

Olmstead Subcabinet Meeting Agenda

Monday, December 17, 2018 • 3:00 p.m. to 4:30 p.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**
 - a) Subcabinet meeting on November 26, 2018 **3**
- 5) Reports**
 - a) Chair
 - b) Executive Director
 - 1) Public input session schedule **11**
 - c) Legal Office
 - d) Compliance Office **[Agenda items 1-5d 3:00 – 3:05]**
- 6) Action Items**
 - a) Quality of Life Follow-Up Survey (OIO/Improve Group) **[3:05 – 3:25] 211**
 - b) 2018 Annual Report on Olmstead Plan Implementation **[3:25 – 3:40] 15**
 - c) Olmstead Plan Draft proposed amendments **[3:40 – 4:00] 99**
 - d) Workplan Compliance Report for December **[4:00 – 4:05] 127**
 - e) Revised Subcabinet Procedures **[4:05 – 4:10] 135**
- 7) Informational Items and Reports**
 - a) Workplan activities requiring report to Subcabinet
 - 1) Transition Services 3D.2 – Findings and recommendations regarding timely discharge from AMRTC and MSH (DHS) **[4:10 – 4:15] 147**
 - b) Informational Items **[4:15 – 4:25] 153**
 - 1) Update on work with state contractors on inclusion of people with disabilities (MDHR)
 - 2) Civic Engagement and Olmstead (MDHR) **155/175**
- 8) Public Comments** **[4:25 – 4:30]**
- 9) Adjournment**

Next Subcabinet Meeting: January 28, 2019 – 3:00 p.m. – 4:30 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

DRAFT

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Item:

- 4) *Approval of Minutes*
 - a) *Subcabinet meeting on November 26, 2018*

Presenter:

Commissioner Tingerthal (Minnesota Housing)

Action Needed:

- Approval Needed
- Informational Item (no action needed)

Summary of Item:

Approval is needed of the minutes for the November 26, 2018 Subcabinet meeting.

Attachment(s):

4a) Olmstead Subcabinet meeting minutes – November 26, 2018

DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET**Olmstead Subcabinet Meeting Minutes**

Monday, November 26, 2018 • 3:00 p.m. to 5:00 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

1) Call to Order

Commissioner Tingerthal welcomed everyone and provided meeting logistics.

2) Roll Call

Subcabinet members present: Mary Tingerthal, Minnesota Housing; Shawntera Hardy, Department of Employment and Economic Development, joined the meeting at 3:21 p.m. (DEED); Roberta Opheim, Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); Tom Roy, Department of Corrections (DOC); Colleen Wieck, Governor’s Council on Developmental Disability (GCDD); Jan Malcolm, Minnesota Department of Health, joined the meeting at 3:05 p.m. (MDH)

Designees present: Chuck Johnson, Department of Human Services (DHS); Tim Henkel, Department of Transportation (DOT); Rowzat Shipchandler, Minnesota Department of Human Rights (MDHR)

Guests Present: Mike Tessner, Darlene Zangara, Rosalie Vollmar, Zoua Vang, and Sue Hite-Kirk, Olmstead Implementation Office (OIO); Ryan Baumtrog and Anne Smetak (Minnesota Housing); Erin Sullivan Sutton, Alex Bartolic, Adrienne Hannert, Linda Wolford (DHS); Emily Jahr, Tom Delaney, Holly Andersen, Jayne Spain and Robyn Widley (MDE); Maura McNellis-Kubat (OMHDD); Darielle Dannen (DEED); Stephanie Lenartz and Mark Kinde (MDH); Kristie Billiar (DOT); Christina Schaffer (MDHR); Gerri Sutton (Met Council); Joan Willshire, Minnesota Council on Disability (MCD); Susan O’Neill, Institute on Community Integration (ICI); Jane McClure, Access Press; Jesse Bethke Gomez, Metropolitan Center for Independent Living; Bradford Teslow, David Sherwood Gabrielson, Jeff Bangsberg, Diane Drost, Don Amorosi, and Noah McCourt (members of the public)

3) Sign Language and CART providers: Mary Catherine (Minnesota Housing); ASL Interpreting Services, Inc.; Paradigm Captioning and Reporting Services, Inc.**4) Agenda Review**

Commissioner Tingerthal asked if there were any changes needed to the agenda. None were noted. She reminded any attendees interested in providing public comment to sign up in the back of the room.

5) Approval of Minutes**a) Subcabinet meeting on October 29, 2018**

Commissioner Tingerthal asked if there are any changes needed to the minutes for the October Subcabinet meeting. No edits were requested

Motion: Approve October 29th Subcabinet meeting minutes

Action: Motion – Henkel

Second – Shipchandler

In Favor – All

5) Reports**a) Chair**

Commissioner Tingerthal announced

- We received notice from the Court that the next Status Conference will be held in April. More information will be shared once we have a specific date and agenda.
- A Subcabinet meeting is scheduled for January 29th. The Executive Order by Statute continues for at least 90 days after the start of the new administration. Meeting invitations will be sent out to our current member list as a placeholder. The invitations will be updated as needed. A recommendation has been made to issue a new Executive Order continuing the Olmstead Subcabinet. OIO staff will provide a basic orientation packet for new Commissioners.

b) Executive Director

Darlene Zangara announced that OIO has a new Communications Specialist and welcomed Zoua Vang.

c) Legal Office

No report.

d) Compliance Office

Mike Tessneer provided a brief overview of the process to amend the Olmstead Plan and timeline for 2019 found on page 15 of the packet.

Questions/Comments

- Colleen Wieck (GCOD) requested clarification regarding “approves”...amendments to the Plan. Suggested change would be “approve draft”...amendments to the Plan
- Colleen Wieck also requested instruction to use plain language whenever possible. Darlene Zangara (OIO) reported on the goal of transitioning public documents to plain language version. Priority documents are: Strategic Review and overview of The Olmstead Plan

6) Action Items**a) Direct Care and Support Services Workforce Workplans**

Commissioner Tingerthal reminded the Subcabinet that at the October Subcabinet meeting, DHS and DEED presented workplans based upon the recommendations the Direct Care/Support Workforce working group. As a result of discussion at the meeting, approval of the workplans was tabled to allow the agencies to further review and modify the workplans. Alex Bartolic (DHS) and Darielle Danenn (DEED) walked through the proposed workplans.

Questions/Comments:

Strategy 2: Expand the worker pool to ensure that people with disabilities have the workforce they need to live, learn, work and enjoy life in the most integrated setting

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- Commissioner Tingerthal asked if Direct Support Connect follows best practices of other states that have done this successfully. Alex Bartolic (DHS) stated several states were interviewed, with few having a robust directory. (Direct Support Connect as an on-line tool is summarized on pg. 33.)
- Commissioner Tingerthal (Minnesota Housing) asked what date the report in activity 2C is due to the Legislature. Alex Bartolic (DHS) stated that the report is due to go to the Legislature in January. The report to the Subcabinet was scheduled for May to be able to provide follow up from the legislative session. Commissioner Tingerthal asked if the Subcabinet could get the report at the same time as the Legislature. Ms. Bartolic agreed that could be added to the workplans with the follow up provided at the May date.
- For accountability purposes with 2D, Minnesota State contact information will be passed on to the OIO team.

Strategy 4: Increase job satisfaction (including quality of the job)

- Commissioner Roy (DOC) asked if any efforts will be taken to determine why people are not satisfied or leave a job. Ms. Bartolic stated the stakeholder group did not commit to that activity at this time, however as data is received there may be several indicators to be further reviewed.

Strategy 6: Promote service innovation

- Commissioner Tingerthal asked if Department of Administrations, STAR Program, will be a part of this strategy. It was affirmed that they are.

Commissioner Tingerthal asked any members of the public who wanted to provide public comment on this topic to speak to the Subcabinet at this time.

Jeff Bangsberg (member of the public)

Written copy of testimony was not provided. Highlights included:

- Mr. Bangsberg expressed gratitude to DEED and DHS on their lead in recognizing this important work over the last two years. He thanked the Subcabinet for their commitment to the workplan. He also acknowledged Ms. Bartolic and Ms. Dannen for all their efforts. He emphasized the need for data from both agencies, as well as MDH in working with the Legislature. He closed by addressing the Subcabinet and workgroup members present that he found the process really thoughtful, one that doesn't overpromise but hits on the fundamental points. He encouraged advocacy communities to use it as well.

Roberta Opheim (OMHDD) and Commissioner Hardy (DEED) both emphasized the need for a good road map when approaching the Legislature.

Motion: Approve Direct Care and Support Services Workforce workplans

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

DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET**b) November 2018 Quarterly Report**

Mike Tessneer reviewed the Executive Summary highlighting the areas where progress is being made and goals were met. Agency staff reported on the following goals that have been targeted for improvement (Not met or not on track) or need further explanation.

Questions/Comments

- Rowzat Shipchandler (MDHR) asked if the Court views some goals as more important than others, and what the Court's view is for not meeting certain goals. Responses from Mike Tessneer (OIO) and Commissioner Tingerthal were that the Court has not set a directive on goal priorities, but rather consistently asks if the quality of life for people with disabilities is being improved. The measurable goals are to show improvement/progress. If there is none, then something different can be done to meet a goal. Colleen Wieck (GCDD) referenced goal categories and their order as referenced on pg. 39. Commissioner Tingerthal further stated that Subcabinet processes such as Strategic Review and Plan Amendment also bring to light goals that are not being met.

Positive Supports 3A

- Roberta Opheim (OMHDD) asked if the individuals currently reported on are the same 13 from the beginning of the reporting process. Erin Sullivan Sutton (DHS) will confirm if it is the same 13 individuals or not and referenced BIRFs reporting (pd. 69).
- Colleen Wieck (GCDD) wanted to know if a technical assistance team was working with Minnesota Security Hospital-St. Peter. Follow up will be provided by Ms. Sullivan Sutton. DHS has reported quarterly on the challenges of appropriate services and ratio of providers for individuals with high-level needs.

Crisis Services 4A

- Roberta Opheim (OMHDD) requested that DHS review licensing rules concerning individuals who go into the hospital. She has heard that facilities are refusing to take individuals back and do a 60-day transition plan.

Education 2

- Tom Delaney (MDE) clarified a needed edit in the **Comment on Performance** (pg. 79). It should say that Minnesota saw an *increase* in the number of students enrolled not a decrease. He also addressed the importance of having the percentage of proportional data as well as numeric data. Both types of data will be provided to the Subcabinet.

Quality of Life Measurement Results

- Colleen Wieck requested that when the Quality of Life Survey Report comes to the Subcabinet, specific time be made available to review the comparisons to the NCI survey. Commissioner Tingerthal agreed.

Motion: Approve the November Quarterly Report**Action: Motion – Hardy****Second – Shipchandler****In Favor - All**

DRAFT MINUTES ARE SUBJECT TO CHANGE BY FINAL APPROVAL OF THE SUBCABINET**c) Plan amendment public input process /proposed workplans**

Darlene Zangara (OIO) walked through an overview of the Olmstead Plan Amendment Public Input process. She also walked through the workplan to implement the process.

Questions/Comments

- Rowzat Shipchandler (MDHR) suggested intentionally framing the sessions to address what we have control over and what we do not. Her observation from last year is the need to let the general public know what the Executive Branch has control over, what is a Federal issue, and what needs to happen at the State Legislature.
- Colleen Wieck (GCDD) requested as much advance notice as possible with the listening session schedule.
- Commissioner Hardy (DEED) requested thoughtful consideration of locations. She suggested partnering with specific communities already targeted.
- Commissioner Tingerthal commented to agency staff at the meeting, the need for them to attend the listening sessions or assign their staff to attend. This is more critical as listening sessions will immediately follow the transition of commissioners.

Motion: Approve Workplan

Action: Motion – Malcolm Second – Opheim In Favor - All

d) Workplan Compliance Report for November

Commissioner Tingerthal reported that 6 workplan activities were reviewed. There were no exceptions to report. The lists of activities reviewed were attached to the Workplan Compliance report.

Motion: Approve November Compliance Report

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

7) Public Comments

Commissioner Tingerthal asked those who signed up for public comment to speak to the Subcabinet.

Don Amorosi (member of the public)

Public Comment Form was provided and will be filed appropriately with the official meeting records. Copies were not provided to Subcabinet members. Comments included the following:

- Mr. Amorosi described how his son was in need of mental health crisis services on July 12, 2018. Both Hennepin and Carver counties indicated he did not meet criteria. It was suggested to call 911 for any further assistance. On July 13, 911 arrived at the residence of his son. In the home alone, his son was tased and pepper sprayed. Upon his son's exit from the house, he was shot 10 times, handcuffed and died.
- Mr. Amorosi continues to work with MDH, DHS, Minnetonka High School, and Chanhassen Mayor and City Council; however the crisis units will not even respond to DHS inquiries.
- The following suggestions were made for more oversight and accountability:

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- Expand Crisis Service Goal 5 to include measurable goals and outcomes for law enforcement and 911 to increase access to care during a crisis;
- Mental health training for law enforcement to better avoid discrimination against those suffering from mental illness or a crisis;
- Mandated de-escalation training for law enforcement;
- Oversight and accountability for law enforcement and 911; and
- Additional resource funding for crisis units.

Questions/Comments:

- Commissioner Tingerthal and Roberta Opheim (OMHDD) expressed their condolences. Ms. Opheim asked for clarification of which county crisis unit did not respond. Mr. Amorosi stated he was told to call Hennepin County and they referred them to Carver County. It was Carver County who said they couldn't send a unit because his son did not meet criteria. When Mr. Amorosi asked directly what the criteria was, he was told his son needed to be suicidal, homicidal or something about hadn't eaten in several days.

Noah McCourt (member of the public)

Public Comment Form was provided and will be filed appropriately with the official meeting records. Copies were not provided to Subcabinet members. Comments included the following:

- Mr. McCourt read a letter he received from a parent of an autistic child: Carver County Social Services and Crisis Services were "completely missing in action". 911 at times was the only service available to them. He experienced trauma and victimization at the hands of law enforcement. After eight months he drafted a letter to the Chief of Police hoping for an opportunity to be an advocate. A meeting with law enforcement, or acknowledgement of the letter, never happened.
- Failures of public policy that are occurring with Crisis Teams need to be addressed

Questions/Comments:

- Commissioner Tingerthal stated public comments will be taken into consideration by means of Plan amendment process.
- Commissioner Hardy thanked Mr. Amorosi and Mr. McCourt for their personal accounts and connections to the work of the Subcabinet. She stated the work is about changing systems that have not always been structured to keep people at the center.

8) Adjournment

Commissioner Hardy (DEED) announced this was her last meeting as she is not seeking reappointment. She expressed her thanks to the Subcabinet and members of her team for their leadership with this work.

Commissioner Roy (DOC) announced this was also his last meeting and expressed thanks to all.

Commissioner Tingerthal adjourned the meeting at 4:55 p.m.

Next Subcabinet Meeting: December 17, 2018 – 3:00 p.m. – 4:30 p.m.

Minnesota Housing – Lake Superior Conference Room, 400 Wabasha Street North, Suite 400, St Paul

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Items:

5(b) Executive Director Report

Presenter:

Darlene Zangara (OIO)

Action Needed:

- Approval Needed
- Informational Item (no action needed)

Summary of Item:

This is an update on the schedule for the public input sessions for Round 1 and Round 2 of the Plan Amendment Process. It will be reviewed during the Executive Director's Report.

Attachment(s):

5 b) Public input session schedule

[AGENDA ITEM 5b1]

Public Input Sessions for Plan Amendment Process

Public input played a vital role in the development of the Olmstead Plan and continues to inform and shape amendments to the plan. To ensure the Plan remains relevant and responsive to the needs of the community, it is mandated that public input is solicited and incorporated (as appropriate) on an annual basis.

ROUND 1: December 20, 2018 to January 31, 2019

During this round, there will be opportunities to comment on the Olmstead Plan and proposed amendments. All public input sessions will take place from 5:30 p.m. to 7:00 p.m. on the following dates and places.

- Monday, January 7th - Redwood Falls
- Wednesday, January 9th – Mankato
- Monday, January 14th – Phone/videoconference
- Tuesday, January 22nd – Hibbing
- Thursday, January 24th – Twin Cities

Locations will be determined.

ROUND 2: February 26 to March 11, 2019

During this round, there will be opportunities to comment on proposed amendments via phone/videoconference only.

- Wednesday, February 27th – 2:00 to 3:30 PM
- Wednesday, March 6th – 6:00 to 7:30 PM

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Items:

6 (b) 2018 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 – 2018 Annual Report on Olmstead Plan Implementation

Minnesota Olmstead Subcabinet

Annual Report on Olmstead Plan Implementation



REPORTING PERIOD

Data acquired through October 31, 2018

DATE REPORT REVIEWED BY SUBCABINET

December 17, 2018

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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 2018).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 17, 2018 includes data acquired through October 31, 2018. 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 forty-seven measurable goalsⁱ in the Olmstead Plan. As shown in the chart below, twenty-seven of the annual goals were either met or are on track to meet the annual goal.ⁱⁱ Fifteen of the annual goals were not met or not on track to meet the annual goals. For those fifteen goals, the report documents how the agencies will work to improve performance on each goal. Five goals are in process.

Status of Goals - 2018 Annual Report	Number of Goals
Met annual goal	25
On track to meet annual goal	2
Not on track to meet annual goal	0
Did not meet annual goal	15
In Process	5
Goals Reported	47

*The status for each goal is based on the most recent annual goal reported. Each goal is counted 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 September 2018, the Olmstead Subcabinet examined a Strategic Review of Plan implementation over the three-year period. This review identified significant accomplishments in measurable goals and strategies and workplans as well as areas where lack of progress on measurable goals that relate to the improvement in the lives of people with disabilities.
- In October 2018, the Olmstead Subcabinet completed the third comprehensive review of the Olmstead Plan workplans. The annual results of the review of workplans can be found on page 77 of this report. Of the 231 workplan activities reviewed this year, only 5 were reported as exceptions.
- The Subcabinet has initiated the third 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 2019.
- During 2017, the Quality of Life Survey was completed. This survey established a baseline. The [Olmstead Plan Quality of Life Survey Baseline Report](#) was accepted by the Olmstead Subcabinet on March 26, 2018. Subsequent surveys will use the baseline to measure progress on the Plan's impact on improving quality of life for people with disabilities. The first follow up survey is expected to be completed in December of 2018.

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:

- In the first three quarters of the 2018 goal, 140 individuals left Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) programs to more integrated settings. This exceeds the 2018 annual goal of 72. (Transition Services Goal One A)
- In the first three quarters of the 2018 goal, 598 individuals with disabilities under age 65 in a nursing facility longer than 90 days moved to more integrated settings. This is 79% of the 2018 annual goal. (Transition Services Goal One B)
- In the first three quarters of the 2018 goal, 867 individuals moved from other segregated settings to more integrated settings. This exceeds the 2018 annual goal of 500. (Transition Services Goal One C)
- Planning for individuals experiencing a transition has improved through adherence to Transition Protocols. Current performance is at 88.5% compliance. (Transition Services Goal Four)
- The utilization of the Person Centered Protocols has improved over the last four quarters. Of the eight person centered elements measured in the protocols, performance on all elements improved over the 2017 baseline. Four of the eight elements show progress over the previous quarter, and three of the eight are at 90% or greater in this quarter. (Person-Centered Planning Goal One)

Timeliness of Waiver Funding Goal One

- There are fewer individuals waiting for access to a DD waiver. At the end of the current quarter 73% of individuals were approved for funding within 45 days. Another 20% had funding approved after 45 days.

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 1,263 individuals accessing housing or 96% of the annual goal. (Housing and Services Goal One)
- There was an increase in the number of individuals obtaining competitive integrated employment. Over 3,830 new individuals found employment. (Employment Goals One, Two, Three and Four)

The emergency use of manual restraint continues to decrease.

- Fewer people are experiencing emergency use of manual restraint. There was a reduction of 48 individuals or 7% 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 Two to decrease the percentage of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting.
- Transition Services Goal Three to increase the number of individuals leaving the MSH to a more integrated setting.
- Lifelong Learning and Education Goal Two to increase the number of students with disabilities enrolling in integrated postsecondary education settings.
- Positive Supports Goal Three A to reduce the number of reports of emergency use of mechanical restraints with approved individuals.
- Positive Supports Goal Four to reduce the number of students experiencing emergency use of manual restraints.
- Crisis Services Goals One and Two to increase the percentage of children and adults who remain in the community after a mental health crisis.
- Crisis Services Goal Four A to increase the percentage of people who are housed five months after discharge from the hospital (due to a crisis).

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, and 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 as reported for the annual goal:		
Setting	Annual Reporting period	Number moved
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	July 2016 – June 2017	182
• Nursing Facilities	July 2016 – June 2017	824
• Other segregated settings	July 2016 – June 2017	1,054
• Anoka Metro Regional Treatment Center (AMRTC)	July 2017 – June 2018	77
• Minnesota Security Hospital (MSH)	January – December 2017	76
Net number who moved from segregated to integrated settings		2,213

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 settingsⁱⁱⁱ 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	June 30, 2018
A) Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72	84	84	84	72
B) Nursing Facilities (NF) under age 65 in NF > 90 days	707	740	740	740	750
C) Segregated housing other than listed above	1,121	50	250	400	500
Total	1,900	874	1,074	1,224	1,322

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

Annual Goals

- **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**
- **2018 Goal:** For the year ending June 30, 2018 the number of people who have moved from ICFs/DD to a more integrated setting will be **72**

Baseline: January - December 2014 = 72

RESULTS:

The 2017 goal was **met**. [Reported in February 2018]

The 2018 goal is **on track**. [Last reported in November 2018]

Time period	Total number of individuals leaving	Transfers ^{iv} (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	138	18	62	58
2016 Annual (July 2015 – June 2016)	180	27	72	81
2017 Annual (July 2016 – June 2017)	263	25	56	182
2018 Quarter 1 (July – September 2017)	48	1	5	42
2018 Quarter 2 (October – December 2017)	81	2	17	62
2018 Quarter 3 (January – March 2018)	62	6	20	36
Totals (Q1 + Q2 + Q3)	191	9	42	140

ANALYSIS OF DATA:

The 2017 goal of 84 was met. From July 2016 – June 2017, the number of people moving from an ICF/DD to a more integrated setting was 182. For the 2018 goal, during the first three quarters, 140 people moved from an ICF/DD to a more integrated setting which exceeds the annual goal of 72.

COMMENT ON PERFORMANCE:

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

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

DHS continues to work with private providers and Minnesota State Operated Community Services (MSOCS) that have expressed interest in voluntary closure of ICF/DD. Providers are working to develop service delivery models that better reflect a community-integrated approach requested by people seeking services. A total of 12 out of 15 MSOCS ICF/DD converted to other uses since January 2017 for a reduction of 72 state-operated ICF/DD beds. DHS is working with one county to determine the best way to serve the 12 adults currently being served in the remaining three settings. No timeline for conversion of these homes has been confirmed.

For the period January through June 2018, a total of 51 ICF/DD beds were decertified in six locations. One facility decertified 8 beds that were vacant. The remaining five facilities (43 beds) were closed.

UNIVERSE NUMBER:

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

TIMELINESS OF DATA:

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

B) NURSING FACILITIES

Annual Goals

- **2017 Goal:** For the year ending June 30, 2017 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**
- **2018 Goal:** For the year ending June 30, 2018 the number of people who have moved from Nursing Facilities (for persons with a disability under 65 in facility longer than 90 days) to a more integrated setting will be **750**

Baseline: January - December 2014 = 707

RESULTS:

The 2017 goal was **met**. [Reported in February 2018]

The 2018 goal is **on track**. [Last reported in November 2018]

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	1,043	70	224	749
2016 Annual (July 2015 – June 2016)	1,018	91	198	729
2017 Annual (July 2016 – June 2017)	1,097	77	196	824
2018 Quarter 1 (July – September 2017)	264	14	48	202
2018 Quarter 2 (October – December 2017)	276	21	54	201
2018 Quarter 3 (January – March 2018)	259	20	44	195
Totals (Q1 + Q2 + Q3)	799	55	146	598

ANALYSIS OF DATA:

The 2017 goal of 740 was met. From July 2016 – June 2017, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 824.

For the 2018 goal, during the first three quarters, 598 people under the age of 65 moved to a more integrated settings. This is 79% of the annual goal of 750. If moves continue at approximately the same rate, the 2018 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 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.

UNIVERSE NUMBER:

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

TIMELINESS OF DATA:

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

C) SEGREGATED HOUSING**Annual Goals**

- **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**.
- **2018 Goal:** For the year ending June 30, 2018, the number of people who have moved from other segregated housing to a more integrated setting will be **500**.

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

RESULTS:

The 2017 goal was **met**. [Reported in February 2018]
 The 2018 goal is **on track**. [Last reported in November 2018]

Time period	Total moves	Receiving Medical Assistance (MA)			No longer on MA
		Moved to more integrated setting	Moved to congregate setting	Not receiving residential services	
2015 Annual (July 2014 – June 2015)	5,703	1,137 (19.9%)	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
2016 Annual (July 2015 – June 2016)	5,603	1,051 (18.8%)	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
2017 Annual (July 2016 – June 2017)	5,504	1,054 (19.2%)	492 (8.9%)	3,466 (63.0%)	492 (8.9%)
2018 Quarter 1 (July – September 2017)	1,461	298 (20.4%)	110 (7.5%)	922 (63.1%)	131 (9.0%)
2018 Quarter 2 (October – December 2017)	1,381	297 (21.5%)	116 (8.4%)	854 (61.8%)	114 (8.3%)
2018 Quarter 3 (January – March 2018)	1,522	272 (17.9%)	143 (9.4%)	972 (63.8%)	135 (8.9%)
Total (Q1 + Q2 + Q3)	4,364	867 (19.9%)	369 (8.5%)	2,748 (62.9%)	380 (8.7%)

ANALYSIS OF DATA:

The 2017 goal of 400 was met. From July 2016 – June 2017, of the 5,504 individuals moving from segregated housing, 1,054 individuals (19.2%) moved to a more integrated setting. For the 2018 goal, during the first three quarters, 867 individuals moved to a more integrated setting which exceeds the annual goal of 500.

COMMENT ON PERFORMANCE:

During the first three quarters reported for the 2018 goal, there were significantly more individuals who moved to more integrated settings (19.9%) than those who moved to congregate settings (8.5%). This analysis also shows the number of individuals who are not receiving residential services and those no longer on MA. These categories are defined below.

The data indicates that a large percentage (62.9%) 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).

Annual Goals

- **2018 Goal:** By June 30, 2018, the percent of people at AMRTC awaiting discharge will be reduced to no more than **32%**
- **2019 Goal:** By June 30, 2019 the percent of people at AMRTC awaiting discharge will be reduced to no more than **33%**

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.²

RESULTS:

The 2018 goal was **not met.** [Reported in August 2018]

The 2019 goal is **not on track.** [Last reported in November 2018]

Time period	Percent awaiting discharge (daily average)	
2016 Baseline (July 2015 – June 2016)	Daily Average = 42.5% ³	
	Mental health commitment	Committed after finding of incompetency
2017 Annual (July 2016 – June 2017)	44.9%	29.3%
2018 Annual (July 2017 – June 2018)	36.9%	23.8%
2019 Goal Quarter 1 (July – September 2018)	50.9%	27.7%

² The baseline included individuals at AMRTC under mental health commitment and restore to competency.

³ This data for July 2015 - June 2016 was reported as a combined percentage for individuals under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency). After July 2016, the data is reported for the two categories.

ANALYSIS OF DATA:

The 2018 goal to reduce to no more than 32% was not met. From July 2017 – June 2018, 36.9% of those under mental health commitment at AMRTC no longer meet hospital level of care and were awaiting discharge to the most integrated setting.

For the 2019 goal, during the first quarter, 50.9% of those under mental health commitment at AMRTC no longer met hospital level of care and were awaiting discharge to the most integrated setting. This percentage is higher than 7 of the last 8 quarters. The goal is not on track to meet the 2019 goal to reduce the percentage awaiting discharge to 30%.

From July 2017 – June 2018, 77 individuals at AMRTC under mental health commitment left and moved to an integrated setting. An additional 20 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	Committed after finding of incompetency ^{vi}
July 2016 – June 2017	267	155	2	110	54	56
July 2017 – June 2018	274	197	0	77	46	31
Quarter 1 (July – Sept 2018)	71	51	0	20	17	54

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.

During Quarter 1, the percentage of patients hospitalized at AMRTC who are civilly committed after being found incompetent continues to increase and is currently around 75%.

The percentage of patients hospitalized at AMRTC who are under mental health commitment only is around 25%. With the continued decrease in the number of patients hospitalized at AMRTC under only mental health commitments, every patient not needing hospital level of care has greater impact on the overall percentage.

During the last year there was a higher percentage of individuals awaiting discharge for those under mental health commitment (50.9%) than for those who were civilly committed to AMRTC after being found incompetent (27.7%). However, the percentage of patients hospitalized at AMRTC who are civilly committed after being found incompetent continues to increase and is currently around 75%.

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 and discharge 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.
- Improvements in AMRTC's notification process to courts and parties in criminal cases for individuals who were civilly committed after a finding of incompetency who no longer meet hospital criteria of care.

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 has convened 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 the community. Counties and community providers will be consulted and engaged in this effort as well. Annual reporting to the Olmstead Subcabinet on the status of these efforts will begin by December 31, 2018.

UNIVERSE NUMBER:

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

TIMELINESS OF DATA:

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

TRANSITION SERVICES GOAL THREE: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital to a more integrated setting will increase to 10 individuals per month.

Annual Goals

- **2017 goal:** By December 31, 2017 the average monthly number of individuals leaving to a more integrated setting will increase to **8 or more**
- **2018 Goal:** By December 31, 2016 the average monthly number of individuals leaving to a more integrated setting will increase to **9 or more**

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

RESULTS:

The 2017 goal was **not met**. [Reported in February 2018]

The 2018 goal is **not on track**. [Last reported in November 2018]

Time period	Total number of individuals leaving	Transfers ^{iv} (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (January – December 2015)	188	107	8	73 Average = 6.1
2016 Annual (January – December 2016)	184	97	3	84 Average = 7.0
2017 Annual (January – December 2017)	199	114	9	76 Average = 6.3
2018 Quarter 1 (Jan – March 2018)	64	47	2	15 Average = 5.0
2018 Quarter 2 (April – June 2018)	53	32	0	21 Average = 7.0
2018 Quarter 3 (July – Sept 2018)	44	28	1	15 Average = 5.0

ANALYSIS OF DATA:

The 2017 goal of 8 or more was not met. From January – December, 2017, the average monthly number of individuals leaving Forensic Services⁴ to a more integrated setting was 6.3.

For the 2018 goal, in the first three quarters, the average monthly number of individuals leaving Forensic Services to a more integrated setting was 5.7. This goal is not on track to meet the 2018 goal of 9 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 (those civilly committed after being found incompetent on a felony or gross misdemeanor charge, those who are committed as Mentally Ill and Dangerous (MI&D), and Other committed).

⁴ 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 ^{vi}	Total moves	Transfers	Deaths	Moves to integrated
2015 Annual (January – December 2015)	Committed after finding of incompetency	99	67	1	31
	MI&D committed	66	24	7	35
	Other committed	23	16	0	7
	Total	188	107	8	(Avg. 6.1) 73
2016 Annual (January – December 2016)	Committed after finding of incompetency	93	62	0	31
	MI&D committed	69	23	3	43
	Other committed	25	15	0	10
	Total	187	100	3	(Avg. 7.0) 84
2017 Annual (January – December 2017)	Committed after finding of incompetency	133	94	2	27
	MI&D committed	55	17	6	32
	Other committed	11	3	1	7
	Total	199	114	9	(Avg. 6.3) 76
2018 Quarter 1 (Jan – March 2018)	Committed after finding of incompetency	45	36	0	9
	MI&D committed	19	11	2	6
	Other committed	0	0	0	0
	Total	64	47	2	(Avg. 5.0) 15
2018 Quarter 2 (April – June 2018)	Committed after finding of incompetency	31	24	0	7
	MI&D committed	21	8	0	13
	Other committed	1	0	0	1
	Total	53	32	0	(Avg. 7.0) 21
2018 Quarter 3 (July – Sept 2018)	Committed after finding of incompetency	31	20	0	11
	MI&D committed	12	7	1	4
	Other committed	1	1	0	0
	Total	44	8	1	(Avg. 5.0) 15

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 in 2017 increased the base funding for state operated facilities 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. These positions are primarily in direct care positions such as registered nurses, forensic support specialists and human services support specialists. As of September 2018, 97% of professional positions are filled and 96.2% of direct care positions were filled.

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.
- Individuals whose county case management staff has refused or failed to adequately participate in developing an appropriate provisional discharge plan for the individual

Some barriers to discharge identified by the Special Review Board (SRB), in their 2017 MI&D Treatment Barriers Report as required by Minnesota Statutes 253B.18 subdivision 4c(b) included:

- The patient lacks an appropriate provisional discharge plan
- A placement that would meet the patient's needs is being developed
- Funding has not been secured

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. As a result of these efforts, through November 2018, Forensic Services recommended reductions-in-custody to the Special Review Board for 73 individuals, 55 of which were granted thus far, with 11 results pending.
- Collaboration within DHS to expand community capacity and individualized services for a person's transitioning.

Committed after finding of incompetency

Forensics also admits and treats individuals who are civilly committed after being found incompetent on felony or gross misdemeanor charges. These individuals are provided mental health treatment and competency education.

DHS has convened 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. Annual reporting to the Olmstead Subcabinet on the status of these efforts will begin by December 31, 2018.

UNIVERSE NUMBER:

In Calendar Year 2017, 581 patients received services at MSH. This may include individuals who were admitted more than once during the year. The average daily census was 358.4.

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, 2020, 100% of people who experience a transition will engage in a process that adheres to the Person-Centered, Informed Choice and Transition protocol. Adherence to the transition protocol will be determined by the presence of the ten elements from the My Move Plan Summary document listed below. [People who opted out of using the My Move Summary document or did not inform their case manager that they moved are excluded from this measure.] [Revised March 2018]⁵

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

RESULTS:

This goal is **in process**. [Last reported in November 2018]

Time period	Number of transition case files reviewed	Number opted out	Number not informing case manager	Number of remaining files reviewed	Number not adhering to protocol	Number adhering to protocol
Quarter 1 July – Sept 2017	29	6	0	23	11 of 23 (47.8%)	12 of 23 (52.2%)
Quarter 2 Oct – Dec 2017	26	3	1	22	7 of 22 (31.8%)	15 of 22 (68.2%)
Quarter 3 Jan – March 2018	25	5	3	17	2 of 17 (11.8%)	15 of 17 (88.2%)
Quarter 4 April – June 2018	34	6	2	26	3 of 26 (11.5%)	23 of 26 (88.5%)

⁵ This goal was revised in the March 2018 Olmstead Plan to use the current measure. The February 2018 Quarterly Report (Doc 680-1) included results using the previous measure.

ANALYSIS OF DATA:

For the last quarter reported (April – June 2018), of the 34 transition case files reviewed, 6 people opted out of using the My Move Plan document and 2 people did not inform their case manager that they were moving. Of the remaining 26 case files, 23 files (88.5%) adhered to the transition protocol. Adherence to the transition protocols has improved over the last four quarters and over baseline.

The plan is considered to meet the transition protocols if all ten items below (from “My Move Plan” document) are present:

- a. Where is the person moving?
- b. Date and time the move will occur.
- c. Who will help the person prepare for the move?
- d. Who will help with adjustment during and after the move?
- e. Who will take the person to new residence?
- f. How will the person get his or her belongings?
- g. Medications and medication schedule.
- h. Upcoming appointments.
- i. 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?
- j. Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

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

COMMENT ON PERFORMANCE:

In January 2018, Lead Agency Review began requiring lead agencies to remediate missing or non-compliant 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. Corrective action plans will be required when patterns of non-compliance are evident. Because the move occurred prior to the Lead Agency site review, transition measures related to the contents of the My Move Plan Summary cannot be remediated. However, Lead Agencies are provided information about which components of the My Move Plan were compliant/non-compliant for each of the transition cases that were reviewed.

TIMELINESS OF DATA:

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

III. MOVEMENT OF INDIVIDUALS FROM WAITING LISTS

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

TIMELINESS OF WAIVER FUNDING GOAL ONE: Lead agencies will approve funding at a reasonable pace for persons: (A) exiting institutional settings; (B) with an immediate need; and (C) with a defined need for the Developmental Disabilities (DD) waiver. [Revised March 2018]⁶

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 percentages by urgency of need category were: Institutional Exit (42%); Immediate Need (62%); and Defined Need (42%).

Assessments between January – December 2016

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

RESULTS:

This goal is **in process**. [Last reported in November 2018]

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	Pending funding approval
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%)

⁶ This goal was added to the March 2018 Olmstead Plan to replace Waiting List Goals One – Five. The February 2018 Quarterly Report (Doc 680-1) included reporting for this goal under the Waiting List Goals.

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	Pending funding approval
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%)

Time period: July – September 2017

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	29	21 (72%)	6 (21%)	2 (7%)
Immediate Need	122	83 (68%)	32 (26%)	7 (6%)
Defined Need	297	189 (64%)	80 (27%)	28 (9%)
Totals	448	293 (66%)	118 (26%)	37 (8%)

Time Period: October – December 2017

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	28	14 (50%)	12 (43%)	2 (7%)
Immediate Need	110	74 (67%)	34 (31%)	2 (2%)
Defined Need	229	141 (62%)	71 (31%)	17 (7%)
Totals	367	229 (62%)	117 (32%)	21 (6%)

Time Period: January - March 2018

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	19	16 (84%)	2 (11%)	1 (5%)
Immediate Need	114	79 (69%)	26 (23%)	9 (8%)
Defined Need	256	177 (69%)	63 (25%)	16 (6%)
Totals	389	272 (70%)	91 (24%)	26 (7%)

Time Period: April - June 2018

Urgency of Need Category	Total number of people assessed	Reasonable Pace Funding approved within 45 days	Funding approved after 45 days	Pending funding approval
Institutional Exit	20	12 (60%)	6 (30%)	2 (10%)
Immediate Need	121	89 (74%)	26 (21%)	6 (5%)
Defined Need	311	227 (73%)	61 (20%)	23 (7%)
Totals	452	328 (73%)	93 (20%)	31 (7%)

ANALYSIS OF DATA:

For the most recent quarter reported (April – June 2018), of the 452 individuals assessed for the Developmental Disabilities (DD) waiver, 328 individuals (73%) had funding approved within 45 days of the assessment date. In the previous quarter, of the 389 individuals assessed, 272 individuals (70%) had funding approved within 45 days of assessment. This quarter achieved the highest proportion of people being approved for funding within 45 days since the measure has been in place, even with a greater number of people receiving assessments.

COMMENT ON PERFORMANCE:

Lead agencies receive monthly updates regarding the people who are still waiting for DD funding approval through a web-based system. Using this information, lead agencies can view the number of days a person has been waiting for DD funding approval and whether reasonable pace goals are met. If reasonable pace goals are not met for people in the Institutional Exit or Immediate Need categories, DHS directly contacts the lead agency and seeks remediation. DHS continues to allocate funding resources to lead agencies to support funding approval for people in the Institutional Exit and Immediate Need categories.

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

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

Below is a summary table with the number of people still waiting for funding approval at specific points of time. Also included is the average and median days waiting of those individuals who are still waiting for funding approval. The average days and median days information has been collected since December 1, 2015. This data does not include those individuals who had funding approved within the 45 days reasonable pace goal. The total number of people still waiting for funding approval as of October 1, 2018 (114) has decreased since October 1, 2017 (152).

