Jensen v. Minnesota Department of Human Services, No. 09-cv-1775

Class Action Settlement Agreement, Dkt. 104 (filed June 23, 2011)

DEFENDANTS' STATUS REPORT

Monthly Data Covering September through October 2012

David Ferleger
Independent Advisor and Monitor

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STATUS REPORTS

1. Defendants' status reports will be submitted every two months.

2. The first status report will cover January to August, 2012. Under the Court's July 17, 2012 Order, the first status report is due September 17, 2012.

3. Each report (after the first report) will cover the prior two calendar months. The reports will be due on the 17th of the month.

4. Each section of the status report begins with the text of the settlement. This is followed by a grid. The grid's fields consist of:

- *Evaluation Criteria*: Based on the settlement provisions. The "ECs" will be used to assess compliance.
- *Person Responsible*: The state official/staff who is specifically responsible for implementation of the listed item.
- *Documentation for Verification*: A designation of the documentation material which supports and demonstrates the status of compliance. The documentation shall be submitted separately with each status report.
- *Next Steps*: A summary of the next steps planned by the Person Responsible (and any other appropriate person/agency) to achieve or maintain compliance.
- *Status*: A statement of the status of the item, for example, "completed," "completed [date]," "incomplete," or "not in compliance," or "maintaining compliance," or an identification of a percentage compliance level, or a note of another conclusion regarding the status of compliance for the item.

5. For convenience, original Settlement Agreement section numbering is maintained (*e.g.*, IV. METO CLOSURE). The alphabetical sub-section headings are also maintained.

SCOPE

"Scope: **The scope of DHS obligations regarding people with developmental disabilities in this Agreement pertain only to the residents of the Facility, with the exception of the provisions of Recitals, Paragraph7, and Section X, 'Systemwide Improvements.'" (Section III.F.)**

Recitals, Par. 7.

> **"The State of Minnesota further declares, as a top concern, the safety and quality of life of the Residents of the Facility. The State agrees that its goal is to provide these residents with a safe and humane living environment free from abuse and neglect. The State also agrees that its goal is to utilize the Rule 40 Committee and Olmstead Committee process described in this Agreement to extend the application of the provisions in this Agreement to all state operated locations serving people with developmental disabilities with severe behavioral problems or other conditions that would qualify for admission to METO, its Cambridge, Minnesota successor, or the two new adult foster care transitional homes."**

Section X includes:

A. **Expansion of Community Support Services (long term monitoring, crisis management, training). This Section X.A. consists of "goals and objectives; they do not constitute requirements." Sec. X.A.1.**
B. **Olmstead Plan**
C. **Rule 40**
D. **Minnesota Security Hospital**
E. **Anoka Metro Regional Treatment Center**

IV. METO CLOSURE

The METO program will be closed by June 30, 2011. Any successor to METO shall: (1) comply with the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999); (2) utilize person centered planning principles and positive behavioral supports consistent with applicable best practices including, but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports* (http://apbs.org) (February, 2007); (3) be licensed to serve people with developmental disabilities; (4) only serve "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety" pursuant to METO's original statutory charge under Minn. Stat. § 252.025, subd. 7; and (5) notify parents and guardians of residents, at least annually, of their opportunity to comment in writing, by e-mail, and in person, on the operation of the Facility.

Section IV

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
1. METO closed by June 30, 2011.	Doug Seiler	The METO program closed 6-30-11. The document provided is the letter confirming the new tax ID number issued by the IRS, (Exhibit 1A).		Completed 6-30-11	
2. METO successors comply *Olmstead v. L.C.*	Doug Seiler Roger Deneen	The Department will be issuing a Departmental Bulletin notifying interested parties of the purpose of the program and its admission, continued stay criteria, and discharge criteria. The draft bulletin is (Exhibit 2A). The MSHS-Cambridge sought and was granted from DHS Licensing, a variance. This variance was necessary to adapt the program to a short term intensive treatment setting designed to return the individual to the most integrated	Finalize the bulletin after the 9-20-12 meeting between parties and monitor **11-17-12 update** In discussion at the 11-14-12 Parties meeting the Department agreed to revise the draft bulletin to emphasize early intervention through CSS and the use of the MSHS –Cambridge program as a crisis intervention for evaluation and stabilization. The final draft bulletin will be shared with		

		setting in accordance with Olmstead verses a residential program and to adopt specific components of the settlement agreement related to the prohibited techniques and use of emergency restraint. Licensing variance is (Exhibit 2B)	Plaintiff's counsel, and consultants then issues by 12-15-12.		
3. METO successors utilize person centered planning principles and positive behavioral supports consistent with applicable best practices including, but not limited to the Assoc. of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports*	Doug Seiler Roger Deneen	Draft Departmental Bulletin (Exhibit 2A) Policy on Therapeutic Interventions and Emergency use of Personal Safety Techniques (Exhibit 3A)	See EC #2		
4. METO successors serve only "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety."	Doug Seiler Roger Deneen	Draft Departmental Bulletin (Exhibit 2A)	See EC #2		
5. METO successors notify parents and guardians of residents, at least annually, of their opportunity to comment in writing, by e-mail, and in person, on the operation of the Facility	Doug Seiler Roger Deneen	Annual Survey of individuals served, families, and guardians **11-17-12 update** (Exhibit 98 – The name of the individual and the family member was redacted on one of the forms.)	Facilities will issue the first survey to individuals served, families, and guardians no later than 9-30-12 **11-17-12 update** On September 7th 17 surveys were mailed to family or other concerned persons. As of 10-1-12 three surveys were completed and returned. Two were returned due to incorrect address. The correct address was found for one of these		

			and the survey was sent 11-12-12.		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V.A. PROHIBITED TECHNIQUES – RESTRAINT

A. Except as provided in subpart V. B., below, the State and DHS shall immediately and permanently discontinue the use of mechanical restraint (including metal law enforcement-type handcuffs and leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, soft cuffs, posey cuffs, and any other mechanical means to restrain), manual restraint, prone restraint, chemical restraint, seclusion, and the use of painful techniques to induce changes in behavior through punishment of residents with developmental disabilities. Medical restraint and psychotropic and/or neuroleptic medications shall not be administered to residents for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior modification.

Section V.A

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
6. The State/DHS immediately and permanently discontinued all the prohibited restraints and techniques.	Doug Seiler Roger Deneen	Policy on Therapeutic Interventions and Emergency use of Personal Safety Techniques (Exhibit 3A) **11-17-12 update** On October 26th the SOS received a corrective order from DHS Licensing Division (Exhibit 103)	Continue monitoring		

7. The State/DHS has not used any of the prohibited restraints and techniques.	Doug Seiler Roger Deneen	During the interval of this status report there were no reports of the use of prohibited restraints and techniques. **11-17-12 update** On October 26th the SOS received a corrective order from DHS Licensing Division (Exhibit 103)	Continue monitoring		
See quotations in "Comments" below for the exceptions are provided in V.B					
8. Medical restraint, and psychotropic/ neuroleptic medication have not been administered to residents for punishment, in lieu of habilitation, training, behavior support plans, for staff convenience or as behavior modification.	Doug Seiler Roger Deneen	During the interval of this status report there were no reports of the use of medical restraint or psychotropic/neuroleptic medication for punishment, in lieu of habilitation, training, behavior support plans, for staff convenience, or as behavior modification.	Continue monitoring		

[ADD DEFINITIONS AND EXCEPTIONS FROM ATT A]

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V. B. PROHIBITED TECHNIQUES - POLICY

B. Policy. Notwithstanding subpart V. A. above, the Facility's policy, "Therapeutic Interventions and Emergency Use of Personal Safety Techniques," Attachment A to this Agreement, defines manual restraint, mechanical restraint, and emergency, and provides that certain specified manual and mechanical restraints shall only be used in the event of an emergency. This policy also prohibits the use of prone restraint, chemical restraint, seclusion and time out. Attachment A is incorporated into this Agreement by reference.

Section V.B

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
There were instances of the specified manual /mechanical restraint. **Yes X No** **Number of instances: 7** **11-17-12 update** **Number of Instances: 1**		Each instance of the use of emergency restraint will result in the following documents being included in this report: DHS form 3652 Documentation for the Implementation of Controlled Procedure DHS form 3653 Consultation with Expanded Interdisciplinary Team Following Emergency Use of Controlled Procedure Individual Progress notes Use of Manual Restraint Review			

9. The restraints are used only in an emergency. ***Same requirement is at section V.E. below. The requirement is evaluated here only.***	Doug Seiler Roger Deneen	DHS form 3652 Documentation for the Implementation of Controlled Procedure DHS form 3653 Consultation with Expanded Interdisciplinary Team Following Emergency Use of Controlled Procedure Individual Progress notes Use of Manual Restraint Review Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G **11-17-12 update** (Exhibit 100)	Continue monitoring		
10. The Policy (Att. A) was followed in each instance of manual / mechanical restraint.	Doug Seiler Roger Deneen	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G In exhibit 9A the facility did not provide timely notice to some of the mandated parties. DHS form 3653 was not completed as the individual was discharged to a community psychiatric hospital. In exhibit 9C DHS form 3653 was not completed as the individual was discharged to a community psychiatric hospital. **11-17-12 update** (Exhibit 100)	Continue monitoring		

11. There were no instances of prone restraint, chemical restraint, seclusion or time out.	Doug Seiler Roger Deneen	During the interval of this status report there were no reports of the use of prone restraint, chemical restraint, seclusion, or time out. **11-17-12 update** Exhibit 100 includes reporting form 31032. This form reports the use of Side lying hold There were no observed or reported uses of time out or seclusion.	Continue monitoring		
Seclusion is evaluated under Section V.C. ***Chemical restraint is evaluated under Section V.D.***					

"Emergency": "Situations when the client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute an emergency." (Settlement, App. A).

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V.C. PROHIBITED TECHNIQUES – SECLUSION AND TIME OUT FROM POSITIVE REINFORCEMENT

C. Seclusion and Time Out from Positive Reinforcement.

1. The Facility's use of seclusion is prohibited.
2. Seclusion means the placement of a person alone in a room from which egress is: a. noncontingent on the person's behavior; or b. prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving the room.
3. The Facility's use of Room Time out from positive reinforcement is prohibited.
4. Time out means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the individual program plan for reduction or elimination. Room time out means removing a person from an ongoing activity to a room (either locked or unlocked).

Section V.C

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	

12. There were zero instances of the use of Seclusion.	Doug Seiler Roger Deneen	During the interval of this status report there were no reports of the use of prone restraint, chemical restraint, seclusion, or time out. **11-17-12** During the interval of this status report there were no reports of the use of prone restraint, chemical restraint, seclusion, or time out.	Continue monitoring		
13. There were zero instances of the use of Room Time Out from Positive Reinforcement..	Doug Seiler Roger Deneen	During the interval of this status report there were no reports of the use of prone restraint, chemical restraint, seclusion, or time out. **11-17-12** During the interval of this status report there were no reports of the use of prone restraint, chemical restraint, seclusion, or time out.	Continue monitoring		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V.D. PROHIBITED TECHNIQUES – CHEMICAL RESTRAINT

D. Chemical Restraint. The Facility shall not use chemical restraint. 1. A chemical restraint is the administration of a drug or medication when it is used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement and is not a standard treatment or dosage for the resident's condition. 2. Orders or prescriptions for the administration of medications to be used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement shall not be written as a standing order or on an as-needed basis (PRN).

Section V.D

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
14. There were zero instances of drug / medication use to manage resident behavior OR to restrain freedom of movement.	Alan Radke	During the interval of this status report there were no reported instances of drug/medication use to manage resident behavior or to restrain freedom of movement **11-17-12** During the interval of this status report there were no reported instances of drug/medication use to manage resident behavior or to restrain freedom of movement	Continue monitoring		

15. There were zero instances of PRN orders (standing orders) of drug/ medication used to manage behavior or restrict freedom of movement.	Alan Radke	During the interval of this status report there were no reported instances of PRN orders (standing orders) of drug/medication used to manage behavior or restrict freedom of movement **11-17-12 update** Dr. Peter Miller, consulting psychiatrist for the MSHS Cambridge program reviewed all uses of PRN medications administered during September. He found the use of the medication directly related to mental health symptoms and not to restrict movement or physically slow the patient down. (Exhibit 101 – The email was amended to include only the information relevant to EC).	Continue monitoring **11-17-12 update** The Department is instituting additional processes and monitoring. These will include: to ensure the individual or family/guardian agrees to the medication plan (including PRN medication); use of PRNs are reviewed and authorized by an RN with consultation by a psychiatrist as necessary; if the individual declines the medication it is not administered; and each administration of a PRN will be reported out in a process similar to the emergency use of restraint process.		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V.E. PROHIBITED TECHNIQUES – THIRD PARTY EXPERT

E. Third Party Expert. The Department shall establish a protocol to contact, on a rotating basis, a qualified Third Party Expert from a list of at least five (5) qualified Third Party Experts pre-approved by Plaintiffs and Defendants. The costs for the Third Party Expert shall be paid by the Department. This consultation shall occur as soon as reasonably possible upon the emergency presenting but no later than thirty (30) minutes after an emergency use of restraint consistent with the Facility's policy, *Therapeutic Interventions and Emergency Use of Personal Safety Techniques,* Attachment A to this Agreement. The Facility staff shall consult with the Third Party Expert in order to obtain professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices. If the scheduled qualified Third Party Expert is not immediately available, DHS shall then utilize the Medical Officer Review protocol as described in subpart V.F, below. If the parties cannot develop the qualified list of Third Party Experts within 30 days of final approval of this Agreement, DHS shall utilize the Medical Officer Review described in subpart V. F, below.

Section V.E

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
16. There is a protocol to contact a qualified Third Party Expert.		The Department was not able to secure the services of qualified Third Party Experts. In accordance with section V. F. of the Settlement Agreement the Medical Officer Review was initiated.	Discuss on 8-20-12 with parties and monitor **11-17-12 up date** The Department has renewed efforts to recruit a pool of third party experts. Seven individuals have been contacted. One has tentatively agreed. One declined but is forwarding the solicitation to another provider. Two have offered to discuss further.		
17. There is a list of at least 5 Experts pre-approved by Plaintiffs & Defendants.					

18. DHS has paid the Experts for the consultations.					
19. A listed Expert been contacted in each instance of emergency use of restraint.					
20. Each consultation occurred no later than 30 minutes after presentation of the emergency.					
21. Each use of restraint was an "emergency." ***This requirement is evaluated at E.C. ___ above.***					
22. The consultation with the Expert was to obtain professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices.					
If the Expert was not available, see V.F. below.					

"Emergency": "Situations when the client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute an emergency." Settlement, App. A.

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V.F. PROHIBITED TECHNIQUES – MEDICAL OFFICER REVIEW

F. Medical Officer Review. No later than thirty (30) minutes after an emergency use of restraint begins, the responsible supervisor shall contact the Department's medical officer on call in order that the medical officer may assess the situation, suggest strategies for de-escalating the situation, and approve of or discontinue the use of restraint. The consultation with the medical officer shall be documented in the resident's medical record.

Section V.F

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
There were instances of the specified manual /mechanical restraint. **Yes X No** **Number of instances: 7** **11-17-12 up date** **Number of Instances: 1**	Doug Seiler Roger Deneen	Each instance of the use of emergency restraint will result in the following documents being included in this report: DHS form 3652 Documentation for the Implementation of Controlled Procedure DHS form 3653 Consultation with Expanded Interdisciplinary Team Following Emergency Use of Controlled Procedure Individual Progress notes Use of Manual Restraint Review			

23. The responsible supervisor contacted the DHS medical officer on call not later than 30 minutes after the emergency restraint use began.	Doug Seiler Roger Deneen	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. Page 2 under section "Third Party Expert Consulted" **11-17-12 up date** (Exhibit 100)	Continue monitoring		
24. The medical officer assessed the situation, suggested strategies for de-escalating the situation, and approved of or discontinued the use of restraint.	Alan Radke	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. Page 2 under section "Third Party Expert Consulted **11-17-12 up date** (Exhibit 100)	Continue monitoring		
25. The consultation with the medical officer was documented in the resident's medical record.	Doug Seiler Roger Deneen	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. Page 2 under section "Third Party Expert Consulted" **11-17-12 up date** (Exhibit 100)	Continue monitoring		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

V.G. PROHIBITED TECHNIQUES – ZERO TOLERANCE FOR ABUSE AND NEGLECT

G. Zero Tolerance for Abuse and Neglect. The State affirms its commitment to comply with the reporting requirements relating to abuse of vulnerable persons pursuant to Minn. Stat. § 626.557 *et seq*. The State's goal is to achieve "zero tolerance" for abuse (including verbal, mental, sexual, or physical abuse) and neglect, whether from other residents or from staff. Any staff member who has committed staff on resident abuse or neglect shall be disciplined pursuant to DHS policies and the collective bargaining agreement, if applicable. Where appropriate, the State shall refer matters of suspected abuse or neglect to the county attorney for criminal prosecution.

Section V.G

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
There were allegations of abuse (including verbal, mental, sexual, or physical abuse) or neglect. **Yes X No** **Number of allegations: 2** **11-17-12 up date** **Number of allegations: 1**	Doug Seiler Roger Deneen	Incident reports and reports of suspected maltreatment			

26. All allegations were fully investigated and conclusions were reached.	Doug Seiler Roger Deneen	Policy on Zero Tolerance for Abuse and Neglect of Vulnerable Adults and Minors. (Exhibit 26A) There have been two reports of suspected abuse/neglect. Both occurred in the transitional foster care site. Neither report was substantiated. (Exhibit 26B 26C) **11-17-12 up date** The suspected abuse neglect was reported to the common entry point (Exhibit 102 was redacted to protect the names of the mandated reporters). The report was not substantiated.	Continue monitoring		
27. All staff members found to have committed abuse or neglect were disciplined pursuant to DHS policies and collective bargaining agreement, if applicable.	Doug Seiler Roger Deneen				
28. Where appropriate, the State referred matters of suspected abuse of neglect to the county attorney for criminal prosecution.	Doug Seiler Roger Deneen				

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

VI.A. RESTRAINT REPORTING AND MANAGEMENT – REPORTING WITH FORM 31032

A. METO Form 31032 (Attachment C "Documentation of Implementation of Controlled Procedures") shall be completed by the end of the shift during which use is made of manual or mechanical restraint. Attachment C is incorporated into this Agreement by reference.

Section VI.A

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
29. Form 31032 was fully completed whenever use was made of manual or mechanical restraint.	Doug Seiler Roger Deneen	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. **11-17-12 update** (Exhibit 100)	Continue monitoring		
30. For each use, Form 31032 was timely completed, that is, by the end of the shift.	Doug Seiler Roger Deneen	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. **11-17-12 update** (Exhibit 100)	Continue monitoring		
31. Each Form 31032 indicates that no prohibited restraint was used.	Doug Seiler Roger Deneen	Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. **11-17-12 update** (Exhibit 100)	Continue monitoring		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

VI.B. RESTRAINT REPORTING AND MANAGEMENT – 24 HOURS TO REPORT

B. DHS shall undertake reasonable efforts to submit within twenty four (24) hours, but no later than one (l) business day, the completed METO Form 31032 by electronic means, fax or personal delivery, to the following: a. Office of Health Facility Complaints ("OHFC"); b. Ombudsman for Mental Health and Developmental Disabilities; c. DHS Licensing; d. DHS Internal Reviewer; e. Client's family and/or legal representative; f. Case manager; g. Plaintiffs' counsel.

Section VI.B

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
Within 24 hours, and no later than one business day, Form 31032 in each instance was submitted to:	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G. **11-17-12 update** (Exhibit 100) On October 25th the SOS received a correction order from DHS Licensing Division (Exhibit 99)	Continue monitoring		
32. ... Office of Health Facility Compliance	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			
33. ... Ombudsman for MH & DD	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			
34. ... DHS Licensing	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			
35. ... DHS Internal Reviewer	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			
36. ... Client's family and/or legal representative	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			
37. ... Case manager	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			

38. ... Plaintiffs' counsel	Doug Seiler Roger Deneen	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G.			

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

VI.C. RESTRAINT REPORTING AND MANAGEMENT – NOT REPLACE OTHER

C. The reporting requirements in this Section VI shall not replace any other applicable requirement for incident reporting, investigation, analysis and follow up.

Section VI.C

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
Following are other applicable requirements for incident reporting, investigation, analysis and follow up: _____, _____.	Doug Seiler Roger Deneen	Reports of suspected abuse or neglect	Continue monitoring		
39. Those other reports, investigations, analyses and follow up were made in each case of restraint use.	Doug Seiler Roger Deneen	There have been no reports of suspected abuse or neglect pertaining to the 1 incident of the use of emergency restraint.	Continue monitoring		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

VII.A. INTERNAL AND EXTERNAL REVIEW OF THE USE OF RESTRAINTS – INTERNAL REVIEWER

In order to monitor the Facility's use of manual and mechanical restraints, the Department will utilize one of its qualified employees as an internal reviewer and shall fund the costs of the external reviewer within the Office of Health Facility Complaints.

A. Internal Reviewer.

1. The Department shall designate one employee with responsibility for monitoring the Facility's use of restraints ("internal reviewer"). Presently this is Richard S. Amado, Ph.D., Director of the Department's Office for Innovation in Clinical and Person Centered Excellence, whose duties include a focus on the elimination of restraints.
2. The Facility shall complete METO Form 31032 and provide it to the internal reviewer, and all others listed in Section VI. B., above, within twenty-four (24) hours of the use of manual or mechanical restraint. 3. The internal reviewer shall consult with staff at the Facility in order to assist eliminating the use of manual and mechanical restraints.

Section VII.A

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
40. DHS designated one employee (Richard S. Amado, Ph.D.) with responsibility for monitoring the Facility's use of restraints as the Internal Reviewer.	Doug Seiler	Position description for internal expert (Exhibit 40A)			
41. The Facility provided Form 31032 to the Internal Reviewer within 24 hours of the use of manual or mechanical restraint	Doug Seiler	Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G **11-17-12 update** (Exhibit 99) (Exhibit 100)	Continue monitoring		

42. The Internal Reviewer consulted with Facility staff to assist eliminating the use of manual and mechanical restraints.	Rick Amado	Use of Manual Restraint Review included in Exhibits 9A, 9B, 9C, 9D, 9E, 9F, and 9G **11-17-12 update** (Exhibit 100)	Discuss with parties and monitor 8-20-12 **11-17-12 update** The Department, with input from the Monitor and Plaintiffs' counsel, has expanded the role of the Internal Reviewer. (Exhibit 104)		

"Facility: Facility means the Minnesota Extended Treatment Options ("METO") program, its Cambridge, Minnesota successor, and the two new adult foster care transitional homes to which residents of METO have been or may be transferred." Sec. III.B.

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

VII.B. INTERNAL AND EXTERNAL REVIEW OF THE USE OF RESTRAINTS – EXTERNAL REVIEWER

B. **External Reviewer.**

1. The external reviewer will be approved by Plaintiffs and Defendants before hire and will be an employee of the Office of Health Facility Complaints, Minnesota Department of Health and shall have full enforcement authority consistent with the Office of Health Facility Complaints, as set forth in Minn. Stat. § l44A.53, et. seq.
2. DHS will fund the costs of the external reviewer.
3. The external reviewer will have the following credentials:
   a. Ph.D. in psychology, education, clinical social work, or a related field;
   b. Certification or eligible for certification as a Board certified Behavior Analyst at the Doctoral level;
   c. Experience in person centered planning;
   d. Experience using the integration of diagnostic findings, assessment results and intervention recommendations across disciplines in order to create an individual program plan;
   e. Experience and demonstrated competence in the empirical evaluation of mood and behavior altering medications.
4. Every three (3) months, the external reviewer shall issue a written report informing the Department whether the Facility is in substantial compliance with this Agreement and the policies incorporated herein. The report shall enumerate the factual basis for its conclusion and may make recommendations and offer technical assistance. The external reviewer shall provide Plaintiffs and the Department with a draft report. The Plaintiffs and the Department will have fifteen (15) business days to provide written comment. The external reviewer's final report shall be issued to Plaintiffs and the Department thereafter.
5. The external reviewer shall issue quarterly reports to the Court for the duration of this Agreement. The reports shall describe whether the Facility is operating consistent with best practices, and with this Agreement. The external reviewer's reports shall be filed on the Court's public electronic court filing system, or any successor system, with appropriate redaction of the identities of residents or other personal data information that is statutorily protected from public disclosure.
6. The external reviewer shall not be a "Special Master" nor "Court Appointed Monitor." The external reviewer shall have full enforcement authority consistent with the Office of Health Facility Complaints' authority set forth in Minn. Stat. § 144A.53, *et. seq.*
7. In addition to the external reviewer's authority described above, the following shall have access to the Facility and its records, including of residents for the purpose of ascertaining whether the Facility is complying with this Agreement: a. The Office of Ombudsman for Mental Health and Developmental Disabilities, consistent with its authority under Minn. Stat. § 245.94. This Settlement Agreement shall be deemed adequate basis for the Office of Ombudsman to exercise its powers under Minn. Stat. § 245.94, subd. 1. b. The Disability Law Center, consistent with its authority under 42 U.S.C. § 15043. This Settlement Agreement shall be deemed adequate basis for the Disability Law Center, as the designated Protection and Advocacy organization in Minnesota, to

exercise its authority under 42 U.S.C. § 15043. c. Plaintiffs' counsel, upon notice to and coordination with, the Minnesota Attorney General's Office and pursuant to the Protective Order in this case.

Section VII.B

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
43. There is an External Reviewer.	Minnesota Department of Health	The External Reviewer is not in place	Recruitment is on going **11-17-12 update** The parties have agreed to modify the settlement agreement allowing the Monitor to perform the external reviewer duties. The Monitor is drafting language to submit to the court.	See discussion between the parties and court monitor 9-20-12	
44. The External Reviewer was approved by the Plaintiffs and Defendants before hire.	Minnesota Department of Health	Both the Plaintiff's consultants and the defendant are engaged in the interviewing of candidates			
45. The External Reviewer is an employee of the Office of Health Facility Complaints, Minnesota Department of Health.	Minnesota Department of Health				
46. The External Reviewer has full enforcement authority consistent with the Office of Health Facility Complaints' authority, as set forth in Minn. Stat. § l44A.53, *et. seq.*	Minnesota Department of Health				

47. DHS funds the costs of the external reviewer.		Interagency Agreement (Exhibit 47A)		Completed	
48. The External Reviewer has all the following credentials: **a. Ph.D. in psychology, education, clinical social work, or a related field;** **b. Certification or eligible for certification as a Board certified Behavior Analyst at the Doctoral level;** **c. Experience in person centered planning;** **d. Experience using the integration of diagnostic findings, assessment results and intervention recommendations across disciplines in order to create an individual program plan;** **e. Experience and demonstrated competence in the empirical evaluation of mood and behavior altering medications.**	Minnesota Department of Health				

49. After providing Plaintiffs and the Department the opportunity to review and comment on a draft, the External Reviewer issued written quarterly reports (beginning 3/5/12) informing the Department whether the Facility is in substantial compliance with the Agreement and the incorporated policies, enumerating the factual basis for its conclusions.	Minnesota Department of Health				
50. There are recommendations and offers of technical assistance.	Minnesota Department of Health				
51. The External Reviewer filed the quarterly reports with the Court.	Minnesota Department of Health				
52. The following have access to the Facility and its records: The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' counsel.	Doug Seiler Roger Deneen	There have been no reports from the Ombudsman, Disability Law Center, or Plaintiff's counsel regarding problems in accessing the programs. **11-17-12 update** There have been no reports from the Ombudsman, Disability Law Center, or Plaintiff's counsel regarding problems in accessing the programs	Continue monitoring		

53. The following exercised their access authority: The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' counsel	The Office of Ombudsman for Mental Health and Developmental Disabilities, The Disability Law Center, and Plaintiffs' counsel				

"Best Practices: Best practices means generally accepted professional standards." Section III.E.

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

VIII. TRANSITION PLANNING

The State shall undertake best efforts to ensure that each resident is served in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings. The State shall actively pursue the appropriate discharge of residents and provide them with adequate and appropriate transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting and where the individual does not object. Each resident and the resident's family and/or legal representative shall be permitted to be involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication method he or she prefers. To foster each resident's self-determination and independence, the State shall use person centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs. Each resident shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality life. The State shall undertake best efforts to provide each resident with reasonable placement alternatives. It is the State's goal that all residents be served in integrated community settings with adequate protections, supports, and other necessary resources which are identified as available by service coordination. This paragraph shall be implemented in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.,* 527 U.S. 582 (1999).

