Jensen Settlement Agreement Comprehensive Plan of Action (CPA)

Report to Court
In Response to March 18, 2016 Order (Doc. No. 551)
Filed May 31, 2016

Minnesota Department of **Human Services**

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DHS Verification Activities

In the Court's March 18, 2016 Order (Doc. No. 551), the Department of Human Services (the "Department") was directed to complete a number of verifications activities regarding information that was reported in the *Jensen Settlement Agreement Comprehensive Plan of Action (CPA) – Ninth Compliance Update Report, Reporting Period: May 1 – September 30, 2015* ("Ninth Compliance Update Report") (Doc. No. 531).[1]

Restraint Reporting (ECs 28-30)

With respect to Restraint Reporting (ECs 28-30), the Court sought "additional detail…to clarify whether any of the reported 911 calls at the facilities involved the use of prohibited restraints…" (Doc. No. 551 at 9.) The Court recommended that the Department appoint an independent subject matter expert to investigate these 911 calls. In order to meet the deadline set by the Court for completion of this investigation, the Department sought and received Court approval to use the Internal Reviewer to conduct this investigation.

The Internal Reviewer reports:

> During the reporting period, there were ten calls to 911 made by facility staff regarding facility residents. They are summarized in the following table. 911 calls were generated in regards to five individuals. In three of the ten incidents, handcuffs were used. In two of those three incidents, the individuals were arrested, with one person being charged with resisting arrest. In the other situation in which an arrest was made and handcuffs were used, the individual had been using dangerous objects to aggress against staff. In the third incident, the individual was handcuffed and "taken down" by the officer after grabbing at the officer's shirt. The individual subsequently calmed and was not arrested. Two of the three incidents with handcuff use were with the same individual. There were no incidents during the reporting period in which law enforcement used a Taser, and there were no reports of injury to facility residents following police intervention.

911 Call	Date	Restraint by Police	Arrested	Other specific information
J1	5/24/2015	None	Not arrested	Being unsafe and potential violent.

[1] The following abbreviations are used throughout this document: "JSA," *Jensen* Settlement Agreement (Doc. No. 104); "CPA," the Second Amended Comprehensive Plan of Action (Doc. No. 283); "EC," Evaluation Criteria; "MLB," Minnesota Life Bridge; "SLP," Successful Life Project; "JOQACO," Jensen/Olmstead Quality Assurance and Compliance Office; "CSS," Community Support Services; "DSD," Disability Services Division; "MSOCS," Minnesota State Operated Community Services.

J1	9/17/2015	None	Not arrested and remained at home	J1 called to request transport to Mercy Hospital but subsequently calmed down.
J1	9/22/2015	None	Not arrested	Threatening comments, eloping, and staff following on road. Calmed when officers arrived.
D1	6/7/2015	None	Not arrested	Attempting to hitchhike to St Paul and swung at staff in public. Staff called 911 for assistance.
D1	6/22/2015	Handcuffs used	Arrested and charged with resisting arrest and disorderly conduct after becoming agitated and argumentative with police	Packed bags and attempted to hitchhike to Seattle.
D1	7/19/2015	Handcuffs and manual restraint used	Not arrested and remained at home	Grabbed at officer's chest resulting in police take down and handcuffs being used.
D1	9/1/2015	None	Not arrested	Police called because D1 was missing and was transported back by police.
C1	6/10/2015	None	Not arrested	Police called because C1 was missing but located prior to police finding him.
S1	7/30/2015	Handcuffs used	Arrested	Attacking staff with dangerous objects and ran into the road.
R1	8/11/2015	None	Not arrested	Eloped and walking to Wal-Mart.

There are two potential concerns regarding 911 calls when efforts to reduce restraint use are underway: (a) calling 911 merely for the purpose of having officers perform restraint,

> and (b) law enforcement using restraint procedures incommensurate with need or beyond what would be used in a situation with a person who does not have disabilities. Review of the information in the incident reports regarding the relevant 911 calls by the facility during this reporting period indicates neither of these is occurring. Handcuffs and manual restraint were used only when the individual was arrested or when the individual was grabbing at the responding officer. There is no evidence of improper nor widespread use of restraint used by police in these instances. Accordingly, there is no need to have the Department's Quality Assurance Leadership Team address this issue on a systemic level.

Staff Training (ECs 54-57)

With respect to Staff Training (ECs 54-57), the Court sought additional information "[t]o aid the Court in evaluating [the Department's] compliance with the *Jensen* Settlement Agreement and the CPA…" (Doc. No. 551 at 11.) The Court proposed that the Department appoint an independent subject matter expert to "evaluate and provide feedback…on staff training curriculum" at the facility (Minnesota Life Bridge). (*Id.*) In particular, the Court proposed a "focus on the requirements in EC 55 providing that training must be both 'consistent with applicable best practices' and 'competency-based,'" and an assessment of "whether training is appropriately standardized across divisions throughout [the Department]." (*Id.*) In order to meet the deadline set by the Court for completion of this evaluation, the Department sought and received Court approval to use the Internal Reviewer to conduct this evaluation.

The Internal Reviewer reports:

> List of Training Considered: Minnesota Life Bridge lists five formal elements to their staff training in compliance with EC 54-57: (a) Effective and Safe Engagement, (b) Positive Behavior Supports, (c) Person Centered Thinking, (d) Crisis/Post Crisis Intervention and Assessment, and (e) Medically Monitored Restraint.
>
> **Effective and Safe Engagement (EASE)**
>
> *Training Description provided by MLB.* Participants learn to: Practice communication safety strategies; Practice authorized personal protective strategies; Explore team models for safety; Practice authorized physical safety strategies; Practice 360 Safety Planning and Balanced Teamwork; and Practice authorized group physical safety strategies designed for three or more team members. Content contained in the procedure include:
>
> To provide an understanding of the *Jensen* Settlement Agreement (JSA) and its relation to use of Manual Restraints in an Emergency.
>
> To provide information on closely monitoring an individual's physical condition during a manual restraint for signs of distress.
>
> To review MLB Procedure #15868, Therapeutic Interventions and Emergency Use of Personal Safety Techniques.
>
> To define Emergency and Emergency Use of Manual Restraint.

To clarify the allowed and prohibited procedures in an Emergency.

To clarify the release and attempted release criteria when implementing Emergency Manual Restraints.

Source of Information used in EASE review: EASE written materials and demonstration videos online, competency assessments, interview of former trainees, and a telephone interview with the leader of training initiative for the Department. Please note that this training was not attended in person by the Internal Reviewer, so this report cannot assess fidelity of training implementation. There is Product Evidence, but not Observation Evidence.

The *standards* used in this review for purposes of comparison to Best Practices included (a) the Centers for Medicare & Medicaid Services (CMS) Guidance to Surveyors for ICF IID -Appendix J, Guidance 483.450(b)(1)(iv)(B) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf), (b) the Joint Commission Standards on Restraint (www.jointcommission.org), and (c) accreditation/certification standards utilized by NADD: Advancing Mental Wellness for People with Intellectual or Developmental Disabilities (www.thenadd.org).

The Internal Reviewer completed a thorough review of EASE training and informational materials. The review noted many effective aspects of the EASE training and materials, and also noted some concerns and suggestions for improvement. These suggestions and concerns have been fully discussed with the developers of the EASE training within the Department. The EASE system is 16 hours of general training plus additional training specific to Minnesota Life Bridge residents.

It must be noted that evaluation of any crisis intervention program should begin with a recognition that even when necessary to assure safety at certain times, crisis intervention is only performed when other support systems for an individual have failed or have proven otherwise ineffective. It is contradictory to the spirit of the JSA and the CPA (as well as Best Practices in supporting persons with Intellectual or Developmental Disabilities) that crisis intervention be relied upon, as positive supports are called for as the primary means for intervention.

There are many aspects to the EASE Program, which are consistent with the best practice standards previously referenced, and they are enumerated below:

1. Builds in understanding of trauma
2. Knowledge of person
3. Consideration of the person's past experience with any restraint
4. Focuses on person centeredness
5. De-escalation and communication
6. Emphasis on the learning cycle for teams and focus on teamwork, including ongoing practice and mentoring for care providers in the application of EASE
7. Self-care (with specific connection to Minnesota Employee Assistance Plan)
8. Managing one's own stress as a care provider
9. Competency evaluation as opposed to simply completing the training

10. Respect for person and positive relationships
11. Imminent risk of harm is well defined
12. Cultural considerations are included
13. Inclusion of emotional environment
14. Cognitive level considered
15. Mentioned physiological response during crisis ("amygdala hijack")
16. Consistent with CMS and Joint Commission guidelines
17. Video: avoidance and proxemics very well done, slide and pivot
18. The training materials discussed the JSA, which is a unique strength of having a Minnesota program as opposed to using a commercial package. While this is not specifically addressing a best practice standard, it does represent the Department's efforts to promote the vision of the JSA.

In addition to the 18 points noted above representing the strengths of the EASE Program, the review also noted some concerns and suggestions for improvement. It is recognized that any addition to the EASE training curriculum would require additional time for the training sessions. There were no materials in the curriculum which seemed extraneous. The suggestions are enumerated below:

1. While the EASE program is generic to the Department, a discussion of why challenging behaviors are more likely among persons with Intellectual or Developmental Disabilities is suggested for disability support providers, including MLB.
2. The content on negotiation strategies should be strengthened and enhanced. The Occupational Safety and Health Administration has produced excellent materials on negotiation as a means for workplace safety (https://www.osha.gov/SLTC/workplaceviolence/otherresources.html). This could include offering and highlighting the choices a person does have.
3. It needs to be more thoroughly stated that the need for physical intervention is a sign that positive supports have broken down and are not effective.
4. In Module 2, page 37 of the EASE workbook, this quote appears: *"Better to be judged by twelve than carried by six." - Booker T. Washington.* This quote could easily be misinterpreted and misapplied, thus used as a rationale for using prohibited procedures. This concern was shared with the developer of EASE, who noted that this is discussed further in the training to prevent misunderstandings.
5. An article is included in the EASE materials reviewing aggressive behavior directed towards nurses. The article uses the terms "assailant" and "victim." That is not a helpful way to present people whom we support and care providers if we wish to present positive means to avoid instances of aggression (p 414).
6. While Positive Behavior Support is mentioned, additional content, specifically focusing on instructional procedures for persons served, is necessary, along with a more thorough connection to positive support and person centered thinking strategies.
7. The show of support strategy, also used in other commercial packages, such as Mandt Training, is presented in the EASE materials. Caution is needed, as for some people who are potentially aggressive, this specifically elicits aggression.

8. Four specific concerns were noted during review of the videos presenting physical intervention strategies:
    (1) There is a risk of hyper- extending the person's wrist in the arm control technique which appears on 1:55-2:07 in the video entitled "Release From Front Choke 4."
    (2) There is a risk of asphyxiation in a move in which the person is wrapped up. The concern is brought up, but not with enough gravity. This appears in the video "Escort Option 6."
    (3) A deflecting move to strike at the abdomen could be misconstrued as a clubbing move to hit the person as a strike rather than just deflecting. This appears in the video entitled "Third Block Strategy."
    (4) In the instructional video for "The Base," content should emphasize thumbs being tucked back to prevent thumbs catching when bringing hands up for protecting one's face. This concern was shared with the developer of EASE, who noted that this is discussed further in the training.

Each of these was discussed with the developers of EASE, who noted that during the actual training, these are verbally discussed and practiced. The trainer noted that these concerns are addressed verbally in the training sessions and are individualized as needed. The training has not been observed directly, and this is not verified. It is recommended that the videos be revised to present these cautions in the videos as well as the actual training sessions.

