Olmstead Subcabinet Meeting Agenda

Monday, December 18, 2017 • 9:30 a.m. to 11:00 a.m.
Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

1) Call to Order
2) Roll Call
3) Agenda Review

4) Approval of Minutes **3**
a) Subcabinet meeting on November 27, 2017

5) Reports
a) Chair
b) Executive Director
c) Legal Office
d) Compliance Office

6) Action Items
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b) 2017 Annual Report on Olmstead Plan Implementation **57**
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d) Community Engagement 5D.1 – Workplan for Community Engagement Plan (OIO) **161**
e) Workplan Compliance Report for December (OIO) **167**
f) Adjustment to Workplan Activity EM 2A.2 – Interagency data system (DHS) **175**

7) Informational Items and Reports
a) Workplan activities requiring report to Subcabinet **179**
1) Community Engagement 5C – OIO Communication Plan (OIO) **181**
2) Community Engagement 5E – Workgroup Scope of Work (OIO) **185**

8) Public Comments

9) Adjournment

Next Subcabinet Meeting: January 29, 2018 – 3:00 p.m. – 4:30 p.m.
Minnesota Housing, 400 Wabasha Street North, Suite 400

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Item:

4) Approval of Minutes
a) Subcabinet meeting on November 27, 2017

Presenter:

Commissioner Tingerthal (Minnesota Housing)

Action Needed:

☒ **Approval Needed**

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

Summary of Item:

Approval is needed of the November 27, 2017 Subcabinet meeting minutes.

Attachment(s):

Olmstead Subcabinet meeting minutes - November 27, 2017

Olmstead Subcabinet Meeting Minutes

Monday, November 27, 2017 • 4:00 p.m. to 5:30 p.m.
Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

1) **Call to Order**
Action: N/A
The meeting was called to order at 4:03 p.m. by Commissioner Mary Tingerthal (Minnesota Housing). Commissioner Tingerthal provided meeting logistics. She also indicated that representatives of Departments of Transportation, Corrections and Health will not be in attendance for today's meeting.

2) **Roll Call**
Action: N/A
Subcabinet members present: Mary Tingerthal, Minnesota Housing; Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities (OMHDD); Colleen Wieck, Governor's Council on Developmental Disabilities (GCDD); Shawntera Hardy, Department of Employment and Economic Development (DEED) joined the meeting by phone at 4:10)

Designees present: Chuck Johnson, Department of Human Services (DHS); Daron Korte, Department of Education (MDE); Rowzat Shipchandler, Department of Human Rights (MDHR)

Guests present: Mike Tessneer, Rosalie Vollmar, Darlene Zangara, Diane Doolittle, Shannon Eckman and Sue Hite-Kirk, Olmstead Implementation Office (OIO); Eric Mattson, Anne Smetak and Ryan Baumtrog (Minnesota Housing); Carol LaBine, Alex Bartolic, Carol Anthony, Linda Wolford, Adrienne Hannert, Erin Sullivan Sutton and Maisha Giles (DHS); Darielle Dannen, Chris McVey, Jan Thompson and Allen Lunz (DEED); Tom Delaney, Sarah Knoph, Jayne Spain and Emily Jahr (MDE); Christen Donley (DOC); Kristie Billiar (DOT); Leigh Benvenuti and Maura McNellis-Kubat (OMHDD); Ellena Schoop (MN.IT); Mary Kay Kennedy (ACT); Gerri Sutton (Met Council); Kamal Hassan (ISKA Inc./Advocate).

Guests present via telephone: Kim Pettman, Lori Dusan

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

3) **Agenda Review**
Commissioner Tingerthal proposed a change to the agenda. Agenda items 7b1 and 7b2 include two MDH reports carried over from the October meeting. Staff most familiar with the reports were unable to be present so those reports will be moved to a future meeting.

Commissioner Tingerthal Mary reminded any attendees wishing to make public comment should sign up.

4) Approval of Minutes

a) Subcabinet meeting on October 23, 2017

Motion: Motion to approve the October 23rd meeting minutes

Action: Motion – Wieck Second – Johnson In Favor - All

5) Reports

a) Chair

There was no report.

b) Executive Director

Darlene Zangara (OIO) provided an update on the Quality of Life Survey. As of November 21, 2017 there were 1,925 interviews completed and 89 interviews scheduled. The Quality of Life Survey results report is being drafted and will be circulated for review. Dr. Conroy will be providing an in-depth data analysis and feedback on the draft report.

c) Legal Office

There was no report. Commissioner Tingerthal reminded members that there is a Status Conference scheduled with the Court on December 8, 2017, with an agenda expected any day. Agencies will be contacted if the Court requests special items, or requests agency attendance.

d) Compliance Office

Mike Tessneer reported that he has followed up with Commissioner Hardy (DEED) and Assistant Commissioner Shipchandler (MDHR) regarding concerns raised at the last Subcabinet meeting. The concerns were regarding workplan activities related to increasing the number of ethnically and racially diverse providers and the training of those providers.

- DHS and DEED are examining their data collected from providers to see if there is a better way to measure the number of ethnically and racially diverse providers.
- The workplan items related to this will be extracted from the workplan activities related to training activities and made into freestanding activities.
- The activities will focus on increasing the number of providers and the number of trained providers.
- More details on what can be measured and which work plans will be modified will be identified at a later meeting.

Commissioner Hardy thanked OIO Compliance for finding a solution to help make sure this kind of information is in the forefront for the purpose of tracking outcomes.

6) Action Items

a) Proposed Baselines for Review

1) Employment Goal 2 (DHS)

Alex Bartolic (DHS) reported on the proposed baseline for Employment Goal 2. In 2014, of the 50,157 people age 18-64 receiving services from certain Medicaid funded programs, 6,137 were in competitive integrated employment. The baseline was established using a proxy measure. It includes the number of people who have monthly earnings of over $600 a month.

Commissioner Tingerthal asked for clarification on the overall goal. The way it reads now, it includes both a number and percentage increase which is a little confusing. She asked if the overall goal intended to be an increase over baseline or an increase in the percentage. Commissioner Tingerthal asked the Subcabinet members if they had a preference of counting people or determining percentages. Colleen Wieck (GCDD) stated it would be a positive gain if we could add 5,000 people working over the next few years given changes at the federal level. Commissioner Tingerthal stated that the goal should be clarified to show an increase in number of people instead of percentage, during the Plan amendment process.

Motion: Motion to Approve the Proposed Baseline
Action: Motion – Wieck Second – Shipchandler In Favor – All

1) **Transportation Goal 3 (DOT)**

Kristie Billiar (DOT) reported on the proposed baseline for Transportation Goal 3. The baseline is exclusively for Greater Minnesota transit and establishes the baseline of public transportation that meets the minimum service guidelines based on service population and operating hours. In December 2016, public transportation in Greater Minnesota was meeting minimum service guidelines for access 47% of the time for weekdays, 12% of the time for Saturdays, and 3% of the time for Sundays.

Commissioner Tingerthal stated that achieving the overall goal of 90%, would be a significant uptick. Kristie Billiar stated that funding has been provided for roughly doubling service hours, with emphasis on employment transportation first.

Gerri Sutton (Met Council) stated that the way transit is measured in the metropolitan area is quite different than Greater Minnesota. The current Metro market areas are based on employment, population density and income. Their baseline is measured in two ways: geographic area and population. For that reason, it was difficult to fit a Metro baseline into the parameters of this goal. Met Council plans to propose an amendment during the Plan amendment process that relates to this goal.

Commissioner Tingerthal asked if the Plan amendment would be lead to a two-part goal. Ms. Billiar stated that she believed that would be the case, based on the different measures used by DOT and Met Council. Commissioner Tingerthal reminded members that approval is for establishing a baseline for Greater Minnesota.

Motion: Motion to Approve the Proposed Baseline
Action: Motion – Shipchandler Second – Korte In Favor - All

b) **November 2017 Quarterly Report**

Mike Tessneer reviewed the executive summary of the November 2017 Quarterly Report. This report included twenty-six measurable goals, nine were met and five are on track. Seven were not met and two were not on track. Three goals are in process.

Highlights include:

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

- More individuals are leaving Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) programs to more integrated settings. After three quarters, 143 individuals left ICF/DD programs to more integrated settings. This exceeds the annual goal of 84.
- More individuals are leaving nursing facilities for more integrated settings. After three quarters, 590 individuals moved from nursing facilities. This is 80% of the annual projected goal.
- More individuals are leaving other segregated settings to more integrated settings. After three quarters, 780 individuals moved from other segregated settings to more integrated settings. This exceeds the annual goal of 400.
- There is an increase in the number of individuals exiting the Anoka Metro Regional Treatment Center (AMRTC) in a timely fashion. The percent of individuals at the AMRTC who do not need a hospital level of care has trended down over the past three quarters.
- There is an increase in the number of individuals leaving the Minnesota Security Hospital (MSH) to a more integrated setting. Over the past two quarters, the average number of individuals leaving to a more integrated setting has increased.

Movement of individuals from waiting lists

- There continues to be no need for a waiting list for the CADI waiver. Successful efforts to provide individuals access to the CADI waiver have prevented the need for a waiting list.
- There are fewer individuals waiting for access to a DD waiver. At the end of the current quarter there were 152 individuals on the waiting list compared to 237 the previous quarter.

Increasing system capacity and options for integration

- More people gained access to integrated housing. There was an increase of 998 individuals accessing housing or 98% of the annual goal.
- There was an increase in the number of individuals obtaining competitive integrated employment. Over 2,066 individuals found employment exceeding the annual goal of 1,500.
- Fewer people are experiencing the use of emergency use of manual restraint. There was a reduction of 69 individuals or 9% from the previous year.

The following measurable goals have been targeted for improvement:

- Transition Services Goal Four to increase the percent of individual's transition plans that meet the required protocols.

- Waiting List Goal Three to eliminate the waiting list for persons in the Institutional Exit and Defined Need categories.
- Person Centered Planning Goal One to increase the percent of individual's plans that meet the required protocols.
- Positive Supports Goal Three A to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Housing and Services Goal One to increase the number of individuals living in integrated housing.
- Lifelong Learning and Education Goal Two to increase the number of students with disabilities enrolling in an integrated postsecondary education setting.
- Crisis Services Goal Four A to increase the percent of people housed five months after being discharged from the hospital.

Two goals (Crisis Services Goals One and Two) are included in the Addendum to update data previously reported. The newly reported data provides more complete information. The status of these goals did not change.

The agencies reviewed the status of each goal detailed in the Quarterly Report. A summary of questions and responses are noted below.

Person-Centered Planning Goal One
Erin Sullivan Sutton (DHS) pointed out that there is one item in particular that is being missed in individual plans and that is a global statement of the person's dreams and aspirations. Commissioner Tingerthal questioned whether DHS had a sense for why so many individual's plans were missing that item. DHS staff believe it has to do with the fact that these individuals have probably never been asked this question before and for that reason may have trouble answering the question.

Roberta Opheim (OMHDD) hopes that they emphasize continuous improvement and don't just stop when they meet most of the criteria.

Crisis Services Goal Four
Roberta Opheim (OMHDD) emphasized that her concern under this area is that there are a large number of people in emergency rooms that need to get out but they are more difficult to plan for. Services are needed quickly, yet hospitals are restricted in the availability of more intensive housing supports. There is not enough affordable housing or supported housing, and individuals with fewer needs aren't moving out to make room for those with more needs.

Commissioner Tingerthal commented that a bonding bill was introduced last session that would provide capital for facilities that would be in between emergency room and permanent housing if enacted.

Erin Sullivan Sutton stated that a cross-administration work group is beginning to meet regarding issues with moving individuals out of AMRTC and MSH.

Motion: Motion to Approve the Quarterly Report
Action: Motion – Johnson Second – Wieck In Favor – All

c) **Communications 2A.2 – Workplan for implementation of public input process**

Darlene Zangara provided an overview of the Olmstead Plan Amendment Public Input Plan. She also reviewed the workplan to implement the process. Summary of the public input workplan includes:

- Five listening sessions held throughout the state;
- Host venues, collaborate with organizations, and utilize technology for listening sessions as needed;
- Subcabinet members will be informed of the dates of the listening sessions and may be asked to participate;
- Three focus groups held with traditionally under-represented communities;
- One video/phone conference call listening session;
- Two online input opportunities;
- Ongoing public input through social media, email, phone, etc.
- Timelines are from December 20, 2017 - January 31, 2018 and February 27 – March 11, 2018;
- Communications plan toolkit developed for state agencies; and
- Process developed for closing the feedback loop.

Motion: Motion to approve Workplan
Action: Motion – Wieck Second – Korte In Favor - All

Darlene Zangara (OIO) read a statement from Kim Pettman, member of the public, on the topic of public input process at Subcabinet meetings. Highlights of her statement included:

- Place public comment time at the beginning of meetings before decisions are made;
- Allow enough time at the meetings for the public to speak without being rushed; and
- All those in attendance are asked to stay during public comment time.

Darlene Zangara recommended that these issues be explored as part of the OIO, Community Engagement Workgroup scope of work for 2018. Commissioner Tingerthal asked that the workgroup take a look at the issues and provide recommendations to the Subcabinet.

d) Workplan Compliance Report for November

Mike Tessneer (OIO) reported that of the 15 workplan activities reviewed:

- 14 activities (93%) were completed and 1 activity (7%) is being reported as an exception.

- Darlene Zangara (OIO) reported on the exception for Community Engagement 5D.1, and provided the reason for the exception and the plan to remedy.

Motion: Motion to Approve Workplan Compliance Report and Adjustment to Workplan
Action: Motion – Johnson Second – Shipchandler In Favor - All

6) Informational Items and Reports

a) Follow up from previous meetings – Commissioner Tingerthal suggested that in the interest of time, all other agenda items be held to allow for enough time for public comment. She stated there is a timeline for Plan Amendment Process and encouraged members to review this carefully.

7) Public Comments

Commissioner Tingerthal asked Mary Kay Kennedy to come forward to speak to the Subcabinet.

Mary Kay Kennedy – Minnesota Advocating Change Together (ACT)

The Olmstead Academy is a leadership program in process. She invited members of the Subcabinet and the public to join them with Judge Frank at the Federal Courthouse on December 15, 2017, beginning at 1:00 p.m. At this time, the program's current teams will be reporting to the community the results of their disability integration projects. The program is also beginning to recruit for the class of 2018. Acceptance into the year-long program is required. Recruiting and application information were provided.

8) Adjournment

The meeting was adjourned at 5:28.

Next Subcabinet Meeting: December 18, 2017 – 9:30 a.m. – 11:00 a.m.
Minnesota Housing, 400 Wabasha Street North, Suite 400

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Items:

6 (b) Preliminary Quality of Life Baseline Report

Presenter:

Darlene Zangara (OIO) and The Improve Group

Action Needed:

☒ Approval Needed

☐ Informational Item (no action needed)

Summary of Item:

This is the preliminary draft of the Quality of Life Baseline Report.

Attachment(s):

6a – Preliminary Olmstead Plan Quality of Life Baseline Report

State of Minnesota

Preliminary Olmstead Plan Quality of Life Baseline Report

A comprehensive and longitudinal study of the quality of life of a sample of Minnesotans with disabilities.

Phase 1 Analysis

Submitted by The Improve Group
12-11-2017

Acknowledgements

We would like to thank the following individuals for their contributions to the Olmstead Quality of Life Baseline Survey.

Interviewers

Anne Flueckiger
Barbara Hinz
Cassie Fredricks
Cheryl Morris
Dan Pysno
Dave Edens
Erika Herrmann
Erin McCloskey
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Jenna Askevold
Jennifer Onsum
Julie Olson
Julie Vogeler
Katrina Simons
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Pepper (Adeline) Green
Steve Guberman
Teresa O'Keefe

Advisory Group members

Darlene Zangara, Olmstead Implementation Office (OIO)
Diane Doolittle, OIO
Melody Johnson, OIO
Mike Tessneer, OIO
Dan Newman, Minnesota Department of Human Services (DHS)
Claire Wilson, DHS
Colleen Wieck, Minnesota Governor's Council on Developmental Disabilities
David Sherwood-Gabrielson, Minnesota Department of Employment and Economic Development (DEED)
Eve Lo, DEED
Dr. Jim Conroy, Consultant
Nagi Salem, Minnesota Department of Health
Sarah Thorson, DHS

A special thank you to the Center for Outcome Analysis and Dr. Jim Conroy for their support in adapting the Quality of Life survey tool for Minnesota's Olmstead Plan.

For additional information or to receive this report in an alternative format please contact the Olmstead Implementation office at (651) 296-8081 or MNOlmsteadPlan@state.mn.us.

Contents

Executive summary

The Olmstead Quality of Life Survey is designed to assess and track the quality of life for people with disabilities. The results of this survey will be critically important to understanding how the State of Minnesota is meeting the goals of the Olmstead Plan.

People surveyed

The survey was conducted between February 2017 and November 2017. Over 2,000 people, selected by random sample, participated in the survey. This survey was designed specifically for people with disabilities of all ages who are authorized to receive state-paid services in potentially segregated settings. This survey seeks to talk directly with individuals to get their own perceptions and opinions about what affects their quality of life. The primary groups included in the survey sample are:

- People with physical disabilities
- People with intellectual/developmental disabilities
- People with mental health needs/dual diagnosis (mental health diagnosis and chemical dependency)
- People who are deaf or hard of hearing
- People who are blind or visually impaired
- People with brain injuries

The settings from which the survey sample was drawn were selected based on a 2014 report developed by the Minnesota Department of Human Services for the Olmstead Subcabinet.[1] The report highlighted potentially segregated settings. These settings include:

- Center Based Employment
- Day Training and Habilitation (DT&H)
- Board and Lodging
- Supported Living Facilities (SLF)
- Boarding Care
- Nursing Facilities and Customized Living Facilities
- Community Residential Services (Adult Foster Care and Supported Living Services)
- Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD)

Survey results

The results of this report reflect the experiences of the participants and are not generalizable. This report should be viewed as a high-level analysis. This is a draft of the Phase 1 report, and the results are based on unweighted data. This means the results in this report do not account for any potential non-response bias. As such, results listed in this report may shift.

[1] MN Department of Human Services. (2014). Minnesota Olmstead Plan: Demographic Analysis, Segregated Setting Counts, Targets and Timelines.

Decision-making.

- The survey measured participants' decision-making, as compared to what decisions paid staff made for them. This was scored 0 to 100 on the Decision Control Inventory (DCI). Minnesota's average DCI score is 66.2 out of 100.

Quality of life.

- Interviewers asked participants 14 questions, the answers to which were then calculated into an overall quality of life score. Minnesota's baseline quality of life score is 76.6 out of 100.

Earnings.

- More than 800 participants reported some earnings, including wages or piecework. On average, participants earned $95 per week. Hourly earnings ranged from $3.30 to $7.60 depending on employment type.

Outings.

- Participants averaged 32 outings per month, which is lower than the general population (46 outings outside the house per month, not counting work).[2]

Integration.

- Integration scores are highest for activities such as competitive employment, self-employment, volunteer work, and supported employment. In contrast, integration is lowest in day training and habilitation, sheltered employment or workshops, and adult day programs. This is consistent with other research. However, these scores indicate a higher level of potential segregation in certain community-based settings.

Relationships.

- Relatives were the most commonly reported relationship type (46 percent), followed by staff of any type (26 percent), and other friends (22 percent).

A baseline

This data will serve as a baseline for comparison in future surveys. Going forward, the Olmstead Quality of Life Survey will help us understand whether increased community integration and self-determination are occurring for people with disabilities in certain settings. The first follow-up survey is to be conducted in late 2018.

Phase 2 Analysis

The next phase of analysis will focus on reporting outcomes based on geography, setting, and disability type. This phase of analysis will also attempt to account for any non-response bias.

[2] "Service Excellence Summary: Baseline Data Summary for Briefing" COA, May 2017

Purpose

The State of Minnesota's Olmstead Plan requires a longitudinal study be conducted to assess and track the quality of life for people with disabilities in certain settings. In a longitudinal study, individuals are tracked over time to measure changes in their quality of life. This helps the State of Minnesota determine the effectiveness of its Olmstead Plan, including whether increased community integration and self-determination are occurring for people with disabilities. The Olmstead Subcabinet selected the Center for Outcomes Analysis Quality of Life Survey tool to measure changes in quality of life as people with disabilities choose to move to more integrated settings. Interviewers conducted 2,000 surveys with people with disabilities across the State of Minnesota between February and November 2017. This report serves as a starting point, outlining the baseline survey findings. A random sample of participants from this baseline survey will be selected for a follow-up survey to be conducted at least 12 months after the first survey, starting in late 2018. Data from the follow-up survey will be available in 2019.

Background

Minnesota's Olmstead Plan comes as part of the State of Minnesota's response to two court cases when individuals with disabilities challenged their living settings. In a 1999 civil rights case, *Olmstead v. L.C.*, the U.S. Supreme Court held that it is unlawful for governments to keep people with disabilities in segregated settings when they can be supported in the community. The case was brought by two individuals with disabilities who were confined in an institution even after health professionals said they could move to a community-based program. In its ruling, the U.S. Supreme Court said unjustified segregation of people with disabilities violates the Americans with Disabilities Act.[3] This means states must offer services in the most integrated setting, including providing community-based services when possible. The Court also emphasized it is important for governments to develop and implement a plan to increase integration.

In 2009, individuals who had been secluded or restrained at the Minnesota Extended Treatment Options program filed a federal class action lawsuit, *Jensen et al v. Minnesota Department of Human Services*.[4] The resulting settlement required policy changes to significantly improve the care and treatment of people with developmental and other disabilities in Minnesota. One provision of the *Jensen* settlement agreement provided Minnesota would develop and implement an Olmstead Plan.

An Olmstead Plan documents a state's plans to provide services to people with disabilities in the most integrated setting appropriate for the individual. Minnesota's Olmstead Plan keeps the State accountable to the *Olmstead* ruling. The goal of the plan is to make Minnesota a place where "people with disabilities are living, learning, working, and enjoying life in the most integrated setting."[5]

[3] U.S. Department of Justice Civil Rights Division. (n.d.). Olmstead: Community Integration for Everyone. Retrieved from ADA.gov: https://www.ada.gov/olmstead/olmstead_about.htm

[4] Minnesota Department of Human Services. (2017, 10 11). Jensen Settlement. Retrieved from Department of Human Services: https://mn.gov/dhs/general-public/featured-programs-initiatives/jensen-settlement/

[5] Olmstead Subcabinet. (2017). Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan. Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-292991

As part of the Plan's "Quality Assurance and Accountability" section, subsequent surveys will be conducted two or three times during the following three years to measure changes from the baseline. The Olmstead Quality of Life Survey is longitudinal. Over time, this will measure progress in quality of life based on reports from Minnesotans with disabilities.

Key process steps timeline

1999: *Olmstead v. L.C.* U.S. Supreme Court case makes it unlawful for governments to keep people with disabilities in segregated settings. States begin developing Olmstead Plans.

December 2011: The *Jensen et al v. Minnesota Department of Human Services* case settlement requires development of a Minnesota Olmstead Plan.

January 2013: Governor Mark Dayton issues an executive order establishing the Olmstead Subcabinet. This group begins developing the Minnesota Olmstead Plan.

June 2013 – June 2015: The Olmstead Implementation Office (OIO) receives more than 400 public comments. The Olmstead Implementation Office and Subcabinet members attend more than 100 public listening sessions to guide their development of the plan.

April 2014: The Olmstead Subcabinet votes to approve the Center for Outcomes Analysis Quality of Life survey tool as the most appropriate way of measuring the quality of life of people with disabilities.

June 2014: Research and evaluation firm The Improve Group is selected to conduct the pilot study through a contract with Minnesota Management Analysis and Development.

June – December 2014: The Olmstead Quality of Life Survey is piloted with approximately 100 people with disabilities. People with disabilities support survey implementation. Considerations from the pilot are incorporated into the Quality of Life Survey Administration Plan.

January 2015: Governor Mark Dayton issues another executive order, further defining the role and nature of the Olmstead Subcabinet.

August 2015: The first Minnesota Olmstead Plan is released. The Plan was revised in February 2017.

September 2015: The U.S. District Court for the District of Minnesota approves the Minnesota Olmstead Plan, citing components that ensure continued improvements for people with disabilities, like the survey.

July 2016: The Minnesota Department of Human Services' Institutional Review Board grants approval to the Olmstead Quality of Life Survey. IRB approval is required because of the significant vulnerability of the people to be surveyed.

August 2016: Olmstead Implementation Office issues a request for proposals for administration of the full survey.

September 2016: The Improve Group is selected as the vendor to carry out the full survey.

Winter 2016: A survey advisory group is created.

February 2016 – November 2017: The Improve Group implements the baseline Olmstead Quality of Life survey with 2,000 people with disabilities across Minnesota.

November – December 2017: The Improve Group analyzes and reports survey results to the Olmstead Implementation Office.

Late 2018: The first follow-up survey is conducted with a random sample of participants from the baseline survey to detect any changes in quality of life.

Methodology

Tool selection

Olmstead Implementation Office reviewed seven possible tools for consideration and presented them to the Subcabinet. The office used the following criteria to judge the tools: applicability across multiple disability groups and ages, validity and reliability, ability to measure changes over time, and whether integration is included as an indicator in the survey. The Subcabinet voted to use a field-tested survey tool developed by the Center for Outcome Analysis (COA). The tool was tailored to the Minnesota Olmstead Plan for this survey. The Subcabinet selected the COA tool because it is **reliable, valid, low-cost, and repeatable for all disability types.** That said, the tool is not applicable to all people with disabilities as it specifically measures quality of life only for those in the potentially segregated settings identified for the population of interest**.**

The COA tool meets the criteria above as it can be used with respondents with any disability type; is longitudinal, measuring change over time; and includes reliability and validity data. The COA Quality of Life survey tool measures:

- How well people with disabilities are integrated in and engaged with their community;
- How much autonomy people with disabilities have in day-to-day decision-making; and
- Whether people with disabilities are working and living in the most integrated setting that they choose.

The Olmstead Quality of Life Survey is only one way the experiences of people with disabilities will be gathered. The survey is intended to be a tool for providing oversight and accountability for the plan.

Population of interest[6]

The population of interest for the baseline survey is people with disabilities who are living and working in settings that were a focus of the Minnesota Olmstead Plan. This includes people in these eight settings of all ages and disability types.

Table 1: Description of settings

Center Based Employment	**Programs that provide opportunities for people with disabilities to learn and practice work skills in a separate and supported**

[6] The Improve Group. (2016). Quality of Life Survey Administration Plan.

	environment. Participants may be involved in the program on a transitional or ongoing basis, and are paid for their work, generally under a piecework arrangement. The nature of the work and the types of disabilities represented in the workforce vary widely by program and by the area in which the organization is located.
Day Training and Habilitation (DT&H)	Licensed supports to provide persons with help to develop and maintain life skills, participate in community life, and engage in proactive and satisfying activities of their own choosing. Health and social services directed toward increasing and maintaining the physical, intellectual, emotional and social functioning of people with developmental disabilities
Board and Lodging	Board and Lodge facilities vary greatly in size—some resemble small homes and others are more like apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with a private or attached bathroom. There are common areas for dining and other activities. Many offer a variety of supportive services (housekeeping or laundry) or home care services (assistance with bathing or medication administration) to residents.
Supported Living Facilities (SLF)	Facilities that provide supervision, lodging, meals, counseling, developmental habilitation, or rehabilitation services under a Minnesota Department of Health license to five to more adults who have intellectual disabilities, chemical dependencies, mental illness, or physical disabilities.
Boarding Care	Boarding Care homes are licensed by the Minnesota Department of Health and are homes for persons needing minimal nursing care. They provide personal or custodial care and related services for five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
Nursing Facilities and Customized Living Services	Nursing facilities are inpatient health care facilities that provide nursing and personal care over an extended period of time (usually more than 30 days) for people who require convalescent care at a level less than that provided in an acute facility, people who are chronically ill or frail elderly, or people with disabilities. Customized living is a package of regularly scheduled individualized health-related and supportive services provided to a person residing in a residential center (apartment buildings) or housing with services establishment.

Community Residential Setting (Adult Foster Care and Supported Living Services)	Adult foster care includes individual waiver services provided to persons living in a home licensed as foster care. Foster care services are individualized and based on the individual needs of the person and service rates must be determined accordingly. People receiving supported living services are receiving additional supports within adult foster care.
Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD)	Residential facilities licensed as health care institutions and certified by the Minnesota Department of Health to provide health or rehabilitative services for people with developmental disabilities or related conditions and who require active treatment.

Who is not included

The goal of the baseline survey was to be as inclusive as possible, given the constraints of the project and acknowledging that certain populations may be missed by the baseline survey. This population does not include people who are incarcerated, youth living with their parents, people living in their own home or family home, people who are currently experiencing homelessness, or people who are receiving services in settings other than the identified eight. For these reasons, it is important to note the results can only be generalized for these eight settings.

Data sources

Data for the survey sample was provided by the Minnesota Department of Human Services (DHS) and the Minnesota Department of Employment and Economic Development (DEED). DHS holds data for all data sources except Center Based Employment. DHS provided data for all people with disabilities with authorized services in the other seven services and settings as of July 2016. The vendor has a data sharing agreement with DHS that allowed access to the individual-level data needed for the survey.

DEED holds data for people receiving services through Center Based Employment. Initially, DEED could not share identifiable data with the vendor. However, DEED provided the vendor with ID numbers, provider information, and residential status information for individuals in Center Based Employment as of January 2016. The vendor used this information to remove individuals who may receive DHS residential services from the DEED dataset so there was no duplication in the sample. This eliminated the possibility of an individual being selected twice.

In summary, the four main sources of data include data from DHS, data from DEED, outreach tracking data, and the Quality of Life (QOL) survey tool. Data from DHS and DEED primarily included individual demographic data such as name, birthdate, race/ethnicity, disability, guardianship status, contact information, and information about services received. Outreach tracking data included details about contacts made with the person and/or their guardian to participate in the survey.[7]

[7] The Improve Group. (2016). Quality of Life Survey Administration Plan.

Sampling

The population of interest for the survey was people with disabilities who are authorized to receive state-paid services in the potentially segregated settings identified above. The sample includes:

- People with physical disabilities
- People with intellectual/developmental disabilities
- People with mental health needs/dual diagnosis (mental health diagnosis and chemical dependency)
- People who are deaf or hard of hearing
- People who are blind or visually impaired
- People with brain injury

The selected methodology for the QOL Survey is **simple random sampling**, which refers to a randomly-selected sample from a larger sample or population, given all individuals in the sample had an equal chance to be chosen. Simple random sampling is easier to understand, sample, analyze, and reproduce. Simple random sampling also allows for more flexibility to accommodate changes in setting definitions. As such, the simple random sample method is the most flexible approach for the long term and maximizes chances for inclusion. Given the primary research questions and tight timeline for the QOL Survey, a simple random sample design was the most efficient and effective approach that could provide the strongest foundation for future surveys.