Section VIII

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
54. The State has undertaken best efforts to ensure that each resident is serve in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings.	Doug Seiler Roger Deneen Alex Bartolic	List of individuals discharged from MSHS Cambridge .since 12-5-11 (Exhibit 54 A). Of the fourteen people nine had formal discharge plans. Three individuals were transferred and two individuals were taken to jails. Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J) **11-17-12 update** Two individuals were transitioned to the community during this review period. RW was discharged on 10-5-12 with a length of stay of 149 days. NK was discharged on 10-26-12 with a length of stay of 1064 days.	Continue monitoring **11-17-12 update** The expanded role of the Internal Reviewer includes the examination of the transition process and recommendations to Departmental leadership on any changes necessary to improve the process in accordance with section VIII if the Settlement (Exhibit104)		

55. The State actively pursued the appropriate discharge of residents and provided them with adequate and appropriate transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting and where the individual does not object.	Doug Seiler Roger Deneen Alex Bartolic	Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J)	Continue monitoring **11/17/12 update** The independent reviewer will be recommending to the program to add a transition plan section to the intake process. The practice will be instituted and reported on in the next bimonthly defendant's status report.		
56. Each resident and the resident's family and/or legal representative has been permitted to be involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication method he or she (or they) prefer.	Doug Seiler Roger Deneen Alex Bartolic	Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J)	Continue monitoring		
57. To foster each resident's self-determination and independence, the State used person centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.	Doug Seiler Roger Deneen Alex Bartolic	Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J)	Continue monitoring		

58. Each resident has been given the opportunity to express a choice regarding preferred activities that contribute to a quality life.	Doug Seiler Roger Deneen Alex Bartolic	Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J)	Continue monitoring		
59. The State undertakes best efforts to provide each resident with reasonable placement alternatives.	Doug Seiler Roger Deneen Alex Bartolic	Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J)	Continue monitoring		
60. The provisions under this Section have been implemented in accord with the *Olmstead* decision.	Doug Seiler Roger Deneen Alex Bartolic	Individual's treatment plan and discharge plan (Exhibits 54 B, 54 C, 54 D, 54E, 54E, 54F, 54G, 54H, 54I, 54J)	Continue monitoring		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

61. Facility treatment staff received training in positive behavioral supports, person centered approaches, therapeutic interventions, personal safety techniques, crisis intervention, and post crisis evaluation.	Doug Seiler Roger Deneen	The training curriculum includes positive behavioral supports, person centered thinking, person centered, team work, prevention and crisis response, medically monitored restraint, personal safety techniques, and critical action review experience (Exhibit 61 A) **11-17-12 update** Upon review of the first Bimonthly report the Monitor identified that training in the area of person centered planning was deficient by 3 hours. (Exhibit 105)	Continue staff training **11-17-12 update** The Department has scheduled an additional training for 11-21-12 and 11-28-12 to ensure all staff have the required 16 hour training. This 3 hour component will include: Review and practice with the Person Centered Thinking tool "Important To/Important For" Review and practice with the Person Centered Thinking tool " Working/Not Working" Review using Working/Not Working to inform Important To/Important For Review of the Person Centered Thinking activity "Trust, Respect, and Partnership". All staff new to the program will receive the complete 16 hour training in Person Centered Thinking.		

62. This training was consistent with applicable best practices, including but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports* (http://apbs.org) (February, 2007)	Doug Seiler Roger Deneen	Training curriculum (Exhibit 61 A)			

IX.A. OTHER PRACTICES AT THE FACILITY – STAFF TRAINING

A. The Facility treatment staff shall receive training in positive behavioral supports, person centered approaches, therapeutic interventions, personal safety techniques, crisis intervention, and post crisis evaluation. The training is explained more fully in Attachment B which is incorporated into this Agreement by reference. All training shall be consistent with applicable best practices, including but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports* (http://apbs.org) (February, 2007).

Section IX.A

"*Best Practices:* Best practices means generally accepted professional standards." Section III.E."

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

IX.B. OTHER PRACTICES AT THE FACILITY – HOURS OF TRAINING

B. 1. Staff at the Facility shall receive the specified number of hours of training subsequent to September l, 2010 and prior to December 31, 2011: Therapeutic interventions (8 hours); Personal safety techniques (8 hours); Medically monitoring restraint (1 hour). Staff at the Facility shall not be eligible to impose restraint until the above specified training has been completed and then only certain restraints in an emergency as set forth in Attachment A to this Agreement, "Therapeutic Interventions And Emergency Use Of Personal Safety Techniques."

2. Staff at the Facility shall receive the specified number of hours of training subsequent to September 1, 2010 and prior to March 31,2012: Person centered planning and positive behavior supports at least sixteen (16) hours on person centered thinking/planning), (40 hours); Post Crisis Evaluation and Assessment, (4 hours).

Section IX.B

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
63. Facility staff receive the specified number of hours of training subsequent to September l, 2010 and prior to December 31, 2011: Therapeutic interventions (8 hours); Personal safety techniques (8 hours); Medically monitoring restraint (1 hour).	Doug Seiler Roger Deneen	Staff training transcripts (Exhibit 63A) **11-17-12 update** (Exhibit 105)	**11-17-12 update** A review of staff training records has been completed. Staff without the necessary training in therapeutic interventions, personal safety techniques, and medically monitored restraint are scheduled for training to be completed prior to 12-31-12. Until this training is complete they are not authorized to participate in the emergency use of restraint		

64. For each instance of restraint, all staff involved in imposing restraint received all the above training.	Doug Seiler Roger Deneen	DHS form 3652 Exhibit 9A, 9B, 9C, 9D, 9E, 9F, and 9G. Staff training transcripts (Exhibit 63A) **11-17-12 update** (Exhibit 105)	Continue to monitor **11-17-12 update** A review of staff training records has been completed. Staff without the necessary training in therapeutic interventions, personal safety techniques, and medically monitored restraint are scheduled for training to be completed prior to 12-31-12. Until this training is complete they are not authorized to participate in the emergency use of restraint.		

65. Facility staff receive the specified number of hours of training subsequent to September 1, 2010 and prior to March 31,2012: Person centered planning and positive behavior supports at least sixteen (16) hours on person centered thinking/planning), (40 hours); Post Crisis Evaluation and Assessment, (4 hours)	Doug Seiler Roger Deneen	Staff training transcripts (Exhibit 63A) **11-17-12 update** Upon review of the first Bimonthly report the Monitor identified that training in the area of person centered planning was deficient by 3 hours. (Exhibit 105)	**11-17-12 update** The Department has scheduled an additional training for 11-21-12 and 11-28-12 to ensure all staff have the required 16 hour training. This 3 hour component will include: Review and practice with the Person Centered Thinking tool "Important To/Important For" Review and practice with the Person Centered Thinking tool " Working/Not Working" Review using Working/Not Working to inform Important To/Important For Review of the Person Centered Thinking activity "Trust, Respect, and Partnership". All staff new to the program will receive the complete 16 hour training in Person Centered Thinking.		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

IX.C. OTHER PRACTICES AT THE FACILITY – VISITOR POLICY

C. Visitor Policy. The State and DHS shall permit residents unscheduled and scheduled visits with immediate family and/or guardians, at reasonable hours, unless the Interdisciplinary Team (IDT) reasonably determines the visit is contraindicated. Visitors shall be allowed full and unrestricted access to the resident's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, consistent with all residents' rights to privacy. Residents shall be allowed to visit with immediate family members and/or guardians in private without staff supervision, unless the IDT reasonably determines this is contraindicated.

Section IX.C

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
66. Residents are permitted unscheduled and scheduled visits with immediate family and/or guardians, at reasonable hours, unless the Interdisciplinary Team (IDT) reasonably determines the visit is contraindicated.	Doug Seiler Roger Deneen	Facility procedure on Client Care and Visitor Procedure 15899 (Exhibit 66A) **11-17-12 Update** Policy was revised and implemented (Exhibit 106)	Current procedure is being revised Continue to monitor		
67. Visitors are allowed full and unrestricted access to the resident's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, consistent with all residents' rights to privacy.	Doug Seiler Roger Deneen	Facility procedure on Client Care and Visitor Procedure 15899 (Exhibit 66A) **11-17-12 Update** Policy was revised and implemented (Exhibit 106)	Continue to monitor		

68. Residents are allowed to visit with immediate family members and/or guardians in private without staff supervision, unless the IDT reasonably determines this is contraindicated.	Doug Seiler Roger Deneen	Facility procedure on Client Care and Visitor Procedure 15899 (Exhibit 66A) **11-17-12 Update** Policy was revised and implemented (Exhibit 106)	Continue to monitor		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

IX.D. OTHER PRACTICES AT THE FACILITY – NO INCONSISTENT PUBLICITY

D. Upon Court approval of this Agreement, the State and DHS will discontinue any marketing of, recruitment or publicity inconsistent with the mission of the Facility.

Section IX.D

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
69. There is marketing, recruitment and publicity does regarding the Facility.		(Exhibit 2A)	**11-17-12 update** In discussion at the 11-14-12 Parties meeting the Department agreed to revise the draft bulletin to emphasize early intervention through CSS and the use of the MSHS –Cambridge program as a crisis intervention for evaluation and stabilization. The final draft bulletin will be shared with Plaintiff's counsel, and consultants then issues by 12-15-12.		

70. The facility has a mission consistent with the Settlement Agreement.	Doug Seiler Roger Deneen	(Exhibit 2A)	See EC #69		
71. The recruitment, publicity and marketing are consistent with the mission.	Doug Seiler Roger Deneen	(Exhibit 2A)	See EC #69		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

IX.E. OTHER PRACTICES AT THE FACILITY – POSTING REQUIREMENTS

E. Pursuant to Minn. Stat. § 144.652, subd. 1, the Facility shall continue to post the Health Care Bill of Rights, the name and phone number of the person within the Facility to whom inquiries about care and treatment may be directed, and a brief statement describing how to file a complaint with the Office of Health Facility Complaints, including the address and phone number of that office.

Section IX.E

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
72. The Facility continues to post the Health Care Bill of Rights, the name and phone number of the person within the Facility to whom inquiries about care and treatment may be directed, and a brief statement describing how to file a complaint with the Office of Health Facility Complaints, including the address and phone number of that office.	Doug Seiler Roger Deneen	The program provides a client hand book (Exhibit 72A) which includes the health care bill of rights and how to contact the Office of Health Facility Complaints and the Ombudsman for Mental Health and Developmental Disabilities. Additionally the program posts this information in the living areas.			
73. The Health Care Bill of Rights posting is in a form and with content which is understandable by residents and family/guardians.	Doug Seiler Roger Deneen	(Exhibit 72A)			

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

X.A. SYSTEM WIDE IMPROVEMENTS – EXPANSION OF COMMUNITY SUPPORT SERVICES

A. **Expansion of Community Support Services.**

1. *The provisions below on long term monitoring, crisis management, and training represent the Department's goals and objectives; they do not constitute requirements. [ITALICS ADDED]* State Operated Community Support Services ("CSS") will be expanded in an effort to deliver the right care at the right time in the most integrated setting for individuals with developmental disabilities. The expansion of this service will allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities receive the appropriate level of care at the right time, in the right place, and in the most integrated setting in accordance with the U.S. Supreme Court decision in *Olmstead v. L.C,* 527 U.S. 582 (1999).

"goals & objectives;" not requirements

a. *Long term monitoring. CSS will identify and provide long term monitoring of individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and prevent multiple transfers within the system. Approximately seventy five (75) individuals will be targeted for long term monitoring.*
b. *Crisis management. Intervention and technical assistance will be provided where the consumer lives, strengthening the capacity for the clinic to serve clinically complex individuals in their homes. CSS mobile wrap-around response teams will be located across the state for proactive response to maintain living arrangements. The maximum time for CSS to arrange a crisis intervention will be three (3) hours from the time the parent or legal guardian authorizes CSS' involvement. CSS will partner with Community Crisis Intervention Services to maximize support, complement strengths, and avoid duplication. CSS will provide augmentative training, mentoring and coaching.*
c. *Training. CSS will provide staff at community based facilities and homes with state of the art training encompassing person centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking. Mentoring and coaching as methodologies will be targeted to prepare for increased community capacity to support individuals in their community. [ITALICS ADDED]*

2. Expansion of CSS will begin in February of 2011 with an estimated completion date of June 30, 2011. This increase will be an additional fourteen (14) full time equivalent positions which will equate to fifteen (15) people. The proposed positions are as follows: Two (2) Behavior Analyst 3 positions; One (1) Community Senior Specialist 3; Two (2) Behavior Analyst 1; Five (5) Social Worker Specialist positions; and Five (5) Behavior Management Assistants. Total cost of salaries for these staff is estimated by DHS to be eight hundred twenty three thousand dollars ($823,000). The estimated cost of equipment and space is estimated by DHS to be one hundred seven thousand eight hundred dollars ($107,800). The term "behavior analyst" refers to individuals with requisite educational background, experience, and credentials recognized by national associations such as the Association of Professional Behavior Analysts.

Section X.A

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
74. The expansion of community services under this provision allows for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities receive the appropriate level of care at the right time, in the right place, and in the most integrated setting in accordance with the U.S. Supreme Court decision in *Olmstead v. L.C*, 527 U.S. 582 (1999).	Doug Seiler	Settlement Agreement Tracking: Community Support Services Areas document August 30, 2012 (Exhibit 74A) This document includes data from July 2011 through August 2012 **11-17-12 update** (Exhibit 107)	Continue monitoring		
75. The State identifies, and provides long term monitoring of, individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and to prevent multiple transfers within the system.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		

76. Approximately seventy five (75) individuals are targeted for long term monitoring.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107) The settlement agreement allows for 75 individuals to receive long-term monitoring. It should be noted that during fiscal year 2012 the average number was 27 and during fiscal year 2013 thus far the average is 33 per month. Although this is well below the projected 75, it appears that this may be the number of individuals with clinical and situational complexities who are at risk for admission into the Cambridge program. CSS is continuing to monitor.	Continue monitoring **11/17/12 update**		
77. CSS mobile wrap-around response teams are located across the state for proactive response to maintain living arrangements.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		
78. CSS arranges a crisis intervention within three (3) hours from the time the parent or legal guardian authorizes CSS' involvement.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		

79. CSS partners with Community Crisis Intervention Services to maximize support, complement strengths, and avoid duplication.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		
80. CSS provides augmentative training, mentoring and coaching	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		
81. CSS provides staff at community based facilities and homes with state of the art training encompassing person centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		
82. CSS mentoring and coaching as methodologies are targeted to prepare for increased community capacity to support individuals in their community.	Doug Seiler	(Exhibit 74A) **11-17-12 update** (Exhibit 107)	Continue monitoring		

83. An additional fourteen (14) full time equivalent positions (15 FTE) were added between February 2011 and June 30, 2011, configured as follows: • **Two (2) Behavior Analyst 3 positions;** • **One (1) Community Senior Specialist 3;** • **Two (2) Behavior Analyst 1;** • **Five (5) Social Worker Specialist positions;** • **Five (5) Behavior Management Assistants**	Doug Seiler	Staffing report August 2012 (Exhibit 83A). **11-17-12 update** (Exhibit 108)	Maintain current staff compliment		
84. None of the identified positions are vacant.	Doug Seiler	All positions are currently filled. (Exhibit 83A) **11-17-12 update** All positions are currently filled (Exhibit 108)			

"The term 'behavior analyst' refers to individuals with requisite educational background, experience, and credentials recognized by national associations such as the Association of Professional Behavior Analysts." Sec. X.A.2.

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

X.B. SYSTEM WIDE IMPROVEMENTS – OLMSTEAD PLAN

B. *Olmstead* Plan

1. Within sixty (60) days of the Court's approval of this Agreement, the Department will establish an *Olmstead* Planning Committee which will issue its public recommendations within ten (l0) months of the Court's Order approving this Agreement. Within eighteen (18) months of the Court's approval of this Agreement, the State and the Department shall 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 individual needs and in the "Most Integrated Setting," and is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead* v. *L.C., 527* U.S. 582 (1999).

2. The Olmstead Planning Committee must be comprised of no less than fifteen (15) members with demonstrated understanding of the spirit and intent of the *Olmstead* decision, best practices in the field of disabilities, and a longstanding commitment to systemic change that respects the human and civil rights of people with disabilities. The Committee must be comprised of stakeholders, including parents, independent experts, representatives of the Department, the Ombudsman for Mental Health and Developmental Disabilities, Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center, Plaintiff's counsel, and others as agreed upon by the parties.

Section X.B

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	

85. An Olmstead Planning Committee was established by February 5, 2012	Maureen O'Connell	The Olmstead Planning Committee was established with the first meeting 3-7-12. (Exhibit 85A) The Committee's web site contains membership list, meeting schedules, meeting minutes and resource documents. (http://www.dhs.state.mn.us/Olmstead) (Exhibit 85B)		Completed	
86. The Committee's public recommendations were issued by October 5, 2012.	Maureen O'Connell	Olmstead Planning Committee web site(Exhibit 85B) **11-17-12 update** (Exhibit 109)	Continue monitoring	Completed	

87. By June 5th, 2013, the State and the Department developed and implemented a comprehensive *Olmstead* plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the "Most Integrated Setting," and which is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead* v. *L.C., 527* U.S. 582 (1999).	Maureen O'Connell	Olmstead Planning Committee web site (Exhibit 85B)	Continue monitoring **11-17-12 update** The Department has received the Committee's recommendations and is beginning the planning process for writing and implementing the Minnesota Olmstead Plan. The Olmstead Committee recommendations (Exhibit 109) is on the DHS website soliciting public comment.		
88. The Olmstead Planning Committee is comprised of no less than fifteen (15) members with demonstrated understanding of the spirit and intent of the *Olmstead* decision, best practices in the field of disabilities, and a longstanding commitment to systemic change that respects the human and civil rights of people with disabilities, and with the required stakeholder representation.	Maureen O'Connell	Olmstead Planning Committee web site (Exhibit 85B)		Completed	

"Best Practices: Best practices means generally accepted professional standards." Section III.E.
DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

X.C. SYSTEM WIDE IMPROVEMENTS – RULE 40

C. **Rule 40.**

1. Within sixty (60) days from the date of the Order approving this Agreement, the Department shall organize and convene a Rule 40 (Minn. R. 9525.2700-.2810) Advisory Committee ("Committee") comprised of stakeholders, including parents, independent experts, DHS representatives, the Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center, Plaintiffs' counsel and others as agreed upon by the parties, to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the "most integrated setting" and "person centered planning, and development of an *'Olmstead* Plan'" consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C,* 527 U.S. 582 (1999). The Committee's review of best practices shall include the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors.
2. Within sixty (60) days from the date of the Court's approval of this Agreement, a public notice of intent to undertake administrative rule making will be issued.
3. DHS will not seek a waiver of Rule 40 for the Facility.

Section X.C

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
89. By February 5, 2012, the Department convened a Rule 40 Advisory Committee with the designated membership approved by the parties.	Alex Bartolic	Rule 40 Committee web site http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166534 (Exhibit 89)		Completed	

90. The function, operations and the product, of the Committee are to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the "most integrated setting" and "person centered planning, and development of an *'Olmstead* Plan'" consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C,* 527 U.S. 582 (1999).	Alex Bartolic	Rule 40 Committee web site(Exhibit 89)	Continue monitoring **11-17-12 update** The Rule 40 sub committees have issued their recommendations pertaining to use of positive supports, person centered planning, prohibited procedures, implementation strategies, training, monitoring and oversight. The Department is drafting summary documents to be reviewed by the Committee to ensure the language captures the intent of the Committee. The Department will be drafting legislation to modify state statute 245D (licensing Act for Home and Community Based Waiver Services) that will incorporate Committee recommendations.		
91. The Committee's review of best practices included the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors.	Alex Bartolic	Rule 40 Committee web site (Exhibit 89)		Completed	

92. The Committee issued a public notice of intent to undertake administrative rule making by February 5, 2012.	Alex Bartolic	Request for Comments On possible rule governing Aversive and deprivation procedures. (Exhibit 92) Rule 40 Committee web site (Exhibit 89)		Completed	
93. DHS did not seek a waiver of Rule 40 for the Facility.	Doug Seiler Roger Deneen	No licensing variance has been sought.		Completed	

"Best Practices: Best practices means generally accepted professional standards." Section III.E.

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

X.D. SYSTEM WIDE IMPROVEMENTS – MINNESOTA SECURITY HOSPITAL

D. Minnesota Security Hospital.

1. Within sixty (60) days upon Court approval of this Agreement, the State shall undertake best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability. No later than July 1, 2011, there shall be no transfers or placements of persons committed solely as a person with a developmental disability to the Minnesota Security Hospital. This prohibition does not apply to persons with other forms of commitment, such as mentally ill and dangerous, mentally ill, chemically dependent, psychopathic personality, sexual psychopathic personality and sexually dangerous persons. Nor does this prohibition pertain to persons who have been required to register as a predatory offender under Minn. Stat. § 243.166 or 243.167 or to persons who have been assigned a risk level as a predatory offender under Minn. Stat. § 244.052.

2. There shall be no change in commitment status of any person originally committed solely as a person with a developmental disability without proper notice to that person's parent and/or guardian and a full hearing before the appropriate adjudicative body.

3. No later than December 1, 2011, persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender

status set forth in paragraph 1, above, shall be transferred by the Department to the most integrated setting consistent with *Olmstead* v. *L.c.*, 527 U.S. 581 (1999).

Section X.D

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
94. Beginning at least by February 5, 2012, the State takes best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability.	Carol Olson Doug Seiler Roger Deneen Alex Bartolic	Joint communication from the DHS commissioner and the Ombudsman for DD/MH (Exhibit 94A) Community Support Services Tracking Log—MI/Dangerous Inquiries for Persons with Intellectual Disabilities (Exhibit 94B) **11-17-12 update** Community Support Services Tracking Log—MI/Dangerous Inquiries for Persons with Intellectual Disabilities (Exhibit 110)	Continue monitoring		
95. Beginning no later than July 1, 2011, there are no transfers or placements of persons committed solely as a person with a developmental disability to the Minnesota Security Hospital (subject to the exceptions in the provision).	Carol Olson Doug Seiler Roger Deneen Alex Bartolic	There have been no transfers or placements of persons committed solely as a person with developmental disability	Continue monitoring		

96. There has been no change in commitment status of any person originally committed solely as a person with a developmental disability without proper notice to that person's parent and/or guardian and a full hearing before the appropriate adjudicative body.	Carol Olson Doug Seiler Roger Deneen Alex Bartolic	There has been no change in commitment status of persons originally committed as a person with developmental disability.	Continue monitoring		
97. Beginning no later than December 1, 2011, all persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender status set forth in paragraph 1, above, are transferred by the Department to the most integrated setting consistent with *Olmstead* v. *L.C.*, 527 U.S. 581 (1999).	Carol Olson Doug Seiler Roger Deneen Alex Bartolic	There are three individuals who currently reside at the Minnesota Security Hospital who meet this criteria. All three have pending placements. (Exhibits 97A, 97B, and 97C) **11-17-12 update** Two of the three men have been transitioned to the community (Exhibits 111A and 111B)	Continue monitoring **11-17-12 update** The last individual is awaiting transition to the community pending county approval		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

X.E. SYSTEM WIDE IMPROVEMENTS – ANOKA METRO REGIONAL TREATMENT CENTER

E. **Anoka Metro Regional Treatment Center.** Persons committed solely as a person with a developmental disability may be transferred to AMRTC only if they have an acute psychiatric condition. Within thirty (30) days of the Court's approval of this Agreement, any AMRTC resident committed solely as a person with a developmental disability who does not have an acute psychiatric condition will be transferred from AMRTC. The transfer shall be to the most integrated setting consistent with *Olmstead* v. *L.c.,* 527 U.S. 581 (1999).
Section X.F.

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
98. Beginning no later than January 5, 2012, all AMRTC residents committed solely as a person with a developmental disability and who do not have an acute psychiatric condition are transferred from AMRTC to the most integrated setting consistent with *Olmstead* v. *L.C.,* 527 U.S. 581 (1999)	Alan Radke Doug Seiler Dave Hartford	During the interval of this status report there was one individual admitted to AMRTC with a developmental disability under a Rule 20.01 treat to competency order and under a civil commitment Developmentally Disabled. He was admitted from the Competency Restoration **11-17-12 update** During the period of this report there were no persons admitted to the AMRTC committed solely as a person with a developmental disablity	Continue monitoring		

DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

X.F. SYSTEM WIDE IMPROVEMENTS – LANGUAGE

F. DHS shall substitute the term "developmental disabilities" for the term "mental retardation" where it appears in any DHS policy, bulletin, website, brochure, or other publication, at the next printing or revision of the publication, provided the change does not directly conflict with federal law, jeopardize receipt of federal funds, or impair the health care billing process. DHS also agrees to draft a bill for the Minnesota Legislature that will require the replacement of terms such as "insane," "mentally incompetent," "mental deficiency," and other similar inappropriate terms that appear in Minnesota statutes and rules.

Section X.F

Evaluation Criteria	Person Responsible	Documentation for Verification	Next Steps	Status	
This section is applicable to locations where the term "mental retardation" appears in any DHS policy, bulletin, website, brochure, or other publication					
99. The term "mental retardation" has been replaced with "developmental disabilities" in any DHS policy, bulletin, website, brochure, or other publication.	Alex Bartolic	The Department has initiated audits to identify where out dated language was use and replaced it with current language. Additionally when outdated language has been identified by the Plaintiffs and their consultants the Department has moved to replace the out dated language.	Continue monitoring		

100. DHS drafted and submitted a bill for the Minnesota Legislature that will require the replacement of terms such as "insane," "mentally incompetent," "mental deficiency," and other similar inappropriate terms that appear in Minnesota statutes and rules.	Tom Ruter	Laws of Minnesota 2012, Chapter 216, Article 12, Sec. 10.	Convene working group to identify areas where out dated and/or offensive language exists. Draft legislation for the 2013 session **11-17-12 update** The working group is in the process of drafting the legislation for the 2013 legislative session.	Working group convened 8-11-12	

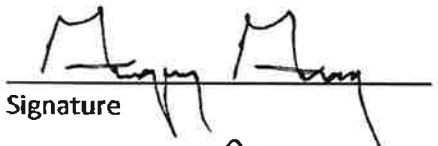
DOCUMENTATION / ADDITIONAL INFORMATION: See supplemental material.

SUBMISSION

The above information is true and correct to the best of my knowledge, information and belief.

Affirmed and submitted to the Court through its Independent Advisor and Monitor

by:



Signature

Gregory Coray

Printed Name

Chief Compliance Officer

Title

for the Defendants & the Department of Human Services

Date November 19, 2012

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EXHIBIT 111B **DISCHARGE SUMMARY – CB (CONTAINS PRIVATE DATA)**

Exhibit 98

Minnesota Department of **Human Services**

Minnesota Specialty Health System - Cambridge

Date_____

RE: MSHS-Cambridge Services Survey

Dear_____:

Minnesota Specialty Health System-Cambridge is interested in providing quality services to the individuals we work with each day. We are most interested in hearing from you about the services we provide.

Attached you will find a short survey with a self-addressed stamped envelope.

Please take a moment of your time to provide us with your feedback and thank you in advance for sharing your thoughts regarding our services with us.

Sincerely,

Katy Mattson,
MSHS-Cambridge Admission's Officer/Discharge Coordinator

Attachment

Mail To:
MSHS-Cambridge
1425 East Rum River Drive South
Cambridge, MN 55008
OR
Fax To: 763-689-7216

Date: 9/6/12

Family and Concerned Persons Survey

Research confirms that it is frequently more effective for Transitional Services Programs to include persons who are significant in a client's life in treatment, that doing so results in better outcomes for the clients with whom we work.

In order for us to provide effective services it is crucial that we obtain feedback. We would greatly appreciate it if you would take the time to fill out this form. Or, in addition, if you wish you may certainly contact the Treatment Director, Stuart Hazard, who can be reached at 763-689-7169, or the Program Administrator, Paula Halverson, who is at 651-431-5010.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Does Not Apply	Comments
Program staff were respectful and courteous in their interactions with clients and family members	1	2	3	4	(5)	N/A	
Program staff listened to family concerns and suggestions and used that information to develop services when possible	1	2	(3)	4	5	N/A	
The information which was presented by program staff was helpful	1	2	3	(4)	5	N/A	
Overall, my experience in working with this program was a positive one	1	2	3	(4)	5	N/A	

If you have any other comments or feedback, please use the space below.

See Attached

I found the staff very friendly and helpful when I visited [redacted] I also thought the facility was clean and orderly.

My only concern is that there seems to be little structure for the individuals. I can't help but wonder if there should be more planned activities and work for them to do. Very often when I call my daughter to talk to her she says she had done nothing all day.

Maybe this is a budget issue, or maybe I am getting a wrong picture of the situation. Whatever it is, my impression is she is not really required to do much of anything all day.

Thank you,

[redacted]

Mail To:
MSHS-Cambridge
1425 East Rum River Drive South
Cambridge, MN 55008
OR
Fax To: 763-689-7216

Date: 9/6/12

Family and Concerned Persons Survey

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	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Does Not Apply	Comments
Program staff were respectful and courteous in their interactions with clients and family members	1	2	3	(4)	5	N/A	
Program staff listened to family concerns and suggestions and used that information to develop services when possible	1	2	3	(4)	5	N/A	
The information which was presented by program staff was helpful	1	2	3	(4)	5	N/A	
Overall, my experience in working with this program was a positive one	1	2	3	(4)	5	N/A	

If you have any other comments or feedback, please use the space below.

Mail To:
MSHS-Cambridge
1425 East Rum River Drive South
Cambridge, MN 55008
OR
Fax To: 763-689-7216

Date: 9/6/12

Family and Concerned Persons Survey

Research confirms that it is frequently more effective for Transitional Services Programs to include persons who are significant in a client's life in treatment, that doing so results in better outcomes for the clients with whom we work.

