MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

Meeting Minutes: Olmstead Leadership Forum

Date: 06/28/2021
Location: Zoom online meeting platform

Call to Order

Shelley Madore welcomed everyone and thanked them for attending.

Attendance

Leadership Forum Members

- Ryan Baumtrog, Minnesota Housing (MHFA)
- Chris McVey, Department of Employment and Economic Development (DEED)
- Brian Collins, Department of Corrections (DOC)
- Colleen Wieck, Governor's Council on Developmental Disabilities (GCDD)
- Ann Schulte, Minnesota Department of Health (MDH)
- Daron Korte, Minnesota Department of Education (MDE)
- Scott Buetel, Minnesota Department of Human Rights (MDHR)
- Gerri Sutton, Metropolitan Council (MetC)
- Lisa Harrison-Hadler, Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD)

Olmstead Implementation Office Staff

- Shelley Madore
- John Patterson
- Diane Doolittle
- Chloe Ahlf
- Carolyn Sampson
- Mike Tessneer
- Rosalie Vollmar

Guests

- Gloria Smith, Department of Human Services (DHS)
- Dan Baker (DHS)
- Dee Torgerson (DEED)
- Kate Erickson (DOC)
- Kristie Billiar, Minnesota Department of Transportation (MNDOT)
- Sue Hite-Kirk (MHFA)
- Veritext Captioning and Reporting Services, Inc. (CART provider)

Agenda Review

Shelley Madore reviewed the agenda and proceeded with no changes.

Agenda Items

Leadership Forum Roles and Responsibilities - Proposed Charter

Shelley Madore walked through the charter and answered questions. The Olmstead Subcabinet is scheduled to review and approve proposed changes to the Subcabinet Procedures at their July 26, 2021 meeting. The proposed changes will establish the Leadership Forum. The Subcabinet will also be asked to approve the charter for the Leadership Forum.

Questions and Comments

Shelley Madore described how the Big 5 workgroup recommendations will be reported to the Leadership Forum. The Leadership Forum will determine if the workgroup should do more exploratory work or if recommendations should be passed on to the Subcabinet for review and approval.

A recommendation was made to add specific language to the charter about how the Leadership Forum will actively include Black, Indigenous and People of Color.

Recommendation and Nomination of Chairs

Shelley Madore introduced Lisa Harrison-Hadler and Brian Collins as the proposed co-chairs of the Leadership Forum. Commissioner Ho (Minnesota Housing), Chair of the Olmstead Subcabinet, will review the nominations for approval at the July 26, 2021 Subcabinet meeting.

Questions and Comments

None

Proposed Meeting Schedule

Shelley Madore referred to the proposed meeting schedule for the Leadership Forum and Subcabinet meetings.

Questions and Comments

None

Review of Establishing Measurable Goals

Mike Tessneer oriented the members to their future responsibilities by reviewing "the Life Cycle of a Measurable Goal." This included an analysis of how goals change over time to ensure progress. He walked through three employment goals to demonstrate the process.

Questions and Comments

As goals are first identified and then subsequent barriers are identified, the Leadership Forum can further determine approach for looking at issues in a different way.

Review of Draft May 2021 Quarterly Report

Mike Tessneer reviewed the executive summary of the May 2021 Quarterly Report. The Leadership Forum is asked to make recommendations for approval at the July 26, 2021 Subcabinet Meeting.

Following approval of the proposed changes to the Subcabinet Procedures and approval of the charter of the Leadership Forum, the Leadership Forum will be assigned responsibility for reviewing all subsequent quarterly reports and making recommendations to the Subcabinet for approval. The August 2021 Quarterly Report will be reviewed for approval at the August 23, 2021 Leadership Forum meeting.

Questions and Comments:

A request was made to add more summary detail to the Quality of Life results.

A suggestion was made for the Leadership Forum to think about performance improvement plans where improvement has not been seen for several years.

In response to a question, Dan Baker (DHS) indicated that Gertrude Matemba-Mutasa or Doug Annett from DHS are the individuals delegated to sign off on use of mechanical restraints through the external program review committee.

Additional comments were made about Quality of Life, public guardianship and employment. Mr. Tessneer concurred that issues around these topics are all opportunities for the Leadership Forum to have deeper collaborative discussions along with perhaps agency presentations to further understand agency functions and goals.

Adjournment

The meeting was adjourned at 4:35 p.m.

Next Meeting

Date: August 23, 2021
Time: 3:00 to 4:30 p.m.
Location: Zoom meeting platform
Agenda items: (submit proposed agenda items to diane.doolittle@state.mn.us)

- August 2021 Quarterly Report
- 2020 Olmstead Plan Quality of Life Survey

Alternate forms of this document

To request alternate formats of this document, please email mnolmsteadplan@state.mn.us

Olmstead Leadership Forum Meeting Agenda

Monday, June 28, 2021 • 3:00 p.m. to 4:30 p.m.

1) **Call to Order**

2) **Roll Call / Question**

   What influence has the Olmstead Plan had had on your agency and the overall policies and practices within your agency?

3) **Agenda Review**

4) **Agenda Items**

   a) Leadership Forum Roles and Responsibilities / Proposed Charter **3**

   b) Recommendation/ Nomination of Chairs

   c) Proposed Meeting Schedule **7**

   d) Review of Establishing Measurable Goals

   e) Review of Draft May 2021 Quarterly Report **11**

5) **Adjournment**

Next Meeting: August 23, 2021 from 3:00 p.m. to 4:30 p.m.

Next Meeting Topics:

- August 2021 Quarterly Report
- 2020 Olmstead Plan Quality of Life Survey

Leadership Forum Meeting Agenda Item

June 28, 2021

Agenda Item:

4a) Leadership Forum Roles and Responsibilities and Proposed Charter

Presenter:

Shelley Madore

Action Needed:

☐ Approval Needed

☒ Informational Item (no action needed)

Summary of Item:

This is the proposed charter for the Leadership Forum including the roles and responsibilities.

Attachment(s):

4a - Leadership Forum Proposed Charter

[AGENDA ITEM 4a]

Olmstead Subcabinet Workgroup Charter

Workgroup Name:	**Date:** June 28, 2021
Olmstead Leadership Forum	**Subcabinet Approval:**
	Subcabinet to Review:

Workgroup Chairs: Brian Collins (DOC) and Lisa Harrison-Hadler (OMHDD)

Workgroup Members *(include agency or organization, if applicable)*:
Ryan Baumtrog (MHFA), Scott Beutel (MDHR), Tim Henkel (DOT), Daron Korte (MDE), Mike Mc Elhiney (MDVA), Ann Schulte (MDH), Erin Sullivan Sutton (DHS), Gerri Sutton (MetC), Dee Torgerson (DEED), Colleen Wieck (GCDD), and a designee from DPS.

OIO Staff *(lead OIO staff, if applicable)*:

Workgroup Purpose / Objective:

The Olmstead Leadership Forum will have the following responsibilities:

1. A Leadership Forum will be convened to carry out designated responsibilities of the Subcabinet.
   a) The Leadership Forum will include from each agency, a designee with decision-making authority.
   b) The Leadership Forum will review performance results for every Olmstead goal, review reports from workgroups, review public input to amend the Olmstead Plan and prepare recommendations to be considered by the Subcabinet. (See Article VII – Section B for more details)
   c) The Leadership Forum will have a charter to include information such as membership, alternative members, scope of duties, meeting frequency, and meeting minutes.

Responsibilities delegated to the Leadership Forum by the Subcabinet

1) Work to identify and address barriers to providing services and meaningful opportunities within the most integrated settings for persons with disabilities throughout Minnesota;
2) Work to identify and address areas of disparity in opportunities for individuals with disabilities including individuals from racial and ethnic communities. The desired outcome is the opportunity to live, work, and engage in the most integrated settings; and
3) Provide ongoing recommendations for further amendment of the Olmstead Plan.

Relationship to Olmstead Plan *(include applicable measurable goals, strategies, workplan action items, etc.)*

The Leadership Forum has the primary responsibility to monitor the operational implementation of the Olmstead Plan, identify areas where insufficient progress is being made and work to modify the Plan to improve progress. The Leadership Forum members are responsible to report to the Subcabinet on Plan progress as it relates to their specific agencies.

Plan to engage people with disabilities, families and the public *(include plan for including people of color and indigenous communities)*

The Leadership Forum will actively participate in conjunction with workgroup leaders, in periodic community engagement activities organized by the Olmstead Implementation Office.

Scope:

The primary focus of the Leadership Forum is on the evolution of the system to align with the integration mandate as specified in the Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*

https://www.ada.gov/olmstead/q&a_olmstead.htm

Implementation Timeframe:

Implementation of the Olmstead Plan is authorized by Executive Order 19-13 and will continue until the Order is modified or rescinded.

Anticipated Outcome / Deliverables:

The faithful implementation of the Olmstead Plan with active engagement of people with disabilities and their supporters in modifying the Plan over time.

Key Measures:

The key measures are the measurable goals identified in the Olmstead Plan.

Reporting Schedule:

The Leadership Forum will convene up to six times per year to monitor the Plan implementation quarterly and review the entire Plan for modifications annually.

