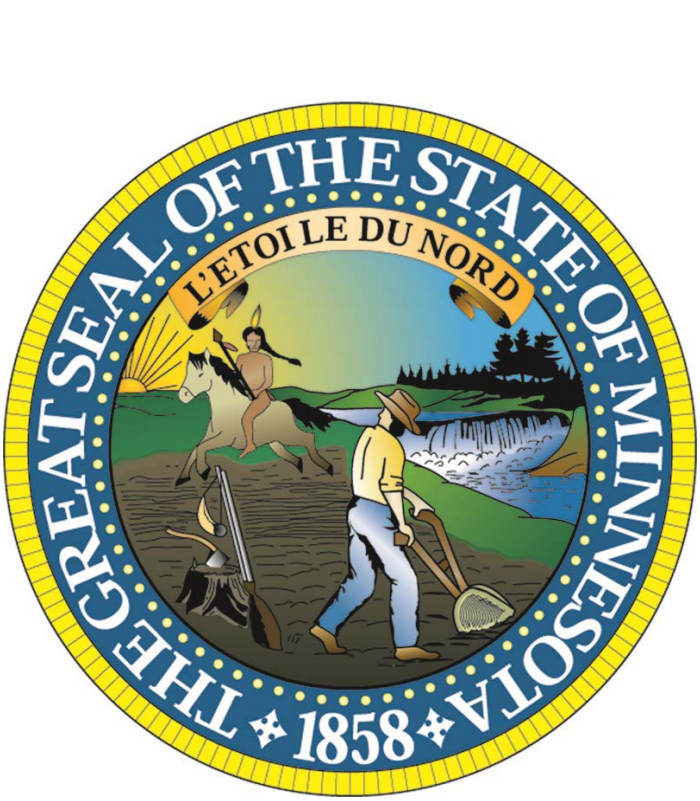
Putting the Promise of *Olmstead* into Practice: Minnesota's Olmstead Plan



August 10, 2015 Revision

Feedback

The Olmstead Subcabinet welcomes feedback to inform the implementation of Minnesota's Olmstead Plan. There are several ways to provide your comments and thoughts:

Method	**Steps to follow**
Online	1. Go to: Mn.gov/Olmstead 2. Click "Participate" and follow instructions for the online form
In an Email	Send an email to this address: MNOlmsteadPlan@state.mn.us
In the Mail	Send a letter to: Olmstead Implementation Office 400 Sibley Street, Suite 300 St. Paul, MN 55101
On the Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail. 651-296-8081

Contents

INTRODUCTION AND BACKGROUND INFORMATION 8
Introduction 9
Background Information 9
Olmstead v. L.C. 9
Federal enforcement and guidance related to the *Olmstead* decision 10
Why does Minnesota have an Olmstead Plan? 11
Developing Minnesota's Olmstead Plan 11
Olmstead Subcabinet vision statement 12
Demographics & implications 12
Public comments 13
The August 2015 Plan 16
MEASURABLE GOALS 18
Topic Areas and Measurable Goals 19
Measurable goals 20
Format of topic areas 21
Measurable Goals at a Glance 22
Person-Centered Planning 32
What this topic means 32
Vision statement 34
What we have achieved 34
Measurable goals 35
Transition Services 38
What this topic means 38
Vision statement 39
What we have achieved 39
Measurable goals 39
Housing and Services 44
What this topic means 44
Vision statement 44
What we have achieved 44
Measurable goals 45

Employment....48
What this topic means....48
Vision statement....49
What we have achieved....49
Measurable goals....50
Lifelong Learning and Education....54
What this topic means....54
Vision statement....54
What we have achieved....55
Measurable goals....55
Waiting List....58
What this topic means....58
Vision statement....58
What we have achieved....59
Measurable goals....59
Transportation....64
What this topic means....64
Vision statement....64
What we have achieved....64
Measurable goals....65
Healthcare and Healthy Living....70
What this topic means....70
Vision statement....71
What we have achieved....71
Measurable goals....71
Positive Supports....74
What this topic means....74
Vision Statement....75
What we have achieved....76
Measurable goals....76
Crisis Services....82
What this topic means....82
Vison statement....82

What we have achieved 82
Measurable goals 83
Community Engagement 88
What this topic means 88
Vision statement 88
What we have achieved 88
Measurable goals 89
Topic areas under development 92
Assistive Technology 92
Preventing Abuse and Neglect 92
PLAN MANAGEMENT AND OVERSIGHT 94
Plan Management and Oversight 95
Olmstead Subcabinet and Olmstead Implementation Office 95
Quality assurance and accountability 95
Quality of Life survey 96
Dispute resolution oversight 97
Updating and Extending the Olmstead Plan 97
Communications and public relations 98
Cross-agency coordination of data strategies 98
Cross-agency coordination of legislative and funding strategies 99
Definitions of key terms 102
Common Acronyms 108
APPENDICES 110
Appendix A – Governor's Executive Orders Related to Olmstead 112
Appendix B – Sample Workplan 122
Appendix C – Index of Documents Related to Olmstead Plan Implementation 132

Minnesota Olmstead Subcabinet

August 10, 2015

To the People of Minnesota,

On behalf of the Olmstead Subcabinet, I am pleased to present this new Olmstead Plan for the State of Minnesota. The title of the Plan – *Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan* – speaks to our intentions and our commitment.

We are firmly committed to building a future where people with disabilities experience lives of inclusion and integration in the community – just like people without disabilities. We envision a Minnesota where people with disabilities have the opportunity to live close to their families and friends and as independently as possible, to work in competitive, integrated employment, to be educated in integrated schools and to participate fully in community life.

This Plan is about choice, not about closure. The goals in this Plan will pave the way for Minnesotans with disabilities to express their preferences for how they choose to live, learn, work and engage in community life, while receiving the supports they need. The goals are also focused on increasing the options available for people with disabilities when they express those choices.

We intend this Plan to be both a proclamation of our commitment to integration and inclusion and a vital, dynamic roadmap for making our vision a reality. Because we will learn by implementing the Plan, it cannot be a static document. We expect that people with disabilities and their families will tell us what is working – and what is not working – when it comes to improving the quality of their lives. We will ask and we will listen, and we have proposed how we will amend this Plan in the future to improve the outcomes of our actions. We see this as a starting point – not a final destination.

Thank you to the people with disabilities that helped us to be bold in the commitments we make in this Plan. Thank you to the staff of our agencies who have worked to create ambitious, but realistic goals. Thank you to the thousands of people around the state who will work together on the many actions that it will take to bring reality closer to the vision statements expressed in this Plan for more people with disabilities.

Mary Tingerthal, Chair
Olmstead Subcabinet

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INTRODUCTION AND BACKGROUND INFORMATION

Introduction

The State of Minnesota is firmly committed to ensuring that people with disabilities experience lives of inclusion and integration in the community, just like the lives of people without disabilities. We envision a Minnesota where people with disabilities have the opportunity, both now and in the future, to live close to their families and friends and as independently as possible, to work in competitive, integrated employment, to be educated in integrated settings, and to participate in community life.

This *Olmstead* Plan is a groundbreaking, comprehensive plan to provide people with disabilities opportunities to live, learn, work, and enjoy life in integrated settings. We intend this Plan to be both a resounding proclamation of our commitment to inclusion and a vital, dynamic roadmap to making our vision a reality for present and future generations of Minnesotans.

Background Information

An Olmstead Plan is a "public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings."[1] It is named after a United States Supreme Court decision called "*Olmstead v. L.C.*"[2]

Olmstead v. L.C. arose out of the Americans with Disabilities Act (ADA), a landmark piece of legislation which Congress enacted in 1990. Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[3] With those words, Congress equated segregation with discrimination, and, in Title II of the Act, prohibited public entities from discriminating against individuals with disabilities.[4] Regulations implementing Title II require public entities to provide services in the *most integrated* setting appropriate to the needs of qualified individuals with disabilities.[5] Congress has explained that "the most integrated setting" means one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible…"[6] This regulation is known as "the integration mandate."

Olmstead v. L.C.

In 1999, the United States Supreme Court held that the unjustified segregation of people with disabilities violates Title II of the ADA.[7] *Olmstead v. L.C.* involved two women with disabilities who were confined in an institution even though health professionals determined they were ready to move into a community-based program. The Court held that the ADA's integration mandate requires public entities to provide community-based services to persons with disabilities when:

a) Such services are appropriate;
b) The affected individuals do not oppose community-based treatment; and

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[1] "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.,"* U.S. Department of Justice, Civil Rights Division, June 22, 2011, Question 12, p. 4 ("DOJ Statement"), last accessed August 6, 2015, http://www.ada.gov/olmstead/q&a_olmstead.htm.
[2] *Olmstead v. L.C.,* 527 U.S. 581 (1999).
[3] "DOJ Statement, p. 1, *citing* 42 U.S.C. §12101(a)(2).
[4] 42 U.S.C. §12132.
[5] 28 C.F.$. §35.130(d).
[66] 28 C.F.R. Pt. 35, App. A (2010)(addressing §35.130).
[7] *Olmstead v. L.C.,* 527 U.S. 581 (1999).

c) Community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving disability services from the public entity.[8]

To comply with the integration mandate, public entities must reasonably modify their policies, procedures or practices to avoid discrimination.[9] In *Olmstead v. L.C.*, the Supreme Court stated that a State could meet this reasonable-modifications standard if it has a comprehensive, effectively working plan for placing people with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by endeavors to keep State institutions fully populated.[10]

The *Olmstead* decision is about more than how services are provided *by* the government *to* people with disabilities; it is a landmark civil rights case "heralded as the impetus to finally move individuals with disabilities out of the shadows, and to facilitate their full integration into the mainstream of American life."[11]

Likewise, Minnesota's Olmstead Plan is more than a government planning document about providing services. In its fruition, the Plan will facilitate opportunities for people with disabilities to live their lives fully included and integrated into their chosen communities.

Federal enforcement and guidance related to the *Olmstead* decision

Presidents Bill Clinton, George W. Bush, and Barack Obama acted to support the *Olmstead* decision through federal agency initiatives. In recent years, the Department of Justice (DOJ) has applied an expansive understanding of the *Olmstead* decision. As examples, the DOJ has taken action against government entities that had long waiting lists for community-based services, against programs that placed too much emphasis on segregated employment, and against governments that attempted to reduce funding for personal care services (which could force people into institutional settings).[12] The DOJ has also issued guidance for government entities to help them comply with the principles of the ADA and the *Olmstead* decision. Minnesota consulted this guidance in developing its Olmstead Plan.[13]

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[8] *Olmstead v. L.C.,* 527 U.S. at 607.

[9] 28 C.F.R. §35.130(b)(7).

[10] *Olmstead v. L.C.,*527 U.S. at 603.

[11] Perez, Thomas. *Assistant Attorney General Thomas E. Perez Testifies Before the U.S. Senate Committee on Health, Education, Labor and Pensions.* Washington, D.C. Thursday, June 21, 2012. Accessed August 30, 2013, http://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html.

[12] For a list of recent DOJ enforcement actions, review US DOJ, "Olmstead: Community Integration for Everyone." Accessed August 5, 2015, http://www.ada.gov/olmstead/olmstead_enforcement.htm.

[13] In particular, drafting teams consulted Question and Answer #12, *What is an Olmstead Plan?* In "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*" Accessed August 5, 2015, http://www.ada.gov/olmstead/q&a_olmstead.htm.

Why does Minnesota have an Olmstead Plan?

Minnesota has an Olmstead Plan to ensure that Minnesotans with disabilities have opportunities for lives of integration and inclusion. To this end, in both 2013 and 2015, Governor Mark Dayton issued Executive Orders forming an Olmstead Subcabinet and charged the subcabinet with developing and implementing an Olmstead Plan.[14] Moreover, we know that implementing a comprehensive, effectively working Plan will keep the state accountable to complying with the letter and spirit of the *Olmstead* decision and the ADA.

Beyond that, however, Minnesota has an Olmstead Plan to fulfill an agreement made in the settlement of a class action lawsuit in U.S. District Court in a case called *Jensen v. DHS.*[15] *Jensen* involved people with developmental disabilities who had been residents of a Department of Human Services (DHS) facility. In 2011, that case resolved in a settlement agreement, which included a provision for an Olmstead Plan. The settlement agreement stated: "the State and the Department shall develop and implement a comprehensive *Olmstead* plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs in the "most Integrated Setting," and is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.,* 527 U.S.582 (1999).

Developing Minnesota's Olmstead Plan

Minnesota began working on its Olmstead Plan since 2012. That year, the state formed the Olmstead Planning Committee, which included people with disabilities, family members, providers, advocates, and decision-makers from the Minnesota Department of Human Services (DHS).

In January, 2013, Governor Mark Dayton issued Executive Order 13-01 establishing a subcabinet to develop and implement a comprehensive plan supporting freedom of choice and opportunity for people with disabilities. The Olmstead Subcabinet, then chaired by Lieutenant Governor Yvonne Prettner Solon, includes the commissioner or commissioner's designee from the following state agencies:

- Department of Corrections
- Department of Education
- Department of Employment and Economic Development
- Department of Health
- Department of Human Rights
- Department of Human Services
- Department of Transportation
- Minnesota Housing Finance Agency

Representatives from the Office of the Ombudsman for Mental Health and Developmental Disabilities and the Governor's Council on Developmental Disabilities are *ex officio* members of the subcabinet.

In January 2015, Governor Dayton issued Executive Order 15-03 which further defined the role and nature of the Olmstead Subcabinet. He subsequently designated Commissioner Mary Tingerthal of the Minnesota Housing Finance Agency to be the chair of the subcabinet.

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[14] Executive Orders 13-01 and 15-03, available in Appendix A and at http://mn.gov/governor/images/EO-13-01.pdf

[15] *Jensen, et. al. v. Department of Human Services, et. al.,* Civil No. 09-cv-1775 (DWF/FLN).

Olmstead Subcabinet vision statement

To make the promise of Olmstead a reality in Minnesota, the subcabinet has adopted a vision statement to guide the implementation of the Plan:

People with disabilities are living, learning, working, and enjoying life in the most integrated setting.

The Olmstead Subcabinet embraces the *Olmstead* decision as a key component of achieving a Better Minnesota for all Minnesotans, and strives to ensure that Minnesotans with disabilities will have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment and to participate in community life. This includes:

- The opportunity and freedom for meaningful choice, self-determination, and increased quality of life, through: opportunities for economic self-sufficiency and employment options; choices of living location and situation, and having supports needed to allow for these choices;
- Systemic change supports self-determination, through revised policies and practices across state government and the ongoing identification and development of opportunities beyond the choices available today; and
- Readily available information about rights, options and risks and benefits of these options, and the ability to revisit choices over time.

Demographics & implications

To better understand how to make the subcabinet's vision a reality, demographic information was reviewed about the state's population of people with a disability. Although this Olmstead Plan applies to people with disabilities as defined in the ADA,[16] available demographic data used a different definition of disability, one that excluded persons living in congregate settings.[17] Nevertheless, the information we have still helps us understand essential features and trends about the populations of Minnesotans with disabilities.

For example, data shows that Minnesotans with disabilities live in poverty at a higher rate than Minnesotans without disabilities;[18] and that the highest rates of disabilities among working-age Minnesotans are American Indians and U.S.-born African Americans.[19]

Minnesota's population is aging. The current retirement-to-working age ratio is about 22%, but by 2040, the retirement-to-working age ratio is projected to be almost 40%.

According to a 2012 study on homelessness in Minnesota, 55% of adults experiencing homelessness reported a serious mental illness, 51% reported a chronic physical health condition, 31% reported

[16] 42 U.S.C. §12102 The term "disability" means, with respect to an individual - (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.
[17] Data from the American Community Survey and Decennial Census and Population Estimates, via Minnesota Compass, http://www.mncompass.org/demographics/
[18] Ibid.
[19] Ibid.

evidence of a traumatic brain injury, and 22% reported a substance abuse disorder. 70% (3,719 adults) reported at least one of these conditions.[20]

Recent media attention has focused on one disability that has increased dramatically. According to the Centers for Disease Control, autism has increased from a prevalence rate of 1 in 1,000 in 1970, to 1 in 150 in 2000, to 1 in 88 in 2012.[21]

These trends have implications for how best to address the needs of people with disabilities in Minnesota. Service planners must recognize that different communities (both cultural and regional) have different needs and that unemployment and poverty continue to be significant issues for people with disabilities. The shifting prevalence of different disability types among different age groups will require changes in programs and accommodations in schools, employment, housing, and supports. The aging population in Minnesota has two big implications: an increase in the number of people with disabilities who may need services *and* a decrease in the number of potential workers in direct service jobs.

Public comments

Since drafting the original Olmstead Plan, the subcabinet and state agency staff members, have continued to accept and encourage public comments on the Olmstead Plan and its implementation. Between June, 2013 and June, 2015, over 400 public comments were received by the Olmstead Implementation Office. In addition, since the original plan was submitted, members of the Olmstead Subcabinet and the Olmstead Implementation Office have attended more than 100 public listening sessions, or information sessions with specific groups. We listened to these comments and used them to determine the scope of the Plan, the topics it contains, and what outcomes the Plan should achieve.

All public comments were reviewed and distributed to the appropriate State agencies so that the agency teams would consider them in the drafting and implementation of the Plan.

Several themes emerged from stakeholder comments[22] during the most recent comment period (April 24, 2014 to June 19, 2015). Of the 175 comments received, 80% of the comments related to 11 theme areas. Those themes are summarized below and indicate the number of comments related to the theme. The total comments exceed 175 because some individuals commented on more than one area.

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[20] Wilder Research, "2012 Minnesota Homeless Study Fact Sheet," 2012, 2–3. Accessed October 3, 2013, http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota%202012%20Study/Long-term%20Homelessness,%20Fact%20Sheet.pdf.

[21] CDC, "Autism Spectrum Disorders: Data & Statistics." Accessed August 30, 2013, http://www.cdc.gov/ncbddd/autism/data.html.

[22] These themes are based on a qualitative review of information from individuals who made comments online or at listening sessions from April 2014 – June 2015. We realize that these opinions may not reflect the opinions of all relevant stakeholders or Minnesotans in general.

Theme Definitions

1) **Options and Choices** (107 comments) – People expressed that a "one size fits all" plan will not work. An array of options needs to be funded and available for people to meet the needs and choices of individuals. An example would be providing opportunities for integrated housing and competitive integrated employment or intentional communities such as sober housing, or center based day activities.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, Housing & Services, and Employment

2) **Financial Resources** (51 comments) – People noted that rates for reimbursement of service and affordability of service are important. They also noted that there should be adequate funding for services.
   - Influence of comments in this theme can be seen in Transition Services, Waiting List, Health Care & Healthy Living, and Crisis Services

3) **Quality Assurance/Accountability** (41 comments) – People expect agencies to be accountable for the goals within the Plan. Work needs to be transparent and consistent in order for the public to hold agencies accountable. People also expressed the need to resolve conflict with agencies in a more effective and efficient manner. Examples include having a clear understanding of who will monitor providers to ensure that they are implementing person centered plans and ensuring that individuals have opportunities to make informed choices.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, and Plan Management & Oversight

4) **Access** (41 comments) – People shared that not everyone can access the programs/services. This may be physical access, lack of awareness about programs/services, and/or policy barriers that prevent access. For example a person may need services, but the types of services they need are not available in their area. Or they may need services but they do not meet the qualification criteria to enter a given program.
   - Influence of comments in this theme can be seen in Transition Services, Housing & Services, Employment, Lifelong Learning & Education, Waiting List, Transportation, and Crisis Services

5) **Risk** (35 comments) – People expressed concern about personal safety. People perceive the opportunity to try different things as a risk, particularly if there is no option to return to what they were doing previously. Making changes in our lives is always a risk and we need to understand how that change may impact us positively and/or negatively.
   - Influence of comments in this theme can be seen in Person Centered Planning and Transition Services

6) **Person-Centered** (28 comments) – People feel strongly that individuals should be able to make informed decisions in all areas of their lives. For example, people with disabilities should have opportunities to make informed decisions and not be told they only have one option available.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, Housing & Services, Employment, and Lifelong Learning & Education

7) **Barriers/Disincentives** (24 comments) – People shared that there are many policies that prevent individuals, families and businesses from achieving the Olmstead vision. An example would be a policy that requires a person with a disability be determined unable to work in order to receive services that they need, when in fact they can work.
   - Influence of comments in this theme will be identified in workplans that correspond to the measurable goals.

8) **Engagement** (24 comments) – People said that individuals with disabilities should be meaningfully involved in the direction of those policies and other things that impact their lives. While each individual defines meaningful engagement differently their voice is important and needs to be heard more consistently. "Nothing about us, without us" is often quoted by people with disabilities seeking changes to policy.
   - Influence of comments in this theme can be seen in Community Engagement

9) **Data** (22 comments) – People are dissatisfied with many of the data sources being used. They expressed that data needs to be robust and understandable. . Many people feel that as a state we collect a great deal of data about our citizens. Based on comments received it has been difficult for people to understand why we used certain data in the past. Many people also shared that they felt some data was too limited and didn't represent enough people with disabilities to be impactful in making change.
   - Influence of comments in this theme can be seen in cross agency coordination of data strategies section and all topic areas

10) **Training and Technical Assistance** (22 comments) - People said that training and technical assistance is needed for everyone. An example would be training for creating person centered plans so that there is consistency in how plans are being developed statewide. This training should be available to providers, advocates, people with disabilities and their families.
   - Influence of comments in this theme can be seen in Person Centered Planning, Transition Services, Housing & Services, Employment, Lifelong Learning & Education, Positive Supports

11) **Accessible Communications** (22 comments) - People are dissatisfied with the current level of accessibility in state communications. Providing accessible communications will lead to transparency and awareness. An example would be documents that cannot be read with a screen reader, or only providing information through a website.
   - Influence of comments in this theme can be seen in the Communications and public relations section

The August 2015 Plan

The August 2015 Plan focuses on setting measurable goals to both: 1) increase opportunities for people with disabilities to receive services that best meet their individual needs in the most integrated setting; and, 2) improve service delivery to promote a better quality of life. In this way, the Plan differs from the original and other previous versions, which laid out processes to implement tasks, but in many areas lacked measurable goals to achieve defined outcomes.

Going forward, the Olmstead Plan will contain measurable goals and broad strategies to achieve them, but the detailed actions to implement the strategies will be contained in separate workplans created by the responsible agencies. In October, 2015, workplans will be posted on the Olmstead website and submitted to the U.S. District Court. The subcabinet will review progress on the workplans on a periodic basis. More information on the workplans is available in the Plan Management and Oversight section.

During the drafting of the current Plan, care was taken to make sure all content from the original and previous versions of the Plan was accounted for. To verify this, a comparison document was created showing all of the action items from the March 20, 2015 Plan and how they relate to the August 2015 Plan and agency workplans. The comparison document is posted on the Olmstead website and available to the public upon request.

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MEASURABLE GOALS

Topic Areas and Measurable Goals

The August 2015 Plan is organized into 13 topic areas that cover different aspects of improving the quality of life for people with disabilities as indicated in the table below.