People Pending Funding Approval as of April 1, 2017

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	13	91	82
Immediate Need	16	130	93
Defined Need	172	193	173
Total	201		

People Pending Funding Approval as of July 1, 2017

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	13	109	103
Immediate Need	26	122	95
Defined Need	198	182	135
Total	237		

People Pending Funding Approval as of October 1, 2017

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	12	136	102
Immediate Need	36	120	82
Defined Need	104	183	137
Total	152		

People Pending Funding Approval as of January 1, 2018

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	1	144	144
Immediate Need	22	108	74
Defined Need	66	184	140
Total	89		

People Pending Funding Approval as of April 1, 2018

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	5	65	61
Immediate Need	20	109	73
Defined Need	35	154	103
Total	60		

People Pending Funding Approval as of July 1, 2018

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	6	360	118
Immediate Need	26	115	85
Defined Need	62	120	70
Total	94		

People Pending Funding Approval as of October 1, 2018

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	12	112	74
Immediate Need	26	110	78
Defined Need	76	132	106
Total	114		

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.

DRAFT

IV. QUALITY OF LIFE MEASUREMENT RESULTS

The results for the 2017 National Core Indicator (NCI) survey for individuals with intellectual and developmental disabilities were published in September 2018. 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, the overall sample size for the 2017 survey was 2,199.

Summary of National Core Indicator Survey Results from Minnesota in 2016 - 2017

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.

Question	2015 - 2016		2016-2017	
	Yes	No	Yes	No
1. Do you have a paid job in your community?	41%	59%	35%	65%
2. Would you like a job in the community	52%	48%	47%	53%
3. Do you like where you work?	92%	8%	89%	11%
4. Do you want to work somewhere else?	34%	66%	28%	72%
5. Did you go out shopping in the past month?*	92%	8%	92%	8%
6. Did you go out on errands in the past month?*	91%	9%	89%	11%
7. Did you go out for entertainment in the past month?*	83%	17%	82%	18%
8. Did you go out to eat in the past month?*	86%	14%	89%	11%
9. Did you go out for a religious or spiritual service in the past month?*	46%	54%	47%	53%
10. Did you participate in community groups or other activities in community in past month?	37%	63%	43%	57%
11. Did you go on vacation in the past year?	58%	42%	48%	52%
12. Did you have input in choosing your home?	56%	44%	45%	55%
13. Did you have input in choosing your roommates?	34%	66%	22%	78%
14. Do you have friends other than staff and family?	83%	17%	82%	18%
15. Can you see your friends when you want to?	77%	23%	81%	19%
16. Can you see and/or communicate with family whenever you want?	94%	6%	87%	13%
17. Do you often feel lonely?	11%	89%	10%	90%
18. Do you like your home?	89%	11%	88%	12%
19. Do you want to live somewhere else?	29%	71%	26%	74%
20. Does your case manager ask what you want?	89%	11%	84%	16%
21. Are you able to contact case manager when you want?	87%	13%	89%	11%
22. Is there at least one place you feel afraid or scared?	30%	70%	18%	82%
23. Can you lock your bedroom?	42%	58%	45%	55%
24. Do you have a place to be alone at home?	99%	1%	98%	2%
25. Have you gone to a self-advocacy meeting?	30%	70%	29%	71%

*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 is designed to be a longitudinal survey, which means participants will be re-surveyed in the future. The Quality of Life Baseline Survey was conducted between February and November 2017. At completion, 2,005 people, selected by random sample, participated in the survey. This survey was designed specifically for people with disabilities of all ages in all settings. In Minnesota, the survey was targeted to people who are authorized to receive state-paid services in potentially segregated settings. This survey sought to talk directly with individuals to get their own perceptions and opinions about what affects their quality of life.

The [Olmstead Plan Quality of Life Survey Baseline Report](#) was accepted by the Olmstead Subcabinet on March 26, 2018. Key baseline results were included in the May 2018 Quarterly Report and the full report was attached as an exhibit.

It is expected that subsequent Quality of Life Surveys will be conducted two or three times during the following three years to measure changes from the baseline. The next survey is expected to be completed in December of 2018. Future surveys are subject to adequate funding.

The difference between the baseline survey and follow-up surveys will be used to better understand whether increased community integration and self-determination are occurring for people with disabilities receiving services in selected settings.

The first follow-up survey is currently underway. The 2018 Quality of Life Survey began in June 2018 and will continue throughout November 2018. The goal is to capture 500 completed surveys. The surveys will be analyzed and compared to the results from the baseline survey.

As of November 14, 2018, of the 500 individuals, 453 individuals (91%) have been interviewed. Of the 47 interviews remaining to reach 500, 44 individuals are scheduled for an interview.

Summary of activities:

- 3,482 calls made
- 496 consents received
- 453 interviews completed
- 44 interviews scheduled

Other key activities that have occurred to date include:

- Outreach to providers, guardians and individuals with disabilities to establish interviews;
- Interviews are being conducted;
- Regular meetings with Olmstead Implementation Office, DHS, DEED, Quality of Life Advisory Group and the Improve Group to monitor progress; and
- Development of research questions and analysis plan for the final report.

The 2018 Quality of Life Survey Results report is expected to be presented to the Olmstead Subcabinet by December 31, 2018.

V. INCREASING SYSTEM CAPACITY AND OPTIONS FOR INTEGRATION

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

PERSON-CENTERED PLANNING GOAL ONE: By June 30, 2020, plans for people using disability home and community-based waiver services will meet protocols. Protocols are based on the principles of person-centered planning and informed choice. [Revised March 2018]⁷

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

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

RESULTS:

This goal is **in process**. [Last reported November 2018]

Time Period	(1) Preferences	(2) Dreams Aspirations	(3) Choice	(4) Rituals Routines	(5) Social Activities	(6) Goals	(7) Living	(8) Work
Baseline April – June 2017	74%	17%	79%	62%	83%	70%	80%	71%
Quarter 1 July – Sept 2017	75.9%	6.9%	93.1%	37.9%	93.1%	79.3%	96.6%	93.1%
Quarter 2 Oct –Dec 2017	84.6%	30.8%	92.3%	65.4%	88.5%	76.9%	92.3%	92.3%
Quarter 3 Jan – March 2018	84.6%	47.3%	91.6%	68.9%	93.5%	79.6%	97.5%	94.1%
Quarter 4 April – June 2018	80.2%	40.1%	92.8%	67.1%	94.5%	89.5%	98.7%	78.9%

⁷ This goal was revised in the March 2018 Olmstead Plan to use the current measure. The February 2018 Quarterly Report (Doc 680-1) included results using the previous measure.

ANALYSIS OF DATA:

During the last quarter reported (April – June 2018), of the 237 case files reviewed, the eight required criteria were present in the percentage of files shown above. Performance on all eight elements has improved over the 2017 baseline. Four of the eight elements showed progress from the previous quarter. Three of the eight are at 90% or greater this quarter.

Total number of cases and sample of cases reviewed

Time Period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)
Quarter 1 (July – September 2017)	934	192
Quarter 2 (October –December 2017)	1,419	186
Quarter 3 (January – March 2018)	8,613	628
Quarter 4 (April – June 2018)	1,226	237

Counties Participating in Audits⁸

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. Mahnomon	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 ⁹
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 ¹⁰		51. Beltrami
35. Polk	43. Washington		
36. Clay			
37. Aitkin			

⁸ Agency visits are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS).

⁹ The MN Prairie Alliance includes Dodge, Steele, and Waseca counties.

¹⁰ The SW Alliance includes Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock counties.

July – September 2017	October – December 2017	January – March 2018	April – June 2018
52. Pennington	58. Stearns	61. Dakota	64. Big Stone
53. Winona	59. McLeod	62. Scott	65. Des Moines Valley Alliance ¹¹
54. Roseau	60. Kandiyohi	63. Ramsey	66. Kanabec
55. Marshall			67. Nicollet
56. Kittson			68. Rice
57. Lake of the Woods			69. Sibley
			70. Wilkin

COMMENT ON PERFORMANCE:

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

In January 2018, Lead Agency Review began requiring lead agencies to remediate missing or non-compliant 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. Corrective action plans will be required when patterns of non-compliance are evident. For the purposes of corrective action person-centered measures are grouped into two categories: development of a person-centered plan and support plan record keeping.

For the lead agencies reviewed during this time period, most counties reviewed were required to develop corrective action plans in at least one category for at least one disability waiver program. Big Stone County was not required to develop corrective action plans in the area of person-centered practices.

UNIVERSE NUMBER:

In Fiscal year 2017 (July 2016 – June 2017), 47,272 individuals received disability home and community-based services.

TIMELINESS OF DATA:

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

¹¹ The Des Moines Valley Health and Human Services Alliance includes Cottonwood and Jackson counties.

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 (A) major life decisions and (B) everyday decisions, and to be (C) always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey.

	2014 Baseline	2015 Goal	2016 Goal	2017 Goal
(A) Major life decisions	40%	45% or greater	50% or greater	55% or greater
(B) Everyday decisions	79%	84% or greater	85% or greater	85% or greater
(C) Always in charge of their service and supports	65%	70% or greater	75% or greater	80% or greater

A) INPUT INTO MAJOR LIFE DECISIONS

2017 Goal

- By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions to **55% or higher**

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

RESULTS:

The 2017 goal was **not met**. [Reported in November 2018]

Time Period	Number Surveyed	Percent reporting they have input into major life decisions
Baseline (2014 survey)	--	40%
2015 Annual (2015 survey)	400	44.3%
2016 Annual (2016 survey)	427	64%
2017 Annual (2017 survey)	1,987	51%

ANALYSIS OF DATA:

The 2017 NCI survey results indicated that 51% of people reported they have input into major life decisions. The 2017 goal of 55% or higher was not met. The 2017 results of 51% are a decrease from the previous year results of 64%. However, when looking at the four data points (including the baseline) the 2016 results for this measure of 64% appears to be an outlier in the trend line.

The data for this measure is taken from the NCI-DD survey. The population surveyed included adults with Intellectual or Developmental Disabilities (I/DD) who get case management services and at least one other service. In odd numbered years, starting in 2017, the NCI-DD survey is used to look for trends at the regional level. This requires a larger sample. Therefore the sample size in odd numbered years will be substantially larger than the sample size in even numbered years. While there are some differences on individual questions among the regions there does not appear to be systematic regional variation.

COMMENT ON PERFORMANCE:

The percent of individuals reporting they have input into major life decisions decreased in 2017 as compared to 2016. One possible reason is that people are more aware of their rights and/or they

may have changing expectations as they become more aware of different options. The table below shows the percentage by the setting that people live in (ICF/DD, community group residential setting, own home or parent/family home). There is substantial variation in the results of the measure based on setting.

Percent of individuals reporting they have input into major life decisions by setting

Residential setting	2016	2017
Own home	80%	74%
Live with family	77%	64%
ICF/DD	61%	48%
Group Residence	50%	41%
Foster/host	--	42%

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

2017 Goal

- By 2017, 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 2017 goal was **met**. [Reported in November 2018]

Time Period	Number Surveyed	Percent reporting they have input in everyday decisions
Baseline (2014 survey)	--	79%
2015 Annual (2015 survey)	400	84.9%
2016 Annual (2016 survey)	427	87%
2017 Annual (2017 survey)	2,043	92%

ANALYSIS OF DATA:

The 2017 NCI survey results indicated that 92% of people reported they have input in everyday decisions. The 2017 goal of 85% or greater was met.

The data for this measure was taken from the NCI-DD survey. The population surveyed included adults with Intellectual or Developmental Disabilities (I/DD) who get case management services and at least one other service. In odd numbered years, starting in 2017, the NCI-DD survey is used to look for trends at the regional level. This requires a larger sample. Therefore the sample size in odd numbered years will be substantially larger than the sample size in even numbered years.

COMMENT ON PERFORMANCE:

While there are some differences on individual questions among the regions there does not appear to be systematic regional variation.

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**2017 Goal**

- By 2017, increase the percent of people with disabilities other than I/DD who report they are always in charge of their services and supports to **80% or higher**

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

RESULTS:

The 2017 goal was **not met**. [Reported in November 2018]

Time Period	Number Surveyed	Percent reporting they are always in charge of their services and supports
Baseline (2015 survey)	--	65%
2016 Annual (2016 survey)	1,962	72%
2017 Annual (2017 survey)	377	63%

ANALYSIS OF DATA:

The 2017 NCI survey results indicated that 63% of people reported they are always in charge of their services and supports. The 2017 goal of 80% or greater was not met.

The data for this measure was taken from the NCI-AD survey. The population surveyed 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. In even numbered years the NCI-AD is used to look for trends at the regional level. This requires a larger sample. Therefore the sample size in even numbered years will be substantially larger than the sample size in odd numbered years.

COMMENT ON PERFORMANCE:

The percent of individuals reporting they are always in charge of their services and supports decreased in 2017 as compared to 2016. Further investigation was conducted on this measure. There is substantial variation based on where a person resides. The overall change from 2016 to 2017 is statistically significant. However, when testing the changes by the different residential setting, the only change that is statistically significant is the change in 'Group Home'. Therefore, the primary driver of the decrease in the percent of people who feel that they are always in control of their services and supports appears to be the change in the people who reside in Group Homes.

Percent reporting they are always in charge of their services and supports by setting

Residential setting	2016	2017
Own home	74%	68%
Group home	71%	49%
Foster home	77%	65%

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).

2018 Goal

- By June 30, 2018 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 4,009 over baseline to **10,026** (about 67% 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 2018 goal to increase by 4,009 over baseline was **not met**. [Reported in November 2018]

Time period	People in integrated housing	Change from previous year	Increase over baseline
2014 Baseline (July 2013 – June 2014)	5,995	--	--
2015 Annual (July 2014 – June 2015)	6,910	+915	915 (15.3%)
2016 Annual (July 2015 – June 2016)	7,605	+695	1,610 (26.8%)
2017 Annual (July 2016 – June 2017)	8,745	+1,140	2,750 (45.8%)
2018 Annual (July 2017 – June 2018)	9,869	+1,263	3,852 (64.2%)

ANALYSIS OF DATA:

From July 2017 through June 2018 the number of people living in integrated housing increased by 3,852 (64%) over baseline to 9,869. Although the 2018 goal was not met, the increase of 3,852 was 96% of the annual goal of 4,009. The increase in the number of people living in integrated housing from July 2017 to June 2018 was 1,263 compared to an increase of 998 in the previous year.

As of November 2018 a new methodology is being used to report the data in this measure. All previously numbers dating back to 2014 were recalculated using the new method. A change to the baseline will be proposed through the Olmstead Plan amendment process beginning in December 2018.

COMMENT ON PERFORMANCE:

Although the 2018 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.

2017 Goal

- By September 30, 2017, the number of new individuals with disabilities working in competitive integrated employment will be **2,969**.

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 2017 goal was **not met**. [Reported in February 2018]

Time period Federal Fiscal Year (FFY)	Number of Individuals Achieving Employment Outcomes		
	Vocational Rehabilitation Services (VRS)	State Services for the Blind (SSB)	Total
Baseline (2014)	--	--	2,738
2015 Annual (October 2014 – Sept 2015)	3,104	132	3,236
2016 Annual (October 2015 – Sept 2016)	3,115	133	3,248
2017 Annual (October 2016 – Sept 2017)	2,713	94	2,807

ANALYSIS OF DATA:

From October 2016 – September 2017, the number of people with disabilities working in competitive integrated employment was 2,807. The 2017 annual goal of 2,969 was not met. This number represents a decrease from the previous year, and an increase of 69 over baseline.

VRS: In FFY 17, the number of applications and completed plans increased over FFY 16 (applications increased 2.8%; plans completed increased 6%). Despite those increases, the number of employment outcomes for FFY 17 dropped to 2,713, a 12.9% decrease from FFY 16.

SSB: In FFY 17 the total number of customers served was 1,054. This is a decrease from the two previous years, (1,289 in FFY 16 and 1,265 in FFY 15). SSB continues to receive a steady number of applications, 279 in FFY 17. In FFY 17 SSB served a higher proportion of first time customers (38.3%) compared to 36.0% in FFY 16 and 35.4% in FFY 15. SSB also served a higher proportion of youth 14-21

years (26.5%) in FFY 17, compared to 19.5% in FFY 16 and 23.8% in FFY 15. This is a shift that will likely continue under WIOA's emphasis on transition students.

COMMENT ON PERFORMANCE:

VRS: This reduction in the number of individuals who achieved competitive integrated employment is a reflection of the changing demographics of persons being served and the increased complexity of their circumstances. Since the passage of the Workforce Innovation and Opportunity Act (WIOA), VRS has only been able to serve persons in category 1—those with the most significant disabilities. Additionally, the number of youth with intellectual and developmental disabilities being served has increased by 93% since FFY 15, largely due to the WIOA Section 511 mandate. This population requires intensive and long-term services in order to achieve an employment outcome.

The performance targets for this goal were set in early 2015, well before it was possible to fully comprehend the impact that WIOA would have on the public VR program. WIOA mandates have led to dramatic changes in the demographics of persons being served and have reduced the dollars available to assist participants in securing and maintaining competitive integrated employment. WIOA has also implemented new federal performance measures which focus on the individual's attainment of credentials and measurable skill gains.

SSB: The data provided in the table above must be interpreted within the context of the current customer demographics and policies. The time and effort needed to obtain employment depends upon each customer's specific circumstances and the policies that define the processes that staff must adhere to. Although the total number of SSB customers who obtained employment in FFY 17 decreased, the data show that, under recent policy changes, SSB is serving customers with more complex and longer-term needs.

In mid-FFY 17, SSB received guidance from Rehabilitation Services Administration that cases could not be closed until a customer maintained employment for at least 90 days without any substantive services and expanded upon the previous services that were permitted during this time. SSB immediately changed its policy and directed staff to hold closures and return customers to active enrollment status where appropriate. SSB operated under these guidelines for much of FFY 17, during which case closures were delayed. Following a recent consultation with WINTAC (a federal technical assistance center), SSB overturned the policy. This may have contributed to reducing the number individuals who were counted as achieving competitive integrated employment.

Additionally, SSB has been operating under an Order of Selection for two years, which prioritizes applicants with more functional limitations and higher needs. First time customers, youth, and those with more functional limitations typically require more services and training than repeat customers or adults, leading to longer enrollment times and a slower turnover rate.

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.

2018 Goal

- By June 30, 2018, the number of individuals in competitive integrated employment will increase to 8,737.

Baseline: In 2014, of the 50,157 people age 18-64 in Medicaid funded programs, 6,137 were in competitive integrated employment. 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).

RESULTS:

The 2018 annual goal to increase the number of individuals in competitive integrated employment to 8,737 was **met**. [Reported in November 2018]

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
Baseline (July 2013 – June 2014)	50,157	6,137	12.2%	--	--
July 2014 – June 2015	49,922	6,596	13.2%	459	459
2017 Annual (July 2015 – June 2016)	52,383	8,203	15.7%	1,607	2,066
2018 Annual (July 2016 – June 2017)	54,923	9,017	16.4%	814	2,880

ANALYSIS OF DATA:

During July 2016 – June 2017, there were 9,017 people in competitive integrated employment earning at least \$600 a month. The 2018 goal to increase the number of individuals in competitive integrated employment to 8,737 was met.

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.

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 3.5% in June of 2017.
- **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 integrated employment. During this time period, however, there was not a similar growth in employment among people with disabilities at the national level.
- **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 received federal approval for HCBS waiver amendments that allow the state to offer three new employment services: Exploration, Development, and Support. These services are now available to waiver recipients and current recipients are transitioning their services at annual reevaluations. The Minnesota Department of Human Services is providing training and technical assistance to implement these services.
- **Implementing employment innovation grants:** DHS is has executed innovation grants and is currently selecting recipients for the latest round of innovation to promote innovative ideas to improve outcomes for people with disabilities in the areas of work, living, and connecting with others in their communities.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it will be reported 16 months after the end of the reporting period.

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.

2018 Goal

- By June 30, 2018, the number of additional students with Developmental Cognitive Disabilities (DCD) in competitive integrated employment will be **150**.

Baseline: 2014 group total in competitive integrated employment = 313 (35%) (N=894)
2017 group total in competitive integrated employment = 450 (50%) (N=900)

RESULTS:

The 2018 goal of 150 was **met**. [Reported in August 2018]

Time Period	Number of students with DCD, ages 19-21 that enter into competitive integrated employment
2016 Annual (October 2015 to June 2016)	137
2017 Annual (October 2016 to June 2017)	192
2018 Annual (October 2017 to June 2018)	179

ANALYSIS OF DATA:

The 2018 goal of 150 students in competitive integrated employment was met. During the 2017 - 2018 school year, 179 students with developmental cognitive disabilities (101 males and 78 females) ranging in ages from 19-21, participated in competitive integrated employment. All students worked part-time as 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:

Twenty school districts provided supports to students through the Employment Capacity Building Cohort (ECBC) during the 2017-2018 school year. The ECBC teams surpassed the competitive, integrated employment goal by 29 students because they used multiple strategies learned during the ECBC training sessions. Impactful team activities included: information sessions on Workforce Innovation and Opportunity Act (WIOA) and limitations on the use of subminimum wages; Pre-Employment Transition Services; DB101 estimator sessions; utilization of the Informed Choice Conversation and Informed Choice Toolkit materials; piloting a new customized Minnesota Career Information System (MCIS) for students with disabilities; conducting individual career interest and learning style inventories; and learning about essential job development strategies.

The local ECBC teams are ensuring that students with developmental cognitive disabilities, ages 19-21 have choices and opportunities for competitive, meaningful, and sustained employment in the most integrated setting before exiting from secondary education. All of the 2017-2018 ECBC teams have expressed interest in continuing in the cohort model. In addition, two additional district teams will be invited to the ECBC for the 2018-2019 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.

2017 Goal

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

Baseline: As of April 30, 2016, there are 16 certified peer support specialists employed by Assertive Community Treatment (ACT) teams or Intensive Residential Treatment Services (IRTS) throughout Minnesota.

RESULTS:

The 2017 goal was **met**. [Reported in February 2018]

Time Period ending	Number of employed peer support specialists	Increase over baseline
Baseline (As of April 30, 2016)	16	N/A
2017 Annual (As of December 31, 2017)	46	30

ANALYSIS OF DATA:

As of December 31, 2017 there were 46 certified peer support specialists employed by Assertive Community Treatment (ACT) teams or Intensive Residential Treatment Services (IRTS). The 2017 goal to increase the number of peer support specialists to 30 (14 over baseline) was met.

COMMENT ON PERFORMANCE:

During the month of December 2017, DHS contacted all of the Assertive Community Treatment (ACT) team or Intensive Residential Treatment Services (IRTS) providers to get a count of the number of employed certified peer support specialists.

DHS continues to refine the application and interview approach and are more successful in getting individuals who are more “work ready” than in the past. In the current peer training class, 6 of the 24 participants have a promise of employment upon successful completion of the training.

Contracted facilitators will be piloting a new format for the training. This training will be offered evenings and weekends for 3-4 weeks for working individuals to accommodate parents who have day care considerations.

DHS staff are meeting with providers to offer technical assistance for the implementation of peer services.

TIMELINESS OF DATA:

In order for this data to be reliable and valid, it is reported the month after it is collected. The data is collected for a point in time only.

LIFELONG LEARNING AND EDUCATION GOAL ONE: By December 1, 2019 the number of students with disabilities^{vii}, receiving instruction in the most integrated setting^{viii}, will increase by 1,500 (from 67,917 to 69,417)

2016 Goal

- By December 1, 2016 the number of students receiving instruction in the most integrated settings will increase by **600** over baseline to **68,517**

Baseline: In 2013, of the 109,332 students with disabilities, 67,917 (62.1%) received instruction in the most integrated setting.

RESULTS:

The 2016 goal was **met**. [Reported in February 2018]

Time Period	Students with disabilities in most integrated setting	Total number of students with disabilities (ages 6 – 21)
Baseline (January – December 2013)	67,917 (62.1%)	109,332
January – December 2014	68,434 (62.1%) (517 over baseline)	110,141
2015 Annual January – December 2015	69,749 (62.1%) (1,832 over baseline)	112,375
2016 Annual January – December 2016	71,810 (62.3%) (3,893 over baseline)	115,279

ANALYSIS OF DATA:

During 2016, the number of students with disabilities receiving instruction in the most integrated setting increased by 3,893 over baseline to 71,810. The 2016 goal of an increase of 600 over baseline to 68,517 was met. 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 almost unchanged from the previous year. This is 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.

LIFELONG LEARNING AND EDUCATION 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 (from 2,107 to 2,599). [Revised in March 2018]

2018 Goal

- By June 30, 2018, the number of students with disabilities who have enrolled in an integrated postsecondary setting in the fall after graduating will increase by 230 over baseline to 2,337.

Baseline: Based on 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 enrolled in the fall of 2014 into an integrated postsecondary institution.

RESULTS:

The 2018 goal of 2,337 was **not met**. [Reported in November 2018]

Time Period	Students with disabilities graduating	Students enrolling in accredited institution of higher education	Change from baseline
2016 Baseline – 2014 SLEDS (August 2014 – July 2015 data)	6,749	2,107 (31.2%)	--
2017 Annual Goal – 2015 SLEDS (August 2015 – July 2016 data)	6,722	2,241 (33.3%)	134 (2.1%)
2018 Annual Goal – 2016 SLEDS (August 2016 – July 2017 Data)	6,648	2,282 (34.3%)	175 (3.1%)

ANALYSIS OF DATA:

Of the 6,648 student with disabilities who graduated in 2016, there were 2,282 students (34.3%) who enrolled in an accredited institution of higher education in fall 2016. This was an increase of 175 over the baseline. The 2018 goal to increase to 2,337 was not met.

Beginning with the 2015 SLEDS data, additional data was provided by student race and ethnicity. This supplemental information includes the percentage of high school students with disabilities within each of five racial or ethnic groups that graduated from high school and subsequently enrolled in an accredited institution of higher education in the fall of that year. For example, in 2015, 22% of the American Indian or Alaskan Native students with disabilities who graduated from high school that year subsequently enrolled in accredited institutions of higher education.

Percentage of graduates with disabilities in each racial/ethnic group enrolling in accredited institutions of higher education

Racial or Ethnic Group	2015 SLEDS	2016 SLEDS
American Indian or Alaskan Native	22%	23%
Asian or Pacific Islander	35%	35%
Hispanic	27%	28%
Black, not of Hispanic Origin	28%	28%
White, not of Hispanic Origin	35%	36%

COMMENT ON PERFORMANCE:

While Minnesota saw an increase in the number of students enrolled in institutions of higher education in the fall 2016, the increase was not enough to meet the annual goal. Students may be choosing to enter into short term certificate programs, within a technical college for specific skills training. To be considered enrolled in an accredited institution of higher education for the purposes of SLEDs reporting, a student must be on a credit earning track towards a certificate, diploma, two or four year degree, or other formal award.

In addition, Minnesota continues to have a strong employment outlook and many students with disabilities are choosing to enter the job market in entry-level positions, gaining experience, independence or saving money for college, as higher education expenses continue to be on the rise. SLEDs 2016 data reported that 2,901 (44%) of students with disabilities were employed in competitive integrated employment. The SLEDs website is located at <http://sleds.mn.gov/>.

Based on a review of disaggregated data, a targeted activity was designed to increase successful postsecondary enrollment results for Black and American Indian students with disabilities. This aligns with MDE's current federal State Systemic Improvement Plan (SSIP). For school year 2017-18, MDE staff collaborated with TRIO Student Support Services currently serving students at institutions of higher education. Using a scale-up approach, for school year 2018-19, MDE will disseminate additional Minnesota Postsecondary Resource Guides at Minneapolis Technical and Community College, Hennepin Technical College and Fond Du Lac Technical College. In addition, MDE staff will share on-line training resources that are currently located on Normandale Community College website at <http://www.normandale.edu/osdresources>.

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, 96% of students with disabilities in 31 target school districts will have active consideration of assistive technology (AT) during the student’s annual individualized education program (IEP) team meeting. 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. [Revised March 2018]

2018 Goal

- By June 30, 2018, the percent of students who have active consideration of assistive technology during the annual IEP team meeting will increase to 94%.

Baseline: From October – December 2016, of the 28 students with IEPs, 26 (92.8%) had active consideration of assistive technology during their annual IEP team meeting.

RESULTS:

The 2018 goal to increase to 94% was **met**. [Reported in August 2018]

Time period	Number of student IEP team meetings	Number with active consideration of AT	Percent with active consideration
Baseline (Oct – Dec 2016)	28	26	92.8%
January – June 2017	80	77	96.3%
2018 Annual (July 2017 – June 2018)	274	260	94.9%

ANALYSIS OF DATA:

During the 2017-2018 school year, Assistive Technology Teams Project (ATTP) members in 21 school districts completed a total of 274 *Assistive Technology (AT) Consideration Surveys* with all district teams responding. Almost ninety-five percent (94.9%) of the completed surveys reported that the IEP teams met the criteria for active consideration of AT during the IEP meeting. The 2018 annual goal of 94% was met. During the 2017-2018 school year, there were 38,547 students with IEPs in the 21 school districts.

Active consideration is defined as IEP team consideration of at least one element of the *Student, Environments, Tasks and Tools (SETT) Framework* as measured by the *AT Consideration Survey*. For the 5.1% in which the criteria for active consideration were not met, ATTP team members reported that teams considered the student, environment, task(s), and/or tool(s) of the *SETT Framework* but not specifically in the context of AT. This is the first full school year that specific data was collected regarding active consideration including student factors, environment(s), task(s) and tool(s) in the *SETT Framework*.

COMMENT ON PERFORMANCE:

To support the implementation of the *SETT Framework*, MDE offers the AT Teams Project (ATTP), an intensive, three-year project to support schools and districts to meet their AT needs through a cohort design that includes professional development. For the 2018-19 school year, 14 districts will continue into the second and third year ATTP training cohorts, and 11 new districts will begin the first year cohort. All regions in Minnesota are represented within the 2018-19 cohort. Based on statewide scale-up of the ATTP, MDE expects a larger number of sampled IEP meetings, for a larger number of students with disabilities, while improving the percentage of those IEP meetings in which criteria are met for

active consideration of AT. MDE looks forward to sharing additional data under the new annual goal set for June 30, 2019.

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 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. [Reported in February 2018]

Time Period	Curb Ramp Improvements	PROW Compliance Rate
Calendar Year 2014	1,139	24.5%
Calendar Year 2015	1,594	28.5%
Calendar Year 2016	1,015	35.0%

ANALYSIS OF DATA:

In 2016, the total number of curb ramps improved was 1,015, bringing the system to 35.0% compliance under PROW.

COMMENT ON PERFORMANCE:

In 2016, MnDOT constructed fewer curb ramps than in the 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%.

2017 Goal

- By December 31, 2017 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 intersections where APS signals were installed was 118.

RESULTS:

The 2017 goal was **met** (using Calendar Year 2016 data). [Reported in February 2018]

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
Calendar Year 2016	692 of 1,179 APS (59% of system)	100	574

ANALYSIS OF DATA:

In Calendar Year 2016, an additional 100 APS installations were provided. Based on the 2016 data, the 2017 goal to increase by 50 was met.

COMMENT ON PERFORMANCE:

MnDOT has already met its goal of 50% system compliance.

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: MnDOT maintained 620 miles of sidewalks. Of the 620 miles, 285.2 miles (46%) met the 2010 ADA Standards and Public Right of Way (PROW) guidance.

RESULTS:

The 2017 goal was **met** (using Calendar Year 2016 data). [Reported in February 2018]

Time Period	Sidewalk Improvements	PROW Compliance Rate
Calendar Year 2014	N/A	46%
Calendar Year 2015	12.41 miles	47.3%
Calendar Year 2016	18.8 miles	49%

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).

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:

The 2017 goal was **met** (using Calendar Year 2016 data). [Reported in February 2018]

Time Period	Service Hours	Change from baseline
Baseline – Calendar Year 2014	1,200,000	N/A
Calendar Year 2015	1,218,787	18,787
Calendar Year 2016	1,454,701	254,701

ANALYSIS OF DATA:

During 2016, the total number of service hours increased to 1,454,701. The 2017 goal was met. The increase in the number of service hours is ahead of the 2020 goal of 1,428,000.

COMMENT ON PERFORMANCE:

The rapid increase in service hours was due in part to an off year solicitation to expand service under the New Starts Program in which operational and capital funds were provided to introduce new routes.

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 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. [Revised in March 2018]

Greater Minnesota 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.”¹²

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.

RESULTS:

This goal is **in process**. [Reported in November 2018]

¹² Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transitinvestment.

Percentage of public transportation meeting minimum service guidelines for access

Time period	Weekday	Saturday	Sunday
December 2016 (Baseline)	47%	12%	3%
December 2017	47%	16%	5%

ANALYSIS OF DATA:

In Greater Minnesota the larger communities providing fixed route and complimentary para-transit 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. The increase in Sunday service is attributed to the addition of service in Rochester.

COMMENT ON PERFORMANCE:

Each year in January the transit systems will be analyzed for the level of service they have implemented. Transit systems do include unmet needs in their applications, but the actual service implemented can vary based on a host of factors including; lack of drivers and limited local funding share and local service priorities. Transit systems are in the process of developing their Five Year Plans which will provide greater detail on future service design.

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 Minnesota¹³

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

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.

¹³ Source: MnDOT Greater Minnesota Transit Investment Plan, 2017

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

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

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

RESULTS:

This goal is **on track** to meet the 2025 on time performance goal of 90%. [Reported in February 2018]

Service level	2014 baseline	2016 on-time performance	Increase over baseline
Transit Link	97%	98.5%	1.5%
Metro Mobility	96.3%	96.8%	0.5%
Metro Transit	86%	87.1%	1.1%
<ul style="list-style-type: none"> • Bus • Green light rail • Blue light rail • Commuter rail 		<ul style="list-style-type: none"> • Bus..... 85.1% • Green..... 82.9% • Blue..... 87.2% • Commuter... 93.2% 	
Greater Minnesota	76%	76%	No change

ANALYSIS OF DATA:

The 2016 on-time performance improved from 2014 for transit link, Metro Mobility and Metro Transit. The on-time performance stayed the same in Greater Minnesota.

COMMENT ON PERFORMANCE:

The average on-time performance for 2016 was 89.6%. If this trend continues, this goal is on track to meet the 2025 goal.

TIMELINESS OF DATA:

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

TRANSPORTATION GOAL FIVE: By 2040, 100% percent of the target population will be served by regular route level of service for prescribed market areas 1, 2, and 3 in the seven county metropolitan area. [Adopted March 2018]

2018 Goal

- By April 30, 2018, annual goals will be established

Baseline: The percentage of target population served by regular route level of service for each market area is as follows: Market Area 1 = 95%; Market Area 2 = 91%; and Market Area 3 = 67%.

Time Period	Market Area 1	Market Area 2	Market Area 3
Baseline – June 2017	95%	91%	67%

RESULTS:

The 2018 goal to establish annual goals was **met**. [Reported in August 2018]

Proposed Annual Goal:

- By 2025, the percentage of target population served by regular route level of service for each market area will be:
 - Market Area 1 will be 100%
 - Market Area 2 will be 95%
 - Market Area 3 will be 70%

The percentage for each market area will be reported on an annual basis to determine if progress is being made toward the goals.

COMMENT ON PERFORMANCE:

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 shows 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 <https://metro council.org/METC/files/63/6347e827-e9ce-4c44-adff-a6afd8b48106.pdf>

TIMELINESS OF DATA:

Data will be collected in January of each year. In order for this data to be reliable and valid, it will be reported four months after the end of the reporting period.

HEALTH CARE AND HEALTHY LIVING GOAL ONE: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care¹⁴ focusing specifically on cervical cancer screening will increase by 833 people compared to the baseline. [Revised in March 2018]

2017 Goal

- By December 31, 2017 the number accessing appropriate care will increase by **518** over baseline

Baseline: In 2013 the number of women receiving cervical cancer screenings was 21,393.

RESULTS:

The 2017 goal was **met**. [Reported in November 2018]

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
January – December 2017	27,270	<632>	5,877

ANALYSIS OF DATA:

During calendar year 2017 the number of women with disabilities and/or serious mental illness who had a cervical cancer screening was 27,270. The 2017 annual goal to increase by 518 over baseline was met. The number accessing cervical cancer screenings increased steadily from the 2013 baseline through the 2015 reporting period. Although, the number decreased in 2016 and 2017 from the 2015 reporting period, 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.

The March 2018 Olmstead Plan included a new strategy to develop and implement measures for health outcomes. The health outcome includes monitoring and reporting 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. The first reporting of that measure is included below. The information is broken down in three groupings.

¹⁴ Appropriate care will be measured by current clinical standards.

Adults with disabilities with serious mental illness (SMI)

Time Period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	14,796	3,107	21.00%
January – December 2015	16,511	3,438	20.82%
January – December 2016	12,701	2,673	21.05%
January – December 2017	12,659	2,504	19.78%

Adults with disabilities without serious mental illness (SMI)

Time Period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	13,977	2,780	19.89%
January – December 2015	15,117	2,931	19.39%
January – December 2016	12,593	2,469	19.61%
January – December 2017	13,467	2,549	18.93%

Adults without disabilities

Time Period	Acute inpatient hospital stay	Unplanned acute readmission within 30 days	Readmission rate
January – December 2014	3,735	295	7.90%
January – December 2015	5,351	386	7.21%
January – December 2016	2,522	159	6.30%
January – December 2017	3,109	239	7.69%

The number and rate of all-cause readmissions among people with disabilities, with and without Serious Mental Illness (SMI), dropped slightly from 2016 to 2017. A dropping rate of hospital readmissions is a positive trend. This means that people with disabilities are not experiencing a “bounce-back” to the hospital as frequently as they were in previous years. No single cause has been pinpointed for the improvement between 2016 and 2017. Health plans and hospitals have many reasons to strive toward improving these numbers, including the Integrated Care Systems Partnership initiative in Special Needs Basic Care.

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.

HEALTH CARE AND HEALTHY LIVING 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

2017 Goal

- By December 31, 2017 the number of children accessing dental care will increase by 820 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 2017 goal was **met**. [Reported in November 2018]

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
January – December 2017	21,439	<4,551>	5,079

ANALYSIS OF DATA:

During calendar year 2017 the number of children with disabilities who had an annual dental visit was 21,439. This was an increase of 5,079 over baseline. The 2017 annual goal to increase by 820 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 increased slightly in 2015 and then has decreased by 4,884 since 2015. It's important to note that 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. During 2017, the reduction in the number of children with an annual dental visit is likely due to how they are counted. The annual dental visit measure only counts children who were continuously enrolled with a Managed Care Organization (MCO) or as a Fee-for-Service recipient for 11 of a 12 month period. During this time frame a large MCO ended its contract with DHS in many counties. This resulted in families switching health plans and not being counted in the measure. The measure counted only people with continuous coverage in a single health plan.

The March 2018 Olmstead Plan includes a new strategy to develop and implement measures for health outcomes. This measure includes monitoring and reporting the number of enrollees (adults and children with disabilities) who used an emergency department for non-traumatic dental services. The intention is to get a more complete picture of level of access of people with disabilities to dental care.

Time period	Number of children with emergency department visit for non-traumatic dental care	Change from previous year
January – December 2014	314	
January – December 2015	330	16
January – December 2016	324	<6>
January – December 2017	185	<139>

During 2016 and 2017, there has been a reduction in the number of children using emergency departments for non- traumatic dental care. This may be as a result of a dental collaborative that incentivizes managed care plans to closely monitor and assist in helping people find preventative dental care.

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

2017 Goal

- By December 31, 2017 the number of adults accessing dental care will increase by 670 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 2017 goal was **met**. [Reported in November 2018]

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
January – December 2017	50,060	<1,350>	28,667

ANALYSIS OF DATA:

During calendar year 2017 the number of adults with disabilities who had an annual dental visit was 50,060. This was an increase of 28,667 over baseline. The 2017 annual goal to increase by 670 over baseline was met. There were significant gains between the 2013 baseline year and the 2014 reporting period. The number of children with adults accessing dental care increased slightly in 2015 and then has decreased by 5,411 since 2015. 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. During 2017, the reduction in the number of adults with an annual dental visit is likely due to how they are counted. The annual dental visit measure only counts

adults who were continuously enrolled with a Managed Care Organization (MCO) or as a Fee-for-Service recipient for 11 of a 12 month period. During this time frame a large MCO ended its contract with DHS in many counties. This resulted in families switching health plans and not being counted in the measure. The measure counted only people with continuous coverage in a single health plan.

