Minnesota Olmstead Subcabinet

Quarterly Report on Olmstead Plan Measurable Goals

REPORTING PERIOD

Data acquired through April 30, 2019

DATE APPROVED BY SUBCABINET

May 28, 2019

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I. PURPOSE OF REPORT

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

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

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

This quarterly report includes data acquired through April 30, 2019. Progress on each measurable goal will be reported quarterly, semi-annually, or annually. Reports are reviewed and approved by the Olmstead Subcabinet. After reports are approved they are made available to the public on the Olmstead Plan website at Mn.gov/Olmstead. [i]

This quarterly report also includes Olmstead Implementation Office (OIO) compliance summary reports on the status of workplans.

EXECUTIVE SUMMARY

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

Status of Goals – May 2019 Quarterly Report	Number of Goals
Met annual goal	2
On track to meet annual goal	3
Not on track to meet annual goal	3
Did not meet annual goal	0
In Process	6
Goals Reported	**14**

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

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

- During this quarter, 48 individuals left ICF/DD programs to more integrated settings. After one quarter, 67% of the annual goal of 72 has been achieved. (Transition Services Goal One A)
- During this quarter, 233 individuals with disabilities under age 65 in a nursing facility longer than 90 days moved to more integrated settings. After one quarter, 31% of the annual goal of 740 has been achieved. (Transition Services Goal One B)
- During this quarter, 322 individuals moved from other segregated settings to more integrated settings. After one quarter, 64% of the annual goal of 500 has been achieved. (Transition Services Goal One C)

- The utilization of the Person Centered Protocols has continued to improve during this quarter as indicated by the presence of eight person centered elements in case files reviewed. Performance improved over last quarter on all eight elements. Performance on six of the eight elements was at least 90% and five of the eight were above 95%. (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 71% of individuals were approved for funding within 45 days. Another 25% had funding approved after 45 days.

Increasing system capacity and options for integration

- The number of transit service hours in Greater Minnesota increased by 169,316 over baseline during the last year.

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 Three to reduce the number of reports of emergency use of mechanical restraints with approved individuals.

II. MOVEMENT FROM SEGREGATED TO INTEGRATED SETTINGS

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

QUARTERLY SUMMARY OF MOVEMENT FROM SEGREGATED TO INTEGRATED

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

Net number of individuals who moved from segregated to integrated settings during the reporting period:		
Setting	**Reporting period**	**Number moved**
• Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	July – Sept 2018	48
• Nursing Facilities (individuals under age 65 in facility > 90 days)	July – Sept 2018	233
• Other segregated settings	July – Sept 2018	322
• Anoka Metro Regional Treatment Center (AMRTC)	Jan – Mar 2019	22
• Minnesota Security Hospital (MSH)	Jan – Mar 2019	24
Net number who moved from segregated to integrated settings		**649**

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

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

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

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

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

2019 goal

- For the year ending June 30, 2019 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 goal is **on track** to meet the 2019 goal of 72.

Time period	Total number of individuals leaving	Transfers[iv] (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	138	18	62	**58**
2016 Annual (July 2015 – June 2016)	180	27	72	**81**
2017 Annual (July 2016 – June 2017)	263	25	56	**182**
2018 Annual (July 2017 – June 2018)	216	15	51	**150**
2019 Quarter 1 (July – September 2018)	65	4	13	**48**

ANALYSIS OF DATA:
From July – September 2018, the number of people who moved from an ICF/DD to a more integrated setting was 48. This is 38 more people than in the previous quarter. After one quarter, the number is 67% of the annual goal of 72. The goal is on track.

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

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

DHS continues to work with private providers and Minnesota State Operated Community Services (MSOCS) that have expressed interest in voluntary closure of ICFs/DD. Providers are working to develop service delivery models that better reflect a community–integrated approach requested by people seeking services. A total of 12 out of 15 MSOCS ICFs/DD converted since January 2017 for a reduction of 72 state-operated ICF/DD beds. Three MSOCS ICFs/DD continue to serve 13 adults. Hennepin County is working closely with the people being served and their families to identify new providers to provide services to those individuals. No timeline for conversion of these homes has been confirmed.

For the period July through December 2018, 96 ICF/DD beds from 14 sites were closed. Of these, 57 were converted to small foster care settings (group homes) serving 4 or fewer people in approximately 18 sites. The remainder of the beds appear to have been decertified due to long term vacancy. The total number of ICF/DD beds decertified during 2018 was 138.

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

2019 goal

- For the year ending June 30, 2019, 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 goal is **on track** to meet the 2019 goal of 750.

