the greatest extent possible in the development of a person-centered profile centering on learning from the person and those who know the person best about their history, preferences, life experiences, interests, talents, and capacities among other areas within 30 days of admission. This profile will be updated and revised as more is learned over time on at least a monthly basis. A revised person-centered profile format will be developed from the current person-centered description to include the above areas and to include a method to note when revisions and additions are made, by whom, and in what venue (e.g., a person-centered meeting of the support team, interview, an individual update by a staff member, a phone call).	Settlement Agreement Section IV. METO Closure	
2.2	From the understanding in the person-centered profile, a person-centered plan will be completed which includes the development of a shared vision of the future to work towards within 30 days of admission, as well as agreements and shared objectives and commitments .	Settlement Agreement Section IV. METO Closure	

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EC#	Evaluation Criteria	CPA Section	Reporting
2.3	The person-centered plan will directly inform the development of the individualized program plan (or Coordinated Service Support Plan). Such plans will build on the strengths and interests of the individual, and moving towards increasing relationships, roles, and community integration in these areas of life.	Settlement Agreement Section IV. METO Closure	
2.4	The person-centered plan will directly inform the development of a Positive Behavior Support Plan. Life direction, talents, and interests will be capitalized on in any planned intervention. Each behavior support plan will include teaching strategies to increase competencies and build on the strengths of the person.	Settlement Agreement Section IV. METO Closure	
2.5	Each behavior support plan will be unique to each individual. The use of token economies and contingent reinforcement will be used sparingly, not for punishment, and only when weighed again the potential risks to the person's image and competencies in terms of exercising personal autonomy.	Settlement Agreement Section IV. METO Closure	
2.6	Each behavior support plan will include a summary of the person's history and life experiences, the difficulties and problems the person is experiencing, past strategies and results, and a comprehensive functional behavioral analysis, from which strategies are derived.	Settlement Agreement Section IV. METO Closure	
2.7	Each Functional Behavioral Analysis will include a: a. Review of records for psychological, health and medical factors which may influence behaviors; b. Assessment of the person's likes and dislikes (events / activities / objects / people); c. Interviews with individual, caregivers and team members for their hypotheses regarding the causes of the behavior; d. Systematic observation of the occurrence of the identified behavior for an accurate definition/description of the frequency, duration and intensity; e. Review of the history of the behavior and previous interventions, if available; f. Systematic observation and analysis of the events that immediately precede each instance of the identified behavior; g. Systematic observation and analysis of the consequences following the identified behavior; h. Analysis of functions that these behaviors serve for the person; i. Analysis of the settings in which the behavior occurs most/least frequently. Factors to consider include the physical setting, the social setting, the activities occurring and available, degree of participation and interest, the nature of teaching, schedule, routines, the interactions between the individual and others, degree of choice and control, the amount and quality of social interaction, etc. j. Synthesis and formulation of all the above information into a hypothesis regarding the underlying causes and/or function of the targeted behavior.	Settlement Agreement Section IV. METO Closure	

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EC#	Evaluation Criteria	CPA Section	Reporting
	or shall be consistent with the standards of the Association of Positive Behavior Supports, Standards of Practice for Positive Behavior Supports (http://apbs.org).		
2.8	Each positive behavior support plan will include: 1. Understanding how and what the individual is communicating; 2. Understanding the impact of others' presence, voice, tone, words, actions and gestures; 3. Supporting the individual in communicating choices and wishes; 4. Supporting workers to change their behavior when it has a detrimental impact; 5. Temporarily avoiding situations which are too difficult or too uncomfortable for the person; 6. Enabling the individual to exercise as much control and decision making as possible over day-to-day routines; 7. Assisting the individual to increase control over life activities and environment; 8. Teaching the person coping, communication and emotional self-regulation skills; 9. Anticipating situations that will be challenging, and assisting the individual to cope or calm; 10. Offering an abundance of positive activities, physical exercise, and relaxation, and 11. As best as possible, modifying the environment to remove stressors (such as noise, light, etc.).	Settlement Agreement Section IV. METO Closure	
2.9	The format used for Positive Behavioral Support Plans will be revised to include each of the above areas, and will be used consistently.	Settlement Agreement Section IV. METO Closure	
3.	Facilities serve only "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety."	Settlement Agreement Section IV. METO Closure	**Semi-Annual**
3.1	3.1 All referrals for admission will be reviewed by the admissions coordinator to assure that they are persons with a Developmental Disability and meet the criteria of exhibiting severe behaviors and present a risk to public safety taking into account court ordered admissions.	Settlement Agreement Section IV. METO Closure	
4.	Facilities notify legal representatives of residents and/or family to the extent permitted by law, at least annually, of their opportunity to comment in writing, by e-mail, and in person, on the operation of the Facility.	Settlement Agreement Section IV. METO Closure	**Annual**
4.1	Initiate annual written survey process to all legal representatives of residents and/or family to the extent permitted by law whose individual of interest was served within the past year which solicits input on the operation of the Facility. Each survey will be in the relevant language, and will include notification that comments on Facility operations may be offered in person or by mail or telephone by contacting Facility director or designee.	Settlement Agreement Section IV. METO Closure	

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EC#	Evaluation Criteria	CPA Section	Reporting
4.2	Aggregate data will be collected from survey responses received from each survey process. Facility staff will develop an action plan to outline changes which will be made as a result of survey data, and implement those changes.	Settlement Agreement Section IV. METO Closure	
5.	The State/DHS immediately and permanently discontinues all the prohibited restraints and techniques.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	**Exception** [59]
5.1	DHS will issue a memorandum to all Facility staff confirming the Department's commitment to provide services and supports which are consistent with best practices including: 1) Providing individuals with a safe and therapeutic environment which includes positive behavioral supports and training on behavioral alternatives; 2) Recognizing that restraints are not a therapeutic intervention; 3) An immediate prohibition on prone restraint, mechanical restraints, seclusion and time out; 4) The Facilities' goal towards immediate reduction and eventual elimination of restraint use whenever possible; and 5) Restraint use is permitted only when the client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety; client refusal to receive / participate in treatment shall not constitute and emergency.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
5.2	The Facility shall remove "mechanical restraint," "prone restraint," "prone hold" and all other prohibited techniques from all current Facility forms and protocols.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
5.3	Facility policy(s) on Emergency Interventions shall minimally include: 1) The type of emergency interventions permitted and prohibited; 2) The protocol for administering emergency interventions; 3) The authorization and supervision needed for each emergency intervention; 4) The medical monitoring required during and after each restraint; 5) The review requirements of each emergency intervention (administrative, internal and external); 6) The data collection and aggregate data review of restrictive intervention usage. The Facility policy shall separate and clearly delineate "therapeutic interventions" from "emergency restraint / interventions." Current Facility policy/procedures shall be revised to comply with these requirements.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	

[59] Exception Reporting has the meaning that the reporting will occur more frequently than semi-annually, if concerns are noted.

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EC#	Evaluation Criteria	CPA Section	Reporting
5.4	All Facility staff members have received competency-based training on the policy / procedures identified immediately above.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
5.5	Competency-based training on the policy / procedures identified above has been incorporated into Facility orientation and annual training curricula.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
6.	The State/DHS has not used any of the prohibited restraints and techniques.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	**Exception**
6.1	Facility Staff will specify on Restraint Form which emergency technique was employed, verifying that a prohibited technique was not used.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
6.2	The supervisor will review each restraint with staff by the end of his/her shift, verifying that: 1) The threat of imminent harm warranted the emergency intervention, 2) The intervention was an approved technique and no suspicion exists that a prohibited technique was used; and 3) When applicable, what immediate corrective measures / administrative actions need to be taken.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
6.3	Any/all use of prohibited techniques, e.g., prone restraints, mechanical restraints, seclusion, timeout, etc., will be investigated as potential allegations of abuse. Facility Staff are required to immediately report any suspected use of prohibited restraints / techniques to their supervisor.)	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
6.4	Reporting and review forms/procedures are revised, and utilized, to incorporate the above 6.1, 6.2 and 6.3.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
7.	Medical restraint, and psychotropic/ neuroleptic medication have not been administered to residents for punishment, in lieu of habilitation, training, behavior support plans, for staff convenience or as behavior modification.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	**Exception**
7.1	Facility policy shall specifically forbid the use of restrictive interventions, including medical restraints and/or psychotropic/neuroleptic medication for: the purposes of punishment; in lieu of habilitation, training, or behavior support plans; for staff convenience; or as a behavior modification.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	
7.2	Facility policy will specify medication management protocols consistent with best practices in the support and treatment of individuals with cognitive and/or mental health disabilities.	Settlement Agreement Section V.A. Prohibited Techniques – Restraint	