The March 2018 Olmstead Plan added a new strategy to develop and implement measures for health outcomes. This measure includes monitoring and reporting the number of enrollees (adults and children with disabilities) who used an emergency department for non-traumatic dental services. The intention is to get a more complete picture of level of access of people with disabilities to dental care.

Time period	Number of adults with emergency department visit for non-traumatic dental care	Change from previous year
January – December 2014	3,884	--
January – December 2015	4,233	349
January – December 2016	4,110	<123>
January – December 2017	2,685	<1,425>

During 2016 and 2017, there has been a reduction in the number of adults using emergency departments for non- traumatic dental care. This may be as a result of a dental collaborative that incentivizes managed care plans to closely monitor and assist in helping people find preventative dental care.

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.

2018 Goal

- By June 30, 2018, the number of people experiencing a restrictive procedure will be **reduced by 5% from the previous year or 46 individuals**

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 2018 goal to reduce by 5% from the previous year or 46 individuals was **met**. [Reported in November 2018]

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
2018 Annual (July 2017 - June 2018)	644 (unduplicated)	48
Quarter 1 (July - September 2017)	260 (duplicated)	N/A – quarterly status of annual goal
Quarter 2 (October - December 2017)	265 (duplicated)	N/A – quarterly status of annual goal
Quarter 3 (January - March 2018)	267 (duplicated)	N/A – quarterly status of annual goal
Quarter 4 (April – June 2018)	284 (duplicated)	N/A – quarterly status of annual goal

ANALYSIS OF DATA:

The 2018 goal to reduce the number of people experiencing a restrictive procedure by 5% from the previous year or 46 individuals was met. From July 2017 – June 2018, the number of individuals who experienced a restrictive procedure decreased from 692 to 644. This was a 7% reduction of 48 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 was met in the first year of implementation.

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 External Program Review Committee (EPRC) 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 is tracked, monitored and reported in the quarterly reports.

UNIVERSE NUMBER:

In Fiscal Year 2017 (July 2016 – June 2017), 42,272 individuals received services in licensed disability services, e.g., home and community-based services.

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.

2018 Goal:

- By June 30, 2018 the number of reports of restrictive procedures will be reduced by 369.

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 2018 goal to reduce by 369 to 7,006 was **met**. [Reported in November 2018]

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
2018 Annual (July 2017 – June 2018)	*3,739	+ 156
Quarter 1 (July – September 2017)	991	N/A – quarterly status of annual goal
Quarter 2 (October – December 2017)	955	N/A – quarterly status of annual goal
Quarter 3 (January – March 2018)	904	N/A – quarterly status of annual goal
Quarter 4 (April – June 2018)	843	N/A – quarterly status of annual goal

* The annual total of 3,739 is greater than the sum of the four quarters or 3,693. This is due to late submissions of 46 BIRF reports of restrictive procedures throughout the four quarters.

ANALYSIS OF DATA:

From July 2017 - June 30, 2018 the number of restrictive procedures reports was 3,739. The 2018 goal to reduce to 7,006 was met. During Quarter 4, there was a decrease of 61 from 904 during the previous quarter. It is important to note that the 2018 overall goal was met in the first year of implementation.

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.

UNIVERSE NUMBER:

In Fiscal Year 2017 (July 2016 – June 2017), 42,272 individuals received services in licensed disability services, e.g., home and community-based services.

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^{ix}, 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.

2018 Goal: By June 30, 2018, reduce mechanical restraints to no more than:

- 185 reports of mechanical restraint
- 13 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:

- The 2018 goal to reduce to 185 reports was **not met**. [Reported in November 2018]
- The 2018 goal to reduce to no more than 13 individuals was **met**. [Reported in November 2018]

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
2018 Annual (July 2017 – June 2018)	*671	13
Quarter 1 (July – September 2017)	192	15
Quarter 2 (October – December 2017)	167	13
Quarter 3 (January – March 2018)	158	13
Quarter 4 (April – June 2018)	153	13

* The annual total of 671 is greater than the sum of the four quarters or 670. This is due to late submission of 1 BIRF report of mechanical restraints throughout the four quarters.

ANALYSIS OF DATA:

This goal has two measures.

- From July 2017 – June 2018, the number of reports of mechanical restraints was 671. This is an increase of 7 from the previous year. The 2018 goal to reduce to 185 was not met.
- At the end of the reporting period (June 2018), the number of individuals for whom the emergency use of mechanical restraint was approved was 13. This remains unchanged from the previous year. The 2018 goal to reduce to no more than 13 individuals 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 EPRC 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.

2017 Goal

- By June 30, 2017, the number of students experiencing emergency use of restrictive procedures will be reduced by 80 students or .02% of the total number of students receiving special education services.

Baseline: During school year 2015-2016, school districts (which include charter schools and intermediate districts) reported to MDE that 3,034 students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting. In 2015-2016, the number of reported students receiving special education services was 147,360 students. Accordingly, during school year 2015-2016, 2.06% students receiving special education services experienced at least one emergency use of a restrictive procedure in the school setting.

RESULTS:

The 2017 goal was **not met**. [Reported in February 2018]

Time period	Students receiving special education services	Students who experienced restrictive procedure	Change from previous year
Baseline 2015-16 school year	147,360	3,034 (2.1%)	N/A
2016-17 school year	151,407	3,476 (2.3%)	+ 442 (0.2%)

ANALYSIS OF DATA:

School districts reported that of the 151,407 students receiving special education services, restrictive procedures were used with 3,476 of those students (2.3%). This was an increase of 442 students from the previous year and an increase of 0.2 percent. The 2017 goal to reduce by 80 students was not met.

The actual number of reported special education students increased by 4,047 from the 2015-16 school year.

The restrictive procedure summary data is self-reported to MDE by July 15 for the prior school year. The data included for 2016-17 has been reviewed and clarified as needed. The data includes all public schools, including intermediate districts, charter schools and special education cooperatives.

The 2018 MDE report to the Legislature, “School Districts’ Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools” includes more detailed reporting on the 2016-17 school year data. The legislative report is available at:

<http://education.state.mn.us/MDE/about/rule/leg/rpt/2018reports/>

2016-17 school year:

- Physical holds were used with 3,172 students, up from 2,743 students in 2015-2016.
- Seclusion was used with 976 students, up from 848 students in 2015-2016.
- Compared to the 2015-16 school year, the average number of physical holds per physically held student is 5.5, down from 5.7; the average number of uses of seclusion per secluded student was 7.3, down from 7.6; and the average number of restrictive procedures per restricted student was 7.0, down from 7.3.

While the number of students who have experienced the use of restrictive procedures has increased from the previous year, the percentage of students went up very slightly in 2016-17. 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:

- The MDE Restrictive Procedures Stakeholders Workgroup (2017 Workgroup) is focusing its attention on reducing the use of restrictive procedures, and specifically to eliminate the use of seclusion. Districts are requesting more tools to avoid the need for restrictive procedures.
- The 2017 Workgroup and MDE made significant progress in implementation of the 2016 statewide plan. See the 2018 legislative report for more details.
- The 2017 Workgroup and MDE continue to work toward ensuring the accuracy of data reporting for use in its development of improvement strategies.
- The 2017 Workgroup and MDE continue to work toward availability of mental health services across the state; and improving the capacity of school districts to provide professional development in support of progress toward this activity’s annual goals.

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.

2017 Goal

- By June 30, 2017, the number of incidents of emergency use of restrictive procedures will be reduced by 563 incidents, or by 0.2 incidents of restrictive procedures per student who experienced the use of a restrictive procedure.

Baseline: During school year 2015-2016, school districts (which include charter schools and intermediate districts) reported 22,028 incidents of emergency use of a restrictive procedure in the school setting. In school year 2015-2016, the number of reported students who had one or more emergency use of restrictive procedure incidents in the school setting was 3,034 students receiving special education services. Accordingly, during school year 2015-2016 there were 7.3 incidents of restrictive procedures per student who experienced the use of a restrictive procedures in the school setting.

RESULTS:

The 2017 goal to reduce by 0.2 incidents per student was **met**. [Reported in February 2018]

Time period	Incidents of emergency use of restrictive procedures	Students who experienced use of restrictive procedure	Rate of incidents per student	Change from previous year
Baseline (2015-16 school year)	22,028	3,034	7.3	N/A
2016-17 school year	24,285	3,476	7.0	+ 2,257 incidents <0.3> rate

ANALYSIS OF DATA:

During the 2016-17 school year there were 24,285 incidents of emergency use of restrictive procedures. There were 7.0 incidents of restrictive procedures per student who experienced the use of a restrictive procedure. Although there was an increase of 2,257 incidents from the previous year, there was a decrease of 0.3 incidents per student. The 2017 goal to reduce by 0.2 incidents per student was met.

The restrictive procedure summary data is self-reported to MDE by July 15 for the prior school year. The data included for 2016-17 has been reviewed and clarified as needed. The data includes all public schools, including intermediate districts, charter schools and special education cooperatives.

The 2018 MDE report to the Legislature, "School Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools" includes more detailed reporting on the 2016-17 school year data. The report is available at: <http://education.state.mn.us/MDE/about/rule/leg/rpt/2018reports/>

2016-17 school year:

- There were 24,285 restrictive procedures incidents. This was an increase of approximately 10.2 percent up from the 22,028 reported in 2015-16.
- There were 17,200 physical holds reported, up from 15,584 in 2015-16.
- There were 7,085 uses of seclusion, up from 6,425 in 2015-16.
- The total number of reported students with disabilities increased by 3,625 from 2015-16.

COMMENT ON PERFORMANCE:

- The MDE Restrictive Procedures Stakeholders Workgroup (2017 Workgroup) is focusing its attention on reducing the use of restrictive procedures, and specifically to eliminate the use of seclusion. Districts are requesting more tools to avoid the need for restrictive procedures.
- The 2017 Workgroup and MDE made significant progress in implementation of the 2016 statewide plan. See the 2018 legislative report for more details.
- The 2017 Workgroup and MDE continue to work toward ensuring the accuracy of data reporting for use in its development of improvement strategies.
- The 2017 Workgroup and MDE continue to work toward availability of mental health services across the state; and improving the capacity of school districts to provide professional development in support of progress toward this activity's annual goals.

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.

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 was **not met**. [Reported in February 2018]

Time period	Total Episodes	Community	Treatment	Other
Annual Goal (6 months data) January – June 2016	1,318	1,100 (83.5%)	172 (13.2%)	46 (3.5%)
July – December 2016	1,128	922 (81.7%)	142 (12.6%)	64 (5.7%)
January – June 2017	1,521	1,196 (78.6%)	264 (17.4%)	61 (4%)
Annual Total* July 2016 – June 2017	2,653	2,120 (79.9%)	407 (15.3%)	126 (4.8%)

*The Annual totals are greater than the sum of the two semi-annual reports. This is due to the late submission of four reports during the last reporting period.

- 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:

From July 2016 to June 2017, of the 2,653 crisis episodes, the child remained in their community after the crisis 2,120 times or 79.9% of the time. This is slightly above the baseline. The annual goal of 83% was not met.

COMMENT ON PERFORMANCE:

There has been an overall increase in the number of episodes of children receiving mental health crisis services, with likely more children being seen by crisis teams. In particular the number of children receiving treatment services after their mental health crisis has increased by more than 30% since baseline and by almost 50% since December of 2016. While children remaining in the community after crisis is preferred, it is important for children to receive the level of care necessary to meet their needs at the time. DHS will continue to work with mobile crisis teams to identify training opportunities for serving children in crisis, and to support the teams as they continue to support more children with complex conditions and living situations.

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.

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 was **not met**. [Reported in February 2018]

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%)
July – December 2016	5,554	3,066 (55.2%)	1,657 (29.8%)	831 (15.0%)
January – June 2017	5,263	2,778 (52.8%)	1,785 (33.9%)	700 (13.3%)
Annual Total* July 2016 – June 2017	10,825	5,848 (54.0%)	3,444 (31.8%)	1,533 (14.2%)

*The Annual totals are greater than the sum of the two semi-annual reports. This is due to the late submission of eight reports during the last reporting period.

- 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.

ANALYSIS OF DATA:

From July 2016 to June 2017, of the 10,825 crisis episodes, the person remained in their community 5,848 times or 54% of the time. This is a decrease from the baseline. The 2017 goal was not met.

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]

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 2017 goal was **not met**. [Reported in February 2018]

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)
Quarter 4 (April – June 2017)	18 (duplicated)
Annual Total (July 2016 – June 2017)	62 (unduplicated)

ANALYSIS OF DATA:

From July 2016 – June 2017, the number of people who discontinued disability waiver services after a crisis was 62. The 2017 annual goal of 45 or fewer was not met. The quarterly numbers are duplicated counts. People may discontinue and resume 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.

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

2018 Goal

- By June 30, 2018, the percent of people who are housed five months after discharge from the hospital will increase to 84%.

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.

RESULTS:

This 2018 goal was **not met**. [Reported in November 2018]

Time period	Discharged from hospital	Status five months after discharge from hospital					
		Housed	Not housed	Treatment facility	Not using public programs	Deceased	Unable to determine type of housing
2016 Baseline 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%
2017 Annual Goal 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%
2018 Annual Goal July 2016 – June 2017	15,237	12,017	1,015	1,158	559	115	338
		78.8%	6.9%	7.6%	3.7%	0.8%	2.2%

- “**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 2016 – June 2017, of the 15,237 individuals hospitalized due to a crisis, 12,017 (78.8%) were housed within five months of discharge. This was a 0.2% increase from the previous year. In the same time period there was a 0.2% decrease of individuals in a treatment facility within five months of discharge. The 2018 goal to increase to 84% was not met.

COMMENT ON PERFORMANCE:

There has been an overall increase in the number of individuals receiving services. In June 2017, the number of people receiving services in a treatment facility was nearly double the amount 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 working to sustain and expand the number of grantees utilizing 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 grants began in June of 2016, with a fourth round of grants planned for 2019.

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

2018 Goal

- By June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91%.

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.

RESULTS:

This 2018 goal was **met**. [Reported in November 2018]

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	
2016 Baseline July 2014 – June 2015	13,786	12,298	89.2%
2017 Annual Goal July 2015 – June 2016	15,027	14,153	94.2%
2018 Annual Goal July 2016 – June 2017	15,237	14,343	94.1%

ANALYSIS OF DATA:

From July 2016 – June 2017, of the 15,237 individuals hospitalized due to a crisis, 14,343 (94.1%) received community services within 30 days after discharge. This was a 0.1% decrease from the previous year. The 2018 goal to increase to 91% 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.

2018 Goal

- By June 30, 2018, the percent of people who receive crisis services within 10 days will increase to 87%.

Baseline: From July 2015 – June 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.

RESULTS:

This 2018 goal was **met**.

Time period	Number referred for crisis services	Number receiving services within 10 days	Percentage receiving services within 10 days	Average days for service
July 2015 – June 2016 (Baseline)	808	690	85.4%	2.3
July 2016 – June 2017	938	843	89.9%	2.0
July 2017 – June 2018	2,258	2,008	88.9%	2.1

ANALYSIS OF DATA:

From July 2017 – June 2018, of the 2,258 people referred for crisis services, 2,008 of them (88.9%) received services within 10 days. This was an increase of 3.5% over baseline and a decrease of 1.0% from the previous year. The average number of days waiting for services was 2.1. The 2018 goal to increase to 87% was met.

COMMENT ON PERFORMANCE:

After a crisis intervention, individuals are referred to crisis stabilization services. Crisis stabilization services are mental health services to help the recipient to return to/maintain their pre-crisis functioning level. These services are provided in the community and are based on the crisis assessment and intervention treatment plan.

These services:

- consider the need for further assessment and referrals;
- update the crisis stabilization treatment plan;
- provide supportive counseling;
- conduct skills training;
- collaborate with other service providers in the community; and/or
- provide education to the recipient’s family and significant others regarding mental illness and how to support the recipient.

An infusion of funding during the 2016-2017 biennium supported the expansion of crisis services to 24/7 availability across the state. These crisis services include referral to stabilization services that help ensure that clients are able to return to and maintain their pre-crisis levels of functioning. Referrals to stabilization services are often made with a “warm hand-off” that is expected to ensure that clients access the new service to which they have been referred. For example, a crisis staff may sit with the client while they make the phone call to schedule the crisis stabilization service within 10 days following the crisis event. In addition, workforce development activities are underway to help ensure that an adequate number of providers are available to meet the needs of clients experiencing crisis and needing crisis stabilization services following an initial assessment and/or intervention.

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.

COMMUNITY ENGAGEMENT GOAL ONE: By June 30, 2020, the number of individuals with disabilities who participate in Governor appointed Boards and Commissions, the Community Engagement Workgroup, Specialty Committee and other Workgroups and Committees established by the Olmstead Subcabinet will increase to 245 members. [Revised March 2018]

2018 Goal

- By June 30, 2018, the number of individuals with disabilities participating in Governor’s appointed Boards and Commissions, Community Engagement Workgroup, Specialty Committee, and other Workgroups and Specialty Committees established by the Olmstead Subcabinet will increase to 184.

Baseline: Of the 3,070 members listed on the Secretary of State’s Boards and Commissions website, 159 members (5%) self-identified as an individual with a disability. In 2017, the Community Engagement Workgroup and the Specialty Committee had 16 members with disabilities.

RESULTS:

The 2018 goal of 184 was **met**.

Time Period	Number of individuals on Boards and Commissions with a disability	Number of individuals on Olmstead Subcabinet workgroups with a disability	Total number
June 30, 2017 (Baseline)	159	16	175
As of July 31, 2018	171	26	197

ANALYSIS OF DATA:

Of the 3,240 members listed on the Secretary of State's Boards and Commissions website, 171 members (approximately 5%) self-identify as an individual with a disability. In addition, 26 individuals on Olmstead Subcabinet workgroups (Community Engagement Workgroup and Preventing Abuse and Neglect Specialty Committee) self-identified as individuals with a disability. The 2018 goal to increase the number to 184 was met. While, the number of individuals on Boards and Commissions with a disability increased, the percentage of members with disabilities remained the same (at 5 percent).

The number of individuals may contain duplicates if a member participated in more than one group throughout the year. There may also be duplicates from year to year if an individual was a member of a group during the previous year and the current year.

COMMENT ON PERFORMANCE:

The Minnesota Department of Human Rights, the Olmstead Implementation Office (OIO) and the Governor's Office collaborated to engage in outreach and recruitment efforts in both the Metro area and Greater Minnesota. A project was initiated which included two types of sessions. The first included a series of five informational sessions held throughout the state with people of color and individuals with disabilities. The purpose was to help participants learn more about serving on Governor-appointed Boards and Councils and the process for applying for and receiving an appointment. The second type of session was a facilitated training session for members of Governor's appointed Boards and Commissions on strategies for creating more accessible and inclusive Boards and Councils.

The outcome of these efforts produced very small numbers of individuals with disabilities who attended the events and who subsequently applied for positions with Boards and Commissions. The number of individuals with disabilities appointed was extremely small. The collaborators agreed that new measures will be taken to strategically outreach and recruit people with disabilities. A revamped effort with regional forums will take place in October 2018. The planning session is currently underway for new series of targeted outreach activities. The events will obtain evaluation results and data will be analyzed for impact.

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. Data is accessed through the Secretary of State's website.

COMMUNITY ENGAGEMENT GOAL TWO: By June 30, 2020, the number of individuals with disabilities involved in planning publicly funded projects identified through bonding bills will increase by 5% over baseline. [Adopted March 2018]

2018 Goal to increase the number of individuals involved in planning publicly funded projects:

- By April 30, 2018, establish a baseline and annual goals

RESULTS:

The 2018 goal to establish a baseline was **not met**.

COMMENT ON PERFORMANCE:

To achieve this goal of establishing a baseline and annual goals, the Olmstead Implementation Office (OIO) reviewed the 2017 bonding bills that were approved through legislation. It was determined that

the OIO would select one bonding bill to analyze and learn more about tracking the impact of the law and any engagement with people with disabilities. With this information, a baseline and annual goals would be established.

OIO identified the “accommodation for hard of hearing in state-funded capital projects” as the focus for this task. This law went into effect in January 2018.

After researching the project and meeting with a variety of experts in the area, OIO concluded that it is not possible to establish a baseline or maintain consistency with a tracking system. The findings to support this decision include:

- The law requires that commissioners or agency heads may only approve a contract for publicly funded capital improvement when it meets the conditions for accommodating hard of hearing.
- There is no requirement for this project or any bonding project to engage with people with disabilities or to track such engagement efforts.
- Because there is no requirement to track the engagement of individuals with disabilities in this process, there is no reliable or valid data available.

OIO will propose a new goal that focuses on engagement efforts with people with disabilities and the impact of those efforts. The new proposed goals and strategies are expected to be presented to the Subcabinet in December 2018.

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 Olmstead Subcabinet reviewed and accepted the [Comprehensive Plan for Prevention of Abuse and Neglect of People with Disabilities](#) on January 29, 2018. The Subcabinet directed that staff from DHS, MDH, MDE and OMHDD will review the report and identify the recommendations that can be implemented by adding and updating existing strategies and workplan items. Following Subcabinet approval of changes to strategies and workplans, The Subcabinet expects to work with members of the Specialty Committee and others to identify recommendations that might be best addressed through broader community action.

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. [Revised March 2018]

2018 GOAL:

- 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.

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 years =40).

RESULTS:

The 2018 goal was **not met** (due to unreliable data). [Reported in August 2018]

COMMENT ON PERFORMANCE:

The strategy targeted in this measurable goal was to utilize data from the Minnesota hospitals to identify vulnerable individuals who had been the victim of abuse and neglect. This data would be used to identify patterns and geographic locations for targeted prevention strategies.

The Minnesota Department of Health (MDH) identified the codes used to identify cases of abuse or neglect associated with treatment provided by the hospitals. After analysis of the data, it was determined that this data source would not be valid or reliable for this purpose.

MDH is proposing a collaboration with DHS to determine which databases they maintain that could be used as a data source. The data would be utilized by MDH epidemiologists to identify patterns of abuse and neglect and geographic locations for targeted prevention strategies.

A new measurable goal, associated strategies, and a baseline will be proposed at the December, 2018 Subcabinet meeting. The intent is to describe trends across person, place and time and thus offer Minnesota a public health surveillance indicator.

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:

The 2017 goal to establish a baseline was **met**. The annual goals previously established can remain unchanged. The baseline was incorporated into the March 2018 Olmstead Plan. The annual goals remained unchanged. [Reported in February 2018]

BASELINE:

From July 2015 – June 2016, there were 2,835 individuals who experienced a substantiated or inconclusive abuse or neglect episode. Of those individuals, 126 (4.4%) had a repeat episode of the same type of abuse or neglect within six months.

Time Period	Total Number of People	Number of Repeat Episode
Baseline (July 2015 - June 2016)	2,835	126 (4.4%)

ANALYSIS OF DATA:

From July 2015 – June 2016, 2835 people had a substantiated or inconclusive abuse or neglect episode. Of those people, 126 (4.44%) experienced a substantiated or inconclusive abuse or neglect had a repeat episode of the same type within six months. Episodes include physical abuse, sexual abuse, emotional abuse, financial exploitation, caregiver or self-neglect.

Data is from reports of suspected maltreatment of a vulnerable adult made to the Minnesota Adult Abuse Reporting Center (MAARC) by mandated reporters and the public when a county was responsible for response. Maltreatment reports when DHS licensing or Minnesota Department of Health (MDH) were responsible for the investigation of an individual associated with a licensed provider involved are not included in this report.

COMMENT ON PERFORMANCE:

Counties have responsibility under the state's vulnerable adult reporting statute to assess and offer adult protective services to safeguard the welfare of adults who are vulnerable and have experienced maltreatment. The number of substantiated and inconclusive allegations is impacted by the number of maltreatment reports opened for investigation.

TIMELINESS OF DATA:

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

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.

2018 Goal

- By July 31, 2018, the number of identified schools and students will decrease by 10% from baseline

Baseline: From July 2013 to June 2016, there were 13 identified schools that had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years. There were 66 students with a disability who were identified as alleged victims of maltreatment within those schools.

RESULTS:

This 2018 goal was **met**. [Reported in November 2018]

Time Period	Number of schools with three or more investigations	Number of students with disabilities identified as alleged victims
July 2013 - June 2016	13	66
July 2016 - June 2017	1	14
July 2017 - June 2018	1	8

ANALYSIS OF DATA:

Thirteen baseline schools were identified as having three or more investigations of maltreatment involving allegations of physical abuse of students with a disability during a three year period (July 2013- June of 2016). The identified schools were encouraged to participate in an approved Positive Behavioral Interventions and Supports (PBIS) training to help with de-escalation and behavior management skills of staff. It was expected that with participation in PBIS training the number of students with a disability who were identified as alleged victims of maltreatment (physical abuse) within the 13 identified schools would decrease.

The results in subsequent years show a reduction in the number of reports of physical abuse in those schools and number of involved students, however, a correlation between PBIS training and reduction of investigations, as well as involved number of students with disabilities as alleged victims, could not be substantiated. The observed reductions may be attributable to other involved factors, such as enhanced training opportunities on abuse and neglect, and increased online resources regarding mandated reporting and increased school accountability.

COMMENT ON PERFORMANCE:

There has been a reduction in reports of physical abuse in the majority of the identified schools. Upon further review of the data and subsequent meetings with OIO Compliance Office, MDE will propose a revision to this goal during the 2019 Plan Amendment process. Goal revision will focus more closely on reducing actual incidence of student maltreatment with preventative strategies that are aligned with other Prevention of Abuse and Neglect activities in the Olmstead Plan.

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.^x 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.

Reporting period	Number of Workplan Activities				
	Reviewed during time period	Completed	On Track	Reporting Exceptions	Exceptions requiring remedial Subcabinet action
November 2017	15	14	0	1	0
December 2017	14	14	0	0	0
January 2018	46	45	0	1	0
February 2018	20	16	2	2	0
March 2018	18	16	2	0	0
April 2018	21	19	1	1	0
May 2018	9	9	0	0	0
June 2018	15	15	0	0	0
July 2018	49	49	0	0	0
August 2018	8	8	0	0	0
September 2018	9	9	0	0	0
October 2018	7	7	0	0	0
Totals	231	221	5	5	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.

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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 third 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.

People with disabilities are achieving competitive integrated employment in greater numbers. The number of students with developmental cognitive disabilities and people with disabilities in vocational programs funded by 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. The number of individuals with developmental disabilities authorized for waiver services at a reasonable pace continues to show improvement.

The ability of people with disabilities to access housing continues to improve. This year 1,263 individuals obtained housing or 96% of the annual goal.

Fewer people with disabilities are experiencing the use of emergency manual restraint. There was a reduction of 48 individuals which exceeded the annual goal of 46 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 Two to decrease the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting.
- Transition Services Goal Three to increase the number of individuals leaving the MSH to a more integrated setting.
- 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 Goals One and Two to increase the percent of children and adults who remain in the community after a mental health crisis.
- 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.

DRAFT

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, 2018 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, 2019.

DRAFT

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 2019.

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} As of the May 2018 Quarterly Report The terminology changed from "Restore to Competency" to "Committed after Finding of Incompetency." The change clarifies the status of the individual when they enter the program that works on competency (Rule 20). The population being measured in this goal did not change.

^{vii} "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.

^{viii} "Most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day.

^{ix} Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.

^x 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 17, 2018

Agenda Items:

6 (c) *Olmstead Plan Draft 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

Addendum to Annual Report on Olmstead Plan Implementation

Draft Potential Amendments to Measurable Goals

December 10, 2018

This addendum includes the draft potential amendments to Olmstead Plan measurable goals and strategies being proposed by the Olmstead Subcabinet agencies.

The Olmstead Subcabinet will review these amendments on December 10, 2018. 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 will begin obtaining public comment on these draft amendments on December 20, 2018 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.

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HOUSING AND SERVICES GOAL ONE (page 48 of Plan)

REASON FOR CHANGE

The measure used to report progress on Housing and Services Goal One includes data on housing achieved through the Bridges rental assistance program. While preparing the numbers for the November 2018 Quarterly Report, an issue was detected in how the outcomes were being reported. All previously reported numbers dating back to 2014 were recalculated using the new method. The baseline was recalculated using the same methodology and needs to be incorporated into the Plan.

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 ~~5,569~~ 5,547 (from ~~5,995~~ 6,017 to 11,564 or about a 92% increase).

Baseline: In State Fiscal Year 2014, there were an estimated 38,079 people living in segregated settings.¹ Over the last 10 years, ~~5,995~~ 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.²

Annual Goals to increase the number of individuals living in the most integrated housing with a signed lease:

- ~~● By June 30, 2015, there will be an increase of 617 over baseline to 6,634 (about 10% increase)~~
- ~~● By June 30, 2016, there will be an increase of 1,580 over baseline to 7,597 (about 26% increase)~~
- ~~● By June 30, 2017, there will be an increase of 2,638 over baseline to 8,655 (about 44% increase)~~
- ~~● By June 30, 2018, there will be an increase of 4,009 over baseline to 10,026 (about 67% increase)~~
- By June 30, 2019, there will be an increase of ~~5,569~~ 5,547 over baseline to 11,564 (about a 92% increase)

NO PROPOSED CHANGES TO STRATEGIES

¹ Based on "[A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report](#)" and information from ICFs/DD and Nursing Facilities.

² The programs that help pay for housing included in this measure are: Group Residential Housing (three setting types which require signed leases), Minnesota Supplemental Aid Housing Assistance, Section 811, and Bridges.

LIFELONG LEARNING AND EDUCATION GOAL ONE (page 58 of Plan)

REASON FOR CHANGE

The number of students with disabilities varies each year. Reporting by the number of students does not accurately reflect performance. Changing the goal to a percentage allows for fluctuations in the total number of students with disabilities. The number of students with disabilities receiving instruction in the most integrated setting will continue to be reported to the Subcabinet.

Goal One: By December 1, ~~2021 2019~~ the ~~percentage number~~ of students with disabilities³, receiving instruction in the most integrated setting⁴, will increase ~~to 63%. by 1,500 (from 67,917 to 69,417).~~

Baseline: In 2013, of the 109,332 students with disabilities, 67,917 (62.1%) received instruction in the most integrated setting.

Annual Goals to increase the percentage number of students with disabilities receiving instruction in the most integrated settings:

- ~~• By December 1, 2015 there will be an increase of 300 over baseline to 68,217~~
 - ~~• By December 1, 2016 there will be an increase of 600 over baseline to 68,517~~
 - ~~• By December 1, 2017 there will be an increase of 900 over baseline to 68,817~~
 - ~~• By December 1, 2018 there will be an increase of 1,200 over baseline to 69,117~~
 - ~~• By December 1, 2019 there will be an increase of 1,500 over baseline to 69,417~~
- By December 1, 2019 the percentage of students with disabilities receiving instruction in the most integrated setting will increase to 62.5%.
 - By December 1, 2020 the percentage of students with disabilities receiving instruction in the most integrated setting will increase to 62.75%.
 - By December 1, 2021 the percentage of students with disabilities receiving instruction in the most integrated setting will increase to 63%.

NO PROPOSED CHANGES TO STRATEGIES

³ "Students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years.

⁴ "Most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day.

[AGENDA ITEM 6c]

LIFELONG LEARNING AND EDUCATION GOAL TWO (page 58 of Plan)**REASON FOR CHANGE**

The number of students with disabilities varies each year. Reporting by the number of students does not accurately reflect performance. Changing the goal to a percentage allows for fluctuations in the total number of students with disabilities. The number of students with disabilities enrolling in an integrated postsecondary education setting will continue to be reported to the Subcabinet. A strategy is being added to support progress on the goal.

Goal Two: By June 30, 2020 the ~~percentage number~~ of students with disabilities who have enrolled in an integrated postsecondary education setting within one year of leaving high school will increase ~~to 36% by 492~~ (from ~~the 2016 baseline of 31% 2,107 to 2,599~~).

Baseline: Based on 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 (31%) enrolled in the fall of 2014 into an integrated postsecondary institution.

Annual Goals to increase the ~~percentage number~~ of students with disabilities 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 ~~percentage number~~ will increase to 35% 2,467
- By June 30, 2020, the ~~percentage number~~ will increase to 36% 2,599

PROPOSED CHANGES TO STRATEGIES**Goal Two****Increase the Number of Students with Disabilities Pursuing Post-Secondary Education**

- Utilize the "[Postsecondary Resource Guide-Successfully Preparing Students with Disabilities.](#)" [This resource guide and training modules](#) provide regional technical assistance to IEP teams including youth and families, to increase the number of students with disabilities who enter into integrated, postsecondary settings.
- MDE will continue working with the [National Secondary Transition Technical Assistance Center](#) (NSTTAC) to provide regional capacity building training for the purpose of increasing the number of students with disabilities who are in a postsecondary education setting by 2020.
- ~~For school year 2017-18, MDE staff collaborated with three TRIO Student Support Services currently serving students at institutions of higher education. Using a scale-up approach, for school year 2018-19, MDE will disseminate additional Minnesota Postsecondary Resource Guides at Minneapolis Technical and Community College, Hennepin Technical College and Fond Du Lac Technical College. In addition, MDE staff will share on-line training resources that are currently located on the Normandale Community College website at <http://www.normandale.edu/osdresources>.~~

LIFELONG LEARNING AND EDUCATION GOAL THREE (page 59 of Plan)

REASON FOR CHANGE

Based on lessons learned during the initial year of plan implementation, amendments are being proposed to expand the measures for the goal. The measures will report the number of school districts being trained on active consideration of assistive technology and the number of students potentially impacted by that training. In addition to reporting on these measures, strategies have been added to analyze the data collected to determine the impact of the school district trainings.

Goal Three: By June 30, 2020, ~~96% of students with disabilities in 31 target school districts~~ will have active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) team meeting. ~~The framework to measure a~~Active consideration ~~will be is~~ based upon the "special factors" requirement as described in Individuals with Disabilities Education Act (IDEA) of 2004.

There are two measures for this goal:

(A) School districts trained in active consideration

Baseline: From December 2016 to December 2018, fifteen school districts have completed MDE training in active consideration of assistive technology (AT) during the student's annual individualized education program (IEP) meeting to ensure education in the most integrated setting.

Annual Goals to increase the number of school districts that completed MDE training in active consideration of assistive technology (AT):

- By June 30, 2019, the number of school districts that completed AT training will increase to 21.
- By June 30, 2020, the number of school districts that completed AT training will increase to 31.

(B) Students with disabilities in districts trained in active consideration

Baseline: From December 2016 to December 2018, 11.1% (15,106 of 136,245) of students with disabilities statewide (K-12) are served in school districts that have completed MDE training in active consideration of AT during the student's annual individualized education program (IEP) team meeting to ensure education in the most integrated setting.⁵

Annual Goals to increase the percentage of students with disabilities statewide in school districts that have completed training in active consideration of assistive technology during their annual IEP team meeting.

- By June 30, 2019, the percentage of students with disabilities in school districts that have completed MDE training will increase to 15%.
- By June 30, 2020, the percentage of students with disabilities in school districts that have completed MDE training will increase to 20%.

⁵ Source: MDE 2017 Child Count data for trained school districts and the state total, not including intermediate school districts and educational cooperatives.

[AGENDA ITEM 6c]

~~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** to increase the percent of students who have active consideration of assistive technology during their annual IEP team meeting:~~

- ~~● By June 30, 2018, the percent of students who have active consideration of assistive technology during the annual IEP team meeting will increase to 94%~~
- ~~● By June 30, 2019, the percent of students who have active consideration of assistive technology during the annual IEP team meeting will increase to 95%.~~
- ~~● By June 30, 2020, the percent of students who have active consideration of assistive technology during the annual IEP team meeting will increase to 96%~~

PROPOSED CHANGES TO STRATEGIES**Goal Three****Expand Effectiveness of Assistive Technology Teams Project**

- Continue to host AT Teams Projects, designed to support school district AT Teams in providing services that are in alignment with legal standard and best practices in AT. Target districts for this goal will be AT Teams Project participants. There are currently 31 school districts actively participating in the AT Teams Project.
- Develop protocols for consideration of AT that includes documentation to record the four potential outcomes and to demonstrate that AT consideration was effective.
- Each target district will gather baseline data on the outcome of consideration of AT for the students on whose IEP team they serve. A matrix of potential determinations will be provided to each team member, which will then be provided to MDE as part of the team's agreement for participation in the AT Teams Project.
- It is a best practice to document the decision making process used to consider the student's need for assistive technology. For example a statement regarding the discussion of assistive technology needs may be documented in the minutes of the IEP meeting and may be included in other components of the IEP.
- MDE will develop an implementation fidelity and scale-up measures to evaluate the extent to which school districts apply MDE training for active consideration of AT in individualized education program (IEP) meetings. This data will be used to evaluate implementation and impact in school districts for students with disabilities.

Analyze Data to Determine Impact of Training on Active Consideration

- Compare the percentages of students with disabilities educated in the most integrated setting (ED 1) of school districts completing MDE training, compared to their own previous annual percentages, to measure impact of training within the school district.
- Compare the percentages of students with disabilities educated in the most integrated setting (ED 1) of school districts completing MDE training, compared to all other school districts, to measure impact of training within the school district and in annual state data,
- Annually review the effectiveness of current MDE training strategies for school districts to use active consideration of assistive technology as a strategy for ensuring the education of students with disabilities in the most integrated setting (ED 1).
- Develop alternative measures to evaluate the impact of AT training for students with disabilities who may remain in the same instructional setting, but may experience quality of life improvements as a result of the school district completing AT training.

TRANSPORTATION GOAL ONE (page 68 of Plan)

REASON FOR CHANGE

Based on the data reported for Calendar Year 2016, the 2020 overall goal has been achieved. Because the goal has been exceeded, new targets are being set.

Goal One: By December 31, 2020, accessibility improvements will be made to: (A) ~~6,600~~ 4,200 curb ramps (increase from base of 19% to ~~49%~~ 38%); (B) ~~380~~ 250 accessible pedestrian signals (increase from base of 10% to ~~70%~~ 50%); and (C) by October 31, 2021, improvements will be made to ~~55~~ 30 miles of sidewalks (increase from base of 46% to 60%).

(A) Curb Ramps

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

- By December 31, 2020 accessibility improvements will be made to an additional 6,600 ~~4,200~~ curb ramps⁶ bringing the percentage of compliant ramps to approximately ~~49%~~ 38%.

(B) Accessible Pedestrian Signals

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

- By December 31, ~~2020~~ 2019, an additional ~~380~~ 250 Accessible Pedestrian Signals (APS) installations will be provided on MnDOT owned and operated signals bringing the percentage to ~~70%~~ 50%.

~~Annual Goals to increase the number of APS installations:~~

- ~~By December 31, 2015 an additional 50 APS installations will be provided~~
- ~~By December 31, 2016 an additional 50 APS installations will be provided~~
- ~~By December 31, 2017 an additional 50 APS installations will be provided~~
- ~~By December 31, 2018 an additional 50 APS installations will be provided~~
- ~~By December 31, 2019 an additional 50 APS installations will be provided~~

(C) Sidewalks

Baseline: In 2012, MnDOT maintained 620 miles of sidewalks. Of the 620 miles, 285.2 miles (46%) met the 2010 ADA Standard and Public Right of Way (PROW) guidance.

- By October 31, 2021 improvements will be made to an additional ~~55~~ 30 miles of sidewalks bringing total system compliance to 60%.