Time period	Total number of individuals leaving	Transfers (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (July 2014 – June 2015)	1,043	70	224	**749**
2016 Annual (July 2015 – June 2016)	1,018	91	198	**729**
2017 Annual (July 2016 – June 2017)	1,097	77	196	**824**
2018 Annual (July 2017 – June 2018)	1,114	87	197	**830**
2019 Quarter 1 (July – September 2018)	310	28	49	**233**

ANALYSIS OF DATA:
From July – September 2018, the number of people under 65 in a nursing facility for more than 90 days who moved to a more integrated setting was 233. This is one more person than in the previous quarter. After one quarter, the number is 31% of the annual goal of 750. The goal is on track.

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

2019 goal

- For the year ending June 30, 2019, 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 goal is **on track** to meet the 2019 goal of 500.

		Receiving Medical Assistance (MA)			
Time period	**Total moves**	**Moved to more integrated setting**	**Moved to congregate setting**	**Not receiving residential services**	**No longer on MA**
2015 Annual (July 14 – June 15)	5,703	**1,137 (19.9%)**	502 (8.8%)	3,805 (66.7%)	259 (4.6%)
2016 Annual (July 15 – June 16)	5,603	**1,051 (18.8%)**	437 (7.8%)	3,692 (65.9%)	423 (7.5%)
2017 Annual (July 16 – June 17)	5,504	**1,054 (19.2%)**	492 (8.9%)	3,466 (63.0%)	492 (8.9%)
2018 Annual (July 17 – June 18)	5,967	**1,188 (19.9%)**	516 (8.7%)	3,737(62.6%)	526 (8.8%)
2019 Quarter 1 (July – Sept 2018)	1,585	**322 (20.3%)**	123 (7.8%)	987 (62.3%)	153 (9.6%)

ANALYSIS OF DATA:
From July – September 2018, of the 1,585 individuals moving from segregated housing, 322 individuals (20.3%) moved to a more integrated setting. After one quarter, the number is 64% of the annual goal of 500. The goal is on track.

COMMENT ON PERFORMANCE:
During the quarter, there were significantly more individuals who moved to more integrated settings (20.3%) than who moved to congregate settings (7.8%). This analysis also illustrates the number of individuals who are no longer on MA and who are not receiving residential services as defined below.

The data indicates that a large percentage (62.3%) 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).

2019 goal

- By June 30, 2019, the percent of people at AMRTC awaiting discharge will be reduced to **≤ 30%**

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. [1]

RESULTS:
This goal is **not on track** to meet the 2019 goal of ≤ 30%.

Time period	Percent awaiting discharge (daily average)	
2016 Annual (July 2015 – June 2016)	Daily Average = 42.5%[2]	
	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 Quarter 1 (July – September 2018)	**50.9%**	27.7%
2019 Quarter 2 (October – December 2018)	**35.3%**	41.6%
2019 Quarter 3 (January – March 2019)	**34.8%**	23.9%

ANALYSIS OF DATA:
From January – March 2019, 34.8% of those under mental health commitment at AMTRC no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting. This is a slight decrease from 35.3% in the previous quarter. The average of the first three quarters is 40.3%. Although the goal is moving in the right direction, it is not on track to meet the annual goal of 30%.

From January – March 2019, 11 individuals at AMRTC under mental health commitment left and moved to an integrated setting. The table below provides information about those individuals who left AMRTC. It includes the number of individuals under mental health commitment and those who were civilly committed after being found incompetent on a felony or gross misdemeanor charge who moved to integrated settings.

[1] The baseline included individuals at AMRTC under mental health commitment and individuals committed after being found incompetent on a felony or gross misdemeanor charge (restore to competency).
[2] The 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 separately for the two categories.

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
2017 Annual (July 2016 – June 2017)	267	155	2	**110**	**54**	56
2018 Annual (July 2017 – June 2018)	274	197	0	**77**	**46**	31
2019 Quarter 1 (July – Sept 2018)	71	51	0	**20**	**8**	12
2019 Quarter 2 (Oct –Dec 2018)	76	56	1	**19**	**11**	8
2019 Quarter 3 (Jan – March 2018)	84	62	0	**22**	**11**	11

COMMENT ON PERFORMANCE:
AMRTC continues to serve a large number of individuals who no longer need hospital level of care, including those under a mental health commitment and those who need competency restoration services. Those committed after a finding of incompetency, accounted for approximately 50% of AMRTC's census in this quarter.

During this quarter there was a higher percentage of individuals awaiting discharge under mental health commitment (34.8%) than for those who were civilly committed after being found incompetent (23.9%). The patient acuity and complexity of discharge planning increases as AMRTC admits more patients from community hospitals and other DHS sites.

There are currently proposals at the legislature to establish a Community Competency Restoration Task Force to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

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

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

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

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

- Improvements in the treatment and discharge planning processes 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.

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.

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.

2019 goal

- By December 31, 2019 the average monthly number of individuals leaving to a more integrated setting will increase to **≥ 10**

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:
This goal is **not on track** to meet the 2019 goal of **≥ 10**.