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EC#	Evaluation Criteria	CPA Section	Reporting
8.	Restraints are used only in an emergency.	Settlement Agreement Section V.B. Prohibited Techniques – Policy	**Exception**
8.1	Facility Staff will clearly document, on the restraint form, the circumstances leading up to the restraint and what imminent risk of harm precipitated the application of the restraint. This shall include what antecedent behaviors were present, what de-escalation and intervention strategies were employed and their outcomes.	Settlement Agreement Section V.B. Prohibited Techniques – Policy	
8.2	In the event a restraint was used in the absence of imminent risk of harm, staff will be immediately retrained on Facility policies addressing the "Therapeutic Interventions and Emergency Use of Personal Safety Techniques" policy with such retraining being entered into their training file.	Settlement Agreement Section V.B. Prohibited Techniques – Policy	
9.	The Policy (Settlement Agreement Att. A, as it may be revised after court approval, dissemination and staff training) was followed in each instance of manual restraint	Settlement Agreement Section V.B. Prohibited Techniques – Policy	**Exception**
9.1	As part of its data management processes, the Facility will collect, review and analyze information related to staff's adherence to restraint policy.	Settlement Agreement Section V.B. Prohibited Techniques – Policy	
10.	There were no instances of prone restraint, chemical restraint, seclusion or time out. [Seclusion: evaluated under Sec. V.C. Chemical restraint: evaluated under Sec. V.D.]	Settlement Agreement Section V.B. Prohibited Techniques – Policy	**Exception**
10.1	Facility policy shall clearly identify prone restraint, chemical restraint, seclusion and timeout as "prohibited."	Settlement Agreement Section V.B. Prohibited Techniques – Policy	
11.	There were zero instances of the use of Seclusion. Facility policy shall specify that the use of seclusion is prohibited.	Settlement Agreement Section V.C. Prohibited Techniques – Seclusion and Time Out	**Exception**
12.	There were zero instances of the use of Room Time Out from Positive Reinforcement. Facility policy shall specify that the use of time out from positive reinforcement is prohibited.	Settlement Agreement Section V.C. Prohibited Techniques – Seclusion and Time Out	**Exception**

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EC#	Evaluation Criteria	CPA Section	Reporting
13.	There were zero instances of drug / medication use to manage resident behavior OR to restrain freedom of movement. Facility policy specifies the Facility shall not use chemical restraint. A chemical restraint is the administration of a drug or medication when it is used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement and is not a standard treatment or dosage for the resident's condition.	Settlement Agreement Section V.D. Prohibited Techniques – Chemical Restraint	**Exception**
14.	There were zero instances of PRN orders (standing orders) of drug/ medication used to manage behavior or restrict freedom of movement. Facility policy specifies that PRN/ standing order medications are prohibited from being used to manage resident behavior or restrict one's freedom of movement.	Settlement Agreement Section V.D. Prohibited Techniques – Chemical Restraint	**Exception**
15.	There is a protocol to contact a qualified Third Party Expert.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
15.1	Facility policy stipulates that a Third Party Expert will be consulted within 30 minutes of the emergency's onset.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
16.	There is a list of at least 5 Experts pre-approved by Plaintiffs & Defendants. In the absence of this list, the DHS Medical or designee shall be contacted.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
17.	DHS has paid the Experts for the consultations.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
18.	A listed Expert has been contacted in each instance of emergency use of restraint.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
19.	Each consultation occurred no later than 30 minutes after presentation of the emergency.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
20.	Each use of restraint was an "emergency."	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	

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EC#	Evaluation Criteria	CPA Section	Reporting
21.	The consultation with the Expert was to obtain professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices. If the Expert was not available, see V.F. below.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
21.1	On the restraint form, Facility staff will identify the Third Party or other expert and will document all recommendations given by the consultant, techniques, and the efficacy and outcomes of such interventions. When reviewing the restraint form, 24 hours post-restraint, Designated Coordinator will verify that Facility staff contacted the medical officer within 30 minutes of the emergency's onset.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
22.	The responsible Facility supervisor contacted the DHS medical officer on call not later than 30 minutes after the emergency restraint use began.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	**Exception**
23.1 [sic]	On the Restraint Form, the Facility supervisor will document both the date/time that the emergency restraint began and the date/time s/he contacted the designated medical officer.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
23.	The medical officer assessed the situation, suggested strategies for de-escalating the situation, and approved of, or discontinued the use of restraint.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	**Exception**
23.1	The Facility supervisor will document on the restraint form and in the resident's record, the medical officer's de-escalation strategies, the outcome of those strategies used, and whether approval was needed and/or given for continued restraint use.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
24.	The consultation with the medical officer was documented in the resident's medical record.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	**Exception**
24.1	When conducting his/her post-restraint review, the Designated Coordinator will verify that the supervisor contacted the medical officer within 30 minutes of the emergency restraint and documented the details in the resident's medical record.	Settlement Agreement Section V.E. Prohibited Techniques – 3rd Party Expert	
25.	All allegations were fully investigated and conclusions were reached. Individuals conducting investigations will not have a direct or indirect line of supervision over the alleged perpetrators; the DHS Office of the Inspector General satisfies this requirement. Individuals conducting investigations, interviews and/or writing investigative reports will receive competency-based training in best practices for conducting abuse / neglect investigations involving individuals with cognitive and/or mental health disabilities and interviewing.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	**Exception**

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EC#	Evaluation Criteria	CPA Section	Reporting
25.1	DHS employees having responsibility for investigative duties will receive 8 hours of continuing education or in-service training each year specific to investigative practices.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
25.2	Each investigation will undergo a quality review by a peer or supervisor who has, at minimum been trained in the requirements set forth in this Implementation Plan.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
25.3	The Department will maintain an electronic data management system, to track all information relevant to abuse/neglect investigations. This data management system will minimally include: 1) Incident date; 2) Report date; 3) Incident location; 4) Provider; 5) Allegation type; 6) Alleged victim; 7) Alleged perpetrator(s); 8) Injuries sustained; 9) Assigned investigator; 10) Date investigative report is completed; 11) Substantiation status; 12) Systemic issues identified and the corrective measures taken to resolve such issue; 13) Whether or not the case was referred to the county attorney; and 14) Whether or not charges were filed; and 15) Outcome of charges.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
25.4	Allegations substantiated by DHS Licensing (Office of Inspector General) will be documented in the client's Facility record.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
26.	All staff members found to have committed abuse or neglect were disciplined pursuant to DHS policies and collective bargaining agreement, if applicable.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
26.1	All substantiated allegations of staff abuse or neglect are referred to Human Resources for human resources action in accordance with the definitions set forth under the Vulnerable Adults Act. All perpetrators will be disciplined in accordance with DHS policies and procedures and Union Contracts.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
27.	Where appropriate, the State referred matters of suspected abuse or neglect to the county attorney for criminal prosecution.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	

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EC#	Evaluation Criteria	CPA Section	Reporting
27.1	All allegations of abuse or neglect related to care of residents of a Facility will be submitted to the common entry point to determine whether or not the case will be referred to the county attorney for criminal prosecution.	Settlement Agreement Section V.G. Prohibited Techniques – Zero Tolerance for Abuse and Neglect	
28.	Form 31032 (or its successor) was fully completed whenever use was made of manual restraint.	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	**Exception**
28.1	When reviewing the restraint form 24 hours post-restraint, the Designated Coordinator will verify that Form 31032 (or any successor) was completed timely, accurately and in its entirety.	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	
29.	For each use, Form 31032 (or its successor) was timely completed by the end of the shift.	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	**Exception**
29.1	When reviewing the restraint form 24 hours post-restraint, the Designated Coordinator will verify that Form 31032 (or any successor) was completed timely, accurately and in its entirety.	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	
30.	Each Form 31032 (or its successor) indicates that no prohibited restraint was used.	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	**Exception**
30.1	Staff will indicate what type of restraint was used on Form 31032 (or any successor).	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	
30.2	When reviewing the restraint form, 24 hours or one business day post-restraint, the Designated Coordinator will verify that no prohibited techniques were used.	Settlement Agreement Section VI.A. Restraint Reporting & MGMT – Form 31032	
31.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the Office of Health Facility Complaints.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
31.1	Form 31032 (or its successor) is sent to the Office of Health Facility Complaints within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	