Topic Areas	Why are these Topic Areas important?
Person Centered Planning	This topic area supports all other topic areas with goals that increase the use of practices that begin with listening to individuals about what is important to them in creating and maintaining a community life that they personally value.
Transition Services Housing and Services Employment Lifelong Learning and Education Waiting Lists	These topic areas contain goals that will focus on increasing the movement of people with disabilities from segregated to integrated settings.
Transportation Healthcare and Healthy Living Positive Supports Crisis Services Assistive Technology Prevent Abuse and Neglect	These topic areas contain goals that will focus on building capacity of programs, practices and resources that will support people with disabilities as they live, work and learn in the settings that they choose.
Community Engagement	This topic area contains goals that focus on engaging people with disabilities in multiple aspects of community life and decision making.

Measurable goals

The measurable goals established in this Plan are indicators of progress towards achieving the integration mandate of the Americans with Disabilities Act, which requires public entities to:

> "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities", with integrated settings being defined as those which "enable individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . ."

Although the measurable goals will be used to measure progress and hold the public entities accountable, they do not include all efforts in this direction. Over time, based upon lessons learned through implementation, goals will be refined and new goals may be added.

The criteria for drafting the measurable goals were set by using the U.S. District Court's Orders in *Jensen v. DHS,* the Settlement Agreement in that case, and the Statement of the Department of Justice on Enforcement of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.,* issued June 22, 2011.

The following criteria were used for setting measurable goals:

- **Baseline**: Each measurable goal for increased integration or improvement of quality of life begins with an analysis of the extent to which people with disabilities are in the most integrated settings and have the necessary supports to meet their needs.

- **Concrete and reliable**: Each measurable goal is a concrete and reliable commitment to expand the number of individuals in the most integrated settings and necessary supports that best meet individual needs.

- **Realistic**: Each measurable goal must be realistically achievable.

- **Strategic**: Each measurable goal sets its outcomes and activities over a three to five-year period.

- **Specific and reasonable timeframes**: Each measurable goal has specific and reasonable timeframes for which State agencies will be held accountable.

- **Funding**: Each measurable goal will address the extent to which there is funding to support the goal including potential reallocation of funds.

Format of topic areas

Each topic area contains eight sections as described below:

- **Stakeholder comments**
  This section includes comments from stakeholders that voice the thoughts of people with disabilities on the topic area.
- **What this topic means**
  This section provides a narrative description of the topic area.
- **Vision statement**
  This section contains a Vision Statement that describes the state's aspirations for the topic area.
- **What we have achieved**
  This section includes key accomplishments, important reports and documents related to the topic area that were either required by the Plan or related to and utilized in implementation of the Plan to date. The referenced reports are listed in Appendix A and are available on the Olmstead website.
- **Measurable goals**
  This section contains one or more measurable goals that meet the criteria described above.
- **Rationale**
  This section includes statements that support the reasons that the particular measurable goals were selected to be the appropriate measurements for the activities within the topic area and the status of funding for the goals in the topic area.
- **Strategies**
  This section contains several key strategies that will need to be implemented to accomplish the measurable goals in that area. Responsible agencies will develop workplans that will include steps for implementing these strategies. The workplans will be posted on the Olmstead website and reviewed regularly by the subcabinet.
- **Responsible agencies**
  This section lists the state agencies that will be primarily responsible for the implementation of the activities described in the topic area.

Measurable Goals at a Glance

The table below provides a summary of the measurable goals contained in the Plan that indicate targeted outcomes within three to five years. More information about the specific goals is included in the topic area sections of the Plan.

Topic	Goals	Agency*
Person-Centered Planning	**Goal One:** By June 30, 2020, plans for people using disability home and community-based waiver services will meet required protocols. Protocols will be based on the principles of person centered planning and informed choice. **Annual Goals** for the percent of plans that meet required protocols: • By June 30, 2016, the percent of plans will increase to 30% • By June 30, 2017, the percent of plans will increase to 50% • By June 30, 2018, the percent of plans will increase to 70% • By June 30, 2019, the percent of plans will increase to 85% • By June 30, 2020, any plans that do not meet the required protocols will be revised to contain required elements of person centered plans.	DHS, DEED, MDE
	Goal Two: By 2017, increase the percent of individuals with disabilities who report that they exercised informed choice, using each individual's experience regarding their ability: to make or have input into major life decisions and everyday decisions, and to be always in charge of their services and supports, as measured by the National Core Indicators (NCI) survey. **Annual Goals** for the percent reporting they have input into major life decisions: • By 2015, the percent will increase to > 45% • By 2016, the percent will increase to > 50% • By 2017, the percent will increase to ≥ 55% **Annual Goals** for the percent reporting they have input in everyday decisions: • By 2015, the percent will increase to ≥ 84% • By 2016, the percent will increase to ≥ 85% • By 2017, the percent will increase to ≥ 85% **Annual Goals** the percent reporting they are always in charge of their services and supports: • By 2015, the percent will increase to ≥ 70% • By 2016, the percent will increase to ≥ 75% • By 2017, the percent will increase to ≥ 80%	

* Agency acronyms are listed at the end of the table

Topic	Goals	Agency*
Transition Services	**Goal One:** By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings will be 7,138. **Annual Goals** for the number of people moving from ICFs/DD, nursing facilities and other segregated settings • By June 30, 2015, the number moving will be 874 • By June 30, 2016, the number moving will be 1,074 • By June 30, 2017, the number moving will be 1,224 • By June 30, 2018, the number moving will be 1,322 • By June 30, 2019, the number moving will be 1,322 • By June 30, 2020, the number moving will be 1,322	DHS, DOC, MHFA
	Goal Two: By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting will be reduced to 30% (based on daily average). **Annual Goals** to reduce the percent of people at AMRTC awaiting discharge: • By June 30, 2016 the percent will reduce to ≤ 35% • By June 30, 2017 the percent will reduce to ≤ 33% • By June 30, 2018 the percent will reduce to ≤ 32% • By June 30, 2019 the percent will reduce to ≤ 30%	
	Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month. **Annual Goals** to increase average monthly number of individuals leaving MSH: • By December 31, 2015 the number will increase to ≥ 10 • By December 31, 2016 the number will increase to ≥ 11 • By December 31, 2017 the number will increase to ≥ 12 • By December 31, 2018 the number will increase to ≥ 13 • By December 31, 2019 the number will increase to ≥ 14	
	Goal Four: By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person centered planning process that adheres to transition protocols that meet the principles of person centered planning and informed choice. **Annual Goals** to increase the percent of plans that adhere to transition protocols: • By June 30, 2016, the percent will increase to 15% • By June 30, 2017, the percent will increase to 30% • By June 30, 2018, the percent will increase to 50%	

Topic	Goals	Agency*
Housing & Services	**Goal One:** By June 30, 2019, the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing will increase by 5,547 (from 6,017 to 11,564 or about a 92% increase). **Annual Goals** to increase the number living in the most integrated housing: • By June 30, 2015, the number will increase by 617 over baseline • By June 30, 2016 the number will increase by 1,580 over baseline • By June 30, 2017 the number will increase by 2,638 over baseline • By June 30, 2018 the number will increase by 4,009 over baseline • By June 30, 2019 the number will increase by 5,547 over baseline	DHS, MHFA
Employment	**Goal One:** By September 30, 2019 the number of new individuals receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive, integrated employment will increase by 14,820. **Annual Goals** to increase the number in competitive, integrated employment**:** • By September 30, 2015, the number will increase by 2,853 • By September 30, 2016, the number will increase by 2,911 • By September 30, 2017, the number will increase by 2,969 • By September 30, 2018, the number will increase by 3,028 • By September 30, 2019, the number will increase by 3,059	DHS, DEED, MDE
	Goal Two: By June 30, 2020, of the 50,157 people receiving services from certain Medicaid funded programs, there will be an increase of 5,015 or 10% in competitive, integrated employment. **Annual Goals** to increase the number in competitive, integrated employment • By June 30, 2017, a data system will be developed. • By June 30, 2017, the number will increase by 1,500 individuals • By June 30, 2018, the number will increase by 1,100 individuals • By June 30, 2019, the number will increase by 1,200 individuals • By June 30, 2020, the number will increase by 1,200 individuals	
	Goal Three: By June 30, 2020, the number of students with developmental cognitive disabilities, ages 19-21 that enter into competitive, integrated employment will be 763. **Annual Goals** for the number of students in competitive, integrated employment: • By June 30, 2016, the number will be 125 • By June 30, 2017, the number will be 188 • By June 30, 2018, the number will be 150 • By June 30, 2019, the number will be 150 • By June 30, 2020, the number will be 150	

Topic	Goals	Agency*
Lifelong Learning & Education	**Goal One:** By December 1, 2019 the number of students with disabilities, receiving instruction in the most integrated setting, will increase by 1,500 (from 67,917 to 69,417). **Annual Goals** for the number of students in the most integrated settings: • By December 1, 2015 the number will increase by 300 over baseline • By December 1, 2016 the number will increase by 600 over baseline • By December 1, 2017 the number will increase by 900 over baseline • By December 1, 2018 the number will increase by 1,200 over baseline • By December 1, 2019 the number will increase by 1,500 over baseline	MDE, DHS, DOC
	Goal Two: By October 1, 2020 the number of students who have entered into an integrated postsecondary setting within one year of leaving secondary education will increase by 250 (from 225 to 475). **Annual Goals** to increase the number of students entering an integrated postsecondary education setting are: • By October 1, 2016 the number will increase by 50 over baseline • By October 1, 2017 the number will increase by 100 over baseline • By October 1, 2018 the number will increase by 150 over baseline • By October 1, 2019 the number will increase by 200 over baseline • By October 1, 2020 the number will increase by 250 over baseline	

Topic	Goals	Agency*
Waiting List	**Goal One:** By October 1, 2016, the Community Access for Disability Inclusion (CADI) waiver waiting list will be eliminated.	DHS
	Goal Two: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace. **For persons exiting institutional settings** • Beginning December 1, 2015, as people residing in an institutional setting are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person makes an informed choice of alternative community services that are more integrated, appropriate to meet their individual needs, and the person is not opposed to moving, and would like to receive home and community based services. **For persons with an immediate need** • Beginning December 1, 2015, as people are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person meets criteria under Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b)**.** **For persons with a defined need** • Beginning December 1, 2015, as people are assessed as having a defined need for waiver services within a year from the data of assessment, and within available funding limits, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days of determining the defined need.	
	Goal Three: By March 1, 2017, the DD waiver waiting list will be eliminated for persons leaving an institutional setting and for persons with immediate need as defined by Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b).	
	Goal Four: By December 31, 2018, within available funding limits, waiver funding will be authorized for persons who are assessed and have a defined need on or after December 1, 2015, and have been on the waiting list for more than three years.	
	Goal Five: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.	

Topic	Goals	Agency*
Transportation	**Goal One:** By December 31, 2020 accessibility improvements will be made to 4,200 curb ramps (increase from base of 19% to 38%) and 250 Accessible Pedestrian Signals (increase from base of 10% to 50%). By January 31, 2016, a target will be established for sidewalk improvements. **Annual Goals** to increase the number of APS installations: • By December 31, 2015, there will be an additional 50 APS installations • By December 31, 2016, there will be an additional 50 APS installations • By December 31, 2017, there will be an additional 50 APS installations • By December 31, 2018, there will be an additional 50 APS installations • By December 31, 2019, there will be an additional 50 APS installations	MnDOT, Metro-politan Council
	Goal Two: By 2025, additional rides and service hours will increase the annual number of passenger trips to 18.8 million in Greater Minnesota (approximately 50% increase). **Annual Goals** to increase the annual number of passenger trips: • By 2015 the number of trips will increase to 13,129,593 • By 2020 the number of trips will increase to 16,059,797 • By 2025 the number of trips will increase to 18,800,000	
	Goal Three: By 2020, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access.	
	Goal Four: By 2020, transit systems' on time performance will be 90% or greater statewide.	

Topic	Goals	Agency*
Healthcare & Healthy Living	**Goal One:** By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care, focusing specifically on cervical cancer screening, and follow up care for cardiovascular conditions will increase by 833 people compared to the baseline. **Annual Goals** to increase the number of individuals accessing appropriate care: • By December 31, 2016 the number will increase by 205 over baseline • By December 31, 2017 the number will increase by 518 over baseline • By December 31, 2018 the number will increase by 833 over baseline	DHS, MDH
	Goal Two: By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by 1,229 children and 1,055 adults over baseline. **Annual Goals** to increase the number of **children** accessing dental care: • By December 31, 2016 the number will increase by 410 over baseline • By December 31, 2017 the number will increase by 820 over baseline • By December 31, 2018 the number will increase by 1,229 over baseline **Annual Goals** to increase the number of **adults** accessing dental care: • By December 31, 2016 the number will increase by 335 over baseline • By December 31, 2017 the number will increase by 670 over baseline • By December 31, 2018 the number will increase by 1,055 over baseline.	
Positive Supports	**Restrictive procedures for people with disabilities are prohibited except when used in an emergency situation. These goals seek reduction to the exceptions to restrictive procedures.** **Goal One:** By June 30, 2018 the number of individuals receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) who experience a restrictive procedure, such as the emergency use of manual restraint when the person poses an imminent risk of physical harm to themselves or others and it is the least restrictive intervention that would achieve safety, will decrease by 5% or 200. **Annual Goals** to reduce number of people experiencing a restrictive procedure: • By June 30, 2015 the number will be reduced by 5% or 54 • By June 30, 2016 the number will be reduced by 5% or 51 • By June 30, 2017 the number will be reduced by 5% or 49 • By June 30, 2018 the number will be reduced by 5% or 46	DHS, MDE, MDH, DOC

Topic	Goals	Agency*
Positive Supports	**Goal Two:** By June 30, 2018, the number of Behavior Intervention Reporting Form (BIRF) reports of restrictive procedures for people receiving services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, (for example, home and community based services) will decrease by 1,596. **Annual Goals** to reduce the number of reports of restrictive procedures: • By June 30, 2015 the number will be reduced by 430 • By June 30, 2016 the number will be reduced by 409 • By June 30, 2017 the number will be reduced by 388 • By June 30, 2018 the number will be reduced by 369	DHS, MDE, MDH, DOC
	Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544, with limited exceptions to protect the person from imminent risk of serious injury. (Examples of a limited exception include the use of a helmet for protection of self-injurious behavior and safety clips for safe vehicle transport). By December 31, 2019 the emergency use of mechanical restraints will be reduced to ≤ 93 reports and ≤ 7 individuals. **Annual Goals** to reduce the use of mechanical restraints: • By June 30, 2015, reduce to 461 reports and 31 individuals • By June 30, 2016, reduce to 369 reports and 25 individuals • By June 30, 2017, reduce to 277 reports and 19 individuals • By June 30, 2018, reduce to 185 reports and 13 individuals • By June 30, 2019, reduce to 93 reports and 7 individuals	
	Goal Four: By June 30, 2017, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 316. **Annual Goals** to reduce the number experiencing restrictive procedures at school: • By June 30, 2015, the number will be reduced by 110 • By June 30, 2016, the number will be reduced by 105 • By June 30, 2017, the number will be reduced by 101	
	Goal Five: By June 30, 2017, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251. **Annual Goals** to reduce number of incidents of restrictive procedures in school: • By June 30, 2015, the number will be reduced by 781 • By June 30, 2016, the number will be reduced by 750 • By June 30, 2017, the number will be reduced by 720	

Topic	Goals	Agency*
Crisis Services	**Goal One:** By June 30, 2018, the percent of children who receive children's mental health crisis services and remain in their community will increase to 85% or more. **Annual Goals** to increase the percent of children who remain in their community after a crisis: • By June 30, 2016, the percent will increase to 81% • By June 30, 2017, the percent will increase to 83% • By June 30, 2018, the percent will increase to 85%	DHS, MDE
	Goal Two: By June 30, 2018, the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other setting) will increase to 89% or more. **Annual Goals** to increase the percent of adults who remain in their community after a crisis: • By June 30, 2016, the percent will increase to 84% • By June 30, 2017, the percent will increase to 86% • By June 30, 2018, the percent will increase to 89%	
	Goal Three: By June 30, 2017, the number and percent of people who discontinue waiver services after a crisis will decrease to 45% or less. (Leaving the waiver after a crisis indicates that they left community services, and are likely in a more segregated setting.) **Annual Goals** to decrease the number who discontinue waiver services after a crisis: • By June 30, 2015, the number will decrease to no more than 60 people • By June 30, 2016, the number will decrease to no more than 55 people • By June 30, 2017, the number will decrease to no more than 45 people	
	Goal Four: By June 30, 2018, people in community hospital settings due to a crisis, will have appropriate community services within 30 days of no longer requiring hospital level of care, and will have a stable, permanent home within 5 months after leaving the hospital. • By February, 2016 a baseline and annual goals will be established.	
	Goal Five: By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary, placement within ten days. • By January 31, 2016, establish a baseline of the length of time it takes from referral for crisis intervention to the initiation of crisis services and develop strategies and annual goals to increase access to crisis services, including specific measures of timeliness.	

Topic	Goals	Agency*
Community Engagement	**Goal One:** By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992. **Annual Goals** to increase the number of self-advocates: • By June 30, 2016, the number will increase by 50 • By June 30, 2017, the number will increase by 75 • By June 30, 2018, the number will increase by 100 • By June 30, 2019, the number will increase by 150 **Annual Goals** to increase the number involved in public planning projects**:** • By June 30, 2016, the number will increase by 50 • By June 30, 2017, the number will increase by 75 • By June 30, 2018, the number will increase by 100 • By June 30, 2019, the number will increase by 150	OIO
Topic Areas Under Development		
Assistive Technology	By 2016, a baseline and measurable goals will be established for expanding the use of assistive technology to increase access to integrated settings.	ADM
Prevent Abuse & Neglect	By 2016, a baseline and measurable goals will be established on statewide levels and trends of abuse, neglect, exploitation, injuries, and deaths.	MDH

Agency Acronyms

ADM – Department of Administration	MDH – Minnesota Department of Health
DEED – Department of Employment and Economic Development	MHFA – Minnesota Housing Finance Agency
DHS – Department of Human Services	MnDOT – Minnesota Department of Transportation
DOC – Department of Corrections	OIO – Olmstead Implementation Office
MDE – Minnesota Department of Education	

Person-Centered Planning

Stakeholder Comment	
"…as a family member of a person with intensive support needs, I often feel that my input, preferences, and direction are ignored, in an effort to enforce a particular view of what services for people with disabilities should look like."	Robert Bonner (2015)
"One person's outcome is not going to be the same as another person's outcome, so you need to take time to really determine what [are] those outcomes that you're looking for, and they need to be based on that individuals and their families and [their] value system."	Dan Zimmer (2013)
"Please continue to listen to people who receive services. They know what they need. They know what works best for them."	Rick Hammergren (2013)

What this topic means

This topic is about putting the person at the center of the person's plan for services and about offering informed choice for integrated options.

Historically, the term "person-centered planning" was used to describe specific planning approaches for people with developmental disabilities that were designed to combat the tendency of professionals and systems to view people primarily through labels and deficits rather than as unique and whole individuals with potential and gifts to share. "Person-centered" services have continued to evolve as counterpoints to "system-centered" or "professionally-driven" approaches. The ADA and United States Supreme Court rulings have affirmed and emphasized "most integrated" and individualized approaches that are consistent with "person-centeredness" for all people with disabilities. As the social aspects of recovery and community success continue to emerge as critical to overall health and wellness, terms and approaches such as "patient-centered" or "person-centered recovery practices" are also emerging.

As a result, today the term "person-centered plan" is used in many fields (e.g. health care, nursing care, aging, mental health, employment, education). Although the details of person-centered planning are expressed differently in these contexts, all of these approaches aid practitioners and communities in developing whole life, person-driven approaches to supporting people who experience barriers to full engagement in community living. Broadly, the term is used to describe a value-based orientation and methods of organizing discovery and planning for services, treatment, and support that are likely to yield more person-driven and balanced results.

Terms like "person-centered planning" and "person-driven planning" are distinct, but they share the fundamental principle that **government and service providers begin by listening to individuals about what is important to them in creating or maintaining a personally-valued, community life. Planning of supports and services is not driven or limited by professional opinion or available service options but focused on the person's preferences and whole life context.** Effective support and services are identified to help people live, learn, work, and participate in their preferred communities and on their own terms. Many state and federal policies now mandate person-centered delivery of long-term services and supports. In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued a rule that applies to all Home and community Based Services; this rule provides a description of a person-

centered service plan. The full rule, 42 CF.R. Pt. 430, 431 et al, is available at http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf (§441.725 contains the description of a person-centered service plan).

The Minnesota Olmstead Plan sees person-centered planning as foundational to overcoming system biases and supporting peoples' ability to engage fully in their communities. The following definition is meant to help providers, families, communities and individuals in understanding what qualifies as a person-centered plan in the Olmstead Plan. It is recognized that people may choose different levels of responsibility in the planning process, from taking complete charge of their own planning, service arrangements and budgets to relying on a designated representative or family member to assist them. The planning process may incorporate a variety of approaches, tools, and techniques based on the person's request or understanding to ensure that the options reviewed and offered are the most appropriate based on the person's goals and preferences. A process used to complete person-centered planning is acceptable under the Olmstead Plan only if that process clearly demonstrates alignment with the definition, values and principles as described in the Olmstead Plan. Additional efforts will be taken to clarify and support Minnesota communities and individuals in achieving this vision of planning and organizing services in Minnesota.

Definition of Person-Centered Planning

Person-centered planning *is an organized process of discovery and action meant to improve a person's quality of life.* Person-centered plans must identify what is *important to* a person (e.g. rituals, routines, relationships, life choices, status and control in areas that are meaningful to the person and lead to satisfaction, opportunity, comfort, and fulfillment) and what is *important for* the person (e.g. health, safety, compliance with laws and general social norms). What is important for the person must be addressed in the context of his or her life, goals and recovery. This means that people have the right and opportunity to be respected; share ordinary places in their communities; experience valued roles; be free from prejudice and stigmatization; experience social, physical, emotional and spiritual well-being; develop or maintain skills and abilities; be employed and have occupational and financial stability; gain self-acceptance; develop effective coping strategies; develop and maintain relationships; make choices about their daily lives; and achieve their personal goals. It also means that these critical aspects cannot be ignored or put aside in a quest to support health and safety or responsible use of public resources.

Statement of Core Values and Principles of Person-Centered Planning

Person-centered planning embraces the following values and principles:

- People (with an authorized representative, if applicable) direct their own services and supports when desired.
- The quality of a person's life including preferences, strengths, skills, relationships, opportunity, and contribution is the focal point of the plan.
- The individual who is the focus of the plan (or that person's authorized representative) chooses the people who are involved in creating the context of the plan.
- Discovery of what is important to and for the person is not limited to what is currently available within the system or from professionals.
- People are provided sufficient information, support and experiences to make informed choices that are meaningful to them and to balance and take responsibility for risks associated with choices.

- Services, treatments, interventions and supports honor what is important to people (e.g. their goals and aspirations for a life, overall quality of life) and promote dignity, respect, interdependence, mastery and competence.
- Plans include sufficient proactive support and organization to prevent unnecessary life disruption and/or loss especially during transition periods or crisis recovery.
- Community presence, participation, and connection are expected and supported through the use of natural relationships and community connections in all aspects of the plan to assist in ending isolation, disconnection and disenfranchisement of the individuals.
- The process is based on mutually respectful partnerships that empower the person who is the focus of the plan and is re respectful of his or her important relationships and goals.
- The context of a person's unique life circumstances including culture, ethnicity, language, religion, gender and sexual orientation and all aspects of the person's individuality are acknowledged when expressed and embraced and valued in the planning process.