Time period	Total number of individuals leaving	Transfers [iv] (-)	Deaths (-)	Net moved to integrated setting
2015 Annual (Jan – Dec 2015)	188	107	8	73 Average = 6.1
2016 Annual (Jan – Dec 2016)	184	97	3	84 Average = 7.0
2017 Annual (Jan – Dec 2017)	199	114	9	76 Average = 6.3
2018 Annual (Jan – Dec 2018)	212	130	3	79 Average = 6.6
2019 Quarter 1 (Jan – March 2019)	58	32	2	**24** Average = **8.0**

ANALYSIS OF DATA:

During January – March 2019, the average monthly number of individuals leaving Forensic Services[3] to a more integrated setting was 8. The average number moving to an integrated setting decreased from 9.3 the previous quarter. This goal is not on track to meet the annual goal of at least 10 per month.

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

Time period	Type	Total moves	Transfers	Deaths	Moves to integrated
2015 Annual (January – December 2015)	Committed after finding of incompetency	99	67	1	31
	MI&D committed	66	24	7	35
	Other committed	23	16	0	7
	Total	**188**	**107**	**8**	**(Avg. 6.1) 73**
2016 Annual (January – December 2016)	Committed after finding of incompetency	93	62	0	31
	MI&D committed	69	23	3	43
	Other committed	25	15	0	10
	Total	**187**	**100**	**3**	**(Avg. 7.0) 84**
2017 Annual (January – December 2017)	Committed after finding of incompetency	133	94	2	27
	MI&D committed	55	17	6	32
	Other committed	11	3	1	7
	Total	**199**	**114**	**9**	**(Avg. 6.3) 76**
2018 Annual (January – December 2018)	Committed after finding of incompetency	136	97	0	39
	MI&D committed	73	31	3	39
	Other committed	3	2	0	1
	Total	**212**	**130**	**3**	**(Avg. 6.6) 79**
2019 Quarter 1 (January – March 2019)	Committed after finding of incompetency	41	28	0	13
	MI&D committed	13	3	2	8
	Other committed	4	1	0	3
	Total	**58**	**32**	**2**	**(Avg. 8.0) 24**

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 by identifying individuals who could be served in more integrated settings.

[3] 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.

Legislation in 2017 increased the base funding to improve clinical direction and support to direct care staff treating and managing clients with complex conditions, some of whom engage in aggressive behaviors. The funding will enhance the current staffing model to achieve a safe, secure and therapeutic treatment environment. These positions are primarily in direct care positions such as registered nurses, forensic support specialists and human services support specialists. The positions that remain to be filled are in professional areas such as psychologists, social workers, recreational and occupational therapists. Through the third quarter of fiscal year 2019, (January - March 2019), 99.2% of funded professional positions are filled and 96.1% of funded 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 to discharge 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;
- Individuals who are undocumented; and
- 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; and
- 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, January through December 2018, Forensic Services reviewed 106 cases, recommended reductions-in-custody to the Special Review Board for 70 individuals, 64 of which were granted. So far in 2019, from January- March 2019, Forensic Services

reviewed 48 cases, recommended reductions-in-custody to the Special Review Board for 14, 10 of which were granted and, 13 are still pending decision from the Special Review Board; and

- Collaboration with DHS/Direct Care and Treatment entities to expand community capacity and individualized services for a person's transitioning.

Committed after finding of incompetency

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

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

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

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

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.]

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.**

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
FY18 Quarter 1 July – Sept 2017	29	6	0	23	11 of 23 (47.8%)	**12 of 23 (52.2%)**
FY18 Quarter 2 Oct – Dec 2017	26	3	1	22	7 of 22 (31.8%)	**15 of 22 (68.2%)**
FY18 Quarter 3 Jan – March 2018	25	5	3	17	2 of 17 (11.8%)	**15 of 17 (88.2%)**
FY18 Quarter 4 April – June 2018	34	6	2	26	3 of 26 (11.5%)	**23 of 26 (88.5%)**
FY19 Quarter 1 July –Sept 2018	19	6	0	13	5 of 13 (38.5%)	**8 of 13 (61.5%)**
FY19 Quarter 2 Oct – Dec 2018	36	5	0	31	10 of 31 (32.3%)	**21 of 31 (67.7%)**

ANALYSIS OF DATA:
For the period from October – December 2018, of the 36 transition case files reviewed, 5 people opted out of using the My Move Plan document. Of the remaining 31 case files, 21 files (67.7%) adhered to the transition protocol.

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

1. Where is the person moving?
2. Date and time the move will occur.
3. Who will help the person prepare for the move?
4. Who will help with adjustment during and after the move?
5. Who will take the person to new residence?
6. How will the person get his or her belongings?
7. Medications and medication schedule.
8. Upcoming appointments.

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

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

COMMENT ON PERFORMANCE:
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. Two of the five counties reviewed during this reporting quarter were 100% compliant in their transition case sample.