In order for us to provide effective services it is crucial that we obtain feedback. We would greatly appreciate it if you would take the time to fill out this form. Or, in addition, if you wish you may certainly contact the Treatment Director, Stuart Hazard, who can be reached at 763-689-7169, or the Program Administrator, Paula Halverson, who is at 651-431-5010.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Does Not Apply	Comments
Program staff were respectful and courteous in their interactions with clients and family members	1	2	3	4	5	N/A	
Program staff listened to family concerns and suggestions and used that information to develop services when possible	1	2	3	4	5	N/A	
The information which was presented by program staff was helpful	1	2	3	4	5	N/A	
Overall, my experience in working with this program was a positive one	1	2	3	4	5	N/A	

If you have any other comments or feedback, please use the space below.

Exhibit 99

Exhibit 99

Minnesota Department of **Human Services**

October 25, 2012

Patricia Carlson, CEO
Minnesota Specialty Health System - Cambridge
P.O. Box 64979
Saint Paul, MN 55164

License Number: 804294 (245B-RS-N)

CORRECTION ORDER

Dear Ms. Carlson:

On October 25, 2012, a review of licensing requirements was completed for an Emergency Restraint report submitted to the Department of Human Services on September 21, 2012 from Minnesota Specialty Health System - Cambridge, located at 1425 East Rum River Drive South, Cambridge, Minnesota. The review was conducted to determine compliance with state and federal laws and rules governing the provision of residential services to persons with developmental disabilities under Minnesota Statutes, Chapter 245B. As a result of this review a Correction Order is being issued.

A. Reason for Correction Order

Pursuant to Minnesota Statutes, section 245A.06, if the Commissioner of Department of Human Services finds that a license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the Commissioner may issue a Correction Order to the license holder.

The following violation(s) of state or federal laws and rules were determined as a result of the licensing review. Corrective action for each violation is required by Minnesota Statutes, section 245A.06 and is hereby ordered by the Commissioner of Human Services.

1. Citation: Minnesota Rules, part 9525.2770, subpart 5.

   Violation: For one consumer whose record was reviewed (C1) a controlled procedure was implemented on an emergency basis on September 17, 2012. The license holder did not ensure that staff followed the reporting and review requirements required in their policy.

   The license holder's policy number 6260, Therapeutic Interventions and Emergency Use of Personal Safety Techniques, stated that:

   "The completed MSHS – Cambridge form #31032 shall be submitted electronically, faxed or personally delivered to the following offices or persons. A reasonable effort must be made to submit it within 24 hours, but in no event later than the next business day.

(1) Office of Health Facility Complaints;
(2) Ombudsman for Mental Health and Developmental Disabilities;
(3) DHS Licensing;
(4) DHS Internal Reviewer;
(5) Client's family and/or legal representative;
(6) Case Manager;
(7) Plaintiffs' Council."

It was determined that the license holder failed to implement their policy for reporting the use of a controlled procedure which was implemented on September 17, 2012. The license holder failed to notify the Ombudsman for Mental Health and Developmental Disabilities, the Department of Human Services (DHS)-Licensing Division, and the DHS Internal Reviewer, within 24 hours, or in no event later than the next business day, as required in the license holder's policy.

On September 17, 2012, the DHS-Licensing Division received an email from the license holder. The email stated, "Attached is the Documentation for Implementation of Controlled Procedures form dated 2012/09/17 for [C1]." Upon opening the email it was determined that the report was not attached. On September 18, 2012, DHS–Licensing Division and the DHS Internal Reviewer sent a reply email to the license holder requesting the attachment. On September 21, 2012 the Ombudsman for Mental Health and Developmental Disabilities sent an email stating they had not yet received the attachment. On September 21, 2012, the DHS Internal Reviewer sent an email stating, "I had it resent to me and I have attached it to this message." In a separate email DHS-Licensing asked the DHS Internal Reviewer when they had received the attachment and the reply was, "Yesterday, 9/20."

It was determined that the DHS Internal Reviewer received the attachment on September 20, 2012, DHS Licensing Division on September 21, 2012 and Ombudsman for Mental Health and Developmental Disabilities on September 21, 2012.

Repeat Violation: This is a repeat licensing violation. The license holder was cited for similar violation in the following orders:

- February 15, 2012
- July 5, 2012
- July 12, 2012

Corrective Action Ordered: Within 30 days of receipt of this order submit written documentation detailing how compliance with this licensing requirement has been achieved and will be maintained throughout the program.

If you fail to correct the violations specified in the Correction Order within the prescribed time lines the Commissioner may issue an Order of Conditional License or may impose a fine and order other licensing sanctions pursuant to Minnesota Statutes, sections 245A.06 and 245A.07. No submissions are required as a result of this correction order.

Submissions required as part of a corrective action ordered must be sent to your Licensor at:

Commissioner, Department of Human Services
ATTN: Dawn Bramel
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

B. Right to Request Reconsideration

If you believe any of the citations are in error, you have the right to request that the Commissioner of Human Services reconsider the parts of the Correction Order that you believe to be in error. The request for reconsideration must be in writing and received by the Commissioner within 20 calendar days after receipt of this report. Your request for reconsideration must be sent to:

Commissioner, Department of Human Services
ATTN: Legal Unit
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

Please note that a request for reconsideration does not stay any provisions or requirements of the Correction Order. The Commissioner's disposition of a request for reconsideration is final and not subject to appeal under Minnesota Statutes, chapter 14.

If you have any questions regarding this Correction Order, please contact me as soon as possible.

Dawn Bramel, Acting DD Unit Manager
Minnesota Department of Human Services
Division of Licensing
651-431-6539

cc: Penny Messer, Isanti County Adult Services Director

Minnesota Department of **Human Services**

Minnesota Specialty Health System - Cambridge

November 16, 2012

Commissioner, Department of Human Services
Attn: Dawn Bramel
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

RE: License Number 804294(245B-RS-N)

Ms. Bramel;

Please find enclosed the responses to two correction orders for MSHS Cambridge dated 10/25/2012 and 10/26/2012. If you have any questions or concerns please feel free to contact me at 651-431-5010 or via e-mail at paula.halverson@state.mn.us.

Sincerely,

Paula Halverson

Paula Halverson
Director, MSHS

Cambridge Licensing Response
License # 804294
Correction Order
DHS License Review – Correction order sent 10/25/12 and 10/26/12

Date and #	Citation	Citation Description	Corrective Action Ordered	Target Date / Individual responsible	Attachments and Plans
10/25/12 Citation #1	245A.06 MN Rules part 9525.2770, subpart 5	Failure to report Emergency Use of Controlled Procedure according to facility procedure.	Within 30 days of receipt or this order submit written documentation detailing how compliance with this licensing requirement has been achieved and will be maintained throughout the program.	1a. Completed 10/31/12 – Charlene Reinhart 1b. Completed 11/14/12 – Charlene Reinhart 2. Training will be completed 11/30/12.	1. Corrected the technical process for notifying interested parties via the following: a. Incorporated internal and external parties within the same e-mail to ensure that all parties visualize the content and note if there are discrepancies or errors. b. Revised Emergency Use of Controlled Procedure Notification process and created checklist from notification/reporting protocol to be checked off and signed by both primary implementing and secondary observing authorities. (See attachment #1 – revisions highlighted in yellow) 2. Training and competency check off of Lead Workers, Supervisors, and other designees on the new process will be completed.
10/26/12 Citation #1	245A.06 MN Rules part 9525.2770,	Failure to documents a restraint as such; failure to	Within 30 days of receipt or this order submit written documentation detailing how compliance with this	1. Completed on 11/8/12 – Paula Halverson 2. 12/31/12 – MSHS	1. Director, MSHS met with SOS staff development and reviewed the corrective action on 11/8/12 and requested a change in teaching

	subparts 2,5, & 6	demonstrate the need for the restraint that was not correctly documented.	licensing requirement has been achieved and will be maintained throughout the program.	Management – Stuart Hazard. 3. 12/31/12 – MSHS Cambridge staff and SOS Staff Development.	curriculum that would inform staff of change in technique description/definition of "simple escort" re: topography vs. function or intent (immediate). 2. All staff to review Policy 6260 Therapeutic Intervention and Emergency Use of Personal Safety Techniques by December 31st, 2012. 3. Complete revised TI/PST training with all MSHS Cambridge staff by 12/31/12. Objective of the training is for participants to be competent in the following: a. Accurately categorize restraint vs non restraint. b. Document physical safety strategies.

Submitted by: Paula Halverson, MSHS Director

Paula Halverson

EMERGENCY USE OF CONTROLLED PROCEDURE (EUCP) NOTIFICATIONS CHECKLIST

Date /Time of EUCP: _____ _____ ☐ AM ☐ PM Client Name: _____

A. FIRST STEP NOTIFICATIONS

☐ 1. Notify Stuart, Margaret, Mitch and Paula of the use of an emergency controlled procedure and send a copy of the form. Stuart, Margaret, Mitch or Paula **must** review the form before it is scanned, e-mailed, faxed or post office mailed.

☐ 2. Send an e-mail using the template found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\1st E-mail for EUCP (copies to Paula, Doug, Mike T, T. Ruter, P. Carlson). Complete the body of the e-mail describing the use in SBAR (Situation, Background, Assessment, Response) format. *[The documentation form will be sent once it is completed and reviewed (see B 5-9 below).]*

3. Notifications for use of an emergency controlled procedure may be sent via e-mail, fax or via United States Postal Service (USPS). ***EXCEPTION:*** Ombudsman and Plaintiff's Counsel notifications must be sent via e-mail or fax **AND** US Mail. A reasonable effort must be made to complete notification within 24 hours, but in no event later than the next business day.

☐ ** ***In addition to e-mail or fax notification, the Legal Representative and County Case Manager must receive verbal notification within 24 hours.***

☐ 4. Determine the method you will use for notification and document all notifications on the last page of the DHS-3652 form.

☐ FIRST STEP NOTIFICATIONS COMPLETED

B. E-MAIL NOTIFICATIONS

☐ 1. Scan the completed DHS-3652 form to your own e-mail.

- Press Scan on the printer/copier.
- Press E-mail.
- Press Input on the screen – enter your e-mail address [e.g., joe.bloe@state.mn.us]
- Click on File Name on the screen. Press Clear.
- Type on File Name line: *EUCP Form for [client's initials].*
- Press OK.
- Press Scan button on screen.

☐ 2. Go to your Outlook e-mail and open the e-mail you just sent yourself (the form will show under "Message" – it looks like an attachment).

☐ 3. Click on File, then Save As.

- Go to the client's I drive Cont Proc, PRN & EIDT Documentation folder and click on Save. You can rename the document before hitting Save (e.g. 2012-11-15 EUCP e-mail) but you don't have to.

☐ 4. Your original e-mail will reappear. Right click on the attachment and click on copy.

☐ 5. Open the following file: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\E-Mail for EUCP Template.

- The *E-mail for EUCP Template* document is a template e-mail that includes agencies/persons to be notified except legal representative and/or county case manager (CCM). You must add the e-mail addresses for the legal representative and/or CCM as appropriate. This information may be found in the client's I drive folder on the Contact Information Form. **NOTE: This template must be used as it contains encryption for the attachment. E-mailing PHI information outside of the state system without encryption is a HIPAA and data privacy violation!**

☐ 6. Go to the body of the e-mail, right click and click on Paste. The document will show as an attachment.

☐ 7. Click on [date] and enter the date of use from the form.

☐ 8. Click on [client name] and enter the appropriate information.

☐ 9. Click on the send button to send the e-mail. **Note: Before clicking send, verify that any e-mail addresses you added are entered correctly and that attachment is there.** You can double click on the attachment to open it. Close the attachment before hitting the send button.

☐ 10. Go into your Sent Items box and print the e-mails. Put the printed e-mails in the gray box along with the original report form.

☐ E-MAIL NOTIFICATIONS COMPLETED

C. FAX NOTIFICATIONS

☐ 1. Open the following folder: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates. **NOTE: These templates must be used as they contain the required privacy notice for sending protected health information (PHI).**

☐ 2. Open, complete and print each fax cover sheet template for the DHS Internal Reviewer, Ombudsman, DHS Licensing, and OHFC. **NOTE:** The plaintiff's counsel does not have a fax number on file.

☐ 3. Open the fax cover sheet template for Legal Rep or CCM. Complete and print one form for Legal Rep and one form for CCM. Fax number information may be found in the client's I drive folder on the Contact Information Form.

☐ 4. For each form, load the cover sheet and the completed DHS-3652 (Documentation for Implementation of Controlled Procedures) form into the printer/copier.

☐ 5. Press Fax button.

☐ 6. Type in phone number listed under FAX number on the template form. Press Send.

☐ 7. When the documents have finished transmitting, you will receive a Fax transmission report. Attach all transmission reports to the original fax cover sheets and put in gray box along with the original report form.

☐ FAX NOTIFICATIONS COMPLETED

D. UNITED STATES POSTAL SERVICE (USPS) DELIVERED NOTIFICATIONS

Until further notice, copies of the EUCP form for the Ombudsman and the Plaintiff's counsel **must be sent** via US mail **in addition to** e-mail or fax. Also, in the event an individual does not have a fax number or e-mail address, or the fax number/e-mail address communication fails, notification must be sent via USPS.

- Addresses for agencies/persons to be notified may be found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\DHS-3652-Contact Info - Notifications for EUCP. Labels and stamps for the Plaintiff's counsel and the Ombudsman are available in the Op Center.
- The Legal Rep and County Case Manager addresses may be found in the client's I drive folder on the Contact Information Form.

☐ MAIL NOTIFICATIONS COMPLETED

I ACKNOWLEDGE THAT THE ABOVE NOTIFICATION PROCESS HAS BEEN FOLLOWED AND COMPLETED.

_____ _____

Signature of Person Completing Notifications *Date / Time*

When completed, send this checklist to HIMS.

Process for Emergency Use of Controlled Procedures Notifications

A. Notify Stuart, Margaret, Mitch and Paula of the use of an emergency controlled procedure and send a copy of the form. Stuart, Margaret, Mitch or Paula **must** review the form before it is scanned, e-mail, faxed or post office mailed. (See attached e-mails for details.)

B. Send an e-mail using the template found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\1st E-mail for EUCP (copies to Paula, Doug, Mike T, T. Ruter, P. Carlson). Complete the body of the e-mail describing the use in SBAR (Situation, Background, Assessment, Response) format. *[The documentation form will be sent once it is completed and reviewed (see 9-14 below).]*

C. Notifications for use of an emergency controlled procedure may be sent via e-mail, fax or via United States Postal Service (USPS). ***EXCEPTION:*** Ombudsman and Plaintiff's Counsel notifications must be sent via e-mail or fax **AND** US Mail. A reasonable effort must be made to complete notification within 24 hours, but in no event later than the next business day.

** ***In addition, the Legal Representative and County Case Manager must receive verbal notification within 24 hours.***

D. Determine the method you will use for notification and document all notifications on the last page of the DHS-3652 form.

E-mail notifications

A. Scan the completed DHS-3652 form to your own e-mail.
1. Press Scan on the printer/copier.
2. Press E-mail.
3. Press Input on the screen – enter your e-mail address [e.g., joe.bloe@state.mn.us]
4. Click on File Name on the screen. Press Clear.
5. Type on File Name line: *EUCP Form for [client's initials].*
6. Press OK.
7. Press Scan button on screen.

B. Go to your Outlook e-mail.
8. Open the e-mail you just sent yourself (the form will show under "Message" – it looks like an attachment). Click on File, then Save As.
9. Go to the client's I drive Cont Proc, PRN & EIDT Documentation folder and click on Save. You can rename the document before hitting Save (e.g. 2012-11-15 EUCP e-mail) but you don't have to.
10. Your original e-mail will reappear. Right click on the attachment and click on copy.
11. Open the following file: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\E-Mail for EUCP Template
    - The *E-mail for EUCP Template* document is a template e-mail that includes agencies/persons to be notified except legal representative and/or county case manager (CCM). You must add the e-mail addresses for the legal representative and/or CCM as appropriate. This information may be found in the client's I drive folder on the Contact Information Form. **NOTE: This template must be used as it contains encryption for the attachment. E-mailing PHI information outside of the state system without encryption is a HIPAA and data privacy violation!**
12. Go to the body of the e-mail, right click and click on Paste. The document will show as an attachment.
13. Click on [date] and enter the date of use from the form.
14. Click on [client name] and enter the appropriate information.

15. Click on the send button to send the e-mail. **Note: Before clicking send, verify that any e-mail addresses you added are entered correctly and that attachment is there.** You can double click on the attachment to open it. Close the attachment before hitting the send button.
16. Go into your Sent Items box and print the e-mails. Put the printed e-mails in the gray box along with the original report form.

Fax Notifications

1. Open the following folder: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates. **NOTE: These templates must be used as they contain the required privacy notice for sending protected health information (PHI).**
2. Open, complete and print each fax cover sheet template for the DHS Internal Reviewer, Ombudsman, DHS Licensing, and OHFC. **NOTE:** The plaintiff's counsel does not have a fax number on file.
3. Open the fax cover sheet template for Legal Rep or CCM. Complete and print one form for Legal Rep and one form for CCM. Fax number information may be found in the client's I drive folder on the Contact Information Form.
4. For each form, load the cover sheet and the completed DHS-3652 (Documentation for Implementation of Controlled Procedures) form into the printer/copier.
5. Press Fax button.
6. Type in phone number listed under FAX number on the template form. Press Send.
7. When the documents have finished transmitting, you will receive a Fax transmission report. Attach all transmission reports to the original fax cover sheets and put in gray box along with the original report form.

United States Postal Service (USPS) Delivered Notifications

Until further notice, copies of the EUCP form for the Ombudsman and the Plaintiff's counsel must be sent via US mail **in addition to** e-mail or fax. Also, in the event an individual does not have a fax number or e-mail address, or the fax number/e-mail address communication fails, notification must be sent via USPS.

- Addresses for agencies/persons to be notified may be found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\DHS-3652-Contact Info - Notifications for EUCP. Labels and stamps for the Plaintiff's counsel and the Ombudsman are available in the Op Center.
- The Legal Rep and County Case Manager addresses may be found in the client's I drive folder on the Contact Information Form.

If you find that you have sent this information to the wrong e-mail address, fax number or mailing address:

- Notify SOS HIMS immediately.
  Sondra Johnson (651-295-2302); or
  Bridgette Nevala (612-390-5626)
- Please include the following details in the notification:
  - Who the e-mail or fax was sent to
  - What documents or information was sent
  - The date the e-mail or fax was sent
  - The date it was discovered
  - If the e-mail was successfully recalled**

To recall an e-mail:

- Go into the sent items folder
- Double click on the e-mail that was sent in error
- Click on the Actions button on the toolbar
- Click the Recall this message button
- A box will appear

- Make sure *delete unread copies of this e-mail* is checked and that the *tell me if the recall fails or succeeds* box is checked
- Click on OK button
- A notice will appear in your inbox on whether or not the recall failed or succeeded

E-mail: TO: All MSHS-Cambridge Staff FROM: Paula Halverson SENT 7/25/12 at 1:16 PM

Subject: Must read: EUCP

I writing to provide some clear direction on fillling out the EUCP, especially since Dr. Marr is no longer here to review the document:

1. Please make sure that either Stuart, Stephanie or I review the EUCP for the completion of the document before it is submitted within the 24 hours to designated individuals. (Please send out to all three of us. Stuart is the primary, Stephanie secondary and myself third).
2. All areas need to be filled in except of course the boxes for Designated Coordinator Review and the BMRC section within 24 hours.
3. The page "Notifications (within 24 hours of use)" needs to be completed with the dates and signatures, etc. So if I am going to e-mail out the notification I would indicate that example: 10:20am it would be sent out to DHS internal reviewer, DHS licensing, etc. Legal representative and CCM would potentially have different times if they do not have e-mails but you would indicate estimated time you would be doing this. I would write this all down so it is completed than send out to the designated individuals. This whole form needs to be completed prior to sending out the document. The "notification" portion of the document is a part of the form and we are to send out the completed form.
4. If prone hold is checked if we used this to transition this to a side lying position this has to be in transition to the other position. This position cannot be held for a length of time since this position is prohibited.

E-mail: TO All MSHS-Cambridge Staff FROM Natalie Marr SENT 6/11/12 at 12:10 PM
Subject: Emergency Use of Controlled Procedure (EUCP) Form Notifications (page 3) and Process revision

MSHS Cambridge staff –

I am writing this email as an informational memo to the campus in the interim of doing some more specific training on this issue. We have successfully completed and sent in restraint reports to the many parties court ordered to get these documents in the settlement. The completion of this paperwork and the notifications to several parties is a feat in and of itself, in addition to the fact that this is during a time of understandable distress for the campus following the need to use an emergency procedure. I applaud you all for your hard work in both realms. We have been notified by our partners at DHS licensing after each of these reports being sent out, with some helpful hints on what information they see as lacking in the documentation. I have asked on a few occasions for information to be added, reworded, etc. to address DHS licensing's requests. This is mostly due to the fact that we have not in the past been as detailed in these EUCP reports because there are usually corresponding incident reports, progress notes, etc., that flesh this out for us. Because the parties in the litigation are *only* seeing the EUCP form, we need to be more detailed than we have in the past.

In order to assist you all with completing the EUCP documentation, please do the following:

1) For the time being I want to review and assist the writers of the EUCP form to incorporate all the elements I know that DHS licensing has been asking us to be more specific about. If I am on vacation or out on sick leave I will send out an all staff communication naming who is acting on behalf for this task. If possible, prior to completing and signing the EUCP report, please contact me and provide me a copy so I can review and recommend any needed changes, additions, etc.
2) It's best to contact me or my back-up before the restraint form is finalized, but if the report must be finalized in order to be completed and signed by the involved parties prior to a shift's end and I am not available, please go ahead and complete the form. In these cases the restraint form *should not* be sent out to the parties named in the settlement until I or my back-up can review it first. In such a case I may have someone complete a memo adding or explaining any needed elements to send with the restraint form.
3) Remember when sending out the forms to all parties that the timeline for this to occur is "in 24 hours, or at least by the next business day". Please take your time with the documentation and use the time we have allotted to make sure the EUCP form has all the elements needed. For instance, if the restraint occurs on the weekend, it *can wait* for me or my back-up to review it on Monday, which is the next business day. Again, if you are awaiting review of the documentation *no restraint forms* should be scanned, emailed, faxed, or post office mailed to the parties named in the settlement until this has occurred. The verbal notifications to the legal guardian and case manager do still need to occur though.
4) Lastly Doug Seller, Paula Halverson, Mike Tessneer (who is our DHS Compliance Office representative on the settlement) will also need to be informed of the use of EUCP in an SBAR (Situation, Background, Assessment, Response) formatted email, as soon as is feasible. These parties should also get a copy of the restraint form once it is completed.

This practice is only temporary while we all are learning what items the parties named in the settlement are wanting to see on the EUCP documentation, and it is meant to assist the staff who are completing these documents with the process until we are all more familiar with it. Just as a reminder, the EUCP form is the only information that many of these parties have the authority to have access to under HIPPA and data privacy provisions, so if additional information is requested pass this along to your supervisor to be addressed. We aren't obligated to any timelines with additional information, so do not worry that timelines aren't getting met.

I attached Char's most recent email with all of the links to the documents needed in completing the EUCP reports for your reference as well. Please let me know if you have any questions about this memo or the EUCP reporting process in general. Thanks for all your great work.

Natalie M. Marr, Psy D., LP
Clinical Director
Minnesota Specialty Health System
Cambridge, Brainerd, Willmar, Wadena, Lino L. Bridgehouse
Office 763 689 7376 Blackberry 763 228 5690

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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

Plaintiffs,

vs.

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

Defendants.

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

PLACEHOLDER FOR EXHIBIT 100 TO DEFENDANTS' STATUS EPORT

This document is a place holder for the following items which are filed in conventional or physical form with the Clerk's Office:

Exhibit 100 to Defendants' Status Report

If you are a participant in this case, this filing will be served upon you in conventional format.

This filing was not e-filed for the following reason(s):

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

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

☐ Physical Object (description):

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

☒ Item Under Seal pursuant to a court order* (Pursuant to Protective Order: Doc. No. 57)

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

☐ Other (description):

Exhibit 101

From: Tessneer, Michael L (DHS)
Sent: Monday, October 22, 2012 2:49 PM
To: David Ferleger (david@ferleger.com); Shamus O'Meara (SPO@johnson-condon.com); Annie Mullin (masantos@johnson-condon.com)
Cc: Akbay, Amy K (DHS); Gray, Gregory N (DHS) (gregory.gray@state.mn.us); Alpert, Steve; Ikeda, Scott (Scott.Ikeda@ag.state.mn.us); Carlson, Patricia L (DHS); Opheim, Roberta (OMHDD); Wieck, Colleen (ADM)
Subject: FW: Request to the parties and issues from 10-4-12 letter for Plaintiffs' counsel

David, Shamus, Annie,

Below and attached are the Department's responses to the identified Requests to the Parties #6 (visitor policy), # 7, #9, #10, and issues identified in the 10-4-12 letter from Plaintiffs' counsel.

Please contact me if you have any questions.

Thank you

Mike

There is a concern that chemical restraints appear to be based on the PRN use of psychotropic medications and other medications used to deal with agitation

Dr. Peter Miller is a Regional Medical Director for SOS and is the consulting psychiatrist for the MSHS-Cambridge. Dr. Miller performed a review of **all consumers** currently receiving services at MSHS-Cambridge. In his findings he reports:

In summary there were 10 instances of PRN use in the last month. Each of these was for a relatively less dangerous medication (not an antipsychotic) and all seemed to be triggered by exacerbation of mental health symptoms and not directed only at disruptive behavior. In 2 cases there was a very clear emotional trigger with sudden explosive anger; the anger by itself might not always indicate a mental illness, but the sudden onset and level of severity was very much supportive of these reflecting symptoms of mental illness.

- In none of these cases was there evidence of chemical restraint, no use of medication to restrict movement or physically slow the patient down.
- Only 3 of the 10 patients at the program had PRN use.
- Of the 3 out of 10 who were on PRN's there were 10 incidents of PRN use. Each of these was for a relatively less dangerous medication (not an antipsychotic) and all seemed to be triggered by exacerbation of mental health symptoms and not directed only at disruptive behavior. In two cases there was a very clear emotional trigger with sudden explosive anger; the anger by itself might not always indicate a mental illness, but the sudden onset and level of severity was very much supportive of these reflecting symptoms of mental illness.
- In all 3 cases there were behavioral treatment strategies available for these individuals.
- Documentation clearly shows a good degree of effort by staff to defuse the situations, re-direct, offer alternatives, etc. Medication was not turned to as a first resort.
- The program has a detailed process of developing a list of triggering symptoms based on a standard assessment for mental health symptoms (the BPRS). Thus there are efforts at several levels to reduce the use of PRN orders when patients are admitted, set up orders to be sure that PRN medications are ordered for symptoms of mental illness, and staff intervene with a number of other modalities and approaches before turning to medication. The total program use of medication was 10 per about 500 patient days in this sample, less than 3% of patient days.

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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

Plaintiffs,

vs.

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

Defendants.

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

PLACEHOLDER FOR EXHIBIT 102 TO DEFENDANTS' STATUS EPORT

This document is a place holder for the following items which are filed in conventional or physical form with the Clerk's Office:

Exhibit 102 to Defendants' Status Report

If you are a participant in this case, this filing will be served upon you in conventional format.

This filing was not e-filed for the following reason(s):

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

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

☐ Physical Object (description):

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

☒ Item Under Seal pursuant to a court order* (Pursuant to Protective Order: Doc. No. 57)

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

☐ Other (description):

Exhibit 103

Minnesota Department of **Human Services**

October 26, 2012

Patricia Carlson, CEO
Minnesota Specialty Health System - Cambridge
P.O. Box 64979
Saint Paul, MN, 55164

License Number: 804294 (245B-RS-N)

CORRECTION ORDER

Dear Ms. Carlson:

On October 18, 2012, a review of licensing requirements was completed for an Emergency Use of Controlled Procedure report submitted to the Department of Human Services on August 10, 2012, from Minnesota Specialty Health System - Cambridge, located at 1425 East Rum River Drive, Cambridge, Minnesota. The review was conducted to determine compliance with state and federal laws and rules governing the provision of residential services to persons with developmental disabilities under Minnesota Statutes, Chapter 245B. As a result of this review a Correction Order is being issued.

A. Reason for Correction Order

Pursuant to Minnesota Statutes, section 245A.06, if the Commissioner of the Department of Human Services (DHS) finds that an license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the Commissioner may issue a Correction Order to the license holder.

The following violation(s) of state or federal laws and rules were determined as a result of the review. Corrective action for each violation is required by Minnesota Statutes, section 245A.06 and is hereby ordered by the Commissioner of Human Services.

1. Citation: Minnesota Rules, part 9525.2770, subparts 2, 5 and 6.

   Violation: For one consumer whose record was reviewed (C1), the license holder implemented the emergency use of a controlled procedure on August 10, 2012. The license holder failed to ensure that the required conditions for such use were met.

a. The license holder did not ensure that immediate intervention was needed to protect the person or others from physical injury or to prevent severe property damage that was an immediate threat to the physical safety of the person or others.

b. The procedure used was not the least intrusive intervention possible to react effectively to the emergency situation.

c. The license holder did not ensure that the time of implementation for the escort and time of completion were recorded, and why the escort was judged to be necessary to prevent injury or severe property damage.