The process for selecting the sample was as follows:

- Before finalizing the sample, the vendor conducted power analysis to make sure it was sufficiently representative of the population of interest by service setting, disability type, economic region, race/ethnicity, and age. Power analysis is a technique used to estimate the number of observations required to have a good chance of detecting an effect. In this case, it provided a target number of surveys that needed to be completed for each setting.
- The merged dataset was used to calculate the target number of completed surveys for each setting. The vendor set targets for secondary characteristics such as race and ethnicity, disability type, and economic region before selecting the final sample.[8] The targets were developed from the full sample. These targets were used to help guide outreach and recruitment strategies.

Race and ethnicity

Racial and ethnic disparities in Minnesota were considered in the survey. Since the vendor used simple random sampling to select participants for the survey, it was expected that the race/ethnicity breakdown of those selected for the survey would mirror the demographics of the individuals receiving services in the selected settings.

Outreach and consent process

The vendor used multiple contact methods to reach people selected in the random sample. Such methods included phone calls, mail, and email. The vendor also produced a video explaining the purpose of the

[8] The Improve Group. (2016). Quality of Life Survey Administration Plan.

survey that was posted on the survey's website. The advisory group provided input on contact methods and recommended changes to the outreach strategy to improve the fidelity of the project. Outreach was conducted on a rolling basis, starting in February 2017 and continuing until the end of the survey administration period in November 2017.

To encourage people in the randomly-selected pool to participate in the survey, the vendor conducted phone outreach to participants, guardians, and service providers. When possible, the vendor contacted participants and guardians directly. However, receiving limited contact information for participants and guardians was anticipated; therefore, service providers were the primary point of contact for recruitment. During outreach, the vendor screened participants and either scheduled an in-person interview or conducted a telephone interview. If the participant had a legal guardian, the vendor managed the consent form process for phone interviews, including re-sending consent forms when necessary. Potential participants in the sample were assigned an identification number for use in communication to protect individual-level information. All communication about participants for the purposes of monitoring and scheduling used these assigned identification numbers.

Outreach

For individuals who did not require guardian consent, the vendor sent mail notification of selection. The notification included information about the study, a consent form, and instructions on how to opt out via phone or email. A follow-up phone call occurred within 14 days to schedule an interview. The vendor documented the strategy and effort to receive a clear yes or no from every participant or guardian. Unreachable individuals remained eligible to take the survey until the end of the administration period.

If an individual had a legal guardian, the vendor sent notification of selection to the guardian before contacting the participant. If contact information was available, the vendor sent guardian and provider notification at the same time. When the vendor did not have guardian contact information, the vendor worked with providers and case managers to reach the person's guardian and obtain consent to contact the participant. Providers/case managers could do this by either contacting guardians directly or by providing the vendor with contact information. This contact strategy aligned with the overall outreach strategy as providers and case managers may also have been contacted to help facilitate survey administration by encouraging individuals to participate and by arranging interview times.

Service providers

It was essential to establish credibility and authority with providers by having state agencies make first contact with provider agency directors about the QOL Survey. This showed that the state agency supported the survey and its intended goals. Outreach to providers started immediately before the vendor began outreach to participants and continued, as needed, throughout the project. Outreach took place through existing communication channels, such as bulletins, newsletters, and email listservs.

Additionally, the vendor notified service providers by mail or phone when a client was selected to participate in the survey. The vendor used email to schedule appointments, but did not use email as a primary contact method. The vendor submitted the list of unresponsive providers to Olmstead Implementation Office for follow-up. If an individual was no longer receiving services from the provider, the contact was listed as "not active." Providers may have been asked to:

- Confirm the individual is receiving services at that location

- Help obtain guardian consent (if needed)
- Assist with notifying participants
- Schedule interviews (if appropriate)
- Assist with survey scheduling (if appropriate)
- Provide support during interviews (if requested)

Case managers and other contacts
Case managers at lead agencies, tribes, and other organizations were also asked to help with contacting legal guardians and participants. DHS notified lead agencies about the study and their role in supporting the project via existing communication channels. The vendor contacted case managers and other contacts as needed during the survey administration period.

Consent process
For all survey participants, the vendor obtained guardian and/or individual consent before individuals took the survey. In cases when guardian contact information was unavailable or not current, the vendor contacted providers or case managers (when applicable) with a request for assistance in collecting first consent from participants' guardians.

All participants were given the option to opt out of the survey before an interview was scheduled. Additionally, survey participants could decide at any time during the interview to not finish the survey. Survey participants were also asked to give informed consent at the time of the interview. If the individual did not give consent, or if they did not understand the consent form, they were not interviewed.

The vendor secured a data sharing agreement with DHS, which gave the vendor permission to contact individuals directly to participate in the Olmstead QOL survey and obtain first consent. However, since guardian status and contact information are typically held at the county level, DHS did not have reliable contact information for guardians. If DHS did not have guardian contact information, the vendor worked with providers and case managers to contact guardians to obtain consent.

DEED holds the data for people who receive services through Center Based Employment. To share participant data with the vendor, DEED required Consent to Release Information Form from each program participant or their guardian. The vendor eventually obtained a data sharing agreement with DEED to contact individuals directly.

Considerations for consent process
The informed consent process allowed participants time to formulate their response about whether or not they would like to take the survey. This recognized that when first approached, people may not feel comfortable saying no to a person in a perceived position of authority.

Communications to providers included information about how the vendor and Olmstead Implementation Office would protect participants' privacy and rights during and after the survey. Many providers receiving funding from DHS are asked to support the administration of multiple surveys throughout the year. The vendor recognized the multiple requests providers balance.

The additional steps to gain first consent and access to contact information for participants/guardians from DEED caused a delay in selecting the sample and sending information to providers.

Statistics
The below table illustrates the extent of survey outreach.

Table 2: Overview of survey outreach and contacts

Sample size	**11,667**
Letters sent	19,475
Phone calls made	33,823
Sample contacts by phone (preliminary)	Over 9,000
Consents received	2,409
Declines received	1,898
Miles driven	153,000

Conducting the survey

Survey structure
To reduce the burden on participants and streamline the survey process, the vendor prefilled the demographic, disability, and housing sections of the survey based on State agency data. Based on the pilot, it was anticipated that the data from State agency records would be more accurate than self-reported data. The pilot also showed that asking participants these questions instead of using State data would have increased the length of the survey, which was already long. Few pilot participants were able to complete this section, and the questions were a frequent source of stress. If State agency data was incomplete or missing, the vendor attempted to collect the data from providers or caretakers. If the data was not available and the participant was not able to answer the questions, the fields were left blank.

The QOL Survey is divided into five modules, not including questions about assistive technology. The modules were arranged so that the questions most important to the Olmstead Plan are asked at the beginning of the survey. In terms of both administration and analysis, each module is designed to stand on its own. The pilot showed that some participants may be unable to complete more than one module due to issues related to their disabilities. Because of these considerations, it was inappropriate to require a certain number of modules be completed to constitute a completed survey. As such, surveys were considered complete if 75 percent of the first module is finished. In all, 2,005 surveys were completed; 1,902 participants completed all five modules of the survey.

Survey modes
Interviewers administered the survey in person, which took approximately 45 to 60 minutes. The interviewer read each survey question and entered the person's responses via a tablet using a secure survey platform. Participants were given the option to follow along using a paper copy of the survey. The person selected for the study was intended to be the primary respondent to the survey. However, the

participant had the option to choose a support person to help them respond or to respond on their behalf. The names of everyone participating in the survey were recorded on the consent form.

The vendor planned for four hours per survey for coordination, travel, and survey administration in the Twin Cities metro area. Surveys conducted in greater Minnesota took longer. A protocol for following up with participants who missed, canceled, or rescheduled interviews was developed to ensure everyone had the opportunity to take the survey, while respecting their right to decline in their own way.

Face-to-face interviews were conducted in the location of the participant's choice, which could include their home, workplace, provider office, or a public location. The participant's guardian or another chosen individual could help choose the location. If the interview was scheduled during regular service delivery, the vendor worked with the provider to minimize the disruption to service delivery. In the event the vendor was unable to honor the participant's first choice of location, an alternative location was selected.

Alternative modes
To accommodate the preferences and abilities of potential participants, the survey was also offered as a traditional phone survey, or by videophone or on the web. The pilot showed that offering multiple survey modes would likely boost response rates by allowing options that may be more convenient or comfortable for participants. The study was also more person-centered in offering different survey modes. No participants chose to take the survey via videophone or web.

The vendor managed the consent process for phone interviews, including documenting verbal consent and resending consent forms as needed. If the participant had a legal guardian, the vendor did not conduct an interview until they received documentation of informed consent. In addition, the vendor worked with individuals, guardians, and providers to accommodate other communication tools or survey mode requests.

Person-centered approach
Interviewers used person-centered approaches when scheduling and conducting surveys. This approach meant making the survey as accessible as possible for all participants in terms of formatting, scheduling and conducting the survey. Through all stages of the survey process, interviewers used person-centered communication.

Taking a highly individualized and person-centered approach based on participant and/or guardian preferences regarding survey time and location made it difficult to build other scheduling efficiencies into the overall survey administration.

Communication accommodations

If a case manager, provider, or guardian was involved in scheduling interviews, the vendor asked if accommodations were needed for the person to participate in the survey. All participants received a paper version of the survey in advance to review or reference during in-person interviews. The vendor provided reasonable accommodations to complete the survey as requested by the participant or their representative. If the vendor was unable to provide an accommodation for any reason, the vendor notified Olmstead Implementation Office.

- For participants who were deaf or hard of hearing, the vendor worked with American Sign Language (ASL) interpreters/providers to minimize barriers to scheduling interviews in a timely manner with participants. In addition, the vendor recruited interviewers who could conduct the survey in ASL.
- For participants who were blind or visually impaired, a paper copy of the survey was available in large print text, if helpful. The survey was also made screen reader-compatible and modified to include additional instructions to guide individuals through the survey.
- The vendor worked with specialized interpreters to accommodate deafblind participants. The vendor aimed for the person to be able to work with a trusted interpreter who is knowledgeable about that individual's communication preferences. All materials for consent, communications, and the survey tool were made available in advance.
- Individuals who are nonverbal or have limited expressive communication used a variety of tools such as sign language, technology, or cards to communicate. The vendor worked with the person's staff or another trusted individual to assist with participation in the survey. Additional accommodations included providing the survey materials to be pre-loaded into any existing communication tools the person uses.
- For non-English speaking participants, materials for the survey including the Quality of Life tool, consent forms, and communication materials were translated into Spanish, Somali, Hmong, and other languages. The vendor worked with multiple translation providers to minimize barriers to scheduling the interviews. The vendor also recruited interviewers who speak targeted languages. To accommodate the large variety of language and dialects spoken by potential participants, the person was also given the option to choose an interpreter, such as a family member or trusted community member.

Barriers to completion

The Olmstead Quality of Life survey tool was designed to be administered to people of all disability types. However, some participants were expected to have difficulty completing the survey, including participants who cannot complete a single module. The following are examples of the primary barriers that were experienced during survey implementation:

Survey length

Depending on the individual, the survey took roughly 45 to 60 minutes to complete. Some participants were unable to sit still for that long, while others found the survey cognitively exhausting. Ideally, it was best to schedule a second interview to complete the survey, but this was impractical given the project's constraints. If the participant showed signs of fatigue, the interviewer would ask the person if they wanted to continue with the survey. At this point, the participant could choose to take a break or end the interview. Participants or their support person could request a break or to end the survey at any time. If a participant was having trouble concentrating/sitting still, interviewers would encourage participants to move around the room or take a short activity break.

Survey content

If the participant was uncomfortable with the survey content, the interviewer would ask the person if they wanted to keep going, if they wanted to skip the question, or if they wanted to skip to the next module. Again, participants could also choose to end the survey at these times. Interviewers could also use the

alternate scale for participants who live in their own home without supports. The alternate scale was created by the survey designer for individuals who do not have staff in their home.

If the participant did not understand the questions, the interviewer would ask if there were someone the person would like to have assist with the survey. If there was not a support person available, the interviewer would end the survey.

Interruptions to schedule
Some participants did not handle interruptions to their normal daily schedule well. This could result in severe anxiety or distress. Several individuals did not understand why they were being taken away from their regular activities and, even though they had previously agreed to participate, refused to take the survey. The vendor worked with providers, guardians, and support persons to try to anticipate such situations and schedule interviews outside of structured activity times. The interviewer could also work with the individual and their support person to integrate the survey into regular activities.

Communication needs
The vendor attempted to provide reasonable accommodations for participants, including providing interpreters and supporting the use of assistive technology. However, there were times when the vendor was unable to provide the accommodation at the time of the survey. In the event the vendor was unable to honor the request or new accommodations arose during the survey, the interview was rescheduled.

Outdated contact information
Providers, staff, and guardians were integral to obtaining consent and administering the survey. Frequently, inaccurate or old guardian contact information hindered survey implementation. In other cases, staff turnover, leave, or lengthy response times caused delays, or the vendor could not locate the correct person in the provider organization. Guardian and provider non-response also were also barriers.

Training of interviewers

Survey interviewers had two primary responsibilities: to conduct in-person surveys and to remind people to take the online version of the survey. Efforts were made to recruit interviewers with diverse backgrounds and from a range of geographic regions, so that they reflected the sample population to be surveyed. The vendor partnered with disability service providers to identify survey interviewers, including people with disabilities who are in supported employment contexts. As a result, the vast majority of interviewers are people with a self-disclosed disability or people with a professional background in disability services.

All project staff members, including interviewers, contractors, and staff, were required to complete interviewer training, as was required by the IRB-approved survey administration plan. Training, which was a combination of self-guided trainings, presentations, group discussions, and shadowing, was roughly 40 hours. Training covered the following subjects, with additional topics as needed:

- Vendor policies and procedures
- Human Subjects Training
- Data security and protecting individuals
- Project background

- Orientation to the survey tool
- Person-centered planning
- Interviewing skills and reducing bias
- Consent process
- Providing accommodations
- Reporting abuse/neglect
- Technology and troubleshooting
- Practice surveys

Abuse and neglect

Procedures were in place for documenting and reporting any incidents in which people threatened to hurt themselves or others, or for incidents of reported or suggested abuse or neglect. These procedures required that all incidents of self-reported, observed, or suspected abuse or neglect be reported to the Minnesota Adult Abuse Reporting Center or Common Entry Point (MAARC/CEP) within 24 hours of the interview. All incidents, including incidents that did not require a report, were documented internally and reported to Olmstead Implementation Office. Providers received information about suspected abuse and neglect reporting with the notification of selection.

Documentation and reporting

Interviewers were required to report all suspected cases of abuse or neglect to the supervisor on duty as soon as it was safe to do so. The vendor was responsible for determining if the incident needed to be reported to the MAARC/CEP. The procedure for documenting and reporting abuse was as follows:

At the time of the interview:

- Call 911 to report serious or immediate danger
- Report the incident to the provider or a staff person (if appropriate)
- Complete the Documentation of Suspected Abuse or Neglect Form
- Report the incident to the supervisor on duty

Within 24 hours of the interview:

- Submit the completed Documentation of Suspected Abuse or Neglect Form
- Report the incident to MAARC/CEP (if required)
- Notify Olmstead Implementation Office about the incident and next steps

Within 72 hours of the interview:

- Submit a written report to MAARC/CEP (if required)

Training

Staff members who could have contact with participants were required to complete the DHS Vulnerable Adults Mandated Reporting. Interviewers also received training on study-specific requirements for documenting and reporting suspected abuse and neglect. Ongoing training was provided as needed.

Reported incidents of abuse and neglect
Due to the vulnerability of the population of interest and the training outlined above, interviewers erred on the side of reporting possible abuse or neglect. Out of 2,000 surveys, interviewers reported possible abuse or neglect in 15 cases.

Analysis

The results in this report are the first phase of analysis. The results are high-level data meant to provide a general picture about quality of life. The results are not weighted for any factors, subsequent analyses will attempt to weight data, which may cause overall results to shift. Future analyses will also break out quality of life by setting, geography, and demographics.

Subgroups for analysis

Specific subgroups within the study population were identified as being of interest for understanding the factors impacting quality of life for Minnesota residents with a disability. The table below summarizes the subgroups that will be used for making comparisons or understanding which groups require more focused attention in the future. Additional analysis will be released in 2018.

Table 3: Potential subgroups for analysis of the Quality of Life survey

Potential subgroup	Description
Settings	Eight potentially segregated settings where people with disabilities receive services, including residential and employment settings.
Disability Type	Primary disability types in the sample, including physical disabilities, intellectual/developmental disabilities, mental health needs/dual diagnosis, deaf or hard of hearing, blind or visually impaired, and brain injury.
Geographic	Population living within a specific area of the state with defined geographic boundaries (e.g., Minnesota economic development regions).

Additional analysis could be done by guardianship status, race/ethnicity, age, and living situation.

Statistical methods

The baseline analysis of the Quality of Life survey data includes primarily descriptive statistical methods. Frequencies and measures of variability can also be applied to the responses to questions on the Quality of Life Survey. The results listed in this report are not weighted for non-response error or other factors. Further analysis will try to account for non-response.

Results

Participants were asked about five topics: community integration and engagement, autonomy over daily life, perceived quality of life, closest relationships, and assistive technology. Interviewers recorded

participants' perceptions of their own lives, which aligns with the survey's person-centered approach but may lead to some inaccuracies due to self-reporting. Analysis below applies only to the specific settings from which the sample was drawn; results cannot be generalized to all people with disabilities in Minnesota.

Tables below often compare survey participants to the overall sample. This comparison is meant to show the difference (if any) between people that took the survey to people selected to take the survey.

Demographic breakdown

Table 4: Eligible population, sample, and survey participation by gender

Participant gender	Eligible population (%)	Sample (%)	Survey Participants (%)
Female	38.8%	40.8%	43.1%
Male	51.3%	54.9%	54.9%
Unknown (not reported)	9.9%	4.3%	2.0%
Total	**100.0%**	**100.0%**	**100.0%**

Participation rates were not significantly different based on gender. If gender is "unknown," the individual's gender was not reported in DHS or DEED data. The original DEED data did not include demographic information. This accounts for the high percentage of "unknown" gender in the eligible population.

Table 5: Age of survey sample and survey participants

	Lowest Age	Highest Age	Average Age
Sample	7	102	47
Survey participants	9	90	47

The average age of individuals in the sample and survey participants was 47 years old at the time of selection. The sample included children who are living in selected settings. Surveys with minor participants were completed either by-proxy with the guardian or guardian's appointee or with the guardian present.

Table 6: Eligible population, sample, and survey participation by race

Participant race	Eligible population (%)	Sample (%)	Survey Participants (%)
Asian	1.5%	1.6%	1.5%
Black	6.1%	6.6%	4.3%

Native American	2.1%	2.1%	2.5%
White	78.5%	83.1%	85.9%
Two or more	0.3%	0.3%	0.2%
Other or unknown	11.5%	6.3%	5.5%
Total	**100.0%**	**100.0%**	**100.0%**

Participation rates were low among people who identified their race as Black. This is likely related to low participation rates in the metro area, where 85 percent of potential Black participants receive services. An analysis of response rates will be included in the Phase 2 report.

Race was "unknown" if it was listed as such in agency data or if race was not provided. The original DEED data did not include demographic information. This accounts for the high percentage of "unknown" race in the eligible population.

Table 7: Eligible population, sample, and survey participation by ethnicity

Participant ethnicity	Eligible population (%)	Sample (%)	Survey Participants (%)
Hispanic/Latino	1.4%	1.6%	1.4%
Not Hispanic/Latino	88.3%	96.3%	88.3%
Unknown	10.3%	4.8%	10.3%
Total	**100%**	**100.0%**	**100%**

Participation rates were also low among Hispanic/Latino individuals. Further analysis of contact and completion rates could be conducted to better understand differences in participation rates by ethnicity.

Race was "unknown" if it was listed as such in agency data or if race was not provided. The original DEED data did not include demographic information. This accounts for the high percentage of "unknown" ethnicity in the eligible population.

Survey analysis

The survey analysis is consistent with methods used in previous studies using this survey instrument, and follows guidelines provided by Dr. Jim Conroy and the Center for Outcome Analysis.

The following is a preliminary analysis of the survey responses. The results are presented with unweighted data and are not generalizable to the population. Phase 2 analysis will include weighted results which may be significantly different than the values presented below.

Community Integration and Engagement: Time, Money, and Integration During the Day

Participants described their hours worked, earnings, and integration over the previous week. The hours estimate included how many hours during the week the person worked, on average, in each kind of setting listed. These settings included formal activities such as self-employment, regular competitive employment, supported employment, and unpaid activities like school or volunteering. Social and individual activities were addressed in the next module. Earnings included how much money the person earned from each of these activities. Integration was a rating from 1 (completely segregated and never in

the presence of people without disabilities) to 5 (completely integrated and nearly always in a situation where people without disabilities might be present). For all questions, interviewers were to ask the person first, then whoever knows the person best, such as a guardian, close friend, or staff.[9]

Table 8. Number of participants by day activity type

Day activity type	Number of survey participants in day activity	Unweighted percent of survey participants
Go to work	1,319	66.2%
Go to school	73	5.0%
Go to other day activities	727	39.6%
No activities reported	54	2.7%

Nearly two-thirds of participants (66 percent) reported spending time in a work setting and over one-third (40 percent) said they attend other formal day activities such as an adult day program. A few participants (3 percent) said they do not take part in any formal day activities. This indicates that nearly everyone who participated in the survey attends at least one formal activity during a typical week. It was not uncommon for people to attend more than one activity, such as two different paid activities, or some combination of employment, school, and other day activities.

If the activity was unclear, interviewers asked a series of questions about the activity, including what the individual does at the activity, where they go for the activity, and if they are paid for the activity. The interviewers used the person's responses to classify the setting, relying on state definitions for the activity if available.

Table 9: Number of participants in day activities by type

Day activity type	Number of participants in activity type	Unweighted percent of participants in activity
Self-Employed	9	0.4%
Competitive Employment	151	7.5%
Supported Employment	214	10.7%
Enclave or Job Crew	323	16.1%
Sheltered Employment or Workshop	504	25.1%
Pre-vocational or Vocational Rehabilitation	21	1.0%
Day Training and Habilitation	209	10.4%
Other Job	28	1.4%
Private School	-	-
Public School	10	0.5%
Adult Education	31	1.5%
Other School	32	1.6%
Adult Day Program	506	25.2%
Volunteer Work	155	7.7%

[9] Module descriptions come from "Service Excellence Summary: Baseline Data Summary for Briefing," Center for Outcomes Analysis, May 2017

Day activity type	Number of participants in activity type	Unweighted percent of participants in activity
Other Day Activities	138	6.9%

The most common day activities across participants are Sheltered Employment or Workshop (26 percent), Adult Day Program (25 percent), and Enclave or Job Crew (16 percent); these activities are all considered potentially segregated settings. Additionally, 18 percent of participants reported being in some type of community-based employment, including competitive jobs (7.6 percent) or supported employment in a competitive job (10.5 percent). School settings were the least common, with only 33 participants in any type of school activity.

These activities are not mutually exclusive, and individuals can take part in one more day activities in a week. Approximately one-third of survey participants reported taking part in more than one activity.

Table 10: Average weekly hours by day activity type

Day activity type	Number of survey participants reporting hours	Average weekly hours
Self-Employed	1	1.0
Competitive Employment	145	18.4
Supported Employment	195	17.7
Enclave or Job Crew	295	18.9
Sheltered Employment or Workshop	483	21.6
Pre-vocational or Vocational Rehabilitation	21	16.5
Day Training and Habilitation	198	20.9
Other Job	27	17.1
Private School	-	-
Public School	10	25.8
Adult Education	28	12.7
Other School	30	8.1
Adult Day Program	490	19.9
Volunteer Work	138	4.4
Other Day Activities	129	5.9
All day activities	**1,565**	**20.6**

The average weekly hours across all day activities is 20.6 hours per week. Paid activities, which include any activities where individuals receive wages, held the highest average weekly hours (20.5 hours). While for individual settings, the highest average weekly hours were spent in Public School (25.8 hours), Sheltered Employment or Workshop (21.7 hours), Day Training and Habilitation (20.9 hours), and Adult Day Programs (19.9 hours).

Note that weekly hours were self-reported and may not reflect the actual time spent at each setting.

Table 11: Average weekly earnings by day activity type

Day activity	Number of survey participants reporting earnings	Average weekly earnings
Self-Employed Earnings	4	$222.02
Competitive Employment Earnings	113	$146.25
Supported Employment Earnings	151	$131.57
Enclave or Job Crew Earnings	190	$87.47
Sheltered Employment or Workshop Earnings	259	$63.01
Pre-vocational or Vocational Rehabilitation Earnings	8	$70.64
Day Training and Habilitation Earnings	114	$38.60
Other Job Earnings	20	$91.50
All paid activities	**816**	**$95.18**

More than 800 participants reported some earnings, including wages or piecework. Earnings are based on self-reported amounts and may not reflect actual earnings in all cases. If the participant did not know how much they earn, the field was left blank.

On average, participants earned $95 per week across all settings. Within this, weekly earnings were the highest in more integrated settings like Competitive Employment (where participants earned an average of $146 per week) and Supported Employment ($132 per week). More integrated settings also had higher average hourly earnings, between $7.30 and $7.60 an hour. Self-employment earnings were by far the highest on average, but only four participants reported earning money this way.

Weekly earnings in settings with the most people, including Enclave or Job Crew and Sheltered Employment or Workshop, were far lower on average, at $87 per week or $63 per week, respectively. This breaks down to $5.16 and $3.54 an hour.

The majority of participants who reported earning some or all wages through piecework (114 people total) were in Sheltered Employment and Day Training and Habilitation.

While the Self-Employment Earnings had the highest hourly wages by job type, only one person reported this job type earning. The highest average hourly wages by job type were in the Supported Employment Earnings and Pre-vocational or Vocational Rehabilitation Earnings, both averaging $7.60 an hour. Lowest average hourly wages were in Sheltered Employment or Workshop Earnings ($3.50) and Day Training and Habilitation Earnings ($3.30).

It is important to note that some participants reported a combination of hours and earnings in competitive employment that resulted in an hourly wage that is less than minimum wage. In addition, some people reported weekly earnings in excess of $1,000 or well below the expected wage for the activity type—either due to data entry error or because the participant responded with a value that was well out of range. These responses have not been removed from the preliminary analysis. These results are indicative of the challenges of using self-reported data

Table 12: Integration level by day activity type

Day activity type	Number of survey participants reporting integration level	Average integration level
Self-Employed	9	3.8
Competitive Employment	151	4.1
Supported Employment	213	3.3
Enclave or Job Crew	321	2.2
Sheltered Employment or Workshop	499	1.5
Pre-vocational or Vocational Rehabilitation	21	1.9
Day Training and Habilitation	204	1.4
Other Job	28	2.3
Private School	-	-
Public School	10	2.3
Adult Education	31	2.3
Other School	30	2.3
Adult Day Program	493	1.5
Volunteer Work	149	3.4
Other Day Activities	134	2.4
All Day Activities	**1,608**	**2.1**

The integration level tells us how much interaction participants have during their daily activities with people who do not have disabilities. A higher score indicates more interaction with the general population during the day, while a lower score indicates that people in that work setting are primarily interacting with other individuals with disabilities. An integration score of 3 is right between segregated and integrated, indicating some level of interaction with people who do not have disabilities. A score below 3 indicates activities are mostly or completely in segregated settings.

Integration scores (the average integration levels for each day activity) are highest in the more integrated activities such as competitive employment (4.1), self-employment (3.8), volunteer work (3.4), and supported employment (3.3). In contrast, integration is lowest in Day Training and Habilitation (1.4), Sheltered Employment or Workshops (1.5), and Adult Day Programs (1.5).

The finding that people in more integrated settings have more interaction with people without disabilities is consistent with other research. However, these scores are still significantly lower than in previous studies in other states, and indicate a level of segregation in the community-based settings[10].

Community Integration and Engagement: Integrative Activities Scale

Participants described the number of times they did each of a list of activities in the past four weeks. Activities included visits with friends, relatives, or neighbors, and trips to a grocery store, restaurant, place of worship, mall, or sports event. Participants also shared the average group size with which they

[10] "Service Excellence Summary: Baseline Data Summary for Briefing" COA, May 2017

did this activity, and how often trips of each type typically included interaction with community members not in the "disability system."

Table 13: Average monthly outings by outing type

Outing type	Number of survey participants	Average number of outings
Visit with close friends, relatives or neighbors	1,629	9.6
Go to a grocery store	1,425	4.0
Go to a restaurant	1,608	3.7
Go to a place of worship	832	3.6
Go to a shopping center, mall or other retail store to shop	1,671	3.6
Go to bars, taverns, night clubs, etc.	189	2.2
Go to a movie	820	1.7
Go to a park or playground	932	4.9
Go to a theater or cultural event (including local school & club events)	393	1.7
Go to a library	646	3.3
Go to a sports event	451	2.1
Go to a health or exercise club, spa, or center	466	6.1
Use public transportation (May be marked "N/A")	564	15.0
Other 1	664	5.6
Other 2	196	5.9
Other 3	43	7.9
Other 4	13	9.4
All outings	**1,969**	**31.9**

Participants averaged 32 outings per month, which is lower than the general population (46 outings outside the house per month not counting work[11]).

The most commonly reported activities were shopping (1,671 participants), visiting friends, relatives, or neighbors (1,629 participants), and going to a restaurant (1,608 participants). The least common activities reported were going to bars (189 participants), going to a theater or cultural event (393 participants), and going to a sports event (451 participants).

Nearly three out of four participants reported five or more different types of outings in the previous month. On average, participants reported visiting friends, relatives, or neighbors 9.6 times in the previous four weeks, going to a health or exercise club 6.1 times and going to a park or playground 4.9 times. The "other" categories were added to capture common outing types that may be unique to Minnesota. Common responses may be used to suggest new outing types or be integrated into existing categories during follow up analysis. Frequent responses included participating in sports or physical activities, bingo or other games, and attending group activities such as self-help or arts and crafts groups.