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EC#	Evaluation Criteria	CPA Section	Reporting
32.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the Ombudsman for MH & DD	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	**Exception**
32.1	Form 31032 (or its successor) is sent to the Ombudsman for MH & DD within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
33.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the DHS Licensing	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	**Exception**
33.1	Form 31032 (or its successor) is sent to DHS Licensing within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
34.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the Court Monitor and to the DHS Internal Reviewer	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
34.1	Form 31032 (or its successor) is sent to the Court Monitor and to the DHS Internal Reviewer within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
35.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the legal representative and/or family to the extent permitted by law.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	**Exception**
35.1	Form 31032 (or its successor) is sent to the legal representative, and/or family to the extent permitted by law, within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
36.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the Case manager.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	**Exception**
36.1	Form 31032 (or its successor) is sent to the case manager within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
37.	Within 24 hours, and no later than one business day, Form 31032 (or its successor) in each instance was submitted to the Plaintiffs' Counsel.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	

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EC#	Evaluation Criteria	CPA Section	Reporting
37.1	Form 31032 (or its successor) is sent to the Plaintiffs' Counsel within 24 hours or no later than one business day.	Settlement Agreement Section VI.B. Restraint Reporting & MGMT – Notifications	
38.	Other reports, investigations, analyses and follow up were made in each case of restraint use.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	**Annual**
38.1	The Designated Coordinator will review each client incident, injury and/or restraint use within 1 business day of its occurrence to: 1) Evaluate the immediate health and safety of the individual(s) involved; 2) Ensure no prohibited techniques were used; 3) Ensure all documentation and notifications were properly made; and 4) Determine what, if any, immediate measures must be taken.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	
38.2	The Designated Coordinator will convene an Interdisciplinary Team (IDT) meeting within 5 business days of a restraint to: 1) Review the circumstances surrounding the behavioral emergency; 2) Determine what factors likely contributed to the behavioral emergency, i.e. life event, environmental, relational discord, etc.; 3) Identify what therapeutic interventions, including individualized strategies, were employed and why they were unsuccessful in de-escalating the situation; 4) Review and assess the efficacy of the individual's PBS plan, making changes as needed; 5) Determine if trends/patterns can be identified with this individual or this living area; and 6) Take all corrective measures deemed necessary, indicating what actions are being taken, the party responsible for taking such actions, the date by which these actions will be taken, and how the efficacy of such actions will be monitored. Documentation of the IDT meeting, including attendees, review and actions taken will be thoroughly documented in the individual's record.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	
38.3	When changes to an individual's program plan and/or PBS plan are recommended during the IDT's restraint review, the Designated Coordinator will ensure that such changes are made within 2 business days of the IDT meeting related to the restraint use.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	

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EC#	Evaluation Criteria	CPA Section	Reporting
38.4	A facility-based Positive Behavioral Supports Review (PBSR), comprised of both behavioral analysts and non-clinical staff, will be established and maintained for the purposes of: 1) Reviewing all positive behavioral support plans to ensure they adhere to current best practice; 2) Approving and monitoring the efficacy of all positive behavioral support plans; 3) Reviewing the use of any restrictive and/or emergency interventions, i.e. restraints, 911 calls, etc. The PBSR Committee will meet on a monthly basis.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	
38.5	The PBSR committee will maintain meeting minutes detailing attendance (person/title); chairperson; individual and aggregate data review; issues and trends identified (individual and systemic); corrective measures to be taken; dates by which such corrective measures are to be completed; responsible parties, and follow-up of the previous month's action plans.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	
38.6	The Department will identify and address any trends or patterns from investigations.	Settlement Agreement Section VI.C. Restraint Responses Are Not To Replace Other Incident Reporting, Investigation, Analysis & Follow-Up	
39.	In consultation with the Court Monitor during the duration of the Court's jurisdiction, DHS designates one employee as Internal Reviewer whose duties include a focus on monitoring the use of, and on elimination of restraints.	Settlement Agreement Section VII.B. Restraint Review - Internal Reviewer	**Semi-Annual**
40.	The Facility provided Form 31032 (or its successor) to the Internal Reviewer within 24 hours of the use of manual restraint, and no later than one business day.	Settlement Agreement Section VII.B. Restraint Review - Internal Reviewer	**Exception**
40.1	The shift supervisor/administrator on duty will notify the Internal Reviewer of the restraint within 24 hours and no later than one business day. Notification will be made electronically along with the completed Form 31032 (or its successor).	Settlement Agreement Section VII.B. Restraint Review - Internal Reviewer	
41.	The Internal Reviewer will consult with staff present and directly involved with each restraint to address: 1) Why/how de-escalation strategies and less restrictive interventions failed to abate the threat of harm; 2) What additional behavioral support strategies may assist the individual; 3) Systemic and individual issues raised by the use of restraint; and 4) the Internal Reviewer will also review Olmstead or other issues arising from or related to, admissions, discharges and other separations from the facility.	Settlement Agreement Section VII.B. Restraint Review - Internal Reviewer	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
41.1	The Internal Reviewer will consult with staff present and directly involved with each restraint to address: 1) Why/how de-escalation[sic] strategies and less restrictive interventions [sic] failed to abate the threat of harm; 2) What additional behavioral support strategies may assist the individual; 3) Systemic and individual issues raised by the use of restraint; and 4) the Internal Reviewer will also review Olmstead or other issues arising from or related to, admissions, discharges and other separations from the facility.	Settlement Agreement Section VII.B. Restraint Review - Internal Reviewer	
42.	On April 23, 2013, the Court appointed the Court Monitor as the External Reviewer, with the consent of Plaintiffs and Defendants. DHS funds the costs of the external reviewer.	Settlement Agreement Section VII.B. Restraint Review - External Reviewer	
43.	After providing Plaintiffs' Class Counsel and the Department the opportunity to review and comment on a draft, the External Reviewer issues written quarterly reports informing the Department whether the Facility is in substantial compliance with the Agreement and the incorporated policies, enumerating the factual basis for its conclusions.	Settlement Agreement Section VII.B. Restraint Review - External Reviewer	
44.	In conjunction with duties and responsibilities under the Order of July 17, 2012, the Court Monitor reviews and makes judgments on compliance, makes recommendations and offers technical assistance in his discretion, and files quarterly and other reports with the Court. Timing of reports is subject to the Court's needs, results of Monitor's reviews, and to the monitoring plan pursuant to the Order of August 28, 2013.	Settlement Agreement Section VII.B. Restraint Review - External Reviewer	
45.	The following have access to the Facility and its records: The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' Class Counsel.	External Entity and Plaintiffs' Access	**Annual**
45.1	Open access to the Facility, its successors, and their records is given to the Office of Ombudsman-MH/DD, The Disability Law Center and Plaintiffs' Class Counsel.	External Entity and Plaintiffs' Access	
46.	The following exercised their access authority: The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' Counsel.	External Entity and Plaintiffs' Access	**Annual**
46.1	The Ombudsman-MH/DD, Disability Law Center and Plaintiffs' counsel have all exercised their authority to access the Facility, its successors, and their records.	External Entity and Plaintiffs' Access	