Positive Behavioral Supports (PBS)

Training description provided by MLB. Participants use activities, didactic, demonstrations and eight hours of on-the-job training practicum to acquire fundamentals of Positive Behavior Supports. Participants will describe the three pillars of Positive Behavior Supports: Applied Behavior Analysis, Person Centered Practices and Normalization/Inclusion (social role validation). Distinguish differences between positive/negative reinforcement and positive/negative punishment; list contraindications of punishment; describe how function-based treatment in PBS fits with other treatment models; conduct a simple functional behavior assessment (FBA); link FBA data to intervention approaches; demonstrate rapport-building and interaction skills; and collect objective data on behavior.

The Positive Behavior Supports training includes materials developed by the former Internal Reviewer, who was the original developer, and other Department behavioral health practitioners, as well as material from the current trainer, a BCBA.

Source of Information used in PBS Training review: Training curricula and ancillary materials used and discussion with current and former trainers. Please note that this training was not attended in person by the Internal Reviewer, so this report cannot assess fidelity of training implementation. There is Product Evidence, but not Observation Evidence.

The *standards* used for comparison to best practice included guidelines utilized as

industry standards developed by:

1. The Behavior Analyst Certification Board, a professional association in behavior analysis (BACB.com)
2. Certification standards utilized by NADD: Advancing Mental Wellness for People with Intellectual or Developmental Disabilities (www.thenadd.org)
3. The College of Direct Supports, an computer-based training platform for direct support professionals working with people who have Intellectual or Developmental Disabilities (http://directcourseonline.com/direct-support/).

This training was thoroughly reviewed and found to be consistent with the standards used as reference materials in the following specific areas:

1. Very strong elements of person-centered thinking
2. Very strong explanation of reasons for challenging behavior
3. Inclusion of information regarding types of intervention strategies
4. Description of behavior analysis in plain language
5. Review of data collection and use
6. Explanation of how problem behaviors might make sense to the person
7. Review of the role that the context and environment contribute to problem behavior
8. Definition of the team approach to responding to problem behaviors
9. Significant skill building focus for the person
10. The training materials discussed the Minnesota Positive Supports Rule. While this is not specifically addressing a best practice standard, it does represent the Department's efforts to promote the vision of the JSA.

It must be recognized that the materials presented had to be prioritized given the small amount of time and the desired outcomes of the training for direct care providers. Providing information is critical in the endeavor to adopt and utilize positive supports for persons with challenging behavior. Simply following established behavior support plans without understanding the underlying logic will not equip care providers to adapt their supports to ever-changing patterns of behavior. In this training, the information included important philosophies in an understandable, engaging manner. Plain language is used to teach complex concepts. It is important to note that competency is assessed via print and verbal quizzes.

The review noted that there are areas in which additional material should be added to be consistent with best practices.

1. Setting events were not covered, and it is recommended that they are added.
2. Given the high prevalence of mental health disorders among persons served by MLB, content on mental health should be added.

Both these suggestions have been shared with the current trainer.

This training is consistent with the vision of the *Jensen* Settlement Agreement and the Comprehensive Plan of Action.

Person Centered Training (PCT)

Training Description provided by MLB. Two-day workshop designed by Michael Smull. All trainers certified by the Learning Community for Person Centered Practices. 12-hour interactive training where participants acquire person-centered thinking skills such as: the importance of being listened to and the effects of having no positive control, the role of daily rituals and routines, what is important 'to' and important 'for,' respectfully addressing significant issues of health or safety while supporting choice, how to develop goals that help people get more of what is important 'to' them while addressing the important 'for.' Individualized specific training reviews the specific strategies to implement an individual's person centered plan.

Source of Materials Used in the Review of PCT Training: Attendance of the PCT training by the Internal Reviewer and review of training materials. Please note that this training was reviewed in person, so this report can assess fidelity of training implementation. There is Product Evidence and Observation Evidence.

The *standards* used in this assessment were:

1. The Person Centered Plan Scoring and Checklist Tool initially developed by Kansas University (described in detail in the section of this report detailing Evaluation Tools)
2. Reference materials from The Learning Community for Person Centered Practices (www.learningcommunity.us)
3. Guidance from the Centers for Medicare and Medicaid Support regarding person centered planning.

The training covered all elements of these standards. Training currently given under imprimatur of The Learning Community. Training content is set and required by The Learning Community. Training is provided by the Department and University of Minnesota staff and faculty. There is a high degree of ongoing supervision via mentor training from the Department (the prior Internal Reviewer), and University of Minnesota mentor trainers.

This training utilized the official curriculum from The Learning Community, and met all best practice standards. The process for becoming a trainer is rigorous, and is noted below:

1. Orientation
2. Mentor trainer Observation
3. Mentor guides study
4. Mentor observes first training and assures fidelity
5. Second demonstration, mentor observes and assures fidelity

To maintain certification, trainers must complete three training sessions per year, and must continue to use the official curriculum. Any update to curriculum requires adoption by all trainers. There are no suggestions for improvement made as a result of this review.

This training is consistent with the vision of the JSA and the CPA. As noted with Positive Behavior Supports, following established support plans without understanding

the underlying logic will not equip care providers to participate in the team learning processes which are an assumption of person centered thinking and planning. In this training, the information included important philosophies in an understandable, engaging manner. Plain language is used to teach complex concepts.

Crisis Intervention/Post Crisis Intervention and Assessment

Training description provided by MLB. A classroom training describing the purpose, review framework, process, format and follow up format of a critical action review. How to establish an environment to promote open discussion. Discuss crisis vs emergency; discuss what we can do to support people and prevent unwanted event/emergency/crisis; describe what we do following an incident; how we support everyone involved; and paperwork, individual support, and staff supports.

This training includes materials originally developed by Department behavioral health practitioners as well as the current trainers.

Source of Materials Used in the Review of Crisis Intervention/Post Crisis Intervention Training: The materials used in this review included training materials and information from the current trainers. Please note that this training was not attended in person by the Internal Reviewer, so this report cannot assess fidelity of training implementation. There is Product Evidence, but not Observation Evidence.

The *standards* used for comparison to best practice included guidelines utilized as industry standards developed by: Accreditation/Certification standards utilized by NADD: Advancing Mental Wellness for People with Intellectual or Developmental Disabilities (www.thenadd.org).

This thorough review of the materials resulted in the identification of numerous areas in which the training sessions were consistent with the best practice standards and these are listed below:

1. Solid content leading to understanding of some of the life circumstances of people we support
2. Strategies to prevent unwanted event/emergency/crisis
3. Highlight factors in the environment that lead to or reduce the likelihood of crisis
4. Rapport building
5. Connection to person-centered thinking
6. Focus on Positive Behavior Support
7. Strategies to support recovery post crisis

The review also resulted in suggestions to improve the training.

1. Mental wellness support strategies should be added
2. The term wellness appears in the training and should be defined
3. A competency exam should be added, as required in the CPA

These suggestions have been shared with the current trainers, who made all of the recommended revisions as of May 23, 2016. With the addition of a competency-based assessment, this training is now consistent with the vision of the JSA and CPA. Offering

care providers further information about the nature of crisis and how to respond after a crisis is a necessary element of supporting persons with challenging behaviors.

Medically Monitored Restraint (MMR)

Training Description provided by MLB. Review the medical monitoring of an individual during an emergency use of manual restraint per the *Jensen* Settlement. Learning to recognize physical aspects as the result of an EUMR. Review of EUMR processes and documentation, and vital signs.

Source of Materials Used in the Review of MMR Training: The materials used in this review included training materials and gathering of information from the current trainer. Please note that this training was not attended in person by the Internal Reviewer, so this report cannot assess fidelity of training implementation. There is Product Evidence, but not Observation Evidence.

The *standards* used in this review included the CMS Guidance to Surveyors for ICF IID -Appendix J, Guidance 483.450(b)(1)(iv)(B) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf) and the Joint Commission Standards on Restraint (www.jointcommission.org).

This thorough review of the materials resulted in the identification of numerous areas in which the training sessions are consistent with best practice standards, and these are listed below:

1. Review of *Jensen* Settlement Agreement
2. Highlighting of physical concerns
3. Notes the role of trauma and the need for trauma informed care.
4. Review of prohibited procedures
5. Solid and clear information
6. Competency assessment used in form of a quiz

The review process also identified additional materials that are needed for this training to assure greater consistency with best practice standards and more thorough sharing of the best practices with trainees:

1. It is unclear from the training how vital signs are to be monitored.
2. While it is laudable that trauma-informed care is discussed, it is necessary to add potential ameliorating strategies.
3. The need to maintain dignity and rights is mentioned, but no strategies are listed.

The trainer noted that these are covered verbally in the training sessions and are individualized as needed. The training has not been observed directly, and this is not verified. With the addition of written content related to the three recommendations given above, this training would represent the applicable best practices and will be substantially consistent with the standards used as review.

Standardization of Training across Divisions

The Department will utilize an Independent Subject Matter Expert for this effort. The Internal Reviewer has notified the Quality Assurance Leadership Team that this matter

> will be investigated. Considerations in the use of a standardized training across Department divisions are as follows: (a) establishing the parameters of the Department's Divisions, (b) identifying training practices in evaluation across each of the Divisions, (c) ascertaining the degree of overlap in these training practices, and (d) determination of feasibility of a more standardized approach to training.

JOQACO will follow up with MLB on the recommendations of the Internal Reviewer regarding training. JOQACO will obtain a plan of action to incorporate the recommendations no later than June 10, 2016, with anticipated implementation no later than July 15, 2016. The Executive Director of JOQACO is also currently participating in a business improvement project focused on increasing MLB training compliance with an expected completion date in July 2016.

Community Support Services (ECs 67-72)

With respect to Community Support Services (ECs 67-72), the Court sought information "detailing outcomes related to these ECs." (Doc. No. 551 at 13.) The Court recommended that the Department use the Internal Reviewer to "verify the results reported in the Gap Report," and to "develop a substantive performance report to elaborate on [Community Support Services] and crisis interventions." (*Id.*) In particular, the Court sought information regarding "the services provided to the seventy-five individuals targeted for long-term monitoring," and "the staffing and administration of the Single Point of Entry project." (*Id.* at 14.)

The Internal Reviewer reports:

> **Verification of CSS Numbers of Persons Served**
>
> An attempt was made to verify the total numbers of persons receiving supports from CSS and the number of persons in Long Term Monitoring, utilizing the same time periods reported in the Ninth Compliance Update Report. The attempt for verification was made via queries to the CSS data base, and was performed by a different data analyst than the analyst who ran the queries for the prior report. The Internal Reviewer supervised the query creation. Four queries were done for each time period in question: (1) client served closed during the time period, (2) client served and opened during the time period, (3) opened prior to the time period and closed after the time period, and (4) opened prior to the time period and still open at end of the time period. In the drawing of data for the verification report, visual inspection of the data base revealed that one person had an inaccurate start date due to miscoding by the CSS clinician. This error was corrected in the CSS data base. The results are presented in the following tables.

Total Number Served

	Ninth Compliance Update Report	Verification Query
4/25/2015-6/30/2015	307	304
7/1/2015-8/31/2015	301	295
9/1/2015-9/30/2015	295	281

Long Term Monitoring Number Served

	Ninth Compliance Update Report	Verification Query
4/25/2015-6/30/2015*	61	66
7/1/2015-8/31/2015	62	64
9/1/2015-9/30/2015	65	60

*This time period was chosen at random and an attempt to verify the number here was made using a secondary source of information. A spreadsheet of all persons in Long Term Monitoring at that time was viewed and individual lines were counted following visual inspection. A total of 66 persons were identified in the Long Term Monitoring group during this time period, which was equal to the figure noted in the Verification Report but not the Ninth Compliance Update Report.