An emergency use of controlled procedure (EUCP) was implemented by staff on August 10, 2012. As part of the procedure staff used a manual restraint and an escort. The license holder had sufficient information on the EUCP report to indicate the use of the manual restraint met all requirements. The license holder did not have sufficient information on the EUCP report to indicate the use of the escort met all requirements.

It was reported that staff, "wrapped [his/her] arms around [C1] from behind, holding [C1's] upper arms, for 10 seconds. [C1] stopped aggressing and did not resist or struggle. [Two staff] then escorted [C1] back to [his/her] home, using a simple escort technique. [C1] did not resist or struggle." This documentation did not establish that the immediate intervention of an escort was needed to bring C1 to safety when the person was in danger. Danger of C1 was not established; in fact the report states that C1 had stopped aggressing and did not resist or struggle. The report also does not establish that the use of an escort was the least intrusive intervention possible to react effectively to the emergency situation, and that the procedure complied with other standards in parts 9525.2700 to 9525.2710.

Corrective Action Ordered: Within 30 days of receipt of this order submit written documentation detailing how compliance with this licensing requirement has been achieved and will be maintained throughout the program.

If you fail to correct the violations specified in the Correction Order within the prescribed time lines the Commissioner may issue an Order of Conditional License or may impose a fine and order other licensing sanctions pursuant to Minnesota Statutes, sections 245A.06 and 245A.07.

Submissions required as part of a corrective action ordered must be sent to your Licensor at:

Commissioner, Department of Human Services
ATTN: Dawn Bramel
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

B. Right to Request Reconsideration

If you believe any of the citations are in error, you have the right to request that the Commissioner of Human Services reconsider the parts of the Correction Order that you believe to be in error. The request for reconsideration must be in writing and received by the Commissioner within 20 calendar days after receipt of this report. Your request for reconsideration must be sent to:

Commissioner, Department of Human Services
ATTN: Legal Unit
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

Please note that a request for reconsideration does not stay any provisions or requirements of the Correction Order. The Commissioner's disposition of a request for reconsideration is final and not subject to appeal under Minnesota Statutes, chapter 14.

If you have any questions regarding this Correction Order, please contact me as soon as possible.

Dawn Bramel, Human Services Licensor
Licensing Division
Office of Inspector General
651-431-6539

Minnesota Department of **Human Services**

Minnesota Specialty Health System - Cambridge

November 16, 2012

Commissioner, Department of Human Services
Attn: Dawn Bramel
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

RE: License Number 804294(245B-RS-N)

Ms. Bramel;

Please find enclosed the responses to two correction orders for MSHS Cambridge dated 10/25/2012 and 10/26/2012. If you have any questions or concerns please feel free to contact me at 651-431-5010 or via e-mail at paula.halverson@state.mn.us.

Sincerely,

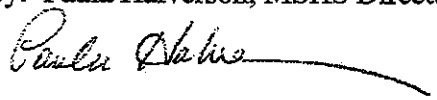
Paula Halverson
Director, MSHS

Cambridge Licensing Response
License # 804294
Correction Order
DHS License Review – Correction order sent 10/25/12 and 10/26/12

Date and #	Citation	Citation Description	Corrective Action Ordered	Target Date / Individual responsible	Attachments and Plans
10/25/12 Citation #1	245A.06 MN Rules part 9525.2770, subpart 5	Failure to report Emergency Use of Controlled Procedure according to facility procedure.	Within 30 days of receipt or this order submit written documentation detailing how compliance with this licensing requirement has been achieved and will be maintained throughout the program.	1a. Completed 10/31/12 – Charlene Reinhart 1b. Completed 11/14/12 – Charlene Reinhart 2. Training will be completed 11/30/12.	1. Corrected the technical process for notifying interested parties via the following: a. Incorporated internal and external parties within the same e-mail to ensure that all parties visualize the content and note if there are discrepancies or errors. b. Revised Emergency Use of Controlled Procedure Notification process and created checklist from notification/reporting protocol to be checked off and signed by both primary implementing and secondary observing authorities. (See attachment #1 – revisions highlighted in yellow) 2. Training and competency check off of Lead Workers, Supervisors, and other designees on the new process will be completed.
10/26/12 Citation #1	245A.06 MN Rules part 9525.2770,	Failure to documents a restraint as such; failure to	Within 30 days of receipt or this order submit written documentation detailing how compliance with this	1. Completed on 11/8/12 – Paula Halverson 2. 12/31/12 – MSHS	1. Director, MSHS met with SOS staff development and reviewed the corrective action on 11/8/12 and requested a change in teaching

	subparts 2,5, & 6	demonstrate the need for the restraint that was not correctly documented.	licensing requirement has been achieved and will be maintained throughout the program.	Management – Stuart Hazard. 3. 12/31/12 – MSHS Cambridge staff and SOS Staff Development.	curriculum that would inform staff of change in technique description/definition of "simple escort" re: topography vs. function or intent (immediate). 2. All staff to review Policy 6260 Therapeutic Intervention and Emergency Use of Personal Safety Techniques by December 31st, 2012. 3. Complete revised TI/PST training with all MSHS Cambridge staff by 12/31/12. Objective of the training is for participants to be competent in the following: a. Accurately categorize restraint vs non restraint. b. Document physical safety strategies.

Submitted by: Paula Halverson, MSHS Director



EMERGENCY USE OF CONTROLLED PROCEDURE (EUCP) NOTIFICATIONS CHECKLIST

Date /Time of EUCP: _____ ☐ AM ☐ PM Client Name: _____

A. FIRST STEP NOTIFICATIONS

☐ 1. Notify Stuart, Margaret, Mitch and Paula of the use of an emergency controlled procedure and send a copy of the form. Stuart, Margaret, Mitch or Paula **must** review the form before it is scanned, e-mailed, faxed or post office mailed.

☐ 2. Send an e-mail using the template found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\1st E-mail for EUCP (copies to Paula, Doug, Mike T, T. Ruter, P. Carlson). Complete the body of the e-mail describing the use in SBAR (Situation, Background, Assessment, Response) format. *[The documentation form will be sent once it is completed and reviewed (see B 5-9 below).]*

3. Notifications for use of an emergency controlled procedure may be sent via e-mail, fax or via United States Postal Service (USPS). ***EXCEPTION:*** Ombudsman and Plaintiff's Counsel notifications must be sent via e-mail or fax **AND** US Mail. A reasonable effort must be made to complete notification within 24 hours, but in no event later than the next business day.

☐ ** ***In addition to e-mail or fax notification, the Legal Representative and County Case Manager must receive verbal notification within 24 hours.***

☐ 4. Determine the method you will use for notification and document all notifications on the last page of the DHS-3652 form.

☐ FIRST STEP NOTIFICATIONS COMPLETED

B. E-MAIL NOTIFICATIONS

☐ 1. Scan the completed DHS-3652 form to your own e-mail.

- Press Scan on the printer/copier.
- Press E-mail.
- Press Input on the screen – enter your e-mail address [e.g., joe.bloe@state.mn.us]
- Click on File Name on the screen. Press Clear.
- Type on File Name line: *EUCP Form for [client's initials].*
- Press OK.
- Press Scan button on screen.

☐ 2. Go to your Outlook e-mail and open the e-mail you just sent yourself (the form will show under "Message" – it looks like an attachment).

☐ 3. Click on File, then Save As.

- Go to the client's I drive Cont Proc, PRN & EIDT Documentation folder and click on Save. You can rename the document before hitting Save (e.g. 2012-11-15 EUCP e-mail) but you don't have to.

☐ 4. Your original e-mail will reappear. Right click on the attachment and click on copy.

☐ 5. Open the following file: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\E-Mail for EUCP Template.

- The *E-mail for EUCP Template* document is a template e-mail that includes agencies/persons to be notified except legal representative and/or county case manager (CCM). You must add the e-mail addresses for the legal representative and/or CCM as appropriate. This information may be found in the client's I drive folder on the Contact Information Form. **NOTE: This template must be used as it contains encryption for the attachment. E-mailing PHI information outside of the state system without encryption is a HIPAA and data privacy violation!**

- ☐ 6. Go to the body of the e-mail, right click and click on Paste. The document will show as an attachment.
- ☐ 7. Click on [date] and enter the date of use from the form.
- ☐ 8. Click on [client name] and enter the appropriate information.
- ☐ 9. Click on the send button to send the e-mail. **Note: Before clicking send, verify that any e-mail addresses you added are entered correctly and that attachment is there.** You can double click on the attachment to open it. Close the attachment before hitting the send button.
- ☐ 10. Go into your Sent Items box and print the e-mails. Put the printed e-mails in the gray box along with the original report form.

☐ E-MAIL NOTIFICATIONS COMPLETED

C. FAX NOTIFICATIONS

- ☐ 1. Open the following folder: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates. **NOTE: These templates must be used as they contain the required privacy notice for sending protected health information (PHI).**
- ☐ 2. Open, complete and print each fax cover sheet template for the DHS Internal Reviewer, Ombudsman, DHS Licensing, and OHFC. **NOTE:** The plaintiff's counsel does not have a fax number on file.
- ☐ 3. Open the fax cover sheet template for Legal Rep or CCM. Complete and print one form for Legal Rep and one form for CCM. Fax number information may be found in the client's I drive folder on the Contact Information Form.
- ☐ 4. For each form, load the cover sheet and the completed DHS-3652 (Documentation for Implementation of Controlled Procedures) form into the printer/copier.
- ☐ 5. Press Fax button.
- ☐ 6. Type in phone number listed under FAX number on the template form. Press Send.
- ☐ 7. When the documents have finished transmitting, you will receive a Fax transmission report. Attach all transmission reports to the original fax cover sheets and put in gray box along with the original report form.

☐ FAX NOTIFICATIONS COMPLETED

D. UNITED STATES POSTAL SERVICE (USPS) DELIVERED NOTIFICATIONS

Until further notice, copies of the EUCP form for the Ombudsman and the Plaintiff's counsel **must be sent** via US mail **in addition to** e-mail or fax. Also, in the event an individual does not have a fax number or e-mail address, or the fax number/e-mail address communication fails, notification must be sent via USPS.

- Addresses for agencies/persons to be notified may be found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\DHS-3652-Contact Info - Notifications for EUCP. Labels and stamps for the Plaintiff's counsel and the Ombudsman are available in the Op Center.
- The Legal Rep and County Case Manager addresses may be found in the client's I drive folder on the Contact Information Form.

☐ MAIL NOTIFICATIONS COMPLETED

I ACKNOWLEDGE THAT THE ABOVE NOTIFICATION PROCESS HAS BEEN FOLLOWED AND COMPLETED.

_____ _____

Signature of Person Completing Notifications *Date / Time*

When completed, send this checklist to HIMS.

Process for Emergency Use of Controlled Procedures Notifications

A. Notify Stuart, Margaret, Mitch and Paula of the use of an emergency controlled procedure and send a copy of the form. Stuart, Margaret, Mitch or Paula **must** review the form before it is scanned, e-mail, faxed or post office mailed. (See attached e-mails for details.)

B. Send an e-mail using the template found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\1st E-mail for EUCP (copies to Paula, Doug, Mike T, T. Ruter, P. Carlson). Complete the body of the e-mail describing the use in SBAR (Situation, Background, Assessment, Response) format. *[The documentation form will be sent once it is completed and reviewed (see 9-14 below).]*

C. Notifications for use of an emergency controlled procedure may be sent via e-mail, fax or via United States Postal Service (USPS). ***EXCEPTION:*** Ombudsman and Plaintiff's Counsel notifications must be sent via e-mail or fax **AND** US Mail. A reasonable effort must be made to complete notification within 24 hours, but in no event later than the next business day.

** ***In addition, the Legal Representative and County Case Manager must receive verbal notification within 24 hours.***

D. Determine the method you will use for notification and document all notifications on the last page of the DHS-3652 form.

E-mail notifications

A. Scan the completed DHS-3652 form to your own e-mail.
1. Press Scan on the printer/copier.
2. Press E-mail.
3. Press Input on the screen – enter your e-mail address [e.g., joe.bloe@state.mn.us]
4. Click on File Name on the screen. Press Clear.
5. Type on File Name line: *EUCP Form for [client's initials].*
6. Press OK.
7. Press Scan button on screen.

B. Go to your Outlook e-mail.
8. Open the e-mail you just sent yourself (the form will show under "Message" – it looks like an attachment). Click on File, then Save As.
9. Go to the client's I drive Cont Proc, PRN & EIDT Documentation folder and click on Save. You can rename the document before hitting Save (e.g. 2012-11-15 EUCP e-mail) but you don't have to.
10. Your original e-mail will reappear. Right click on the attachment and click on copy.
11. Open the following file: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\E-Mail for EUCP Template.
    - The *E-mail for EUCP Template* document is a template e-mail that includes agencies/persons to be notified except legal representative and/or county case manager (CCM). You must add the e-mail addresses for the legal representative and/or CCM as appropriate. This information may be found in the client's I drive folder on the Contact Information Form. **NOTE: This template must be used as it contains encryption for the attachment. E-mailing PHI information outside of the state system without encryption is a HIPAA and data privacy violation!**
12. Go to the body of the e-mail, right click and click on Paste. The document will show as an attachment.
13. Click on [date] and enter the date of use from the form.
14. Click on [client name] and enter the appropriate information.

15. Click on the send button to send the e-mail. **Note: Before clicking send, verify that any e-mail addresses you added are entered correctly and that attachment is there.** You can double click on the attachment to open it. Close the attachment before hitting the send button.
16. Go into your Sent Items box and print the e-mails. Put the printed e-mails in the gray box along with the original report form.

Fax Notifications

1. Open the following folder: I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates. **NOTE: These templates must be used as they contain the required privacy notice for sending protected health information (PHI).**
2. Open, complete and print each fax cover sheet template for the DHS Internal Reviewer, Ombudsman, DHS Licensing, and OHFC. **NOTE:** The plaintiff's counsel does not have a fax number on file.
3. Open the fax cover sheet template for Legal Rep or CCM. Complete and print one form for Legal Rep and one form for CCM. Fax number information may be found in the client's I drive folder on the Contact Information Form.
4. For each form, load the cover sheet and the completed DHS-3652 (Documentation for Implementation of Controlled Procedures) form into the printer/copier.
5. Press Fax button.
6. Type in phone number listed under FAX number on the template form. Press Send.
7. When the documents have finished transmitting, you will receive a Fax transmission report. Attach all transmission reports to the original fax cover sheets and put in gray box along with the original report form.

United States Postal Service (USPS) Delivered Notifications

Until further notice, copies of the EUCP form for the Ombudsman and the Plaintiff's counsel must be sent via US mail **in addition to** e-mail or fax. Also, in the event an individual does not have a fax number or e-mail address, or the fax number/e-mail address communication fails, notification must be sent via USPS.

- Addresses for agencies/persons to be notified may be found at I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\EUCP Notification Process - Info & Templates\DHS-3652-Contact Info - Notifications for EUCP. Labels and stamps for the Plaintiff's counsel and the Ombudsman are available in the Op Center.
- The Legal Rep and County Case Manager addresses may be found in the client's I drive folder on the Contact Information Form.

If you find that you have sent this information to the wrong e-mail address, fax number or mailing address:

- Notify SOS HIMS immediately.
  Sondra Johnson (651-295-2302); or
  Bridgette Nevala (612-390-5626)
- Please include the following details in the notification:
  - Who the e-mail or fax was sent to
  - What documents or information was sent
  - The date the e-mail or fax was sent
  - The date it was discovered
  - If the e-mail was successfully recalled**

To recall an e-mail:

- Go into the sent items folder
- Double click on the e-mail that was sent in error
- Click on the Actions button on the toolbar
- Click the Recall this message button
- A box will appear

- Make sure *delete unread copies of this e-mail* is checked and that the *tell me if the recall fails or succeeds* box is checked
- Click on OK button
- A notice will appear in your inbox on whether or not the recall failed or succeeded

E-mail: TO: All MSHS-Cambridge Staff FROM: Paula Halverson SENT 7/25/12 at 1:16 PM

Subject: Must read: EUCP

I writing to provide some clear direction on filling out the EUCP, especially since Dr. Marr is no longer here to review the document:

1. Please make sure that either Stuart, Stephanie or I review the EUCP for the completion of the document before it is submitted within the 24 hours to designated individuals. (Please send out to all three of us. Stuart is the primary, Stephanie secondary and myself third).
2. All areas need to be filled in except of course the boxes for Designated Coordinator Review and the BMRC section within 24 hours.
3. The page "Notifications (within 24 hours of use)" needs to be completed with the dates and signatures, etc. So if I am going to e-mail out the notification I would indicate that example: 10:20am it would be sent out to DHS internal reviewer, DHS licensing, etc. Legal representative and CCM would potentially have different times if they do not have e-mails but you would indicate estimated time you would be doing this. I would write this all down so it is completed than send out to the designated individuals. This whole form needs to be completed prior to sending out the document. The "notification" portion of the document is a part of the form and we are to send out the completed form.
4. If prone hold is checked if we used this to transition this to a side lying position this has to be in transition to the other position. This position cannot be held for a length of time since this position is prohibited.

E-mail: TO All MSHS-Cambridge Staff FROM Natalie Marr SENT 6/11/12 at 12:10 PM
Subject: Emergency Use of Controlled Procedure (EUCP) Form Notifications (page 3) and Process revision

MSHS Cambridge staff –

I am writing this email as an informational memo to the campus in the interim of doing some more specific training on this issue. We have successfully completed and sent in restraint reports to the many parties court ordered to get these documents in the settlement. The completion of this paperwork and the notifications to several parties is a feat in and of itself, in addition to the fact that this is during a time of understandable distress for the campus following the need to use an emergency procedure. I applaud you all for your hard work in both realms. We have been notified by our partners at DHS licensing after each of these reports being sent out, with some helpful hints on what information they see as lacking in the documentation. I have asked on a few occasions for information to be added, reworded, etc. to address DHS licensing's requests. This is mostly due to the fact that we have not in the past been as detailed in these EUCP reports because there are usually corresponding incident reports, progress notes, etc., that flesh this out for us. Because the parties in the litigation are *only* seeing the EUCP form, we need to be more detailed than we have in the past.

In order to assist you all with completing the EUCP documentation, please do the following:

1) For the time being I want to review and assist the writers of the EUCP form to incorporate all the elements I know that DHS licensing has been asking us to be more specific about. If I am on vacation or out on sick leave I will send out an all staff communication naming who is acting on behalf for this task. If possible, prior to completing and signing the EUCP report, please contact me and provide me a copy so I can review and recommend any needed changes, additions, etc.
2) It's best to contact me or my back-up before the restraint form is finalized, but if the report must be finalized in order to be completed and signed by the involved parties prior to a shift's end and I am not available, please go ahead and complete the form. In these cases the restraint form *should not* be sent out to the parties named in the settlement until I or my back-up can review it first. In such a case I may have someone complete a memo adding or explaining any needed elements to send with the restraint form.
3) Remember when sending out the forms to all parties that the timeline for this to occur is "in 24 hours, or at least by the next business day". Please take your time with the documentation and use the time we have allotted to make sure the EUCP form has all the elements needed. For instance, if the restraint occurs on the weekend, it *can wait* for me or my back-up to review it on Monday, which is the next business day. Again, if you are awaiting review of the documentation *no restraint forms* should be scanned, emailed, faxed, or post office mailed to the parties named in the settlement until this has occurred. The verbal notifications to the legal guardian and case manager do still need to occur though.
4) Lastly Doug Seiler, Paula Halverson, Mike Tessneer (who is our DHS Compliance Office representative on the settlement) will also need to be informed of the use of EUCP in an SBAR (Situation, Background, Assessment, Response) formatted email, as soon as is feasible. These parties should also get a copy of the restraint form once it is completed.

This practice is only temporary while we all are learning what items the parties named in the settlement are wanting to see on the EUCP documentation, and it is meant to assist the staff who are completing these documents with the process until we are all more familiar with it. Just as a reminder, the EUCP form is the only information that many of these parties have the authority to have access to under HIPPA and data privacy provisions, so if additional information is requested pass this along to your supervisor to be addressed. We aren't obligated to any timelines with additional information, so do not worry that timelines aren't getting met.

I attached Char's most recent email with all of the links to the documents needed in completing the EUCP reports for your reference as well. Please let me know if you have any questions about this memo or the EUCP reporting process in general. Thanks for all your great work.

Natalie M. Marr, Psy D., LP
Clinical Director
Minnesota Specialty Health System
Cambridge, Brainerd, Willmar, Wadena, Lino L, Bridgehouse
Office 763-689-7376 Blackberry 763-228-5690

Exhibit 104

Minnesota Department of **Human Services**

Memo

DATE: November 16, 2012

TO: Doug Seiler, SOS Administrator for Special Populations
Roger Deneen, SOS Administrator for Minnesota State Operated Community Services
Dr. Richard Amado

FROM: Patricia Carlson, CEO
State Operated Services Pat Carlson

SUBJECT: Expansion of the Internal Reviewer Role

After consulting with Plaintiff's Counsel, Consultants and the Court Monitor, the role of the Internal Reviewer shall be expanded as follows:

1. Internal Reviewer Responsibilities

a. The Internal Reviewer shall be responsible to continue review of all uses of restraint, uses of PRN medications, and events that result in a 911 call. The recommendations shall be reviewed face-to-face with the MSHS-Cambridge treatment teams, including the staff who were involved in the particular event, and the leadership of MSHS-Cambridge. Among other things, the Internal Reviewer shall note any violation of any of the restraint requirements under the Settlement Agreement.

b. The reviewer shall also consult with MSHS-Cambridge staff and leadership with regard to the elimination of the use of restraints.

c. The reviewer shall also consult with the leadership of MSHS-Cambridge regarding programming, the nature and appropriateness of programming; including vocational services, for people with developmental disabilities and how that relates to the rhythm of the day as well as the individual needs of the consumers being served, attending to the Olmstead obligations under the Settlement Agreement.

d. The Internal Reviewer will conduct at least monthly follow up reviews of all cases where restraint, PRN medication, or a 911 call was used with follow up recommendations to the individual's team, and with regard to the other consultation under a, b and c above.

In addition, for each restraint review the Internal Reviewer will provide a written summary report to the DHS Deputy Commissioner, SOS Chief Executive Officer, Special Populations Administrator, and to Plaintiffs and Monitor, on the findings and recommendations regarding 1) the review of the

emergency restraints at the Cambridge program, 2) all the consultation and follow up under these provisions, 3) progress in elimination of the use of restraints, and 4) systemic issues outside the authority and or purview of MSHS-Cambridge program.

2. Report on the status of activities to assist MSHS-Cambridge to eliminate the use of restraint.

a. *Follow up Review on Use of Restraint, PRN medication, or 911 calls*: During the last week of each month, the Internal Reviewer will provide a follow up consult for all individuals residing in the program who have experienced the use of emergency restraint, PRN medication, or a 911 call. This consult will evaluate the Program's progress in implementing the changes that were recommended following the episode; report the status of changes, any effects of the changes, and will provide a qualitative comment.

b. *Program Consultation*: The Internal Reviewer will maintain a consultation log for every request for consultation, including the monthly reviews. The log will summarize and report the target of the consultation, the initial request or presented problem, the offered solution, and the extent (number of visits, number of hours, etc.) of the consultation activity monthly, and follow up on Program Consultations including evidence of recommendations implemented and results produced.

c. *Rhythm of the Day*: Person Centered Planning materials will be used to ascertain each person's preferred or biologically driven 24-hour cycle. The Internal Reviewer will assess how well the program has incorporated the individual's preferences into that person's daily routine especially at it relates to the use of emergency use of restraint, PRN medications, or 911 calls.

d. *Individual needs of Consumers with consideration of Olmstead:* The Internal Reviewer will assess how the MSHS-Cambridge program is supporting the individual's transition to the most integrated setting in accordance with Olmstead. After the MSHS-Cambridge interdisciplinary team has completed its intake and program plan, the Internal Reviewer will review the plan to determine if the program has adequately identified the services, lifestyle preferences, and supports needed by each person receiving services while at MSHS-Cambridge. The Internal Reviewer, in consultation with CSS as necessary, will identify if any of those services and supports can only be provided at, or are only available at, MSHS-Cambridge, and what would be necessary for the person to be supported in a community setting.

e. *The Internal Reviewer will issue monthly summary reports* to the DHS Deputy Commissioner, SOS CEO, Special Populations Administrator, Compliance Office, and to Plaintiffs and the Monitor, on findings and recommendations regarding the monthly review. The report will minimally include a review of the program's progress in implementation of the individual's consultation recommendations, the application of positive behavioral supports and person centered thinking, the program's consideration of Olmstead, and the identification of issues outside the authority and/or purview of MSHS-Cambridge. The report will be issued on or before the 15th of each month following the review.

Exhibit 105

MSHS Cambridge Training Tracker

Highlighted areas where we are deficient		Therapeutic Intervention (four hours each - Total eight hours)			Total Hours	[illegible]			Total Hours	[illegible]	[illegible] required	[illegible]	[illegible]	[illegible]
Employee Name	Date of Hire	Required to Complete Between Sept 2010 - December 31st, 2011									Required Completion by March 31, 2012			
Gina Johnson	12/13/1995	12/2/2010	5/31/2011	12/20/2011	12:00	12/2/2010	5/31/2011	12/20/2011	12:00	12/6/2011	1/9/2012	15	11/7/2011	1/6/2012
Stephanie Kuznia	11/25/2009	12/21/2010			4:00	12/21/2010			4:00	12/2/2011	3/14/2012	32	3/27/2012	2/14/2012
Catherine Mattson	9/1/1999	5/31/2011	12/20/2011		8:00	5/31/2011	12/20/2011		8:00	11/30/2011	1/9/2012	15	11/7/2011	1/6/2012
Kim Palmer	12/13/1995	8/25/2011	12/20/2011		8:00	8/25/2011	12/20/2011		8:00	12/14/2011	3/14/2012	13	12/12/2011	2/28/2012
Steve Hiebert	8/23/2006	6/2/2011			4:00	6/2/2011			4:00	11/16/2011	1/9/2012	13	11/7/2011	1/6/2012
Elizabeth Klute	1/31/2005	2/9/2011	5/31/2011		[illegible]	2/9/2011	5/31/2011		8:00	12/6/2011	1/9/2012	13	9/7/2011	1/6/2012
Dawn Thomas	11/30/1998	6/1/2011	11/28/2011		[illegible]	6/1/2011	11/28/2011		8:00	12/6/2011	3/14/2012	15	11/15/2011	2/28/2012
Jack Kasl	6/18/2003	6/15/2011	12/22/2011		[illegible]	6/23/2011	12/22/2011		8:00	11/23/2011	2/6/2012	13	9/7/2011	1/6/2012
Mitch Becker	12/13/1995	11/28/2011	12/20/2011		[illegible]	11/28/2011	12/20/2011		8:00	12/20/2012	12/5/2011	60	11/15/2011	2/28/2012
Margaret Carlson	12/13/1995	12/29/2010	12/20/2011		[illegible]	12/29/2010	12/20/2011		8:00	11/16/2011	12/5/2011	80	11/10/2011	1/26/2012
Dana McIntyre	12/13/1995	12/1/2010	6/2/2011	12/20/2011	[illegible]	12/1/2010	6/2/2011	12/20/2011	12:00	11/23/2011	12/5/2011	64	11/7/2011	2/14/2012
Susan Peterson	12/13/1995	12/1/2010	5/31/2011		[illegible]	12/1/2010	5/31/2011		8:00	11/30/2011	1/9/2012	15	12/1/2011	2/28/2012
Judy Roehl	8/15/2001	2/9/2011	6/1/2011	11/28/2011	[illegible]	2/9/2011	6/1/2011		8:00	11/30/2011	1/9/2012	13	11/10/2011	1/6/2012
James Kunshier	12/13/1995	12/21/2010			[illegible]	12/21/2010			[illegible]	11/23/2011	1/9/2012	13	11/15/2011	1/6/2012
Kevin Morgan	12/13/1995	12/2/2010	6/1/2011	12/22/2011	[illegible]	12/2/2010	6/1/2011	12/22/2011	12:00	11/30/2011	3/14/2012	15	12/1/2011	2/14/2012
Stephanie Johnson	4/29/1998	12/29/2010	6/15/2011	12/22/2011	[illegible]	12/29/2010	6/15/2011	12/22/2011	12:00	11/16/2011	1/9/2012	15	11/10/2010	2/14/2012
Penny Hedlund	12/13/1995	12/1/2010	12/22/2011		[illegible]	12/1/2010	12/22/2011		8:00	11/30/2011	1/9/2012	13	12/1/2011	1/6/2012
Stacey Sjestedt	2/21/1996	12/28/2010	12/20/2011		[illegible]	12/28/2010	12/20/2011		8:00	11/9/2011	3/14/2012	15	9/7/2011	2/14/2012
Amy Graham	1/7/1998	12/21/2010	6/1/2011	12/21/2011	12:00	12/21/2010	6/1/2011	12/21/2011	12:00	11/30/2011	3/14/2012	15	11/15/2011	1/6/2012
Perri Prigge	11/30/1998	12/21/2010	11/28/2011		[illegible]	12/21/2010	11/28/2011		8:00	11/30/2011	2/6/2012	13	11/10/2011	1/6/2012
Kathleen Carlson	9/27/1999	12/2/2010	9/19/2011	12/21/2011	16:00	12/2/2010	12/21/2011		8:00	11/23/2011	12/5/2011	80	11/7/2011	1/6/2012
Kendra Cline	1/16/2000	2/9/2011	12/22/2011		[illegible]	2/9/2011	12/22/2011		8:00	11/30/2011	3/14/2012	15	11/15/2011	9/7/2012
Will Coyle	11/30/2011	12/28/2010	8/11/2011		[illegible]	12/28/2010	8/11/2011		8:00	2/15/2012	3/14/2012	13	12/1/2011	2/28/2012
Lavonne Sorenson	4/17/2000	12/2/2010	6/2/2011	12/21/2011	12:00	12/2/2010	6/2/2011	12/21/2011	12:00	11/9/2011	1/9/2012	15	11/15/2011	1/6/2012
Michael Downing	4/15/2002	12/28/2010	5/31/2011	12/22/2011	12:00	12/28/2010	5/31/2011	12/22/2011	12:00	11/23/2011	3/14/2012	15	12/1/2011	2/28/2012
Jesse Gillespie	10/31/2005	2/9/2011	12/22/2011		[illegible]	2/9/2011	12/22/2011		8:00	12/14/2011	3/14/2012	13	12/12/2011	1/26/2012
Kelly McGuire	4/17/2006	12/20/2011	12/22/2011		[illegible]	12/20/2011	12/22/2011		8:00	11/9/2011	1/9/2012	13	11/10/2011	2/28/2012
Brian Kassa	6/26/2006	12/2/2010	6/2/2011		[illegible]	12/2/2010	6/2/2011		8:00	12/14/2011	2/6/2012	15	12/12/2011	1/26/2012
Doni Lamoreaux	6/26/2006	12/28/2010	5/31/2011	11/28/2011	[illegible]	12/28/2010	5/31/2011	11/28/2011	12:00	11/16/2011	3/14/2012	13	11/15/2011	1/26/2012
Dennis Aronson	8/8/2007	12/28/2010	5/31/2011	12/22/2011	12:00	12/28/2010	5/31/2011	12/22/2011	12:00	11/16/2011	3/14/2012	15	12/1/2011	2/14/2012