[11] "Service Excellence Summary: Baseline Data Summary for Briefing" COA, May 2017

Table 14: Average group size by outing type

Outing type	Number of participants reporting group size	Average group size
Visit with close friends, relatives or neighbors	1,568	4
Go to a grocery store	1,395	3
Go to a restaurant	1,565	4
Go to a place of worship	806	3
Go to a shopping center, mall or other retail store to shop	1,624	3
Go to bars, taverns, night clubs, etc.	184	3
Go to a movie	787	3
Go to a park or playground	903	4
Go to a theater or cultural event (including local school & club events)	376	4
Go to a library	628	3
Go to a sports event	436	4
Go to a health or exercise club, spa, or center	447	3
Use public transportation (May be marked "N/A")	544	3
Other 1	642	4
Other 2	189	4
Other 3	41	5
Other 4	13	4
All outing types	**1,951**	**3**

In general, participants reported small to medium group sizes for their outings, with an average group size of 3, the average group size for most outing types.

The largest average group sizes for the primary categories were groups of 4 to sporting events and cultural events. The average group sizes for the "other" outing types ranged from 4 to 5. These outings included a variety of outing types including: participating in sports or physical activities, bingo or other games, and attending group activities such as self-help or arts and crafts groups. Many of these outings will be reclassified, either into existing categories or as new categories, for the Phase 2 analysis.

It is important to note that research suggests large group sizes (five or more people) can be stigmatizing. However, this group size does not differentiate between a group of people with disabilities or a mixed group. When estimating group size, many participants said things like "me and my family" or "me and my friends" for these group outings.

Table 15: Interactions by outing type

Outing type	Number of participants	Average integration level
Visit with close friends, relatives or neighbors	1,592	2.7
Go to a grocery store	1,404	2.5
Go to a restaurant	1,576	2.5
Go to a place of worship	815	3.3

Outing type	Number of participants	Average integration level
Go to a shopping center, mall or other retail store to shop	1,642	2.5
Go to bars, taverns, night clubs, etc.	188	3.1
Go to a movie	798	2.1
Go to a park or playground	910	2.3
Go to a theater or cultural event (including local school & club events)	385	2.6
Go to a library	634	2.3
Go to a sports event	438	2.9
Go to a health or exercise club, spa, or center	453	2.7
Use public transportation (May be marked "N/A")	555	2.7
Other 1	649	3.1
Other 2	194	3.1
Other 3	43	3.0
Other 4	13	3.5
All outing types	**1,936**	**2.5**

Average values for community interaction raged from “A little” (2 on the scale) to “Some” (3 on the scale), with an overall average of 2.5. The types of activities with the most interaction included going to a place of worship (3.3), going to bars (3.1), and going to sports events (2.9). “Other” activities will be recoded and analyzed during follow up analysis. Only 188 participants reported going to bars, and 438 reported going to sporting events.

The activities with the lowest interaction were going to the movies (a score of 2.1), going to libraries (2.3), and parks (2.3).

Table 16: Outing interactions score (Minnesota baseline study)

Study	Participants with an outing interactions score	Outing interactions score
Minnesota baseline	631	45.5

Outing interactions is a measure based on the number of outings and the average interaction rating for those values, converted to a score of 100. A higher score indicates more interaction with community members across outing types. The score is converted to a 100-point scale based on the individual’s average interaction rating for each outing type. Scores are not calculated for individuals with fewer than eight outings. The 100-point scale is used for ease of interpretation by calculating the average interaction rating.

The average score of 45.5 may show people are not interacting much with other community members during their outings.

Decision Control Inventory

Individuals reported who made decisions around food, clothes, sleep, recreation, choice of support agencies, and more. This measure helps delineate paid (staff) versus unpaid (relatives, friends, advocates)

people's roles in decision-making. For example, individuals reported whether paid staff, unpaid allies, or they themselves decided what they could do with their relaxation time. If necessary, interviewers ask clarifying questions to determine if the people making decisions are paid staff or unpaid allies. Unpaid allies include relatives, friends, and advocates. Public guardians are considered paid staff.

Table 17: Decision Control Inventory scores (all items)

Decision Control Inventory item	Number of participants reporting rating	Average rating	Don't know (n)
What foods to buy for the home when shopping	1,928	2.9	34
What to have for breakfast	1,915	3.9	39
What to have for dinner	1,927	3.0	28
Choosing restaurants when eating out	1,823	3.9	117
What clothes to buy in store	1,933	4.3	20
What clothes to wear on weekdays	1,941	4.5	12
What clothes to wear on weekends	1,941	4.5	13
Time and frequency of bathing or showering	1,928	4.1	23
When to go to bed on weekdays	1,931	4.4	16
When to go to bed on weekends	1,932	4.5	14
When to get up on weekends	1,925	4.5	18
Taking naps in evenings and on weekends	1,889	4.7	47
Choice of places to go	1,887	3.6	53
What to do with relaxation time, such as choosing TV, music, hobbies, outings, etc.	1,916	4.6	20
Visiting with friends outside the person's residence	1,747	4.1	182
Choosing to decline to take part in group activities	1,817	4.5	101
Who goes with you on trips, errands, outings	1,854	3.1	78
Who you hang out with in and out of the home	1,831	4.3	98
Choice of Case Manager	1,547	1.8	386
Choice of agency's support persons/staff (N/A if family)	1,706	1.6	208
Choice of support personnel: option to hire and fire support personnel	1,687	1.5	231
What to do with personal funds	1,869	4.0	52
How to spend residential funds	685	2.2	955
How to spend day activity funds	563	2.8	1041
Choice of house or apartment	1,814	3.6	110
Choice of people to live with	1,788	2.2	136
Choice of furnishings and decorations in the home	1,865	3.8	60

Decision Control Inventory item	Number of participants reporting rating	Average rating	Don't know (n)
Type of work or day program	947	2.4	240
Amount of time spent working or at day program	1,046	2.0	268
Type of transportation to and from day program or job	1,178	1.5	273
Express affection, including sexual	1,773	4.5	145
"Minor vices" - use of tobacco, alcohol, caffeine, explicit magazines, etc.	1,773	4.4	136
Whether to have pet(s) in the home	1,737	2.7	177
When, where, and how to worship	1,790	4.7	118

Decision Control Inventory (DCI) scores below 3 indicate that decisions in that area are mostly made by paid staff, and scores above 3 indicate decisions are mostly made by the person and unpaid allies. A score of 3 indicates the decision is equally shared.

The results show most decisions (62 percent) are made by the person or unpaid allies.

Participants had the most decision-making control around how and with whom they spend their free time (4.6); what they wear (4.5); their sleeping schedules (4.5 to 4.7); and their worship behaviors (4.7). The fact that some of these items score near 5.0 indicates all or nearly all of the decisions are made by the person or their allies. Eight items had scores greater than 4.5 (halfway between “mostly unpaid” and “all unpaid”).

Paid staff had more decision-making power in areas that are related to service provision, finances, and staffing. For example, participants’ DCI scores for choice of case manager, support staff, and support personnel were low, ranging from 1.5 to 1.8. Similarly, their DCI scores for spending residential or day activity funds ranged from 2.2 to 2.8; their scores for deciding type of job or day program, number of hours, and how they get there were 1.5-2.4; and their DCI for choosing who to live with was scored 2.2.

There were high numbers of “don’t know” responses for decisions related to money and service provision, including decisions around residential funds (955), day activity funds (1,041), and choice of case manager (365). It is important to note items with high frequencies of ‘don’t know’ responses as areas for possible follow up.

Table 18: Decision Control Inventory module score

Study	Participants with Decision Control Inventory score	Baseline Decision Control Inventory score
Minnesota baseline	1,942	66.2

The DCI scores for individual items are interesting, but these measures can also be converted to a 100-point scale to measure overall power and control. A higher score on the overall DCI scale indicates a higher level of control. A very low score indicates possible oppression or domination. Previous studies

have demonstrated that all the items on this scare are related to the underlying concept of freedom to make choices without being controlled by providers.[12]

The score is converted to a 100-point scale based on the individual's average interaction rating for each item. Scores are not calculated for individuals who responded to fewer than 25 items. Individual scores are averaged for a community score on a scale of 0 to 100. The score is converted to a 100-point scale for ease of interpretation and to be consistent with previous studies.

Minnesota's average baseline score is 66.2 out of 100, which indicates participants and their unpaid allies have a moderate amount of decision making power.

Quality of Life inventory

Individuals reported whether their quality of life is good or bad in 14 different areas, including health, happiness, comfort, and overall quality of life. This measure captures the person's perspective about their quality of life. For example, individuals reported whether their privacy was good, bad, or somewhere in between.

Table 19: Quality of Life ratings (all items)

Item	Number of survey participants responding	Average rating	Don't Know (n)
Health	1,897	3.9	28
Running my own life, making choices	1,803	3.8	108
Family relationships	1,815	4.1	99
Relationships with friends	1,806	4.1	109
Getting out and getting around	1,838	3.9	66
What I do all day	1,860	4.0	45
Food	1,868	4.1	43
Happiness	1,877	4.1	31
Comfort	1,859	4.1	41
Safety	1,874	4.2	32
Treatment by staff/attendants	1,840	4.2	61
Health care	1,854	4.3	42
Privacy	1,838	4.2	55
Overall quality of life	1,851	4.1	44

This table shows participants' average scores for 14 questions about how they rate their quality of life in different areas on a scale of 1 (very bad) to 5 (very good). On average, participants said their quality of life was good in most areas (4 on the scale). The highest scores were in health care (4.3), safety (4.2), treatment by staff (4.2), and privacy (4.2).

[12] "Service Excellence Summary: Baseline Data Summary for Briefing" COA, May 2017

When asked about perceived quality in life, some participants did not know or were unable to answer about: relationships with friends (109 unable to answer); running own life and making choices (108); family relationships (99); getting out and getting around (66); privacy (53); and overall quality of life (41). It is important to note items with high frequencies of 'don't know' responses as areas for possible follow up.

In nearly all surveys (86 percent), each item was answered by the focus person, either by themselves or with support from staff or an ally. This is important because the scores capture the person's own perspective rather than how someone else perceives their quality of life. In eight percent of the surveys, all 14 questions were answered by someone other than the participant, indicating these surveys were completed by proxy with little to no input from the participant. Follow up analysis may include an exploration of the differences between surveys conducted with the individual and surveys conducted by proxy.

Table 20: Quality of Life module score

	Participants with a Quality of Life score	Baseline Quality of Life score
Quality of life score	1,904	76.6

Converting the individual quality of life items into a score out of 100 is helpful for understanding the overall results. A higher score indicates a higher overall quality of life. The score is converted to a 100-point scale based on the individual's average rating for each quality of life item. Scores are not calculated for individuals who responded to fewer than five items. The score is converted to a 100-point scale for ease of interpretation.

People who reported lower quality of life in the different areas received lower scores. These factors added to an individual's score on a scale of 0 to 100.

Minnesota's baseline score is 76.6. This is an important score to watch during follow-up surveys. Of 14 other large-scale studies using the Quality of Life Inventory, the highest baseline score was Maryland with 78.7; the lowest was Wisconsin with 44.7.[13]

Closest Relationships Inventory

Survey interviewers asked participants about their closest relationships. This included the type of relationship—relative, staff, housemate, co-worker, etc. A "close relationship" was anyone the person defined that way. Participants were asked about their five closest relationships; if the participant did not have any close relationships, it was noted as well.

Table 21: Number of close relationships reported (all participants)

Number of relationships reported	Number of survey participants responding	Unweighted percent of survey participants
1	96	5.0%
2	127	6.7%
3	227	11.9%

[13] "Service Excellence Summary: Baseline Data Summary for Briefing" COA, May 2017.

4	238	12.5%
5	1,171	61.6%
No close relationships	43	2.3%
Totals	**1,902**	**100%**

Nearly all of the participants could name at least one close relationship, with over half of participants listing five close relationships (62 percent). Only 43 participants said they did not have any close relationships. The remainder of the missing relationships are due to participants ending the survey before the closest relationships module. Those individuals were not included when calculating total possible relationships.

Table 22: Average number of relationships and total relationships reported (all participants)

Participants reporting relationships	Participants with no relationships	Average number of relationships reported	Total number of relationships reported	Possible relationships
1,859	43	4.2	7,838	9,510

After removing individuals who did not complete the module, the survey had a possible 9,510 relationships. Participants could think of 7,838 relationships; 82 percent of the possible relationships. On average, participants named 4.2 close relationships.
Another notable finding is the high number of people who could name at least one close relationship. Only 43 people could not name a single person.

Table 23: Closest relationships and relationship types (all participants)

Relationship Type	Number reporting closest relationship type	Unweighted percent
Co-worker or schoolmate	193	1.7%
Housemate (not family or significant other)	322	4.9%
Merchant	20	0.1%
Neighbor	82	0.6%
Other paid staff (case manager, nurse, etc.)	687	3.2%
Relative (includes spouse)	3,661	51.8%
Staff of day program, school, or job	480	4.5%
Staff of home	1,422	18.2%
Unpaid friend, not relative	2,947	15.0%
No relationship type listed	29	0.4%

Relatives were the most commonly reported relationship type (52 percent), followed by staff of any type (26 percent), and unpaid friends (15 percent). A relationship type was not provided for 29 of the relationships.

Participants reported a significantly high number of relationships with people who are neither paid nor relatives (22 percent). In comparison, two previous studies found that between 0 and 15 percent of relationships are unpaid friends.[14] This may be because we specifically asked about unpaid friends, which was not true in the previous studies. Another factor is the inclusion of people who are living in the community, a difference from previous studies.

Assistive technology

We also asked participants about assistive technology to learn how it helps those who use it, and why others do not use it. This information will help the State be more effective in connecting people to resources that meet their needs. Because these questions are new to this survey tool, no comparison data exist from previous COA studies.

Table 24: Participants who use assistive technology

Response	Number of participants	Unweighted percent
No	786	41.0%
No, but I need help doing certain tasks and would like to use assistive technology	37	1.9%
Yes, I have used it in the past	21	1.1%
Yes, I use it now	1,071	55.9%
Total	**1,915**	**100.0%**

More than half of the people use assistive technology and 1.9% of the people who are not currently using it would like to do so.

Table 25: How much difference has assistive technology made in increasing your independence, productivity, and community integration?

Response	Number of participants	Unweighted percent
A lot	371	34.9%
Some	253	23.8%
A little	201	18.9%
None	238	22.4%
Total	**1,063**	**100.0%**

Of the people who are using assistive technology, half (59 percent) said it helps them be more independent, more productive, and increases their integration into the community. However, 22 percent said that the assistive technology does not make a difference in increasing their independence, productivity or community integration.

[14] [14] "Service Excellence Summary: Baseline Data Summary for Briefing" COA, May 2017

Table 26: How much has your use of assistive technology decreased your need for help from another person?

Response	Number of participants	Unweighted percent
A lot	661	62.1%
Some	208	19.5%
A little	116	10.9%
None	80	7.5%
Some	208	19.5%
Total	**1,065**	**100.0%**

Of the people who are using assistive technology, 62 percent said it decreases their need for help from another person a lot. Most people (84 percent) said it decreases their need for help some or a lot. Only 8 percent said it did not help decrease their need for help at all.

Reasons people said they do not use assistive technology included: their provider or guardian did not support them using assistive technology, affordability, lack of knowledge or training about how to use the technology, and lack of knowledge about the availability of assistive technology. A few people mentioned that they do not want to use assistive technology.

Limitations

What was measured

Data listed in this report are a preliminary analysis and have not been weighted for non-response bias or other factors. The results should be viewed as a high-level analysis that will be refined in subsequent reports. The results reported in Phase 1 are not generalizable and only reflect the experiences of the participants.

The baseline survey findings included in this report need to be interpreted in context. Most significantly, these findings cannot be generalized for any populations other than people living and working in the eight settings that made up the survey sample. This means the findings do not speak to all people with disabilities in Minnesota.

Quality of life can be measured lots of ways, and this survey is one way to quantify it. While this survey provides good measures of general quality of life, it is limited to specific categories.

The baseline survey includes partially completed surveys. However, the majority of participants completed every module.

Non-response and declining to participate

A person's choice to participate in the survey may be associated with quality of life. People (or guardians on their behalf) also frequently declined taking the survey because of reasons related to the person's disability, including individuals who are non-verbal. Some guardians declined because they were either very happy or very unhappy with the services and did not see the value in participating. Sometimes,

guardians declined taking the survey on behalf of a participant and it was difficult to know if this was the participant's wish.

Some potential participants or their guardians declined to take the survey because, they said, they were happy with their services, and thought the survey was intended as a critique of services. Others declined to take the survey because they were unhappy with services, and believed that their feedback would not lead to change. Some potential participants or guardians said they were declining because of negative perception of the State or State agencies. Some guardians declined on behalf of potential participants because they thought they survey required verbal communication, and did not think the person could participate because of the person's communication style. The vendor worked to explain that the survey was designed to be completed by people with different communication styles.

Some guardians declined on behalf of potential participants because of their level of cognition, their state of health, or their level of focus and attention. The vendor worked to address the above barriers to participation, including offering the option of a by-proxy interview to the guardian in which the guardian or person of the guardian's choice completed the survey on the participant's behalf.

If an individual had a legal guardian, the vendor sent notification of selection to the guardian before contacting the participant. Analysis did not show substantially different participation rate when comparing guardian consents with participant consents.

Conducting the survey
Interviewers recorded participants' perceptions of their lives. This means self-reported data reflect the point of view of the individual being interviewed. While obviously inaccurate responses were omitted, results include other data that may not be exact, for example the group size for various outings.

Interviewers indicated that in many cases, someone other than the participant was involved in answering the survey questions. This included the use of proxies and of support staff or guardians clarifying as communication challenges arose. Some interviewers observed staff or guardians correcting or disagreeing with a participant's response, though staff or guardians rarely explicitly tried to influence answers. Participants with different communication styles answered questions through proxies, and interviewers worked to make participants the center of the conversation by asking them to nod to confirm proxies' answers or by advocating whenever possible for participants to answer themselves.

The most common difficulties around completing the survey were due to communicative or cognitive disabilities. In many cases when participants were bored, distracted, sleepy, or otherwise non-responsive, interviewers did not complete the survey. When one section of questions seemed to cause anxiety for the participant, interviewers used their own discretion to move to the next part of the survey to minimize harm.

Experiences from the field

The Olmstead Quality of Life Survey connected with 2,005 people with disabilities in a unique study. For many participants, the survey's accessibility, person-centeredness, and depth made it the first time they spoke at length about their quality of life.

Interviewers were asked to reflect on the survey process by filling out an optional post-survey debrief form. Roughly half of the interviews posted such a form. These post-survey observations recorded participants' demeanor, actions, and statements during the interviews. Themes from these forms illustrate how participating in the survey affected both participants and interviewers.

Participating in the survey affected many participants as it guided them through reflecting on the services they are or are not receiving. Participants who are happy with their current situation often experienced joy from completing the survey. Some also experienced satisfaction through interacting with interviewers or through the act of completing the survey itself. Others experienced sadness and expressed disappointment or frustration with their situation. Interviewers used their discretion in skipping sections that seemed to negatively affect participants, as in one case when the participant cried while reflecting on their unsatisfying living situation. This flexibility was part of the study's person-centered approach.

Interviewers were impacted as well, often empathizing with participants. Interviewers reported feelings ranging from happiness and care for the people they had interviewed to concern for their wellbeing. Some interviewers reflected on participants' actions and how it made them feel. They also recorded their enjoyment of meeting and going through the interview process with the participants. In some debrief forms, interviewers addressed what they thought was abuse or neglect, which was also reported through mandated channels.

The survey vendor intentionally hired many people with disabilities or with experience with this population as interviewers. Interviewers understood this community and field of work from their personal and professional lives. This led to increased trust from providers and other staff, whose support was key to obtaining survey responses.

Considerations for future work

Minnesota's Olmstead Plan envisions a state where people with disabilities live, learn, work, and enjoy life in the most integrated setting. To achieve this vision, systemic change is required in how State agencies make policies and interact with each other. Through the course of the Olmstead Quality of Life Survey, several policy and process issues were discovered. While these issues are not directly related to the survey outcomes, they still have a bearing on the successful, and full, implementation of the Olmstead Plan.

The items listed below are system-level issues that may need to be addressed to achieve the vision outlined in the Olmstead Plan. These items are not recommendations—they are simply issues that were uncovered during the survey implementation period and appear to be directly affected by the aims of the Olmstead Plan. These items are included in this report so that they are documented and can be referenced for future discussions.

Data quality

The success of this survey hinged on accurate records and accurate guardian contact information. While the clear majority of data received from State agencies was up-to-date, there were some issues to note:

- Guardian contact information is difficult to obtain and often outdated. Due to privacy protections, there is no central repository for guardian contact information. This leaves contact information held mostly by providers and case managers. Moreover, there is no strict requirement that guardians keep their contact information updated. This leaves a system where guardians can be unreachable or very difficult to contact.
- A number of the individuals interviewed in this survey receive services from more than one State agency. Through the course of collecting the individual-level data to develop the survey sample, several barriers were encountered:
    - State agencies have their own data systems, making it difficult to match records or resolve inconsistencies without detailed interagency agreements. While these separate systems protect data, they may hinder program efficiency and choice by making individuals interact with multiple agencies that operate under varying rules.
    - The vendor received excellent support from State agencies through the course of survey implementation. However, the difficulty in initially obtaining sample data and the isolated nature of data systems suggest that to truly achieve a person-centered approach, the State should remove walls between data systems and agencies to create a more integrated system of service.
- Definition of settings
    - The definition of the settings studied in this survey can be classified as political, meaning they are a mix of services classified in a particular way and are subject to change given certain rule or funding alterations. If changes do occur and services are re-classified, repeating the Quality of Life Survey will be difficult.

Next steps

This is the first phase of the baseline survey analysis. The second phase of analysis will provide outcomes by geography, setting, and disability type. The second phase will also attempt to account for any non-response bias that may be present. The Phase 2 analysis report will be released in 2018.

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Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Items:

6 (b) 2017 Annual Report on Olmstead Plan Implementation

Presenter:

Agency Sponsors and Leads

Action Needed:

☒ Approval Needed

☐ Informational Item (no action needed)

Summary of Item:

This is a draft of the Annual Report on progress of Olmstead Plan measurable goals. It provides a summary of progress on the Olmstead Plan measurable goals over the last year.

Attachment(s):

6b – 2017 Annual Report on Olmstead Plan Implementation

[AGENDA ITEM 6B]

Minnesota Olmstead Subcabinet

Annual Report on Olmstead Plan Implementation

REPORTING PERIOD

Data acquired through October 31, 2017

DATE REPORT REVIEWED BY SUBCABINET

December 18, 2017

Contents

I. PURPOSE OF REPORT

This Annual Report provides the status of work being done by State agencies to implement the Olmstead Plan. The Annual Report summarizes measurable goal results and analysis of data as reported in the previous four quarterly reports (February, May, August and November 2017).[1]

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 Annual Report dated December 18, 2017 includes data acquired through October 31, 2017. Progress on each measurable goal is reported when data is reliable and valid in order to ensure the overall report is complete, accurate, timely and verifiable. More details on the progress of the goals can be found in the quarterly reports.

This Annual Report includes Olmstead Implementation Office (OIO) compliance summary reports on status of workplans, and an analysis of trends and risk areas. The report also includes potential Plan amendments that are being considered as part of the ongoing Olmstead Plan amendment process.

EXECUTIVE SUMMARY

This Annual Report covers the fifty measurable goals[i] in the Olmstead Plan. As shown in the chart below, twenty-three of the annual goals were either met or are on track to meet the annual goal.[ii] Twenty of the annual goals were not met or not on track to meet the annual goals. For those twenty goals, the report documents how the agencies will work to improve performance on each goal. Ten goals are in process.

Status of Goals - 2017 Annual Report	Number of Goals
Met annual goal	20
On track to meet annual goal	3
Not on track to meet annual goal	1
Did not meet annual goal	16
In Process	10
Goals Reported	**50**

*The status for each goal is based on the most recent annual goal reported. Each goal is accounted for only once in the table.

[1] Quarterly Reports and other related documents are available on the Olmstead Plan website [www.Mn.gov/Olmstead].

There are a number of major activities that have been completed or are in process designed to make improvements in Olmstead Plan implementation this year.

- In October of 2017, the Olmstead Subcabinet completed the second comprehensive review of the Olmstead Plan workplans. The annual results of the review of workplans can be found on page 70 of this report. Of the 294 workplans reviewed this year, only 7 were reported as exceptions.
- The Subcabinet has initiated the second annual Olmstead Plan amendment process. This review will include multiple opportunities for people with disabilities and the public to review and offer suggestions. The process will be completed in March of 2018.
- During 2017, the Quality of Life Survey was initiated. This survey will establish a baseline. Subsequent surveys will use the baseline to measure progress on the Plan's impact on improving quality of life for people with disabilities. A preliminary report is due to be presented to the Subcabinet in December.

The following is a more detailed list of Plan accomplishments as well as goals needing more attention.

Progress on Movement of People with Disabilities from Segregated Settings to Integrated Settings

During this reporting period, people with disabilities continued to move from segregated to integrated settings. These movements are tracked in the following areas:

- More individuals are leaving Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) programs to more integrated settings. After three quarters, 143 individuals left ICF/DD programs to more integrated settings. This exceeds the annual goal of 84.
- More individuals are leaving nursing facilities for more integrated settings. After three quarters, 590 individuals moved from nursing facilities. This is 80% of the annual goal.
- More individuals are leaving other segregated settings to more integrated settings. After three quarters, 780 individuals moved from other segregated settings to more integrated settings. This exceeds the annual goal of 400.
- There is an increase in the number of individuals exiting the Anoka Metro Regional Treatment Center (AMRTC) in a timely fashion. The percent of individuals at the AMRTC who do not need a hospital level of care has trended down over the past three quarters.
- There is an increase in the number of individuals leaving the Minnesota Security Hospital (MSH) to a more integrated setting. Over the past two quarters, the average number of individuals leaving to a more integrated setting has increased.

More People are Accessing Waiver Services Timely

The Department of Human Services adopted reasonable pace goals and began measuring performance in 2015. Since then, data shows fewer people are waiting to access waiver services.

- Successful efforts to provide individuals access to the CADI waiver have prevented the need for a waiting list since October of 2016.
- There are fewer individuals waiting for access to a DD waiver. At the end of the most recently reported quarter there were 152 individuals waiting to access waiver services, compared to 237 the previous quarter.

Increasing System Capacity and Options for Integration

There continues to be increased capacity and options for integration in housing and employment. During this reporting period:

- More people gained access to integrated housing. There was an increase of 998 individuals accessing housing or 98% of the annual goal.
- There was an increase in the number of individuals obtaining competitive integrated employment. Over 2,066 individuals found employment exceeding the annual goal of 1,500.

The emergency use of manual restraint continues to decrease.

- Fewer people are experiencing emergency use of manual restraint. There was a reduction of 69 individuals or 9% from the previous year.

The following measurable goals have been targeted for improvement:

Goals below have been identified as not meeting projected targets. The agencies, OIO compliance staff, and the Subcabinet are providing increased oversight until projected targets are met.

- Transition Services Goal Four to increase the percent of individual's transition plans that meet the required person centered practices protocols.
- Waiting List Goal Three to eliminate the waiting list for persons in the Institutional Exit and Defined Need categories.
- Person-Centered Planning Goal One to increase the percent of individual's plans that meet the required protocols.
- Positive Supports Goal Three A to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Housing and Services Goal One to increase the number of individuals living in integrated housing.
- Lifelong Learning and Education Goal Two to increase the number of students with disabilities enrolling in an integrated postsecondary education setting.
- Crisis Services Goal Four A to increase the percent of people housed five months after being discharged from the hospital.

The Olmstead Plan is not intended to be a static document that establishes a one-time set of goals for State agencies. Rather, it is intended to serve as a vital, dynamic roadmap that will help realize the Subcabinet's vision of people with disabilities living, learning, working, and enjoying life in the most integrated settings. The dynamic nature of the Plan means that the Olmstead Subcabinet regularly examines the goals, strategies, and workplan activities to ensure that they are the most effective means to achieve meaningful change.

The ultimate success of the Olmstead Plan will be measured by an increase in the number of people with disabilities who, based upon their choices, live close to their friends and family as independently as possible, work in competitive, integrated employment, are educated in integrated school settings, and fully participate in community life. While there is much work to be done to achieve the goals of the Olmstead Plan, significant strides have been made in the last year. It is anticipated that future reports will include additional indicators of important progress towards these larger goals.

II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

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

ANNUAL SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

The table below indicates the number of individuals who moved from various segregated settings to integrated settings for the goals included in this section. The reporting period for each goal is based on the reporting period of the annual goal.

Net number of individuals who moved from segregated to integrated settings during the reporting period:		
Setting	Annual Reporting period	Number moved
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	July 2015 – June 2016	81
• Nursing Facilities	July 2015 – June 2016	729
• Other segregated settings	July 2015 – June 2016	1,051
• Anoka Metro Regional Treatment Center (AMRTC)	July 2016 – June 2017	110
• Minnesota Security Hospital (MSH)	January – December 2016	84
Net number who moved from segregated to integrated settings		2,055

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.

TRANSITION SERVICES GOAL ONE: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[iii] will be 7,138.

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 Baseline	June 30, 2015	June 30, 2016	June 30, 2017
A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84	84
B) Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740	740
C) Segregated housing other than listed above	1,121	50	250	400
Total	**1,900**	**874**	**1,074**	**1,224**

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

Annual Goals

- **2016 Goal:** For the year ending June 30, 2016 the number of people who have moved from ICFs/DD to a more integrated setting will be **84**
- **2017 Goal:** For the year ending June 30, 2017 the number of people who have moved from ICFs/DD to a more integrated setting will be **84**

Baseline: January - December 2014 = 72

RESULTS:
The 2016 goal was **not met**[2].
The 2017 goal is **on track**.

Time period	Total number of individuals leaving	Transfers[iv] (-)	Deaths (-)	Net moved to integrated setting
July 2014 – June 2015	138	18	62	58
July 2015 – June 2016	180	27	72	81
Quarter 1 (July – September 2016)	51	8	9	34
Quarter 2 (October – December 2016)	57	7	15	35
Quarter 3 (January – March 2017)	100	5	21	74
Totals (Q1 + Q2 + Q3)	208	20	45	143

[2] See Addendum to the May 2017 Quarterly Report for information on data adjusted after the February 2017 Quarterly Report. The 2016 goal previously reported as met (101 individuals) is now being reported as not met.