Determination of Verification

1. The effort to verify the reported number of persons identified in the Ninth Compliance Update Report was not successful, as the Verification Query produced a different number of persons. The total numbers served are within a 95% margin for all three time periods. The Long Term Monitoring numbers served are not within a 95% margin in any of the three time periods. The statistic of 95% was selected as it is a common measure of statistical confidence intervals. Recommendations are presented in the Overall Summary of CSS. The CSS data analyst stated that the most likely reason for the lack of a match between the Ninth Compliance Update Report and the Verification Query is that the information reported in the Ninth Compliance Update Report included repetitions in the data and coding errors which have since been corrected, as described below.
2. The attempt to verify one of the entries in the table above using a secondary source of information was successful in verifying the numbers of persons noted in the Verification Query, but as such differed from the number in the Ninth Compliance Update Report. The first attempt to use the secondary source of information did not produce a match with the Verification Query, so CSS staff reviewed the spreadsheet listing all persons receiving Long term Monitoring and the databases, and noted seven erroneous records. The nature of the errors was typically miscoding. These were corrected, resulting in a match with the number served in Long Term Monitoring 4/25/2015-6/30/2015, and serving as a source of verification that the Verification Query was accurate post-corrections.

CSS and Crisis Intervention Substantive Performance Report

The Substantive Performance Report included the following areas for consideration:

1. CSS Quality and Effectiveness
2. CSS Long Term Monitoring Activities

3. CSS Business Case Analysis
4. Overall Summary of CSS Substantive Performance Review

In addition to CSS, the Department offers Crisis Intervention through the Successful Life Project, or SLP. As SLP was the subject of extensive Court Monitor review in the Court's March 18, 2016 Order, this report focuses on CSS.

CSS Quality and Effectiveness

CSS completes quarterly evaluations of all technical assistance recipients. In order to evaluate the effectiveness of CSS technical assistance efforts, these surveys were utilized as a source of information, considering the two quarters covered by the Ninth Compliance Update Report: April – Sept 2015. The table below summarizes selected measures in the results of these surveys. Selection of variables was made via consideration of relevance and general professional practices in measuring customer satisfaction (e.g., Qualtrics, Survey Monkey).

Query and (respondent)	Apr-June, 2015	July – Sept 2015
CSS responded in a timely manner (Care provider)	93% from 14 surveys	95% from 22 surveys
I am satisfied with the services received (Care provider)	93% from 14 surveys	95% from 22 surveys
Requests for services and/or expected outcomes were achieved (Care provider)	93% from 14 surveys	95% from 22 surveys
CSS intervention helped prevent a loss of placement, prevented hospitalization, or prevented placement in a more restrictive setting (Care provider)	86% from 14 surveys	82% from 22 surveys
CSS helped the person's support network understand the person's needs (Legal guardians)	100% from 5 surveys	92% from 12 surveys
CSS staff understood what was important to me (Persons)	100% from 11 surveys	90% from 10 surveys
The class was valuable/useful (Training attendees)	99% from 168 surveys	99% from 162 surveys

The survey results from a multiplicity of sources regarding the scope of CSS activities indicate a high degree of satisfaction with CSS. The response to the question regarding

loss of placement could reflect CSS not providing preventative support earlier in the emerging crisis development. As noted in the Business Case Analysis for CSS (see below), a concern of CSS staff is the fact that CSS often responds when a crisis has already begun. This is also true if referrals come to CSS from the Single Point of Entry: people come to the Single Point of Entry when problems have already begun. Proactive technical assistance before or at the very inception of challenging behavior could prevent some of the difficulties that result in threatened or actual loss of placement. Recommendations are made in the CSS Performance Report Summary regarding potential use of precision business intelligence to increase the operational efficiency of CSS, potentially creating additional time in which CSS could engage in preventative consultation prior to the occurrence of behavioral crises.

CSS Long Term Monitoring Activities

For a review of the activities in which CSS engages with the Long-term Monitoring group, a random sample of five persons receiving this support were selected, and the quarterly reports for activities were reviewed to identify CSS activities. Tables below present the findings arrayed by person.

Type of Contact

	B1	D2	A1	A2	G1
Phone	x	x	x	x	x
In Person	x	x	x	x	x
Attend Team Meeting	x	x	x	x	
Direct Work with Individual		x	x	x	x
Facilitate team communication and communication with family			x		x

Summary: In the random sample drawn, CSS staff interact with the persons and their team utilizing a variety of methods. In-person contact was used for all five persons. Of importance to note is that in their service model, CSS will work directly with individuals. In this sample, activities included teaching coping skills, assisting with problem solving, and in one case, accompanying a person in career exploration and career development activities. This represents a significant difference from the technical assistance model of the Successful Life Project.

Technical Assistance Activities

	B1	D2	A1	A2	G1
Review data including BIRFs	x	x	x	x	
Assist team in problem solving	x	x	x	x	x
Identify specific positive supports	x	x	x		
Assist in identifying more supportive environments			x		
Follow up to EUMRs	x	x			
Complete FBA		x			

File reviews		x	x		x
Develop formal support plans	x	x			
Identification of other supports		x	x	x	
Promote community employment			x		

As demonstrated in this table, CSS staff engage in a wide variety of activities with Long-Term Monitoring group. CSS staff essentially function as outside team members, engaging in activities that are identified by CSS or the team as necessary in improving supports for people in Long-term Monitoring. Some of these activities, such as identifying other supports, fall into more of a case management role, while others, such as completion of Functional Behavioral Assessments, are purely technical functions. A consideration in the review of these activities is whether CSS is duplicating efforts that should typically be performed by the care providers, and the answer is yes, but CSS identifies these as tasks which the existing teams have trouble completing or lack the skill to complete (source of information: interviews with key informants in Business Case Analysis and CSS outcome documentation). The flexibility of the activities is a strength of the CSS model of technical assistance. As a case in point, the activities around promotion of community employment and career development for A1 played a critical role in her acquisition of volunteer positions and identification of career goals. CSS staff functioned as developers of technical documents and assisted in resolving questions such as determining why significant behavioral events occurred and reviewing rights issues such as compliance with medically-required diets. The specific detail of how involved CSS staff are varies by individual case. Please note that there is less activity with G1, as this individual was being transitioned from one CSS staff person to another for reasons of office proximity. The case notes for this individual reflect significant activity to assure continuity of supports, but certainly a smaller variety of activities occurred.

<u>CSS Business Case Analysis</u>

As part of the substantive performance review of CSS, the Internal Reviewer performed a Business Case Analysis. This is an evaluation of business practices using the framework proposed in the book "Managing in a Time of Great Change" by Peter Drucker (Harvard Business Press, 2009). This specific model was adopted due to the fact that the support systems for people with Intellectual or Developmental Disabilities in the State of Minnesota in undergoing significant and rapid changes, particularly in the area of adoption of positive supports and person-centered thinking, both of which are central to CSS operations. The business case analysis is organized around a series of questions, which appear as follows. Four key informants were interviewed to assess the business case for CSS: the CSS administrator, a CSS team leader, a CSS regional manager, and a CSS clinician. Verification of representativeness utilized CSS's outcomes database, completed by all CSS staff, and review of supporting material and documentation. Comments kept in their entirety from informants are noted with quotation marks.

1. What is the desired outcome of the business unit?

There was significant agreement across all four key informants. The desired outcome of CSS is to support individuals and their support networks via positive programming and person-centered approaches. This involves efforts to increase the capacity of the

stakeholders and provide positive outcomes for individuals with clinical complexity.

2. What has changed about the industry?

All person interviewed noted significant changes in the industry, which are directly relevant to CSS operations. Elements are listed below:

A. Change in the Department's regulations regarding behavior support. These include the Positive Supports Rule, the *Olmstead* Plan, and the JSA.
B. The labor force in Minnesota has become more limited due to low unemployment and job opportunities paying similar wages but seen as being "easier."
C. Provider perception that with changes in allowable behavior interventions, they no longer can support the high acuity population.
D. County-based social services seem overwhelmed.
E. Increased demands for CSS to respond to crises. This allows for less time spent in prevention.
F. Increased regulatory and monitoring demands on CSS.
G. Greater demand for CSS to develop more formal behavior support plans and functional behavior assessments. These are more time-intensive than providing simpler support suggestions, which could be sufficient if more preventative activities were possible prior to crises emerging.

3. What is changing about the industry?

All informants noted significant changes in supports for persons with Intellectual or Developmental Disabilities in Minnesota. These changes included:

A. Minnesota's *Olmstead* Plan is driving significant change in vision on community inclusion for all people with disabilities, in turn increasing pressure on CSS to broaden its service scope. CSS now includes efforts to focus on individuals with brain injuries and support for 24/7 mobile crisis teams. This expansion provides more integrated support for people with Intellectual or Developmental Disabilities and mental health concerns, but also increases the CSS workload.
B. There is a significant degree of overlap among services provided by CSS, SLP, and (to a lesser degree) Community Capacity Building. All three Department efforts may provide similar types of services, and as such there can be confusion among technical assistance providers and the community about the role of each group. There can be some people who are on a wait list for technical assistance, and others who have multiple Department clinicians involved.
C. Increased emphasis on staff credentialing. Concern was expressed regarding hiring staff with better credentials, such as having board certification as a behavior analyst, but less experience and clinical skill with people who have IDD.
D. Falling availability of crisis beds.
E. Some providers are closing their doors, though others are opening.
F. The Positive Supports Rule is creating greater interest in positive supports and person-centered thinking. Support providers are asking for more FBAs.
G. Technology is slowly making its way into disability supports.

H. Many leaders in CSS and in the field of disability supports are retiring.

4. What are critical success factors? What is lacking?

A. Ability to teach skills to providers, people with disabilities, and families.
B. Effective and flexible technical assistance strategies.
C. Use of a variety of intervention methods.
D. Coordination across all parties in a person's life.
E. Lacking: "Effective, efficient information management technology resources—including an integrated electronic service record (ideally integrated across [the Department]) that eliminates current need for duplicate documentation (e.g., in Care Manager and our own project tracking system, which generates billing); mobile devices that enable field staff to more efficiently write notes, view documents, etc. on the road; greater implementation of electronic service records and information sharing across the service system (between collaborating providers, etc.)"
F. Lacking: "Provider skill base and staffing. Provider willingness to use positive supports rather than using prior more restrictive strategies. There was a lot of change all at once and people didn't know how to respond."

5. Are the goals for the business unit viable with current resources?

Informants expressed concerns including:

A. Increased demands placed on CSS have resulted in higher caseloads than what is clinically effective with longer wait times for service delivery from CSS to begin. The desired caseload is seven per person, but many CSS staff have a caseload of twelve or more.
B. CSS has been put into a crisis response mode, and that limits the effective prevention activities.

6. Is the organizational structure and practice based on established or benchmarked best practices?

Yes, CSS utilizes training and technical assistance strategies that are consistent with best practices, with the exception of the excessive focus on crisis services, noted previously. There is effective team functioning within CSS, though that could be expanded in areas in which sharing of strategies across CSS staff working with similar kinds of challenges would be helpful.

7. Do positions have clearly defined responsibilities and goals?

Yes, though there is significant variability in the specific practices of what individual team members do, some of which is based on the different skills sets of different CSS workers.

<u>Overall Summary of CSS Substantive Performance Review</u>

In a support system which is rapidly changing to adopt best practices in supporting people with Intellectual or Developmental Disabilities who present behavioral challenges, the smooth and effective operation of technical assistance bodies is critical. The positive

supports rule changed the landscape of how providers could respond to issues of challenging behavior, and in the absence of means for disseminating information and technical assistance, this effort would struggle. The role of CSS is critical in supporting this effort. CSS outcomes are documented by survey and indicate a high degree of customer satisfaction and effectiveness. In-depth analysis of randomly chosen people involved in Long-Term Monitoring efforts document the wide variety of activities CSS staff utilize to provide extra support. A strength of CSS is the flexibility of supports.