Highlighted areas where we are deficient		Therapeutic Intervention (four hours each – total eight hours)			Total Hours	[illegible]			Total Hours	[illegible]	PCT training (16 Hour Required)	PCT Training Total Hours	[illegible] Hours	Post [illegible] Eval – 4 Hours
Employee Name	Date of Hire	Required to Complete Between Sept 2010 – December 31st, 2011									Required Completion by March 31, 2012			
Ricky Hanson	9/30/1998	4/6/2011			4.00	6/1/2011			4.00	12/6/2011	1/9/2012	15	11/10/2011	1/6/2012
Judy Carda	12/13/1995	12/21/2010	6/2/2011	11/28/2011	12.00	12/21/2010	6/2/2011	11/28/2011	12.00	11/9/2011	2/6/2012	15	12/1/2011	2/14/2012
Jane Mell	12/13/1995	12/21/2010	5/31/2011	12/20/2011	12.00	12/21/2010	5/31/2011	12/20/2011	12.00	12/5/2011	1/9/2012	15	12/1/2011	2/14/2012
Mary Lancrain	12/13/1995	12/21/2010	6/2/2011	12/20/2011	12.00	12/21/2010	6/2/2011	12/20/2011	12.00	12/8/2011	2/6/2012	13	11/7/2011	1/6/2012
Char Villnow	12/13/1995	12/21/2010	5/31/2011	12/22/2011	12.00	12/21/2010	5/31/2011	12/22/2011	12.00	11/16/2011	12/5/2011	48	12/1/2011	1/26/2012
Dave Hicks	12/13/2995	12/2/2010	12/21/2011		8.00	12/2/2010	12/21/2011		8.00	11/16/2011	3/14/2012	13	12/1/2011	1/26/2012
Michael Lawrence	1/7/1998	12/1/2010	5/31/2011	12/21/2011	12.00	12/1/2010	5/31/2011	12/21/2011	12.00	11/16/2011	2/6/2012	15	11/15/2011	1/26/2012
Ed Jabs	12/13/1995	12/21/2010	6/2/2011		8.00	12/21/2010	6/2/2011		8.00	12/5/2011	3/14/2012	15	11/10/2011	1/26/2012
Yvonne Lee	12/13/1995	12/2/2010	6/1/2011	12/20/2011	12.00	12/2/2010	6/1/2011	12/20/2011	12.00	12/8/2011	1/9/2012	13	11/7/2011	1/6/2012
Eben Gillespie	12/13/1995	12/29/2010	6/1/2011	11/28/2011	12.00	12/29/2010	6/1/2011	11/28/2011	12.00	11/9/2011	1/9/2012	15	11/10/2011	2/14/2012
Robbin Noren-Mullins	2/7/1996	12/28/2010	5/31/2011		8.00	12/28/2010	5/31/2011		8.00	11/16/2011	2/6/2012	15	11/15/2011	1/26/2012
Maridy Nordlum	12/13/1995	2/9/2011	12/20/2011		8.00	2/9/2011	12/20/2011		8.00	11/30/2011	1/9/2012	15	11/10/2011	1/6/2012
Chris Jones	4/1/1996	12/28/2010	5/31/2011	12/21/2011	12.00	12/28/2010	5/31/2011	12/21/2011	12.00	12/5/2011	1/9/2012	13	11/10/2011	1/6/2012
David Haas	4/1/1996	12/21/2010	12/22/2011		8.00	12/21/2010	12/22/2011		8.00	12/14/2011	1/9/2012	13	12/12/2011	1/6/2012
Matt Johnson	4/7/1999	12/21/2010	6/1/2011	12/21/2011	12.00	12/21/2010	6/1/2011	12/21/2011	12.00	11/9/2011	12/5/2011	80	11/15/2011	2/28/2012
Ron Flaherty	11/28/2002	12/2/2010	6/15/2011	12/22/2011	12.00	12/2/2010	6/15/2011	12/22/2011	12.00	12/14/2011	3/14/2012	15	12/1/2011	1/26/2012
Heather Hauri	4/15/2002	12/29/2010	6/2/2011	11/28/2011	12.00	12/29/2010	6/2/2011	11/28/2011	12.00	12/8/2011	2/6/2012	13	11/10/2011	1/26/2012
Richard Bell	7/15/2002	2/9/2011	6/15/2011		8.00	2/9/2011			4.00	11/30/2011	3/14/2012	15	11/10/2011	1/26/2012
Clay Campion	12/2/2002	12/1/2010	6/15/2011	12/21/2011	12.00	12/1/2010	6/15/2011	12/21/2011	12.00	11/30/2011	2/6/2012	13	11/10/2011	2/28/2012
Dustin Stradal	11/23/2011	6/18/2012	8/11/2011		8.00	12/21/2010	8/11/2011		8.00	2/15/2012	2/6/2012	13	11/7/2011	1/26/2012
Deborah Glassing	11/28/2011	12/12/2011	12/21/2011		16.00	12/12/2011	12/21/2011		16.00	12/5/2011	2/6/2012	13	12/1/2011	1/26/2012
Sharon Nordin	12/13/1995	12/2/2010			4.00	12/2/2010			4.00	12/14/2011	2/6/2012	13	12/1/2011	1/26/2012
Janet Marciniak	9/25/2002	12/21/2010	11/28/2011		8.00	12/21/2010	11/28/2011		8.00	2/21/2012	2/6/2012	15	12/12/2011	2/14/2012
Amanda Bartnick	2/20/2008	12/29/2010	2/20/2011		8.00	12/29/2010	2/20/2011		8.00	12/5/2011	3/14/2012	15	12/1/2011	2/28/2012
Tara Irwin	11/28/2011	12/12/2011	12/21/2011		12.00	12/12/2011	12/21/2011		12.00	12/5/2011	3/14/2012	13	12/1/2011	2/28/2012
Stuart Hazard	12/13/1995	12/21/2010	6/1/2011	11/28/2011	12.00	12/21/2010	6/1/2011	11/28/2011	12.00	11/8/2011	1/9/2012	32	11/7/2011	1/6/2012
Jill Jones	6/22/2011	12/29/2010	5/31/2011	12/20/2011	12.00	12/29/2010	5/31/2011	12/20/2011	12.00	11/30/2011	1/9/2012	13	11/7/2011	1/6/2012

Sharon Nordin: Retired

Janet Marciniak: Had class late, unknown etiology

Richard Bell: Took TI, however went home sick for the second class. Beth Klute BA informed home to reschedule class, which he never did. Not involved in restraint.

Stephanie Kuznia: On Medical Leave The schedule did not reflect on June of 2011 that employee was to attend training for that day. In fact, she was on a schedueld day off.

Dustin Stradal: Employee did not work for MSHS at this time. Do not know why he took late (Was at MSOCS).

Rick Hanson: Unknown, was not involved in restraint.

Will Coyle: Was not a MSHS employee in 2/2012. Was former MSOCS employee.

Jim Kunshier: Intermittent employee: Unknown.

Mitch Becker: Not involved in restraint, unknown as to why he was two months late for class.

Steve Hiebert: Intermittnet- unknown as to why he did not attend. Not involved in a restraint.

Exhibit 106

Effective Date: October 8, 2012 Procedure Number: 15899

Minnesota Specialty Health System - Cambridge

CLIENT CARE

Involvement with Family, Guardians, and Friends

SOS REFERENCE POLICY NUMBER: __None_____

Relationships with family members, guardians, and friends are extremely important to the individuals receiving supports at Minnesota Specialty Health System – Cambridge (MSHS-Cambridge). One of the primary goals of MSHS-Cambridge is to support and foster these positive relationships.

DEFINITIONS:

Support: The resources and individual strategies necessary to promote the development, education, interests, and personal well-being of individuals receiving supports from MSHS-Cambridge.

PROCEDURE:

A. Visits by family members, guardians, and friends, both unscheduled and scheduled, are encouraged and are permitted, at reasonable hours, unless the interdisciplinary team reasonably determines the visit is contraindicated.

B. Visitors shall be allowed full and unrestricted access to the individual's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, consistent with all individuals' rights to privacy.

C. Individual's receiving supports at MSHS Cambridge will be allowed to visit with family members, guardians, and friends in private without staff supervision, unless the interdisciplinary team reasonably determines this is contraindicated and is noted in the individual treatment plan.

D. Individuals receiving supports have access to attorneys, county case managers and spiritual advisors at any time.

E. Individuals receiving supports will be encouraged to plan visits for times that will not significantly impact their daily schedule.

F. Staff will actively encourage communication between family members, guardians, and friends. A combination of visits, letters, and phone contacts will be encouraged. Staff will assist individuals in initiating contact to mark significant celebrations of family members and friends.

G. Individuals receiving supports, family members, county case managers, and guardians will be informed of and provided a copy of this procedure and the Visitor Welcome Letter at admission by the intake coordinator.

H. While promoting these relationships, efforts must still be maintained to assure the safety and well-being of the individuals receiving supports. Precautionary procedures include:

1. All staff must be informed of any specific restrictions for visitation identified in the individual treatment plan. Decisions to restrict a visitor must be reviewed and re-evaluated each time the individual treatment plan is reviewed or at the individual's request.

2. Staff will ask all visitors to report to the home that the individual resides or if a visitor is here for an administrative or clinical meeting, the visitor will sign in at the Administration Office. All visitors will be provided with a Visitor Welcome Letter.

3. Staff will make every reasonable attempt to ensure that visitors shall fill out the Visitor Slip and give to staff prior to the visit and the Visitor Slip is placed in the gray Visitors Box in the Administration Building waiting area for record keeping. The Administrative Assistant will record all Visitor Slips into a Registration Log.

4. Staff must verify who the visitor is. This may include calling the supervisor to verify the visitor or asking to see the visitor's identification.

5. If any maltreatment is suspected, it must be documented and reported immediately in accordance with MSHS-Cambridge Maltreatment Procedure.

6. Issues involving visitors and contraband will be addressed according to the SOS Policy and MSHS – Cambridge Procedure on contraband and program safety.

DATA PRIVACY:

State and Federal laws require government agencies to maintain the privacy of the data that they collect in the course of their business. The release of private information maintained about clients requires the consent of the client, a court order or in accordance with a statutory provision.

REFERENCES:
Jensen Settlement Agreement - *Jensen et al v. Minnesota Department of Human Services et al*
SOS Policy 8100 Contraband and Program Safety
MSHS-Cambridge Procedure: Contraband and Program Safety
MSHS-Cambridge Visitor Welcome Letter
MSHS-Cambridge Visitor Slip #20030

CANCELLATIONS: This procedure supersedes MSHS - Cambridge Procedure #15899 dated 9/15/09.

AUTHENTICATION SIGNATURES:

Stephanie Larson, RN
Administrative Nursing Supervisor/Operations Manager

10/2/12
Date

Paula Halverson,
Director, Minnesota Specialty Health System

10/2/12
Date

Minnesota Department of **Human Services**

Welcome to Minnesota Specialty Health System-Cambridge

We would like to welcome your visit to the program and provide you with information we hope you'll find helpful.

- As a family member, guardian, or friend, both unscheduled and scheduled visits are encouraged and are permitted, at reasonable hours, unless the interdisciplinary team reasonably determines the visit is contraindicated.
- You will be allowed full and unrestricted access to the individual's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms, consistent with all individuals' rights to privacy.
- Individuals receiving supports at MSHS Cambridge will be allowed to visit with you in private without staff supervision, unless the interdisciplinary team reasonably determines this is contraindicated and it is noted in the individual treatment plan.
- Individuals receiving supports have access to attorneys, county case managers and spiritual advisors at any time.
- Individuals receiving supports will be encouraged to plan visits for times that will not significantly impact their daily schedule.
- We will actively encourage communication between the individual receiving supports and family members, guardians, and friends. A combination of visits, letters, and phone contacts will be encouraged. We will assist individuals in initiating contact to mark significant celebrations of family members and friends.

- While promoting these relationships, efforts will still be maintained to assure the safety and well-being of the individuals receiving supports. These measures include:
  - All specific restrictions for visitation will be identified in the individual treatment plan. Decisions to restrict a visitor will be reviewed and re-evaluated each time the individual treatment plan is reviewed or at the individual's request.
  - Staff will ask you to report to the home where the individual resides or if you are here for an administrative or clinical meeting, you will be asked to sign in at the Administration Office.
  - You will be asked to fill out a Visitor Slip and give it to staff prior to the visit for record keeping.
  - Staff will verify your identity. This may include calling the supervisor or asking to see your identification.
  - State law prohibits tobacco, tobacco-related devices, firearms, weapons, alcohol, and controlled substances on facility property.

If you have questions, you may contact the MSHS-Cambridge Treatment Director, Stuart Hazard at 763-689-7169.

State Operated Services Staff Development

Training Participant List cont'd:

Class Title: Involvement with Family, Guardians and Friends **Date:** Oct. 3, 2012

Location: Procedure #15899 Eff: 10/8/2012 **Time:** **Hours:** 6.25

Instructor/s: ~~Stuart Hazard, MH Professional~~

Signature/s: Mitch Becker, Bldg Supv. Please Review & See Mitch for training if you have questions.

Employee ID #	Name (PRINT – Last & First)	Signature	Location (Unit/Department)
00169294	Becker, Mitch AGS	Mitch Becker	Homes 3 & 4
00614892	Hazard, Stuart Dir		Campus
00347084	Hiebert, Steve Invest		Campus
00765434	Klute, Beth BA 1		Homes 3 & 4
	Kuznia, Stephanie RNAS		Campus
00094490	McIntyre, Dana RTsr	Dana McIntyre RTsr	Campus
01016033	Marciniak, Janet RN		Homes 3 & 4
00309678	Mattson, Katy		Campus
00318061	Palmer, Kim LSW		Homes 3 & 4
00813025	Sjostedt, Stacey BA 1		Homes 3 & 4
01030098	Carlson, Kathy	HSS	Homes 3 & 4
01032246	Cline, Kendra	HSS	Homes 3 & 4
	Coyle, Will	nights	Homes 3 & 4
01068773	Downing, Michael	HSS	Homes 3 & 4
01102690	Gillespie, Jesse	nights	Homes 3 & 4
00937570	Graham, Amy		Homes 3 & 4
00704731	Hedlund, Penny		Homes 3 & 4
01148262	Irwin, Tara, LPN	nights	Homes 3 & 4
01107864	Kassa, Brian	nights	Homes 3 & 4
00343550	Kunshier, Jim	int	Homes 3 & 4
01107874	LaMoreaux, Doni		Homes 3 & 4
01105753	McGuire, Kelly		Homes 3 & 4
00358678	Morgan, Kevin	HSS	Homes 3 & 4
00096951	Peterson, Sue		Homes 3 & 4
01022686	Prigge, Perri		Homes 3 & 4
00246326	Roehl, Judy		Homes 3 & 4
01034091	Sorenson, LaVonne	HSS	Homes 3 & 4
	Lancraine, Mary		Intermittent
01030110	Jones, Jill		
	Jennings, Dylan		
01148262	Urness, Randa LPN		

State Operated Services Staff Development

Training Participant List

Class Title: MSHS-Cambridge Procedure #15899 Involvement with Family, Guardians, and Friends
MSHS-Cambridge Visitor Welcome Letter

Date: 10/03/2012

Topic:

Location: **Time:** **Hours:** .5

Instructor/s: **Instructor/s Signature:**

Employee ID #	Name (PRINT – Last & First)	Signature	Location (Unit/Department)
00059634	Aronson, Dennis SDS		Campus
	Bartnick, Amanda RN		Homes 7 & 8
01070670	Bell, Richard		Homes 7 & 8
01073558	Campion, Clayton		Homes 7 & 8
00100296	Carda, Judy		Homes 7 & 8
~~00317047~~	~~Carlson, Margaret ACS~~		~~Homes 7 & 8~~
01040275	Flaherty, Ron		Homes 7 & 8
00508374	Gillespie, Eben		Homes 7 & 8
01001225	Haas, David		Homes 7 & 8
00099574	Hanson, Rick		Homes 7 & 8
01068779	Hauri, Heather		Homes 7 & 8
00282599	Hicks, David BA1		Homes 7 & 8
00283945	Jabs, Edwin		Homes 7 & 8
00361860	Jensen, Stephanie		Homes 7 & 8
01025211	Johnson, Matthew J		Homes 7 & 8
01001222	Jones, Chris		Campus
01030110	Jones, Jill A		Homes 7 & 8
00123164	Lancrain, Mary		Homes 7 & 8
00283598	Lawrence, Mike		Homes 7 & 8
00309721	Lee, Yvonne		Homes 7 & 8
00101464	Mell, Jani		Homes 7 & 8
00816488	Nordlum, Maridy		Homes 7 & 8
00556589	Noren-Mullins, Robbin		Homes 7 & 8
01073560	Stradal, Dustin		Homes 7 & 8
01009551	Thomas, Dawn BA1		Homes 7 & 8
00134090	Villnow, Char		Homes 7 & 8
01153182	Anderson, Verna BA2		7+8
01152712	Nelson, Shana RN		7+8

State Operated Services Staff Development

Training Participant List

Class Title: MSHS-Cambridge Procedure #15899 Involvement with Family, Guardians, and Friends
MSHS-Cambridge Visitor Welcome Letter

Date: 10/03/2012

Topic:

Location: **Time:** **Hours:** .5

Instructor/s: **Instructor/s Signature:**

Employee ID #	Name (PRINT – Last & First)	Signature	Location (Unit/Department)
01152712	Nelson, Shana	Shana Nelson RN	NR SG
00614892	Hazard, Stuart		Admin.
	Larson, Stephanie		
01016033	Marciniak, Janet	Janet Marciniak	RN Consultant
00306215	Mattson, Katy	Katy Mattson	
0027974	Johnson, Gina	Gina Johnson	OAS SR.
	Hiebert, Steve		
	Taylor, Ron		

Exhibit 107

SETTLEMENT AGREEMENT TRACKING: COMMUNITY SUPPORT SERVICES AREAS
REPORTING PERIOD: FY 13 –SEPTEMBER 2012 (AND SUMMARY NOTES FROM FY 12)
DATE OF REPORT: OCTOBER 24, 2012

Section/page	Requirement	Progress/Status/Data		Evaluation
Reference tracking document Item (s) # 75 and 76	CSS will identify and provide long term monitoring of persons with clinical & situational complexities to avert crisis, provide strategies for service entry changing needs and prevent multiple transfers with the system (Target maximum 75)	-Monitoring services called Extended Supports -Service protocols and procedures completed -Established internal Extended Supports Review Committee -CSS Staff trained re monitoring and reporting -Set up/development = complete FY 12 = 27 cases <u>FY 13</u> July = 33 August = 33 September = 33		FY 13 **Year to date:** 100% Extended Supports cases maintaining least restrictive residence with crisis prevention plans implemented
Reference tracking document Item(s) 74, 77 and 78 And 97	Intervention & technical assistance will be provided where the person lives, strengthening capacity for the person to remain at home. CSS services will be statewide and respond within 3 hours from authorization by guardian and provide augmentative training coaching and mentoring	# CSS Cases summary FY 12 = Average 449 served per month	# Wrap Around summary FY 12 = Average 10 new cases per month	FY 13 **Year to date:** Weekly triage/diversion meetings held for appropriate level of care 100% of CSS cases response within time specified per team and authorizations completed Discharge transition from MSH -2 clients confirmed move Oct.

		# Open Cases – <u>FY 13</u>
		July = 472
		Aug = 467
		Sep = 459
			# New Wrap Around/Aug
			<u>FY 13</u>
			July = 3
			Aug = 4
			Sept = 4	

Reference	CSS will partner with Community	-Quarterly partnering with Metro Crisis Coordination		Implementation: On-going

tracking document Items # 79	Crisis Intervention Services to maximize support, complement strengths and avoid duplication	Program (MCCP) -Referral partnerships with community crisis homes established with technical assistance provided, as needed/requested -August: Partnering request from SE provider organization -Sept: Established parmate3rs for Se collaboration including training/mentoring	per collaborative agreements Collaboration via shared service contracts
Reference tracking document items 80 and 81, 82	CSS will provide staff at community based facilities and homes with training in person centered thinking, multi modal assessment, positive behavior supports, consultation and facilitation skills	FY 12 -Training provided per individual cases *(see open cases above)* -# trainings provided per FY 12 training contracts: 77 -# individuals received training: 730 <u>FY 13</u> **July** # trainings provided = 15 # people trained = 157 **Aug** # trainings provided = 12 # people trained = 117 **Sept** # trainings provided = 15 # trained 216	Implementation: On-going per referrals and training contracts Evaluation surveys received are positive. Measures of the impact of training implementation to be determined by re-referrals after training and within 6 months **# of re-referrals** July = 0 August = 1 Sept = 1
Reference tracking document Item #83 and # 84	Expansion of CSS will include 14 FTEs	See attachment for names and positions None of the positions vacant	100% Staff trained and providing case work

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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

Plaintiffs,

vs.

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

Defendants.

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

PLACEHOLDER FOR EXHIBIT 108 TO DEFENDANTS' STATUS EPORT

This document is a place holder for the following items which are filed in conventional or physical form with the Clerk's Office:

Exhibit 108 to Defendants' Status Report

If you are a participant in this case, this filing will be served upon you in conventional format.

This filing was not e-filed for the following reason(s):

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

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

☐ Physical Object (description):

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

☒ Item Under Seal pursuant to a court order* (Pursuant to Protective Order: Doc. No. 57)

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

☐ Other (description):

AG: #3120732-v1

Exhibit 109

The Promise of *Olmstead:*

Recommendations of the Olmstead Planning Committee

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Table of Contents

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PREFACE

The Olmstead Planning Committee (OPC) recommendations contained in this document are guided by a Vision and Principles Statement that the OPC intends for the State of Minnesota and the Department of Human Services (DHS) to use as a guide in the development of the Minnesota *Olmstead* Plan. The recommendations cover a wide array of *Olmstead* issues. There are, however, important topics and specific populations that the OPC could not adequately address because of the short amount of time it had to complete its work, the lack of expertise among OPC members in some areas and the composition of the OPC. For example, access to transportation is critically important if people with disabilities are to be fully integrated into their communities. However, the OPC did not address this issue as transportation funding and planning issues are complex, requiring special expertise which the OPC lacked.

Issues which the OPC did not have adequate time to address but which have been addressed in other states' Olmstead Plans include individuals with disabilities in the corrections system and strategies for addressing the need for additional direct support staff. The needs of children with disabilities and their families are addressed by some recommendations but the OPC recognizes that additional attention should be paid to children and family support needs. The elderly as a specific population group are not discussed because so many seniors do not have a disability covered under the Americans with Disabilities Act[1] (ADA). On the other hand, the recommendations address the Olmstead-related needs of individuals with disabilities of all ages. The OPC also did not address any recommendations regarding the Minnesota Sex Offender Program.
The State, as it prepares its Olmstead Plan, must look broadly across state executive agencies providing services to people with disabilities and do its own analysis of laws, policies and procedures that should be reviewed in light of the ADA and the Olmstead decision.

The OPC wishes to emphasize that its recommended reforms should not be implemented in a manner which causes harm to individuals with disabilities. Individual needs and desires should not be sacrificed in an effort to promote greater community integration. The OPC cautions against reducing existing resources for less integrated settings before sufficient resources supporting more integrated settings are available. An effective *Olmstead* Plan should involve redirecting public resources to more integrated settings but this must be done in an orderly and measured way to ensure that people with disabilities, collectively and individually, continue to benefit from public programs. If an individual with a disability desires to move from an institution or a less integrated setting to a more integrated setting, the move should not be carried out unless and until the services and supports the individual needs are available and in place.

It is important to acknowledge that the good faith efforts and hard work of fifteen individual OPC members resulted in recommendations by consensus rather than unanimity. It would be incorrect and unfair to the group process to assume that every member agreed with every recommendation because

[1] Americans with Disabilities Act of 1990, 104 Stat. 337, 42 U.S.C. Section 12132

this is not the case. Finally, none of the conclusions in this report should be interpreted as agreement by state officials that the State of Minnesota is not in compliance with the integration provisions of the Americans with Disabilities Act.

Olmstead Planning Committee Members:

Christopher Bell (Co-Chair)

Maureen O'Connell/Dave Hartford (Co-Chair)

Phil Claussen

Loren Colman

Milt Conrath

David Godfrey/Ann Berg

John Hastings

Pamela Hoopes

Mickey Kyler

Maureen Marrin

Maridy Nordlum

Shamus O'Meara/ Annie Santos

Roberta Opheim

Lori Schluttenhofer

Colleen Wieck

Administrative Support:

Linda Dahlquist

Margee Holt

Rosalie Vollmar

THE PROMISE OF *OLMSTEAD*

Olmstead v. L.C.

In Olmstead v. L.C.,[2] the United States Supreme Court held that Title II[3] of the Americans with Disabilities Act of 1990 (ADA)[4] requires the placement of persons with mental disabilities in community settings, rather than in institutions, when:

> (1) the state's treatment professionals determine that such a placement is appropriate,
> (2) the transfer is not opposed by the individual, and
> (3) the placement can be reasonably accommodated given the resources available to the state and its obligation to provide for the needs of others with mental disabilities.[5]

A five justice majority held that a failure to provide care for individuals with mental disabilities in the most integrated setting appropriate to their needs is discrimination, in violation of the ADA, unless the state or other public entity can demonstrate an inability to provide for integration into the community without "fundamentally altering" the nature of its programs. The Supreme Court's decision disfavors institutional placement, and looks positively on community living with needed services.

Institutional placement of persons who can benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.[6] The *Olmstead* decision applies to all individuals who have a "disability" as defined by the ADA. As amended in 2008, the ADA includes individuals who have a wide range of medical conditions[7] which substantially limit their major life activities or major bodily functions. A person's ADA disability status is determined without regard to an individual's use of medication, prostheses, mobility devices or other mitigating measures and without regard to the existence of intermittent periods of symptoms and remission.[8]

The Necessity for an *Olmstead* Plan

Olmstead does not require a state plan, but compliance with the court's decision is difficult to demonstrate without a formal *Olmstead* Plan.[9] The Supreme Court made it clear that the

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[2] *Olmstead* v. L.C., (98-536) 527 U.S. 581 (1991).
[3] Title II of the ADA prohibits discrimination on the basis of disability in programs and activities of "public entities" i.e., state and local governments.
[4] 42 U.S.C. Section §12132
[5] 527 U.S. at 607.
[6] 527 U.S. at 600 (1999).
[7] The ADA protects people who have an actual disability, a record of an actual disability or who are regarded as having a disability regardless of the accuracy of that perception. In this document, the focus is on individuals who have an actual disability because it is this group who are in an institution.
[8] There are many individuals who may be protected by the ADA but who do not consider themselves as disabled. This is true for many individuals with a mental illness, among others. Regardless of a person's self-identity, the ADA protects all individuals with substantially limiting physical, sensory or mental impairments.
[9] In addition, federal authorities anticipate development of *Olmstead* plans. See Letter from Timothy Westmoreland, Director, HCFA Center for Medicaid and State Operations and Thomas Perez, Director, Office of Civil Rights of the United States Department of Health and Human Services, to State Medicaid Directors, dated January 14, 2000 http://www.hhs.gov/ocr/olms0114.htm.

establishment and implementation of a "comprehensive, effectively working plan" is a vital criterion for evaluating a state's compliance with the court's decree.