ANALYSIS OF DATA:
The 2016 goal of 84 was not met. From July 2015 – June 2016, the number of people moving from an ICF/DD to a more integrated setting was 81.

For the 2017 goal, during the first three quarters, 143 people moved from an ICF/DD to a more integrated setting which exceeds the annual goal of 84.

COMMENT ON PERFORMANCE:
DHS provides reports to counties about persons in ICFs/DD who are not opposed to moving with community services, as based on their last assessment. As part of the current reassessment process, individuals are being asked whether they would like to explore alternative community services in the 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.

A Person-Centered Planning, Informed Choice and Transition Protocol was approved by the Olmstead Executive Committee in February 2016. A revision including minor edits was approved by the Olmstead Subcabinet in March 2017. Trainings and presentations are being provided to increase education and technical assistance on housing subsidies, methods of working with landlords, and services available to do so, as well as different services that are available to support people as they move from an ICF/DD to an integrated setting.

DHS continues to work with private providers and Minnesota State Operated Community Services (MSOCS) that have expressed an interest in voluntary closures of ICFs/DD. A total of 11 out of 15 MSOCS ICFs/DD converted since January 2017, for a reduction of 66 state-operated ICF/DD beds. One additional ICF/DD facility, serving two people is scheduled to convert in November 2017. DHS is working with one county to determine whether the state or another provider will serve individuals in three more state-operated ICFs. No timeline for conversion of these homes has been confirmed.

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

Annual Goals

- **2016 Goal**: For the year ending June 30, 2016 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 **740**
- **2017 Goal**: For the year ending June 30, 2016 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 **740**

Baseline: January - December 2014 = 707

RESULTS:
The 2016 goal was **not met**[3].
The 2017 goal is **on track**.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
July 2014 – June 2015	1,043	70	224	749
July 2015 – June 2016	1,018	91	198	729
Quarter 1 (July – September 2016)	283	29	53	201
Quarter 2 (October – December 2016)	260	24	57	179
Quarter 3 (January – March 2017)	259	8	41	210
Totals (Q1 + Q2 + Q3)	802	61	151	590

ANALYSIS OF DATA:
The 2016 goal of 740 was not met. From July 2015 – June 2016, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 729.

For the 2017 goal, during the first three quarters, 590 people under the age of 65 moved to a more integrated settings. This is 80% of the annual goal of 740. If moves continue at approximately the same rate, the 2017 goal is on track to be met.

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

In July 2016, Medicaid payment for Housing Access Services was expanded across waivers. Additional providers are now able to enroll to provide this service. Housing Access Services assists people with

[3] See the Addendum to the May 2017 Quarterly Report for information on data adjusted after the February 2017 Quarterly Report. The 2016 goal previously reported as met (767 individuals) is now being reported as not met.

finding housing and setting up their new place, including a certain amount of basic furniture, household goods and/or supplies and payment of certain deposits.

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

This goal was established in 2015 using an interim measure. Progress on the 2015 goal was reported in the February 2016 Quarterly Report and 2016 Annual Report using the interim measure. The interim measure was the same data that was used to measure Housing and Services Goal One and included individuals who moved to integrated housing of their choice, where they have a signed lease, and receive financial support for the cost of housing. An interim baseline was established and approved by the Subcabinet on February 22, 2017 and is included below. In light of the new baseline, the 2015 goal is being reported again utilizing the new baseline. The 2016 and 2017 goals are also being reported.

Annual Goals

- **2015 Goal:** For the year ending June 30, 2015, the number of people who have moved from other segregated housing to a more integrated setting will be **50.**
- **2016 Goal** For the year ending June 30, 2016, the number of people who have moved from other segregated housing to a more integrated setting will be **250.**
- **2017 Goal**: For the year ending June 30, 2017 the number of people who have moved from other segregated housing to a more integrated setting will be **400.**

INTERIM BASELINE: During July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to a more integrated setting. A standardized informed choice process is being implemented. When data from this process is deemed reliable and valid, baseline and goals will be re-evaluated and revised as appropriate.

RESULTS:
The 2015 goal was **met**.
The 2016 goal was **met**.
The 2017 goal is **on track**.

		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**
July 2014 – June 2015	5,703	**1,137 (19.9%)**	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
July 2015 – June 2016	5,603	**1,051 (18.8%)**	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
Quarter 1 (July – September 2016)	1,254	**245 (19.5%)**	99 (7.9%)	790 (63%)	120 (9.6%)
Quarter 2 (October – December 2016)	1,313	**268 (20.4%)**	128 (9.8%)	817 (62.2%)	100 (7.6%)
Quarter 3 (January – March 2017)	1,463	**267 (18.2%)**	131 (9%)	936 (64%)	129 (8.8%)
Totals (Q1 + Q2 + Q3)	4,030	**780 (19.3%)**	358 (8.9%)	2,543 (63.1%)	349 (8.7%)

ANALYSIS OF DATA:
The 2015 goal of 50 was met. From July 2014 – June 2015, of the 5,703 individuals moving from segregated housing, 1,137 individuals (19.9%) moved to a more integrated setting.

The 2016 goal of 250 was met. From July 2015 – June 2016, of the 5,603 individuals moving from segregated housing, 1,051 individuals (18.7%) moved to a more integrated setting.

For the 2017 goal, during the first three quarters, 780 individuals moved to a more integrated setting which exceeds the annual goal of 400.

COMMENT ON PERFORMANCE:
There were significantly more individuals who moved to more integrated settings in the last 3 quarters (19.3%) than who moved to congregate settings (8.9%). This analysis also illustrates the number of individuals who are no longer on MA and who are not receiving residential services as defined below.

The data indicates that a large percentage (63.1%) 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)

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, 2019, the percent of people under mental health commitment at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[v] will be reduced to 30% (based on daily average). [Revised in February 2017]

Annual Goals

- **2017 Goal**: By June 30, 2017 the percent of people at AMRTC awaiting discharge will be **≤ 33%**
- **2018 Goal:** By June 30, 2018, the percent of people at AMRTC awaiting discharge will be **≤ 32%**

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.[4]

RESULTS:
The 2017 goal was **not met.**
The 2018 goal is **not on track.**

Time period	Percent awaiting discharge (daily average)	
July 2015 – June 2016	Daily Average = 42.5%[5]	
	Mental health commitment	Restore to competency
Quarter 1 (July – September 2016)*	40.5%	33.0%
Quarter 2 (October – December 2016)*	44.0%	35.1%
Quarter 3 (January – March 2017)	50.9%	28.8%
Quarter 4 (April – June 2017)	44.3%	20.3%
Annual Total (July 2016 – June 2017)	**44.9%**	**29.3%**
Quarter 1 (July – September 2017)	34.8%	28.2%

***Data for July – December 2016 was previously reported as a combined percentage for individuals under mental health commitment and under restore to competency. The goal was revised in February 2017 to include only those under mental health commitment. The data is now being reported separately for each group.

ANALYSIS OF DATA:
The 2017 goal of 33% was not met. From July 2016 – June 2017, 44.9% of those under mental health commitment at AMTRC no longer meet hospital level of care and were awaiting discharge to the most integrated setting.

For the 2018 goal, during the first quarter, 34.8% of those under mental health commitment at AMTRC no longer met hospital level of care and were awaiting discharge to the most integrated setting. The percentage of individuals awaiting discharge under restore to competency was 28.2%.

[4] The baseline included individuals at AMRTC under mental health commitment and restore to competency.
[5] The data for July 2015 - June 2016 included individuals at AMRTC under mental health commitment and restore to competency.

From July 2016 – June 2017, 110 individuals at AMRTC under mental health commitment left and moved to an integrated setting. An additional 30 individuals moved to an integrated setting in Quarter 1. The table below provides information about those individuals who left AMRTC. It includes the number of individuals under mental health commitment and under restore to competency who moved to integrated settings.

Time period	Total number of individuals leaving	Transfers	Deaths	Net moved to integrated setting	Moves to integrated setting by	
					Mental health commitment	Restore to competency
Quarter 1 (July - Sept 2016)	61	27	0	34	5	29
Quarter 2 (Oct - Dec 2016)	57	38	1	18	7	11
Quarter 3 (Jan - Mar 2017)	81	53	1	27	18	9
Quarter 4 (April – June 2017)	68	37	0	31	24	7
Annual Totals July 2016 – June 2017	**267**	**155**	**2**	**110**	**54**	**56**
Quarter 1 (July – Sept 2017)	65	35	0	30	**21**	9

COMMENT ON PERFORMANCE:
AMRTC continues to serve a large number of individuals who no longer need hospital level of care, including those who need competency restoration services prior to discharge. There is a higher percentage of individuals awaiting discharge under mental health commitment (34.8%) than those who are at AMRTC under restore to competency (28.2%). Multiple efforts may be contributing to the improvement in percentage of individuals awaiting discharge under mental health commitment from the previous quarter, including an increase in the frequency of collaborative meetings with county partners and improvements in AMRTC's treatment and discharge planning procedures. While the percentage of individuals awaiting discharge has declined, it is difficult to determine whether this is a trend.

It remains unclear why the percentage remains significantly higher for those under mental health commitment. One contributing factor for the growing difference in percentage for those awaiting discharge under restore to competency is the expansion of the Community Competency Restoration Program in St. Peter, allowing for the transfer of individuals at AMRTC who no longer meet hospital level of care criteria resulting in a reduction in the length of stay.

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

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

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

Ongoing efforts are facilitated to improve the discharge planning process for those served at AMRTC:

- Improvements in the treatment planning process to better facilitate collaboration with county partners. AMRTC has increased collaboration efforts to foster participation with county partners to aid in identifying more applicable community placements and resources for individuals awaiting discharge.
- Improvements in AMRTC's notification process for individuals who no longer meet hospital criteria of care to county partners and other key stakeholders to ensure that all parties involved are informed of changes in the individual's status and resources are allocated towards discharge planning.

In order to meet timely discharge, individual treatment planning is necessary for individuals under mental health commitment who no longer need hospital level of care. This can involve the development of living situations tailored to meet their individualized needs which can be a very lengthy process. AMRTC continues to collaborate with county partners to identify, expand, and develop integrated community settings.

DHS is convening a cross-division, cross-administration working group to improve the timely discharge of individuals at MSH and AMRTC to identify: barriers, current and future strategies, and any needed efficiencies that could be developed between AMRTC and MSH to support movement to community. Counties and community providers will be consulted and engaged in this effort as well. DHS will report back to the Olmstead Subcabinet on these efforts annually starting December 31, 2018.

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, 2019, the average monthly number of individuals leaving Minnesota Security Hospital to a more integrated setting will increase to 10 individuals per month. [Revised in February 2017]**

This goal was established in 2015 based on all discharges from Minnesota Security Hospital. The baseline, overall goal and annual goals were amended in the February 2017 Plan. Progress on the 2016 Goal was reported in the February 2017 Quarterly Report. In light of the revisions, the 2016 goal is being reported again utilizing the new annual goal. The 2017 goal is also being reported.

Annual Goals

- **2016 Goal**: By December 31, 2016 the average monthly number of individuals leaving to a more integrated setting will increase to **≥ 7**
- **2017 goal:** By December 31, 2017 the average monthly number of individuals leaving to a more integrated setting will increase to **≥ 8**

Baseline: From January – December 2014, the average monthly number of individuals leaving Minnesota Security Hospital (MSH) was 9 individuals per month.

RESULTS:
The 2016 goal was **met**.
The 2017 goal is **not on track**.

Time period	Total number of individuals leaving	Transfers [iv] (-)	Deaths (-)	Net moved to integrated setting	
January – December 2015	188	107	8	73	Average = 6.1
January – December 2016	184	97	3	84	Average = 7.0
Quarter 1 (January – March 2017)	45	22	3	20	Average = 6.7
Quarter 2 (April – June 2017)	51	27	3	21	Average = 7.0
Quarter 3 (July – September 2017)	52	28	1	23	Average = 7.7
Total (Q1 + Q2 + Q3)	148	77	7	64	Average = 7.1

ANALYSIS OF DATA:
The 2016 goal of ≥7 was met. From January – December, 2016, average monthly number of individuals leaving Forensic Services[6] to a more integrated setting was 7.0.

For the 2017 goal, in the first three quarters, average monthly number of individuals leaving Forensic Services to a more integrated setting was 7.1. Despite the increases in the last two quarters, this goal is not on track to meet the 2017 goal of 8 or more.

Beginning January 2017, Forensic Services began categorizing discharge data into three areas. These categories allow analysis surrounding continued barriers to discharge. The table below provides detailed information regarding individuals leaving Forensic Services, including the number of individuals who moved to integrated settings (under restore to competency, Mentally Ill and Dangerous (MI&D) committed, and Other committed).

[6] MSH includes individuals leaving MSH, Transition Services, Forensic Nursing Home, and the Competency Restoration Program at St Peter. These four programs are collectively referred to as Forensic Services.

Time period	Type	Total moves	Transfers	Deaths	Moves to integrated
January – December 2015	Restore to competency	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**
January – December 2016	Restore to competency	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**
Quarter 1 (Jan – March 2017)	Restore to competency	23	15	1	7
	MI&D committed	19	7	1	11
	Other committed	3	0	1	2
	Total	45	22	3	(Avg. 6.7) 20
Quarter 2 (April – June 2017)	Restore to competency	31	24	1	6
	MI&D committed	16	2	2	12
	Other committed	4	1	0	3
	Total	51	27	3	(Avg. 7.0) 21
Quarter 3 (July – Sept 2017)	Restore to competency	39	24	0	15
	MI&D committed	12	3	1	8
	Other committed	0	0	0	0
	Total	52	27	1	(Avg. 7.7) 23
Totals (Q1 + Q2 + Q3)	Restore to competency	93	63	2	28
	MI&D committed	47	12	4	31
	Other committed	7	1	1	5
	Total	**147**	**76**	**7**	**(Avg. 7.1) 64**

COMMENT ON PERFORMANCE:
MSH, Transition Services, Forensic Nursing Home, and the Competency Restoration Program (CRP) at St. Peter serve different populations for different purposes. Together the four programs are known as Forensic Services. DHS efforts continue to expand community capacity. In addition, Forensic Services continues to work towards the mission of Olmstead through identifying individuals who could be served in more integrated settings.

Legislation this past session increases the base funding to improve clinical direction and support to direct care staff treating and managing clients with complex conditions, some of whom engage in aggressive behaviors. The funding will enhance the current staffing model to achieve a safe, secure and therapeutic treatment environment.

MI&D committed and Other committed
MSH and Transition Services primarily serve persons committed as Mentally Ill and Dangerous (MI&D), providing acute psychiatric care and stabilization, as well as psychosocial rehabilitation and treatment services. The MI&D commitment is for an indeterminate period of time, and requires a Special Review Board recommendation to the Commissioner of Human Services, prior to approval for community-based placement (Minnesota Stat. 253B.18). MSH also serves persons under other commitments. Other

commitments include Mentally Ill (MI), Mentally Ill and Chemically Dependent (MI/CD), Mentally Ill and Developmentally Disabled (MI/DD).

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

- Individuals with Level 3 predatory offender designation;
- Individuals over the age of 65 who require either adult foster care, skilled nursing, or nursing home level care;
- Individuals with DD/ID with high behavioral acuity; and
- Individuals who are undocumented.

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

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

Restore to Competency

Individuals under competency restoration treatment, Minn. R. Crim. R. 20.01, may be served in any program at Forensic Services. Primarily CRP serves this population, and the majority of individuals are placed under a concurrent civil commitment to the Commissioner, as Mentally Ill. The limited purpose of CRP services is to restore a person's capacity to meaningfully participate in criminal proceedings, and his/her discharge is governed by the criminal court.

Competency restoration treatment may also be paired with a civil commitment of MI&D. These individuals would be served at MSH, and in rare circumstances Transition Services or the Forensic Nursing Home. For this report, the "Restore to Competency" category represents any individual who had been under court ordered competency restoration treatment, though not under commitment as MI&D (as transitions to more integrated settings for those under MI&D requires Special Review Board review and Commissioner's Order).

- All individuals at CRP competency entered the program under "treat to competency" orders.
- Forensic Services has expanded programming to individuals under "treat to competency", by opening a Community Competency Restoration Program in the St. Peter community.
- While AMRTC continues to provide care to those who may be under this legal status, individuals referred to CRP in St Peter are determined to no longer require hospital-level care.

DHS is convening a cross-division, cross-administration working group to improve the timely discharge of individuals at MSH and AMRTC to identify barriers, current and future strategies, and any needed

efficiencies that could be developed between AMRTC and MSH to support movement to community. Counties and community providers will be consulted and engaged in this effort as well. DHS will report back to the Olmstead Subcabinet on these efforts annually starting December 31, 2018.

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, 2018, 50% of people who transition from a segregated setting will engage in a person centered planning process that adheres to transition protocols that meet the principles of person centered planning and informed choice.

The Person-Centered Planning, Informed Choice and Transition Protocol was approved by the Subcabinet Executive Committee on February 10, 2016. A revision including minor edits was approved by the Olmstead Subcabinet in March 2017. When people express an interest and are making a transition, lead agency staff are required to apply the protocol. The first time data became available for this goal was July 2016. A new baseline was established and approved by the Subcabinet on February 27, 2017 and is included below.

Annual Goal

- **2017 Goal[7]:** By June 30, 2017, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person-centered planning and informed choice will increase to 30%.

Baseline: From July – September 2016, of the 31 transition cases reviewed, four cases (12.9%) adhered to transition protocols that meet the principles of person-centered planning and informed choice.

RESULTS:
The 2017 goal of 30% was **not met**.

Time period	Total number of cases reviewed (disability waivers)	Number of transition cases reviewed (disability waivers)	Number of cases meeting protocols	% of cases meeting protocols
Quarter 1 July – Sept 2016	289	31	4	12.9%
Quarter 2 Oct – Dec 2016	311	23	6	26%
Quarter 3 Jan – March 2017	386	27	2	7%
Quarter 4 April – July 2017	213	34	2	6%
Annual July 2016 – June 2017	1,199	115	14	**12.2%**

[7] Data was not available to measure progress on the 2016 goal.

ANALYSIS OF DATA:
The DHS Lead Agency Review implemented case file review protocols beginning July 2016 to monitor lead agencies implementation of the Person-Centered, Informed Choice and Transition Protocol. A sample of people who have been identified as having a transition in their living setting were added to the case file review.

During July 2016 – June 2017, DHS reviewed 1,199 case files through the lead agency review process to determine the percent of people choosing to move to a more integrated setting who have a plan that "adheres to transition protocols that meet the principles of person-centered planning and informed choice". Of these case files, 115 indicated a transition had occurred. Fourteen (12.2%) of the 115 case files met the criteria of person-centered planning and informed choice. The 2017 annual goal to increase to 30 percent of plans that adhere to transition protocol standards was not met.

COMMENT ON PERFORMANCE:
The Person-Centered, Informed Choice and Transition Protocols were initiated with lead agencies in July of 2016. Since the lead agency review looks at documentation completed up to 364 days prior to the site visit, reviews through the first three quarters of 2017 included plans that were written before the protocol was issued.

Since July 2016, the Lead Agency Review Team has made recommendations to each county visited on how to improve their person-centered practices. Counties are in varying stages on their person-centered journey. The recommendations encourage lead agencies to set expectations for the quality and content of support plans as well as to seek out and provide training for their staff on providing person-centered practices. This may involve changes in agency practices as well as changes to how agencies work with their community partners.

Beginning in January 2018, DHS will require individual remediation when lead agencies do not comply with the person-centered protocols. When findings from a case file review indicate that files do not contain all required documentation, the agency will be required to bring all cases into full compliance by obtaining or correcting the documentation. All corrections must be made within 60 days of the Lead Agency Review site visits. Corrective action plans will be required when patterns of non-compliance are evident.

DHS conducted regional day-long training and technical assistance sessions with counties and tribes during May through September 2017. Due to high demand, DHS has scheduled an additional five training sessions through December 2017. A supervisor tool kit is being developed to support counties, tribes and contracted case management providers in the oversight of plan development according to the protocol. The expectation is that the number of plans that adhere to the protocols will increase over time and during 2018.

Criteria used in case file reviews
The plan is considered to meet the person-centered protocols if all eight items below are present:
1. The support plan describes goals or skills that are related to the person's preferences.
2. The support plan includes a global statement about the person's dreams and aspirations.
3. Opportunities for choice in the person's current environment are described.
4. The person's current rituals and routines are described.
5. Social, leisure, or religious activities the person wants to participate in are described.

6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.
7. The person's preferred living setting is identified.
8. The person's preferred work activities are identified.

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 the person will 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.

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. MOVEMENT OF INDIVIDUALS FROM WAITING LISTS

This section reports progress on the movement of individuals from the home and community-based services waiting lists. A new urgency categorization system for the Developmental Disabilities (DD) waiver waiting list was implemented on December 1, 2015. The new 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.

WAITING LIST GOAL ONE: By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.

Baseline: As of May 30, 2015, the CADI waiver waiting list was 1,420 individuals.

2016 goal

- By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.

RESULTS:

The CADI waiting list remains at zero and is **on track** to stay at zero. CADI waiver services continues to show that no one is on the waiting list.

Time period	Number on CADI waiver waiting list at end of quarter	Change from previous quarter
April – June 2015	1,254	<174>
July – September 2015	932	<322>
October – December 2015	477	<455>
January – March 2016	193	<284>
April – June 2016	7	<186>
July – September 2016	0	<7>
October – December 2016	0	0
January – March 2017	0	0
April – June 2017	0	0
July – September 2017	0	0

ANALYSIS OF DATA:

As of October 1, 2016 the Community Access for Disability Inclusion (CADI) waiver waiting list was eliminated. As of September 30, 2017 the CADI waiver waiting list remains at zero.

COMMENT ON PERFORMANCE:

DHS will continue to monitor and report quarterly on any occurrence of individuals being placed on the CADI waiver waiting list. DHS will continue to monitor data and work with lead agencies to ensure that eligible individuals are allocated the CADI waiver and do not end up on the waiting list.

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.

WAITING LIST GOAL TWO: **By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.**

A new baseline was established and approved by the Subcabinet on May 22, 2017 and is included below.

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:
The goal is **in process**.

Time period: January – March 2017

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Still on waiting list
Leaving an Institution	31	22 (71%)	5 (16%)	4 (13%)
Immediate Need	90	60 (67%)	18 (20%)	12 (13%)
Defined Need	288	155 (54%)	52 (18%)	81 (28%)
Totals	409	237 (58%)	75 (18%)	97 (24%)

Time period: April – June 2017

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Still on waiting list
Leaving an Institution	36	15 (42%)	16 (44%)	5 (14%)
Immediate Need	117	63 (54%)	37 (32%)	17 (14%)
Defined Need	353	163 (46%)	127 (36%)	63 (18%)
Totals	506	241 (48%)	180 (35%)	85 (17%)

ANALYSIS OF DATA:
In the most recent quarter reported (April – June 2017), of the 506 individuals assessed for the Developmental Disabilities (DD) waiver, 241 individuals (48%) had funding approved within 45 days of the assessment date. In the previous quarter, of the 409 individuals assessed, 237 individuals (58%) had

funding approved within 45 days of assessment. Although there was a lower percentage of individuals with funding approved within 45 days in the last quarter reported, there was a smaller percentage who remained on the waiting list.

COMMENT ON PERFORMANCE:
Lead agencies receive monthly updates regarding the people who are on the DD waiver waiting list through a web-based system. Using this information, lead agencies can view the number of days a person has been on a waiting list 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 waiting list situations on an intermittent basis, requiring DHS to engage with each agency to resolve individual situations. When a waiting list issue arises, a lead agency may be unfamiliar with the reasonable pace funding requirement due to the infrequency of this issue at their particular agency. DHS continues to provide training and technical assistance to lead agencies as waiting list issues occur and has added staff resources to monitor compliance with reasonable pace goals.

While a smaller proportion of people moved off the waiting list at a reasonable pace, compared to the previous quarter, a higher percentage had funding approved overall. This quarter, 83 percent of people had funding approved, an increase from 76 percent during the previous quarter.

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

Waiting List Status
Below is a summary table with the number of people still on the waiting list as of the first day of April, July and October, 2017. Also included is the average and median days waiting of those individuals who are still on the waiting list. The average days and median days information was collected since December 1, 2015. This data does not include those individuals who had funding approved within the 45 days reasonable pace goal. The total number of people still on the waiting list as of October 1, 2017 (152) has decreased since July 1, 2017 (237).

Waiting List Status as of April 1, 2017

Category	Number of people on waiting list	Average days on waiting list	Median days on waiting list
Institutional Exit	13	91	82
Immediate Need	16	130	93
Defined Need	172	193	173
Total	201		

Waiting List Status as of July 1, 2017

Category	Number of people on waiting list	Average days on waiting list	Median days on waiting list
Institutional Exit	13	109	103
Immediate Need	26	122	95
Defined Need	198	182	135
Total	237		

Waiting List Status as of October 1, 2017

Category	Number of people on waiting list	Average days on waiting list	Median days on waiting list
Institutional Exit	12	136	102
Immediate Need	36	120	82
Defined Need	104	183	137
Total	**152**		

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.

WAITING LIST GOAL THREE: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a (b) and 256B.092, subdivision 12(b).

RESULTS:
The goal to eliminate the waiting list was **not met.**

INSTITUTIONAL EXIT CATEGORY

Time period	Number of people assessed	Still on waiting list at end of period
January – March 2016	14	1 (7%)
April – June 2016	31	9 (29%)
July – September 2016	20	7 (35%)
October – December 2016	29	5 (17%)
January – March 2017	31	4 (13%)
April – June 2017	36	5 (14%)

IMMEDIATE NEED CATEGORY

Time period	Number of people assessed	Still on waiting list at end of period
January – March 2016	93	10 (11%)
April – June 2016	126	10 (8%)
July – September 2016	100	14 (14%)
October – December 2016	89	7 (8%)
January – March 2017	90	12 (13%)
April – June 2017	117	17 (14%)

ANALYSIS OF DATA:
In the most recent quarter reported (April - June 2017), for persons in the Institutional Exit category, five individuals (14%) remained on the DD waiver waiting list at the end of the reporting period. For persons in the Immediate Need category, seventeen individuals (14%) remained on the DD waiver waiting list at the end of the reporting period. The goal to eliminate the waiting list for these two categories was not met.

COMMENT ON PERFORMANCE:
DHS focuses its technical assistance on approving waiver funding for persons in the Institutional Exit and Immediate Need categories. DHS directly contacts lead agencies if people in these categories have been waiting longer than 45 days. If this goal is not met, DHS continues to provide technical assistance to the lead agency to approve funding for persons in these categories.

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

The proportion of people in the Institutional Exit category who were still on the waiting list in this quarter remained relatively constant from previous quarters. The overall goal to eliminate the Institutional Exit and Immediate Need categories was not met. Demonstrating complete elimination of these categories is challenging as, because of the process used to screen new DD waiver recipients, most new recipients will appear on the waiting list prior to accessing the waiver. DHS plans to recommend updates to this goal during the Olmstead Plan amendment process to better define success as people in these two categories accessing waiver funding at a reasonable pace. Going forward, DHS will work with lead agencies to continue to approve funding according to the reasonable pace goals.

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.

WAITING LIST GOAL FOUR: **By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.**

RESULTS:
This goal is **in process**. DHS began collecting new DD waiting list data beginning December 1, 2015. As of the date of this report, three years have not passed since this implementation date. This data will be available in December 2018 and will be reported the next quarterly report following both the Annual Goal measurement date and a determination that the data is reliable and valid.

WAITING LIST GOAL FIVE: **By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.**

RESULTS:
This goal is **in process**.

DEFINED NEED CATEGORY

Time period	Number of people assessed	Still on waiting list
January – March 2016	217	74 (34%)
April – June 2016	323	102 (32%)
July – September 2016	285	88 (31%)
October – December 2016	257	65 (25%)
January – March 2017	288	81 (28%)
April – June 2017	353	63 (18 %)

ANALYSIS OF DATA:
In the most recent quarter reported (April – June 2017), for persons in the Defined Need category, 63 people (18%) out of 353 people remained on the DD waiver waiting list.

COMMENT ON PERFORMANCE:
DHS encourages lead agencies to approve funding for persons in the Defined Need category following approval of persons in the Institutional Exit and Immediate Need categories and as waiver budget capacity allows. If a lead agency makes a determination that it does not have sufficient capacity to approve funding for persons in the Defined Need category, DHS expects the lead agency to maintain a budget reserve of 3% or less, pursuant to Minnesota statute.

In this quarter, the proportion of people who were still on the waiting list in the Defined Need category decreased from the previous quarter.

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

The results for the 2016 National Core Indicator (NCI) survey for individuals with intellectual and developmental disabilities were published in June 2017. The national results of the NCI survey are available on their website at www.nationalcoreindicators.org. The Minnesota state reports are also available on the NCI website at www.nationalcoreindicators.org/states/MN. In Minnesota, 428 individuals were interviewed for the 2016 survey.

Summary of National Core Indicator Survey Results from Minnesota in 2015 - 2016

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

	2015 - 2016	
Question	**Yes**	**No**
Do you have a paid job in your community?	41%	59%
Would you like a job in the community	52%	48%
Do you like where you work?	92%	8%
Do you want to work somewhere else?	34%	66%
Did you go out shopping in the past month?*	92%	8%
Did you go out on errands in the past month?*	91%	9%
Did you go out for entertainment in the past month?*	83%	17%
Did you go out to eat in the past month?*	86%	14%
Did you go out for a religious or spiritual service in the past month?*	46%	54%
Did you participate in community groups or other activities in community in past month?	37%	63%
Did you go on vacation in the past year?	58%	42%
Did you have input in choosing your home?	56%	44%
Did you have input in choosing your roommates?	34%	66%
Do you have friends other than staff and family?	83%	17%
Can you see your friends when you want to?	77%	23%
Can you see and/or communicate with family whenever you want?	94%	6%
Do you often feel lonely?	11%	89%
Do you like your home?	89%	11%
Do you want to live somewhere else?	29%	71%
Does your case manager ask what you want?	89%	11%
Are you able to contact case manager when you want?	87%	13%
Is there at least one place you feel afraid or scared?	30%	70%
Can you lock your bedroom?	42%	58%
Do you have a place to be alone at home?	99%	1%
Have you gone to a self-advocacy meeting?	30%	70%

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

QUALITY OF LIFE SURVEY

The Quality of Life Survey Administration Plan is currently being implemented by The Improve Group. The survey is expected to include data from 2,000 surveys.