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EC#	Evaluation Criteria	CPA Section	Reporting
47.	The State undertakes best efforts to ensure that each resident is served in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings. Each individual currently living at the Facility, and all individuals admitted, will be assisted to move towards more integrated community settings. These settings are highly individualized and maximize the opportunity for social and physical integration, given each person's legal standing. In every situation, opportunities to move to a living situation with more freedom, and which is more typical, will be pursued.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**
47.2	Regarding transition planning for individuals entering more restrictive settings, the tasks under Evaluation Criteria 48 to 53 shall be fulfilled.	Settlement Agreement Section VIII. Transition Planning	
48.	The State actively pursues the appropriate discharge of residents and provided them with adequate and appropriate transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting and to which the individual does not object.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**
48.1	Each individual currently living at MSHS-Cambridge, and any individuals admitted prior to its closure, will have an appropriate transition plan developed within 30 days of admission in accordance with the individual needs and preference for the most integrated setting possible. (For this purpose "admission" and "commitment" are treated the same.).	Settlement Agreement Section VIII. Transition Planning	
48.2	For individuals who may by law or court order be required to enter more restrictive and less integrated circumstances, such as incarceration in a prison, person-centered planning and transition planning is given the same importance as voluntary admissions. All efforts will be towards preparation and transition, safeguarding, negotiating with facilities, supports while in a facility, and implementing immediate post-facility transition into well-matched supports.	Settlement Agreement Section VIII. Transition Planning	
49.	Each resident, the resident's legal representative and/or family to the extent permitted by law, has been permitted to be involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication method he or she (or they) prefer.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
49.1	Each individual and/or the individual's family and/or legal representative as desired by the individual or required by guardianship is permitted, actively encouraged, and welcomed to be involved in the individual's person-centered planning and decision making to the greatest extent practicable utilizing whatever communication method the individual prefers and respecting the individual's right to choose the participants. Invitations to all planning and evaluation meetings will be extended. Alternate means of participation will be extended to those who cannot travel or attend, including phone and video conferencing.	Settlement Agreement Section VIII. Transition Planning	
49.2	Each individual will be invited and encouraged to participate in and take leadership in the person-centered planning processes when this is possible and desired by the person. In all circumstances, the person-centered planning process will be engaged in for and with all individuals, with the understanding that transition and change will happen, that the people are vulnerable, and may need the alliance and support of other allies to support the process of moving forward. High quality person-centered planning, including the development of person-centered profiles, plans, and transition plans, will not be delayed or minimized by a person's perceived level of readiness to take leadership of the process, or willingness to engage in the process.	Settlement Agreement Section VIII. Transition Planning	
50.	To foster each resident's self-determination and independence, the State uses person-centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**
50.1	Person-centered planning: 1) Will be started immediately upon meeting the person, before admission if possible; 2) Will be on-going; 3) Will be supported by a team of people who represent the interests of the person, if need be; 4) Without exception, and only if the person objects to the inclusion of specific people, the support team will include willing family members, case managers, current, past and future service workers, and at least one individual who is in a freely-given relationship with the person which is conflict-free. This can include a community advocate, citizen advocate, family member, or other individual who only has the welfare of the individual to consider. If the individual is unable or unwilling to participate, people who know about and care for the individual, with the individual's approval, will still be invited to engage in sharing their perspectives about what that positive future can be and what is needed to bring it about. This process will begin at first contact, with a first person-centered plan drawn up by day 30 after admission or 45 days from approval of this Plan.	Settlement Agreement Section VIII. Transition Planning	

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EC#	Evaluation Criteria	CPA Section	Reporting
50.2	Each Person-Centered Plan will be enriched, altered and moved forward at least every 30 days as the person becomes better known and moves toward a new living situation. As plans for this new living situation emerge, each plan will include all activities relevant for transition to a new living situation, relevant and necessary supports to assure the person will have good success, and protections that need to be in place.	Settlement Agreement Section VIII. Transition Planning	
50.3	The information from each Person-Centered Plan will be fully incorporated into each person's transition plan, Positive Behavior Support Plan, goal plans, and service objectives within any Individual Service Plan.	Settlement Agreement Section VIII. Transition Planning	
50.4	All plan facilitators will have, or function under the active supervision of a staff person who has, significant experience and background in facilitation, social devaluation and its consequences, and the principles of Normalization / Social Role Valorization, person-centered thinking, and the various and vast array of useful tools and techniques which may be of use for a particular person. Any such supervisor shall co-sign and be responsible for the plan and plan process. In this manner, a thoughtful, authentic, individualized and successful planning process will result in meaningful outcomes. Evidence of use of various, individualized techniques for different individual people will be clear in the development of person -centered plans. (PATH, MAPS, Personal Futures Planning, One Page Profiles, and Helen Sanderson's Person-Centered Thinking, are examples).	Settlement Agreement Section VIII. Transition Planning	
50.5	An annual learning and professional development plan which includes the above areas will be developed with and for each facilitator of person-centered processes. It may include reading, research, formal, and informal training, mentoring, and development events. These learning and professional development plans will include a minimum of 25 hours per year of educational activities (formal and informal) focused on person-centered planning, and will be completed as planned. Attendance at professional conferences, in and out of state, will be supported and facilitated.	Settlement Agreement Section VIII. Transition Planning	
50.6	Person-Centered Planning will include the intentional development of each support team's understanding and analysis of the individual's particular life experiences and how they have impacted the person. Themes, patterns, potential responses, and lessons should be drawn from this knowledge. Biographical timelines, or other person-centered means to capture histories and understand the person will be conducted for each person, with the collaboration of the person and family, if appropriate.	Settlement Agreement Section VIII. Transition Planning	

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EC#	Evaluation Criteria	CPA Section	Reporting
50.7	The development of a person-centered description or personal profile will be used to develop the initial person-centered plan.	Settlement Agreement Section VIII. Transition Planning	
50.8	The formats for the Person-Centered Plan, person-centered description or personal profile will be revised to comply with the content requirements of this CPA. The Individual Program Plan will incorporate the Person-Centered Plan. The Person-Centered Plan will be re-designed to reflect a person-centered approach and style. This will include adding: 1) The focus person's goals, interests and vision for the future; 2) The identification of any actions and plans towards achieving those goals; 3) Support to be provided and by whom; 4) Use of everyday, informal language and avoidance of unnecessary service jargon. Objectives for the Person-Centered Plan will be drawn directly from the person-centered description / profile.	Settlement Agreement Section VIII. Transition Planning	
51.	Each resident has been given the opportunity to express a choice regarding preferred activities that contribute to a quality life.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**
51.1	For each person served at a Facility, the Person-Centered Plan will include preferred activities, areas in which the person wants to learn and grow, relationships to strengthen, and competencies to learn.	Settlement Agreement Section VIII. Transition Planning	
51.2	Frequent, daily opportunities will be built into daily life for each person to engage in meaningful activities that are personalized, individualized, and selected by the person. These will be activities planned with the person, and carried out in an individualized fashion. "House activities" will generally not be consistent with providing individualized, person-centered activities which the person freely chooses to engage in.	Settlement Agreement Section VIII. Transition Planning	
52.	It is the State's goal that all residents be served in integrated community settings and services with adequate protections, supports and other necessary resources which are identified as available by service coordination. If an existing setting or service is not identified or available, best efforts will be utilized to create the appropriate setting or service using an individualized service design process.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
52.1	Each individual's Person-Centered Plan will embody continuously increasing clarity at each revision/ development meeting on what an ideal living situation may look like for the person. These will support and describe "must haves" components which must be in place in any considered situation. This may include living situations which are not offered in existing structured services. It may also be impossible to "show" a person a service that matches their needs, even though they may select that option from several.	Settlement Agreement Section VIII. Transition Planning	
52.2	If an existing service/living situation is identified and selected by the individual with assistance from the support team, alterations, enhancements, and additional supports will be added whenever appropriate to ensure robust community supports which meet the essential needs for assistance, structure, and support as outlined in the Person-Centered Plan. "Must haves" identified as in 52.1 are required to be in place.	Settlement Agreement Section VIII. Transition Planning	
52.3	If an existing residential service is not identified or available, the appropriate services must be created, using an individualized service design process.	Settlement Agreement Section VIII. Transition Planning	
52.4	When a living situation is identified as a possibility, the individual and the support team as appropriate will have multiple opportunities to visit, meet potential house-mates, interview the staff and provider, spend time in the situation, and be given the opportunity to make a choice about the living situation, request program enhancements or adjustments, or decline the option.	Settlement Agreement Section VIII. Transition Planning	
52.5	When a discharge into an alternative living situation is agreed upon, the transition plan will be further developed and finalized. This pre-discharge iteration of the transition plan will include not only the sharing of information and documents transfers between providers, 1) An individualized plan to facilitate a smooth move; 2) Assistance to the person to navigate the move with ease, and arrange for safeguarding and transfer of the person's belongings ; 3) Planning for and making purchases for new home, ; 4) Assistance to become familiar with new neighborhood, area, town; 5) Planning for packing and move day ; 6) Personalization of new home; 7) Notification of family and friends ; 8) Post office and utility changes ; 9) Introductions to neighbors; 10) Setting up opportunities to deepen relationships with future housemates; 11) Celebrations, welcoming, and farewells; 12) Designing layout of space, window treatments, etc. These types of considerations are a part of the typical processes that valued adults in our culture when preparing to move, and these and others shall be considered.	Settlement Agreement Section VIII. Transition Planning	