The various elements of the Performance Review also note areas for improvement in efficiency. Please note that some of these are outside of CSS's direct control.

1. Ability to work in a more proactive manner.

Time is always better spent with prevention than with crisis management. There may be some technological means for assisting in this, noted below in Suggestion 3. The opportunity to intervene well upstream of a crisis can prevent significant difficulties later. CSS works primarily in a tertiary intervention when considered from a public health model perspective, working directly with people who are experiencing challenge and designing individualized supports. This is the most time-intensive approach. Primary (population-wide) and secondary (intervention package approaches) levels of intervention should be considered.

2. Resolve issues of overlap with the Successful Life Project and Community Capacity Building- Disability Services Division

There is a significant amount of overlap with other bodies providing technical assistance in the area of behavior support, most notably among *Jensen* class members receiving assistance from CSS and the Successful Life Project. This can result in unnecessary duplication of efforts and time spent with two different clinicians providing assistance, while other people are on a wait list receiving no assistance. This also creates confusion of roles and team process. It is recommended that the Department develop a clear decision rule on how technical assistance providers get assigned.

3. Use of information management systems and data

CSS staff note some challenges with use of technology and information. Needing to keep redundant records was noted as a significant burden for CSS staff and causes a resulting lack of efficiency. Efforts to verify numbers of persons served by CSS reported in the Ninth Compliance Update Report was not successful, with differing numbers of persons appearing in a Verification Query (please refer to the appropriate section in this report for further detail). This is a concern and validity of data should be addressed as a high priority. Databases regarding persons served should be visually inspected and compared to secondary sources of information semi-annually. The review completed for purposes of this report resulted in identification of errors in the database and improvements in data accuracy. This process should occur on an ongoing basis and should include both the Long Term Monitoring and Total Number Served databases.

It was noted within CSS and other elements of internal reviews that the Department maintains operational business intelligence. However, the Department should investigate a precision business intelligence presence which could sit on top of existing digital records

systems. In addition to increasing efficiency, there are a number of potential positive outcomes:

A. CSS and other Department operations could look for efficiencies across clinicians, for example, essentially replacing heuristic operations with information-based decision making for the assignment of clinicians and programs.
B. Greater levels of information about specific clinical needs of people could be used to digitally identify small Communities of Practice for clinical staff working in similar situations. This would best be done for time-limited periods to assure sharing of learning and knowledge.
C. Structural information could be leveraged to add further detail on clinical operations and supports, assisting with risk management and caseload coordination. For example, CSS noted a preferred caseload of seven per clinician, though caseloads approach or exceed twelve in some cases. Analyzing workflow can assist in finding process improvements and optimization. For example, can the variety of different interventions and CSS activities be chosen based on information about likely effectiveness rather than clinical heuristics? Some activities with equal likelihood of positive outcome have vastly different time commitments.
D. Given the large numbers of people receiving support from CSS, greater levels of information about specific clinical needs would allow for use of a population health management strategy, looking at broader needs and allowing for larger scale interventions. For example, if it is determined that large numbers of people need stress management intervention, a training or brochure could be developed and only emailed/sent to the people for whom it would be needed. Alternatively, regional training could be offered in the areas where it is most needed.
E. Predictive Analytics for Behavioral Crisis. CSS reports that they are spending more time in crisis response and less time in prevention. Use of clinical analytics to predict which persons are more likely to escalate into crisis can assist in identifying where CSS staff should spend their time. There are a number of risk assessment and prediction tools, including one developed in part by the Internal Reviewer. This can be done in a non-digital manner as well.

Any time any type of precision business intelligence strategy is used, effort to implement and time spent in utilization must be balanced against likely gain. Simple commercial computer programs like Excel are often as effective as expensive proprietary programs while offering greater flexibility. CSS staff would need to see the likely outcomes as being worth their efforts to input information. Data must be clean, accurate, and semantically consistent in order to be useful.

Single Point of Entry

The purpose of the Single Point of Entry (SPE) efforts is to manage and coordinate the system of supports response for persons who are nearing behavioral crisis.

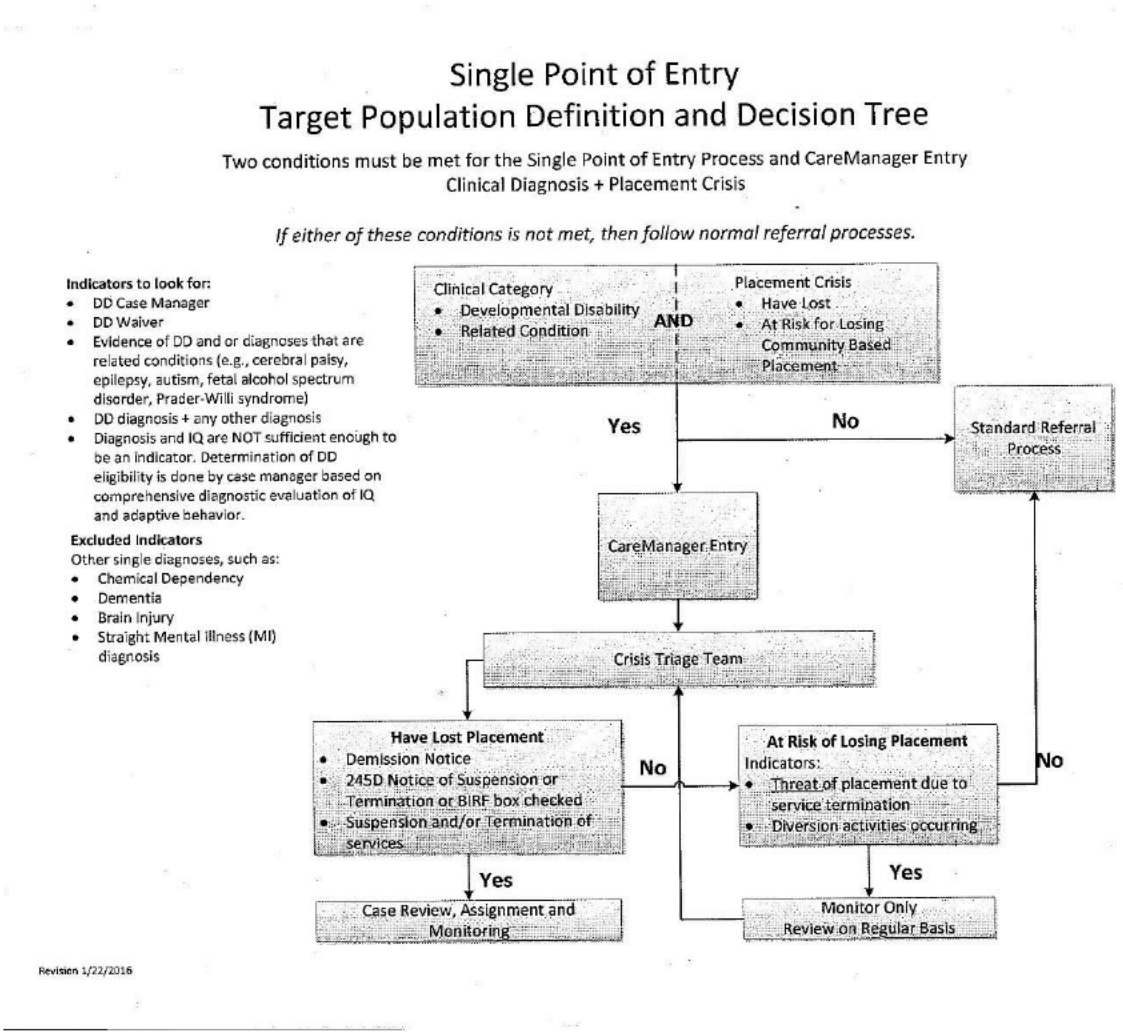
Sources of Information Used in This Report: Documentation regarding SPE was utilized

including description of SPE, flowcharts, and information bulletins; and interviews with SPE staff and stakeholders.

The process utilized by SPE is depicted in the following graphic, and will be summarized briefly herein.

1. Persons can come into the SPE process either by phone or by email. Persons also can enter into this system as a result of significant Behavioral Incident Report Forms (tracked by the Disability Services Division) or from the receipt of 245D provider demission/discharge notices.
2. The initial response is to determine eligibility. This is done by Central Pre-Admissions, and the primary consideration is the presence of an Intellectual or Developmental Disability. Excluded indicators are listed and exclude single indicators of Chemical Dependency, Dementia, Brain Injury, or sole diagnosis of Mental Illness.
3. If Central Pre-Admission determines a lack of eligibility, an appropriate referral is made to the appropriate State Agency.
4. If eligibility is established, the individual is entered into the Care Manager data management system, and the person's status is reviewed.
5. Status is reviewed in a daily triage call every weekday morning and Friday afternoons as needed. Participants in the call include administration from the Disability Services Division with administrative, clinical, and resource expertise, three Disability Services Division Navigators, and leadership of CSS and SLP.

The purpose of these daily calls is to manage information regarding the approach to behavioral crisis. As a result of the triage calls, individuals can be identified as needing consultation from technical assistance regarding the behavioral challenges from CSS or SLP, or the identification of alternative residential supports. A key decision to be made in this process is the designation of a lead agency or lead person.



There are two primary elements of staffing effort involved in this process: Central Pre-Admissions and the SPE calls.

Central Pre-Admissions represents the initial step in the SPE. Central Pre-Admissions has a total of 17 Full-Time Equivalent staff and includes:

- 7 RN Sr.'s
- 7 SPA Sr.'s
- 1 OASI Sr.
- 1 LADC
- 1 Program manager

As noted in the Ninth Compliance Update Report, the additional effort in the role played by Central Pre-Admissions is not a challenge, as the number of new persons involved is small.

Staffing of SPE

Staffing for the SPE involves one project manager, one case manager, and representatives

from DSD, SLP, and CSS. The DSD representatives include Navigators. Please note that the Navigator position is not official at the current point, and no start date to the official status is established, but is likely to follow the list of final recommendations being developed by the Department in the move to Phase 2 of the SPE.

Outcomes of the SPE

1. A large number of persons with Intellectual or Developmental Disabilities and behavioral challenges have received additional tracking and monitoring through SPE. As reported in the Ninth Compliance Update Report, 96 persons have been monitored during that time period. The source of information here is reports generated by SPE detailing number of persons served.
2. SPE has resulted in quicker assignment to support services from CSS as CSS participates in SPE and service referrals are generated directly through this participation. This eliminates a step in the referral process.
3. SPE has expedited individual cases in moving through the service system with specific referrals for service provision generated directly through SPE. This also eliminates a step in the referral process.

Challenges in Administration of the SPE

1. Technology. As noted in the Ninth Compliance Update Report, the technological substrate of SPE is the CareManager system, which still is not operating as planned. Information is often entered into both the CareManager and Avatar databases, despite the fact that when CareManager was purchased, the Department was assured that these two digital systems would be linked. Many of the fields on the data entry interface for CareManager do not apply to current use and cannot be removed at this point. CareManager often is not able to track significant information, such as storing the history of changes in residence. The generation of reports using CareManager can be difficult and time consuming for staff, with resulting inefficiency. The business needs of SPE should drive further development of CareManager.
2. Dedicated work space for Central Pre-Admissions as related to SPE efforts was reported to not suit the specific business needs.
3. The decision of when to add a person to the SPE versus utilizing other existing processes to add support via other Department programs continues to represent a challenge. Central Pre-Admissions reports difficulties in identifying solid decision rules for when a person should be entered into the SPE.
4. Staffing of SPE. Significant expertise and commitment of time is involved in the daily calls, which results in opportunity cost for the Department, in that highly skilled behavioral professionals and administrators are not engaged in other activities which could build capacity to provide enhanced services for persons with Intellectual or Developmental Disabilities who engage in challenging behavior.
5. Identification of Services for Persons Followed by SPE. While the SPE is able to follow individual cases and identify the need for alternative supports when a person is or can no longer be served by previous care providers, this is incumbent on those additional services being, in fact, available. Triage efforts cannot always

be based on what a person needs, and may be driven by what "open beds" are available. This is a particular need when a person is committed to the Commissioner.