Our goals for this topic intend to ensure that people receive supports and service according to the principles of person-centered planning embodied above and required by law.

Vision statement

People with disabilities will decide for themselves where they will live, learn, work, and conduct their lives. The individual will choose the services to support these decisions through a planning process directed by the individual or the individual's representative, that discovers and implements what is important to the person and for the person and is meant to improve the person's quality of life. People with disabilities will receive information about the benefits of integrated settings through visits or other experiences in such settings and will have opportunities to meet with other people with disabilities who are living, working, learning and receiving services in integrated settings.

What we have achieved

- Trained and provided technical assistance to 4,655 people on person centered thinking, and person centered planning since 2012. Developed a Person-Centered Organizational Development Tool for use by providers and trained 470 provider staff from across the state.
- In 2015, engaged four agencies in a yearlong training and technical assistance project with DHS and the Institute on Community Integration to create organizational and system change to support person centered practices.
- Adapted and tested a Person-Centered Plan Scoring Criteria and Checklist tool to assess whether plans contain characteristics of a person centered plan. Once approved by the subcabinet it will be made available on the Olmstead website and upon request in multiple formats.
- Over 1,300 people attended the two day 2015 Minnesota Age and Disability Odyssey conference which had as its theme "Person Centered Perspectives".
- 607 provider agencies received grant funding to further person centered practices.
- Selected a Quality of Life Survey Tool for implementation.
- Secured funding for and completed the pilot survey designed to test the effectiveness of the selected survey tool.

- Completed "Minnesota's Olmstead Plan Quality of Life Survey Pilot Study" Report
- Requested and received funding for the full implementation of the Quality of Life Survey for the 2016-2017 biennium.

Measurable goals

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

Baseline: In state fiscal year, 38,550 people were served on the disability home and community based services. However, a baseline for the current percentage of plans that meet the principles of person centered planning and informed choice needs to be established.

Annual Goals to increase the percent of plans that meet the required protocol:

- By June 30, 2016, the percent of plans that meet the required protocols will increase to 30%
- By June 30, 2017, the percent of plans that meet the required protocols will increase to 50%
- By June 30, 2018, the percent of plans that meet the required protocols will increase to 70%.
- By June 30, 2019, the percent of plans that meet the required protocols will increase to 85%
- By June 30, 2020, any plans that do not meet the required protocols will be revised to contain required elements of person centered plans.

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

- By 2017, increase the percent of people with intellectual and developmental disabilities (I/DD) who report they have input into major life decisions[23] to 55% or higher.

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

  Annual Goals to increase the percent of people reporting they have input into major life decisions:

  - By 2015, the percent will increase to > 45%
  - By 2016, the percent will increase to > 50%
  - By 2017, the percent will increase to ≥ 55%

[23] Of those not currently living with family, percentage who chose or had input into where they live; of those not currently living with family, percentage who chose or had some input in choosing their roommates; among those with a day program or activity, percentage who chose or had some input in where they go during the day. Calculation was made by totaling the number of responders who answered the three questions, and totaling the number of affirmative responses and calculating the percentage.

- By 2017, increase the percent of people with intellectual and developmental disabilities who make or have input in everyday decisions[24] to 85% or higher.

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

  Annual Goals to increase the percent of people reporting they have input in everyday decisions:

  - By 2015, the percent will increase to ≥ 84%
  - By 2016, the percent will increase to ≥ 85%
  - By 2017, the percent will increase to ≥ 85%

- By 2017, increase the percent of people with disabilities other than I/DD who are always in charge of their services and supports[25] to 80% or higher.

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

  Annual Goals to increase the percent of people reporting they are always in charge of their services and supports:

  - By 2015, the percent will increase to ≥ 70%
  - By 2016, the percent will increase to ≥ 75%
  - By 2017, the percent will increase to ≥ 80%

Rationale

- The primary focus in this area is to assure that person centered planning principles, including meaningful informed choice, are included in the planning process for all persons. This will begin with those receiving disability home and community based service waivers because they are a known group and an evaluation system is in place to sample plans on a routine basis. This group of people would also be under the federal requirements for person centered planning for home and community based services which took effect in March 2014. The intent is to extend the person centered planning requirements across populations beyond those using home and community based services.
- No baseline exists for the quality of person centered plans or the degree to which plans contain required principles of person centered planning and the informed choice of individuals. The National Core Indicator survey is a **sample survey** and has been validated for people with developmental disabilities. The NCI survey has been expanded for use by older adults and people with disabilities at risk of nursing facility level of care. The NCI survey will be used as a proxy to measure informed choice until the Olmstead Quality of Life survey is implemented.
- The Quality of Life Survey, has been validated across, all ages, all settings, and all disability groups.
- There is sufficient funding to implement these goals.

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[24] Among those with a paid community job, percentage who chose or had some input in where they work; percentage who choose or help decide their daily schedule; percentage who choose or help decide how to spend their free time. Calculation was made by totaling the number of responders who answered the three questions, and totaling the number of affirmative responses and calculating the percentage.

[25] The percent who respond "yes" they are in charge of the supports and services.

Strategies

Broaden the Effective Use of Person-centered Planning Principles and Techniques for People with Disabilities

- Define and initiate person centered planning services to assist people with disabilities in expressing their needs and preferences about quality of life.
- Expand person centered planning principles across more populations to include Medical Assistance recipients using mental health or home care services, those served through DEED, MDE, those leaving correctional facilities, and those requiring a coordinated plan between education, human services, and/or health. Provide training on person centered planning practices and informed choice to people with disabilities and their families, counties, tribes, and providers.
- Actively promote and encourage implementation of best practices and person-centered strategies that support individualized service and housing options through, for example, Housing Options Best Practices Forum and communities of practice on person centered planning and transition protocols.
- Evaluate progress towards goals, and determine if additional strategies will be necessary to provide everyone receiving services through one of the four disability home and community-based service waivers with person centered plans, that include meaningful informed choice.

Evaluate the Effectiveness of Person-Centered Planning Principles and Techniques

- Use the NCI survey for measuring progress and add the Quality of Life survey when available in 2016. See the Plan Management and Oversight section of the Plan for more information on the Quality of Life Survey.
- Using the established protocols, measure the quality of plans and the extent to which they contain required elements of person centered planning through regular county and state audits. These audits will include technical assistance and/or improvement plans as indicated.
- Evaluate the potential of a monitoring role by the State Quality Council in light of 2015 legislative appropriations.

Responsible Agencies

- Department of Human Services
- Department of Employment and Economic Development
- Minnesota Department of Education

Transition Services

Stakeholder Comments		
	"There needs to be funding for people that are in a nursing facility less than 90 days who need new housing."	DebJo Sathrum (2014)

What this topic means

This topic is about facilitating individuals' transitions from segregated to more integrated settings and about maintaining integrated settings when a person with a disability is at risk of entering or returning to a segregated setting.

When people with disabilities make transitions, we will take affirmative steps to provide an informed choice about the most integrated settings. This might mean that the person moves from a segregated setting to an integrated setting; it might mean that a person at risk of segregation remains in the most integrated setting; or it might mean that the person chooses not to make a change. Whatever the choice, our goal is to discover how to deliver services in a way that improves a person's quality of life. We will do this by using person-centered planning to ensure that the individual's preferences and needs are the focal point of the service plan; that the individual or the individual's representative directs services and supports; and by providing meaningful information about and exposure to integrated options.

One way this will be accomplished is to establish transition protocols that adhere to the following five principles:

- **Involvement of the Individual and Family:** Each person, and the person's family and/or legal representative, and any others chosen by the person shall be permitted to be involved in any evaluation, decision-making and planning processes, to the greatest extent practicable, using whatever communication method the person prefers.
- **Use of Person Centered Principles and Processes:** To foster each person's self-determination and independence, the state shall ensure the use of person-centered planning principles at each stage of the process to facilitate the identification of the person's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.
- **Expression of Choice and Quality of Life:** Each person shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality of life.
- **Life Options and Alternatives:** The state agencies shall undertake best efforts to provide each person with reasonable alternatives for living, working and education.
- **Provision of Adequate Services in Community Settings:** It is the goal that all people be served in integrated community settings with adequate supports, protections, and other necessary resources which are identified as available by service coordination.

Vision statement

We will provide services to people with disabilities in a way that helps them achieve their life goals. Services will be appropriate to individual needs, will reflect individual life choices, and will enable people with disabilities to conduct their activities in the most integrated setting-one that allows people with disabilities to interact with nondisabled persons to the fullest extent possible.

What we have achieved

- Since November 2013[26] the numbers of people exiting institutional settings are as follows: Intermediate Care Facilities for individuals with Developmental Disabilities (ICFs/DD) = 107; Nursing Facilities (for persons with a disability under age 65 in facility longer than 90 days) = 1,002; Anoka Metro Regional Treatment Center (AMRTC) = 398; and Minnesota Security Hospital = 150.
- The MSHS-Cambridge facility was closed and replaced by community services.
- Developed and began initial implementation of transition protocols that meet the principles of person centered planning and informed choice for individuals exiting segregated settings.
- Life Bridge, AMRTC and Minnesota Security Hospital (MSH) staff have been trained and are using the transition protocols. Implementation with counties is underway.

Measurable goals

Goal One: By June 30, 2020, the number of people who have moved from segregated settings to more integrated settings[27] will be 7,138.

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

	Baseline*	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20	Cumulative Total
Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)	72*	84	84	84	72	72	72	468
Nursing Facilities (NF) under age 65 in NF > 90 days	707*	740	740	740	750	750	750	4,470
Segregated housing other than listed above	Not Available[28]	50	250	400	500	500	500	2,200
Total		**874**	**1,074**	**1,224**	**1,322**	**1,322**	**1,322**	**7,138**

*Calendar year 2014

[26] As reported in subcabinet bimonthly reports to the Court November 2013 – March 2015.

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

[28] A baseline is not available because there is no standardized informed choice process currently in place to determine how many individuals in segregated settings would choose or not oppose moving to an integrated setting. Once this baseline is established, the goals will be re-evaluated and revised as appropriate.

Goal Two: By June 30, 2019, the percent of people at Anoka Metro Regional Treatment Center (AMRTC) who do not require hospital level of care and are currently awaiting discharge to the most integrated setting[29] will be reduced to 30% (based on daily average).

Baseline: In State Fiscal Year 2014, the percent of people at AMRTC who no longer meet hospital level of care and are currently awaiting discharge to the most integrated setting was 33% on a daily average. During State Fiscal Year 2015, a change in utilization of AMRTC (see Rationale section for description of change) caused an increase in the percent of the target population to 36% (above the 2014 level) which resulted in the need to adjust the goal over the next four years.

Annual Goals to reduce the percent of people at AMRTC awaiting discharge:

- By June 30, 2016 the percent awaiting discharge will be reduced to ≤ 35%
- By June 30, 2017 the percent awaiting discharge will be reduced to ≤ 33%
- By June 30, 2018 the percent awaiting discharge will be reduced to ≤ 32%
- By June 30, 2019 the percent awaiting discharge will be reduced to ≤ 30%

Goal Three: By December 31, 2019, the average monthly number of individuals leaving Minnesota Security Hospital will increase to 14 individuals per month.

Baseline: In Calendar Year 2014, the average monthly number of individuals leaving Minnesota Security Hospital was 9 individuals per month.

Annual Goals to increase average monthly number of individuals leaving Minnesota Security Hospital:

- By December 31, 2015 the average monthly number of discharges will increase to ≥ 10
- By December 31, 2016 the average monthly number of discharges will increase to ≥ 11
- By December 31, 2017 the average monthly number of discharges will increase to ≥ 12
- By December 31, 2018 the average monthly number of discharges will increase to ≥ 13
- By December 31, 2019 the average monthly number of discharges will increase to ≥ 14

Goal Four: By June 30, 2018, 50% of people who transition from a segregated setting will engage in a person centered planning process that adheres to transition protocols that meet the principles of person centered planning and informed choice.

Baseline: The baseline of the quality of transition plans will be established as the new transition protocols are implemented.

Annual Goals to increase the percent of plans that adhere to transition protocol standards:

- By June 30, 2016, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person centered planning and informed choice will increase to 15%.

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

- By June 30, 2017, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person centered planning and informed choice will increase to 30%.
- By June 30, 2018, the percent of those choosing to move to a more integrated setting who have a plan that adheres to transition protocols that meet the principles of person centered planning and informed choice will increase to 50%.

Rationale

- Individuals exiting institutional settings may be included in the housing goal when they move into integrated housing.
- In 2014, due to a change in Minnesota law, the percent of individuals at AMRTC under criminal court jurisdiction for competency restoration increased. These individuals' discharges from the program are not governed by medical stability but by the criminal court process. This issue inflates the number and percent of individuals who do not meet hospital level of care and await discharge.
- It is projected that the census of ICFs/DD will decrease over time, therefore the number of people who leave an ICF-DD over time will also decrease.
- There is not a standardized informed choice process in place to determine how many individuals in segregated settings would choose or not oppose moving to a more integrated setting. In order to improve the accuracy of the baseline and measurable goals one and three, an informed choice process needs to be implemented and data on these choices will be collected and used to determine if adjustments to the goals are needed.
- There is no baseline against which to measure quality of transition planning and implementation because the protocols are currently being implemented for other segregated settings. After one year of data is collected, the degree to which the transition meets the transition protocols, goals will be adjusted.
- Data tracking to monitor moves to more integrated settings must be developed. It is known when people leave institutional settings, but additional data for reporting may be needed to track moves from a potentially segregating setting, such as foster care.
- Some settings in the Segregated Settings report are potentially segregating, and may in fact be an integrated option for the person, such as a foster care setting where one person lives with staff support and engaged with neighbors and friends, or where two roommates who have chosen to live together and be supported by a provider in a licensed setting. The informed choice process and implementation of the new federal standards on the characteristics of home and community based services will provide additional information over the next few years.
- Annual goals reflect a ramp up period to train, fully implement, and monitor the transition protocols. There are existing funds to support these goals.

Strategies

Improve Ability to Gather Information about Housing Choices

- By December 2016, an informed choice process will be implemented for all people who receive long-term services and supports to determine the number of individuals who would choose or do not oppose moving to an integrated setting. Once that information is known (projected to be in June 2017), the baseline and measurable goals in goals one and three will be reassessed.

Implement New Transition Protocols

- Test, refine and implement transition protocols for individuals moving to integrated settings from segregated settings to ensure that planning includes what's important to the individual as well as for the individual. Transition protocols must align with the Jensen Settlement Agreement, the five principles of transition planning, and relevant components of the final rule of Home and Community Based Services standards. Testing is occurring through August 2015, with implementation of the revised protocol and tools beginning in September, 2015. Final draft protocols will be submitted to the subcabinet for approval by February 1, 2016. Approved protocols will be posted on the Olmstead website and made available in other formats upon request.
- Implement the federal rule governing Home and Community-Based Services (HCBS) settings requiring assessment and person centered planning practices which are complementary to the transition protocols. The transition for full compliance with the rule will be completed by 2019.

Increase Service Options for Individuals Making Transitions

- Provide targeted technical assistance and mentoring to build statewide capacity with lead agencies and providers to successfully transition people to more integrated settings, and use innovative approaches to individualized housing and supports.
- Provide targets for service development, and support counties, tribes and providers in developing alternatives to segregated settings, such as alternatives to shift staff foster care.
- Evaluate the current range of services available, such as those through home and community based service waivers, and redesign services as necessary to make available flexible options to support transitions to more integrated settings.

Monitor and Audit the Effectiveness of Transitions

- Develop materials to help people with disabilities, families and guardians understand options, answer questions and connect with those who can assist them in making an informed choice and planning for a transition.
- Lead agencies and the state will conduct audits of transition planning done by counties and providers to determine and gather the degree to which the transition meets the transition protocols.
- Monitor both the number and percent of AMRTC patients under restore to competency orders and civil commitments for mental health treatment.
- DHS, DEED and DOC will work together to ensure efficient and successful transitions for people leaving DOC facilities and entering community services.

Responsible Agencies

- Department of Human Services
- Department of Corrections
- Minnesota Housing Finance Agency

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Housing and Services

Stakeholder Comments		
	"I have been trying to get rental assistance since November 2013 and as of September 25, 2014, I still have not been able to get any help."	Susan Nelson (2014)
	"Some of the folks I've been working with that are in nursing homes desperately want to return to the homes they've lived in most of their lives."	*Jan Peterson (2013)*
	"[Use measures like] I have my own lease; a roommate isn't forced on me; I can come and go as I please. That makes sense. That's real."	*Ethan Roberts (2013)*

What this topic means

Housing and Services is about:

- People having meaningful options about where to live, and with whom.
- The state supports housing costs for people with disabilities who choose to live in integrated settings.

Housing and Services is not about closing potentially segregated settings. According to the Department of Justice, "Individuals must be provided the opportunity to make an informed decision. Public entities must take affirmative steps to remedy a history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice. Such steps include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet with other people with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and addresses any concerns or objections raised by the individual or another relevant decision-maker."

Vision statement

People with disabilities will choose where they live, with whom, and in what type of housing. They can choose to have a lease or own their own home and live in the most integrated setting appropriate to their needs. Supports and services will allow sufficient flexibility to support individuals' choices on where they live and how they engage in their communities.

What we have achieved

- Completed "A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report" to determine number of people who live in segregated settings.
- 2015 State legislative session authorized some initial policy changes to the Group Residential Housing (GRH) program. Once fully implemented these policy changes will increase flexibility of housing benefits to allow more individuals to move from segregated to integrated settings.
- 2015 State legislative session authorized an additional $2.5 million to support the expansion of the Bridges rental assistance program which is available to people with a mental illness who are at risk of or currently living in segregated settings.

- Applied for and received federal funding in 2014 and 2015 for 160 Section 811 housing vouchers for people with disabilities exiting out of segregated settings into their own homes.
- Engaged in strategic planning between MHFA and DHS as a means to align housing and service supports.

Measurable goals

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

Baseline: In State Fiscal Year 2014, there were an estimated 38,079 people living in segregated settings[30]. Over the last 10 years, 6,017 individuals with disabilities moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing[31].

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

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

Rationale

- There were an estimated 38,079 people living in potentially segregated settings in SFY 2014.
- At this time it not known how many of those individuals would choose or not oppose living in an integrated setting. Until that information is available, a subset of the 38,079 will be engaged through a set of flexible housing programs.
- There is sufficient funding authorized and forecasted to meet the target in the goal.
- Individuals accessing these housing options may include those exiting segregated settings such as: Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH), Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD), people with disabilities under age 65 in Nursing Facilities and other segregated settings. This number may also include people exiting the Department of Corrections facilities.
- DHS will monitor for unintended consequences to ensure appropriate new capacity is developed.

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

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

Strategies

Create More Affordable Housing

- Increase the number of affordable housing opportunities for people with disabilities exiting segregated settings by re-allocating existing funding.

Improve the Ability to Gather Information about Housing Choices

- Implement a process to gather and measure choices made by people with disabilities regarding housing.
- Once a process for capturing and measuring choice is in place, analyze the data and report annually to the subcabinet on progress in meeting goals.

Implement Reform for Housing Assistance Programs

- Implement housing policy changes adopted in 2015 legislative session. These policy changes will promote choice and access to integrated settings by reforming programs that currently provide combined housing and supports to allow greater flexibility.

Improve Future Models for Housing in the Community

- Increase access to information about integrated housing for people with disabilities through outreach, technical assistance and improved technology.
- Actively promote and encourage counties, tribes, and other providers to implement best-practices and person-centered strategies related to housing.
- Develop policy recommendations and strategies to access Medicaid coverage for housing related activities and services for people with disabilities.
- Identify and assess barriers for individuals to obtain and maintain housing, and provide recommendations to the subcabinet of strategies to address policy and funding barriers.

Responsible Agencies

- Department of Human Services
- Minnesota Housing Finance Agency

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Employment

Stakeholder Comments	
"In the spirit of person centered planning, it is important to recognize that appropriate choices need to be considered for everyone with a disability. For that to happen, it needs to be recognized that some individuals cannot and/or choose not to be competitively employed and need center-based employment as a vocational option."	Margie Sillery (2015)
"Community employment and integration is important for people with disabilities, however, we need to provide options and choice."	Anonymous (2013)
"Employment is a critical gateway to the core goals of Olmstead and drives many individual choices associated with living and participating in the most integrated community setting. Without a competitive job, many of the goals of *Olmstead* are challenging, if not impossible to achieve."	Don Lavin (2013)

What this topic means

Employment is about:

- Ensuring that people with disabilities have choices for competitive, meaningful, and sustained employment in the most integrated setting.
- Changing the prevailing attitudes, expectations, and beliefs about the integration of people with disabilities into the competitive workplace.

Employment is not about eliminating certain service options or closing specific facilities, instead it is about the state taking affirmative steps that include providing information about the benefits of integrated settings; facilitating visits or other experiences in such settings; and offering opportunities to meet people with disabilities who live, work and receive services in integrated settings, with their families, and with community providers. Public entities also must make reasonable efforts to identify and addresses any concerns or objections raised by the individual or another relevant decision-maker.

Employment Statistics

According to the Cornell University Employment and Disability Institute's Disability Status Report (data for 2010, published in 2012)[32]:

- The employment rate of working-age people (ages 21 to 64) with disabilities in Minnesota was 44.4%. For the general population it was 81.7%
- The percentage of working-age people with disabilities who were unemployed and actively looking for work was 12.3%. For people without a disability who were actively looking for work it was 33.5%.
- The percentage of working-age people with disabilities working full-time/full-year was 22.2% with average annual earnings of $36,300. For working-age people without disabilities, 58.3% were working full-time/full-year with average annual earnings of $45,300.

According to the 2014 State Rehabilitation Council Annual Report:

[32] Employment and Disability Institute conducts research and provides continuing education and technical assistance on many aspects of disability in the workplace. It is important to note that this information is based on US Census data which does not include information on people living in institutional settings.

- In FFY 2015, Vocational Rehabilitation Services (VRS) anticipates serving about 16,910 persons under Title I of the Rehabilitation Act, all of whom will be individuals with a significant disability.
- Estimate of the Number of Persons Potentially Eligible for Services. Of the approximately 225,000 Minnesotans between the ages of 16 and 64 with two or more long-lasting disabilities, it is estimated that approximately 150,000 are eligible for vocational rehabilitation services of which approximately 11% received State Vocational Rehabilitation Services. For comparison, according to DEED, in 2014, 13% of unemployed Minnesotans utilized the services of the State's Workforce Centers.

Vision statement

People with disabilities will have choices for competitive, meaningful, and sustained employment in the most integrated setting.