Action Plan for Implementing Charter

Activity	Responsibility	Due Date
Gather measurable goal performance data and complete quarterly and annual reports	Compliance	Quarterly
Organize and implement workgroups as directed by the Subcabinet on specified topics.	OIO	Annually
Review workgroup progress and make recommendations to workgroup leaders and report progress to Subcabinet	Leadership Forum	Semi-annually
Convene Leadership Forum meetings, post meeting schedule and meeting minutes on the website.	Leadership Forum Co-chairs	Up to 6 times each year

This Workgroup is authorized by Executive Order 19-13 and created pursuant to the July 26, 2021 Olmstead Subcabinet Procedures. Any material changes to the Charter must be approved by the Olmstead Subcabinet to be effective. The Olmstead Subcabinet may withdraw or amend approval of this Charter at any time. All Charters should be brought back to the Olmstead Subcabinet for review and update at least annually.

Approval of Charter:

_____ _____

Commissioner Ho Date
Chair, Olmstead Subcabinet

Leadership Forum Meeting Agenda Item

June 28, 2021

Agenda Item:

4c) Proposed Meeting Schedule

Presenter:

Shelley Madore

Action Needed:

☐ Approval Needed

☒ Informational Item (no action needed)

Summary of Item:

This is the proposed meeting schedule for Subcabinet and Leadership Forum through 2022.

Attachment(s):

4c - Subcabinet and leadership Forum Proposed Meeting Schedule

[AGENDA ITEM 4c]

Subcabinet and Leadership Forum

Proposed Meeting Schedule

Meeting Date	Who
June 28, 2021	Leadership Forum
July 26, 2021	Subcabinet
August 23, 2021	Leadership Forum
September 27, 2021	Leadership Forum
October 25, 2021	Subcabinet
November 22, 2021	Leadership Forum
January 24, 2022	Subcabinet
February 28, 2022	Leadership Forum
April 25, 2022	Subcabinet
May 23, 2022	Leadership Forum
July 25, 2022	Subcabinet
August 22, 2022	Leadership Forum
September 26, 2022	Leadership Forum
October 24, 2022	Subcabinet
November 28, 2022	Leadership Forum

Leadership Forum Meeting Agenda Item

June 28, 2021

Agenda Item:

4e) May 2021 Quarterly Report on Olmstead Plan Measurable Goals

Presenter:

Mike Tessneer

Action Needed:

☐ Approval Needed

☒ Informational Item (no action needed)

Summary of Item:

This is a draft of the May 2021 Quarterly Report. Mike Tessneer will provide an overview of the Executive Summary of the Report. Upon review of this document the Leadership Forum will make recommendations for action to the Subcabinet.

Attachment(s):

4e - May 2021 Quarterly Report on Olmstead Plan Measurable Goals

[AGENDA ITEM 4e]

Minnesota Olmstead Subcabinet

Quarterly Report on Olmstead Plan Measurable Goals

REPORTING PERIOD

Data acquired through April 30, 2021

Date to be Reviewed by Leadership Forum

June 28, 2021

Contents

[AGENDA ITEM 4e]

I. PURPOSE OF REPORT

This quarterly report provides the status of work being completed by State agencies to implement the Olmstead Plan. The goals related to the number of people moving from segregated settings into more integrated settings; the number of people who are no longer on the waiting list; and the quality of life measures will be reported in every quarterly report.

Reports are compiled on a quarterly basis. For the purpose of reporting, the measurable goals are grouped in four categories:

1. Movement of people with disabilities from segregated to integrated settings
2. Movement of individuals from waiting lists
3. Quality of life measurement results
4. Increasing system capacity and options for integration

This quarterly report includes data acquired through April 30, 2021. Progress on each measurable goal will be reported quarterly, semi-annually, or annually. This report will be reviewed by the Olmstead Leadership Forum and recommended for acceptance by the Olmstead Subcabinet. After reports are accepted they are made available to the public on the Olmstead Plan website at Mn.gov/Olmstead. [i]

EXECUTIVE SUMMARY

This quarterly report covers thirteen measurable goals.[ii] As shown in the chart below, six of those goals were either met or are on track to be met. Three goals were categorized as not on track, or not met. For those three goals, the report documents how the agencies will work to improve performance on each goal. Four goals are in process.

Status of Goals – May 2021 Quarterly Report	Number of Goals
Met annual goal	1
On track to meet annual goal	5
Not on track to meet annual goal	3
Did not meet annual goal	0
In process	4
Goals Reported	**13**

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

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

- During this quarter, 37 individuals left ICF/DD programs to more integrated settings. After one quarter, 51% of the annual goal of 72 has been achieved. (Transition Services Goal One A)
- During this quarter, 123 individuals with disabilities under age 65 in a nursing facility longer than 90 days moved to more integrated settings. After one quarter, 16% of the annual goal of 750 has been achieved. (Transition Services Goal One B)
- During this quarter, 259 individuals moved from other segregated settings to more integrated settings. After one quarter, 51% of the annual goal of 500 has been achieved. (Transition Services Goal One C)
- After three quarters, 22.5% percent of people at AMRTC no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting. This is ahead of the goal to decrease to 30%. (Transition Services Goal Two)

Timeliness of Waiver Funding Goal One

- There are fewer individuals waiting for access to a DD waiver. At the end of the current quarter 63% of individuals were approved for funding within 45 days. Another 26% had funding approved after 45 days.

Increasing system capacity and options for integration

- The utilization of the Person Centered Protocols continues to show improvement. During this quarter, the combined average of presence of the eight person centered elements measured in the protocols was 93.5%. Five of the eight elements achieved 99% or higher. (Person-Centered Planning Goal One)
- The number of individuals experiencing a restrictive procedure is lower, at 183 individuals this quarter compared to 193 in the previous quarter. (Positive Supports Goal One)
- The number of reports of use of restrictive procedures is lower, at 573 reports this quarter compared to 702 in the previous quarter. (Positive Supports Goal Two)
- During Calendar Year 2019, Greater Minnesota transit service hours increased by 8,348 hours from the previous year. (Transportation Goal 2)
- During Calendar Year 2020, on-time performance improved for Metro Mobility (96.4% up from 93%) and Metro Transit (87.3% up from 82.7%), while Transit Link performance dropped slightly (96% from 97%). (Transportation Goal Four A)

The following measurable goals have been targeted for improvement:

- Transition Services Four to adhere to transition protocol for individuals experiencing a transition.
- Positive Supports Three to reduce the number of reports of emergency use of mechanical restraints with approved individuals.

II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

This section reports on the progress of five separate Olmstead Plan goals that assess movement of individuals from segregated to integrated settings.

QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

The table below indicates the cumulative net number of individuals who moved from various segregated settings to integrated settings for each of the five goals included in this report. The reporting period for each goal is based on when the data collected can be considered reliable and valid.

Net number of individuals who moved from segregated to integrated settings during reporting period

Setting	Reporting period	Number moved
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	July - Sept 2020	37
• Nursing Facilities (individuals under age 65 in facility > 90 days)	July - Sept 2020	123
• Other segregated settings	July - Sept 2020	259
• Anoka Metro Regional Treatment Center (AMRTC)	Jan - Mar 2021	27
• Minnesota Security Hospital (MSH)[1]	Jan - Mar 2021	19
Total	--	**465**

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

[1] For the purposes of this report Minnesota Security Hospital (MSH) refers to individuals residing in the facility and committed as Mentally Ill and Dangerous and other civil commitment statuses and individuals under competency restoration treatment, Minn. R. Crim. R. 20.01.

TRANSITION SERVICES GOAL ONE: By June 30, 2022, the number of people who have moved from segregated settings to more integrated settings[iii] will be 9,782. *[Extended in April 2021 Revision]*

Annual Goals for the number of people moving from ICFs/DD, nursing facilities and other segregated housing to more integrated settings are set forth in the following table:

	2014 Base line	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	June 30, 2020	June 30, 2021	June 30, 2022
A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84	84	72	72	72	72	72
B) Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740	740	750	750	750	750	750
C) Segregated housing other than listed above	1,121	50	250	400	500	500	500	500	500
Total		**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**	**1,322**	**1,322**

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

2021 goal

- For the year ending June 30, 2021 the number of people who have moved from ICFs/DD to a more integrated setting will be **72**

Baseline: January - December 2014 = 72

RESULTS:

This goal was extended in the April 2021 Olmstead Plan Revision. The goal is **on track** to meet the 2021 goal to move 72 people from ICFs/DD to a more integrated setting.

Time period	Total number of individuals leaving	Transfers[iv] (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	138	18	62	**58**
2016 Annual (July 2015 – June 2016)	180	27	72	**81**
2017 Annual (July 2016 – June 2017)	263	25	56	**182**
2018 Annual (July 2017 – June 2018)	216	15	51	**150**
2019 Annual (July 2018 – June 2019)	298	20	58	**220**
2020 Annual (July 2019 – June 2020)	174	13	75	**86**
2021 Quarter 1 (July – September 2020)	58	1	20	**37**

ANALYSIS OF DATA:

From July – September 2020, the number of people who moved from an ICF/DD to a more integrated setting was 37. This is an increase of 28 from 9 the previous quarter. After one quarter, the number is 51% of the annual goal of 72. The goal is on track to meet the 2021 annual goal.