If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.[10] States have recognized that such a plan affects the entire service system and have adopted plans of broad scope.

Federal Government Enforcement of *Olmstead*

As part of the New Freedom Initiative, in June 2001, President George W. Bush issued an Executive Order "Community-Based Alternatives for Individuals with Disabilities."[11] The order directed six federal agencies to assist states to identify and remove barriers to *Olmstead* implementation. On the tenth anniversary of the *Olmstead* decision, President Obama launched the "Year of Community Living,"[12] a new effort requiring cooperation between executive branch agencies in the implementation of the *Olmstead* decision.

Primary guidance on the breadth of *Olmstead* comes from technical assistance guidance issued by the U.S. Department of Justice (DOJ) in June 2011.[13] Using a question and answer format, the DOJ makes clear that *Olmstead* applies to housing, home and community based services, and employment, among other areas. In addition, *Olmstead* is not limited by the parameters of a state's Medicaid program and its remedies are broad. The DOJ's expansive view of *Olmstead* was made clear in the testimony of Thomas E. Perez, Assistant Attorney General for Civil Rights, before the Senate Committee on Health, Education, Labor and Pensions.[14] Mr. Perez first noted that the "*Olmstead* decision was rightly called the Brown v. Board of Education of the disability rights movement." He then noted *Olmstead* enforcement efforts have been driven by three goals: (1) people with disabilities should have opportunities to live life like people without disabilities; (2) people with disabilities should have opportunities for true integration, independence, recovery, choice and self-determination in all aspects of life including where they live, spend their days, work, or participate in their community; and (3) people with disabilities should receive quality services that meet their individual needs.

Finally, Assistant Attorney General Perez stated that *Olmstead* applies to situations in which individuals seek integrated supported employment services but are instead placed by the States in employment settings in which they have little or no opportunity to interact with non-disabled workers or to learn valuable skills that would assist them in working in competitive employment.

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[10] 527 U.S. at 605-606 (1999).
[11] Executive Order No. 13217, June 18, 2001.
[12] President Obama Commemorates Anniversary of *Olmstead* and Announces New Initiatives to Assist Americans with Disabilities, June 22, 2009.
[13] 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., June 22, 2011.*
[14] Assistant Attorney General Thomas E. Perez testifies before the U.S. Senate Committee on Health, Education, Labor and Pensions, Washington, D.C. on Thursday, June 21, 2012.

Jensen Settlement

In July 2009, three former residents of the Minnesota Extended Treatment Options program (METO) in Cambridge, Minnesota, and their parents, brought a class action lawsuit (Class) against the State of Minnesota and the Minnesota Department of Human Services (DHS) in the United States District Court, District of Minnesota, on behalf of residents of METO with developmental disabilities who were subjected to the use of restraints and seclusion in alleged violation of the United States Constitution and other federal and state laws. In June 2011 the Plaintiffs, on behalf of the Class, and the State reached a comprehensive class action settlement agreement (Settlement Agreement), which was approved by court on December 5, 2011.

Among other things, the Settlement Agreement required the State to close METO by June 30, 2011, and mandated that any successor program comply with the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999) and utilize person centered planning principles and positive behavioral supports. The Settlement Agreement also mandated that as part of system wide improvements, DHS establish an "Olmstead Planning Committee" (OPC) charged with making public recommendations as to the establishment of a State Plan by October 5, 2012. By June 5, 2013, the State and DHS are mandated 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 individual needs and in the "most integrated setting," consistent and in accord with the *Olmstead* decision.

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VISION AND PRINCIPLES STATEMENT

I. Vision Statement

The Minnesota *Olmstead* Plan ("Plan") will empower and support people with disabilities of all ages and abilities to live with dignity and independence in the most integrated setting consistent with their own preferences and based upon their own choice. The intended outcome of the Plan is to expand, strengthen, and integrate high quality and effective systems of community-based services and supports that are person-centered, individually-directed, and adequately funded.

II. Principles governing the content of the Plan

The primary principles governing the content of the Plan are as follows:

- Disability is a natural part of human experience. Disability does not mean "inability."
- An individual with a disability is a human being equally as worthy of dignity and respect as all other human beings.
- "In enacting the ADA, Congress recognized that physical and mental disabilities in no way diminish a person's right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers." 42 U.S.C. §12101(a)(2) Note.
- The ADA and the Supreme Court's *Olmstead* decision requires state and local governments to administer services, programs, and activities in a manner that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.
- The State of Minnesota, like the Nation's "proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. §12101(a)(7).
- The State of Minnesota ("State") is committed to enabling individuals with disabilities to move from institutions to the most integrated setting appropriate, consistent with their desires. The State is equally committed to take steps necessary to avoid the risk of individuals with disabilities being unnecessarily institutionalized.
- The guiding principle in State disability policy development and funding decisions will be to support individuals with disabilities to have access to community living opportunities including employment opportunities, accessible and affordable housing, public

transportation, access to recovery and rehabilitation services, lifelong learning and educational opportunities, assistive technology, and health care, with access to the needed services and supports to make these opportunities a reality.

- Each individual with a disability will be empowered to make an informed decision, notwithstanding any myths, fears, or stereotypes that the individual may be experiencing regarding his or her capacity to live in the community with needed services and supports. The ability to make informed decisions will include the opportunity to speak with peers who are successfully living, learning, working and enjoying life in community-based integrated settings.

- Family members and significant others, as appropriate, may play an important role in supporting an individual with a disability to make informed choices.

- In order to support self-direction and to maximize independence, individuals with disabilities will be empowered to make choices for themselves on matters in their lives, just as non-disabled individuals do, including on issues which involve risks. Quality of life is enhanced when individuals with disabilities gain more control in their lives including deciding whether to take a risk.

- The goals when developing individual services and supports will include accessibility, quality, person-centered planning, and wherever possible, individually-controlled decision-making. An accurate ongoing and comprehensive system of assessment of an individual's abilities and functional limitations will be available to facilitate the individual in making choices about supports and services.

- A full array of services and supports are needed to address the broad range of individuals with disabilities including persons with stable, degenerative chronic medical conditions or multiple disabilities.

- Public and private mechanisms of financing programs and activities must be reexamined to enable federal, state, county, and individual funding to be used in the most creative, effective and efficient means available.

- All programs and activities developed or maintained under this Plan must be free of discrimination on all bases in accordance with applicable federal and state law and must address the diversity of individuals with disabilities in terms of race, ethnicity, national origin, age, gender, religion, language, ability to communicate, sexual orientation, geography, and ability to pay.

III. Principles for Developing, Implementing and Evaluating the Plan

The primary principles that inform the development and implementation of the Plan are the following:

- Individuals with disabilities, their families, and advocates will play a significant role in the development, implementation and evaluation of the Plan. In addition, the State must engage other persons, entities and state councils who are or will be impacted by the Plan.

- All State agencies, not just the Department of Human Services, must collaborate in and be responsible for developing and implementing the Plan. This includes sharing costs and budget responsibilities as appropriate. The OPC strongly recommends that the Governor establish an *Olmstead* sub-cabinet to ensure the most efficient and effective inter-agency coordination, planning and implementation of the Plan. Key Minnesota State agencies identified by the OPC includes: Department of Human Services (DHS), Minnesota Housing, Minnesota Department of Education (MDE), Department of Corrections (DOC), Minnesota Department of Health (MDH), Department of Employment and Economic Development (DEED) and Department of Transportation (DOT).

- The Plan will take into account past and current reform efforts.

- The Plan will be developed and implemented with specific, measurable and achievable goals and timetables and in a manner that provides for transparency and accountability.

- The Plan will include a commitment by the State to the long-term effort necessary for its effective and efficient implementation regardless of changes in leadership.

- Any savings attributable to implementation of the Plan will be reinvested into expanding the availability of appropriate housing and services instead of using such funds for other purposes.

- Ongoing community engagement and training will be critical to implementation, evaluation, and revision as the Plan evolves to meet changing needs and resources.

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CHANGING THE SERVICE SYSTEM TO EMPOWER INDIVIDUALS WITH DISABILITIES

Since the 1970's society's views of people with disabilities has been evolving to recognize the uniqueness of an individual's abilities and limitations. Despite forty years of improvement, lack of employment and resulting poverty frequently cause individuals with disabilities to enter into the social services system. While the requirement for an individualized assessment and response is a cornerstone of disability policy this is not always reflected in the service system. Although person-centered planning is considered a "best practice" often times individuals feel like their choices are not honored as authorization for services and supports comes from a "case manager."

There are certain assumptions that must be acknowledged if individuals with disabilities are to be empowered:

- Every individual should be presumed competent, unless declared otherwise by a court, to direct the planning process, make choices, achieve his or her goals and outcomes, and build a meaningful life in the community.
- Every individual has strengths, can express preferences, and can make choices.
- Every individual with a disability should have his or her choices and preferences accurately assessed and understood using a formal assessment process which is regularly updated. Currently, DHS is developing MnCHOICES as an assessment tool.
- Every individual with a disability should be provided a budget for housing and services which he or she can use to make choices with, as appropriate, the assistance of family and significant others.
- Every individual should be able to have the timely assistance of an advocate such as a certified peer specialist, peer integration specialist or self-advocate.
- Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.
- Through the individualized planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.
- An individual's cultural background is recognized and valued in the individualized planning process.

Empowering Choice While Managing Risk

Empowering individuals to live their own lives in the community of their choosing, as mandated by *Olmstead*, raises complex challenges around the issues of risk of harm and potential liability. Few endeavors in life, if any, can be accomplished without some risk of harm. Moreover, taking a risk can have positive as well as potential negative consequences. However, the ability to make choices

enhances the quality of life of persons with disabilities. Most people weigh the potential benefits and the potential negatives when considering a course of action, whether or not this is done consciously or unconsciously.

When it comes to disability, however, risk taking is often viewed as having only potential negative consequences. Perceived or actual risk to the health and safety of people with disabilities or others in the community can undercut efforts at individual empowerment and community integration.

Continuing efforts to provide persons with disabilities real control over decisions affecting how they participate in all aspects of community life raises concerns in a variety of contexts. State and county officials,[15] providers of disability services, family members[16] and people in the community sometimes believe there is a potential for harm to people with disabilities and others resulting from unrestricted community integration of people with disabilities.

Many of these concerns arise from myths, fears and stereotypes about disability and disease. For this reason, disability rights advocates crafted the ADA to permit public and private disability programs to exclude only those persons whose disabilities posed a significant risk of substantial harm to others which could not be mitigated by some form of mandated accommodation which would not impose an undue burden or alter the nature of the program in question.[17] Risk to self is not a permitted statutory basis for exclusion of a person with a disability under the ADA.

However, perceived or actual fear about the health and safety of persons with disabilities and others in the community can and will torpedo efforts at integration unless they are dealt with effectively. There are many policy complexities to the appropriate management of risk in the context of community integration. Many persons with disabilities are perfectly able to accurately assess risks and rewards without assistance and without someone second-guessing their decisions. People with disabilities should not be subjected to risk management policies which are not applied to non-disabled adults in similar circumstances.

Moreover, every human being, including a person with a disability, has abilities and limitations. A valid risk management policy must be applied on a case-by-case basis to evaluate whether some form of accommodation, service, or support, which, if provided, would enable an individual to safely perform an activity or achieve a personal goal.

Finally, an effective risk management policy must be able to respond to systemic barriers created by fears of risk of harm to self or others. Fear about the possibility of litigation, bad publicity, or individual liability must be adequately addressed on a systemic as well as an individual basis.

The OPC recognizes that unique strategies have been developed by different disability populations regarding peer supports. Therefore, it is important to support multiple strategies to assist individuals

[15] Hall-Lande, J.; Hewitt, A.; Bogenschutz, M.; Laliberte, T., "County Administrator Perspectives on the Implementation of Self-Directed Supports, Journal of Disability Policy Studies, Feb. 16, 2012.
[16] Assistant Attorney General Thomas E. Perez, Testimony Before the U.S. Senate Committee on Health, Education and Pensions, June 21, 2012.
[17] The ADA Title II (state and local governments) regulatory restriction permitting exclusion of a person with a disability only if the disability would pose a direct threat to others and not to self is found at 28 C.F.R. § 35.109. Similar ADA language applicable to private places of public accommodations, including social service agencies, may be found at 42 U.S.C. § 12182(d)(3) and 28 C.F.R. § 36.208.

with disabilities. For example, although self- advocates serving persons with developmental disabilities and certified peer specialists serving people experiencing mental illness are closely related in terms of outcomes achieved, they employ different successful practices. The OPC supports throughout its recommendations the expansion of peer supports for all disabilities. Thus, one of the recommendations below is to develop a new peer support called a Peer Integration Specialist. A certified peer specialist or a self-advocate could also be a Peer Integration Specialist. The key idea is to make peer support a critical component of the new service system.

Recommendations for Empowering Choice

- The State should support the development of a position called a Peer Integration Specialist that helps train and support individuals with disabilities to learn to speak for themselves, understand their rights, and express their preferences. This will include funding to support the training and coordination of a network around the state, and payment to assist other individuals with disabilities in making choices and moving to the most integrated settings. Some funding will be dedicated to supporting Peer Integration Specialists to meaningfully participate in workgroups and task forces that affect services and quality evaluation.

- The State should support a self-advocacy network in Minnesota that helps train and support individuals with developmental disabilities to learn to speak for themselves, understand their rights, and express their preferences. This will include funding to support the training and coordination of a self-advocacy network around the state, and payment to self-advocates to assist other individuals with disabilities in making choices and moving to the most integrated settings. Some funding will be dedicated to supporting self-advocates to meaningfully participate in workgroups and task forces that affect services and quality evaluation.

- The State should involve persons with disabilities, their families and advocates in the implementation, evaluation and updating of MnCHOICES to ensure it accurately identifies the abilities and desires of all people with disabilities.

- The State should provide regular training on empowerment of individuals with disabilities and, their right to live, learn, work and participate in community living according to principles of the *Olmstead* decision. Such training should be offered on a statewide and systematic basis.

- The State should address risk management policies and standards in a consistent manner. Currently, the State Quality Council and several private entities are considering policies and standards for risk management. Best efforts should be made to ensure that existing and proposed risk management policies and standards are reviewed and do not conflict with applicable law including the ADA. In performing that review, the State should ensure that all laws and rules address the balance of choice versus risk and ensure that choice is given more weight than given to risk. The State should include in this review the Vulnerable Adult and Nurse Practices statutes to ensure they do not reduce individual choice.

- The State should develop a process to ensure that there is enforcement of consumer choice by all providers including but not limited to case managers as well as service providers.

- The State should provide ongoing training to stakeholders on applicable risk management policies and standards to ensure that concerns about empowering individuals with disabilities to be fully integrated into the community is not derailed by unwarranted health and safety concerns.

Goals

- The State should, over the next five years, hire and train 1,000 Certified Peer Specialists to assist individuals in understanding, making and implementing their choices.

- The State should, over the next five years develop a network of 500 paid Peer Integration Specialists to perform the same functions as the Peer Specialists with individuals whose primary diagnosis is other than mental illness.

- The State should, over the next five years, develop a network of 500 paid or volunteer self-advocates to perform the same functions as the Peer Specialists with individuals whose primary diagnosis is other than mental illness.

COMMUNITY-BASED SERVICES AND SUPPORTS

Introduction

Currently, we have a system of community supports which are widespread, fragmented, and difficult to access. Any given support or service is probably dependent on diagnosis, age and level of care required. The new vision of the OPC for the future system is to begin with an assessment of the individual with a disability which is centered on the person. The assessment will help the system develop community support plans tailor-made to meet the strengths, goals, preferences and assessed needs that the individual will have to enter and/or live successfully in the community and offer the maximum possibility to interact with persons who do not have a disability. This applies to all ages across all disability types. To achieve this goal a functional assessment tool, MnCHOICES, is in development and will be rolled out statewide by the end of 2013.

Minnesota's current system lacks the flexibility to respond to the array of services that people with disabilities need to successfully live in the community. The waivers are complex and while they have an array of services from a menu, or combination of menus, the services offered by a specific waiver may still not match what the individual needs. New treatments and assistive technology rapidly evolve. Some of these services and supports may not be currently available through the existing menu of services. A new emphasis must be on asking the person with a disability what they would need in the community and then meet that critical need regardless of service menus.

Also, a strategy for moving away from waiver usage is to expand other non-waivered community-based services and supports. Medicaid State plan services would need to be enhanced and revamped to recognize this emphasis on community living.

Another problem with our current system of community supports is that it is expensive. Changes must be made that emphasize the goal is to do whatever is necessary to remain in or return to the community, so long as the provision of these services and supports is cost neutral with regard to Medicaid, including the costs of institutionalization of the person.

People with disabilities have continually faced a system that thinks it knows what the person needs. However, the system cannot imagine the full range of supports that might be important or necessary for the success of a person, and should not, because of that inability to imagine the service, deny funding it. People with disabilities envision a community-based system that emphasizes choice of housing options and services and gives more control to the individual.

Home and Community-Based Waivers

The "What We Have" report prepared for the OPC by DHS with the help of Truven Analytics provides important background information on Home and Community-Based Waivers that will be referenced for this section of the report.[18]

[18] MN DHS *What We Have Report*, Sept. 19, 2012, http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_171804.doc.

Minnesota has five Medicaid Home and Community-Based Services (HCBS) waivers that provide the bulk of services and supports for people with disabilities living in the community. The five waivers are: the Elderly Waiver (EW), Developmental Disabilities (DD) Waiver, and Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC) and Brain Injury (BI) waivers. A brief description of these services is provided in Appendix A.

Table 12 from the "What We Have" report, provides important utilization and expenditure information for the waivers for state fiscal years 2008-2012 and is provided in Appendix A. The data shows that the majority of recipients in each waiver are using waiver services to live in community settings. However, with the DD waiver it is estimated that 60% of the waiver recipients are living in congregate settings including foster care homes, customized living, residential services, and out of home supportive living services.

Another table from the "What We Have" report is printed below. This table shows the number of persons on waiver services that are living in congregate settings.

Table 5: Monthly Data for Number of People Receiving Publicly Funded Services in Congregate Settings, 2006 – 2010

Program	2006	2007	2008	2009	2010	Avg Annual Increase
Nursing Facilities (NF)	21,011	20,233	19,468	18,783	18,219	-4%
Intermediate Care Facilities/DD (ICF/DD)	1,897	1,864	1,850	1,825	1,779	-2%
Children's Residential Treatment (Rule 5)	227	225	242	180	202	-3%
Alternative Care Services (AC)	531	472	363	210	71	-40%
Brain Injury Waiver (BI)	807	847	889	920	885	2%
Community Alternatives for Disabled Individuals Waiver (CADI)	3,542	4,055	4,582	4,876	5,136	10%
Community Alternative Care Waiver (CAC)	49	51	51	53	51	1%
DD Waiver – Corporate Foster Care	7,642	n/a	n/a	7,808	8,252	2%
DD Waiver – Family Foster Care	1,086	n/a	n/a	975	899	-5%
Elderly Waiver (EW)	6,416	6,696	6,780	6,780	6,479	0%

Notes:

- n/a means no information available for this report because data was not analyzed for these years.
- NF and ICF/DD data are based on the average monthly number of people receiving Medicaid services in a SFY
- Data for NF does not include individuals under age 65 at two facilities that are IMD. A private facility, Andrew Residence, served 221 people in 2011 according to Truven Health analysis of MDS data from DHS in May 2012.
- Data for AC, BI, CADI, CAC, and EW are based the number of people as of December of the year with a current living arrangement of "congregate setting" indicated in the most recent assessment
- Data for the DD Waiver is based on the number of people as of December 2006, July 2009, or December 2010 with a current support listed as "Foster Care – shift staff" i.e., corporate foster care, "Foster Care – family" or "Foster Care – live-in caregiver." Family or live-in caregiver foster care arrangements are categorized as Family Foster Care.

Sources:

- NF and ICF/DD data from MN DHS, November 2011 Forecast.
- DD Waiver data for 2009 provided by the Minnesota DHS in July 2009.
- Other services data from Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012.

The "What We Have" report concludes "within Minnesota's HCBS program, thousands of people receive residential services where the entity that owns the residence also furnishes services at the location. Some of these individuals may be better served in their own home or apartment, with the ability to change service providers without moving."[19] The growth and cost of waiver spending on adult foster care also led to a moratorium on the building of adult foster care beds in 2009.

The growth of the waiver programs has been addressed by the legislature placing caps on waiver allocations. Thus, there are waiting lists for DD and CADI waivers. Currently, for fiscal year 2013, 72 new DD waiver allocations are allowed and 720 for CADI[20]. The other waivers do not have allocation limits and do not have current waiting lists. The waiting lists for these services must be addressed by the State in the Plan.

The HCBS waivers are managed by DHS, the counties and tribes through an annual waiver allocation process. DHS establishes an annual waiver budget for each county or tribe. Counties and tribes are required to manage their waiver budgets, which include:

- Adding new recipients;
- Managing waiting lists based on DHS established priorities; and
- Planning for the anticipated and unanticipated changes in needs of waiver recipients.

The management elements must be consistent with federal regulation requirements including the Centers for Medicare & Medicaid Services' (CMS) approved waiver plan governing home and community-based waiver services and DHS priorities. Policies and procedures must be submitted to DHS for initial approval and for approval prior to any changes or revisions being implemented and available to the public upon request.

For the DD Waiver, each calendar year, DHS gives counties and tribes a DD Waiver budget from which to manage DD Waiver authorizations and spending. Home care costs for waiver participants are included in the county's budget. The annual enrollment period runs from September 1 through November 30 each year. The initial allocation a county or tribe receives the following year is directly related to the number of people being served in that county during the enrollment period.

For the BI, CAC and CADI Waivers each state fiscal year (July 1 through June 30) DHS gives counties and tribes a CCT (CADI, CAC, BI) Waiver budget from which to manage CCT waiver authorizations. Home care costs for waiver participants are included in the county's budgets. County budgets are based on daily resource amounts established for new conversions and diversions. The budget allocation methodology for each individual determines the daily resource amount.

For CCT Waivers, the county first screens a person for one of the CCT waivers then selects an available allocation. DHS takes information from the new waiver participant's Long Term Care (LTC) screening document and applies the budget allocation methodology to establish the daily resource amount. DHS

[19] MN DHS, *What We Have Report*, September 2012

[20] MN DHS Disability Services Division, *Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities*, July 2012 found on https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6568-ENG

contributes the daily amount to the county's or tribe's budget beginning when the person is opened and authorized for services.

While the waiver process has allowed for greater flexibility and local control to plan and meet the assessed needs of a person for supports and services, there are many concerns with the current system. The most recent DHS report[21] for fiscal year 2012 shows that counties and tribes spent $163 million less than the total amount allocated.

DHS points out however, that this figure does not indicate significant under spending of the amount appropriated, because the allocation amount includes a factor to account for the counties' and tribes' need to manage spending within the allocation amount. In addition, the difference between actual spending and the appropriated funds was approximately $9 million for all four waivers, and for the two waivers that had waiting lists – CADI and DD – the difference between actual spending and the appropriation was very close. It was 0.6% for CADI and 0.3% for DD. The OPC has concerns that under spending occurs while there are waiting lists for the DD and CADI waivers and individuals are in more restrictive settings because they cannot access the necessary waiver or other resources to allow them to return to the community.

Reform 2020[22] acknowledges that the current system is not sustainable. The OPC agrees with this assessment and makes the following recommendations.

Recommendations for Home and Community-Based Waiver Services

- Establish and communicate to every individual with a disability his/her (monthly or annual) budget for housing and services. This budget amount will assist an individual to make informed choices on services and supports similar to a budget for a person without a disability. This individualized budget approach will require establishing a state-wide methodology for accurately assessing the cost per service/support. The current plan is for MnCHOICES to be the methodology for calculating individualized budgets.

- The waiting lists for the DD and CADI waivers must be tracked, monitored and the Plan must contain a plan to reduce waiting lists. The State should consider a systematic method of reducing waiting lists in keeping with the spirit and intent of the *Olmstead* decision.

- DHS should monitor access to services statewide across all disabilities (including transportation, cultural competency, and geographical disparities) and report the results to the public.

- The State should consider changes to the home and community based waivers to allow for the provision of "other supports necessary to enter, or successfully remain in the community."

[21] MN DHS Disability Services Division, *Annual Report on the Use and Availability of Home and Community-Based Services Waivers*, July 2012
[22] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535B-ENG

- The State should continue to create a common waiver service menu so that people using waivered services can get access to the complete array of services including Independent Living Skills that will enable living in the most integrated setting.

- The State should re-examine family supports and consider the entire family unit when doing assessment and planning for an individual with a disability. This support of families is particularly needed for families of children with disabilities and is also beneficial if a parent has a disability.

Medicaid State Plan Services

Medicaid State plan services also provide important services and supports that assist people with living in the community. Important services as described in Appendix A include Personal Care Assistance (PCA), Private Duty Nursing, Home Health Services, Adult Rehabilitative Mental Health Services (ARMHS), Assertive Community Treatment (ACT) and Children's Therapeutic Services and Supports (CTSS). Unlike the HCBS waivers, an individual with a disability does not need to meet an institutional level of care to be eligible for state plan services. To qualify for state plan services a person must be eligible for Medicaid and the services must be medically necessary. An individual can be on a waiver and also use state plan services. Also, an individual on a waiver waitlist can access state plan services. Thus, State plan services support individuals transitioning from institutional care.

The waivers were initially developed as alternatives to institutions for the elderly and specific disability populations. State plan services were also developed to assist individuals with mental illness to transition from institutional care. In 2001, ARMHS became a state plan service, followed in 2005 by the addition of ACT services.

However, several gaps in State plan services need to be addressed. Redesigning the PCA program through Reform 2020 is supported by the OPC. The redesigned PCA program called Community First Support Services (CFSS) proposes individualized service budgeting, flexible and improved services and participants have more choice. The OPC supports the direction the State is taking with CFSS.

While Reform 2020 is a positive step there are other problems with Medicaid State plan services that could be addressed by DHS. Several reports have highlighted that a population falling through the cracks in the current system of community supports are those individuals with complex, co-occurring disabilities. Additionally, they are often individuals who have had interactions with law enforcement and are deemed a public safety risk. Finally, they are frequent users of emergency rooms, detoxification services, hospitals and state run facilities. These individuals require multi-disciplinary teams with specialized expertise and extensive experience.

In order to keep individuals with complex disabilities in the community the State must build a better, more coordinated statewide crisis system that serves all disabilities. The use of crisis services must be a signal that individuals may need more intensive community services for some time period. Thus, a wraparound system must be designed so that individuals can have services delivered in the community which allows the individuals to remain in their own homes or apartments. Currently, people in crisis

often end up in an institution and may lose their homes. With the lack of affordable housing it becomes difficult to move back to the community once you have lost your home.

Many states have identified the need to enhance crisis services as a part of *Olmstead* settlements with the Department of Justice (DOJ). Virginia has agreed to develop a comprehensive crisis system that will help divert individuals from unnecessary institutionalization. Georgia is increasing its existing community services to 20 Assertive Community Treatment (ACT) teams, two intensive case management teams, two community support teams, maintains a crisis hotline, case management services, five crisis stabilization units, and peer support services. Over the next five years Delaware is seeking to prevent unnecessary hospitalization by expanding and deepening its crisis services, including a hotline, crisis walk-in centers, mobile crisis teams, crisis apartments and short term crisis stabilization programs. Delaware will also provide community treatment teams and case management to individuals living in the community who need intensive levels of support.

For people experiencing mental illness a barrier to receiving certain State plan services such as Assertive Community Treatment (ACT) is the lack of access to critical services until an individual meets the state definition of Serious and Persistent Mental Illness (SPMI). The SPMI definition in the Minnesota Comprehensive Mental Health Act has been viewed in the mental health community as too restrictive for a long time. It does not cover many individuals with severe anxiety related diagnoses who are unable to function without a high level of supports. Use of SPMI criteria makes many "first onset" individuals without extensive hospitalizations ineligible for very beneficial services which can prevent deterioration and functional limitations.

Another gap in State plan services is the lack of a robust Adult Rehabilitative Mental Health Services (ARMHS). ARMHS is critical to supporting persons with mental illnesses to remain as independent as possible in the community, but the State must upgrade it to meet its purpose: the service limits are too low and inflexible, the rates are very low, variable authorization of ARMHS' services results in persons being treated inconsistently across the State, providers are either dropping or having to subsidize ARMHS, which is not a sound trajectory for an important mental health service which has been found effective in stabilizing individuals for successful living in the community.

Another identified gap is the need for comprehensive, early identification and intensive intervention services under 1915(i) for children and adults who have a first episode of serious mental illness, including crisis services, in-home supports, employment or education including Individualized Placement and Support (IPS), family-caregiver education and support and services to support stable housing. The lack of service intensity and flexibility is a serious gap in Minnesota's service menu. This service is critical to meet the individual's needs early in the onset of an illness and during recovery. The menu of services listed should be available to persons as needed during their first episode of mental illness. These services must be available to all who meet the criteria and provided without regard to other conditions including physical disabilities, intellectual and developmental disabilities and age.