What we have achieved

- Adopted "Minnesota Employment First Policy" which promotes the opportunity for people with disabilities to make informed choices about employment. This policy views competitive, integrated employment as the first and preferred option for individuals with disabilities. It does not call for the elimination of certain service options or close specific facilities.
- Established two stakeholder groups that included people with disabilities to advise the Interagency Employment Panel, comprised of MDE, DEED and DHS.
- Completed "A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report" which identified settings that primarily provide segregated employment.
- DEED initiated changes in the state rule governing the Extended Employment (EE) program that cap non-integrated and subminimum wage subprograms and define procedures that shift funding to integrated competitive employment.
- In collaboration with DEED, DHS and MDE and individuals from the Employment First Coalition, technical assistance and training was provided to twelve local education agencies through the Employment Community of Practice during the 2014-2015 school years.
- As part of the "Olmstead Plan: Work and Benefits Family Outreach Plan", 1,115 youth with disabilities received benefit summaries and Disability Benefits estimator sessions to inform them of their employment planning choices and how integrated employment benefits work together. This was done through collaboration across DEED, DHS and MDE. Disability Benefits 101 (DB101.org) is a planning tool that provides information and resources on employment, health coverage and benefits. This is an on-going resource.
- The 2015 Minnesota legislature provided additional funding for the 2016-20117 biennium for programs that serve people with disabilities in integrated settings including: $2.0 million for Individual Placements and Supports (IPS) Employment under Minn. Stat. 265A.13-14; $.5 million for Extended Employment (EE) under Minn. Stat. 268A.15; and $2.0 million for deaf and hard of hearing services to youth and adults under Minn. Stat. 268A.16.
- DHS submitted a request to CMS to modify the Home and Community Based waiver to include services supporting integrated employment, informed by stakeholder input.

Measurable goals

Goal One: By September 30, 2019 the number of new individuals[33] receiving Vocational Rehabilitation Services (VRS) and State Services for the Blind (SSB) who are in competitive, integrated employment will increase by 14,820.

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

Annual Goals to increase the number of individuals in competitive, integrated employment**:**

- By September 30, 2015, the number of new individuals with disabilities working in competitive, integrated employment will be 2,853
- By September 30, 2016, the number of new individuals with disabilities working in competitive, integrated employment will be 2,911
- By September 30, 2017, the number of new individuals with disabilities working in competitive, integrated employment will be 2,969
- By September 30, 2018, the number of new individuals with disabilities working in competitive, integrated employment will be 3,028
- By September 30, 2019, the number of new individuals with disabilities will be working in competitive, integrated employment will be 3,059

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

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

Annual Goals to increase the number of individuals in competitive, integrated employment

- By June 30, 2017, a data system will be developed to measure the following: the number of individuals who are working in competitive, integrated employment; the number of individuals not working in competitive, integrated employment; and the number of individuals not working in competitive, integrated employment who would choose or not oppose competitive, integrated employment.
- By June 30, 2017[34], the number of individuals in competitive, integrated employment will increase by 1,500 individuals

[33] "New" individuals mean individuals who were closed successfully from the VR program. This is an unduplicated count of people working successfully in competitive, integrated jobs. These numbers are based on a historic trend for annual successful employment outcomes.

[34] The projected increase of 1,500 individuals includes increases for 2016 and 2017. This is necessary as data for 2016 will not be available until 2017.

- By June 30, 2018, the number of individuals in competitive, integrated employment will increase by 1,100 individuals
- By June 30, 2019, the number of individuals in competitive, integrated employment will increase by 1,200 individuals
- By June 30, 2020, the number of individuals in competitive, integrated employment will increase by 1,200 individuals

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

MDE, DEED and DHS will focus efforts on two groups of students consecutively.

- The first group (2014 group) will be all students with developmental cognitive disabilities, ages 19-21 receiving special education services and included in MDE's December 1, 2014, Unduplicated Child Count.
- The second group (2017 group) will be those students with developmental cognitive disabilities, ages 19-21 receiving special education services and included in MDE's December 1, 2017, Unduplicated Child Count.

Through our collaborative work MDE, DEED, and DHS will develop and enhance interagency strategies that can be replicated across other populations of students with disabilities.

Annual Goals for the number of students that enter into competitive, integrated employment:

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

- By June 30, 2016 (using FY 15 and FY 16 data), the number of students with Developmental Cognitive Disabilities (DCD) in competitive, integrated employment will be 125.
- By June 30, 2017, the number of additional students in competitive, integrated employment will be 188.

2017 group total in competitive, integrated employment = 450 (50%) (N=900)

- By June 30, 2018, the number of students in competitive, integrated employment will be 150.
- By June 30, 2019, the number of additional students in competitive, integrated employment will be 150.
- By June 30, 2020, the number of additional students in competitive, integrated employment will be 150.

Rationale

- The second goal targets 50,157 working age individuals with disabilities in certain Medicaid funded programs who are receiving Long Term Services and Supports and/or Mental Health treatment services. These are programs where there is the most opportunity for strategies to be carried out to increase competitive, integrated outcomes. Some individuals served in these programs also receive Extended Employment services under Vocational Rehabilitation Services.

- The DHS employment data system has limitations. The data system does not provide a way to measure an increase in competitive, integrated employment.
- The Post School Outcome is a sample survey and does not represent the entire population. This will be used until a broader set of measures is developed. At that time the baseline and measurable goals will be revised.
- Students with Developmental Cognitive Disability (DCD) are at the greatest risk of entering into a segregated employment setting after leaving high school. In setting the baseline and goal, a sample of post-school outcome data was used.
- Because of the limitations of the data, it is not possible to determine if the growth in the level of employment is reasonable, so a baseline will be established in 2017 using a new data system and annual goals may be revised.
- In the next five years, there is a projected increase in excess of 20,000 individuals seeking competitive, integrated employment through VRS. These individuals include students exiting school or DHS programs.
- There is existing funding to support these goals.

Strategies

Implement the Employment First Policy

- Implement Minnesota Employment First Policy which encourages competitive, integrated employment.

Develop an Interagency Data System to Improve Measurement of Integrated Employment

- DHS will establish a data collection system to measure movement into competitive, integrated employment. The data system will be compatible with the system used by VRS and will include: Employment Type/Work Setting (Facility-based, Crew, Competitive Employment, Self-employed); Hourly Wage; Number hours worked per week; Benefits provided (health care, dental, etc.); Employer of record (Provider or employer); Number of people currently in segregated settings who do not oppose moving into Competitive Employment; specific information on subpopulations; and Individual level identifying information to track outcomes over time.

Reform Funding Policies to Promote Competitive, Integrated Employment

- Beginning in the 2015-2016 school year any new Special Education Transition Disabled Funds for vocational evaluations, and/or employment placement will be used in competitive, integrated, employment settings.
- Redirect funds to follow and support an individual's informed choice for employment.

Develop Additional Strategies for Increasing Competitive, Integrated Employment among People with Disabilities

- Adopt the evidence-based practice of engaging youth in paid work before exiting school.
- Build capacity at state/regional levels by expanding evidence-based and promising practices, such as:
    - Project SEARCH (youth)
    - Individual Placements and Supports (IPS) Employment program (for adults with serious mental illness)

- Provide training, technical assistance, public information and outreach regarding competitive, integrated employment to individuals and families, providers, educators, vocational rehabilitation services, staff, county and tribal case managers and other stakeholders

Implement the Workforce Innovation and Opportunity Act (WIOA) and Section 503

- Implement federal requirements under Workforce Innovation and Opportunity Act (WIOA), the federal law governing publicly funded workforce development programs.
- Implement federal rule Section 503 that sets a hiring goal for federal contractors and subcontractors that 7% of each job group in their workforce be qualified people with disabilities.

Implement the Home and Community Based Services (HCBS) Rule in a Manner that Supports Competitive, Integrated Employment

- Implement federal requirements regarding employment under the Centers for Medicare and Medicaid Services Home and Community-Based Services Rule, the federal rule that governs waivered services for individuals with disabilities.
- Request modification of HCBS waiver plan to support competitive, integrated employment.

Responsible Agencies

- Department of Human Services
- Department of Employment and Economic Development
- Minnesota Department of Education

Lifelong Learning and Education

Stakeholder Comments		
	"Perhaps the most important benefit of inclusion rests in the academic benefits for students with special needs. These students become engaged in their education as opposed to staying unchallenged inside segregated classrooms."	Leslie Sieleni (2013)
	"My hopes for my daughter were dashed when the special education team at her school told me that the best option for her future would be placement in a sheltered workshop because mainstreaming wasn't working for her, they assumed they were correct so no other options were explored. Fortunately a teacher friend suggested having her reassessed at a different school, whose opinion was much more varied and positive."	Jane Harris (2013)
	"School inclusion is missing; disability should be part of all diversity. Acceptance requires association. There is token inclusion. Exposure leads to new attitudes. There is no systemic or structural change toward inclusion. Inclusion in schools will lead to real change faster."	Michael Stern (2013)
	"People with disabilities are not well represented in higher education and employment due to a lack of accessibility and adequate preparatory opportunities."	Bridget Siljander (2013)

What this topic means

Minnesota strives to ensure students with disabilities receive an equal opportunity to obtain a high quality education in the most integrated setting that prepares them to participate in the community, including employment and postsecondary education.

The federal Individuals with Disabilities Education Act (IDEA) of 2004[35] requires that students with disabilities receive special education services in the least restrictive environment appropriate to meet their needs. This means that removal from regular education classes occurs only when a student cannot be successfully educated in regular classes, even with supplemental aids and services. When a student is removed from the regular educational environment for part of the day, the student must still be educated with non-disabled peers as much as possible.

The learning needs of the student and the services to be provided must be designated in an individualized education program (IEP). Under state law, all students with disabilities are provided the special instruction and services which are appropriate to their needs, and their individualized education program must address the student's needs for transition from secondary services to postsecondary education and training, employment, community participation, recreation, and leisure and home living.

Vision statement

People with disabilities will experience an inclusive education system at all levels and lifelong learning opportunities that enable the full development of individual talents, interests, creativity, and mental and

[35] IDEA is a federal law that governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

physical abilities. They will be educated in the most integrated educational setting from preschool through grade twelve and will transition to the most integrated post-secondary setting or employment.

What we have achieved

- A "Postsecondary Resource Guide – Successfully Preparing Students with Disabilities" and four training modules were created in collaboration between Minnesota Department of Education and the Minnesota State Colleges and Universities (MNSCU). The Resource guide can be viewed at www.normandale.edu/advising-and-services/students-with-disabilities/resources-and-links.
- Adopted a reintegration protocol to transition students placed at the Minnesota Corrections Facility (MCF) – Red Wing to more integrated settings. The protocol is a collaborative effort of the Minnesota Department of Education, MCF – Red Wing and Institute on Community Integration at the University of Minnesota.

Measurable goals

Goal One: By December 1, 2019 the number of students with disabilities[36], receiving instruction in the most integrated setting[37], will increase by 1,500 (from 67,917 to 69,417).

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

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

- By December 1, 2015 there will be an increase of 300 over baseline to 68,217
- By December 1, 2016 there will be an increase of 600 over baseline to 68,517
- By December 1, 2017 there will be an increase of 900 over baseline to 68,817
- By December 1, 2018 there will be an increase of 1,200 over baseline to 69,117
- By December 1, 2019 there will be an increase of 1,500 over baseline to 69,417

Goal Two: By October 1, 2020 the number of students who have entered into an integrated postsecondary setting within one year of leaving secondary education will increase by 250 (from 225 to 475).

Baseline: Using the 2014 Post School Outcome Survey, of the 962 students with disabilities who participated in the survey, 225 (23.3%) entered into an integrated postsecondary setting within one year of leaving secondary education.

Annual Goals to increase the number of students entering an integrated postsecondary education setting are:

- By October 1, 2016 there will be an increase of 50 over baseline to 275
- By October 1, 2017 there will be an increase of 100 over baseline to 325
- By October 1, 2018 there will be an increase of 150 over baseline to 375
- By October 1, 2019 there will be an increase of 200 over baseline to 425

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[36] "students with disabilities" are defined as students with an Individualized Education Program age 6 to 21 years;
[37] "most integrated setting" refers to receiving instruction in regular classes alongside peers without disabilities, for 80% or more of the school day

- By October 1, 2020 there will be an increase of 250 over baseline to 475

Rationale

Goal One

- In 2013, Minnesota schools identified and provided special education services to 109,332 students with disabilities ages 6 to 21, as reported on the IDEA Section 618 Data. Of that number, 67,917 students with disabilities (62.1%) received instruction in regular classes 80% or more of their school day. Of that number, 41,415 students with disabilities (37.9%) received instruction in regular classes less than 79% or less of their school day.
- A particular focus of attention includes students with Autism Spectrum Disorders or Developmental Cognitive Disabilities ages 6 – 18, who comprise 19.9% of students with disabilities. However, this same student group comprised 12.6% of students with disabilities receiving instruction in regular classes for 80% or more of their school day.
- The projected growth in the number of students in integrated classrooms (to 63.3% of the current base) is attainable given previous success in the application of the identified strategies.

Goal Two

- The Minnesota Post School Outcome Survey measures both competitive employment, enrollment in higher education as well as participation in other employment or postsecondary education training programs as defined by the National Post School Outcome Center.
- The Post School Outcome Survey provides information from a snapshot in time. It will be used as a short-term proxy measure to identify how many students with disabilities are enrolled in an integrated postsecondary setting. This methodology will be used until a broader data system is developed. At that time, the baseline and measurable goals will be reviewed and adjusted.

Strategies

Goal One

Improve and Increase the Effective Use of Positive Supports in Working with Students with Disabilities

- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) which improves the capacity of school districts to include students in integrated classrooms. There are currently 479 schools implementing PBIS, with another 53 set to begin in fall of 2015. By the 2015-2016 school year there will be 532 or 26.5% of Minnesota schools implementing PBIS, impacting an estimated 247,009 students (30% of all students).

Continue Strategies to Effectively Support Students with Low-Incidence Disablities

- Continue implementation of the Regional Low Incidence Disability Projects (RLIP). These projects provide equitable services to students with low incidence disabilities (those students in categorical areas comprising less than 10% of students receiving special education services) throughout the state. The projects support equity in service through professional development, technical assistance and access to qualified educators to support access to a free, appropriate public education in the student's home district.

Improve Graduation Rates for Students with Disabilities

- Continue the implementation of the IDEA State Performance Plan (SPP), including the State Systemic Improvement Plan (SSIP) and the State Identfied Measurable Result (SIMR). Application of these strategies has proven successful in increasing graduation rates for students with disabilities.

Improve Reintegration Strategies for Students Returning Back to Resident Schools

- Continue collaboration between MDE and DOC at the Minnesota Correctional Facility in Red Wing. This project will improve reintegration of students with disabilities exiting the facility to their resident district or to a more integrated setting.
- Implement a reintegration protocol statewide for students placed out of state or in juvenile correctional facilities.

Goal Two

Increase the Number of Students with Disabilities Pursuing Post-Secondary Education

- Utilize the "Postsecondary Resource Guide- Successfully Preparing Students with Disabilities." This resource guide and training modules provide regional technical assistance to IEP teams including youth and families, to increase the number of students with disabilities who enter into integrated, postsecondary settings.
- MDE will continue working with the National Secondary Transition Technical Assistance Center (NSTTAC) to provide regional capacity building training for the purpose of increasing the number of students with disabilities who are in a postsecondary education setting by 2020.
- MDE will begin to explore a broader data system to measure how many students with disabilities are graduating from high school entering into an integrated postsecondary education setting after graduation.

Responsible Agencies

- Minnesota Department of Education
- Department of Corrections
- Department of Human Services

Waiting List

Stakeholder Comment		
	"I believe that our waiver rules and systems are set up exactly the same way as organ transplants: you may have a high need, and be on an imaginary "list," but each time a new waiver opportunity – or a new organ in my example –is available, someone else may always be seen as needier than you and be put at the top of the list ahead of you."	Sharon Armus (2013)

What this topic means

In this topic, "waiver services" refers to two home and community-based service waiver programs for people with disabilities that have waiting lists: 1) Community Access for Disability Inclusion (CADI); and, 2) Developmental Disabilities (DD). Waivers are funded by a combination of federal Medical Assistance (MA) and state funds. They are called "waiver services" because the federal government waives the institutional requirements of MA to allow funds to be used for services in the home and community when people would otherwise require the level of care provided in institutional settings.

MA funding for institutional care is not an entitlement, but can be obtained through an application process through which a person with a disability becomes eligible for these services. This means that states can set limits on the growth of these programs. In Minnesota, waiver services waiting lists occur because the budgets for the waiver services are limited by: 1) the amount the federal government approves in the state waiver plans; and, 2) the amount the legislature appropriates for the state share of the service costs. A waiting list is created when people who are eligible for the service do not have immediate access to the service because of the funding limits. In addition to the waiver services, Minnesota may provide other services to people with disabilities while they are on the waiting list for waiver services.

The urgency of an individual's need for waiver services varies. Some people are waiting to exit institutional settings; some people are at serious risk of institutionalization because they lack supports to remain in the community; some people in the community are not at risk of institutionalization, but will need waiver services within a year in order to remain in the community. We will prioritize access to waiver funding and services according to these levels of urgency. Additionally, the waiver services waiting list will move at a reasonable pace, according to urgency of need, and not controlled by endeavors to keep institutions populated.

In this topic area, we will use statutory priorities for accessing waiver service planning and funding so that the waiver services waiting lists move at a reasonable pace according to urgency of need.

Vision statement

Individuals who qualify for home and community based waiver services will be approved for services at a reasonable pace, determined by the individual's urgency of need.

What we have achieved

- The Department of Human Services (DHS) worked with stakeholders to create four categories for individuals currently on the waiting list to indicate urgency for waiver services and reasonable pace standards for each category. The four categories are: institutional exit, immediate need, defined need, and future need. The categories, reasonable pace standards and recommendations were published in the Home and Community-Based Supports and Services Waiver Waiting List Report.
- DHS conducted an analysis of the waiver services waiting lists and funding that would be required to eliminate the waiting list and provided the information to the legislature in a "Report on Program Waiting Lists" in December 2014. In 2015, the legislature authorized changes to the management of the waiver services, including strategies that increase the state's ability to use funds to serve people on the waiting list. Under the new legislation, county and tribal agencies (lead Agencies) are required to spend at least 97% of their waiver services funding allocation while maintaining a list of persons waiting for waiver services, or the lead agency must submit a corrective action plan to DHS' Commissioner for approval stating actions the lead agency will take to assure reasonable and timely access to waiver services for persons waiting for services. Minn. Stat. §§ 256B.0916, subd. 12 and 256B.49, subd. 27.
- Technical assistance and communications have occurred with lead agencies to maximize funding utilization; increase numbers served, and redistribute funding across lead agencies where necessary to meet statutory priorities. Minn. Stat. § 256B.0916, subd. 12 and 256B.49, subd. 27
- In 2015, the legislature appropriated $300 million towards elimination of waiver services waiting lists.
- Truven Health Analytics September 2014[38] reports shows that Minnesota ranks number one in the country for serving people with a disability at home and in their communities as measured by home and community based service waiver recipients per 1,000 people based on CMS federal reporting, 2010-2011.

Measurable goals

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

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

Goal Two: By December 1, 2015, the Developmental Disabilities (DD) waiver waiting list will move at a reasonable pace.

Baseline: In April 2015, there were 3,586 individuals on the DD waiver waiting list.

Persons exiting institutional settings will move off the waiting list at a reasonable pace, which means that:

[38] Truven Health Analytics. (September 2014). *Medicaid 1915(C) Waiver Data Based on the CMS 372 Report, 2010-2011*. Prepared for Centers for Medicare and Medicaid Services. Accessed July 16, 2014.

- Beginning December 1, 2015, as people residing in an institutional setting are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person makes an informed choice of alternative community services that are more integrated, appropriate to meet their individual needs, and the person is not opposed to moving, and would like to receive home and community based services.

Persons with an immediate need will move off the waiting list at a reasonable pace, which means that:

- Beginning December 1, 2015, as people are assessed, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days after the person meets criteria under Minn. Statutes, sections 256B.49, subdivision 11a(b) and 256B.092, subdivision 12(b)**.**

  The current statutory criteria are: The person has an unstable living situation due to age, incapacity, or sudden loss of primary caregivers; is moving from an institution due to bed closure; experiences a sudden closure of their current living arrangement; requires protection from confirmed abuse, neglect, or exploitation; experiences a sudden change in need that can no longer be met through state plan services or other funding resources alone or meet other priorities established by DHS.

Persons with a defined need of requiring services within a year of assessment will move off the waiting list at a reasonable pace, which means that:

- Beginning December 1, 2015, as people are assessed as having a defined need for waiver services within a year from the data of assessment, and within available funding limits, waiver service planning and funding will be authorized as soon as possible, but no later than 45 days of determining the defined need.

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

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

Goal Five: By June 30, 2020, the DD waiver waiting list will be eliminated, within available funding limits, for persons with a defined need.

Rationale

- The Legislature authorized sufficient funding to end the CADI waiver waiting list over the 2016-2017 biennium by allowing previous legislative limits on growth to expire. The date for goal one is October 2016 because it is projected to take 15 months to complete assessments and funding authorizations. DHS will establish targets for lead agencies to expedite the process of authorizing funding.
- The reasonable pace standards outlined in goal two will be implemented on December 1, 2015, and planned new data systems and training will be provided on the new urgency categories and standards to lead agencies. Annual data will be available by December 2016, at which time a baseline will be established and the reasonable pace goals will be reevaluated, including reevaluation of sufficiency of funding and a determination of what funding would be needed to eliminate any remaining waiting list. An interim analysis of data will be conducted throughout the first year to monitor progress and assess targets.
- While it is anticipated that the waiting list for persons exiting an ICF/DD and persons with immediate need will be eliminated by January 15, 2017, which is 45 days from the completion of annual assessments of those on the waiting list, there is a lag in the data before analysis can be completed, which is why March 1, 2017, is the goal three date. The assumptions for this goal will be evaluated as the baseline of the number of people in these two urgency categories is obtained.
- Although there was a legislatively authorized increase in funding for DD waivers beginning July 1, 2015, due to the limits of the DD waiver plan, it may not be sufficient to completely eliminate the waiting list for persons in the "defined need" category. Limits on growth are based on legislative appropriations and the federally approved waiver plan. The federally approved DD waiver plan currently has a limit on funding growth of 300 persons/year.
- Individuals are considered as moving off the waiting list once they are authorized for funding.
- An individual will be identified as having a "future need" if, after assessment, the individual does not meet criteria for the other three categories (institutional exit, immediate need, and defined need) and instead identified a future need for services that is over a year from the assessment date. An individual with a future need will be placed on a waiver eligibility list, but will not be placed on the waiting list. People will be offered an assessment annually, or any time that their needs or situation change. At that point, the reasonable pace standards will be applied.
- Kentucky and Tennessee have implemented similar urgency categories for individuals on the waiting list. The experience from these states shows that people in the emergent categories move off the waiting list quickly. Those with planned needs tend to wait longer. DHS anticipates that the urgency category populations will be similar to the experience of those states.

Strategies

Reform Waiting List Protocols to Incorporate Urgency of Need

- Implement new urgency of need categorization system and report to the subcabinet as outlined in the Home and Community-Based Supports and Services Waiver Waiting List Report, dated March 3, 2015. Reporting on the new urgency categorization system, the new reasonable pace standards, and an estimate on funding needed to eliminate the waiting list will be reported to the legislature annually and to the subcabinet twice each year.