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EC#	Evaluation Criteria	CPA Section	Reporting
52.6	The format for the transition plan will incorporate and provide for address of the elements in 52.5 above.	Settlement Agreement Section VIII. Transition Planning	
53.	The provisions under this Transition Planning Section have been implemented in accord with the Olmstead decision.	Settlement Agreement Section VIII. Transition Planning	**Semi-Annual**
53.1	Any living arrangement, day service, or other service which is administered or organized in a segregated manner must be justified in writing as a part of the transition plan as being necessary. In a "segregated manner" means that the people served are all people with disabilities who have not specifically chosen to live or be served together. This justification will be accompanied by objectives to increase social and physical integration which will be included in service planning objectives and program planning.	Settlement Agreement Section VIII. Transition Planning	
53.2	All services provided and planned for, and transitioned into must be adequate, appropriate, and carefully monitored. This need for monitoring will be carefully weighed by each person-centered team and addressed. This includes services at the Facility and new living and working situations into which a person is transitioning.	Settlement Agreement Section VIII. Transition Planning	
53.3	All services provided will include assisting people to have meaningful roles in community life, civic life, relationships, work and career, home, and areas of personal interest. When appropriate, these areas of engagement will be envisioned by the team alongside the individual served, and opportunities will be created for this engagement in everyday life. These roles and engagements will be consistently identified and addressed within the Person-Centered Planning, Transition, and the Positive Behavior Support Plans development processes.	Settlement Agreement Section VIII. Transition Planning	
53.4	The above areas of engagement (community life, civic life, relationships, career, home, personal interests) will be included in each Person-Centered Plan as focus areas for planning and related objectives.	Settlement Agreement Section VIII. Transition Planning	
54.	Facility treatment staff received training in positive behavioral supports, person-centered approaches, therapeutic interventions, personal safety techniques, crisis intervention and post crisis evaluation.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	**Annual**
54.1	Facility staff in all positions receive annual standardized training in: 1.Therapeutic Interventions 2. Personal safety techniques 3. Medically monitoring restraint	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	

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EC#	Evaluation Criteria	CPA Section	Reporting
	4. Positive Behavior Supports 5. Person-Centered Approaches 6. Crisis Intervention 7. Post-Crisis Evaluation and Assessment		
54.2	All new or temporary Facility staff in all positions receive standardized pre-service training in: 1.Therapeutic Interventions 2. Personal safety techniques 3. Medically monitoring restraint 4. Positive Behavior Supports 5. Person-Centered Approaches 6. Crisis Intervention 7. Post-Crisis Evaluation and Assessment	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
54.3	The Department will record, monitor and follow-up with the Facility administration to ensure that all facility treatment staff receive all necessary training including, but not limited to, EC 62-64, below.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
55	Facility staff training is consistent with applicable best practices, including but not limited to the Association of Positive Behavior Supports, Standards of Practice for Positive Behavior Supports (http://apbs.org). Staff training programs will be competency-based with staff demonstrating current competency in both knowledge and skills.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	**Annual**
55.1	All Facility staff training programs will be competency-based with staff demonstrating current competency in both knowledge and skills.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
55.2	Training curricula are developed, based on, and consistent with best practices in: 1) Positive Behavioral Supports; 2) Person-Centered approaches/practices; 3) Therapeutic Intervention Strategies; 4) Personal safety techniques; and 5) Crisis intervention and post crisis evaluation.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
55.3	Each training program (that is, 1) Positive Behavioral Supports; 2) Person-Centered approaches/practices; 3) Therapeutic Intervention Strategies; 4) Personal Safety techniques; and 5) Crisis intervention & post crisis evaluation), will be evaluated at least annually and revised, if appropriate, to ensure adherence to evidence-based and best practices.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	

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EC#	Evaluation Criteria	CPA Section	Reporting
55.4	DHS will ensure training programs promote sensitivity awareness surrounding individuals with cognitive and mental health disabilities and how their developmental level, cultural/familial background, history of physical or sexual abuse and prior restraints may affect their reactions during behavioral emergencies.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
55.5	DHS will ensure that training programs are designed to also develop staff's self-awareness of how their own experiences, perceptions and attitudes affect their response to behavioral issues and emergencies.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
56.	Facility staff receive the specified number of hours of training: Therapeutic interventions (8 hours); Personal safety techniques (8 hours); Medically monitoring restraint (1 hour).	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	**Annual**
56.1	Competency-based training curriculum is developed which minimally provides 8 hours training in Therapeutic Interventions; Personal Safety Techniques and 1 hour in Medically Monitoring Restraints.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
56.2	All current employees receive 8 hours of competency-based training on Therapeutic Interventions.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
56.3	All current employees receive 8 hours of competency-based training on Personal Safety Techniques.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
56.4	All current employees receive 1 hour of competency-based training on Medically Monitoring restraints.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
57.	For each instance of restraint, all Facility staff involved in imposing restraint received all the training in Therapeutic Interventions, Personal Safety Techniques, and Medically Monitoring Restraint.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	**Annual**
57.1	No staff member is permitted to be assigned to direct support services until having received all required orientation and/or annual in-service training on all elements of EC 56, above.	Settlement Agreement Section IX.A. Other Practices at the Facility – Staff Training	
58.	Facility staff receive the specified number of hours of training: Person-centered planning and positive behavior supports (with at least sixteen (16) hours on person-centered thinking / planning): a total 40 hours; Post Crisis Evaluation and Assessment (4 hours).	Settlement Agreement Section IX.B. Other Practices at the Facility – Hours of Training	**Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
59.	Residents are permitted unscheduled and scheduled visits with immediate family and/or guardians, at reasonable hours, unless the Interdisciplinary Team (IDT) reasonably determines the visit is contraindicated.	Settlement Agreement Section IX.C. Other Practices at the Facility – Visitor Policy	**Annual**
59.1	Facilitate and allow all individuals to have scheduled and unscheduled visits with immediate family and/or guardians and other visitors if not contraindicated by court order or person-centered plans.	Settlement Agreement Section IX.C. Other Practices at the Facility – Visitor Policy	
60.	Visitors are allowed full and unrestricted access to the resident's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, consistent with all residents' rights to privacy.	Settlement Agreement Section IX.C. Other Practices at the Facility – Visitor Policy	**Annual**
60.1	Facilitate all visitors access to the individual's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, with attention paid to the right of individual privacy and person-centered plans or court requirements.	Settlement Agreement Section IX.C. Other Practices at the Facility – Visitor Policy	
61.	Residents are allowed to visit with immediate family members and/or guardians in private without staff supervision, unless the IDT reasonably determines this is contraindicated.	Settlement Agreement Section IX.C. Other Practices at the Facility – Visitor Policy	**Annual**
61.1	Provide privacy, if desired by the individual, for all individuals when visiting with immediate family members and/or guardians, unless the person-centered plans reasonably determines this is contraindicated or visitation rules are court ordered.	Settlement Agreement Section IX.C. Other Practices at the Facility – Visitor Policy	
62.	There is no marketing, recruitment of clients, or publicity targeted to prospective residents at the Facility.	Settlement Agreement Section IX.D. Other Practices at the Facility – No Inconsistent Publicity	**Annual**
63.	The Facility purpose is clearly stated in a bulletin to state court judges, county directors, social service supervisors and staff, county attorneys and Consumers and Families and Legal Representatives of consumers of Developmental Disabilities services. Any admission will be consistent with the requirements of this bulletin.	Settlement Agreement Section IX.D. Other Practices at the Facility – No Inconsistent Publicity	
63.1	Clearly state the Facility's purpose in a bulletin to state court judges, county directors, social service supervisors and staff, county attorneys and Consumers and Families and Legal Representatives of consumers of Developmental Disabilities services.	Settlement Agreement Section IX.D. Other Practices at the Facility – No Inconsistent Publicity	

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EC#	Evaluation Criteria	CPA Section	Reporting
64.	The Facility has a mission consistent with the Settlement Agreement and this Comprehensive Plan of Action.	Settlement Agreement Section IX.D. Other Practices at the Facility – No Inconsistent Publicity	**Semi-Annual**
65.	The Facility posts a Patient / Resident Rights or Bill of Rights, or equivalent, applicable to the person and the placement or service, the name and phone number of the person within the Facility to whom inquiries about care and treatment may be directed, and a brief statement describing how to file a complaint with the appropriate licensing authority.	Settlement Agreement Section IX.E. Other Practices at the Facility – Posting Requirements	**Annual**
66.	The Patient / Resident Bill of Rights posting is in a form and with content which is understandable by residents and family / guardians.	Settlement Agreement Section IX.E. Other Practices at the Facility – Posting Requirements	**Annual**
66.1	Apart from any Patient/Resident Rights or Bill of Rights format which may be required by state law, an alternative version at an appropriate reading level for residents, and with clearly understandable content, will be posted and provided to individuals, parents and guardians on admission, reviewed at IDT meetings, and annually thereafter.	Settlement Agreement Section IX.E. Other Practices at the Facility – Posting Requirements	
67.	The expansion of community services under this provision allows 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).	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
67.1	Community Support Services (CSS) provides assessment, triage, and care coordination so that persons with developmental disabilities can receive the appropriate level of care in the most integrated setting.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
67.2	Collect and manage data to track CSS interventions noted in 67.1 and their outcomes.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	