2019 Lead Agency Reviews
Lead Agency Review completed Round 3 of site visits to all lead agencies administering HCBS programs in November 2018. The results of those reviews are included in this report. No site visits took place between January and March 2019 to allow for Round 3 summaries and reports to be created and to prepare a new database for the start of Round 4. Site visits resumed in April of 2019.

For quarterly reporting purposes, reporting on this goal will be as follows:
- May 2019 Quarterly Report includes data from the final five counties visited in 2018.
- August 2019 Quarterly Report will not include a report as there are no site visits during the reporting period (January – March 2019).
- November 2019 Quarterly Report will include data from the April - June 2019 agency reviews.

Beginning in April 2019, the Lead Agency Review team will examine all cases in the sample where it is evident that the person moved during the timeframe of our review for compliance with the “My Move Plan Summary” document (or indication that it was declined by the person/CM was not aware of the move). Currently, only a small sample of transition cases are pulled based on a separate query methodology. This change in sampling methodology will likely lead to more cases being reviewed for transition compliance. However, this may lead to variation among data reported if no sample cases moved during the timeframe of our review. Based on Lead Agency Review experience in 2018, it is believed that there will be an increased number of cases reported to the Subcabinet.

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

III. TIMELINESS OF WAIVER FUNDING

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

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

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

Assessments between January – December 2016

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

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

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%)**

Time Period: July - September 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	22	17 (77%)	4 (18%)	1 (5%)
Immediate Need	102	81 (79%)	18 (18%)	3 (3%)
Defined Need	227	163 (72%)	57 (25%)	7 (3%)
Totals	**351**	**261 (74%)**	**79 (23%)**	**11 (3%)**

Time Period: October - December 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	42	32 (76%)	10 (24%)	0 (0%)
Immediate Need	108	84 (78%)	24 (22%)	0 (0%)
Defined Need	232	154 (66%)	63 (27%)	15 (6%)
Totals	**382**	**270 (71%)**	**97 (25%)**	**15 (4%)**

ANALYSIS OF DATA:

From October – December 2018, of the 382 individuals assessed for the Developmental Disabilities (DD) waiver, 270 individuals (71%) had funding approved within 45 days of the assessment date. An additional 97 individuals (25%) had funding approved after 45 days. Only 15 individuals (4%) assessed are pending funding approval.

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 April 1, 2019 is 79 people. This has decreased since April 1, 2017 (201).

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**		

People Pending Funding Approval as of January 8, 2019

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	10	138	101
Immediate Need	18	115	79
Defined Need	65	144	88
Total	**93**		

People Pending Funding Approval as of April 1, 2019

Category	Number of people pending funding approval	Average days pending	Median days pending
Institutional Exit	3	278	215
Immediate Need	15	113	88
Defined Need	61	197	147
Total	**79**		

TIMELINESS OF DATA:

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

IV. QUALITY OF LIFE MEASUREMENT RESULTS

NATIONAL CORE INDICATORS (NCI) SURVEY

The results for the 2017 NCI survey for individuals with intellectual and developmental disabilities were reported in the November 2018 Quarterly Report.

QUALITY OF LIFE SURVEY

The Olmstead Plan Quality of Life Survey: First Follow-Up 2018[4] report was accepted by the Olmstead Subcabinet On January 28, 2019. The analysis of the follow-up survey results have shown that this long-term study is valuable and has helped to identify important characteristics affecting overall quality of life. Researchers recommend waiting a longer period of time before resurveying respondents. It a recommended that the second follow-up survey should occur in summer of 2020.

[4] Olmstead Plan Quality of Life Survey: First Follow-up 2018 Report is available on the Olmstead Plan website at www.mn.gov/olmstead.

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.**

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.**

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%
FY18 Quarter 1 July – Sept 2017	75.9%	6.9%	93.1%	37.9%	93.1%	79.3%	96.6%	93.1%
FY18 Quarter 2 Oct –Dec 2017	84.6%	30.8%	92.3%	65.4%	88.5%	76.9%	92.3%	92.3%
FY18 Quarter 3 Jan – March 2018	84.6%	47.3%	91.6%	68.9%	93.5%	79.6%	97.5%	94.1%
FY18 Quarter 4 April – June 2018	80.2%	40.1%	92.8%	67.1%	94.5%	89.5%	98.7%	78.9%
FY19 Quarter 1 July – Sept 2018	90.0%	53.8%	96.2%	52.3%	93.8%	90.8%	98.5%	98.5%
FY19 Quarter 2 Oct – Dec 2018	91.5%	62.1%	98.1%	60.7%	94.8%	96.7%	98.6%	98.6%

ANALYSIS OF DATA:
For the period from October – December 2018, in the 201 case files reviewed, the eight required criteria were present in the percentage of files shown above. Performance on seven of the eight elements have improved over the 2017 baseline. Six of the eight elements show consistent progress, and six of the eight are at 90% or greater this quarter and four are above 95%.