- Due process protections available to people with disabilities will be modified as necessary, to reflect new waiting list protocols.
- A workplan will be developed for the analysis of baseline data on urgency of need and reasonable pace as it becomes available to understand: the needs of persons waiting; identify potential options to meet their needs; complete evaluation of existing programs to determine if there are changes which would enable programs to be more effective; conduct analysis of options; and provide recommendations for a plan that will meet the needs of those with disabilities to receive needed services in the most integrated settings. This plan will be provided to the subcabinet.

Implement Initiatives to Speed up Movement from Waiting Lists

- Technical assistance will be provided to lead agencies to help them expedite required assessments and authorization of funding so people can begin services and come off the waiting list. This will include strategies such as allowing case managers to use the DD Screening and Long Term Care Consultation documents to begin planning for services, and completing required assessment updates, rather than limiting assessments to certified assessors. This draws on additional capacity of contracted private agency case managers in addition to lead agency staff, allowing planning to begin more quickly.
- Targets for progress will be given to lead agencies, particularly those with the highest numbers of people waiting, and their contracted case management providers, to assure progress. This will include data on those who have been waiting the longest, so that priority can be given to those waiting the longest within each category, in addition to those with a known urgent need. Technical assistance will be provided to these parties to streamline processes where appropriate to facilitate access to funding over the year.

Reform Management of Waiting List Management Systems

- The Waiver Management System, which is used with lead agencies and DHS to manage waiver funding, will be revised to gather needed data on waiting list categories of need, and the date when funding is authorized.

Responsible Agency

- Department of Human Services

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Transportation

Stakeholder Comments	
"There is a meager sidewalk along a portion of the highway through town. …the sidewalk and the crossing areas at major intersections adjacent to U.S. Highway 61 were clogged with snow and ice. A person with disabilities couldn't have gotten close enough to the crosswalk button to press it many days after a snow storm."	Mike Brooks (2015)
"The Department of Transportation should consider developing weekly direct transportation routes to some of the smaller rural areas in small towns that will allow individuals with disabilities, seniors, and families with limited or no transportation options access to shopping hubs, medical centers, recreation, social activities and the larger communities."	*Dalaine Remes (2013)*
"…in rural MN we do not have regularly scheduled Public Transportation. We have public transportation when we have enough volunteer drivers – and then only Monday through Friday and before 6 p.m."	Deanna Steckman (2013)

What this topic means

Transportation is a key aspect in an individual's independence and quality of life. Transportation is also part of a communities' foundation and recognizes the importance, significance and context of place—not just as destinations, but also where people live, work, learn, and enjoy life regardless of socio-economic status or individual ability.

The Minnesota Department of Transportation (MnDOT) in conjunction the Department of Human Services will integrate Olmstead principles in the state's transportation systems. The state will continue to focus on providing accessibility improvements in its right of way and improving transit access and ridership. The state will also ensure that transportation is as integrated as possible and that transportation allows people with disabilities to participate their communities.

Vision statement

People with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections. They will have increased access to transit options and transportation modes.

What we have achieved

- Completed the Minnesota Transit Funding Primer Technical Report which inventories transportation funding programs available in Minnesota from the federal and state governments, including funding levels and details about the administration of each program. The goal of the report is to identify opportunities for coordination and was completed through a partnership between MnDOT and the Minnesota Council on Transportation Access (MCOTA).
- Updated the MnDOT "ADA Transition Plan" to reflect changes in program delivery and facilities inventory.
- Published the "Olmstead Transportation Forum Final Report" which summarized a statewide open forum on transportation for people with disabilities facilitated by DHS and MnDOT.
- Inclusion of accessibility features in all transportation projects has been an ongoing commitment since 2009.

Measurable goals

Goal One: By December 31, 2020, accessibility improvements will be made to 4,200 curb ramps (increase from base of 19% to 38%) and 250 accessible pedestrian signals (increase from base of 10% to 50%). By January 31, 2016 a target will be established for sidewalk improvements.

Curb Ramps

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

- By December 31, 2020 accessibility improvements will be made to 4,200 curb ramps[39] bringing the percentage of compliant ramps to approximately 38%.

Accessible Pedestrian Signals

Baseline: In 2009: 10% of eligible state highway intersections with accessible pedestrian signals (APS) were installed.

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

Annual Goals to increase the number of APS installations:

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

Sidewalks

Baseline: In 2012: 46% of sidewalks on MnDOT right of way met 2010 ADA Standard and Public Right of Way (PROW) guidance.

- By January 31, 2016, an annual target for remaining un-remediated sidewalks will be established.

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

Goal Two: By 2025, additional rides and service hours will increase the annual number of passenger trips to 18.8 million in Greater Minnesota (approximately 50% increase).

Baseline: In 2014 the annual number of passenger trips was 12,543,553

Annual Goals to increase the annual number of passenger trips:

- By 2015 the annual number of passenger trips will increase to 13,129,593
- By 2020 the annual number of passenger trips will increase to 16,059,797
- By 2025 the annual number of passenger trips will increase to 18,800,000

Goal Three: By 2020, expand transit coverage so that 90% of the public transportation service areas in Minnesota will meet minimum service guidelines for access.

Transit access is measured against industry recognized standards for the minimal level of transit availability needed by population size. Availability is tracked as span of service, which is the number of hours during the day when transit service is available in a particular area. The measure is based on industry recognized standards and is incorporated into both the Metropolitan Council Transportation Policy Plan and the MnDOT Greater Minnesota Transit Investment Plan[40].

Baseline: A baseline for access will be established in 2016.

Goal Four: By 2020, transit systems' on time performance will be 90% or greater statewide.

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

Baseline for on time performance in 2014 was:

- Transit Link – 97% within a half hour
- Metro Mobility – 96.3% within a half hour timeframe
- Metro Transit – 86% within one minute early – four minutes late
- Greater Minnesota – Baseline to be developed in 2016

Five year goals to improve on time performance:

- Transit Link – maintain current performance (97% within a half hour)
- Metro Mobility – maintain current performance (96.3% within a half hour timeframe)
- Metro Transit – improve to a service level of 90% or greater
- Greater Minnesota – To be developed in 2016

[40] Greater Minnesota Transit Investment Plan is available at www.dot.state.mn.us/transit/reports/investmentplan

Rationale

Goal One

- All of the goals focus on five year timelines and are consistent with MnDOT's project planning and programming based on anticipated funding with improvements to the accessibility of the system tracked on an annual basis. The annual tracking provides the status of the system and allows us to see emerging trends and needs in how accessibility is being provided.
- Accessibility improvements are required to be delivered as part of roadway projects rather than a standalone program to ensure that accessibility is routinely provided in all projects. The mix of roadway projects in a given fiscal year is dynamic, which is why we are unable to determine a precise number of curb ramp improvements in a given year. The goal has been based on historical averages and anticipated funding.
- The goal is constrained primarily by MnDOT's budget overseen by the legislature; however accessible pedestrian facilities are identified as a portion of MnDOT's budget in the Minnesota State Highway Investment Plan (MnSHIP). MnSHIP investment policy has allocated 1.6% of MnDOT's capital budget for the first 10 years and 1.8% of MnDOT's capital budget for years 11-20 to accessible pedestrian facilities, representing a rolling average investment of $12 million a year.

Goals Two - Four

- The goal appears in state statute and has a timeframe of ten years. Meeting the legislative goal is important to realizing the overarching vision of the Olmstead Plan because the availability of transit is consistently identified as important by the disability community as integral to living an independent, integrated life.
- The model to estimate transit need was developed during the 2011 Greater Minnesota Transit Investment Plan using demographic factors that can be updated with new estimates from the State Demographer's Office. This model will be re-evaluated when the Greater Minnesota Transit Investment Plan is updated in 2016.
- The measures that have been selected for this goal also allow for tracking of progress in the seven county Metro area in the areas of access and reliability, allowing for a more complete picture of how transit needs are being met for people with disabilities.
- Achieving the first four years of the goal is realistic based on current funding forecasts from Minnesota Management and Budget (MMB). In the fifth year and beyond, the goal will likely not be met without increased funding for Greater MN transit from the Minnesota legislature.
- The primary barriers that we face in achieving the goal are: (1) budgetary: (2) not being able to determine at a population level the degree to which meeting public transit goals provides benefit to the Olmstead population and (3) the impact of reduced capacity in program specific transportation to individuals' overall transportation access.

Strategies

Goal One

Increase the Number of Accessibility Improvements Made as Part of Construction Projects

- Accessibility improvements are included as part of any project meeting the alterations threshold, as required by the ADA, to ensure program consistency and ongoing investment. In general the alteration threshold is met when there is a pavement project such as a mill and overlay, bridge rehabilitation, or signal replacement. The four year schedule of projects is found in MnDOT's State Transportation Improvement Plan (STIP). [41]
- MnDOT will continue to work with our local partners though our project development process to encourage additional accessibility improvements whenever possible.

Increase Involvement in Transportation Planning by People with Disabilities

- MnSHIP is scheduled to be rewritten in 2016 and the investment levels will be reassessed as part of the plan update. MnSHIP is developed with significant public input and sets investment targets, including those for accessibility improvements, for the agency based on system conditions and revenue.

Goals Two - Four

Improve the Ability to Assess Transit Ridership by People with Disabilities

- At this time the only regular and ongoing data set available to public transit on ridership is a count of total one way rides. This data does not differentiate whether a rider has a disability or not. MnDOT, in conjunction with DHS, will explore the data and data privacy issues surrounding identifying the ridership of a specific user group. Options that will be explored are:
    - Requiring funders of specific clients to gather information on the means of travel for their clients.
    - Identifying the legal and data privacy issues of having riders voluntarily provide information on their disability status as a means to gain population-specific information.

Improve Transit Services for People with Disabilities

- MnDOT, the Metropolitan Council, and local transit systems are the responsible parties with DHS providing a significant support and coordinating role. The agencies will collaborate through established planning processes and contract oversight to ensure that continual progress to the targets is being made.
- On time performance efforts will be focused initially on those services with poor on time performance.

Responsible Agencies

- Department of Transportation
- Metropolitan Council

[41] More information on STIP can be found at www.dot.state.mn.us/planning/program/stip.html

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Healthcare and Healthy Living

Stakeholder Comments		
	"I need to be in a community where there are adequate health supports."	John Grobe (2015)
	"People with developmental disabilities have unique medical needs the regular doctor or specialist doesn't know how to treat."	David Hanke (2015)
	"Many people with mental illnesses need at least bi-annual dental care to mitigate the impact of dry mouth and other side effects from some psychiatric medications that negatively impact dental health."	Sue Abderholden (2013)

What this topic means

Healthcare is "the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions."[42]
Healthy living is making choices which are intended to improve a person's health. For example, healthy living includes having support to be active every day, to eat healthy foods, and to use medicine safely and as prescribed.

Health disparities are defined as significant differences in "the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates."[43] Health disparities for people with disabilities present barriers to full integration. Some problems with access to healthcare that exist for many Minnesotans have a significant impact on people with disabilities. For example, some people with disabilities may not be able to schedule dental appointments on a regular basis because there are not enough dentists and dental hygienists able to provide care. This is due to location (in parts of Greater Minnesota, there are not enough dental practitioners to serve all people); to affordability (not everyone has insurance coverage that includes dental care); and to some providers not knowing how to serve people with disabilities. Many people with disabilities develop other diseases (hypertension, heart disease, diabetes, stroke, cancer) at a higher frequency than people without disabilities. Some people with disabilities die at a much younger age than people without disabilities[44].

Minnesota is engaged in significant healthcare reform, including expanding coordinated care, engaging in statewide health improvement initiatives, and encouraging use of electronic healthcare records; an important aspect of the Olmstead Plan is to ensure that integration and inclusion of people with disabilities will be incorporated in these efforts.

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[42] American Heritage Medical Dictionary, "Healthcare." Boston: Houghton Mifflin Harcourt Publishing, 2008, 236
[43] Minority Health and Health Disparities Research and Education Act of 2000, United States Public Law 106-525, available at http://www.gpo.gov/fdsys/pkg/PLAW-106publ525/pdf/PLAW-106publ525.pdf
[44] As examples of studies showing health disparities for people with disabilities, review CDC "Disability and Secondary Conditions" in Healthy People 2010, http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review_focus_area_06.pdf and Goodell, Druss, and Walker. *Mental disorders and medical comorbidity*, Policy Brief No. 21, February 2011, Robert Wood Johnson Foundation. Accessed October 17, 2013, http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html.

Vision statement

People with disabilities, regardless of their age, type of disability, or place of residence, will have access to a coordinated system of health services that meets individual needs, supports good health, prevents secondary conditions, and ensures the opportunity for a satisfying and meaningful life.

What we have achieved

- MDH and DHS established baseline information about primary care teams across Minnesota that are able to provide integrated, person-centered primary care for people with disabilities
- DHS published "Health Care and Community Supports Administrations Overview of Behavioral Health Homes" which described the extensive stakeholder involvement and progress toward implementing a framework developed to provide services in a person-centered system of care for Minnesotans with serious mental illness who are Medicaid consumers and have complex chronic health conditions.
- DHS conducted a study on dental access and reimbursement for Minnesota Health Care Programs (MHCP). The findings "Recommendations for Improving Oral Health Services Delivery System-February 2014" were reported to the legislature.
- DHS completed a dental study submitted to legislature entitled "Delivery System for Oral Health" which built on the February 2014 report referenced above.
- DHS completed a report entitled "Olmstead Plan: Baseline Data for Current Care" focusing on variations in utilization of primary care in Medicaid (including dental) by persons with and without disabilities.
- MDH completed a system analysis describing barriers that need resolution for transitioning youth with special health care needs to adult health care. This "Olmstead Benchmark Report" was completed October 2014 and includes a plan for addressing those barriers.
- MDH completed "The Status of Oral Health in Minnesota" September 2013 report describing the status of dental diseases and oral health conditions in the state. This report includes information related to disparities in the status of dental diseases and oral conditions among population groups.

Measurable goals

Goal One: By December 31, 2018, the number/percent of individuals with disabilities and/or serious mental illness accessing appropriate preventive care[45] focusing specifically on cervical cancer screening and follow up care for cardiovascular conditions will increase by 833 people compared to the baseline.

As specific indicators that individuals with disabilities are accessing appropriate care, cervical cancer screening and follow-up care for cardiovascular conditions will be tracked. These are two areas where health care outcome disparities have been identified.

- Cervical Cancer screening - Reduce disparities in cervical cancer screening by 10% (increase of 616 more women being screened).
- Follow-up care for cardiovascular conditions - Reduce disparities in appropriate follow-up care for cardiovascular conditions by 5% (increase of 217 more people receiving appropriate follow-up care).

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

Baseline: In 2013[46], the number of women receiving cervical cancer screenings was 21,393 and the number of individuals accessing follow up care for cardiovascular conditions was 1,589.

Annual Goals to increase the number of individuals accessing appropriate care:

- By December 31, 2016 the number accessing appropriate care will increase by 205 over baseline
- By December 31, 2017 the number accessing appropriate care will increase by 518 over baseline
- By December 31, 2018 the number accessing appropriate care will increase by 833 over baseline

Goal Two: By December 31, 2018, the number of individuals with disabilities and/or serious mental illness accessing dental care will increase by 1,229 children and 1,055 adults over baseline.

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

Annual Goals to increase the number of children accessing dental care:

- By December 31, 2016 the number of children accessing dental care will increase by 410 over baseline
- By December 31, 2017 the number of children accessing dental care will increase by 820 over baseline
- By December 31, 2018 the number of children accessing dental care will increase by 1,229 over baseline

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

Annual Goals to increase the number of adults accessing dental care:

- By December 31, 2016 the number of adults accessing dental care will increase by 335 over baseline
- By December 31, 2017 the number of adults accessing dental care will increase by 670 over baseline
- By December 31, 2018 the number of adults accessing dental care will increase by 1,055 over baseline.

Rationale

- The "Baseline Data for Current Care" report identified health care disparities between people with disabilities and/or serious mental illness as compared to people without disabilities and/or mental illness in three areas. Those areas included cervical cancer screening for women; follow up care for cardiovascular conditions; and access to dental care for children. Data does not show disparities among adults in access to dental care. However, there is concern that there may be disparities in the intrusiveness of procedures for adults with disabilities (for example more tooth extractions versus preventive services).

[46] Baselines for these goals are from the 2013 "Olmstead Plan: Baseline Data for Current Care" Report.

- Achieving the cervical cancer screening goal, reduces the disparity by 10% (ensuring at least 616 more women have screenings over the 2013 baseline of 21,393).
- Achieving the follow up care for cardiovascular conditions goal, reduces the disparity (ensuring at least 217 more people receive appropriate follow-up care over 2013 baseline of 1,589).
- Achieving the accessing dental visits goal for children, reduces the disparity (ensuring at least 1,229 children over the baseline of 16,360).
- Measuring access to health care does not provide an indication of the health care outcome achieved for the individual. Measures for health care outcomes need to be established.

Strategies

Improve Dental Care for People with Disabilities

- Implement increase in dental payment rates in January 2016. Increase in dental rates has historically resulted in increased access to dental care for people with disabilities.
- Implement the recommendations from the "Recommendations for Improving Oral Health Services Delivery System" Report and the follow up report, "Delivery System for Oral Health."
- Implement "Minnesota Oral Health Plan."
- Increase the number of providers and the level of access of people with disabilities to providers.

Expand the Use of Health Care Homes and Behavioral Health Homes

- Implement behavioral health homes in July 2016. Behavioral health homes models have demonstrated improved overall health for people with severe mental illness.
- Continue to expand the number of health care homes. Health care homes provide comprehensive health care for people with disabilities.

Improve Access to Health Care for People with Disabilities

- Continue health care messaging targeted for people with disabilities to ensure that people with disabilities and their family members are able to access primary health care providers that understand their disabilities.
- Continue health care messaging to providers in the medical community regarding disabilities and disparities of health care among people with disabilities.
- Increase the level of access to adult health care by transition age youth.

Develop and Implement Measures for Health Outcomes

- Develop and implement health outcome measures. Studying health outcomes will indicate the effectiveness of the health care delivery system and identify potential opportunities for improvement.

Responsible Agencies

- Department of Human Services
- Minnesota Department of Health

Positive Supports

Stakeholder Comment		
	Our child was removed from the school environment in November 2013 due to the excessive use of restrictive procedures and the harm done to him because of it. He has been on home bound services since then."	Sharon Kostiuk (2015)

What this topic means

An essential component of quality of life is being treated with dignity and respect. Minnesota is committed to supporting people through the use of positive practices, and prohibitions on use of aversive and restrictive procedures. There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques. There is strong evidence that positive approaches and planning that builds on the strengths and interests of the person are effective. Implementation of this vision will require a culture change throughout the service system, reinforcing positive skills and practices and replacing practices which may cause physical, emotional, or psychological pain or distress. This new culture and standards to evaluate it will include:

- Person-centered planning that includes a balance of what is important *for* the person with what is important *to* the person;
- Individual plans for services that reflect principles of the most integrated setting, consistent with Minnesota's Olmstead Plan;
- Types and use of positive and social behavioral supports;
- Prohibitions on use of restraints and seclusion; and,
- Requirement that care is appropriately informed by a recognition and understanding of past trauma experienced by an individual.

Department of Human Services (DHS)

Restrictive procedures for individuals with disabilities are prohibited except when used in an emergency situation[47]. The Legislature codified these requirements for providers of disability services when it passed Minn. Stat. Chapter 245D, which applies to the majority of disability services, including home and community based service waivers, and services provided in an Intermediate Care Facility for Persons with Developmental Disabilities. On August 31, 2015, with the adoption of the Positive Supports Rule, those same requirements will apply to all services and facilities licensed by the Commissioner of Human Services when provided to a person with developmental disabilities. The statute and the rule prohibit restrictive intervention, except for:

- Emergency use of manual restraint, which may be used only when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or

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

programming on their own do not constitute an emergency. This definition applies to DHS-licensed services and facilities. See Minn. Stat. §245D.02, subd. 8a.

- Transitions when providers begin working with an individual for whom the use of a restrictive procedure was used before admission and the team agrees that the procedure must be faded rather than immediately stopped to prevent injury to the person or others; and/or
- Limited exceptions for use of mechanical restraints when a person is at imminent risk of serious injury due to self-injurious behavior and less restrictive strategies would not achieve safety.

Reporting, clinical consultation, and oversight are required in those circumstances as specified by statute and rule.

Department of Education (MDE)

In the educational setting, restrictive procedures are prohibited except when used in an emergency situation. As defined in Minnesota Statutes section 125A.0941, in an educational setting, "emergency" means a situation where immediate intervention is needed to protect a child or other individual from physical injury. Emergency does not mean circumstances such as: a child who does not respond to a task or request and instead places his or her head on a desk or hides under a desk or table; a child who does not respond to a staff person's request unless failing to respond would result in physical injury to the child or other individual; or an emergency incident has already occurred and no threat of physical injury currently exists. See Minn. Stat. §125A.0941(b).

A restrictive procedure is defined in that statute as a physical hold or seclusion. In an educational setting, "seclusion" means confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion. See Minn. Stat. §125A.0941(g).

Training requirements for school staff and other requirements related to reporting are delineated in Minnesota statutes section 125A.0942. MDE will strive to ensure that students with disabilities receive evidence based positive supports to enable them to be educated in an inclusive setting, to have access and make progress in the general education curriculum and have improved educational outcomes.

Our goals for this topic area strive to reduce the overall incidence of emergency restrictive procedures in educational and in Department of Human Services settings.

Vision Statement

People with disabilities will be treated with respect and dignity. They will receive services that provide positive, therapeutic supports and practices; trauma-informed care; and person-centered thinking and planning. Physical intervention will occur only in an emergency when an individual's conduct creates an imminent risk of physical harm to self or another and less restrictive strategies will not achieve safety.

What we have achieved

- Implemented the new disability services provider Standards (Minnesota Statute 245D) which include positive support standards.
- Promulgated the Positive Supports Rule, Minnesota Rules Chapter 9544, which repeals Minnesota Rules, parts 9525.2700 to 9525.2810 (also known as Rule 40) and requires the use of positive supports. The Positive Supports Rule is on track to become effective on August 31, 2015.
- A "Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports" was completed. The plan initially is a collaboration between the Departments of Education and Human Services, and will expand in the future.
- Developed a list of Crisis Prevention/ Intervention Training Programs to help individualized education program teams reduce the use of restrictive procedures
- Prone restraint will be no longer be permitted by law as of August 1, 2015 in Minnesota school districts and will apply to children of all ages. (Statute 125A.0942)
- Completed annual Report to legislature "A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools."

Measurable goals

Minnesota Statute 245D, and Minnesota Rule part 9544 prohibit the use of restraint and seclusion except as authorized under limited circumstances for emergencies (Situations when a client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Property damage, verbal aggression, or refusal to receive/ participate in treatment does not constitute an emergency.)