[AGENDA ITEM 4e]

COMMENT ON PERFORMANCE:
Transitions to more integrated settings continued through the timeframe of the COVID-19 pandemic. While some transitions slowed in the spring, there was a trend of increased transitions during mid-late summer as pandemic restrictions loosened. In addition, the Moving Home Minnesota program was granted an exception to the 180 days limit of transition coordination for people moving from institutional settings. This allowed additional time for the transition if it was delayed due to the pandemic, e.g. facility on lockdown, individual tested positive for COVID-19.

The pandemic has severely impacted the already statewide workforce shortage, particularly for direct support professionals. This has in turn increased the barriers for people seeking to live in their own homes with staff supporting them on an individual basis.

DHS provides reports to counties about persons in ICFs/DD who are not opposed to moving with community services, as based on their last assessment. As part of the current reassessment process, individuals are being asked whether they would like to explore alternative community services in the next 12 months. Some individuals who expressed an interest in moving changed their minds, or they would like a longer planning period before they move.

For those leaving an institutional setting, such as an ICF/DD, the Olmstead Plan reasonable pace goal is to ensure access to waiver services funding within 45 days of requesting community services. DHS monitors and provides technical assistance to counties in providing timely access to the funding and planning necessary to facilitate a transition to community services.

DHS continues to work with private providers that have expressed interest in voluntary closure of ICFs/DD. Providers are working to develop service delivery models that better reflect a community–integrated approach requested by people seeking services. As of 2019, Minnesota State Operated Community Services (MSOCS) no longer has any ICFs/DD settings.

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

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

B) NURSING FACILITIES

2021 goal

- For the year ending June 30, 2021, the number of people who have moved from Nursing Facilities (for persons with a disability under 65 in facility longer than 90 days) to a more integrated setting will be **750.**

Baseline: January - December 2014 = 707

RESULTS:
This goal was extended in the April 2021 Olmstead Plan Revision. The goal is **not on track** to meet the 2021 goal to move 750 people under 65 in a nursing facility for more than 90 days to a more integrated setting.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	1,043	70	224	**749**
2016 Annual (July 2015 – June 2016)	1,018	91	198	**729**
2017 Annual (July 2016 – June 2017)	1,097	77	196	**824**
2018 Annual (July 2017 – June 2018)	1,114	87	197	**830**
2019 Annual (July 2018 – June 2019)	1,176	106	190	**880**
2020 Annual (July 2019 – June 2020)	1,241	86	240	**915**
2021 Quarter 1 (July – Sept 2020)	180	7	50	**123**

ANALYSIS OF DATA:
From July – September 2020, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 123. This is a decrease of 99 from 222 the previous quarter. After one quarter, the number is 16% of the annual goal of 750. The goal is not on track to meet the 2021 annual goal.

COMMENT ON PERFORMANCE:
During this quarter, nursing facilities were in lock down due to COVID-19. This resulted in a reduced number of admissions and discharges.

DHS reviews data and notifies lead agencies of people who accepted or did not oppose a move to more integrated options. Lead agencies are expected to work with these individuals to begin to plan their moves. DHS continues to work with partners in other agencies to improve the supply of affordable housing and knowledge of housing subsidies.

In July 2020, the Housing Stabilization Services[2] benefit went into effect. These services include housing search and support services for individuals moving from homelessness (or other housing instability) to more stable housing situations. Because these are State plan services, people do not need to be on a waiver to access them. Minnesota is the first state in the nation to offer such a service through its Medicaid program.

[2] This was formerly called Housing Access Services and Housing Access Coordination.

[AGENDA ITEM 4e]

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

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

C) SEGREGATED HOUSING

2021 goal

- For the year ending June 30, 2021, the number of people who have moved from other segregated housing to a more integrated setting will be **500.**

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

RESULTS:
This goal was extended in the April 2021 Olmstead Plan Revision. The goal is **on track** to meet the 2021 goal to move 500 people from other segregated settings to a more integrated setting.

[Receiving Medical Assistance (MA)]

Time period	Total moves	Moved to more integrated setting	Moved to congregate setting	Not receiving residential services	No longer on MA
2015 Annual (July 14 – June 15)	5,703	**1,137 (19.9%)**	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
2016 Annual (July 15 – June 16)	5,603	**1,051 (18.8%)**	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
2017 Annual (July 16 – June 17)	5,504	**1,054 (19.2%)**	492 (8.9%)	3,466 (63.0%)	492 (8.9%)
2018 Annual (July 17 – June 18)	5,967	**1,188 (19.9%)**	516 (8.7%)	3,737 (62.6%)	526 (8.8%)
2019 Annual (July 18 – June 19)	5,679	**1,138 (20.0%)**	484 (8.5%)	3,479 (61.3%)	578 (10.2%)
2020 Annual (July 19 – June 20)	5,967	**1,190 (19.9%)**	483 (8.1%)	3,796 (63.6%)	498 (8.4%)
2021 Quarter 1 (July – Sept 2020)	424	**259 (61.1%)**	56 (13.2%)	105 (24.8%)	4 (0.9%)

ANALYSIS OF DATA:
From July – September 2020, of the 424 individuals moving from segregated housing, 259 individuals (61.1%) moved to a more integrated setting. This is a decrease of 18 people from 277 the previous quarter. After one quarter, the number is 51% of the annual goal of 500. The goal is on track to meet the 2021 annual goal.

COMMENT ON PERFORMANCE:
While transitions to more integrated settings continued through the timeframe of the COVID-19 pandemic, they have been slower this year than last. While case managers continue to work with individuals, they were not meeting in person. People had less opportunity to explore housing options. Focus shifted to managing the pandemic: staffing shortages, adhering to new protocols, shift in or suspension of services, COVID outbreaks, finding meaningful new routines and ways to connect, etc.

As pandemic restrictions loosen, it is anticipated that more individuals will seek more integrated settings. Also notable, a statewide restriction on eviction during the pandemic has reduced the turnover in housing which resulted in fewer housing options.

The COVID-19 pandemic has severely impacted the already statewide workforce shortage, particularly for direct support professionals. This has in turn increased the barriers for people seeking to live in their own homes with staff supporting them on an individual basis.

During the quarter, there were significantly more individuals who moved to more integrated settings (61.1%) than who moved to congregate settings (13.2%). The data indicates that a large percentage (24.8%) of individuals who moved from segregated housing are not receiving publicly funded residential services. Based on trends identified in data development for Crisis Services Goal Four, it is assumed the majority of those people are housed in their own or their family's home and are not in a congregate setting.

COMMENT ON TABLE HEADINGS:
The language below provides context and data definitions for the headings in the table above.

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

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

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

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

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

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

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

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

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

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

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

TRANSITION SERVICES GOAL TWO: By June 30, 2022, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[v] will be reduced to 30% (based on daily average).
[Measure revised in April 2021 Revision]

2021 goal

- By June 30, 2021 the percent awaiting discharge will be 30% or lower

Baseline: From July 2014 - June 2015, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 36% on a daily average. [3]

RESULTS:
This goal was amended in the April 2021 Olmstead Plan Revision, to include all individuals at AMRTC in the measure. The previous goal measure included only individuals under mental health commitment. The goal is **on track** to meet the new 2021 goal of 30% or lower.

Percent awaiting discharge (daily average)

Time period	Mental health commitment	Committed after finding of incompetency	Combined
2016 Annual (July 2015 – June 2016)	41.8%	44.7%	42.5%
2017 Annual (July 2016 – June 2017)	44.9%	29.3%	37.1%
2018 Annual (July 2017 – June 2018)	36.9%	23.8%	28.3%
2019 Annual (July 2018 – June 2019)	37.5%	28.2%	26.5%
2020 Annual (July 2019 – June 2020)	36.3%	22.7%	29.5%
2021 Quarter 1 (July – September 2020)	29.9%	25.2%	**27.3%**
2021 Quarter 2 (October – December 2020)	41.7%	28.4%	**33.6%**
2021 Quarter 3 (January – March 2021)	27.7%	20.4%	**22.5%**

ANALYSIS OF DATA:
From January - March 2021, 27.7% of those under mental health commitment at AMRTC no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting. During the same period, the percentage of individuals awaiting discharge who were civilly committed after being found incompetent was 20.4%. The combined total of all individuals at AMRTC awaiting discharge was 22.5%, which is a decrease of 11.1% from the previous quarter. After three quarters, the combined rate is 27.8%. The goal is on track to meet the 2021 goal of 30% or lower.

From January – March 2021, 14 individuals at AMRTC under mental health commitment left and moved to an integrated setting. The table below provides information about those individuals who left AMRTC. It includes the number of individuals under mental health commitment and those who were civilly.

[3] The baseline included individuals at AMRTC under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency).

[AGENDA ITEM 4e]

Time period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moves to integrated setting	
					Mental health commit-ment	Committed after finding of incompetency
2017 Annual (July 2016 – June 2017)	267	155	2	**110**	**54**	56
2018 Annual (July 2017 – June 2018)	274	197	0	**77**	**46**	31
2019 Annual (July 2018 – June 2019)	317	235	1	**81**	**47**	34
2020 Annual (July 2019 – June 2020)	347	243	0	**104**	**66**	38
2021 Quarter 1 (July – September 2020)	100	77	0	**23**	**14**	9
2021 Quarter 2 (Oct – December 2020)	80	59	0	**21**	**19**	2
2021 Quarter 3 (Jan – March 2021)	90	63	0	**27**	**14**	13

COMMENT ON PERFORMANCE:
COVID-19 precautions have not had an impact on the ability to admit or discharge patients at AMRTC during this reporting period.