The Improve Group:

- Continues to obtain consent releases and schedule appointments
- Maintains communications with lead agencies and service providers and coordinated communications with OIO and the agencies
- Continues to interview individuals for the Quality of Life Survey
- Continues to strategically navigate through various barriers to obtain access and consents from guardianship services, guardians and providers
- Continues strategic outreach efforts in partnership with DHS and DEED to secure consents

Data as of October 25, 2017:

- More than 1,600 interviews have been completed
- 161 interviews have been scheduled

The OIO and the Improve Group are meeting weekly to provide support, troubleshoot problems, and monitor survey implementation.

December 2017 Update:

As of November 30, 2017, 2005 surveys were completed.

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.

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

The Person-Centered Planning, Informed Choice and Transition Protocol was approved by the Subcabinet Executive Committee on February 10, 2016. A revision including minor edits was approved by the Olmstead Subcabinet in March 2017. When people express an interest and are making a transition, lead agency staff are required to apply the protocol.

The first time data became available for this goal was July 2016. A new baseline was established and approved by the Subcabinet on February 27, 2017 and is included below.

Baseline: During the period July 2014 – June 2015, 38,550 people were served by disability home and community based services. From July – September 2016, of the 31 transition cases reviewed, four cases (12.9%) adhered to transition protocols that meet the principles of person-centered planning and informed choice.

Annual Goal

- **2017 Goal[8]:** By June 30, 2017, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person-centered planning and informed choice will increase to 30%.

RESULTS:
The 2017 goal of 50% was **not met.**

Time Period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)	Number of cases meeting protocols	Percent of cases meeting protocols
Quarter 1 July – Sept 2016	1,682	289	47	16.3%
Quarter 2 Oct – Dec 2016	2,030	311	57	18.3%
Quarter 3 Jan – March 2017	3,311	386	48	12.4%
Quarter 4 April – June 2017	1,357	213	15	7%
Annual July 2016 – June 2017	8,380	1,199	167	**13.9%**

[8] Data was not available to measure progress on the 2016 goal.

ANALYSIS OF DATA:
From June 2016 - July 2017, 1,199 files were reviewed. Of those files, 167 (13.9%) were identified as having plans that were person-centered. The 2017 goal of 50% was not met. Because different counties are reviewed each quarter, the change in percent from one quarter to the next does not mean the counties from the previous quarter are doing better or worse.

In July 2016, the DHS Lead Agency Review began monitoring lead agency implementation of the Person-Centered, Informed Choice and Transition Protocol[9]. Though lead agencies are responsible to ensure each person has a support plan that includes all required person-centered elements, the Lead Agency Review is focusing on key areas of the protocol.

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, eight were identified as being cornerstones of a person-centered plan. If all eight items are present, the plan is considered to meet the person-centered protocols.

The eight key areas are listed below.
1. The support plan describes goals or skills that are related to the person's preferences.
2. The support plan includes a global statement about the person's dreams and aspirations.
3. Opportunities for choice in the person's current environment are described.
4. The person's current rituals and routines are described.
5. Social, leisure, or religious activities the person wants to participate in are described.
6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.
7. The person's preferred living setting is identified.
8. The person's preferred work activities are identified.

Current DHS standard requires that **all eight** items are present in the support plan (or in supporting documents, i.e. assessment or case notes) held by the lead agency. If **one** of the eight items is missing, the support plan is considered as not meeting the protocols of a person-centered plan. The item most commonly missing is item two, "The support plan includes a global statement about the person's dreams and aspirations."

If the requirement for item 2 were not included in the calculation and only seven items were counted, the compliance for Quarter 4 would increase from 7% to 33%. DHS is evaluating the method for reporting data collected via the lead agency review process and whether the current way of requiring all eight items is an accurate reflection of what is happening in lead agencies. DHS will make recommendations during the Olmstead Plan amendment process of any changes necessary.

[9] A Person-Centered Planning, Informed Choice and Transition Protocol was approved by the Olmstead Executive Committee in February 2016. A revision including minor edits was approved by the Olmstead Subcabinet in March 2017.

Counties Participating in Audits*

July – September 2015	October – December 2015	January – March 2016	April – June 2016
1. Koochiching	7. Mille Lacs	13. Hennepin	19. Renville
2. Itasca	8. Faribault	14. Carver	20. Traverse
3. Wadena	9. Martin	15. Wright	21. Douglas
4. Red Lake	10. St. Louis	16. Goodhue	22. Pope
5. Mahnomen	11. Isanti	17. Wabasha	23. Stevens
6. Norman	12. Olmsted	18. Crow Wing	24. Grant
			25. Freeborn
			26. Mower
			27. Lac Qui Parle
			28. Chippewa
			29. Ottertail

July – September 2016	October – December 2016	January – March 2017	**April – June 2017**
30. Hubbard	38. Cook	44. Chisago	47. MN Prairie Alliance[10]
31. Cass	39. Fillmore	45. Anoka	48. Morrison
32. Nobles	40. Houston	46. Sherburne	49. Yellow Medicine
33. Becker	41. Lake		50. Todd
34. Clearwater	42. SW Alliance[11]		51. Beltrami

*Agencies visited are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS)

COMMENT ON PERFORMANCE:
The Person-Centered, Informed Choice and Transition Protocols were initiated with lead agencies in July of 2016. Since the lead agency review looks at documentation completed up to 364 days prior to the site visit, reviews through the first three quarters of 2017 included plans that were written before the protocol was issued.

Since July 2016, the Lead Agency Review Team has made recommendations to each county visited on how to improve their person-centered practices. Counties are in varying stages on their person-centered journey. The recommendations encourage lead agencies to set expectations for the quality and content of support plans as well as to seek out and provide training for their staff on providing person-centered practices. This may involve changes in agency practices as well as changes to how agencies work with their community partners.

Beginning in January 2018, DHS will require individual remediation when lead agencies do not comply with the person-centered review protocols. When findings from case file review indicate files did not contain all required documentation, the agency is required to bring all cases into full compliance by obtaining or correcting the documentation. All corrections must be made within 60 days of the Lead

[10] The MN Prairie Alliance includes Dodge, Steele, and Waseca counties.
[11] The SW Alliance includes Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock counties.

Agency Review site visits. Corrective action plans will be required when patterns of non-compliance are evident.

DHS conducted regional day-long training and technical assistance sessions with counties and tribes during May through September 2017. Due to high demand, DHS has scheduled an additional five training sessions through December 2017. A supervisor tool kit is being developed to support counties, tribes and contracted case management providers in the oversight of plan development according to the protocol. The expectation is that the number of plans that adhere to the protocols will increase over time and during 2018.

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.

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

A) INPUT INTO MAJOR LIFE DECISIONS

2016 Goal

- By 2016, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions to **50% or higher**

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

RESULTS:
The 2016 goal was **met**.

Time Period	Number Surveyed	Percent reporting they have input into major life decisions
2015 survey	400	44.3%
2016 survey	427	64%

ANALYSIS OF DATA:
The 2016 goal to increase to 50% or greater was met. The 2016 NCI survey results indicated that 64% of people reported they have input into major life decisions.

The 2017 goal will be reported after the 2017 NCI survey results become available.

COMMENT ON PERFORMANCE:
Significant gains were made regardless of what setting people live in (ICF/DD, community group residential setting, own home or parent/family home). That said, people living in ICFs/DD (61%) or community group residential setting (50%) were significantly less likely than those in their own (80%) or parent/family home (77%) to report having input into major life decisions.

The population surveyed in the 2016 survey included adults with Intellectual or Developmental Disabilities (I/DD) who get case management services and at least one other service.

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

B) INPUT IN EVERYDAY DECISIONS

2016 Goal

- By 2016, increase the percent of people with intellectual and developmental disabilities who report they make or have input in everyday decisions to **85% or higher**

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

RESULTS:
The 2016 goal was **met**.

Time Period	Number Surveyed	Percent reporting they have input in everyday decisions
2015 survey	400	84.9%
2016 survey	427	87%

ANALYSIS OF DATA:
The 2016 goal to increase to 85% or greater was met. The 2016 NCI survey results indicated that 87% of people reported they have input in everyday decisions.

The 2017 goal will be reported after the 2017 NCI survey results become available.

COMMENT ON PERFORMANCE:
The 2016 goal of 85% or greater was achieved regardless of living arrangement. People living with parents/family were the least likely to report control over everyday decisions (86%) compared with 92% of people who live in their own home or apartment. Eighty-eight percent of the people living in ICFs/DD and 89% of those living in community-based group residential settings report having input into everyday decisions. The population surveyed in the 2016 survey included adults with Intellectual or Developmental Disabilities (I/DD) who get case management services and at least one other service.

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

C) ALWAYS IN CHARGE OF THEIR SERVICES AND SUPPORTS

2016 Goal

- By 2016, increase the percent of people with disabilities other than I/DD who report they are always in charge of their services and supports to **75% or higher**

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

RESULTS:
The 2016 goal was **not met.**

Time Period	Number Surveyed	Percent reporting they are always in charge of their services and supports
2016 survey	1,962	72%

ANALYSIS OF DATA:
The 2016 NCI survey results indicated that 72% of people reported they are always in charge of their services and supports. The 2016 goal of 75% or greater was not met.

The 2017 goal will be reported after the 2017 NCI survey results become available.

COMMENT ON PERFORMANCE:
The population surveyed in the 2016 survey included adults with a physical disability as identified on a long-term services and supports assessment for Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), Brain Injury (BI) waivers, Home Care services or Developmental Disability screening document and who receive case management and at least one other service.

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

HOUSING AND SERVICES GOAL ONE: By June 30, 2019, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 5,547 (from 6,017 to 11,564 or about a 92% increase).

2017 Goal

- By June 30, 2017 the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease with a signed lease and receive financial support to pay for the cost of their housing will increase by 2,638 over baseline to **8,655** (about 44% increase)

Baseline: From July 2013 – June 2014, there were an estimated 38,079 people living in segregated settings. Over the 10 year period ending June 30, 2014, 6,017 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing. Therefore, 6,017 is the baseline for this measure.

RESULTS:
The 2017 goal to increase by 2,638 over baseline was **not met**.

Time period	People in integrated housing	Change from previous year	Increase over baseline
2015 Annual (July 2014 – June 2015)	6,920	+903	903 (15%)
2016 Annual (July 2015 – June 2016)	7,608	+688	1,591 (26.4%)
2017 Annual (July 2016 – June 2017)	8,606	+998	**2,589** (43%)

ANALYSIS OF DATA:
From July 2016 through June 2017 the number of people living in integrated housing increased by 2,589 (43%) over baseline to 8,606. Although the 2017 goal was not met, the increase of 2,589 was 98% of the annual goal. The increase in the number of people living in integrated housing from July 2016 to June 2017 was 998 compared to an increase of 688 in the previous year.

COMMENT ON PERFORMANCE:
Although the 2017 annual goal was not met, the result was larger than the previous year. A contributing factor to missing the goal may be the tight housing market. When there is a tight housing market, access to housing is reduced and landlords may be unwilling to rent to individuals with limited rental history or other similar factors.

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

EMPLOYMENT GOAL ONE: By September 30, 2019 the number of new individuals receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive, integrated employment will increase by 14,820.

2016 Goal

- By September 30, 2016, the number of new individuals with disabilities working in competitive, integrated employment will be **2,911**.

Baseline: In 2014, Vocational Rehabilitation Services and State Services for the Blind helped 2,738 people with significant disabilities find competitive, integrated employment.

RESULTS:
The 2016 goal was **met**.

	Number of Individuals Achieving Employment Outcomes		
Time period	Vocational Rehabilitation Services (VRS)	State Services for the Blind (SSB)	Total
October 2014 – September 2015	3,104	132	3,236
October 2015 – September 2016	3,115	133	**3,248**

ANALYSIS OF DATA:
The 2016 goal of 2,911 people with disabilities working in competitive integrated employment was met. From October 2015 – September 2016, 3,248 people with disabilities secured competitive integrated employment. This number represents an increase of 510 over the baseline.

COMMENT ON PERFORMANCE:
During October 2015 – September 2016, Minnesota's economy was strong. The health of the state's economy and the demand for qualified workers was a positive factor affecting the number of people with disabilities successfully achieving competitive integrated employment.

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

EMPLOYMENT GOAL TWO: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,015 or 10% in competitive, integrated employment.

A new baseline was established and approved by the Subcabinet on November 27, 2017 and is included below. This is the first quarterly report using the baseline.

2017 Goal

- By June 30, 2017, a data system will be developed to measure the following: the number of individuals who are working in competitive integrated employment; the number of individuals not working in competitive integrated employment; and the number of individuals not working in competitive integrated employment who would choose or not oppose competitive integrated employment.
- By June 30, 2017, the number of individuals in competitive integrated employment will increase by 1,500 individuals

Baseline: In 2014, there were 50,157 people age 18-64 who received services from one of the following programs: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD). Of the 50,157 total MA recipients, there were 6,137 in competitive integrated employment.

RESULTS:

- The 2017 goal to develop a data system is **in process**.
- The 2017 annual goal to increase by 1,500 over baseline was **met**.

MA Recipients (18 -64) in Competitive Integrated Employment (CIE)

Time period	Total MA recipients	Number in CIE ($600+/month)	Percent of MA recipients in CIE	Change from previous year	Increase over baseline
July 2013 – June 2014 (Baseline)	50,157	6,137	12.2%	--	--
July 2014 – June 2015	49,922	6,596	13.2%	459	459
July 2015 – June 2016	52,383	8,203	15.7%	1,607	2,066

ANALYSIS OF DATA:
The 2014 baseline was established as 6,137. As of June 2016 an additional 2,066 people in certain Medicaid programs are earning at least $600 a month as compared to baseline data. Most notably, the increase between June 2015 and June 2016 is more than three times greater than the increase between June 2014 and June 2015. The results from the first three reporting periods show strong progress towards an increase of 5,015 (10%) in the number people in competitive integrated employment by June 30, 2020.

The data reported is a proxy measure to track the number of individuals in competitive integrated employment from certain Medicaid programs and includes the number of people who have monthly earnings of over $600 a month. This is calculated by dividing the annual earnings of an individual (as reported by financial eligibility workers during re-qualification for Medicaid) by the number of months they have worked in a given fiscal year. The Olmstead Plan amendment process will incorporate that number into the baseline for this goal.

During development of the employment data dashboard in 2015, DHS tested the use of $600 a month as a proxy measure for competitive integrated employment. This was done by reviewing a random sample of files across the state. DHS staff verified that information from the data system matched county files and determined that when people were working and making $600 or more, the likelihood was they were in competitive integrated employment.

COMMENT ON PERFORMANCE:
Possible contributing factors to explain the increase in the number of people in certain Medicaid programs in competitive integrated employment include:

- ***Improving economy:*** During the same time period of this data, the overall unemployment rate in Minnesota fell from 4.2% in June of 2014 to 3.4% in June of 2016.[12]
- ***Increased awareness and interest:*** Providers and lead agencies are paying attention to the goals of people to work in competitive integrated employment.
- ***Implementation of the Workforce Innovation and Opportunities Act (WIOA)***: Signed into law in July 2014, this act amended Section 511 of the Rehabilitation Act and placed additional requirements on employers who hold special wage certificates to pay people with disabilities subminimum wages. In response to WIOA requirements, some employers may have increased wages to above minimum wage or some service providers may have put greater emphasis on services leading to competitive

[12] Minnesota Unemployment Statistics. Labor Market Information - Minnesota Department of Employment and Economic Development. Accessed September 27, 2017 https://mn.gov/deed/data/

integrated employment. During this time period, however, there was not a similar growth in employment among people with disabilities at the national level.[13]

- ***Interagency efforts to increase competitive integrated employment:*** During the time period of this data, DHS, DEED, and MDE have all made efforts to meet Minnesota's Employment First Policy and Olmstead Plan goals. This included interagency coordination and projects contained as part of the employment section of Minnesota's Olmstead Plan.

Moving Forward

Moving forward, DHS continues to work to ensure that all Minnesotans with disabilities have the option of competitive integrated employment. DHS seeks to meet its Olmstead Plan measurable goal and continuously improve efforts around employment. Part of these efforts include:

- ***Providing three new employment services in the Medicaid Home and Community Based Services (HCBS) waivers:*** Minnesota has submitted HCBS waiver amendments to CMS that would allow the state to offer three new employment services: Exploration, Development, and Support. These services will provide new options and resources behind competitive integrated employment.
- ***Improving communication to people with disabilities and training for service professionals:*** DHS will be undertaking several efforts in the coming year to improve its communication, training, and guidance around employment. These efforts include mailings to people receiving HCBS services, improvements in employment data dashboards, trainings for service professionals, and website updates.
- ***Releasing and implementing employment innovation grants:*** DHS is currently implementing innovation grants totaling $1.8 million to promote innovative ideas to improve outcomes for people with disabilities in the areas of work, living, and connecting with others in their communities. Additionally, over the next year, DHS will be selecting grant recipients for $2 million of grant money to provide innovation solutions for youth with disabilities to achieve competitive integrated employment.

Data Improvement

DHS seeks to continuously improve its data and measures around competitive integrated employment. These efforts will allow DHS to refine its proxy measure for competitive integrated employment to more completely capture the definition of competitive, integrated employment found in Minnesota's Employment First Policy.[14] Some of these efforts include:

- ***Informed Choice Data:*** DHS added Informed Choice Employment questions to both the MnCHOICES and Mental Health Information Systems (MHIS) to determine those working in competitive integrated employment, those not working, and those interested in Competitive Integrated Employment (CIE). DHS is in the process of analyzing and validating the data from both sources in order to integrate the information to get an unduplicated count of the number of individuals in CIE or wanting CIE. This new data is important because it will allow DHS to look at the provision of services and employment outcomes according to a person's informed choice decision about employment.

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[13] nTide Jobs Report: Steady Job Numbers May Signal Start of Turnaround for People with Disabilities. Accessed September 27, 2017 http://researchondisability.org/home/ntide/ntide-news-item/2016/04/01/ntide-jobs-report-steady-job-numbers-may-signal-start-of-turnaround-for-people-with-disabilities

[14] Minnesota's Employment First Policy is available at: http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_190416.pdf

- ***Employment Data Dashboards:*** DHS is refining dashboards to display employment outcome information for people in certain Medicaid programs. As part of these efforts, DHS is looking at the "employer of record" for people earning wages to help greater clarify who is employed through competitive employers and who is employed through special, subminimum wage certificate holders. Currently this is a manual process for validating the "employer of record".
- ***Interagency Data Sharing and Coordination:*** DHS is working with MDE and DEED to share and create consistency across the employment data in each agency. These efforts are included in the Olmstead Plan workplans.

EMPLOYMENT GOAL THREE: **By June 30, 2020, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive, integrated employment will be 763.**

2017 Goal

- By June 30, 2017, the number of additional students with Developmental Cognitive Disabilities (DCD) in competitive integrated employment will be **188**.

Baseline: 2014 group total in competitive, integrated employment = 313 (35%) (N=894)

RESULTS: The 2017 goal of 188 was **met**.

Time Period	Number of students with DCD, ages 19-21 that enter into competitive integrated employment
October 2015 to June 2016	137
October 2016 to June 2017	192

ANALYSIS OF DATA:

The 2017 goal of 188 students in competitive integrated employment was met. During the 2016 - 2017 school year, 192 students (105 males and 87 females) ranging in ages from 19-21 with developmental cognitive disabilities, participated in competitive integrated employment. All students worked part-time because their primary job is that of being a secondary student. Students were employed in a variety of businesses with wages ranging from $9.50 to $14.00 an hour. Students received a variety of supports including: employment skills training, job coaching, interviewing skill development, assistive technology, job placement and the provision of bus cards.

COMMENT ON PERFORMANCE:

In the fall of 2016, sixteen local education agencies continued to be a part of the Employment Capacity Building Cohort (ECBC). Three additional local education agencies joined in October due to interest from their local Special Education Director. ECBC teams participated in multiple capacity building trainings.

Local ECBC Teams met and exceeded the competitive, integrated 2017 employment goal. Teams used multiple evidence-based strategies learned from the capacity building sessions. Strategies included: Career Planning using the Minnesota Career Information System, Pre-Employment Transition Services and Limitations on the use of Subminimum Wages under WIOA, using resources within DB101 such as estimator sessions, Informed Choice Conversation and Informed Choice Toolkit materials and learned about essential job development strategies. The local ECBC teams are ensuring that students with DCD, ages 19-21 have choices and opportunities for competitive, meaningful, and sustained employment in the most integrated setting before exiting from secondary education. Many of the 2015-2017 ECBC

teams have expressed interest in continuing in the cohort model. Three additional district teams will be invited to the ECBC for the 2017-2019 school years.

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

EMPLOYMENT GOAL FOUR: By December 31, 2019, the number of Peer Support Specialists who are employed by mental health service providers will increase by 82. [New in February 2017]

2017 Goal

- By December 31, 2017, the number of employed peer support specialists will increase by 14

RESULTS:
This goal is **in process**. The first report on progress for this goal will be reported in the next quarterly report following both the Annual Goal measurement date and a determination that the data is reliable and valid.

EDUCATION GOAL ONE: By December 1, 2019 the number of students with disabilities[vi], receiving instruction in the most integrated setting[vii], will increase by 1,500 (from 67,917 to 69,417)

2015 Goal

- By December 1, 2015 the number of students receiving instruction in the most integrated settings will increase by **300** over baseline to **68,217**

Baseline: In 2013, of the 109,332 students with disabilities, 67,917 (62.11%) received instruction in the most integrated setting.

RESULTS:
The 2015 goal was **met**.

Time Period	Students with disabilities in most integrated setting	Total number of students with disabilities (ages 6 – 21)
January – December 2014	68,434 (62.1%) (517 over baseline)	110,141
January – December 2015	69,749 (62.1%) (1,832 over baseline)	112,375

ANALYSIS OF DATA:
The 2015 goal of an increase of 300 to 68,217 was met. During 2015, the number of students with disabilities receiving instruction in the most integrated setting increased by 1,832 over baseline to 69,749. Although the number of students in the most integrated setting increased, the percentage of students in the most integrated setting when compared to all students with disabilities ages 6 – 21 remains unchanged from the previous year due to an increase in the total number of students with disabilities.

COMMENT ON PERFORMANCE:
MDE will continue the expansion of Positive Behavioral Interventions and Supports (PBIS) and implementation of Regional Low Incidence Disability Projects (RLIP) using a combination of access to qualified educators, technical assistance and professional development to increase the number of students with disabilities, ages 6 – 21, who receive instruction in the most integrated setting.

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.

EDUCATION GOAL TWO: By June 30, 2020, the number of students who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase by 425 (39%) (from 2,174 to 2,599). [Revised in February 2017[15]]

2017 Goal

- By June 30, 2017 there will be an increase of 100 (34%) over baseline to 2,274.

Baseline: Using the 2014 Minnesota's Statewide Longitudinal Education Data System (SLEDS), of the 6,749 students with disabilities who graduated statewide in 2014, a total of 2,174 (32.2%) attended an integrated postsecondary institution from August 2014 to July 2015.

RESULTS:
The 2017 goal was **not met**.

Time Period	Students graduating	Students entering an accredited institution of higher education	Change from baseline
2014 SLEDS Data [Baseline] (August 2014 – July 2015)	6,749	2,174 (32.2%)	--
2015 SLEDS Data (August 2015 – July 2016)	6,747	2,154 (31.9%)	<20>

ANALYSIS OF DATA:
Of the 6,747 student with disabilities who graduated in 2015, there were 2,154 students (31.9%) who enrolled in an accredited institution of higher education in fall 2015, spring 2016, or both. This was a decrease of 20 students from the 2014 baseline.

COMMENT ON PERFORMANCE:
The SLEDS data that was available and used for this report did not include data provided by the Minnesota Office of Higher Education, and is not publicly accessible at the SLEDS website. In addition, MDE defines ideal performance as immediate enrollment in an accredited institution of higher education in the fall after graduation in the spring (as opposed to delayed enrollment) and the data used for this report includes spring enrollment data by students who delayed enrollment. MDE will propose

[15] This goal was amended in the Olmstead Plan February 2017 Revision and was first reported in the November 2017 Quarterly Report.

changes to this goal through the Olmstead Plan amendment process to use SLEDS data to be consistent in publicly reporting results.

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

EDUCATION GOAL THREE: **By June 30, 2020, 80% of students in 31 target school districts will meet required protocols for effective consideration of assistive technology (AT) in the student's individualized education program (IEP). Protocols will be based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.**

2016 Goal

- By December 31, 2016, pilot teams will establish a baseline and annual goals of the number of students for whom there is effective consideration of Assistive Technology.

RESULTS:
The 2016 goal to establish a baseline and annual goals was **met**. The proposed baseline and annual goals were approved by the Subcabinet on August 28, 2017.

Baseline:

- From October – December 2016, of the 28 students with IEPs, 26 (92.8%) had active consideration[16] of assistive technology in their IEP.

Time Period	IEP meetings held with AT team member present	Number of IEPs with active consideration of assistive technology	Percent
October 1, 2016 – December 31, 2016	28	26	92.8%

Annual Goals to increase the number of students in 31 target school districts whose IEP meet the required protocols for active consideration of AT:

- By June 30, 2018, increase to 94% of students whose IEP meet required protocols for active consideration of AT.
- By June 30, 2019, increase to 95% of students whose IEP meet required protocols for active consideration of AT.
- By June 30, 2020, increase to 96% of students whose IEP meet required protocols for active consideration of AT.

COMMENT ON PERFORMANCE:
Schools from around the state nominate teams of educators to engage in MDE's AT Teams Project. The AT Teams Project is a three-year cohort design that includes professional development. The AT Teams range in membership from four to six members, and include school administrators, general education

[16] The term "active consideration" more accurately reflects how the agency measures performance on this goal. An update will be made to the goal language "effective consideration" during the Plan amendment process.

teachers, special education teachers, and special education related services providers. Participants go on to serve as AT mentors and coaches in their districts.

AT Teams participate in annual face-to-face professional development and quarterly webinars to engage in coaching and to report on outcomes for their district specific action plans. Ongoing professional development includes self-analysis of current performance in eight areas of assistive technology, as defined by the Quality Indicators for AT (QIAT). View the QIAT community for AT professional's website (http://qiat.org/).

For the 2016-17 school year, 31 AT Teams participated in MDE's AT Teams Project. Seven of those teams were additional for setting the baseline data as they were funded under a fourth year of the project. Throughout the 2016-17 school year, individual AT Team members reported data from a sample of IEP team meetings in which they participated.

AT Teams will meet again in October 2017 in order to evaluate performance. For the 2017-18 school year, 16 AT Teams will continue into the second and third year training cohorts, and 8 new AT Teams will begin the first year cohort. MDE will provide additional data under the new annual goal set for June 30, 2018.

TRANSPORTATION GOAL ONE: **By December 31, 2020 accessibility improvements will be made to (A) 4,200 curb ramps (increase from base of 19% to 38%); (B) 250 Accessible Pedestrian Signals (increase from base of 10% to 50%); and (C) by October 31, 2021, improvements will be made to 30 miles of sidewalks. [Revised in February 2017]**

A) Curb Ramps

- By December 31, 2020 accessibility improvements will be made to 4,200 curb ramps bringing the percentage of compliant ramps to approximately 38%.

Baseline: In 2012: 19% of curb ramps on MnDOT right of way met the Access Board's Public Right of Way (PROW) Guidance.

RESULTS:
The goal is **on track** to meet the 2020 goal.

Time Period	Curb Ramp Improvements	PROW Compliance Rate
Calendar Year 2014	1,139	24.5%
Calendar Year 2015	1,594	28.5%

ANALYSIS OF DATA:
In 2015, the total number of curb ramps improved was 1,594, bringing the system to 28.5% compliance under PROW.

COMMENT ON PERFORMANCE:
In 2015, MnDOT constructed more curb ramps than in any other previous construction season, but the implementation of the plan remains consistent with required ADA improvements. Based on variations within the pavement program, it is anticipated that there will be seasons when the number of curb ramps installed will be lower.

B) Accessible Pedestrian Signals

- By December 31, 2019, an additional 250 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the percentage to 50%.

2016 Goal

- By December 31, 2016 an additional 50 APS installations will be provided.

Baseline: In 2009: 10% of 1,179 eligible state highway intersections with accessible pedestrian signals (APS) were installed. The number of APS signals was 118.

RESULTS:
The 2016 goal was **met** (using Calendar Year 2015 data).

Time Period	Total APS in place	Increase over previous year	Increase over 2009 baseline
Calendar Year 2014	523 of 1,179 APS (44%) of system	--	405
Calendar Year 2015	592 of 1,179 APS (50%) of system	69	474

ANALYSIS OF DATA:
In Calendar Year 2015, an additional 69 APS installations were provided. Based on the 2015 data, the 2016 goal to increase by 50 was met.

COMMENT ON PERFORMANCE:
MnDOT has already met its goal of 50% system compliance. MnDOT will propose measurable goal adjustments to the Subcabinet for provisional approval.

C) Sidewalks

- By October 31, 2021, improvements will be made to an additional 30 miles of sidewalks.

2017 Goal:

- By October 31, 2017, improvements will be made to an additional 6 miles of sidewalks.

Baseline: In 2012: 46% of sidewalks on MnDOT right of way met 2010 ADA Standards and Public Right of Way (PROW) guidance. Total sidewalk mileage is 613.8.

RESULTS:
This goal is **in process.**

Time Period	Sidewalk Improvements	PROW Compliance Rate
Calendar Year 2014	N/A	46%
Calendar Year 2015	12.41 miles	47.3%

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 TWO: By 2025, the annual number of service hours will increase to 1.71 million in Greater Minnesota (approximately 50% increase). [Revised in February 2017]

2017 Goal

- By December 31, 2017, the annual number of service hours will increase to 1,257,000

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

RESULTS:
This goal is **in process**. The first report on progress for this goal will be reported in the next quarterly report following both the Annual Goal measurement date and a determination that the baseline data is reliable and valid.

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

TRANSPORTATION GOAL THREE: By 2025, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access. [Revised in February 2017]

Transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT "Greater Minnesota Transit Investment Plan."[17]

2017 Goal

- A baseline for access will be established by April 30, 2017.

RESULTS:
The 2017 goal to establish a baseline was **met**. A new baseline was established using MnDOT data for access to transportation in Greater Minnesota. The baseline was approved by the Subcabinet on November 27, 2017. After consulting with the Olmstead Implementation Office (OIO) Met Council staff determined that the existing measurable goal does not adequately apply to transportation issues in the metropolitan area. The Met Council will be proposing a new goal related to transportation in the metropolitan area in the Olmstead Plan amendment process.