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EC#	Evaluation Criteria	CPA Section	Reporting
67.3	Provide necessary administrative/ management support within CSS to accomplish data management and analysis.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
67.4	Focus weekly "diversion" meetings to include person-centered development strategies rather than considering only existing vacancies and challenges. From this perspective: 1) Review any proposed admissions to more restrictive settings and consider all possible diversion strategies; 2) Review status of transition planning for all living at the Facility, 3) Add active, individualized planning / development focus to these transition discussions which is consistent with the Olmstead Plan and includes such activities as developing a person-centered request for proposals for any person or persons at the Facility without an identified and appropriate targeted home in the community.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
67.5	Weekly diversion meetings consider all individuals in danger of losing their living situation with an emphasis upon development of integrated alternatives where none are available.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
67.6	CSS has additional administrative / managerial support to insure documentation and analysis of all diversion efforts and their impact on individuals' stability regarding living situations and behavioral / mental health.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
67.7	CSS provides continuous and on-going diversion from institutionalization and placement in less integrated settings whenever possible by establishing procedures for assessment, care planning, and providing additional services, supports and expertise for individuals in jeopardy of losing their placements or living situations due to behavioral or mental health problems.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
67.8	The Department will collect and review data relative to admissions and transitions. This shall include, but not be limited to: 1) individual's name, date of birth and county of origin; 2) current residence, provider and type of residential setting, e.g., independent living, family of origin, group home, ICF/ID, etc.; 3) date the individual moved to or was admitted to current residence; 4) previous residences, providers and residential settings; 5) dates of previous admissions and transitions including reason(s) for moves.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
68.	The Department identifies, and provides long term monitoring of, individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and to prevent multiple transfers within the system.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
68.1	For DHS-operated services, the Department will maintain State and regional quality assurance committees to review data on a monthly basis. This review will include: 1) identifying individuals at heightened risk and determining intervention strategies; 2) reviewing data by county, region and provider to determine if trends or patterns exist and necessary corrective measures; and 3) maintaining meeting minutes detailing attendance (person/title), chairperson, individual and aggregate data review, issues and trends identified (individual and systemic), corrective measures to be taken, dates by which such corrective measures are to be completed, responsible parties, and follow-up of the previous months' action plans.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
68.2	The Department will maintain an electronic data collection system, which tracks the status of all corrective action plans generated by State and regional quality assurance committees, following up with the appropriate provider or county to ensure task completion.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
69.	Approximately seventy five (75) individuals are targeted for long term monitoring.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
69.1	CSS will identify individuals with clinical and situational complexities who have been served by CSS and who would likely benefit from more intensive monitoring.		
69.2	Seventy five individuals who are significantly at-risk for institutionalization or loss of home due to behavioral or other challenges will be identified for intensive monitoring and, if needed, intervention with additional supports and services.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
69.3	These 75 individuals will be identified by CSS in collaboration with lead agency case managers based upon frequency of behaviors dangerous to self or others, frequency of interactions with the criminal justice system, sudden increases in usage of psychotropic medications, multiple hospitalizations or transfers within the system, serious reported incidents, repeated failed placements, or other challenges identified in previous monitoring or interventions and cost of placement. The status of these individuals will be reviewed at least semi-annually by CSS.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	

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EC#	Evaluation Criteria	CPA Section	Reporting
70.	CSS mobile wrap-around response teams are located across the state for proactive response to maintain living arrangements.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
70.1	Describe locations of the 9 teams that have been established in 23 locations throughout the state.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
70.2	Provide CSS with administrative / managerial support for the 9 teams to insure sufficient data collection and central data management	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
70.3	Document responses from CSS to individual's satisfaction surveys.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
71.	CSS arranges a crisis intervention within three (3) hours from the time the parent or legal guardian authorizes CSS' involvement.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
71.1	Strategically establish nine teams in 23 locations throughout the State to respond within 3 hours of a request for service. CSS admissions contacts the person's case manager as soon as they learn of a potential or actual crisis situation.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
71.2	Streamline authorization procedure to facilitate CSS' response to reported crises as quickly as possible.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
72.	CSS partners with Community Crisis Intervention Services to maximize support, complement strengths, and avoid duplication.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
72.1	There is ongoing collaboration with the Metro Crisis Coordination Program (MCCP), whose intent is to provide a crisis safety net range of services for persons with developmental disabilities or related conditions; MCCP is a collaborative effort of seven counties in the Twin Cities metropolitan area. (metrocrisis.org)	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
72.2	Each county, and tribe as relevant, will have a system of locally available and affordable services to serve persons with developmental disabilities.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
72.3	Continue quarterly meetings with MCCP.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
73.	CSS provides augmentative training, mentoring and coaching.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
73.1	CSS Staff will offer and provide training, as requested or determined to be lacking, on coaching, mentoring and Augmentative training.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
73.2	CSS will update training manual as necessary.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
73.3	CSS will have sufficient administrative/ managerial staff to track/analyze training as well as mentoring and coaching services provided.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
74.	CSS provides staff at community based facilities and homes with state of the art training encompassing person-centered thinking, multi- modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
74.1	CSS determines locations for teams and/or home-based staff. CSS creates position descriptions that identify the necessary knowledge, skills, and abilities. CSS hires or trains staff with necessary qualifications and skills to provide training.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
74.2	CSS insures that all vacant trainer positions are filled as efficiently as possible and with appropriately qualified staff.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
74.3	Training curricula are reviewed routinely to insure consistency with best practices.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
75.	CSS' mentoring and coaching as methodologies are targeted to prepare for increased community capacity to support individuals in their community.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
75.1	CSS will mentor and develop coaches in the community with a vision to support individuals in communities.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
75.2	Track issues including frequency of behaviors dangerous to self or others, frequency of interactions with the criminal justice system, sudden increases in usage of psychotropic medications, multiple hospitalizations or transfers within the system, serious reported incidents, repeated failed placements, or other challenges identified in previous monitoring or interventions and cost of placement.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
75.3	Provide additional administrative/ managerial support to CSS sufficient to enable timely and complete data collection, entry and analysis	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
76.	An additional fourteen (14) full time equivalent positions were added between February 2011 and June 30, 2011, configured as follows: Two (2) Behavior Analyst 3 positions; One (1) Community Senior Specialist 3; (2) Behavior Analyst 1; Five (5) Social Worker Specialist positions; and Five (5) Behavior Management Assistants.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
76.1	Review position descriptions, update as necessary.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
76.2	Work with DHS Human Resources on advertising positions.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
76.3	Fill any vacancies in functionally equivalent positions, with the required qualifications. As necessary to fulfill this Comprehensive Plan of Action, fill any position.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
77.	None of the identified positions are vacant.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
77.1	Fill as quickly as possible and with qualified applicants all vacancies in these and other functionally equivalent positions. Provide sufficient salary, bonus and other structures and incentives to ensure that the positions are filled.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	
78.	Staff conducting the Functional Behavioral Assessment or writing or reviewing Behavior Plans shall do so under the supervision of a Behavior Analyst who has the requisite educational background, experience, and credentials recognized by national associations such as the Association of Professional Behavior Analysts. Any supervisor will co-sign the plan and will be responsible for the plan and its implementation.	Settlement Agreement Section X.A. System Wide Improvements – Expansion of Community Support Services	**Semi-Annual**
79.	The State and the Department developed a proposed Olmstead Plan, and will implement the Plan in accordance with the Court's orders. The Plan will be comprehensive and will use measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the "Most Integrated Setting," and which is consistent and in accord with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). The Olmstead Plan is addressed in Part 3 of this Comprehensive Plan of Action.	Settlement Agreement Section X.B. System Wide Improvements – Olmstead Plan	**According to the Olmstead Plan reporting process**

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EC#	Evaluation Criteria	CPA Section	Reporting
80.	Rule 40 modernization is addressed in Part 2 of this Comprehensive Plan of Action. DHS will not seek a waiver of Rule 40 (or its successor) for a Facility.	Settlement Agreement Section X.C. System Wide Improvements – Rule 40	**Annual**
81.	The State takes best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability.	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	**Annual**
82.	There are no transfers or placements of persons committed solely as a person with a developmental disability to the Minnesota Security Hospital (subject to the exceptions in the provision).	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	**Exception**
82.1	DHS will communicate to all County Attorneys and state courts responsible for commitments, and to all county directors and case managers, that pursuant to the order of the federal court approving this Plan, no person committed with a sole diagnosis of developmental disability may be transferred or placed at the Minnesota Security Hospital. Such communication will be made from the Commissioner within 30 days of the order approving this plan and, in addition, by DHS staff who become aware of any such proposed commitment or transfer.	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	
82.2	The Jensen Implementation Team will document any proposed transition to or placement at MSH of any person committed solely as a person with a developmental disability, including but not limited to any diversion efforts prior to transfer or placement and any subsequent placements.	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	
83.	There has been no change in commitment status of any person originally committed solely as a person with a developmental disability without proper notice to that person's parent and/or guardian and a full hearing before the appropriate adjudicative body.	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	**Annual**
83.1	The Jensen Implementation Team will document any changes in commitment status of a person originally committed solely as a person with a developmental disability. The documentation will include any notifications and a description of any hearing, and copies of petitions and other papers submitted in connection with notification and/or hearing.	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	