Total number of cases and sample of cases reviewed

Time Period	Total number of cases (disability waivers)	Sample of cases reviewed (disability waivers)
FY18 Quarter 1 (July – September 2017)	934	192
FY18 Quarter 2 (October –December 2017)	1,419	186
FY18 Quarter 3 (January – March 2018)	8,613	628
FY18 Quarter 4 (April – June 2018)	1,226	237
FY19 Quarter 1 (July – September 2018)	832	130
FY19 Quarter 2 (October – December 2018)	2,087	201

Counties Participating in Audits[5]

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

July – September 2016	October – December 2016	January – March 2017	April – June 2017
30. Hubbard	38. Cook	44. Chisago	47. MN Prairie Alliance[6]
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[7]		51. Beltrami
35. Polk	43. Washington		
36. Clay			
37. Aitkin			

[5] Agency visits are sequenced in a specific order approved by Centers for Medicare and Medicaid Services (CMS).
[6] The MN Prairie Alliance includes Dodge, Steele, and Waseca counties.
[7] 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[8]
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

July – September 2018	October – December 2018
71. Brown	75. Benton
72. Carlton	76. Blue Earth
73. Pine	77. Le Sueur
74. Watonwan	78. Meeker
	79. Swift

2019 Lead Agency Reviews

Lead Agency Review completed Round 3 of site visits to all lead agencies administering HCBS programs in November 2018. The results of those reviews are included in this report. No site visits took place between January and March 2019 to allow for Round 3 summaries and reports to be created and to prepare a new database for the start of Round 4. Site visits resumed in April of 2019.

For quarterly reporting purposes, reporting on this goal will be as follows:

- May 2019 Quarterly Report includes data from the final five counties visited in 2018.
- August 2019 Quarterly Report will not include a report as there are no site visits during the reporting period (January – March 2019).
- November 2019 Quarterly Report will include data from the April - June 2019 agency reviews.

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, four of the five counties reviewed were required to develop corrective action plans in at least one category for at least one disability waiver program. One county was not required to develop corrective action plans in the area of person-centered practices.

[8] The Des Moines Valley Health and Human Services Alliance includes Cottonwood and Jackson counties.

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

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

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

Annual 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 overall goal was met and reported in the November 2018 Quarterly Report. Progress on this goal will continue to be reported as **in Process**.

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 2018)	265 (duplicated)	N/A – quarterly number
Quarter 2 (October – December 2018)	258 (duplicated)	N/A – quarterly number

ANALYSIS OF DATA:
The overall goal to reduce the number of individuals who experienced a restrictive procedure from the baseline of 1,076 to 876, or less, by June 30, 2018 was met. The total number of people experiencing a restrictive procedure from July 1, 2017 – June 30, 2018 was 644. That is a reduction of 432 from the baseline. This outperformed the overall goal of 200 by 216%. DHS is continuing to report progress past the goal end date of June 30, 2018.

From October - December 2018, the number of individuals who experienced a restrictive procedure was 258. This is a decrease of 7 from the previous quarter. The quarterly numbers are duplicated counts. Individuals may experience restrictive procedures during multiple quarters in a year. The quarterly numbers can be used as indicators of direction, but cannot be used to measure annual progress.

COMMENT ON PERFORMANCE:
There were 258 individuals who experienced a restrictive procedure this quarter:

- 233 individuals 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.
- 25 individuals experienced restrictive procedures other than EUMRs (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). DHS staff and the Interim Review Panel provide follow up and technical assistance for all reports involving restrictive procedures *other than* EUMR. It is anticipated that focusing technical assistance with this subgroup will reduce the number of individuals experiencing restrictive procedures and the number of reports (see Positive Supports Goal Three).

Under the Positive Supports Rule, the External Program Review Committee (EPRC) convened in February 2017 has the duty to review and respond to Behavior Intervention Reporting Form (BIRF) reports involving EUMRs. Beginning in May 2017, the EPRC conducted outreach to providers in response to EUMR reports. It is anticipated the EPRC's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR. The purpose of EPRC engagement in these cases is to provide guidance to help reduce the frequency and/or duration of future emergency uses of manual restraint. The EPRC is training new members on the EUMR guidance and follow up process and beginning to look at "post guidance" intervention data to identify results/trends.

During this quarter (October - December 2018), the EPRC reviewed BIRFs, positive support transition plans, and functional behavior assessments. Based on the content within those documents, the committee conducted EUMR-related outreach involving 21 people. This number does not include people who are receiving similar support from other DHS groups. Some examples of guidance provided by committee members include discussions about the function of behaviors, helping providers connect with local behavior professionals or other licensed professionals, providing ideas on positive support strategies, and explaining rules and law.