Approximately one third of individuals at AMRTC no longer need hospital level of care, including those under a mental health commitment and those who need competency restoration services. Those committed after a finding of incompetency, accounted for approximately 50% of AMRTC's census during this quarter.

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

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

- Violent or aggressive behavior (i.e. hitting others, property destruction, past criminal acts);
- Predatory or sexually inappropriate behavior;
- High risk for self-injury (i.e. swallowing objects, suicide attempts); and
- Unwillingness to take medication in the community.

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

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one month after the end of the reporting period.

TRANSITION SERVICES GOAL THREE: By December 31, 2020, the average monthly number of individuals leaving Minnesota Security Hospital[4] to a more integrated setting will increase to 10 individuals per month.

2020 goal

- By December 31, 2020 the average monthly number of individuals leaving to a more integrated setting will increase to 10 or more

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

RESULTS:

The table below is for the goal from the March 2020 Olmstead Plan Revision. This goal was amended in the April 2021 Olmstead Plan Revision, to change the measure being used. Progress on the amended goal will be reported in the next quarterly report. This goal is **in process**.

Time period	Total number of individuals leaving	Transfers [iv] (-)	Deaths (-)	Net moved to integrated setting	Monthly average
2015 Annual (Jan – Dec 2015)	188	107	8	73	**6.1**
2016 Annual (Jan – Dec 2016)	184	97	3	84	**7.0**
2017 Annual (Jan – Dec 2017)	199	114	9	76	**6.3**
2018 Annual (Jan – Dec 2018)	212	130	3	79	**6.6**
2019 Annual (Jan – Dec 2019)	217	121	5	91	**7.6**
2020 Annual (Jan – Dec 2020)	129	67	9	53	**4.4**
2021 Quarter 1 (Jan – Mar 2021)	37	14	4	19	**6.3**

ANALYSIS OF DATA:

From January 1 – March 2021, the average monthly number of individuals leaving the facility to a more integrated setting was 6.3. The average number moving to an integrated setting increased by 2.3 from 4.0 the previous year. This goal was amended in the April 2021 Olmstead Plan Revision, to change the measure being used. Progress on the amended goal will be reported in the next quarterly report.

Discharge data is categorized into three areas to allow analysis around possible barriers to discharge. The table below provides a breakdown of the number of individuals leaving the facility by category. The categories include: committed after being found incompetent on a felony or gross misdemeanor charge, committed as Mentally Ill and Dangerous (MI&D) and Other committed.

[4] For the purposes of this report Minnesota Security Hospital (MSH) refers to individuals residing in the St Peter facility and committed as Mentally Ill and Dangerous and other civil commitment statuses and individuals under competency restoration treatment, Minn. R. Crim. P. 20.01.

[AGENDA ITEM 4e]

Time period	Type	Total moves	Transfers	Deaths	Moves to integrated
2015 Annual (January – December 2015)	Committed after finding of incompetency	99	67	1	31
	MI&D committed	66	24	7	35
	Other committed	23	16	0	7
	Total	**188**	**107**	**8**	**(Avg. = 6.1) 73**
2016 Annual (January – December 2016)	Committed after finding of incompetency	93	62	0	31
	MI&D committed	69	23	3	43
	Other committed	25	15	0	10
	Total	**187**	**100**	**3**	**(Avg. = 7.0) 84**
2017 Annual (January – December 2017)	Committed after finding of incompetency	133	94	2	27
	MI&D committed	55	17	6	32
	Other committed	11	3	1	7
	Total	**199**	**114**	**9**	**(Avg. = 6.3) 76**
2018 Annual (January – December 2018)	Committed after finding of incompetency	136	97	0	39
	MI&D committed	73	31	3	39
	Other committed	3	2	0	1
	Total	**212**	**130**	**3**	**(Avg. = 6.6) 79**
2019 Annual (January – December 2019)	Committed after finding of incompetency	138	89	1	48
	MI&D committed	73	33	4	36
	Other committed	6	1	0	5
	Total	**217**	**123**	**5**	**(Avg. = 7.4) 89**
2020 Annual (January – December 2020)	Committed after finding of incompetency	78	52	1	25
	MI&D committed	46	15	8	23
	Other committed	5	0	0	5
	Total	**129**	**67**	**9**	**(Avg. = 4.4) 53**
2021 Quarter 1 (Jan – Mar 2021)	Committed after finding of incompetency	19	**9**	1	9
	MI&D committed	9	3	3	3
	Other committed	9	2	0	7
	Total	**37**	**14**	**4**	**(Avg. = 6.3) 19**

COMMENT ON PERFORMANCE:
The St Peter facility continues to experience increased challenges in discharging individuals to more integrated settings due to the COVID-19 pandemic. At times, community providers are unable to accept new admissions because they are experiencing staffing shortages due to illness or individuals they are currently serving have tested positive for COVID.

In addition to community provider's inability to serve new admissions, the St Peter facility has needed to restrict individual access to the community both in outings and passes. This has resulted in individuals being unable to practice community reintegration skills that are often required by the Forensic Review Panel, the Special Review Board, and/or community providers prior to an individual's discharge.

With pandemic restrictions being lifted, community access via staff-supervised outings is now being allowed for individuals within the secure perimeter. In addition, access to the local St. Peter community is being allowed for those individuals residing. Unescorted passes for home/overnight visits remain restricted at this time.

Individuals committed to the facility are provided services tailored to their individual needs. DHS efforts continue to expand community capacity and continues to work towards the mission of the Olmstead Plan or decision by identifying individuals who could be served in more integrated settings.

MI&D committed and Other committed

Persons committed as Mentally Ill and Dangerous (MI&D), are provided acute psychiatric care and stabilization, as well as psychosocial rehabilitation and treatment services. The MI&D commitment is for an indeterminate period of time, and requires a Special Review Board recommendation to the Commissioner of Human Services, prior to approval for community-based placement (Minnesota Stat. 253B.18). Less frequently, persons under other commitments may receive services at the St Peter facility. Other commitments include Mentally Ill (MI), Mentally Ill and Chemically Dependent (MI/CD), Mentally Ill and Developmentally Disabled (MI/DD), or a combination of these commitment types.

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

- Individuals with Level 3 predatory offender designation or history of problematic sexual behavior;
- Individuals over age 65 who require adult foster care, skilled nursing, or nursing home level care and may not qualify for funding sources that can adequately address their service needs;
- Individuals with DD/ID with high behavioral acuity;
- Individuals with undocumented citizenship status; and
- Individuals who do not have support for discharge from their county of commitment due to lack of agreement between Forensic Services and the county of commitment on whether this person is appropriate and ready for a reduction in custody. Forensic Services has noted that the county of commitment often declines to participate in provisional discharge planning for these individuals.

Some barriers to discharge identified by the Special Review Board (SRB), in their 2018 MI&D Treatment Barriers Report as required by Minnesota Statutes 253B.18 subdivision 4c(b) included:

- Patient has outstanding treatment needs;
- Patient requires more time to demonstrate skill acquisition:
- Patient needs to address dynamic risk factors; and
- Patient has behavior/psychological instability;

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

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

A summary of the Forensic Review Panel efforts include:

- From January to March 2020: Reviewed 60 cases; recommended reductions for 9 cases with 10 being granted. (There are times the Special Review Board (SRB) supports a reduction that the Forensic Review Board did not recommend).
- From April to June 2020: Reviewed 60 cases; recommended reductions for 25 cases. To date, 17 have been granted and 19 reviews are pending.
- From July to September 2020: Reviewed 63 cases; recommended reductions for 22 cases. The SRB supported 22 reductions in custody and three petitions were withdrawn.
- From October to December 2020: Reviewed 51 cases; recommended reductions for 10 cases. To date, the SRB has approved four reductions with a total of 18 cases pending.
- From January to March 2021: Reviewed 66 cases; recommended reductions for 18 cases. To date, the SRB has supported 12 reductions and denied 38. Six petitions were withdrawn during this timeframe and 10 results are pending.

Committed after finding of incompetency

Forensic Services recently moved away from having unit(s) specifically designated to serve individuals under Rule 20 status to increase our capacity to serve those under MI&D status. Forensic Services will continue to serve individuals under MI/CD/DD commitments, although it will be less frequently.

AMRTC will continue to provide care to those who may be under the legal status “Committed after findings of incompetency” Minn. R. Crim. P. 20.01.

The discontinuation of competency restoration services provided on the St. Peter campus will likely impact the discharge rate. This change in discharges will be reflected in the new monthly goal which is now 4 or more per month.

UNIVERSE NUMBER:

In Calendar Year 2020, 502 unique patients received services at Forensic Services. This number reflects only counting an individual only once even if served more than once during the year. The average daily census was 358.19

TIMELINESS OF DATA:

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

TRANSITION SERVICES GOAL FOUR: By June 30, 2022, 90% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of the ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.] *[Extended in April 2021 Revision]*

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

RESULTS:
This goal was extended in the April 2021 Olmstead Plan Revision. The goal is **not on track** to meet the 2022 goal of 90%.