In addition to Reform 2020, the State can also make changes to State plan services under a new provision of the Affordable Care Act. In the short term, with the new regulations regarding 1915 (i) the State can combine new services and target the services to specific populations. In addition, the State

can improve care management of individuals with multiple co-occurring disabilities by developing health homes.

Although the OPC did not include timelines or goals in this section of the report, it is believed that these recommendations require urgent attention. Timelines should reflect this urgency. The OPC recommends that DHS prioritize the recommendations and set ambitious, specific, realistic goals and timelines to accomplish each recommendation.

Recommendations for Medicaid State Plan Services

- Evaluate and consider adding the following services to the Medicaid state plan:
    - An inter-agency employment initiative which should include a DHS state plan service under 1915(i) to add a broad employment supports service for all people with disabilities who need services to get and keep employment. This should include the aspects of IPS, autism specific employment supports, family stabilization services and other supported employment services that can be covered by Medicaid.
    - Expand and adequately fund the ARMHS service to better support individuals experiencing mental illness who are living in the community.
    - Caregiver-family education and supports, including respite services.
    - Supports to assure stability in housing.
    - Intensive early intervention for young children with autism.
- Develop regional crisis services to assure the provision of assessment, triage, and care coordination so that persons with disabilities receive the appropriate level of care in the most integrated setting.
    - Enhance care management/care coordination at the point when individuals experience contact with law enforcement, psychiatric hospitalization, or emergency room visits related to actions that present a risk of harm to themselves or others. These services will be available where the consumer lives, strengthening the capacity of the system to serve individuals with clinical complexities in their home community.
    - Include mobile wrap-around service response teams located across the state for proactive response to maintain living arrangements. The time for the crisis response should be as soon as possible with a maximum time of three hours from the time of request.
    - Crisis services will provide families, caregivers, and staff at community-based facilities and homes with state of the art training encompassing person-centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative

thinking. Training, mentoring and coaching as methodologies will result in increased community capacity to support individuals in their community.

- The crisis services will include short term respite capacity for planned respite. The services will also include crisis/short term bed capacity with the ability to provide assessment, evaluation, treatment and stabilization services that will avoid the inappropriate use of more restrictive settings, institutions, psychiatric hospitals, or jails. The crisis/short term treatment bed capacity could also support individuals transitioning to new living arrangements.

- Funding for these services needs to be sustainable and provide for flexibility in service delivery.

- Expand consultative services and make them available state-wide through the use of telepresence.

- Support workforce development for public and private providers. Development should include a short-term training component for existing professionals that achieves competency in the areas of positive behavioral supports and person-centered planning and thinking. It should also include a long-term strategy to develop a sufficient number of individuals with advanced training and competencies in treatment for individuals with developmental disabilities, people with mental illness and co-occurring chemical dependency issues and other clinical complexities.

- Support services should also be designed to provide technical assistance and support to families and other natural support caregivers regardless of setting.

- Develop comprehensive, early identification and intensive intervention services for children and adults who have a first episode of serious mental illness. Evaluate changing eligibility for services from SPMI to SMI thus enabling people experiencing mental illness to access more intensive community services at an earlier stage of the illness.

Non-Medicaid Funded Services and Supports

There are also important services and supports that are funded by the state and counties. These services and supports as described in Appendix A. The services and supports include Day Training and Habilitation (DT&H), Alternative Care (AC), Consumer Support Grant (CSG), Semi-Independent Living Services (SILS) and Family Support Grant (FSG). Table 1 in Appendix A shows utilization trends for community-based services. Of the services listed, CSG has the highest average annual increase. CSG is a state-funded alternative to Medicaid-reimbursed home care. Individuals receive a monthly cash grant to pay for a variety of services and supports in lieu of other services including home health aide, PCA and/or PDN. The CSG is flexible and allows for consumer direction.

Health Care Services

Comprehensive health care coverage, including but not limited to medical, mental health, chemical health, vision, audio and dental services, occupational and physical therapy including medications, assistive technology, medical equipment and preventative care are critical to living in the community. There are gaps and barriers to accessing health care services in the community. Some of these barriers include appropriate providers not available in all areas of the state, providers refuse to treat individuals with disabilities, and some providers do not accept Medicaid payment.

Recommendations for Health Care Services

- Develop payment rates which are adequate to ensure access to health care services.
- Increase access to preventative health care services in the community by considering using state-employed health care professionals, mobile clinics using telemedicine and other technologies and the additional incentives to reach those who are underserved.

Navigation, Referral and Coordination

The "What We Have" report describes Minnesota's referral and coordination systems[23]. Minnesota Centers for Independent Living (CIL) and the Minnesota Board on Aging also provide important services that assist individuals to remain living in the community. Other important resources are Peer Support Specialists, Ombudsmen for Long-Term Care, Mental Health and Developmental Disabilities and State Managed Care Programs.

Recommendations for Navigating the System

- The State should support and collaborate with Minnesota Centers for Independent Living (CIL) to improve statewide coverage. Additional centers will increase access to resources within the community to enable living in the most integrated setting.
- The State should work toward making the service system easier to understand and to access.

Transportation

The OPC did not have time to adequately explore the issue of transportation for persons with disabilities; however, the lack of transportation was frequently mentioned as a barrier to community integration.

Recommendation for Transportation

- The Plan must establish measurable transportation goals related to increasing community integration.

[23] MN DHS, *What We Have*, September 2012

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WHERE PEOPLE LIVE

Introduction

Minnesota has undergone a massive transformation in the last several decades in moving persons from institutions to community-based settings. In the 1980s, Minnesota led the nation in the use of nursing homes and Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD). Policy changes at the state and federal level created opportunities to shift toward community-based care, most notably, the creation of the §1915(c) home and community-based waiver option under Medicaid. In addition, litigation in the late 1970s and early 1980s required the downsizing of state institutions and mandated the availability of home and community-based service options. Over time, moratoriums were placed on the development of nursing facilities and ICFs/DD and most recently adult foster care. In 2010, it is estimated that 87% of the public funds for long-term care services for people with disabilities is spent on home and community-based services.[24]

Yet, the definition of community setting continues to evolve as persons with disabilities have been moved out of institutions. No longer is it enough to move someone from an institution to a smaller facility in a community setting and claim community integration has been achieved. What is an institution? What is the most integrated setting? The vision of *Olmstead* requires new analysis.

The Department of Justice provides some guidance:

> The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible..."
>
> Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings include, but are not limited to(1)congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting 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 individuals with disabilities[25].

Other federal agencies such as the U.S. Department of Housing & Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) have recently issued guidance to the States on the implementation of *Olmstead*. In addition CMS is expected to issue the final rule regulating where 1915(c) home and community based services waivers can pay for services. The proposed rule released on April 14, 2011, was more descriptive of the types of settings that will qualify for waiver funding. The final rule is expected to be issued this fall.

[24] Source: MN Department of Human Services Data Warehouse. http://www.dhs.state.mn.us/main/dhs16_166837#

[25] US DOJ Civil Rights Division *Statement of the DOJ on Enforcement of the Integration Mandate of Title II of the ADA and Olmstead v. L.C.*, http://www.ada.gov/olmstead/q&a_olmstead.htm

Background

People with disabilities currently live in many different settings which are regulated by DHS and MDH. See Appendix B for a brief background on each of the settings. The legislative report *"Evaluation of Current and Potential Housing Options for Persons with Disabilities"* prepared by the Disability Services Division in April 2011[26], states: "Compared to other states, Minnesota traditionally has higher utilization rates of congregate settings to provide services and oversight to persons with disabilities and other groups, at higher costs per person" (page 13)[27]. In the table below, the State provided data to Senator Harkin in an August 28, 2012, letter that indicates that state funding for people with disabilities totals approximately 1.2 billion dollars. Out of the 1.2 billion dollars, 35% or approximately 413 million dollars is spent on people with disabilities to live in their own homes. The remaining 65% is spent on a range of settings from small adult foster care homes to large institutes for mental disease and nursing facilities.

Table 1 - State Funding for People with Disabilities in SFY2011 (By Setting)

Setting	State Funding	Percent
Group Homes	$ 542,418,377	45.88%
Own Homes	$ 413,859,087	35.01%
Supervised Living Facility	$ 68,645,635	5.81%
ICF/DD	$ 64,203,703	5.43%
Nursing Facilities	$ 50,056,644	4.23%
Psychiatric Hospitals	$ 32,854,227	2.78%
IMD	$ 7,443,974	0.63%
Board and Care Homes	$ 2,792,675	0.24%
Total	$ 1,182,274,322	100%

Currently, Medicaid pays the room and board and services provided in nursing facilities, ICFs/DD and Children Rule 5 facilities. Minnesota has five Home and Community-based Waivers and important Medicaid State plan services such as Personal Care Assistance, Private Duty Nursing and Mental Health services that pay for services in the community (See Appendix A for a description of waiver services and State plan services). The waivers do not pay for room and board but pay for the services that support the individual with a disability to live in the setting.

The Group Residential Housing (GRH) program is an income supplement to assist people with disabilities to pay for room and board in *licensed or registered* settings. The current maximum income supplement for the GRH Housing Rate is $867 per month per resident. Services might be provided by Medicaid waivers, the GRH Supplemental Service Rate, the Difficulty of Care (DOC) payment, private foundation grants, or private pay. (See Appendix B for the matrix of services provided).

[26] MN DHS Disability Services Division, *Evaluation of Current and Potential Housing Options for Persons with Disabilities*, April 2011

[27] MN DHS Disability Services Division, *Evaluation of Current and Potential Housing Options for Persons with Disabilities*, April 2011

The MSA Shelter Needy program is an income supplement to assist people with disabilities move into affordable housing. Services might be provided by the Medicaid self-directed supports option or Medicaid home and community-based waiver services, private foundation grants, or private pay.

The three waivers that serve the most people are the DD, CADI and EW waivers. The 2011 Legislative Report on Housing,[28] provides detail on persons using those three waivers by setting. In fiscal year 2009, the DD waiver served 14,000 individuals. Of those individuals, 55 percent (8,000) lived and received services in a corporate foster care setting. In contrast, in 2008, 71 percent of persons served by the CADI waiver lived in their own homes or with family and friends, 18 percent lived in corporate foster care and 11 percent lived in assisted living facilities.

The Elderly Waiver (EW) includes "customized living services," which is a package of individualized services provided to EW individuals who live in a housing with services establishment that is licensed as an assisted living facility. Between 2001 and 2008 the percentage of EW participants using customized living services grew, from 7 percent to 35 percent. The 2011 Legislative Report on Housing concludes that "service costs could be reduced if more persons on the HCBS waivers were able to find suitable housing in the community, which is where they are increasingly seeking to reside."

Recent housing reports[29] have documented barriers to living in the community for persons with disabilities. Below are some of the common barriers:

- The actual cost of market-rate housing is prohibitive to low-income individuals, including persons with disabilities.
- Consumers and service providers lack information about available funding, housing and service options.
- A lack of affordable and accessible housing options
- A lack of permanent supported housing
- A lack of housing in suitable locations near employment and accessible transportation
- Inadequate availability of accessible transportation options for people living in the community
- Individuals may not be able to access community settings based on: financial and credit history, eviction records, arrest records and/or unmet need for support services.
- There are inadequate community based services and supports on a statewide basis to permit persons with disabilities, including serious mental illness to live in market-rate housing.
- There is an inadequate focus of housing services and supports targeted to transition-aged youth.

[28] MN DHS Disability Services Division *Evaluation of Current and Potential Housing Options for Persons with Disabilities, April 2011*
[29] *Options Too: Acting Together to Promote Community Alternatives for People with Disabilities*, February 2007 and MN DHS Disabilities Division, *Evaluation of Current and Potential Housing Options for People with Disabilities*, April 2011

DHS has several initiatives that currently support people moving from congregate settings to the community. In February, 2011, Minnesota was awarded a Money Follows the Person Rebalancing Demonstration Grant from the U.S. Department of Health and Human Services.[30] Minnesota will leverage an award of up to $187.4 million over five years to improve community services and support people in their homes rather than institutions.

Minnesota's goals for Money Follows the Person are to:

- Simplify and improve the effectiveness of transition services that help people return to their homes after hospital or nursing facility stays;
- Advance promising practices to better serve individuals with complex needs in the community;
- Increase stability of individuals in the community by strengthening connections among healthcare, community support, employment, and housing systems; and
- Increase use of home and community-based services by setting priorities to address specific institutional needs for reform.

Throughout the demonstration, DHS will continue to increase the proportion of State Medicaid expenditures for HCBS relative to those spent on institutional long-term care.

The OPC recognizes Money Follows the Person Grant, Return to Community Living, and Return to Community Living for People with Mental Illness are important initiatives that are primarily aimed at moving people with disabilities from nursing facilities, ICFs/DD and hospitals from the facility to the community.

In addition, if approved by the federal government and state legislature, two housing proposals in the *Reform 2020 Section 1115 Waiver* the Housing Stability Services Demonstration and Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot support the goals of *Olmstead* and should be included in the *Olmstead* Plan.

Persons needing accessible housing may also benefit from the access to market rate housing using waiver-provided funding for home accessibility modifications. For these reasons, the OPC believes that it should be possible to significantly reduce the number of persons in more expensive housing over a five year period. The OPC recognizes that there will be significant system planning to be undertaken to attain the identified numerical percentage reductions in settings such as corporate foster care and nursing homes including the likely need of closing beds and even facilities when people with disabilities are enabled to move into the community. The Plan developed by the State must set numerical goals and periodically measure progress to assure the strategies are working as designed.

[30] Money Follows the Person Rebalancing Demonstration webpage: www.dhs.state.mn.us/main/dhs16_162194#

Recommendations for Housing in the Community

- The State must significantly increase the ability of persons with disabilities to afford and have access to market rate housing that the individual controls.

- Increase state funding for and access to rental assistance programs for persons with disabilities.

- Evaluate state funded housing and supports programs to determine if they are adequate, efficient, appropriately used or can be expanded based on the identified need. This includes Minnesota's income supplement programs, in particular Group Residential Housing and Minnesota Supplemental Assistance - Shelter Needy Option.

- Expand programs such as the Crisis Housing Fund that provide temporary rental, mortgage, and utility assistance for persons with disabilities to retain their housing while they are temporarily in less integrated settings or treatment facilities.

- Increase funding for a statewide rental housing vacancy referral system to provide information to people about available affordable and accessible housing units.

- The State shall use best efforts to form private/public partnerships to fund additional, affordable and accessible housing for people with disabilities. Such partnerships may include seeking grants from foundations or corporations.

- Annually, during the assessment process and subsequent reviews, individuals with disabilities should be asked if they want to move to a more integrated community setting or make other changes to their living situation. This currently occurs in nursing facilities and should be expanded across all settings.

- Those who express an interest in moving to a different setting should be informed of the resources available to them for housing and services.

    - A person-centered discharge plan and community support plan should be developed for people who choose to move to a new setting.

    - A Peer Integration Specialist will be available to assist the individual with a disability during the planning process to ensure their personal needs and preferences are considered.

- Evaluate the impact of the adult foster care moratorium on the increased utilization of more restrictive settings including nursing homes, ICF/DDs, Board and Lodge Facilities with and without Services, and Housing with Services Establishments, hospitals, Intensive Residential Treatment Services (IRTS), or other inpatient residential settings.

- Evaluate the populations residing in other settings including Board and Lodging establishments with and without services to determine if there is an *Olmstead* issue.

- The Plan should build upon the strategies identified in the Evaluation of Current and Potential Housing Option for Persons with Disabilities Report of April 2011 by:
    - Improving access to rent subsidies;
    - Creating and promoting accessible housing and accessible communities;
    - Making better use of existing housing stock to expand choice and access; and
    - Assisting persons with disabilities to become homeowners through the land trust program.

- The State must develop a plan to assist providers in transitioning their service array to a different model.

- Use existing data systems to better inventory and monitor the continuum of housing options and the movement toward integrated community settings in Minnesota and develop improvements as necessary. This includes data systems used by DHS, Department of Health, Minnesota Housing, HUD, Department of Corrections, Department of Public Safety, and Housing Authorities statewide.

- The State should convene a multi-agency collaborative Housing Task Force to work on the recommendations listed above, foster the development of new initiatives to address these identified issues, and help establish specific, measurable and achievable goals.

Goals

- Increase the availability and access to integrated community settings in order to ensure that all people with disabilities have the ability to live in the most integrated setting possible.

- Reduce the number of persons with disabilities residing in nursing homes and ICFs/DD by 2,000 individuals over a five year time period through Money Follows the Person.

- A minimum reduction of 5% over the next five years in adult foster care beds and housing with services establishments. The money saved from reducing less integrated bed capacity should not be part of a budget reduction exercise but rather be reinvested into an array of existing or new and enhanced services.

    - Information about current use of family foster care and corporate foster care, and an analysis of capacity needed, will be available in the February 2013 foster care needs determination report to the Legislature.[31] The needs determination should inform the Plan.

[31] 2012 Laws of Minnesota, Chapter 247, Article 4, Section 6.

STATE OPERATED SERVICES

State Operated Services (SOS) is a division of the Minnesota Department of Human Services (DHS) that provides direct care services to people with mental illnesses, chemical dependency, intellectual disabilities, and traumatic brain injuries. These services range from short-term acute care in hospital settings to long-term residential support services. SOS typically serves people who have difficulty being served by other providers, including people committed to the Commissioner of DHS. See Appendix C for a description of all state operated services.

The *Olmstead* concept of "most integrated setting" poses three important challenges for SOS services:

- Residential services: Some SOS services are provided in congregate residential settings that are populated primarily by individuals with disabilities. To comply with *Olmstead,* the State and counties need to work with residents to develop plans to consider and/or implement moves to more integrated settings.

- Acute care services: It is often extremely difficult to discharge patients to more integrated settings when they no longer need a hospital level of care in SOS hospitals for individuals with complex, co-occurring conditions that require a unique array of services not available in most communities. This conflicts with the *Olmstead* standard of serving people with disabilities in the most integrated setting possible.

- Forensics services: The forensic population faces numerous barriers to discharge back to the community. With length of stays in the 10-25 year range it is clear the *Olmstead* standard of serving individuals is not always being met.

Minnesota State Operated Community Services

Minnesota State Operated Community Services (MSOCs) provides community-based residential, vocational, and crisis respite services for about 450 people with disabilities annually. MSOCs have fifteen residential homes licensed as ICFs/DD that usually house six people for a total of about 90 residents at a time. MSOCs also operate 90 corporate foster care homes serving approximately 355 individuals annually. In addition, MSOCs provides a wide range of vocational training and supports for individuals in 19 Day Training and Habilitation (DT&H) sites serving about 863 individuals annually.

Recommendations for Minnesota State Operated Community Services

- The State and counties should engage in a person centered planning process to offer individuals residing in MSOCs facilities a choice to move to a more integrated setting.

- Recommendations under the Where People Work section regarding DTHs and the Where People Live section regarding ICFs/DD and foster care recommendations apply to MSOCs.

- Review and study what role MSOCs can play to assist with transitioning an individual to another setting, providing crisis services, etc. This study would help determine what role MSOCs should

play in the safety net system to assist with the transition to non-state operated programs some of the most difficult to serve individuals.

State Operated Forensic Services (SOFS)

The term "forensic" is used by SOS to refer to specialized statewide evaluation and treatment to individuals with disabilities who are involved with the legal system due to a crime. During fiscal year 2012 Minnesota spent $68 million to provide forensic services to individuals residing on a campus in St. Peter, Minnesota. This includes the Minnesota Security Hospital (MSH). See Appendix C for a description of SOS forensic services. The MSH is a supervised living facility for individuals who have been committed as Mentally Ill and Dangerous (MI&D) by a court. The supervised living facility funding includes all costs paid by the state to serve individuals in this setting, including behavioral health treatment and other medical care. In 2011, Minnesota opened a forensic nursing home to serve individuals from the Minnesota Security Hospital, the Minnesota Sex Offender Program (MSOP), or persons who are on a medical release from the Department of Corrections (DOC).

As patients at MSH complete their treatment, they are moved to the Transition Readiness program and the Transition Services program, both of which prepare the individual to move back into their chosen local community. Upon completion of those programs, a Special Review Board and county representatives review each individual's record and decide whether or not the individual should be released to the community (see next section for more detail). In a presentation to the *Olmstead* Planning Committee, SOS staff estimated that MSH has 50 people in the Transition Readiness program and 82 people in Transition Services, all of whom could move to the community if the move were supported by the county, recommended by the Special Review Board, and approved by the Commissioner. However, very few people overcome these hurdles. Only 11 people were provisionally discharged from Transition Services in 2011, and only 12 people were provisionally discharged in 2010. The two Transition programs support 35% of the Minnesota State Hospital population.

In addition, SOS's St. Peter-based Competency Restoration Program has 26 beds. The purpose of this program is to provide treatment for people to restore their competence to stand trial. The average length of stay in this program is six months. SOS staff estimate that, at any one time, 40% of the beds in the program are occupied by people who have completed an evaluation and whose report has been submitted to the court. A major barrier to disposition and discharge is that criminal courts hold jurisdiction over these patients and have up to three years to take action.

The OPC requested information regarding the length of stay for individuals in forensic services. Data for patients served by forensic services on September 13, 2012, is included in Appendix C. The data provides a snapshot of the length of stay by current program, legal status and county of finance. The data shows that 108 of the Minnesota Security Hospital's forensic patients have been in forensic services for 10-25 plus years. Of the 108 patients, the county of finance for half of the patients is Hennepin County. In addition, there were 147 patients in five transition programs; 55 of them had been in forensic services for 10-25 plus years.

Civil Commitment and State Operated Forensic Services

Like most other states the inpatient forensic population of Minnesota consists of people who are being held according to Minnesota Rules of Criminal Procedure 20.01 (Incompetent to Stand Trial) and Minnesota Rules of Criminal Procedure 20.02 (Not Guilty by Reason of Mental Illness or Deficiency). However, Minnesota is unique and has a third large category of commitment status— Mentally Ill and Dangerous (MI&D)[32]—which is a civil commitment of indeterminate length (MN Statute 253B.18 subd.3). Other states do not have a population labeled MI&D through a civil process.

Currently, there are approximately 420 people committed as MI&D in Minnesota; this number is comprised of approximately 270 inpatient at State Operated Forensics Services (SOFS) and 150 residing in the community[33] in varying degrees of independence (such as Adult Foster Care, Institute for Mental Disease (IMD),[34] community nursing home, Intensive Residential Treatment Service (IRTS), Board and Lodge, or apartment). The inpatient population at SOFS increases at the rate of approximately 10 to 15 individuals per year. Indeterminate civil commitments means that individuals are committed through the civil court system and the provisional discharge is approved or denied[35] by the Special Review Board (SRB). The SRB is a quasi-judicial panel of mental health and legal experts which was "established to address the treatment needs of the patient and protect public safety."[36] Thus, SOFS staff does not have the authority to discharge patients. The rate of admission via civil court proceedings, versus the rate of provisional discharges via the SRB, has resulted in an ever-increasing inpatient population at SOFS.

Another barrier to discharge for individuals at SOFS is that the resources necessary for supporting the individual's return to the community are under the direct control of the county social services agency. Counties do not have targeted funding for people that raise public safety concerns. This creates an incentive for counties to give preference to individuals without histories of public safety concerns. All of these factors contribute to the limited numbers of people leaving SOFS, even though SOFS staff believes that a large number of people in the program could live safely and successfully in the community.

Recommendations for State Operated Forensics Services

- The State in collaboration with the counties must develop an appropriate array of community based services, including Forensic Assertive Community Treatment Teams, to assist individuals to remain in the community and assist those returning to the community.

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[32] The MI and D civil commitment is an "indeterminate" civil commitment which means that the petitioning party does not have to re-prove that the client meets the statutory definition at the expiration of a pre-determined time period as is the case with "determinate" civil commitments such as the Mental Illness or Chemically Dependent civil commitment, which must be "re-proved" annually. Instead, the burden shifts and the MI and D client must prove that s/he is no longer MI and D and qualifies for what is referred to as a "full discharge." These "full discharges" are granted to only a few people a year.

[33] Via the Provisional Discharge at a rate of approximately 10 to 15 per year.

[34] Most notably Andrew Residence in Minneapolis.

[35] Technically the SRB only makes a recommendation to the Commissioner of DHS, who has the final say, but the Commissioner rarely disagrees with the SRB's recommendation.

[36] Per the DHS website: The next level of appeal is the quasi-judicial SCAP (Supreme Court Appeal Panel, formerly known [and still in statute] as the Judicial Appeal Panel), then the Minnesota Court of Appeals, and finally the Minnesota Supreme Court before federal courts are accessed. The factors that the SRB considers are found in Minnesota Statute 253B and State Operated Services Policy 10020 and are essentially a combination of the client's clinical progress and public safety. Other relevant Policies are SOS 10030 and SOS 6050.

- The State should establish a committee made up of multiple stakeholders to review, analyze and recommend changes to the Minnesota Statute 253B.18 subd.3 regarding civil commitment of indeterminate length for persons who are mentally ill and dangerous to the public.

- The State should educate the Special Review Board and the Supreme Court Appeal Panel on the various community services and supports available to the individual to achieve a successful and safe return to community life.

- The State and counties should develop and implement a plan to move 132 individuals to a more integrated community-based setting within a maximum of 2 years, based on client preference and within the parameters of the identified community and client safety risk. To assist individuals returning to the community, a person-centered discharge process should be developed that includes sufficient Peer Integration Specialists with the capacity to work knowledgeably within specific disability groups and as part of the multidisciplinary treatment team to aid the individuals.

- Within one year, the State should develop an annual review process to assess all patients in forensic services to determine if the individual can move to a more integrated setting in the community given adequate supports and safeguards. The review should take place annually or at the time the individual is making significant progress in treatment. When the review process determines that a return to the community is warranted, sufficient community resources must be made available to support the individual's return to the community. The State must then initiate a petition supporting return to the community on behalf of the individual unless the individual objects. To assist individuals returning to the community, a person-centered discharge process must be developed that includes sufficient Peer Integration Specialists with the capacity to work knowledgeably within specific disability groups and as part of the multidisciplinary treatment team to aid the individuals.

- The State should seek technical assistance to address the treatment-related aspects contributing to extremely long length of stays to assure that the treatment program at the Minnesota Security Hospital is evidence-based and meets current treatment standards.

- The State must rebalance forensic financial resources from the institution to community-based services.

Anoka Metro Regional Treatment Center and Community Behavioral Health Hospitals

Anoka Metro Regional Treatment Center (AMRTC) provides psychiatric services for patients who have acute mental illnesses requiring a hospital level of care and who are civilly committed. AMRTC has eight 25-bed units, and admitted 450 patients in 2011. SOS's Community Behavioral Health Hospitals (CBHH) also provide acute psychiatric care, but in small, 16-bed facilities that admitted a total of 1,488 patients in 2011. The average length of stay at AMRTC in 2011 was 88 days. At the CBHHs, the average length of stay is much lower, usually less than 20 days[37].

[37] SOS Utilization Presentation to OPC May 3,2012 http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/opc_docs_030.doc

Like other hospitals, AMRTC and the CBHHs have utilization management systems that monitor utilization of their hospital beds and determine when a patient no longer requires a hospital level of care. However, discharging patients when they no longer require hospital services is very challenging due to several factors, including the complexity of discharge planning for patients with complex chronic disabilities; the challenges of coordinating effectively among hospital social workers, counties and community providers; the difficulty of finding appropriate providers of services for people with aggressive histories; a lack of housing with services for patients with complex needs; and complicated funding streams that can make it difficult to fund appropriate placements.

As a result of these factors, AMRTC patients spent 10,670 days at AMRTC in 2011 when they did not meet criteria for a hospital level of care. Patients at the CBHHs spent an additional 3,300 days not meeting criteria, for a total of over 14,000 bed days during which the patients did not meet a hospital level of care[38]. This represents about 15.4 million dollars of inappropriate care expenses, borne primarily by the state.

The fact that so many patients remain in SOS hospitals who no longer need inpatient hospitalization is of extreme concern, but concern is compounded by the fact that the CBHHs are usually full and AMRTC has a waiting list that recently exceeded 100 people. When beds are filled by patients whose conditions don't require them to be in a hospital, those beds are not available for others who do require a hospital level of care. A significant amount of SOS staff time is spent managing the waiting list, which is typically reduced by diversions. Diversions include: contract bed referrals, hospitals writing their own provisional discharge, requesting a remote provisional discharge, IRTS referrals, nursing homes, assisted livings, and the use of ACT teams.

Each week AMRTC bed management staff and Hennepin, Ramsey, Dakota and Washington Counties case management staff review clients on the waiting list and hold meetings to plan for discharge of patients currently at AMRTC. AMRTC is starting to work with rural counties as well, so that discharge planning begins earlier in a patient's stay at AMRTC, thus reducing the number of days when patients don't meet a hospital level of care.

The AMRTC is licensed as a hospital but for Medicaid purposes is still considered an Institution for Mental Disease (IMD).[39] Because most people served in IMDs are not eligible for Medicaid coverage, AMRTC services are primarily funded through a state general fund appropriation, with counties paying a share. Under Reform 2020, Minnesota is requesting a waiver of the Institutions for Mental Diseases exclusion for AMRTC because it is operating as a tertiary hospital. This would allow Medicaid financing for the people aged 22-64 at AMRTC. If successful, Minnesota plans to use the state money that is saved to develop community-based, non-hospital services for individuals with more intensive and specialized needs to move from AMRTC to the community.