6. Level of Awareness in the community about SPE. Existing means of disseminating information from the Department were used to inform the community about the SPE process. Interviews of County Administrators and Case Managers regarding SPE noted a lack of detailed information about SPE activities and processes, though all interviewed were aware of SPE and reported that they could find the information about how to make referrals.

Interface of SPE and Minnesota Life Bridge (MLB): When SPE results in a referral to MLB, the information is received by the MLB Admission/Transition Coordinator who determines if information is missing and if so, tries to track it down to determine eligibility. MLB clinical staff, including a BCBA, and an RN, can ask for further information, and often do so, but this is only successful when prior care providers are responsive to these requests.

Oversight from the Quality Assurance Committee: The Internal Reviewer presented a brief summary of SPE and the Court request to review SPE to the Quality Assurance Leadership Team on May 18, 2016. The Quality Assurance Leadership Team will thoroughly review the findings of this report regarding the SPE at the June 15, 2016 meeting and will consider its role in oversight, system-wide challenges, and providing input into recommendations to improve any impediments to compliance with related ECs.

Verification of Findings: Correspondence between multiple sources of information including interview and document reviews, including description of SPE, flowcharts, and information bulletins, served as the means of verification of findings.

The total numbers of persons receiving supports from CSS and the number of persons in Long Term Monitoring were verified by the program area at the time of the Ninth Compliance Update Report; however, they were unable to be recreated at a later date by the Internal Reviewer. As noted, data collection and database maintenance has been an area of challenge for CSS. JOQACO will follow up with CSS on the recommendations of the Internal Reviewer regarding database maintenance. JOQACO will obtain a plan of action to incorporate these recommendations no later than June 10, 2016, with anticipated implementation no later than July 15, 2016.

As detailed in the Ninth Compliance Update Report and other sections of this report, the focus of JOQACO has shifted from data collection and reporting to compliance and measurement, including verification activities. With this new focus, JOQACO will play a greater role in reviewing and verifying the information contained in future reports. JOQACO will use a standard, documented process to pull data so that it can be recreated at a later date.

JOQACO will also explore with the Internal Reviewer the feasibility of the introduction of a precision business intelligence presence.

With respect to the recommendations of the Internal Reviewer regarding overlap of crisis intervention services, JOQACO will follow up with CSS. JOQACO will obtain a plan of action to incorporate the recommendations no later than June 10, 2016, with anticipated implementation no later than July 15, 2016.

With respect to the Internal Reviewer's comments regarding CSS's ability to work in a more proactive manner, the Department agrees that time is always better spent on prevention rather than crisis management. As noted in other sections of this report, the Department does utilize services to avoid crisis and strives to employ the most effective and efficient delivery methods available to provide the right service at the right time and place. JOQACO will explore with the Internal Reviewer the primary and secondary intervention approaches mentioned in his report as potential improvements to CSS and SPE services.

Staff Qualifications (ECs 78, 89)

With respect to Staff Qualifications (ECs 78, 89), the Court sought aid in evaluating whether these ECs are being met. The Court proposed that the Department use the Internal Reviewer to conduct this investigation, and directed that the investigation "be based on more than [the Department's] own assertions." (Doc. No. 551 at 15.)

The Internal Reviewer reports:

> This section includes content regarding two areas of staff qualification:
> 1. CSS qualification for Behavior Analysts (EC 78)
> 2. Experience requirements for Minnesota Life Bridge staff (EC 89)
>
> EC 78: CSS Qualification for Behavior Analyst
> EC 78 requires that "staff conducting the Functional Behavioral Assessment or writing or reviewing Behavior Plans shall do so under the supervision of a Behavior Analyst who has the requisite background, experience, and credentials recognized by national associations such as the Association of Professional Behavior Analysts."
>
> For CSS, there are two staff who perform this supervisory function. The first staff person is a credentialed Behavior Analyst with a BCBA, a nationally recognized credential. The Internal Reviewer verified this by checking the Behavior Analyst Certification Board (BABC)'s online directory of credentialed behavior analysts. The verification was performed May 3, 2016. This meets the EC 78 standard.
>
> The second person acting as a supervisor is a Licensed Psychologist at a Master's Level. The Internal Reviewer verified this via inspection of the licensing document. As psychology is licensed at a state, and not a national, level this staff person does not have

credentials issued by a national association. EC 78 specifically excludes Behavior Analysts who have a psychology license but no other national certification. Due to the broader level of knowledge in most psychology training programs, professional acceptance of psychology licenses as a higher level of education than BCBAs is common, and psychology certifications have a broader acceptance for third party service payment. This staff person has applied for the credential of National Association of Dual Diagnosis Clinical Credential (NADD-CC), an internationally-recognized, competency-based credential. That credentialing effort is in progress and has not yet been conferred. The Internal Reviewer has verified with NADD that this staff person does have all materials in to NADD, and is awaiting examination, which is scheduled for May 25, 2016. When NADD-CC is conferred, this staff person will meet the EC 78 standard.

Similar MLB Qualifications: While not specifically required in the Court's Order, the Internal Reviewer also verified that the Behavior Analyst 3 for Minnesota Life Bridge, does have the credential of BCBA as well. This was verified by checking BABC's online directory of credentialed behavior analysts. The verification was performed May 3, 2016.

EC 89: MLB Experience Requirements for New Hires or Transfer
EC 89 requires that "Staff hired for new positions as well as to fill vacancies, will only be staff who have experience in community based, crisis, behavioral and person-centered services and whose qualifications are consistent with the Settlement Agreement and currently accepted professional standards."

There were seven new hires into MLB during the reporting period. The Internal Reviewer inspected their resumes and determined that they had the requisite prior experience and were in compliance with EC 89. Each had in excess of one year of prior work experience. The Internal Reviewer verified that the prior positions met EC 89 requirements.

There were five transfers from other Department sites where they were providing direct supports to an MLB site during the reporting period. The Internal Reviewer verified that the prior experience was of sufficient duration to be in compliance with EC 89. Each had in excess of one year of prior work experience. The Internal Reviewer verified that the prior positions met EC 89 requirements.

Evaluation Tools (*See* ECs 47-52, 98)

With respect to Evaluation Tools (*see* ECs 47-52, 98), the Court directed the Department to "compile, verify, and report on the results of the assessments conducted with [the] evaluation tools" discussed in the Ninth Compliance Update Report. (Doc. No. 551 at 16.) The Court further directed the Department to "investigate whether a uniform evaluation tool can be utilized to evaluate individual outcomes across [the Department's] service spectrum." (*Id.*) The Court recommended that the Department use the Internal Reviewer to conduct this investigation. (*Id.*)

The Internal Reviewer reports:

This section includes content regarding two Evaluation Tools:

1. Positive Behavior Support Comprehensive Evaluation Tool (PBS CET)
2. Person Centered Plan Report Scoring Criteria and Checklist

Positive Behavior Support Comprehensive Evaluation Tool (PBS CET)

The Positive Behavior Support Comprehensive Evaluation Tool (PBS CET) is a tool used by the Successful Life Project team to guide technical assistance and support for SLP members. The SLP team adapted the PBS CET from the Positive Environment Checklist originally developed by the Rehabilitation Research and Training Center on Positive Behavior Supports and a subsequent revision used in Missouri. The Positive Environment Checklist was widely disseminated on a national basis and was considered a best practice by the research community. The existing PBS CET was developed by the Department to evaluate service delivery within the framework of person-centered practices and positive behavior support. Adaptations were made to ensure each item was objectively worded and could lead clearly to recommendations that, when indicated, the SLP team could support the organization to address. The prior Internal Reviewer provided assistance in the development of the PBS CET. The Internal Reviewer looked at the questions in the PBS CET, comparing them to national standards in positive behavior support as developed by the Association for Positive Behavior Support (www.apbs.org), Board Certification in Behavior Analysis (bacb.com), and NADD: Advancing Mental Wellness for Persons with Intellectual or Developmental Disabilities (www.thenadd.org), and saw an excellent correspondence between the PBS CET and existing standards.

The PBS CET is used as part of initial efforts to provide technical assistance and includes 76 questions in 12 categories. Successful Life Project Behavior Analysts complete the PBS CET by reviewing documentation, interview with Care Providers, observation, and direct assessment. Successful Life Project Behavior Analysts work directly with teams of care providers to prioritize and select individual recommendations for follow-up and implementation.

A PBS CET was completed for eight persons during the reporting period for the Ninth Compliance Update Report. The number of recommendations for each person listed in the PBS CET is listed in the table appearing below. Additionally appearing in the table as the last row, is information on the number of recommendations actually implemented by care providers. These data were drawn from Successful Life Project activity tracking documentation completed by each Successful Life Project Behavior Analyst. The PBS CET completed during the reporting period for C1 was not utilized, as C1 changed residences and provider. Successful Life Project did maintain technical assistance throughout the move, and used the Functional Behavior Assessment to guide subsequent technical assistance. As PBS CETs are very specific to location, many of the items no longer applied to the new setting, and the team judged that the Functional Behavior Assessment provided sufficient information.

	B1	K1	L1	M1	A1	A3	C1	S2
Physical environment		1	2	1		1	1	

Social setting		3	2	2	1			1
Structure/predictability of routine		1	2	2				2
Communication	3	2	2	2			1	2
General agency expectations		2	3	2		1		
Community access and involvement		4	2	2		1	1	1
Support of Staff	2	3	1	1	1	1	1	
Response to challenging behavior	2	2	4	1		1	2	1
Monitoring and decision making	4	2	2	2	1	2		2
Person Centered Planning	3	1	2	1			2	2
Additional supports	2	2	2	2	1		1	2
Management	1	2	2	2	1	1	1	1
Recommendations used	3	1	5	3	2	4	NA	1

Verification of PBS CET results: Two PBS CETs were chosen at random using a random number generator, K1 and B1 (presented as first two columns). The Internal Reviewer conducted a thorough review of other documents for these two individuals, including Functional Behavior Assessments, Support Plans, Meeting Notes, and Case Notes looking for consistency with the items identified as suggestions in the PBS CETs. The question was whether the items noted in the PBS CET were also noted in other supporting documents. Findings for these two individuals suggested a very high degree of overlap, thus providing a source of verification for the validity of the PBS CET.

It is notable that only a fraction of the recommendations were implemented for each person during the reporting period. The PBS CET is intended to provide a menu of possible interventions, and individual teams select the interventions which they implement. It is typically not advisable to implement too many changes in support simultaneously, although the outcome of positive supports should be a comprehensive plan addressing lifestyle, instructional, and support elements. A potential suggestion is to present PBS CET recommendations in a staged manner, allowing teams and clinicians the flexibility to select areas of highest importance initially.

Please note that the PBS CET has been renamed the Positive Behavior Support System Evaluation Tool (PBS SET) since the completion of the Ninth Compliance Update Report.