Time period	Number of transition case files reviewed	Number opted out	Number not informing case manager	Number of remaining files reviewed	Number not adhering to protocol	Number adhering to protocol
Baseline Oct – Dec 2017	26	3	1	22	7 of 22 (31.8%)	**15 of 22 (68.2%)**
FY 2018 Qtr 3 and 4 Jan – June 2018	59	11	5	43	5 of 43 (11.6%)	**38 of 43 (88.4%)**
FY 2019 (July 2018 - June 2019)	78	20	4	54	19 of 54 (35.2%)	**35 of 54 (64.8%)**
FY 2020 (July 2019 - June 2020)	158	27	11	120	26 of 120 (21.7%)	**94 of 120 (78.3%)**
FY 2021 Quarter 1 July - Sept 2020	5	1	0	4	2 of 4 (50.0%)	**2 of 4 (50.0%)**
FY 2021 Quarter 2 Oct – Dec 2020	40	5	4	31	6 of 31 (19.4%)	**25 of 31 (80.6%)**

ANALYSIS OF DATA:
From October – December 2020, of the 40 transition case files reviewed, 5 people opted out of using the My Move Plan document and 4 individuals did not inform their case manager of their plan to move. Of the remaining 31 files, 25 files (80.6%) adhered to the transition protocol. This is an increase of 30.6% from the previous quarter of 50%. After two quarters the combined average is 65.3%. Performance on this goal is inconsistent and does not appear to be on track to meet the 2022 goal of 90%.

The plan is considered to meet the transition protocols if all ten items below (from "My Move Plan" document) are present:
1. Where is the person moving?
2. Date and time the move will occur.
3. Who will help the person prepare for the move?
4. Who will help with adjustment during and after the move?
5. Who will take the person to new residence?

6. How will the person get his or her belongings?
7. Medications and medication schedule.
8. Upcoming appointments.
9. Who will provide support after the move; what they will provide and how to contact those people (include informal and paid support), including supporting the person to adjust to the changes?
10. Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

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

COMMENT ON PERFORMANCE:
Four of the five lead agencies reviewed during this reporting period had at least one person experience a move. Washington County had the highest numbers of people moving among the ten counties reviewed.

For five of the six cases that did not adhere to protocol, the My Move Plan Summary was not present in the case file during the time of the review. One case file had the My Move Plan present but did not address all ten items listed above to meet the transition protocol. Because the move occurred prior to the lead agency review, transition measures related to the contents of the My Move Plan Summary cannot be remediated. However, counties are provided information about which items of the My Move Plan were compliant/non-compliant for each of the transition cases that were reviewed.

In April 2019, Lead Agency Review implemented changes to the sampling methodology utilized to identify transition cases. Prior to April 2019, a discrete transition sample was selected based on claims data for people who had moved within 18 months of the case file review period. As of April 2019, the Lead Agency Review team now reviews transition protocol compliance for anyone within the overall case file review sample who moved during the 18 month review period.

When findings from case file review indicate files do not contain all required documentation, the lead agency is required to bring all cases into full compliance by obtaining or correcting the documentation. Corrective action plans are required when patterns of non-compliance are evident. Because the move occurred prior to the lead agency site review, transition measures related to the contents of the My Move Plan Summary cannot be remediated.

However, lead agencies are provided information about which components of the My Move Plan were compliant/non-compliant for each of the transition cases that were reviewed.

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

III. TIMELINESS OF WAIVER FUNDING

This section reports progress of individuals being approved for home and community-based services waiver funding. An urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The system categorizes urgency into three categories including Institutional Exit, Immediate Need, and Defined Need. Reasonable pace goals have been established for each of these categories. The goal reports the number of individuals that have funding approved at a reasonable pace and those pending funding approval.

TIMELINESS OF WAIVER FUNDING GOAL ONE: Lead agencies will approve funding at a reasonable pace for persons with a need for the Developmental Disabilities (DD) waiver.

- **By June 30, 2022, the percentage of persons approved for funding at a reasonable pace for each urgency of need category will be: (A) institutional exit (71%); (B) immediate need (74%); and (C) defined need (66%).** *[Amended in the April 2021 Revision to add targets.]*

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

Assessments between January – December 2016

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

RESULTS:
This goal was amended in the April 2021 Olmstead Plan Revision to add a 2022 target. This goal is **in process** to meet the 2022 goals.

Time period: Fiscal Year 2018 (July 2017 – June 2018)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	96	**63 (66%)**	26 (27%)	7 (7%)
Immediate Need	467	**325 (70%)**	118 (25%)	24 (5%)
Defined Need	1,093	**734 (67%)**	275 (25%)	84 (8%)
Totals	1,656	**1,122 (68%)**	419 (25%)	115 (7%)

[AGENDA ITEM 4e]

Time period: Fiscal Year 2019 (July 2018 - June 2019)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	105	84 (80%)	18 (17%)	3 (3%)
Immediate Need	451	339 (75%)	98 (21.7%)	14 (3%)
Defined Need	903	621 (69%)	235 (26%)	47 (5%)
Totals	**1,459**	**1,044 (72%)**	**351 (24%)**	**64 (4%)**

Time Period: Fiscal Year 2020 (July 2019 – June 2020)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	71	43 (61%)	22 (31%)	6 (8%)
Immediate Need	273	174 (64%)	84 (31%)	15 (5%)
Defined Need	786	443 (56%)	247 (32%)	96 (12%)
Totals	**1,130**	**660 (59%)**	**353 (31%)**	**117 (10%)**

Time Period: Fiscal Year 2021 Quarter 1 (July – September 2020)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	18	11 (61%)	7 (39%)	0 (0)
Immediate Need	61	41 (67%)	15 (25%)	(8%)
Defined Need	163	108 (66%)	42 (26%)	13 (8%)
Totals	**242**	**160 (66%)**	**64 (27%)**	**18 (7%)**

Time Period: Fiscal Year 2021 Quarter 2 (October - December 2020)

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	8	6 (75%)	2 (25%)	0 (0%)
Immediate Need	43	31 (72%)	11 (26%)	1 (2%)
Defined Need	161	97 (60%)	41 (26%)	23 (14%)
Totals	**212**	**134 (63%)**	**54 (26%)**	**24 (11%)**

ANALYSIS OF DATA:

From October – December 2020, of the 212 individuals assessed for the Developmental Disabilities (DD) waiver, 134 individuals (63%) had funding approved within 45 days of the assessment date. An additional 54 individuals (25%) had funding approved after 45 days. Only 24 individuals (11%) assessed are pending funding approval. This goal was amended in the April 2021 Olmstead Plan Revision to add a 2022 target. This goal is in process.

COMMENT ON PERFORMANCE:

Lead agencies receive monthly updates regarding the people who are still waiting for DD funding approval through a web-based system. Using this information, lead agencies can view the number of

days a person has been waiting for DD funding approval and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS continues to allocate funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.

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

Not all persons who are assessed are included in the above tables. Only individuals who meet the criteria of one of the three urgency categories are included in the table. If an individual's need for services changes, they may request an immediate reassessment or information will be collected during a future assessment.

Below is a summary table with the number of people pending funding approval at a specific point of time. Also included is the average and median days waiting of those individuals pending funding approval. The average days and median days information has been collected since December 1, 2015. This data does not include those individuals who had funding approved within the 45 days reasonable pace goal.

Number of People Pending Funding Approval by Category

As of Date	Total Number	Institutional Exit	Immediate Need	Defined Need
April 1, 2017	**201**	13	16	172
July 1, 2017	**237**	13	26	198
October 1, 2017	**152**	12	36	104
January 1, 2018	**89**	1	22	66
April 1, 2018	**60**	5	20	35
July 1, 2018	**94**	6	26	62
October 1, 2018	**114**	12	26	76
January 8, 2019	**93**	10	18	65
April 1, 2019	**79**	3	15	61
July 1, 2019	**96**	10	22	64
October 1, 2019	**125**	9	29	87
January 1, 2020	**117**	7	23	87
April 1, 2020	**135**	9	33	93
July 1, 2020	**132**	8	16	108
October 1, 2020	**113**	4	24	85
January 1, 2021	**97**	5	17	75
April 1, 2021	**100**	4	15	81

[AGENDA ITEM 4e]

Average Number of Days Individuals are Pending Funding Approval by Category

As of Date	Institutional Exit	Immediate Need	Defined Need
April 1, 2017	91	130	193
July 1, 2017	109	122	182
October 1, 2017	136	120	183
January 1, 2018	144	108	184
April 1, 2018	65	109	154
July 1, 2018	360	115	120
October 1, 2018	112	110	132
January 8, 2019	138	115	144
April 1, 2019	278	113	197
July 1, 2019	155	125	203
October 1, 2019	262	132	197
January 1, 2020	216	167	205
April 1, 2020	252	152	198
July 1, 2020	318	239	228
October 1, 2020	504	223	289
January 1, 2021	447	345	283
April 1, 2021	310	342	327

Median Number of Days Individuals are Pending Funding Approval by Category

As of Date	Institutional Exit	Immediate Need	Defined Need
April 1, 2017	82	93	173
July 1, 2017	103	95	135
October 1, 2017	102	82	137
January 1, 2018	144	74	140
April 1, 2018	61	73	103
July 1, 2018	118	85	70
October 1, 2018	74	78	106
January 8, 2019	101	79	88
April 1, 2019	215	88	147
July 1, 2019	75	86	84
October 1, 2019	166	103	103
January 1, 2020	104	119	105
April 1, 2020	195	78	121
July 1, 2020	257	165	148
October 1, 2020	367	100	197
January 1, 2021	413	346	189
April 1, 2021	287	332	220

TIMELINESS OF DATA:

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

IV. QUALITY OF LIFE MEASUREMENT RESULTS

This section includes reports on two quality of life measures. The National Core Indicator Survey and the Olmstead Plan Quality of Life Survey.