[38] MN DHS SOS Admissions and Discharge Data Request to OPC May 3, 2012
http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/opc_docs_028.pdf

[39] IMDs are defined as facilities of 16 or more beds in which a majority of residents are age 22-64 and have diagnoses of mental illness. MA does not pay for services provided to residents in IMDs unless the resident is under age 21 or over age 65.

Recommendations for Anoka Metro Regional Treatment Center

- The State and Counties should develop sufficiently robust community and housing services to improve the patient flow through the mental health treatment system, and within a maximum of two years eliminate the AMRTC wait list.
- Within a maximum of two years, AMRTC will ensure that patients who reach stability are discharged in 3-5 working days.
- SOS should evaluate how to make the AMRTC wait list more transparent and accountable. The waiting list data should be included in the annual AMRTC Utilization Data report.
- SOS should continue to work with the Counties to implement person centered discharge planning that includes a multidisciplinary approach, including Certified Peer Specialists and other Peer Integration Specialists with knowledge of the needs of the individual. This includes family and natural supports as appropriate.

Community Support Services

Community Support Services (CSS) advances the SOS mission by strengthening the community living of people with clinically complex challenges. This is done through initiating and guiding innovative behavioral supports, building collaborative support networks and advocating for person-centered approaches. By facilitating activities that promote SOS as a leading partner in Minnesota's service systems, CSS involvement ensures that SOS has the capacity to meet targeted goals for providing state-of-the-art services.

Minnesota Specialty Health System - Cambridge

In considering the values and expectations of the *Olmstead* decision it is the OPC's recommendation to develop a robust set of alternative services specifically designed to support individuals with developmental disabilities who exhibit severe behaviors which present a risk to public safety. These services, once implemented, will support people in the most integrated setting and eliminate the need for placement in the MSHS Cambridge program. The recommended services described in this section are also described in the section on Community-Based Supports and Services where the recommendation is to make them available for all persons with disabilities who are or may be at risk of crisis.

Recommendations for MSHS-Cambridge

- Development of regional crisis services that consist of mobile teams of professionals and paraprofessional staff. This service will allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities and those who exhibit severe

behaviors which present a risk to public safety receive the appropriate level of care in the most integrated setting in accordance with the *Olmstead* decision.

- This service will provide long term monitoring of individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for changing needs, and prevent admissions to the MSHS Cambridge program, community jails and Minnesota Security Hospital.

- The long-term monitoring will be implemented at the point when individuals experience contact with law enforcement, psychiatric hospitalization, or emergency room visits related to actions that present a significant risk of harm to themselves or others or when school age youth experience truancy.

- These services will be provided where the person lives, strengthening the capacity of the system to serve individuals with clinical complexities in their home.

- Crisis services will include mobile wrap-around response teams located across the state for proactive response to maintain living arrangements. The time for the crisis response should be as soon as possible with a maximum time of three hours from the time of request.

- This service will provide families, caregivers, and staff at community-based facilities and homes with state of the art training encompassing person-centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking. Training, mentoring and coaching as methodologies will result in increased community capacity to support individuals in their community.

- The service will include short-term respite capacity for planned respite. The service will also include crisis/short-term treatment bed capacity with the ability to provide assessment, evaluation, treatment, and stabilization services that will avoid the inappropriate use of more restrictive settings, institutions, psychiatric hospitals, or jails. The crisis/short-term treatment bed capacity could also support individuals transitioning to new living arrangements.

- Funding for these services needs to be stable and provide for flexibility in service delivery.

- Expand consultative services and make them available state-wide through the use of telepresence.

- Support work force development for public and private providers. It should include a short-term training component for existing professionals that achieves competency in the areas of positive behavioral supports and person-centered planning and thinking. It should also include a long-term strategy to develop a sufficient number of individuals with advanced training and competencies in treatment for individuals with developmental disabilities and other co-occurring clinical complexities.

- In order to secure this new work force and keep it stable, consideration should be given to the establishment of wage subsidies for specific professionals and paraprofessionals with the highly technical skill sets.

- Support services should also be designed to provide technical assistance and support to families and other natural support caregivers regardless of setting.

- The OPC is aware that there are a number of services that currently exist that provide portions of the services described targeted to specific disability population. It is recommended that the State, in developing the Plan, consider incorporating these services into a comprehensive crisis service network.

Goal

- End the use of the MSHS-Cambridge through the development of a robust array of community services.

Child and Adolescent Behavioral Health Services (CABHS)

- A priority of the Money Follows the Person grant is to move children from the Child and Adolescent Behavioral Health Services program in Willmar to their homes.

- The State must develop the capacity statewide to provide children with complex disabilities access to hospital or intensive residential treatment services in their communities.

Department of Corrections (DOC)

- DHS and DOC should convene a workgroup with Community corrections and other stakeholders to review transition services from correctional institutions to the community, jails to SOS facilities, mental health courts and other issues as identified by the agencies.

WHERE PEOPLE WORK

Introduction

The OPC's vision is that Minnesota will make and carry out a plan that will tap the underused employment potential of the disability community. Consistent with the *Olmstead* decision, the OPC's goal is to increase the number of individuals with all types of disabilities working in integrated community settings and to increase their earnings. Planning and implementation will require sustained coordination across state agencies. The Plan must also ensure that people with disabilities who do not choose to work in the community continue to receive services that effectively meet their individual needs. Further, the Plan must acknowledge and address the lack of fluidity in access of services across an individual's lifetime. Fear of being unable to have timely access to more intensive (and less integrated) services- should they be needed in the future-prevents many from achieving the highest possible level of independence and integration. The Plan must move away from placing labels and limits on individuals with disabilities and move toward providing services based on individual choice with the supports needed to succeed.

The *Olmstead* planning process must play a key role in improving the employment situation of Minnesotans with disabilities. Despite the legal rights that flow from the ADA, the Individuals with Disabilities Education Act (IDEA), and the *Olmstead* decision, the rates of employment of people with disabilities have not improved. As of June 2012, according to the Bureau of Labor Statistics, only 32 percent of working age people with disabilities were in the labor force (those working plus those actively seeking employment), and only about 27.6 percent were actually working. As an employer, the State of Minnesota is even further behind, despite a project entitled "Minnesota as an Exemplary Employer," which was launched in 2007 to establish State government as a model employer of adults with disabilities.

With the convergence of President Obama's executive order directing the executive branch of the federal government to hire an additional 100,000 federal workers with disabilities by 2015; the National Governors Association "A Better Bottom Line';[40] Senator Tom Harkin's "Unfinished Business';[41] and the Oregon federal district court case to determine if *Olmstead's* community integration mandate applies to sheltered workshops, the state must make this the priority it needs to be and foster real change in employment outcomes for people with disabilities.

Employment levels among individuals with disabilities remain unacceptably low even though evidence suggests that the many myths associated with hiring people with disabilities are just that – the State needs to educate employers and the workforce about the benefits associated with an inclusive workforce that far outweigh perceived difficulties. In addition, to create the expectation of work, as opposed to dependency on services, the State needs to help young people with disabilities transition successfully from school to higher education and competitive, integrated employment that can lead to quality careers and economic security. People with disabilities, including those with complex disabilities, have the right to enjoy their lives as much as do people without disabilities. Working and

[40] National Governor's Association *"A Better Bottom Line: Employing People with Disabilities,"*www.subnet.nga.org/ci/1213
[41] Senator Tom Harkin, *"Unfinished Business: Making Employment of People with Disabilities a National Priority,"* July 2012.

earning money are basic aspects of typical adult life. To quote the late Justin Dart, a powerful advocate for people with disabilities, "Disabled does not mean 'unable'."

Employment Policy Leadership

Background

Inside state government several agencies work on employment. Accordingly, the Plan has to address more than DHS programs and will require ongoing collaboration and coordination across agencies. The OPC recommends that Governor Dayton establish an *Olmstead* sub-cabinet. One of the topics of focus should be employment of people with disabilities. There are several initiatives at the federal level that require a coordinated state response; and the goals in OPC's recommendations cannot be reached without sustained collaborative leadership.

These federal initiatives include:

- The National Governor's Association has a new employment initiative "A Better Bottom Line".
- Senator Harkin announced that an additional 1 million people with disabilities should be employed.
- President Obama announced that an additional 100,000 people with disabilities should be employed in federal government.
- The U.S. Department of Labor may promulgate rules for any federal contractor to do a 7 percent set aside for people with disabilities.
- The DOJ has taken a new interest in the *Olmstead* decision and day/employment services and filed an amicus brief in the Oregon lawsuit.
- The Government Accountability Office report on Transition-Age Students noted problems with lack of coordination.
- The Office of Special Education letter indicating that school work transition programs must also consider the least restrictive environment.
- The Office of Disability Employment Policy has selected lead states in teaching other states how to increase integrated employment .
- Centers for Medicare and Medicaid Services Bulletin dated September 16, 2011, limits the use of Medicaid waiver funding for center-based employment and clarifies that employment services must be provided in the most integrated setting.

In addition to these federal initiatives, the State of Minnesota lags in hiring people with disabilities based upon the Affirmative Action plans that have been approved by the Minnesota Management and Budget department. The issue of employment of people with disabilities should be addressed by the Governor established Olmstead sub-cabinet to coordinate and lead future efforts. This leadership team could pick up the recommendations of the OPC and move the issues forward.

Recommendations for Employment Policy Leadership

- The *Olmstead* sub-cabinet must include a focus on employment. The sub-cabinet level work must involve representatives from Minnesota Department of Education (MDE), DHS including cross representation, Department of Employment and Economic Development (DEED), the business and higher education communities to lead efforts to increase employment of all persons with disabilities. It is further recommended that this sub-cabinet leverage the resources and work currently being done by the State Rehabilitation Council, the Governor's Workforce Development Council, and others as appropriate.
- Charge this sub-cabinet with the task of exploring the possibility of coordinating all employment service funding systems under one state unit.
- Charge this sub-cabinet with the task of improving employment-related policies and practices across all state agencies. Attention should be paid to reducing and not creating any new disincentives for individuals seeking competitive employment (i.e. not losing health care benefits if employed).

Communication and Messaging

Background

Among service areas (MDE, DHS, and DEED) terminology and definitions pertaining to work are varied and inconsistent. Unfortunately, the federal definition of disability as it pertains to Social Security benefits requires that a person be unable to participate in substantial gainful employment. For the purposes of this plan and in keeping with the intent of the ADA, this committee broadens this definition to include those people with disabilities who are able to participate in employment because of support services provided. Definitions should correspond to the recent CMS bulletin and get to the idea of "work" being competitive and integrated. The OPC recommends that all state websites be reviewed to understand what is being communicated about employment. This review could include all website sections dealing with day programs and other employment-related services. Feedback should be solicited from individuals and families as well as from businesses or employers.

Core Service Definitions – Employment: The following definitions of employment are based on the descriptions of employment services available under the Centers for Medicare and Medicaid Services [42] and the U.S. Department of Health and Human Services (HHS) Substance Abuse Mental Health Services Administration (SAMHSA).

- ***Competitive Employment:*** Sustained paid employment in the community at prevailing wages and independent of support services.
- ***Supported Employment-Individualized Employment and Support:*** Sustained paid employment at or above minimum wage in an integrated setting with ongoing support. The intended outcome of

[42] CMCS Informational Bulletin, *Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services*, September 16, 2011

this service is sustained paid employment and work experience which leads to further career development and independent community-based employment.

- ***Supported Employment- Small Group Employment Support:*** Services and training activities provided in groups of 2-8 workers in businesses and community settings which promote integration into the workplace and interaction with non-disabled co-workers. The intended outcome of this service is sustained paid employment and work experience which leads to further career development and independent, integrated community-based employment paid at or above minimum wage. Note: while CMS defines small-group employment support services including groups as large as eight individuals, DHS allows as many as ten.

- ***Center-Based Employment***: Pre-vocational services provided in facility-based work settings, such as "sheltered workshops." Work may be paid by piece-rate or productivity rate below minimum wage according to Section 14(C) of the Fair Labor Standards Act. The intended outcome of this service is paid employment and work experience which leads to further career development and independent, integrated community-based employment paid at or above minimum wage.

- ***Individual Placement and Support – Supported Employment (IPS-SE):*** IPS-SE helps people with severe mental illness work at regular jobs of their choosing. Although variations of supported employment exist, IPS-SE refers to the evidence-based practice of supported employment. Refer to the Resources section at the end of this document for more information regarding IPS-SE.

Recommendations for Communication and Messaging

- Across service areas, use consistent definitions of employment support services.

- Ensure that state websites and materials communicate a message that values integrated employment.

- Invest in messaging targeted to re-educate the business community on the value of employing people with disabilities as well as to invalidate current myths that serve as barriers to employment. Ensure that employers have access to current information and technical assistance to support hiring of persons with disabilities.

Transition-Aged Students

Background

Students with disabilities are considered to be "in transition" between educational services and adult services beginning at the age of 14. While special education programs define the end of transition as occurring at age 22, some students covered by their parents' health plans are actually in transition until the age of 26. For the purpose of this report, "transition-aged students" refers to students between the ages of 14 years and 22 years.

OPC members attempted to collect employment data on transition-aged students from MDE. It appears that MDE has limited information on employment data for these students. MDE does have

information about dropout rates, graduation rates, and school inclusion. MDE might work with DHS and Vocational Rehabilitation Services (VRS) unit of DEED in gathering data. The information should be made available by disability type and by regions.

In writing the Plan, the State will need baseline information for the number of transition-aged students who are:

- on a waiting list for employment services
- entering Day Training & Habilitation (DTH) programs
    - participating in center-based employment
    - participating in community employment
    - participating in non-work activities
- entering post-secondary education
- employed including: self-employment, competitive employment, supported employment, customized employment, center based employment, and employment from one's own home

Of significant concern is in the area of Individualized Education Programs (IEPs) for transition-aged youth. The MDE's most recent Part B Annual Performance Report can be viewed at the following URL: http://education.state.mn.us/MDE/SchSup/SpecEdComp/. As referenced in the report, an unacceptably high percentage of audited IEPs for transition-aged students did not contain appropriate measureable post-secondary work or education goals.

Recommendations for Transition-Aged Students

- Implement MDE initiatives to ensure that all transition-aged students have a current IEP that includes career/employment planning goals based on robust, current vocational assessments.
- Implement a data tracking system for the work experiences of transition-aged students (number of work experiences, length/hours, and level of integration).
- Ensure students and their families are receiving information, education, and training about integrated employment, work incentives, self-advocacy, and career planning.

Goals

- Increase the number of transition-aged students who enter post-secondary education by a minimum of 5 percent each year for the next five years.
- Increase the number of transition-aged students who enter into integrated employment by a minimum of 5 percent each year for the next five years.

Adult Employment

Background

The overall goal is to increase the number of people in integrated employment and increase their employment earnings. DHS has published three goals on the topic of employment:

- Create and promote resources that help individuals plan for economic security.
- Create incentives and supports that increase individuals' opportunities to achieve their employment goals and result in increased income earnings.
- Implement policy and legislative changes to remove barriers to employment for individuals.

The OPC received a report from VRS/DEED that they utilize an individual tracking system and submit a detailed performance report to the federal government. This performance report includes placement type, hours worked, earnings, benefits, etc. DHS has periodically surveyed DTH programs for similar information. However, there is currently no tracking system capable of giving real-time data regarding level of integration of services being provided by DTH and Supported Employment service providers. DHS should consult with other states that are leading the nation in integrated employment practices to determine how they are tracking individuals.

Implementation of an improved employment outcome tracking system would set the stage for developing benchmarks for increased integrated employment outcomes. It would enable action steps such as ensuring that current and appropriate vocational assessments are completed. It would also ensure that a county or Vocational Rehabilitation plan is reviewed to ensure informed choice of a continuum of work opportunities (including competitive, integrated employment), and identification of available options and work experiences based on the assessment. Coming rate methodology changes include 15-minute unit service billing rather than per-diem billing which is currently standard for many services. This may afford opportunities to effectively tie information regarding service integration, wages, and hours to service authorization and billing.

Recommendations and goals focus on increased integrated employment in the community. As of this writing, there exist significant concerns in Minnesota and across the nation that center-based employment ("sheltered workshop") environments violate the spirit and intent of *Olmstead* and its integration mandate. The solution to these concerns is not an easy one. People with disabilities cannot lose services that effectively meet their individual needs and the employment aspects of the Plan must take into account the varied needs of individuals with different needs. For this reason, the OPC's recommendations focus on "positive" efforts to create integrated opportunities, rather than recommend that center-based services be eliminated without viable replacement services that meet those individual needs.

Recommendations for Adult Employment

- Restructure funding mechanisms and contracts with providers to encourage investment in integrated community employment and incent innovative services which lead to integrated employment, including increased outreach to community-based employers.

- Implement a data tracking system to gather wage/hour/level of integration information for persons receiving DTH and other employment-related services.
- Invest in training and technical assistance for people with disabilities, their families, their support networks and employers with a focus on work and employment incentives.
- In future updates of the MnCHOICES assessment tool, add specific questions that evaluate whether the individual with a disability is satisfied with the level of integration, the number of hours of employment, earnings/benefits, and his/her career path.
- Increase access to Individual Placement and Support –Supported Employment (IPS-SE) Services for individuals with mental illness by expanding the number of IPS-SE providers statewide through training, technical assistance and increased service funding.

Goals

- Increase integrated community employment by a minimum of 5 percent each year for the next five years. Integrated community employment includes both individual employment with supports and working in a small group with supports in the community.
- Increase the number of providers who offer IPS–SE services by 5 percent each year over the next five years.

Employment Resources

Many resources are available to guide efforts to make integrated employment a reality for people with disabilities. The list below is not meant to be exhaustive. It represents a starting point for current effective practices in employment.

- www.mnddc.org/asd-employment/index.html
- www.communityinclusion.org/
- www.ntarcenter.org/home
- www.dol.gov/odep/ietoolkit/
- www.ncstac.org/
- www.dartmouth.edu/~ips/page56/page56.html
- http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

Information regarding IPS-SE:

- www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_137895.pdf
- www.positivelyminnesota.com/Programs_Services/Pathways_to_Employment/IPS_SE_JJ_2009.pdf

MEASURING COMMUNITY INTEGRATION

Measuring community integration is a critical component of a State's Olmstead Plan. The *Olmstead* vision and the subsequent DOJ guidance states "the most integrated setting is one that enables individuals with disabilities to interact with non-disabled persons to the fullest extent."[43]

Measuring Community Integration at the Individual Level

The ultimate purpose of the *Olmstead* decision is that individuals experience more rich and varied opportunities to live, work, learn and recreate among all citizens in the mainstream of American life. Therefore, we must at some point track and measure the individual integration situations of the people supported by public funds. According to Dr. James Conroy, of the Center for Outcomes Analysis, there are three kinds of measures of integration. One is measures of the freedom to place oneself into situations and places with peer citizens who do not have disabilities ("choice" measures). The second is measures of the depth and intimacy of integrative activities ("intensity" measures). The third is measures of the actual frequency of such events ("frequency" measures).

"Choice" measures are about freedom, basic rights, and barriers. They include items such as "If you want to go out somewhere [where everyday citizens without disabilities might go] on the spur of the moment, can you?" and "Do you have to get permission to go out?" Items like these are available in dozens of scales and surveys, and can easily be reduced to 5 to 10 key questions. All of these will reflect the degree to which a person is free to choose to enter integrated situations. (People may choose not to take advantage of this freedom, of course.) This type of measurement is simple and brief, though there is no nationally recognized single tool.

"Intensity" measures about intimacy have been difficult to develop and validate. When properly designed, they would reflect the common observation that a person can be "in" the community without being "of" the community – one may live in an everyday neighborhood but still not participate in neighborhood life and activities. They also relate to the fact that for some people, one intimate friend is plenty, and for others, ten is just not enough. These measures have been the most difficult to develop and validate, and probably should not be considered for immediate application. They must await further research.

The third kind of measure, "frequency," is widely used, tested, and understood. The "gold standard" of measuring integration began in 1986: the Harris poll of Americans with (and without) disabilities.[44] This survey has been conducted at least every few years since then, and therefore offers not only a national database, but also a comparison with the integrative activity behavior of citizens without disabilities. The Harris scale measured how often people visited with friends, went shopping, went to a place of worship, engaged in recreation, and so on, in the presence of non-disabled citizens. The scale

[43] US DOJ Civil Rights Division *Statement of the DOJ on Enforcement of the Integration Mandate of Title II of the ADA and Olmstead v. L.C.*, http://www.ada.gov/olmstead/q&a_olmstead.htm

[44] Taylor, H., Kagay, M., & Leichenko, S. (1986). *The ICD Survey of Disabled Americans*. Conducted by Louis Harris and Associates. New York: The International Center for the Disabled, and Washington, DC: National Council for the Handicapped.

simply counted the number of "outings" to places where non-disabled citizens might be present. The scale was restricted to the month preceding the survey. It could be answered reliably by third parties who knew the focus individual well, including support workers and family members.

This scale was also used in the National Consumer Survey of 1990 with 13,075 Americans with developmental disabilities[45]. In addition, these authors tested the scale for reliability, and found it acceptable. [46] Thus there is a very rich national basis for comparison of individual and group experiences of integrative activities.

The decades of research conducted by the Center for Outcome Analysis on deinstitutionalization, employment, and self-determination also employed the "frequency" measure derived from the Harris poll approach.[47] Their version of the integration measures have been used in more than 50 projects, covering more than 180,000 face to face quality of life data collections over the years.

Most recently, the Harris and National Consumer Survey measures were adopted and adapted with minor revisions by the National Core Indicators project of the Human Services Research Institute.[48] The Core Indicators are now utilized for small samples of about 200 to 600 people every year in 36 states.

Because the "frequency" measures are the most concrete of the three kinds of measures, and because they have been developed, tested, and very widely utilized, thus offering "benchmark" comparative data, the recommended approach has to be an adaptation of the Harris, National Consumer Survey, Center for Outcome Analysis, and National Core Indicators instruments. Permission may or may not be granted by HSRI for the Core Indicators version, but the National Consumer Survey and the Center for Outcome Analysis versions are available for use at no cost.

Below are the dimensions included in the most recent version of the Core Indicators to give a sense of the dimensions and the breadth of this approach to an Integration Measure.

- Amount of Times Went on Vacation in the Past Year
- Amount of times went out for entertainment in past month
- Amount of times went out for exercise in past month
- Amount of times went out on errands/appointments in past month
- Amount of times went out to a restaurant/coffee shop in past month
- Amount of times went out to religious services in past month
- Amount of times went shopping in past month
- In the past month person went out for entertainment
- In the past month person went out for exercise
- In the past month person went out on errands/appointments
- In the past month person went shopping

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[45] Conroy, J., Feinstein, C., Lemanowicz, J., Devlin, S., & Metzler, C. (1990). *The report on the 1990 National Consumer Survey*. Washington DC: National Association of Developmental Disabilities Councils.

[46] The interrater reliability of this scale was reported to be low when the two interviews were separated by 8 weeks, during which genuine changes in the frequency of outings were likely, but very high when the time interval was corrected for (.97).

[47] http://www.eoutcome.org

[48] http://www.nationalcoreindicators.org/indicators/domain/individual-outcomes/community-inclusion/

- In the past month person went to religious services
- In the past month went out to a restaurant or coffee shop
- In the past year person went on vacation

To these standardized and well tested indicators, we suggest that several items on the right and freedom to move into the presence of citizens without disabilities ("choice" measures) should be added. This kind of measure is independent of how often it is utilized. Freedom is important, one would say, even if it is not taken advantage of.

Measuring Community Integration at the Systems Level

Currently, there is not an agreed upon definition of community integration (it means different things to different people and to different agencies) and therefore there is not a standard to measure community integration. There is no common strategy used by states to measure system effectiveness in achieving community integration and inclusion for people with disabilities in Home and Community-Based Services (HCBS). A major impediment is finding agreement amongst stakeholders on what to measure. Since there is finite opportunity to assess each service user, the data sources must prioritize measures and survey items. As a result, the data sources have different strategies to measure the topic. A recent U.S. Department of Health and Human Services environmental scan of measures used in HCBS highlights the challenge (2010)[49], where a number of complimentary outcomes directly intersect with the construct of integration and inclusion. Existing evaluative \measures have similar constructs that focus on the following themes: friends and family relationships, support needed for relationships, employment and school attendance, and social roles. In addition, at least 15 existing measures, from many data sources, seek information about community inclusion and integration explicitly.

There is also no common strategy on how to measure the many constructs and domains related to community integration and inclusion. To appropriately evaluate integration and inclusion, it is necessary for measures to adequately capture the diversity of the service delivery system. For example, employment is often times used as an associated measure to integration and inclusion. As pointed out in the environmental scan of measures used in HCBS, employment is measured in a number of different ways. It is often times measured dichotomous, where a person either has a job or is unemployed. Using such a measure to indicate more or less integration or inclusion can be misleading since employment in the HCBS system can be achieved in both integrated and segregated settings (U.S. Dept. of Health and Human Services, 2010).

The OPC has identified the need to develop a data system that tracks trends and outcomes of services and supports by population and over time. Currently the State has fragmented data systems within DHS and across other State agencies. These various systems have been mandated or developed to monitor services for a particular disability population, a specific program or service and therefore they are not integrated. Thus, they can be difficult to use to identify trends over time and across

[49] U.S. Department of Health and Human Services. (2010). *Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services.* AHRQ Publication No. 10-0042-EF, Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research

populations. Additionally, the data is often not easily understood by all stakeholders because terminology is not consistent and it is difficult to compare information across populations or groups within specific populations. In some instances, data is not collected. In consent decrees/settlements across the nation The Department of Justice is requiring specific data be collected to measure integration over time and across populations. It is important that the state of Minnesota develop a framework and indicators of community integration and implement a process to gather and trend this data over time.

There are several examples of measurement tools that have been developed and used by state's to measure community integration and the outcomes of community services long term services and supports. To assist state's in assessing community integration for a state's mental health system for adults with serious mental illness and children with serious emotional disturbances the Substance Abuse and Mental Health Services Administration (SAMHSA) recently developed "A Pilot Self-Assessment Tool For State Mental Health Agencies: An Effort to promote Community Integration of Persons with SMI and SED placed in Institutional Treatment Settings" available on the OPC website[50]. This provides an example of the type of measurement documentation that will need to be developed that includes community integration progress indicators across long term services and supports for the disability populations that fall within the scope of the Plan.

As evidenced in the recent measurement tools related to the outcomes and quality of life of people with disabilities have been developed as indicators of community integration. The National Core Indicators were developed by the Human Services Research Institute and the National Association of State Directors of Developmental Disability Services and are currently used in 36 states[51]. The Participant Experience Survey, which was originally developed by Thompson Reuter through a contract with CMS was developed for use with HCBS, and adapted by Minnesota for use with older adults and people with disabilities of all ages. Region 10, in Minnesota, developed a VOICE review process to focus on a person's life and inclusion in community activities that is used as an alternative licensing process. The DHS Continuing Care administration has been working on the development of measures of CHOICE outcomes, including work in developing dashboards and report cards, the HCBS Partner Panel, the State Quality Council, and the MnCHOICES assessment and support planning development. While many options exist to monitor and report outcomes and quality of life indicators related to community integration, currently in Minnesota this type of data is not collected consistently and across populations in a way that progress is trended and reported.

Recommendations for Measuring Community Integration

- Review, develop if necessary, evaluate and implement a measurement rubric that tracks the movement of people with disabilities from specific types of congregate care facilities to community settings over time. In doing so, enhance the tools developed by SAMHSA to include measurement domains across financing/resources, movement to the community/recidivism, housing and community capacity/utilization that are appropriate to specific populations (e.g. developmental

[50] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_documents#otherplans

[51] http://www.nationalcoreindicators.org/

disability, mental health, brain injury, physical disability) and long term services and supports in Minnesota (e.g. HCBS, nursing home, psychiatric hospitals, sheltered work programs).

- Implement an outcome measurement process that gathers specific outcome indicators related to the populations included in the Plan about the quality of their lives in the community. This measurement process should gather data across several areas of life domains including health, safety, well-being, employment, social relationships, home, satisfaction with services and supports, choice and control, and inclusion/integration. It should provide comparative analyses opportunities across programs, populations and in comparison with other similar states.

- The data gathered to monitor community integration and the outcomes experienced by people who have been integrated should be easily accessible to the general population and should provide comparisons of the progress made in Minnesota over time and in comparison with other similar states. Annual progress should be reported.

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UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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

Plaintiffs,

vs.

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

Defendants.

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

PLACEHOLDER FOR EXHIBITS 110, 111A And 111B TO DEFENDANTS' STATUS REPORT

This document is a place holder for the following items which are filed in conventional or physical form with the Clerk's Office:

Exhibits 110, 111A and 111B to Defendants' Status Report

If you are a participant in this case, this filing will be served upon you in conventional format.

This filing was not e-filed for the following reason(s):

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

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

☐ Physical Object (description):

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

☒ Item Under Seal pursuant to a court order* (Pursuant to Protective Order: Doc. No. 57)

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

☐ Other (description):

AG: #3120737-v1