Person Centered Plan Report Scoring Criteria and Checklist

The Department uses a review tool to assess the quality of transition plans for persons transitioning from Minnesota Life Bridge. The Person Centered Plan Report Scoring Criteria and Checklist was modified from a tool developed at Kansas University, which identified best practices in Person Centered Planning. The Kansas University tool was widely disseminated and is considered an industry standard. This was modified by the

Department and faculty from the University of Minnesota to provide greater levels of specificity in regards to practices and terminology specific to Minnesota. The tool includes 30 questions regarding the quality of the Person Centered Plan and three questions for Follow Up; each question is scored on a three point scale, 0-2, with 0 being no mention of the item, 1 being some information provided, and 2 being thorough description and source of data noted. The Follow Up items are based upon actual utilization and team process. There is very little overlap in content area between this tool and the PBS CET discussed in the prior section. They focus on very different areas and are used for different purposes, although the PBS CET does include one section which asks whether Person Centered Planning is being used or not. That section of the PBS CET does not present a means for evaluation of the quality of those plans. The Ninth Compliance Update Report noted that three transition plans were completed during the reporting period, and these had been scored using the Person Centered Plan Report Scoring Criteria and Checklist, with findings of 94%, 95%, and 94%.

Results of the Assessment Tool Use

Use of the Person Centered Plan Report Scoring Criteria and Checklist to judge quality of the person centeredness of the transition plans indicates that the transition plans developed by the Department reflect many of the best practices of Person Centered Planning. The areas in which one or more of the three transition plans did not receive full scores per the review performed by the Internal Reviewer were as follows:

1. Brief story or history of the person's life is provided (score of 1)
2. A global statement of the person's dream is made (score of 1)
3. Work/school/retirement activities the person wants to engage in are described (score of 1)
4. Materials, equipment, assistive technology needed to assist the person to achieve his or her goals are described (score of 0)
5. Process for monitoring the person centered plan is described (score of 1)

These findings were shared with Minnesota Life Bridge staff who will consider the potential need to revise the transition plans to either fully address these items or provide a rationale for why the item was not considered (e.g., no assistive technology needed).

Verification: The Internal Reviewer independently scored the transition plans using the Person Centered Plan Report Scoring Criteria and Checklist and did an item-by-item review to verify the findings of the prior desk audits. The Person Centered Plan Report Scoring Criteria and Checklist includes three Follow-up items regarding subsequent use of the assessment tool in service provision. These were not scored, as they are outside the scope of a desk audit of the documents.

D2: 90% inter-rater reliability. All three disagreements involved the prior reviewer scoring a 2, and the Internal Reviewer scoring a 1.

S3: 94% inter-rater reliability. Both disagreements involved the prior reviewer scoring a 2, and the Internal Reviewer scoring a 1.

S1: 94% inter-rater reliability. Both disagreements involved the prior reviewer scoring a 2, and the Internal Reviewer scoring a 1.

If scoring inter-rater reliability was scored as dichotomous (i.e., present or not present,

> collapsing 1 and 2 into a single score), inter-rater reliability would have been 100%. These are professionally acceptable levels of inter-rater reliability, and serve as verification of the initial scoring.
>
> **Use of a uniform evaluation tool to evaluate individual outcomes across [the Department's] service spectrum**
>
> The Department will utilize an Independent Subject Matter Expert for this effort. The Internal Reviewer has notified the Quality Assurance Leadership Team that this matter will be investigated. Considerations in the use of a uniform evaluation tool are as follows: (a) establishing the parameters of the Department's service spectrum, (b) identifying current practices in evaluation across each of the service areas, (c) determining informational needs from the different evaluative practices, (d) ascertaining the degree of overlap in these information needs across the service spectrum, and (e) determination of feasibility of a uniform evaluation tool.

While the ECs examined here are about evaluation tools used to review the quality of plans developed in the provision of services to persons with disabilities, the Court's March 18, 2016 Order seems to seek information regarding a more direct measure – are individuals' lives being improved by the Department's efforts? The Department is currently involved in multiple survey development projects and data collection improvements that, when complete, should render data to that point. In the interim, the Department has collected a few examples of results of services for the Court's consideration:

One individual who had struggled for years with daily multiple aggressions towards others, self, property and the community began to embrace their Person Centered Plan approximately three years ago. As of now, the person has been aggression-free for over two years and is proud of this accomplishment. For the first time, they have non-paid people in their life. They are an active member at their church, participate in social groups, and even shared their life story with community peers. They have been on vacation trips without MSOCS staff. They are a role model and mentor to their housemates. They are an active participant in MSOCS monthly activities, helping to prepare and support other peers during the activities. They are known in the community and greeted by name when out and about. They coordinate their own team meetings, plan the location, invite people and conduct the gatherings. They have an email account and are included in all email communications with their team. This year, their Jarvis order was discontinued as they have been medication-compliant and target behavior-free, and the court found no reason to continue the order.

Another individual had recently moved to a new home from MLB and was getting acclimated to living with a new housemate. One day, the housemate became upset, and the person got caught up in the episode. The techniques the staff were trying to address the situation were not effective. The person said to the housemate and staff, "Why don't we do 'what's working and not working'?" calling on the person-centered thinking skill they had learned at MLB. This framework for the discussion generated a solution that worked, the situation was de-escalated, and the person was proud of how they helped their housemate in a time of need.

A third individual had been in corporate foster care with a provider who was certain that they had schizophrenia. Staff reported that the person was hearing voices and constantly fighting with roommates and was in danger of losing the placement. The person also was in a vocational program where the main work room was crowded and noisy. After completing an evaluation, the SLP Behavior Analyst uncovered that the person, although diagnosed with major hearing loss, had become expert at reading lips and would often misperceive that they were being attacked. Additionally, the person reported that the noise in the workroom at the vocational placement was agitating them, and they were experiencing the same issues of misreading a situation, taking things personally, and getting into altercations with peers and staff. The SLP Behavior Analyst learned of a program designed especially for individuals with hearing loss. The person toured the house and became excited to move to the new program. The person moved in January 2016 and is thriving. Additionally, this placement is not corporate foster care, rather it is an independent housing option designed to promote independent living skills. The person is currently working a program to move into their own apartment someday. They have also gotten into a vocational program for the deaf and hard of hearing and continue to succeed and learn new job skills.

Response to Court Monitor's May 11, 2016 Report to the Court

In addition to the verification activities assigned to the Department, the Court's March 18, 2016, Order also directed the Court Monitor to perform verification regarding the information in the Ninth Compliance Update Report on mobile teams under EC 93 and the Successful Life Project (SLP) under EC 98, as well as evaluate the results of the SLP. The Court Monitor's Report to the Court (Doc. No. 565), filed on May 11, 2016, is troubling in many respects, including misinformation, unsupported conclusions, and exceeding the scope of the Court's Order. The Department responds below:

Finding 1: The Gap Report for EC 93 and 98 is not based on DHS internal verification of the underlying source information.

As described in the Ninth Compliance Update Report, on February 9, 2016, the *Jensen* Implementation Office underwent a shift in focus. Up to this point, the office functioned mainly to coordinate and report efforts to comply with the Jensen Settlement Agreement and the Comprehensive Plan of Action. In that role, the *Jensen* Implementation Office relied on the program areas and reporters to verify the information provided. As was done with the Ninth Compliance Update Report, reporters accordingly signed affidavits attesting to those efforts. In this way, the Ninth Compliance Update Report is, contrary to the Court Monitor's conclusion, based on DHS internal verification of the underlying source information.

The recent shift in focus of the office, which accompanies a name change to the Jensen/Olmstead Quality Assurance and Compliance Office (JOQACO), will result in a dual-

verification process where the office will also verify information provided to it during future reporting periods. This process will provide an overall more robust program of Department internal oversight. Going forward, upon receiving reports from program areas, JOQACO will re-verify the information by examining source data. As reported in the 2015 Annual Report (Doc. No. 553-1) filed with the Court on March 31, 2016, the office has already started this practice. JOQACO is also now engaged in a Department-Wide Quality Assurance Plan, expanded Internal Reviewer responsibilities, development of a pool of independent Subject Matter Experts who can be called upon for verification or technical assistance, and increased internal data analysis. These efforts will be detailed in future reports, with particular attention paid to the direction regarding verification included in the Court's March 18, 2016, Order.

Finding 2: DHS does not provide Mobile Teams as required by EC 93 and, during the Gap Report period, failed to implement planned Mobile Teams with allocated funds.

The Department disagrees with the Court Monitor's assertion that the Department does not provide mobile support teams as required by EC 93. As stated in the Ninth Compliance Update Report, the Department does provide "mobile teams," although the Department is not yet augmenting private staff as envisioned in the Department's Bulletin #14-76-01, *Transition of Minnesota Specialty Health System (MSHS) – Cambridge to Minnesota Life Bridge: Admission and Discharge Processes, Transition Planning and Community Mobile Support Services*, issued April 29, 2014. (Doc. No. 531 at 61.) In the Ninth Compliance Update Report, the Department listed examples of mobile supports provided by MLB and CSS staff, which comports with the statement in the Bulletin, "The Program...offers mobile support services to serve individuals in their current setting. […] These services will be provided in collaboration with the Community Support Services and other crisis services."

The Court Monitor does not contend that the Department failed to provide the types of services listed in the Ninth Compliance Update Report; instead, the Court Monitor contends that the form in which these services were provided does not meet the definition of "mobile teams."[2] The Court Monitor does not actually provide the definition against which he is measuring the Department's compliance with EC 93, and is unable to point to a definition of "mobile teams" anywhere within the JSA, the CPA, Department Bulletin #14-76-01 or this Court's Orders.

[2] In doing so, the Court Monitor exceeds the scope of the duties he was assigned by the Court's Order. The Court Monitor was specifically instructed to "verify that efforts reported with respect to mobile teams are accurate and complete" and to "verify whether the data relied upon by Defendants with respect to the deployment of mobile teams is reliable and valid." (Doc. No. 551 at 20.) Instead of determining whether the Department in fact provided the services it reported in the Ninth Compliance Update Report or evaluating the validity and reliability of the data that the Department relied upon, the Court Monitor engages in a lengthy critique of the form in which services were delivered that was neither requested by the Court's Order nor warranted by what the Department reported for EC 93.

By its plain meaning, "team" simply refers to "a group of people who work together," or "a number of persons associated together in work or activity."[3] The fact that the Department did not have separate, distinct, defined groups of staff providing mobile supports during the reporting period was acknowledged in the Ninth Compliance Update Report, but this does not mean that the Department failed to provide mobile supports while working in a team environment. The Department provided mobile team supports within the plain meaning of "team" when MLB and/or CSS staff coordinated efforts with each other, as well as with case managers and other external parties, to provide supports to people in their current setting.

The Department also objects to the Court Monitor's broad and unsupported assertion that "DHS officials agree that the DHS does not provide mobile teams." The Court Monitor apparently bases this statement on the idea that MLB contemplated hiring dedicated mobile team staff, but has not yet done so. However, the Court Monitor's assertion is misguided. First, the mere fact that MLB explored an alternative means of providing mobile team services does not negate the services that were provided during the reporting period. Second, the Court Monitor relies on misstated facts and speculative statements. For example, the Court Monitor states, "Despite this go-ahead, MLB has not been permitted to establish mobile teams." The Court Monitor cites no evidence to support his statement that MLB had a "go-ahead" to proceed beyond the planning stage with hiring the proposed positions. As explained in the Ninth Compliance Update Report, the creation of distinct, separate teams raised legal concerns that were not resolved during the reporting period: "There are also potential legal concerns that the Department needs to explore, including liability within another provider's site." (Doc. No. 531 at 61.) The Court Monitor also states, "No documentation has been provided for dropping the mobile team project in the documents or e-mails provided by DHS (DHS represented that it was providing all mobile team information)." But the Department was not asked to and did not represent that it provided *all* information relating to mobile teams. The Court Monitor requested documents that would verify specific statements in the Ninth Compliance Update Report, which the Department provided.