NATIONAL CORE INDICATOR (NCI) SURVEY

The results for the 2019 National Core Indicator (NCI) survey for individuals with intellectual and developmental disabilities were reported in The February 2021 Quarterly Report. The national results of the NCI survey with state-to-state comparison are available at www.nationalcoreindicators.org. The Minnesota state reports are available at www.nationalcoreindicators.org/states/MN

OLMSTEAD PLAN QUALITY OF LIFE SURVEY

The Olmstead Plan Quality of Life Survey: Second Follow-Up 2020 Final Report[5] was accepted by the Olmstead Subcabinet on April 26, 2021. This report is a follow-up to the Olmstead Plan Quality of Life Survey: First Follow-Up 2018 in 2018 and the Olmstead Plan Quality of Life Survey Baseline Report conducted in 2017. This study includes people with disabilities of all types and ages in segregated settings, or at risk of being place in segregated settings.

The Subcabinet authorized this longitudinal survey to track progress of the quality of life (QOL) of Minnesotans with disabilities as the Olmstead Plan is being implemented. The results of the QOL surveys are shared with state agencies implementing the plan so they can evaluate their efforts and better serve Minnesotans with disabilities.

Key Facts about the Second Follow-up Survey (2020)

- A total of 561 people completed the survey. This included 509 who participated in the baseline survey and 52 who were added to the sample to allow more nuanced understanding of experiences of people who are Black, Indigenous and People of Color.
- The Olmstead Quality of Life Survey is a multi-year effort to assess the quality of life for people with disabilities who receive state services in potentially segregated settings. Minnesota Department of Human Services identified places such as group homes, nursing facilities and center-based employment as having the potential to be segregated settings.
- The results in this report reflect the experiences of the respondents and speak directly to the settings from which the sample was drawn. Therefore, results cannot be generalized to all people with disabilities in Minnesota.

Highlights from the Second Follow-up Survey

The survey measures quality of life over time for a specific population in Minnesota: people who access services in potentially segregated settings. The needle on quality of life has not moved since 2017, despite millions of dollars in investments and well-intentioned initiatives. In many areas, this data indicates a continued decline in integration that the State must reverse.

The survey detected no definitive changes in the key elements measuring quality of life, but some interesting information surfaced.

[5] More information about the Quality Of Life Survey is available online at www.mn.gov/olmstead.

- Participants had the same amount of power over decisions that affect them as in previous years. On average, paid staff made big decisions. Participants with public guardians had less decision-making control and less integration on their outings than those with no guardian or a private (usually family) guardian.
- COVID-19 had a clear impact on survey participants and findings. At the same time, we know from the 2017 and 2018 surveys that the pandemic is not the only factor that has stalled progress. Previous surveys show that segregation was a problem before the pandemic disrupted day programs and social opportunities. In some instances, participants shared how providers and staff enforcing COVID-19 restrictions lowered their quality of life. We must document these impacts because this may be the only statewide survey that captured the experiences of people with disabilities in Minnesota during the pandemic.
- Participants engaged with their communities far less during COVID-19. Only some could turn to the internet in place of in-person activities. This is partly because access to technology required to join online events is not universal. The survey did not ask whether participants had access to the internet, but 84 percent took it by phone rather than video call.
- Roughly 7% of participants said life was better or much better during the pandemic. One reason they shared was reduced stress from not having to participate in day activities and outings. This shows that people's quality of life could be better if they could make these decisions for themselves.

Next Steps

- The OIO will be hosting public meetings on the report findings.

Background

- The Olmstead Subcabinet selected the Center for Outcome Analysis (COA) Quality of Life survey tool for the study. This tool was selected because it is reliable, valid, low-cost and could be used with all people with disabilities. The OIO then conducted a pilot survey to test the effectiveness of the tool.

V. INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

This section reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported in each quarterly report. The information for each goal includes the overall goal, annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance and the universe number, when available. The universe number is the total number of individuals potentially affected by the goal. This number provides context as it relates to the measure.

PERSON-CENTERED PLANNING GOAL ONE: **By June 30, 2022, plans for people using disability home and community-based waiver services will meet protocols. Protocols are based on the principles of person-centered planning and informed choice.**

- **By June 20, 2022, the eight required criteria will be present at a combined rate of 90%.**
  [Amended in the April 2021 Revision to add a target]

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

Element	Required criteria	Percent
1	The support plan describes goals or skills that are related to the person's **preferences**.	74%
2	The support plan includes a global statement about the person's **dreams and aspirations**.	17%
3	Opportunities for **choice** in the person's current environment are described.	79%
4	The person's current **rituals and routines** are described.	62%
5	**Social**, leisure, or religious **activities** the person wants to participate in are described.	83%
6	Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.	70%
7	The person's preferred **living** setting is identified.	80%
8	The person's preferred **work** activities are identified.	71%
ALL	Combined average of all 8 elements	67%

RESULTS:
This goal was amended in the April 2021 Olmstead Plan Revision to add a numeric target for 2022. The goal is **on track** to meet the 2022 goal of 90%.

Table amounts are percentages

Time period Fiscal Year (Months)	(1) Prefer-ences	(2) Dreams Aspirations	(3) Choice	(4) Rituals Routines	(5) Social Activities	(6) Goals	(7) Living	(8) Work	Avg of all 8
Baseline (April – June 2017)	74	17	79	62	83	70	80	71	67
FY 18 (July 17 – June 18)	81.3	31.3	92.5	59.8	92.4	81.3	96.3	89.6	78.1
FY 19 (July 18 – June 19)	91.8	58.4	97.9	59.8	96.0	95.3	98.7	99.0	87.1
FY 20 (July 19 – June 20)	91.1	77.2	98.9	77.1	98.8	97.0	99.1	98.7	92.2
FY 21 Q1 (July – Sept 20)	94.0	75.9	98.8	72.3	97.6	98.8	97.6	98.8	91.7
FY 21 Q2 (Oct – Dec 20)	95.4	79.3	99.7	74.4	99.7	99.7	100	100	93.5

[AGENDA ITEM 4e]

ANALYSIS OF DATA:
For the period from October - December 2020, in the 328 case files reviewed, the eight required elements were present in the percentage of files shown above. The combined average of the eight elements was 93.5%, an improvement of 1.8% from the previous quarter. Five of the eight elements achieved 99% or above. The remaining 3 all showed improvement. The goal is on track to meet the 2022 goal of 90%.

Total number of cases and sample of cases reviewed

Time period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)
Fiscal Year 18 (July 2017 - June 2018)	12,192	1,243
Fiscal Year 19 (July 2018 - June 2019)	4,240	515
Fiscal Year 20 (July 2019 - June 2020)	18,992	1,245
FY 21 Quarter 1 (July – September 2020)	558	83
FY 21 Quarter 2 (October – December 2020)	2,754	328

Lead Agencies Participating in the Audit [6]

Time period	Lead agencies
Fiscal Year 18 (July 2017 – June 2018)	(19) Pennington, Winona, Roseau, Marshall, Kittson, Lake of the Woods, Stearns, McLeod, Kandiyohi, Dakota, Scott, Ramsey, Big Stone, Des Moines Valley Alliance, Kanabec, Nicollet, Rice, Sibley, Wilkin
Fiscal Year 19 (July 2018 – June 2019)	(15) Brown, Carlton, Pine, Watonwan, Benton, Blue Earth, Le Sueur, Meeker, Swift, Faribault, Itasca, Martin, Mille Lacs, Red Lake, Wadena
Fiscal Year 20 (July 2019 – June 2020)	(20) Mahnomen, Koochiching, Wabasha, Goodhue, Traverse, Douglas, Pope, Grant, Stevens, Isanti, Olmsted, St. Louis, Hennepin, Carver, Wright, Crow Wing, Renville, Lac Qui Parle, Chippewa, Otter Tail
FY 21 Q1 (July – Sept 2020)	(2) Mower, Norman
FY 21 Q2 (Oct – December 2020)	(5) Houston, Freeborn, Nobles, SWHHS Alliance (Lincoln, Lyon, Murray, Pipestone, Redwood, Rock), Washington

COMMENT ON PERFORMANCE:
The Lead Agency Review team looks at twenty-five person-centered items for the disability waiver programs (Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disability Inclusion (CADI) and Developmental Disabilities (DD). Of those twenty-five items, DHS selected eight items as being cornerstones of a person-centered plan.