~~Annual Goals to improve sidewalks:~~

- ~~By October 31, 2017 improvements will be made to an additional 6 miles of sidewalks~~
- ~~By October 31, 2018, improvements will be made to an additional 6 miles of sidewalks~~

⁶ ADA Title II Requirements for curb ramps at www.fhwa.dot.gov/civilrights/programs/doj_fhwa_ta_glossary.cfm

- ~~By October 31, 2019, improvements will be made to an additional 6 miles of sidewalks~~
- ~~By October 31, 2020, improvements will be made to an additional 6 miles of sidewalks~~
- ~~By October 31, 2021, improvements will be made to an additional 6 miles of sidewalks~~

NO PROPOSED CHANGES TO STRATEGIES

TRANSPORTATION GOAL FIVE (page 70 of Plan)

REASON FOR CHANGE

Transportation Goal Five was adopted in the March 2018 Revised Olmstead Plan provides that by April 30, 2018, annual goals will be established. The annual goal below was reviewed and approved by the Subcabinet at the August 27, 2018 meeting. The annual goal need to be incorporated into the Plan.

Goal Five: By 2040, 100% percent of the target population will be served by regular route level of service for prescribed market areas 1, 2, and 3 in the seven county metropolitan area.

Baseline: The percentage of target population served by regular route level of service for each market area is as follows: Market Area 1 = 95%; Market Area 2 = 91%; and Market Area 3 = 67%.

- ~~By April 30, 2018, annual goals will be established.~~
- By 2025, the percentage of target population served by regular route level of service for each market area will be:
 - Market Area 1 will be 100%
 - Market Area 2 will be 95%
 - Market Area 3 will be 70%

The percentage for each market area will be reported on an annual basis to determine if progress is being made toward the goals.

NO PROPOSED CHANGES TO STRATEGIES

POSITIVE SUPPORTS GOAL THREE (page 80 of Plan)

REASON FOR CHANGE

The goal to reduce the number of individuals approved for emergency use of mechanical restraint essentially acts as a quota. While the number of individuals is not expected to increase, it may never reach zero because new people continue to enter the system. It is expected that the number will remain low. However, an actual number cannot be assigned as a goal as it substitutes for the judgment of the clinicians that serve on the External Program Review Committee (the body that considers requests for emergency use of procedures) and the commissioner's delegated decision maker on those requests. Instead of evaluating individual needs on a case-by-case basis, the Department is put in the position of either disregarding the best interests of the individual or failing to meet the goal.

This goal also includes a measure of the number of reports of mechanical restraint. Both the number of reports and the number of individuals approved have been drastically reduced since the implementation of the Olmstead Plan. At this point, the agency suggests that the measure based on the number of individuals approved for emergency use of mechanical restraint be deleted and continue only the measure to decrease the number of reports of mechanical restraint.

Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544⁷, 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: (A) ≤ 93 reports; and (B) ≤ 7 individuals.

Baseline: In SFY 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals.

Annual Goals to reduce the use of mechanical restraints:

- ~~By June 30, 2015, reduce mechanical restraints to no more than
(A) 461 reports of mechanical restraint
(B) 31 individuals approved for emergency use of mechanical restraint~~
- ~~By June 30, 2016, reduce mechanical restraints to no more than
(A) 369 reports of mechanical restraint
(B) 25 individuals approved for emergency use of a mechanical restraint~~
- ~~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 a mechanical restraint~~
- ~~By June 30, 2018, reduce mechanical restraints to no more than
(A) 185 reports of mechanical restraint
(B) 13 individuals approved for emergency use of a mechanical restraint~~
- By June 30, 2019, reduce mechanical restraints to no more than
(A) 93 reports of mechanical restraint

⁷ Minnesota Security Hospital (MSH) is governed by the Positive Supports Rule when serving people with a developmental disability.

~~(B) 7 individuals approved for emergency use of a mechanical restraint~~

NO PROPOSED CHANGES TO STRATEGIES

POSITIVE SUPPORTS GOAL FOUR/FIVE (pages 80-81 of Plan)

REASON FOR CHANGE

MDE is proposing to add new strategies to improve progress in achieving Positive Supports Goals Four and Five. Amendments are based upon lessons learned during the initial plan implementation, including information gathered through the restrictive procedures workgroup.

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.

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.

PROPOSED CHANGES TO STRATEGIES

Reduce the Use of Restrictive Procedures in Working with People with Disabilities

- Monitor data systems that: (1) assess progress in the reduction of the emergency use of restrictive procedures; (2) assess the number of individuals experiencing restrictive procedures and the number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.
- MDE will improve data reporting tools for improved data quality.
- Annually evaluate progress and determine if there are additional measures to be taken to reduce the use of mechanical restraints that are used to prevent imminent risk of serious injury due to self-injurious behaviors. The external review committee provides oversight and technical assistance.
- Publish annual reports on the progress in reducing the use of restrictive procedures and recommendations.
- Work with the Department of Health to evaluate opportunities to coordinate tracking with DHS and reduce use of restrictive procedures for people with disabilities in MDH-licensed facilities.
- Continue to implement MDE's Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate the Use of Prone Restraint. (Statewide Plan) If the legislature acts to eliminate the use of seclusion in schools, MDE will adjust goals four and five as needed to reflect the changes.
- MDE will document progress in Statewide Plan implementation and summarize restrictive procedure data in the annual legislative report submitted February 1 of each year. MDE will track individual uses of seclusion on students receiving special education services by requiring districts to submit individual incident reports of each use of seclusion. These reports will assist MDE and the Restrictive Procedures Work Group in identifying areas of concern and developing strategies for eliminating the use of seclusion.
- In alignment with the statewide plan, MDE will identify and recruit districts with the highest per capita use of physical holds and seclusion to partner with MDE to develop a district level team and conduct a district readiness assessment to initiate implementation of evidence-based practices that match the district's needs in an active implementation framework.

[AGENDA ITEM 6c]

- Restrictive procedures may only be used in the school setting in an emergency, by licensed professionals, who have received training which includes positive behavioral interventions, de-escalation, alternatives to restrictive procedures, and impacts of physical holding and seclusion.
- MDE will provide evidence-based strategies to use with students with disabilities who have significant needs that result in self-injurious or physically aggressive behaviors.
- MDE will collaborate with DHS to expand the list of effective evidence-based strategies for districts to use to increase staff capacity and reduce the use of restrictive procedures.

Reduce the Use of Seclusion in Educational Settings

- Engage the Restrictive Procedures Work Group⁸ at least annually to review restrictive procedure data, review progress in implementation of the Statewide Plan, and discuss further implementation efforts and revise the Statewide Plan as necessary.
- Engage the Restrictive Procedures Work Group to make recommendations to MDE and the 2016 legislature on how to eliminate the use of seclusion in schools on students receiving special education services and modify the Statewide Plan to reflect those recommendations. The recommendations shall include the funding, resources, and time needed to safely and effectively transition to a complete elimination of the use of seclusion on students receiving special education services.
- MDE has hired a consultant to facilitate the Restrictive Procedures Stakeholder Work Group meetings beginning in December of 2018 for increased stakeholder engagement in recommending to the Commissioner specific and measurable implementation and outcome goals for reducing the use of restrictive procedures.

⁸ Statute 125A.0942 states the Commissioner of MDE must consult with interested stakeholders, including representatives of advocacy organizations, special education directors, teachers, paraprofessionals, intermediate school districts, school boards, day treatment providers, county social services, state human services staff, mental health professionals, and autism experts.

CRISIS SERVICES GOAL THREE (page 86 of Plan)

REASON FOR CHANGE

DHS is proposing to remove the goal. The reporting period has ended. Throughout the reporting of this goal, comments on performance have indicated that the majority of people have reopened on waived services and the remaining individuals are moving into a setting appropriate to their situation.

~~**Goal Three: By June 30, 2017, the number of people who discontinue waiver services after a crisis will decrease to 45 people or fewer. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.)**~~

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

~~**Annual Goals** to decrease the number of people who discontinue waiver services after a crisis:~~

- ~~● By June 30, 2015, the number will decrease to no more than 60 people.~~
- ~~● By June 30, 2016, the number will decrease to no more than 55 people.~~
- ~~● By June 30, 2017, the number will decrease to no more than 45 people.~~

COMMUNITY ENGAGEMENT GOAL TWO/THREE (page 92 of Plan)

REASON FOR CHANGE

As reported in the August 2018 Quarterly Report, OIO concluded that it is not possible to establish a baseline or maintain consistency with a tracking system to measure the existing goal. Two new goals are being proposed to replace Goal Two.

~~**Goal Two: By June 30, 2020, the number of individuals 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 individuals involved in planning publicly funded projects:~~

- ~~• By April 30, 2018, establish a baseline and annual goals~~

Goal Two

- By March 31, 2020, the (A) number of individuals with disabilities to participate in public input opportunities related to the Olmstead Plan, and (B) the number of comments received by individuals with disabilities (including comments submitted on behalf of individuals with disabilities will increase by 5% over baseline.
- By April 30, 2019, a baseline will be established using 2018-2019 Public Input opportunities data.

Goal Three

- By December 31, 2021, the number of engagement activities for Olmstead Plan's measurable goals that are evaluated utilizing the Civic Engagement Evaluation Framework will increase by 5% over baseline.
- By December 31, 2019, a baseline will be established.

PREVENTING ABUSE AND NEGLECT GOAL TWO (page 94 of Plan)

REASON FOR CHANGE

During the first year of implementation, it was determined that the data source being used contained some unexplained inconsistencies. Analysis of the data showed intermittent reporting from hospitals across the state. As a result, MDH staff began training hospital staff to improve identification and reporting of abuse and neglect of vulnerable individuals. The new goal is being expanded to include gathering data from other medical settings other than emergency rooms and hospitals in order to provide a more complete picture of reporting of abuse and neglect in health care settings.

New strategies are being added to analyze and validate claims data and to continue training hospital and medical clinic staff to improve consistent and timely reporting.

Goal Two: By January 31, 2020, the number of ~~emergency room (ER) visits and hospitalizations cases~~ of vulnerable individuals being treated due to abuse and neglect will decrease by ~~30%~~ 50% compared to baseline.

There are two measures for this goal:

(A) Emergency room visits and hospitalizations

Annual Goals to decrease number of emergency room visits and hospitalizations due to abuse and neglect

- By April 30, 2019, establish a baseline
- By January 31, 2020, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 10% compared to baseline
- By January 31, 2021, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 20% compared to baseline
- By January 31, 2022, the number of emergency room visits and hospitalizations due to abuse and neglect will be reduced by 30% compared to baseline

(B) Medical treatment(s) other than emergency room or hospital

Annual Goals to decrease number of medical treatments other than emergency room visits and hospitalizations due to abuse and neglect

- By April 30, 2019, establish a baseline
- By January 31, 2020, the number of medical treatments due to abuse and neglect will be reduced by 10% compared to baseline
- By January 31, 2021, the number of medical treatments due to abuse and neglect will be reduced by 20% compared to baseline
- By January 31, 2022, the number of medical treatments due to abuse and neglect will be reduced by 30% 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 years = 40).~~

~~**Annual Goals** to reduce the number of ER visits and hospitalizations due to abuse and neglect:~~

- ~~• 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~~

PROPOSED CHANGES TO STRATEGIES

Goal Two

Use Data to Identify Victims and Target Prevention

- Analyze MHA data on vulnerable individuals who have been the victim of abuse and neglect.
- Analyze provider claims data and validate data from the electronic health records.
- Continue to train hospital and clinic-based health information management staff charged with coding clinicians' notes in order to improve accuracy of codes assigned.
- Identify patterns and geographic areas for targeted prevention efforts.

Monitor and Improve Accountability of Providers

- Report ~~semi-annually~~quarterly to the Olmstead Subcabinet the number of citations issued to Intermediate Care Facilities for Individuals with Intellectual Disabilities that document failure to report abuse, neglect and other maltreatment. Also included will be the number of citations issued to Supervised Living Facilities that document failure to comply with the development of an individualized abuse prevention plan, as required by Minnesota Statute 626.557 subd.14 (b).

PREVENTING ABUSE AND NEGLECT GOAL FOUR (page 95 of Plan)

REASON FOR CHANGE

Amendment of this goal is proposed based upon lessons learned during the initial year of plan implementation, specifically the importance of:

- Incorporating determinations rather than allegations into the metric in order to use the true incidence of maltreatment as a continuous improvement measure.
- Having the primary and annual measure be the number of students with disabilities identified as victims in determinations of maltreatment in order use the true incidence of maltreatment as a continuous improvement measure, and for that measure to be as directly related to impact on children with disabilities as possible. Patterns of determinations in school districts and buildings continues to be valuable in analysis and root cause determinations, and will continue to be a component of data analysis for this goal and reporting to the Olmstead Subcabinet.
- Using an annual measure that reviews statewide data on the number of students with disabilities each year as a measure of progress, while still analyzing cumulative data to identify schools and specific issues with a multi-year pattern of needing MDE training and technical assistance.
- Using an annual measure of the number of students with disabilities in determinations of maltreatment rather than the state percentage of students with disabilities because the latter percentage would be too small for meaningful communication of the impact on identified students, as well as strategies and progress for this goal.

Goal Four: By July 31, 2020, the number of students with disabilities statewide identified as victims in determinations of maltreatment will decrease by 10% compared to baseline.

Baseline: From July 2015 to June 2016, there were 20 students with a disability statewide identified as victims in determinations of maltreatment.

Annual Goals: to reduce the number of students with disabilities statewide identified as victims in determinations of maltreatment:

• By July 31, 2019, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 5% from baseline to 19 students.

• By July 31, 2020, the number of students with disabilities identified as victims in determinations of maltreatment will decrease by 10% from baseline to 18 students.

Annual reporting to the Subcabinet of number of students with disabilities identified as victims in determinations of maltreatment will also include explanation of this number as a percentage of the state population of students with disabilities, and in relation to the number of reports received by MDE annually.

~~**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.**~~

~~Baseline: From July 2013 to June 2016, there were 13 identified schools that had three or more investigations of alleged maltreatment of a student with a disability within the three preceding years. There were 66 students with a disability who were identified as alleged victims of maltreatment within those schools:~~

~~**Annual Goals** to reduce 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 and the number of students with a disability who are identified as alleged victims of maltreatment within those schools:~~

- ~~● By July 31, 2018, the number of identified schools and students will decrease by 10% from baseline~~
- ~~● By July 31, 2019, the number of identified schools and students will decrease by 25% from baseline~~
- ~~● By July 31, 2020, the number of identified schools and students will decrease by 50% from baseline~~

PROPOSED CHANGES TO STRATEGIES

Goal Four

Utilize School Tracking Database

- Utilize database to track and identify schools that have multiple investigations of alleged maltreatment of students with a disability in order to provide those schools with focused MDE training and technical assistance. The number of schools in this category will continue to be annually reported to the Olmstead Subcabinet in a data table.

Continue and Expand Training for School Personnel

- ~~● Continue the expansion of the MDE approved School Wide PBIS system to include schools that demonstrate a higher number of reports of alleged maltreatment of students.~~
- Provide targeted MDE technical assistance, training, and support to schools through:
 - Annual training for schools on child maltreatment and mandated reporting requirements, PBIS, restrictive procedures, and discipline.
 - Development of web based trainings and informational materials on relevant topic areas (mandated reporting, child maltreatment, PBIS, etc.) to distribute to schools and incorporate into school/staff development trainings.

Improve School Accountability for Training

- Collect annual verification from school districts indicating all school employees have been trained on mandated reporter duties and protections from retaliation when a report is made in good faith. Targeted MDE technical assistance and training will be provided to schools that cannot provide annual verification.

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Item:

6 (d) 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 three exceptions to report.

Darlene Zangara (OIO) will report on three activities related to the Community Engagement Plan that are delayed. She will provide a status update and a plan to remedy with a new deadline.

The Workplan Compliance Report includes the list of activities with deadlines in November that were reviewed by OIO Compliance in December and verified as completed.

Attachment(s):

6d - Workplan Compliance Report for December 2018

[AGENDA ITEM 6d]

Workplan Compliance Report for December 2018

Total number of workplan activities reviewed (see attached)	11	
• Number of activities completed	8	73%
• Number of activities on track	0	0%
• Number of activities reporting exception	3	27%

Exception Reporting

There are three activities being reported as exceptions.

Workplan Activity, Deadline and Agency
<p>3 Activities related to the development of a Community Engagement Plan:</p> <ul style="list-style-type: none"> • Community Engagement 3D.1a - Develop a Community Engagement plan with measurable and actionable strategies for advancing engagement between state agencies and people with disabilities. Present Plan to Subcabinet. (Deadline: Present Plan to Subcabinet by 12/31/2018) • Community Engagement 3D.1d - Obtain input on how to measure the effectiveness utilizing outcomes of engagement across all Subcabinet agencies. (Deadline: Complete measurement tool by 11/30/2018) • Community Engagement 3D.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. (Deadline: Complete by 11/30/2018) <p>Expected Outcome: 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.</p> <p>Agency: Olmstead Implementation Office(OIO)</p>
Status Reported and Reason for Exception
<p>The Community Engagement Plan DRAFT has been developed. The evaluation tool was recently developed and will be incorporated into the Plan. Two Community Engagement goals are being proposed during the Plan Amendment process. The Community Engagement Plan will be updated pending approval of the goals and analysis of public input received on the two goals.</p>
Plan to Remedy, Action Needed and New Deadline
<p>The Community Engagement Plan including the evaluation tool, will be presented to the Subcabinet by March 31, 2019.</p>

[AGENDA ITEM 6d]

Workplan Reporting for December 2018 (listed alphabetically)

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency Response
CE 3D.1a	Develop a Community Engagement plan with measurable and actionable strategies for advancing engagement between state agencies and people with disabilities. Present Plan to 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.	12/31/2018	OIO	Delayed. See Exception report.
CE 3D.1b	Work with Subcabinet agencies to identify best practices and barriers to engagement.	See D.1a above	11/30/2018	OIO	Verified as complete
CE 3D.1c	Work with Department of Human Rights to develop tools and best practices to evaluate engagement efforts.	See D.1a above	11/30/2018	OIO MDHR	Verified as complete
CE 3D.1d	Obtain input on how to measure the effectiveness utilizing outcomes of engagement across all Subcabinet agencies.	See D.1a above	Complete tool by 11/30/2018	OIO	Delayed. See Exception report
CE 3D.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.1a above	11/30/2018	OIO MDHR	Delayed. See Exception report
CM 1E.2	Produce and disseminate a monthly "Olmstead News and Updates" electronic newsletter to interested stakeholders.	Accessible communications will be available to individuals and communities. People with disabilities, their families and supporters will be informed about Olmstead Plan implementation.	11/30/2018 (monthly)	OIO	Verified as complete for November 2018 occurrence
CM 2D.2	Maintain a monthly calendar to monitor and implement communication activities.	Audiences will be engaged in the Olmstead Plan implementation through communications.	11/30/2018 (monthly)	OIO	Verified as complete for November 2018 occurrence

[AGENDA ITEM 6d]

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency Response
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.	11/30/2018 (annually)		Verified as complete for November 2018 occurrence.
QL 5I	<p>Monitor the creation of the Olmstead Quality of Life Survey Report</p> <p>Complete analysis</p> <ul style="list-style-type: none"> • The analysis will be focused on comparing survey score changes from the baseline across all relevant variables. The other component of this analysis will focus on measuring the impact different variables have on survey scores. • The report will highlight the major changes from baseline to follow-up. It will identify changes in survey module scores and scan for any significant changes in scores across service setting and region. • A comprehensive analysis of all relevant variables and include the results of the regression methodology that will be further developed in the planning stages of this work. • Data tables of all results will be included in the report. 	See 5C above	11/30/2018	OIO	Verified as complete.
QL 5J	Submit the Quality of Life Survey results final report to the Subcabinet.	See 5C above	12/31/2018	OIO	Verified as complete. Report included in December Subcabinet packet

[AGENDA ITEM 6d]

Activity	Key Activity	Expected Outcome	Deadline	Agency	Agency Response
TS 3D.2	<p>Convene a cross division, cross-administration working group to improve the timely discharge of individuals at Anoka Metro Regional Treatment Center (AMRTC) and Minnesota Security Hospital (MSH) to identify:</p> <ul style="list-style-type: none"> • barriers • current and future strategies • needed efficiencies that could be developed between AMRTC and MSH <p>Include engagement and consultation with counties and community providers in this effort.</p> <p>Report to Subcabinet on working group findings and recommendations.</p>	People at AMRTC and MSH will be discharged in a timely manner.	12/31/2018	DHS	Verified as complete. Report included in December Subcabinet packet

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Item:

6 (e) Revisions to Subcabinet Procedures

Presenter:

Commissioner Mary Tingerthal

Action Needed:

- Approval Needed**
- Informational Item (no action needed)**

Summary of Item:

The Olmstead Subcabinet Procedures were last approved in March 2017. Some revisions are being proposed to the March 2017 Procedures and are indicated with track changes. Subcabinet review and approval is being requested.

Attachment(s):

6e) Olmstead Subcabinet Procedures

OLMSTEAD SUBCABINET PROCEDURES

Approved: March 10, 2015
 Revised: January 25, 2016
 Revised: March 27, 2017
 Revised: December 17, 2018

PREAMBLE

On January 28, 2013, Governor Dayton created the Olmstead Subcabinet to develop and implement a comprehensive Minnesota Olmstead Plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs in the most integrated setting, consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).¹ On January 28, 2015, the Governor issued a second Executive Order defining the Subcabinet's duties, and requiring the Subcabinet to adopt procedures to execute its duties.²

On April 25, 2013, the federal district Court in *Jensen, et. al. v. DHS, et. al.*, ordered the State and the Department of Human Services (DHS) to develop and implement a comprehensive *Olmstead* Plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individuals needs in the most integrated setting, consistent with the *Olmstead* decision.³

Minnesota's Olmstead Plan was approved by the Court on September 29, 2015.⁴ The Plan was subsequently amended by the Subcabinet in June 2016, February 2017, and March 2018. ~~was amended in June 2016 to incorporate new measurable goals and strategies.⁵ A revised February 2017 Plan was developed after an extensive amendment process. The Revised February 2017 Plan was submitted to the Court on February 28, 2017.⁶~~

Article I PURPOSE OF PROCEDURES

The purpose of these procedures is to set forth clear and orderly processes for the Subcabinet to implement the Olmstead Plan in furtherance of the Orders of the Governor and the Court.

¹ Executive Order 13-01, January 28, 2013.

² Executive Order 15-03, January 28, 2015.

³ *Jensen, et. al. v. Department of Human Services, et. al.*, Civil No. 09-cv-1775 (DWF/FLN) Doc. 212.

⁴ Id. At Doc. 510.

~~⁵ Id. At Doc. 569.~~

~~⁶ Id. At Doc. 616.~~

Article II **MEMBERSHIP**

A. COMMISSIONER MEMBERS.

Subcabinet members are appointed by the Governor. Members are the Commissioner, or the Commissioner's designee, of the following State agencies and *ex-officio* members from two State entities.⁷

1. Department of Human Services;
2. Minnesota Housing Finance Agency;
3. Department of Employment and Economic Development;
4. Department of Transportation;
5. Department of Corrections;
6. Department of Health;
7. Department of Human Rights;
8. Department of Education.
9. Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities (*ex-officio* member); and
10. Executive Director of the Minnesota Governor's Council on Developmental Disabilities (*ex-officio* member).

B. COMMISSIONER DESIGNEES.

Each Commissioner member may designate one person from the Commissioner's agency to serve in his or her stead on the Subcabinet, and only that designee may serve until such time as the Commissioner replaces the designee with a different designee. A Commissioner may establish or replace a designee by providing written notice to the Chair.

A designee alternate may also be named using the same procedures used for naming a designee. The Chair has discretion to approve or reject a request for a designee alternate.

⁷ Executive Order 15-03, January 28, 2015.

[AGENDA ITEM 6e]

The Commissioner's designee or designee alternate shall exercise the rights and responsibilities of the Commissioner when the Commissioner is not present. It is the expectation that Commissioner designees and designee alternates will be Deputy or Assistant Commissioners. Exceptions may be granted at the discretion of the Chair.

The Olmstead Implementation Office (OIO) shall maintain a list of all Commissioner designees and designee alternates.

C. EX OFFICIO MEMBERS.

The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities are *ex officio* members of the Subcabinet.⁸ The *ex officio* members are voting members and may serve on Subcabinet committees.

D. CHAIR.

A Subcabinet chair will be designated by the Governor.

E. MEMBER EXPECTATIONS.

Members are expected to:

1. Attend assigned meetings;
2. Serve on workgroups and subcommittees as the Chair requests;
3. Prepare for active participation in discussion and decision-making by consulting with agency staff, and by reviewing meeting materials;
4. Act as the liaison between the Olmstead Subcabinet and the member's agency or office;
5. Inform the member's agency or office about Subcabinet activities and actions;
6. Ensure the member's agency takes appropriate steps to further progress on Olmstead Plan goals and to comply with OIO Compliance Procedures; and
7. Perform such other duties as required to fulfill the obligations of the Subcabinet.

⁸ Executive Order 15-03, January 28, 2015

Article III
DUTIES OF THE CHAIR

The Subcabinet chair shall:

- A. Chair Subcabinet meetings and develop meeting agendas in consultation with the Executive Committee;
- B. Serve on the Executive Committee;
- C. Be responsible for establishing, amending, and updating Subcabinet procedures;
- D. Provide direction to the ~~OIO~~Olmstead Implementation Office; supervise the performance of the Executive Director of the OIO; and annually evaluate the Executive Director's performance;
- E. Designate the OIO Director of Compliance, who shall report to the Chair;
- F. Provide direction to compliance staff assigned to the OIO; supervise performance of the OIO Director of Compliance; and annually evaluate the OIO Director of Compliance's performance;
- G. Direct OIO staff to annually prepare a budget, staffing plan and work plan that is sufficient to carry out OIO activities in a timely and high-quality manner;
- H. Appoint chairpersons and other members of committees, in consultation with other Subcabinet members; and to appoint another commissioner member of the Subcabinet to chair a meeting of the Subcabinet or the Executive Committee in the absence of the Chair.
- I. Provide leadership to the Subcabinet; and
- J. Serve as a spokesperson for the Olmstead Subcabinet.

Article IV
OPEN MEETINGS

All Subcabinet, committee, and workgroup meetings shall be open to the public and to the extent possible and practicable, conducted in accordance with Minnesota Statutes, Chapter 13D.

Article V
COMMITTEES

A. EXECUTIVE COMMITTEE.

The Subcabinet shall establish an executive committee comprised of three Commissioner Members, which shall include the Subcabinet chair and the Commissioner of Human Services, or his or her designee or designee alternate. All three members shall have a vote. A majority of executive committee members or their designees or designee alternates shall constitute a quorum.

1. RESPONSIBILITIES OF EXECUTIVE COMMITTEE.

The executive committee is responsible for preliminary review of agenda items before presentation to the Subcabinet, for developing recommendations to the Subcabinet, and for conducting the interim business of the Subcabinet.

2. AUTHORITY OF THE EXECUTIVE COMMITTEE.

The executive committee shall have authority to act on behalf of the Subcabinet during the interim between regularly scheduled Subcabinet meetings.

3. MEETINGS.

The Executive Committee shall meet at the call of the chair.

B. OTHER SUBCABINET COMMITTEES.

The Chair, in consultation with the Subcabinet, may establish any other committees comprised of members of the Subcabinet as necessary to carry out the Subcabinet’s responsibilities.

C. SPECIALTY COMMITTEES.

The Subcabinet may establish specialty committees that may include members outside of the Subcabinet. Each specialty committee shall develop a charter that describes the scope of its work, and shall report regularly to the Subcabinet if directed. The Chair shall approve members of any specialty committee.

Article VI
SUBCABINET MEETINGS

A. SCHEDULE.

The Subcabinet shall hold no fewer than six regularly scheduled meetings annually. The Subcabinet may hold additional meetings as directed by the Chair.

B. RULES.

All Subcabinet and committee meetings shall be conducted in accordance with Robert's Rules of Order, newly revised, 11th edition, unless otherwise specified in these procedures.

C. QUORUM.

A majority of the Subcabinet members or their designees or designee alternates shall constitute a quorum necessary to conduct Subcabinet business.

D. VOTES.

Voting will be conducted by voice vote. A roll call vote may be taken on any issue at the request of one or more of Subcabinet members present. Commissioners' designees or designee alternate shall have a vote if the Commissioner is not present. Votes on an action taken in the meeting shall be recorded in a journal kept for that purpose. The journal must be open to the public during all normal business hours where records of the Subcabinet are kept.

F. ACCESSIBILITY.

Subcabinet meetings shall be held in locations and be conducted in a manner accessible to people with disabilities. Subcabinet materials shall be provided in forms accessible to people with disabilities.

F. NOTICE.

A schedule of regular meetings shall be kept on file in the OIO office and shall be posted on the Olmstead website. Notice of special meetings shall be given according to the requirements of Minnesota Statutes, Chapter 13D, to the extent possible and practicable.

[AGENDA ITEM 6e]

G. AGENDA AND MATERIALS.

The OIO shall prepare and distribute meeting agenda and materials to the Subcabinet members seven calendar days before meetings of the full Subcabinet. The OIO will make reasonable efforts to also post the meeting agenda and materials to the Olmstead website seven calendar days before meetings of the full Subcabinet.

H. KEEPING OF MINUTES.

The OIO shall keep and publish minutes of Subcabinet and Executive Committee meetings. The minutes shall provide a record of all matters presented to the Subcabinet, including all reports and materials, presented motions, actions, and all votes taken. The draft minutes of Subcabinet and Executive Committee meetings shall be published on the Olmstead website within fourteen calendar days of the meeting.

I. PUBLIC COMMENT.

The Olmstead Subcabinet will utilize reasonable measures to facilitate public comment at meetings of the full Subcabinet.

Article VII
SUBCABINET DUTIES

The Subcabinet's duties, established by Executive Order ~~15-03~~, are:

A. GENERAL DUTY.

The Subcabinet shall implement Minnesota's Olmstead Plan.

B. SPECIFIC DUTIES AS SET FORTH IN EXECUTIVE ORDER.

1. Provide oversight for and monitor the implementation and modification of the Olmstead Plan, and the impact of the Plan on the lives of people with disabilities;
2. Provide ongoing recommendations for further modification of the Olmstead Plan;
3. Ensure interagency coordination of the Olmstead Plan implementation and modification process;
4. Convene periodic public meetings to engage the public regarding Olmstead Plan implementation and modification;
5. Engage persons with disabilities and other interested parties in Olmstead Plan implementation and modification and develop tools to keep these individuals aware of the progress on the Plan;

[AGENDA ITEM 6e]

6. ~~Continue to implement the ongoing Quality of Life survey process to measure the quality of life of people with disabilities over time; Develop a quality improvement plan that details methods the Subcabinet must use to conduct ongoing quality of life measurement and needs assessments and implement quality improvement structures;~~
7. ~~Establish a process to review existing State policies, procedures, laws and funding, and any proposed legislation, to ensure compliance with the Olmstead Plan, and advise State agencies, the legislature, and the Governor's office on the policy's effect on the plan;~~
8. ~~Establish a process to more efficiently and effectively respond to reports from the Court and the Court Monitor;~~
- 9.7. Convene, as appropriate, workgroups consisting of consumers, families of consumers, advocacy organizations, service providers, and/or governmental entities of all levels that are both members, and non-members, of the Subcabinet;
- 10.8. Appoint any successor to the current Executive Director of the Olmstead Implementation Office (OIO); and
- 11.9. ~~Maintain~~ Adopt procedures to ~~ensure they define execute its duties, establish~~ a clear decision-making process, facilitate execution of the Subcabinet's duties, and appropriately define the role of the OIO, and revise such procedures as necessary ~~and to further define and clarify the role of the OIO.~~

Article VIII**OLMSTEAD IMPLEMENTATION OFFICE****A. REPORTING.**

The Executive Director of the OIO shall report to the Subcabinet chair. The OIO Director of Compliance shall report to the Subcabinet chair.

B. DUTIES.

The duties of the OIO are as described in the Olmstead Plan in the section titled Plan Management and Oversight.⁹

C. COMPLIANCE.

The OIO Director of Compliance will maintain OIO Compliance Procedures that document how Subcabinet agencies will work with OIO.

⁹ ~~Jensen, Doc. 616.~~

Article IX
WORKGROUPS

The Subcabinet may convene workgroups consisting of consumers, their families, advocacy organizations, service providers, and/or other governmental entities. Workgroups may include members of the Subcabinet. Each workgroup shall develop a charter that describes the scope of its work, and shall report regularly to the Subcabinet if directed. The Chair shall approve members of any workgroup, with input from the Subcabinet members.

Article X
AMENDMENTS

The Subcabinet may amend these procedures as appropriate to carry out Subcabinet duties. Amendments shall be by majority vote.

DRAFT

DRAFT

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Item:

7(a) Workplan activity reports to be presented to Subcabinet

- 1) Transition Services 3D.2 – Findings and recommendations regarding timely discharge from AMRTC and MSH*

Presenter:

Erin Sullivan Sutton (DHS)

Action Needed:

- Approval Needed
- Informational Item (no action needed)

Summary of Item:

This report provides an update on a workplan activity and will be presented to the Subcabinet.

Attachment(s):

7a)1 Olmstead Plan Workplan - Report to Olmstead Subcabinet

Olmstead Subcabinet Meeting Agenda Item

**OLMSTEAD PLAN WORKPLAN
REPORT TO OLMSTEAD SUBCABINET**

Topic Area	Transition Services
Strategy	Increase service options for individuals making transitions
Workplan Activity	TS 3D.2
Workplan Description	<p>Convene a cross division, cross-administration working group to improve the timely discharge of individuals at Anoka Metro Regional Treatment Center (AMRTC) and Minnesota Security Hospital (MSH) to identify:</p> <ul style="list-style-type: none"> • barriers • current and future strategies • needed efficiencies that could be developed between AMRTC and MSH <p>Include engagement and consultation with counties and community providers in this effort.</p> <p>Report to Subcabinet on working group findings and recommendations.</p>
Deadline	December 31, 2018
Agency Responsible	DHS
Date Reported to Subcabinet	December 17, 2018

OVERVIEW

Individuals under mental health commitment have 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 include a lack of housing options and housing providers no longer accepting applications for waiting lists.

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

- 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.
- Inadequate funding for the “elder waiver”.
- No funding available for undocumented individuals.

Olmstead Plan Transition Services Goals 2 and 3 measure transition to community settings for people who have been at Anoka Metro Regional Treatment Center (AMRTC) and those discharging from Minnesota Security Hospital (MSH). These goals show that there continues to be progress toward increasing the number of people who are able to move to the community.

The Olmstead November 2018 Quarterly report reported that from July 2018 – September 2018, the percentage of individuals under mental health commitment at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the community awaiting discharge was 50.9%. This did not meet the annual goal of less than or equal to 32%; and it was an increase from previous quarters. However, we had been seeing a trend in the right direction with the past two annual averages. The percentage of patients hospitalized at AMRTC who are civilly committed after being found incompetent continues to increase and is currently around 75%.

MSH also continues to move individuals to integrated settings but not at the pace of the Olmstead annual goals. 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.

REPORT

DHS AMRTC and MSH staff continue to work to partner with counties, as well as continually reviewing processes to see what can be done differently to support counties in moving their persons from our hospitals.

DHS AMRTC and MSH staff are also working with the Behavioral Health Division at DHS to review the Whatever it Takes/ Transitions to Community grant to see if it can be modified to better aid in moving persons from AMRTC and MSH care.

Behavioral Health Division staff are in the process of implementing the Mental Health Innovations grants which are designed to address the patient flow challenges in state operated Community Behavioral Health Hospitals (CBHHs) and the AMRTC. These grants are designed to increase community capacity to address complex behavioral health needs. The Behavioral Health Division has also created a mental health innovations project advisory panel consisting of key stakeholders including counties, Direct Care and Treatment (DCT) staff, advocates, people with lived experience, metro and rural providers and tribal members. The panel will help determine the sustainability and effectiveness of the grants while also making recommendations regarding strengthening the continuum of care for people with complex needs.

The landscape of disability services in the community has changed drastically for providers in the past 5 years. There has been an increase in people who have been demitted from community providers now competing with people leaving AMRTC and MSH, all needing independent living options in the community. Current housing shortages and workforce shortages further complicate this considerably.

To address the difficulty in finding community placements for individuals leaving AMRTC and MSH, DHS has put the following processes into place:

- Support lead agencies to access funding for people who are waiver-eligible through this new legislation.
- Increase county/tribal case worker involvement: implementing county collaborative meetings at AMRTC and MSH, clarifying county and DHS staff roles and expectations in discharge planning.
- Highlight DHS oversight authority with discharge planning process.
- Implement collaborative work across policy areas within DHS to speed up the waiver determination process.
- Mental Health Innovations Grants and Advisory Panel
- Building infrastructure by selecting bonding projects to establish behavioral health crisis facilities across the state. DHS has issued an RFP and will utilize community input in selecting the projects.
- The implementation and support for FACT (Forensic Assertive Community Treatment, a specialized program serving people with severe mental illnesses who are transitioning and re-entering the community from correctional facilities.

Specifically, MSH and AMRTC staff are working with county agencies directly on specific discharge planning. MSH has added an additional social worker with the 2017 Legislated funding with primary role of working on discharges. The MSH Executive Director is meeting with the Hennepin County Social Service Director on an every other month basis to discuss patient transitions to community and specifically barrier themes. This type of planning currently occurs at AMRTC with county staff. Through this increased collaboration, frequent communication, and clarification of roles and duties, it is hoped that these efficiencies will impact the ability for people with disabilities living in institutions to successfully transition their lives in the community.

It is recommended that there be continued advocacy for the development of more appropriate disposition options in the community, which will greatly aid in discharging persons from MSH and AMRTC. DHS will continually work with our county partners to better communication and improve processes to aid the counties in locating appropriate disposition sites. This continued work will provide positive impact on transitioning more individuals to appropriate disposition sites, but will not have the magnitude of impact new disposition options would. Additional recommendations for investment, program expansion and innovation were generated by Governor Task Forces on [Mental Health](#) in 2016 and [Housing](#) in 2018.

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Item:

7(b) Informational Items

2) Civic Engagement and Olmstead (MDHR)

Presenter:

Commissioner Kevin Lindsey/ Rowzat Shipchandler (MDHR)

Action Needed:

- Approval Needed
- Informational Item (no action needed)

Summary of Item:

This report provides an update on work being done by the Minnesota Department of Human Rights related to Civic Engagement.

Attachment(s):

- *Meaningful Engagement Makes a Difference – Building Bridges Between Government and Communities*
- *A Guide to Evaluate Civic Engagement*

Olmstead Subcabinet Meeting Agenda Item



Meaningful Engagement Makes a Difference

Building Bridges Between
Government and Communities



CIVIC ENGAGEMENT IN MINNESOTA



CONTENTS

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LETTER FROM THE COMMISSIONER

In reflecting upon the work that has been completed since the publication of the Civic Engagement Plan in 2016, I am astounded that only two years have passed. The Civic Engagement Steering Committee, civic engagement practitioners in administrative agencies, and the staff of the Minnesota Department of Human Rights (MDHR) have been very busy.

I feel very fortunate to have had a front row seat to see the work come to fruition. Some of the more notable efforts include:

- Creation of a civic engagement project evaluation tool that was developed after the assessment of three large scale civic engagement efforts,
- Implementation of a civic engagement training series for practitioners and senior leadership,
- Creation of a standing civic practitioners network to share best practices and impact policy,
- A recruitment campaign that was launched with the Governor's Office and the Olmstead Implementation Office to diversify State boards and commissions,
- Agencies have committed resources by hiring civic engagement practitioners, recognizing civic engagement work within job descriptions, and incorporating civic engagement in long range plans,
- Convening of the first statewide Civic Engagement Summit, which drew governmental leaders and citizens from every corner of Minnesota,
- Publication of the civic engagement newsletter that has more than 2,000 subscribers, and
- Presentation of several civic engagement case studies at the 2018 Human Rights Symposium.

In reading this report, I hope that you will be left with a deep appreciation for how our collective efforts over the past few years have fundamentally changed the culture of the State of Minnesota in how it approaches and values civic engagement.