Additionally, it should be noted that the Court Monitor overstated or misstated various aspects of the report of Manfred Tatzmann, *Report on DSD Crisis Improvement Project* (2015). For example, the Court Monitor stated, "During the Gap Report period, DHS commissioned a *substantial* analysis of the *crisis* it was facing." (Emphasis added.) But there is no indication that the Tatzmann report was commissioned in response to a "crisis" in the Department; instead, the report states that the author was contracted "to conduct research and gather data to *identify innovative approaches* for creating physical capacity to serve the immediate crisis needs and ongoing long-term needs of individuals in the target population . . . ." *Id.* at 4 (emphasis added). The author also noted that this report was "not intended to be a thorough analysis of DHS's community crisis residential programs, operations, or alternatives available elsewhere." *Id.* at 3. It is difficult to understand how commissioning a report to help identify innovative models of

[3] Merriam-Webster Dictionary (online), *available at* http://www.merriam-webster.com/dictionary/team.

service delivery somehow invalidates the mobile team supports that the Department provided during the reporting period.

Finding 3: DHS' Gap Report information on EC 93 is not accurate; very few mobile supports were provided

The Department disagrees with the Court Monitor's assertion that very few mobile supports were provided. The Court Monitor reviewed 17 deployments of mobile supports which were initiated during the reporting period. It should be noted that these 17 deployments do not encompass all mobile support activities during the period, just the agreed-upon sample of those that were *initiated* during the period. Next, the Court Monitor discounted all but four of the 17 deployments, stating they were not mobile supports. It appears that the Court Monitor discounted the other 13 deployments because he did not consider them to be "crisis situations."

There is no indication in EC 93 that these mobile supports are intended to be limited to crisis situations. EC 93 comes under a section of the CPA about closing the Cambridge facility and replacing it with community homes and services, and details supports to be provided to those community homes and services. While the Court's March 18, 2016, Order directed the Court Monitor to look at "the deployment of mobile teams in response to crisis situations" (Doc. No. 551 at 20), mobile supports can be useful in a variety of circumstances and the Department strives to make them available in the most appropriate and effective ways possible. In particular, the Department seeks to provide supports, mobile or otherwise, that prevent a crisis from occurring rather than waiting until a crisis arises to provide assistance. Accordingly, while some portion of the 17 deployments reviewed by the Court Monitor may not rise to his idea of a crisis, they were important and useful supports and should not be discounted as a sample of the mobile supports provided during the reporting period and reported in the Ninth Compliance Update Report.

Additionally, while claiming that "[t]he evidence is that mobile supports are essentially not present," the Court Monitor fails to identify a single situation where a lack of supports resulted in a negative outcome for an individual or where a crisis situation was not addressed. If anything, the Court Monitor's finding seems to indicate that the Department is providing services beyond what is required by EC 93.

Finding 4: Mobile supports were not utilized to prevent residential admission of any individuals during the report period.

The Department disagrees with the Court Monitor's assertion that mobile supports were not utilized to prevent residential admissions of any individuals. As the Court Monitor states, seven of 11 people who were referred for admission to MLB during the reporting period were determined to be eligible for services. Four of the seven eligible persons were in either a hospital or jail at the time of the referral. For those people, mobile supports were not appropriate. Notably, one of the remaining three persons was, with the assistance and support of SLP, able to

remain in their community foster care home with the support of their private provider. Accordingly, the Court Monitor's finding that mobile supports were not utilized to prevent residential admission of any individuals is not supported by the data or by the Court Monitor's analysis.

Finding 5: Slow movement of individuals through the "temporary" MLB successor facilities is impeding timely provision of services to those eligible for MLB.

The Department disagrees with the Court Monitor's assertion that timely provision of MLB services is being impeded. First, this finding is inaccurate. During the reporting period, three of the seven eligible persons were placed on a wait list.[4] By the end of the reporting period, only one person remained on the wait list. Second, this finding exceeds the scope of the duties the Court assigned to the Court Monitor with respect to EC 93. The Court Monitor was specifically instructed to "verify that efforts reported with respect to mobile teams are accurate and complete" and to "verify whether the data relied upon by Defendants with respect to the deployment of mobile teams is reliable and valid." (Doc. No. 551 at 20.) This finding has no bearing on whether the efforts that the Department reported regarding mobile teams are accurate and complete or whether the data relied upon by the Department with respect to mobile teams is reliable and valid.

The Department further disagrees with the Court Monitor's assertion, "The MLB bottleneck exacerbates the need for crisis services, including mobile teams. The absence of mobile teams (and of mobile supports) is therefore likely to lead to the unnecessary institutionalization of people in the community who are in crisis." The first problem with this assertion is that it inaccurately presumes that the Department is not providing mobile team supports. As stated above, the Department does provide mobile team supports to persons in crisis, and to persons before they are in crisis. Second, as also noted above, a number of the referrals to MLB come from hospital and jail settings, rendering mobile supports not appropriate. The idea that a lack of mobile teams or mobile supports will lead to unnecessary institutionalization in these instances is pure speculation, and the Court Monitor has referenced no evidence that such institutionalizations have actually occurred because of an "absence" of mobile supports.

[4] If admission to MLB is not immediately available for persons found eligible for services, the person's situation is reviewed weekly by a cross-departmental team that includes participants from MLB, Central Pre-Admission, MSOCS, CSS, and DSD Community Support Team. This cross-departmental team evaluates the status of the person and determines what options may meet the person's needs until services are provided.

Finding 6: SLP-wide data raises concerns regarding SLP's success in achieving its goals.

The Department disagrees with the Court Monitor's assertion that the data raises concerns regarding SLP's success in achieving its goals. As noted, there are 343 SLP members. The Court Monitor chose to include in his sample 18 individuals selected at random from the Priority List (the 43 individuals most in need of support) plus various numbers of individuals from other categories of SLP members, largely defined by living situation. The Court Monitor included in his sample *all* SLP members: people in jail, in the Minnesota Sex Offender Program, in a hospital, in a skilled nursing facility, in an intermediate care facility, or at MLB. This group encompassed all SLP members at the Minnesota Security Hospital (MSH).[5] The Court Monitor also separately requested and received a list of all SLP member admissions to MSH and Anoka Metro Regional Treatment Center (AMRTC) since the initiation of SLP.

The Court Monitor highlights the numbers of admissions to MSH and AMRTC, as well as noting that 55 SLP members had no change in residence while a few made moves to various settings, including five people who moved to less restrictive settings. The Court Monitor then makes an unsupported leap of logic to say these data points "raise concerns regarding SLP's success in achieving its goals."

By including the entire population of SLP members at MSH in the sample, the Court Monitor ensured that the most challenging situations would be included in his review. The Department did not dispute that there would be value in reviewing those cases. However, a general overview of the program and its success cannot be extrapolated from such a sample. For example, the Court Monitor states, "[f]rom the SLP sample, there are six SLP members currently at MSH…" implying that there must be a statistical equivalent in the remainder of the SLP group. However, the six SLP members at MSH in the SLP sample are, in fact, *all* of the SLP members at MSH. They were all in the sample because the Court Monitor specifically chose to include them, not because they are statistically representative of the entire population of SLP members.[6] Due to the sample chosen, no meaningful conclusions can be drawn from the sample regarding SLP's overall success in achieving its goals.

Additionally, with respect to the 55 individuals for whom there was no change of residence, it is impossible to draw any conclusions without additional information regarding the quality of those residences. To say that such data raises concerns ignores the possibility that this is a reflection of positive stability.

As noted in the Ninth Compliance Update Report, since its formation in the fall of 2014, SLP has had considerable success in achieving its goals. It has moved through Phase 1, making

[5] This group also would have encompassed any SLP members at AMRTC, but there are no SLP members currently at AMRTC.

[6] It should also be noted that these six individuals are at MSH due to co-occurring bases, as contemplated by the *Jensen* Settlement Agreement. The Court Monitor provides no context about why these individuals were admitted to or continue to reside at MSH, making it impossible to reach any conclusion about SLP's effectiveness.

contact with the majority of class members and former residents of the Cambridge facility for the purposes of initial evaluation of health and safety. It established the Priority List of individuals deemed at risk of losing their housing or in need of immediate follow up for clinical or other reasons related to their living conditions, supports, or services. It has gained staff in various regions of the state to support individuals and their teams, and a nurse to perform desk medical reviews and make associated health, nutrition, and medication recommendations.

Work has now moved on to Phase 2, including a comprehensive program assessment known as the Positive Behavior Support Comprehensive Evaluation Tool (PBS CET), functional behavior assessment, and associated recommendations for behavioral supports, person-centered practices, and quality of life enhancement. The SLP team has developed formal processes and protocols as a group of experts in Positive Behavior Support focused on building the capacity of teams who request assistance to improve their support of individuals with complex needs. This work includes significant effort to communicate available services to providers, lead agencies, guardians, and advocates. As productive working partnerships are developed, a primary indicator of SLP success has been the number of recommendations from the functional behavior assessments and PBS CETs that teams have chosen to adopt.

Finding 7: SLP is not sufficiently mature or ready for review of its outcomes or of success in meeting the court-ordered goals.

The Department disagrees with the Court Monitor's assertion that SLP is not sufficiently mature or ready for review. It is difficult to understand how the Court Monitor can make such a conclusion when he provides no evidence that SLP's outcomes were unreviewable or that the services provided by SLP were deficient. To the contrary, in later findings, the Court Monitor recognizes that SLP Behavior Analyst staff "demonstrate much activity and concern for the individuals they serve" and that the SLP nurse "is an outstanding positive resource for SLP and does excellent, thorough work." Nowhere does the Court Monitor provide evidence that SLP is not appropriately tracking members, prioritizing and providing services, and making progress toward the stated goals of preventing re-institutionalization and other transfers to more restrictive settings, and maintaining the most integrated setting.

Instead, the Court Monitor relies on a handful of isolated statements that are presented without context. For example, the Court Monitor relies on the fact that the Department did not claim compliance for EC 98 in the Ninth Compliance Update Report. But the fact that the Department does not yet deem EC 98 fully completed does not mean that SLP is "not sufficiently mature or ready for review." The Court Monitor's reliance on a statement made in a spreadsheet created and maintained by Dr. Tim Moore for internal program use is similarly flawed. The Court Monitor emphasizes that Dr. Moore "rates compliance with EC 98 as 'Incomplete' and projects a deadline of November 30, 2016, extended from the earlier August 31, 2014." But the Court Monitor fails to note the six out of eight "actions" listed in that spreadsheet and designated "complete," and that the status updates for the two actions listed "incomplete" indicate significant progress toward completion. The Court Monitor further relies on SLP Operational

Meeting minutes that are seven and eight months old to support his claim that "*[a]s of this report*, SLP's processes and staff responsibilities are not yet fully defined or operationalized" (emphasis added). These isolated statements serve only to show that SLP continues to assess and refine its operations and that, contrary to the Court Monitor's claim, SLP has "begun to consider how to assess its own outcome results."

An additional key indicator of success, and the purpose of SLP as described in EC 98, is keeping individuals from losing their homes and entering restrictive placements. Of the 68 individuals who have been on the Priority List, only four have entered a more restrictive placement (including hospitalization longer than a 72-hour hold) while receiving SLP services.[7]

Finding 8: It is impossible to determine at this point whether or when the gaps and deficiencies will be addressed and overcome, or whether the late 2016 self-identified compliance deadline for the critical EC 98 will be met.

The Department disagrees with this assertion of the Court Monitor, which is entirely unsupported by his analysis. First, the Court Monitor does not identify "the gaps and deficiencies" he refers to and does not explain how the administrative changes referenced will prevent the Department from overcoming these unspecified gaps and deficiencies. For example, the Court Monitor suggests that the new internal structure the Department developed to oversee compliance with the *Jensen* Settlement Agreement is a barrier to compliance with EC 98, but provides no explanation. It is difficult to understand how compliance with EC 98 will be hindered by the organizational changes that moved SLP under JOQACO and shifted the focus of JOQACO to compliance monitoring and measurement. As the Court itself recognized, the Department's new internal structure to oversee compliance with the JSA has the potential to "improve DHS's compliance efforts and ultimately improve the lives of individuals with disabilities throughout the state." The Court Monitor also states that "[t]he new Commissioner made changes," but does not identify these changes, nor explain how such changes show anything other than a responsiveness to the circumstances.