In January 2018, the Lead Agency Review process began requiring lead agencies to remediate all areas of non-compliance with the required person-centered elements. When the findings from case file review indicate files did not contain all required documentation, the lead agency is required to bring all cases into full compliance by obtaining or correcting the documentation. Corrective action plans are required when patterns of non-compliance are evident. For the purposes of corrective action, the person-

[6] Agency visits are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS)

centered measures are grouped into two categories: development of a person-centered plan and support plan record keeping.

For the lead agencies reviewed during this time period, only two lead agencies (Nobles and SWHHS) were required to develop corrective action plans in at least one category of the person-centered measures. Houston, Freeborn, and Washington counties were not required to develop corrective action plans in the area of person-centered practices. It is important to note that these five lead agencies were all in different spectrum in their journey of applying person-centered practices. While some lead agencies have fully integrated person-centered practices into their work as evident in their support planning process, others are still working on training staff, especially for the new staff that joined the lead agencies in the last couple years.

UNIVERSE NUMBER:
In Fiscal year 2017 (July 2016 – June 2017), there were 47,272 individuals receiving disability home and community-based services.

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

POSITIVE SUPPORTS GOAL ONE: **By June 30, 2022, the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will not exceed 506.** *[Extended in the April 2021 Revision]*

Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:
This goal was extended in the April 2021 Olmstead Plan Revision. Progress of the annual goal cannot be determined using duplicated numbers. The goal is **in process**.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
2014 Baseline (July 2013 – June 2014)	1,076 (unduplicated)	N/A
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
2016 Annual (July 2015 – June 2016)	761 (unduplicated)	106
2017 Annual (July 2016 - June 2017)	692 (unduplicated)	69
2018 Annual (July 2017 - June 2018)	644 (unduplicated)	48
2019 Annual (July 2018 - June 2019)	642 (unduplicated)	2
2020 Annual (July 2019 - June 2020)	561 (unduplicated)	81
2021 Q1 (July - September 2020)	193 (duplicated)	N/A – quarterly number
2021 Q2 (October - December 2020)	183 (duplicated)	N/A – quarterly number

ANALYSIS OF DATA:
From October – December 2020, the total number of people who experienced a restrictive procedure was 183. This was a decrease of 10 from the previous quarter. The quarterly numbers are duplicated counts. Individuals may experience restrictive procedures during multiple quarters in a year. Progress on the annual goal cannot be determined until the numbers for the four quarters are unduplicated.

COMMENT ON PERFORMANCE:
There were 183 individuals who experienced a restrictive procedure this quarter:

- 163 individuals were subjected to Emergency Use of Manual Restraint (EUMR) only. This was a decrease of 18 people from last quarter. Such EUMRs are permitted and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.
- 20 individuals experienced restrictive procedures other than EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). This was a decrease of 7 from the previous quarter. DHS staff and the External Program Review Committee provide follow up and technical assistance for all reports involving restrictive procedures *other than* EUMR. It is anticipated that focusing technical assistance with this subgroup will reduce the number of individuals experiencing restrictive procedures and the number of reports (see Positive Supports Goal Three).

Under the Positive Supports Rule, the External Program Review Committee (EPRC) convened in February 2017 has the duty to review and respond to Behavior Intervention Reporting Form (BIRF) reports involving EUMRs. Beginning in May 2017, the EPRC conducted outreach to providers in response to EUMR reports. It is anticipated the EPRC's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR. The purpose of EPRC engagement in these cases is to provide guidance to help reduce the frequency and/or duration of future emergency uses of manual restraint. The EPRC looks at trends in EUMR over six months to identify which providers currently need additional support. They also look at trends in 911 calls to monitor that decreases in EUMR are not replaced by increases in 911 calls.

During this quarter, the EPRC reviewed BIRFs, positive support transition plans, and functional behavior assessments. Based on the content within those documents, the committee conducted EUMR-related assistance involving 44 people. This number does not include people who are receiving similar support from other DHS groups. Some examples of guidance provided by committee members include discussions about the function of behaviors, helping providers connect with local behavior professionals or other licensed professionals, providing ideas on positive support strategies, and explaining rules and the law.

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

POSITIVE SUPPORTS GOAL TWO: **By June 30, 2022, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will not exceed 2,821.** *[Extended in the April 2021 Revision]*

Baseline: From July 2013 – June 2014 of the 35,668 people receiving services in licensed disability services, e.g., home and community based services, there were 8,602 BIRF reports of restrictive procedures, involving 1,076 unique individuals.

RESULTS:
This goal was extended in the April 2021 Olmstead Plan Revision. The goal is **on track** to meet the 2022 goal to not exceed 2,821.

Time period	Number of BIRF reports	Reduction from previous year
2014 Baseline (July 2013 – June 2014)	8,602	N/A
2015 Annual (July 2014 – June 2015)	5,124	3,478
2016 Annual (July 2015 – June 2016)	4,008	1,116
2017 Annual (July 2016 - June 2017)	3,583	425
2018 Annual (July 2017 - June 2018)	3,739	+156
2019 Annual (July 2018 - June 2019)	3,223	516
2020 Annual (July 2019 - June 2020)	3,126	97
2021 Q1 (July – September 2020)	702	N/A – quarterly number
2021 Q2 (October – December 2020)	573	N/A – quarterly number

ANALYSIS OF DATA:
From October – December 2020, the number of restrictive procedure reports was 702. This was a decrease of 129 from the previous quarter. After two quarters the total number of 1,275 is 45% of the annual goal to reduce to 2,821. The goal is on track to meet the 2022 goal.

COMMENT ON PERFORMANCE:
There were 573 reports of restrictive procedures this quarter. Of those reports:

- 480 reports were for emergency use of manual restraint (EUMR). Such EUMRs are permitted and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.
    - Under the Positive Supports Rule, the External Program Review Committee (EPRC) has the duty to review and respond to BIRF reports involving EUMRs. Convened in February 2017, the Committee's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR.
    - This is a decrease of 151 reports of EUMR from the previous quarter.
- 93 reports involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures).
    - The EPRC provides ongoing monitoring over restrictive procedures being used by providers with persons under the committee's purview. DHS staff provide follow up and technical assistance for all reports involving restrictive procedures that are not implemented according to requirements under 245D or the Positive Supports Rule. The close monitoring and engagement by the EPRC with the approved cases of emergency use of procedures enables

DHS to help providers work through some of the most difficult cases of ongoing use of mechanical restraints. Focusing existing capacity for technical assistance primarily on reports involving these restrictive procedures is expected to reduce the number of people experiencing these procedures, as well as reduce the number of reports seen here and under Positive Supports Goal Three.
  - The number of non-EUMR restrictive procedure reports increased by 22 from the previous quarter.

- 10 uses of seclusion or timeout involving 5 people were reported this quarter:
  - 10 reports of seclusion occurred at the Forensic Mental Health Program in St Peter (formerly known as Minnesota Security Hospital). This was an increase of 2 reports from the previous quarter. As necessary, DHS Licensing Division investigates and issues correction orders for any violations of the Positive Supports Rule associated with use of mechanical restraint.
  - There were no reports of time out this quarter.

- 2 uses of penalty consequences were reported this quarter. Technical assistance was provided in each instance and these reports were determined to be coding errors.

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

POSITIVE SUPPORTS GOAL THREE: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[vi], with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport).

- **By June 30, 2022, the emergency use of mechanical restraints, other than the use of an auxiliary device[7] will be reduced to no more than 88 reports.** *[Extended in the April 2021 Revision]*

2021 Goal

- By June 30, 2021, reduce mechanical restraints, other than use of auxiliary devices, to no more than 93 reports

Baseline: From July 2013 - June 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals. In SFY 2019, of the 658 reports of mechanical restraints, 336 were for use of auxiliary devices to ensure a person does not unfasten a seatbelt in a vehicle. The number of reports other than use of auxiliary devices were 322.

RESULTS:
This goal was extended in the April 2021 Olmstead Plan Revision. The goal is **not on track** to meet the 2021 goal of no more than 93.

[7] Auxiliary devices ensure a person does not unfasten a seat belt in a vehicle and includes seatbelt guards, harnesses and clips.

Time period	Total number of reports (includes auxiliary devices)	Number of individuals at end of time period
2014 Baseline (July 2013 – June 2014)	2,083	85
2015 Annual (July 2014 – June 2015)	912	21
2016 Annual (July 2015 – June 2016)	691	13
2017 Annual (July 2016 – June 2017)	664	16
2018 Annual (July 2017 – June 2018)	671	13
2019 Annual (July 2018 – June 2019)	658	12
2020 Annual (July 2019 – June 2020)	530	10

Time period	Reports (other than seat belt devices)	Reports on use of auxiliary devices	Total number of reports (includes auxiliary devices)	Number of individuals at end of time period
2019 Annual Baseline (July 2018 – June 2019)	332	336	658	12
2020 Annual (July 2019 – June 2020)	273	257	530	10
2021 Q1 (July – Sept 2020)	**23**	40	63	10
2021 Q2 (Oct – Dec 2020	**34**	47	81	9

ANALYSIS OF DATA:
From October – December 2020, the number of reports of mechanical restraints other than auxiliary devices was 34. This was an increase of 11 from the previous quarter. At the end of the reporting period, the number of individuals for whom the use of mechanical restraint use was approved was 9. This is a decrease of 1 from the last quarter. After two quarters, the total number of 57 is 57% of the 2021 goal to reduce to 93. The goal is not on track.