I look forward with great anticipation as the bright future of civic engagement between all communities and State government unfolds to build a more inclusive Minnesota.

Sincerely,

A handwritten signature in black ink that reads "Kevin M. Lindsey". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Kevin M. Lindsey
Commissioner
Minnesota Department of Human Rights



BACKGROUND AND HISTORY

The Diversity and Inclusion Council (Council) was established by Governor Mark Dayton in 2015 upon signing of Executive Order 15-02. “A government that serves all the people of Minnesota should reflect all of Minnesota,” Governor Dayton said of the Council. “We must ensure that all of our citizens have equal opportunities to work for their state government, to do business with the state and to participate fully in our democracy.” The Council is made up of three committees – Civic Engagement, Contracting Practices and Employment Practices.

In December 2015, a diverse Steering Committee, comprised of members from both the public and private sector, began meeting to create a civic engagement strategic plan for the State of Minnesota’s Executive Branch.

The Committee explored the question, “Why is Civic Engagement important?” The reasons included strengthening our democracy by building trust with government and confronting the consent of the governed; and ensuring quality public policy is implemented by taking into consideration all ideas within society.

The Civic Engagement Plan was released in October 2016. The plan consisted of four sections and corresponding goals and strategies, in

addition to the central concept of Meaningful Engagement. The plan also prioritized communities of color, American Indian communities, LGBTQ communities and individuals with disabilities.

The committee defined meaningful engagement as the intentional effort of government to facilitate meaningful dialog with all members of the public in its work and the development of policy. Meaningful engagement means that relationships and conversations are reciprocal, authentic and intentional to create opportunities for all communities to participate in the process. In addition, meaningful engagement educates all who participate and is undertaken for the purpose of impacting public policy.

Other plan sections included:

- Laying the Foundation for Meaningful Engagement
- Build Infrastructure
- Diversify Boards and Commissions
- Interagency Strategy

It has been an incredible honor to be part of Gov. Dayton’s groundbreaking efforts in civic engagement. This effort ensures that government is inclusive and works for all its citizens, especially those from historically disenfranchised communities. From the first meeting in December 2015, I continue to be encouraged by the genuine efforts and tremendous progress made by many agencies that bring life to (and then some) the Civic Engagement Plan established in Fall 2016. While there is always room to improve and to do more, I truly believe the foundation has been set to continue making the vision of authentic and meaningful engagement a reality for everyone in Minnesota.

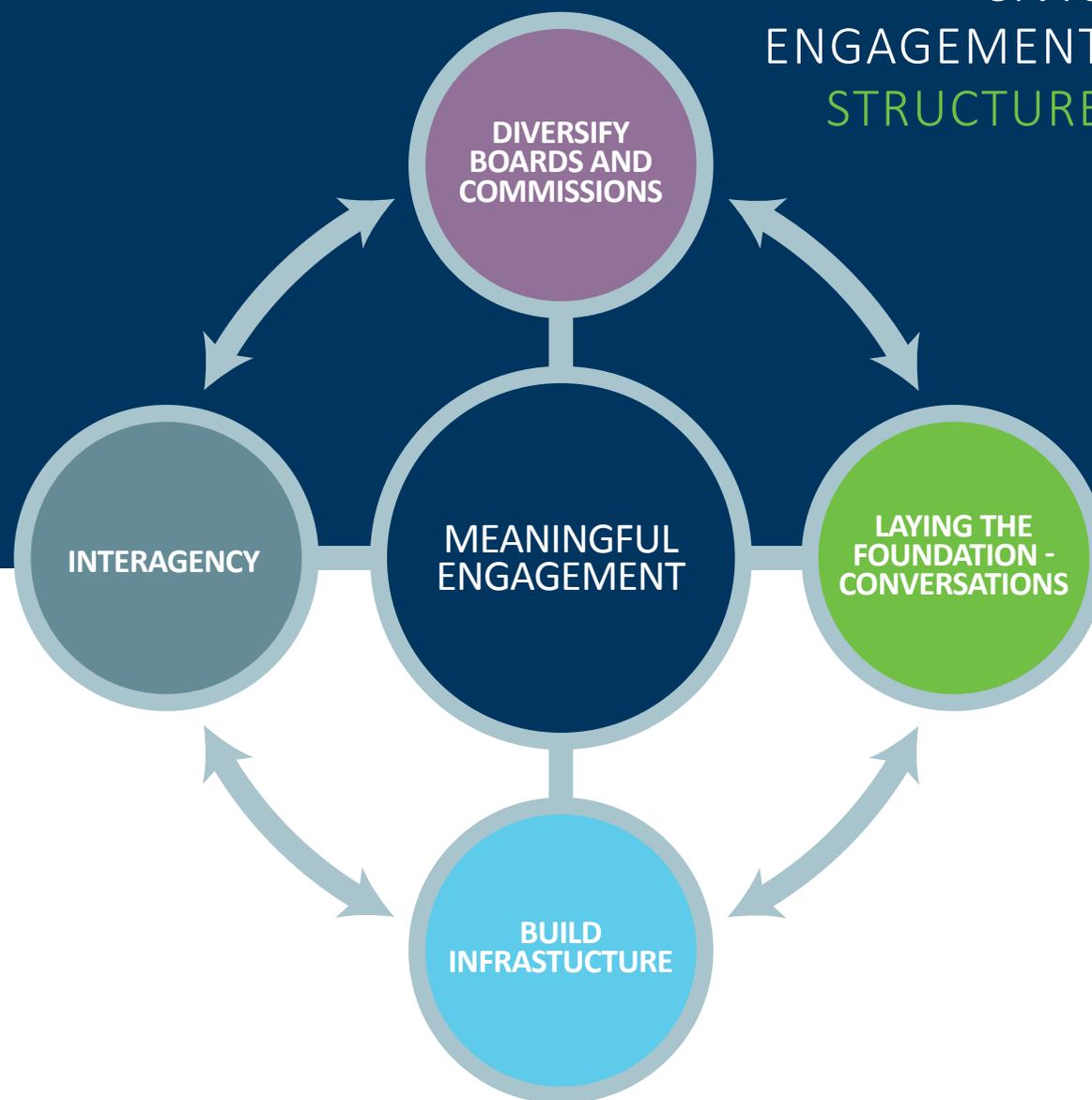
– Rose Chu, MN Education Equity Partnership



CIVIC ENGAGEMENT STRUCTURE

During the past two years, progress has been made on each pillar of the Civic Engagement Plan. The Steering Committee continues to meet to ensure accountability. Minnesota Department of Human Rights (MDHR) hired two staff people and formed an Implementation Committee of leaders driving change within their agencies and a Practitioners Group designed to bring front line staff together. Most importantly, agencies worked hard to improve their own civic engagement efforts.

This report highlights some of the more notable plan accomplishments and is not meant to identify every effort undertaken.



LAYING THE FOUNDATION FOR MEANINGFUL ENGAGEMENT

INTRODUCTION

Communities of color, American Indian communities, LGBTQ communities and individuals with disabilities have been underrepresented in policy making and their absence in the policy making process is detrimental to the long term interests of the State of Minnesota.

This section of the plan set out the following goals:

1. Build trust through community engagement conversations, and
2. Build trust through all interactions with community.

MEANINGFUL ENGAGEMENT CONVERSATIONS

Over the past two years, State governmental leaders and administrative agencies partnered with nonprofit organizations and educational institutions to convene community conversations throughout the State of Minnesota.

These community conversations have allowed community members to meet with Commissioners and other agency officials in informal settings to build trust and authentic relationships in which people can ask questions, get information and understand that their opinions matter.

“People with intellectual and developmental disabilities have a wide variety of abilities, interests and needs,” said Sandra Gerdes, executive director of Laura Baker Services, Steering Committee member, and Meaningful Engagement conversation host. “All our clients and their families want is information about what is and is not possible.”

CIVIC ENGAGEMENT SUMMIT

On June 6, 2018, the State of Minnesota held the first Civic Engagement Summit which brought together members of the public, civic engagement practitioners, community organizers, and governmental leaders throughout the State of Minnesota. The inaugural Summit provided the nearly 200 participants with an opportunity to develop their civic engagement skills and increase cultural competency. Summit attendees also gained a better understanding of government operations and how we can collectively create a more cohesive civic engagement network in Minnesota.

During the morning Plenary titled, “Conversations with Minnesota’s Government Leaders,” government leaders including, Secretary of State Steve Simon, Minneapolis Mayor Jacob Frey, St. Paul Mayor Melvin Carter, Governor Dayton’s Chief of Staff Joanna Dornfeld, and more, held small table conversations with Summit attendees in an effort to build trust, listen authentically, and continue to bridge the divide that exists between government and communities.

Summit evaluations showed that 70 percent of attendees rated their overall experience ‘very good’ or ‘excellent.’ Participants appreciated the opportunities for networking, the speakers, and being able to meet their government leaders in ways they had never done before.



Removing Barriers to Successful Integration: Department of Corrections



Many individuals within the United States see the criminal justice system as a means by which communities of color continue to be disenfranchised through disproportionate police oversight, criminal prosecution, criminal sentencing and application of post-conviction collateral consequences. High profile incidents of police brutality and misconduct have further strained relationships between the law enforcement community and communities of color.

The Minnesota Department of Corrections (DOC) has not historically partnered with community members in the creation of policies, procedures and processes.

While the DOC does not have the ability to directly influence every aspect of the criminal justice system, they understand that they can have a positive impact on reducing the number of people who return to prison.

In 2017, the DOC created its first Civic Engagement Subcommittee. Appreciating the importance of collaboration and co-creation, the DOC met with community stakeholders in creating a diverse Civic Engagement Subcommittee that was reflective of the individuals living within correctional facilities. The DOC solicited information from several administrative agencies to discuss best practices before launch of the Subcommittee.

Workgroups were created in three areas to examine trends in their correction system and to make suggestions for changes. The three areas are: Community-based organizations; Health (mental,

physical, chemical and trauma); and System Barriers (employment, jobs, training and education).

“The project impacts not only offenders, but their families, friends and communities who are also impacted by their incarceration,” said Lisa Wojcik, DOC’s Assistant Commissioner.

“This committee gives communities of color and the American Indian and disability communities the opportunity to learn about the processes of the DOC,” Wojcik said. “It gives them the opportunity to have a voice in outcomes and a chance to affect unintended consequences that may need exploration.”

Subcommittee members participated in making policy and procedural recommendations. They suggested strategy infrastructure that:

- Allow for the exchange of ideas that could lead to changes and improved leadership,
- Engage communities that can influence practices and decision-making.

“This project was different from other projects,” Wojcik noted. “There were community members responsible for drafting recommendations. Staff on each workgroup were available to answer questions and provide clarity. It was an opportunity for our staff to listen to and learn from community members’ perspectives.”

BUILDING INFRASTRUCTURE

INTRODUCTION

While many agencies were undertaking civic engagement initiatives at the time of the development of the civic engagement plan, many community members and agency leaders believed that there was an opportunity to improve upon engagement tactics and measurement, emphasize the importance of community involvement and address internal barriers to effective engagement.

To address those challenges, the plan set out the following goals:

1. Communities should be viewed as a valuable source for ideas, transformation and leadership by administrative agencies.
2. Agency leadership, culture, policy and practice support meaningful engagement.
3. Agencies should devote adequate resources to facilitate meaningful engagement with community.
4. Agencies measure the effectiveness of meaningful engagement.

CIVIC ENGAGEMENT TRAINING

In spring of 2017 and 2018, MDHR held a series of trainings for State employees. Training topics included:

- Facilitating Effective Meetings
- Conflict Resolution
- Evaluating Civic Engagement
- Stakeholder Engagement

Over 350 people participated in the training series and gained practical skills and knowledge to improve how they engage with community. Additionally, the training series provided more space for practitioners to continue to build relationships, find places for collaboration, and de-silo their work. On a macro level, the training series helped raise visibility of the Diversity and Inclusion Council's Civic Engagement work, served as a model for agencies to replicate when providing civic engagement training to their staff, and further contributed to an environment of constant learning and connection within the civic engagement initiative.

Training evaluations from that 85 percent of participants were overall satisfied with the training and 80 percent reported having a deeper understanding of civic engagement because of the training they attended.

"It was great - practical, realistic examples that helped me think of engagement in a different perspective," said a participant from Conflict Resolution training provided by the Minnesota Bureau of Mediation Services.

.....

Meaningful engagement with the public is a skill. State employees are often hired for their technical expertise in a subject area, but have not had training in civic engagement. The civic engagement training series was designed to help those working on projects gain skills and learn to facilitate effective meetings and navigate the conflict that is inherent in the policy making process.

– Rowzat Shipchandler, Deputy Commissioner MDHR

AGENCY ASSESSMENTS

In July 2017, Governor Dayton asked his cabinet level agencies to provide a Diversity and Inclusion update to his office. In light of this, MDHR created an Assessment Tool to assist agencies in assessing their civic engagement efforts. The Assessment Tool asked agencies how senior leadership was championing civic engagement, whether civic engagement was embedded into agency strategic plans and staff position descriptions, and the degree to which agencies were reaching out to communities of color, American Indian communities, LGBTQ communities and individuals with disabilities.

Many of the agencies highlighted very specific things they had done to enhance leadership support of civic engagement and create an agency culture that valued civic engagement. The Minnesota Department of Health's (MDH) strategic plan included a goal of listening to and engaging with communities. MDH created a Community Engagement Plan with community partners, compiled a comprehensive list of external stakeholders and incorporated position descriptions that emphasize civic engagement. The Minnesota Department of Human Services (DHS) also embedded civic engagement into its strategic plan and made inclusion a priority for boards, commissions and advisory committees that impact DHS policy.

The Minnesota Department of Education (MDE) found MDHR's Assessment Tool to be helpful. Assistant Commissioner Hue Nguyen said, "Staff at MDE benefited from filling out the assessment. It made us think more strategically about what we are doing and who should be involved in the work. It will serve as a nice benchmark in a year to see if we've accomplished what we said we would. It would also help to see if as an agency we've matured, perhaps the next set of priorities will deepen the work."

In the aggregate, the assessment indicated the following:

- Many agencies have pockets that are leading the way in civic engagement.
- More needs to be done to institutionalize civic engagement practice throughout individual agencies.
- Evaluating and measuring civic engagement continues to be an area of need.
- More needs to be done to share successes of agencies.
- Agencies need to put greater emphasis in working with underrepresented communities.

As part of agency commitments to civic engagement, several agencies have created advisory groups to help them more effectively further their mission. The Minnesota Pollution Control Agency (MPCA) was one of these. The MPCA is tasked with protecting and improving the State's environment and related health. With a progressively more diverse population, it became more important for the agency that all have a voice in decisions that affect the environment. To that end, MPCA created the Environmental Advisory Group that allows every community the chance to be part of the process.

This group represents low-income residents and communities of color. Thirteen of the 16-member group are people of color, including four people from the Native American community. The Environmental Justice Advisory Group amplifies the voice of previously underrepresented communities. The direct connection between agency decision-makers and the opportunity to establish this relationship are the key principles of meaningful engagement.

– Ned Brooks, Director of MPCA Environmental Justice Program



EVALUATION METRICS PROJECT

In a survey administered in 2015, all cabinet level agencies asked for help with measuring their civic engagement work. In response to this need and with funding from the Bush Foundation, MDHR issued a contract with the Improve Group.

The Improve Group researched existing civic engagement evaluation measurements and metrics used by a sample of executive branch agencies, other government entities, nonprofits, and businesses, around the State, country or even internationally. They developed a menu of evaluation measures and metrics that agencies can use and a written guide to assist agencies.

Three projects, listed below, were chosen as pilots for the evaluation. Although all three are very different in their focus, mission and vision, the framework and strategies in which they perform engagement to connect within the State and with the community at large are applicable to others in government.

- The Environmental Quality Board (EQB) - boards and commissions, agencies that convene public meetings and those that conduct environmental review
- Rethinking I-94 Project, Minnesota Department of Transportation (MnDOT) - agencies that are engaged with large public infrastructure projects which require coordination between technical experts, contractors, and engagement staff as well as any other projects that directly impact physical locations where people congregate and live
- Community Engagement Work Group, Olmstead Implementation Office (OIO) - agencies who convene advisory groups, large interagency initiatives, and service delivery programs

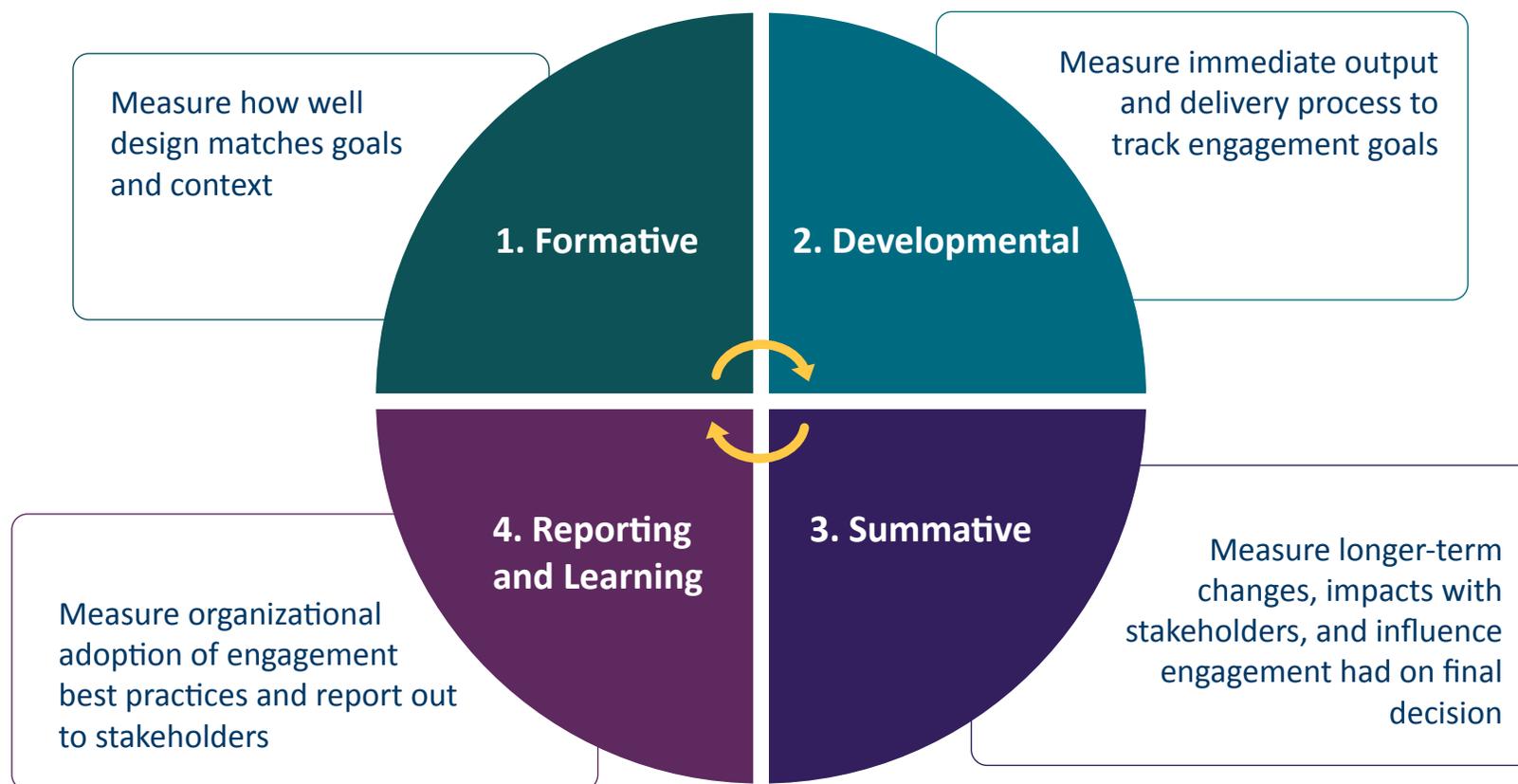
“The evaluation metrics project has been a great benefit for the Environmental Quality Board’s efforts to enhance civic engagement. It was very helpful to get specific recommendations grounded in stakeholder input and relevant literature,” said Katie Pratt Director of Communications and Public Engagement at the Environmental Quality Board. “The final report from this project will serve as a foundation for our on-going work to improve our public meetings and relationships with Minnesotans. As a public-facing board that includes the heads of nine separate State agencies, this project will make an impact well beyond our own board activities.”

Through their desk research and in working with MDHR staff, pilot project staff, and an evaluation advisory committee, the Improve Group developed a breakthrough Evaluation Framework. This framework views evaluation in a cyclical and continuous lens that includes multiple types of evaluation.

“As an evaluator and somebody that has done community engagement work in the public sector, I am very excited about the potential impact of this work. Through our research, we identified a lot of individual evaluation frameworks for specific programs operating in different public sector agencies, but we noticed a definite absence in a comprehensive model that could help folks think about evaluating civic engagement in a new way,” said Daren Nyquist, Evaluation Director at the Improve Group. “It’s my hope that this work will help civic engagement practitioners start to think about evaluating their work and its impact in the community.”

The report can be found at mn.gov/mdhr

EVALUATION FRAMEWORK



CIVIC ENGAGEMENT PRACTITIONERS GROUP

The Practitioners Group has been key to building a network of civic engagement practitioners across the State. The Practitioners Group has met monthly since its first convening in January 2017. The meetings have been opportunities to receive training, discuss best practices, and develop strategy.

The Practitioners Group has become the foundation of the civic engagement network at the State. The Practitioners Group has become the place for civic engagement practitioners to go to develop their leadership, find support, navigate challenges, and work together to address systemic barriers to authentic engagement at the State.

Since its formation, the Practitioners Group has met to discuss a variety of topics including:

- Fostering Connections Between Government and Community
- Digital Engagement
- Creating Welcoming Meetings

FOOD POLICY WORK GROUP

Food often plays an important role in creating a welcoming environment and setting the stage for successful civic engagement. However, due to ambiguity within the State's policy, civic engagement practitioners were unsure as to when food could be used. A number of practitioners formed a work group and began work with Minnesota Management and Budget to address the food policy. The recommendations that have come out of the work group has not only provided clarification on the food policy itself, but also highlights how food enhances civic engagement and how to set in place healthy options and culturally appropriate food choices.

The civic engagement practitioners meetings gave me an opportunity to develop valuable relationships and connect with other agency wide engagement coordinators. The authenticity and knowledge of the guest speakers has given me the chance to grow as a communications and engagement coordinator. I'm very fortunate to be part of this talented group of practitioners and look forward to many more engagement meetings.

– Kevin Walker, Public Affairs Coordinator MnDOT



DIVERSIFYING BOARDS AND COMMISSIONS

INTRODUCTION

The State of Minnesota has more than 220 boards, agencies councils and taskforces (Boards). The Boards have a variety of powers such as licensing, registering members of various professions, providing advice on public policy and overseeing grant, loan or compensation programs. When the plan was being developed, the steering committees found disparities in board composition from some communities. In order to address these, the plan set out the following goals:

1. Boards should be reflective of the demographics of people of color, American Indian Communities, individuals with disabilities and individuals who identify as LGBTQ in the State of Minnesota;
2. Appointing Authorities and Boards should expand recruiting and outreach efforts to communities of color, American Indian Communities, individuals with disabilities and individuals who identify as LGBTQ in the State of Minnesota; and
3. Improved data collection efforts.

BOARDS AND COMMISSIONS INFORMATION SESSIONS

In November 2017, the State contracted with Nexus Community Partners to organize a series of Information Sessions around MN to recruit new and diverse voices onto State boards and commissions. MDHR, the Governor's office, and the Olmstead Implementation Office, partnered with Nexus to host sessions in Bemidji, Duluth, Worthington, Rochester, St. Paul, Brooklyn Center, and St. Cloud.

In 2018, the partners held three additional Information Sessions in Minneapolis, Shoreview and Fergus Falls. The Information Sessions helped educate the public about boards and commissions at the State, the open appointments process, and how communities can have an impact into State policy making. Continued effort will be needed to translate interest in positions. Of those who responded to the evaluations, 95% indicated that they were more interested or strongly interested in serving on a State board or commission after coming to the session.

CREATING INCLUSIVE AND WELCOMING BOARDS TRAINING

Nexus Community Partners also held a training for creating welcoming board environments in January 2018. This training was meant to provide current board members and their staff with tools to create more welcoming and hospitable environments for new board members.

The training brought together over 70 people to talk about this topic for the very first time. This first time event was very successful in that several board members asked MDHR to host future events and provide more technical assistance on recruiting and retention strategies.



Boards and commissions impact the lives of Minnesotans every day. Governor Dayton has made a strong commitment to ensure that Minnesota boards and commissions reflect the diverse communities that they serve.

– Andrew Olson, Assistant Chief of Staff for Appointments



Engaging Stakeholders in Education Outcomes:

Department of Education

Congress has enacted a number of civil rights laws prohibiting discrimination in educational programs and activities receiving federal financial assistance. Some of these laws include: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990.

Civil Rights Laws represent our commitment to end discrimination in education and to bring the formerly excluded into the mainstream of American education. These laws help us deliver on the promise that every individual has the right to develop his or her talents to the fullest. As a result, profound changes in American education has occurred and the educational outcomes for millions of students have improved.

While progress has occurred, work still remains. In 2015, the federal government passed the Every Student Succeeds Act (ESSA) which governs the country's K-12 public education policy. ESSA replaced the Improving America's School Act of 1994 and the Elementary and Secondary Education Act of 1965, which is occasionally referred to as No Child Left Behind.

When ESSA was passed, the Minnesota Department of Education (MDE) reported an on-time graduation rate of 82% for all students. Unfortunately, significant racial disparities existed for some racial and ethnic groups. The disaggregated on-time graduation rates for Hispanic students – 67%; Black students – 62% and American Indian students – 49% were appreciably lower than the State average.

Minnesota saw the development of its stakeholder engagement program as a means to make a positive impact on educational achievement and to develop schools that reflect the values and priorities of parents, students and communities.

MDE traveled throughout Minnesota to consult with stakeholders such as Minnesota's 11 sovereign tribal nations, to start committees and to convene focus groups. MDE made it a priority to listen to the unique community needs, barriers and opportunities with Minnesota schools.

One community that was positively impacted through the stakeholder engagement initiative was Minnesota's English Language Learner (ELL) community. The ELL community is one of the fastest growing student populations in Minnesota.

"Our stakeholder engagement effort affects all students, parents and educators in Minnesota," according to Hue Nguyen, Assistant Commissioner for the Minnesota Department of Education. "It is the blueprint by which we hold our schools and ourselves accountable for the outcomes of our students."

The efforts of MDE are beginning to pay dividends as on-time graduation rates are improving. The percentage of students of color graduating on time has improved from 58% in 2012 to 69% in 2017.

Participation, Not Exclusion: Olmstead Initiative



Participation, not exclusion. The Olmstead Initiative is named after the 1999 United States Supreme Court decision entitled *Olmstead v. L.C.* which requires States to:

1. Stop the unnecessary segregation of anyone living with a disability, and;
2. Provide comprehensive planning of community-based services to people with disabilities in order to provide them with choices to live in integrated settings.

Minnesota's Olmstead Plan began as part of a settlement reached in the 2011 case known as *Jensen, et. al. v. Minnesota Department of Human Services*. Minnesota's Olmstead Plan seeks to help people with disabilities live, work and enjoy life in the most integrated setting possible for them. Governor Mark Dayton established through executive order an Olmstead Subcabinet and the Olmstead Implementation Office to support the implementation of Minnesota's Olmstead Plan.

The Olmstead Plan provides a robust civic engagement component calling for administrative agencies with the Subcabinet to evaluate and assess their efforts to connect with people with disabilities. The Olmstead Implementation Office has met with the Olmstead Subcabinet administrative agencies to help collect richer data, to fine tune assessment practices and to deepen their commitment as partners in the work of the Olmstead Plan.

"Outreach and evaluating administrative agency engagement

are our two major activities right now," said Darlene Zangara, executive director of Minnesota Olmstead Implementation Office.

One recent opportunity for inclusion that the Olmstead Subcabinet recently identified was increasing the representation of people with disabilities on State boards and commissions within Minnesota's Executive Branch. Participation on State boards and commissions provide people with disabilities an opportunity to directly influence public policy and decisions that impact their ability to live in integrated settings.

Historically, ensuring participation of people with disabilities on State boards and commissions has not been a priority. In an effort to address this shortcoming, the Olmstead Implementation Office partnered with Governor Dayton's Office of Appointments and the Minnesota Department of Human Rights to host a series of informational meetings on how to apply to serve on boards and commissions. Meetings were held throughout Minnesota and emphasized the importance of being engaged in public policy.

"I think the main benefit for the Olmstead Initiative is that we are able to align our vision of inclusion with those of the Minnesota Department of Human Rights and Governor Dayton," Zangara said. "However, for any of us to just say that we're not deliberately excluding anyone from our current processes isn't acceptable. It takes meaningful, deliberate and intentional engagement to get real involvement."

INTERAGENCY STRATEGY

INTRODUCTION

The State of Minnesota has created interagency taskforces to develop solutions to addressing society's most pressing disparities. Engagement is critical to success. In order to deepen civic engagement in these efforts, the plan identified the following goals:

1. Interagency efforts should play an active role in leveling the playing field of information with disenfranchised communities about policy, systems and process.
2. Interagency efforts should be intentional in building trust with community at all stages. Trust is built through clear and transparent communication.
3. Interagency efforts should be proactive, thoughtful and strategic in determining the role of senior agency leadership in meaningful engagement efforts.

OLMSTEAD IMPLEMENTATION OFFICE

The Civic Engagement initiative supported the Olmstead Implementation Office in its effort to reach its community engagement goals. A few examples of this include:

- Partnering to attend a meaningful engagement conversation with Laura Baker Services, a disability organization in Northfield.
- Providing technical support and guidance in the creation of a community engagement workgroup.

- Partnering on the Boards and Commissions Information Sessions to recruit people with disabilities for State boards and commissions.

HEADING HOME

Earlier this year, the Interagency Council to End Homelessness released its 2018-20 Action Plan. Engagement was a critical part of the planning process. Partners in philanthropy, business, faith communities, tribal and local government, housing and service providers and people who have experienced homelessness shared their insights. The plan articulates a shared set of goals, principles and strategies that will help to focus and align efforts of many partners across Minnesota to prevent and end homelessness.



If you ask them, people experiencing homelessness or housing crises will tell you what they need. Increasingly, the programs and systems designed to serve people experiencing homelessness recognize that putting people first - and really listening to what they say - achieves better, more lasting results. Over 1,000 Minnesotans helped shape the 'Heading Home Together' plan to prevent and end homelessness in Minnesota. While all of that advice helped create a better plan, I am particularly grateful for the many people who in the midst of their own housing crisis took time to share their expertise about what every community needs to end homelessness.

– Cathy ten Broeke, State Director to Prevent and End Homelessness

LOOKING FORWARD

Civic engagement happens where there are people. Some areas of our country have a weak culture of civic engagement. In those areas where civic engagement is weak, we see turmoil, lack of trust, dysfunction, division and a lower quality of life.

In those areas where there is a strong culture of engagement between people and government we see fewer intractable problems, greater equity, more civic pride and a higher quality of life.

Institutions and government cannot solve community issues on their own – this work calls upon every individual to work together. A healthy democracy demands the involvement of all. Let us truly value one another moving forward. Capitalizing on the ideas and talents of everyone ensures the common good and sets us on a path toward healthy prosperity for ourselves and our children.

Let us build a strong inclusive Minnesota for all.



THANK YOU

STEERING COMMITTEE PAST AND PRESENT

Maher Abduselam	African American Leadership Forum
Khalid Adam	Community
Patrice Bailey	Council for Minnesotans of African Heritage
Anne Barry	Community
Barbara Battiste	Legislative Office on the Economic Status of Women
Deven Bowdry	MN Department of Employment and Economic Development
Ned Brooks	MN Pollution Control Agency
James Burroughs	Office of Governor Mark Dayton
Blake Chaffee	MN Department of Employment and Economic Development
Juin Charnell	Community
Marisol Chiclana-Ayala	MN Department of Health
Nkem Chirpich	Community
Rose Chu	MN Education Equity Partnership
Jane Conrad	East Central Area Labor Council
Patricia Fenrick	MN Department of Human Services
Kriystauhl Fitchett	African American Leadership Forum
Victoria Ford	Community
Cedrick Frazier	Education Minnesota
Michelle Fure	Metropolitan Council
Sandra Gerdes	Laura Baker Services Association
Emilia Gonzalez Avalos	Navigate MN
LaRone Greer	MN Department of Human Services
Sia Her	Council of Asian Pacific Minnesotans
Nicholas L Jenkins	Bloomington Human Rights Commission
Henry Jimenez	MN Council on Latino Affairs

Ellie Krug	Community
Kathryn LeMieux	Red Wing Human Rights Commission
Kevin Lindsey	MN Department of Human Rights
Noah J McCourt	Community
Abby Miller	Community
Kathy Mouacheupao	Metropolitan Regional Arts Council
Hue Nguyen	MN Department of Education
Judy Elling Przybilla	SW Regional Development Commission
Guadalupe Quintero	Community
Erika Rivers	MN Department of Natural Resources
Sherry Sanchez Tibbetts	Fond du Lac Tribal and Community College
Julie Strother	Office of Secretary of State Steve Simon
Timothy Sumner	Beltrami County Commissioners
Justin Terrell	Council for Minnesotans of African Heritage
Pheng Thao	Community
Meagan Tinajero	Community
Katie Troyer	Office of Governor Mark Dayton
Joann Usher	Rainbow Health Initiative
Pa-Shie Vang	Asian American Organizing Project
Sarah Walker	Community
Chang Wang	Thomson Reuters
Mark Westergaard	Richfield Human Rights Commission
Gwen Willems	Community
Joan Willshire	Minnesota Council on Disability
Kolu Wilson	MN Department of Employment and Economic Development

IMPLEMENTATION COMMITTEE PAST AND PRESENT

Dave Bartholomay	Bureau of Mediation Services
Deven Bowdry	MN Department of Employment and Economic Development
Ned Brooks	MN Pollution Control Agency
Lee Buckley	MN Department of Corrections
James Burroughs	Office of Governor Mark Dayton
Beth Carlson	MN Department of Natural Resources
Marisol Chiclana-Ayala	MN Department of Health
Richard Davis	MN Department of Transportation
Amy Dellwo	MN Department of Human Services
Michelle Fure	Metropolitan Council
Tracey Gibson	MN Management & Budget
Lee Her	MN Department of Education
Edwin Hudson	MN Management & Budget
Margaret Kaplan	MN Housing Finance Agency
Mariah Levison	Bureau of Mediation Services
Hue Nguyen	MN Department of Education
Jenn O' Rourke	Metropolitan Council
Alice Roberts-Davis	MN Department of Administration
Sarah Rudolf	MN Department of Transportation
Barb Sporlein	MN Housing Finance Agency
Luchelle Stevens	MN Department of Human Services
Marcio Thompson	Office of Higher Education
Adosh Unni	MN Department of Education
Kolu Wilson	MN Department of Employment and Economic Development
Lisa Wojcik	MN Department of Corrections
Christine Yaeger	MN Department of Natural Resources

IN MEMORIAM

Ann Kaner-Roth from the Office of Secretary of State served on the original Steering Committee. She provided guidance on Diversifying Boards and Commissions. We continue this work in her honor.

FUNDERS

Thank you to the Bush Foundation for providing generous grant support to this project. Their funding allowed us to complete the evaluation work, fund a staff position, and host boards and trainings information sessions.

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Meaningful Engagement Makes a Difference

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A Guide to Evaluate Civic Engagement

December 2018



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LETTER FROM THE COMMISSIONER

In 2015, Governor Mark Dayton executed Diversity and Inclusion Council Executive Order 15–02 replacing Affirmative Action Executive Order 91–14. The Diversity and Inclusion Executive Order represented a fundamental change in approaching employment and business contracting opportunities between state government and historically disenfranchised communities. Minnesota would strive to become an employer and business partner of choice instead of being satisfied with merely ensuring compliance with anti-discrimination laws.



The most innovative aspect of the Executive Order was the direction given by the Governor to have all administrative agencies within the Governor’s Cabinet take action to ensure that historically disenfranchised communities have the opportunity to participate in public policy development. Minnesota Department of Human Rights (Department) was charged with the responsibility of chairing the civic engagement practices committee and assisting administrative agencies in fulfilling the vision for civic engagement.

In surveying administrative agencies, one of the most overwhelming needs identified by administrative agencies was to provide technical assistance on developing metrics to successfully measure civic engagement projects. When we reviewed the existing literature for civic engagement, we found very few resources tailored to the type of work the State of Minnesota is doing.

As a result, the Department entered into a competitive bid process that ultimately resulted in the Improve Group examining three civic engagement projects and publishing this report. While we designed this guide for civic engagement practitioners and mid-level managers responsible for implementing civic engagement strategies, we also continue to recognize that strong support from leadership is vital to both the measurement and the overall effectiveness of civic engagement efforts.

We believe that the ideas contained within this report will propel existing civic engagement efforts forward while setting the stage for further refinement of leading best practices concerning effectively measuring civic engagement efforts.

On behalf of the civic engagement steering committee, thank you for your interest in ensuring that all Minnesotans have an opportunity to meaningfully engage with their government in developing public policy.

Sincerely,

Kevin M. Lindsey
Commissioner
Minnesota Department of Human Rights

A GUIDE TO EVALUATE CIVIC ENGAGEMENT

PURPOSE

This document is intended to be a guide that can be used to evaluate civic engagement projects within government agencies. By following a structure of data collection and analysis as discussed in this guide, our hope is for those conducting civic engagement work to refine their skills, create stronger relationships, and ultimately build a more responsive state government.

This guide outlines the major components of designing a civic engagement evaluation, how to think about applying those components in your particular engagement context and provides some planning tools to start designing your own evaluation. The information in this document was heavily influenced by working with civic engagement projects occurring in three State of Minnesota agencies. The lessons highlighted in this guide are informed by real world scenarios. While this document has a main focus on these three pilot projects, their experiences are common when evaluating any program, so they can be applied to other engagement related projects by other government entities.

The sections in this guide provide a step-by-step process to follow when designing a civic engagement evaluation. Each section explains key steps in the evaluation process, including:

1. Developing a theory of change for your civic engagement work
2. Understanding the use and purpose of your evaluation
3. Developing a continuous cycle of evaluation
4. Creating good evaluation questions
5. How to think about and design each phase of the evaluation
6. Identifying potential metrics of civic engagement

Our intention is to provide a blueprint for state and local agencies to design their own evaluation systems. This guide is a general approach that will have to be modified and refined to fit the unique context of each agency. We expect that as the practice of civic engagement increases in the public sector, some pieces of the framework presented here may lose their meaning or become redundant. Evaluation is a journey, as is civic engagement, and this document delivers a tool that should be thought of as the first step in that journey.

NOTES ON DEFINITIONS:

There are key words in this document that will need to be defined by state agencies according to specific contexts. Words like engagement, stakeholder, community, and leadership may mean different things depending on the specific agency and program. This document is not proscriptive in defining these terms, so if you come across a word that needs clarification while reading, define it in a way relevant to your own civic engagement context.

BACKGROUND & METHODS

In December 2015, after Gov. Mark Dayton established the Diversity and Inclusion Council with Executive Order 15-02, a diverse Steering Committee, comprised of members from both public and private sectors, began meeting to create a civic engagement strategic plan for the State of Minnesota's Executive Branch.

The Civic Engagement Plan was released on October 2016. While developing this plan more than 20 cabinet agencies asked for help with measuring their civic engagement work. In response to this need and with funding from the Bush Foundation, the Minnesota Department of Human Rights was able to retain a consultant to develop an evaluation framework around civic engagement. Three projects were chosen in different Minnesota state agencies as pilots. While the focus of each of these three projects is different, we believe that the elements of engagement are universal and applicable to other engagement efforts.