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EC#	Evaluation Criteria	CPA Section	Reporting
84.	All persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender status set forth in paragraph 1, above, are transferred by the Department to the most integrated setting consistent with Olmstead v. L.C. , 527 U.S. 581 (1999).	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	**Annual**
84.1	Provide current census, and identifying information, of any people living at MSH committed solely as a person with a developmental disability.	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	
84.2	Provide documentation of any transition/ placement from MSH since 12/5/2011 of any persons committed solely as a person with a developmental disability. Any such transfer/placement shall be to the most integrated setting consistent with Olmstead v. L.C., 527 U.S. 581 (1999).	Settlement Agreement Section X.D. System Wide Improvements – Minnesota Security Hospital	
85.	All AMRTC residents committed solely as a person with a developmental disability and who do not have an acute psychiatric condition are transferred from AMRTC to the most integrated setting consistent with Olmstead v. L.C. , 527 U.S. 581 (1999).	Settlement Agreement Section X.E. System Wide Improvements – Anoka Metro Regional Treatment Center	**Exception**
85.1	DHS will communicate to all County Attorneys and state courts responsible for commitments, and to all county directors and case managers that, pursuant to the order of the federal court approving this Plan, no person committed with a sole diagnosis of developmental disability may be transferred or placed at the Anoka Metro Regional Treatment Center. Such communication will be made from the Commissioner within 30 days of the order approving this plan and, in addition, by DHS staff who become aware of any such proposed commitment or transfer.	Settlement Agreement Section X.E. System Wide Improvements – Anoka Metro Regional Treatment Center	
85.2	The Jensen Implementation Team will document any proposed transition to or placement at Anoka Metro Regional Treatment Center of any person committed solely as a person with a developmental disability, including but not limited to any diversion efforts prior to transfer or placement and any subsequent placements.	Settlement Agreement Section X.E. System Wide Improvements – Anoka Metro Regional Treatment Center	
86.	The term "mental retardation" has been replaced with "developmental disabilities" in any DHS policy, bulletin, website, brochure, or other publication. DHS will continue to communicate to local government agencies, counties, tribes, courts and providers that they should adhere to this standard.	Settlement Agreement Section X.F. System Wide Improvements – Language	

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EC#	Evaluation Criteria	CPA Section	Reporting
86.1	All references to outdated terminology used to describe persons with Developmental Disabilities have been updated with clarification on the Departments use of people first language inserted in areas where historical documents are found. In addition to, or in lieu of, updating each webpage, DHS shall maintain the previously established "disclaimer" language to explain the presence in historical documents of outdated terminology.	Settlement Agreement Section X.F. System Wide Improvements – Language	
87.	DHS drafted and submitted a bill for the Minnesota Legislature that will require the replacement of terms such as "insane," "mentally incompetent," "mental deficiency," and other similar inappropriate terms that appear in Minnesota statutes and rules.	Settlement Agreement Section X.F. System Wide Improvements – Language	
87.1	On the removal of inappropriate terms that appear in Minnesota statutes and Rules, see 2013 legislation at Chapter 62 and Chapter 59, Article 3, section 21 signed by the Governor on May 16, 2013. DHS will not seek to repeal or replace this legislation.	Settlement Agreement Section X.F. System Wide Improvements – Language	
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.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	
89.	Staff hired for new positions as well as to fill vacancies, will only be staff who have experience in community based, crisis, behavioral and person-centered services and whose qualifications are consistent with the Settlement Agreement and currently accepted professional standards. Staff reassigned from MSHS-Cambridge will receive additional orientation training and supervision to meet these qualifications within 6 months of reassignment.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Annual**
90.	Provide integrated vocational options including, for example, customized employment.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Annual**
91.	All requirements in this Comprehensive Plan of Action are fully met for each individual served in the area of Person-Centered Planning.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
92.	All requirements in this Comprehensive Plan of Action are fully met for each individual served in the area of Transition Planning.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Annual**
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.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Semi-Annual**
94.	All sites, programs and services established or utilized under this Comprehensive Plan of Action shall be licensed as required by state law.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Annual**
95.	Residents currently at MSHS-Cambridge transition to permanent community homes.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	
96.	Training plan for staff strongly emphasizes providing tools and support services in a person's home as quickly as possible. Staff will also be trained in delivering community based programs and processes.	Closure of MSHS-Cambridge and Replacement with Community Homes and Services	**Annual**
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.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	**Semi - Annual**
98.1	Successful Life Project (SLP) staff will initiate a statewide review process on or about October 1, 2014 to perform an initial assessment on all persons included in the therapeutic follow-up group no later than November 30, 2014. This review will be a brief face-to-face meeting with each individual to assess the general well-being of the person in his or her home and to determine if there are any critical or immediate health or safety issues.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	

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EC#	Evaluation Criteria	CPA Section	Reporting
98.2	A tool to help reviewers screen individuals and document findings during the initial assessment was developed from existing instruments.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	
98.3	During the initial assessment, immediate follow-up will take place on any person for whom home health and safety concerns have been identified. Appropriate actions and referral will be made as appropriate.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	
98.4	The results of this initial assessment process will assist the SLP in prioritizing needs of individuals for the next phase of the therapeutic follow-up, a more robust assessment using the Community Compliance Review Tool.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	
98.5	Following the completion of the initial assessment and the prioritization of persons included in the therapeutic follow-up group, MLB will begin the ongoing comprehensive compliance reviews using the Community Compliance Review Tool.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	
98.6	A bulletin will be distributed widely to announce the Successful Life Project in the fall of 2014.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	
98.7	Behavior analysts or other staff contact the guardian by telephone before the initial assessment (the first face-to-face visit) to explain why they are coming and what to expect, and gets verbal consent to contact the person. The manager may assist with some contacts if there are barriers or issues that may arise.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	
98.8	If the person / guardian refuses to give consent for an initial assessment or any subsequent compliance review, individual letters will be sent to each person, guardian, provider, county case manager, family and other team members to explain the project and the process of following up with people, and information on how to contact SLP for more information or to consent to the initial assessment or compliance review.	Therapeutic Follow-Up of Class Members and Clients Discharged from METO/MSHS-Cambridge	