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

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

Annual Goals to reduce the number of people experiencing a restrictive procedure:

- By June 30, 2015 the number of people experiencing a restrictive procedure will be reduced by 5% from the previous year or 54 individuals
- By June 30, 2016 the number of people experiencing a restrictive procedure will be reduced by 5% from the previous year or 51 individuals
- By June 30, 2017 the number of people experiencing a restrictive procedure will be reduced by 5 % from the previous year or 49 individuals
- By June 30, 2018 the number of people experiencing a restrictive procedure will be reduced by 5% from the previous year or 46 individuals

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

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

Annual Goals to reduce the number of reports of restrictive procedures:

- By June 30, 2015 the number of reports of restrictive procedure will be reduced by 430
- By June 30, 2016 the number of reports of restrictive procedure will be reduced by 409
- By June 30, 2017 the number of reports of restrictive procedure will be reduced by 388
- By June 30, 2018 the number of reports of restrictive procedure will be reduced by 369

Goal Three: Use of mechanical restraint is prohibited in services licensed under Minn. Statute 245D, or within the scope of Minn. Rule, Part 9544[48], with limited exceptions to protect the person from imminent risk of serious injury. Examples of a limited exception include the use of a helmet for protection of self injurious behavior and safety clips for safe vehicle transport). By December 31, 2019 the emergency use of mechanical restraints will be reduced to ≤ 93 reports and ≤ 7 individuals.

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

Annual Goals to reduce the use of mechanical restraints:

- By June 30, 2015, reduce mechanical restraints to no more than
    - 461 reports of mechanical restraint
    - 31 individuals approved for emergency use of mechanical restraint
- By June 30, 2016, reduce mechanical restraints to no more than
    - 369 reports of mechanical restraint
    - 25 individuals approved for emergency use of a mechanical restraint
- By June 30, 2017, reduce mechanical restraints to no more than
    - 277 reports of mechanical restraint
    - 19 individuals approved for emergency use of a mechanical restraint
- By June 30, 2018, reduce mechanical restraints to no more than
    - 185 reports of mechanical restraint
    - 13 individuals approved for emergency use of a mechanical restraint
- By June 30, 2019, reduce mechanical restraints to no more than
    - 93 reports of mechanical restraint
    - 7 individuals approved for emergency use of a mechanical restraint

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

Goal Four: By June 30, 2017, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 316.

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

Annual Goals to reduce the number of students experiencing restrictive procedures at school:

- By June 30, 2015, the number of students experiencing emergency use of restrictive procedures will be reduced by 110
- By June 30, 2016, the number of students experiencing emergency use of restrictive procedures will be reduced by 105
- By June 30, 2017, the number of students experiencing emergency use of restrictive procedures will be reduced by 101

Goal Five: By June 30, 2017, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251.

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

Annual Goals to reduce the number of incidents of restrictive procedures in school:

- By June 30, 2015, the number of incidents of emergency use of restrictive procedures will be reduced by 781
- By June 30, 2016, the number of incidents of emergency use of restrictive procedures will be reduced by 750
- By June 30, 2017, the number of incidents of emergency use of restrictive procedures will be reduced by 720

Rationale

- Progress towards the goals will be measured through incident tracking from two sources:[49]

  Behavioral Intervention Reporting Forms (BIRFs) (Goals 1 – 3)
  Individuals who experience the use of a restrictive procedure while receiving services by a 245D licensed provider (a provider of disability services, for example: home and community based services) will be identified through submitted BIRFs. Providers are required to submit BIRFs to DHS and the Ombudsman for Mental Health and Developmental Disabilities for any sort of behavioral intervention, including all restrictive procedures, within 3-5 days of their use.

  For the purposes of Goal One and Goal Two, the baseline includes reports of mechanical restraints, self-injury protection equipment, seat belt restraints, time-out, seclusion and penalty consequences. For Goal Three, the baseline includes only reports about mechanical restraints, self-injury equipment and seat belt restraints.

[49] Restrictive procedures are defined differently by MDE and DHS, therefore there are two different reporting processes.

Providers are required to submit a single report for each use of manual restraint, emergency use of manual restraint and seclusion. For other practices, such as the use of seat belt clips or deprivation procedures, they may report multiple incidents in a week in one report. In order to understand the utilization trends it is important to know the number of individuals experiencing restrictive procedures and the number of incidents or application of emergency use of restrictive procedures. (Further information is available in the Positive Support Transition Plan Instructions[50], which implements the Minnesota Statute, Chapter 245D)

Annual restrictive procedure summary reports (Goals 4-5)
Baseline data includes students who experience the use of a restrictive procedure by school staff while in the school setting as well as the number of restrictive procedure incidents. A restrictive procedure includes physical holds and seclusions, as defined in Minnesota Statutes section 125A.0941. Summary student data will be identified by an annual restrictive procedure summary report submitted by school districts to the Minnesota Department of Education (MDE) on an annual basis. That data will be summarized in the annual legislative report submitted on February 1st of each year.

- These two measures are reasonable because they track every incident of restrictive procedures in their respective areas.
- Mechanical restraints are approved through a review process by a team of clinicians who also provide technical assistance and monitoring of the plans to reduce use of restraints.
- Note that when the new positive supports rule (Minn. Rule, part 6544) goes into effect in August 2015, providers with 245A licenses who serve people with developmental disabilities will also be reporting through the BIRF system, which may require a reassessment of the baseline and goals.
- We believe the targets to be realistic based upon the experience from other states and Minnesota's success following positive supports training.
- There is funding to support actions related to the current goals. The Governor proposed additional resources for the Department of Education for technical assistance, but it was not adopted by the 2015 legislature.

Strategies

Improve and Increase the Effective Use of Positive Supports in Working with People with Disabilities

- Implement the Positive Supports Rule (Minnesota Rules Chapter 9544) which becomes effective on August 31, 2015. This rule prohibits the use of restrictive procedures except in emergencies. The rule also requires training, technical assistance, and mentoring to disability service providers on positive support practices and the statutory and rule requirements.
- Continue the expansion of the Positive Behavioral Interventions and Supports (PBIS) which improves the capacity of school districts to include students in integrated classrooms. There are currently 479 schools implementing PBIS, with another 53 set to begin in fall of 2015. By the 2015-2016 school year there will be 532 or 26.5% of Minnesota schools implementing PBIS, impacting an estimated 247,009 students (30% of total students).
- Implement DHS's "Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports", which is a collaboration between DHS and MDE to build system capacity locally engaging with schools, providers, counties, tribes, people with disabilities, families, advocates, and

[50] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810B-ENG

community members. The strategies will be expanded across other agencies as applicable in the future. There will be regular reporting to the subcabinet on progress, and recommendations to address barriers and increase capacity.

- Continue implementation of training for the Department of Corrections staff on crisis intervention teams, motivational interviewing, traumatic brain injury, and Aggression Replacement Training (ART)[51]as appropriate for correctional settings.

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

- Establish data systems to: (1) assess progress in the reduction of the emergency use of restrictive procedures; assess the number of individuals experiencing restrictive procedures and the number of incidents or applications of restrictive procedures; and (3) to identify situations to be targeted for technical assistance.
- Implement the statutory change that no longer permits the use of prone restraints in school settings by August 1, 2015.
- The advisory committee report as required by the Jensen Settlement Agreement and the Comprehensive Plan of Action (CPA) will be reviewed for possible additional recommendations that may be implemented.
- Annually evaluate progress and determine if there are additional measures to be taken to reduce the use of mechanical restraints that are used to prevent imminent risk of serious injury due to self-injurious behaviors. The external review committee provides oversight and technical assistance.
- Publish annual reports on the progress in reducing the use of restrictive procedures and recommendations.
- Work with the Department of Health to evaluate opportunities to coordinate tracking with DHS and reduce use of restrictive procedures for people with disabilities in MDH-licensed facilities.
- Implement MDE's Statewide Plan to Reduce the Use of Restrictive Procedures and Eliminate the Use of Prone Restraint. (Statewide Plan)If the legislature acts to eliminate the use of seclusion in schools, MDE will adjust goals four and five as needed to reflect the changes.
- MDE will document progress in Statewide Plan implementation and summarize restrictive procedure data in the annual legislative report submitted February 1st of each year. MDE will track individual uses of seclusion on students receiving special education services by requiring districts to submit individual incident reports of each use of seclusion. These reports will assist MDE and the Restrictive Procedures Work Group in identifying areas of concern and developing strategies for eliminating the use of seclusion.
- Restrictive procedures may only be used in the school setting in an emergency, by licensed professionals, who have received training which includes positive behavioral interventions, de-escalation, alternatives to restrictive procedures, and impacts of physical holding and seclusion.
- MDE contracted to develop three online training modules which contain evidence based strategies to use with students with disabilities who have significant needs that result in self-injurious or physically aggressive behaviors. These modules will be available for the 2015-2016 school year.

[51] ART is an evidence-based cognitive behavioral practice for working with youth who have a history of serious aggression and antisocial behavior. Multiple studies have shown ART's effectiveness for youth confined in juvenile correctional facilities.

Reduce the Use of Seclusion in Educational Settings

- Engage the Restrictive Procedures Work Group[52] at least annually to review restrictive procedure data, review progress in implementation of the Statewide Plan, and discuss further implementation efforts and revise the Statewide Plan as necessary.
- Engage the Restrictive Procedures Work Group to make recommendations to MDE and the 2016 legislature on how to eliminate the use of seclusion in schools on students receiving special education services and modify the Statewide Plan to reflect those recommendations. The recommendations shall include the funding, resources, and time needed to safely and effectively transition to a complete elimination of the use of seclusion on students receiving special education services.

Responsible Agencies

- Department of Human Services
- Department of Education
- Department of Health
- Department of Corrections

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

Crisis Services

Stakeholder Comment		
	"My son ended up in the hosp[ital] as his Consumer Directed Community Supports (CDCS) waiver person said that there was little they could do when I asked about getting increased services when they put him back on drugs that made our situation worse…"	Linda Huber (2015)
	"The hospital social workers looked for any open beds in crisis facilities or psych unities in the state, but as I expected, nothing was available. He ended up staying in the ER for four days while they continued to look for placement. He then spent the weekend at the closest available adolescent psych bed which was in Des Moines, Iowa."	Alice Ploghoft (2015)

What this topic means

When people with disabilities experience a crisis, it is important that they experience as little disruption in their living situation as possible and avoid unnecessary stays in institutional settings. The term 'crisis' covers a range of situations, such as behaviors that present potential harm, the loss of a caregiver, or a significant change in a medical or health condition that compromises the ability of a person to manage their symptoms.

Vison statement

People with disabilities will live, work, attend school, and conduct their daily lives in community settings even when experiencing a life crisis. If this is not possible, disruption to daily life will be brief, minimal, and targeted to meet the individual's choices and needs.

What we have achieved

- Established a process for school districts so students with complex disabilities can access crisis services.
- "Crisis Triage and Handoff Process" Report was completed which summarized the crisis services currently available, barriers in accessing services, and recommendations to address the barriers.
- Secured $50 million in new funding from the state legislature for expansion of mental health services- inclusive of funds to prevent crisis from occurring and funds to address crisis when they do occur. Examples include:
    - Expanded crisis line to include consultations for people with traumatic brain injuries and developmental disabilities in crisis
    - Expanded mobile crisis teams, Assertive Community Treatment (ACT) capacity, and quality standards
    - Funded first episode psychosis initiative to ensure early intervention for individuals experiencing a psychosis as a means to minimize life disruption and maximize recovery.
    - Funded programming in schools to keep youth in schools and out of corrections (This program links mental health services, law enforcement and educational settings)

Measurable goals

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

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

Annual Goals to increase the percent of children who remain in their community after a crisis:

- By June 30, 2016, the percent who remain in their community after a crisis will increase to 81%
- By June 30, 2017, the percent who remain in their community after a crisis will increase to 83%
- By June 30, 2018, the percent who remain in their community after a crisis will increase to 85%

Goal Two: By June 30, 2018, the percent of adults who receive adult mental health crises services and remain in their community (e.g., home or other settings) will increase to 89% or more.

Baseline: In State Fiscal Year 2014 of 5,051 episodes, the person remained in their community 82% of the time:

Annual Goals to increase the percent of adults who remain in their community after a crisis:

- By June 30, 2016, the percent who remain in their community after a crisis will increase to 84%
- By June 30, 2017, the percent who remain in their community after a crisis will increase to 86%
- By June 30, 2018, the percent who remain in their community after a crisis will increase to 89%

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

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

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

- By June 30, 2015, the number will decrease to no more than 60 people (percent will adjust in relation to total number served in FY 15).
- By June 30, 2016, the number will decrease to no more than 55 people (percent will adjust in relation to total number served in FY 16).
- By June 30, 2017, the number will decrease to no more than 45 people (percent will adjust in relation to total number served in FY 17).

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

- By February, 2016 a baseline and annual goals will be established.

Goal Five: By June 20, 2020, 90% of people experiencing a crisis will have access to clinically appropriate short term crisis services, and when necessary placement within ten days.

- By January 31, 2016, establish a baseline of the length of time it takes from referral for crisis intervention to the initiation of crisis services and develop strategies and annual goals to increase access to crisis services, including specific measures of timeliness.

Rationale

- The State will reform crisis services across programs and funding sources to create a system that delivers timely responses to crisis and reduces the unnecessary use of restrictive and segregated settings. Crisis services will address any diagnosis, including complex or multiple conditions. The goals measure impact of reform of services in three areas: children's mental health; adult mental health; and disability home and community based waivers.
- Inadequate level of crisis services may result in people being unnecessarily hospitalized or placed in other segregated settings. Goal three measures the impact of improved crisis services on individuals receiving waiver services. Improvement in crisis services is projected to decrease the number of individuals who no longer receive waiver services. By expanding in home intervention and short term residential services, people will avoid unnecessary hospitalizations or other restrictive services.
- Baselines and measurement of progress is based on people who receive a crisis service for the count of incidents and individuals. Whether or not a person remains in their community is determined in one of three ways.
    - For children's mental health crisis services, where/how the incident is resolved is recorded and reported. Any resolution where the child remains at home or in school is considered "remaining in their community".
    - For adult mental health crisis services, outcome is determined by referrals made (either community-based provider or not community-based).
    - For waiver services, an analysis was performed to measure whether or not the crisis service in each episode was a residential or community-based service and whether or not the person left the waiver (stopped community-based services) following a crisis episode. A person could go to the emergency room, and maybe even have a short period of hospitalization, and still be counted as remaining in the community, as long as they return in a short period of time and do not lose home and community-based waiver services.
- Crisis services do three things: (1) stabilize a person in their current setting; (2) triage to determine if more intensive services are necessary; and (3) divert people from unnecessarily accessing segregated settings. The most effective measure for crisis services is maintaining stability in their current setting. This can be influenced by timely and appropriate crisis services and increased capacity of community providers delivering positive supports strategies.
- $50 million additional state investment for mental health expansion was authorized in the 2015 legislative session.
- Timely access to crisis services which are clinically appropriate is a best practice.

Strategies

Evaluate and Establish a Baseline and Measurements for the Effectiveness of Crisis Services

- Examine the utilization of crisis services by July 1, 2016 to determine:
    - the number of people who use crisis services
    - the number of individuals demitted from where they live/work after a crisis episode
    - single point of access
    - effectiveness of current crisis services for people with complex co-occurring conditions
    - timeliness of crisis interventions
    - length of time crisis services are used, and barriers to permanent, stable services, and housing.

- Establish a baseline for the length of time it takes to access crisis services by January 31, 2016, and establish annual goals.
- Evaluate the capacity (strengths and barriers) of the crisis system to provide timely access to in home intervention and residential crisis services and identify solutions, including development of additional crisis residential homes and mobile crisis services, increased specialized staffing and/or streamlined processes to efficiently authorize and access funding.
  Evaluate the length of time someone remains in a residential crisis setting when stable, and reasons for delay in moving back to their living situation. Identify solutions to expedite the development of permanent housing and service options to more quickly move people out of crisis homes when level of service no longer needed.

Implement Additional Crisis Services

- Implement the $50 million investment in mental health services for the 2016-2017 biennium
    - Increase access to children's mental health crisis services in schools (Goals 1, 2, 5)
    - Increase capacity of mental health crisis services providers to respond to the needs of people with complex needs (i.e., co-existing mental health and intellectual/ developmental disabilities) (Goals 1, 2, 5)
    - Expand and enhance Assertive Community Treatment (ACT) teams (Goal 4)
    - Expand housing with supports (Goal 4)
    - Expand mobile crisis teams (Goals 1, 2, 4)
- Implementation of recommendations from the Community-Based Services Steering Committee (DHS and stakeholder committee focused on safety net service infrastructure) which are due December, 2015, to close gaps in available state operated safety net and crisis capacity.
- Expand home and community-based crisis services
    - Develop residential crisis options throughout the state to have timely access to crisis services that are clinically appropriate.
        - By December 31, 2015, in collaboration with counties, develop a plan to increase in-home respite.
        - By August 2016, develop 20 additional crisis respite beds.
        - Annually evaluate and determine the number of crisis respite beds that are necessary to meet the needs and develop additional capacity if necessary.
    - Develop additional mobile crisis intervention and clinical expertise that supports providers and families so that people remain in their homes, jobs, and community.

- DHS will develop a single point of access and streamlined referral requirements to improve the quality of the crisis response outcomes for people with disabilities. The initial phase to start September 1, 2015 will be targeted to persons with developmental or intellectual disabilities in crisis and at risk of losing their current placement.

Develop a Set of Proactive Measures to Improve the Effectiveness of Crisis Services

- Train schools and providers, including child care centers, on positive practices and working with children who have experienced trauma in their lives. These practices have proven to reduce the use of emergency restrictive procedures and crisis episodes.
- Implement Behavioral Health Homes in July 2016. Behavioral Health Homes provide an array of primary care and mental health services which can be accessed in managing crisis episodes.
- Implement the Forensic Assertive Community Treatment (FACT) team model. This service focuses on individuals exiting correctional facilities with serious mental illness and provides a flexible set of community based mental health services to support the individuals in returning to the community.
- Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis.

Responsible Agencies

- Department of Human Services
- Minnesota Department of Education

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Community Engagement

Stakeholder Comments		
	"Give people a chance to show that we can do it, yes, we can. Everybody deserves a chance and everybody learns differently. Everyone has a dream where they want to live, work and be happy."	*Patricia Ann Wallace (2013)*
	"By including self-advocacy, peer-to peer support, and leadership training into the Olmstead Plan, self-advocates would have an increased ability to create change within the system that impacts their lives on a daily basis."	*Laura Birnbaum (2013)*
	"Not enough mental health providers are employing certified peer specialists."	*NAMI Minnesota (2013)*

What this topic means

In the *Olmstead* decision, the U.S. Supreme Court ruled that states must eliminate unnecessary segregation of persons with disabilities and ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

Community engagement is one way to measure the level of integration. All Americans have a right to engage in activities of their choosing that help them connect with other people and give them greater control over their lives, such as building friendships and relationships with people they choose, joining a faith community, volunteering or taking on a leadership role with a neighborhood organization, attending cultural events, or participating in community decision-making (for example, voting).

There are four main strategic actions to ensure community engagement is happening:

- Increase the number of employed certified Peer Support Specialists
- Increase the number of Self advocates
- Increase the number of people with disabilities involved in planning publicly funded projects
- Increase the number of leadership opportunities

Vision statement

People with disabilities will have the opportunity to fully engage in their community and connect with others in ways that are meaningful and aligned with their personal choices and desires.

What we have achieved

- The Olmstead Community Engagement Plan was approved by the subcabinet.
- 14 public listening sessions were held since 2013.
- The Olmstead Implementation Office presented 92 informational sessions between July 2014 and July 2015.
- The Olmstead Implementation Office had 7 meetings and appearances with key legislators before and during the 2015 legislative session.

Measurable goals

Goal One: By June 30, 2019, the number of individuals involved in their community in ways that are meaningful to them will increase to 1,992. (This includes increases in the numbers of: self-advocates; individuals involved in publicly funded projects; and Certified Peer Support Specialists.)

Baseline: As of June 30, 2014, the number of individuals engaged in their community is 1,242.

Self-Advocates

- **By June 30, 2019 the number of self-advocates will increase to 1,575.**

  Baseline: There are 1,200 active self-advocates involved in the Self Advocates Minnesota (SAM)[53] network statewide and participating in Tuesday's at the Capitol[54].

Annual Goals to increase the number of self-advocates:

- By June 30, 2016, the number of self-advocates will increase by 50 for a total of 1,250.
- By June 30, 2017, the number of self-advocates will increase by 75 for a total of 1,325.
- By June 30, 2018, the number of self-advocates will increase by 100 for a total of 1,425.
- By June 30, 2019, the number of self-advocates will increase by 150 for a total of 1,575.

Involvement in Publicly Funded Projects

- **By June 30, 2019, the number of people with disabilities involved in planning publicly funded projects at the subcabinet agency level will increase to 417.**

  Baseline: There were 42 individuals with disabilities involved in planning 6 publicly funded projects.

Annual Goals to increase the number of people involved in public planning projects**:**

- By June 30, 2016, the number people with disabilities involved in a publicly funded project will increase by 50 for a total of 92.
- By June 30, 2017, the number people with disabilities involved in a publicly funded project will increase by 75 for a total of 167.
- By June 30, 2018, the number people with disabilities involved in a publicly funded project will increase by 100 for a total of 267.
- By June 30, 2019, the number people with disabilities involved in a publicly funded project will increase by 150 for a total of 417.

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[53] Self- Advocates Minnesota is a statewide network of regional self-advocacy groups coordinate through Advocating Change Together.

[54] Tuesday's at the Capitol is coordinated by the Minnesota Consortium for Citizens with Disabilities and brings together self-advocates, families, providers, law makers and agency staff for policy discussions every Tuesday during the legislative session.

Certified Peer Support Specialists

- By January 4, 2016, the initial Survey regarding employed Certified Peer Support Specialists will have been completed to establish a baseline and set measurable goals.

Rationale

- Meaningful community engagement is individual and can be difficult to define. Community engagement is a process that recognizes the value of creating ongoing, long-term relationships for the benefit of the greater community. It brings an interactive, collective problem-solving element into the process that capitalizes on the collective strengths of the various stakeholders.
- Self- Advocates - The baseline does not reflect the total number of active self-advocates. There are many self-advocacy groups however not all groups identify with the title of self-advocacy making identification more complex. Further data collection will be necessary to develop a more robust representation of what exists within the state.
- Public projects- There are hundreds of projects happening each year for which there is no current method of tracking. However, Minnesota has historically involved people with disabilities making sure that publicly funded projects are accessible and this continues as we move into the future.
- Peer Support Specialists -The Department of Human Services (DHS) provides funding for the peer support specialist certification course. A survey was conducted through a third party however; this data is more than two years old and the response rate was well under 40%. Based on the low response rate and time past since the survey was conducted it was determined that new data is needed to create a valid baseline from which to set goals. Anecdotal information received from DHS also identifies a range of barriers for this employment that need further exploration.

Strategies

Increase the Number of Leadership Opportunities for People with Disabilities

- Gather additional data and reassess goal within one year, through surveys, focus groups and other methods.
- Conduct a survey of all Governor appointed disability councils, boards, groups, etc. regarding existing leadership opportunities and capacity.
- Work with the Governor appointed councils, groups, boards, etc. to create plans that coordinate their goals with Olmstead goals.

Increase the Use of Self-Advocates in Implementing the Olmstead Plan

- Identify leadership and other training programs that can help develop self-advocates, such as Partners in Policy Making®[55] and the Olmstead Academy[56].
- Recommend the use of self-advocates as paid surveyors/auditors throughout implementation of the Olmstead Plan.
- Utilize self-advocates as trainers for the Olmstead Community Engagement Plan.
- Explore potential funding sources to enable support of self-advocates and their organizations, including but not limited to grants.