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

POSITIVE SUPPORTS GOAL TWO: **By June 30, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596.**

Annual 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 overall goal was reported as met in the November 2018 Quarterly Report. Progress on this goal will continue to be reported as **in process**.

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 2018)	781	N/A – quarterly number
Quarter 2 (October – December 2018)	780	N/A – quarterly number

ANALYSIS OF DATA:
The overall goal to reduce the number of restrictive procedure reports from the baseline of 8,602 to 7,006, or less, by June 30, 2018 was met. The total number of BIRF reports of restrictive procedures from July 1, 2017 – June 30, 2018 was 3,739. That is a reduction of 4,863 from the baseline. This outperformed the goal by 304%. DHS is continuing to report progress past the goal end date of June 30, 2018. From October – December 2018, the number of restrictive procedure reports was 780. This was a decrease of 1 from the previous quarter.

COMMENT ON PERFORMANCE:
There were 780 reports of restrictive procedures this quarter. Of the 780 reports:

- 620 reports were for emergency use of manual restraint (EUMR). Such EUMRs are permitted and not subject to phase out requirements like all other "restrictive" procedures. These reports are monitored and technical assistance is available when necessary.
    - Under the Positive Supports Rule, the External Program Review Committee (EPRC) has the duty to review and respond to BIRF reports involving EUMRs. Convened in February 2017, the Committee's work will help to reduce the number of people who experience EUMRs through the guidance they provide to license holders regarding specific uses of EUMR.
    - Beginning in May 2017, the EPRC 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.
    - This is an increase of 1 report of EUMR from the previous quarter.

- 160 reports involved restrictive procedures other than EUMR (i.e., mechanical restraint, time out, seclusion, and other restrictive procedures). The EPRC provides ongoing monitoring over restrictive procedures being used by providers with persons under the committee's purview. DHS staff provide

follow up and technical assistance for all reports involving restrictive procedures that are not implemented according to requirements under 245D or the Positive Supports Rule. The close monitoring and engagement by the EPRC with the approved cases of emergency use of procedures enables DHS to help providers work through some of the most difficult cases of ongoing use of mechanical restraints. Focusing existing capacity for technical assistance primarily on reports involving these restrictive procedures is expected to reduce the number of people experiencing these procedures, as well as reduce the number of reports seen here and under Positive Supports Goal Three.
    - The number of non-EUMR restrictive procedure reports decreased by 2 from the previous quarter.
- 13 uses of seclusion or timeout involving 8 people were reported this quarter:
    - 9 uses involving 4 people occurred at Minnesota Security Hospital, in accordance with the Positive Supports Rule (i.e., not implemented as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience).
    - 2 uses involving 2 people occurred at Minnesota Sex Offenders Program, in accordance with the Positive Supports Rule (i.e., not implemented as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience).
    - 1 report involving 1 person was reported as an unapproved use of seclusion. DHS staff provided technical assistance to the providers for this case and referred the reports to Licensing Intake.
    - 1 report involving 1 person was a coding error and was discovered when DHS contacted the provider to provide technical assistance.
    - The number of seclusion or time out reports decreased by 12 from the previous quarter.

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

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

- **By June 30, 2019, the emergency use of mechanical restraints will be reduced to no more than 93 reports. [Revised March 2019]**

2019 Goal

- By June 30, 2019, reduce mechanical restraints to no more than **93** reports of mechanical restraint

Baseline: From July 2013 - June 2014, there were 2,038 BIRF reports of mechanical restraints involving 85 unique individuals.

RESULTS:
The 2019 goal for number of reports is **not on track**.

Time period	Number of reports during the time period	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 2018)	137	12
Quarter 2 (October – December 2018)	147	11

ANALYSIS OF DATA:
From October through December 2018, the number of reports of mechanical restraints was 147. This was an increase of 10 from the previous quarter. This goal is not on track to meet the annual goal of no more than 93. At the end of the reporting period (December 31, 2018), the number of individuals for whom the use of mechanical restraint use was approved was 11. This is a decrease of 1 from the previous quarter.

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

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

provided by panel members. Prior to February 2017, the duties of the ERPC were conducted by the Interim Review Panel.

Of the 147 BIRFs reporting use of mechanical restraint in Quarter 2:

- 123 reports involved 10 of the 11 people with review by the EPRC and approval by the Commissioner for the emergency use of mechanical restraints during the reporting quarter.
    - This is an increase of 6 reports from Quarter 1.
    - For 1 person with an approved plan including the use of mechanical restraint, there were no uses of mechanical restraint during this quarter.
- 73 reports involved devices to prevent a person from unbuckling their seatbelt during travel.
- 16 reports involving 4 people, were submitted by Minnesota Security Hospital for uses of mechanical restraint that were not implemented as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.
- 4 reports involving 1 person were submitted by a provider whose use was within the 11-month phase out period.
- 3 reports involving 3 different people were coding errors discovered when DHS staff contacted provider to provide technical assistance.
- 1 report involving 1 person, were submitted by Minnesota Sex Offender Program for uses of mechanical restraint that were not implemented as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

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

SEMI-ANNUAL AND ANNUAL GOALS

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

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

2018 Goal
By December 31, 2018, the annual number of service hours will increase to 1,314,000.

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

RESULTS:
The 2018 goal was **met** (using Calendar Year 2017 data).