Second, the Court Monitor's analysis contains inaccurate statements. For example, the Court Monitor states that, during the reporting period, "top leadership left the organization (Anne Barry, Direct Care and Treatment, and Steve Jensen, MLB)." Anne Barry did not leave the organization; she continues to serve the Department as an Assistant Commissioner and the Court Monitor provides no evidence that a "void" was created when she transitioned from Deputy to Assistant Commissioner. The Court Monitor also states, "During the chaos, DHS obtained at least two outside management consultation evaluations on what it considered to be a crisis." But these two reports make no reference to an internal "crisis" or "chaos" at the Department. Instead, the reports state that the authors were contracted "to conduct research and gather data to identify innovative approaches for creating physical capacity to serve the immediate crisis needs

[7] This does not include one demission in which the provider chose not to initiate services with SLP despite multiple attempts, and one individual currently admitted to a behavioral health hospital for treatment but not demitted from his/her home.

and ongoing long-term needs of individuals in the target population," Manfred Tatzmann, *Report on DSD Crisis Improvement Project*, at 4 (2015), and to help Community Based Services "assess the most effective organization structure to serve their client's needs," Management & Analysis Development, *Department of Human Services, Community Based Services Organization Design*, at 2 (2015). If anything, these reports demonstrate the ongoing efforts of the Department to continue to refine its services and to most effectively meet the needs of Minnesotans and its obligations under the JSA.

Lastly, the "self-identified compliance deadline" the Court Monitor references was taken from a spreadsheet maintained by SLP for its own internal use. A program area's internal goal does not create a binding obligation on the Department.

Finding 9: SLP has insufficient authority to secure cooperation from others to further its court-ordered goals.

The Department disagrees with the premise of this finding. The Court Monitor states, "although the CPA empowers the Department to act effectively with regard to obtain *[sic]* cooperation from counties and providers, the SLP sees itself as able merely to offer recommendations and assistance, which counties and providers may freely reject." Contrary to the Court Monitor's assertion, the CPA does not "empower" the Department to do anything above and beyond what is allowed by statute. SLP operates as a supportive service. It has worked hard to develop positive working relationships with counties, providers and support teams in which teaching and learning can occur. This culture is an important aspect of the program and serves the principles of person-centeredness, as well. As noted above, a lead indicator of the success of the program is the frequency with which teams have adopted the recommendations of SLP.

The Court Monitor cites a few examples in which SLP staff encountered hesitation or a lack of responsiveness from a provider, team, or case manager, but provides no evidence that SLP "merely . . . offer[ed]" recommendations or assistance in these situations and did not ultimately secure cooperation. SLP provides many more examples of successful collaboration with counties, providers and support teams which have resulted in improvement to the lives of persons with disabilities (*e.g.*, pages 31-32).

Finding 10: The SLP "full assessment," which is key to a EC 98 goal, is many months behind schedule.

The Court Monitor inexplicably and erroneously claims that the Ninth Compliance Update Report "inaccurately states that the second phase began March 16, 2015." This statement in the Ninth Compliance Update Report is, in fact, accurate. While the first individual's full assessment was not completed until June 18, 2015, Phase 2 was initiated on March 16, 2015. This error is perhaps an indication that the Court Monitor fails to understand the complexity of the full assessment and the time it takes to complete one.

The implementation of Phase 2, which includes the full assessment of SLP members, is taking longer than anticipated. The timeline set out in the SLP Bulletin, a Department goal and not a CPA obligation, turned out to be an unrealistic one.

The full assessment of Phase 2 is a lengthy process. First, SLP needs to obtain signed consent forms from each SLP member and/or their legal representative and schedule informational meetings. Only then can the assessment begin. Completion of an assessment usually requires about three to five visits, once or twice a week, to the residence to build rapport with the person and the team and to observe what is working and what is not working. It then takes approximately eight hours to review available reports and evaluations. Writing and editing the report with the team can take a few days to a few weeks, depending upon schedules.

Contrary to the Court Monitor's report that 10 assessments were completed during the reporting period, SLP records (provided to the Court Monitor) show that 11 persons completed full assessments during that time. Five of these 11 SLP members also had a Functional Behavioral Assessment completed.[8] Completion of the Functional Behavioral Assessment can take an additional one to two months. The amount of time required is largely dependent on the ability of the facility staff to gather data needed to complete the assessment..

As noted by the Court Monitor in another finding, the SLP BCBAs do much able work. Based on the experience they have gained with the tool, staff continue to revise the assessment tool and are identifying ways to decrease the time needed to complete a full assessment.

Finding 13: The Gap Report's statement regarding discovery of two previously unlocated people is not accurate.

The Department agrees that the following statement in the Ninth Compliance Update Report is not accurate in that the events described actually occurred before the reporting period: "During this reporting period, the Office of Special Investigations was able to locate two people; Successful Life Project has contacted both these people and have completed their assessments . . ." (Doc. No. 531 at 64.) The Department informed the Court Monitor of this inadvertent error and stated that it would inform the Court about the error in the Department's May 31 report. The documents provided to the Court Monitor, however, do confirm that the two individuals referenced in the Ninth Compliance Update Report were unable to be located, were located and completed assessments in late 2014, and have subsequently been unable to be reached or located. This misstatement in the Ninth Compliance Update Report was due to an unintentional error in reporting from the program, something which the new JOQACO focus on verification activities should prevent from reoccurring in the future.

The Court Monitor states that the two individuals "though considered off the map by SLP, were never 'unlocated,' " but fails to distinguish how "off the map" is different from "unlocated." Contrary to the Court Monitor's implication that SLP failed to provide requested

[8] Some of these Functional Behavioral Assessments were completed outside the reporting period.

services to these individuals, the documentation provided to the Court Monitor indicates that one individual has not been able to be reached since s/he completed his/her initial assessment and that the other individual stated s/he was not interested in returning to Minnesota or receiving services.

Finding 14: The Gap Report's other factual representations are generally accurate with several major exceptions.

The Department agrees with the Court Monitor's assertion that the other factual representations are generally accurate, but disagrees with the claim that there are "several major exceptions."

For example, with respect to Phase 2 of SLP, the Court Monitor erroneously equates the date that the first full assessment was complete with the date that Phase 2 was initiated, fails to appreciate the lengthy and complex process to complete a full assessment, and instead incorrectly concludes that the information in the Ninth Compliance Update Report is "incomplete and misleading." The Court Monitor also incorrectly states the number of full assessments completed during the reporting period (as described above).

Additionally, with respect to the section of the Ninth Compliance Update Report regarding E1, while verified as accurate, the Court Monitor seems to take issue with the fact that some of the reported events took place outside of the reporting period. The Department included this information, clearly noted as to timing, due to the particular interest the Court has expressed in this situation, to provide context to the update. The Court Monitor goes on to note that the information is "incomplete and misleading" with no indication of what is missing or confusing. The Department stands by its report.

Court Monitor's Review Methodology and Cost

The methodology the Court Monitor used to conduct his review was unnecessarily lengthy and costly. On April 5, 2016, Dr. Colleen Wieck sent an email to the Court Monitor on behalf of herself and Ms. Roberta Opheim detailing an appropriate sampling strategy and suggesting an efficient way to review and verify what was stated in the Ninth Compliance Update Report relating to ECs 93 and 98. (See Exhibit A.) In a letter dated April 5, 2016, the Court Monitor responded by, in essence, dismissing Dr. Wieck and Ms. Opheim's suggested methodology. (See Exhibit B.) Had the Court Monitor used the methodology suggested by Dr. Wieck and Ms. Opheim, the Court Monitor's review could have been accomplished in a much shorter time frame and, consequently, would have been less costly. The Court Monitor's methodology was not the most cost effective way of accomplishing the Court's objectives.

Additionally, the Department finds itself in a familiar place, that of having to pay for and respond to a report to the Court that is filled with inaccurate and misleading information. The Department has in the past paid the Court Monitor tens of thousands of taxpayer dollars for

reports shown by the Department's responses to be inaccurate and without support. As but one example, the Court Monitor spent numerous hours conducting interviews, reviewing documents, and contacting a number of Department staff as a basis for a report issued on April 14, 2015, entitled "Report to the Court: Verification of Representations by the State" (Report) (Doc. No. 414) in which the Court Monitor erroneously concluded that the Department made inaccurate and unverifiable statements in its compliance report to the Court. In a response dated October 30, 2014 (Doc. No. 429), the Department demonstrated that the Report was filled with inaccurate findings and conclusions for which the Department had to pay thousands of dollars. (Doc. Nos. 436, 436-1). The current report is no different and now, the Department must pay over $20,000 to the Court Monitor for another inaccurate and unsupported report.

Despite its many deficiencies, the Court Monitor uses his report to conclude that the Department does not demonstrate sufficient internal verification mechanisms. The Department disagrees. The Department has made great strides towards satisfaction of the JSA and the CPA, and continues to implement and improve processes of service provision and of internal oversight, both in pursuit of compliance with the JSA and beyond.

Correcting Misconceptions

The Court concludes its March 18, 2016, Order by noting that there continue to be misconceptions in the public about the purpose and intent of the JSA or Minnesota's Olmstead Plan, and urging the Department to address them. The Department has tackled this task on several fronts and will continue to provide information and education whenever and wherever possible.

To better understand and target the misconceptions, the Department has reviewed correspondence to the Court, queried front-line staff, and inquired of the Court's Consultants. The Department has included a reminder of the principles of the JSA and the Olmstead Plan in internal meetings. Several bulletins and FAQs have recently been issued and more are in progress to elaborate on and explain various facets of the JSA and the Olmstead Plan. Technical assistance is provided from multiple sources in the Department to providers, case managers, and teams. Department staff frequently give presentations to the public on the JSA and related topics such as person-centered planning and positive supports.

Through the Department's efforts to better understand public perceptions, the Department has observed that the identified misconceptions tend to relate most closely to the Olmstead Plan or to system changes mistakenly attributed to the Olmstead Plan. The Department and the Olmstead Implementation Office (OIO) are part of a joint communications group that focuses on misconceptions about the *Olmstead* Plan. This communications group is working with a focus group of families and providers to better understand areas of concern and how the Department and OIO communications can more effectively address these concerns; the long-term goal is for this focus group to serve as an ongoing committee. The joint communications group has

produced written materials and slide shows to educate the public about the Olmstead Plan, including an Olmstead overview document that has been revised to use more plain language, informational pages explaining how mental health services are impacted by Olmstead, and an overview document of Olmstead activities in 2016. Other communications efforts include responding to letters by providers and families to explain what Olmstead is and is not; presenting to stakeholders, including providers and parent/advocacy groups; providing trainings and technical assistance to counties about the Person-Centered Planning, Informed Choice and Transitions Protocol; participating in learning communities and communities of practice relating to person-centered approaches, person-centered planning, and positive supports; and holding forums and webinars to explain the federal Home and Community-Based Services rule, which is driving systems changes that members of the public mistakenly attribute to the Olmstead Plan. This group intends to take additional steps to address the concerns of the public, such as holding community meetings, updating the Olmstead website with the new materials, and launching an e-mail update newsletter to facilitate ongoing communications.

The Department remains committed to the JSA and improving lives of Minnesotans with disabilities. The efforts detailed in this report demonstrate that changes implemented at the Department are improving the provision of services and facilitating the Department's own compliance evaluation. These measures will ensure that the Department makes a real and positive impact on the lives of individuals with disabilities now and into the future.