Increase the Use of Peer Support Specialists in Implementing the Olmstead Plan

- Survey those who have completed the Peer Support Specialist Certification program to get a baseline for how many have current employment in the field and what barriers may be preventing employment.
- Recommend utilizing Certified Peer Support Specialists as surveyors/auditors throughout implementation of the Plan.
- Review current reimbursement rates for the four services Certified Peer Support Specialists that are eligible to bill and make change recommendations, if needed.
- Survey service providers to get more information on use and employment of Certified Peer Support Specialists.

Increase Participation of People with Disabilities in Providing Input on Public Projects

- Design and deliver training programs for those who want to participate in providing input on publicly funded projects.
- Recommend inclusion of people with disabilities on decision making panels.

[55] Partners in Policymaking® is a training program created by the Minnesota Governor's Council on Developmental Disabilities. The program educates parents and self-advocates on the power of advocacy to influence public policy while building better inclusion and integration within the community.
[56] The Olmstead Academy is a training program offered by Advocating Change Together. The program is aimed at creating a culture in Minnesota where self-advocates play a meaningful role in the state's Olmstead Plan.

Topic areas under development

The following topics areas will be developed during the first year of implementation of this new Olmstead Plan and will be included in the Plan as modifications. They will contain the same items as the other topic areas as described above.

Assistive Technology

- By 2016, a baseline and measurable goals will be established for expanding the use of assistive technology to increase access to integrated settings.

Preventing Abuse and Neglect

- By 2016, a baseline and measurable goals will be established on statewide levels and trends of abuse, neglect, exploitation, injuries, and deaths.

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PLAN MANAGEMENT AND OVERSIGHT

Plan Management and Oversight

Olmstead Subcabinet and Olmstead Implementation Office

In 2013 Governor Dayton issued an Executive Order (13-01) that established the Olmstead Subcabinet to develop and implement a comprehensive Olmstead Plan. The original version of the Plan, drafted in 2013, established an Olmstead Implementation Office (OIO) to have day to day responsibility for overseeing implementation of the Plan.

In January of 2015, Governor Dayton issued a new Executive Order (15-03) that articulated the role of the subcabinet in more detail. Among other things, the order directed the subcabinet to oversee and monitor Plan implementation and modification; to appoint an Executive Director of the OIO; and to develop a quality improvement plan.

The Executive Order further directed the subcabinet to adopt procedures that would include clarifying and defining the role of the OIO. Accordingly, in March 2015, the subcabinet adopted procedures that established a dual role for the OIO: (1) quality assurance and accountability, including compliance evaluation, verification and oversight; and (2) engagement with the community, especially people with disabilities, including on-going management of communications and the Quality of Life survey.

As part of its primary role of providing direction and oversight of the development and implementation of the Olmstead Plan, the subcabinet has a particular responsibility to monitor the impact of the activities being undertaken by State agencies and delivery agents such as counties and providers. The subcabinet must be attentive to the possibility of unintended consequences of these actions, and should also watch for opportunities to simplify or change the delivery of services to achieve better results.

Quality assurance and accountability

Development and Oversight of Workplans

In order to achieve the measurable goals, the OIO and State agencies will need to develop specific strategies and workplans. Each measurable goal is supported by several key strategies. Key strategies will be supported by workplans.

Within 60 days of the publication of the new Olmstead Plan, the state agencies will develop a workplan for each of these strategies. The OIO compliance staff will oversee the development of the workplans. The workplans will be approved by the subcabinet and will be made available to the public on the Olmstead website.

The OIO compliance staff and the subcabinet will use the workplans throughout the year to review the progress of the work and to direct any adjustments to the work if progress is not timely, or if changes to the workplans are needed based on actual experience in the field, including results from the Quality of Life survey.

Following completion of the workplans, the OIO Director of Compliance will develop a schedule for reporting on the activities in the workplans. The frequency of reporting to the Olmstead Implementation and the subcabinet will be determined by taking into account specific deadlines that are critical to achieving the outcomes specified in the measurable goals. The reporting schedule will be provided to the subcabinet and will be made available to the public on the Olmstead website.

Compliance Evaluation, Verification and Oversight

The Director of Compliance will have the primary responsibility for overseeing the implementation and compliance activities undertaken by State agencies in the implementation of the Plan. Each State agency will be responsible for ensuring that its own activities are in compliance with state and federal law and regulations and any relevant court orders and are verifiable. The Director of Compliance will work with senior staff from each agency to develop protocols for periodic evaluation, verification and oversight of activities that are directly related to the implementation of the Plan.

The subcabinet will hold regular meetings at least six times per year and will schedule additional meetings as necessary to complete its work. The Director of Compliance will present a summary of compliance activities at each subcabinet meeting.

The subcabinet will provide periodic written reports to the public detailing progress on the measurable goals. These reports will also be provided to the Court by the Department of Human Services while the implementation of the Plan remains under the jurisdiction of the Court.

Quality of Life survey

The Executive Director will have primary responsibility for the oversight of annual surveys of people with disabilities to determine quality of life, including:

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

In 2014, the Olmstead Implementation Office completed significant work that will allow it to move forward and complete the initial survey to establish the baseline data against which future surveys will be compared. Steps completed include:

- Selected a Quality of Life Survey Tool that is tested, reliable, validated, low cost, systematic, and repeatable, and it will apply to all people with disabilities.
- Secured funding for and completed the pilot survey designed to test the effectiveness of the selected survey tool
- Submitted "Minnesota's Olmstead Plan Quality of Life Survey Pilot Study" Report
- Requested and received funding for the full implementation of the Quality of Life Survey for the 2016-2017 biennium

By June 30, 2016 the initial Quality of Life Survey will be completed to establish a sample baseline. The survey will be conducted annually for the next three years.

A critical piece of establishing the baseline will be the identification of 12,000 potential survey participants to develop a valid sample of 3,000 respondents.

The results of each annual Quality of Life survey will be shared with the subcabinet, and state agencies that are implementing the Plan so that they can evaluate whether changes should be made in these activities. The results of each annual Quality of Life survey will also be shared with the public.

Dispute resolution oversight

The Executive Director began work under the original Olmstead Plan to put in place a system for effectively working with people with disabilities that have a need for assistance in resolving disputes. Working with the State Department of Human Rights, the OIO identified those offices within State government that have formal dispute resolution processes in place, and established a set of protocols for referring people with disabilities to the most appropriate of these offices. These protocols are set forth in the "Olmstead Dispute Resolution Process Work Plan".

In 2016, the Olmstead Implementation Office will work with the State Department of Human Rights to develop a set of recommendations for any changes that may be necessary to improve performance under the Dispute Resolution process.

Updating and Extending the Olmstead Plan

The Olmstead Plan is not intended to be a static document that simply establishes a one-time set of goals for state agencies as they provide services for people with disabilities. Rather, it is intended to serve as a vital, dynamic roadmap that will help realize the subcabinet's vision of people with disabilities living, learning, working, and enjoying life in the most integrated settings.

As the subcabinet agencies work to accomplish the improvements described in the measurable goals, much will be learned regarding what practices are having a positive impact on the quality of life for people with disabilities. As improvements are made in the ability to gather and use better data, there will likely be opportunities to adjust the goals to accomplish improvements more quickly or in a better way. It will therefore be important that there is an established process for amending the Plan.

In addition to its on-going oversight of workplans, the subcabinet will establish an annual process for reviewing the measurable goals and evaluating whether the goals should be amended for future years. Based on these evaluations, the subcabinet will employ a formal process to amend the Plan. Any proposed amendments will be posted for review by the public and the court, and will allow for a specific public comment period of at least 30 days. Following the comment period, the subcabinet will consider whether any changes to the proposed amendments are warranted as a result of the public comments. Any subsequent changes to the proposed amendments will be posted for a brief public review period prior to adoption of the amendments to the Plan by the subcabinet.

Because many of the measurable goals have a time horizon of three to five years, the subcabinet will also put in place a strategic review of the Plan in 2018. The subcabinet will consider results of the Quality of Life survey, achievements under the measurable goals, and feedback from people with disabilities, families, providers, counties and tribal governments, and state agencies in establishing annual targets for the measurable goals for the subsequent three to five year period. This strategic review may also indicate that some goals should be replaced because they are not the most effective measure and/or that goals need to be added.

Communications and public relations

The Olmstead Implementation Office has primary responsibility for oversight and management of communications about the Olmstead Plan with the general public, and particularly with people with disabilities.

State agencies that are implementing activities as part of the Olmstead Plan have the responsibility to work with the Olmstead Implementation Office to ensure that materials developed to inform the public about these activities are developed within the principles of Olmstead. For example, one principle of this Olmstead Plan is to increase the number of individuals in the most integrated settings – and is not a plan to eliminate certain options or close certain facilities.

The Olmstead Implementation Office will develop a Communications Plan that will guide the direct communication messages and activities of the Office, but will also establish guidelines for materials that are developed by State agencies.

The subcabinet and Olmstead Implementation Office use relationships and tools to provide accurate, timely and useful information about the vision, goals and activities of the Olmstead Plan in ways that are accessible and effective. This will raise awareness and understanding in the Plan and increase long-term engagement with members of the public, including people with disabilities.

The Olmstead Implementation Office will also have primary responsibility for handling and tracking communications from and regarding individuals with disabilities that express concerns about services they are receiving from State or local agencies. Such communications may be initially delivered directly to the Office and to State agencies. The Office will track the receipt and handling of such communications and ensure that they are handled promptly and in accordance with the principles of the Plan.

Cross-agency coordination of data strategies

Within each of the Topic Areas in this Olmstead Plan, there is at least one Strategy that requires better and different collection and/or analysis of data in order to change certain key processes, to establish baselines against which progress can be measured or to measure outcomes. Because these strategies involving data are so pervasive within the Plan, it will be essential that the subcabinet and the Olmstead Implementation Office develop a means of promoting cross-agency collaboration around these strategies.

The Olmstead Implementation Office will develop a workplan within 60 days of the publication of this new Plan that will contain key activities necessary to ensure that this cross-agency collaboration will take place. The Office will consult with the Commissioner of MN.IT, which is the consolidated information technology office for the State of Minnesota, in the development of this workplan. This workplan will be approved by the subcabinet, and overseen and reviewed in the same manner described for the workplans described above.

Cross-agency coordination of legislative and funding strategies

Within each of the Topic Areas in this Olmstead Plan, there are activities described that are essential to the accomplishment of the outcomes described in the measurable goals. Each of these activities is subject to funding and policy directives that are the result of State or Federal appropriations and legislative and regulatory actions. In order for certain changes in activity to occur, it may be necessary for State agencies to propose and pursue statutory changes or regulatory waivers. It may also be necessary for State agencies to request authorization to redirect funding or to request additional funding in order to accomplish certain outcomes. The need for such statutory, regulatory and funding requests may become apparent as more and better data is available to analyze the outcome of the activities anticipated by the Plan.

The subcabinet will work to ensure the needs for statutory, regulatory, or funding changes that arise as a result of implementing the Olmstead Plan are fully considered as part of the biennial budget and legislative planning process.

Feedback

The Olmstead Subcabinet welcomes feedback to inform the implementation of Minnesota's Olmstead Plan. There are several ways to provide your comments and thoughts:

Method	**Steps to follow**
Online	3. Go to: Mn.gov/Olmstead 4. Click "Participate" and follow instructions for the online form
In an Email	Send an email to this address:
In the Mail	Send a letter to: Olmstead Implementation Office 400 Sibley Street, Suite 300 St. Paul, MN 55101
On the Phone	Speak to a staff member at the Olmstead Implementation Office, or leave your comment on voicemail. 651-296-8081

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Definitions of key terms

245A: The Human Services Licensing chapter of the Minnesota State Statutes.

§245D Standards: Many services for people with disabilities that are provided in people's home and/or in community settings and that are funded through Medicaid waivers are regulated under Minnesota Statutes §245D. (While Medicaid pays for the services covered by §245D, some people may receive these same services through other funding sources. The §245D standards apply to these services regardless of payment source.) The Minnesota Legislature created §245D in 2012 to establish standards for services that had previously been unlicensed. Additional services and standards were added to the statute in the 2013 session, including guidelines for the emergency use of manual restraint and requirements for positive support transition plans. The §245D standards was implemented January 1, 2014.

Assertive Community Treatment: Assertive Community Treatment (ACT) is an intensive, comprehensive, non-residential treatment, rehabilitation, and supportive mental health service that uses a team approach. Services are consistent with Adult Rehabilitative Mental Health Services, except that ACT additionally provides services are (a) delivered by multidisciplinary, qualified staff who have the capacity to provide most mental health services necessary to meet the person's needs, using a total team approach; (b) directed to persons with a identified serious mental illness (i.e. primarily schizophrenia, schizoaffective disorder, bipolar disorder) who require intensive services; and (c) offered on a time-unlimited basis and available 24 hours per day, 7 days per week, 365 days per year.

Behavioral health home: Health homes services are comprehensive and timely high-quality services provided by a designated provider and specifically include: care management; care coordination; health promotion; transitional care; patient and family support; referral to community and social support services; and improved exchange of health information. [Reference Section 2703 of the Affordable Care Act]. DHS is developing behavioral health home services for adults and children with serious mental illness.

Behavior Intervention Reporting Form: The Behavior Intervention Reporting form (BIRF) is the form prescribed by the commissioner to collect data specific to incidents of emergency use of manual restraint and positive support transition plans for persons in accordance with the requirements of Minnesota Statutes, section 245.8251, subdivision 2.

Bridges: This program, operated by Minnesota Housing Finance Agency and implemented in collaboration with the Department of Human Services, is administered through local housing agencies. It provides rental assistance and access to support services for households in which at least one adult member has a serious mental illness and their income is below 50 percent of the area median income. Under the Bridges program, households are stabilized in the community until a Section 8 certificate or voucher becomes available for them to access. [Reference: Minnesota Statutes §462A.2097]

Certified Peer Specialist: An individual with a lived experience of mental illness who has been trained and certified by the State of Minnesota to provide Medicaid reimbursable rehabilitation services in Adult Mental Health Rehabilitation Services (ARMHS), Assertive Community Treatment Teams (ACT), Intensive Residential Treatment Services (IRTS) and Crisis services.

Competitive Integrated Employment: Competitive integrated employment means work: (1) performed on a full-time or part-time basis, with or without supports, including self-employment; (2) paying at least minimum wage, as defined by the Fair Labor Standards Act, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by workers without a disability; (3) paid by an employer who is not the individual's service provider; (4) performed in an integrated setting typically found in the competitive labor market where people with disabilities have the opportunity to interact with non-disabled co-workers during the course of performing their work duties to the same extent that non-disabled co-workers have to interact with each other when performing the same work; and (5) provides the employee with a disability with the same opportunities for advancement as employees without disabilities in similar positions.

Disability: See persons/people with a disability

Emergency: In an educational setting, "emergency" means a situation where immediate intervention is needed to protect a child or other individual from physical injury. Emergency does not mean circumstances such as: a child who does not respond to a task or request and instead places his or her head on a desk or hides under a desk or table; a child who does not respond to a staff person's request unless failing to respond would result in physical injury to the child or other individual; or an emergency incident has already occurred and no threat of physical injury currently exists. See Minn. Stat. §125A.0941(b).

Emergency use of manual restraint: means using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency. This definition applies to DHS-licensed services and facilities. See Minn. Stat. §245D.02, subd. 8a.

Employment First: A set of core values for people with disabilities, including: a) employment is the first and preferred outcome for all working-age individuals with disabilities, including those with complex and significant disabilities, for whom working in the past has been limited or has not traditionally occurred; b) use typical or customized employment techniques to secure membership in the workforce, where employees with disabilities are included on the payroll of a competitive business or industry or are self-employed business owners; c) assigned work task offer at least minimum or prevailing wages and benefits; and d) typical opportunities exist for integration and interactions with co-workers without disabilities, with customers, and the public.

Extended Employment: The Extended Employment (EE) Program is a performance-based state funded program administered by DEED that annually provides ongoing employment support services for nearly 5000 workers with the most significant disabilities. Services are provided through performance-based contracts with a statewide network of non-profit Commission on Accreditation of Rehabilitation

Facilities (CARF) accredited Extended Employment Providers. Service payments are based on reported work hours and reimbursed at differing rates for supported, community and center-based employment. [Reference: Minnesota Statutes §268A.15 and Minnesota Rules parts 3300.2005 – 3300.2055]

Group Residential Housing: Group Residential Housing (GRH) is a state funded income supplement program that pays for room and board costs, and sometimes services, for low-income elderly and adults with disabilities living in some licensed, registered or exempt settings. The program aims to reduce and prevent institutional residence or homelessness.

Health care home: A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

Home and Community-Based Services: Home and community-based services (HCBS) are services and supports that are provided to people living in their communities who otherwise require the level of care provided in an institution, such as a nursing facility or a hospital.

Individual Placement and Supports (IPS): IPS is an evidence based approach to supported employment (SE) that helps people living with serious mental illnesses to identify, acquire and maintain competitive employment in their local community. IPS is different from a traditional brokered model of vocational rehabilitation. IPS emphasizes integration of employment services within mental health treatment and utilizes rapid engagement in job search, individualized placement services, systematic job development and ongoing employment support services.

Individualized Education Program (IEP): An IEP is a formal written agreement and plan for provision of special education, including related services, to a child with a disability. It is developed, reviewed and revised through a team process in accordance with IDEA regulations. The required elements of an IEP are detailed in IDEA regulations and Minnesota Statutes §125A.08.

Informed choice: Informed choice includes: (a) informing individuals through appropriate modes of communication, about the opportunities to exercise informed choice, including the availability of support services for individuals who require assistance in exercising informed choice; (b) assisting individuals in exercising informed choice in making decisions; (c) providing or assisting individuals in acquiring information that enables them to exercise informed choice in the development of their individualized plans with respect to the selection of outcomes, supports and services, service providers, the most integrated settings in which the supports and services will be provided, and methods for procuring services; (d) developing and implementing flexible policies and methods that facilitate the provision of supports and services and afford individuals meaningful choices; and (e) ensuring that the availability and scope of informed choice is consistent with the obligations of the respective agencies. [*Source*: Based on 1998 Amendments to the Rehabilitation Act]

Lead agencies: Lead agencies are counties, tribes and managed care organizations responsible to plan, provide, arrange and monitor services for eligible persons to ensure consistent delivery of supports and services.

Mechanical restraint: Mechanical restraint means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. Restraints are used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury. It does not include use of devices that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.

Medical Assistance for Employed Persons with Disabilities (MA-EPD): MA-EPD is a work incentive that promotes competitive employment and the economic self-sufficiency of people with disabilities by assuring continued access to Medical Assistance for necessary health care services. MA-EPD allows working people with disabilities to qualify for MA under higher income and asset limits than standard MA. The goal of the program is to encourage people with disabilities to work and enjoy the benefits of being employed.

Minnesota Supplemental Aid (MSA) Housing Assistance: A state-funded income supplement for people who are eligible for Minnesota Supplemental Aid (MSA) and have high housing costs. MSA Housing Assistance provides up to $200 per month in 2013 for MSA participants who are age 18 – 64 and are relocating from an institution, or eligible for self-directed PCA services, or are receiving home and community based waiver services and have monthly housing costs of more than 40% of their income and have applied for rental assistance, if eligible.

Most integrated setting: The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." [*Source:* US Department of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., Retrieved from http://www.ada.gov/olmstead/q&a_olmstead.pdf]

Person-centered: This concept is described in the Person-Centered Planning measurable goals section of the Plan (see page 31).

Person-centered planning: Person-centered planning, based upon a set of core concepts and principles, is an on-going process of assisting someone to plan their life and supports. There is no one clearly defined process of person-centered planning, but many processes that share the same general philosophical background. (See page 31)

Person-centered thinking: Person-centered thinking is incorporating the core concepts and principles of person-centeredness into one's approach in working with people with disabilities. It is the foundation of person-centered planning. (See page 31)

Persons/people with disabilities: An individual with a disability is a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

Positive Behavior Interventions and Supports (PBIS): PBIS is a state-initiated project that provides districts and individual schools throughout Minnesota with the necessary training and technical support to promote improvement in student behavior across the entire school, especially for students with challenging social behaviors. It establishes clearly defined outcomes that relate to students' academic and social behavior, systems that support staff efforts, practices that support student success, and data to guide decision-making.

Positive practices: Positive practices are supports that treat people who receive services with respect and dignity, increase quality of life, build skills and decrease interfering behaviors. Programs and services licensed or certified by the Minnesota Department of Human Services must be positive with a focus on quality of life, including building skills people need to achieve their articulated desired life, self-management and self-efficacy, not just alleviating target symptoms. Positive support strategies are based on individualized assessment that emphasizes teaching a person productive and self-determined skill and behaviors without the use of restrictive interventions.

Project SEARCH: Project SEARCH is an evidence-based internationally recognized employer-driven model that was developed at Cincinnati Children's Hospital Medical Center (CCHMC). The Project SEARCH High School Transition Program model is for students with developmental disabilities in their last year of high school eligibility.

Prone restraint: Prone restraint is a type of physical holding that places a person in a face down position.

Restrictive procedures: Restrictive procedures, also referred to as "restrictive interventions", are procedures prohibited in Minnesota Statutes, section 245D.06, subdivision 5 and sections125A.0941 and 125A.0942; prohibited procedures identified in Minnesota Rules part 9544.0060; and the emergency use of manual restraint. They include, but are not limited to, actions that restrict a person's autonomy in some manner, including deprivation procedures, chemical restraint, seclusion and physical holding.

Seclusion: In an educational setting, "seclusion" means confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion. See Minn. Stat. §125A.0941(g).

Section 811: This program allows people with disabilities who are low income and between the ages of 18-62to live as independently as possible in the community by subsidizing rental housing opportunities with access to appropriate supportive services. The newly reformed Section 811 program is authorized to operate in two ways: (1) the traditional way, by providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities; and (2) providing project rental assistance to state housing agencies.

Segregated settings: Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with people with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other people with disabilities. [*Source*: "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C." http://www.ada.gov/olmstead/q&a_olmstead.htm]

Self-advocacy: Self-advocacy is a movement of individual and organizations working to empower people with intellectual and developmental disabilities to speak for themselves, make their own decisions and stand up for their own rights.

Subminimum wage: A wage less than the established federal minimum wage that may be permitted under an exemption in the Fair Labor Standards Act (FLSA) that provides for the employment of certain individuals at wage rates below the minimum wage, including individuals whose earning or productive capacity is impaired by a physical or mental disability. In order to pay a subminimum wage to an individual with a disability, the employer must obtain a certificate from the U.S. Department of Labor and conduct periodic time and productivity studies to establish the rate of payment based on performance norms. [Information is available at http://www.dol.gov/compliance/topics/wages-subminimum-wage.htm]

Transition age youth/students: Transition age youth refers to students with disabilities in grades nine through twelve as well as students with disabilities age eighteen to twenty-one receiving secondary transition services.