Time Period	Service Hours	Change from baseline
Baseline – Calendar Year 2014	1,200,000	N/A
Calendar Year 2015	1,218,787	18,787
Calendar Year 2016	*1,418,908	*218,908
Calendar Year 2017	1,369,316	169,316

*See the addendum for information about discrepancies in the previous reported 2016 data.

ANALYSIS OF DATA:
During 2017, the total number of service hours was 1,369,316. Although this was a decrease from the previous year, the 2018 goal to increase to 1,314,000 was met.

COMMENT ON PERFORMANCE:
The 2017 numbers downward trend is the result of seven providers merging into a consolidated service area. There has been no loss of coverage as the result of the mergers and the lower service hours reflect efficiency of provider consolidation. While the 2016 -2017 numbers are reflecting a downward trend MnDOT is on track to meet the 2025 goal.

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

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

Ten year goals to improve on time performance:

- Transit Link – maintain performance of 95% within a half hour
- Metro Mobility – maintain performance of 95% within a half hour
- Metro Transit – improve to 90% or greater within one minute early – four minutes late
- Greater Minnesota – improve to a 90% within a 45-minute timeframe

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

RESULTS:

The goal is **in process**.

On time performance percentage by transit system[9]

Time Period	Transit Link	Metro Mobility	Metro Transit	Greater MN
Calendar Year 2014 (Baseline)	97%	96.3%	86%	76%
Calendar Year 2016	98%	95.3%	85.1%	76%
Calendar Year 2017	98.5%	96.8%	86.4%	Pending
Calendar Year 2018	98%	95.3%	84.8%	Pending

ANALYSIS OF DATA:

During 2018, the on time performance for Transit Link and Metro Mobility was the same as 2016 but slightly lower than 2017. The on time performance for Metro Transit was 84.8% which was lower than any of the previous years. The Greater Minnesota transit on time performance data is not yet available. It will be available and reported upon the adoption and release of the Five Year Plan.

The Metro Transit system is made up of three types of services: bus, light rail (Blue and Green lines) and the Northstar commuter rail. The on-time performance for each service type is shown below.

On time performance percentage for Metro Transit system

Time Period	Bus	Light Rail (Blue/Green line)	Northstar Commuter Rail	Metro Transit System[10]
Calendar Year 2014 (Baseline)	--	--	--	86%
Calendar Year 2016	85.8%	82.9%	93.2%	85.1%
Calendar Year 2017	85.1%	89.5%	93.2%	86.4%
Calendar Year 2018	83.7%	86.7%	94.7%	84.8%

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

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

Metro Transit bus and light rail on time performance dropped from 2017, while commuter rail improved. Metro Transit's system-wide on-time performance dropped from 2017 as it is weighted by ridership, and bus and light rail performance drive the result.

COMMENT ON PERFORMANCE:
Metro Transit bus on-time performance dropped due to 35W road construction projects leading into downtown Minneapolis and the impact to bus service. Metro Transit light rail performance declined from 2017 to 2018 due to the signal improvement projects that were underway in downtown Minneapolis and Bloomington in 2018. The significant improvement from 2016 to 2017 for Metro Transit light rail was due to the change in methodology on measuring on-time performance.

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

PROPOSED BASELINE

COMMUNITY ENGAGEMENT GOAL TWO: By April 30, 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. [Added March 2019]

Community Engagement Goal Two adopted in the March 2019 Revised Olmstead Plan provides that by April 30, 2019, a baseline will be established. The baseline below was reviewed and approved by the Subcabinet at the May 28, 2019 meeting.

2019 Goal

- By April 30, 2019, a baseline will be established using 2018-2019 Public Input opportunities data.

RESULTS:
The 2019 goal to establish a baseline was **met**.

BASELINE:

Time Period	Number of individuals who participated in public input opportunities related to Olmstead Plan	Number of comments received
December 20, 2018 – March 11, 2019	192	249

ANALYSIS OF DATA:
During the 2019 Plan amendment process, 192 people participated in public input yielding close to 249 individual comments. The data includes public input received during the 2018-2019 Plan amendment process. The data for the 2020 goal will be tracked and analyzed from all established public input processes and not limited to the Annual Plan Amendment Process.