The evaluation framework discussed in this document was informed and influenced by a wide variety of sources and intended to model a process of meaningful engagement. Through interviews, group discussions, literature reviews and individual work with pilot projects there was a wide variety of information collected from nearly 100 people practicing civic engagement in the public sector, and from community members who have participated in civic engagement events.

PILOT PROJECTS

Environmental Quality Board (EQB) – By statute, the Environmental Quality Board is required to meet each month to consider issues related to land, air, water, climate, and other environmental factors affecting Minnesota. Board and public meetings are things that government agencies do frequently, and EQB sought to create institutional change by creating and utilizing new engagement practices. The results of the evaluation will be used to rethink the design of the current EQB meeting structure and how it can be more engaging to communities across Minnesota.

Minnesota Department of Transportation (MnDOT) – The Rethinking I-94 project began in 2016 as a long-term effort to improve MnDOT's relationships with the communities in a 15-mile study area between the downtowns of Minneapolis and St. Paul. With goals of enhancing mobility, safety, and interconnectivity in the corridor, Rethinking I-94 intends to reconnect neighborhoods, revitalize communities and ensure residents have a meaningful voice in transportation decisions that affect their lives. The Rethinking I-94 project team wanted to get involved as an evaluation pilot project to develop their own engagement evaluation framework that could be used as template for evaluating their work in the future.

Olmstead Implementation Office (OIO) – The Olmstead Plan is a blueprint for the state of Minnesota to make sure people with disabilities have opportunities to live, work, and enjoy life in the most integrated setting. Inclusion and civic engagement has been an important part of this work. At the time of application to be involved in this project, OIO was building a community engagement plan and knew that evaluation would be a key component. The primary aim was to develop an evaluation framework, with the input of community members, to measure the impact of their engagement work within the disability community. Looking out over the next few years, OIO also hopes to develop tools for other state agencies to utilize when engaging with the disability community.

WHAT WE LEARNED:

ISSUES THAT LAY THE FOUNDATION FOR EVALUATING CIVIC ENGAGEMENT

The following ideas were developed through initial interviews and literature reviews that kicked off this project. These ideas formed the initial design of the work with the pilot projects and are important things to keep in mind when evaluating civic engagement.

MEASURE WHAT CAN BE CONTROLLED

A common theme within the literature reviews and conversations with practitioners is that civic engagement is all about process, communication, and iteration. If the end goal of engagement is to build resilient relationships that inform decision-making, the engagement process must have a design that fosters relationship building.

Each of the pilot projects indicated a specific need to develop indicators for success that went beyond simple output metrics such as how many attended events. Pilot projects felt that these types of metrics could not measure the true breadth of their work and missed the human relationships that civic engagement can build. Pilots felt these measures had a place in civic engagement evaluation but should not be the primary measures of engagement.

There is also a growing body of academic and applied literature, focused on evaluating civic engagement that suggests measuring the process of civic engagement (how engagement is designed and delivered) is the best way to evaluate engagement work. The thinking behind this argument is that civic engagement practitioners cannot control the opinions of or actions of people. While we are concerned with understanding the ultimate impact of civic engagement, like increasing trust in government institutions, such outcomes are byproducts and ultimately outside the day-to-day control of those practicing civic engagement. Instead, the bulk of civic engagement evaluation should be focused on measuring the actual processes that can be controlled. Evaluating things like the design of an engagement strategy, the effectiveness of communicating the purpose for the engagement, and the reach of your engagement are specific processes that can be changed to be more effective if the right information is collected.

The point of engagement work is to build relationships that are resilient. While we cannot force other people to trust government, we can control our actions to foster positive relationships. To evaluate civic engagement, we must focus on measuring things that can be controlled or at least influenced by direct action. Measuring process is about identifying points that can be appraised from start to finish. If you're measuring just the output, like event attendance, you'll be missing opportunities to learn about how community is impacted by your engagement.

FEEDBACK LOOPS ARE CRITICAL

A common theme emerged from interviews with community members who participated in the civic engagement work of the pilot projects. Community members stated that when participating in civic

engagement events, they typically receive no communication back as to how their input affected the final decisions of the project. Over time, this frustration can lead to engagement fatigue where people simply stop participating out of frustration. This response was particularly strong in underrepresented communities where there is a lack of trust in government agencies.

Therefore, building in feedback loops – regularly communicating to and seeking feedback from – civic engagement participants is critical not only to maintain relationships, but also when collecting valuable information that can be used to improve engagement strategies.

START YOUR EVALUATION JOURNEY WITH SMALL STEPS

The evaluation framework presented here might seem overwhelming and there will be questions about where to start. Evaluation is a process about asking a question and collecting information to answer it. If implementing the entire framework seems impossible, focus initially on answering one or two key questions that are immediately relevant to your work. Use the guides in the document to help you think about what question to ask and what data to collect. Over time, the evaluation process will become more comfortable. Eventually, you'll be able to expand the depth of your questions and data collection.

WHAT IS EVALUATION?

Program evaluation is as a systematic approach to collecting information, analyzing it, and using that information to answer questions about programs, projects, and policies. In terms of civic engagement, evaluation is a critical tool to help practitioners design effective strategies, determine potential impacts of their work, and refine their civic engagement skills over time.

Evaluation is often thought of as an activity that occurs at the end of a project to determine success or failure. This notion is generally accurate, but it only defines one small slice of what evaluation can do. On a larger scale, evaluation is all about implementing a system of evaluative thinking. Evaluative thinking is a mindset that focuses on answering questions with real-world information rather than intuition. Evaluation seeks to identify assumptions, pose thoughtful questions, and make informed decisions.

Civic engagement is complex work; however the evaluation of it does not have to be. Having a clear purpose for your evaluation will help focus your efforts. For example, if you want to know if your engagement is designed in an appropriate manner, then a few simple conversations with the right community stakeholders will provide some information about the appropriateness of your design. By keeping the purpose of your evaluation clear and meaningful, it will help to simplify your process.

Civic engagement work occurs in contexts that are fluid and ever changing. Without a way to assess our successes and challenges, all we have to guide us is our gut instinct, leaving the door wide open for assumptions to go unchecked and increasing the likelihood of negative outcomes. Therefore, evaluating civic engagement is an essential component to creating good engagement practices.

A THEORY OF CHANGE FOR CIVIC ENGAGEMENT

In the evaluation world, a Theory of Change explains how a series of actions will produce outcomes that will lead to a set of intended impacts. Often an evaluation begins with a Theory of Change to help determine what to measure and what we hope to see as a result of our work. Theories of change are useful in understanding how organizational strategies are connected and how they are intended to create transformations.

Developing a Theory of Change should be a starting point for agencies looking to evaluate their civic engagement. Such a document articulates why civic engagement is needed; what we want to achieve with civic engagement; and what steps must be taken to realize the initiative's goals. It should outline variables outside the civic engagement initiative that could impact your results. It also includes a forward-thinking vision to define success. Theories of change are uncommon for civic engagement in the public sector, and they are an overlooked planning tool. Creating a Theory of Change for civic engagement is a key first step that should always be considered when designing a system of evaluation.

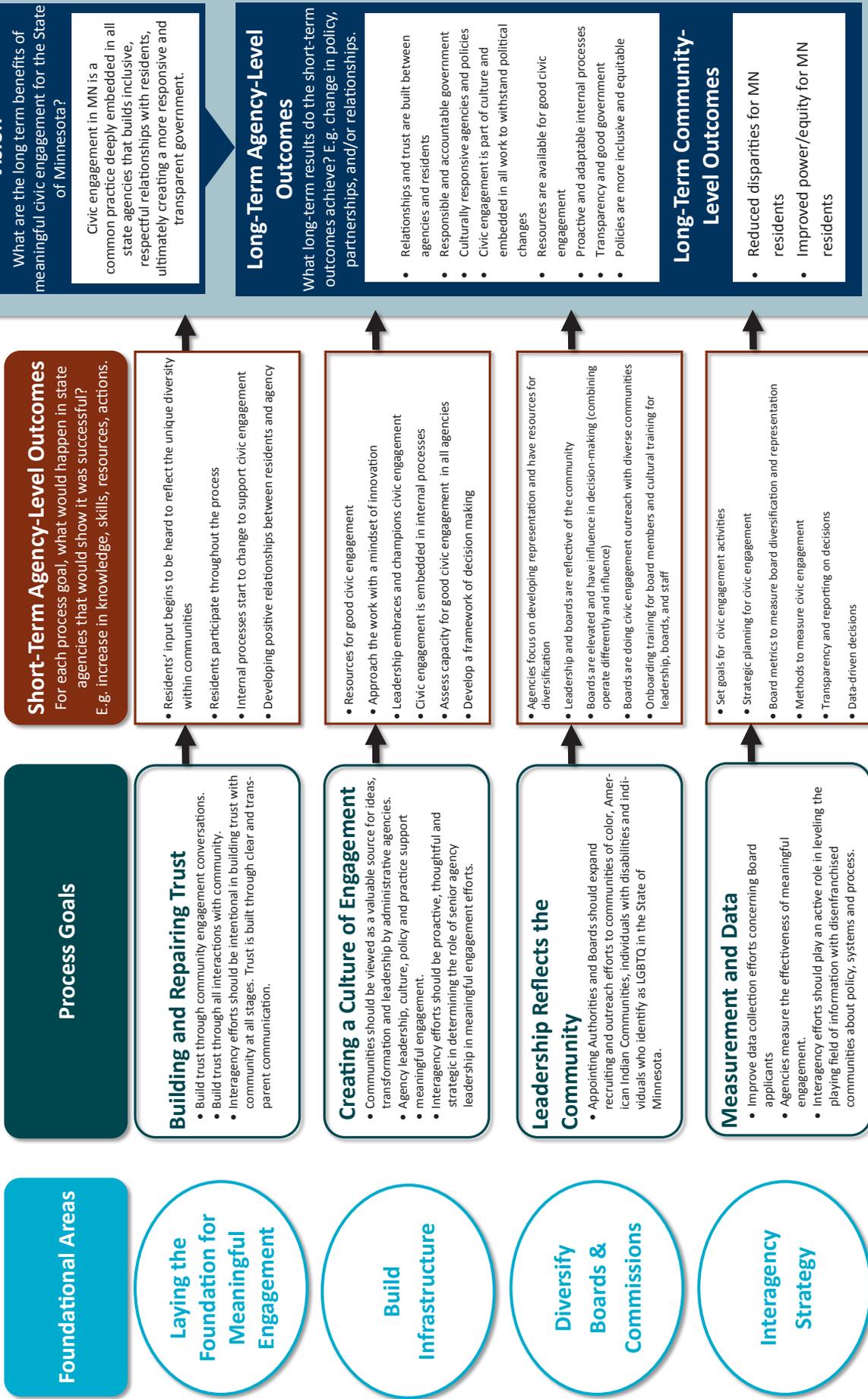
A model of a Theory of Change is illustrated in this guide. On the next page, the 2016 Civic Engagement Plan is used as a model, however, the questions that are needed to develop a Theory of Change can be applied to any model of engagement. The State of Minnesota's Civic Engagement Practitioners Group, comprised of state and local government employees as well as community members, helped shape and refine the model illustrated on page nine. Over the course of two meetings, the group worked to define short-term goals, long-term goals, and a vision for success. The process generated some great discussion on how certain terms should be defined, what people wanted to see come out of their work, and the overall purpose of trying to evaluate civic engagement.

This guide provides a completed Theory of Change and a sample worksheet used to develop a theory of change for your specific civic engagement context. The Theory of Change laid out on the next page is an important blueprint for beginning to measure civic engagement and it should be the first step in designing your own evaluation. It is a global view of what we think will happen given the adoption and implementation of good civic engagement practices. As such, the process goals, short-term outcomes, and long-term outcomes all provide indicators of success that can be measured (or at least estimated). A useful template that agencies can use to begin their own Theory of Change discussions is also included on page ten.

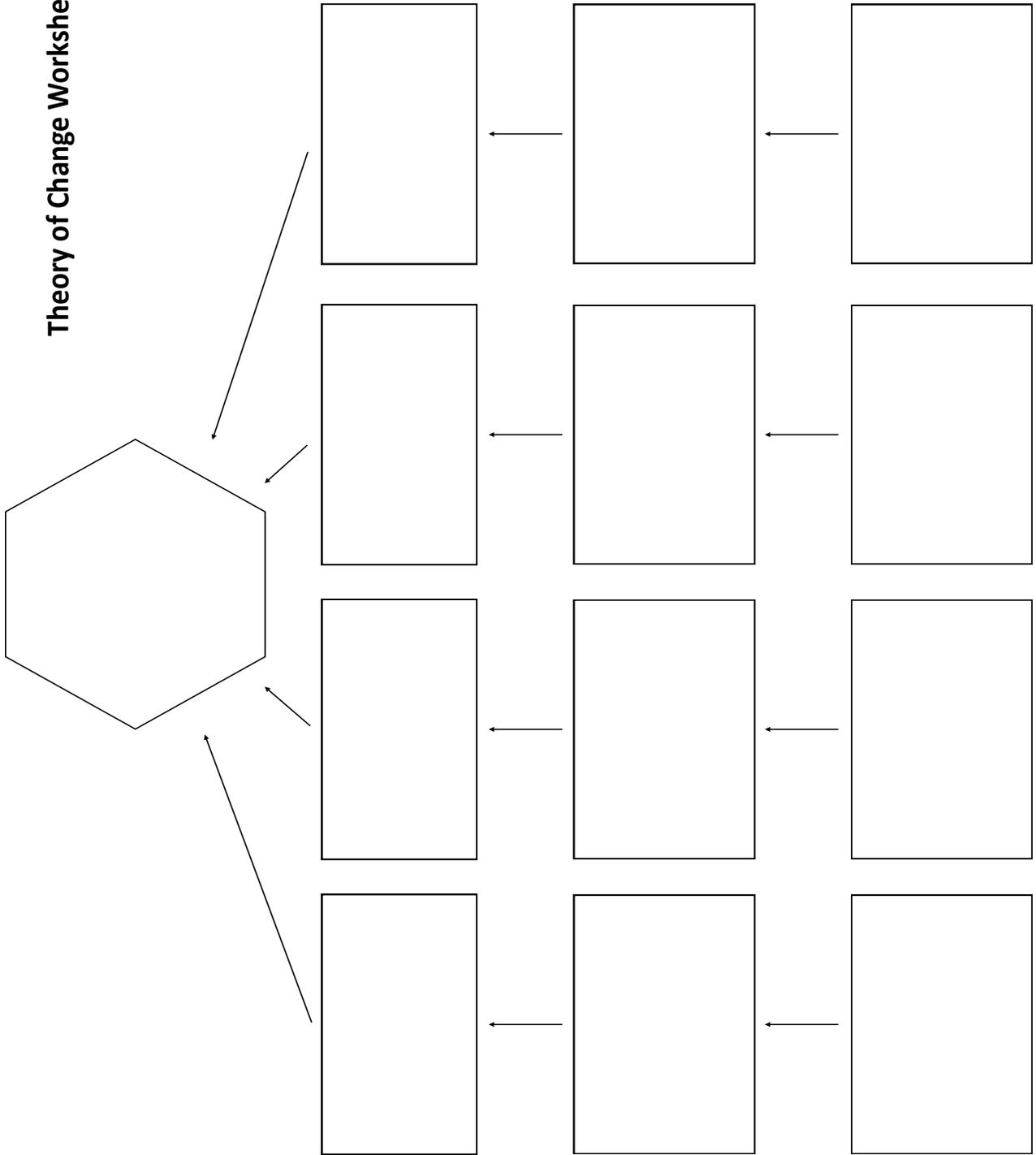
THEORY OF CHANGE QUESTIONS

1. What changes is civic engagement trying to create or what problems is it trying to solve?
2. What are your strategies for how you will realize these changes? Why are these strategies the ones to invest in?
3. What would be the outcomes of these strategies?
4. What is the logic between strategy and outcomes?
5. What is the ultimate long-term outcome for your civic engagement?

Theory of Change MN Department of Human Rights: Civic Engagement



Theory of Change Worksheet



4. Long-term Outcome and/or Vision for the future

If all this happens...

3. What are the short term outcomes and how will you know they are being achieved?

How will you measure?

2. What are the strategies to achieve each goal and what are the assumptions for them to be effective?

If these are the goals, what strategies are needed?

1. Foundational goals of civic engagement or what problems are you trying to solve?

CIVIC ENGAGEMENT EVALUATION FRAMEWORK

DEFINING EVALUATION USE AND PURPOSE

After developing a Theory of Change to understand the goals of your civic engagement work, the next step of an evaluation is to define the explicit use and purpose of the evaluation. It is a time to plan out when data will be gathered, how it will be analyzed, and what types of reports or other products will be produced.

In most cases, there is often only one use for the evaluation. However, civic engagement evaluation design must encompass many different uses. The following are key uses and purposes that are relevant to evaluating civic engagement.

Types of evaluation uses that are important to remember when evaluating civic engagement:

FORMATIVE EVALUATION (DESIGN)

Focused on designing the right engagement approaches and tools for each context

DEVELOPMENTAL EVALUATION (DELIVERY)

Focused on building data collection systems to allow for continual process improvement

REPORTING & LEARNING (AGENCY CAPACITY)

Focused on reporting out evaluation and engagement results to stakeholders and driving organization-wide improvements to civic engagement efforts

SUMMATIVE EVALUATION (IMPACT)

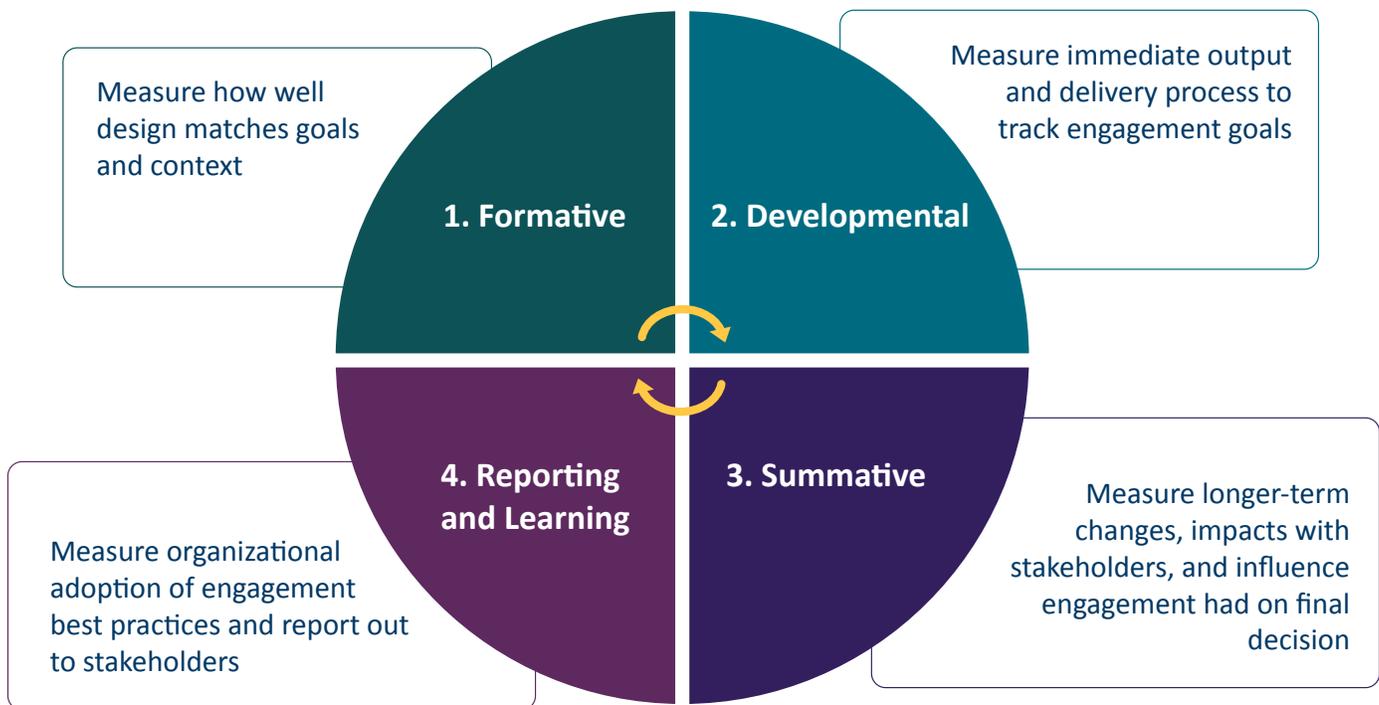
Focused on collecting data to understand outputs and impacts of the civic engagement work

CIVIC ENGAGEMENT EVALUATION: A GUIDING FRAMEWORK

If we consider each of the uses that evaluating civic engagement should have (formative, developmental, summative, and reporting & learning), it is easy to understand that evaluating civic engagement is not a linear process. Civic engagement work itself is not linear, it's a continuous process that does not provide a clear point in time where an evaluation should happen. Therefore, evaluating civic engagement should occur throughout all stages of engagement.

The diagram below attempts to illustrate this idea by highlighting the types of evaluation that can be used and where they fit in the general process of conducting civic engagement work. The diagram is a general framework that can be used for thinking about evaluating civic engagement, when it should occur, and what types of things could be measured. The hope is that this framework can help people design a systematic approach that folds evaluation directly into their civic engagement work.

This framework is a conceptual model of how evaluating civic engagement evaluation is a continuous cycle of data collection, process improvement, and reporting. The idea can be described with more detail of each evaluation phase:



1. FORMATIVE PHASE:

A team designs an engagement approach and evaluates the efficacy of its design and purpose to improve the initial engagement approach.

Typical questions answered in this phase could include:

- What are the short and long-term goals/purposes of the engagement event or campaign?
- Who are the stakeholders and what do you want them to do?

- c. What is the communication plan to report back to stakeholders?
- d. Have engagement activities been tested with stakeholders?
- e. Do goals align with stakeholder goals and their community/cultural contexts?
- f. Is the engagement accessible culturally, physically, and mentally?

2. DEVELOPMENTAL PHASE:

Engagement events or activities are implemented, and data collection tools are put in place to monitor short-term outputs. Adjustments to the engagement approach are made as data is analyzed.

Typical questions answered in this phase could include:

- a. Have engagement efforts attempted to reach all stakeholders?
- b. What do participants like? Are participants “satisfied”?
- c. Have participants been representative of all stakeholder groups?
- d. Has participation increased or decreased?
- e. Do participants know the purpose of the engagement work and how their input is being used?

3. SUMMATIVE PHASE:

At the end of the engagement campaign (or at regular intervals if engagement is ongoing) all data collected is analyzed and summarized. This phase may also require additional new data collection.

Typical questions answered in this phase could include:

- a. What were the key impacts that resulted from the engagement? How did those impacts match initial goals?
- b. What impact did public engagement have on the final decision/issue/project?
- c. How has engagement changed the attitudes or behaviors of participants?
- d. Were the level of staff resources and skills adequate to achieve the engagement goals?
- e. How did engagement build positive outcomes with stakeholders like trust, relationship, empowerment, etc.?
- f. What strategies worked well and why? What strategies didn't work well and why?

4. REPORTING & LEARNING PHASE:

After impacts are fully analyzed, the evaluation enters a reporting and learning phase. In this phase, results and impacts of the engagement evaluation are shared with community stakeholders and organizational leadership. The point here is to show participants how their input had a tangible impact and to help organizational leaders understand what's working well (or not).

Typical questions answered in this phase could include:

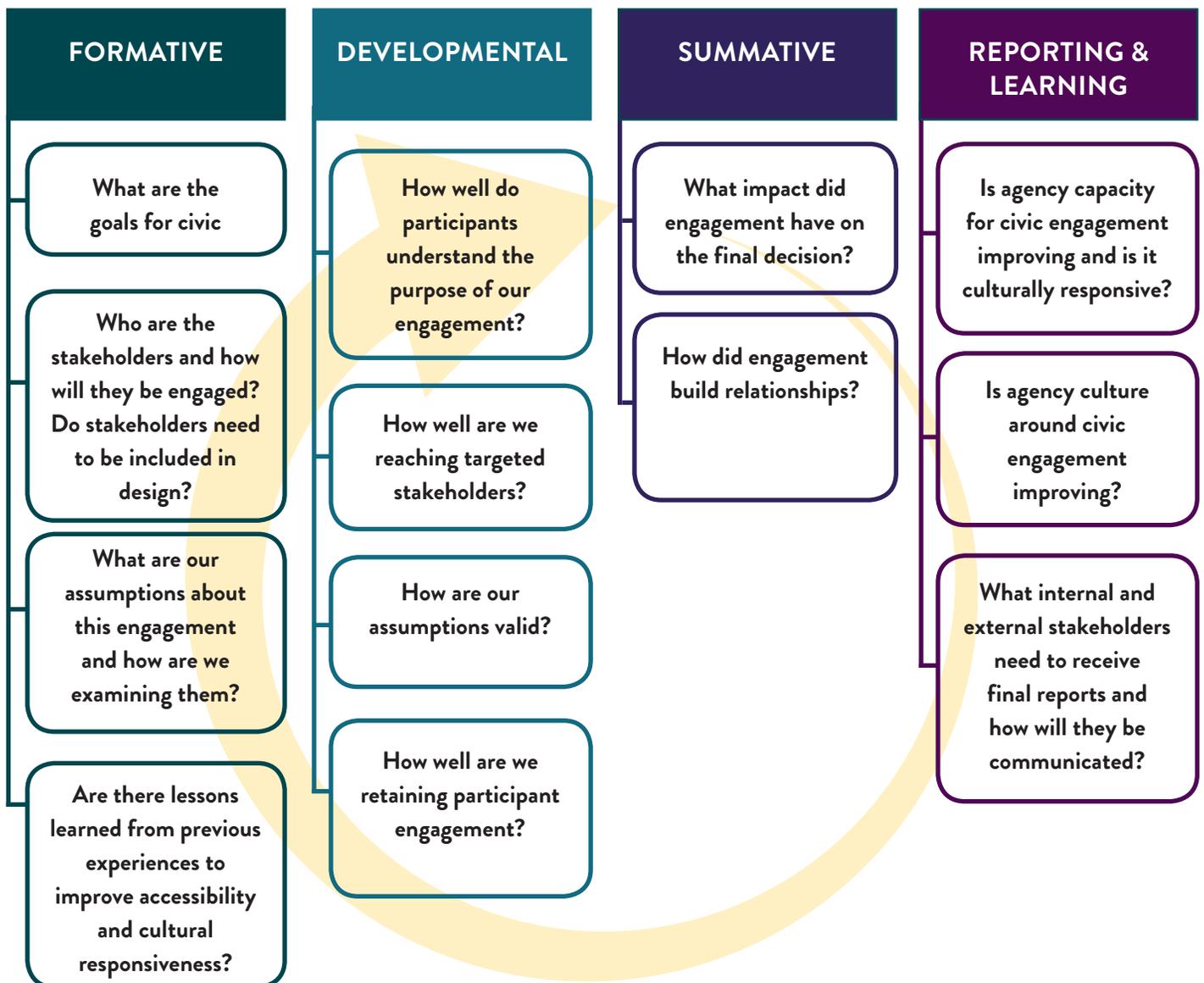
- a. How is agency capacity for conducting effective engagement improving (staff, budget, resources, etc.)?
- b. What skills are needed in the organization for civic engagement to be more effective?
- c. How are staff gaining experience in practicing civic engagement?
- d. What accountability mechanisms are in place for incorporating lessons learned?
- e. How are norms around civic engagement changing in the organization?
- f. How can engagement be improved?

CRITICAL EVALUATION QUESTIONS BY PHASE

After designing a Theory of Change and understanding the purpose of your evaluation, the next step is to develop some thoughtful questions to answer. Useful evaluation is focused on answering specific questions. Evaluation questions help to bring focus to what data needs to be collected and how it will be analyzed. Evaluating civic engagement work should always be guided by key questions that if answered effectively, will help improve your civic engagement work.

While any question can be asked and answered in each evaluation phase presented in the framework, there are certain critical questions that should be considered. These questions flow from the civic engagement values outlined in the 2016 Civic Engagement Plan. Depending on the project and context, additional questions can and should be asked.

CRITICAL QUESTIONS TO ASK IN EACH EVALUATION PHASE



Answering (or at least trying to answer) the evaluation questions listed in each phase is essential for designing the correct approach to civic engagement, implementing that approach effectively, and building a body of knowledge to continuously improve.

NOTE ON EVALUATION QUESTIONS

Evaluation questions are designed to be high-level questions. They are not specific questions that will go into a survey or be asked in an interview. Evaluation questions generally should avoid “yes” or “no” responses, but rather should seek to answer how or why something is happening and if it is good or not. Examples of how to do this include:

1. Refer to the Theory of Change and identify any possible changes that need to be made for your specific engagement work
2. Identify what phase you are in according to the civic engagement evaluation framework
3. Determine if you are measuring a process or outcome
4. Design your questions with these good practices in mind:
 - a. Evaluation questions should be measurable
 - b. Evaluation questions should be clear, specific, and well-defined
 - c. Evaluation questions should match the purpose of your engagement work and align with the evaluation phase

BEST PRACTICES FROM PILOT PROJECTS:

- Have an understanding of how you are collecting data and how the tools will work in the field. For example, if you’re utilizing a paper survey, think about who is responsible for collecting the information and who will be recording all of the information to analyze and share.
- Data can come in all forms. Instead of having people fill out a survey, consider something more interactive like having people place dots on a question they agree or disagree with or using a voting jar where folks drop a marble to provide their answer to a question. These types of data collection activities are quicker and often less burdensome than a traditional survey format.
- Be aware that any information you collect from participants may be public data. Consider anonymity and data privacy when deciding how you will collect information. Make sure participants are agreeing to share this information and that they won’t feel vulnerable for sharing their information.
- OIO asked their Community Engagement Advisory Board for feedback after every meeting. The information was critical in honing the board’s collaboration over time and improving everybody’s experience. Without this information and the changes to the process that were made because of it, the board’s work would have floundered. Take every opportunity to ask people about their experience, there are a lot of lessons to be learned.

DESIGNING AND IMPLEMENTING THE EVALUATION

Now that you have a sense of the purpose of your work (Theory of Evaluation), the purpose of your evaluation (evaluation framework phase), and some evaluation questions, the next thing to do is design your evaluation. Each of the four evaluation phases (Formative, Developmental, Summative, and Reporting & Learning) require slightly different tools and design activities. This section provides some ideas to help design and implement each individual evaluation phase.

FORMATIVE

PHASE	WHEN?	WHY?	HOW?
FORMATIVE	<ul style="list-style-type: none"> • Pre-Project • Project development • Engagement Planning 	<ul style="list-style-type: none"> • Understand the need for engagement • Clarify the goals for engagement • Understand the assumptions engagement strategies are based on 	<ul style="list-style-type: none"> • Staff interviews • Stakeholder analysis/ interviews • Logframe Matrix

The formative evaluation phase is focused on clarifying goals, understanding assumptions, and designing the right approach to match community needs. As such, this phase can be considered a planning phase. A successful formative evaluation phase will provide a deeper understanding of targeted stakeholders, how those stakeholders will be engaged, and engagement goals that can be measured. This is also the phase in which community stakeholders can be brought into the process to help design civic engagement strategies. Sample templates are available in the appendix.

EXPERIENCE IN THE FIELD: ENVIRONMENTAL QUALITY REVIEW BOARD

When engaging with community members to develop a deeper understanding of their experiences with EQB, the agency learned of several barriers that were hampering stakeholder engagement with the agency. Because they learned this in the design phase of their evaluation work, they were able to incorporate this knowledge into the overall design of their civic engagement and communication planning. Taking the time to gather stakeholders in an open conversation and asking their opinions about your work, is not an easy thing to do. Last, it requires humility and vulnerability. Asking stakeholders for their feedback and actively listening to their thoughts will provide critical information that will help guide your engagement work and ultimately make that work stronger.

QUESTIONS TO ASK AND HOW TO ANSWER THEM

QUESTION	WHY ASK THIS QUESTION	HOW TO ANSWER IT	SOURCES OF DATA	DATA COLLECTION METHODS	DATA COLLECTION TOOLS
What are the goals for civic engagement?	<ul style="list-style-type: none"> Clarify Goals to measure progress 	<ul style="list-style-type: none"> Complete Logframe matrix 	<ul style="list-style-type: none"> Staff Community stakeholders 	<ul style="list-style-type: none"> Facilitated staff conversations Informal conversation with community stakeholders 	<ul style="list-style-type: none"> Logframe matrix template
Who are the stakeholders and how will they be engaged? Do stakeholders need to be included in design?	<ul style="list-style-type: none"> Understand the target audience interests and cultural needs Determine if stakeholders should help design engagement activities 	<ul style="list-style-type: none"> Complete stakeholder analysis matrix Community profiles (eg. census data) 	<ul style="list-style-type: none"> Staff Community stakeholders Existing community demographic data 	<ul style="list-style-type: none"> Facilitated staff conversations Informal conversation with community stakeholders 	<ul style="list-style-type: none"> Stakeholder analysis matrix template
What are our assumptions about this engagement and how are we examining them?	<ul style="list-style-type: none"> Understand potential biases in engagement strategies and fix them 	<ul style="list-style-type: none"> Complete Logframe matrix 	<ul style="list-style-type: none"> Staff Community stakeholders 	<ul style="list-style-type: none"> Facilitated staff conversations Informal conversation with community stakeholders 	<ul style="list-style-type: none"> Logframe matrix template
Are there lessons learned from previous experiences to improve accessibility and cultural responsiveness?	<ul style="list-style-type: none"> Focus on organizational learning and continuous improvement 	<ul style="list-style-type: none"> Consult with other civic engagement practitioners Develop project library of lessons learned 	<ul style="list-style-type: none"> Staff Project library 	<ul style="list-style-type: none"> Informal staff conversations Refer to project library 	<ul style="list-style-type: none"> Civic Engagement wrap-up form template

DEVELOPMENTAL

PHASE	WHEN?	WHY?	HOW?
DEVELOPMENTAL	<ul style="list-style-type: none"> • During civic engagement work (after planning) 	<ul style="list-style-type: none"> • Make changes/ improvements on the fly • Gain understanding of what is working and what's 	<ul style="list-style-type: none"> • Focus on measuring process • Stakeholder interviews • Participant surveys

The developmental evaluation phase is focused on understanding how the civic engagement work is unfolding. By collecting data at engagement events and focusing on measuring your processes surrounding civic engagement work, you can begin to understand what specific tactics may or may not be working and make adjustments in real time. This phase can be considered a phase of continuous improvement and should continue until an end of the civic engagement project is determined. A successful developmental evaluation phase should increase the effectiveness of your engagement work over time and can be used to build a library of lessons learned.

BEST PRACTICES FROM PILOT PROJECTS:

- Community members don't know how their input is being used, or its ultimate impact. Building in a plan for continued communication with community members so they feel important and valued is essential for any civic engagement activities. "There is frustration because those engaged don't feel that [government agencies are] very forthcoming in their process. Is community input about reconnecting neighborhoods influencing [government agencies]? On the website, there's an inventory of things they've done and high-level assessment of what has been heard, but that doesn't translate into [government agencies] embracing community input."
- Civic engagement fatigue occurs when people are asked to provide input over and over again and they don't see any of the results, so they become less likely to engage with government agencies. "Community want to be able to trust in powerful organizations. But we haven't been told what is going to happen afterwards. If people want to be on the process, you need to be able to justify exclusion or inclusion of the ideas that they share."
- Each of the pilot projects expressed interest in the ability to tell stories with the data they collected. OIO wanted to be able to explain people's experiences with accessibility in civic engagement. MnDOT wanted to understand people's hopes with Reimagining I-94 and EQB wanted to understand how communities interact with the agency. While the type of stories pilots wanted to tell have vastly different contexts, they have one common need – qualitative data. Collecting and analyzing qualitative data is different than quantitative data. It requires more time to collect and synthesize. It also requires a different process to store and archive the data. However, it is the most powerful data to collect, because it will provide deeper insight into the questions you are seeking to answer

QUESTIONS TO ASK AND HOW TO ANSWER THEM

QUESTION	WHY ASK THIS QUESTION	HOW TO ANSWER IT	SOURCES OF DATA	DATA COLLECTION METHODS	DATA COLLECTION TOOLS
How well do participants understand the purpose of our engagement?	<ul style="list-style-type: none"> To make sure your goals are being clearly communicated 	<ul style="list-style-type: none"> Seek critical feedback 	<ul style="list-style-type: none"> Stakeholders Event participants Digital analytics 	<ul style="list-style-type: none"> Participant surveys Informal conversations with community stakeholders Online campaign monitoring 	<ul style="list-style-type: none"> Interview protocol Survey tool (quick and convenient) Analytics tool
How well are we reaching targeted stakeholders?	<ul style="list-style-type: none"> To make sure you're reaching your engagement goals and make changes 	<ul style="list-style-type: none"> Measure engagement process (did everything happen to maximize engagement?) Compare your goals with known outcomes 	<ul style="list-style-type: none"> Stakeholders Event participants Digital analytics Existing community level demographic data 	<ul style="list-style-type: none"> Participant surveys Informal conversations with community stakeholders Online campaign monitoring 	<ul style="list-style-type: none"> Interview protocol Survey tool (quick and convenient) Analytics tool
How valid are our assumptions?	<ul style="list-style-type: none"> Understand potential biases in engagement strategies and fix them 	<ul style="list-style-type: none"> Seek critical feedback 	<ul style="list-style-type: none"> Staff Stakeholders Event participants Digital analytics 	<ul style="list-style-type: none"> Facilitated staff conversations Participant surveys Informal conversations with community stakeholders Online campaign monitoring 	<ul style="list-style-type: none"> Interview protocol Survey tool (quick and convenient) Analytics tool
How well are we retaining participant engagement?	<ul style="list-style-type: none"> Understand if relationships are being developed 	<ul style="list-style-type: none"> Seek critical feedback Track participation 	<ul style="list-style-type: none"> Staff Stakeholders Event participants Digital analytics 	<ul style="list-style-type: none"> Participant surveys Informal conversations with community stakeholders Online campaign monitoring 	<ul style="list-style-type: none"> Interview protocol Survey tool (quick and convenient) Analytics tool

SUMMATIVE

PHASE	WHEN?	WHY?	HOW?
SUMMATIVE	<ul style="list-style-type: none"> • After engagement campaign is complete or goals have dramatically shifted 	<ul style="list-style-type: none"> • Understand the full scope and breadth of the engagement work • Understand the impact of the engagement work • Document the lessons learned from the engagement work 	<ul style="list-style-type: none"> • Network mapping • Stakeholder interviews • Participant surveys • Analyze previously collected data • Analyze how public feedback influenced final decision and/or state agency

The summative evaluation phase is intended to develop and understand the breadth and depth of the engagement work. This phase can be considered the outcome phase and requires a full analysis of the outputs of the engagement work, like number of events and number of participants, as well as trying to assess the impact civic engagement had on individual participants and/or on the agency itself.

The summative phase attempts to draw a link to the effectiveness of the engagement by trying to understand what relationships were built, how participants experienced the work, and what impact engagement had on final decision making. Given the very fluid nature of civic engagement, it will always be difficult to make a direct connection. However, a useful approach in this situation is the concept of triangulation. If multiple data points (from different sources) are telling a similar story, then there is a reasonable justification to feel confident that the emerging theme is not an outlier.

EXPERIENCE IN THE FIELD: OLMSTEAD IMPLEMENTATION OFFICE

The goal of OIO's evaluation and engagement framework is to increase the state's knowledge about accessibility in civic engagement. OIO knows that not all civic engagement opportunities are accessible to individuals with a disability. The problem is that there are no coordinated efforts to collect information to understand the extent of the problem. With an evaluation plan in place OIO will be able to build a deeper understanding of the issue and how to correct it. Collecting the right information is great, but what happens next? OIO understood that evaluation is not useful if it's not being communicated, which is why they built the evaluation plan right along with their communications plan. The same is true with civic engagement overall – you aren't going to see improvement if you aren't reporting your work and findings to other people, sharing your learning with other groups and agencies.