Workforce Innovation and Opportunity Act (WIOA): WIOA is the federal Workforce Innovation and Opportunity Act signed into law on July 22, 2014. WIOA supersedes the Workforce Investment Act (WIA) of 1998 and amends the Rehabilitation Act of 1973, the Wagner-Peyser Act and the Adult Education and Family Literacy. Disability service and employment policy provisions that affect people with disabilities include a priority focus on youth with disabilities and their preparation for competitive, integrated employment. At a state level, memorandums of understanding must be developed between Vocational Rehabilitation, Education, Assistive Technology and the Medicaid agency. WIOA also sets limits on the use of the Special Subminimum wage including new requirements for oversight and review. Most of the provisions in WIOA became effective July 1, 2015. The WIOA provisions on Subminimum wage provisions will become effective 7/22/16. More information on WIOA can be found on the US Department of Labor website at: http://www.doleta.gov/wioa/

Common Acronyms

ACT - Assertive Community Treatment

ADA – Americans with Disabilities Act

ADM – Department of Administration

AMRTC – Anoka Metro Regional Treatment Center

APS – Accessible Pedestrian Signals

BIRF – Behavior Intervention Reporting Form

CADI - Community Access for Disability Inclusion

DCD – Developmental Cognitive Disabilities

DD – Developmental Disabilities

DEED – Minnesota Department of Employment and Economic Development

DHS – Minnesota Department of Human Services

DOC – Minnesota Department of Corrections

DOJ – United States Department of Justice

EE – Extended Employment

FACT - Forensic Assertive Community Treatment

GRH – Group Residential Housing

HCBS – Home and Community-Based Services

ICF/DD – Intermediate Care Facility/Facilities for Persons with Developmental Disabilities

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IPS – Individual Placement and Supports

MA – Medical Assistance

MA-EPD – Medical Assistance for Employed Persons with Disabilities

MCF - Minnesota Correctional Facility

MCOTA – Minnesota Council on Transportation Access

MDE – Minnesota Department of Education

MDH – Minnesota Department of Health

MDHR – Minnesota Department of Human Rights

MHCP – Minnesota Health Care Programs

MHFA – Minnesota Housing Finance Agency

MMB - Minnesota Management and Budget

MnDOT – Minnesota Department of Transportation

MNSCU - Minnesota State Colleges and Universities

MnSHIP - Minnesota State Highway Investment Plan

MSA – Minnesota Supplemental Aid

MSH – Minnesota Security Hospital

MSHS – Minnesota Specialty Health System

NCI – National Core Indicators

OIO – Olmstead Implementation Office

PBIS – Positive Behavioral Interventions and Supports

SAM - Self-Advocates Minnesota

SSB – State Services for the Blind

SFY – State Fiscal Year

VR – Vocational Rehabilitation

VRS—Vocational Rehabilitation Services

WIOA – Workforce Innovation Opportunity Act

APPENDICES

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Appendix A – Governor's Executive Orders Related to Olmstead

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STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON

GOVERNOR

Executive Order 13-01

Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Creation of Minnesota's Olmstead Plan

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the power invested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, the State of Minnesota is committed to ensuring that inclusive, community-based services are available to individuals with disabilities of all ages;

Whereas, the State of Minnesota recognizes that such services advance the best interests of all Minnesotans by fostering independence, freedom of choice, productivity, and participation in community life of Minnesotans with disabilities;

Whereas, the unnecessary and unjustified segregation of individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by Title II of the American with Disabilities Act of 1990 (the ADA), 42 U.S.C. §§ 12101 *et seq.*, which requires that states and localities administer their programs, services, and activities, in the most integrated setting appropriate to meet the needs of individuals with disabilities;

Whereas, in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the United States Supreme Court interpreted Title II of the ADA to require states to place individuals with disabilities in community settings, rather than institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities;

Whereas, the State of Minnesota has taken steps in response to the *Olmstead* decision through the past and current efforts of State agencies and the establishment and work of the Minnesota *Olmstead* Planning Committee, whose recommendations to the Commissioner of the Minnesota Department of Human Services are hereby acknowledged;

Whereas, barriers to affording opportunities within the most integrated setting to persons with disabilities still exist in Minnesota; and

Whereas, the State of Minnesota must continue to move more purposefully and swiftly to implement the standards set forth in the *Olmstead* decision and the mandates of Title II of the ADA through coordinated efforts of designated State agencies so as to help ensure that all Minnesotans have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment, and to participate in community life.

Now, Therefore, I hereby order that:

1. A Sub-Cabinet, appointed by the Governor, consisting of the Commissioner, or Commissioner's designees, of the following State agencies, shall develop and implement a comprehensive Minnesota *Olmstead* Plan: (i) that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the most integrated setting, and (ii) that is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999):

   a) Department of Human Services;

   b) Minnesota Housing Finance Agency;

   c) Department of Employment and Economic Development;

   d) Department of Transportation;

   e) Department of Corrections;

   f) Department of Health;

   g) Department of Human Rights; and

   h) Department of Education.

   The Sub-Cabinet shall be chaired by Lieutenant Governor Yvonne Prettner Solon.

The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities shall be *ex officio* members of the Sub-Cabinet.

The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s), and consult with other entities and State agencies, when appropriate, to carry out its work.

2. Each Commissioner, or Commissioner's designee, shall evaluate policies, programs, statutes, and regulations of his/her respective agency against the standards set forth in the *Olmstead* decision to determine whether any should be revised or modified to improve the availability of community-based services for individuals with disabilities, together with the administrative and/or legislative action and resource allocation that may be required to achieve such results.

3. The Sub-Cabinet shall work together and with the Governor's Office to seek input from consumers, families of consumers, advocacy organizations, service providers, and relevant agency representatives.

4. The Sub-Cabinet shall promptly develop and implement a comprehensive Minnesota *Olmstead* Plan.

This Executive Order shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 28th day of January, 2013.

_____

Mark Dayton
Governor

Filed According to Law:

_____

Mark Ritchie
Secretary of State

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STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON

GOVERNOR

Executive Order 15-03

Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Implementation of Minnesota's Olmstead Plan; Rescinding Executive Order 13-01

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the power invested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, the State of Minnesota is committed to ensuring that inclusive, community-based services are available to individuals with disabilities of all ages;

Whereas, the State of Minnesota recognizes that such services advance the best interests of all Minnesotans by fostering independence, freedom of choice, productivity, and participation in community life of Minnesotans with disabilities;

Whereas, the unnecessary and unjustified segregation of individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by Title II of the American with Disabilities Act of 1990 (the ADA), 42 U.S.C. §§ 12101 *et seq.*, which requires that states and localities administer their programs, services, and activities, in the most integrated setting appropriate to meet the needs of individuals with disabilities;

Whereas, in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the United States Supreme Court interpreted Title II of the ADA to require states to place individuals with disabilities in community settings, rather than institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably

accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities;

Whereas, barriers to affording opportunities within the most integrated setting to persons with disabilities still exist in Minnesota;

Whereas, the Olmstead Sub-Cabinet was created in Executive Order 13-01 to develop and implement a comprehensive Minnesota Olmstead Plan, which received provisional approval from the Court on January 9th, 2015;

Whereas, the Olmstead Implementation Office (OIO) was created as part of the Minnesota Olmstead Plan, to extend authority of the Sub-Cabinet to facilitate the implementation of the Plan, and is integral to the success of realizing the vision of *Olmstead*; and

Whereas, the work of the Olmstead Sub-Cabinet is ongoing, and further authority is needed by the Sub-Cabinet to effectively implement the Minnesota Olmstead Plan to ensure that all Minnesotans have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment, and to participate in community life.

Now, Therefore, I hereby order that:

1. A Sub-Cabinet, appointed by the Governor, consisting of the Commissioner, or Commissioner's designees, of the following State agencies, shall implement Minnesota's Olmstead Plan:

    a) Department of Human Services;

    b) Minnesota Housing Finance Agency;

    c) Department of Employment and Economic Development;

    d) Department of Transportation;

    e) Department of Corrections;

    f) Department of Health;

    g) Department of Human Rights; and

    h) Department of Education.

    The Governor shall designate one of the members of the Sub-Cabinet to serve as chair.

The Ombudsman for the State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities shall be *ex officio* members of the Sub-Cabinet.

The Sub-Cabinet shall allocate such resources as are reasonably necessary, including retention of expert consultant(s), and consult with other entities and State agencies, when appropriate, to carry out its work.

2. The duties of the Sub-Cabinet are:

    a. Provide oversight for and monitor the implementation and modification of the Olmstead Plan, and the impact of the Plan on the lives of people with disabilities.

    b. To provide ongoing recommendations for further modification of the Olmstead Plan.

    c. Ensure interagency coordination of the Olmstead Plan implementation and modification process.

    d. Convene periodic public meetings to engage the public regarding Olmstead Plan implementation and modification.

    e. Engage persons with disabilities and other interested parties in Olmstead Plan implementation and modification and develop tools to keep these individuals aware of the progress on the Plan.

    f. Develop a quality improvement plan that details methods the Sub-Cabinet must use to conduct ongoing quality of life measurement and needs assessments and implement quality improvement structures.

    g. Establish a process to review existing state policies, procedures, laws and funding, and any proposed legislation, to ensure compliance with the Olmstead Plan, and advise state agencies, the legislature, and the Governor's Office on the policy's effect on the plan.

    h. Establish a process to more efficiently and effectively respond to reports from the Court and the Court Monitor.

    i. Convene, as appropriate, workgroups consisting of consumers, families of consumers, advocacy organizations, service providers, and/or governmental entities of all levels that are both members, and non-members, of the Sub-Cabinet.

3. The Sub-Cabinet shall appoint an Executive Director of the Olmstead Implementation Office (OIO), who will report to the Chair of the Sub-Cabinet. The OIO shall carry out

the responsibilities assigned to the Sub-Cabinet, as directed by the Chair of the Sub-Cabinet.

4. The Sub-Cabinet shall adopt procedures to execute its duties, establish a clear decision making process, and to further define and clarify the role of the OIO. The Chair is responsible for the drafting of these procedures, and will present them for review at the first Sub-Cabinet meeting of 2015 and approval at the second Sub-Cabinet meeting of 2015.

This Executive Order is effective fifteen days after publication in the State Register and filing with the Secretary of State, and shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 28th day of January, 2015.

Mark Dayton
Governor

Filed According to Law:

Steve Simon
Secretary of State

Appendix B – Sample Workplan

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Sample Workplan

A sample of a completed workplan is included on the following pages. Each workplan will contain the following items for each strategy:

- **Key Activities** – Each strategy will have several key activities which will be measured. The activities will be selected because progress on these activities is critically important to implementation of a strategy. These activities may include identification of policy barriers, funding needs and communication plans.

- **Narrative Describing Expected Outcomes** – Each activity will have a narrative that describes why the activity is important and what outcomes are expected if the activity is completed.

- **Primary Measure** (Output, Outcome or Deadline) – Each activity will have one or more measurements in this section, such as a number of people served by a particular program or a date by which the activity must be completed.

- **Staff Lead(s) and Roles** – Each activity will have an identified lead person and their agency/department (some activities involved more than one agency may have more than one lead person) and their role(s).

- **Other Agencies, Partners and Roles** – Each activity may identify other agency(ies)/ department(s) or other parties (such as counties or people with disabilities) that will have a particular role in the activity.

- **Status Indicator** (On Track/Completed (Green), Delayed/Caution (Yellow), Corrective Action Needed (Red)) – The status indicator for each activity will be used by the activity lead person when they present their status report to the Olmstead Implementation Office and the subcabinet on a scheduled basis to indicate if the activity is on track or if it has issues that are causing problems or delays.

- **Status Notes** – The status notes will be used along with the status indicator to explain the status of each activity.

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Housing and Services Workplan - DRAFT

Executive Sponsor: Jennifer DeCubellis (DHS) and Ryan Baumtrog (MHFA)

Lead: Erin Sullivan Sutton (DHS) and xxx (MHFA)

Key Activity	Narrative Explaining Expected Outcome	Primary Measure (Output, Outcome or Deadline)	Staff Leads and Roles	Other Agencies, Partners and Roles	Status: • On Track / Completed • Delayed/ Caution • Corrective-Action	Status Notes
1. Create more affordable housing						
a) Fully utilize the new Section 811 Project Rental Assistance (811) funding	In the last two years, DHS and MHFA applied for and received 811 funding for a total of 160 people with disabilities who are exiting a segregated setting or who are at risk of segregation, and who have a signed lease and access to supportive services.	85 eligible households will have permanent affordable housing with 811 funding (10/30/2016) 75 additional eligible households will have permanent affordable housing with 811 funding (6/30/2019)	Vicki Farden, Minnesota Housing (MHFA), Program Manager Heidi Sandberg, Department of Human Services (DHS), Housing Coordinator	DHS – Tenancy Supports Coordination		
b) Fully utilize the re-allocated Regional Treatment Center (RTC) funding and the increased Bridges Rental Assistance base funding	MHFA re-allocated funds from the RTC to the Bridges rental assistance program, and the 2015 Legislature allocated additional funding for the Bridges program. Bridges supports the cost of housing for people with disabilities who are exiting a segregated setting or who are at risk of segregation, and who have a signed lease and access to supportive services.	Increase the number of eligible households who will have affordable, integrated housing under the Bridges program over the SFY14 baseline of 713: * SFY15: Increase by 35 * SFY16: Increase by 107 * SFY17: Increase by 173 * SFY18: Increase by 172 * SFY19: Increase by 134	Carrie Marsh (MHFA), Program Manager Gary Travis (DHS), Mental Health Housing Coordinator	DHS – Mental Health and Tenancy Supports Coordination		

Housing and Services Workplan - DRAFT
Executive Sponsor: Jennifer DeCubellis (DHS) and Ryan Baumtrog (MHFA)
Lead: Erin Sullivan Sutton (DHS) and xxx (MHFA)

Key Activity	Narrative Explaining Expected Outcome	Primary Measure (Output, Outcome or Deadline)	Staff Leads and Roles	Other Agencies, Partners and Roles	Status: • On Track / Completed • Delayed/ Caution • Corrective-Action	Status Notes
c) Measure and increase housing stability for people who move to more integrated settings using the new Bridges Rental Assistance funding	Affordable housing and supportive services will increase housing stability.	Increase the percent of people using the new Bridges rental assistance funding in affordable, integrated housing who stay in their housing for at least six months: * SFY15: 70% * SFY16: 70% * SFY17: 75% * SFY18: 75% * SFY19: 80%	Julia Welle Ayres (DHS), Project Manager Carrie Marsh (MHFA), Program Manager Gary Travis (DHS), Mental Health Housing Coordinator			
2. Improve the ability to capture information about housing choices						
a) Implement a process to capture and measure choices made by people with disabilities regarding housing.	At this time, it is not known how many people living in potentially segregated settings would choose or not oppose living in an integrated settings.	Implement through the Transition Protocols. See the Transition Section.	Alex Bartolic (DHS), Division Director			
b) Once a process for capturing and measuring choice is in place, analyze the data and report annually to the subcabinet on progress in meeting goals.	As people who choose or are not opposed to living in integrated settings are identified and supported to move, this number will decrease.	Implement through the Transition Protocols. See the Transition Section.	Alex Bartolic (DHS), Division Director			
3. Implement reform for housing assistance programs						

a) Implement housing policy changes adopted in 2015 legislative session.	Policy changes will promote choice and access to integrated settings by reforming programs that currently provide combined housing and supports to allow greater flexibility: * Give people more control regarding the county in which they prefer to live * Remove barriers to working * Separate the service payment from the housing payment so that people can choose providers In SFY14, approximately 29,400 people received GRH.	Implement new policies: * July 1, 2015: Issue Bulletin and new Forms ; complete statewide webinar and in-person trainings for counties, tribes and providers; establish process for responding to and publishing providers' frequently asked questions * January 30, 2016: Release GRH Orientation training * July 1, 2016: Add GRH Supplemental Services into DHS's Health Care Provider Manual, and complete trainings for counties and service providers in using DHS's service billing system. * July 1, 2016: Issue Bulletin and complete trainings for counties, tribes and providers in new work incentives. * December 30, 2016: All systems changes complete. Increase the number of people who will have affordable, integrated housing using GRH over the SFY14 baseline of 4,533: * SFY15: Increase by 474 * SFY16: Increase by 1,168 * SFY17: Increase by 1,874 * SFY18: Increase by 2,796 * SFY19: Increase by 3,817	Julia Welle Ayres (DHS), Project Manager Kristine Davis (DHS), GRH Lead			
4. Improve Future Models for Housing in the Community						

a) Increase access to information about integrated housing for persons with disabilities through outreach, technical assistance and improved technology solutions for accessing affordable housing.	There are currently people with disabilities who are eligible for supports to pay for the cost of housing, but who are not receiving them. MHFA contracted with HousingLink, a web-based tool to locate affordable rental housing openings, to * promote and increase access to HousingLink services in the disability community, and * add features that are most relevant to people with disabilities. DHS contracted with the World Institute on Disabilities to develop the Housing Benefits 101 website (mn.HB101.org) to makes housing information more accessible. Each Continuum of Care (CoC) will identify one "coordinated entry" point so that anyone wanting to access housing and supports designated for people experiencing homelessness knows where to go and only has to go to that one place to be served.	Market MSA to county financial workers (12/31/16), and increase the number of people who will have affordable, integrated housing using MSA Housing Assistance over the SFY14 baseline of 711: * SFY15: Increase by 108 * SFY16: Increase by 230 * SFY17: Increase by 496 * SFY18: Increase by 916 * SFY19: Increase by 1,436 Market new GRH policy changes that increase choice and access to contract managers and providers (6/30/2016) Launch new HousingLink website and fully market to the disability community (9/30/15) Promote and train providers, counties and tribes on HB101 (6/30/16) Develop the housing planning tool on HB101 to help people with disabilities explore their options (6/30/16) Each CoC will implement an initial Coordinated Entry system (10/30/2015)	Joel Salzer (MHFA), Manager Julia Welle Ayres (DHS), Project Manager Kristine Davis (DHS), GRH Lead Beth Grube (DHS), MSA and HB101 Lead Ji-Young Choi (MHFA), Housing Specialist Pat Leary (DHS), Housing	CoCs Minnesota Interagency Council on Homelessness		

Housing and Services Workplan - DRAFT

Executive Sponsor: Jennifer DeCubellis (DHS) and Ryan Baumtrog (MHFA)

Lead: Erin Sullivan Sutton (DHS) and xxx (MHFA)

Key Activity	Narrative Explaining Expected Outcome	Primary Measure (Output, Outcome or Deadline)	Staff Leads and Roles	Other Agencies, Partners and Roles	Status: • On Track / Completed • Delayed/ Caution • Corrective-Action	Status Notes
b) Actively promote and encourage counties, tribes and other providers to implement best practices and person-centered strategies related to housing.	Support communities in discovering, sharing and implementing successful practices in individualizing the process of helping a person access and maintain housing.	Implement Transition Protocols and Person-Centered Planning. See Transition Section and Person-Centered Planning Section. Continue to host statewide bimonthly Housing Options Best Practices Forums.	Alex Bartolic (DHS), Division Director Julia Welle Ayres (DHS), Project Manager			
c) Develop policy recommendations and strategies to access Medicaid coverage for housing related activities and services for individuals with disabilities.	The Centers for Medicaid and Medicare Services released guidance in June 2015 on using Medicaid funding for housing-related services for people with disabilities.	Preliminary recommendations proposed to DHS leadership (12/31/15)	Don Allen (DHS) Kristine Davis (DHS)			
d) Identify and assess barriers for individuals to obtain and maintain housing, and provide recommendations to the sub-cabinet of strategies to address policy and funding barriers.	As the state deploys strategies to help people move to more integrated housing, new barriers will emerge that need to be addressed.	Report policy and funding barriers to the subcabinet at the end of each fiscal year.				

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Appendix C – Index of Documents Related to Olmstead Plan Implementation

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Alphabetical Index of Documents Related to Olmstead Plan Implementation

Below is an alphabetical listing of reports and documents referenced in the August 2015 Olmstead Plan. The reports were either required by the Olmstead Plan or related to and utilized in the development of the August 2015 Plan.

Appendix C contains a compilation of these reports and is available on the Olmstead website. The list below provides information on each report including the page number where the report is referenced within the August 2015 Plan and the page number the report can be found in Appendix C.

Title of Report/Document	Plan page	Plan Topic Area	Author*	Date	Appendix C page #
ADA Transition Plan	64	Transportation	MnDOT	January 2015	5
A Demographic Analysis, Segregated Settings Counts, Targets and Timelines Report	44, 49	Housing Services, Employment	DHS	September 2014	75
A Report on Districts' Progress in Reducing the Use of Restrictive Procedures in Minnesota Schools	76	Positive Supports	MDE	February 2015	119
Crisis Prevention/Intervention Training Programs	76	Positive Supports, Crisis Services	MDE	June 2015	193
Crisis Triage and Handoff Process	82	Positive Supports, Crisis Services	DHS	February 2015	199
Delivery System for Oral Health	71, 72	Healthcare & Healthy Living	DHS	February 2015	223
Greater Minnesota Transit Investment Plan	66	Transportation	MnDOT	January 2011	237
Health Care and Community Supports Administrations Overview of Behavioral Health Homes	71	Healthcare & Healthy Living	DHS	January 2015	299
Home and Community-Based Supports and Services Waiver Waiting List Report	59	Waiting List	DHS	March 2015	325
Minnesota Employment First Policy	49	Employment	Olmstead SC	September 2015	345
Minnesota Oral Health Plan	73		MDH	January 2013	349
Minnesota Transit Funding Primer Technical Report	64	Transportation	MCOTA	January 2015	405
Minnesota's Olmstead Plan Quality of Life Survey Pilot Study	35, 96	Person Centered Planning, Quality Assurance	Improve Group	December 2015	415
Olmstead Benchmark Report (Barriers in Transitioning Youth to Adult Health Care)	71	Healthcare & Healthy Living	MDH	October 2014	493

Title of Report/Document	Plan page	Plan Topic Area	Author*	Date	Appendix C page #
Olmstead Community Engagement Plan	88	Community Engagement	OIO	March 2015	503
Olmstead Dispute Resolution Process Work Plan	97	Quality Assurance	OIO	February 2015	535
Olmstead Plan Baseline Data for Current Care	71, 72	Healthcare & Healthy Living	DHS	January 2015	541
Olmstead Plan: Work and Benefits Family Outreach Plan		Employment	DHS, DEED, MDE	July 2014	595
Olmstead Transportation Forum Final Report	64	Transportation	DHS, MnDOT	June 2014	615
Positive Support Transition Plan Instructions	79	Positive Supports	DHS		711
Postsecondary Resource Guide – Successfully Preparing Students with Disabilities	55, 57	Lifelong Learning & Education	MDE, MnSCU	2014	731
Recommendations for Improving Oral Health Services Delivery System- February 2014	71	Healthcare & Healthy Living	DHS	February 2014	775
Report on Program Waiting Lists	59	Waiting List	DHS	December 2014	853
Statewide Plan for Building Effective Systems for Implementing Positive Practices and Supports	76, 79	Positive Supports	DHS, MDE	October 2014	869
The Status of Oral Health in Minnesota	71	Healthcare & Healthy Living	MDH	September 2013	955

* Authors

DEED	Department of Employment and Economic Development
DHS	Department of Human Services
MCOTA	Minnesota Council on Transportation Access
MDE	Department of Education
MDH	Minnesota Department of Health
MnDOT	Minnesota Department of Transportation
MnSCU	Minnesota State Colleges and Universities
OIO	Olmstead Implementation Office