BASELINE:
In December 2016, the percentage of public transportation in Greater Minnesota meeting minimum service guidelines for access was 47% on weekdays, 12% on Saturdays and 3% on Sundays.

Percentage of public transportation meeting minimum service guidelines for access	
Weekday	47%
Saturday	12%
Sunday	3%

[17] Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transitinvestment.

ADDITIONAL INFORMATION

Minimum service guidelines for Greater Minnesota are established based on service population (see table below). In Greater Minnesota the larger communities are attaining the weekday span of service. Smaller communities (less than 7,500) are not yet meeting the weekday level of access in all instances. Very few transit systems in Greater Minnesota operate Saturday or Sunday Service. This is mainly due to limited demand for service.

Minimum Service Guidelines for Greater Minnesota[18]

Service Population	Number of Hours in Day that Service is Available		
	Weekday	Saturday	Sunday
Cities over 50,000	20	12	9
Cities 49,999 – 7,000	12	9	9
Cities 6,999 – 2,500	9	9	N/A
County Seat Town	8 (3 days per week)*	N/A	N/A

***As systems performance standards warrant**

COMMENT ON PERFORMANCE:

Each year in January the transit systems will be analyzed for the level of service they have implemented. Transit systems apply for funding on an annual basis. The applications take unmet needs into account. However, the actual service implemented can vary based on various factors including; lack of drivers and limited local funding share. The performance should increase as the span of service is established and the priority service expansion for transit systems is considered.

TIMELINESS OF DATA:

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

TRANSPORTATION GOAL FOUR: By 2025, transit systems' on time performance will be 90% or greater statewide. [Revised in February 2017]

2016 Goal

- In 2016, establish baseline and goals for on time performance for Greater Minnesota.

RESULTS:

The 2016 goal to establish baseline and goals was **met**. Baseline and goals for on time performance for Greater Minnesota were approved by the Subcabinet on February 22, 2017. They are included below in bold text.

Reliability will be tracked at the service level, because as reliability increases, the attractiveness of public transit for persons needing transportation may increase.

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
- **Greater Minnesota – 76% within a 45 minute timeframe**

[18] Source: MnDOT Greater Minnesota Transit Investment Plan, 2017

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
- **Greater Minnesota – improve to a 90% within a 45 minute timeframe**

HEALTH CARE GOAL ONE: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care[19] focusing specifically on cervical cancer screening, and follow up care for cardiovascular conditions will increase by 833 people compared to the baseline.

2016 Goal

- By December 31, 2016 the number accessing appropriate care will increase by **205** over baseline

Baseline: In 2013 the number of women receiving cervical cancer screenings was 21,393 and the number of individuals accessing follow up care for cardiovascular conditions was 1,589.

RESULTS:

The 2016 goal was **met**.

Time Period	Number receiving cervical cancer screenings	Change from previous year	Change from baseline
January – December 2013	21,393	Baseline Year	Baseline Year
January – December 2014	28,213	6,820	6,820
January – December 2015	29,284	1,071	7,891
January – December 2016	27,902	<1,382>	6,509

The beta blocker measure for follow up care for cardiovascular conditions is no longer reflective of current clinical practice and has been discontinued.

ANALYSIS OF DATA:

During calendar year 2016 the number of women with disabilities and/or serious mental illness who had a cervical cancer screening was 27,902. The 2016 annual goal to increase by 205 over baseline was met. The number accessing cervical cancer screenings increased steadily from the 2013 baseline through the 2015 reporting period. The number decreased from 29,284 in 2015 to 27,902 in 2016, a difference of 1,382. The December 31, 2018 overall goal to increase by 833 has already been reached.

COMMENT ON PERFORMANCE:

2014 changes in state law regarding Medicaid eligibility resulted in a large increase in overall Medicaid enrollment as compared to the 2013 baseline. DHS will continue to work on improving access and quality of preventive care for people with disabilities. DHS plans to recommend an additional health care measure during the Olmstead Plan amendment process.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

[19] Appropriate care will be measured by current clinical standards.

HEALTH CARE GOAL TWO: By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by (A) 1,229 children and (B) 1,055 adults over baseline.

A) CHILDREN ACCESSING DENTAL CARE

2016 Goal

- By December 31, 2016 the number of children accessing dental care will increase by 410 over baseline

Baseline: In 2013, the number of children with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 16,360.

RESULTS:
The 2016 goal was **met**.

Time period	Number of children with disabilities who had annual dental visit	Change from previous year	Change from baseline
January – December 2013	16,360	Baseline Year	Baseline Year
January – December 2014	25,395	9,035	9,035
January – December 2015	26,323	928	9,963
January – December 2016	25,990	<333>	9,630

ANALYSIS OF DATA:
During calendar year 2016 the number of children with disabilities who had an annual dental visit was 25,990. This was an increase of 9,630 over baseline. The 2016 annual goal to increase by 410 over baseline was met. There were significant gains between the 2013 baseline year and 2014 reporting period. The number of children with disabilities accessing dental care has leveled off and has not seen appreciable increases since 2014. The December 31, 2018 overall goal to increase by 1,229 has already been reached.

COMMENT ON PERFORMANCE:
2014 changes in state law regarding Medicaid eligibility resulted in a large increase in overall Medicaid enrollment as compared to the 2013 baseline. DHS plans to recommend an additional health care measure during the Olmstead Plan amendment process.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

B) ADULTS ACCESSING DENTAL CARE

2016 Goal

- By December 31, 2016 the number of adults accessing dental care will increase by 335 over baseline

Baseline: In 2013, the number of adults with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 21,393.

RESULTS:
The 2016 goal was **met**.

Time period	Number of adults with disabilities who had annual dental visit	Change from previous year	Change from baseline
January – December 2013	21,393	Baseline Year	Baseline Year
January – December 2014	52,139	30,746	30,746
January – December 2015	55,471	3,332	34,078
January – December 2016	51,410	<4,061>	30,017

ANALYSIS OF DATA:
During calendar year 2016 the number of adults with disabilities who had an annual dental visit was 51,410. This was an increase of 30,017 over baseline. The 2016 annual goal to increase by 355 over baseline was met. The number of adults accessing dental care increased steadily between the 2013 baseline period and the 2015 reporting period. The number decreased from 55,481 in 2015 to 51,410 in 2016, a difference of 4,071. It's important to note that the December 31, 2018 overall goal to increase by 1,055 has already been reached.

COMMENT ON PERFORMANCE:
2014 changes in state law regarding Medicaid eligibility resulted in a large increase in overall Medicaid enrollment as compared to the 2013 baseline.

DHS plans to recommend an additional health care measure during the Olmstead Plan amendment process.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it will be reported 8 months after the end of the reporting period.

POSITIVE SUPPORTS GOAL ONE: By June 30, 2018 the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will decrease by 5% or 200.

Annual Goal

- **2017 Goal**: By June 30, 2017, the number of people experiencing a restrictive procedure will be **reduced by 5% from the previous year or 49 individuals**

Baseline: In 2014 the number of individuals who experienced a restrictive procedure was 1,076.

RESULTS:
The 2017 goal was **met**.

Time period	Individuals who experienced restrictive procedure	Reduction from previous year
2015 Annual (July 2014 – June 2015)	867 (unduplicated)	209
2016 Annual (July 2015 – June 2016)	761 (unduplicated)	106
2017 Annual (July 2016 - June 2017)	**692 (unduplicated)**	**69**

ANALYSIS OF DATA:
The 2017 goal to reduce the number of people experiencing a restrictive procedure by 5% from the previous year or 49 individuals was met. From July 2016 to June 2017, the number of individuals who experienced a restrictive procedure decreased from 761 to 692. This was a 9% reduction of 69 from the previous year. It's important to note that the June 30, 2018 overall goal to reduce the number of people experiencing restrictive procedures by 200 has already been reached.

COMMENT ON PERFORMANCE:
DHS conducts further analysis regarding the number of individuals who experienced a restrictive procedure during the quarter. Each Quarterly Report includes the following information:

- The number of individuals who were subjected to Emergency Use of Manual Restraint (EUMR) only. Such EUMRs are permitted and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.
- The number of individuals who experienced restrictive procedures other than EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). DHS staff and the Interim Review Panel 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 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 External Program Review Committee conducted outreach to providers in response to EUMR reports. It is anticipated 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. The impact of this work toward reducing the number of EUMR reports will be tracked and monitored over the next several quarterly reports.

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, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596.**

Annual Goal

- **2017 Goal**: By June 30, 2017 the number of reports of restrictive procedures will be reduced by **388**.

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

RESULTS:
The 2017 goal was **met**.

Time period	Number of BIRF reports	Reduction from previous year
2015 Annual (July 2014 – June 2015)	5,124	3,478
2016 Annual (July 2015 – June 2016)	4,008	1,116
2017 Annual (July 2016 - June 2017)	**3,583***	**425**

***The annual total of 3,583 is greater than the sum of the four quarters or 3,521. This is due to late submissions of 62 BIRF reports of restrictive procedures throughout the four quarters.

ANALYSIS OF DATA:
The 2017 goal to reduce the number of reports of restrictive procedures by 388 was met. From July 2016 to June 2017, the number of restrictive procedure reports decreased from 4,008 to 3,583 or 425. It's important to note that the June 30, 2018 overall goal to reduce the number of reports people by 1,596 has already been reached.

COMMENT ON PERFORMANCE:
DHS conducts further analysis regarding the reports of restrictive procedures during the quarter. Each Quarterly Report includes the following information:

- The number of reports 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 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.

  - Beginning in May 2017, the External Program Review Committee conducted outreach to providers in response to EUMR reports. The impact of this work toward reducing the number of EUMR reports will be tracked and monitored over the next several quarterly reports.
- The number of reports that involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). 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 External Program Review Committee provides ongoing monitoring over restrictive procedures being used by providers with persons under the committee's purview. 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 uses of seclusion and the number of individuals involved.

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[viii], with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport).**

- **By December 31, 2019 the emergency use of mechanical restraints will be reduced to ≤ 93 reports and ≤ 7 individuals.**

2017 Goal: By June 30, 2017, reduce mechanical restraints to no more than:

A) **277** reports of mechanical restraint
B) **19** individuals approved for emergency use of mechanical restraint

Baseline: From July 2013 - June 2014, there were 2,038 (Behavior Intervention Reporting Form) BIRF reports of mechanical restraints involving 85 unique individuals.

RESULTS:
(A) The 2017 goal for number of reports was **not met**.
(B) The 2017 goal for number of individuals was **met**.

Time period	(A) Number of reports during the time period	(B) Number of individuals at end of time period
2015 Annual (July 2014 – June 2015)	912	21
2016 Annual (July 2015 – June 2016)	691	13
2017 Annual (July 2016 – June 2017)	**664***	**16**

***The annual total of 664 is greater than the sum of the four quarters or 648. This is due to late submissions of 16 BIRF reports of mechanical restraints throughout the four quarters.

ANALYSIS OF DATA:
This goal has two measures. One of the measures met the 2017 goal, and the second did not.

From July 2016 to June 2017, the number of reports of mechanical restraints was 664. Although the number of reports decreased by 27 from 2016, the 2017 goal to reduce the number of reports to 277 was not met.

At the end of the reporting period (July 2016 – June 2017), there were 16 individuals for whom the emergency use of mechanical restraints was approved. The 2017 goal to reduce the number of individuals approved to 19 was met.

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

These requests are reviewed by the External Program Review Committee (EPRC) to determine whether or not they meet the stringent criteria for continued use of mechanical restraints. The EPRC consists of members with knowledge and expertise in the use of positive supports strategies. The EPRC sends its recommendations to the DHS Commissioner's delegate for final review and either time-limited approval or rejection of the request. With all approvals by the Commissioner, the EPRC includes a written list of person-specific recommendations to assist the provider to reduce the need for use of mechanical restraints. In situations where the EPRC believes a license holder needs more intensive technical assistance, phone and/or in-person consultation is provided by panel members. Prior to February 2017, the duties of the ERPC were conducted by the Interim Review Panel.

DHS conducts further analysis regarding the number of reports of mechanical restraint and the number of individuals approved for the use of mechanical restraints and is included in each Quarterly Report.

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 FOUR: By June 30, 2020, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 318 students or decrease to 1.98% of the total number of students receiving special education services. [Revised in February 2017]

2016 Goal

- By June 30, 2016, the number of students experiencing emergency use of restrictive procedures will be reduced by **105**.

Baseline: Use of restrictive procedures in schools is prohibited, except in the case of an emergency. In 2014 the number of students who experienced at least one restrictive procedure in a school setting was 2,740.

RESULTS:
The 2016 goal was **not met**.

Time period	Students who experienced restrictive procedure	Change from previous year
2014-15 school year	2,779	+39
2015-16 school year	3,034	+255

ANALYSIS OF DATA:
The 2016 goal to reduce by 105 students was not met. Instead there was an increase of 255 students over baseline. Although the goal was not met, the average number of restrictive procedure per restricted student decreased. The full Minnesota Department of Education (MDE) report, "A Report on District's Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools" is available at: http://education.state.mn.us/MDE/about/rule/leg/rpt/rep17/

The restrictive procedure summary data is self-reported to MDE by July 15 for the prior school year. The data included for 2015-16 has been reviewed and clarified as needed. The data included all public schools, including intermediate districts, charter schools and special education cooperatives.

2015-16 school year:

- Physical holding was used with 2,743 students and seclusion was used with 848 students. These numbers differ from the data reported in the 2016 legislative report, which reported 2,541 physical holds and 840 seclusions.
- Compared to the 2014-15 school year, the average number of physical holds per physically held student was 5.7, down from 6.1; the average number of uses of seclusion per secluded student was 7.6, down from 7.8; and the average number of restrictive procedures per restricted student was 7.3, down from 8.0.
- School districts reported 147,360 students receiving special education services. Restrictive procedures were used with 3,034 of those students. The actual number of reported special education students increased by 7,375 from the 2014-15 school year. The percentage of students who experienced the use of a restrictive procedures slightly increased to 2.06 percent of the special education population for the 2015-16 school year.

While the number of students who have experienced the use of restrictive procedures has increased over the last two years, the percentage of students remained the same in 2014-15 and went up very slightly in 2015-16. This is due in part to better and more consistent data reporting by districts, and the increase in the number of students receiving special education services.

COMMENT ON PERFORMANCE:

- Prone restraint is now a prohibited procedure. It is believed that this caused an increase in the use of other restrictive procedures.
- The Restrictive Procedures stakeholder's work group (2016 Work Group) is focusing its attention on reducing the use of restrictive procedures, and specifically to eliminate the use of seclusion. Districts are in need of capacity building and the 2016 Work Group requested funding for the upcoming legislative session so students can remain in more inclusive settings. District staff need more tools to avoid the need for restrictive procedures.

- The requested funding in the 2017 legislative report would be used to provide resources so school districts can have experts observe and consult with students with behavioral needs to ensure effective and consistent programming is in place, and professional development of administrators and special education and general education direct providers on trauma informed practices. This will enable districts to reduce the number of students experiencing, and/or the frequency of use of, restrictive procedures. The 2017 legislature did not approve the funding request.
- The 2016 Work Group is moving forward to implement the 2016 statewide plan contained in the 2017 legislative report. The focus for the upcoming year is on problem solving with focus areas in data analysis, training, developing a framework for a Teacher Exchange program, and making resources available to school district administrators, staff, parent advocacy groups, and parents. The 2016 Work Group will also review the quarterly seclusion data as it works on the focus areas.
- In the 2016-17 school year, 43 new schools entered PBIS cohort training. This increases the active number of PBIS schools in the state to 576 (28% of MN schools). MDE staff will be reviewing the list of trained PBIS schools and cross referencing it with the list of schools that have reported use of restrictive procedures and will include this in future reports.
- An amendment to this goal was approved by the Subcabinet on February 22, 2017. The amended goal adjusted the annual goals to include a secondary measure to adjust for fluctuations in the number of students. Reporting on the amended goal will begin when the data is considered to be valid and reliable.

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

POSITIVE SUPPORTS GOAL FIVE: By June 30, 2020, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251 or by 0.8 incidents of restrictive procedures per student who experienced the use of restrictive procedures in the school setting. [Revised February 2017]

2016 Goal

- By June 30, 2016, the number of incidents of emergency use of restrictive procedures will be reduced by 750.

Baseline: In 2014, school districts (which include charter schools) reported to MDE that there were a total of 19,537 incidents which involved the emergency use of restrictive procedures occurring in schools.

RESULTS:
The 2016 goal was **not met**.

Time period	Number of Reports	Change from previous year
2014 – 15 school year	22,119	+2,582
2015 – 16 school year	22,028	-91

ANALYSIS OF DATA:
The 2016 goal to reduce by 750 incidents was not met. Instead there was a decrease of 91 emergency incidents of restrictive procedures from the previous year. The full MDE report, "A Report on District's Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools" is available at: http://education.state.mn.us/MDE/about/rule/leg/rpt/rep17/

The restrictive procedure summary data is self-reported to MDE by July 15 for the prior school year. The data included for 2015-16 has been reviewed and clarified as needed. The data included all public schools, including intermediate districts, charter schools and special education cooperatives.

2015-16 school year:

- Across the state, during the 2015-16 school year, school districts reported 15,584 physical holds and 6,425 uses of seclusion for a total of 22,028 restrictive procedures incidents.
- This was a decrease of approximately 0.4 percent from the 2014-15 school year reporting.
- The decrease occurred even though the total number of reported students with disabilities increased by 7,375 for the 2015-16 year.
- When comparing the data from the last two reporting periods, there has been a decrease in the use of restrictive procedures during the 2015-16 school year, and specifically, a reduction in the use of seclusion and an increase in the use of physical holds. This may be due in part to MDE's discussions with school districts to ensure that districts report a physical hold if one is used to escort a student (with more than minimal resistance) to seclusion.

COMMENT ON PERFORMANCE:
- Prone restraint is now a prohibited procedure. It is believed that this caused an increase on the use of other restrictive procedures.
- The Restrictive Procedures stakeholder's work group (2016 Work Group) is focusing its attention on reducing the use of restrictive procedures, and specifically to eliminate the use of seclusion. Districts are in need of capacity building and the 2016 Work Group requested funding for the upcoming legislative session so students can remain in more inclusive settings. District staff need more tools to avoid the need for restrictive procedures.
- The requested funding would be used to provide resources so school districts can have experts observe and consult with students with behavioral needs to ensure effective and consistent programming is in place, and professional development of administrators and special education and general education direct providers on trauma informed practices. This will enable districts to reduce the number of students experiencing and/or the frequency of use of restrictive procedures. The 2017 legislature did not approve the funding request.
- The 2016 Work Group is implementing the 2016 statewide plan contained in the 2017 legislative report. The focus for the upcoming year is on problem solving with focus areas in data analysis, training, developing a framework for a Teacher Exchange program, and making resources available to school districts administrators and staff and parent advocacy groups and parents. The 2016 Work Group will also review the quarterly seclusion data as it works on the focus areas.
- In the 2016-2017 school year, 43 new schools entered PBIS cohort training. This increases the active number of PBIS schools in the state to 576 (28% of MN schools). MDE staff will be reviewing the list

of trained PBIS schools and cross referencing it with the list of schools who have reported use of restrictive procedures and will include this in future reports.

- An amendment to this goal was approved by the Subcabinet on February 22, 2017. The amended goal adjusted the annual goals to include a secondary measure to adjust for fluctuations in the number of students. Reporting on the amended goal will begin when the data is considered to be valid and reliable.

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

CRISIS SERVICES GOAL ONE: By June 30, 2018, the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more.

Annual Goals

- **2017 Goal:** By June 30, 2017, the percent who remain in their community after a crisis will increase to **83%**

Baseline: In State Fiscal Year 2014 of 3,793 episodes, the child remained in their community 79% of the time.

RESULTS:
The 2017 goal is **on track**. [20]

Time period	Total Episodes	Community	Treatment	Other
2016 Annual (6 months data) January – June 2016	1,318	1,100 (83.5%)	172 (13.0%)	46 (3.5%)
Semi- annual July - December 2016	1,128	922 (81.7%)	142 (12.6%)	64 (5.7%)

- Community = emergency foster care, remained in current residence (foster care, self or family), remained in school, temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, residential treatment (Children's Residential Treatment).
- Other = children's shelter placement, domestic abuse shelter, homeless shelter, jail or corrections, other.

ANALYSIS OF DATA:
The 2017 goal is on track to meet the 83% goal. From July to December 2016, of the 1,128 crisis episodes, the child remained in their community after the crisis, 922 times or 81.7% of the time. The 2014 baseline measure included people from age 18 to 21. Under the new reporting system, the measure includes children ages birth to 17. People from age 18 to 21 are now included in the Crisis Services Goal 2 measure for adults.

[20] See Addendum to the November 2017 Quarterly Report for information on data adjusted after the May 2017 Quarterly Report.

COMMENT ON PERFORMANCE:
When children are served by mobile crisis teams, they are provided a mental health crisis assessment in the community and receive further help based on their mental health need. Once risk is assessed and a crisis intervention is completed, a short term crisis plan is developed to assist the individual to remain in the community, if appropriate.

Mobile crisis teams focus on minimizing disruption in the life of a child during a crisis. This is done by utilizing a child's natural supports the child already has in their home or community whenever possible. DHS has worked with mobile crisis teams to identify training opportunities that would help increase their capacity to address the complexities they are seeing and has committed to providing trainings in identified areas specific to crisis response. This increases the teams' ability to work with individuals with complex conditions/situations effectively.

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.

CRISIS SERVICES GOAL TWO: By June 30, 2019, the percent of adults who receive adult mental health crisis services and remain in their community (e.g., home or other setting) will increase to 64% or more. [Revised in February 2017]

Annual Goals

- **2017 Goal:** By June 30, 2017, the percent who remain in their community after a crisis will increase to 60%

Baseline: From January to June 2016, of the 5,206 episodes, for persons over 18 years, the person remained in their community 3,008 times or 57.8% of the time.

RESULTS:

- The 2017 goal is **not on track**. [21]

Time period	Total Episodes	Community	Treatment	Other
Annual Goal (6 months data) January – June 2016	5,436	3,136 (57.7%)	1,492 (27.4%)	808 (14.9%)
Semi-annual July – December 2016	5,554	3,006 (55.2%)	1,657 (29.8%)	831 (15.0%)

- Community = remained in current residence (foster care, self or family), temporary residence with relatives/friends.
- Treatment = chemical health residential treatment, emergency department, inpatient psychiatric unit, residential crisis stabilization, intensive residential treatment (IRTS)
- Other = homeless shelter, jail or corrections, other.

[21] See Addendum to the November 2017 Quarterly Report for information on data adjusted after the May 2017 Quarterly Report.

ZANALYSIS OF DATA:
The 2017 goal is not on track to meet the 60% goal. From July to December 2016, of the 5,554 episodes, the person remained in their community 3,006 times or 55.2% of the time. This is a decrease from the baseline.

COMMENT ON PERFORMANCE:
When individuals are served by mobile crisis teams, they are provided a mental health crisis assessment in the community and receive further help based on their mental health need. Once risk is assessed and a crisis intervention is completed, a short term crisis plan is developed to assist the individual to remain in the community, if appropriate. Mobile crisis teams focus on minimizing disruption in the life of an adult during a crisis by utilizing the natural supports an individual already has in their home or community for support whenever possible. DHS has worked with mobile crisis teams to identify training opportunities that would help increase their capacity to address the complexities they are seeing and has committed to providing trainings in identified areas specific to crisis response. This increases the teams' ability to work with more complex clients/situations effectively.

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.

CRISIS SERVICES GOAL THREE: By June 30, 2017, the number of people who discontinue waiver services after a crisis will decrease to 45 or fewer. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.) [Revised in February 2017]

Annual Goals
- **2016 Goal**: By June 30, 2016, the number will decrease to no more than **55** people
- **2017 Goal**: By June 30, 2017, the number will decrease to no more than **45** people

Baseline: State Fiscal Year 2014 baseline of 62 people who discontinued waiver services (3% of the people who received crisis services through a waiver).

RESULTS:
The 2016 goal was **not met**.
This 2017 goal is **in process**.

Time period	Number of people who discontinued disability waiver services after a crisis
2015 Annual (July 2014 – June 2015)	54 (unduplicated)
2016 Annual (July 2015 – June 2016)	71 (unduplicated)
Quarter 1 (July – September 2016)	16 (duplicated)
Quarter 2 (October – December 2016)	10 (duplicated)
Quarter 3 (January – March 2017)	16 (duplicated)

ANALYSIS OF DATA:
The 2016 goal to decrease to no more than 55 was not met. From July 2015 to June 2016 the number of people who discontinued disability waiver services after a crisis was 71.

For the 2017 goal, during the first three quarters, the number of people who discontinued disability waiver services after a crisis was 16, 10 and 16. The quarterly numbers are duplicated counts. People may discontinue disability waiver services after a crisis in multiple quarters in a year. The quarterly numbers can be used as indicators of direction, but cannot be used to measure annual progress. The annual number reported represents an unduplicated count of people who discontinue disability waiver services after a crisis during the four quarters. The results of the 2017 goal will be reported in February 2018.

COMMENT ON PERFORMANCE:
Given the small number of people identified in any given quarter as part of this measure, as of March 2017, DHS staff is conducting person-specific research to determine the circumstances and outcome of each identified waiver exit. This will enable DHS to better understand the reasons why people are exiting the waiver within 60 days of receiving a service related to a behavioral crisis and target efforts where needed most to achieve this goal.

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

CRISIS SERVICES GOAL FOUR: By June 30, 2018, people in community hospital settings due to a crisis, will have appropriate community services within 30 days of no longer requiring hospital level of care and, within 5 months after leaving the hospital, and they will have a stable, permanent home.

(A) Stable Housing

Baseline: From July 2014 – June 2015, 81.9% of people discharged from the hospital due to a crisis were housed five months after the date of discharge compared to 80.9% in the previous year.

2017 Goal

- By June 30, 2017, the percent of people who are housed five months after discharge from the hospital will increase to 83%.

RESULTS:
This 2017 goal was **not met**.

		Status five months after discharge from hospital					
Time period	**Discharged from hospital**	**Housed**	**Not housed**	**Treatment facility**	**Not using public programs**	**Deceased**	**Unable to determine type of housing**
July 2014 – June 2015	13,786	**11,290**	893	672	517	99	315
		81.9%	6.5%	4.9%	3.7%	0.7%	2.3%
July 2015 – June 2016	15,027	**11,809**	1,155	1,177	468	110	308
		78.6%	7.7%	7.8%	3.1%	0.7%	2.1%

- **"Housed"** is defined as a setting in the community where DHS pays for services including ICFs/DD, Single Family homes, town homes, apartments, or mobile homes.
  [NOTE: For this measure, settings were not considered as integrated or segregated.]
- **"Not housed"** is defined as homeless, correction facilities, halfway house or shelter.
- **"Treatment facility"** is defined as institutions, hospitals, mental and chemical health treatment facilities, except for ICFs/DD.

ANALYSIS OF DATA:
From July 2015 – 2016, of the 15,027 individuals hospitalized due to a crisis, 11,809 (78.6%) were housed within five months of discharge. This was a 3.3% decrease from the previous year. In the same time period there was a 2.9% increase of individuals in a treatment facility within five months of discharge. The 2017 goal to increase to 83% was not met.

COMMENT ON PERFORMANCE:
There has been an overall increase in the number of individuals receiving services. In June 2016, the number of people receiving services in a treatment facility was nearly double the number of people receiving treatment in a treatment facility at baseline. This indicates more people are receiving a higher level of care after discharge. This includes Intensive Residential Treatment Services (IRTS) and chemical dependency treatment programs that focus on rehabilitation and the maintenance of skills needed to live in a more independent setting.

Additionally, a contributing factor to missing the goal may be the tight housing market. When there is a tight housing market, access to housing is reduced and landlords may be unwilling to rent to individuals with limited rental history or other similar factors. DHS is expanding the number of grantees for the Housing with Supports for Adults with Serious Mental Illness grants. These grants support people living with a serious mental illness and residing in a segregated setting, experiencing homelessness or at risk of homelessness, to find and maintain permanent supportive housing. The first round of grants began in June of 2016, with additional rounds occurring every six months. DHS expects to see the impact of this work in later data.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported 16 months after the end of the reporting period.

(B) Community Services

Baseline: From July 2014 – June 2015, 89.2% people received follow-up services within 30-days after discharge from the hospital compared to 88.6% in the previous year.

2017 Goal

- By June 30, 2017, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 90%.

RESULTS:
The 2017 goal was **met**.

Time period	# of people who went to a hospital due to crisis and were discharged	# and percentage of individuals who received community services within 30-days after discharge	
July 2014 – June 2015	13,786	12,298	89.2%
July 2015 – June 2016	15,027	14,153	94.2%

ANALYSIS OF DATA:
From July 2015 – 2016, of the 15,027 individuals hospitalized due to a crisis, 14,153 (94.2%) received community services within 30 days after discharge. This was a 5% increase over the previous year. The 2017 goal to increase to 90% was met.

COMMENT ON PERFORMANCE:
Follow-up services include mental health services, home and community-based waiver services, home care, physician services, pharmacy, and chemical dependency treatment.

Mental health services that are accessible in local communities allow people to pursue recovery while remaining integrated in their community. People receiving timely access to services at the right time, throughout the state, help people remain in the community. Strengthening resources and services across the continuum of care, from early intervention to inpatient and residential treatment, are key for people getting the right supports when they need them. Community rehabilitation supports like Adult Rehabilitative Mental Health Services (ARMHS), Assertive Community Treatment (ACT), and Adult Day Treatment provide varying intensity of supports within the community. Intensive Residential Rehabilitative Treatment Services (IRTS) and Residential Crisis services can be used as a stepdown or diversion from in-patient, hospital services. DHS continues to fund grants and initiatives aimed at providing community-based mental health services throughout the state and across the care continuum.

TIMELINESS OF DATA:
In order for this data to be reliable and valid, it is reported 16 months after the end of the reporting period.

CRISIS SERVICES GOAL FIVE: By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days. [Revised February 2017]

2017 Goal
- By June 30, 2017, decrease the average length of a crisis episode to **79** days.

RESULTS:
This goal is **in process**. The first report on progress for this goal will be reported in the next quarterly report following both the Annual Goal measurement date and a determination that the data is reliable and valid.