QUESTIONS TO ASK AND HOW TO ANSWER THEM

QUESTION	WHY ASK THIS QUESTION	HOW TO ANSWER IT	SOURCES OF DATA	DATA COLLECTION METHODS	DATA COLLECTION TOOLS
<p>What impact did engagement have on the final decision?</p>	<ul style="list-style-type: none"> To understand what outcomes to communicate Understand the successes and challenges 	<ul style="list-style-type: none"> Seek critical feedback 	<ul style="list-style-type: none"> Stakeholders Event participants Digital analytics 	<ul style="list-style-type: none"> Participant surveys Informal conversations with community stakeholders Online campaign monitoring 	<ul style="list-style-type: none"> Interview protocol Survey tool (quick and convenient) Analytics tool
<p>How did engagement build relationships?</p>	<ul style="list-style-type: none"> To understand the most effective strategies for civic engagement 	<ul style="list-style-type: none"> Measure engagement process (did everything happen to maximize engagement?) Compare goals with known outcomes 	<ul style="list-style-type: none"> Stakeholders Event participants Digital analytics Existing community level demographic data 	<ul style="list-style-type: none"> Participant surveys Informal conversations with community stakeholders Online campaign monitoring 	<ul style="list-style-type: none"> Interview protocol Survey tool (quick and convenient) Analytics tool

REPORTING & LEARNING

PHASE	WHEN?	WHY?	HOW?
REPORTING & LEARNING	<ul style="list-style-type: none"> • Post-Project 	<ul style="list-style-type: none"> • Report outcomes to community stakeholders • Report engagement efforts to internal stakeholders • Understand civic engagement capacity and resource gaps 	<ul style="list-style-type: none"> • Staff interviews • Internal & external communications plan • Document lessons learned and resource needs

The reporting and learning phase is critical to not only building the overall civic engagement capacity of an agency, but also strengthening relationships that have already been built through engagement. According to literature and people interviewed for this project, one of the most common frustration community members experience around civic engagement is not knowing how their feedback impacted a project. Building in an explicit reporting phase to communicate engagement and project results to community stakeholders is necessary to maintain positive relationships. Similarly, understanding, documenting, and reporting to internal stakeholders about civic engagement outcomes is equally important to obtaining the resources required to ensure civic engagement becomes a core competency in state agencies.

BEST PRACTICES FROM PILOT PROJECTS:

- Requiring a report on your evaluation activities is a good way to create accountability and ensure that consistent evaluation of civic engagement efforts. Thinking about the way you report back your findings in a way that is meaningful and engaging to your audience is important if you want them to see the results of their participation.
- MnDOT, OIO, and EQB all use multiple modes of communication from printed material to social media and each have communications plans to follow. Consider developing a communications plan that defines your stakeholders so that you are able to disseminate evaluation outcomes in a way that resonates with different audiences.
- Sharing results and outcomes to community members you collect data from is important throughout the evaluation, but especially now as you close the feedback loop in this phase. In the beginning phases of OIO's work with their Community Engagement Advisory Group, members felt concerned that they were not receiving appropriate information about next steps or why their input was valuable. Because OIO was asking for feedback from the group, they heard this concern and made procedural changes to their processes that ensured there was more communication to the group between meetings.

QUESTIONS TO ASK AND HOW TO ANSWER THEM

QUESTION	WHY ASK THIS QUESTION	HOW TO ANSWER IT	SOURCES OF DATA	DATA COLLECTION METHODS	DATA COLLECTION TOOLS
<p>Is agency capacity for civic engagement improving and is it culturally responsive?</p>	<ul style="list-style-type: none"> To understand what resources are needed to improve civic engagement skills To continually build knowledge on executing civic engagement in culturally responsive ways 	<ul style="list-style-type: none"> Review previously collected data Seek feedback from staff on resource needs 	<ul style="list-style-type: none"> Previously collected evaluation data Staff 	<ul style="list-style-type: none"> Staff interviews Document review 	<ul style="list-style-type: none"> Project reflection protocol
<p>What internal and external stakeholders need to receive final reports of engagement efforts and how will they be communicated?</p>	<ul style="list-style-type: none"> Develop a communications plan so that results of the civic engagement can be communicated to stakeholders 	<ul style="list-style-type: none"> Stakeholder mapping Communications plan 	<ul style="list-style-type: none"> Previously collected data Staff Community stakeholders 	<ul style="list-style-type: none"> Staff interviews Document review Informal conversations with community stakeholders 	<ul style="list-style-type: none"> Communications plan template Interview protocols

MEASUREMENT

FOUR GENERAL WAYS TO MEASURE CIVIC ENGAGEMENT

The heart of civic engagement evaluation is understanding what you want to measure and why. Sometimes finding the right measurement is tricky and it's difficult to even figure out what information is possible to collect. Developing a Theory of Change, understanding the purpose of your evaluation, and developing clear evaluation questions will help to clear up the confusion, but sometimes it's easier to just read a list of ideas to get the creativity flowing. This section can help with that, it lays out general ways to measure civic engagement and provides a list of possible measurement by evaluation phase that have been collected through this project.

Based on the literature reviewed for this work, there are multiple ways to measure civic engagement. They can be categorized into four major ideas:

1. Design

Attempts to measure how well the design of the engagement activity or campaign matches the context and purposes of the engagement work

2. Delivery

Attempts to measure the immediate outputs or outcomes of each engagement activity and how well they track with the overarching goals of the engagement work

3. Impact

Attempts to measure the longer-term, planned changes that have occurred within target stakeholders/communities

4. Agency capacity

Attempts to measure organizational adoption of engagement best practices and the learnings resulting from evaluative exercises

Trying to figure out what indicators should be measured is often confusing. Data can be collected on anything and it is very tempting to just decide that you'll collect everything and cherry pick only the most positive data points to tell your story. This approach will only make evaluation more difficult and will lead you to make the wrong conclusions about the efficacy of your civic engagement work. When developing indicators there are key elements to consider for civic engagement evaluation:

- Indicators should answer your evaluation questions – the questions you want to answer in each evaluation phase will influence the data you collect.
- Indicators should be relevant to civic engagement goals – the goals developed during the formative phase will drive many of your engagement indicators.

- Indicators should be observable – indicators should focus on action and/or changes.
- Indicator data should be feasible to obtain – resources are scarce in the civic engagement world. Focus on indicators where data is relatively easy to collect.

MEASUREMENT TIPS FROM PILOT PROJECTS

Here are some of the ways the pilot projects have decided to measure engagement:

- Design your evaluation with some of the stakeholders your civic engagement efforts impact. Determine what questions are important for you to answer, then choose three data points that can answer your questions. These data points can be from existing data your agency has access to, information you collect on a regular basis, or a follow-up survey from your engagement touch points. Measurement is more about a systematic approach than it is about having fancy tools.
- In order to measure the extent to which Rethinking I-94 is reaching under-represented voices, this team created indicators that included events taking place in community settings (measured by number or percent of meetings held in community spaces) and convenience of meetings and events to public transportation (measured by percent of public engagement events located within 1/8 mile of a transit stop).
- When thinking about how to measure a government agency’s awareness of barriers people with disabilities face when participating in civic engagement, OIO considered indicators such as number of interactions agency staff have with leaders of the disability community to identify barriers to participation and tracking the number and types of accommodations people request when participating in civic engagement events.

EXPERIENCE IN THE FIELD: OLMSTEAD IMPLEMENTATION OFFICE

When developing potential indicators to include in their civic engagement evaluation plan, OIO asked their Community Engagement Advisory Committee to provide their input. Through a review of existing literature, a list of potential indicators were developed and then attached to the specific evaluation questions that were also vetted by the group. The committee was then asked, “if we want to learn this (evaluation question), is each indicator on this list going to be helpful?” If members didn’t think an indicator was going to be helpful, there was a conversation to refine it until it looked to be more useful.

Through this process a list of indicators for each evaluation question was developed. The process proved itself extremely helpful because it helped to craft indicators that were both relevant to the OIO’s overall purpose of their evaluation and to members of the community.

BEST PRACTICES FROM PILOT PROJECTS:

- Preliminary interviews with stakeholders are essential to gain understanding of the context and reality facing the community members before designing your evaluation of civic engagement practices. Each of the pilot projects knew (or discovered) that implementing their civic engagement work without some exploratory conversations in the community led to designing ineffective engagement strategies. When it comes to designing civic engagement and its corresponding evaluation, it is best to seek feedback on your design from stakeholders within community and outside of your state agency.
- MnDOT learned the importance of having stakeholders and community members define what success should look like for Rethinking I-94's civic engagement practices. Then indicators were created from this information. Not only did MnDOT receive useful information on defining indicators, the mere act of including community members in the process helped to strengthen relationships. Including community stakeholders in the evaluation design process is a great way to engage with people and improve transparency.
- All three of the pilot projects are developing evaluation tools by sharing them with stakeholders and asking for feedback. This way the stakeholders are engaged in the process and more likely to be champions of the work and encourage others to use these tools as well. In evaluation, this is called tool validation. Tool validation assures that the questions you're asking and how you're collecting information are appropriate while maximizing the chances for collecting useful information and decreasing negative outcomes.
- OIO learned that it is very important to train people in the community (such as board members) to be collaborative and work together before expecting them to do collaborative work on a board. Such training includes providing some background about the mission and purpose of the board, board member expectations, administrative processes. Assuming people can engage effectively without any specific guidance or training limits the opportunities for participation to only those familiar with how state systems operate.
- The International Association for Public Participation (www.iap2.org) has a useful chart outlining the engagement spectrum. Understanding where your engagement falls within this spectrum may help you define evaluation questions for this phase.

NOTES ON INDICATORS:

Since there is not an all-encompassing metric to measure civic engagement, the metrics included in this section should be considered as indicators. Indicators are meant to track progress toward a goal and provide some guidance to changes that need to be made. One indicator measures one aspect of a program. This means single indicators can provide some insight, but they should be looked at holistically and regularly monitored to be truly useful. In terms of civic engagement, qualitative and quantitative data should be considered equally significant. In fact, more important information will be gleaned through qualitative stories than through quantitative counts such as attendance or levels of satisfaction.

POTENTIAL INDICATORS BY PHASE

Through a comprehensive literature review, interviews, and individual work with pilot projects we have put together a list of potential metrics that can be used to answer the critical evaluation questions for each phase. These phases have an emphasis on collecting data in the field and lend themselves more toward developing indicators and less on internal planning conversations.

These indicators are described as ‘potential indicators’ for a reason. Each civic engagement project or campaign occurs in unique contexts that change rapidly. The indicators listed on this page are meant as a tool for evaluators of civic engagement to look at, think about, and innovate from. Some of the potential indicators listed here will work in your civic engagement context, and some will not. If you do not see anything that resonates, consider the core of what the indicator is trying to measure and see if you can change it to fit your needs. As stated in the opening paragraphs of this document, evaluation is a journey – start with something you know. If that does not work at first, do not be afraid to innovate or try new things until you find a measure or process that makes sense.

DEVELOPMENTAL

How well do participants understand the purpose of our engagement?

- Percentage of participants that agree [insert engagement technique] was of value in communicating project information to them
- Percentage of participants engaged understood their role in the process
- Review public documents used to market [insert engagement technique] for purposes and goals
- Review of incoming communications to project contact
- Percentage to participants agreeing that communication and purpose of the event was clear

How well are we reaching targeted stakeholders?

- Comparing number and target of separate techniques used to involve/engage the public to original plan
- An acceptable level of awareness exists with stakeholder groups that can be evidenced by digital analytics, conversations with community groups, and participant surveys
- Collected participant demographic data is representative of community profiles
- [number/ percentage] of meetings held in community spaces (meeting people where they are)

How are our assumptions holding up?

- Opinions of people who participated agree that [insert engagement technique] was of value in capturing their input
- Percentage of participants agree that their voice was heard
- Amount of staff time dedicated to public engagement (number of FTEs/percentage of weekly time), relative to project (size, level of impact, purpose in the spectrum of engagement) is acceptable
- Are community members involved in design of the engagement

How well are we retaining participant engagement?

- Percentage of stakeholders willing to participate in future engagement efforts
- Percentage of participants that rate environment as welcoming
- Percentage of participants that perceive that they had an adequate opportunity to participate
- Percentage of events accessible to individuals with a disability
- Percentage of requested accommodations being made
- Accounting of all outgoing communications - what were they, how many, and where they went

SUMMATIVE

What impact did engagement have on the final decision?

- Proportion of events in which the agency followed up with communities justifying integration of community input or justification of exclusion
- Proportion of events in which the agency followed up with communities repeating back what had been heard
- Percentage of participants perceive that they received proper feedback of the engagement results
- Percentage of participants that said they learned something from the engagement process
- Percentage of participants that mention they did something because of their involvement
- Review of the decision making process and how civic engagement impacted the final outcome (what changes were made from the start to the end?)

How did engagement build relationships?

- Percentage of participants agree they felt respected during the engagement process
- At least [set target percentage] of stakeholders participating agree that the information provided by the agency was clear and adequate
- Responses to public inquiries are made within [set target number working days] of the day of receipt
- Review of stakeholders will to continue working with the engagement process
- Network map of relationships at the beginning and end of engagement process
- Diversity of participants increased over time
- Accounting of all outgoing communications - what were they, how many, and where they went

FORMATIVE

What are the goals for civic engagement?

- What do you want to see happen from the work?
- What will success look like?
- What will you be asking stakeholders to do? Why is participation worth their time?
- Complete logframe matrix

Who are the stakeholders and how will they be engagement? Do stakeholders need to be involved in design?

- Complete civic engagement stakeholder analysis
- Develop community demographics or profile of the issue or project area
- How can stakeholders be involved in designing your civic engagement?

What are our assumptions about this engagement and how are we examining them?

- Complete logframe matrix
- Develop indicators to test your assumptions identified in logframe matrix
- Identify community stakeholders to interview to test your assumptions before engagement begins

Are there lessons learned from previous experiences to improve accessibility and cultural responsiveness?

- Complete logframe matrix
- Complete stakeholder civic engagement stakeholder analysis
- Validate both logframe matrix and stakeholder analysis with accessibility experts
- Validate both logframe matrix and stakeholder analysis with community stakeholders

REPORTING & LEARNING

Is agency capacity for civic engagement improving and is it culturally responsive?

- Review process and documentation for completing and archiving engagement project wrap-up forms
- Review process for evaluation reporting to ensure learnings are being disseminated
- Track staff training as it pertains to civic engagement skill development
- Review summative report data to understand trends in cultural responsiveness

What internal and external stakeholders need to receive final reports and how will they be communicated?

- Develop external communication plan that is matched with stakeholder analysis
- Develop internal communication plan to inform practitioners and leadership of lessons learned, outcomes, and resources they may need
- Develop good CRM databases practices to maintain communication with stakeholders over time

CONCLUSION

Evaluation is often described as a journey because it rarely follows a straight path and the knowledge that is picked-up along the way can change the way you think about the world. It's also described as a journey because the process of evaluative thinking needs to be learned and refined over time. It's our hope that this guide has provided a general process to follow when embarking on the first steps of your evaluation journey.

In the current climate of declining public trust in government institutions, civic engagement exists as a primary strategy to help build a bridge between community and state agencies. However, without the proper evaluation of civic engagement and making sure that the work is building and sustaining relationships, it will be difficult to know if any bridge is being built at all.

The good news is that evaluation does not need to be overly complicated. Even so, it requires a systematic and continuous approach that involves community stakeholders in the process. This guide outlines a comprehensive way to think about civic engagement evaluation and it will hopefully spark an interest in adopting the process in your own civic engagement work.

EXPERIENCE IN THE FIELD: MNDOT

MnDOT created an engagement toolkit for the Reimagining I-94 project that walks a project team through the process of developing a community engagement plan. A missing component of this plan, when initially created, was how to evaluate the community engagement work. When the Reimagining I-94 project was selected as a pilot for this civic engagement evaluation project, it was immediately clear that developing an evaluation plan to mesh with their existing engagement plan was going to be the best use of resources.

After several discussions with the project team about the development of their community engagement toolkit and how staff have been using it, an idea emerged. The project team explained that the reason the toolkit had been so useful is that it encourages a developmental process for continuous learning. The Reimagining I-94 project is a long project that will span several years. As such, relationships must be maintained and constantly tended to. Staff were collecting information about how their engagements were proceeding, but there was no system to analyze the data in a meaningful way and staff felt overwhelmed with all the information.

The engagement toolkit also had several key elements that provided more context for how to design a useful evaluation plan. The plan laid out the project's values pertaining to civic engagement, which mostly focus on hearing underrepresented voices. The plan also laid out major phases of the work from planning to operations and maintenance. Defining values and major work phases are good reference points to measure against.

With this context, interviews with community members, and hours of facilitated discussion, an evaluation plan was completed. The evaluation plan is focused on a developmental approach and follows the major steps laid out in this guide. It explains what questions to ask in each project phase, what data to collect, and how to collect it. The value of the plan isn't so much that it developed a revolutionary way of measuring civic engagement work, but the plan lays out a process to evaluation that can be repeated and helps limit the feelings of confusion many staff experience.

APPENDIX

The Appendix some sample templates for your use. Feel free to develop your own as well.

A template you can use follows:

1. Stakeholder analysis
2. Logframe
3. Wrap up

Civic Engagement Stakeholder Analysis Template

Stakeholder	Interest	Why should they be engaged?	How should they be engaged?	How can they be included in the design?
Name and description	What interests do you think they have in your project or how will they be affected by it?	What will you be asking of them?	What tactics do you think will be effective in engaging them?	What assumptions do you have that need to be tested?

Logframe Matrix Template

Aims		Indicator	Data Source	Assumption
		How will you know things are happening? What will you measure?	How will you measure?	What needs to be true for this to happen?
4. Goal(s)	Ultimate goal(s) of your civic engagement project. Here you should think about the big changes or outcomes you want to see at the end of the engagement.			
3. Results	Things you want to see happen from the output. This could include things like growing awareness of the project, more community events, or changing opinions.			
2. Outputs	The things that you want your civic engagement to generate. Outputs are immediate and tangible like comments, event attendance, or website clicks.			
1. Activities	Your list of civic engagement tactics that will be completed.			

THEN THIS SHOULD HAPPEN

IF THIS HAPPENS

AND THIS HOLDS TRUE

INSTRUCTIONS

1. Start at #1 and list out the civic engagement activities you plan to implement
2. Think about indicators: how can you measure progress
3. Think about data sources: list the sources of data you from which you can draw information
4. Think about assumptions: what needs to be true for you to accomplish what you want. Understanding assumptions can often highlight indicators, so don't hesitate to go back and update your indicators list.
5. Repeat the previous steps for Aims 2-4

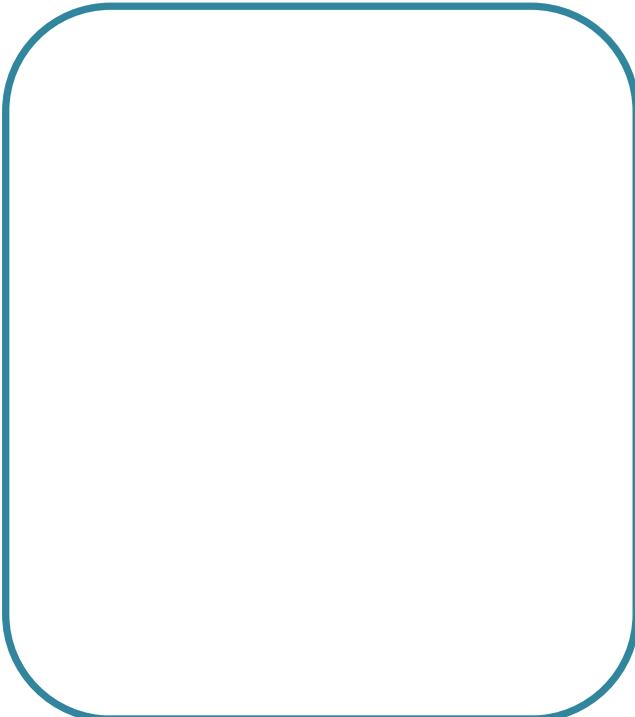
Civic Engagement Wrap-Up

Project: _____

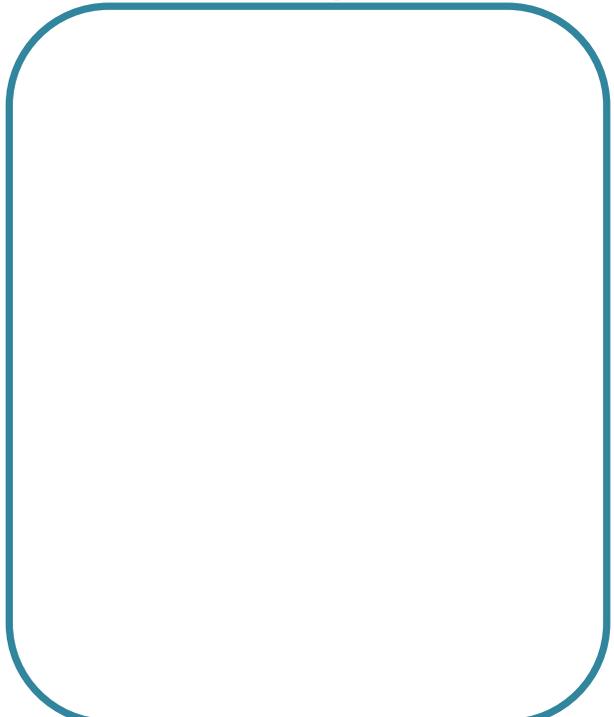
Length: _____ (weeks/months/years)

Scope: _____ (small, medium, large)

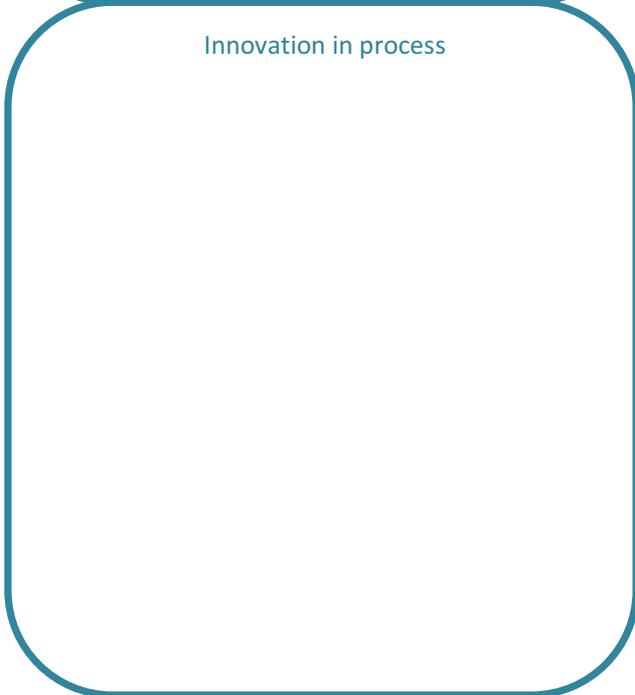
Successes



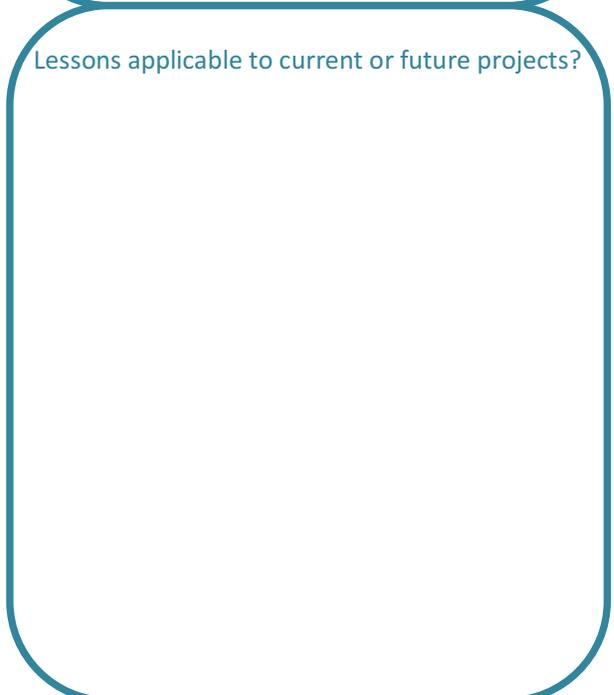
Challenges



Innovation in process



Lessons applicable to current or future projects?



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The dozens of community members willing to give their time to participate in interviews and focus groups...
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mn.gov/mdhr

Upon request, this information can be made available in alternative formats for individuals with disabilities by calling the numbers above.

12/3/2018

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Items:

6 (a) *Quality of Life Follow-Up Survey Report*

Presenter:

Darlene Zangara (OIO) and The Improve Group

Action Needed:

- Approval Needed
- Informational Item (no action needed)

Summary of Item:

This is the report on the Quality of Life Follow-Up Survey. A power point presentation will provide an overview of the Report

Attachment(s):

6a –

- *Olmstead Plan Quality of Life Follow-Up Survey Report*
- *Olmstead Plan Quality of Life Follow-Up Survey Power point handouts*

Olmstead Plan Quality of Life Survey

FIRST FOLLOW-UP – 2018 RESULTS

DECEMBER 2018

TheImproveGroup

December 2018 Report (this report)

- High-level look at follow-up survey outcomes
- Review of survey module score changes over time
- Initial linear regression model results

TheImproveGroup

January 2019 Report

- Detailed analysis of results across different subgroups (setting, geography, demographics, etc.)
- More detailed review of linear regression models identifying association and further areas of research

TheImproveGroup

Survey purpose

Survey is designed to assess and track quality of life for Minnesotans with disabilities who receive services in potentially segregated settings

TheImproveGroup

Survey goals

- Complete at least 500 interviews
- Achieve geographic representation
- Achieve representation across identified settings
- Achieve demographic representation

Survey results

Survey scores

The Olmstead Quality of Life Survey has four distinct modules that measure different aspects of integration and quality of life. For each module, the results are presented as an overall module score.

- **Integrative activities scale** – interaction with community members
- **Decision control inventory** – autonomy in choice-making
- **Quality of life** – perceived quality of life
- **Close relationships** – family, friends, and trusted relationships
- **Use of assistive technology** (add-on)

TheImproveGroup

Integrative activities scale

Study	Respondents with an outing interactions score	Outing interactions score
Baseline	1,936	37.7
Follow-up	497	36.5

TheImproveGroup

Decision control inventory

Study	Respondents with decision control inventory score	Decision control inventory score
Baseline	1,942	66.2
Follow-up	504	67.6

TheImproveGroup

Quality of life scales

Study	Respondents with a quality of life score	Quality of life score
Baseline	1,904	76.6
Follow-up	501	77.4

TheImproveGroup

Closest relationships

Study	Number who responded	Average number of close relationships
Baseline	1,902	4.12
Follow-up	505	3.74

TheImproveGroup

Use of assistive technology

Reported use of assistive technology	Number responding at baseline	Percent of respondent at baseline	Number responding at follow-up	Percent of respondent at follow-up
No	786	41.0%	213	42.3%
No, but I need help doing certain tasks and would like to use assistive technology	37	1.9%	8	1.6%
Yes, I have used it in the past	21	1.1%	7	1.4%
Yes, I use it now	1,071	55.9%	275	54.7%
Total	1,915	100.0%	503	100.0%

TheImproveGroup

Use of assistive technology

Difference use of assistive technology has made	Number responding at baseline	Percent of respondent at baseline	Number responding at follow-up	Percent of respondents at follow-up
A lot	661	62.1%	162	59.3%
Some	208	19.5%	64	23.4%
A little	116	10.9%	31	11.4%
None	80	7.5%	16	5.9%
Total	1,065	100.0%	273	100.0%

TheImproveGroup

Results overview

Community integration: 36.5 indicates respondents are not interacting much with other community members during their outings. No significant change since baseline.

Decision control: 67.6 indicates respondents and their support person have a **moderate amount** of decision making power. No significant change from baseline.

Overall quality of life: 77.4 indicates most respondents said their quality of life was **“good”**. No significant change from baseline.

Closest relationships: Average number of close relationships per respondent dropped from **4.12** to **3.74**, but still relatively high compared to other states.

Assistive technology: most respondents used assistive technology and described it as helping **a lot** with increasing their independence.

TheImproveGroup

Characteristics associated with overall quality of life

LINEAR REGRESSION MODELS

The **Improve** Group

Respondent characteristics

What is linear regression?

- A statistical analysis that attempts to show relationships between different variables or characteristics

Example: If you wanted to know what housing characteristics affected housing prices, linear regression would help determine what specific things about a home (size, location, age, etc.) had a strong association with housing price.

The **Improve** Group

Respondent characteristics

Characteristics included in the models:

- Demographics
- Guardianship status
- Cost of services
- Residential setting
- Day setting
- Waiver type
- Weekly earnings
- Day integration
- Total monthly outings
- Number of outing types
- Average outing group size
- Adaptive behaviors

TheImproveGroup

Results overview

The models identified several key characteristics:

Region: most of the differences occurred between the metro region and greater Minnesota. On average, the metro area reported lower scores.

Service type: on average, both day and residential services were associated with lower decision control inventory scores. Service type is not associated with the other module scores.

Average cost of services per day: on average, higher average daily cost of services is associated with lower quality of life. However, this finding does not suggest that lowering the cost of services for all service recipients will lead to higher quality of life.

Guardianship status: on average, respondents with a public guardian have lower quality of life scores than respondents with a private guardian. Respondents who do not have a legal guardian have higher decision control inventory scores and fewer close relationships than respondents with a legal guardian.

TheImproveGroup

Next steps

January 2019 Report

- Detailed survey score results by region, service setting, and demographics
- Further analysis of regression results that explain how each characteristic is associated with survey scores, strength of association
- Identify specific areas of further research to consider

Olmstead Subcabinet Meeting Agenda Item

December 17, 2018

Agenda Items:

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Presenter:

Darlene Zangara (OIO) and The Improve Group

Action Needed:

- Approval Needed
- Informational Item (no action needed)

Summary of Item:

This is the report on the Quality of Life Follow-Up Survey. An overview will be provided by the Improve Group.

Attachment(s):

6a –Olmstead Plan Quality of Life Follow-Up Survey

Olmstead Quality of Life Survey: First Follow-up – 2018

December 2018 Report

Submitted by The Improve Group

Submitted December 11, 2018

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Executive summary

The Olmstead Quality of Life Survey is designed to be a multi-year effort to assess and track the quality of life for people with disabilities who receive services in potentially segregated settings.¹ This report outlines the results of the Olmstead Quality of Life Survey's first follow-up survey and compares results to baseline survey data collected in 2017. The results of this survey are critically important to understanding how Minnesota is meeting the goals of its Olmstead Plan.

The purpose of the Olmstead Quality of Life Survey is to talk directly to Minnesotans with disabilities who receive services in potentially segregated settings to collect individuals' perceptions and opinions about what affects their quality of life.

About the Olmstead Quality of Life Survey: First Follow-up – 2018

The Olmstead Quality of Life Survey: First Follow-up – 2018 was conducted between June and November 2018. A total of 511 people completed the survey. The follow-up survey respondents were selected from a random sample of 2,005 baseline survey respondents. The results of this survey will be used along with future follow-up surveys to measure the progress of Minnesota's Olmstead Plan implementation.

Focus population

To be eligible to participate in the Olmstead Quality of Life Survey Baseline – 2017, respondents had to be authorized to receive state-paid services in potentially segregated settings in July 2016. Since the survey is intended as a longitudinal study, everyone who took part in the 2017 baseline survey was eligible to participate in the follow-up survey,

¹ Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with people with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limited visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other people with disabilities. [See US Department of Justice, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.," http://www.ada.gov/olmstead/q&a_olmstead.htm]

regardless of whether the person was still receiving services in potentially segregated settings.

The potentially segregated settings included in this study were based on a 2014 report developed by the Minnesota Department of Human Services for the Olmstead Subcabinet. The settings include:

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

Survey results

The Olmstead Quality of Life Survey has four distinct modules that measure different aspects of integration and quality of life. For each module, the results are presented as an overall module score. The baseline and follow-up sample results for each module are as follows:

Outings and interactions

The survey measured the amount of interaction respondents have with community members during outings. These results are presented as an outing interactions score. The average outing interactions score for the follow-up sample was 36.5, compared to 37.7 at baseline. There was no significant change from baseline to follow-up.

Decision control inventory (choice-making)

The survey measured respondents' autonomy in choice-making in the baseline sample and in the follow-up sample. These results are presented as a decision control inventory score. The average decision control inventory score in the follow-up sample was 67.6, compared to 66.2 in the baseline sample. There was no significant change from baseline to follow-up.

Quality of life

The quality of life inventory captured the respondents' perspective in 14 different areas including health, happiness, comfort, and overall quality of life. These results are presented as a quality of life score. The average quality of life score in the follow-up sample is 77.4, compared to 76.6 in the baseline sample. There was no significant change from baseline to follow-up.

Close relationships

Overall, respondents listed fewer close relationships in the follow-up sample compared to the baseline. The average number of close relationships listed in the follow-up sample is 3.7, compared to 4.1 in the baseline sample. There was a statistically significant change downward from baseline to follow-up. However, since the change was less than 1 person, it is difficult to determine if this was a meaningful change in practical terms. This difference will need further exploration.

Characteristics associated with overall quality of life

Linear regression models were used to determine how respondent demographics, setting characteristics, and other important characteristics of an individual's life were related to each of the four module scores: outing interactions, choice-making power, perceived quality of life, and closest relationships. The regression models show that all the module scores are related to one another. This helps validate that these variables are important constructs of an individual's quality of life. These models also identified several key characteristics that were associated with the module scores. These characteristics include:

- Guardianship status
- Region
- Outings (number and type)
- Cost of services
- Service setting
- Waiver type

These characteristics point to important associations that may drive overall quality of life for an individual. These associations will be further explored in an upcoming technical analysis report in January 2019.

Understanding the results

Past studies conducted by the developer of the survey showed that noticeable change can only be expected in the short term (about one year) when a large transition has occurred, such as moving from institution to community. And even in these studies, changes become statistically significant only at approximately two years. Given that a large transition like de-institutionalization did not occur during the period of study and the relatively short amount of time between the baseline and follow-up surveys, it is not unreasonable to expect little to no change in survey scores.

While there were no significant changes noted in overall quality of life in this first follow-up survey, the longitudinal nature of the survey is critical to continue to monitor progress on Minnesota's Olmstead Plan implementation. The initial analysis of follow-up survey results has shown that the survey can identify important characteristics affecting overall quality of life and effectively measure change over time.

Data limitations

The results in this report reflect the perceptions of the respondents and speak directly to their individual experiences. The survey sample was selected from well-defined groups of people receiving services in potentially segregated settings. As such, the results are reflective of the experiences of Minnesotans receiving services in those settings and cannot be generalized to all people with disabilities in Minnesota.

Next steps

This report is intended as a high-level overview of the first follow-up survey results. A detailed technical report describing the relationships outlined in the regression models and survey results by region, service setting, and other individual characteristics will be completed in January 2019.

A second random sample of baseline respondents will be selected for a second follow-up survey. To provide enough time to see significant changes in module scores between the baseline survey and the second follow-up survey, the current recommendation is to conduct the second follow-up survey starting in summer 2020.

Purpose

Minnesota's Olmstead Plan is a broad series of key activities the state must accomplish to ensure people with disabilities are living, learning, working, and enjoying life in the most integrated setting of their choice. The Plan helps achieve a better Minnesota because it helps Minnesotans with disabilities have the opportunity to live close to their family and friends, live more independently, engage in productive employment, and participate in community life.

Minnesota's Olmstead Plan's "Quality Assurance and Accountability" section states that a longitudinal survey should be implemented to measure quality of life over time. The Olmstead Quality of Life Survey is the tool that has been chosen to satisfy this directive.

The Olmstead Quality of Life Survey was designed as a multi-year effort. In 2017, a baseline survey was conducted to gather initial data about quality of life for Minnesotans with disabilities who received services in potentially segregated settings. In 2018, the first follow-up survey was conducted with a random sample of people that participated in the baseline survey.

The Olmstead Quality of Life Survey: First Follow-up – 2018 has a dual purpose: to gather information about quality of life for Minnesotans with disabilities who receive services in potentially segregated settings, and to compare this year's information with the baseline results to show any changes in quality of life over time for the focus population.

This report outlines the results of the Olmstead Quality of Life Survey's first follow-up and compares those results to baseline survey data. This report is intended as a high-level overview of the first follow-up survey results. A detailed technical report describing a more in-depth analysis of survey data will be released in January 2019.

Background

Minnesota's Olmstead Plan was developed 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.² 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*.³ 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 required Minnesota to 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."⁴

² U.S. Department of Justice Civil Rights Division. (Retrieved November 2017). Olmstead: Community Integration for Everyone. Retrieved from ADA.gov: https://www.ada.gov/olmstead/olmstead_about.htm

³ Minnesota Department of Human Services. (2017). Jensen Settlement. Retrieved from Department of Human Services: <https://mn.gov/dhs/general-public/featured-programs-initiatives/jensen-settlement/>

⁴ 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

Olmstead Quality of Life Survey as a multi-year effort

The Olmstead Quality of Life Survey was conceived as a multi-year effort. In 2017, a baseline survey was conducted to gather initial data about quality of life for Minnesotans with disabilities who receive services in potentially segregated settings. In 2018, the first follow-up survey was conducted with a sample of baseline survey respondents. While the follow-up survey results can stand alone as a measure of quality of life for the focus population, the results are more meaningful when compared to the results from the baseline survey. By returning to the same group of respondents over time, it is possible to measure changes in quality of life from one year to the next. Because the survey respondents are representative of the focus population, the results can be generalized to the Minnesotans with disabilities who receive services in potentially segregated settings.

Baseline Survey – 2017

The Improve Group was selected to conduct the Olmstead Quality of Life Baseline Survey in 2016. The baseline survey was conducted between February and November of 2017. The baseline survey was a large statewide survey of 2,005 Minnesotans with disabilities who receive services in potentially segregated settings. The baseline survey results function as a “snapshot” of quality of life for this focus population. The baseline data are also the standard by which future years’ results will be measured against to determine any changes in quality of life. The results from this survey were published in December 2017.

First Follow-up Survey – 2018

The Olmstead Quality of Life Survey: First Follow-up – 2018 was conducted by The Improve Group from June to November of 2018. The follow-up survey was administered to a randomly selected sample of 511 respondents who participated in the baseline survey.

Though we obviously cannot expect significant changes over short time periods, the one-year follow-up serves several important functions. This smaller follow-up should be seen as a “proof of concept” for an ongoing commitment to track changes over the long run and a chance to understand specific characteristics that are associated with overall quality of life for people receiving services in potentially segregated settings.

Minnesota's Olmstead Plan 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.

2009: The federal class action lawsuit known as *Jensen et al v. Minnesota Department of Human Services* is filed.

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

January 2013: Governor Mark Dayton issues an Executive Order 13-01 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 Outcome Analysis Quality of Life survey tool as the most appropriate way of measuring the quality of life of people with disabilities.

June – December 2014: The Olmstead Quality of Life Survey is piloted by The Improve Group. Approximately 100 people with disabilities participated in the pilot. People with disabilities were hired to conduct the surveys. Considerations from the pilot survey are incorporated into the Quality of Life Survey Administration Plan.

January 2015: Governor Mark Dayton issues Executive Order 15-03 further defining the role and nature of the Olmstead Subcabinet.

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, such as the Quality of Life survey.

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

February 2017 – November 2017: The Improve Group implements the Olmstead Quality of Life baseline survey with 2,005 people with disabilities across Minnesota.

December 2017: The Improve Group analyzes and reports survey results to the Olmstead Subcabinet as well as the Olmstead Implementation Office.

June 2018 – November 2018: The first follow-up survey is completed with a random sample of baseline survey respondents to detect any changes in quality of life.