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EC#	Evaluation Criteria	CPA Section	Reporting
99.	The scope of the Rule 40 modernization shall include all individuals with developmental disabilities served in programs, settings and services licensed by the Department, regardless of the setting in which they live or the services which they receive. As stated in the Settlement Agreement, the modernization of Rule 40 which will be adopted under this Comprehensive Plan of Action shall reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the 'most integrated setting' and 'person centered planning, and development of an 'Olmstead Plan'" consistent with the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 582 (1999).	Modernization of Rule 40	
100.	Within the scope set forth above, the rule-making process initiated by the Department of Human Services pursuant to the Settlement Agreement, the Department shall by December 31, 2014 propose a new rule in accordance with this Comprehensive Plan of Action ("Proposed Rule"). This deadline may be extended for good cause shown upon application to the Court not later than 20 days prior to the deadline. Should the Department of Human Services believe that it requires additional rule-making authority to satisfy the requirements of this Plan, in order to apply the rule to all providers covered by Rule 40 and the scope of this Plan, the Department will seek an amendments to statutes in the 2014 Minnesota Legislative session to ensure that the scope of the Rule 40 modernization stated above is fulfilled and will apply to all of the facilities and services to persons with developmental disabilities governed by Rule 40. Any proposed amendment(s) are subject to the notice and comment process under EC __ below. If legislative approval for the requested authority is not obtained in the 2014 Minnesota Legislative session, the Court may use its authority to ensure that the Adopted Rule will apply consistent with the scope set forth in EC 99. By August 31, 2015, the Department of Human Services shall adopt a new rule to modernize Rule 40 ("Adopted Rule"). This deadline may be extended for good cause shown upon application to the Court not later than 60 days prior to the deadline.	Modernization of Rule 40	**Annual**
101.	The Proposed Rule shall address the temporary use and tapering of carefully monitored individual medical restraints for self-injurious behavior while non-restraint positive behavior supports are implemented under professional supervision.	Modernization of Rule 40	**Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
	In formulating the Proposed Rule, and any other methods or tools of implementation, the Department shall carefully consider the recommendations of Dr. Fredda Brown, whose consultation on the Rule 40 modernization the Department requested with regard to matters on which the Advisory Committee had not reached consensus. The Department shall document the results of this review.		
102.	The Proposed Rule shall be consistent with and incorporate, to the extent possible in rule, the Rule 40 Advisory Committee's consensus recommendations stated in its Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013). During the rule-making process, the Department shall advocate that the final rule be fully consistent with the Rule 40 Advisory Committee's recommendations. The phrase "to the extent possible in rule" above is intended to recognize that some elements of the Committee's recommendations are not susceptible to the format of rules and, therefore, will be implemented by the Department through policies, bulletins, contract provisions, and by other means. Not later than (30) days prior to public notice of the content of the Proposed Rule, the Department shall provide a draft of the rule to Plaintiffs' Class Counsel, the Court Monitor, the Ombudsman for Mental Health and Developmental Disabilities, and the Executive Director of the Governor's Council on Developmental Disabilities for review and comment and, if requested by any of these entities, for discussion in a conference prior to public notice of the content of the Proposed Rule. The Department will share with these entities the intended final content not later than five (5) days prior to the public notice.	Modernization of Rule 40	
103.	Within thirty (30) days of the promulgation of the Adopted Rule, Plaintiffs' Class Counsel, the Court Monitor, the Ombudsman for Mental Health and Developmental Disabilities, or the Executive Director of the Governor's Council on Developmental Disabilities may suggest to the Department of Human Services and/or to the Olmstead Implementation Office that there are elements in the Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013) which have not been addressed, or have not adequately or properly been addressed in the Adopted Rule. In that event, those elements shall be considered within the process for modifications of the Olmstead Plan. The State shall address these suggestions through Olmstead Plan sub-cabinet and the Olmstead Implementation Office. Unresolved issues may be presented to the Court for resolution by any of the above, and will be resolved by the Court.	Modernization of Rule 40	**Semi - Annual**

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EC#	Evaluation Criteria	CPA Section	Reporting
104.	The Department of Human Services shall implement the Adopted Rule and take other steps to implement the recommendations of the Rule 40 Advisory Committee.	Modernization of Rule 40	

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UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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

Plaintiffs,

vs.

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

Defendants.

File No. 09-CV-01775-DWF-BRT

PLACEHOLDER FOR IDENTIFIER KEY TO *JENSEN* SETTLEMENT AGREEMENT COMPREHENSIVE PLAN OF ACTION (CPA) – AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT – REPORTING PERIOD: OCTOBER 1, 2015 – JUNE 30, 2016

This document is a placeholder for the following item which is filed in conventional or physical form with the Clerk's Office:

Identifier Key to *Jensen* Settlement Agreement Comprehensive Plan of Action (CPA) – August 2016 Semi-Annual Compliance Report – Reporting Period: October 1, 2015 – June 30, 2016

If you are a participant in this case, this filing will be served upon you in conventional format. This filing was not e-filed for the following reason:

☐ Voluminous Document* (Document number of order granting leave to file conventionally:)

☐ Unable to Scan Documents (e.g., PDF file size of one page larger than 2MB, illegible when scanned)

☐ Physical Object (description):

☐ Non Graphical/Textual Computer File (audio, video, etc.) on CD or other media

☒ Item Under Seal pursuant to court orders* (Pursuant to Protective Orders Doc. Nos. 57, 114, 190, 239)

☐ Item Under Seal pursuant to the Fed. R. Civ. P. 52 and Fed. R. Crim. P. 49.1 (Document number of redacted version: ___)

☐ Other (description):

*Requires Judicial Approval

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 CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE 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 Director of the Jensen / Olmstead Quality Assurance and Compliance Office ("JOQACO").

2. I am familiar with the above-captioned case and settlement.

3. In order to verify that the information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report"), is correct and accurate, JOQACO:

(A) had individuals with personal knowledge of specific information in the Report review the specific information, verify its correctness and accuracy, and

attest to the correctness and accuracy of the specific information in an affidavit; and

(B) conducted the supplemental verification activities described in relevant sections of the Report.

4. Based upon this process and my own personal knowledge, I verify that the information in the Report is correct, accurate, and complete.

FURTHER YOUR AFFIANT SAYETH NOT.

MARGARET FLETCHER BOOTH

Subscribed and sworn to before me on August 30, 2016

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/2017

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, PHD, CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE 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, Jensen / Olmstead Quality Assurance & Compliance Office (JOQACO).

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criteria 39, 41, and 93.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

DANIEL J. BAKER

Subscribed and sworn to before me on 8/29/16, 2016

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/2017

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, PHD, CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE 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 Director, Jensen / Olmstead Quality Assurance & Compliance Office (JOQACO), formerly known as the Jensen Implementation Office.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criteria 39, 41, 81 (information relating to discharge of O1), and 98.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

M. Fletcher-Booth

MARGARET FLETCHER BOOTH

Subscribed and sworn to before me on August 30, 2016

Jolayne Lange

NOTARY PUBLIC

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/2017

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 MARK BROSTROM CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF ISANTI)

MARK BROSTROM, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Manager, Minnesota Life Bridge Treatment Homes.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criteria 3, 47, 48, 49, 50, 51, 52, 53, 56, 58, 64, and 93.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office (JOQACO) at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

MARK BROSTROM

Subscribed and sworn to before me on August 26, 2016

NOTARY PUBLIC

GINA P. JOHNSON
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2020

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 STEVEN DAHL CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

STEVEN DAHL, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Director, Community Support Services.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criteria 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, and 93.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office ("JOQACO") at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

Steven Dahl
STEVEN DAHL

Subscribed and sworn to before me on
August 25, 2016

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/2017

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 KAREN SULLIVAN HOOK CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

KAREN SULLIVAN HOOK, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Deputy Senior Counsel.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Update regarding Evaluation Criteria 81 (information relating to discharge of O1), and 103.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office ("JOQACO") at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

KAREN SULLIVAN HOOK

Subscribed and sworn to before me on August 29, 2016

NOTARY PUBLIC

JULIE L. TINKHAM
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2020

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 AMBER MAKI CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF ISANTI)

AMBER MAKI, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Clinical Coordinator / Behavior Analyst 3 Supervisor, in Community Based Services.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criteria 2, 47, 48, 49, 50, 51, and 52.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office (JOQACO) at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

AMBER MAKI

Subscribed and sworn to before me on August 26, 2016

GINA P. JOHNSON
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2020

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 CAROL OLSON CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

CAROL OLSON, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Executive Director, Forensic Services.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criterion 81.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office ("JOQACO") at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

Carol Olson

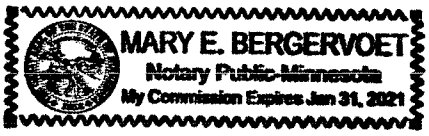
CAROL OLSON

Subscribed and sworn to before me on

August 29, 2016

Mary E. Bergervoet

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 MICHAEL SCHARR CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

MICHAEL SCHARR, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as the Northern Regional Manager, Community Support Services.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criteria 73, 74, and 78.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office ("JOQACO") at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

MICHAEL SCHARR

Subscribed and sworn to before me on August 26, 2016

JOLAYNE SUE LANGE
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 01/31/2017

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 MICHAEL TESSNEER CONCERNING VERIFICATION OF DEFENDANTS' AUGUST 2016 SEMI-ANNUAL COMPLIANCE REPORT

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

MICHAEL TESSNEER, being first duly sworn on oath, states as follows:

1. I am employed by the Minnesota Department of Human Services ("DHS") as Director of Compliance, Olmstead Implementation Office.

2. I am familiar with the above-captioned case and settlement and understand that this affidavit is a verification of information set forth in Defendants' August 2016 Semi-Annual Compliance Report ("Report").

3. I have personal knowledge of the information I provided for the following sections of the Report and verify that the information I provided is correct and accurate:

A. October 1, 2015 to June 30, 2016 Updates regarding Evaluation Criterion 79.

4. I further hereby verify the data contained in the portions of the Report described above at paragraph 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 the Jensen / Olmstead Quality Assurance and Compliance Office ("JOQACO") at DHS so that the data can be filed under seal.

FURTHER YOUR AFFIANT SAYETH NOT.

MICHAEL TESSNEER

Subscribed and sworn to before me on August 25, 2016

NOTARY PUBLIC

STACIE LYNN BROOKS
Notary Public-Minnesota
My Commission Expires Jan 31, 2021