COMMENT ON PERFORMANCE:
The baseline data was based on public input received during the 2018-2019 Olmstead Plan amendment process. Input was gathered in two rounds. Round One took place from December 20, 2018 to January 31, 2019 and included five listening sessions (Redwood Falls, Mankato, Hibbing, Saint Paul and a videoconference session based in St Paul), email, phone, and online comment opportunities. Round Two took place from February 26, 2019 to March 11, 2019 and included two webinar listening sessions, one teleconference listening session, email, phone and online comment opportunities. All sessions were coordinated with, and sponsored by the OIO and community partners.

A report on recommendations for improvement of the public input processes is expected to be presented to the Subcabinet in July 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.

VI. COMPLIANCE REPORT ON WORKPLANS AND MID-YEAR REVIEWS

This section summarizes the monthly review of workplan activities and review of measurable goals 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 on an ongoing basis.[vii]

The first review of workplan activities occurred in December 2015. Ongoing monthly reviews began in January 2016 and include activities with deadlines through the month prior and any activities previously reported as an exception.

The summary of those reviews are below.

	Number of Workplan Activities				
Reporting period	**Reviewed during time period**	**Completed**	**On Track**	**Reporting Exceptions**	**Exceptions requiring Subcabinet action**
December 2015 – December 2016	428	269	125	34	0
January – December 2017	284	251	32	8	1
January – December 2018	219	207	5	7	0
January 2019	38	38	0	0	0
February 2019	17	14	3	0	0
March 2019	15	15	0	0	0
April 2019	17	17	0	0	0

MID-YEAR REVIEW OF MEASURABLE GOALS REPORTED ON ANNUALLY

OIO Compliance staff engages in regular and ongoing monitoring of measurable goals to track progress, verify accuracy, completeness and timeliness of data, and identify risk areas. These reviews were previously contained within a prescribed mid-year review process. OIO Compliance staff found it to be more accurate and timely to combine the review of the measurable goals with the monthly monitoring process related to action items contained in the workplans. Workplan items are the action steps that the agencies agree to take to support the Olmstead Plan strategies and measurable goals.

OIO Compliance staff regularly monitors agency progress under the workplans and uses that review as an opportunity to identify any concerns related to progress on the measurable goals. OIO Compliance staff report on any concerns identified through the reviews to the Subcabinet. The Subcabinet approves any corrective action as needed. If a measurable goal is reflecting insufficient progress, the quarterly report identifies the concerns and how the agency intends to rectify the issues. This process has evolved and mid-year reviews are utilized when necessary, but the current review process is a more efficient mechanism for OIO Compliance staff to monitor ongoing progress under the measurable goals.

VII. ADDENDUM

Data Discrepancies: Transportation Goal Two
It was determined that there was a discrepancy involving data previously reported for the following goal.

For Calendar Year 2016, the number of service hours was overestimated for several systems that failed to report. The correct number of service hours has been updated in the table. Controls have now been added to providers reporting requirements to ensure timely submission of the data. Even with the downward change to the service hours the 2017 goal was still met.

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

Previously Reported (February 2018 Quarterly Report, page 45)

- The 2017 goal to increase to 1,257,000 was **met** (using Calendar Year 2016 data).

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

Updated Reporting

- The 2017 goal to increase to 1,257,000 was **met** (using Calendar Year 2017 data).

Time Period	Service Hours	Change from baseline
Baseline – Calendar Year 2014	1,200,000	N/A
Calendar Year 2015	1,218,787	18,787
Calendar Year 2016	1,418,908	218,908

ENDNOTES

[i] Reports are also filed with the Court in accordance with Court Orders. Timelines to file reports with the Court are set out in the Court's Orders dated February 12, 2016 (Doc. 540-2) and June 21, 2016 (Doc. 578). The annual goals included in this report are those goals for which data is reliable and valid in order to ensure the overall report is complete, accurate, timely and verifiable. See Doc. 578.

[ii] Some Olmstead Plan goals have multiple subparts or components that are measured and evaluated separately. Each subpart or component is treated as a measurable goal in this report.

[iii] This goal measures the number of people exiting institutional and other segregated settings. Some of these individuals may be accessing integrated housing options also reported under Housing Goal One.

[iv] Transfers refer to individuals exiting segregated settings who are not going to an integrated setting. Examples include transfers to chemical dependency programs, mental health treatment programs such as Intensive Residential Treatment Settings, nursing homes, ICFs/DD, hospitals, jails, or other similar settings. These settings are not the person's home, but a temporary setting usually for the purpose of treatment.

[v] As measured by monthly percentage of total bed days that are non-acute. Information about the percent of patients not needing hospital level of care is available upon request.

[vi] Minnesota Security Hospital is governed by the Positive Supports Rule when serving people with a developmental disability.

[vii] All approved adjustments to workplans are reflected in the Subcabinet meeting minutes, posted on the website, and will be utilized in the workplan review and adjustment process.