COMMUNITY ENGAGEMENT GOAL ONE: **By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992.**

A) By June 30, 2019 the number of self-advocates or people with disabilities involved in leadership opportunities (such as governor-appointed boards and councils) will increase to 1,575.

B) By June 30, 2019, the number of people with disabilities involved in planning publicly funded projects (such as stadium plans, sidewalk improvements, public infrastructure, etc.) at the subcabinet agency level will increase to 417. [Revised in February 2017]

A) SELF ADVOCATES

2017 Goal

- By June 30, 2017, the number of self-advocates will increase by 50 for a total of 1,325.

RESULTS:
The goal was **not met** as there was no reliable and valid data to report for the 2017 goal.

B) PUBLICLY FUNDED PROJECTS

2017 Goal

- By June 30, 2017, the number people with disabilities involved in a publicly funded project will increase by 75 for a total of 167.

RESULTS:
The goal was **not met** as there was no reliable and valid data to report for the 2017 goal.

COMMENT ON PERFORMANCE (Goals 1(A) and 1(B)):
During the implementation of the goal's strategies, it was learned that the data used to measure progress could not be confirmed valid and reliable over time. A primary issue was the difficulty in obtaining data in a form that would allow for a determination of whether the number of self-advocates and the number of people with disabilities involved in publicly funded projects were unduplicated numbers.

To address this issue and improve future performance under the goal, the workplan items supporting this goal were amended in June 2017. The amended workplan includes the following:

- OIO will develop a census survey for all known self-advocacy programs and other leadership programs. The census will be completed annually. It is anticipated that the survey will help to track self-advocates and other advocates with disabilities.
- OIO, in collaboration with Minnesota Department of Human Rights Civic Engagement team, will develop a plan to train people with disabilities who are interested in participating as a member in governor-appointed boards and councils.
- Review bonding proposals approved in the 2017 legislative session to identify select projects that would be enhanced with consultation from the State Council on Disability and other governor appointed disability councils.
- As required by the workplan, a Community Engagement workgroup has been established.

PREVENTING ABUSE AND NEGLECT GOAL ONE: By September 30, 2016, the Olmstead Subcabinet will approve a comprehensive abuse and neglect prevention plan, designed to educate people with disabilities and their families and guardians, all mandated reporters, and the general public on how to identify, report and prevent abuse of people with disabilities, and which includes at least the following elements:

RESULTS:
The goal was met in 2016 and reported as met in the 2016 Annual Report. The Abuse and Prevention Plan was approved by the Olmstead Subcabinet on September 28, 2016. One of the recommendations in the Plan was the appointment of a Preventing Abuse & Neglect Specialty Committee to oversee the Abuse and Prevention Plan. A charter for the Specialty Committee was reviewed and conceptually approved by the Olmstead Subcabinet on October 24, 2016.

The Specialty Committee began its work in June of 2017 and continues to be **in process**. The Specialty Committee is preparing a final report to the Subcabinet that will include specific recommendations on preventing abuse and neglect in Minnesota. The Subcabinet and state agencies will review the recommendations and determine how they can best be incorporated into the Plan, strategies, and workplans.

PREVENTING ABUSE AND NEGLECT GOAL TWO: By January 31, 2020, the number of emergency room (ER) visits and hospitalizations of vulnerable individuals due to abuse and neglect will decrease by 50% compared to baseline.

2017 Goal

- By January 31, 2017, a baseline and annual goals will be established. At that time, and on an annual basis, the goals will be reviewed and revised as needed based on the most current data.

RESULTS:
The 2017 goal to establish a baseline was **met.**

Baseline:
From 2010-2014, there were a total of 199 hospital treatments that reflect abuse and/or neglect to a vulnerable individual. The calculated annual baseline is 40 (199/5 =40).

Annual Goals:
The annual goals that were previously established for 2018, 2019, and 2020 can remain as they are with no revisions.

ANALYSIS OF DATA:
Hospital data was divided into the 11 different Economic Development Regions (EDR) to conduct a regional analysis. While over half of Minnesota's population lives in the 7 county metro area, the most cases were located in the South Central region. The South Central EDR contains the following counties: Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Waseca and Watonwan, for a total population of 231,683. Though the population of the 7 county metro is over 23 times larger that of the South Central EDR, 114 of the total 199 (57%) hospital visits were located in the South Central EDR. The next two highest regions included the 7 county metro area with a total of 45 (23%), and the Arrowhead

EDR, with a total of 17 (9%). Information about Minnesota's EDR's can be found here: https://apps.deed.state.mn.us/assets/lmi/areamap/edr.shtml

This data is provided annually from the Minnesota Hospital Association (MHA) to the Division of Health Promotion and Chronic Disease (HPCD) at Minnesota Department of Health (MDH). HPCD then provides only the data relevant to this Preventing Abuse and Neglect goal to the Health Regulation Division at MDH in an aggregate level, as to not allow any providers or individuals to be identified. However, this data is self-reported information from the hospitals and so it relies on hospital staff coding information consistently across the state. MDH has no reason to believe the data is not reliable and valid, but acknowledges the limitations of self-reported data.

Since the South Central EDR is comprised of nine different counties, it is not possible that this outlier is the result of one staff person or even one hospital coding more completely or consistently than staff at other hospitals across the state; although it could be evidence of more robust reporting from one hospital system. It is also possible that the reporting in other areas of the state is not as robust is it is in the South Central EDR. Based on this analysis of the baseline data, the South Central EDR will be an area to concentrate the public campaign efforts on, but will also be mindful that there may be other discrepancies at play that could be causing the higher incidence of reporting in this area.

Therefore, while it currently appears that this outlier is reflecting a region where abuse and neglect of individuals with disabilities is occurring at a higher rate than the rest of the state, MDH intends to monitor this outlier over time. Collateral data, such as licensing and/or certification survey data, will also be reviewed to help validate or refute the results of the MHA baseline data.

COMMENT ON PERFORMANCE:
Progress toward the goal is determined to be on track for meeting the goal. The public education campaign targeted to providers who serve individuals with disabilities, individuals with disabilities, families, and advocates was initiated on July 1, 2017. Targeted prevention efforts will also be conducted in areas with higher rates of hospitalizations and ER visits due to abuse and neglect of vulnerable individuals.

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

PREVENTING ABUSE AND NEGLECT GOAL THREE: By December 31, 2021, the number of vulnerable adults who experience more than one episode of the same type of abuse or neglect within six months will be reduced by 20% compared to the baseline.

2017 Goal

- By December 31, 2017, a baseline will be established. At that time, and on an annual basis, the goals will be reviewed and revised as needed based on the most current data.

RESULTS:
This goal is **in process**. The first report on progress for this goal will be reported in the next quarterly report following both the Annual Goal measurement date and a determination that the data is reliable and valid.

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

2017 Goal

- By July 31, 2017, a baseline and annual goals will be established.

RESULTS:

This goal is **in process**. The first report on progress for this goal will be reported in the next quarterly report following both the Annual Goal measurement date and a determination that the data is reliable and valid.

VI. COMPLIANCE REPORT ON WORKPLANS AND MID-YEAR REVIEWS

This section summarizes the monthly review of workplan activities and the mid-year reviews completed by OIO Compliance staff.

WORKPLAN ACTIVITIES

OIO Compliance staff reviews workplan activities on a monthly basis to determine if items are completed, on track or delayed. Any delayed items are reported to the Subcabinet as exceptions. The Olmstead Subcabinet reviews and approves workplan implementation, including workplan adjustments proposed by the agencies on an ongoing basis.[ix] In the event proposed agency actions are insufficient, the Subcabinet may take remedial action to modify the workplans.

The first review of workplan activities occurred in December 2015 and included activities with deadlines through November 30, 2015. Ongoing monthly reviews began in January 2016 and include activities with deadlines through the month prior and any activities previously reported as an exception.

The summary of those reviews are below.

	Number of Workplan Activities				
Reporting period	Reviewed during time period	Completed	On Track	Reporting Exceptions	Exceptions requiring remedial Subcabinet action
December 2015	67	41	19	7	0
January 2016	49	18	25	6	0
February 2016	42	24	10	8	0
March 2016	34	19	10	5	0
April 2016	30	13	15	2	0
May 2016	28	15	13	0	0
June 2016	25	19	5	1	0
July 2016	53	47	4	2	0
August 2016	30	23	6	1	0
September 2016	15	8	6	1	0
October 2016	16	10	5	1	0
November 2016	25	21	4	0	0
December 2016	14	11	3	0	0
January 2017	40	35	2	3	0
February 2017	24	18	6	0	0
March 2017	15	10	4	1	1
April 2017	15	12	3	0	0
May 2017	11	9	2	0	0
June 2017	20	19	1	0	0
July 2017	57	54	3	0	0
August 2017	26	22	1	3	0
September 2017	18	16	2	0	0
October 2017	29	28	8	0	0

MID-YEAR REVIEW OF MEASURABLE GOALS REPORTED ON ANNUALLY

OIO Compliance staff engages in regular and ongoing monitoring of measurable goals to track progress, verify accuracy, completeness and timeliness of data, and identify risk areas. These reviews were previously contained within a prescribed mid-year review process. OIO Compliance staff found it to be more accurate and timely to combine the review of the measurable goals with the monthly monitoring process related to action items contained in the workplans. Workplan items are the action steps that the agencies agree to take to support the Olmstead Plan strategies and measurable goals.

OIO Compliance staff regularly monitors agency progress under the workplans and uses that review as an opportunity to identify any concerns related to progress on the measurable goals. OIO Compliance staff report on any concerns identified through the reviews to the Subcabinet. The Subcabinet approves any corrective action as needed. If a measurable goal is reflecting insufficient progress, the quarterly report identifies the concerns and how the agency intends to rectify the issues. This process has evolved and mid-year reviews are utilized when necessary, but the current review process is a more efficient mechanism for OIO Compliance staff to monitor ongoing progress under the measurable goals.

VII. ANALYSIS OF TRENDS AND RISK AREAS

The purpose of this section is to summarize areas of the Plan that are at risk of underperforming against the measurable goals. The topic areas are grouped by categories used in the Quarterly Reports.

MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

For the second year, progress continues on people with disabilities moving from segregated settings into more integrated settings. Annual goals on movement from ICF/DD, nursing facilities, and other segregated settings were achieved. Goals for the timely movement from the AMRTC and MSH were not met, however, data shows consistent movement in the right direction.

People with disabilities are achieving competitive and integrated employment in greater numbers. The number of people with disabilities in vocational rehabilitation programs and vocational programs funded the medical assistance both exceeded their annual goals to get people into competitive integrated employment.

These trends are being supported by changes in state processes such as annual review of services by Lead agencies. This process is now informed by person centered principles that are sensitive to the expressed desires of the individual about where they live and work and how services are provided.

At the federal level, changes to the home and community based services regulations and the Workforce Innovation and Opportunities Act have adopted person centered principles requiring individual choice for where people live and work. These changes will continue to positively influence people with disabilities opportunity to choose a more integrated life.

INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

Progress continued this year on people with disabilities accessing authorization to waiver services. People accessing the CADI waiver continued resulting in no need for a waiting list. The number of individuals with developmental disabilities authorized for waiver services continues to show improvement.

The ability of people with disabilities to access housing continues to improve. This year 998 individuals obtained housing or 98% of the annual goal.

Fewer people with disabilities are experiencing the use of emergency manual restraint. There was a reduction of 69 individuals which exceeded the annual goal of 49 individuals

These positive achievements are important but more work is to be done. The following measurable goals have been targeted for improvement:

- Transition Services Goal Four to increase the percent of individual's transition plans that meet the required protocols.
- Waiting List Goal Three to eliminate the waiting list for persons in the Institutional Exit and Defined Need categories.
- Person-Centered Planning Goal One to increase the percent of individual plans that meet the required protocols.

- Positive Supports Goal Three A to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Housing and Services Goal One to increase the number of individuals living in integrated housing.
- Lifelong Learning and Education Goal Two to increase the number of students with disabilities enrolling in an integrated postsecondary education setting.
- Crisis Services Goal Four A to increase the percent of people housed five months after being discharged from the hospital

These areas have been highlighted for the agencies and the Subcabinet as areas in need of increased monitoring. Each agency has identified plans bring each goal into the specified performance criteria.

VIII. POTENTIAL AMENDMENTS TO THE PLAN

The Olmstead Subcabinet is engaged in the Plan review and amendment process. Agencies have developed a number of potential amendments to the measurable goals. Initial draft potential plan amendments are attached hereto as an Addendum in accordance with the Court's February 22, 2016 Order (Doc. 544). The Olmstead Subcabinet will begin obtaining public comment on the draft amendments on December 20, 2017 and the attached drafts are subject to change.

In addition to the measurable goal amendments attached hereto, there will be additional proposed changes to the Introduction and Background Information and Plan Management and Oversight sections, and supporting descriptions of the measurable goals. Public comment to the full proposed Plan will be sought throughout March. After the proposed amendments are finalized and approved by the Subcabinet, final amendments will be reported to the Court on or before March 31, 2017.

ENDNOTES

[i] 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.
[ii] Goals that are in process include goals that have not yet reached the annual goal date, and goals that have not been reported on to date. On track and not on track designations are not included in the table as they indicate progress on annual goals to be reported on in 2017.
[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] "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.
[vii] "Most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day.
[viii] Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.
[ix] All approved adjustments to workplans are reflected in the Subcabinet meeting minutes, posted on the website, and will be utilized in the annual workplan review and adjustment process.

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Items:

6 (c) Olmstead Plan Proposed Amendments

Presenter:

Agency Sponsors and Leads

Action Needed:

☒ Approval Needed (provisionally approve to be attached to Annual Report and go out for public comment)

☐ Informational Item (no action needed)

Summary of Item:

This includes the draft potential amendments to Olmstead Plan measurable goals being proposed by the Subcabinet agencies. Once provisionally approved by the Subcabinet the draft amendments will be attached as an Addendum to the Annual Report and posted for public comment.

Attachment(s):

6c – Addendum to Annual Report on Olmstead Plan Implementation – Draft Potential Amendments to Measurable Goals

[AGENDA ITEM 6c]

Addendum to Annual Report on Olmstead Plan Implementation

Draft Potential Amendments to Measurable Goals

December 11, 2017

This addendum includes the draft potential amendments to Olmstead Plan measurable goals being proposed by the Olmstead Subcabinet agencies.

The Olmstead Subcabinet will review these amendments on December 18, 2017. These draft potential amendments are being included with the Annual Report in accordance with the Court's February 22, 2016 Order (Doc. 544). The Olmstead Subcabinet is in the process of obtaining public comment on these draft amendments and these amendments are subject to change.

The measurable goals appear in the order that they occur in the Plan, with the page number and the reason for the change noted. Redline changes indicate the edits to the original language from the Plan.

Contents

[AGENDA ITEM 6c]

PERSON-CENTERED PLANNING GOAL ONE (page 37 of Plan)

REASON FOR CHANGE

Current standard used to measure this goal, requires that **all 8** items below are present in the support plan (or in supporting documents) held by the lead agency (assessment, case notes, etc.).

1. The support plan describes goals or skills that are related to the person's preferences.
2. The support plan includes a global statement about the person's dreams and aspirations.
3. Opportunities for choice in the person's current environment are described.
4. The person's current rituals and routines are described.
5. Social, leisure, or religious activities the person wants to participate in are described.
6. Action steps describing what needs to be done to assist the person in achieving his/her goals or skills are described.
7. The person's preferred living setting is identified.
8. The person's preferred work activities are identified.

If **one** of the eight items is missing, the support plan is considered as not meeting the protocols of a person-centered plan. The item most commonly missing is item two, "The support plan includes a global statement about the person's dreams and aspirations."

DHS believes a more effective strategy of working towards true achievement of person-centered practices is to evaluate the ***progress*** of lead agencies rather than disqualifying a plan for not having all eight items. Since a different group of counties is reviewed each year, this a better representation of system-wide improvement.

Beginning January 2018, DHS will require individual remediation when lead agencies do not comply with person-centered review protocols. When findings from the case file review indicate file did not contain all required documentation, the agency is required to bring all cases into full compliance by obtaining or correcting the documentation. Compliance is attested to by the lead agency supervisor or manager.

Goal One: By June 30, 2020, at least 90% of support plans for people using disability home and community-based waiver services will include at least six of the eight key items in the person-centered ~~meet required~~ protocols. Protocols are ~~will be~~ based on the principles of person-centered planning and informed choice.

Baseline: In state fiscal year 2014, 38,550 people were served on the disability home and community-based services. In fiscal year 2017, of the 1,201 disability cases reviewed as part of the Lead Agency reviews, 661 (55%) were identified as having at least six of eight key items in the person-centered protocols. ~~However, a baseline for the current percentage of plans that meet the principles of person centered planning and informed choice needs to be established.~~

Annual Goals to increase the percent of plans that meet the required protocol:

- By June 30, 2018, at least 70% of plans will include at least 6 of 8 required items
- By June 30, 2019, at least 80% of plans will include at least 6 of 8 required items
- By June 30, 2020, at least 90% of plans will include at least 6 of 8 required items

- ~~By June 30, 2016, the percent of plans that meet the required protocols will increase to 30%~~

- ~~By June 30, 2017, the percent of plans that meet the required protocols will increase to 50%~~
- ~~By June 30, 2018, the percent of plans that meet the required protocols will increase to 70%~~
- ~~By June 30, 2019, the percent of plans that meet the required protocols will increase to 85%~~
- ~~By June 30, 2020, any plans that do not meet the required protocols will be revised to contain required elements of person-centered plans.~~

[AGENDA ITEM 6c]

TRANSITION SERVICES GOAL ONE (page 42 of Plan)

REASON FOR CHANGE

An interim baseline was established and approved by the Subcabinet on February 22, 2017. During July 2013 – June 2014, of the 5,694 individuals moving, 1,121 moved to a more integrated setting. The baseline needs to be incorporated into the Plan.

Goal One: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[1] will be 7,138.

Annual Goals for the number of people moving from: **(A)** ICFs/DD; **(B)** nursing facilities; and **(C)** other segregated housing to more integrated settings are set forth in the following table.

	2014 Baseline	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019	June 30, 2020	Cumulative Total
(A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72*	84	84	84	72	72	72	468
(B) Nursing Facilities (NF) under age 65 in NF > 90 days	707*	740	740	740	750	750	750	4,470
(C) Segregated housing other than listed above	~~Not Available~~ 1,121[2]	50	250	400	500	500	500	2,200
Total	**1,900**	**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**	**7,138**

*Calendar Year 2014

[1]This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options being reported under Housing Goal One.

[2] An interim baseline was~~ill be~~ established in February~~early~~ 2017. A standardized informed choice process is being implemented. When data from this process is deemed reliable and valid, baseline and goals will be re-evaluated and revised as appropriate.

[AGENDA ITEM 6c]

TRANSITION SERVICES GOAL FOUR (page 44 of Plan)

REASON FOR CHANGE
A baseline was established and approved by the Subcabinet on February 27, 2017. The baseline needs to be incorporated into the Plan

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Goal Four: By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person-centered planning process that adheres to transition protocols that meet the principles of person-centered planning and informed choice.

Baseline: From July – December 2016, of the 31 transition cases reviewed, four cases (12.9%) adhered to transition protocols that meet the principles of person-centered planning and informed choice. ~~The baseline of the quality of transition plans will be established as the new transition protocols are implemented.~~

Annual Goals to increase the percent of plans that adhere to transition protocol standards:

- By June 30, 2016, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person-centered planning and informed choice will increase to 15%.
- By June 30, 2017, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person-centered planning and informed choice will increase to 30%.
- By June 30, 2018, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person-centered planning and informed choice will increase to 50%.

[AGENDA ITEM 6c]

EMPLOYMENT GOAL TWO (page 53 of Plan)

REASON FOR CHANGE

The 2014 baseline for Employment Goal Two established the number of people receiving services from certain Medicaid funded programs. However, at that time, a data system was not yet developed to measure the number of those individuals who were working in competitive integrated employment. A proxy measure is now available to track the number of individuals in competitive integrated employment. A proposed baseline was developed using the proxy measure and approved by the Subcabinet on November 27, 2017. The Subcabinet requested that the goal be rewritten to use the number of individuals instead of percentage. The baseline needs to be incorporated into the Plan.

Goal Two: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,00~~015~~ over baseline to 11,137 ~~or 10%~~ in competitive integrated employment.

Baseline: In 2014, ~~there were~~ of the 50,157 people age 18-64 in Medicaid funded programs, 6,137 were in competitive integrated employment. ~~who received services from one of the following~~ Medicaid funded programs include: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD).

Annual Goals to increase the number of individuals in competitive integrated employment

- By June 30, 2017, a data system will be developed to measure the following: the number of individuals who are working in competitive integrated employment; the number of individuals not working in competitive integrated employment; and the number of individuals not working in competitive integrated employment who would choose or not oppose competitive integrated employment.
- By June 30, 2017, the number of individuals in competitive integrated employment will increase by 1,500 individuals[3] to 7,637
- By June 30, 2018, the number of individuals in competitive integrated employment will increase by 1,100 individuals to 8,737
- By June 30, 2019, the number of individuals in competitive integrated employment will increase by 1,200 individuals to 9,937
- By June 30, 2020, the number of individuals in competitive integrated employment will increase by 1,200 individuals to 11,137

[3] The projected increase of 1,500 individuals includes increases for 2016 and 2017. This is necessary as data for 2016 will not be available until 2017.

[AGENDA ITEM 6c]

LIFELONG LEARNING AND EDUCATION GOAL TWO (page 58 of Plan)

REASON FOR CHANGE

The February 2017 Revision of the Olmstead Plan established a baseline for this goal using newly available Statewide Longitudinal (SLEDS) data. However, the baseline used does not align to publicly accessible data reports from SLEDS for this goal, and does not include data from the Minnesota Office of Higher Education.

In addition, MDE defines ideal performance for this goal as students with disabilities enrolling in an accredited institution of higher education in the fall of the same year as their graduation (as opposed to delayed enrollment to the next year). The proposed change will use public SLEDS data which more closely aligns with tracking the successful same-year transition of students from high school graduation directly into fall enrollment in institutions of higher education. The public SLEDS data also includes enrollment in accredited certificate and one year programs.

Goal Two: By June 30, 2020 the number of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase by 492 ~~425 (39%)~~ (from ~~2,174~~ 2,107 to 2,599).

Baseline: Based on~~Using the~~ 2014 Minnesota's Statewide Longitudinal Education Data System (SLEDS), of the 6,749 students with disabilities who graduated statewide in 2014, a total of 2,107 ~~4 (32.2%)~~ enrolled in the fall of 2014 into ~~attended~~ an integrated postsecondary institution. ~~from August 2014 to July 2015.~~

Annual Goals to increase the number of students enrolling in an integrated postsecondary education setting in the fall after graduating are:

- By June 30, 2018, the number will increase to 2,337.
- By June 30, 2019, the number will increase to 2,467.
- By June 30, 2020, the number will increase to 2,599.

- ~~By June 30, 2017 there will be an increase of 100 (34%) over baseline to 2,274~~
- ~~By June 30, 2018 there will be an increase of 225 (36%) over baseline to 2,399~~
- ~~By June 30, 2019 there will be an increase of 325 (37%) over baseline to 2,499~~
- ~~By June 30, 2020 there will be an increase of 425 (39%) over baseline to 2,599~~

[AGENDA ITEM 6c]

LIFELONG LEARNING AND EDUCATION GOAL THREE (page 58 of Plan)

REASON FOR CHANGE

A baseline and annual goals for the number of students for whom there is effective consideration of Assistive Technology were established and approved by the Subcabinet on August 28, 2017. At the same time, the Subcabinet asked for clarification on the term effective consideration. It was determined at that time, that active consideration is a more accurate term. MDE is requesting amendment of the goal to replace "effective consideration" with "active consideration."

Goal Three: By June 30, 2020, ~~80~~96% of students with disabilities in 31 target school districts will ~~meet required protocols for effective~~have annual active consideration of assistive technology (AT) during ~~in~~ the student's individualized education program (IEP) team meeting. ~~Protocols~~The framework to measure active consideration will be based upon the "Special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.

Baseline:

From October – December 2016, of the 28 students with IEPs, 26 (92.8%) had active consideration of assistive technology in their IEP.

Annual Goals

- ~~By December 31, 2016, pilot teams will establish a baseline and annual goals of the number of students for whom there is effective consideration of AT.~~
- By June 30, 2018, increase to 94% of students whose IEP meet required protocols for active consideration of AT.
- By June 30, 2019, increase to 95% of students whose IEP meet required protocols for active consideration of AT.
- By June 30, 2020, increase to 96% of students whose IEP meet required protocols for active consideration of AT.

[AGENDA ITEM 6c]

WAITING LIST GOALS ONE - FIVE (page 64 of Plan)

REASON FOR CHANGE

After implementing the reasonable pace goals for two years, DHS would like to shift the focus of the measurable goals to timeliness of funding approval for waivered services. The proposal is to combine Goals Two, Three, Four, and Five into one goal. This is in line with how the goal has been cumulatively reported in the quarterly reports since August 2016. Goal One is being deleted as it has already been met.

A new baseline was established to measure progress of individuals accessing waivered services at a reasonable pace. The baseline was approved by the Subcabinet on May 22, 2017 and needs to be incorporated into the Plan.

~~**Goal One: By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.**~~

~~Baseline: As of May 30, 2015, the CADI waiver waiting list was 1,420 individuals.~~

Goal One~~Two~~: Lead agencies will approve funding at a reasonable pace for persons (A) exiting institutional settings; (B) with an immediate need; and (C) with a defined need for the Developmental Disabilities (DD) waiver.

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 (34%)
Immediate Need	393	243 **(62%)**	113 (29%)
Defined Need	1,018	427 **(42%)**	290 (28%)
Totals	**1,500**	**707 (47%)**	433 (29%)

~~**By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.**~~

~~Baseline: In April 2015, there were 3,586 individuals on the DD waiver waiting list.~~

(A) Persons exiting institutional settings will have funding approved ~~move off the waiting list~~ at a reasonable pace, which means that:

- Beginning December 1, 2015, as people residing in an institutional setting are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days

after the person makes an informed choice of alternative community services that are more integrated, appropriate to meet their individual needs, and the person is not opposed to moving, and would like to receive home and community-based services.

(B) Persons with an immediate need will have funding approved~~move off the waiting list~~ at a reasonable pace, which means that:

- Beginning December 1, 2015, as people are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person meets criteria under Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b)**.**

  The current statutory criteria are: The person has an unstable living situation due to age, incapacity, or sudden loss of primary caregivers; is moving from an institution due to bed closure; experiences a sudden closure of their current living arrangement; requires protection from confirmed abuse, neglect, or exploitation; experiences a sudden change in need that can no longer be met through state plan services or other funding resources alone or meet other priorities established by DHS.

(C) Persons with a defined need of requiring services within a year of assessment will have funding approved ~~move off the waiting list~~ at a reasonable pace, which means that:

- Beginning December 1, 2015, as people are assessed as having a defined need for waiver services within a year from the date of assessment, and within available funding limits, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days of determining the defined need.

~~Goal Three: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b).~~

~~Goal Four: By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.~~
~~Goal Five: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.~~

[AGENDA ITEM 6c]

TRANSPORTATION GOAL THREE (page 69 of Plan)

REASON FOR CHANGE
A proposed baseline for access to transportation in Greater Minnesota using MnDOT data was established and approved by the Subcabinet on November 27, 2017. The baseline needs to be incorporated into the Plan.

Goal 5 is being added to address access to transit service in the metro area. Metro Area Public Transit measures the percent of population served by regular route transit. This proposal is to adopt the baseline and measurable goal currently used by Metro Area Public Transit.

Goal Three: By 2025, expand transit coverage so that 90% of the public transportation service areas in Greater Minnesota will meet minimum service guidelines for access.

Greater Minnesota t~~T~~ransit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT "Greater Minnesota Transit Investment Plan."[4]

Baseline: ~~A baseline for access will be established by April 30, 2017.~~
In December 2016, public transportation in Greater Minnesota was meeting minimum service guidelines for access 47% on weekdays, 12% on Saturdays and 3% on Sundays.

Goal 5: By 2040~~,~~ the percent of the target population served by regular route level of service for prescribed market areas 1, 2, and 3 will be 100%.

Metro Area Public Transit utilization is measured by distinct market areas for regular route level of service. This measure estimates demand potential for all users of the regular route system. The market area is created based on analysis that show the demand for regular route service is driven primarily by population density, automobile availability, employment density and intersection density (walkable distance to transit). This measure is based on industry standards incorporated into the Transportation Policy Plan's - Regional Transit Design Guidelines and Performance Standards. The Metro Area also provides non-regular route services in areas that are not suitable for regular routes, such as dial-a-ride transit.

Policy Plan Guidelines/Standards and https://metrocouncil.org/METC/files/63/6347e827-e9ce-4c44-adff-a6afd8b48106.pdf

[4] Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transitinvestment.

[AGENDA ITEM 6c]

HEALTHCARE AND HEALTHY LIVING GOALS ONE and TWO (page 74-75 of Plan)

REASON FOR CHANGE

The follow up care for cardiovascular conditions measure in Health Care Goal One is no longer reflective of current clinical practice and has been discontinued.

Two additional items are being added under two strategies. These include health care measures related to quality of coordination of care for adults with disabilities and initial data analysis has shown that there is a significant difference in outcomes between people with disabilities and those without.

Goal One: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care[5] focusing specifically on cervical cancer screening ~~and follow-up care for cardiovascular conditions~~ will increase by 833 people compared to the baseline.

As specific indicators that individuals with disabilities are accessing appropriate care, cervical cancer screening ~~and follow-up care for cardiovascular conditions~~ will be tracked. Th<u>is is an area</u> ~~ese are two areas~~ where <u>a</u> health care outcome disparit<u>y</u>~~ies have been~~ <u>was</u> identified.

- Cervical cancer screening - Reduce disparities in cervical cancer screening by 10% (increase of 616 more women being screened).
- ~~Follow-up care for cardiovascular conditions - Reduce disparities in appropriate follow-up care for cardiovascular conditions by 5% (increase of 217 more people receiving appropriate follow-up care).~~

Baseline: In 2013, the number of women receiving cervical cancer screenings was 21,393<u>.</u> ~~and the number of individuals accessing follow-up care for cardiovascular conditions was 1,589.~~[6]

Annual Goals to increase the number of individuals accessing appropriate care:

- By December 31, 2016 the number accessing appropriate care will increase by 205 over baseline
- By December 31, 2017 the number accessing appropriate care will increase by 518 over baseline
- By December 31, 2018 the number accessing appropriate care will increase by 833 over baseline

Goal Two: By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by 1,229 children and 1,055 adults over baseline.