Methodology

Survey tool selection

The Olmstead Implementation Office reviewed seven possible tools for consideration and presented them to the Subcabinet. The office used the following criteria, provided by the Subcabinet, to judge the tools:

- applicability across multiple disability groups and ages
- validity and reliability
- ability to measure changes over time
- whether integration is included as an indicator in the survey
- low cost

The Subcabinet voted to use a field-tested survey tool developed by Dr. Jim Conroy with the Center for Outcome Analysis (COA). The tool was tailored to meet the needs of Minnesota's Olmstead Plan. The COA survey tool was selected because it best met the selection criteria listed above.

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

Focus population

The focus population for the Olmstead Quality of Life Survey is Minnesotans with disabilities who receive services in potentially segregated settings.⁵ The survey's focus

⁵ The Improve Group. (2016). Quality of Life Survey Administration Plan.

population includes people of all ages and disability types, in the eight service settings described in Table 1.

Table 1: Description of settings

Setting	Description
Center Based Employment	Programs that provide opportunities for people with disabilities to learn and practice work skills in a separate and supported environment. Respondents 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 in a day setting to provide people 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 Lodging facilities are licensed by the Minnesota Department of Health (or local health department) and 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. Board and Lodging facilities vary greatly in size—some resemble small homes and others are more like apartment buildings.

Setting	Description
Supervised Living Facilities (SLF)	Facilities that provide supervision, lodging, meals, counseling, developmental habilitation, or rehabilitation services under a Minnesota Department of Health license to five or 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 people 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 (Assisted Living)	<p>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.</p> <p>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.</p>
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	Residential facilities licensed as health care institutions and certified by the Minnesota Department of Health to provide

Setting	Description
Developmental Disabilities (ICF/DD)	health or rehabilitative services for people with developmental disabilities or related conditions and who require active treatment.

Populations not included

The goal of this survey is to be as inclusive as possible; however, the survey methodology and eligibility criteria does not include all Minnesotans with disabilities.

The eligible population does not include people who are incarcerated, youth living with their parents, people living in their own home or family home who do not receive day services in selected settings, people who are currently experiencing homelessness, or people who are receiving services in settings other than the eight settings identified above. **For these reasons, the survey results can only be generalized for the people receiving services in these eight service settings and are not representative of the experiences of all Minnesotans with disabilities.**

Selecting the survey sample

The focus population for the first follow-up survey is Minnesotans with disabilities who receive services in potentially segregated settings and who were included in the baseline survey population.

The sample includes people of all disability types, including people with multiple disabilities. Disability types include:

- 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 Olmstead Quality of Life Survey is simple random sampling. This refers to a randomly selected sample from a larger sample or population, where each person in has an equal chance of being selected. Simple random sampling is generally easier to understand and reproduce compared to other sampling techniques

like stratification. Simple random sampling also allows for more flexibility to accommodate changes in setting definitions.

Race and ethnicity

The racial and ethnic diversity of the focus population and of Minnesota were considered in planning the survey. By using the process of simple random sampling to select respondents for the survey, the race/ethnicity breakdown of people selected for the survey was designed to mirror the demographics of Minnesotans receiving services in the selected settings. Thus, the potential sample would be representative of the people receiving services in potentially segregated settings, but not the state overall.

Data sources

For the purposes of the baseline survey, four main sources of data were used: Minnesota Department of Human Services (DHS) data, Minnesota Department of Employment and Economic Development (DEED) data, outreach tracking data, and data gathered through use of the Quality of Life Survey itself.

DHS and DEED provided the data for the survey sample. These data consisted primarily of individual demographic data for potential respondents, such as name, birthdate, race/ethnicity, disability, guardianship status, contact information, and information about services received.

DHS holds data for people who receive services in seven of the settings included in this survey. DHS does not hold data for people who receive services in Center Based Employment. DHS provided service and screening data for all potential respondents who were authorized to receive services in potentially segregated settings as of July 2016. DHS and The Improve Group have a data-sharing agreement that allowed The Improve Group to access individual-level data needed for the survey.

The data for people receiving services through Center Based Employment is held by DEED. Initially, DEED could not share identifiable data with The Improve Group. However, DEED did provide ID numbers, provider information, and residential status information for potential respondents in Center Based Employment as of January 2016. Residential status information was used to identify people who were potentially receiving residential services through DHS. The Improve Group used this information to remove individuals who were listed as living in Adult Foster Care or another DHS setting in the DEED data set. Removing these individuals minimized the risk of duplication in the final sample.

Outreach tracking data included details about contact made with the person and/or their guardian to participate in the survey, as well as any contact made with other allies, providers, et cetera.⁶

For the follow-up survey, The Improve Group requested updated service and screening data from DHS and DEED for the 2,005 people who participated in the baseline survey. The Improve Group used this data to identify individuals who were no longer authorized to receive services in potentially segregated settings. This data was also used to calculate the attrition rate for the baseline survey respondents. This data update was completed in the summer of 2018.

Survey outreach and consent process

The Improve Group used multiple contact methods to reach people selected to participate in the follow-up survey. These methods included mail, phone calls, and email.

From June 2018 through November 2018, outreach was conducted on a “rolling basis” to potential respondents from the random sample. This meant that initial contact with potential respondents was based on the date that the respondents completed their baseline survey. The goal was for the follow-up surveys to be administered in the same calendar month as the baseline survey, in an attempt to maximize the duration between surveys.

Outreach

To encourage potential respondents from the randomly selected sample to participate, The Improve Group conducted outreach in a variety of ways. Up to three mailings were sent to potential respondents without guardians, guardians, and service providers. In addition, there were outreach and follow-up conversations via phone and email, when appropriate.

Individuals who did not respond to outreach remained eligible to take the survey until the end of the administration period.

For the purposes of protecting individual-level information during outreach and scheduling, potential respondents were assigned identification numbers.

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

Respondents without guardians

Within 14 days of a mailing being sent, follow-up phone calls were made to potential respondents without guardians. Outreach phone calls were also made to service providers associated with potential respondents, as appropriate. When email addresses were available, emails were also sent.

Respondents with guardians

When potential respondents had legal guardians, The Improve Group conducted outreach to the person's guardian to obtain consent and schedule the survey. Outreach to guardians was conducted by mail, phone, and email. First, The Improve Group sent a letter notifying the guardian that the person had been selected for the survey. The letter included a consent form and instructions for scheduling the survey. If requested by the guardian on the consent form, The Improve Group contacted the potential respondent or support person directly.

Consent process

For all survey respondents, The Improve Group obtained guardian and/or respondent consent before administering the survey. In cases when guardian contact information was unavailable or not current, The Improve Group contacted providers or case managers (when applicable) to request help in obtaining guardian contact information or in collecting guardian consent forms.

All respondents were given the option to opt out of the survey at any time during the outreach and scheduling process. Respondents without guardians were asked to give informed consent at the time of the interview. Respondents with a legal guardian were asked to assent to the survey using the same consent form. The consent form included a notice of the person's right to decline or stop the survey at any time. If a respondent declined to consent or did not understand the consent form, he or she was not interviewed.

Considerations for consent process

The informed consent process allowed respondents time to formulate their response about taking the survey. This recognized that when first approached, people may not feel comfortable declining to participate in the survey, especially when speaking to someone in a perceived position of authority.

All communications to providers included information about how The Improve Group and the Olmstead Implementation Office would protect respondents' privacy and rights

during and after the survey. The Improve Group recognized that service providers are asked to support the administration of multiple surveys throughout the year. The Improve Group worked directly with providers to minimize the burden of supporting the Olmstead Quality of Life Survey on staff time.

Outreach results

Table 2: Overview of survey outreach

	Baseline survey	First follow-up survey
Sample size	11,667	1,000
Phone calls made	33,823	3,720
Contacts made	Over 9,000	1,746
Consents received	2,409	534
Declines received	1,898	190

Conducting the survey

Survey structure

The Olmstead Quality of Life Survey includes four modules and a series of questions about assistive technology:

- Community integration and engagement
- Choice-making power
- Perceived quality of life
- Closest relationships
- Use of assistive technology

Although the survey was administered as a package, each module is designed to stand on its own. During the pilot, few respondents were able to complete the survey in 60 minutes. In addition, some respondents were only able to complete one module, often for reasons related to their disabilities. Because of this experience, it was determined to

be inappropriate to require respondents to respond to all four modules in order to consider surveys complete. As such, surveys were considered complete if 75 percent of any module was finished. During the baseline survey, 2,005 surveys were completed and 1,902 (95%) respondents completed all four modules of the survey and the assistive technology questions. For the follow-up survey, 497 (97%) respondents completed all four modules as well as the questions on assistive technology.

Demographic information

To reduce the burden on respondents and streamline the survey process, The Improve Group relied on state agency data for demographic data, disability types, and service setting.

Person-centered approach

Interviewers used person-centered approaches when scheduling and conducting surveys. This meant making the survey as comfortable and accessible as possible for all respondents in terms of survey format, scheduling, and conducting the survey.

Survey modes

Most survey interviews were administered in-person, with an average survey length of 45 minutes. Interviewers read the survey questions to the respondent and entered the responses via a tablet using a secure survey platform. Respondents were given the option to follow along during the survey by using a paper copy of the survey.

The person selected for the survey was intended to be the primary respondent to the survey. However, the respondent could choose a support person to help with the survey or to answer on their behalf. In some cases, the support person was selected by the guardian. Everyone who was present for the survey was asked to sign the consent form.

If possible, the respondent chose the location for the survey. Interview sites included people's homes, workplaces, provider offices, and a variety of public locations. A respondent's guardian, staff, or other support person could help choose the location. If the interview was scheduled at a place where the person receives services, The Improve Group worked with the provider to minimize the disruption to service delivery. In the event The Improve Group was unable to honor the respondent's first choice of location, an alternative location was selected.

Alternative modes

To accommodate the preferences and abilities of potential respondents, people were given the option to complete the survey by phone, videophone, or online. The pilot showed that offering multiple survey modes would likely boost response rates by allowing options that may be more convenient or comfortable for respondents. Some respondents chose the phone option; however, no respondents chose to take the survey via videophone or web.

Communication accommodations

The Improve Group provided reasonable accommodations to complete the survey as requested by the respondent or the support person. If a case manager, provider, or guardian was involved in scheduling interviews, The Improve Group asked if accommodations were needed for the person to participate in the survey. The Improve Group was able to honor all requests for accommodations during the baseline and follow-up surveys.

Accommodations provided include:

- Advance copies of survey materials including consent forms and the survey tool.
- American Sign Language (ASL) interpreters.
- Large print text for respondents who were blind or visually impaired.
- Screen reader-compatible surveys.
- Individuals who were nonverbal or had limited expressive communication were able to use any communication supports needed to respond to the survey. Examples include: personal sign language, technology, or cards to communicate. If needed, The Improve Group worked with the person's staff or another support person to assist with participation in the survey.
- The Improve Group worked with specialized interpreters to accommodate deafblind respondents. If possible, The Improve Group arranged for the respondent to be able to work with a qualified interpreter who is knowledgeable about that individual's communication preferences.
- For non-English speaking respondents, The Improve Group provided interpretation services in the respondent's language.
- While the survey tool itself was not translated into other languages, the consent form and other communication materials could be requested in several languages including Spanish, Somali, and Hmong.

- The Improve Group worked with multiple interpretation providers to minimize barriers to scheduling the interviews.

Barriers to completion

The Olmstead Quality of Life Survey tool was designed to be administered to people of all disability types, and accommodations were provided to make it as easy as possible for respondents to complete the survey. However, it was not possible to remove all the barriers people faced in completing the survey.

The following are examples of the primary barriers respondents faced to completing the survey:

Survey length

On average, the survey took 45 minutes to complete. The survey length was a barrier for respondents with limited attention spans or who struggle to sit still for an extended period. In addition, interviewers reported that some respondents found the survey cognitively exhausting. If the interviewer observed that the respondent was struggling to concentrate or showed signs of fatigue, the interviewer asked the respondent and/or support person if the respondent wanted to continue the survey. At this point, the respondent could choose to take a break or end the interview. If the respondent wanted to continue, the interviewer would encourage the respondent to move around the room or take a short activity break before returning to the survey. In addition, the respondent or the support person could request a break or end the survey at any time.

Survey content

Some respondents were not comfortable answering one or more questions on the survey. If the respondent was uncomfortable with the survey content, the interviewer would ask the person if he or she wanted to skip the question, skip to the next module, or end the survey.

If the respondent did not understand the questions, the interviewer would ask if there was someone the person would like to have assist with the survey. If there was not a support person available and the interviewer did not feel comfortable continuing the survey without support, the interviewer would end the survey.

Interruptions to schedule

Some respondents 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 Improve Group 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 the support person to integrate the survey into regular activities.

Communication needs

The Improve Group attempted to provide reasonable accommodations for respondents, including providing interpreters and supporting the use of assistive technology. In the event The Improve Group was unable to honor the request in time for the scheduled survey 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. Sometimes, inaccurate or outdated contact information made survey outreach challenging. At times, The Improve Group was unable to obtain updated provider or guardian contact information for potential respondents. If updated contact information was not available, the person was removed from outreach.

Training of interviewers

During the baseline survey, The Improve Group hired interviewers with diverse backgrounds and from a range of geographic regions around the state. The hiring process was designed to ensure that the interviewers reflected the focus population in many ways. When recruiting potential applicants, The Improve Group partnered with disability service providers to recruit survey interviewers who have personal experiences with disability. This included people who identify as having a disability, people with experience in disability services, and people with significant personal experience with individuals who have a disability. All the follow-up survey interviewers had also worked on the baseline survey.

All project staff members, including interviewers and contractors, are required to complete annual interviewer training, as was required by the IRB-approved survey administration plan. The baseline training consisted of 40 hours of self-guided trainings, presentations, group discussions, and supportive shadowing.

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 the Olmstead Implementation Office.

Reported incidents of abuse and neglect

Due to the vulnerability of the focus population, interviewers erred on the side of reporting possible abuse or neglect. That means some cases reported by The Improve Group had already been investigated or resolved. In the baseline survey, interviewers reported 15 cases of possible abuse or neglect. For the follow-up survey, interviewers reported one case of possible abuse or neglect.

Olmstead Quality of Life Survey: First Follow-up – 2018 Results

Results in this report apply only to Minnesotans with disabilities who receive services in potentially segregated settings. The results cannot be generalized to all people with disabilities in Minnesota.

Respondents were asked about the same five topics in the baseline and follow-up surveys:

- Community integration and engagement
- Choice-making power
- Perceived quality of life
- Closest relationships
- Use of assistive technology

Interviewers recorded respondents' perceptions of their own lives, which aligns with the survey's person-centered approach. As such, it is important to note that all results are self-reported. Demographic data such as age, race, and ethnicity were collected through agency records.

Demographic breakdown

The tables below compare survey respondents in the baseline sample, in the follow-up sample, and in the population eligible to take the survey as of July 2016. The eligible population refers to people who could have been selected to participate in the survey because they were authorized to receive services in potentially segregated settings. The baseline and follow-up survey respondents were representative of Minnesotans with disabilities who receive services in potentially segregated settings.

Table 3: Comparison of eligible population, survey respondents in baseline sample, and survey respondents in follow-up sample by gender

Respondent gender	Eligible population	Baseline respondents	Follow-up respondents
Female	41.9%	43.1%	43.1%
Male	56.2%	54.9%	54.4%
Unknown (not reported)	1.9%	2.0%	2.5%
Total	100.0%	100.0%	100.0%

Participation rates were not significantly different based on gender in the baseline sample or in the follow-up sample. If gender is “unknown,” the individual’s gender was not reported in DHS or DEED data.

Table 4: Comparison of age of eligible population, survey respondents in baseline sample, and survey respondents in follow-up sample

Respondent age	Youngest age	Oldest age	Average age
Eligible population	7	102	47
Baseline respondents	9	90	47
Follow-up respondents	13	79	46

When respondents were selected to participate in the survey, the average age of survey respondents at baseline was 47 and the average age in the follow-up sample was 46. The sample included children who were living in potentially segregated settings. Surveys with minors were completed by proxy with the guardian, the guardian’s appointee, or with the guardian present. The range of ages of follow-up respondents was slightly smaller (13 to 79 years old) than the range of ages of baseline respondents (9 to 90 years old).

Table 5: Comparison of eligible population, survey respondents in baseline sample, and survey respondents in follow-up sample by race

Respondent race	Eligible population	Baseline respondents	Follow-up respondents
Asian	1.7%	1.5%	1.4%
Black	6.9%	4.3%	4.1%
American Indian	2.2%	2.5%	2.1%
White	85.1%	85.9%	86.7%
Two or more races	0.3%	0.2%	0.2%
Other or unknown	3.8%	5.5%	5.5%
Total	100.0%	99.9%	100.0%

Relative to the eligible population, respondent rates were similar in the baseline sample and in the follow-up sample. Race was “unknown” if it was listed as such in agency data or if race was not provided. While the survey respondents are representative of people receiving services in potentially segregated settings, the eligible population does not completely mirror statewide demographics. The eligible population has a lower proportion of people who identify as Asian or who identify as two or more races than the state overall. In addition, the eligible population has a higher proportion of people who identify as American Indian than the state overall.

Table 6: Comparison of eligible population, survey respondents in baseline sample, and survey respondents in follow-up sample by ethnicity

Respondent ethnicity	Eligible population	Baseline respondents	Follow-up respondents
Hispanic/Latino	1.4%	1.4%	0.6%
Not Hispanic/Latino	88.3%	88.3%	94.7%
Unknown	10.3%	10.3%	4.7%
Total	100.0%	100.0%	100.0%

Participation rates in the follow-up sample were lower for individuals who identify as Hispanic/Latino and individuals whose ethnicity is unknown compared to the baseline sample and the eligible population.

Geographic breakdown

Table 7: Comparison of eligible population, survey respondents in baseline sample, and survey respondents in follow-up sample by region of service

Region of service	Eligible population	Baseline respondents	Follow-up respondents
Central MN	12.3%	15.8%	15.5%
Metro MN	45.0%	34.2%	34.6%
Northeast MN	11.5%	11.5%	11.2%
Northwest MN	9.2%	13.0%	13.5%
Southeast MN	9.5%	12.1%	12.3%
Southwest MN	12.1%	13.5%	12.9%
Total	99.6%	100.0%	100.0%

Participation rates were lower in the seven-county metropolitan area than in the rest of the state in the baseline sample and in the follow-up sample. The regions were based on where the person received services as of July 2016 and have not been updated to reflect any potential location changes (i.e., respondent moved to a different region) at the time of the baseline and follow-up survey.

Breakdown by service setting

Table 8: Comparison of eligible population, survey respondents in baseline sample, and survey respondents in follow-up sample by service setting

Service setting	Eligible population	Baseline respondents	Follow-up respondents
Adult Foster Care	58.6%	73.1%	72.0%
Boarding Care	0.3%	0.3%	0.2%
Board and Lodging	4.3%	3.6%	3.9%
Center Based Employment	5.0%	4.5%	4.7%
Day Training & Habilitation	37.4%	46.7%	46.8%
Intermediate Care Facilities for Persons with Developmental Disabilities	6.5%	5.3%	4.7%
Nursing Facilities and Customized Living	19.8%	13.0%	11.7%
Supervised Living Facilities	0.5%	0.5%	0.2%

Note: Percentages do not equal 100 due to overlap between settings.

Respondents in Adult Foster Care and Day Training & Habilitation had higher participation rates relative to the eligible population, whereas respondents in Nursing Facilities had lower participation both in the baseline sample and the follow-up sample.

Survey module scores

Community integration and engagement: integrative activities scale

Outing interactions is a measure based on the number of outings and the average interaction rating for those outings. For ease of interpretation, the score is converted to a 100-point scale based on the individual's average interaction rating for each outing type. A higher score (closer to 100) indicates more interaction with community members across outing types.

Outing interaction scores apply to Minnesotans with disabilities who received services in potentially segregated settings.

Table 9: Outing interactions score in baseline sample and in follow-up sample

Study	Respondents with an outing interactions score	Outing interactions score
Baseline	1,936	37.7
Follow-up	497	36.5

The average score of 37.7 in the baseline sample and 36.5 in the follow-up sample may show people are not interacting much with other community members during their outings. Results showed that there was not a significant difference in respondents' reports of outing interactions over time. This suggests that respondents were interacting with their community members at similar levels at the time of the baseline and follow-up surveys.

Decision control inventory (choice-making)

Respondents reported who made decisions in their life pertaining to food, clothes, sleep, recreation, choice of support agencies, and more. This measure provides some understanding to the role paid staff and unpaid allies have in day-to-day decision-making. Paid staff includes people who are paid to provide services or supports in any setting. Public guardians are considered paid staff. Unpaid allies include relatives, friends, and advocates. For example, respondents reported whether paid staff, unpaid allies, or they themselves decided what they could do with their relaxation time. If necessary, interviewers asked clarifying questions to determine if the people making decisions were paid staff or unpaid allies.

A higher score (closer to 100) on the overall decision control inventory scale indicates a higher level of choice-making power for the individual. A very low score indicates more decisions are being made by others for that individual. Previous Center for Outcome

Analysis studies have demonstrated that all the items on this scale are related to the underlying concept of freedom to make choices without being controlled by providers.

Scores were calculated for individuals who responded to at least 25 of the 34 items on the decision control inventory scale. Individual scores were averaged for an overall score. The score was then converted to a 100-point scale for ease of interpretation.

Table 10: Decision control inventory score in baseline sample and in follow-up sample

Study	Respondents with decision control inventory score	Decision control inventory score
Baseline	1,942	66.2
Follow-up	504	67.6

Minnesota's average baseline score (66.2) and average follow-up score (67.6) indicate respondents have a moderate amount of choice-making power. Results showed that there was not a significant difference in respondents' report of decision control over time. This suggests that respondents had a similar level of choice-making power at the time of the baseline and follow-up surveys.

Quality of life inventory

The quality of life inventory captures the respondent's perspective of his or her quality of life. Individuals reported on the quality of their life in 14 different areas including health, happiness, comfort, and overall quality of life. For example, individuals reported whether their privacy was good, bad, or somewhere in between.

Converting the individual quality of life items into a score out of 100 is helpful for understanding the overall results. The score was 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 of the 14 items. A higher score (closer to 100) indicates higher perceived quality of life.

Table 11: Quality of life score in baseline sample and in follow-up sample

Study	Respondents with a quality of life score	Quality of life score
Baseline	1,904	76.6
Follow-up	501	77.4

Minnesota's average baseline score (76.6) and average follow-up score (77.4) indicate respondents perceived their quality of life to be good on a scale of very bad to very

good. Results showed that there was not a significant difference in respondents' report of quality of life over time. This suggests that respondents perceived a similar level of quality of life at the time of the baseline and follow-up surveys.

Closest relationships inventory

Survey interviewers asked respondents about their closest relationships. This included the type of relationship, e.g. relative, staff, housemate, co-worker, et cetera. A "close relationship" could also be defined by the respondent. Respondents were asked about their five closest relationships; if the respondent did not have any close relationships that was noted as well.

Table 12: Number of close relationships reported in baseline sample and in follow-up sample

Number of relationships reported	Number responding at baseline	Percent of respondents at baseline	Number responding at follow-up	Percent of respondents at follow-up
1	96	5.0%	20	4.0%
2	127	6.7%	50	9.9%
3	227	11.9%	66	13.1%
4	238	12.5%	80	15.8%
5	1,171	61.6%	250	49.5%
None provided	43	2.3%	39	7.7%
Totals	1,902	100.0%	505	100.0%

Nearly all respondents named at least one close relationship. Nearly two-thirds of baseline respondents (62 percent) and half of follow-up respondents (50 percent) listed five close relationships. Forty-three respondents did not name a close relationship in the baseline survey and 39 respondents did not name a close relationship in the follow-up survey. The remainder of responses with no relationships are due to respondents ending the survey before the closest relationships module could be completed. Individuals who could not complete this module were not included when calculating total possible relationships. Overall, respondents in the follow-up sample reported a lower number of relationships.

Table 13: Average number of close relationships in baseline sample and follow-up sample

Study	Number who responded	Average number of close relationships
Baseline	1,902	4.12
Follow-up	505	3.74

On average, survey respondents in the baseline sample and in the follow-up sample reported four close relationships on a scale from 0 to 5. Results showed that the sample of respondents in the follow-up sample reported fewer close relationships than the baseline sample.

Table 14: Closest relationships and relationship types reported at baseline and follow-up

Relationship type	Number reporting relationship type at baseline	Percent at baseline	Number reporting relationship type at follow-up	Percent at follow-up
Co-worker or schoolmate	193	1.7%	43	2.3%
Housemate (not family or significant other)	322	4.9%	80	4.2%
Merchant	20	0.1%	1	0.1%
Neighbor	82	0.6%	14	0.7%
Other paid staff (case manager, nurse, etc.)	687	3.2%	68	3.6%
Relative (includes spouse)	3,661	51.8%	937	49.5%
Staff of day program, school, or job	480	4.5%	75	4.0%
Staff of home	1,422	18.2%	385	20.4%
Unpaid friend, not relative	2,947	15.0%	288	15.2%

Relatives were the most commonly reported relationship type in the baseline sample (52 percent) and in the follow-up sample (50 percent), followed by staff of home in the baseline sample (18 percent) and in the follow-up sample (20 percent). Compared to studies in other states, which typically find rates of unpaid friendships ranging from 0 to

15 percent,⁷ respondents reported a high number of relationships with unpaid friends in both the baseline and follow-up samples (15 percent).

Assistive technology

Survey interviewers also asked respondents 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 of Minnesota 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 Center for Outcome Analysis studies. Assistive technology responses apply to Minnesotans with disabilities who receive services in potentially segregated settings.

Table 15: Respondents who use assistive technology in baseline sample and in follow-up sample

Response	Number responding at baseline	Percent of respondents at baseline	Number responding at follow-up	Percent of respondents at follow-up
No	786	41.0%	213	42.3%
No, but I need help doing certain tasks and would like to use assistive technology	37	1.9%	8	1.6%
Yes, I have used it in the past	21	1.1%	7	1.4%
Yes, I use it now	1,071	55.9%	275	54.7%
Total	1,915	99.9%	503	100.0%

More than half of respondents reported using assistive technology in both the baseline and follow-up samples. Only 1.9 percent of respondents in the baseline sample and 1.6 percent of respondents in the follow-up sample reported that they were not currently using assistive technology but would like to use it in the future.

⁷ Center for Outcome Analysis. (2017). Service Excellence Summary: Baseline Data Summary for Briefing.

Table 16: “How much difference has assistive technology made in increasing independence, productivity, and community integration?” in the baseline sample and in the follow-up sample

Response	Number responding at baseline	Percent of respondents at baseline	Number responding at follow-up	Percent of respondents at follow-up
A lot	661	62.1%	162	59.3%
Some	208	19.5%	64	23.4%
A little	116	10.9%	31	11.4%
None	80	7.5%	16	5.9%
Total	1,065	100.0%	273	100.0%

Of the people who report they were using assistive technology, most respondents in the baseline sample (62 percent) and in the follow-up sample (60 percent) reported that assistive technology had increased their independence, productivity, and community integration “a lot.” Only 8 percent of people in the baseline sample and 6 percent of people in the follow-up sample said it did not have an impact on independence, productivity, and community integration.

Table 17: “How much has your use of assistive technology decreased your need for help from another person?” in the baseline sample and in the follow-up sample

Response	Number responding at baseline	Percent of respondents at baseline	Number responding at follow-up	Percent of respondents at follow-up
A lot	371	34.9%	103	38.0%
Some	253	23.8%	73	26.9%
A little	201	18.9%	52	19.2%
None	238	22.4%	43	15.9%
Total	1,063	100.0%	271	100.0%

Of the people who report they are using assistive technology, 35 percent in the baseline sample and 38 percent in the follow-up sample said it decreases their need for help from another person “some” or “a lot.” However, 22 percent in the baseline sample and 16 percent in the follow-up sample said that assistive technology does not decrease their need for help at all.

Reasons people said they do not use assistive technology were similar in the baseline and follow-up samples. Respondents reported the following reasons: provider or guardian did not support them using assistive technology; they could not afford it; they lacked knowledge or training about how to use the technology; and they lacked

knowledge about the availability of assistive technology. A few people mentioned that they do not want to use assistive technology.

Respondent characteristics associated with overall quality of life

Results in this report apply only to Minnesotans with disabilities who receive services in potentially segregated settings. Results cannot be generalized to all people with disabilities in Minnesota.

Methodological approach

The Olmstead Quality of Life Survey Advisory Group chose to use a statistical technique known as linear regression to determine how respondent demographics, setting characteristics, and other important characteristics were related to each of the four module scores: outing interactions, decision control (choice-making), perceived quality of life, and closest relationships.

Linear regression is a commonly used type of analysis that is useful in identifying characteristics strongly associated with a specified outcome. For example, if a person had data on housing characteristics and wanted to know what characteristics were associated with housing price, running a linear regression would help to determine what specific variables were strongly associated with price. In relation to the Olmstead Quality of Life Survey, linear regression can point out respondent characteristics that are strongly associated with quality of life. In this case, linear regression can help identify the areas that could have the greatest impact on improving overall quality of life.

The analysis had two basic steps. The first step was to examine characteristics related to the module scores using the full baseline sample of 2,005 respondents. The second step examined whether these same characteristics were related to the module scores at follow-up using the 511 respondents who participated in both the baseline and follow-up surveys.

The regression models and results apply to only Minnesotans with disabilities who receive services in potentially segregated settings.

Characteristics included in models

Based on previous research and input from the Olmstead Quality of Life Survey Advisory Group, several important characteristics thought to be related to each of the module

scores (outing interactions, choice-making power, perceived quality of life, and number of close relationships) were considered. A list of all the characteristics included in the regression models and a description of each are provided below.

Table 18: Description of characteristics included in regression models

Characteristic	Description
Demographics	Respondent demographic information including gender, age, race, and region of service are included in the demographic breakdown section of this report. Demographic data was provided by DHS and DEED.
Guardianship status	Records from DHS and DEED were used to indicate whether respondents had a guardian at the time of the baseline survey. For respondents receiving services through DHS, guardianship data includes the type of guardian, such as public or private.
Cost of services	DHS records were used to calculate the average cost of services per day for each respondent.
Residential setting	Residential settings are services that include housing and other related services. Residential settings include: adult foster care, boarding care, board and lodging, intermediate care facilities for persons with developmental disabilities, nursing facilities and customized living, and supervised living facilities. If respondents were authorized to receive services in any of these settings, they were marked as receiving residential services.
Day setting	Day settings are services that are provided during the day. These services often offer employment, occupational activities, or formal enrichment activities. The two-day settings included in the Olmstead Quality of Life Survey are center-based employment and day training and habilitation. If respondents were authorized to receive services in either of these settings, they were marked as receiving day services.
Waiver type	Minnesotans with disabilities or chronic illnesses who need certain levels of care may qualify for home and community-based waiver programs. The majority of survey respondents receive waived services through the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), or Brain Injury (BI) waivers.
Weekly earnings	Average weekly earnings were based on self-reported data. Respondents who participate in day activities where they can earn income were asked to estimate their weekly income. These day activities include: self-employment, competitive employment, supported employment, enclave or job crew, sheltered employment, vocational programs, and day training and habilitation.

Characteristic	Description
Day integration	Respondents were asked about their level of integration with people who do not have disabilities during their day activities (e.g., employment, education, and volunteer work). This day integration scale captures how many hours each respondent spends in each of these activities and how integrated they felt while engaging in these activities.
Total monthly outings	Respondents reported on the number of times they went on a variety of outings over the course of a month. The total number of outings is an overall count of outings of all types in the previous four weeks.
Number of different outing types reported	Respondents reported the types of outings they participated in over the previous four weeks. Outing types include: visits with friends, relatives, or neighbors; and trips to a grocery store, restaurant, place of worship, mall, or sports event.
Average group size on outings	Respondents were asked how many people went with them on each outing. If the respondent reported a range, the interviewer recorded the average group size. The average group size represents the average group size for all reported outings. Average group size included the respondent.
Adaptive behaviors	A scale was created to assess respondents' adaptive behaviors. The adaptive behaviors scale was created using items from the Long Term Care and Developmental Disabilities screening documents. This scale is a measure of respondents' independent functioning and helps to account for differences in level of need. Example items included how well a person is able to manage dressing, grooming activities, communication, mobility, and transferring.

Regression model findings in baseline and follow-up samples

Using regression models, several characteristics were found to be significantly associated with the module scores in the baseline and follow-up samples; these are provided in Tables 19 – 22.

The regression results suggest that these characteristics are areas that have a link to the overall quality of life in potentially segregated settings. However, further research is required to determine exactly how they are associated with overall quality of life.

Table 19: Characteristics associated with respondents' outing interactions in baseline sample and in follow-up sample

Baseline	Follow-up
Minnesota region	Outing interaction score reported at baseline
Total monthly outings	
Number of different types of outings	
Quality of life	
Number of close relationships	

Minnesota region, total monthly outings, number of different outing types, quality of life, and the number of close relationships were associated with respondents' outing interaction score in the baseline sample. These results indicate there is a relationship between these characteristics and respondents' outing interaction scores at baseline.

Only the baseline outing interaction score was associated with respondent's outing interaction score in the follow-up sample. These results indicate a respondent's outing interaction score in the baseline sample is associated with the respondent's outing interactions score in the follow-up sample.

Additional analysis and detailed interpretation of these findings will be presented in the January report.

Table 20: Characteristics associated with respondents' decision control (choice-making) in the baseline sample and in the follow-up sample

Baseline	Follow-up
Minnesota region	Residential setting
Guardianship status	Day setting
Cost of services	Decision control (choice-making) score reported at baseline
Residential setting	
Day setting	
Weekly earnings	
Total monthly outings	
Average group size on outings	
Adaptive behaviors	
Quality of life	

Minnesota region, guardianship status, cost of services, residential and day setting, weekly earnings, total monthly outings, average group size on outings, adaptive behaviors, and quality of life were associated with respondents' decision control score in the baseline sample. These results indicate there is a relationship between these characteristics and the respondents' decision control inventory scores at baseline.

Residential setting, day setting, and the baseline decision control score were associated with respondents' decision control score in the follow-up sample. These results indicate there is a relationship between these characteristics and the level of choice-making respondents reported on the follow-up survey.

Additional analysis and detailed interpretation of these findings will be presented in the January report.

Table 21: Characteristics associated with respondents' quality of life in the baseline sample and in the follow-up sample

Baseline	Follow-up
Respondent gender	Respondent gender
Cost of services	Minnesota region
Waiver type	Cost of services
Weekly earnings	Quality of life score reported at baseline
Day integration	
Number of different types of outings	
Outing interactions	
Decision control	
Number of close relationships	

Respondent gender, cost of services, waiver type, weekly earnings, day integration, number of different types of outings, outing interactions, choice-making, and number of close relationships were associated with respondents' quality of life score in the baseline sample. These results indicate there is a relationship between these characteristics and the respondents' quality of life scores at baseline.

Respondent gender, Minnesota region, cost of services, and the quality of life score at baseline were associated with respondents' quality of life score in the follow-up sample. These results indicate there is a relationship between these characteristics and respondents' quality of life scores on the follow-up survey.

Additional analysis and detailed interpretation of these findings will be presented in the January report.

Table 22: Characteristics associated with respondents' number of close relationships in the baseline sample and in the follow-up sample

Baseline	Follow-up
Respondent race	Respondent age
Minnesota region	Respondent gender
Guardianship status	Minnesota region
Weekly earnings	Waiver type
Number of different types of outings	Quality of life
Average group size on outings	Number of close relationships reported at baseline
Outing interactions	
Quality of life	

Respondent race, Minnesota region, guardianship status, weekly earnings, number of different types of outings, average group size on outings, outing interactions, and quality of life were associated with the number of close relationships respondents reported in the baseline sample. These results indicate there is a relationship between these characteristics and the number of close relationships respondents reported at baseline.

Respondent age, respondent gender, Minnesota region, waiver type, quality of life, and the number of close relationships reported in the baseline sample were associated with the number of close relationships respondents reported in the follow-up sample.

Additional analysis and detailed interpretation of these findings will be presented in the January report.

Summary of findings

Examination of the demographics characteristics showed that the baseline and follow-up samples looked the same in terms of gender, age, region of service, and setting type. The baseline and follow-up samples appeared to be representative of the eligible population with minimal differences present. In total, the Olmstead Quality of Life Survey methodology is representative of Minnesotans with disabilities receiving services in potentially segregated settings.

In terms of changes from the baseline survey to the follow-up survey, there were no significant changes for the outing interactions, choice-making, and perceived quality of life module scores. While there were no significant changes in survey scores, this is not entirely unexpected. Past studies by the developer of the survey showed that noticeable change can only be expected in the short term (about one year) when a large transition has occurred, such as moving from institution to community. And even in these studies, changes become statistically significant only at approximately two years. Given that a large transition like de-institutionalization did not occur during the period of study and the relatively short amount of time between the baseline and follow-up surveys, it is not unreasonable to expect little to no change in survey scores.

The regression models comparing respondent characteristics to overall quality of life confirmed that the four survey modules are all measuring different facets of quality of life. These models showed that all the module scores (outing interactions, decision control, perceived quality of life, and number of close relationships) are related to one another. This helps validate that these characteristics are important constructs of an individual's quality of life.

The models identified several key characteristics that were associated with the module scores in the baseline sample and in the follow-up sample. These associations are complex and should not be interpreted as causal. Additional analysis is needed in order to better understand the impact of these characteristics on overall quality of life. The preliminary results indicate the following characteristics are associated with overall quality of life:

- **Region:** The regression models indicate there is an association between region of services and overall quality of life. Most of the differences occurred between the metro region and greater Minnesota. The results suggest there are measurable differences between rural and urban communities that affect the quality of life of Minnesotans with disabilities who receive services in potentially

segregated settings. Additional analysis is needed to better understand the direction and impact of these differences.

- Average daily cost of services: On average, higher average daily cost of services is associated with lower quality of life. However, this finding does not suggest that lowering the cost of services for all service recipients will lead to higher quality of life.
- Service type: Service type, in addition to service setting, does have an impact on overall quality of life. On average, both day and residential services were associated with lower decision control inventory scores. Service type is not associated with the other module scores.
- Guardianship status: Guardianship status is related to overall quality of life. On average, respondents with a public guardian have lower quality of life scores than respondents with a private guardian. Respondents who do not have a legal guardian have higher decision control inventory scores and fewer close relationships than respondents with a legal guardian.
- Outing interaction scores: On average, respondents with higher outing interactions scores also report higher overall quality of life. This indicates there is a relationship between how much respondents interact with community members outside the home and overall quality of life.

Conclusion and next steps

This report is intended to be an overview of the Olmstead Quality of Life Survey: First Follow-up – 2018 results. It serves as the first set of data points that can be compared to the baseline results in the attempt to detect and monitor change in quality of life, over time, for Minnesotans with disabilities who receive services in potentially segregated settings. While there were no significant changes noted in overall quality of life in this first follow-up, the longitudinal nature of the survey is critical to continue to monitor progress on Minnesota's Olmstead Plan implementation. The initial analysis of follow-up survey results has shown that the survey can identify important characteristics affecting overall quality of life and can effectively measure change.

A second follow-up survey will be valuable to continue to monitor the state's progress in improving quality of life for the focus population. A second follow-up survey would also allow more opportunity to confirm quality of life predictor characteristics that have been identified in this report. As this first follow-up survey showed, a one-year time span between surveys may be too short. Therefore, to increase the chances of seeing significant changes in module scores between the baseline survey and the second follow-up survey, it is recommended that the second follow-up survey begin no earlier than summer 2020.

As for immediate next steps, a detailed technical analysis report describing the relationships outlined in the regression models and survey results by region, service setting, and other individual characteristics will be shared at the January 2019 Olmstead Subcabinet meeting. The more detailed regression results will further explain how each characteristic is associated with survey scores, the strength of the association, and identify future areas of research that will be important to consider.