COMMENT ON PERFORMANCE:
Under the requirements of the Positive Supports Rule, in situations where mechanical restraints have been part of an approved Positive Support Transition Plan to protect a person from imminent risk of serious injury due to self-injurious behavior and the use of mechanical restraints has not been successfully phased out within 11 months, a provider must submit a request for the emergency use of these procedures to continue their use.

These requests are reviewed by the External Program Review Committee (EPRC) to determine whether they meet the stringent criteria for continued use of mechanical restraints. The EPRC consists of members with knowledge and expertise in the use of positive supports strategies. The EPRC sends its recommendations to the DHS Commissioner's delegate for final review and either time-limited approval or rejection of the request. The EPRC provides person-specific recommendations as appropriate to assist the provider to reduce the need for use of mechanical restraints. In situations where the EPRC believes a license holder needs more intensive technical assistance, phone and/or in-person consultation is provided by panel members.

The EPRC annually evaluates progress and determines if there are additional measures to be taken to reduce the use of mechanical restraint. The EPRC Annual Evaluation Report is available on the following

webpage under the Annual Reports tab: https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/positive-supports/extension-request/eprc.jsp

Of the 81 BIRFs reporting use of mechanical restraint in Quarter 2:

- 47 reports involved auxiliary devices to prevent a person from unbuckling their seatbelt during travel. All 47 uses involved 5 people in which the use of auxiliary devices was approved by the Commissioner. This is an increase of 7 from the previous quarter. This increase is likely due to people going into the community more frequently as Covid-19 restrictions were relaxed in Minnesota.

- 34 reports involved use of another type of mechanical restraint. This is an increase of 11 from the previous quarter. The total number of people who experienced a mechanical restraint increased by 5 people.
    - 21 reports involved 3 people who had the use of self-injury protection equipment (examples include helmets, splints, braces, mitts, and gloves) reviewed by the EPRC and approved by the Commissioner for the emergency use of mechanical restraint. This was an increase of 1 report from the previous quarter and a decrease of 2 people.
    - 11 reports involving 6 people, were submitted by the St Peter facility (formerly called Minnesota Security Hospital). This was an increase of 8 reports from the facility and an increase of 4 people. As necessary, DHS Licensing Division investigates and issues correction orders for any violations of the Positive Supports Rule associated with use of mechanical restraint.
    - 2 reports involving 1 person were submitted by a provider whose use was within the 11 month phase out period. 11 month phase out periods are allowed under Minn. Stat. 245D.06, Subd.8 when a person starts services with a new provider after having previously been supported by a different caregiver who used prohibited procedures (e.g. hospitals, non-licensed providers or caregivers, services from other states, etc.)

TIMELINESS OF DATA:

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

SEMI-ANNUAL AND ANNUAL GOALS

This section includes reports on the progress of measurable goals related to increasing capacity of the system and options for integration that are being reported semi-annually or annually. Each specific goal includes: the overall goal, the annual goal, baseline, results for the reporting period, analysis of the data and a comment on performance.

TRANSPORTATION GOAL TWO: By 2025, the annual number of service hours will increase to 1.71 million in Greater Minnesota (approximately 50% increase). By 2025, the annual number of service hours will increase to 1.71 million in Greater Minnesota (approximately 50% increase).

2020 Goal

- By December 31, 2020, the annual number of service hours will increase to 1,428,000.

Baseline: In 2014 the annual number of service hours was 1,200,000.

RESULTS:
The 2019 goal to increase to 1,428,000 service hours was **met** (using Calendar Year 2019 data).

Time Period	Service Hours	Change from baseline
Baseline – Calendar Year 2014	1,200,000	N/A
Calendar Year 2015	1,218,787	18,787
Calendar Year 2016	1,418,908	218,908
Calendar Year 2017	1,369,316	169,316
Calendar Year 2018	1,442,652	242,652
Calendar Year 2019	1,451,000	251,000

ANALYSIS OF DATA:
During 2019, the total number of service hours was 1,451,000. This was an increase of 8,348 service hours from the previous year. The 2020 goal to increase to 1,451,000 was met.

COMMENT ON PERFORMANCE:
The 2019 numbers have increased over 2018 and the downward adjustment in 2017. The 2019 numbers reflect a modest increase in total service hours. MnDOT is on track to meet the 2025 goal.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported one year after the end of the reporting period.

TRANSPORTATION GOAL FOUR: By 2025, transit systems' on time performance will be 90% or greater statewide.

Ten year goals to improve on time performance:

- Transit Link – maintain performance of 95% within a half hour
- Metro Mobility – maintain performance of 95% within a half hour
- Metro Transit – improve to 90% or greater within one minute early – four minutes late

Baseline for on time performance in 2014 was:

- Transit Link – 97% within a half hour
- Metro Mobility – 96.3% within a half hour timeframe
- Metro Transit – 86% within one minute early – four minutes late

RESULTS:

The goal is **in process**. The results for Greater Minnesota are reported separately and will be included in a future Quarterly report.

On time performance percentage by transit system[8]

Time Period	Transit Link	Metro Mobility	Metro Transit
Calendar Year 2014 (Baseline)	97%	96.3%	86%
Calendar Year 2016	98%	95.3%	85.1%
Calendar Year 2017	98.5%	96.8%	86.4%
Calendar Year 2018	98%	95.3%	84.8%
Calendar Year 2019	97%	93.0%	82.7%
Calendar Year 2020	96%	96.4%	87.8%

ANALYSIS OF DATA:

During 2020, the on time performances for Transit Link and Metro Mobility is above the 95% goal. The on time performance for Metro Transit was 87.8% which is lower than the 90% goal. The Metro Transit system is made up of three types of services: bus, light rail (Blue and Green lines) and the Northstar commuter rail. The on-time performance for each service type is shown below.

[8] Beginning in 2017, on-time performance for the Metro Transit system was defined as up to 1 minute early and 5 minutes late. This is the preferred methodology when on-time performance is reported for the entire system. The 2016 results previously reported were updated to use this methodology. This did not change the goal status.

All three components of the Metro Transit system improved from 2019. Accordingly, Metro Transit's system-wide on-time performance also improved from 2019.

On time performance percentage for Metro Transit system

Time Period	Bus	Light Rail (Blue/Green line)	Northstar Commuter Rail	Metro Transit System[9]
Calendar Year 2014 (Baseline)	--	--	--	86%
Calendar Year 2016	85.8%	82.9%	93.2%	85.1%
Calendar Year 2017	85.1%	89.5%	93.2%	86.4%
Calendar Year 2018	83.7%	86.7%	94.7%	84.8%
Calendar Year 2019	82.2%	83.4%	93.3%	82.7%
Calendar Year 2020	87.5%	88.3%	96.8%	87.8%

COMMENT ON PERFORMANCE:
Metro Transit on-time performance improved for all modes due to the impacts of the COVID-19 pandemic including dramatic reductions in traffic congestion and a loss of ridership. Transit's system-wide on-time performance is weighted by ridership so bus and light rail performance drive the result. Bus ridership was the most resilient during the pandemic so bus on-time performance was weighted more heavily compared to recent years.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported three months after it is collected.

[9] Metro transit (weighted) represents on-time performance for the Metro transit modes combined. The percentage is weighted based on ridership, and is not an average of the three modes.

VI. COMPLIANCE REPORT ON WORKPLANS

The Quarterly Reports will no longer include a quarterly review of workplans. Workplan activities will continue at an agency level. In the event a measurable goal is reflecting insufficient progress, OIO Compliance will review agency workplans.

The April 2021 Olmstead Plan includes revised language regarding workplans and is included below.

Development of workplans (page 102)
In order to achieve the measurable goals, the OIO and State agencies develop specific strategies and workplans. Each measurable goal is supported by several key strategies, which are articulated in the Plan. Key strategies are supported by workplans.

Workplans describe the action items that agencies will use to support the strategies and goals. For each strategy identified in the Plan, the workplans identify a series of key activities, expected outcomes, deadlines and the agency or agencies responsible for implementation. Workplans are the purview of the responsible State agencies. The agencies develop the workplans to encompass anticipated action items over 1-2 years.

The Subcabinet agencies will use the workplans throughout the year to review the progress of the work and to direct any adjustments to the work if progress is not timely, or if changes to the workplans are needed based on actual experience in the field, including results from the Quality of Life survey.

ENDNOTES

[i] October 24, 2020, jurisdiction of the Federal Court ended.
[ii] Some Olmstead Plan goals have multiple subparts or components that are measured and evaluated separately. Each subpart or component is treated as a measurable goal in this report.
[iii] This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options also reported under Housing Goal One.
[iv] Transfers refer to individuals exiting segregated settings who are not going to an integrated setting. Examples include transfers to chemical dependency programs, mental health treatment programs such as Intensive Residential Treatment Settings, nursing homes, ICFs/DD, hospitals, jails, or other similar settings. These settings are not the person's home, but a temporary setting usually for the purpose of treatment.

[v] As measured by monthly percentage of total bed days that are non-acute. Information about the percent of patients not needing hospital level of care is available upon request.
[vi] Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.