(A) Children accessing dental care

Baseline: In 2013, the number of children with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 16,360.

Annual Goals to increase the number of children accessing dental care:

- By December 31, 2016 the number of children accessing dental care will increase by 410 over baseline
- By December 31, 2017 the number of children accessing dental care will increase by 820 over baseline

[5] Appropriate care will be measured by current clinical standards.

[6] Baselines for these goals are from the 2013 "Olmstead Plan: <u>Baseline Data for Current Care" Report.</u>

- By December 31, 2018 the number of children accessing dental care will increase by 1,229 over baseline

(B) Adults accessing dental care

Baseline: In 2013, the number of adults with disabilities continuously enrolled in Medicaid coverage during the measurement year accessing annual dental visits was 21,393.

Annual Goals to increase the number of adults accessing dental care:

- By December 31, 2016 the number of adults accessing dental care will increase by 335 over baseline
- By December 31, 2017 the number of adults accessing dental care will increase by 670 over baseline
- By December 31, 2018 the number of adults accessing dental care will increase by 1,055 over baseline.

Strategies (1 and 4)

Improve Dental Care for People with Disabilities

- Monitor the implementation of the increase in dental payment rates in January 2016 and thereafter. Increase in dental rates has historically resulted in increased access to dental care for people with disabilities.
- Implement the recommendations from the "Recommendations for Improving Oral Health Services Delivery System" Report and the follow up report, "Delivery System for Oral Health."
- Implement the "Minnesota Oral Health Plan."
- Increase the number of providers and the level of access of people with disabilities to providers.
- Monitor and report the number of adult enrollees who used an emergency department for non-traumatic dental services to give a more complete picture of the level of access of people with disabilities to dental care.

Develop and Implement Measures for Health Outcomes

- ~~Develop and implement health outcome measures. Studying health outcomes will indicate the effectiveness of the health care delivery system and identify potential opportunities for improvement.~~
- Monitor and report the number and percentage of adult public program enrollees [with disabilities] who had an acute inpatient hospital stay that was followed by an unplanned acute readmission to a hospital within 30 days.

[AGENDA ITEM 6c]

CRISIS SERVICES GOAL FIVE (page 87 of Plan)

REASON FOR CHANGE

Originally, information from the Single Point of Entry was used to this measure goal and the focus population included people with developmental disabilities. However, the "N" was quite small and the data quality was not at the level DHS was comfortable reporting. In the proposed goal, the wording for this goal would remain the same.

DHS would begin measuring this goal with data that is reflective of people accessing crisis residential, crisis stabilization and inpatient hospital stays after receiving crisis service referrals with data from the Mental Health Information System (MHIS) and Medical Assistance (MA) claims data from MMIS. This would change the focus of the goal to mental health crisis services, rather than Single Point of Entry access.

Goal Five: By June ~~23~~30, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

Baseline: ~~Between September 1, 2015 and January 31, 2016, the average length of a crisis episode was 81.3 days.~~

In fiscal year 2016, of the people on Medical Assistance who were referred for clinically appropriate crisis services, 85.4% received those services within 10 days. The average number of days was 2.3.

Annual Goals

- By June 30, 2018, the percent of people who receive crisis services within 10 days will increase to 87%.
- By June 30, 2019, the percent of people who receive crisis services within 10 days will increase to 88%.
- By June 30, 2020, the percent of people who receive crisis services within 10 days will increase to 90%.

~~to decrease the average length of a crisis episode:~~

- ~~By June 30, 2017, decrease the average length of a crisis episode to **79** days.~~
- ~~By June 30, 2018, decrease the average length of a crisis episode to **77** days.~~
- ~~By June 30, 2019, decrease the average length of a crisis episode to **75** days.~~
- ~~By June 30, 2019, develop and establish a baseline and measurable goals that reflect the broader community crisis services.~~

[AGENDA ITEM 6c]

COMMUNITY ENGAGEMENT GOAL ONE (page 92 of Plan)

REASON FOR CHANGE
The proposed change will measure identified areas where people with disabilities can participate in Governor's Councils and Boards and publicly funded projects.

Goal One: By June 30, 202019, the number of individuals with disabilities who are involved in leadership opportunities ~~their community in ways that are meaningful to them~~ will increase to 245. ~~1,992.~~ ~~(This includes increases in the numbers of: (A) self-advocates; and (B) individuals involved in publicly funded projects.)~~

~~Baseline: As of June 30, 2014, the number of individuals engaged as self-advocates, in leadership roles (such as Governor appointed councils) or in publicly funded projects is 1,242.~~

(A) ~~Self-Advocates~~ Leadership Opportunities

By June 30, 202019 the number of ~~self-advocates or~~ people with disabilities involved in leadership opportunities (such as governor-appointed boards and councils, Community Engagement workgroup and other OIO workgroups/committees) will increase to 245 or (8%) of members. ~~1,575.~~

Baseline: Of the 3,070 members on the Secretary of State's Boards and Commissions, 159 members (5%) are individuals with a disability. ~~There are 1,200 active self-advocates involved in the Self Advocates Minnesota (SAM) network statewide and participating in Tuesday's at the Capitol [7]~~

Annual Goals to increase the number involved in leadership opportunities~~of self-advocates~~:

- By June 30, 2018, the number of people with disabilities in leadership opportunities will increase to 184 or 6%.
- By June 30, 2019, the number of people with disabilities in leadership opportunities will increase to 215 or 7%.
- By June 30, 2020, the number of people with disabilities in leadership opportunities will increase to 245 or 8%.
- ~~By June 30, 2016, the number of self-advocates will increase by 50 for a total of 1,250.~~
- ~~By June 30, 2017, the number of self-advocates will increase by 75 for a total of 1,325.~~
- ~~By June 30, 2018, the number of self-advocates will increase by 100 for a total of 1,425.~~
- ~~By June 30, 2019, the number of self-advocates will increase by 150 for a total of 1,575.~~

(B) Involvement in Publicly Funded Projects

By June 30, 202019, the number of people with disabilities involved in ~~planning~~ publicly funded projects identified through bonding bills will increase by 5% over baseline.

Annual Goals to increase the number of people involved in publicly ~~planning~~funded projects**:**

- By April 30, 2018, establish a baseline and annual goals.

~~[7] Self- Advocates Minnesota is a statewide network of regional self-advocacy groups coordinated through Advocating Change Together. Tuesdays at the Capitol is coordinated by the Minnesota Consortium for Citizens with Disabilities and brings together self-advocates, families, providers, law-makers and agency staff for policy discussions every Tuesday during the legislative session.~~

~~**(such as stadium plans, sidewalk improvements, public infrastructure, etc.) at the Subcabinet agency level will increase to 417**~~**.** ~~Baseline: There were 42 individuals with disabilities involved in planning 6 publicly funded projects (such as stadium plans, sidewalk improvements, public infrastructure, etc.).~~

~~**Annual Goals** to increase the number of people involved in public planning projects**:**~~

- ~~By June 30, 2016, the number people with disabilities involved in a publicly funded project will increase by 50 for a total of 92.~~
- ~~By June 30, 2017, the number people with disabilities involved in a publicly funded project will increase by 75 for a total of 167.~~
- ~~By June 30, 2018, the number people with disabilities involved in a publicly funded project will increase by 100 for a total of 267.~~
- ~~By June 30, 2019, the number people with disabilities involved in a publicly funded project will increase by 150 for a total of 417.~~

[AGENDA ITEM 6c]

PREVENTING ABUSE AND NEGLECT GOAL TWO (page 96 of Plan)

REASON FOR CHANGE
A baseline was established and approved by the Subcabinet on May 22, 2017. The baseline needs to be incorporated into the Plan.

Goal Two: By January 31, 2020, the number of emergency room (ER) visits and hospitalizations of vulnerable individuals due to abuse and neglect will decrease by 50% compared to baseline.

Baseline:
From 2010-2014, there were a total of 199 hospital treatments that reflect abuse and/or neglect to a vulnerable individual. The calculated annual baseline is 40 (199/5 = 40).

Annual Goals to reduce the number of ER visits and hospitalizations due to abuse and neglect:

- ~~By January 31, 2017, a baseline and annual goals will be established. At that time, and on an annual basis, the goals will be reviewed and revised as needed based on the most current data.~~
- By January 31, 2018, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% compared to baseline
- By January 31, 2019, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 30% compared to baseline
- By January 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 50% compared to baseline

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Item:

6 (d) Proposed Olmstead Plan Workplans
Community Engagement 5D.1 – Workplans on Community Engagement Plan

Presenter:

Darlene Zangara (OIO)

Action Needed:

☒ **Approval Needed**

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

Summary of Item:

Attached is a proposed workplan to complete the Community Engagement Plan as a requirement of activity CE 5D.1. The proposed additions to the workplan are D.1a – D.1f. D.2 is also being adjusted.

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

Attachment(s):

Olmstead Plan Workplan – Community Engagement– Activity 5D.1

Olmstead Subcabinet Meeting Agenda Item

[AGENDA ITEM 6d]

OLMSTEAD PLAN WORKPLAN
REPORT TO OLMSTEAD SUBCABINET

Topic Area	Community Engagement
Strategy	The Community Engagement Workgroup will provide the OIO and the Subcabinet with recommendations regarding key elements of the Olmstead Plan as specified in the Charter
Workplan Activity Number	CE 5D.1
Workplan Key Activity	OIO will develop a workplan to create a new Community Engagement Plan and report to the Subcabinet.
Workplan Deadline	December 31, 2017
Agency Responsible	OIO
Date Reported to Subcabinet	December 18, 2017

OVERVIEW

At the November 27, 2017 meeting, the Subcabinet adopted the Community Engagement Outcomes below as the basis for the revised Olmstead Community Engagement Plan. Using these outcomes, OIO will develop a Community Engagement Plan, with measurable and actionable strategies for advancing equitable engagement between state agencies and people with disabilities.

Workplan Activity 5D.1 requires OIO to develop a workplan to create a new Community Engagement Plan. The proposed workplan is attached.

REPORT

Community Engagement Plan Outcomes

Outcomes	**Description of Outcomes**
1. Humanity, Dignity & Empowerment	"We are the experts on our own lives." • Shift systemic attitudes, biases, and assumptions about people with disabilities. • Change the low expectations of the potential of people with disabilities. • Take the time to listen and understand our voices, experiences, abilities and ideas.
2. Person-Centered Listening & Learning	"Listen to each individual person and what they dream and hope for their life and community." • Take the time to listen, have tough conversations, build relationships, make connections, and learn about and understand the culture and identity of each person. • The input and ideas of diverse people with disabilities must be heard, valued, and used to shape decisions.

Outcomes	**Description of Outcomes**
3. Diversity, Accessibility, & Equity	"Be intentional and proactive about bringing under-represented communities at the decision-making table and taking down barriers to engagement and participation." • Make engagement accessible and equitable (location, accommodation, transportation, interpretation, cultural competency, remote access, etc.); establish standards for accessibility in meetings and events. • Adopt best practices for engagement.
4. Transparency & Accountability	"Be clear about how decisions are made, how our feedback informed those decisions, and who is accountable for implementing those decisions." • Be transparent about who is accountable for implementing and evaluating the Olmstead Plan; engage people with disabilities in evaluation efforts. • Work to close the "feedback loop" in a timely and meaningful way at all levels, from an individual complaint to a large-scale engagement effort.
5. Active Leadership, Inclusion & Participation	"People with disabilities must be involved in decision-making that directly affects our lives." • Involve people with disabilities throughout the whole process. • Make sure that decision-making tables are inclusive and accessible for diverse people with disabilities to participate. • Cultivate leaders with disabilities at every level of government.

[AGENDA ITEM 6d]

Strategy 5: The Community Engagement Workgroup will provide the OIO and the Subcabinet with recommendations regarding key elements of the Olmstead Plan as specified in the Charter.

5	Key Activity	Expected Outcome	Deadline	Other Agency(s) or Partners
A	Convene Community Engagement workgroup meetings and implement scope of work.	The Community Engagement workgroup will provide support, expertise and guidance to the three identified strategic focuses in scope of work.	All meetings completed by **December 18, 2017**	OIO
C	Community Engagement workgroup will make recommendations for updating and enhancing the OIO Communication Plan. **Report to the Subcabinet** on the recommendations.	The Community Engagement workgroup and the Subcabinet will support the implementation of a communication plan for diverse communities with disabilities.	Report to Subcabinet by **December 31, 2017**	OIO
D.1	OIO will develop a workplan to create a new ~~Community Engagement workgroup will review and revise the~~ Community Engagement Plan and ~~present the Plan in a~~ **report to the Subcabinet.**	Strengthen the community engagement between members of the disability communities and the OIO and state agencies on matters impacting the implementation of the Olmstead Plan.	Report to Subcabinet by **December 31, 2017** **(Exception 11/2017)** ~~**November 30, 2017**~~	OIO
D.1a	Develop a Community Engagement plan with measurable and actionable strategies for advancing engagement between state agencies and people with disabilities.	See D.1 above	Present plan to Subcabinet by **November 30, 2018**	OIO
D.1b	Work with Subcabinet agencies to identify best practices and barriers to engagement.	See D.1 above	Complete by **November 30, 2018**	OIO
D.1c	Work with Department of Human Rights to develop tools and best practices to evaluate engagement efforts.	See D.1 above	Complete by **November 30, 2018**	
D.1d	Obtain input on how to measure the effectiveness utilizing outcomes of engagement across all agencies.	See D.1 above	Complete measurement tool by **November 30, 2018**	OIO

5	Key Activity	Expected Outcome	Deadline	Other Agency(s) or Partners
D.1e	Align and partner with the department of Human Rights to develop evaluation measurements and metrics to assist OIO and subcabinet agencies in engagement work.	See D.1 above	Complete by **November 30, 2018**	OIO MDHR
D.1f	Provide quarterly updates to the Subcabinet on the status of the development of the Community Engagement Plan. The update will address progress on activities D.1a –D.1e above.	See D.1 above	Report to Subcabinet beginning **March 31, 2018** and quarterly thereafter thru completion of the Plan.	OIO
D.2	Develop work plan to implement the Community Engagement Plan. **Report to the Subcabinet**.	Best practices for all Subcabinet agencies will create a more accessible and inclusive community engagement.	Report to Subcabinet by ~~**March 31, 2018**~~ **January 31, 2019**	OIO
E	Community Engagement workgroup will develop recommendations for the scope of work for 2018. **Report to the Subcabinet** on recommendations.		Report to Subcabinet by **December 31, 2017**	OIO

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Item:

6 (e) Workplan Compliance Report for December

Presenter:

Mike Tessneer (OIO Compliance)

Action Needed:

☒ **Approval Needed**

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

Summary of Item:

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

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

Attachment(s):

Workplan Compliance Report for December 2017

[AGENDA ITEM 6e]

Workplan Compliance Report for December 2017

Total number of workplan activities reviewed (see attached)	14	
• Number of activities completed	14	100%
• Number of activities on track	0	0%
• Number of activities reporting exception	0	0%

Exception Reporting

There are no exceptions to report.

[AGENDA ITEM 6e]

Workplan Activities Reviewed in December 2017 (listed alphabetically)

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency report
CM 2D.2	Maintain a monthly calendar to monitor and implement communication activities.	Audiences will be engaged in the Olmstead Plan implementation through communications.	Begin by **August 31, 2017 and monthly thereafter**	OIO	Verified as complete for November occurrence.
CE 5C	Community Engagement workgroup will review, make recommendations for updating and enhancing the OIO Communication Plan. **Report recommendations to the Subcabinet** on the recommendations.	The Community Engagement workgroup and the Subcabinet will support the implementation of a communication plan for diverse communities with disabilities.	Report to Subcabinet by **December 31, 2017**	OIO	Report included in December 2017 Subcabinet packet
CE 5D.1	OIO will develop a workplan to create a new Community Engagement Plan and **report to the Subcabinet**.	Strengthen the community engagement between members of the disability communities and the OIO and state agencies on matters impacting the implementation of the Olmstead Plan.	Report to Subcabinet by **December 31, 2017 (Exception 11/2017)** ~~**November 30, 2017**~~	OIO	Report included in December 2017 Subcabinet packet
CE 5E	Community Engagement workgroup will develop recommendations for the scope of work for 2018. **Report to the Subcabinet** on recommendations.		Report to Subcabinet by **December 31, 2017**	OIO	Report included in December 2017 Subcabinet packet
PS 2A	Evaluate restrictive procedures data to determine: • progress in the reduction of the emergency use of restrictive procedures • trends in utilization • action plan • need for technical assistance	People with disabilities will experience an increase in the use of positive supports and reduction of the use of restrictive procedures.	Evaluate data and create action plan by **November 1, 2017 and annually thereafter** (covering data from previous fiscal year)	DHS	Verified as complete for November 2017 occurrence.
PR1 2H	Develop recommendations for the Subcabinet on the proposed Abuse and Neglect Prevention Plan. Recommendations will be based on: • Specialty Committee meetings that included research, examination, and identification of best practices. • Public input from listening sessions	The Specialty Committee will develop recommendations for the Subcabinet on the Abuse and Neglect Prevention Plan.	Develop recommendations by **November 30, 2017**	OIO, Specialty Committee	Verified as complete.

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency report
PR4 1C	Generate specified report and analyze necessary data from FY14-FY16 to establish baseline.	Establish baseline data that identifies all schools that have had three investigations of alleged maltreatment in the form of physical abuse involving a student with a disability within the three year time period of FY14 – FY16. Determine the number of students with a disability who are named as alleged victims of an investigation of alleged maltreatment in the form of physical abuse within those schools.	Generate report to use as baseline by **November 30, 2017**	MDE	Verified as complete.
PR4 2A	Draft and send a letter to all identified schools to notify them of having three or more investigations of alleged maltreatment in the form of physical abuse involving a student with a disability within their schools within the three year time period of FY14-FY16, and to inform them of the current school year's Positive Behavioral Interventions and Supports (PBIS) training application process and deadlines.	Identified schools will become aware of having three or more investigations of alleged maltreatment in the form of physical abuse involving a student with a disability within their schools within the three year time period of FY14-FY16 and will consider applying for schoolwide MDE approved PBIS cohort training opportunities.	Issue letters by **November 30, 2017 and annually thereafter**	MDE	Verified as complete for November 2017 occurrence.
QL 3A.2	Convene weekly meeting with vendor and provide progress report to workgroup. Convene monthly meetings with the vendor and the Quality of Life Workgroup.	A detailed plan with action steps, roles and timelines will ensure that work is delivered as needed and on time.	Meet weekly with vendor and monthly with QOL workgroup through **December 31, 2017**	OIO	Verified as complete for November 2017 occurrence.
QL 3A.3	Provide a monthly report to the Subcabinet on the progress of survey implementation.	The Subcabinet will be apprised of action steps, benchmarks and deliverables of the Quality of Life Survey.	Report to Subcabinet by **June 30, 2017 and monthly thereafter**	OIO	Included in QL 4B and 4C as
QL 4A	Analyze results of the surveys.	As surveys get completed, analyze within framework of approved Analysis Workplan	Analyze results of survey by **November 30, 2017**	OIO	Verified as complete

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency report
QL 4B	Develop preliminary Analysis Report for Subcabinet Executive Committee.	A preliminary report will outline areas identified and shared with the Subcabinet Executive Committee.	Submit preliminary report to the Executive Committee by **November 30, 2017**	OIO	Complete on December 18, 2017
QL 4C	Submit the final report of QOL survey results **to the Subcabinet** for approval.	A final report with findings will be submitted to the Subcabinet.	Report to Subcabinet by **December 31, 2017**	OIO	Report included in December 2017 Subcabinet packet
TR 1A.1	Include accessible pedestrian signals (APS) and curb ramps in all MnDOT projects meeting the alterations threshold. Sidewalks will be provided in alteration projects per MnDOT policy. Annually report status to OIO Compliance based on previous year construction season.	In the next five years MnDOT will provide accessibility improvements on pedestrian facilities within it right of way.	Report status by **November 30, 2017 and annually thereafter**	DOT	Verified as complete for November 2017 occurrence

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Item:

6 (f) Adjustment to Workplan Activity – Employment 2A.2

Presenter:

Erin Sullivan Sutton (DHS)

Action Needed:

☒ **Approval Needed**

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

Summary of Item:

This is a request for an adjustment of a workplan activity. The current workplan activity, description and deadline is included as well as the requested adjustment and reason for adjustment.

Attachment(s):

Adjustment Needed to Workplan Activity

[AGENDA ITEM 6f]

ADJUSTMENT NEEDED TO WORKPLAN ACTIVITY

Workplan activity, description, deadline	**Sponsor, Reason for Adjustment, Adjustment needed**
Workplan Activity: **Employment 2A.2** - Develop an interagency system to establish baseline, and measure competitive integrated employment outcomes, including outcome measures by race and ethnicity. **Deadline:** Establish baselines by **December 31, 2017**	**Agency/Sponsor:** DHS, DEED, MDE **Reason for Adjustment:** DHS currently does not have the legal authority to share data with DEED. Currently, DHS is able to measure competitive integrated employment with its internal data systems. **Adjustment Needed:** Update OIO on status by **June 30, 2018**

Olmstead Subcabinet Meeting Agenda Item

December 18, 2017

Agenda Item:

7 (a) Workplan activities requiring report to Subcabinet

1) *Community Engagement 5C – OIO Communication Plan (OIO)*
2) *Community Engagement 5E – Workgroup Scope of Work (OIO)*

Presenter:

Darlene Zangara (OIO)

Action Needed:

☐ **Approval Needed**

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

Summary of Item:

These reports to the Subcabinet provide an update on a workplan activity.

Attachment(s):

- *7a1 – 7a2 - Olmstead Plan Workplan - Report to Olmstead Subcabinet*

OLMSTEAD PLAN WORKPLAN
REPORT TO OLMSTEAD SUBCABINET

Topic Area	Community Engagement
Strategy	The Community Engagement Workgroup will provide the OIO and the Subcabinet with recommendations regarding key elements of the Olmstead Plan as specified in the Charter
Workplan Activity Number	CE 5C
Workplan Key Activity	Community Engagement workgroup will make recommendations for updating and enhancing the OIO Communication Plan. Report to the Subcabinet on the recommendations.
Workplan Deadline	December 31, 2017
Agency Responsible	OIO
Date Reported to Subcabinet	December 18, 2017

OVERVIEW

The Community Engagement Workgroup worked to enhance and update the OIO Communication Plan. The Subcabinet and OIO use relationships and tools to provide accurate, timely and useful information about the vision, goals and activities of the Olmstead Plan in ways that are accessible and effective. This will raise awareness and understanding in the Plan and increase long-term engagement with members of the public, including people with disabilities.

REPORT

The Community Engagement Workgroup worked to enhance and update the OIO Communication Plan. See attached document - OIO Communications Plan 2018.

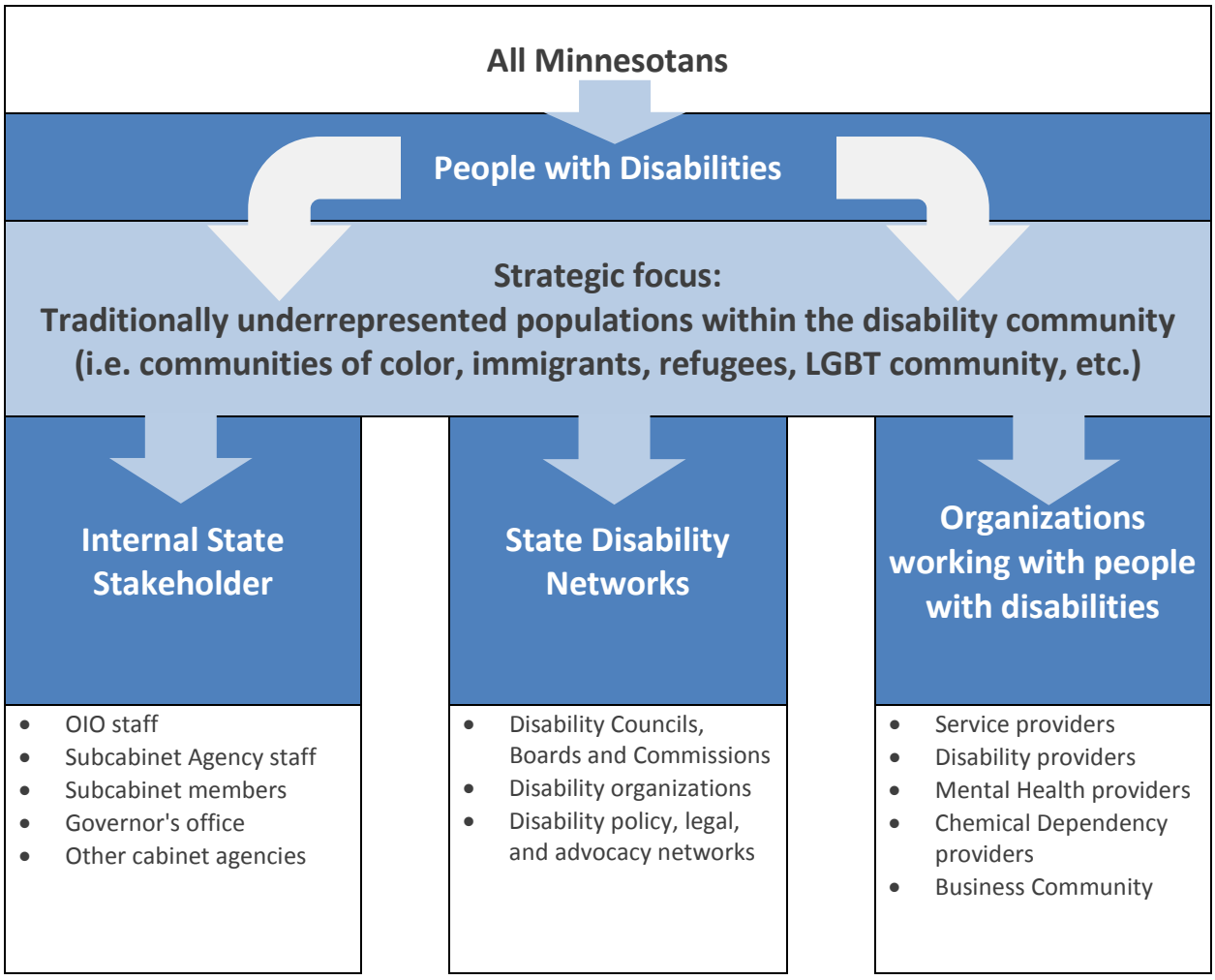
MINNESOTA
OLMSTEAD IMPLEMENTATION OFFICE

Communications Plan 2018

COMMUNICATIONS GOALS

- Increase statewide awareness of and investment in the Minnesota Olmstead Plan.
  - All staff and stakeholders have a common understanding and can communicate effectively about Olmstead.
  - The public has a clear and consistent understanding of Olmstead, how it impacts them, and how they can get more involved.
  - All communications to stakeholders and the public are accessible and inclusive.

AUDIENCES



STRATEGIES

Strategy 1: Build communications strategy and infrastructure across audiences and platforms.

Strategy 2: Build tools to strengthen two-way, reciprocal, and responsive communication between the OIO, state agencies, and the general public.

Strategy 3: The Communication Plan will be kept current and effective.

COMMUNICATION PRIORITIES FOR 2018

1) **Robust Public Input Opportunities**

    a. ***Public Toolkit*** for stakeholders and public. Resources to access the Olmstead Plan website and Facebook page for public input opportunities so that information regarding the Olmstead Plan is transparent and can generate meaningful feedback.

    b. ***OIO Accessibility checklist*** for public input opportunities, whether paper materials or meeting spaces, to ensure inclusivity and access.

2) **Accessible and Inclusive Internet communication platforms**

    a. ***Email marketing, Facebook and website.*** Overall effectiveness communicating with stakeholders will be evaluated with help from the Community Engagement Workgroup.

    b. ***Accessibility Quality Check Process***. Accessibility checklist and procedures utilized for documents, materials, and web postings to create accessible and inclusive Internet communications.

3) **Communication Materials**

    a. Quarterly Newsletter, OIO Quarterly & Annual Report Leaflet and Executive Summaries for Special Reports. Materials published by OIO will have plain language versions.

    b. Accessible Formats. Materials published by OIO will be available in alternative formats or other language upon request.

[AGENDA ITEM 7a2]

OLMSTEAD PLAN WORKPLAN
REPORT TO OLMSTEAD SUBCABINET

Topic Area	Community Engagement
Strategy	The Community Engagement Workgroup will provide the OIO and the Subcabinet with recommendations regarding key elements of the Olmstead Plan as specified in the Charter
Workplan Activity Number	CE 5E
Workplan Key Activity	Community Engagement workgroup will develop recommendations for the scope of work for 2018. Report to the Subcabinet on recommendations.
Workplan Deadline	December 31, 2017
Agency Responsible	OIO
Date Reported to Subcabinet	December 18, 2017

OVERVIEW

The charter states that the Community Engagement workgroup and OIO will identify the scope of work and develop work plan for Year 2. The plan for Year 2 will be developed and presented to the Subcabinet by December 18, 2017.

REPORT

After discussions and deliberations by the Community Engagement workgroup, along with the development of Community Engagement Outcomes, revision of the Communication Plan and development of the Public Input Process Framework, they decided the work has just started. It is critical to continue the workgroup so they can begin the development of a Community Engagement plan, advise on the implementation and evaluation strategies for Public Input Processes and Communication Plan. The workgroup would continue to provide guidance and support to the three core strategic focuses:

1) Inclusive and Accessbile Public Input Processes.
2) Meaningful engagement between members of disability communities, OIO and state agencies on matters impacting the implementation of the Olmstead Plan.
3) Communication Plan to increase statewide awareness and investment in the Minnesota Olmstead Plan.

The core elements of the Scope of Work for 2018 includes:

1. **Review the efficiency and effectiveness of the OIO's Public Input Processes**.
    a. Public Input Process for Subcabinet meetings
    b. Annual Olmstead Plan Amendment Process
    c. Special Topic– Public Input Opportunity

2. **Development of Community Engagement Plan**
    a. Develop a plan with measurable and actionable strategies for advancing engagement between state agencies and people with disabilities.

b. Work with Subcabinet agencies to identify best practices and barriers to engagement.
c. Provide input on how to measure the effectiveness of engagement across all agencies.

3. **Review the efficiency and effectiveness of OIO's communications and outreach efforts**.
    a. Internet Communications
    b. Engaging with under-represented communities
    c. Feedback loop processes